

Forensic Mental Health Services Oversight Committee
(Public Law 2013, Chapter 434, Section 12)
Meeting December 20, Room 436 State House, 10am to 3pm
AGENDA

1. Welcome

Senate Chair, Senator Stan Gerzofsky and House Chair, Representative Drew Gattine

2. Discussion of tours of Riverview Psychiatric Center and the mental health unit at the Maine State Prison held on December 3, 2013

3. Public Law 2013, chapter 434, section 12 (Duties of the oversight committee)

Representatives of Department of Corrections and Department of Health and Human Services invited

A. Memoranda of understanding between DOC and DHHS

B. Addition of staff and training of staff at Maine State Prison

C. Regarding the mental health unit, decision-making authority on admission, release and transfer, eligibility standards, due process safeguards for placement and treatment.

D. Impact on resources and population at Riverview Psychiatric Center

4. Public perspectives on forensic mental health services and Public Law 2013, Chapter 434

Briefings, 15 minutes each: Representatives of the Disability Rights Center, Maine Civil Liberties Union, Consumer Council System of Maine, NAMI Maine and Maine Association of Criminal Defense Lawyers invited

5. Information requests and planning for final meeting of FMHSOC

Final Meeting Date for the Forensic Mental Health Services Oversight Committee, 10am to 3pm, January 7, 2014, Room 436, State House

Legal context

This memorandum serves as a request to the Department of Health and Human Services (DHHS) and the Department of Corrections (DOC) for information and materials to enable the Forensic Mental Health Services Oversight Committee (FMHSOC) to perform its duties, as set forth in Public Law 2013, Chapter 434, Section 12. The provision of information and materials by the Department of Corrections, Department of Health and Human Services, State Board of Corrections, the judicial branch and the Office of the Attorney General is required by Public Law 2013, Chapter 434, Section 12, Subsection 4.

FMHSOC duties; oversight

This request for information is structured to follow the duties of the FMHSOC to review and consider for the purposes of making recommendations to the Legislature on issues A through F and to oversee the implementation of Public Law 2013, Chapter 434.

- A. Any memorandum of understanding executed between the Department of Corrections and the Department of Health and Human Services for the purposes of implementation;
- B. The addition of new staff and training of staff at the Maine State Prison;
- C. Decision-making authority related to admissions, release and transfer to and from the Intensive mental health unit;
- D. Eligibility standards;
- E. Due process safeguards for placement and treatment decisions; and
- F. Impact on resources and population of Riverview Psychiatric Center and county jails.

Requests for information and materials:

A. Any memorandum of understanding executed between the Department of Corrections and the Department of Health and Human Services for the purposes of implementation. Request to DHHS and DOC.

- 1. Please provide copies of the most recent drafts of memoranda of understanding between DOC and DHHS.
- 2. Please provide information regarding the status of all memoranda of understanding, whether they are in final form and when they will be executed.

B. The addition of new staff and training of staff at the Maine State Prison (MSP). Request to DOC.

- 1. How will new staff be hired and trained? Please provide an update on new staff and training at MSP.
- 2. Please provide a timeline for hiring new staff and for providing training to new and current staff.
- 3. With regard to the state employee Correctional Care and Treatment Workers who will staff the intensive mental health unit at MSP please provide information on the training that they will receive in behavioral health, techniques to anticipate and de-escalate

behavioral health care crises and management of behavioral health crises.

4. With regard to the state employee Correctional Officers who will staff the intensive mental health unit at MSP please provide information on the training that they will receive in behavioral health, techniques to anticipate and de-escalate behavioral health crises and management of behavioral health crises.

5. With regard to the personnel employed by CCS who will staff the intensive mental health unit at MSP please provide information on the training that they will receive in behavioral health, techniques to anticipate and de-escalate behavioral health crises and management of behavioral health crises.

6. What are the staffing needs at the intensive mental health unit related to the expansion? What is the "delta" between the current staffing and the new staffing? What is the cost differential between the current staffing in the current mental health unit and the expanded unit? In addition to the staff provided by the vendor are there additional state staff that will need to be utilized to manage the expanded intensive mental health unit?

C. Decision-making authority related to admissions, release and transfer to and from the Intensive mental health unit at MSP. Request to DOC and DHHS.

1. Section A.1 of the draft MOA provided last week states that the RPC Superintendent can refer a defendant to the intensive mental health unit if it is determined that there is no bed available at RPC and if the Superintendent determines that the person is "appropriate for referral" to the intensive mental health unit. What are the criteria for determination of whether a person is appropriate for referral? Are there clinical criteria?

2. Please provide information and copies of any written materials being considered by DOC or DHHS related to decision-making authority related to admissions, release and transfer to and from the intensive mental health unit at MSP. Is the November 25th draft regarding placement and transfer of prisoners the most recent draft?

3. If DOC or DHHS has consulted with any other state or state agencies or other hospitals or prisons regarding decision-making authority for admissions, release and transfer to and from the intensive mental health unit at MSP, please describe the consultation and the results of the consultation and provide copies of any written materials obtained during the consultation.

4. Please provide a timeline for the development of memoranda of agreement, protocols or standards for decision-making authority related to admissions, release and transfer to and from the intensive mental health unit at MSP, including as the other facility Riverview Psychiatric Center and the county jails and other correctional facilities.

5. How will decisions be made regarding admitting and releasing prisoners and defendants to and from the intensive mental health unit?

6. What are the eligibility standards for admission to the intensive mental health unit? Are there clinical criteria as well as criteria related to "legal status"?

D. Eligibility standards.

1. Please provide information and copies of any written materials being considered by DOC or DHHS regarding eligibility standards for the intensive mental health unit at MSP. Is the November 25th draft regarding prisoners under guardianship the most recent draft?

2. If DOC or DHHS has consulted with any other state or state agency or other hospitals or prisons regarding eligibility standards for the intensive mental health unit at MSP, please describe the consultation and the results of the consultation and provide copies of any written materials obtained during the consultation.

3. Please provide a timeline for the development of memoranda of agreement, protocols or standards for eligibility standards for the intensive mental health unit at MSP.

4. Notwithstanding the limitations in the number beds in the current or expanded intensive mental health unit, what is the current estimate of DOC and DHHS of the number of persons who would be eligible for placement at the intensive mental health unit under each of the criteria described in the statute:

- Section 3069-A(1). An adult inmate transferred from a jail, eligible for admission to RPC, but for whom no Riverview bed is available
- Section 3069-A(2). An adult inmate transferred from a jail for evaluation
- Section 3069-B. A defendant transferred from RPC pursuant to court order

5. How will the DOC and DHHS prioritize the placement of inmates or defendants in the prison unit if there are more persons eligible for placement than available beds?

E. Due process safeguards for placement and treatment decisions.

1. What due process safeguards will be in place related to placement and treatment decisions? What access will advocates have to prisoners and defendants in the prison unit?

2. Please provide information and copies of any written materials being considered by DOC or DHHS regarding due process safeguards for placement and treatment decisions for the intensive mental health unit at MSP.

3. If DOC or DHHS has consulted with other state or other hospitals or prisons regarding due process safeguards for placement and treatment decisions for, please describe the consultation and the results of the consultation and provide copies of any written materials obtained during the consultation.

4. Please provide a timeline for the development of memoranda of agreement, protocols

or standards for due process safeguards for placement and treatment decisions for the intensive mental health unit at MSP.

F. Impact on resources and population of Riverview Psychiatric Center and county jails.

1. Please provide information and copies of any written materials developed to date on the impact of the intensive mental health unit at MSP on RPC and the county jails.
2. What will be the impact of Public Law 2013, Chapter 434 on staffing resources and funding at Riverview and the county jails?
3. Where do the DOC and DHHS anticipate the biggest impact of Public Law 2013, Chapter 434 will be?
4. Has Public Law 2013, Chapter 434 increased or decreased the flexibility of RPC in terms of transfer and treatment options available to these patients?
5. Prior to Public Law 2013, Chapter 434 was MSP able to take in patients from RPC who have been determined to be not criminally responsible or incompetent to stand trial?

G. Oversight; funding

1. Our understanding is that the DOC is already operating a 21-bed forensic intensive mental health unit and that Chapter 434 allows and funds an expansion of that existing unit from 21 to 32 beds. Is the funding from Chapter 434 covering the cost of the entire unit or just the incremental expansion from 21 to 32 beds.
2. Describe the clinical services currently being provided in the mental health unit and any differences from a clinical services perspective that will occur after the expansion.
3. What are the historical costs of operating the current mental health unit over the past three fiscal years?
4. What does the DOC anticipate the cost will be of operating the intensive mental health unit in subsequent fiscal years?
5. Is all of the funding that the legislature provided being paid to the vendor or are there costs to either DOC or DHHS being covered by the appropriation? If there are costs not covered by the appropriation please detail them and provide the amount and source of the funding.
6. Describe the clinical and/or quality standards that are utilized to determine whether the mental health services are effective.
7. Please provide any documentation, communication or correspondence from CMS to DHHS indicating that the existence or expansion of the MSP intensive mental health unit is a consideration or factor in the decision by CMS to continue to provide funding to RPC.

MEMORANDUM OF AGREEMENT

Between

Maine Department of Corrections

and

Maine Department of Health and Human Services
for the Placement and Transfer of Prisoners into the
Department of Corrections Intensive Mental Health Unit

DRAFT 11/25/2013

This Memorandum of Agreement ("MOA") is entered into this xx day of XXXX, 20xx by and between signatories Maine Department of Health and Human Services ("DHHS") and Maine Department of Corrections ("DOC").

RECITALS

WHEREAS, DHHS and DOC recognize the mutual benefit of utilizing the Department of Corrections Intensive Mental Health Unit for eligible prisoners who would otherwise be the responsibility of a jail or state mental health institute;

NOW THEREFORE, in consideration of these mutual covenants -as to the procedures and scope of responsibilities for each party regarding the placement and transfer of such prisoners into the DOC Intensive Mental Health Unit;

A. DHHS agrees:

1. For an adult male prisoner referred by a jail to a state mental health institute for possible civil commitment, the Superintendent of the Riverview Psychiatric Center shall evaluate the eligibility of the prisoner for admission to a state mental health institute under Title 34-B, section 3863, and the availability of a suitable bed at the Center. If the Superintendent confirms the prisoner is eligible for admission and that no suitable bed is available, but that the prisoner is appropriate for referral to the Maine State Prison's Intensive Mental Health Unit, the Superintendent may refer the prisoner to the DOC Director of Treatment, or designee, for a determination whether to accept the prisoner for transfer to the Maine State Prison's Intensive Mental Health Unit;
2. For an adult male prisoner referred by the State Forensic Service for transfer from a jail in order to conduct an examination under Title 15, section 101-D, subsection 1, 2, 3, or 9, because the jail cannot provide an appropriate setting for the examination, but the Intensive Mental Health Unit can, the Superintendent of the Riverview Psychiatric Center may refer the prisoner, on behalf of the State Forensic Service, to the DOC's Director of Treatment, or designee, for a determination whether to accept the prisoner for transfer to the Maine State Prison's Intensive Mental Health Unit;

3. For an adult male prisoner committed by a court to the custody of DHHS for observation under Title 15, section 101-D, subsection 4, and with respect to whom the court has found the prisoner has a mental illness as a result of which the prisoner poses a likelihood of serious harm to others; there is not sufficient security at a state mental health institute to address the likelihood of serious harm; and there is no other less restrictive alternative to placement in a prison mental health unit, the Superintendent may refer the prisoner to the DOC's Director of Treatment, or designee, for a determination whether to accept the prisoner for placement into the Maine State Prison's Intensive Mental Health Unit;
4. The Superintendent may not refer any person who is currently the subject of a court finding of incompetent to stand trial or not criminally responsible by reason of insanity;
5. Upon referral, the Superintendent shall provide whatever supporting documentation is requested by the DOC Director of Treatment, or designee;
6. DHHS shall immediately accept the return of any prisoner placed in the Intensive Mental Health Unit for observation pursuant to 3. above whose placement has been terminated by DOC;
7. DHHS shall provide consultation services as needed related to the treatment of any male prisoner placed in or admitted to the Intensive Mental Health Unit, regardless of whether the prisoner was transferred to or placed in the unit pursuant to this Memorandum of Agreement; and
8. When the DOC is proposing to obtaining a court order for involuntary medication of any male prisoner placed in or admitted to the Intensive Mental Health Unit, DHHS shall make available a professional qualified to prescribe the medication to provide a second clinical opinion as to whether the recommendation for the medication is supported and, if necessary, to testify at the involuntary medication proceedings, regardless of whether the prisoner was transferred to or placed in the unit pursuant to this Memorandum of Agreement.

B. DOC agrees:

1. DOC shall determine whether to accept a prisoner within a maximum of 10 days from the referral from DHHS and the provision of any requested documentation;
2. DOC shall provide all transportation for any prisoner who has been accepted;
3. DOC shall provide all care, custody, and treatment of a prisoner who has been accepted into the Intensive Mental Health Unit until the prisoner's

return to the jail has been ordered by DOC or the prisoner's placement from DHHS has been terminated; and

4. DOC shall inform the jail it must immediately accept the return of any prisoner transferred to the Intensive Mental Health Unit for treatment or examination pursuant to A.1. or 2. above whose return has been ordered by DOC.

C. Both Parties agree that:

1. The DOC Commissioner, or designee, has the discretion to either approve or deny any request for the transfer or placement of a prisoner into the DOC Intensive Mental Health Unit and to order the return of a prisoner to a jail or terminate a prisoner's placement from DHHS at any time;
2. This MOA may be amended at any time by mutual agreement of the parties, provided that, for any amendment to be operative or valid it shall be reduced to writing and signed by both parties; and
3. This Agreement shall be construed, governed, and interpreted under the laws of the State of Maine, and if any provisions of this Agreement or parts thereof are held to be invalid under such laws, the other such provisions or parts thereof will nevertheless continue in full force and effect.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement as of the day, month and year first written above.

MAINE DEPARTMENT OF CORRECTIONS

By: _____

Signature

Name:

Title:

Mailing Address:

_____ Date

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

By: _____

Signature:

Name:

Title:

Mailing Address:

_____ Date

MEMORANDUM OF AGREEMENT
between
Maine Department of Corrections
and
Maine Department of Health and Human Services
for the Placement of Prisoners under Guardianship
DRAFT 11/25/2013

This Memorandum of Agreement ("MOA") is entered into this xx day of XXXX, 20xx by and between signatories Maine Department of Health and Human Services ("DHHS") and Maine Department of Corrections ("DOC").

RECITALS

WHEREAS, DHHS and DOC recognize the need, at times, for the appointment of DHHS guardians to make medication decisions for prisoners in the custody of DOC;

NOW, THEREFORE, in consideration of these mutual covenants as to the procedures and scope of responsibilities for each party regarding guardianship of prisoners in the DOC Intensive Mental Health Unit;

A. DHHS agrees:

1. For a male prisoner placed in or admitted to the Maine State Prison's Intensive Mental Health Unit, DHHS shall, upon referral from DOC, expedite the process of assessing the appropriateness of guardianship for the purpose of making medication decisions;
2. DHHS shall initiate an on-site guardianship evaluation within a maximum of 10 days from the referral from DOC;
3. As part of the evaluation, DHHS shall engage in a face to face discussion with the Intensive Mental Health Unit Treatment Team;
4. DHHS shall complete the evaluation and present it to the Intensive Mental Health Unit Treatment Team within 30 days;
5. DHHS shall participate in a case conference with members of the Intensive Mental Health Unit Treatment Team to deliver the evaluation findings;
6. If it is determined that the prisoner is appropriate for guardianship, DHHS shall expedite the application to the court for the appointment of a guardian, initially using the process for the court appointment of an emergency guardian, to be followed by timely application for the appointment of a permanent guardian; and

7. DHHS shall apply for the emergency guardianship within a maximum of 10 days from the determination that guardianship is appropriate

B. DOC agrees:

1. DOC shall make the prisoner, Intensive Mental Health Unit Treatment Team members, and prisoner/patient records available to DHHS;
2. DOC shall provide DHHS the appropriate, secure, confidential meeting space and office space to conduct and complete the evaluation; and
3. If it is determined the prisoner is appropriate for guardianship, DOC shall make the Intensive Mental Health Unit Treatment Team members available to provide witness testimony as needed for the emergency and permanent guardianship proceedings.

C. Both Parties agree that :

1. This MOA may be amended at any time by mutual agreement of the parties, provided that for any amendment to be operative or valid, it shall be reduced to writing and signed by both parties; and
2. This Agreement shall be construed, governed, and interpreted under the laws of the State of Maine, and if any provisions of this Agreement or parts thereof are held to be invalid under such laws, the other such provisions or parts thereof will nevertheless continue in full force and effect.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement as of the day, month and year first written above.

MAINE DEPARTMENT OF CORRECTIONS

By: _____ Date _____
Signature
Name:
Title:
Mailing Address:

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

By: _____ Date _____
Signature:
Name:
Title:
Mailing Address:



State of Maine Department of Corrections

**Maine State Prison
Forensic Unit Proposal**

October 25, 2013

October 25, 2013

To: Commissioner Ponte, Associate Commissioners Breton and Dr. Fitzpatrick

RE: Maine Department of Corrections — MSP Forensic Unit Proposal

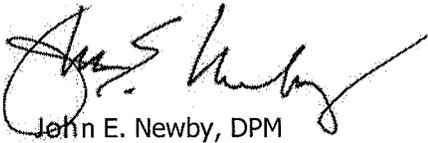
Dear Commissioner Ponte,

Per your request, the previously submitted proposal has been amended to include, adjustment of language in job description, the suggested comparison of location for the unit as well as a hypothetical daily schedule / workflow for staff.

Detailed in this proposal we have identified the best model for treatment services which we believe will offer the greatest levels of success for this unit. Additionally contained within this proposal are the associated pricing for conducting services with details listed separately of projected startup cost and amended shared risk model.

We appreciate the opportunity to submit this proposal for the provision of staffing and mental health treatment services at Maine State Prison Forensic Unit. If you have any additional questions and or concerns, please do not hesitate to contact us directly.

Respectfully Submitted,



John E. Newby, DPM

Regional Vice President, CCS

S^{#412}

Robyn Hodges, PsyD

Regional Mental Health Director, CCS

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Status Report from Forensic Unit Subcommittee

October 25, 2013

Subcommittee Members: Robyn Hodges, Psy.D., Dan Bannish, Psy.D., Charlene Donovan, Ph.D., Larry Reccoppa, MD, Dean Rieger, MD, John Newby, DPM

Focus of 10-15-13 Status Report:

- Update full committee on information gathered from other states operating forensic units both in hospital settings and in correctional settings
- Propose staffing plan for MSP Unit
- Propose curriculum plan for MSP Unit

I. Information From Other States

Mental Health Providers in several states were contacted in order to gain information about similar forensic mental health units located in state hospital or state correctional settings. Contacts were asked about the overall approach to unit management, unit staffing and curriculum utilized for various client populations placed in these units. The following states were contacted and provided at least some of the requested information:

- | | |
|---------------|---------------|
| Connecticut | Missouri |
| Massachusetts | Ohio |
| Rhode Island | Kansas |
| Florida | West Virginia |
| Georgia | Delaware |
| Colorado | |

**awaiting information from South Dakota and New Hampshire

Some similar themes emerged in the areas of staffing and range of programming hours, with units offering full days of programming facilitated by various staff members and inclusive of programming across evenings and weekends. A relatively intensive utilization of nursing staff was also noted, particularly in the units located in hospital settings. Most hospital based units engaged in notable amounts of psychological assessments, with less emphasis on such assessments found in correctional based units.

II. Proposed Staffing Plan for MSP Unit

The staffing plan proposed below was developed based on information gathered from other states with similar forensic mental health units, as well as our understanding at this point in the development of the structure of the unit in terms of client populations that will be served. The following assumptions were made:

- a. The unit will function at or near capacity for the 32 beds.
- b. The population will likely be composed of at least three groups of patients:
 - i. An acutely ill group that stabilizes over time and returns to Riverview, a referring county jail, or the DOC general population or DOC identified step down unit.
 - ii. An acutely ill group that stabilizes over time but to a level of functioning that suggests a clinical need to remain on the MSP Unit for a lengthy period of time (the length of a DOC sentence, or while a criminal case works its way through the court system, etc.).
 - iii. A group of patients awaiting competency evaluations, although at this time it is not possible to estimate the level of acuity of this population, it may prove highly variable.
- c. Programming needs for these different populations will be different and require different approaches by various staff members. We anticipate:

Acute Stabilization Phase - acute psychiatric symptoms and serious impairments of functioning (typically 7-10 days). This phase will involve Medical and Psychiatric assessment, diagnosis and medication administration. If psychotropic medication is offered but refused by the patient across time, involuntary medication procedures may be indicated. Conversely, if level of psychiatric need is low the patient can be returned to the sending facility.

- ii. Baseline Phase — Once medically and psychiatrically stable the goal will be returning the offender to a level of functioning consistent with that prior to the most the recent exacerbation of symptoms (7-14 days beyond transition from acute phase). If baseline level of functioning is adequate to manage in general population setting, the patient can be returned to the sending facility. If not adequate to manage in a general population setting the patient is moved to the next phase.
- iii. Treatment Phase - Skill based treatment with the goal of expanding ability to function in the community or population. This will involve understanding of symptoms as it relates to medication compliance and management of problematic behavior. Some patients may

progress to population and other lower functioning patients will remain on the unit until their cases are adjudicated or sentences are completed.

- d. Programming will be conducted during day shifts and partially through evening shifts 7 days a week.
- e. Sufficient security staffing is necessary in order to ensure unit safety, and that patients are available and monitored during programming activities.
- f. Onboarding and orientation will be needed for clinical and security staff. CCS would like to offer onboarding and orientation starting 2/1/14 in preparation for the unit opening on 2/15/14.
- g. Recruitment for the unit will be successful. (If recruitment is not successful, the unit cannot fully open.)

Keeping these assumptions in mind as well as the information gathered from similar unit in other states, the subcommittee offers this staffing proposal:

Program Administrator -1.0

[Qualifications: RN, Master's Degree in Psychology, Business Administration, Education, Leadership or other similar areas]

- Management of overall program
- Manage schedules for nursing staff, clinicians and physicians
- Liaison between CCS, DOC and DHHS
- Coordinate admissions and discharges
- Ensure policies and procedures are followed
- Implementation and maintenance of CQI Program

Psychiatrist- 1.0

[Qualifications: MD, DO]

- Medication management
- Evaluation and treatment in a timely manner
- Coordination of the involuntary medication protocol and representing DOC/CCS in involuntary medication hearings
- Participate in medical treatment review committees
- Participate in CQI Program

- Active participant in treatment team

Psychologist 1.0

[Qualifications: Doctorate level in psychology]

- Clinical Team Leader to oversee program delivered to patients
- Develop and implement goals and objectives for clinical services
- Supervision of other clinical staff
- Management of more challenging presentations
- Diagnostic clarification and administration of psychological assessments
- Participate in CQI Program

Master's Level Providers- 2.4

[Qualifications: Master's degree in Counseling, Social Work or Psychology]

- Primary clinician assigned to patients
- Provide individual and group therapy
- Conduct intake assessments
- Provide crisis management services
- Design and implement treatment plans
- Gather psychosocial information from the community
- Active participant in treatment team
- Participate in CQI Program

Bachelor's Level Mental Health Technicians- 4.2

[Qualifications: Bachelor's degree in Psychology, Recreation Therapy or similar areas of study]

- Facilitate recreational/activity therapy (both in-cell and out of cell programming)
- Provide psychoeducational groups
- Lead structured leisure activities
- Assist in the enhancement of quality of life for the patients

The request for 4.2 MH Techs is generated by a programming need for 2 MH Techs on day shift/7 days per week, and 1 MH Tech on evening shift/7 days per week. These team members will provide the significant majority of programming activities and will ensure a meaningful programming schedule occurs on a daily basis. As noted above, it is common practice to offer programming 7 days per week across day and evening shift in similar units in other states. The

activities provided by these team members will provide opportunities for patients to practice what is learned in treatment groups.

RN's- 5.6

[Qualifications: Registered Nurse in the state of Maine]

- Management of day-to-day medical needs including sick calls
- Facilitate medication pass daily
- Conduct daily rounds on both unit
- Active participant in the treatment team
- Provide psychoeducation groups regarding medical issues
- Assist in the delivery of an integrated care approach
- Participate in the CQI Program
- Administer involuntary medications as needed

The request for 5.6 nurses allows for 2 RN's on day shift (8 hours) 7 days per week and 1 RN on both evening and night shift 7 days per week. Having an RN 24/7 is a consistent practice in other states.

Medical Doctor- 0.2

[Qualifications: MD or DO]

- Provide comprehensive intakes for new patients
- Prescribe a planned regimen of total patient care
- Provide emergency treatment on site
- Assist in providing an integrated care approach
- Participate in the CQI Program

The proposed physician staffing is predicated on receiving assistance from the existing medical department should there be a high maintenance patient or an influx of patients. The addition of these hours is meant to complement our current program rather than to have an isolated physician for the unit.

Mental Health Administrative Assistant-

1.0 [Qualifications: High school diploma or GED]

- Obtain and provide necessary information based on Release of Information (ROI)

- Maintain and report unit statistics
- Record meeting minutes
- Conduct periodic health record audit under the direction of Program Administrator and/or Psychologist to ensure documentation is entered into the health record in a timely manner
- Manage administrative tasks related to the Mental Health Team

Correctional Officers- 2 per unit per shift

In order to ensure the safety of patients and staff on the unit with the acuity level expected it is strongly recommended 2 officers to be on each unit each shift. Appropriate levels of Correctional Officer staffing will ensure that clients are made available for treatment programming that occurs out of cell, and will also be available to provide necessary monitoring for these activities. As it is assumed that patients will present with an acute level of symptoms that prevents programming participation out of cell for at least some periods, Correctional Officer staff will be necessary to ensure that in-cell programming efforts are also appropriately monitored. This will decrease the risk of incidents of assaults and will enable the vulnerable clinical population to feel their environment is safe and enable them to fully partake in out of cell activities. On occasion, as is in the same case as the physician, assistance may be required from the general body of correctional officers at MSP.

III. Treatment Model and Curriculum

The proposed evidenced based curriculum programs will be infused into an overarching treatment philosophy based on Social Learning model. The members of the subcommittee tasked with review of other programs were particularly impressed with the Social Learning Program (SLP) in place in other settings, and the flexibility it allows for other curricula to be utilized along with SLP. SLP is a highly effective approach to improving the level of functioning for chronically institutionalized mentally ill patients. As an example of utilization in one system, we have included the Mission statement for a unit within a state hospital:

"The mission of the Social Learning Programs at X State Hospital is to provide comprehensive psychosocial rehabilitation and recovery-oriented services. The purpose of the program is to teach and support adults with severe and persistent mental illness overcome difficulties and facilitate the process of recovery. Measurable outcomes of the program's mission and purpose include the ability to safely live and function in a less restrictive setting, reliable performance of activities of daily living, improved social and occupational functioning, and a higher perceived quality of life while respecting a client's autonomy and self-determination. A Social Learning Program is a highly structured, milieu-based, inpatient approach to rehabilitation for individuals with the most severe problem behaviors and skills deficits. It consists of a comprehensive integrated network of skills training techniques and supports based on learning theory, individually tailored to client needs. A premium is placed on staff

training and competency assessment. The Social Learning Program can also incorporate most evidence-based individual and group interventions to meet the individual needs and functioning of program residents."

This approach appears to dovetail with the mission of the current program, and has flexibility to allow various levels of presenting symptomatology, as is expected in the MSP Unit. SLP also provides the flexibility to continue current programs that have shown success in the Mental Health Unit currently active at MSP, such as the Level System and the Incentive-Based Points Program. The Level System dictates the level of restraint and supervision necessary to safely manage patients outside of the cell; items allowed that can safely be maintained in the cell, and the amount of freedom and privileges both within the unit and off the unit. The Incentive-Based Points Program is individually tailored, allowing patients to earn points based on participation in treatment and activities that progress them toward their treatment goals. The points can then be exchanged to obtain items from commissary that they may otherwise not be able to obtain.

Adopting the Social Learning Model will require that all team members, including Correctional Officers and Unit Case Managers, participate in training in order to fully understand and implement the tenets on the program. Training should occur before the unit opens, as well as at designate intervals across time. The CCS CQI program will develop and implement CQI studies designed to ensure the program is implemented according to the training and expectations of SLP.

Proposed Evidence Based Curriculum:

There are a variety of evidence-based curricula that could prove useful in the proposed program at MSP. Taken as a whole, these programs address recovery and rehabilitation treatment targets for the patient population expected at this unit. The subcommittee members assigned to this task focused on a few specific factors when reviewing potential options for programming. First, we looked at programming designed specifically for a population diagnosed with serious mental illness, that included programming during more acute phases of illness, as well as programming that addressed maintenance and relapse prevention topics. We also considered programming that was developed for a correctional population, and addressed recidivism risk factors, as the subcommittee believes that amongst this unit's many charges, one is to assist clients in becoming more effective in their behavioral choices in all aspects of functioning, and not just issues related to mental illness. It is expected that programming will also address each patient's noted risk factors for criminal recidivism as they are able to participate in such programming. It is expected that the Treatment Team will utilize various programs based on the needs of the patient population across time, and that the program fidelity will be monitored via the CCS CQI Program. As noted above, there are a number of evidence-based programs that were considered, and as deemed appropriate and necessary other programs beyond those highlighted below can be added to the programming rotation within the unit. The following programs outlined below have received the highest recommendations for utilization from the subcommittee members assigned to this task. All programs are designated as evidence-based or evidence-informed.

1) Illness Management and Recovery

IMR focuses on the management of mental health symptoms. This program empowers patients to learn about their mental illnesses and develop coping strategies to manage them. The overall goals for IMR are to learn about mental illness and strategies for treatment, decrease symptoms, reduce relapses and hospitalizations, and make progress toward goals and recovery.

2) Team Solutions

Comprised of approximately 150 hours of evidence-based programming designed to educate individuals about their serious mental health issues and manage symptoms and address relapse prevention issues. Programming is spread across ten workbooks that address the following areas: Recovering Life Goals, Partnering with Your Treatment Team, Understanding Your Illness, Understanding Your Triggers, Getting the Best Results from Your Medicine, Managing Stress and Problems, Substances and You, Recognizing and Responding to Relapse, Managing Crisis, and Putting It All Together.

3) Changing Live/Changing Outcomes

This evidence-based program was designed for seriously mentally ill patients receiving treatment in a designated correctional mental health unit. The program focuses on the "central 8" recidivism risk areas, including but not limited to antisocial behavior, antisocial cognitions, criminal history, and antisocial associates as examples. Programming combines treatment of managing serious mental health issues along with learning alternate behavioral choices designed to lower criminal recidivism risk.

4) START NOW

START NOW is an evidence-informed coping skills therapy designed to treat patients with behavioral disorders and associated behavioral problems. This program primarily employs a cognitive behavioral and motivational interviewing focused treatment approach, integrating research, theory and clinical experience within correctional settings.

5) Seeking Safety

Seeking Safety is a program designed to treat trauma, PTSD and substance abuse. This is a present-focused therapy to help individuals attain safety from trauma and substance abuse. The primary clinical need is to establish safety and then addresses a range of cognitive, behavioral, and interpersonal domains.

6) Anger Management for Substance Abuse and Mental Health Clients

This program is a 12 week Cognitive Behavioral group therapy approach to anger problems when the individual is dually diagnosed with substance abuse and mental health issues though

the program has been used successfully for individuals without a substance abuse issue. The goal is to provide effective anger management strategies to reduce frequency and intensity to those who experience anger problems.

7) Cognitive Behavioral Therapy for Depression in Veterans and Military Servicemembers

This curriculum was originally developed for individuals in the military and was developed by the VA. The curriculum can be adapted to other individuals who are experiencing mental health and behavioral conditions. The focus is utilizing cognitive behavioral therapy strategies in the treatment of depression.

Overview and Proposed Next Steps:

The new Forensic/Mental Health Unit at Maine State Prison is being designed to meet the complex needs of a cohort of patients with psychiatric disabilities, cognitive limitations, and extreme behavioral problems. It recognizes that these individuals represent part of a continuum of service needs that require a greater level of structure and intervention to protect staff, other patients, and the patients themselves from physical harm due to their conditions. It also recognizes that these services need to be targeted to effectively address acute and chronic conditions in a humane manner with the goal of functioning safely and productively within the least restrictive environment. The evaluation and program intervention models identified for this unit involve a person-centered, holistic, rehabilitative approach to care. The unit allows for the implementation for short term, moderate, and long term recovery plans.

The level of intensity, monitoring, treatment and structure required to address the immediate and long term needs of this targeted population demands 24/7 onsite healthcare staffing that is trained, consistent, and supervised to provide services appropriately and with fidelity to program. Within the model all intervention is considered clinical, including custody supervision and intervention. Functions and specialties of each staff are important and represent an equally important perspective for the treatment team, particularly related to treatment planning and transition decision making.

The review of similar units within the country revealed some common approaches, philosophies, and policies for this especially difficult population. It was clear that a person-centered, rehabilitative approach is consistently used, but the application is influenced by factors such as geography, census, time frames for completion of evaluations, facility limitations/availability, etc. Consistencies between program schedules, staffing patterns, policies, and curriculum were identified and considered in the developed of this unit proposal. This proposal is Maine-specific and crafted to address factors that differ from other states.

The establishment of this unit offers opportunities relative to looking at the spectrum of mental health care throughout the Maine Mental Health System. It's an opportunity to look at our entire system from each juncture to include court, jail, DHHS, Riverview, prison, probation, and the community. This is also

an opportunity to evaluate our system at each juncture and evaluate our system from a clinical and fiscal standpoint. It is important to recognize that criminal justice is a dynamic system and that the needs and interventions shift over time. Implementation of evidenced-based practice requires constant evaluation and flexibility in order to maximize results. The proximal and distal outcomes need to be established for the unit as well as the system to inform future decision making. We look forward to the continued partnership with the DOC and your feedback regarding this proposal.

Maine State Prison

Forensic Unit Location Comparison

Proposal for Forensic Unit Location

With the arrival of the Forensic Unit in February at MSP there have been discussions regarding the location of the unit. Currently the Mental Health Unit is divided into two pods, A1 and A2, with each pod having 16 cells. The space in A1 and A2 is very limited in terms of office space, work space, and outdoor space which raised discussions regarding the use of C-Pod also located in the SMU. C-Pod is not currently in use and is utilized as a recreation area for both mental health unit and segregation inmates. There are 50 cells in C-Pod with a large outdoor space that has access to a large grass area.

Given the staffing matrix approved, during the busiest part of the day, up to 7 staff members will need to be accommodated for space which includes the Psychiatrist, Psychologist, 2 Social Workers, 2 Mental Health Techs, and a Nurse. That does not include work space for Case Managers, Forensic Evaluators, or staff needing to meet with patients outside our matrix.

A-Pod:

- The space is currently set up as a Mental Health Unit which is a benefit; however it is not set up for the amount of programming and treatment we intend to offer.
- Cells are equipped with cameras and glass doors for better visibility on the lower level of A-2 where we currently house acute inmates.
- We are unlikely to have the number of acute versus chronic exactly divided between the two units which would mean shifting patients between units for programming.
- There are currently 4 spaces for office/group space within the 2 units. One group space could accommodate approximately 8 people and the other perhaps 6 people. There is also a small storage room where a sink is available that could be utilized as interview room.
- One cell in A-2 has been stripped of plumbing and the bed and was created into a comfort room this could be utilized as an interview room or possibly a padded cell.
- The dayrooms are rather small and with the units full will offer limited space.
- Outdoor space is very small with limited space for the MH Techs to provide outdoor programming.

Challenges:

- Given the limited amount of space in the unit for treatment of patients we would need to utilize more space outside the unit.
 - o Within the hall area prior to arriving at the slider of A-1 and A-2, there are two storage closets that could be converted into two small interview rooms. Also within that hall area is the staging room for the Response Team which could be utilized as another

group room that could accommodate a much larger group than what is available on the unit.

- Out in the reception area there is an office available that could be utilized by the MH Techs as a shared space.
 - Nursing staff need access to a sink, the only access would be in A-2 and the space is not large enough for an exam table. The large holding cell in reception could be converted into a small clinic or the space available in the SMU clinic could be utilized.
- The MH Techs would have limited space for group activities and would likely need to utilize C-Pod for more recreation space which is our current practice.
 - The offices available within A1/A2 would be utilized as just clinical space for interviewing patients along with the interview space just outside A1/A2 and then the staff would have their office space for documentation on the 2' floor of SMU.
 - Alternatively, the spaces designated for interview room and group rooms would have to be equipped with jacks and the tower would be utilized for more office space.

C-Pod:

- This unit offers 50 cells with space to separate acute from chronic utilizing the "L" and the wings. There are 15 cells down the wings then 10 cells on the upper and lower tier of the "L."
- C-Pod offers a larger day room space as well as two group rooms (one that accommodate approximately 8 people and the other approximately 6 people) within the pod.
- Staff could utilize the downstairs wing of cells as interview space (meaning chairs and a table with no computer access) taking 15 of the 50 cells off line if those cells were gutted. This space could be used for not only forensic unit staff but also provides space for Case Managers and Forensic evaluators. The cells could also be utilized for different purposes like an Art Room or Music Room for patients to use with the MH Techs.
- 2 additional cells could be stripped down to make safe cells for suicide watch.
- Having more cells allows for the creation of interview space as well as space for a padded cell and if necessary a restraint room for individuals acutely at risk for harm to self or others.
- C-Pod offers a large outdoor space where the MH Techs could provide outdoor activity groups and exercise groups. There is also a grassy area that could be utilized for gardening or other outdoor programming once the fence was pushed out or re-energized.
- C-Pod would allow for the staff to all work within the unit crafting a schedule for the clinicians and MH Techs to utilize the two group rooms in rotation with individual sessions.
- SMU Clinic has several rooms available to create exam rooms that would be separate from the exam rooms used for the segregation inmates.
- C-Pod has a basement area where there is available office space for education or supplemental programming as well as a library and laundry facility.
- Currently there are 7 offices on the 2" floor of SMU of which **4** are currently open. There is a conference room available as well as a large room where work stations could be created given

there are 5 jacks available to hook up computers. Utilizing this office space would allow the team to be in the same area which would enhance communication.

- Cable lines could be run through the cell house to provide in cell programming; however the walls are filled with brick and rebar and would require extensive demolition.

Challenges:

- The cellhouse has not been used in some time and requires some maintenance before the pod would be usable. Those costs would be necessary regardless if you used it for a forensic unit or something else. Those necessary costs would be:
 - HVAC system must be cleaned (estimated cost: \$60,000)
 - Toilets repaired as not all are in working order (estimated cost: \$150,000)
 - The lexan in the windows to the rec yard need to be replaced (estimated cost: \$12,000)
- Additional modifications needed to include:
 - Gut the cells to be utilized as interview rooms (no cost and the items will be recycled for B-pod)
 - Change 5 doors to glass doors for better visibility of the acute patients. MSP has 2 doors worked into the budget already which would mean 3 additional doors would be needed (estimated cost: \$7,000 per door)
 - Additionally 5 cameras for the Lower L cells will also be needed. (estimated cost: not available)
- Maintenance indicated the sprinkler system is the same as B-Pod as opposed to A1/A2. A1/A2 requires two triggers (breaking it and smoke) to turn the water on. In C-Pod the water will come on as soon as the sprinkler head is broken.
- A proper officer's station/nurse's station would need to be constructed. This would allow for security and the nurse to view the entire unit.
- C-Pod would not be able to accommodate a padded cell due to plumbing issues; however we could still create a safer cell on the Lower L by removing unnecessary items from the cell.

Conclusion:

After several tours on both units and attempting to envision the flow of work, C-Pod seems to offer a larger space with more opportunity. We must consider that some individuals could spend a large portion of their lives on the unit and A1/A2 creates a much smaller world for their existence. C-Pod would take some initial modifications to make it usable but the potential for that space is exponential. Over time the fence could be expanded to encompass the grass space which could offer the opportunity to provide more activities and also possibly a gardening area. Utilizing the upstairs area could afford the team a comfortable work space to interact and discuss cases. Utilizing the current clinic makes the most sense and is more cost efficient as no modifications would be needed. The basement area could allow other programming opportunities and access to a library

and laundry facilities. The maintenance supervisor indicated the cells could be modified into interview rooms and the parts can be recycled for B-Pod. C-Pod would also be better having glass doors on the Lower L so the acute patients could be observed. Clearly the costs associated with utilizing C-Pod would be greater; however it would offer a better quality of life for our patients and provide a better working environment for our staff.

A-Pod could be utilized but the flow of work could be disrupted by the need to escort patient's off the unit to interview rooms and the space seems "piece milled" together. The changes to A1/A2 would be minor in that it would just need office space created outside the unit; however it offers no room to expand programming or improve the quality of life aspect for our patients unless we expanded into other areas of the prison. It also has potential to feel cramped given the limited space.

Both units are viable options; however C-Pod is more favorable and offers us the opportunity to expand our programming within the space well beyond what could be accomplished in A-Pod.



Maine State Prison Forensic Unit Staffing Matrix

Minimum Staffing Requirements

Forensic Unit Proposed Staffing Requirements Total

Maine State Prison - Forensic Mental Health Unit

ADP: 32

Total Staff - All Shifts

POSITION	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Hrs/WK	FTE
Program Administrator	8	8	8	8	8			40	1.00
Psychiatrist	8	8	8	8	8			40	1.00
Physician					8			8	0.20
Psychologist	8	8	8	8	8			40	1.00
Masters Level Provider	16	16	16	16	16	8	8	96	2.40
Mental Health Technician	24	24	24	24	24	24	24	168	4.20
RN	32	32	32	32	32	32	32	224	5.60
MH Administrative Assistant	8	8	8	8	8			40	1.00
TOTAL HOURS/FTE WEEK	4	/	/	/	4	v	/	656	16.40

Maine State Prison - Forensic Mental Health Unit

ADP: 32

POSITION	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Hrs/WK	FTE
DAY SHIFT									
Program Administrator	8	8	8	8	8			40	1.00
Psychiatrist	8	8	8	8	8			40	1.00
Physician					8			8	0.20
Psychologist	8	8	8	8	8			40	1.00
Masters Level Provider	16	16	16	16	16	8	8	96	2.40
Mental Health Technician	16	16	16	16	16	16	16	112	2.80
RN	16	16	16	16	16	16	16	112	2.80
MH Administrative Assistant	8	8	8	8	8			40	1.00
TOTAL HOURS/FTE-Da	y	y	y	y	y	y	ll.	488	12.20
Mental Health Technician	8	8	8	8	8	8	8	56	1.40
			RN56						1.40
TOTAL HOURS/FTE-Evening	y	y	y	y	y	7	7	112	2.80
NIGHT SHIFT									
RN								56	1.40
TOTAL HOURS/FTE-Night								56	1.40
TOTAL HOURS/FTE per week	y	y	y	y	y	7	7	656	16.40

Maine State Prison

Forensic Unit Financial Proposal

FTE	Position	Pre-Benefit Hrly rate	Annual Salary	Feb - Jun 13	Start Date: Feb 15
1.0	Program Director	\$43.27	90,000	\$	33,534
1.0	Psychiatrist	\$165.00	343,200	\$	127,877
1.0	Psychologists	\$48.08	100,000	\$	37,260
2.4	Master Social Workers	\$28.92	144,364	\$	53,790
4.2	Recreation Coordinator	\$20.00	174,720	\$	65,101
5.6	RNs	\$29.00	337,792	\$	125,862
0.2	Medical Director	\$95.00	39,520	\$	14,725
1.0	Administrative/medical records	\$15.00	31,200	\$	11,625
16.4			1,260,796	\$	469,776
					70,466 OT/VAC/SICK Backfill
					51,675 Tax
					61,071 Benefits
					80,000 Recruiting
					15,000 Equip & Computers
					40,664 Malpractice, Workers Comp,
					50,000 Legal & Licensure
					152,000 Pharmacy
					65,056 All Other Exp
					49,440 Supplies/ On-Site
					20,000 Programming Materials
					19,000 Travel
					1,144,149 Budgeted Expense
					132,721 Mgmt Fee
					1,276,870 Total Expense

**Consolidated Maine DOC
Trended Proposed Budget Statement
For the Contract Year Ending June 30, 2014**

	<u>JUL 2013</u>	<u>AUG 2013</u>	<u>SEP 2013</u>	<u>OCT 2013</u>	<u>NOV 2013</u>	<u>DEC 2013</u>	<u>JAN 2014</u>	<u>FEB 2015</u>	<u>MAR 2014</u>	<u>APR 2014</u>	<u>MAY 2014</u>	<u>JUN 2014</u>	<u>Total</u>
Wages, Prof Fees, & Benefits	1,082,142	1,067,947	1,052,899	1,067,948	1,081,288	1,098,337	1,118,923	1,041,731	1,204,157	1,170,519	1,218,351	1,170,519	13,372,761
Travel	10,975	10,975	10,621	10,975	29,046	10,975	10,975	11,869	15,306	14,812	15,306	14,812	166,646
Insurance	23,308	23,308	22,587	24,319	23,566	24,319	24,319	26,244	33,588	32,536	33,588	32,536	324,217
Pharmacy	181,165	181,165	175,692	181,165	164,192	169,665	169,665	168,893	204,312	197,721	204,312	197,721	2,195,670
Other On-Site	25,496	25,496	24,674	25,496	24,674	25,496	25,496	28,118	36,766	35,580	36,766	35,580	349,640
Supplies	27,410	27,410	26,526	27,410	26,526	27,410	27,410	28,360	35,388	34,247	35,388	34,247	357,732
Off-Site Services	92,362	92,362	89,383	92,362	89,383	92,362	92,362	83,424	92,362	89,383	92,362	89,383	1,087,491
Other Expenses	43,351	43,351	42,107	43,351	42,107	43,351	43,351	59,699	86,516	83,838	86,516	83,838	701,377
DIRECT EXPENSE	1,486,209	1,472,015	1,444,489	1,473,027	1,480,781	1,489,916	1,512,502	1,448,339	1,708,395	1,658,636	1,722,589	1,658,636	18,555,534
Management Fee	172,906	172,906	167,329	172,906	167,329	172,906	172,906	169,174	201,693	195,187	201,693	195,187	2,162,122
TOTAL EXPENSE	1,659,116	1,644,921	1,611,817	1,645,934	1,648,110	1,662,822	1,685,408	1,617,513	1,910,088	1,853,823	1,924,283	1,853,823	20,717,657
TOTAL START UP COSTS	-	177,300	-	-	-	-	177,300						
TOTAL	1,659,116	1,644,921	1,611,817	1,645,934	1,648,110	1,662,822	1,685,408	1,794,813	1,910,088	1,853,823	1,924,283	1,853,823	20,894,957

Consolidated MDOC
Summary of Budget Revisions

	Current Contract Budget		Cost of New Program at MSP		Revised Contract Budget
Wages, Prof Fees, & Benefits	\$ 12,775,204	\$	652,989	\$	13,428,192
Travel	147,646		19,000		166,646
Insurance	283,553		40,664		324,217
Pharmacy	2,043,670		152,000		2,195,670
Other On-Site	300,200		49,440		349,640
Supplies	322,732		35,000		357,732
Off-Site Services	1,087,491		-		1,087,491
Other Expenses	506,321		195,056		701,377
	-----		-----		-----
DIRECT EXPENSE	17,466,817		1,144,149		18,610,965
Management Fee	2,035,831		132,721		2,168,552
SUBTOTAL	\$ 19,502,648		\$ 1,276,870		\$ 20,779,517
One-Time Start Up Costs	-		177,300		177,300
Credit on Existing Program	(61,861)		-		(61,861)
TOTAL EXPENSE	\$ 19,440,787		\$ 1,454,170		\$ 20,894,957

MSP Forensic Unit

Salaries & Benefits (3 Weeks)	\$	82,500.00	Training
Programming Fees		50,000.00	
Travel		6,400.00	4 Home office Trips
Recruiting			
Advertising		12,000.00	
Drug Testing & Credentialing		1,000.00	
Licensure		2,000.00	
Relocation		5,000.00	
Equipment			
Computers		8,400.00	7 Computers
Medical Equipment		7,000.00	2 Restraint Beds
Other Expenses			
Office Supplies		1,500.00	
Printing & Forms		500.00	
Employee Goodwill		1,000.00	
Total Estimated Costs	\$	<u>177,300.00</u>	



Shared Risk Model

Under the Shared Risk Model, the parties agree that in the event actual costs for Year 2 of the contract exceed \$21,124,657, plus any expenses associated with travel for the Training Initiative, then Provider will share equally in such excess costs up to \$745,000 with the MDOC (50%- 50%). Start-up costs associated with the MSP Forensic unit, estimated at \$177,300, will be excluded from the Shared Risk Model. Start-up costs include but are not limited to travel, equipment, recruiting expenses, and programming fees associated with the start of the Forensic unit. In addition, any Forensic unit salaries incurred prior to February 15, 2014 will be included as part of the start-up costs. Should actual costs for Year 2 exceed \$745,000 over the agreed \$21,124,657 then MDOC shall be solely responsible for such excess costs above \$745,000.

Department of Corrections
CONTRACT FOR SPECIAL SERVICES – 3rd AMENDMENT

BY AGREEMENT of both parties this 7th day of November, 2013, the Contract for Special Services between the State of Maine, Department of Corrections, hereinafter called "Department," and Correct Care Solutions, LLC, hereinafter called "Provider," is hereby amended as follows:

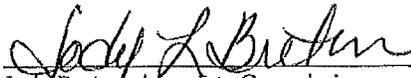
1. Expansion of services to include mental health staffing and programming in order to support the creation of a new Intensive Mental Health Unit (IMHU) to be located at the Maine State Prison (MSP). The IMHU Scope of Work attached hereto outlines the services to be provided to patients of the Intensive Mental Health Unit and the proposed, additional staffing requirements for the Intensive Mental Health Unit are reflected under IMHU Rider D, also attached hereto.
2. The dollar amount of the contract is increased by \$ 1,215,009 from \$78,934,553 to \$80,149,562.
3. Amended Rider E (a/k/a Shared Risk Pricing Model) has been updated to reflect the cost increase as noted above and attached hereto. The shared risk cap and threshold have also been adjusted to account for the additional costs/risks associated with this expansion.

All other terms and conditions of the original contract dated June 19, 2012 and amendments thereto, hereinafter called the "Contract," remain in full force and effect.

IN WITNESS WHEREOF, the Department and Provider, by their duly authorized representatives, have executed this amendment in one (1) original as of the day and year first above written.

Department of Corrections

By:

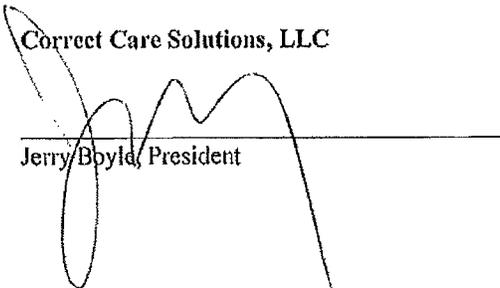


Jody Bretou, Associate Commissioner

and

Correct Care Solutions, LLC

By:



Jerry Bylda, President

Approved, State Purchases Review Committee: _____ Date: _____

Contract Number (CT #): 03A 20120620-6072

Vendor Code: VC00001778839

Old Contract Amount: \$78,934,553

Account Codes: (unchanged)

New Contract Amount: \$80,149,562

New Termination Date: (unchanged)

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IMHU SCOPE OF WORK

PURPOSE:

In order to fulfill the requirements of PL 2013, c. 434 (An Act To Increase the Availability of Mental Health Services), the Provider will engage mental health professionals and staff to develop and administer programming to support the creation of a new Intensive Mental Health Unit to be located at the Maine State Prison. The program shall be operational by February 15, 2014.

IN FURTHERANCE THEREOF,

A. Provider agrees:

1. To develop and implement treatment programs based on research-supported, evidence-based and/or evidence-informed principles of psychiatric rehabilitation and recovery for the discrete populations of patients defined under PL 2013, c. 434 as described above.
2. To administer treatment plans targeted to each individual patient's needs.
3. To collaborate with MDOC onsite personnel utilizing a multidisciplinary Treatment Team to facilitate the treatment programs.
4. To continuously monitor and analyze the staff-to-patient ratio and make appropriate modifications as mutually agreed by the parties.
5. To establish a structure and process for reporting relevant information to the MDOC regarding the Provider's operations and outcomes within a timeframe and in a manner to be determined and agreed by the parties.
6. To develop a method for dialogue with the MDOC on a routine basis to identify and assess processes or issues impacting the treatment programs and/or patient care.
7. To monitor the fidelity and measure the effectiveness of the treatment programs by a variety of means, including but not limited to, CQI evaluations and functional studies.
8. To maintain appropriately trained, licensed and credentialed staff for designated positions.
9. To create, maintain, and publish a schedule of all activities occurring in the Unit.
10. To coordinate with a designated MDOC representative to respond to inquiries and requests for information from advocacy groups and community members regarding the purpose and function of the Intensive Mental Health Unit.

11. To work with the MDOC in good faith to resolve in a mutually satisfactory manner any concerns or issues regarding the implementation or application of the treatment programs or the evolution of the Intensive Mental Health Unit.

B. The parties agree:

1. In the event the population in the IMHU increases by 10% (ten percent) or more from the original base of 32 (thirty-two) patients for a period of 30 (thirty) days or longer, the parties agree to immediately evaluate the staff-to-patient ratio and the positions providing services to ensure adequate levels of care. Upon mutual agreement, the parties will adjust the staffing and associated costs to accommodate any increase described above.
2. MDOC will ensure that a sufficient number of Correctional Officers per shift are assigned to and available for the safe and efficient operation of the Intensive Mental Health Unit.
3. This 3rd Amendment addresses services for the Intensive Mental Health Unit only through Year 2 of the Contract as that term is defined therein. For subsequent Years of the Contract, annual budgets and the shared risk model will be determined by mutual agreement of the parties.

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IMHU RIDER D: STAFFING SUMMARY

MAINE STATE PRISON

INTENSIVE MENTAL HEALTH UNIT

Minimum Staffing Requirements									
Mental Health Unit Proposed Staffing Requirements Total									
Maine State Prison - Mental Health Unit								ADP: 32	
Total Staff - All Shifts									
POSITION	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Hrs/WK	FTE
Program Administrator	8	8	8	8	8			40	1.00
Psychiatrist	8	8	8	8	8			40	1.00
Physician					8			8	0.20
Psychologist	8	8	8	8	8			40	1.00
Masters Level Provider	16	16	16	16	16	8	8	96	2.40
Mental Health Technician	24	24	24	24	24	24	24	168	4.20
RN	32	32	32	32	32	32	32	224	5.60
MH Administrative Assistant	8	8	8	8	8			40	1.00
TOTAL HOURS/FTE WEEK								668	16.40
Minimum Staffing Requirements									
Maine State Prison - Mental Health Unit								ADP: 32	
POSITION	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Hrs/WK	FTE
DAY SHIFT									
Program Administrator	8	8	8	8	8			40	1.00
Psychiatrist	8	8	8	8	8			40	1.00
Physician					8			8	0.20
Psychologist	8	8	8	8	8			40	1.00
Masters Level Provider	16	16	16	16	16	8	8	96	2.40
Mental Health Technician	16	16	16	16	16	16	16	112	2.80
RN	16	16	16	16	16	16	16	112	2.80
MH Administrative Assistant	8	8	8	8	8			40	1.00
TOTAL HOURS/FTE-Day								488	12.20
EVENING SHIFT									
Mental Health Technician	8	8	8	8	8	8	8	56	1.40
RN	8	8	8	8	8	8	8	56	1.40
TOTAL HOURS/FTE-Evening								112	2.80
NIGHT SHIFT									
RN	8	8	8	8	8	8	8	56	1.40
TOTAL HOURS/FTE-Night								56	1.40
TOTAL HOURS/FTE per week								668	16.40

AMENDED RIDER E: SHARED RISK PRICING MODEL

	Year 1	Year 2*	Year 3	Year 4
Comprehensive Services	7/1/12 - 6/30/13	7/1/13 - 6/30/14	7/1/14 - 6/30/15	7/1/15 - 6/30/16
Employees Benefits and Salaries	\$12,857,441	\$42,775,204 13,428,192	\$13,706,755	\$14,152,224
Off-site Expenses (Inpatient; Outpatient; Specialty; ER)**	\$1,541,305	\$1,087,491	\$848,902	\$876,491
All Medical Supplies	\$239,051	\$322,732 357,732	\$254,842	\$263,124
All other Ancillary Services (Includes Pharmacy, Lab and Mobile x-Ray)	\$1,645,069	\$2,343,870 2,545,310	\$1,753,736	\$1,810,732
Administrative Costs	\$958,220	\$937,520 1,192,240	\$1,021,516	\$1,054,716
Management Fee (includes overhead)	\$1,971,749	\$2,035,834 2,168,552	\$2,101,996	\$2,170,310
First Aid Protective Devices	\$74,262	\$64,692	\$63,697	\$65,767
Credit on Existing Program		(\$61,861)		
Annual Totals	\$19,287,097	\$19,502,648 20,717,657	\$19,751,444	\$20,393,364

Four-Year Grand Total: ~~\$78,934,553~~ 80,149,562

* Under the Shared Risk Model, the parties agree that in the event actual costs for Year 2 of the contract exceed \$21,301,957, plus any expenses associated with travel for the Training Initiative, then CCS and the MDOC will share equally (50%- 50%) in such excess costs up to \$745,000. Should actual costs for Year 2 exceed \$745,000 over the agreed \$21,301,957 then MDOC shall be solely responsible for such excess costs above \$745,000.

**Consolidated MDOC
 Summary of Budget Revisions**

	Current Contract Budget	Cost of New Program at MSP	Revised Contract Budget
Wages, Prof Fees, & Benefits	\$ 12,775,204	\$ 652,989	\$ 13,428,192
Travel	147,646	19,000	166,646
Insurance	283,553	40,664	324,217
Pharmacy	2,043,670	152,000	2,195,670
Other On-Site	300,200	49,440	349,640
Supplies	322,732	35,000	357,732
Off-Site Services	1,087,491	-	1,087,491
Other Expenses	506,321	195,056	701,377
DIRECT EXPENSE	17,466,817	1,144,149	18,610,965
Management Fee	2,035,831	132,721	2,168,552
SUBTOTAL	\$ 19,502,648	\$ 1,276,870	\$ 20,779,518
Credit on Existing Program	(61,861)	-	(61,861)
TOTAL EXPENSE	\$ 19,440,787	\$ 1,276,870	\$ 20,717,657



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Your application evaluation results will be emailed to the address you use to login to your online account.

Qualified applicants will be placed on an Employment Register for this classification.

The Bureau of Human Resources reserves the right to use any scoring methods necessary to identify the most qualified candidates.

Career Opportunity Bulletin

CORRECTIONAL CARE & TREATMENT WORKER

Code: 524805 (Mental Health Unit)

Pay Grade: 18 (\$14.85 - 19.35/hr.)

Open for Recruitment: December 10, 2013 - December 23, 2013

The Department of Corrections, Maine State Prison, has five current vacancies in Warren.

JOB DESCRIPTION

This position will perform paraprofessional work in support of mental health professionals and security staff in the development, implementation, adjustment and ongoing delivery of prisoners' care and treatment in a correctional facility. Employee will be a participating member in the interdisciplinary treatment team. The primary focus of this work is the coordination and monitoring of individual treatment plans (ITP's). This is consistent with the Correctional Care and Treatment Worker classification.

Typical Duties

- Interviews prisoners in order to gather information and assist professional staff in the development of psychosocial files and ITP's.
- Monitors and documents prisoner behavior, analyzes prisoner progress and prepares and submits regular and/or special written reports to treatment team in order to provide information and assist in the implementation of ITP's.
- Coordinates scheduling of prisoner activities in order to ensure required attendance in accordance with terms and conditions of ITP's.
- Maintains and monitors case/ITP files in order to ensure documentation is up-to-date and in compliance with applicable laws and regulation.
- Counsels and assists prisoners individually and in groups in order to provide emotional support, guidance and/or referral to mental health and/or other staff to resolve problems and issues.
- Interviews prisoners in order to identify prisoner problems/issues and gather information to be used in determining ITP effectiveness.
- Confers with treatment team colleagues in order to provide information and recommend modifications and/or adjustments to ITP's as necessary.
- Maintains unit classification files, assists prisoners with preparation of classification/program requests and confers and consults with classification staff in order to maintain and provide information.
- Responds to security emergencies in order to provide assistance to security staff and assist in ensuring facility and prisoner security.

MINIMUM REQUIREMENTS

In order to qualify, you must have, a five (5) year combination of education, training, and/or experience providing a knowledge of correctional institution security and/or care-and-treatment programs which includes experience working on interdisciplinary teams and interacting with offenders in a care/treatment capacity. **Preference will be given to candidates who are currently certified as Correctional Officers.**

Correctional & Treatment Worker (524800)

• • •

Value of State-paid Dental Insurance: \$13.13 biweekly

Value* of State-paid Health Insurance:

- Level 1: 100% State Contribution (employee pays nothing): \$363.77 biweekly
- Level 2: 95% State Contribution (employee pays 5%): \$345.58 biweekly
- Level 3: 90% State Contribution (employee pays 10%): \$327.39 biweekly
- Level 4: 85% State Contribution (employee pays 15%): \$309.20 biweekly

*The level of the actual value of state paid Health Insurance will be based on the employee's wage rate and status with regard to the health credit premium program as of July 1, 2013.

Value of State's share of Employee's Retirement: 23.4% of pay.

Maine Department of Health and Human Services
Direct Hire Vacancy Announcement

ACUITY SPECIALIST

Code: 4113 Range: 19 Professional/Technical Salary: \$30,326.40-40,539.20

Value of State-paid Health & Dental Insurance: \$358.71 biweekly.

Value of State's share of employee's retirement: 17.07% of pay

Opening Date: November 6, 2013 **Contact:** C. Burns

Closing Date: November 22, 2013 **Telephone:** 207-624-4660

Location: Riverview Psychiatric Center

Agency InformationThe Department of Health and Human Services (DHHS) is driven by its vision of Maine people living safe, healthy and productive lives. Its goal is to assist the people of Maine in Meeting their own needs, as well as the developmental, health and safety needs of their children. It serves the public in an environment that reflects a caring, responsive and well-managed organization

Riverview Psychiatric Center is a center for best practice, treatment, education and research, for individuals with serious, persistent mental illness, and co-occurring substance use disorders.

Job DutiesThis is a paraprofessional position of a leadership nature, working directly with or assisting the nursing staff is maintaining a safe a therapeutic environment in an acute setting. This position monitors the environment and clients for any safety concerns and addresses them promptly to prevent escalation of behaviors and to prevent possible injury to staff/client. Responsibilities may include assignment of a small case management workload consisting of clients with higher behavior risks and serving as a team leader in lieu of the charge nurse.

Responds to requests for guidance and/or support from service providers and other mental health workers in order to resolve crisis situations involving adults experiencing moderate or acute psychiatric crisis.

Observes and communicates directly with persons experiencing crisis in order to assess mental status, current level of functioning, and danger to self or others.

Determines and initiates actions or interventions in order to resolve crisis situations.

Evaluates and oversees implementation of crisis prevention activities and plans in order to comply with applicable laws, rules, policies, and procedures.

Provides functional supervision and instruction to staff in order to ensure consistent application of appropriate methods and techniques of crisis stabilization activities.

Leads review meetings to document crisis events, agency actions, and outcomes in order to gather and analyze data to identify improvements, develop recommendations, determine adequacy of crisis stabilization plans, and to follow-up on results to prevent future occurrences.

Participates in client team meetings in order to facilitate communication between client and treatment team, and to offer recommendations related to effective client treatment.**Requirements**Four (4) years of education and/or progressively responsible experience which would provide knowledge and abilities in the treatment of individuals with mental illness and developmental disabilities.

Application and Information

To apply, please forward a State of Maine Direct Hire application form postmarked on or before the recruitment closing date to:

Cheryl Burns, Personnel Assistant
Riverview Psychiatric Center
11 State House Station
Augusta, Maine 04332

The Direct Hire application form is located at:

The Department of Health and Human Services is an Equal Opportunity/Affirmative Action employer.
We provide reasonable accommodations to qualified individuals with disabilities upon request.

[Position No Longer Available]

ACUITY SPECIALIST Job Opening at Maine Department of Health and Human Services in Augusta, ME

[Position No Longer Available]

 [Forward](#)

 [Print](#)

Click 'Apply Now' to be directed to the job detail page on the Maine Department of Health and Human Services website.

Position:	ACUITY SPECIALIST
Company:	Maine Department of Health and Human Services
Job Location(s):	Augusta, ME
Start Date:	As soon as possible
Employment Term:	Regular
Employment Type:	Full Time
Starting Salary Range:	
Required Experience:	4 years
Required Security Clearance:	None
Related Categories:	HR - Benefits/Compensation, HR - Training and Development, Marketing - Communications/PR

Position Description

STATE OF MAINE
KENNEBEC, ss.

RECEIVED AND FILED
KENNEBEC SUPERIOR COURT
SUPERIOR COURT
2013 NOV 14 11:05 AM
CIVIL ACTION
DOCKET NO. CV-89-088

PAUL BATES, et al.,

MICHELE LUMBERT
CLERK OF COURTS

Plaintiffs

v.

ORDER

COMMISSIONER,
DEPARTMENT OF HEALTH AND
HUMAN SERVICES, et al.,

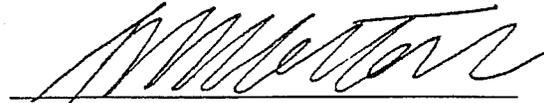
Defendants

Based on the recommendation of the Court Master, and pursuant to a conference with the parties, the Court Master, and the Court on September 27, 2013,

IT IS HEREBY ORDERED:

The authority of the Court Master with respect to Riverview Psychiatric Center as specified in paragraphs 292 through 302 of the Settlement Agreement is hereby reinstated until further order of this Court.

Dated: October 25, 2013


Andrew M. Horton, Superior Court Justice

Yesterday at 7:30 PM

Court Master: Reopen Augusta group homes for Riverview placements

Court Master Daniel Wathen gives DHHS commissioner a deadline.

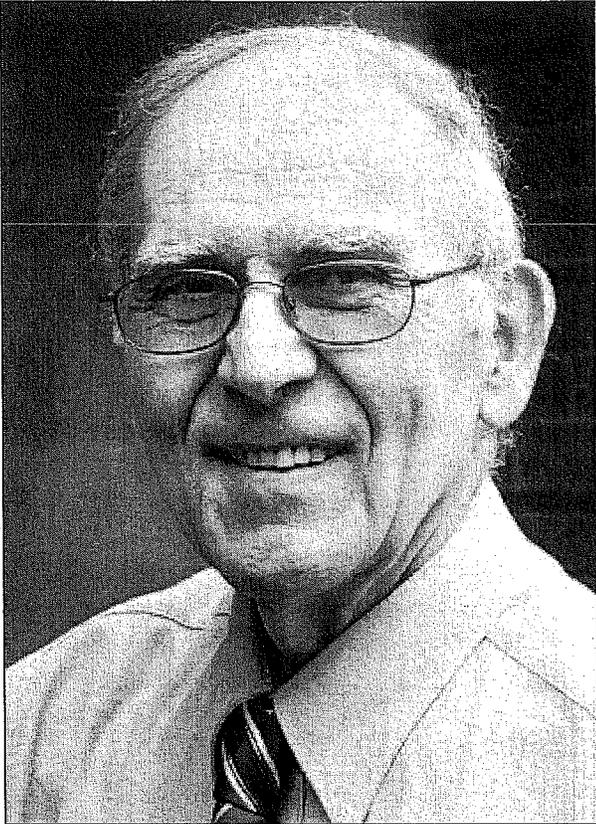
By Betty Adams badams@centralmaine.com
Staff Writer

AUGUSTA — Too many forensic patients are waiting too long to transition from the state-run Riverview Psychiatric Center to a community setting and too many are waiting to get into the hospital.



Daniel Wathen

Staff file photo



[click image to enlarge](#)

Cecil Munson

Contributed photo

Additional Photos Below

[Select images available for purchase in the Maine Today Photo Store](#)

For those reasons, Court Master Daniel Wathen has concluded the state is out of compliance with a settlement agreement and consent decree and has formally recommended to the commissioner of the Department of Health & Human Services that two group homes on Arsenal Street be reopened within the next 130 days. Forensic patients have committed a violent or criminal act and have been ordered to the hospital by the court.

The consent decree settled a 1989 lawsuit filed by patients against the former Augusta Mental Health Institute and holds the state mental health system to agreed-upon standards of care.

Wathen said the two group homes can serve up to 10 people who have court approval to move out of Riverview.

The department, for its part, "has been in conversation with the court master and we are working on an aggressive plan to cultivate additional community options," according to an email Monday from DHHS spokesman John Martins.

Wathen also offered an alternative, saying the department could show him plans within 30

days to open a group home elsewhere within 140 days.

The Arsenal Street group homes, on the same property as the state mental health hospital, were closed in the summer of 2012 and the occupants moved to group homes on Glenridge Drive and Green Street. That move made those former patients eligible for federal Social Security benefits, which they were denied while living on state property.

That move, however, also stunned residents and city officials who did not receive prior notice and raised concerns about public safety because of the patients' proximity to residences.

Wathen told a legislative committee last week that six people have been cleared by a judge to leave the hospital. Four of those have been waiting for six months for a placement to open up, and three more people could get permission to leave in the next few months. The hospital has 92 beds, 44 of which are reserved for forensic patients.

Wathen's letter, sent Friday to DHHS Commissioner Mary Mayhew, says, "The most recent placement that was accomplished involved a wait of approximately one year for an opening to occur."

Wathen said there are no community placements available now or prospects for any soon.

Wathen also reiterated that 18 people are waiting to be admitted to the forensic unit in Riverview, including one person who has been found not criminally responsible for an offense and four people who have been found incompetent to stand trial.

Augusta City Councilor Cecil Munson said that rather than create new group homes in the community, he would prefer to reopen the closed ones on Arsenal Street.

"Or let's spread the group homes out," Munson said. "Let's look at Portland or Bangor. The feeling is that Augusta has really done its part. These folks come from all over the state — they're not just from Augusta."

He said if that posed a problem for treatment, then the group homes near Riverview would be the better alternative.

Munson also noted that state Rep. Corey Wilson, R-Augusta, had proposed using the Arsenal Street property for homeless veterans.

Wathen cited a provision in the consent decree that says the department is out of compliance "with respect to the development and provision of community placements outside Riverview."

Wathen also told the commissioner: "The allowance of 130 days is predicated on the possibility that reactivation may require notice to the community of Augusta.

"I urge the department to take the position that 120 days' notice is not required in order to reactive these existing state-owned group homes on the AMHI campus and to strive for an earlier occupancy date."

Betty Adams — 621-5631 badams@centralmaine.com Twitter: [@betadams](https://twitter.com/betadams)



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Portland, Maine 04101
T/ (207) 774-5444
F/ (207) 774-1103
www.aclumaine.org

Testimony of Oamshri Amarasingham, Esq.
Forensic Mental Health Services Oversight Committee
(Public Law 2013, Chapter 434, Section 12)

December 20, 2013

Senator Gerzofsky, Representative Drew, and members of the Forensic Mental Health Services Oversight Committee, greetings. My name is Oami Amarasingham, and I am Public Policy Counsel for the American Civil Liberties Union of Maine.

The ACLU of Maine testified in opposition to LD 1515 during the First Regular Session of the 126th Legislature, and we shared our concerns with the Joint Standing Committee on Appropriations and Financial Affairs in August. We were (and are) opposed to transfer of patients who need serious medical care to a prison environment—one of the least therapeutic environments imaginable, and we were concerned about the dangerous potential of allowing prison staff to involuntarily medicate prisoners. We were also extremely skeptical LD 1515 would do anything to alleviate the problems at Riverview Psychiatric Hospital. We believe that the human rights violations at the hospital were the result of understaffing and mismanagement, not the fault of the patients. We urged the legislature to reject LD 1515, and to devote its energy and resources towards finding a solution that would actually improve conditions and Riverview and that would assure that federal funding would not be lost.

Today, our chief concern remains the same: inmates that need hospital level care should receive hospital level care – and we cannot expect that level of care to be available at the prison. The Maine State Prison is not a hospital. In fact, the Maine Department of Corrections (DOC) and the Department of Health and Human Services (DHHS) no longer contend that the new facility at the prison will provide hospital level care. Building a mental health unit at the prison will likely mean that inmates who need a high level of treatment will not be transferred to the appropriate setting.

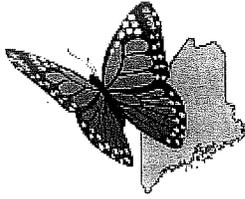
Because Freedom Can't Protect Itself

LD 1515 also authorized the forcible medication of prisoners, and the ACLU remains concerned about this. If someone is competent to make his own medical decisions, he has a basic human right to refuse medical treatment. If the state wants to force medication on someone, the state should be required to obtain a court order, and the person should in all circumstances have the opportunity to present all available objections and defenses before such medication is administered. In the prison setting, there is simply too much danger of medication being used to restrain and pacify, rather than to treat illness. Further, LD 1515 failed to articulate any remedy for a prisoner who is wrongfully forcibly medicated.

With respect to the Memorandum of Agreement between DOC and DHHS, we find paragraph A(3) of the first document particularly alarming. Paragraph A(3) provides that a prisoner committed *by a court* to DHHS custody for observation can be transferred to the prison mental health unit. A court has the power, and expertise, to determine whether a person should be committed to DOC or DHHS custody. As such, a judge's explicit direction that a prisoner should be committed to DHHS custody should not be second-guessed by the department. Presumably, the court placed the prisoner with DHHS rather than DOC for a reason. And, in fact, the statute referenced in paragraph A(3) of the agreement explicitly states that "[i]f the observation is to take place in a correctional facility, the court may not commit the defendant to the custody of the Commissioner of Health and Human Services." 15 M.R.S.A. § 101-D(4).

Finally, since LD 1515 passed into law, the Center for Medicare and Medicaid Services (CMS) has withdrawn 20 million dollars of funding from Riverview for the hospital's failure to rectify problems relating to the physical conditions at Riverview, the abusive treatment of patients, the lack of quality control procedures, and inadequate staffing.

Those problems have still not been rectified. Hiring, training, and supporting a full staff at Riverview might be expensive, but it is a lot cheaper than failure, which (at a minimum) has cost the State of Maine \$20 million in federal funds. We urge this committee to attempt to bring matters back on track.



Consumer Council System of Maine

A Voice for Consumers of Mental Health Services

www.maineccsm.org

Mission Statement: *The Consumer Council System of Maine represents fellow consumers with an effective, organized voice in shaping public policy and mental health services. We hold as essential the participation of all consumers and look to collaborate with allies to find realistic solutions to local and statewide issues and to advance recovery-oriented, consumer-driven mental health care and peer-run recovery opportunities.*

STATEWIDE CONSUMER COUNCIL

December 20, 2013

Paula Gustafson,
Chair

**To Senator Stan Gerzofsky, Representative Drew Gattine and
members of the Forensic Mental Health Oversight Committee**

Ron Welch,
Vice Chair

The CCSM was established as an independent, public instrumentality by the 123rd Legislature to provide an effective, independent consumer voice into mental health policy development, resource allocation, and recovery oriented systems of care.

Dorie Oakes,
Secretary

Karen Evans,
Treasurer

We in the Consumer Community want to add our voice to make sure that there is differentiation between treatment modalities making sure that there is not criminalization of the mentally ill because violence can be easily equated with criminal behavior. This results in members of the public assuming that all individuals with mental illness are violent criminals. We recognize that a person can have violent tendencies separate from a mental illness

Charlie Ames

Harry Clark

Judy Colomy

Kandie Desell

David Eldridge

Judith Harris

We are very concerned that individuals who fall within the following categories might end up at the mental health unit at Warren which could place them at risk of being harmed.

Jeanne Mitchell

Eric McVay

These would include those individuals who live with:

Carolyn Noble

- Traumatic Brain Injury
- Developmental or Intellectual Disabilities
- Organic Brain Syndrome

Dorothy
Treadwell

Jamie Wood

We would like for the Forensic Oversight Committee to take into consideration the following:

- We believe In keeping with the Department's goal to provide the best mental health care possible there is a need to insure that clinical and recovery oriented admission criteria is in place and not corrections criteria/ <http://www.maine.gov/dhhs/samhs/mentalhealth/wellness/>
- We believe it is vital to have peer specialists in the unit who will assist individuals in receiving recovery oriented care
- We believe that how the physical environment in which an individual resides is structured plays a very important part in maintaing wellness and recovery.

We would like to make a request on behalf of our fellow peers that interested members of this committee and representatives from our Consumer Council and Community as well as our allies meet together to have a discussion regarding how to ensure that the forensic mental health unit located at the Warren Correctional Center will provide the best possible continuum of care for those individuals who need and will be receiving mental health services in this setting.

Thank you for your time and consideration,

Simonne

Simonne M. Maline
Executive Director
Consumer Council System of Maine
55 Middle St. Suite 2
Augusta, ME 04330
Office (207) 430-8300 Fax (207) 430-8301
Cell: 592-6036, Toll-Free: 1-877-207-5073
smaline@maineccsm.org
www.maineccsm.org

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD
CIVIL REMEDIES DIVISION

RIVERVIEW PSYCHIATRIC CENTER,

Petitioner,

v.

CENTERS FOR MEDICARE AND
MEDICAID SERVICES,

Respondent.

DAB DOCKET NO: C-14-84
ALJ STEVEN T. KESSEL

**PETITIONER'S MOTION FOR SUMMARY JUDGMENT WITH
INCORPORATED MEMORANDUM OF LAW, AND OPPOSITION
TO CMS' MOTIONS TO DISMISS AND FOR SUMMARY JUDGMENT**

The Petitioner, Riverview Psychiatric Center ("Riverview"),¹ is entitled to summary judgment and CMS' motions to dismiss and for summary judgment should be denied.

INTRODUCTION

In June 2013, CMS notified Riverview that its provider agreement would be terminated on September 2, 2013 as a result of deficiencies identified during surveys in the previous months. For the most part, these deficiencies related to Riverview's forensic unit, which houses patients remanded to Riverview through the criminal justice system. On August 29, 2013, prior to the termination date, CMS accepted Riverview's Plan of Correction. The Plan called for Riverview to create within itself a "distinct part psychiatric hospital," which would include all parts of the facility other than the forensic unit. In this way, most, if not all of the deficiencies

¹ The appeal in this matter was filed by the State of Maine's Department of Health and Human Services ("DHHS"), which, by state statute, maintains Riverview. 22-A Me. Rev. Stat. § 208. CMS contends that only Riverview itself can bring this appeal. CMS Brief, 1 & n.1. Inasmuch as CMS has simply substituted Riverview for DHHS as the party bringing this appeal, *id.*, there is no point debating this issue. Accordingly, this brief will simply refer to Riverview as the appealing party.

related to the forensic unit would not impact the rest of Riverview's eligibility to continue as a Medicare provider.

On September 17, CMS conducted a "revisit survey" to determine whether Riverview had completed implementation of the Plan of Correction. CMS identified various deficiencies, all of which were premised on CMS' erroneous view that the "distinct part" had to be completely segregated from the forensic unit, such that staff and equipment from the former could not be deployed on the latter. By letter dated September 27, 2013, CMS advised Riverview that as a result of its revisit survey findings, it had determined that Riverview's termination would remain effective.

Despite CMS' claim to the contrary, Riverview is entitled to review of the September 17 findings and the September 27 determination. Once CMS accepted Riverview's Plan of Correction, the deficiencies identified in the earlier surveys became moot, and the only issue became whether Riverview successfully completed implementation of the Plan. CMS' conclusion that Riverview had not done so was thus a new "initial determination" subject to review. CMS, in its brief, makes no effort to defend its surveyors' determination that there can be no sharing between the distinct part and another unit, and the determination is plainly wrong. Nothing in the Social Security Act or CMS' regulations require complete segregation between a distinct part and other parts of a facility. In fact, CMS' State Operations Manual not only explicitly states that staff and other resources may be shared, but also recommends that psychiatric hospitals with forensic units consider creating a distinct part to deal with precisely the situation that Riverview faced here. Riverview properly implemented the accepted Plan of Correction. Accordingly, CMS' September 27 determination should be vacated, and its termination of Riverview's provider agreement rescinded.

STATEMENT OF UNDISPUTED MATERIAL FACTS

Statutory Background

The Social Security Act defines a psychiatric hospital as an institution that 1) "is primarily engaged in providing . . . psychiatric services for the diagnosis and treatment of mentally ill persons;" 2) meets certain requirements applicable to hospitals; 3) maintains clinical records on all patients "as the Secretary finds to be necessary;" and 4) "meets such staffing requirements as the Secretary finds necessary. . . ." 42 U.S.C. § 1395x(f). The Act goes on to state that if an institution meets the first and second criteria, and contains a "distinct part" that satisfies the third and fourth criteria, "such distinct part shall be considered to be a 'psychiatric hospital.'" *Id.* In other words, a portion of a psychiatric hospital can itself be considered a psychiatric hospital for purposes of the Social Security Act.

Riverview Psychiatric Center

Riverview is a 92-bed acute care psychiatric hospital in Augusta, Maine. Affidavit of Mary Louise McEwen, ¶ 3, attached hereto as Exhibit 1. It is maintained by Maine's Department of Health and Human Services. *Id.* It provides psychiatric care and treatment for adults. *Id.*, ¶ 4. Riverview also provides forensic services for Maine's correctional and judicial systems, and it is the only hospital in Maine that provides these services. *Id.* Forensic clients include those committed under the criminal statutes for observation and evaluation, those determined incompetent to stand trial, and those committed to the State as not criminally responsible. *Id.*, ¶ 5. A two-year review of the assaults on staff, assaults on other clients, destruction of property, and other criminal behavior shows that the majority of these events are committed by clients who have been ordered by court to Riverview for observation or who have been found not criminally responsible. *Id.*, ¶ 8.

Surveys in March and April, 2013

On March 29, 2013, the Maine Department of Health and Human Services' Division of Licensing and Regulatory Services (the "State Survey Agency")² conducted a "substantial allegation survey" at Riverview and found a number of deficiencies. Exhibit 2 to CMS Brief. By letter dated April 17, 2013, CMS advised Riverview that the State Survey Agency would be conducting a full survey, and that Riverview was not required to submit a Plan of Correction ("POC") until after completion of that survey. *Id.* On May 10, 2013, the State Survey Agency, along with surveyors working under contract with CMS, performed a full survey and identified additional deficiencies. Exhibit 3 to CMS Brief.

The majority of the deficiencies identified by both surveys related to Riverview's Lower Saco Unit. Exhibits 2 and 3 to CMS Brief. This unit exclusively serves Riverview's forensic patients. McEwen Aff., ¶ 5. Many of the deficiencies related to the role of law enforcement officers on the Lower Saco Unit, including their use of Tasers, handcuffs and seclusion techniques. Exhibits 2, 3 and 11 to CMS Brief.

By letter dated June 4, 2013, CMS notified Riverview that as a result of these deficiencies, it had determined that Riverview was not in compliance with various Conditions of Participation ("COPs") found at 42 CFR Part 482, and it was therefore terminating Riverview's Medicare provider agreement effective September 2, 2013. Exhibit 3 to CMS Brief. CMS notified Riverview that it could avoid termination by submitting an acceptable POC within ten days. *Id.*

² The Division of Licensing and Regulatory Services performs surveys on behalf of CMS under a written agreement pursuant to 42 U.S.C. § 1395aa.

CMS Rejects Riverview's Initial Plans of Correction

CMS rejected POCs submitted by Riverview on June 14 and July 18. Exhibits 4 and 5 to CMS Brief. By letter dated August 14, 2013, CMS advised Riverview that because "it is not in compliance with the Medicare COPs and has failed to submit acceptable plans of correction, CMS will terminate the Medicare provider agreement between Riverview Psychiatric Center and the Secretary, effective September 2, 2013." Exhibit 6 to CMS Brief, at 2.

CMS Accepts Riverview's Plan of Correction Creating a Distinct Part Hospital

After CMS' rejection of the first two POCs, and through discussions with CMS personnel, it became clear to Riverview that CMS would not accept any POC allowing for the presence of correctional officers anywhere in the facility. McEwen Aff., ¶ 11. That this is CMS' view is confirmed by the affidavit of Anne M. Pray, a Nurse Consultant employed by CMS to review survey reports and POCs. Exhibit 13 to CMS Brief. In Ms. Pray's opinion, which appears to be based on a single five-page article, "the use of law enforcement techniques in a health care setting can threaten the therapeutic treatment environment for all patients, which necessarily depends on trust between patients and their care providers." *Id.*, ¶ 5.

CMS and State Survey Agency personnel advised Riverview that in order for correctional officers to remain on the forensic unit, Riverview should create within itself a "distinct part psychiatric hospital," which would not include the forensic unit. McEwen Aff., ¶ 13. Because the forensic unit would essentially be carved out, the forensic unit could allow the presence of correctional officers without jeopardizing the rest of the facility's compliance with the applicable COPs. *Id.*, ¶ 14. As will be discussed, guidance issued by CMS in its State Operations Manual recommends that facilities with forensic units consider creating a distinct part when they want to

impose safety and security measures on those units that would otherwise result in the facility not being in compliance with Medicare's COPs.

On August 16, 2013, Riverview submitted a revised POC. *See* Exhibit 2 hereto.³ This POC included the voluntary decertification of the twenty beds on the Lower Saco forensic unit and noted that “[i]t would be an uncommon event that law enforcement would be called to the hospital [*i.e.*, the non-forensic units] on an emergency basis.” *Id.*; McEwen Aff., ¶ 15. This resulted in Riverview having two separate parts – a “distinct part” 72-bed unit that would participate in the Medicare program (the “Hospital”), and a twenty-bed forensic unit (the “Noncertified Part”) that would not participate in the Medicare program.⁴

By letter dated August 29, 2013, CMS accepted Riverview's August 16 POC. Exhibit 8 to CMS Brief; McEwen Aff., ¶ 17. CMS stated that it would conduct a “revisit survey” to “verify compliance with the Medicare Conditions of Participation” and to determine whether “your facility meets Federal requirements for certification as a distinct part psychiatric hospital.” *Id.* CMS further stated: “Failure to correct Condition-level deficiencies will result in termination of the Medicare provider agreement, as stated in our letter of June 4, 2013.” *Id.* (emphasis added). Finally, CMS referred to its “August 14, 2013 notice regarding appeal rights for termination effective September 2, 2013 if your facility is not found to have corrected Condition-level deficiencies.” *Id.*

CMS Conducts Revisit Survey

CMS conducted the revisit survey on September 17, 2013. Attachment A to Exhibit 12 to CMS Brief (“September Survey”). The survey identified deficiencies and concluded that the Hospital was not in compliance with various COPs. *Id.* As will be discussed, every deficiency

³ The cover letter is dated August 14, but it was sent on August 16.

⁴ The “facility” will be used when referring to the entire facility, *i.e.*, both the Hospital and the Noncertified Part.

related to the sharing of staff, equipment, and other resources between the Hospital and the Noncertified Part. The surveyors erroneously believed that there can be no such sharing between a distinct part hospital and the rest of the facility. The survey did not cite any deficiencies of the type that had been identified in the March and May surveys.

1. Governing Body -- 42 C.F.R. § 482.12

CMS found that the Hospital failed to comply with the COP requiring a hospital to have “an effective governing body that is legally responsible for the conduct of the hospital.” September Survey, at 2-3. CMS’ basis for this finding was that there was a “failure to govern the hospital in delineating certified and non-certified sections of the institution and assuring separation of services of the certified portions of the facility as required.” *Id.*, at 2. CMS supported its finding with the facts that 1) the governing body failed to ensure that only Hospital staff responded to emergencies in the Hospital and did not respond to emergencies at the Noncertified Part; 2) minutes from a meeting of Riverview’s Advisory Board reflect discussion of issues relating to the Noncertified Part, but do not reflect discussion of “how the hospital was operationalizing the decertification of portions of the hospital and managing the certified portion of the hospital” and instead note that there were “[n]o new policies to present;” 3) the Hospital “borrowed” an EKG machine from the Noncertified Part; and 4) a single Pyxis Medication Communication System serves both the Hospital and the Noncertified Part. *Id.*, at 2-3.

2. Quality Assessment and Performance Improvement Program – 42 C.F.R. § 482.21

Second, CMS found that the Hospital failed to comply with the COP requiring a hospital to have a “quality assessment and performance improvement program” that “reflects the complexity of the hospital’s organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on

indicators related to improved health outcomes and the prevention and reduction of medical errors.” September Survey, at 3-4. CMS’ sole basis for finding that Riverview was not in compliance with this condition was the fact that Riverview’s contracts for outside services covered the entire facility, and did not distinguish between the Hospital and the Non-Certified Part. *Id.*, at 4.

3. Nursing Services – 42 C.F.R. § 482.23

Next, CMS found that the Hospital failed to comply with the COP requiring a hospital to “have an organized nursing service that provides 24-hour nursing services,” and requiring that the nursing services “be furnished or supervised by a registered nurse.” September Survey, 4-6. This finding was based on the facts that 1) nursing staff, including supervisory nursing staff, were “shared” between the Hospital and the Noncertified Part of the facility; and 2) a single supervisory nurse covered both the Hospital and the Noncertified Part of the facility. *Id.*, at 5-6. Notably, CMS made no finding that the Hospital was ever understaffed. Rather, CMS found only that the occasional “sharing” of staff had the “potential to put hospital patients at risk.” *Id.*, at 5. In the absence of any finding that the sharing of staff ever resulted in the Hospital being understaffed, however, there is no basis for even a finding of potential risk.

4. Staffing and Delivery of Care – 42 C.F.R. § 482.23(b)

CMS found that the Hospital failed to comply with the COP requiring a hospital to have adequate numbers of nurses and other personnel to provide nursing care to all patients as needed, and that staffing be such to ensure “the immediate availability of a registered nurse for bedside care of any patient.” September Survey, 6-7. CMS’ finding was based on the facts that 1) a Unit Manager carried a pager and sometimes responded to calls from the Noncertified Part and was training a new staff member at the Noncertified Part; and 2) staff from the Hospital sometimes

responded to emergencies on the Noncertified Part, and vice versa. *Id.* CMS concluded that the Hospital had insufficient supervisory and staff personnel, *id.*, at 6, but CMS did not find that the Hospital was actually left understaffed when the Unit Manager responded to calls, or when other staff responded to emergencies, on the Noncertified Part. There is thus no factual support for CMS' conclusion.

5. Pharmacy Drug Records – 42 C.F.R. § 482.25(a)(3)

CMS next found that the Hospital failed to comply with the COP requiring that “current and accurate records must be kept of the receipt and disposition of all scheduled drugs.” September Survey, at 7. CMS based its finding on the fact that drug records for both the Hospital and the Noncertified Part were “comingled” and that the “pharmacy did not maintain controlled drug records for the specific certified hospital.” *Id.* CMS did not find that this comingling ever resulted in the Hospital not maintaining current and accurate records of scheduled drugs.

6. After-Hours Access to Drugs – 42 C.F.R. § 482.25(b)(4)

CMS found that the Hospital failed to comply with the COP requiring that “[w]hen a pharmacist is not available, drugs and biologicals must be removed from the pharmacy or storage area only by personnel designated in the policies of the medical staff and pharmaceutical service, in accordance with Federal and State law.” September Survey, at 7-8. CMS found that Riverview’s pharmacy maintained a “night cabinet” to provide medications when the pharmacy is closed and when medications are not available through an automated system, and that access to the night cabinet was limited to the on-duty nurse, but CMS nevertheless concluded that the Hospital was not in compliance. *Id.*, at 8. It based this conclusion simply on the fact that the on-

duty nurse provided medications from the night cabinet to both the Hospital and the Noncertified Part. *Id.*

7. Nursing Services – 42 C.F.R. §482.62(d)

CMS found that the Hospital failed to comply with the COP requiring a hospital to have a “qualified director of psychiatric nursing services” and “adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient’s active treatment program and to maintain progress notes on each patient.”

September Survey, at 8-13. CMS based this finding on the facts that 1) nursing staff assigned to the Hospital sometimes responded to codes or were assigned to work in the Noncertified Part; and 2) the Director of Nurses “splits her time” between the Hospital and the Noncertified Part. *Id.*, at 9-13. However, CMS made no finding that the temporary reassignment of staff, or the dual roles of the Director of Nurses, ever resulted in the Hospital not being adequately staffed or not having a qualified director of nursing services.

8. Nursing Services – 42 C.F.R. §482.62(d)(2)

Finally, CMS found that the Hospital failed to comply with the COP requiring a hospital to have “adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient’s active treatment program.” September Survey, at 13-14. CMS made this finding based on the facts that 1) “[t]he nursing department including the Director of Nursing, some supervisory nursing staff (NOD) as well as other nursing staff including Registered Nurses (RNs) and Mental Health Workers (MHWs) were shared” by the Hospital and the Noncertified Part; 2) staff from the Hospital were sometimes assigned to work in the Noncertified Part; and 3) the “night cabinet” maintained by the pharmacy served both the Hospital and the Noncertified Part, and the nurse in charge of the

cabinet supervised both the Hospital and the Noncertified Part. *Id.* CMS made no finding that this sharing of staff and having a single night cabinet ever resulted in the Hospital having insufficient staff to provide the necessary care to patients.

In sum, every alleged deficiency was premised on, in CMS' view, an improper sharing of staff and other resources between the Hospital and Noncertified Part. Further, for every COP, CMS concluded that the Hospital was out of compliance merely by virtue of the fact that it shared staff and other resources.

CMS' September 27, 2013 Determination

By letter dated September 27, 2013, CMS advised Riverview that based on the September 17 survey, it had "concluded that it will not re-open and revise its initial determination to terminate Riverview Psychiatric Center's Medicare provider agreement." Exhibit 9 to CMS Brief. As will be discussed, there was nothing to re-open or revise – CMS had accepted Riverview's POC, and the purpose of the revisit survey should have been to determine whether Riverview has successfully implemented it. Nevertheless, CMS stated that termination of Riverview's provider agreement "remains effective as of September 2, 2013." *Id.* CMS also referred Riverview to CMS' August 14 letter "for information about requesting a hearing before an Administrative Law Judge . . . under the procedures specified at 42 C.F.R. Part 498." *Id.*

ARGUMENT

I. Riverview Is Entitled to Obtain Review of CMS' Determination to Terminate Riverview's Provider Agreement After Accepting Riverview's Plan of Correction.

Rather than defending the findings from its September 17 survey, CMS argues that Riverview's appeal must be dismissed because those findings are not subject to review. CMS Brief, 13-14. Alternatively, CMS argues that it is entitled to summary judgment because

Riverview has not challenged the deficiencies cited by the March and May surveys, and “[u]ndisputed deficiency findings that are the predicate basis for an initial determination are sufficient to support summary judgment as a matter of law.” CMS Brief, 14-16. What CMS fails to recognize is that where, as here, CMS has accepted a plan of correction, CMS must prove that the provider failed to comply with the plan. *Nazareno Medical Hospice v. HCFA*, DAB CR386, 1995 WL 543450 (“*Nazareno*”); *Guaynabo Hospice Care, Inc. v. HCFA*, DAB CR374, 1995 WL 317324 (“*Guaynabo*”). Not only are the findings from the September 17 revisit survey reviewable, but Riverview is entitled to summary judgment because CMS has failed even to address those findings, much less attempted to show that they were correct.

CMS’ argument appears to be based on its characterization of its September 27 determination as a decision “not to reopen and revise CMS’ initial determination to terminate Riverview’s provider agreement.” CMS Brief, 13. It then argues that decisions of “whether to reopen and revise an initial determination” are not subject to review. *Id.* Instead, argues CMS, Riverview can appeal only CMS’ June 4 determination to terminate Riverview’s provider agreement based on the findings from the March and May 2013 survey reports. *Id.*, 15-16.⁵

Both *Nazareno* and *Guaynabo* demonstrate the error of CMS’ argument.⁶ In *Nazareno*, the State Survey Agency for Puerto Rico conducted a survey of three hospice providers in April 1994. *Id.*, 4. CMS’ predecessor, the Health Care Financing Administration (“HCFA”) notified

⁵ As an initial matter, CMS’ current argument is inconsistent with what CMS told Riverview in August and September. CMS argues in its brief that because Riverview can appeal only the June 4 determination, its deadline for filing an appeal was August 5, 2013. CMS Brief, 15-16. But, when CMS accepted Riverview’s POC on August 29, 2013, it referred to Riverview’s appeal rights “if your facility is not found to have corrected Condition-level deficiencies.” Exhibit 8 to CMS Brief. Then, on September 27, 2013, it referred to the process for requesting a hearing. Exhibit 9 to CMS Brief. At those times, at least, CMS correctly understood that by accepting the POC, CMS had initiated a new process which, if it led to an unfavorable determination, Riverview could appeal.

⁶ While ALJ decisions are not precedential, they are relevant “for the inherent value of any persuasive analysis therein.” *Singing River Rehabilitation & Nursing Center v. CMS*, DAB, Appellate Division No. 2232, 2009 WL 765651, 11 n.7; see also *Park Manor v. CMS*, DAB CR 1263, 2004 WL 3021634 (“both the Board and administrative law judges often cite to previously issued decisions in an effort to give context to their decisions and to be consistent”).

the providers that they were out of compliance with various COPs and that their provider agreements would be terminated. *Id.*, 4-5. HCFA offered each provider the opportunity to submit a plan of correction. *Id.*, 5. On June 23, 1994, HCFA accepted each provider's plan. *Id.* Following subsequent resurveys, HCFA notified the providers that they continued to be out of compliance with COPs, and that it was terminating their provider agreements. *Id.*

On appeal, HCFA argued that the corrective action plans were irrelevant with respect to the issue of whether the providers were in compliance with the COPs. *Id.*, 20. The ALJ rejected this argument. The ALJ stated that

a corrective action plan that has been accepted by HCFA becomes an element of the contract between HCFA and the provider. The corrective action plan defines the manner in which a provider is expected to remedy deficiencies addressed in the plan. HCFA may not ignore a corrective action plan once it has accepted it. In determining whether a provider is complying with conditions of participation, HCFA is obligated to consider the provider's compliance with the terms of the corrective action plan, to the extent that they address any condition for which compliance is being evaluated.

Id. The ALJ then held:

Once HCFA accepts a corrective action plan, both HCFA and the provider are bound by its terms. Where HCFA opts to accept a corrective action plan which addresses condition-level deficiencies, in effect HCFA tells the provider that, if the provider does what it has promised to do in the plan, it will be deemed to have corrected the deficiencies. Thus, compliance by a provider with a corrective action plan becomes the measure of whether the provider has corrected the deficiencies that are addressed by the plan.

Id., 21. The ALJ concluded:

Where HCFA determines to terminate a provider's participation in Medicare after it has accepted a plan of correction from that provider, HCFA must prove, by a preponderance of the evidence, that the provider is not complying with the terms of the plan of correction, to the extent that those terms address conditions of participation with which HCFA contends the provider is noncompliant.

Id., 6.

The ALJ reached similar conclusions in *Guaynabo*. There, the ALJ noted that generally in cases where HCFA has terminated a provider agreement, it must show that its initial termination decision had adequate factual and legal support. *Id.*, 14. But, in cases where HCFA has accepted a plan of correction and then conducted a revisit survey to determine whether the provider successfully implemented the plan, “HCFA must establish also that the provider failed to implement that plan or failed to implement that plan in accordance with its stated terms.” *Id.* (emphasis added). The ALJ found that because HCFA had accepted a plan of correction, HCFA was “bound by the terms of the revised plan it approved.” *Id.*, 26; *see also id.*, 28 (“the plan’s terms “are binding on both parties on the issue of whether Petitioner was in compliance with the condition of physician services by the time of the revisit survey. . . .”).⁷ The ALJ concluded that based on the results of the revisit survey, the termination decision had to be set aside. *Id.*, 24. Among other things, the ALJ held that HCFA could not cite as deficiencies the failure to take measures that the accepted plan of correction did not require. *Id.*, 30-37.

As both of these cases make clear, CMS’ acceptance of a plan of correction is a transformative event. When CMS accepted Riverview’s plan, it essentially contracted that as long as a revisit survey showed that Riverview carried out the plan, CMS would consider Riverview to be in compliance with the COPs.⁸ CMS then conducted the revisit survey to, as

⁷ The ALJ equated an accepted plan of correction to an amendment to a contract:

[T]he provider agreement HCFA wishes to terminate in this case is the equivalent of a contract between HCFA and Petitioner. HCFA and Petitioner had the right to reach agreements on the supplementation of those contractual terms that are required by law, and the parties had the right to stipulate to the methods for correcting alleged breaches and for verifications of such corrections. The supplemental agreements discussed herein, which were reached after the initial survey by HCFA, are not prohibited by law, and they were reached by the parties voluntarily.

Id., 26.

⁸ It is not clear why CMS, when it accepted Riverview’s plan of correction on August 29, 2013, did not rescind or postpone the September 2 termination date pending completion of the revisit survey:

If HCFA receives a plan of correction that it finds acceptable, HCFA will schedule a revisit survey after the last date for correction under the plan but prior to the date of termination itself. According to HCFA, it would never terminate a provider’s participation agreement before such a revisit

CMS itself acknowledged, “determine whether promised corrective actions had been completed and substantial compliance had been achieved by August 27, 2013.” Exhibit 9 to CMS Brief (September 27 letter from CMS). As a result of that survey, CMS determined that because there was sharing of resources between the Hospital and the Noncertified Part, Riverview had not properly implemented the plan of correction and that its provider agreement would therefore be terminated. This was a new determination subject to review. *See* 42 C.F.R. § 498.3(b)(8) (providing for review of initial determination to terminate provider agreement).

That it was a new determination is evident from the September survey itself. Every purported deficiency related to Riverview’s alleged failure to properly segregate the Hospital from the Noncertified Part (the forensic unit) when it created a distinct part psychiatric hospital. Even if these were deficiencies, they were obviously different than the ones identified in March and May, which was well before Riverview decertified the forensic unit. Necessarily, then, CMS’ September 27 decision that Riverview’s provider agreement would remain terminated due to lack of proper segregation was an initial determination – it was the first time such a determination was, or even could have been, made. Indeed, if this were not an initial determination, Riverview could never obtain review of CMS’ determination that it failed to create a distinct part hospital properly.

In sum, not only is Riverview entitled to a review of CMS’ determination, based on the September 17 survey, that Riverview did not comply with the accepted plan of correction, but CMS also bears the burden of showing that Riverview’s lack of compliance was due to the sharing of resources between the Hospital and the Noncertified Part. And, because CMS has not carried that burden, Riverview is entitled to summary judgment.

survey. In some cases, HCFA has “pushed back” the termination date to accommodate the revisit surveys.

Guaynabo, 25.

II. CMS Erred In Concluding That Riverview Had Not Properly Implemented the Accepted Plan of Correction.

CMS does not attempt to defend its September 27 determination that the sharing of staff and other resources between the Hospital and the Noncertified Part was fatal to successful implementation of the POC. In an "Addendum," CMS appears to claim that regardless of any sharing, Riverview never could have met the definition of a "distinct part psychiatric hospital." CMS Brief, 16-18. As discussed above, however, the Social Security Act defines "psychiatric hospital" to include a "distinct part" of such a hospital, and CMS does not explain why the Hospital portion of Riverview does not meet this definition. Further, assuming it was acting in good faith, CMS would not have accepted Riverview's POC calling for creation of a distinct part psychiatric hospital if doing so were legally impossible. *See Nazareno*, at 22-23 ("It would make no sense whatsoever for HCFA to enter into a corrective action plan with a provider unless HCFA concluded that, by complying with the elements of the plan, the provider would remedy the deficiencies addressed by the plan and would thereby be in compliance with Medicare participation requirements."). Moreover, CMS' current position is inconsistent with that of its surveyors who, in September 2013, apparently believed that Riverview could create a distinct part so long as there was no sharing of staff and other resources. Attachment A to Exhibit 12 to CMS Brief.

CMS' position is also contrary to its so-called "State Operations Manual" ("SOM"), a document containing CMS' interpretation of its regulations which is "afforded deference under most circumstances." *Eagle Behavioral Health Services v. CMS*, DAB CR1336 (2005), n.2; *see also Elgin Nursing and Rehabilitation Center v. U.S. Dept. of Health and Human Services*, 718 F.3d 488, 493 (5th Cir. 2013) (SOM, as an agency's interpretation of its own regulations, "becomes of controlling weight unless it is plainly erroneous or inconsistent with the

regulation.”) (quoting *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945)); *Washington Christian Village v. CMS*, DAB CR2403, 2011 WL 3578666, 7 (“Because these SOM provisions ‘reasonably interpret the Act and regulations,’ they are entitled to considerable deference.”).

In the SOM, CMS discusses the statutory requirements for psychiatric hospitals, including the “distinct part” provision. State Operations Manual, CMS Pub. 100-7, chap. 2, § 2042 (rev. 1, May 21, 2004). CMS states: “There are some psychiatric hospitals that are designated as ‘forensic hospitals.’ These hospitals focus on serving individuals who are in the custody of penal authorities.” *Id.* CMS goes on to state:

Regardless of whether a state meets the payment requirements for prisoners housed in these hospitals, the hospital must apply the [conditions of participation], including the restraint and seclusion rules, to all patients including the prisoners. If a hospital wants to apply different health and safety rules to prisoners, it may want to consider establishing a distinct part.

Id. Thus, the SOM contemplates Riverview’s precise situation – needing to use restraints and other measures on forensic patients while keeping the rest of the facility in compliance with the COPs. And, the SOM recommends doing exactly what Riverview did – establishing a distinct part. For CMS to now claim that Riverview cannot create a distinct part is perplexing.⁹

If the ALJ agrees with Riverview that it is entitled to review of CMS’ September 27 determination that it failed to implement the approved COP properly because of excessive sharing of staff and other resources between the Hospital and the Non-Certified Part, Riverview

⁹ Remarkably, CMS argues that when it used “distinct part” in the SOM, it did not mean “distinct part” as used in 42 U.S.C. § 1395x(f), but “in the non-statutory sense ‘distinct’ as something that is distinguishable or separate from something else.” CMS Brief, at 17. This is preposterous. The SOM’s discussion of “distinct parts” for forensic units appears in the same section – and on the very same page – as the discussion of the statutory provision relating to “distinct parts.” It is hard to imagine that CMS would have used this specific phrase – instead of, for example, “separate unit” – had it not intended a reference to the statutory provision.

is necessarily entitled to judgment in its favor. CMS has the burden of coming forward with evidence and proving, by the preponderance of the evidence, that Riverview failed to comply with the accepted plan of correction and that its decision to terminate Riverview's participation was justified. See *Nazareno*, at 6; *Guaynabo*, at 14; see also *Hospicio En El Hogar De Utuado v. HCFA*, DAB CR371, 1995 WL 315880, 6-7 (holding that HCFA has "the burdens of coming forward and proving, by a preponderance of the evidence, that Petitioner failed to comply with conditions of participation in Medicare"). Given that CMS has declined to shoulder that burden, its findings based on the September 2013 survey should be vacated and the termination rescinded.

In any event, CMS' findings are plainly wrong. Congress has explicitly declared that that a "distinct part" of a psychiatric hospital can itself "be considered to be a 'psychiatric hospital.'" 42 U.S.C. § 1395x(f). While the "distinct part" must meet certain criteria, *id.*, there is nothing that prohibits the sharing of personnel, equipment or other resources between the distinct part and rest of the facility.

Beyond repeating the language of the statute, 42 C.F.R. § 482.1(a)(2), CMS has not promulgated regulations interpreting "distinct part." In the SOM, though, CMS discusses in some detail the applicable requirements for a distinct part psychiatric hospital. State Operations Manual, CMS Pub. 100-7, chap. 2, § 2048 (rev. 1, May 21, 2004). It states that the entire institution must be primarily for the treatment of mental illness. *Id.*, § 2048A. Riverview meets this requirement. The distinct part must be "physically distinguishable from the larger institution or institutional complex," such as a group of beds or "a wing, a separate building, a floor, a hallway, or one side of a corridor." *Id.*, § 2048B. Here, the Hospital and the Noncertified Part (the forensic unit) are physically distinguishable. *McEwen Aff.*, ¶ 16. The non-participating

portion of the facility “is required to meet the [conditions of participation] only insofar as it affects the health and safety of patients in the distinct part or provides facilities or services used by such patients.” *Id.*, § 2048C. This is precisely why Riverview created a distinct part – so that the forensic unit could employ appropriate measures to meet that unit’s enhanced safety needs, with the rest of the facility remaining in full compliance with the COPs.¹⁰

Most importantly, the SOM explicitly permits the sharing of staff and other resources between the distinct part and the nonparticipating portion:

It is rare that a distinct part of a hospital is completely self-contained Inpatients of the distinct part may receive specialized services such as physical therapy or occupational therapy in a portion of the hospital not included in the distinct part. Services and facilities that may be shared vary with the type and size of the institution and the size of the distinct part. However, in most instances, the distinct part shares with the rest of the institution such central support services as dietary, housekeeping, maintenance, administration and supervision, and some medical and therapeutic services. The primary consideration in evaluation of shared services is whether the sharing can be done without sacrifice to the quality of care given the patients in the distinct part and without endangering their health and safety.

Id., § 2048C. In the September 17 survey, CMS found that there was sharing, but did not find that the sharing resulted in any sacrifice to the quality of care.¹¹ Quite simply, the survey’s findings do not support CMS’ conclusion that Riverview failed to implement the accepted plan of correction properly.

¹⁰ CMS instructs surveyors to consider “the impact of nonparticipating sections of the institution to ascertain whether there are any hazardous conditions which might endanger patients in the distinct part; for example, the lack of adequate fire or sanitation safeguards, particularly where the distinct part is attached to the rest of the institution.” *Id.*, § 2048AC. Here, CMS made no finding during the September survey that the presence of correctional officers in the forensic unit (or any other condition, for that matter) was somehow affecting the health and safety of patients in the Hospital.

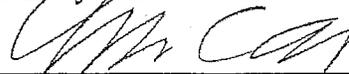
¹¹ While CMS may argue that the fact that staff from the Hospital sometimes went to the Noncertified Unit necessarily means that the Hospital was left understaffed, this is plainly wrong. If a facility sends a nurse home early, this does not necessarily mean that it becomes understaffed. More likely is that the nurse is being sent home because staffing is sufficient. Sending a nurse to another unit is conceptually no different than sending the nurse home. Presumably, if the surveyors had found that sending staff from the Hospital to the Noncertified Unit ever left the Hospital understaffed, they would have so stated in their report.

CONCLUSION

In sum, Riverview is entitled to review of CMS' determination that Riverview did not properly implement the plan of correction CMS had approved. And, CMS' determination was clearly wrong. There is no legal requirement that staff and other resources not be shared between a distinct part and other portions of a facility. To the contrary, CMS has expressly approved of such sharing. Further, CMS never found that any sharing between the Hospital and the Noncertified Part ever resulted in the Hospital being understaffed or otherwise interfered with the Hospital's ability to provide appropriate care to its clients. Accordingly, CMS' termination of Riverview's provider agreement should be rescinded.

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CERTIFICATE OF SERVICE

I hereby certify that on this, the 13th day of December, 2013, I sent via both express delivery for next business day delivery and by email copies of the foregoing brief and exhibits to counsel for the Centers of Medicare and Medicaid Services, Jan B. Brown, Assistant Regional Counsel, Office of the General Counsel, Region I, U.S. Department of Health and Human Services, 2250 JFK Federal Building, Boston, MA 02203.



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