



Department of Health
and Human Services

Maine People Living
Safe, Healthy and Productive Lives

John E. Baldacci, Governor

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June 19, 2009

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RE: Response to Court Master's Progress Report of June 11, 2009

Dear Dan:

Much of your recent progress report to the court, dated June 11, 2009, focuses on our disagreements over the scope of the Department's obligations in presenting budget requests to the Legislature, and the related dispute that was resolved last fall concerning the extent of the state's obligations to fund services to adults who are not eligible for MaineCare. I will not attempt to address those points here, since the parties will be discussing a procedure for resolving those disputes with Justice Horton at the July 1 status conference.

The purpose of this letter is to address other factual assertions and observations made in your report which we believe are misleading, or simply erroneous, and to add some points of clarification regarding the actions the Department intends to take in response to the amount of funding available in this biennial budget.

1. Biennial budget for mental health

In this section of your report, you express concerns regarding several aspects of the budget for adult mental health services, which I would like to address.

Reduction of \$1,615,000 in general fund for private nonmedical institutions for adults with mental illness: This budget initiative primarily reflects implementation of the realignment of housing and support services (i.e., the unbundling of housing supports and treatment services in scattered site PNMI's) that was called for in the Department's approved Consent Decree Plan. It also includes savings from standardizing the contribution that residents of other PNMI's make toward their care. The reduction further anticipates a small amount of savings from rigorous application of prior approval and level of care criteria. The Department's calculations of these savings were based on a reasonable set of assumptions and projections made at the time of budget preparation, which is all that can be expected of a budget document. If these savings are not achieved as projected, the Department will request additional funding in supplemental budget

requests, or will transfer funds from other MaineCare accounts where there may be a surplus, as we have done in the past.

De-appropriation of \$500,000 from special revenue accounts of Dorothea Dix and Riverview Psychiatric Centers: Your report states that this de-appropriation, which occurred in the last few hours of deliberations by the Legislature's Appropriations and Financial Services Committee, is an example of "hospital funds being directed to non-hospital purposes." Given the significant reduction of patient population at Dorothea Dix to an average of 50 patients per day, which has occurred without a corresponding budget reduction, we have decided to de-allocate the entire amount (\$1 million) from the special revenue account at Dorothea Dix. This avoids any effect on Riverview. It is also worth noting that over the course of the past few years, special revenue at both hospitals has nearly tripled, leaving the hospitals with revenue above the amounts budgeted for hospital operations.

Housing subsidies (BRAP): BRAP is flat funded in this budget at \$2,972,414 – i.e., the budget for FY10 provides the same level of funding that was appropriated in FY09. As you correctly noted, the biennial budget does not include the additional \$3,476,288 that the Department had requested for each fiscal year in the budget proposals we submitted in September, 2008. We had requested that amount to address an identified need for additional housing vouchers at that time, and projected increases in demand over the coming year. The Governor did not include this request in his proposed budget. Accordingly, I reiterated the need for more BRAP funding in my letter and oral presentations to the Appropriations and Financial Affairs Committee and Health and Human Services Committee of the Legislature on March 26, 2009.

Flat funding does mean that the Department will be unable to keep up with anticipated growth in demand for BRAP vouchers, and more people (even those leaving a psychiatric hospital bed) will likely be on the waiting list. The BRAP census also will likely drop from the current level of 563 vouchers to about 501 in FY10 as a result of increases in market rents in certain areas of the state. We share your concerns about this situation, but believe the Department has done everything it can to address it up to this point. We will continue to monitor the situation closely and will submit supplemental budget requests to fill the resource gap, consistent with our obligations under the Settlement Agreement. In the meantime, community integration workers will need to develop interim plans with those consumers who are waiting for vouchers, consistent with paragraph 63 of the Settlement Agreement.

As you probably know (but we weren't sure based on the wording of your report), eligibility for BRAP is tied to section 17 clinical criteria, but it is not tied to eligibility for MaineCare.

Grant funding for community services by providers under contract to Department: The chart provided to you, which is attached as Exhibit A to your progress report, shows only the total grant funding to provider agencies operating under contract to the Department. As such, it reflects a very limited portion (\$24.5 million) of the total budget for adult mental health, which is approximately \$240 million. Since several of the services listed on this chart are also provided

under MaineCare, it is somewhat misleading to characterize this chart as showing the “mental health services – community budget.” It is also misleading to suggest that this type of grant funding “has been systematically reduced over the past eight years.” There was a spike in funding in FY02, which I recall reflected one-time funding for dually eligible Medicare/Medicaid recipients (mostly elderly clients). With the exception of that fiscal year, the overall level of funding in this category has remained fairly steady, in the \$24 to \$25 million range. During that same period of time, there have been significant increases in the MaineCare account for adult mental health services to serve consumers who were previously ineligible for MaineCare and therefore dependent upon grant funds.

The \$24.5 million of grant funding for the contracted services listed on Exhibit A has remained essentially flat between FY09 and FY10, even though the Department did request additional funds in several of the service categories, as reflected in the third to last column of the chart. In addition to the requests listed there, which were made to the Governor and provided to the Legislature, I also communicated to both the Appropriations and Financial Affairs Committee and the Health and Human Services Committee on March 26, 2009, orally and in writing, the need for additional grant funds for peer services, vocational services, wraparound funding, and development of new residential treatment beds for those with complex medical needs. As noted above, the Department will continue to monitor the needs for all of services listed on Exhibit A and will submit supplemental budget requests to fill the resource gaps that are identified.

2. Riverview Psychiatric Center

With respect to Riverview Psychiatric Center, your report concludes that “[i]t is beyond dispute...that the last six months have not helped the hospital maintain progress in achieving compliance.” I strongly disagree. I believe that the leadership team and the systems in place at Riverview have clearly demonstrated an ongoing commitment to compliance and ongoing movement in that direction. The facts presented in Riverview’s quarterly performance improvement reports, available on line and in the Department’s quarterly consent decree reports, as well as other publicly available data, support this belief.

Your concerns focus on staffing, performance indicators, and patient discharge issues. I would like to address each issue in turn.

Staffing: Your report suggests that staff vacancies in recent months have impeded progress toward compliance. As you note, the state hiring freeze was expanded in November of 2008 so that direct care positions at the two state hospitals were no longer subject to a blanket exemption. You assert that the hospital was understaffed for more than six months, and that Riverview has maintained minimum staffing ratios by the use of overtime.

In fact, the Department moved quickly to apply for waivers and gain the Governor’s approval to fill the direct care positions that were previously subject to a blanket exemption to the hiring freeze. Few direct care positions remained vacant for long. A review of the staffing trends for FY08, as reported in the Riverview third quarter performance review report, shows a

steady downward trend in overtime from July of 2008 through March of 2009. It is also important to note that, based on Riverview's quarterly performance reports for FY08 and FY09, mandated overtime for comparable six-month periods has decreased. From October 2007 through March 2008, mandated shifts were called 58 times. In the same period for 2008-2009, shifts were mandated 23 times. The hospital continues to strive to reduce these numbers further, but staffing numbers in the last two quarters suggest that hospital leadership has managed the hiring freeze very effectively.

Performance indicators: Your report also claims that "[t]he most recent quarterly report for Riverview provides some basis for concern that there has been slippage in the performance of the hospital. There is a continued increased use of restraint and seclusion, supervisors are not providing performance evaluations; client satisfaction rates are declining, client complaints about lack of respect are increasing, ongoing NAPPI training for staff has decreased and the medication error rate has increased. In addition, there appears to be an unusual rate of turnover in the staff psychologist positions."

Restraint: Hours of restraint per 1000 inpatient hours for the last month in the three most recent reported quarters (quarters ending September 2008, December 2008, and March 2009) are 0.04 (two and a half minutes), 0.04, and 0.16 (nine and a half minutes). These numbers are all below the national weighted mean. The percent of clients restrained in the month ending each of the last three reported quarters is 6.67, 8.18, and 8.04. Numbers in comparable months the previous year were 6.25, 4.46, and 5.45. The numbers from both years represent about five and to nine patient episodes per month. These numbers are all below the national mean plus one standard deviation. From this data, it is difficult to infer a significant change that amounts to a slippage in hospital performance. Riverview's ongoing commitment to decreased use of restraint is further reflected in a hospital celebration last month to mark two years without a single restraint episode on the Lower Kennebec unit.

Seclusion: Hours of seclusion per 1000 inpatient hours for the last month in the three most recent reported quarters (quarters ending September 2008, December 2008, and March 2009) are 0.18 (eleven minutes), 0.16 (nine and a half minutes), and 0.12 (7 minutes). These numbers are all at or below the national weighted mean. The percent of clients secluded in the month ending each of the last three reported quarters is 5.36, 6.36, and 5.36. Numbers in comparable months the previous year were 8.04, 8.04, and 2.73. The numbers from both years represent about three and to nine patient episodes per month. From this data, it is difficult to infer that there has been an increased use in seclusion.

Performance evaluations: Riverview continues to track timeliness of staff performance reviews as one of its performance improvement standards, and is striving to achieve a compliance threshold of 85% timely reviews. The percentage in the last reported month (March 2009) is 75%, representing the highest number of timely reviews since Riverview made the timeliness standard stricter (timeliness meaning within 30 days of due date) nine months earlier. This is an improvement over the 35% reported for July of 2008, the

first month that the stricter standard went into effect. This represents significant improvement.

Client satisfaction rates: The most recent quarterly report does not support a determination that client satisfaction is declining. As stated in the report, overall satisfaction was 79%, up 14% from the previous quarter. In the comparable quarter a year ago, satisfaction was 10 percentage points lower, at 69%. While client satisfaction is in some ways a very subjective measure, the data show improvement over last quarter and a year ago, and do not support a finding of decreased satisfaction.¹

Client complaints – lack of respect: I asked Riverview to review client complaints for the half year from July 1 through December 30, 2008 and for January 1, 2009 through the present. In the first six months reviewed, there were 19 grievances reflecting a client belief that staff had been disrespectful. Three complaints were from civil units, four were from the long-term forensic unit, and twelve were from the acute forensic admissions unit (five from the same client there). During 2009, there were eight grievances regarding staff behavior. Three complaints were from the civil units and the other five were from the forensic units. It is difficult to conclude from this data that there has been a slippage in performance.

NAPPI training: Ongoing NAPPI training has not decreased. All staff providing direct care are current in their NAPPI training. In fact, for the last two years, the hospital has achieved full compliance with the requirement that all staff receive annual training in NAPPI techniques. For reporting purposes, the number resets at zero at the beginning of each year, and the goal is to have 100% by the fourth quarter of each year. For the first three quarters reported in this fiscal year, the percentages of staff having completed annual training for this year is 42%, 50%, and 87%. Riverview is well on track to achieve 100% compliance again this year.

Medication errors: In the six months covered by your report, the monthly medication error rates were slightly above the national mean plus one standard deviation in one month, and at or below for the other five months. This rate reflects between 2 and 7 episodes per month of the 30,000 doses of medication that Riverview provides each month. The measurement, taken alone, does not reflect standard of care. A high medication error rate can indicate that staff are reporting errors without fear of reprisal so that causes can be determined and corrective measures can be taken. In any event, Riverview continues to review every reported medication error, to determine the cause, to assess the possibility of patient harm, and to address the cause with the individual or individuals responsible so that the error can be prevented in the future.

¹ In reviewing client satisfaction rates, we discovered a mathematical error in the performance improvement report for the fourth quarter of FY08 – April, May and June of that year – suggesting that client satisfaction was at an all-time high of 89% in that quarter. A review of the unit-specific numbers in the report – 84%, 79%, 77%, and 55% – shows that client satisfaction was closer to 74% hospital-wide in that period.

Psychologist turnover: Typically psychologists do not stay in state government for a long period. Over the last twelve years, the average length of employment for psychologists at Riverview and AMHI has been around three years. As you note, however, there has been an unusually high rate of staff psychologist turnover in the last several months at Riverview. A similar turnover occurred in 2004. Riverview has noted the departures, and has reviewed the exit interviews for each former employee. One employee left for a job opportunity with higher pay, one left for a job closer to home, one returned to private practice, one left to be with her young children, and one simply found Riverview to be a bad fit and left before completing probation. The unique motives for each resignation makes it hard to draw conclusions about Riverview's ability to hire and retain the staff necessary for achieving compliance based on this admittedly high level of turnover in a short period.

Patient discharges: Your report states that, "[d]ischarge from the civil side of the hospital is hindered by a chronic lack of housing resources, the unavailability of community services for those without MaineCare and a critical shortage of community facilities for mental health clients with complex medical needs. (The one facility that serves those with complex medical needs has a wait list of twelve.) At present there are ten class members waiting for discharge and an eleventh who is no longer tracked because the prospects for community placement are non-existent because of complex medical needs."²

Since you have attended weekly discharge meetings at Riverview, you are aware that hospital and community staff regularly discuss resources necessary for discharge of clinically ready patients. In response to your report, we reviewed the available information on the nine patients who were clinically ready for discharge and thus appeared on the June 2 community standards report on which your comments are based (the tenth patient was noted on the report as a discharged patient). The review was to assess independently whether that information supports a conclusion that chronic lack of housing and a critical shortage of community facilities for those with complex medical needs are hindering discharges from Riverview.

Of the nine patients who were clinically ready for discharge as of the June 2 report, one was discharged on June 15. Three have been offered placements over time but have refused them. One had limited the part of the state to which he was willing to be discharged. He has since agreed to broaden the search, and a bed has been found that meets his needs. One was not willing to agree to a discharge plan with strong community supports, and has since become clinically unready for discharge. One is a person who was adjudged not likely to become competent to stand trial in the foreseeable future, and needs an apartment. No apartment has been found yet. One needs a high intensity, handicapped accessible setting with staff that can

² Your parenthetical note that "[t]he one facility that serves those with complex medical needs has a wait list of twelve" is a little puzzling. The only waiting list of twelve of which I am aware is the list of people waiting for nursing care at the three gero-psychiatric facilities (Gorham Cottage, Hawthorne House and Mount St. Joseph's). No one at Riverview is on that list. Other facilities that serve people with mental illness and complex medical needs are those run by Tri-County Mental Health Services, Volunteers of America, and Northern Maine General (the Franciscan Home at Eagle Lake), and Mount St. Joseph's.

address medical issues, preferably in the central Maine area where her parents live. The search for this very specialized package of care continues. One had in the past refused placements and was recently placed under guardianship to facilitate appropriate placement, but has now developed a medical issue that may require a placement at a nursing facility. His behavior and thought content make his placement problematic.

Our review shows that discharge planning for the individuals who remain in the hospital past a date of discharge readiness is often challenging, but that, by and large, the challenges are unique to each individual. Certainly, there is no excess system capacity to guarantee that beds remain empty and available to ensure immediate discharge. However, the complete picture behind the complexity of the discharge planning does not appear to support specific system development needs, but rather, an individual approach. I do not wish to minimize the importance of a mental health system with adequate capacity to deal with the many unique challenges of people with mental illness and complex medical or other needs. I recognize that there are waiting lists for admission at some residential treatment facilities. However, the June 2 snapshot of the unique individuals who remain at Riverview beyond their date of clinical readiness for discharge simply suggests that we must remain vigilant to assure that their needs are met and that the Department addresses any implications for system development.

You concluded that “[w]hen clients are not discharged in a timely manner, the scarce resources of the hospital are unavailable to others who are in critical circumstances in the community.” This makes sense in the abstract. However, current data about Maine’s mental health system does not reflect this to be an issue. There is a wait for some forensic admissions to Riverview: as of June 8, the average wait between referral and admission for forensic patients was 10 days for Stage III examinations, 7 days for IST admissions, and 3 days for jail transfers. However, there are no people waiting for civil admission to Riverview. In fact, as many as five civil beds (not twelve or thirteen) have been made available for forensic clients without creating a civil waiting list. And the State Forensic Service is working hard to assure expedited evaluations of Stage III and IST patients to ease census pressure in the forensic units. DHHS continues to monitor data from crisis agencies related to wait times in emergency departments to test whether a pressure point is developing there, but there is no indication that wait times for community hospitalization are increasing.

In short, data from the most recent quarterly report and other information related to hospital functioning suggests that, even as the Department has sought freeze exemptions and gone through the process of hiring for top management positions, the quality systems in place at the hospital and remaining leadership staff have in fact maintained a course toward compliance.

3. Clients ineligible for MaineCare

We strongly disagree with most of the assertions in the section of your report entitled “Shift in Department’s Approach to Clients Ineligible for MaineCare,” but will defer comment on much of it since it relates to the core issue that the parties will be discussing with the court on July 1st. There are just a few points that I will address here.

First, your report implies that large numbers of class and non-class members who are ineligible for MaineCare are unable to obtain services. We are not sure what information you are relying upon, but data available to the Department does not support that conclusion. We are using data that APS Healthcare began to collect last September, pursuant to a contract extension that expanded their responsibility for making eligibility determinations and authorizations for grant funded as well as MaineCare services. For community integration (CI) and assertive community treatment (ACT) services, provider agencies are required to submit "Contact for Service Notification Forms" to APS indicating when consumers apply for the services. Reports from this data show when requests for CI or ACT services were not met. For example, data for the 3rd quarter of FY09 shows that 37 individuals were waiting for CI due to a lack of grant funds. This number is not insignificant, and also does not cover all categories of service, but it does not suggest any wholesale reductions or denial of services.

The Department acknowledges that it had to authorize providers to stop accepting new non-MaineCare eligible clients for CI, ACT and daily living support (DLS) services at different times during FY09 in order to have sufficient grant funds to support those already in service. Some providers also reported that they had to stop taking on additional non-MaineCare clients for medication management services for the same reason.³

Relying on unmet needs data, and anticipating your ruling on coverage for non-class members, the Department submitted to the Governor in September 2008 a biennial budget request of \$2,482,000 in grant funds to provide these types of mental health treatment services to non-MaineCare eligible clients. At the time we submitted that request, we were still engaged in the dispute resolution process with you and plaintiffs' counsel over the scope of the Department's obligations to fund these services for non-class members who are ineligible for MaineCare. The September request was not included in the Governor's budget proposal. The dispute resolution process subsequently concluded, and in November, 2009, your determination regarding the scope of the Department's financial obligation became final.

I made a second effort to obtain more funding for these services, as reflected in my letter and oral presentation to both legislative committees on March 26, 2009. By that time, Department staff had completed their efforts to project the total amount of funding needed to provide the entire mix of MaineCare type services (CI, ACT and DLS plus residential treatment, outpatient services, medication management and skills development) to those non-class members who meet the clinical criteria spelled out in MaineCare section 17 but who are not financially eligible for MaineCare, consistent with your ruling on the question addressed in dispute resolution. This new calculation called for \$7.4 million in each fiscal year for this group of services, based on certain assumptions about likely income levels and MaineCare eligibility.

The Legislature did not include any of these funding requests in the FY10/11 budget. Instead, the FY10/11 budget provides the same level of grant funding for these services that was included in the FY09 budget. These grant funds (shown in the far right hand column of the chart

³ It is worth noting that, during this period, the Department made sure that consumers who lost their MaineCare due to spend down, were able to continue those services with grant funds in FY09.

attached as Exhibit A to your report) will be made available starting July 1, 2009 and will be distributed to provider agencies. The Department's plan is to continue to track the requests for services through APS and to submit supplemental budget requests calculated to meet the needs shown by the data collected through APS, as well as through the resource data summaries used to generate unmet needs reports. If, during course of FY10, APS data shows that clients eligible for CI or ACT services are unable to obtain them because of insufficient grant funds, the Department will not only submit a supplemental budget request but will also request an opportunity to meet with you and the plaintiffs' counsel to discuss the possibility of shifting grant funds from other sources to meet these needs in the interim. Client needs for services other than CI and ACT that cannot be met due to inadequate funding will be tracked as unmet needs, and the community support providers will be reminded that they need to work with those clients to develop interim plans. This is entirely consistent with Department's legal obligations under the Settlement Agreement and the Consent Decree Plan.

Conclusion:

It is unfortunate that the only positive development noted in your six months' progress report concerns the Consumer Council of Maine. While we agree that the establishment and operation of that Council is extremely positive, it is not the only progress made in the last six months.

Given the depth of the economic downturn experienced in Maine this past year, and the extremely tight fiscal constraints that have resulted from drastic decreases in state revenue, we believe the Governor and the Legislature did well to maintain the funding levels that it did for adult mental health services in this biennial budget.

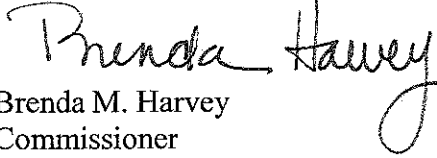
Moreover, despite fiscal constraints, the Department has continued to move towards achieving substantial compliance. The Department has fully implemented all but eight of the 119 system development steps required by the approved Consent Decree Plan. The eight remaining (such as the realignment of housing and support services reflected in the budget initiative discussed above) involve multiple steps that are at varying stages of completion. Most of the systems that require certifications under Part I of the compliance standards are in place, and the Department is ready to prepare those certifications for submission to you. The quarterly performance data shows that many of the highly specific compliance standards are being met. A complex human services delivery system such as the one Maine has in place for adult mental health will never be free of problems, and staff is constantly working to make improvements. I believe it is important to encourage those efforts and to reinforce the positive, particularly in these difficult times.

We will continue to work with you and plaintiffs' counsel to manage the resources that we have available in the best way possible to serve those adults with serious and persistent mental illness.

Daniel E. Wathen, Esq.
June 19, 2009
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Thank you for considering these comments.

Sincerely,


Brenda M. Harvey
Commissioner

cc: Helen Bailey, Esq.
Peter Darvin, Esq.
Patrick Ende, Esq.
Katherine Greason, AAG
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