

STATE OF MAINE  
KENNEBEC, ss.

SUPERIOR COURT  
CIVIL ACTION  
DOCKET NO. CV-89-088

PAUL BATES, et al.,

Plaintiffs

v.

PROGRESS REPORT PURSUANT  
TO PARAGRAPH 299

BRENDA HARVEY, et al.,

Defendants

The following Report covers the period from October 1, 2005, through April 30, 2006. The preparation of this Report has been delayed one month in order to synchronize the reporting period with the filing of quarterly reports from the Department of Health and Human Services. In my last report, dated October 18, 2005, I informed the Court that the Department was under a legislative mandate, invited by the Department, to develop a managed care plan for mental health services by July 1, 2006. The mandate included a requirement that significant savings be achieved in the 06-07 fiscal year. I also reported that I had been unable to approve those portions of the plan submitted by the Department dealing with continuity of care and cost of plan implementation. The introduction of managed care and the fact that the Department's plan was only partially approved gave rise to a degree of uncertainty. Wishing to avoid any undue prolongation of the delay that has marked this litigation, I filed a supplemental order on December 9, 2005, imposing the condition that the mental health portion of the proposed contract for managed care be submitted for approval as a supplement to the plan not later than June 30, 2006. The order

also imposed the requirement that “such other revisions to the plan as I deem necessary, including those relating to crisis services, continuity of care, residential support, vocational services and cost of plan implementation, shall be submitted not later than July 31, 2006.” Against this background, I offer the following report of the progress achieved by the Department between October 2005 and May 2006 in implementing the terms of the Settlement Agreement.

### **Managed Care.**

Since the beginning of the year, the Department has made a substantial effort to design a managed care system for mental health services. The project has absorbed a great deal of time, attention and effort on the part of the entire mental health community. It has become evident that it is not possible to have a final managed care plan in place by July 1, 2006. The Department’s present plans call for an expanded program of advisory service reviews through the end of the calendar year, the issuance of an RFP for an at-risk managed care organization by July 1, and a final contract with a managed care organization by January 1, 2007. Presumably in January, the advisory service reviews will become the basis for a system of prior authorization. In my judgment, full implementation of managed care could require two or more years. Beyond the question of delay and uncertainty, my immediate concern in this area relates to the \$10.4 million dollars of budgeted savings for fiscal year 06-07 that accompanied the legislative mandate for managed care. As yet the Department has not specified how those savings will be achieved. In the current session, the Legislature adopted supplemental budget language to provide that the budgeted savings “may not be achieved through reductions in provider rates below their levels on January 1, 2006 or through eliminations of categories of services provided by community providers or

consumer groups.” With or without those eliminations, it is not possible to assess the potential impact of the budget reduction on services. For example, if the savings are achieved in MaineCare programs, the actual impact is \$30 million. If the savings are achieved in state-funded programs, the flexibility of the system may be affected.

I am also concerned at this point about the degree of participation afforded to consumers and providers in the managed care planning process. Despite an extensive schedule of stakeholder meetings and reports, designed to educate, encourage participation and solicit ideas, the overall effort has been flawed. Thus far the Department has not offered any detail concerning the actual components and specifications that it is considering for inclusion in an RFP or a final contract for managed care. The absence of opportunities for meaningful stakeholder participation was discussed at a May 2 meeting of the Stakeholder Group and, commendably, the Department took corrective action. It is not yet clear whether, in the time that remains, the Department’s action will address the needs of the stakeholders. Effective and meaningful participation by consumers and providers is not only essential to the planning process, it is contemplated by both the Settlement Agreement and the Department’s comprehensive plan

**Completion of the Comprehensive Mental Health Plan, Without Regard to Managed Care.**

As I reported in my December 9, 2005, Order, the Department engaged Elizabeth Jones as a consultant to make recommendations to the Department for improving the method of delivering crisis services, employment services and residential supports. In addition, the consultant will address the adequacy of capacity at Riverview Psychiatric Center. Her work is progressing satisfactorily. She has met with a number of consumers and providers throughout Maine. Her recommendations will be completed before the end

of June 2006 and will be available when I review the terms of the conditional approval of the plan.

**Operation of Riverview Psychiatric Center.**

The hospital continues to serve its vital function as Maine's tertiary facility for psychiatric care. As is reflected in the most recent quarterly performance report attached hereto, the internal operations of the hospital are monitored satisfactorily and continue to improve when measured against national standards and the standards included in the Department's plan. The degree of positive change and improvement achieved at the hospital in the last two and one half years is a tribute to the commitment and dedication of management and staff as well as the effort and involvement of the peer support workers and the clients of the hospital.

In recent months, the hospital experienced a very serious staff injury and continuing safety risk resulting from the actions of a recently committed forensic client. Management has responded to this situation quickly and effectively, establishing an administrative segregation unit and an administrative segregation policy, a copy of which is attached hereto. Such serious incidents test the capabilities and the competence of the entire staff and the Department. Here, the hospital operated responsibly and professionally under intense public scrutiny and in challenging circumstances.

In response to an inquiry from the Superintendent, on April 18, 2006, I issued an interpretive ruling to the effect that the adoption of no smoking policy for the hospital is a matter that implicates the principles and procedures of the Settlement Agreement. (A copy of my ruling is attached hereto.) I concluded that such a policy would require the consent

and approval of the Court Master. A proposal for such a policy may be filed in the near future.

Budget support for the hospital has eroded a bit. When the forensic ACT team was proposed in 2005, the hospital had approximately \$300,000 set aside in its budget for the creation and start up of the team. \$270,000 was specified in the Department's plan. All but approximately \$100,000 of that sum was subsequently diverted to other unrelated Departmental needs and yet no appropriation was sought to replace those funds. Moreover, in the most recent budget proceedings, funds were transferred from the hospital's budget to the MaineCare account. The hospital is now expected to self-fund the creation of the forensic ACT team and complete the funding by billing MaineCare for those clients who are eligible. This is a much weaker and more uncertain financial foundation than that which was proposed. Moreover, no provision has yet been made for funding the housing that will be a necessary part of the effort to effectively expand forensic capacity. It also seems possible that the forensic ACT team will be required to serve the clients covered by L.D. 151, the recently enacted Outpatient Commitment Program. Diminished financial support and expanded responsibilities could seriously compromise the chances of the important forensic initiative successfully addressing the needs of Maine.

There has been considerable legislative and public attention devoted to the question of whether Riverview should be expanded in size and capacity. The two most persistent performance problems at the hospital, length of stay and timely discharge, are directly related to this question. Riverview's capacity to admit new civil clients is affected by its inability to discharge clients into appropriate community placements within a reasonable length of time after the client achieves clinical readiness and no longer benefits from

hospitalization. It should be noted that finding appropriate community placement opportunities is a challenge for every psychiatric hospital in Maine. The difficulties at Riverview have a ripple effect on the other psychiatric hospitals and vice versa. Given that Riverview typically has approximately twenty or more, out of a total of forty eight, non-forensic clients awaiting community placement, some for very long periods of time, the most obvious, immediate and financially prudent solution is to correct the inadequacies in the lower cost and less restrictive community mental health system. Those inadequacies result from both resource and management issues.

In accordance with the performance standards for hospital discharge included in the Department's approved plan, I have reviewed all discharges that have been delayed beyond the specified time. I have attended weekly discharge meetings at the hospital for the last six months. These meetings include hospital staff and community staff from the Department. The needs of clients ready to reenter the community are highly varied and individual. There are no easy solutions or quick fixes. There is no substitute for a detailed and sensitive understanding of the clients, their ever-changing daily needs and circumstances, matched with an equally detailed knowledge of the placement opportunities in the community. The process must culminate in a carefully constructed transition plan that is monitored and followed each step of the way. A few of the more common causes for complexity are: physical conditions and medical needs; a long history of institutionalization; a prior history of aggressive behavior; the unavailability of appropriate residential placement or services; preferences of the client or guardian; client's compatibility with other residents; and provider resistance to community placement. The performance standards for the hospital are challenging, but I am encouraged that the joint

effort of the hospital and the community is beginning to gain momentum. In the most recent month, the hospital admitted thirteen clients and discharged thirteen. Significant transitional work is currently underway for four of the twelve clients who present the most complex needs for a successful community placement. Recently, the Department has responded promptly and effectively when provider practices have deviated from contract requirements and have impeded the discharge process. The Department still has a lot of work to accomplish. The effort being made at the moment, however, seems promising and I plan to continue monitoring it closely. The timely return of clients to their community is not only in the best interests of the clients but it will go a long way towards addressing concerns about hospital size and capacity.

**Legislative Developments.**

Beyond the enactment of the Outpatient Commitment Program, the primary legislative developments relate to the budget. The following chart details the deviations between the plan and the budget presented by the Department for fiscal 06-07.

	PLAN	BUDGET
Consumer Councils	\$338,611.00	\$323,000.00
Additional Warm Line Capacity	\$200,000.00	\$90,000.00
Consumer Involvement in Licensing Review	\$300,000.00	-0-
Develop Crisis Residential Units & Increase Staff and Supports to Divert From Hospitals	\$620,000.00	-0-
ACT Forensic Team	\$270,000.00 Self Funded	-0-
Advocacy Initiative Network	-0-	\$100,000.00
Vocational Supports	-0-	\$200,000.00
Community Supports Non-Categorical Class Member	-0-	\$178,000.00
Geriatric Mental Health	-0-	\$360,000.00

Services		
Specialized Residential Development	\$672,00.00	\$749,000.00

I support the additions included in the budget. The items for vocational supports and housing were added in response to my rulings on the plan. The downward deviations from the plan, however, resulted from the unilateral action of the Department. I presented this same comparison of plan to budget to the appropriate legislative committees. As I explained on those occasions, in the long run, I am less concerned by the reductions than I am by the Department's action in unilaterally altering the plan without seeking an amendment of the plan or engaging in a discussion.

During the legislative session, individual legislators expressed concern for employee safety and management issues at Riverview. In the near future I will consult with the Committee on Health and Human Services and the Committee on Criminal Justice. Working with them, the goal will be to devise a fair and objective means for exploring those issues in a responsible manner.

Finally, along with the superintendent, I continue to meet on a monthly basis with clients in the hospital to listen to their concerns and discuss opportunities for improvement in hospital operations. These meetings are one of the most valuable sources of information available to me.

**Progress Relating to Compliance in the Community System.**

Initially, I must state that conditions for progress and improvement have not been optimal during the last six months. The Department is still adjusting from merger and reorganization, the Commissioner retired and a successor was appointed after a few months, most of the management positions in mental health are filled only on an acting basis, people

are preoccupied with the effort to design and implement managed care on a fast track and a very busy legislative session is still underway. Under these circumstances, the Department has not maintained the focus that is required for successful implementation of the plan.

On May 1, 2006, the Department filed a report pursuant to Paragraph 280 of the Settlement Agreement. The report summarizes progress made during the first three months of 2006 and a copy is attached. The Department's report speaks for itself and progress has indeed occurred. I offer the following comments with respect to designated portions of the report to illustrate the need for a more focused effort on the part of the Department:

*B. Action Steps to Improve Consumer Involvement*

Action Step 1 - The formation of the consumer council system is proceeding more slowly than planned. To some extent the delay was caused by organizational difficulties involving consumers beyond the control of the Department. The plan, however, called for the formation of the State Council and three local councils well before July 1, with the remaining five local councils completed in 06-07. It now appears that no part of the council system will be operational before 06-07. This fact exacerbates the concern about consumer involvement in the important planning stages of managed care.

Action Step 4 - The adequacy of the Maine Warm Line has not been evaluated and no plans are apparent to expand it. The Department reduced its proposed funding from \$200,000 to \$90,000. This smaller sum merely replaced the funding that had previously been provided from a third-party source to pilot the program. Without additional funding and with no evaluation, expansion appears unlikely.

Action Step 6 - The \$300,000 designated in the plan for consumer participation in licensing was not requested. Apparently this is now part of the Consumer Council funding. It seems questionable that both projects can flourish with the funding originally planned for one.

#### *E. Continuity of Care and Crisis Services*

The new continuity of care manager is the person charged with the development of managed care. That fact reflects the reality that in recent months the Department has focused on developing managed care and has been distracted from the more fundamental task of improving continuity of care and crisis services. For example, Action Step 1, misdirected crisis calls, has not been addressed effectively. Under these circumstances, the work of Elizabeth Jones, commissioned by the Department, takes on added importance as we approach the June and July deadlines.

#### *Performance and Quality Improvement Standards*

The performance standards represent a promising means for objectively evaluating the performance of the community mental health system. At present, thirteen of thirty-four performance standards are being met substantially or exceeded. Ten standards, however, have at least one method of measurement for which data is not yet available. It would be desirable if the next quarterly report were to show significant improvement.

#### **Conclusion.**

Overall, progress in achieving compliance during the seven months covered in this report has been less than satisfactory. The operation of Riverview Psychiatric Center is an exception. The remaining problems for the hospital, length of stay and timely discharge,

are receiving increased attention and the Department's effort to improve the availability and management of community placement opportunities shows promise. As we approach the June and July deadlines for completion of the comprehensive plan, it appears unlikely that managed care will be sufficiently developed to receive acceptance. If that situation develops, I will consider plan completion without regard to managed care.

DATED: May 12, 2006

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Daniel E. Wathen  
Court Master