Caswell, Lynne

Subject: FW: Questions from the LD 629 task force

From: Bogart, Molly <Molly.Bogart@maine.gov>
Sent: Wednesday, October 12, 2022 11:49 PM
To: Broome, Anna <Anna.Broome@legislature.maine.gov>
Cc: Caswell, Lynne <Lynne.Caswell@legislature.maine.gov>
Subject: RE: Questions from the LD 629 task force

This message originates from outside the Maine Legislature.

Hi Anna and Lynne,

I'm so sorry that this is later than requested. We have answered as many of the questions as we could in the timeframe. Let me know if you have any follow ups.

1. How many patients received an "emergency discharge" from a residential care facility from 2018-2021? (DHHS, Page 1)

   DLC does not have this data; we are only made aware of discharges that are appealed by the resident/legal representative. Information related to appeals: Since July 2018, DLC has tracked roughly 111 requests for administrative hearings related to discharge from residential care facilities, both emergency and non-emergency. This number is an estimate because DLC does not routinely track this information.

2. How does DHHS track/enforce the obligation for facilities that are initiating an emergency discharge to *"assist the consumer and authorized representatives in locating an appropriate placement."* (Page 1) (Note: The hospital experience is that the burden to locate the next residential facility or placement falls almost entirely on the hospital social workers when the patient is in the hospital emergency room.)

   DLC would only be aware of this issue in the event of an appeal or complaint. A complaint may be investigated, and any noncompliance would be documented through a Statement of Deficiencies that would require a corresponding Plan of Correction from the facility. Additional enforcement actions as outlined in rule could include issuance of a Directed Plan of Correction or Conditional license, or a directive to stop admissions. Each enforcement action is dependent upon the specific circumstances of the incident(s).

3. PNMI App E facilities have an additional termination provision in 97.07-10. Why do only App E facilities have such a requirement? (Page 2)

   Appendix E-Services are community residences for persons with mental illness and have additional service provisions in place due to the Consent Decree, which is unique to persons with severe and persistent mental illness.

4. Why do only PNMI App E providers have to accompany residents to the hospital emergency room? (Page 2)

   This language was added to provider contracts back in 2020 at the request of Hospitals and law enforcement.

5. What kinds of facilities transfer individuals to PNMI App E facilities?

State hospitals, local community-based hospitals, jails, intensive case managers, community-based mental health providers, and other DHHS make referrals.

6. Are residents who file appeals of their discharge by PNMI's afforded any state support during the appeal? (Page 3)

   Licensing involvement is limited to making a referral to the Division of Administrative Hearings to request a Fair Hearing.

   OADS makes waiver participants aware of their appeal rights and other due process and makes them aware that DRM may be able to assist them.

   OBH makes individuals aware of the appeals process and works with DRM to assist in the process. In addition, PNMI E providers are required at intake to review and provide a copy of the Mental Health Rights and Recipients adult manual to all clients, which outlines the grievance process.

7. The response to question 6 on page 6 relating to services received at PNMIs references only PNMI App E facilities. Can you please provide a response for the other PNMI facilities?

   With respect to Licensing, services received depends on the assessed needs of each resident. General services that must be offered for all facility Levels in accordance with Assisted Housing Rules include:

   2.9 "Assisted Housing Services" means the provision by an assisted housing program of housing, activities of daily living and instrumental activities of daily living, personal supervision, protection from environmental hazards, meals, diet care, care management and diversional or motivational activities. These services are further defined as follows:

   > *2.9.1 Personal supervision, meaning awareness of a resident's general whereabouts, even though the resident may travel independently in the community; and, observation and assessment of each resident's functioning or behavior to enhance his or her health or safety or the health or safety of others;*
   >
   > *2.9.2 Protection from environmental hazards, meaning mitigation of risk in the physical environment to prevent unnecessary injury or accident;*
   >
   > *2.9.3 Assistance with Activities of Daily Living and Instrumental Activities of Daily Living;*
   >
   > *2.9.4 Diversional, motivational or recreational activities, meaning activities which respond to residents' interests or which stimulate social interaction, both in individual and group settings;*
   >
   > *2.9.5 Dietary services, meaning the provision of regular and therapeutic diets that meet each resident's minimum daily food requirements, as defined by the Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;*
   >
   > *2.9.6 Care Management Services, meaning a process of working with a resident to identify his/her needs and strengths, develop a service plan and arrange for and monitor service delivery.*

8. How many facilities requested "increased staffing" to manage difficult patients in from 2018-2021 and how many times did DHHS approve that increased staffing and how much was spent each year on this increased staffing? (Page 7)

   This request will require additional time. While we can identify how many waiver participants requested and received additional staffing, tracking the costs requires in depth analysis of the MaineCare claims associated with each member's case.

9. Are all PNMIs eligible for increased staffing as needed?

   Notably, it is the participant who may be eligible for more staffing, based on documented need, in certain PNMI settings.

   Additionally, here is additional information related to the frequency with which PNMIs can work with rate setting to address staffing needs:
   - PNMI Appendix Fs no more than every 6 months for Direct Care only.
   - PNMI Appendix E's generally annually to adjust staffing patterns, as appropriate and necessary, within their daily rate.
   - PNMI Appendix B and D are set on a fee schedule that is a rate based on the average level of staffing needed for different levels of care, per policy requirements.
   - For PNMI Appendix C's the Direct Care rate is set in response to a case mix assessment of resident level of need, so already incorporates resident-specific staffing needs.

10. How many cases have been referred to the Complex Case Unit each year from 2018-2021? (Page 7)

    Additional time is needed to be responsive to this question

11. Does the CCU track data associated with these cases, such as average length of stay? If so, please provide your tracking data.

    Additional time is needed to be responsive to this question

12. OCFS posts data on children in residential treatment both in state and out of state, updated on a monthly basis. Is there a wait list for residential treatment for children? If so, can that be posted?

    While the Department has reported this aggregated number in the past, it is not posted on the OCFS Key Measures Dashboard since that data is provided on a county or district level. The numbers of youth waiting for residential treatment are such that providing those numbers on a county/district level would risk the youth being identifiable. As such, we do not report those numbers on the dashboard.
13. Testimony from the Alliance stated that *"Adults and children are often released back to a community treatment center or to their home or street with no support in place, no plan of long term care. They then wind up back in the ER in a more difficult and challenging state than they were before the initial visit to the ER or hospital."* Can you please respond to this statement.

    From a DLC perspective, once a resident is admitted, residential care/PNMI facilities are required to assess resident needs, develop a service plan and arrange for and monitor service delivery. Residential Care and PNMI facilities are not medical facilities and may not have access to clinical staff on a regular basis and are required to coordinate and assist in accessing appropriate services for residents. This is sometimes accomplished through coordination with the resident's PCP, and sometimes by accessing emergent medical assessment and treatment. Residents in residential care/PNMI facilities who are competent also have the right to refuse treatment, which subsequently requires the facility to make reasonable efforts to consult the PCP, caseworker or other appropriate individuals in order to encourage residents to receive necessary services.

14. Crisis Teams – Hospitals report that crisis teams are directing individuals/families to the emergency department before any crisis teams conduct any community-based intervention to stabilize the individual and refer to services. How many individuals/families have been directed to the ED by the crisis team prior to conducting community-based intervention?

For the OADS crisis team, every referral received is assessed by a crisis team member prior to any recommendation being made. Only if the situation is a medical emergency would the team advise going to the ED. A manual review of crisis records would be required to determine how often this is the case, but anecdotally its rare.

Individuals who call the Maine Crisis Line/988 are assessed and triaged to an appropriate level of care based on this assessment. This year, the Maine Crisis Line answers on average 9138 calls a month, with 85% of those calls being resolved on the phone while about 15% of those calls are transferred to mobile crisis providers. Mobile Crisis providers are expected to serve the client in the community and only use higher levels of care when necessary and appropriate. Our data indicate that over the last 5 years, we have seen a decrease in initial crisis assessments being done in the emergency department.

15. Do you track the clinical behavioral health services (e.g. counselling, med. management) that residents of PNMIs receive? If so, could you provide some of that tracking data; such as what percentage of PNMI residents are receiving behavioral health clinical services? What kinds of services? And how well is the gap between what the community is providing and what hospitals provide being filled?

    Clinical services would be billed through MaineCare. Significant time would be required to identify the relevant MaineCare claims associated with PNMI residents.

16. Can you please request and provide the following information from KEPRO:
    - A sample of the information provided to a residential care facility upon referral.
    - A response to the Alliance's assertion that Kepro is providing insufficient information.
    - Tracking data associated with applications, such as the average length of time it takes for completion of a review regarding a referral? If this is not collected, please let us know.

    Each PNMI program has its unique eligibility criteria, referral, and authorization process, for Appendix E's PNMI referral forms are located on the KEPRO website and require the following information to be submitted
    - Client Demographics
    - Clinical Diagnosis and supporting eligibility materials medical necessity statement as well as LOCUS score
    - Current and prior MH/Co- Occurring treatment history
    - Current medical history
    - Legal involvement
    - Current resources and support
    - Additional information allows the person to upload any other information if needed.

    Due to HIPAA and releases on file at the time of referral, the department is not allowed to provide third-party information. Therefore, once referred to the accepting provider, the provider must obtain releases of information and gather supplemental materials.

    Once the referral is submitted, it is reviewed by KEPRO, approved and the client is placed on the waitlist. OBH PNMI team reviews each application, and when a placement is identified, the referral paperwork is sent to the provider via KEPRO. The provider has three days to acknowledge the referral, five days to make a contract with the person, and 30 days to move the client in. OBH tracks this data on every client entering the services and reports under the Consent Decree.

Take care,
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