

Division of Licensing and Regulatory Services

Annual Report
State Fiscal Year (SFY)
2010

July 1, 2009 to June 30, 2010



Department of Health
and Human Services

Maine People Living
Safe, Healthy and Productive Lives

John E. Baldacci, Governor

Brenda M. Harvey, Commissioner

**Division of Licensing
And
Regulatory
Services**

**Annual Report
SFY 2010**

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I. Background

The Division of Licensing and Regulatory Services was created in 2005 from various licensing units in the legacy Department of Human Services and Department of Behavioral and Developmental Services. The merger of the two departments was guided by the efforts of many advisory groups. Shortly upon creation of the Department of Health and Human Services, an Administrative Processes Oversight Committee was formed. Among its recommendations concerning the department were several pertaining to regulatory oversight activities involving licensing. Chief among those recommendations were:

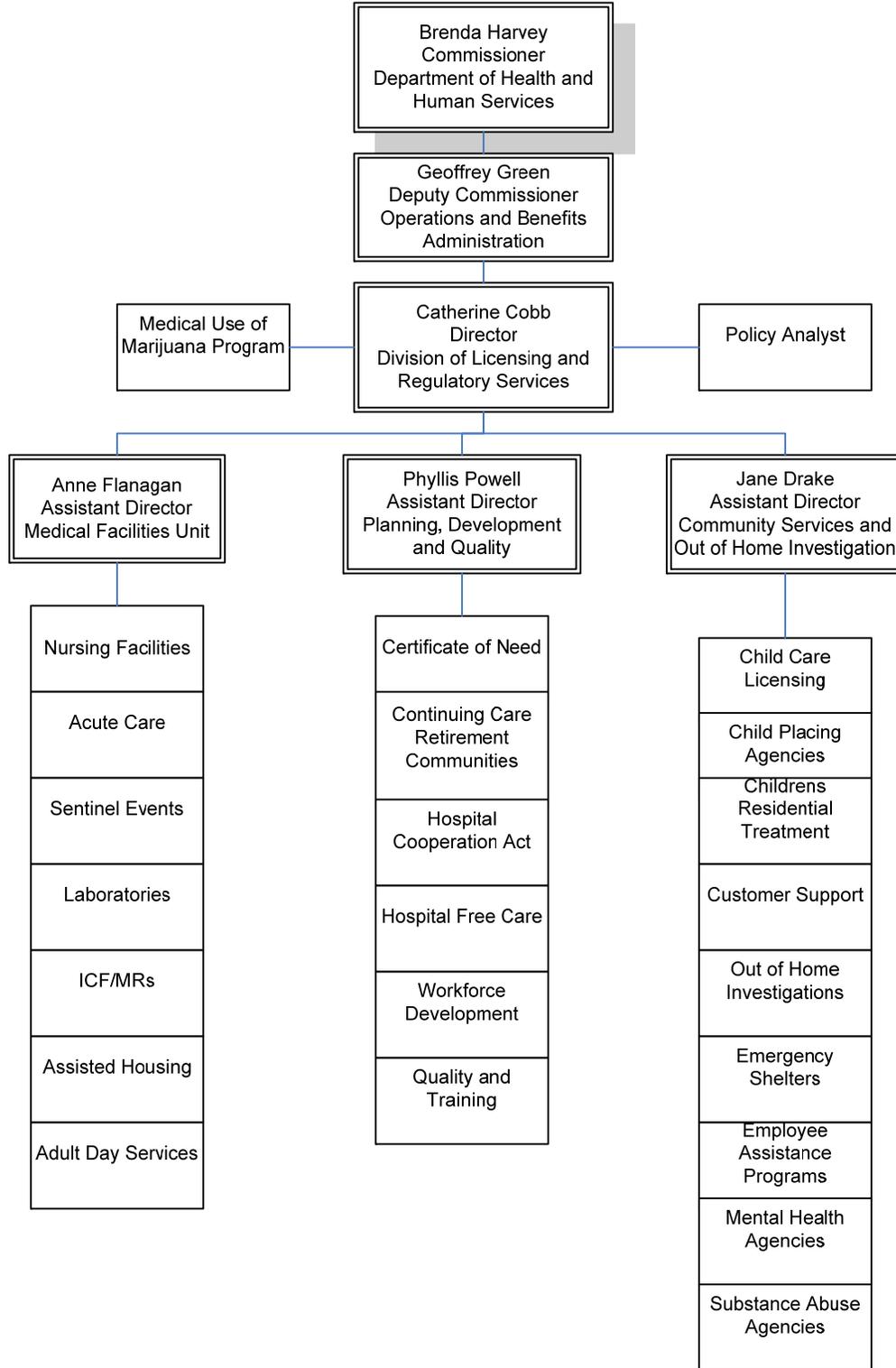
“Assure the consistent application of licensing requirements within and across programs, appropriately balancing the Department’s enforcement responsibility with its responsibility to improve provider quality by providing technical assistance; define clear boundaries between other department functions and ensure that the approach and standards are consistent and mutually consistent and mutually supportive across those functions.”

“We will focus on process improvement; we will cultivate provider partnerships; services to stakeholders will reflect the complexity of needs; and the administration of programs will be efficient and effective. There will be measurable performance objectives by program; performance indicators and staff performance expectations will reflect the Division’s core values and be implemented throughout the Division.”

In 2006, additional regulatory oversight functions were integrated into the Division. These included Certificate of Need regulation, health care antitrust oversight under the Certificate of Public Advantage Act, management of free care guidelines and oversight of continuing care retirement communities.

In 2010, the Division was assigned responsibility for implementing the Maine Medical Use of Marijuana Act. Also, additional duties for long term care workforce development were transferred from the Department of Education.

II. Organization Chart



III. Contact Information

Phone List:

Division Central Number: 1 (800) 791-4080 and 1 (207) 287-9300
Medical, Nursing, and Residential Care Facilities, C.N.A. Registry, and
Customer Support:
1 (800) 383-2441
Home Healthcare Agency (HHA) Hotline: 1 (800) 621-8222
Child Protective Intake Emergency Number: 1 (800) 452-1999
Adult Protective Intake Emergency Number: 1 (800) 452-1999
Sentinel Events Hotline: 1 (207) 287-5813

Address:

SHS #11
41 Anthony Avenue
Augusta, ME 04333-0011

Website:

<http://www.maine.gov/dhhs/dlrs/index.shtml>

District Offices:

Augusta	41 Anthony Ave Augusta, ME 04330	Toll free: 1-800-791-4080 Mainline: 1-207-287-9300 FAX: 1-207-287-9307
Bangor	396 Griffin Road Bangor, ME 04401	Toll Free: 1-800-432-7825 Main Line: 1-207-561-4100 Fax: 1-207-561-4298
Biddeford	208 Graham Street Biddeford, ME 04005	Toll Free: 1-800-322-1919 Main Line: 1-207-286-2400 Fax: 1-207-286-2527
Ellsworth	17 Eastward Lane Ellsworth, ME 04605	Toll Free: 1-800-432-7823 Main Line: 1-207-667-1600 Fax: 1-207-667-8692
Houlton	11 High Street Houlton, ME 04730	Toll Free: 1-800-432-7338 Main Line: 1-207-834-7700 Fax: 1-207-834-7701
Lewiston	200 Main Street Lewiston, ME 04240	Toll Free: 1-800-482-7517 Main Line: 1-207-795-4300 Fax: 1-207-795-4651
Portland	1037 Forest Avenue Suite 11 Portland, ME 04103	Toll Free: 1-800-482-7520 Main Line: 1-207-797-2892 Fax: 1-207-797-2801
Sanford	890 Main Street, Suite 208 Sanford, ME 04073	Toll Free: 1-800-482-0790 Main Line: 1-207-490-5400 Fax: 1-207-490-5463
Skowhegan	98 North Avenue, Suite 10 Skowhegan, ME 04976	Toll Free: 1-800-452-4602 Main Line: 1-207-474-4873 Fax: 1-207-474-4800

IV. Administration

Background

Administration oversees the broad functions of survey and certification of health and long term care facilities, certification and licensing of child care programs, licensing of behavioral health providers, operation of the Registry of Certified Nursing Assistants, other work force development programs, and the regulatory oversight functions described herein.

The Director, Assistant Directors for Planning, Development and Quality, Community Services and Medical Facilities, guide the day to day operation of the Division and lead planning activities. Senior leaders are also responsible for developing and implementing performance metrics for their areas of function to assure that the Division is accountable and continually striving to improve performance.

Program Responsibilities – Division-wide

Administration Staff Table SFY 2010		
Staff	Positions	Duties
Division Director	1	Division-wide/department-wide
Policy Analyst	1	Legislative policy, rules and regulatory changes.
Paralegal	1	FOA requests, Hearings, CNA actions and support to the CNA Registry.
Secretary Associate	1	Supports the Director and administrative activities, building control, and web master.
Assistant Directors	3	Planning, Development and Quality; Community Services; and Medical Facilities
Reception	1	Division-wide
Customer Service Intake	1	Division-wide
Clerk IV	2	Division-wide

Projects/ Collaborations

The Director represents the Division at the Legislature, and is a member of the Department's Integrated Management Team. The Assistant Directors are responsible for policy, planning, management, and stakeholder involvement for their respective programs. Each leads specific strategic plan initiatives.

Receptionist Telephone Calls SFY 2010	
Calls Received	Number of Calls Received 2010
1. Child Care (includes requests for application packets/questions for licensor's/questions for support staff)	4361
2. Miscellaneous calls (includes scheduling conference rooms, picking up mail & escorting visitors from Lobby, giving e-mail/website information, etc.)	2572
3. CNA Registry	2623
4. CRMA	1558
5. Assisted Living	1085
6. Acute (Non Long Term) Care	957
7. Mental Health/Substance Abuse	611
8. Complaint calls	669
8. Long Term Care	765
10. Community Services Director's Office	286
11. Division Director's Office	386
12. ICF/MR	257
13. Medical Facilities Office Manager	553
14. CLIA	84
15. Paralegal	126
16. Healthcare Oversight/PDQ	180
17. CSL Office Manager	150
18. Medical Facilities Director	73
19. Sentinel Event calls	13
20. Medical Marijuana Program	214*
<u>TOTAL</u>	<u>17,523</u>

* Medical Marijuana Program not tracked until 4th qtr sfy10

Policy Analysis, Legislation, and Rules

The policy analyst prepares the annual regulatory agenda and works with other Division staff when drafting proposed amendments to licensing, certification, and registration rules as well as rules governing sentinel events reporting, certificate of need and the certified nursing assistant registry. The policy analyst ensures compliance with the Maine Administrative Procedure Act during the rulemaking process. The Division is responsible for over 35 sets of rules. In addition, the analyst assists the senior leadership team with the drafting and monitoring of legislation

Rulemaking Activity

The following table identifies rules that were enacted as emergency rules or amended during this state fiscal year.

RULEMAKING ACTIVITY SFY 2010 (July 1, 2009 – June 30, 2010)	
Rules	Action
Rules Governing the Maine Registry of Certified Nursing Assistants, 10-144 C.M.R. Ch. 128. <i>Effective August 1, 2009</i>	These rules implement Public Law 2003, chapters 376, 416, 599, and 634; Resolves 2003 chapter 96; and adopted amendments to the Maine Board of Nursing rules (02-380 C.M.R. Ch. 5). They repeal and replace the current Rules Governing the Maine Registry of Certified Nursing Assistants (CNA Registry). The rules incorporate mandated legislative changes and current best practices in the operation of a CNA Registry.

<p>Rules Governing the Reporting of Sentinel Events, 10-144 C.M.R. Ch 114 <i>Effective April 17, 2010</i></p>	<p>To reduce medical errors and improve patient safety, the Maine Legislature enacted Public Law 2009, Chapter 358, which amended the Sentinel Events Reporting statute, 22 MRSA Chapter 1684. The rules have been amended to incorporate the statutory revisions. The amended rule includes the following changes: New definitions of a number of terms including root cause analysis, immediate jeopardy, and near miss; The definition of sentinel events is amended to include the list of serious and preventable events identified by the National Quality Forum; Requires standardized training of providers and staff, reporting and notification procedures; Financial penalties are increased from not more than \$5000 to not more than \$10,000; and Appendix I incorporates by reference “Table 1 – List of Serious Reportable Events, pages 7-16” of the National Quality Forum (NQF), <i>Serious Reportable Events in Healthcare – 2006 Update: A Consensus Report</i>.</p>
<p>[EMERGENCY RULE] Rules Governing the Maine Medical Use of Marijuana Program 10-144 CMR Chapter 122 <i>Effective May 5, 2010 for 90 days. (Expired August 3, 2010)</i></p>	<p>In November 2009, voters approved an initiated bill that changed Maine's medical use of marijuana laws. The initiated bill replaces the informal system that protected patients who grew and used marijuana for medical conditions. The Governor signed Public Law 2009, Ch 631 (Emergency Preamble) on April 9, 2010, in which additional changes to the law were enacted by the 124th Legislature.</p>
<p>[NEW] Rules Governing the Maine Medical Use of Marijuana Program 10-144 CMR Chapter 122 <i>Effective August 4, 2010</i></p>	<p>Final adopted Rules Governing the Maine Medical Use of Marijuana Program. They replace the emergency rules.</p>

Legislative Policy Initiatives

The Division submitted several pieces of proposed legislation for consideration. A number of legislative bills pertaining to Division programs became Public Law.

LEGISLATIVE ACTIVITY SFY 2010 (7/1/09-6/30/10)		
LD	Public Law	Title and Comment
1464	PL 09 Ch 621	<p>Criminal background checks and temporary nurse agencies. <i>An Act To Amend Licensing, Certification and Registration Requirements for Health Care Providers and Other Facilities.</i> This law requires licensed, certified, or registered providers to secure a criminal background check prior to hiring or placing a person who will have direct contact with a consumer. Providers will pay for the criminal background checks. This law authorizes the Department of Health and Human Services to investigate complaints against temporary nurse agencies and provides enforcement mechanisms for violations. This law requires the department to use income from penalties to improve the quality of care for residents of long-term care facilities.</p> <p>http://www.mainelegislature.org/legis/bills/bills_124th/chapdocs/PUBLIC621.rtf</p>
1591	PL 09 Ch 556	<p>Certificate of Need law: right of entry and investigation. [Emergency] <i>An Act To Amend the Maine Certificate of Need Act of 2002 Concerning Right of Entry and Investigation.</i> This law authorizes the Department of Health and Human Services to enter and inspect a health care facility or other entity subject to the Maine Certificate of Need Act of 2002 when the department has a reasonable basis to suspect that a violation has occurred.</p> <p>http://www.mainelegislature.org/legis/bills/bills_124th/chapdocs/PUBLIC556.rtf</p>

688	PL 09 Ch 590	<p>DLRS fees. <i>An Act To Update the Laws Affecting the Department of Health and Human Services, Division of Licensing and Regulatory Services.</i> This law authorizes the Department of Health and Human Services to charge a processing fee when a licensed, certified, or registered facility, health care provider, or program must have a license, certificate, or registration reissued by the department because the licensee, certificate holder, or registration holder made changes that require the reissuance of the license, certificate, or registration. The law authorizes the department to establish an annual registration fee for temporary nurse agencies and to increase the initial and renewal licensing fees for nursery schools, not to exceed \$40. The law authorizes the department to charge certain providers a transaction fee to renew licenses electronically. It authorizes the department to charge an annual verification fee to providers to check a certified nursing assistant's credentials and training history. http://www.mainelegislature.org/legis/bills/bills_124th/chapdocs/PUBLIC590.rtf</p>
1704	PL 09 Ch 628	<p>Workforce Development Training <i>An Act To Amend the Laws Regarding Authority over and Oversight of Certified Nursing Assistant Educational Programs.</i> This law transfers the responsibility for approving the curriculum for and certificates granted to activities coordinators in long-term care facilities from the Department of Education to the Department of Health and Human Services. The law also transfers the responsibility and authority for the approval and monitoring of nursing assistant training curricula, faculty and certification programs from DOE to DHHS. The law also transfers the authority to assess fees for certification of nursing assistants, for the competency testing of nursing assistants and for validation of test results to determine eligibility for certification and charge fees for certificates issued and duplicated for out-of-state vocational reciprocity, renewal of certificates and replacement of certificates from DOE to DHHS. The law increases the fees charged for competency testing and the letter of verification of completion of a certified nursing assistant program. http://www.mainelegislature.org/legis/bills/bills_124th/chapdocs/PUBLIC628.rtf</p>

1811	PL 09 Ch 631	<p>Maine Medical Use of Marijuana Program <i>(Emergency) An Act To Amend the Maine Medical Marijuana Act</i></p> <p>This law amends the statutes enacted by Initiated Bill 2009, chapter 1, that allow a person who has been diagnosed by a physician as suffering from certain medical conditions to possess marijuana for medical use. It reflects the recommendations of the Committee on the Implementation of the Maine Medical Marijuana Act and the Criminal Law Advisory Commission. It also clarifies many of the provisions of the statutes including the certification of dispensaries, the process to add new debilitating conditions, and conforms the language of the statutes to other Maine laws.</p> <p>http://www.mainelegislature.org/legis/bills/bills_124th/chapdocs/PUBLIC631.rtf</p>
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V. Assisted Housing and Adult Day Services

Assisted Housing

“Assisted Housing” is an umbrella term describing many types of residential programs for adults, where they receive personal care services, medication assistance, and many other therapeutic services. The Unit works closely with the Long Term Care Ombudsman Program to resolve issues brought forward by the public.

“Private Non-Medical Institutions (PNMI)” and “Residential Care Facilities (RCF)” provide the same services and type of housing. The distinguishing difference is that a PNMI receives Maine Care funds and complies with additional requirements as specified in various sections of the Regulations Governing the Licensing and Functioning of Assisted Housing Programs. Both are described as a house or other place that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services”. Residents live in either private or semi-private bedrooms with common living areas and dining areas. The characteristic of persons served varies, and are identified in the facility’s admissions policy.

There are four levels of PNMI: Levels I, II, III and IV. Each has its own regulatory requirements and is distinguished by the number of residents served and/or type of staff. Each facility is reviewed for regulatory compliance during a complaint investigation and on an annual or bi-annual survey.

Adult Day Services

An Adult Day Health Services Program provides health monitoring and personal care services in addition to a group program of care, therapeutic activities and supervision. A Social Adult Day Services Program is designed to meet the social and supervisory needs of participating adults.

Assisted Living Programs

An Assisted Living Program provides assisted living services to consumers in private apartments in buildings that include a common dining area, either directly or indirectly through contracts. There are two types of programs. Type I provides personal care and medication administration and Type II provides those services and nursing services.

Assisted Housing & Adult Day Program Unit Accomplishments for 2010:

In SFY 2010, the Unit adopted the “California Model” to investigate licensing complaints. The model brings structure to the complaint investigation process, leading field staff to only focus on allegations that might be considered a licensing violation. Since the process is more focused, there is a clearer understanding, prior to staff arriving at the facility, of what needs to be accomplished while on site.

The model also relieves staff from having to write detailed narratives that describe how they arrived at their findings. It only requires staff to highlight and reference their supporting evidence. As a division, we hope this reduces the amount of time to investigate complaints and complete the related paperwork. In order to capture all the benefits of the “California Model” the division is working to obtain computer tablets for all staff so that more onsite work at the facility can be achieved.

Another major accomplishment of the Unit was transitioning the work of all Level IV Residential Care Facilities, from a Microsoft Access database to a more sophisticated Oracle database (ASPEN). The system has allowed our Unit to work more collaboratively with the State Fire Marshal's Office, allowing for more timely inspections. Transitioning into a database like ASPEN allows the division to collect information/data more uniformly and allows for better monitoring of work practices/trends.

Assisted Housing - Provider Table SFY						
Provider Types	Provider Counts			Beds/ Capacity if Applicable		
	2008*	2009	2010	2008	2009	2010
Assisted Living	32	32	36	1465	1467	1653
Level I Residential Care	59	59	52	104	106	97
Level II Residential Care	55	54	48	208	201	179
Level III Residential Care	339	342	340	1446	1444	1440
¹ Level IV Residential Care	190	191	198	5367	5340	5829
Adult Day Care	39	34	33	668	595	579
<u>TOTAL</u>	<u>714</u>	<u>712</u>	<u>707</u>	<u>9258</u>	<u>9153</u>	<u>9777</u>

*2008 data is from report dated January 2009

¹ Multi-level, (meaning part of a nursing facility and part Level IV Residential Care), providers are reported under the level IV section in this table.

Licensure Surveys SFY 2010			
Assisted Housing/ Adult Day Services	2008	2009	2010
<u>TOTAL</u>	<u>331</u>	<u>246</u>	<u>328</u>

Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size.

Assisted Housing Program Complaints Investigated SFY			
Assisted Housing and Adult Day Services	2008	2009	2010
<u>TOTAL</u>	<u>136</u>	<u>84</u>	<u>70</u>

Assisted Housing Staff Table SFY			
Staff	2008	2009	2010
Assisted Housing Supervisor/Manager	1	1	1
RN Consultant	2	.5	.5
Program Licensor	8	7	7
Facilities Licensor	2	2	2
Support Staff	2	1	1
<u>TOTAL</u>	<u>15</u>	<u>11.5</u>	<u>11.5</u>

VI. Behavioral Health

Behavioral Health encompasses all behavioral health programs except hospital in-patient units. The unit's licensors survey and license behavioral health programs as well as investigate complaints. Because of the necessity to align service delivery with policies and contracts of other Offices, the Unit meets regularly with Offices such as the Office of Adult Mental Health, the Office of Substance Abuse, and the Office of Child and Family Services.

Child Placing Agencies with and without Adoption Programs

Child Placing Agencies find or place children under the age of 18 into homes where care is provided on a 24-hour a day basis. Placements include children in the foster care system.

Children's Residential Care Facilities

Children's Residential Care Facilities are residences maintained for board and care of one or more children under the age of 21; often for behavioral services and mental health treatment.

Mental Health Agencies

Mental Health Agencies provide outpatient and/or residential services. The behavioral health unit also reviews agency compliance with the Consent Decree.

Substance Abuse Agencies

Substance Abuse Agencies provide outpatient care, residential programs, driver education and evaluations programs, inpatient care, methadone treatment, halfway houses and shelters.

Employee Assistance Programs

Agencies, organizations, and corporations often have Employee Assistance Programs for employees who are having emotional distress, substance abuse problems, or other issues, that interfere with work performance.

Shelters for Homeless Youth and Emergency Shelters for Children

Shelters provide homeless youth a place to stay while a more long term housing plan is developed. Mental health and substance abuse treatment is not normally provided; referrals for such treatment are made if there is a need.

Behavioral Health Provider Table SFY						
Provider Types	Provider Counts 2008 *	Provider Counts 2009	Provider Counts 2010	License Surveys 2008	License Surveys 2009	License Surveys 2010
Children's Residential	153	149	117	71	48	70
Substance Abuse	90	87	89	48	54	45
Mental Health	120	121	129	32	77	59
** Employment Assistance Programs	n/a	80	88	44	18	25
Children's Placement Agencies	20	21	22	10	13	18
Shelters for Homeless Youth	3	3	3	3	3	1
Emergency Shelters for Children	2	2	2	1	1	1
<u>TOTAL</u>	<u>388</u>	<u>461</u>	<u>450</u>	<u>209</u>	<u>214</u>	<u>219</u>

*Provider counts for 2008 are as of 10/1/2008

**data not available for 2008

Behavioral Health SFY 2010	
Provider Types	Capacity
Children's Residential	1,846 beds
Substance Abuse	27,569 consumers
Mental Health	81,980 consumers
Employment Assistance Programs	33,028 consumers
Children's Placement Agencies	4,935 consumers
Shelters for Homeless Youth	32 beds
Emergency Shelters for Children	22 beds
<u>TOTAL CAPACITY</u>	<u>149,412</u>

Behavioral Health Complaints Investigated SFY			
Provider Types	2008	2009	2010
Children's Residential	22	23	23
Substance Abuse	8	8	4
Mental Health	14	14	23
Employment Assistance Programs	0	0	1
Children's Placement Agencies	2	2	0
Shelters for Homeless Youth	1	1	0
Emergency Shelters for Children	0	0	2
TOTAL	<u>47</u>	<u>48</u>	<u>53</u>

Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size.

Behavioral Health Staff Table SFY			
Staff	2008	2009	2010
Supervisor Behavioral Health	1	1	1
Program Licensor	7	6	6*
Support	1	1	1
TOTAL	<u>9</u>	<u>8</u>	<u>8</u>

***1 program licensor took advantage of the Retirement Incentive Program. Position frozen for 2 years.**

VII. Child Care

Community Care Workers complete inspections annually to determine compliance. Licenses are issued for up to two years. Inspections include a tour of the physical plant, review of records and interviews with staff/providers and others. Community Care Workers are also a resource to providers and provide technical assistance as well as participate in new provider trainings.

When a complaint is received it is assigned to a licensor or an Out of Home Investigator. This determination is based on the nature of the complaint. Complaints alleging non-compliance with licensing rules are assigned to licensors.

Family Child Care is provided in a person's home for 3-12 children under 13.

There are two types of Child Care Facilities:

- *Child Care Center is a facility for 13 or more children under 13*
- *Small Child Care Facility is a facility that is not at the provider's residence and serves 12 or fewer children..*

Nursery School is a facility providing for 3 or more children 33 months or older and under age 8, with no sessions longer than 3 ½ hours.

Child Care Providers SFY						
Provider Types	Provider Counts 2008*	Provider Counts 2009	Provider Counts 2010	Capacity 2008*	Capacity 2009	Capacity 2010
Family Child Care Provider	1,491	1,519	1,537	16,010	15,755	15,194
Child Care Facility	625	726	783	30,990	33,463	31,789
Nursery School	121	131	139	2,643	2,315	2,282
<u>TOTAL</u>	<u>2,237</u>	<u>2,376</u>	<u>2,459</u>	<u>49,643</u>	<u>51,533</u>	<u>49,265</u>

*08 provider counts are as of 10/1/2008 and capacity as of 11/08

Child Care Licensing Complaints and Survey Table SFY			
	2008	2009	2010*
Complaints	302	268	207
Surveys	2,604	2,583	1,946
<u>TOTAL</u>	<u>2,906</u>	<u>2,851</u>	<u>2,153</u>

*In SFY2010, there was a change in methodology that resulted in a decrease in the data for that year.

Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size.

Child Care Licensing Staff Table SFY			
	2008	2009	2010
Supervisors Child Care Licensing	2	2	2
Program Licensors	15	14	14
Support	2	2	2
<u>TOTAL</u>	<u>19</u>	<u>18</u>	<u>18</u>

STATE SANCTIONS SFY 2010				
Denials (New Applications & Non- renewals	Conditional Licenses	Consent Agreements	License Modifications	# of Hearings
15	8	1	1	9*

* Number pending a final decision

VIII. Out of Home Investigations

All allegations of abuse and/or neglect involving children in facilities and institutions that are licensed are triaged and investigated by the Out of Home Investigations Unit. This unit of social workers specializes in interviewing children and has extensive experience and training in investigating child abuse complaints. The routing of the complaint will be based on the substance of the allegations and the probable need to interview a child or children as a result of the allegation. Any allegations regarding possible licensing violations are assessed by the respective licensing worker for that resource. Some of the licensed facilities and institutions that are investigated include child cares, foster homes, and children's residential facilities. The final assessment may have a finding of abuse or neglect and may cite licensing violations. Any licensing violations identified during an assessment of an incident are shared/referred to the appropriate licensing authority for follow-up.

Calendar Year 2009 Statistics*

CHILD CARE INVESTIGATED: 74

Unsubstantiated Assessments: **24**
Unsubstantiated Assessments with Licensing Violations: **38**
Indicated Assessments: 7
Substantiated Assessments: 5
Reports Referred to Licensing: **207**

FOSTER HOMES INVESTIGATED: 54

Unsubstantiated Assessments: **29**
Unsubstantiated Assessments with Licensing Violations: 17
Indicated Assessments: 7
Substantiated Assessments: 1
Reports Referred to Licensing: **58**

RESIDENTIAL INVESTIGATED: 43

Unsubstantiated Assessments: 16
Unsubstantiated Assessments with Licensing Violations: 19
Indicated Assessments: 4
Substantiated Assessments: 4
Reports Referred to Licensing: 62

MENTAL HEALTH INVESTIGATED: 5

Unsubstantiated Assessments: 1
Unsubstantiated Assessments with Licensing Violations: 4
Indicated Assessments: **0**
Substantiated Assessments: **0**
Reports Referred to Licensing: 63

* Information based on calendar year 2009

Out of Home Investigations Workload *SFY 2010			
Provider Type	Complaints Received	Complaints Closed	Complaints Referred
Child Care	282	85	220
Foster Homes	114	60	56
Residential	86	38	50
MH/SA	81	3	80
Dept. ED	65	-	64
<u>Total</u>	<u>628</u>	<u>186</u>	<u>470</u>

*Change in methodology from prior year reporting. Data is not compatible with previous years.

Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size.

Out of Home Investigations Staff Table SFY			
	2008	2009	2010
Staff	Positions	Positions	Positions
Manager/ Supervisor*	0	0	0
Investigators	6	5	5
<u>TOTAL</u>	<u>6</u>	<u>5</u>	<u>5</u>

* Assistant Director manages this program

IX. Healthcare Oversight

Certificate of Need

The Certificate of Need (CON) Act provides the framework for review of proposals by or on behalf of certain health care facilities and nursing facilities involving expansion of plant and equipment, the provision of new services, transfers of ownership and control and other initiatives requiring a CON.

The process is integrated with the priorities of the State Health Plan (SHP) and operates within constraints established by the Capital Investment Fund (CIF). The CIF acts as a limit on annual investment subject to review under the CON statute. Investment is measured based on the third year incremental costs associated with an approved project. Both the SHP priorities and the CIF are determined independently by the Governor's Office of Health Policy and Finance.

The CON Unit has several review types according to the project. Below are tables illustrating the review types and facility types that were reviewed during calendar year (CY) 2009.

Capital Expenditure for Calendar Year (CY) 2009		
Review Type	Number	Amount
Complete Review	12	\$512,961,555
Emergency Review	1	\$0
Expired	1	\$0
Not Subject to Review	20	\$31,102,539
Subsequent Review	2	\$13,666,316
Suspended	3	\$6,195,420
Withdrawn	2	\$8,000,000
		\$571,925,830

Projects by Facility Type CY 2009		
Facility Type	Number	Amount
Hospital	24	\$480,476,733
Nursing Facility	13	\$88,429,097
Other	4	\$3,020,000
		\$571,925,830

The CON Act establishes a number of thresholds that trigger review.

Thresholds		
Category		Amount
Major Medical Equipment		\$1,600,000
Capital Expenditures		\$3,100,000
New Technology		\$1,600,000
Nursing Facility Capital Expenditures		\$718,958
New Health Service		
	Capital Expenditure	\$140,098
	3rd Year Incremental Operating Costs	\$509,449

The CIF established by the Dirigo Health Act, created several categories of projects to enable hospital and non-hospital projects, small and large, to be competitive in their own categories. The Dirigo Health Act did not establish a CIF for nursing facility projects. Instead, the CON Act of 2002 established a nursing home funding pool. In other words, a project increasing Maine Care costs must have an equal decrease in Maine Care costs elsewhere. This maintains budget neutrality while allowing some projects above the nursing facility thresholds to proceed.

CY 2009 Capital Investment Fund			
	Small	Large	Total
Non-Hospital	\$263,213	\$1,491,540	\$1,754,753
Hospital	\$1,842,491	\$10,440,780	\$12,283,271
			\$14,038,024

CON applicants are required to pay a nonrefundable fee for the review of each project. The CON Unit also collects fees for copies of documents requested under the Freedom of Information Act (FOIA).

Revenue CY 2009	
FOIA	\$823.00
CON Applications	\$347,000.00
Total	\$347,823.00

Continuing Care Retirement Communities

To operate a Continuing Care Retirement Community (CCRC), a person must submit an application to the Bureau of Insurance (BOI) for a preliminary Certificate of Authority to operate a CCRC. The CON Unit provides certain assurances to the BOI in order for a certificate to be granted. CCRCs are allowed to accept private pay non-CCRC residents with approval from the Bureau of Insurance upon successful licensure from DLRS and review from the Healthcare Oversight staff.

These facilities may have Maine Care and Medicare patients, subject to Bureau of Insurance restrictions, if they complete the CON process. There are only two CCRCs in Maine.

Hospital Cooperation Act

DLRS is responsible for administrating the annual Hospital and Health Care Provider Act Assessments. Except for state-operated mental health facilities, any hospital licensed by the Department of Health and Human Services is subject to an annual assessment under Chapter 405-A, Para. 1850. Assessments for all hospitals that were collected in CY 2009 totaled \$200,000.00

A hospital may apply for a Certificate of Public Advantage (COPA) pursuant to the Hospital and Health Care Provider Act of 2005. The approval of a COPA would authorize the hospital(s) to enter into a cooperative agreement with another hospital if the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that might result from the agreement. This is a voluntary process that includes participation from the Office of the Attorney General and the Governor's Office of Health Care Policy and Finance (GOHPF). During CY 2009, only one application for a COPA was received. This application was also withdrawn by the applicant in CY 2009.

Hospital Free Care Guidelines

DLRS collects data on the free care policies of hospitals, including minimum income guidelines, to be used in determining whether individuals are unable to pay for hospital services. It sets forth procedures for notifying patients of the availability of free care, determining who is qualified for such care, and annually reporting the quantity of free care provided.

In addition to collecting the data, DLRS also ensures compliance with the Charity Care guidelines and compliance with the notification statutes. DLRS serves as an information resource for hospital staff responsible for Free Care determinations as well as conducting compliance audits.

Calendar Year 2009 Free Care

Hospital	Mandated Free Care Amount	# of Patient Records Reported	Additional Uncompensated Care Amount	# of Patient Records Uncompensated Care
Acadia Health Care	\$1,425,880.00	310	\$6,157,623.00	1,612
Blue Hill Memorial Hospital	\$1,108,077.00	413	\$39,406.00	61
Bridgton Hospital	\$475,764.43	1,019	\$403,769.40	696
Calais Regional Hospital	\$262,113.10	88	\$10,054.04	24
Cary Hospital	\$591,717.00	291	\$111,344.00	65
Central Maine Medical Center	\$6,119,202.62	4,706	\$3,075,141.97	4,074
Charles A. Dean Memorial Hospital	\$164,135.44	51	\$129,862.09	63
Down East Community Hospital	\$1,209,624.32	201		219
Eastern Maine Medical Center	\$6,226,669.00	1,048	\$8,788,027.00	41,775
Franklin Memorial Hospital	\$1,942,814.00		\$815,982.00	
Goodall Hospital	\$13,544,004.00	1,232	**	**
Houlton Regional Hospital	\$973,659.00	377	\$3,569.00	43
Inland Hospital	\$26,579.49	27	\$863,669.77	343
Maine Coast Memorial Hospital	\$1,706,631.00	509	\$224,325.00	240
Maine General Medical Center	\$5,488,989.32	2,125	\$231,591.29	286
Maine Medical Center	\$17,586,993.00	21,358	\$2,225,708.00	1,922
Mayo Regional Hospital	\$1,290,696.00	449	\$322,674.00	121
Mercy Hospital	\$5,341,599.00	4,901	\$2,365,728.00	3,867
Mid Coast Hospital	\$1,942,430.00			
Miles Memorial Hospital	\$1,416,098.33	710		
Millinocket Regional Hospital	\$521,097.45		\$278,701.73	
Mount Desert Island Hospital	\$135,901.04		\$362,519.59	
New England Rehabilitation Hospital of Portland	\$285,670.00	106		
Northern Maine Medical Center	\$336,317.95	104	\$260,836.19	49
Parkview Adventist Medical Center	\$737,448.00	399	**	**
Penobscot Bay Medical Center	\$2,140,333.90	882	\$1,206,401.60	1,440
Penobscot Valley Hospital	\$650,378.76	886	\$292,267.36	664
Redington-Fairview General Hospital	\$648,648.66	234	\$563,125.27	204
Rumford Hospital	\$315,605.83	512	\$206,956.61	332
Sebasticook Valley Hospital	\$1,148,002.00		\$545,930.00	
Southern Maine Medical Center	\$2,804,221.00	1,097	\$193,697.00	229
Spring Harbor Hospital	\$5,271,481.00	1,567	\$485,060.00	143
St. Andrew's Hospital and Healthcare Center	\$169,957.63			
St. Joseph Hospital	\$1,027,197.25	674	\$60,182.82	114
St. Mary's Regional Medical Center	\$6,997,818.80	6,334	**	**

Hospital	Mandated Free Care Amount	# of Patient Records Reported	Additional Uncompensated Care Amount	# of Patient Records Uncompensated Care
Stephens Memorial Hospital	\$1,065,905.00	1,443	\$391,788.00	808
The Aroostook Medical Center	\$1,126,809.00	254	\$581,528.00	181
Waldo County General Hospital	\$865,939.39	1,260	\$202,872.11	763
York Hospital	\$4,410,049.62	6,922	**	**
Totals	\$99,502,458.33	62,489.00	\$31,400,340.84	60,338.00

** Hospitals are required to report the two categories of Free Care (required and not required) separately. However, some hospitals included the non-required Free Care amounts as part of the required total.

The CON Annual Report may be found at the following website:
<http://www.maine.gov/dhhs/dlrs/con/index.shtml#report2009>

Healthcare Oversight – Staff Table By Calendar Year			
Staff	2007	2008	2009
Healthcare Financial Analysts	2	2	3
Support	0	.5	.5
<u>TOTALS</u>	<u>2</u>	<u>2.5</u>	<u>3.5</u>

X. Sentinel Events

In 2002, Maine established a mandatory Sentinel Event reporting system. Sentinel Events are defined as unanticipated deaths and other serious adverse events that are most often preventable. The law applies to all licensed General and Specialty Hospitals, Ambulatory Surgical Centers, End-Stage Renal Disease Facilities/Units, and Intermediate Care Facilities for Persons with Mental Retardation.

Definition of Sentinel Event

Sentinel events are outcomes determined to be unrelated to the natural course of the patient's illness or underlying condition, or proper treatment of that illness, or underlying condition. The law, during the time of this report, characterized sentinel events as:

- Unanticipated death;
- A major permanent loss of function that is not present when the patient is admitted to the health-care facility;
- Surgery on the wrong patient or wrong body part;
- Hemolytic transfusion reaction involving administration of blood or blood products having blood group incompatibilities;
- Suicide of a patient in a healthcare facility where the patient receives inpatient care;
- Infant abduction or discharge to the wrong family; and
- Rape of a patient.
- Stage 3 and 4 pressure ulcers

The law further requires an annual report to the Legislature and public. Maine continues to significantly under-report Sentinel Events based on estimates from national studies. A total of 192 Sentinel Events have been reported and reviewed since the inception of the program in 2004. The overwhelming majority are unanticipated patient deaths.

Maintaining a commitment to a collaborative approach among all stakeholders for identifying, reporting, and sharing aggregate data for all Sentinel Events offers the best opportunity for preventing recurrences.

On September 12, 2009 Legislature approved LD 1435, an Amendment to the previous law. Subsequent Rules were effective April 19, 2010.

Key statutory changes include:

- Sentinel Event definition added the National Quality Forum, 28 Serious Reportable Events;
- Addition of inter-facility transfer patients. Patients suffering a Sentinel Event and are subsequently transferred to another facility are reportable events;
- Facilities must report events upon discovery within one business day;

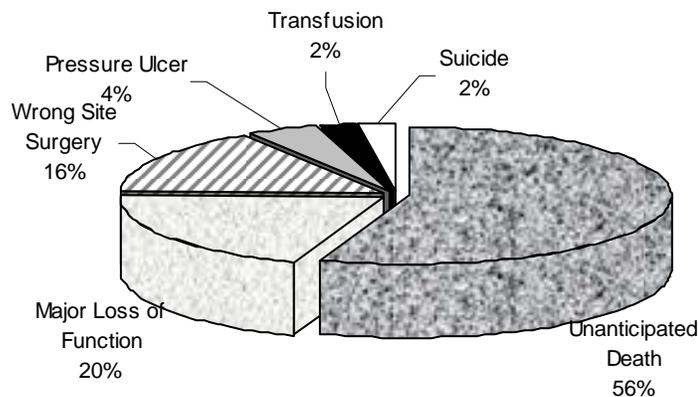
- Confidentiality protections added for all communications and reports of suspected sentinel events;
- Voluntary submission of ‘near miss’ events;
- Requirements for facilities to adopt standardized procedures for identifying and reporting sentinel event;
- Penalty for failure to report Sentinel Events increased to maximum of \$10,000;
- Facility requirements for submitting Root Cause Analysis specified.

Sentinel Events Reported in 2009

Forty-five sentinel events were reported to the Division of Licensing and Regulatory Services in 2009. All cases were reported by licensed hospitals. There were not any reports from Intermediate Care Facilities for persons with Mental Retardation (ICFMR), Ambulatory Surgery Centers or End Stage Renal Disease Centers (ESRD). This number is consistent with the number of reports in 2008 and represents a 50% increase over events reported in 2007. The number of reporting hospitals has increased to 38 or 93%. Three hospitals have never reported a single event. Other states experience reflects that the number of reporting hospitals generally increases when facilities see the relevance of reporting to improving patient safety within their own institutions and the state (Rosenthal et al, 2001).

Maine is the only state that reviews all Sentinel Events and conducts on site visits. Modifications to the case review process have been made to ensure that Sentinel Event Team visits take place within the 45 day period following the report of an event and prior to the submission of the Root Cause Analysis. Findings from medical record case reviews are shared with the facility leaders to enhance their Root Cause Analysis process and contribute to the lessons learned. This collaborative approach is unique to Maine, and provides an independent assessment that augments the facility’s review.

2009 Sentinel Events by Type



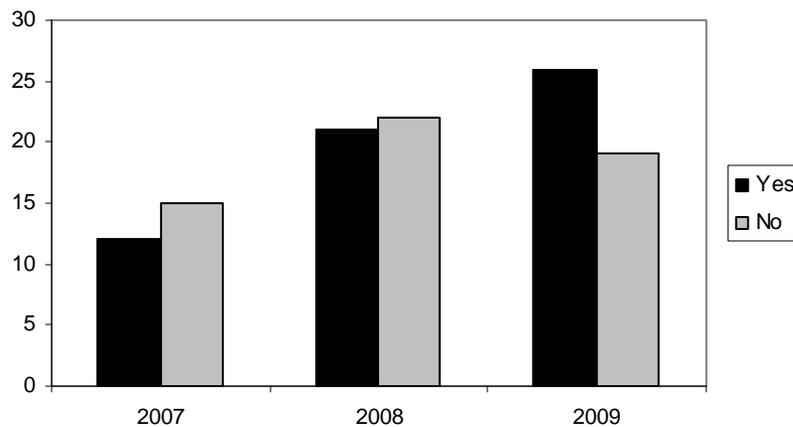
Hospitals reporting Sentinel Events:

	2004	2005	2006	2007	2008	2009
	No. %	No. %	No. %	No. %	No. %	No. %
Reporting hospitals	11 27%	20 49%	25 61%	32 78%	33 80%	38 93%
Non-reporting hospitals	30 73%	21 51%	16 39%	9 22%	8 20%	3 7%
Total	41 100%	41 100%	41 100%	41 100%	41 100%	41 100%

Sentinel Events with a Delay in Treatment

In 2009, 57% of the total cases reported had evidence of delays. DLRS began to review cases for evidence of a delay in treatment in 2007. The number and rate grew to over 50% for Sentinel Events reported in 2008.

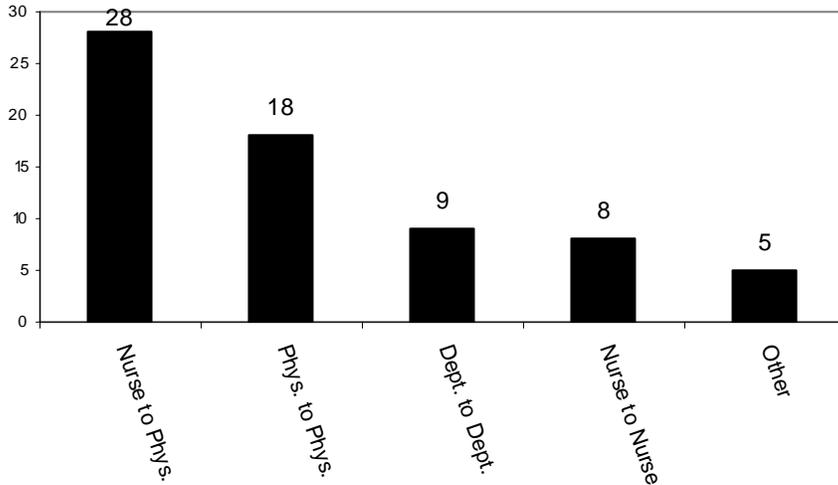
Evidence of Delays



12 cases had evidence of a delay versus 15 without in 2007
 21 cases had evidence of a delay versus 22 without in 2008
 26 cases had evidence of a delay versus 19 without in 2009

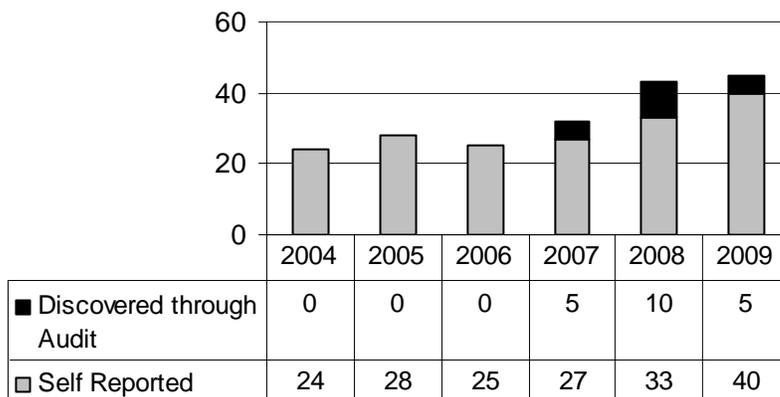
Sentinel Events with Handoff Errors

In 2009 the majority of handoff errors were communication from nurses to physicians. The second most common handoff error was between physicians. These errors are often found as contributing factors of Sentinel Events.



Unreported Sentinel Events discovered through Audit

In 2009, four on site audits to hospitals were conducted by the Sentinel Event Team. These audits are designed to educate and highlight the importance of Sentinel Event reporting. As part of the audit process medical records are reviewed. And unreported Sentinel Events may be discovered. Five unreported Sentinel Events were discovered through this process in 2009.



All sentinel event information submitted to DLRS is privileged and confidential. No information about individual facilities is discoverable or made public. A firewall is maintained between the Sentinel Event Team and the survey unit that regulates facility licensure. Many states have moved to make reporting publicly transparent.

Sentinel Events by Calendar Year		
Staff Table		
Staff	2008	2009
Supervisor	1	1
Health Services Consultants	2	2
TOTALS	3	3

XI. Long Term Care

The Long Term Care Unit is responsible for federal certification and state survey of nursing facilities and intermediate care facilities for persons with mental retardation. Certification functions are performed under contract with the Centers for Medicare and Medicaid Services (CMS). The functions are authorized under Section 1864 of the Social Security Act (the Act) and are referred to collectively as the certification process. In addition, Maine law requires facilities to be licensed under state rules every two years. The surveyors accept the federal requirements as meeting state requirements for more than 90% of the standards.

Facilities are certified every nine to fifteen months using federal regulations and every two years using state licensure rules. Multidisciplinary teams must be federally qualified to participate in long term care surveys and complaint investigations. Complaint and entity-reported incidents are triaged and investigated by 4 centrally managed complaint nurses and district office staff.

The Quality Indicator Survey

During SFY 2010, Maine implemented the Quality Indicator Survey (QIS) which is a computer assisted long-term care survey process designed by the Centers for Medicare and Medicaid Services to determine if Medicare and Medicaid certified nursing homes meet Federal requirements. It was designed to improve consistency and accuracy of quality of care and quality of life problem identification, enable timely and effective feedback on survey processes, systematically review requirements and objectively investigate all triggered regulatory areas, provide tools for continuous improvement, enhance and focus survey resources on facilities (and areas within facilities) with the largest number of quality concerns. This process is being phased in over the next couple of years across the Nation.

There are two Stages to this new process. Stage I investigation provides for an initial review of large samples of residents which includes resident, family, and staff interviews; resident observations; clinical record reviews; and facility level areas such as the environment and infection control. Utilizing onsite automation, the results of these preliminary investigations are combined to provide a comprehensive set of Quality of Care and Life Indicators (QCLIs). After the Stage I review is complete, the data collected is combined with resident assessment data submitted by the facility to the Minimum Data Set system to determine which QCLIs exceed a national threshold and consequently trigger care areas and/or triggered facility-level tasks for further investigation in Stage II.

The Stage II investigation includes: Care area investigations using a set of investigative protocols that assist surveyors in completing an organized and systematic review of triggered care areas; completion of mandatory facility-level tasks; and triggered facility-level tasks which include abuse prohibition, environment, nursing services, sufficient staffing, personal funds, and admission, transfer, discharge.

After all investigations have been completed, the team analyzes the results to determine whether noncompliance with the Federal requirements exists. The QIS uses the same decision-making process to determine noncompliance, including scope and severity designation, as is used in the traditional survey. An exit conference is conducted, during which the nursing home is informed of the survey findings.

The survey team members must be QIS certified along with the other federally mandated qualifications in order to be able to participate in federal certification surveys as Maine is a QIS state.

Skilled Nursing Facility

Skilled nursing facilities provide specialized medical and nursing services and employ a variety of therapy and skilled nursing personnel. The emphasis on restorative services is oriented toward providing services for residents who require and can benefit from skilled nursing and one or more types of skilled restorative services, e.g., physical, occupational or speech therapy.

Nursing Facility

A nursing facility primarily engages in providing long term nursing care and related services to residents who require medical or nursing care; rehabilitation services, health-related care and services.

Multi-Level Residential Care Facility

These facilities are licensed and reported under Assisted Housing program. See page 12. Multi-level facilities are a distinct part of a nursing facility. The LTC Program is responsible for surveys and complaints at these facilities.

Intermediate Care Facility for Mental Retardation (ICF-MR-G or Nsg)

Maine is the only state to differentiate between group and nursing level of care. This differentiation ensures clients with high level medical needs receive quality care and clients with similar needs together to better serve and support them in a homelike environment. The number of facilities is on the decline. They are surveyed every 12-months using federal recertification regulations (annual survey), and state licensure rules.

Once a year, during the annual survey visits, the Utilization Review-Inspection of Care Process (UR-IOC) is conducted following Medicare requirements. This process involves a review of the services provided to all clients within the facility, review of the appropriate placement of clients and verification that an individual client actually resides within the facility. When this process is completed the individual is certified as needing either group or nursing services for a 6-month period. In 6-months, the facilities submit a form (BMS-85) that updates each client's medical and social needs. The clients are then reclassified through a desk audit for an additional 6-months.

ICF-MR-G:

Consumers are generally medically stable and staff does not need to be licensed nurses or CNAs. The primary focus is to provide training and education to each client on how to become more independent in activities of daily living. This training can range from teaching clients to bathe, dress, communicate and eat to managing money and learning to cook.

ICF-MR-NSG:

Individuals have high medical needs, such as gastric tubes, active seizure disorders or medically unstable disease processes. They are required to have licensed nursing staff and CNAs 24-hours, seven days a week. They have two primary focuses: to meet the medical needs of clients while providing education and training toward teaching clients to become more independent in activities of daily living.

RN surveyors must also qualify as a Qualified Mental Retardation Professional (QMRP) in order to conduct surveys. They participate in a 4-6 month training program and complete 1 week of federally required training prior to conducting annual health surveys and investigating complaints independently.

Long Term Care – Provider Table SFY							
Provider Types	Provider Counts 2008	Provider Counts 2009	Provider Counts 2010	Beds/ Capacity 2008	Beds/ Capacity 2009	Beds/ Capacity 2010	Licensed or Certified
Nursing Facilities	109	109	109	6,902	6,894	7,043	Both
ICF/MR	20	17	17	214	199	193	Both
ML - Level IV Residential Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL	129	126	126	7116	7093	7236	

Note: ML- Level IV are reported in Assisted Housing as “Level IV Res Care”.

Long Term Care Surveys – Workload Table SFY						
Provider Types	Annual Surveys 2008	Annual Surveys 2009	Annual Surveys 2010	Other Surveys 2008	Other Surveys 2009	Other Surveys 2010
Nursing Facilities	99	112	119**	182	182	157
ICF/MR	15	20	17	1	1	1
ML - Level IV Residential Care	38	46	20*	1	0	3
<u>TOTAL</u>	<u>152</u>	<u>178</u>	<u>156</u>	<u>184</u>	<u>183</u>	<u>161</u>

*As of 2010, Residential Care ML surveys were significantly reduced due to the implementation of QIS.

** Also due to the implementation of QIS, nursing home facilities were surveyed solely under Federal regulations .

Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size

Long Term Care - Complaint Table SFY						
Provider Types	Received 2008	Received 2009	Received 2010	Investigated 2008	Investigated 2009	Investigated 2010
Nursing Facilities	888	877	880	898	805	780
ICF/MR	117	70	37	96	39	27
ML - Level IV Residential Care	128	122	137	175	137	111
<u>TOTAL</u>	<u>1,133</u>	<u>1,069</u>	<u>1,054</u>	<u>1,169</u>	<u>981</u>	<u>918</u>

Nursing Home Complaints Number of Days from Survey Start to Complaint Closure	
SFY	Days
2008	149
2009	136
2010	126

**Nursing Home Informal Dispute Resolution (IDR) Report
Federal Tags Only SFY**

SFY	Requested	Withdrawn	Number Held	Number of Tags Reviewed	Tags with No Change	No Change Percentage	Tags Revised	Revised Percentage	Tags Deleted	Deleted Percentage
2008	33	7	33	129	43	33%	29	23%	39	30%
2009	28	1	27	97	27	28%	1	1%	39	40%
2010	18	0	17	63	11	18%	1	2%	36	57%

**Long Term Care
Staff Table**

Staff	Positions 2008	Positions 2009	Positions 2010
Managers	.5	.5	1
Supervisor	4	4	4
Health Surveyor	23	24	24
Facilities Surveyors	3	3	3
Support	4.5	4.5	4
TOTAL	35	36	36

1 Health Surveyor and 1 Health Facility Specialist took advantage of Retirement Incentive Program. Position was frozen.

XII. Acute (Non Long Term) Care

Background

The Acute (Non Long Term Care) Team Unit is responsible for federal certification and state surveys. Federal certification is done under contract with CMS. The functions are authorized under Section 1864 of the Social Security Act (the Act) and are referred to collectively as the certification process. In addition, Maine law requires most facilities to be licensed. Multidisciplinary teams must be federally trained to participate in surveys and complaint investigations. The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size. Teams may include licensed social workers, nurses, laboratory specialists, health facility specialists and consultants, including physicians and pharmacists.

The volume of both certification surveys and complaint surveys, have increased in 2010. Although the total number of complaints received in 2010, fell from 399 in 2009 to 291 in 2010, the number of completed investigations was increased. This followed a focused effort to revamp the complaint survey process and increase efficiencies in deploying surveyors to investigate complaints.

General Hospitals

General Hospitals must be both State licensed and certified in Maine. There are 21 General Hospitals in Maine.

Psychiatric Hospitals and Units

Psychiatric Hospitals are specialty hospitals which provide inpatient psychiatric care to mentally ill patients. Psychiatric Hospitals must meet additional Federal requirements. All four are accredited by the Joint Commission. Some psychiatric units are contained within General Hospitals and are designated to provide inpatient psychiatric care. Some have a special payment designation from CMS and are called Prospective Payment Excluded (PPE) Units. There are four PPE psychiatric units.

Rehabilitation Hospitals and Units

Rehabilitation Hospitals are specialty hospitals that provide inpatient rehabilitation services. The single rehabilitation hospital in Maine is accredited. Rehabilitation units have a special payment designation from CMS as PPE units. There are four PPE rehabilitation units.

Critical Access Hospitals

Critical Access Hospitals (CAHs) have 25 or fewer beds which can be utilized as either acute care or swing beds. The CAH designation falls under a special Medicare grant .

This designation as a rural limited service hospital may apply when the hospital is in either a designated Health Professional Shortage Area or a designated Medically Underserved Area. Swing beds allow the CAH to provide skilled nursing services. There are fifteen CAH's in Maine. Only one of these is accredited.

Home Health Agencies

Home Health Agencies (HHAs) are state licensed and federally certified and furnish services to patients under the care of a physician, and under a plan established and periodically reviewed by the physician, on a visiting basis in the patient's place of residence. Services may include part-time or intermittent nursing care; physical or occupational therapy or speech-language pathology services; medical social services, and to the extent permitted in regulations, part-time or intermittent services of a home health aide. HHA surveys are not required annually. The Unit inspects between nine and eleven HHAs each year.

Home Health Care Service Providers

Home Health Care Service Providers (HHCS) offer acute, restorative, rehabilitative, maintenance, preventive or health promotion services through professional nursing or another therapeutic service, such as physical therapy, home health aides, nurse assistants, medical social work, nutritionist services, or personal care services, either directly or through contractual agreement, in a patient's/client's place of residence. These providers are State licensed, but not certified for participation in federal reimbursement programs.

Medicare-Certified Hospices

Hospice delivers a range of interdisciplinary services provided 24 hours a day, 7 days a week to the person who is terminally ill and that person's family. Hospice services are delivered in accordance with hospice philosophy which is a philosophy of palliative care for individuals and families during the process of dying and bereavement. It is life affirming and strengthens the client's role in making informed decisions about care. Providers are required to be both state licensed and CMS certified. Between six and eight hospices are inspected each year.

Volunteer Hospices

Volunteer hospices provide care at no charge. They often work closely with Medicare-certified hospices providers to provide care and support to patients and families and are state licensed. Under state regulations, between three and five Volunteer Hospices are surveyed each year.

End Stage Renal Disease Facilities

End Stage Renal Disease (ESRD) facilities are state licensed and federally certified, and serve patients with renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life. Facilities include renal dialysis centers and renal dialysis facilities. Maine inspects all 17 each year.

Ambulatory Surgical Centers

Ambulatory Surgical Centers (ASC's) are state licensed and federally certified providers "that operate exclusively for the purpose of providing surgical services to patients not requiring hospitalization."

ASC's perform surgical procedures "that generally do not exceed 90 minutes in length and do not require more than four hours recovery or convalescent time". Maine inspects all eighteen each year.

In Federal Fiscal Year 2009, Maine was one of twelve states to participate in a national initiative from the Centers of Medicare and Medicaid Services called **ARRA (American Recovery and Reinvestment Act of 2009)**. **This initiative was aimed at reducing healthcare acquired infections in ASC's.** In Federal Fiscal Year 2010, Maine continued participation in this initiative utilizing new federal survey processes and infection control tools.

ARRA Report FFY 2010

Introduction

The survey activities performed under ARRA, have improved Maine's inspection frequency, utilizing the new infection control survey tool, and improved the survey process through the use of a tracer method.

Survey Activity

DHHS/DLRS completed the four (4) ARRA funded surveys in the 3rd quarter of the federal fiscal year. Educational Trainings have continued and will be reported in the next annual report.

Correspondence received from CMS on September 29, 2010 indicates that they have extended the ARRA grant performance period from September 30, 2010 to March 31, 2011. The amount of this award has been increased to \$60,270.00 (supplemental funding). Maine will continue to perform ASC Surveys and ARRA related activities through the remaining grant period according to guidelines provided by CMS.

Rural Health Centers

Rural Health Centers (RHCs) are federally certified providers of primary care services within certain areas of the state that meet the criteria of rural area location, federally designated shortage area, and/or medically underserved area. Under federal regulations, Maine inspects these centers every six years.

Outpatient Physical Therapy Providers

Three types of organizations may qualify as federally certified Outpatient Physical Therapy/ Outpatient Speech Pathology (OPT/OSP) providers. They are rehabilitation agencies, clinics and public health agencies. Almost all OPT/OSP providers are rehabilitation agencies. A rehabilitation agency provides "an integrated, multidisciplinary program designed to upgrade the physical functions of handicapped,

disabled individuals by bringing together, as a team, specialized rehabilitation personnel.” Maine certifies them every six years.

Comprehensive Outpatient Rehabilitation Facilities

Comprehensive Outpatient Rehabilitation Facilities (CORF) are “established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician.” There are no CORF in Maine.

Portable X-Ray Providers

Portable X-Ray providers offer “diagnostic x-ray tests furnished in a place of residence.” The mobile unit can neither be fixed at any one location nor permanently located in a SNF or a hospital.” Under Federal regulations, Maine certifies them every six years.

Transplant Centers

Transplant Centers are organ-specific transplant programs that furnish organ transplants, and other medical and surgical specialty services required for the care of transplant patients. There is one Transplant Center in Maine. CMS contracted surveyors inspect this facility approximately every three years.

Federally Qualified Health Centers

Federally Qualified Health Center (FQHC’s) are federally certified providers of primary care services within certain areas of the state that meet the criteria of rural area location, federally designated shortage area, and/or medically underserved area. Under federal regulations, Maine conducts complaint surveys for these suppliers.

**Acute (Non Long Term) Care – Provider Table
SFY**

Provider Types	Provider Counts 2008	Provider Counts 2009	Provider Counts 2010	Licensed or Certified	Beds/ Capacity if Applicable 2008	Beds/ Capacity if Applicable 2009	Beds/ Capacity if Applicable 2010
Ambulatory Surgical Center	18	18	18	Both	N/A	N/A	N/A
End Stage Renal Disease	17	17	17	Both	N/A	N/A	N/A
Federally Qualified Health Center	57	59	75	Certified	N/A	N/A	N/A
Laboratories CLIA	985	987	1,006	Certified	N/A	N/A	N/A
Home Health Agencies	59	53	55	Some of each	N/A	N/A	N/A
Hospice	30	28	27	Some of each	14*	14*	30**
Hospital	41	41	41	Both	3,988	4,038	4,033
Occupational Physical and Speech Therapy	16	16	15	Certified	N/A	N/A	N/A
Portable X-Ray	4	4	4	Certified	N/A	N/A	N/A
Rural Health Center	44	44	40	Certified	N/A	N/A	N/A
<u>TOTALS</u>	<u>1,271</u>	<u>1,267</u>	<u>1,298</u>	<u>N/A</u>	<u>4,002</u>	<u>4,052</u>	<u>4,063</u>

*One Hospice has actual licensed bed capacity.

**Two hospices have licensed inpatient hospice houses.

**Acute (Non Long Term) Care – Workload Table
SFY**

Provider Types	Licensure Surveys 2008	Licensure Surveys 2009	Licensure Surveys 2010	Certification Surveys 2008	Certification Surveys 2009	Certification Surveys 2010
Ambulatory Surgical Center	7	15	4	5	5	18
End Stage Renal Disease	6	6	10	10	5	6
*Federally Qualified Health Center	0	0	0	0	0	0
Laboratories CLIA	0	0	0	48	33	45
Home Health Agencies	11	13	14	9	12	14
Hospice	15	7	11	6	2	3
**Hospital	2	0	0	10	9	19
Occupational Physical and Speech Therapy	0	0	0	4	3	3
Portable X-Ray	0	0	0	1	0	2
Rural Health Center	0	0	0	11	4	7
<u>TOTALS</u>	<u>41</u>	<u>41</u>	<u>39</u>	<u>104</u>	<u>73</u>	<u>117</u>

*Federally Qualified Health Centers undergo federal complaint surveys.

**Number of surveys impacted by changes in State statute.

Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size

Acute (Non Long Term) Care Complaint Table SFY						
Provider Type	Received 2008	Received 2009	Received 2010	Investigated 2008	Investigated 2009	Investigated 2010
Ambulatory Surgical Center	0	0	5	0	1	3
End Stage Renal Disease	1	2	3	1	2	2
Federally Qualified Health Ctr.	0	4	3	0	4	4
Laboratories CLIA	2	0	0	0	0	0
Home Health Agencies	20	23	22	11	48	22
Hospice	4	7	2	5	8	1
Hospital	191	237	256	138	184	228
Occupational Physical & Speech Therapy	1	0	0	1	0	1
Portable X-ray	0	0	0	0	0	0
Rural Health Center	4	3	0	5	3	0
TOTALS	<u>221</u>	<u>276</u>	<u>291</u>	<u>161</u>	<u>250</u>	<u>261</u>

Acute (Non Long Term) Care – Staff Table SFY			
Staff	Positions 2008	Positions 2009	Positions 2010
Managers	.5	.5	0
Supervisor	1	1	1
Health Surveyor	6	6	6
Quality Assurance Surveyor (Labs)	1	1	1
Support	1.5	1.5	1
TOTAL	<u>10</u>	<u>10</u>	<u>9.5</u>

x. Clinical Laboratory Improvement Amendments (CLIA)

The Clinical Laboratory Improvement Amendments (CLIA) was enacted by Congress in 1988, establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test is performed. A laboratory is any facility which performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease or impairment of, or assessment of health. Regulations are based on the complexity of the test method; thus, the more complicated the test, the more stringent the requirements. Three categories of tests have been established: waived complexity, moderate complexity (including the subcategory of provider-performed microscopy (PPM)), and high complexity. Based on test complexity, the following five types of CLIA certificates are issued:

Certificate of Waiver

This certificate is issued to approximately 650 laboratories to perform only waived tests.

Certificate of Provider-Performed Microscopy (PPM)

This certificate is issued to 253 laboratories in which a physician, midlevel practitioner or dentist performs the microscopy procedures. This certificate permits the laboratory to also perform waived tests.

Certificate of Registration

This certificate is issued to 67 laboratories that enables the entity to conduct moderate or high complexity laboratory testing or both until the entity is determined by survey to be in compliance with the CLIA regulations.

Certificate of Compliance

This certificate is issued to a laboratory after an inspection by the CLIA program that finds the laboratory to be in compliance with all applicable CLIA requirements. Laboratories holding this type of certificate are inspected biennially by DLRS under the CLIA Program.

Certificate of Accreditation

This is a certificate that is issued to 76 laboratories on the basis of the laboratory's accreditation by an accreditation organization approved by CLIA. Laboratories holding this type of certificate are inspected biennially by their accrediting organization.

Using the Federal CLIA regulations, Maine inspects between 30 and 35 laboratories performing moderate and/or high complexity testing each year.

The CLIA program surveys two percent (2%) of laboratories performing only waived tests. The purpose of these surveys is to gather information for the CLIA Program and to provide an educational component regarding good laboratory practices to the entities performing waived complexity laboratory tests. Maine performs 12 Certificate of Waiver surveys each year. The laboratories are randomly selected.

Maine Medical Laboratory Act

Laboratories as required by the Maine Medical Laboratory Act to have a license. There are 11 laboratories holding Maine Medical Laboratory licenses and 36 entities holding Health Screening Laboratory permits. The Maine Medical Laboratory licenses are issued for a three year period. Health Screening Laboratory permits must be renewed annually.

*CLIA data contained in Acute (Non-long Term) Care Section IX.

xi. Quality/Training/Data

Background

Data generation and quality assurance functions are internally and externally driven. For example, the grant with CMS, which funds federal survey and certification activities, includes various state performance expectations. Quality and performance metrics for the Division are centrally managed. The Quality Unit works under the Planning, Development and Quality umbrella in DLRS.

Program Responsibilities

The Quality Unit supports the Division's overall activities by monitoring compliance with state performance expectations, assisting in the preparation of responses to compliance issues, budgeting and report generation.

The Unit ensures staff performing survey and certification meet DLRS and federal training standards. The federally-required Training Coordinator position is in this Unit.

The Unit shares responsibility with the Office of Maine Care Services for coordination with regard to M.D.S. 2.0 and the upcoming implementation of MDS 3.0, the federal resident assessment instrument used in nursing facilities. The Unit is also responsible for OASIS, which is the assessment instrument used by certified home health agencies.

Division quality initiatives are supported by the Quality Unit. These include migration of various state licensing programs to the federal ASPEN data platform or ALMS data platform; GPRA goals, preparation of data in support of required annual reports, CON Report, Sentinel Events Report, publishing top deficiencies by facility type and improving access to data.

Quality/Training/Data SFY				
Initiatives	2008	2009	2010	Details
Time Management Code Development	X	X	X	Provided program information and perspective in partnership with Financial Services and Payroll to develop task codes that cover each program's functional activities.
Financial Management and Code Development	X	X	X	Provided the Program information and perspective in partnership with Financial Services for a coding system for expenditures by program.
CMS Survey and Certification Grant Reporting and Budgeting- Training Coordinator, QIES Coordinator	X	X	X	Quarterly, annual and specialty reports on budget, expenditures, workload, surveys, training, surveyor qualifications. Monitor performance standards and research outliers. Conduct ad hoc reports for CMS regarding funding allocation, disaster preparedness, computer usage, etc.
Complaint Pilot Initiation and Development	X	X		Coordinated with California for materials and advice. Developed Maine specific forms and procedures. Provided training for the implementation of the pilot. This is now instituted in all programs except Child Care Licensing and Behavioral Health Licensing.
QIS Preparatory Research and Planning		X		Coordinated with other States, Federal contractor, CMS and internal workgroups. Developed detailed schedule of surveys for the six month implementation phase and coordinated OIT activities and support.
QIS Implementation			X	Assisted in implementation of QIS survey in nursing home program.
Creation of Incident Reporting Form and Procedures	X			Created a new form fill incident reporting form and procedures to standardize data gathering/reporting and move the intake of incidents from central location to regional offices.
Legislative Database support for Division		X	X	Maintenance of the Legislative database for the Division
OASIS Coordinator	X	X	X	The Unit is responsible for OASIS, which is the assessment instrument used by certified home health agencies. The OASIS and MDS Coordinator is responsible for providing technical assistance to providers and for coordination of new information/training when it occurs. Responsible for providing technical assistance and coordination of training for providers.

MDS/RAI Coordinator	X	X	X	The Unit shares responsibility with the Office of Maine Care Services for coordination with regard to implementation of M.D.S. 3.0, the federal resident assessment instrument. Responsible for providing technical assistance and coordination of training for providers.
ARRA Program		X	X	Provided financial tracking and end of Federal Fiscal Year reporting of all expenditures related to the number of Ambulatory Surgical Surveys that were designated in the “Recovery Act Funding Proposal”, against the Federal funding that was provided to do those surveys.

Quality Indicator Survey Implementation

A significant achievement in SFY 2010 is the implementation of Quality Indicator Survey in the nursing home program. The material and process developed by CMS was implemented in Maine during SFY 2010 with the Training Coordinator being instrumental in the preparation and implementation. This position has taken on the added responsibility of QIS Certified Trainer for Maine.

Training

The Unit ensures staff performance meets DLRS and federal training requirements. Additionally, it facilitates internal staff development and collaborates with stakeholders to provide best practice workshops and training. See Appendix C for details.

Trainings by Type by SFY			
	2008	2009	2010
CMS Mandatory Trainings	15	18	21
QIS Training (a session consists of a 40 hour classroom, Mock survey and two compliance surveys)			4 Sessions
QIS Train the Trainer Session			1 Session
Division-wide Trainings	3	4	1
Provider Trainings	5	2	4
Other	2	1	7
<u>Total</u>	<u>25</u>	<u>25</u>	<u>33</u>

Collaboration for Quality Initiatives – External Partners

A major function of this Unit is to coordinate the Division’s collaboration with stakeholders from various healthcare areas to improve the quality of care and life of Maine residents living in various settings. This includes coordination of meetings, workgroups, provider training, and the dissemination of information from Federal, State and other sources. Listserves are a primary means of disseminating timely information to providers.

Quality Initiatives SFY				
Partners	2008	2009	2010	Details
Best Practice Committee – support best practice in quality of care/life for nursing home residents	X	X		Coordinated monthly meetings, provider training seminars, participation in work groups for special projects such as the Geriatric Mental Health Curriculum, PASSR changes, development of Mental Health Curriculum. Provided data reports and project updates.
Pressure Ulcer Taskforce – multi disciplinary stakeholder group formed for the purpose of reducing the incidence of pressure ulcers across the continuum of care in Maine	X	X		Coordinated meetings, provided research coordinated a presentation by a Vermont nursing home involved in a quality initiative with a related hospital regarding pressure ulcer reduction project, coordinated a presentation by the New Jersey Hospital Assn. regarding their multidisciplinary approach to the reduction of pressure ulcer rates, and coordinated the Maine Quality Forum’s presentation of hospital pressure ulcer rates in Maine. The group provided support for a pilot program initiated in Maine. Provided data updates on pressure ulcer rates in Maine.
LANE Committee – to improve the quality of care of nursing home residents	X	X	X	Represented DLRS on this committee with Maine Health Care as lead.
Survey and Certification and Case Mix Group	X	X	X	DLRS and OMS provided technical assistance to nursing homes regarding MDS 2.0 coding and reporting. This group met to increase the consistency and accuracy of the messages being provided to the nursing home providers.
MDS 3.0 Preparation Group	X	X	X	Preparation for the implementation of the MDS 3.0 Resident Assessment and Minimum Data Set System. This will impact training needs, case mix calculations, survey process and quality initiatives. Preparation for statewide training in August 2010.
Town Meetings for Nursing Home providers	X	X	X	Planned and prepared for multiple town meeting sessions across the state over the last two years. Provided and presented resources and data in first round of meetings.
MUSKIE	X	X		Create reports as necessary for example pressure ulcers in nursing homes, infection rates in nursing homes, etc.
AIT/RFA Training	X	X		Educating administrators about the licensing and complaint process.

The Government Performance and Results Act (GPRA), part of the Federal Office of Management and Budget, set a goal to reduce nursing home pressure ulcer and restraint rates nationally in the summer of 2006. CMS in turn set goals for each individual state. Because of Maine's pressure ulcer rate being above the national average, a multidisciplinary taskforce mentioned above was formed to focus pressure ulcer prevention across the continuum of care.

Because of the success of the initiative, DLRS was asked to present on its project at the 2009 meeting with CMS, New England state agencies, and hospital and nursing home association leaders. The following pressure ulcer and restraint rates developed from MDS 2.0 data show a major reduction in both restraints and pressure ulcers since the initiation of this goal for Region 1, the nation and Maine in particular.

Chart 1: Pressure ulcer rates through time (January 2003 through March 2010)

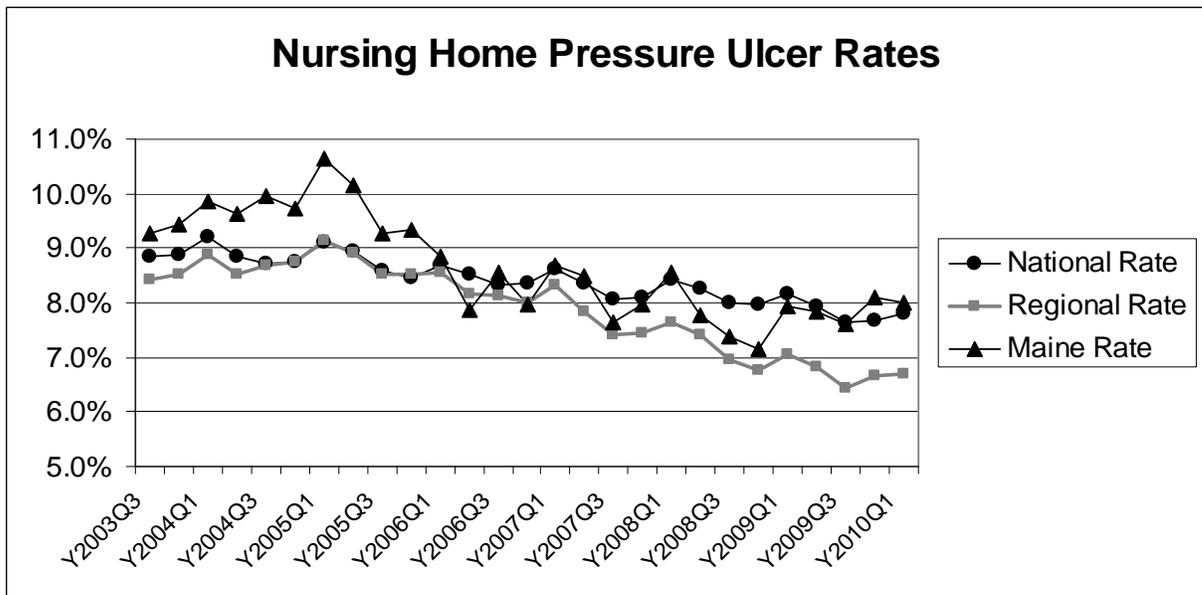
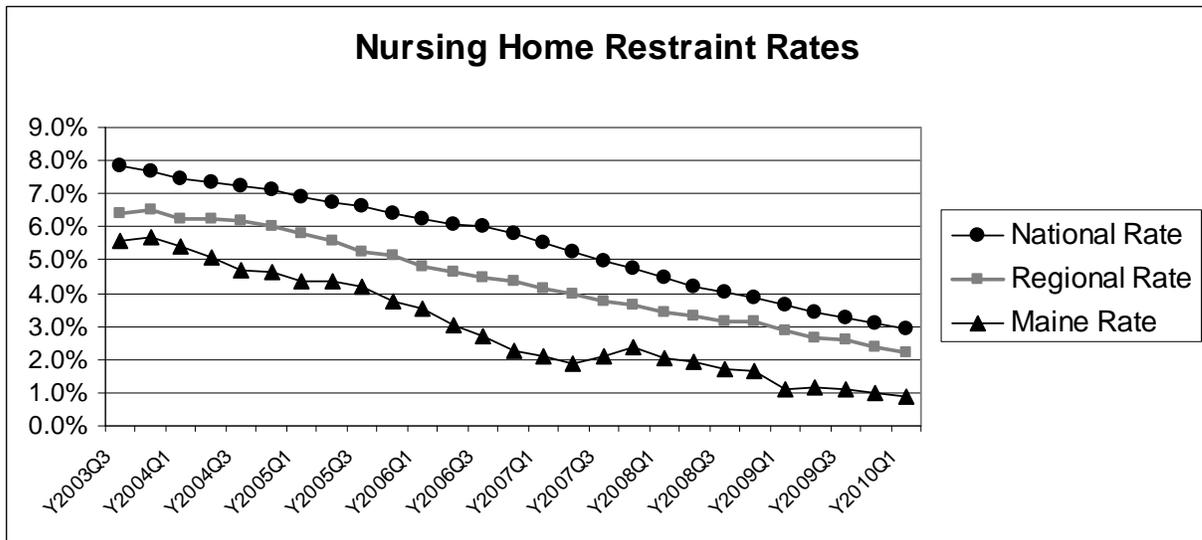


Chart 2: Restraint rates through time (January 2003 through March 2010)



Data and Reports

Division quality initiatives include migration of various state licensing programs to the federal ASPEN data platform or ALMS data platform; GPRA goals; preparation of data in support of required annual reports, CON Report, Sentinel Events Report; publishing top deficiencies by facility type; and improving access to data.

Data Related	2008	2009	SFY 2010	Details
Routine ASPEN Reports on Complaints, enforcement, workload, survey		X	X	Standard reports are being run and distributed daily, weekly, monthly or quarterly depending on specific criteria.
Integrate CLIA and Assisted Housing Level IV survey functions into ASPEN	X	X	X	CLIA migrated to ASPEN. Assisted Housing Level IV provider and survey specific data is now being tracked in ASPEN.
Provide OSCAR 3 and 4 Reports to Providers	X	X		Every 6 months OSCAR 3/4s is distributed to those providers requesting the report. OSCAR Reports were retired in June 2009 and CASPER is the new reporting system.
CASPER Reports			X	New Federal Reporting system.
Data on Hospital Complaints and Citations to the Hospital Review Board	X	X	X	Reports include top 10 deficiencies and complaint allegation details.
Management reports for LTC	X	X	X	Management reports for LTC regarding complaints/ surveys/citations and other workload reports.
Workload Form revised and distributed for division-wide implementation		X	X	Database design and implementation.
Satisfaction Survey Database	For MFU only	X	X	Survey was revised and standardized. A database was developed and training conducted.
Data entry and analysis for Sentinel Events Annual Report		X	X	Data included 2008 calendar year and all preceding data. Data charts created for 2009 calendar year.
Database development for Sentinel Events program	X	X	X	The data schema is 90 % complete. Some programming still needs to be done.
Process Miscellaneous Requests for Data	X	X	X	Provide reports on request.
ASPEN Quality Assurance and Data Scrubbing	X	X	X	Training was conducted. Staff run quality reports and correct erroneous or incomplete data.

Data Related	2008	2009	SFY 2010	Details
Assisted Housing Licensure Interface Development	X	X	X	Coordinated with manager of Assisted Housing and Muskie to develop an interface with ASPEN to improve tracking specific licensure data.
Medical Use of Marijuana Program			X	Data system configured for new program in the ALMS data system. Provided monthly reporting of revenue and expenses and backup support.

Data Related	2008	2009	SFY 2010	Details
QIES Coordination	X	X	X	Meetings to coordinate activities related to ASPEN and other data projects involving DLRS internal partners, Muskie and QIES Automation Coordinator
Coordination with OIT regarding business needs	X	X	X	Projects: CNA web-portal, facilities web-portal, UAP data inclusion into CNA database, equipment needs, QIS implementation plan, program specific needs for data programming, Medical Marijuana Use Program implementation into ALMS data system
DHHS Metrics Dashboard Workgroup			X	Inclusion into the workgroup to recommend revisions for a dashboard metrics system for DHHS.
Quarterly & Annual Report for DLRS		X	X	Provided Quarterly and Annual reports for the division and coordinated the data collection with management for each program, making necessary updates and revisions as needed.
LMS Coordinator	X	X	X	LMS is a Center for Medicare/Medicaid Services data base used to manage federal training provided by CMS. CMS mandates that our surveyors receive basic training for the provider types that they survey. The surveyors are also required to update their skills with these trainings. This data base allows Kathleen Tappan, the training coordinator and Choanna Givens, her back up to nominate (register) a surveyor for CMS classes. It also allows them to track a surveyor's progress in completing CMS basic trainings, satellite broadcasts and CMS updated classes. Kathleen and Choanna will be attending 2 LMS training this fall on using the new software that goes into effect as of October 12, 2010.

Nursing Home and Hospital Complaint Allegations Investigated By SFY					
	SFY	Allegations Investigated	Substantiated	Unknown	% Substantiated
Nursing Homes	2007	1,812	261	2	14.4%
	2008	1,991	271	2	13.6%
	2009	1,790	266	206	16.8%
	2010	1,702	253	124	16.0%
Hospitals	2007	192	37	8	20.1%
	2008	386	68	17	18.4%
	2009	847	130	95	17.3%
	2010	483	84	75	21.0%

Note: Denominator for % substantiated is determined by Number Investigated minus the number unknown.

Staff	SFY 2007	2008	2009
Comprehensive Health Planner	1	1	1
Nurse Education Consultant	1	1	1
Management Analyst I	1	.825	.825
Support	0	0	.5
<u>TOTAL</u>	<u>3</u>	<u>2.835</u>	<u>3.325</u>

xii. Workforce Development

Background

A quality workforce is essential to quality healthcare. DLRS is responsible for developing curricula and training for Personal Support Specialists (PSS), Certified Residential Medication Assistants (CRMA), certifying trainers, registering temporary staffing and personal care agencies, and maintaining the CNA Registry. The CNA Registry responds to inquiries from the public, health care providers, individual CNAs and other state CNA Registries; enhances public safety by annotating information related to known criminal convictions as required by Maine law and substantiated complaints as required by Federal law; and provide information to CNAs on state or federally mandated employment restrictions, eligibility for placement on the Registry, and the appeals process.

In State fiscal year 2010, Public Law Chapter 628 transferred oversight for the C.N.A. training from the Department of Education to the Division of Licensing and Regulatory Services. Also transferred by this legislation, is oversight for training for Activities Coordinators. DLRS will continue to collaborate with the Department of Education and the Maine State Board of Nursing.

Personal Support Specialist (PSS)

A PSS is an unlicensed entry-level worker. Successful completion of a DLRS approved course satisfies training requirements for direct care workers for certain home care programs and residential facilities.

Certified Residential Medication Aide (CRMA)

The CRMA departmental standardized curriculum is designed for unlicensed workers. Successful completion of this course satisfies training requirements for workers who pass medications in certain assisted housing programs as part of their employment.

DLRS supports the PSS and CRMA workforce development programs in the following ways:

- Convenes stakeholders to periodically update the curriculum.
- Provides web-based information on upcoming trainings.
- Maintains a list of approved trainers. New instructors must qualify for and successfully complete a 3-day Train-the-Trainer program.
- Performs quality improvement by monitoring course delivery and course evaluations and makes suggestions/recommendations to trainers.
- Maintains data about students who complete training and is available online. Participant data is stored and duplicate/replacement certificates can be provided on request, as needed by employers.

SFY 2010 CRMA Training

CRMA 3 Day	County	CRMA Bridge	CRMA Re- cert.	CRMA Training	Feeding	PSS Family Only	PSS Test Out	PSS Training	Grand Total
92	ANDROSCOGGIN	16	600	221		4	9	103	1045
2	AROOSTOOK	0	380	151			3	82	618
147	CUMBERLAND	19	707	296			4	214	1387
22	FRANKLIN	0	102	25			0	14	163
7	HANCOCK	0	101	58			8	31	205
69	KENNEBEC	14	627	257			11	130	1108
13	KNOX	2	152	62			1	41	271
9	LINCOLN	0	132	64			0	22	227
26	OXFORD	3	273	71			9	47	429
104	PENOBSCOT	15	478	240			10	130	977
19	PISCATAQUIS	5	74	15			1	15	129
33	SAGadahoc	1	192	52			1	57	336
7	SOMERSET	1	258	121			3	53	443
8	WALDO	1	112	55			2	23	201
9	WASHINGTON	0	110	61			4	25	209
77	YORK	18	568	238			16	160	1077
<u>644</u>	<u>Grand Total</u>	<u>95</u>	<u>4866</u>	<u>1987</u>		<u>4</u>	<u>82</u>	<u>1147</u>	<u>8825</u>

Temporary Nurse Agency (TNA)

A business entity or subdivision that provides nurses within the state to another organization on a temporary basis. Businesses are required to register with DLRS.

Personal Care Agency (PCA)

“Personal Care Agency” means a business entity or subsidiary of a business entity that is not otherwise licensed by the DLRS, that hires and employs unlicensed assistive personnel to provide assistance with activities of daily living to individuals in the places in which they reside, either permanently or temporarily. An individual who hires and employs unlicensed assistive personnel to provide care for that individual is not a PCA agency.

PCA Provider Count SFY		
Provider	2009	2010
Temporary Nurse Agencies	65	67
Personal Care Agencies	116	126
Family Provider Service Option	*	252
Placement Agencies	*	3
Total	191	448

* **no** data available for these providers in 2009

Certified Nursing Assistant (CNA) Registry

DLRS operates Maine's CNA Registry, a requirement for every state. The Maine Registry is operated in accordance with the Omnibus Budget Reconciliation Act of 1987, state statutes and the Maine State Board of Nursing requirements.

CNA Registry Telephone – Register of Calls Received

Type of Call Received	SFY *2/2009 to 6/2009	2010
Facility Registry Checks	3,472	5,342
Individual CNAs Checking Status	718	1,317
Testing Questions	572	914

Type of Call Received	SFY	
	*2/2009to 6/2009	2010
Reciprocity Questions	59	90
Out of State CNA Questions	207	261
Other Calls	1,353	2,508
Web portal usage	*	20,569
<u>TOTAL</u>	<u>6,381</u>	<u>31,001</u>

*data for web portal usage/ Web portal created for utilization in SFY 10

CNA Website: <http://www.maine.gov/dhhs/dlrs/cna/home.html>

CNA Web-portal website: <https://gateway.maine.gov/cnaregistry/>

CNA Hearings Statistics Table SFY			
Type	2008	2009	2010
Abuse	26	21	18
Neglect	12	13	32
Misappropriation of Property	1	3	5
Fraudulent Application	0	0	0
<u>Total Hearings</u>	<u>39</u>	<u>37</u>	<u>55</u>

CNA Registry Summary Report Statistics Table SFY			
	Count 2008	Count 2009	Count 2010
CNA Status			
Active	14,056	15,112	15,779
Inactive	35,571	36,804	38,510
<u>Total CNAs</u>	<u>49,627</u>	<u>51,916</u>	<u>54,289</u>
Active and Annotated	641	676	665
Inactive and Annotated	1,203	1,182	1,209

Workforce Development Staff Table SFY			
Position	2008	2009	2010
Health Services Consultant	2	1	.5
Nurse Educator	1	1	1
Office Associate	4	4	4
<u>Total</u>	<u>7</u>	<u>6</u>	<u>5.5</u>

APPENDIX A

Mission

The mission of the Division of Licensing and Regulatory Services is to support access to quality and effective health care and social services.

Vision

The Division will promote broadly accepted standards and integrated practices effective in helping people have safe and appropriate outcomes. Regulation will be a collaborative process. Enforcement will be appropriate to the scope and severity of the problem.

Values

Our core values describe the attitude and character of our Division. We will hold each other accountable and model these values. The words that describe these values were carefully chosen by us.

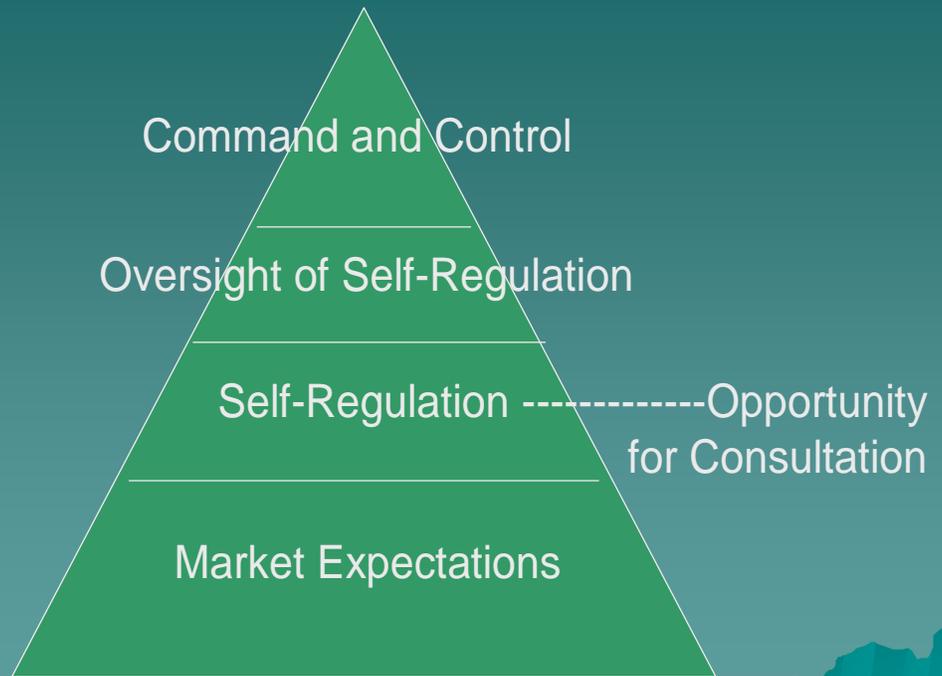
- **Integrity**
 - i. We are conscientious stewards of the resources available to us.
 - ii. These are our values.
 - iii. We practice them daily.
- **Openness**
 - i. The people we are working with will know/be informed of the information we have and what we need.
 - ii. We make sure that everyone has access to information about the processes we are using.
 - iii. We are all informed of our mission, vision and guiding principles.
 - iv. We share current information. As a result, we speak with a unified voice.
- **Quality**
 - i. We have a structured orientation to assure that each new person knows his/her role and responsibilities and understands his/her position in the Division.
 - ii. We receive the training we need in order to stay current with standards of best practice and we consistently implement the standards.
 - iii. We invite your feedback, positive and constructive, to assure we always give our best.
 - iv. We acknowledge verbally or in writing successes and areas needing improvement, large and small.

- **Safety**
 - i. We prioritize the enforcement of regulations for a safe environment for our consumers.
 - ii. We adhere to all employee safety and confidentiality policies.
 - iii. We respect and support the decisions you make regarding your personal safety.
 - iv. When we see a safety issue that needs attention, we advocate correcting it.

- **Trust**
 - i. We tell you the truth.
 - ii. If we don't know, we will say so, find the information, and get back to you.
 - iii. We give you positive feedback along with constructive feedback.
 - iv. When we have to give difficult feedback, we do so privately, openly, directly and clearly and in neither an intimidating nor a humiliating style.
 - v. We do what we say we will do.
 - vi. We assume your best intentions.

- **Validation**
 - i. If we are responsible for a change, we will first seek your input. If we do not take your advice, we will share our reasons with you.
 - ii. We recognize the work done and comment on it.
 - iii. Our work makes a difference. When you struggle, we make ourselves available to you.

Regulatory Framework



Appendix C- * Listserv Addresses

Assisted Living

beas-assisted@lists.maine.gov

Certificate of Need

dhhs-con-request@lists.maine.gov

Child Care Facilities

childcarefacilities@lists.maine.gov

Certified Residential Medication Aids

beas-crma@lists.maine.gov

Family Child Care

familychildcare@lists.maine.gov

Medical Facilities

dlrs-medicalfacilities@lists.maine.gov

Nursery Schools

nurseryschool@lists.maine.gov

Nursing Facilities

dlrs-nursingfacilities@lists.maine.gov

Personal Support Specialist

beas-pss@lists.maine.gov

Behavioral Health

BehavioralHealth-request@lists.maine.gov

*_LISTSERV

An automatic [mailing list server](#) developed by Eric Thomas for [BITNET](#) in 1986. When [e-mail](#) is addressed to a LISTSERV [mailing list](#), it is automatically [broadcast](#) to everyone on the list. The result is similar to a [newsgroup](#) or [forum](#), except that the messages are transmitted as e-mail and are therefore available only to individuals on the list.

Non-Discrimination Notice

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to the DHHS ADA Compliance/EEO Coordinators, #11 State House Station, Augusta, Maine 04333, 207-287-4289 (V), or 287-3488 (V)1-888-577-6690 (TTY). Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to one of the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.

Caring...Responsive...Well-Managed...We are DHHS.

This report was prepared by
The Division of Licensing and Regulatory Services
Department of Health and Human Services
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11 State House Station
Augusta, ME 04333-0011

For further information please contact:

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