Present: Linda Abernethy, Carol Carothers, Charlie Clemons (for Richard Brown), Dan Coffey, Greg Disy, David Emery, Nichi Farnham, Lisa Hall, Dale Hamilton, Dennis King, Mary Mayhew, Mary Louise McEwen, Kim Moody, Jane Moore, Patrick Murphy, Vicki Rusbult

Members not present: Sara Stevens, Simonne Maline

- Facilitator: Helen Wieczorek
- DDPC staff: Jenny Boyden, Bill Dunwoody, Sharon Sprague, Ron Welch, Melissa Hayward (recorder)

Welcome and introductions
Commissioner Mayhew welcomed everyone to the meeting and introductions were made. She then turned the meeting over to the facilitator, Helen. Helen gave everyone a post-it note to ‘get the temperature of the room’ – how do you feel about DDPC – keep the facility open or close it. Voting favored keeping DDPC open.

There is a public comment period added to each meeting, from 1 to 2 pm. Written comments are accepted at any time via the DHHS website. There was no public comment today.

Commissioner Mayhew reviewed the charge of the group and spoke of the $2.5 million general fund reduction in FY 2013, which is a total reduction of $7 million. She asked the group to keep in mind the patients – what is in the best interest in meeting the needs of the patients. A report is due to the Commissioner on 12/1/11.

Helen divided the group into smaller groups, asking each group to come back with their understanding of the mission of the group and any questions/concerns.

- Mission of DDPC: future of the campus; facility needs in order to meet the clients’ needs; integrated with community services, perception of the public with the use of the current buildings; services to involuntary clients as well as inpatient and outpatient; distance some families travel (especially from Aroostook County); meeting the needs of clients with SPMI (severe and persistent mental illness).
- Questions: how will DDPC get by with less funding; how will services not provided by DDPC be picked up in the community; lessons learned from privatization; can services be provided for less; what if DDPC closed; if DDPC closed would community resources be stepped up; forensic needs of patients.
Ron Welch, Director of Office of Adult Mental Health (OAMH)
Ron distributed information to the group and reviewed the public mental health system/services in Maine. Ron stated that his office focuses on those with severe and persistent mental illness – approximately 27,144 based on national prevalence data. Ron discussed class members, the expansion of that population and our responsibility towards them. Dan Coffey asked how Maine compares to other states. Ron stated that the prevalence data he stated was national data from SAMHSA and is the standard used by all states. We only have 12,000 currently enrolled in our programs. David Emery asked for the background information on the consent decree and Ron indicated that is available on the OAMH website. Ron reviewed peer services and announced that a new clubhouse is being built in the Lewiston area with the support of the governor and perhaps one being planned for Bangor as well. The Commissioner said her group also discussed the ability to tap into the work being done by other states. Dennis King stated that NH has developed a new model and Vermont is working on a public-private partnership.

Jenny Boyden, Chief Financial Officer at DDPC and RPC
Total expenditures for adult mental health services was $289,423,423 in FY10. One slide of her presentation was difficult for folks to read; Jenny will send to members. DDPC is facing a $7 million reduction in FY 2013 (a 25% reduction to the DDPC budget). Dale Hamilton asked if this reduction is realistic – can DDPC continue to provide the same services with this reduction? If there is a reduction in services, will the community be able to fill in the gaps? Some of this money may be available for other (private) hospitals. $7 million include $4 million of Disproportionate Share (DSH) money. The Affordable Care Act includes language reducing DSH funding beginning in 2014. It is unclear if the reductions are to include both the Acute Care and IMD DSH funding. We do not know if DSH will be here to support DDPC or the community in the future.

Commissioner Mayhew stated that there has been a growing dependence on federal DSH dollars and now with the feds tightening their budgets and calling into question how we use dollars, especially in mental health services. Reductions in federal funding will cause an increasing burden on the state for General Fund dollars. There are a variety of forces at play as what needs there are and also challenged on the pots of money available for these services.

Jenny reminded the group that DDPC supports the entire campus in operating expenditures. Question was asked: what would DDPC cost if it were not support other agencies/facilities on the campus? Jenny will look into this.

If there is any other financial information, or general information, contact Melissa.
Linda Abernethy, DDPC Superintendent
Linda gave a brief overview (stats) for DDPC. Our average length of stay is about 60 days. DDPC has 64 operational beds, 4 of which are flex beds. These four beds are set aside for a special population – individuals with developmental disabilities and a mental illness and are living in community settings. These folks decompensate quickly and they are re-admitted long enough to adjust meds, stabilize and placed back in their community setting. DDPC must also accommodate individuals who fail PTP (outpatient commitment). Many of our patients also have complex medical issues, i.e. obesity, diabetes, etc. Our average daily census is approximately 57 (2:1 male to female ratio) with age ranges starting at 18 to 88. All units are admission/discharge units. Our staff work very hard for a successful discharge. We do not have forensic clients however we do work closely with the jail, take legal holds when needed.

There was discussion on length of stay comparison with other state or private hospitals. Linda stated that there are more community mental health beds in southern Maine compared to northern Maine. In addition, there are those patients that do not always stabilize within 30-60 days. Carol stated that some families worry about where their loved ones can get long-term psychiatric care, if that is needed. DDPC also provide outpatient services and oversees a dental clinic here on campus.

There was a suggestion of forming a subcommittee to look at other strategies with the budget reduction. What alternatives will there be for mental health patients? If DDPC cuts back on services, can those be provided in the community?

The question was asked if the physical plant works against DDPC. While the buildings are beautiful, it can be difficult. We are in the process of relocating our recreation center and having all services in one building to make it more secure/safe for our patients.

DDPC integrates positions to create efficiencies whenever possible – chief financial officer, quality improvement, occupational therapy, maintenance, etc.

Mary Louise McEwen, RPC Superintendent
ML reviewed the forensic population of RPC. There are 92 beds at RPC, 48 civil and 44 forensic beds. Forensic clients – take folks court-ordered for an evaluation and/or to observe and make a determination if the person’s mental status is capable of standing trial. Several years ago the average length of stay for this is 47 days. However this FY it has been cut back to 28 days for length of stay. The second group is incompetent to stand trial and those folks could remain for up to a year. RPC and state forensic are working hard to decrease this length of stay. The third group is 27 beds (from the 44 forensic beds) and they were found not criminally responsible for their crime and remain in the facility for, on average, five or six years, depending how stable they are,
progressing in their treatment, safe to return to the community, etc. Civil beds are similar beds to DDPC’s population. RPC also oversees two dental clinics – one at RPC and one in Portland. Between the two clinics, they experienced over 8000 visits last year, and there is a waiting list.

We are in the process of trying to look at different models for the NCR (not criminally responsible) clients that are in the hospital because they are the most stable -- perhaps a step-down unit. This would create bed vacancies which could be used for a more acute patient. The NCR individual does not need acute inpatient care; they can be housed at a lower cost as they do not require a licensed hospital setting.

The remainder of the meeting, the group focused on their questions and the additional data needed so the group can continue with their mission. Following are the thoughts/concerns/questions:

- Level of funding to support of DDPC, support involuntary beds as compared to other patients. What portion of DDPC budget covers involuntary beds and what supports other services. Include admin costs as well.
- Information from other providers in the area about what if any pieces that are being done by DDPC can be done by them and if not, why not.
- Side by side comparison for discharge for 4 IMD’s (Institute for Mental Disease) - per day cost based on the Medicare cost reports
- Facility options - what are the options?
- Big picture scenario – what would it look like when DDPC closed, what would mental health services look like, what it would look like if DDPC stayed open.
- What is the role of this property?
- Keep clients foremost in our minds. What is best for the clients? How to determine cost savings? Patient satisfaction?
- Do not want us to lose focus on what the legislature wants us to do.
- Reality of $7 million reduction, what is the impact? Immediate gaps? What are the solutions to address that? What is the capacity in place? How do we create services to fill that gap? Address immediate problem. Short and long term issues.
- Focus on data models. Start with what is needed for certain inpatient services. Does it need to be provided by state hospital? Will DDPC always serve as a safety net? What is the number and beds that any facility will have to play? Does the state have the money to put in a state hospital to provide outcome.
- Safeguard jobs.
- DAFS – BGS – looks at buildings. Do you save the money by shutting facility?
- Deal with outdated buildings. Obligation to hear from economic folks about what the buildings can be used for.
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- Closing Pineland – wasn’t until arrived closing date was set that the whole
discussion and thinking changed. Folks were much more creative about what is
out there for services.
- DDPC, RPC, Acadia, Spring Harbor – meet to decide how to serve those folks
that may lose services. Plan for immediate impact.
- What isn’t in the community that forces people into DDPC?
- Feasibility study with short term and long term solutions for mental health
clients.
- AMHI vs Riverview – streamline things. What was the process about the
determination of beds? Availability of community beds? Decision had been
made to go to the hospital – question of where and how many beds. What can
we learn by going from AMHI to Riverview?
- Community services have really grown.
- What is the future of this hospital related to the space? Is this the right building
for a hospital to achieve the best patient outcome?
- Is there time for DDPC to leave this facility? Is there another state use? Other
state agencies are on campus.

Building/Campus
There was much discussion regarding the age of the buildings. What is the future
of this hospital related to the space? Is this the right building for the hospital to achieve
the best patient outcome?

Some expressed concern about the “institutional” feel of the buildings and the impact of
that on patient recovery. Lisa Hall spoke on the clinical aspect relating to the buildings.
She stated that we have a lot of positives here and that it’s not a bad clinical space.
Many patients enjoy the older buildings, as families do as well. Linda stated that
DDPC is all about the outstanding staff that give excellent care and will continue to do
so whether in the current setting or a new one.

Questions: what is excess dollars spent on the building that you could spend on the
patients? What is the net savings between a new facility and the current one? Can you
separate the costs of the other agencies and if the cost was reasonable, should DDPC
stay in the current buildings? Is this the right set up given the excess costs? What other
role could this physical plant play? What happens to the other state agencies if DDPC
leaves (financially speaking)?

There was a suggestion of holding a meeting at RPC. Mary Louise stated that if anyone
wants a tour, contact her and she will gladly set it up.
Over the course of the day, there were many requests for additional information:

- DDPC budget, beds, other services, admin, facilities (Jenny)
- Side by side cost per discharge of the 4 IMDs (Jenny)
- Immediate impact of the $7 million (Linda)
- Cost benefit in developing RPC versus the cost of AMHI and some information about the benefits of that move both financially and clinically (Jenny & ML)
- Action program from Spring Harbor and Shalom House (Dennis)
- Campus report (Linda)
- OAMH spending over time (Ron)
- Length of stay (Bill)
- Cost of DDPC if we prorated the facilities costs to others on this campus (Jenny)
- Patient satisfaction (Bill)
- Inventory of other support services in the Region and what is the capacity (Ron)
- Reasons patients cannot be discharged.

Suggestion that there be committee rules/structure to this group.

Due to the large amount of data requested, it was felt that subcommittees be formed to review the data and report back to the work group. The three subcommittees are:

- Financial – Jenny (chair), Carol, Dan, Lisa
- Service delivery – Dale, Jane, Kim, Linda, Sharon (chair), Charlie