COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss. **Division of Administrative Law Appeals**

Lyudmila Makarov,
Petitioner

v. Docket No. CR-22-0015

State Board of Retirement,
Respondent

Appearance for Petitioner:

Lyudmila Makarov, *pro se*

Appearance for Respondent:

Yande Lombe, Esq.

Administrative Magistrate:

Timothy M. Pomarole, Esq.

SUMMARY OF DECISION

The petitioner appeals the State Board of Retirement's decision to deny her request to classify her position as a licensed practical nurse to Group 2. The decision is reversed. There is no dispute in this appeal that the petitioner's "regular and major duties" required her to provide "care" for purposes of grounding a Group 2 classification under G.L. c. 32, § 3(2)(g). The petitioner has also met her burden of demonstrating that most of the care she provided was to persons who are "mentally ill" within the meaning of the statute. Accordingly, the petitioner's position is entitled to Group 2 classification.

DECISION

The petitioner, Lyudmila Makarov, appeals the decision of the State Board of Retirement ("the Board") to deny her request that her position as a Licensed Practical Nurse II ("LPN II") be classified to Group 2.

I held an in-person hearing on February 12, 2024. Three witnesses testified at the hearing: Ms. Makarov, and two of her former co-workers, Karin Kovalevich and Elizaveta

Davledzarov. The hearing was recorded. I admitted into evidence Petitioner's Proposed Exhibits 1-4, Respondent's Proposed Exhibits 5-9, and Petitioner's Proposed Exhibits 10-13. The exhibits will be consecutively numbered as Exhibits 1-13. On April 1, 2024, the Board filed a post-hearing brief, whereupon the record was closed.[1]

FINDINGS OF FACT

Based on the evidence presented by the parties, along with reasonable inferences drawn therefrom, I make the following findings of fact:

1. On September 11, 2005, Ms. Makarov entered state service with the Department of Public Health ("DPH") at Western Massachusetts Hospital. She retired in December 2021. (Exhibit 5).

2. Prior to her retirement, Ms. Makarov worked as an LPN II on the "Transitional Care Unit," South 3 ("S3"), at Western Massachusetts Hospital. (Makarov Testimony; Exhibits 1–3, 10, 11).

4. The patient population on S3 included individuals diagnosed with different kinds of dementia, including those with Alzheimer's disease, alcohol-related dementia, frontotemporal dementia, and Lewy body dementia. There were also some patients with Huntington's disease. Occasionally, about once every three months, the population would include a patient who was admitted to provide respite for caregivers.[2] (Exhibits 10–13; Makarov Testimony; Kovalevich Testimony).

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[1] I deny Ms. Makarov's request to admit a post-hearing exhibit, an e-mail from her former colleague, Michelle Hunt RN WCC.

[2] The record does not indicate whether these respite patients had dementia or some other condition. Whatever the case may be, there were relatively few of these patients.

5. By the final year of Ms. Makarov's service, most of the patients on S3 were dementia patients transferred from North 2 ("N2"), the dementia unit, which treated dementia patients that long-term care facilities were unable to manage due to behavioral issues, including aggressive behavior and resistance to treatment. Patients were transferred from N2 to S3 when they no longer attempted to walk on their own initiative or when their ability to walk independently had diminished. If the patients' behavioral issues lessened, they might be transferred from S3 to a long-term care facility, but in at least some cases, the patients' final days were on S3. (Kovalevich Testimony; Makarov Testimony; Davledzaraov Testimony).

6. Although patients who were transferred from N2 to S3 might have a reduced ability to walk, their challenging behaviors persisted. (Kovalevich Testimony; Makarov Testimony).

7. Ms. Makarov, and the other staff on S3, regularly encountered challenging and aggressive behaviors from dementia patients, such as kicking, hitting, grabbing, squeezing, scratching, yelling, swearing, and resistance to care. (Makarov Testimony; Kovalevich Testimony, Exhibits 1–4).

8. The patients with Huntington's Disease were not typically identified as having suffered from dementia, but were assigned to S3 because they exhibited significant behavioral symptoms – including aggression, resistance, and agitation – requiring behavioral management. (Makarov Testimony; Exhibits 1–4, 11).

9. S3 is a locked unit. No one can enter or exit the unit unless they swipe a security badge or are buzzed in. (Exhibit 10). This prevents patients from leaving the unit. (Kovalevich Testimony).

10. As an LPN II, Ms. Makarov spent more than half of her working hours caring for S3 patients. Her care was not restricted to one type of S3 patient. Her care included assisting patients with daily living activities, hygiene, and mobility. (Exhibits 1–3; Makarov Testimony). In view of the challenging behaviors described above, Ms. Makarov could not safely or effectively care for her dementia patients without placing their mental health conditions and the resulting behaviors at the center of the care she provided. (Makarov Testimony; Kovalevich Testimony).

11. On December 30, 2021, the Board reviewed Ms. Makarov's Group 2 application and denied her request. The denial was communicated to her by letter dated December 31, 2021. (Exhibit 8).[3]

12. On January 14, 2022, Ms. Makarov filed a timely appeal of the Board's decision to the Division of Administrative Law Appeals ("DALA"). (Exhibit 9).

ANALYSIS

A member's retirement compensation is based, at least partially, on their group classification. Members may be classified into four groups. G.L. c. 32, § 3(2)(g). Membership in Group 2 includes, but is not limited to, employees "whose regular and major duties require them to have the care, custody, instruction or other supervision of… persons who are mentally ill" or developmentally disabled. G.L. c. 32, § 3(2)(g). "Regular and major duties" require that an employee spends more than half of their working hours engaged in these responsibilities. *Desautel v. State Bd. of Ret.*, CR-18-0080, *3 (Contrib. Ret. App. Bd. Aug. 2, 2023). Here, the Board does not dispute that Ms. Makarov provided "care" for purpose of Group 2. Instead, the

[3] No reason was provided. (Exhibit 8).

issue is whether she spent more than 50% of her workday providing care to members of a Group 2 population, namely, individuals who are "mentally ill."

Patients qualify as "mentally ill" for purposes of grounding a Group 2 classification if their mental illnesses "drive" or "govern" their care. *Popp v. State Bd. of Ret.*, CR-17-848, 2023 WL 11806173, at *4 (Contrib. Ret. App. Bd. Nov. 16, 2023). In other words, "attention to a patient population's mental-health-related symptoms and behaviors" must be "at the heart of the care and supervision they require." *Hanson v. State Bd. of Ret*., CR-22-0268, 2024 WL 4432417, at *3 (Div. Admin. Law App. Sept. 27, 2024).

The eligible care is not limited to "psychiatric or psychological treatment," however. *Larose v. State Bd. of Ret.*, CR-20-357, 2024 WL 4201310, at *3 (Contrib. Ret. App. Bd. Sept. 4, 2024). In *Larose*, for example, although the member's "focus was on treating the patients' physical medical conditions," those conditions were in many instances "caused or worsened by self-harm or lack of self-care resulting from the patients' mental illnesses," which also caused them to resist or refuse treatment, "impacting treatment of their physical medical conditions." *Id.* at *1. Similarly, in *Hanson*, the patients, who were being treated for HIV/AIDS, often had mental illnesses and disorders, resulting in symptoms and behaviors such as "agitation, aggression, obstructiveness, and noncompliance." *Id.* Accordingly, although they received treatment for HIV/AIDS, these "patients' mental illnesses drove and governed their care. The treatment that these patients required revolved around their mental-health-related symptoms and behaviors." *Id.* at *3.[4]

[4] The Board appears to suggest that the care provided to dementia patients on S3 might not qualify as care for individuals who are "mentally ill" within the meaning of the statute to the extent they are being treated for mobility or medical issues. (Post-Hearing Brief, at 9). Because, as noted above, the eligible care is not limited to "psychiatric or psychological treatment," *Larose*, *supra*, the Board's argument misses the mark.

By contrast, patients are not mentally ill for Group 2 purpose if their mental illnesses are "merely incidental or derivative of physical illness diagnoses." *Popp*, *supra*. To put it another way, Group 2 does not encompass care for "patients who happen to have such diagnoses," but whose diagnoses do not determine the care they receive. *Hanson*, *supra*.

In determining whether dementia will be considered a mental illness for purposes of the statute, the Contributory Retirement Appeal Board ("CRAB") has "held that patients with dementia or Alzheimer's disease qualify as mentally ill under G.L. c. 32, § 3(2)(g) where their dementia presents severe enough symptoms to qualify for involuntary commitment and they pose a risk of harm to their caregivers." *Popp, supra, at* *3. The analysis of whether "persons meet the definition of involuntary commitment focuses on a patient's freedom to ingress or egress from the unit or ward in which they receive treatment." *Id.* For example, CRAB has found evidence of "[i]nvoluntary commitment when "patients are confined to a locked ward or unit for the treatment of severe dementia or serious mental illness." *Id.*

Here, most of Ms. Makarov's patients were dementia patients whose behaviors were severe enough to "qualify for involuntary commitment" and who "pose[d] a risk of harm to caregivers." *Popp*, *supra*, at *3. Their mental illnesses "govern[ed]" the care they received on S3 – particularly the care provided by staff members, like Ms. Makarov, whose care included activities like assisting with toileting and movement, which required close, hands-on interactions. Such care could not be safely or effectively provided unless "attention to [these patients'] mental-health-related symptoms and behaviors" was at the "heart" of that care. *Hanson*, *supra*.[5]

[5] Because I have found that most of Ms. Makarov's patients suffered from dementia, I do not need to consider whether the patients on S3 with Huntington's disease were "mentally ill" within the meaning of the statute.

The Board acknowledges that most of the patients on S3 were dementia patients, but asserts that Ms. Makarov does not provide care for persons who are "mentally ill" within the meaning of the statute because, in prior cases in which members were found to have provided care to dementia patients, the members worked in specialized dementia units, whereas S3 is not designated as a specialized dementia unit and is not limited to the care of dementia patients. (Post-Hearing Brief, at 8-10 (citing *Neergheen v. State Bd. of Ret.*, CR-07-439, 2009 WL 5966870 (Div. Admin. Law App. July 24, 2009) (*aff'd*, Contrib. Ret. App. Bd. Nov. 3, 2009); *Nowill v. State Bd. of Ret.*, Decision on Reconsideration, CR-08-558, 2012 WL 13406344 (Contrib. Ret. App. Bd. May 17, 2012); and *Pulik v. State Bd. of Ret.*, CR-10-605, 2012 WL 13406359 (Contrib. Ret. App. Bd. July 10, 2012)). The argument is unavailing.

First, although *Neergheen*, *Nowill*, and *Pulik* although involved members who worked in units specifically designated as dementia units, none of these decisions state that the eligible care is limited to that provided in specialized dementia units or that only dementia patients who are treated in such units qualify as mentally ill under the statute. *Cf. Popp*, *supra*, at *1-2 (determining that member who provided care to individuals in "Hospice Unit," most of whom suffered from dementia, was eligible for Group 2). Moreover, to the extent the Board is suggesting that the eligible care must be "psychiatric or psychological treatment," the suggestion is incorrect. *Larose, supra*.

Finally, even though S3 also admits some non-dementia patients, it arguably "specializes" in the care of dementia patients: these patients make up the majority of the unit's composition, the patients' dementia-related behaviors drive the provision of care, the unit is locked to prevent patients from leaving the unit, and the unit receives dementia patients whose behaviors make them unsuitable for other facilities.

CONCLUSION AND ORDER

For the foregoing reasons, the Board's decision is reversed.

SO ORDERED.

DIVISION OF ADMINISTRATIVE LAW APPEALS

/s/ Timothy M. Pomarole

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Timothy M. Pomarole, Esq.
Administrative Magistrate

Dated: June 27, 2025