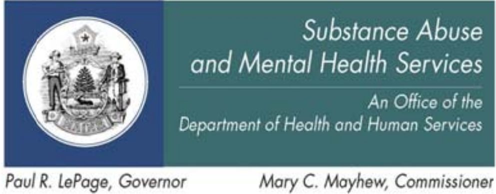

Department of Health and Human Services
Substance Abuse and Mental Health Services
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February 1, 2017

Daniel E. Wathen, Esq.
Pierce Atwood, LLP
77 Winthrop Street
Augusta, ME 04330

RE: *Bates v. DHHS* – Quarterly Progress Report

Dear Justice Wathen:

Enclosed, pursuant to paragraph 280 of the Settlement Agreement, please find the Substance Abuse and Mental Health Services Quarterly Report for the quarter ending December 31, 2016.

A list of the Designated Performance and Quality Improvement Standards is included with this letter to inform interested parties of the changes made to the Consent Decree Plan of October 13, 2006, pursuant to your order of December 13, 2016.

If you have any comments or concerns about the contents of this report, we would be glad to meet to discuss them.

Sincerely,

Sheldon Wheeler
Director, Office of Substance Abuse and Mental Health Services

cc: Kevin Voyvovich, Esq.
Bernadette O'Donnell, Esq.
Phyllis Gardiner, Assistant Attorney General
Jane Gregory, Assistant Attorney General
Mary C. Mayhew, Commissioner DHHS

Department of Health & Human Services, Office of Adult Mental Health Services
Bates v. DHHS Consent Decree
October, November, December 2nd Quarter, SFY 2017
CONSENT DECREE REPORT

SUMMARY
(Section 1A)

The DHHS Office of Substance Abuse and Mental Health Services is required to report to the Court quarterly regarding compliance and progress toward meeting specific standards as delineated in the Bates v. DHHS Consent Decree Settlement Agreement, the Consent Decree Plan of October 2006, and the Compliance Standards approved October 29, 2007. The following documents are submitted as the Quarterly Progress Report for the 2nd quarter of state fiscal year 2017, covering the period October, November, December 2016. A link to the PDF version of each document is provided on the SAMHS website.

		DESCRIPTION
1	**Cover Letter, Quarterly Report:** February 2017 *Section 1*	Letter to Dan Wathen, Court Master, submitting the Quarterly Report pursuant to paragraph 280 of the Settlement Agreement for the quarter ending December 31st, 2016.
2	**Report on Compliance Plan Standards: Community** *Section 2*	Lists and updates the information pertaining to standards approved in October 2007 for evaluating and measuring DHHS compliance with the terms and principles of the Settlement Agreement.
3	**Performance and Quality Improvement Standards** *Section 3*	Details the status of the Department's compliance with specific performance and quality improvement standards required by the Consent Decree October 2006 Plan for this reporting quarter. Reporting includes the baseline, current level, performance standard, and compliance standard for each, including graphs.
4	**Consent Decree Performance and Quality Improvement Standard 5.** *Section 4*	Aggregate report of assignment time to service and completion time of Individual Support Plans (ISPs). Data gathered from Contact for Service Notifications, Prior Authorizations, and Continued Stay Requests via APS Care Connections.
5	**Performance Quality and Improvement Standards, Appendix: Adult Mental Health Data Sources** *Section 5*	Lists and describes all of the data sources used for measuring and reporting the Department's compliance on the Performance and Quality Improvement Standards.
6	**Cover: Unmet Needs and Quality Improvement Initiative** *Section 6*	Provides a brief introduction to the unmet needs report as well as some definitions of the data, initial findings and next steps. Also includes information on the quality improvement initiatives undertaken by SAMHS.
7	**Unmet Needs by CSN** *Section 7*	Quarterly report drawn from the Enterprise Information System (EIS) by CSN (based on client zip code), from resource need data entered by community support case managers (CI, ACT, CRS, and BHH) concerning consumers (class members and non-class members) who

		DESCRIPTION
		indicate a need for a resource that is not immediately available. Providers are required to enter the information electronically upon enrollment of a client in Community Support Services and update the information from their clients' Individual Service Plans (ISPs) every 90 days via an RDS (Resource Data Summary) entered as a component of prior authorization and continuing stay requests made to APS Healthcare via their online system, CareConnections.
8	**BRAP Waitlist Monitoring Report,** *Section 8*	Describes status of the DHHS Bridging Rental Assistance Program's (BRAP) waitlist, focusing on the numbers served over time by priority status.
9	**Class Member Treatment Planning Review** *Section 9*	Aggregate report of document reviews completed on a random sample of class member ISPs by Consent Decree Coordinators following a standardized protocol.
10	**DHHS Integrated Child/Adult Quarterly Crisis Report** *Section 10*	Aggregate quarterly report of crisis data submitted by crisis providers to the Office of Quality Improvement on a monthly basis.
11	**Riverview Psychiatric Center Performance Improvement Report** *Section 11*	Reports on Riverview's compliance with specific indicators re: performance and quality; recording findings, problem, status, and actions for the specified quarter.

Department of Health and Human Service
Office of Substance Abuse and Mental Health Services
Fourth Quarter State Fiscal Year 2016
Report on Compliance Plan Standards: Community
February 1, 2017

	Compliance Standard	Report/Update
I.1	Implementation of all the system development steps in October 2006 Plan	As of March 2010, all 119 original components of the system development portion of the Consent Decree Plan of October 2006 have been accomplished or deleted per amendment.
I.2	Certify that a system is in place for identifying unmet needs	See attached *Cover: Unmet Needs February 2017* And *Unmet Needs by CSN for FY16 Q4 found in Section 10.*
I.3	Certify that a system is in place for Community Service Networks (CSNs) and related mechanisms to improve continuity of care	The Department's certification of August 19, 2009 was approved on October 7, 2009.
I.4	Certify that a system is in place for Consumer councils	The Department's certification of December 2, 2009 was approved on December 22, 2009.
I.5	Certify that a system is in place for new vocational services	The Department's certification of September 17, 2011 was approved November 21, 2011.
I.6	Certify that a system is in place for realignment of housing and support services	All components of the Consent Decree Plan of October 2006 related to the Realignment of Housing and Support Services were completed as of July 2009. Certification was submitted March 10, 2010. The Certification Request was withdrawn May 14, 2010.
I.7	Certify that a system is in place for a Quality Management system that includes specific components as listed on pages 5 and 6 of the plan	Department of Health and Human Services Office of Adult Mental Health Services Quality Management Plan/Community Based Services (April 2008) has been implemented; a copy of plan was submitted with the May 1, 2008 Quarterly Report. A new Quality Plan is being developed.
II.1	Provide documentation that unmet needs data and information (data source list page 4 of compliance plan) is used in planning for resource development and preparing budget requests	Department has submitted its funding requests to meet all identified needs under the Consent Decree, for the upcoming biennial budget. All funds are now part of the base budget.
II.2	Demonstrate reliability of unmet needs data based on evaluation	See *Cover: Unmet Needs and Quality Improvement Initiatives February 2017* and the *Performance and Quality Improvement Standards: February 2017* for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data. SAMHS continues to review the reliability of the unmet needs data to ensure proper identification, recording and implementation of services for unmet needs. See Section 6.
II.3	Submission of budget proposals for adult mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address	The Director of SAMHS provides the Court Master with an updated projection of needs and associated costs as part of his ongoing updates regarding Consent Decree obligations.

	unmet needs *(Amended language 9/29/09)*	
II.4	Submission of the written presentation given to the legislative committees with jurisdiction over DHHS … which must include the budget requests that were made by the Department to satisfy its obligations under the Consent Decree Plan and that were not included in the Governor's proposed budget, an explanation of support and importance of the requests and expression of support … *(Amended language 9/29/09)*	See above.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	MaineCare and Grant Expenditure Report for FY 15 provided in the November 2016 report section 15
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs February 2017* and the *Performance and Quality Improvement Standards: February 2017* for examples of the Department Utilizing the QM system. Performance measures are in all direct service contracts.
III.1a	Document through quarterly or annual reports the data collected and activities to assure reliability (including ability of EIS to produce accurate data)	This quarterly report documents significant data collection and review activities of the SAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	See compliance standard III.1.
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Contract and licensing reviews are conducted as licenses expire. A report from DLRS is available; during the last quarter 19 of 19 agencies had protocols/procedures in place for client notification of rights.
IV.2	If results from the DIG Survey fall below levels established for Performance and Quality Improvement Standard 4.2, 90% of consumers report they were given information about their rights, the Department: (i) consults with the Consumer Council System of Maine (CCSM); (ii) takes corrective action a determined necessary by CCSM; and (iii) develops that corrective action in consultation with CCSM. *(Amended language 1/19/11)*	The percentage for standard 4.2 from the 2015 DIG Survey was 77%. These data are posted on the SAMHS website and provided to the Consumer Council of Maine for consultation. SAMHS distributed the survey in August 2015 and the recipients had until November 30, 2015 to return the survey. The survey is based on the model Perception of Care developed by the New York Office of Alcoholism and Substance Abuse. See longer explanation in Section 5. SAMHS will is contracting out the 2016 Survey.
IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension.	Standard was deleted December 13, 2016.
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if hearing is to be held or if parties concur.	Standard was deleted December 13, 2016.
IV.5	90% hospitalized class members assigned worker within 2 days of request - *must be met for 3 out of 4* quarters	Standard was deleted December 13, 2016. SAMHS will now measure 7 days from referral to face to face contact.
IV.6	90% non-hospitalized class members	Standard was deleted December 13, 2016.

	assigned worker within 3 days of request - <u>*must be met for 3 out of 4 quarters*</u>	SAMHS is now measuring 7 days from referral to face to face contact. Kepro is sending the data in the monthly report to SAMHS.
IV.7	95% of class members in hospital or community not assigned within 2 or 3 days, assigned within an additional 7 days - <u>*must be met for 3 out of 4 quarters*</u>	Standard was deleted December 13, 2016. SAMHS will now measure 7 days from referral to face to face contact.
IV.8	90% of class members enrolled in CSS with initial ISP completed within 30 days of enrollment - <u>*must be met for 3 out of 4 quarters*</u>	See attached *Performance and Quality Improvement Standards: February 2017,* Standard 5-5. This standard has not been met for the past 4 quarters.
IV.9	90% of class members had their 90 day ISP review(s) completed within that time period - <u>*must be met for 3 out of 4 quarters*</u>	See attached *Performance and Quality Improvement Standards: February 2017,* Standard 5-6. This standard has not been met for the past 4 quarters
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. The data has been consistent over time and since May 2011; reports are created quarterly and available to providers upon request. SAMHS will be developing a policy to follow up on overdue ISPs
IV.11	Data collected once a year shows that no more than 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	The 2015 data analysis indicates that out of 1,441 records for review, 173 (12.0%) did not have an ISP review within the prescribed time frame. The Quality Services Specialist has been giving technical support to agencies where class members enrolled in CS did not have their ISP reviewed before the next annual review.
IV.12	Certify in quarterly reports that DHHS is meeting its obligation re: quarterly mailings	Deleted December 13, 2016
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - <u>*must be met for 3 out of 4 quarters*</u>	Deleted December 13, 2016
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - <u>*must be met for 3 out of 4 quarters*</u>	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.15	90% of ISPs reviewed have a crisis plan or documentation as to why one wasn't developed - <u>*must be met for 3 out of 4 quarters*</u>	Deleted December 13, 2016
IV.16	QM system documents that SAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	Deleted December 13, 2016
IV.17	In 90% of ISPs reviewed, interim plans developed when resource needs not available within expected response times - <u>*must be met for 3 out of 4 quarters*</u>	Deleted December 13, 2016
IV.18	90% of ISPs review included service agreement/treatment plan - <u>*must be met for 3 out of 4 quarters*</u>	Deleted December 13, 2016
IV.19	90% of ACT/ICI/CI providers statewide	ACT providers with average caseloads of 10 or fewer

	meet prescribed case load ratios - _must be met for 3 out of 4 quarters_ Note: As of 7/1/08, ICI is no longer a service provided by DHHS.	deleted December 13, 2016. CI providers with average caseloads of 1:40 no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - _must be met for 3 out of 4 quarters_	Deleted December 13, 2016
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads _must be met for 3 out of 4 quarters_	See attached *Performance and Quality Improvement Standards: February 2017,* Standard 10.5. This standard has been met for the last 4 quarters.
IV.21	Independent review of the ISP process finds that ISPs met a reasonable level of compliance as defined in Attachment B of the Compliance Plan	
IV.22	5% or fewer class members have ISP-identified unmet residential support - _must be met for 3 out of 4 quarters_ **and**	See attached *Performance and Quality Improvement Standards: February 2017,* Standard 12.1 Standard met for the last 4 quarters.
IV.23	**EITHER** quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet residential support needs for non-class members do not exceed 15 percentage points of the same for Class Members. See attached unmet needs report Consent Decree Compliance Standards IV.23 and IV.43
IV.24	Meet RPC discharge standards (below); **or** if not met document reasons and demonstrate that failure not due to lack of residential support services • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: February 2017,* Standards 12-2, 12-3 and 12-4 Standard 12.2 was met 3 of the last 4 quarters. Standard 12.3 was met for the last 4 quarters. Standard 12.4 was met 2 of the last 4 quarters.
IV.25	10% or fewer class members have ISP-identified unmet needs for housing resources - _must be met for 3 out of 4 quarters_ **and**	Deleted December 13, 2016
IV.26	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of housing resources. • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and	See attached *Performance and Quality Improvement Standards: February 2017,* Standard 14-4, 14-5 & 14-6 Standard 14-4 met 3 out of the last 4 quarters. Standard 14-5 met for all of the last 4 quarters. Standard 14-6 met 2 out of the last 4 quarters.

	court master)	
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Deleted December 13, 2016.
IV.28	90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in attachment C to the Compliance Plan	Deleted December 13, 2016
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	See IV.30 below
IV.30	Evaluates compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	All involuntary hospital contracts are in place.
IV.31	UR Nurses review all involuntary admissions funded by DHHS, take corrective action when they identify deficiencies and send notices of any violations to the licensing division and to the hospital	Deleted December 13, 2016
IV.32	Licensing reviews of hospitals include an evaluation of compliance with patient rights and require a plan of correction to address any deficiencies.	18 Complaints Received 12 Complaints investigated 5 Substantiated 5 Plan of correction sought 2 Rights of Recipients Violations found this past quarter
IV.33	• 90% of the time corrective action was taken when blue papers were not completed in accordance with terms • 90% of the time corrective action was taken when 24 hour certifications were not completed in accordance with terms • 90% of the time corrective action was taken when patient rights were not maintained	Deleted December 13, 2016
IV.34	QM system documents that if hospitals have fallen below the performance standard for any of the following, SAMHS made the information public through CSNs, addressed in contract reviews with hospitals and CSS providers, and took appropriate corrective action to enforce responsibilities • obtaining ISPs (90%) • creating treatment and discharge plan consistent with ISPs (90%) • involving CIWs in treatment and discharge planning (90%)	Deleted December 13, 2016

IV.35	No more than 20-25% of face-to-face crisis contacts result in hospitalization – <u>*must be met for 3 out of 4 quarters*</u>	See attached *Performance and Quality Improvement Standards: February 2017,* Standard 19.1 and *Adult Mental Health Quarterly Crisis Report 2nd Quarter, State Fiscal Year 2017 Summary Report*. Standard met the last 3 quarters but not FY 17 Q2.
IV.36	90% of crisis phone calls requiring face-to-face assessments are responded to within an average of 30 minutes from the end of the phone call – <u>*must be met for 3 out of 4 quarters*</u> Per amendment dated May 8,2014 the standard now reads as follows: 90% of crisis calls requiring face-to-face assessments are responded to within an average of 60 minutes from the end of the phone call	See attached *Adult Mental Health Quarterly Crisis Report 2nd Quarter, State Fiscal Year 2017 Summary Report*. Starting with July 2008 reporting from providers, SAMHS collects data on the total number of minutes for the response time (calculated from the determination of need for face to face contact or when the individual is ready and able to be seen to when the individual is actually seen) and figures an average. Average statewide calls requiring face to face assessments are responded to within an average of 60 minutes from the end of the phone call – this standard was met FY12, FY13, FY14 Q1, Q2, Q4. FY 15 Q2, Q3, Q4, FY 16, FY17 Q1 and Q2
IV.37	90% of all face-to-face assessments result in resolution for the consumer within 8 hours of initiation of the face-to-face assessment – <u>*must be met for 3 out of 4 quarters*</u>	See attached *Adult Mental Health Quarterly Crisis Report 2nd Quarter, State Fiscal Year 2017 Summary Report*. Standard was consistently met from FY08 Q2 until FY 15. It was met in three out of the last six quarters -- FY 16 Q1 (88.6%),FY 16 Q2 (90.2%), FY 16 Q3 (90.5%),FY16 Q4 (89.1%), FY17 Q1 (18.9%) and Q2 (91.1)
IV.38	90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – <u>*must be met for 3 out of 4 quarters*</u>	Deleted December 13, 2016
IV.39	Compliance Standard deleted 1/19/2011.	
IV.40	Department has implemented the components of the CD plan related to vocational services	As of FY10, Q3, the Department has implemented all components of the CD Plan related to Vocational Services.
IV.41	QM system shows that the Department conducts further review and takes appropriate corrective action if PS 26.3 data shows that the number of consumers under age 62 and employed in supportive or competitive employment falls below 10%. *(Amended language 1/19/11)*	2015 Adult Health and Well-Being Survey: 10 % of consumers in supported and competitive employment (full or part time). SAMHS will is contracting out the 2016 Survey.
IV.42	5% or fewer class members have unmet needs for mental health treatment services – <u>*must be met for 3 out of 4 quarters*</u> **and**	Deleted December 13, 2016
IV.43	**EITHER** quarterly unmet mental health treatment needs for one year for qualified non-class members do not exceed by 15	Unmet mental health treatment needs for non-class members do not exceed 15 percentage points of the same for Class Members.

	percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	See attached unmet needs report Consent Decree Compliance Standards IV.23 and IV.43
IV.44	QM documentation shows that the Department conducts further review and takes appropriate corrective action if results from the DIG survey fall below the levels identified in Standard # 22-1 (the domain average of positive responses to the statements in the Perception of Access Domain is at or above 85%) *(Amended language 1/19/11)* **and**	2015 Adult Health and Well-Being Survey: 83.9% domain average of positive responses.
IV.45	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of mental health treatment services in the community • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: February 2017,* Standards 21.2-21-4 These standards have been met consistently since the beginning of FY08, except that Standard 12.4 (90% within 45 days) was not met in FY16 Q3 and Q4
IV.46	The department documents the programs it has sponsored that are designed to improve quality of life and community inclusion for class members, including support of peer centers, social clubs, community connections training, wellness programs, and leadership and advocacy training programs. Standard amended per amendment dated May 8, 2014	Deleted December 13, 2016
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – *must be met for 3 out of 4 quarters*	Deleted December 13, 2016
IV.48	Provide documentation in quarterly reports of funding, developing, recruiting, and supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	Deleted December 13, 2016
IV.49	Certify that all contracts with providers include a requirement to refer family members to family support services, and produce documentation that contract reviews include evaluation of compliance with this requirement.	Deleted December 13, 2016
IV.50	The department documents the number and types of mental health informational	Deleted December 13, 2016

	workshops, forums, and presentations geared toward the general public that are designed to reduce myths and stigma of mental illness and to foster community integration or persons with mental illness.	

DHHS Office of Substance Abuse and Mental Health Services

Compliance and Performance Standards: Summary Sheet
October – December 2016

Standard 1: Rights, Dignity and Respect

1 Average of positive responses in the Adult Mental Health and Well Being Survey Quality and Appropriateness domain

Standard 4: Rights, Dignity and Respect

4.2 Consumers given information about their rights

Standard 5: Timeliness of ISP

5.5 Class members enrolled in CSW/CI/ACT services where an initial ISP was completed within 30 days

5.6 90 day ISP review completed within specified time frame

Standard 10: Case Load Ratios

10.2 Community Integration Providers Case Load Ratio

10.5 Office of Aging and Disability Public Ward Case Management Case Load Ratio

Standard 12: Housing and Residential Support Services

12.1 Class Members with ISPs, with unmet Residential Support Needs

12.2 Lack of Residential Support impedes Riverview discharge within 7 days of determination of readiness for discharge

12.3 Lack of Residential Support impedes discharge within 30 days of determination

12.4 Lack of Residential Support impedes discharge within 45 days of determination

Standard 13: Housing and Residential Support Services

13.1 Average of positive responses in the Adult Mental Health and Well Being Survey Perception of Outcome domain

Standard 14: Housing and Residential Support Services

14.4 Lack of housing impedes Riverview discharge within 7 days of determination of readiness for discharge

14.5 Lack of housing impedes Riverview discharge within 30 days of determination

14.6 Lack of housing impedes Riverview discharge within 45 days of determination

Standard 18: Acute Inpatient Services (Class Member Involuntary Admissions)

18.3 CI/ACT worker participated in treatment and discharge planning

Standard 19: Crisis Intervention Services

19.1 Face to face crisis contacts that result in hospitalization

19.2 Face to face crisis contacts resulting in follow up and/or referral to community services

Standard 21: Treatment Services

21.2 Lack of MH Treatment impedes Riverview discharge within 7 days of determination of readiness for discharge
21.3 Lack of MH Treatment impedes Riverview discharge within 30 days of determination
21.4 Lack of MH Treatment impedes Riverview discharge within 45 days of determination

Standard 22: Treatment Services

22.1 Average of positive responses in the Adult Mental Health and Well Being Survey Perception of Access domain
22.2 Average of positive responses in the Adult Mental Health and Well Being Survey General Satisfaction domain

Standard 26: Vocational Employment Services

26.1 Class members with ISPs- Unmet vocational/employment needs
26.2 Class members in competitive employment in the community

Standard 28: Transportation

28 Class Members with ISPs- Unmet transportation needs

Standard 31: Recreation/Social/Avocational/Spiritual

31.2 Average of positive responses in the Adult Mental Health and Well Being Survey Social Connectedness domain

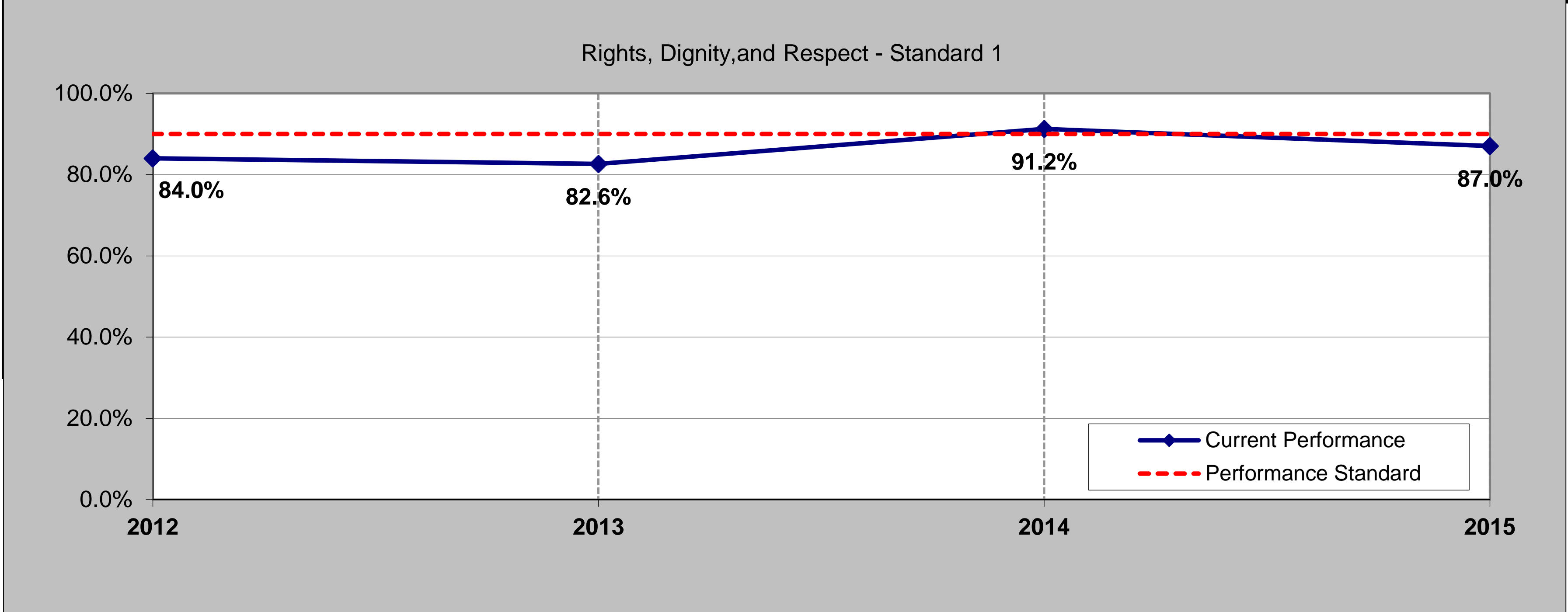
Standard 32: Individual Outcomes

32.1 Consumers with improvement in LOCUS (Baseline to Follow-up
32.2 Consumers who have maintained functioning (Baseline to Follow-up)
32.3 Consumers reporting positively on the Adult Mental Health and Well Being Survey Functional Outcomes domain

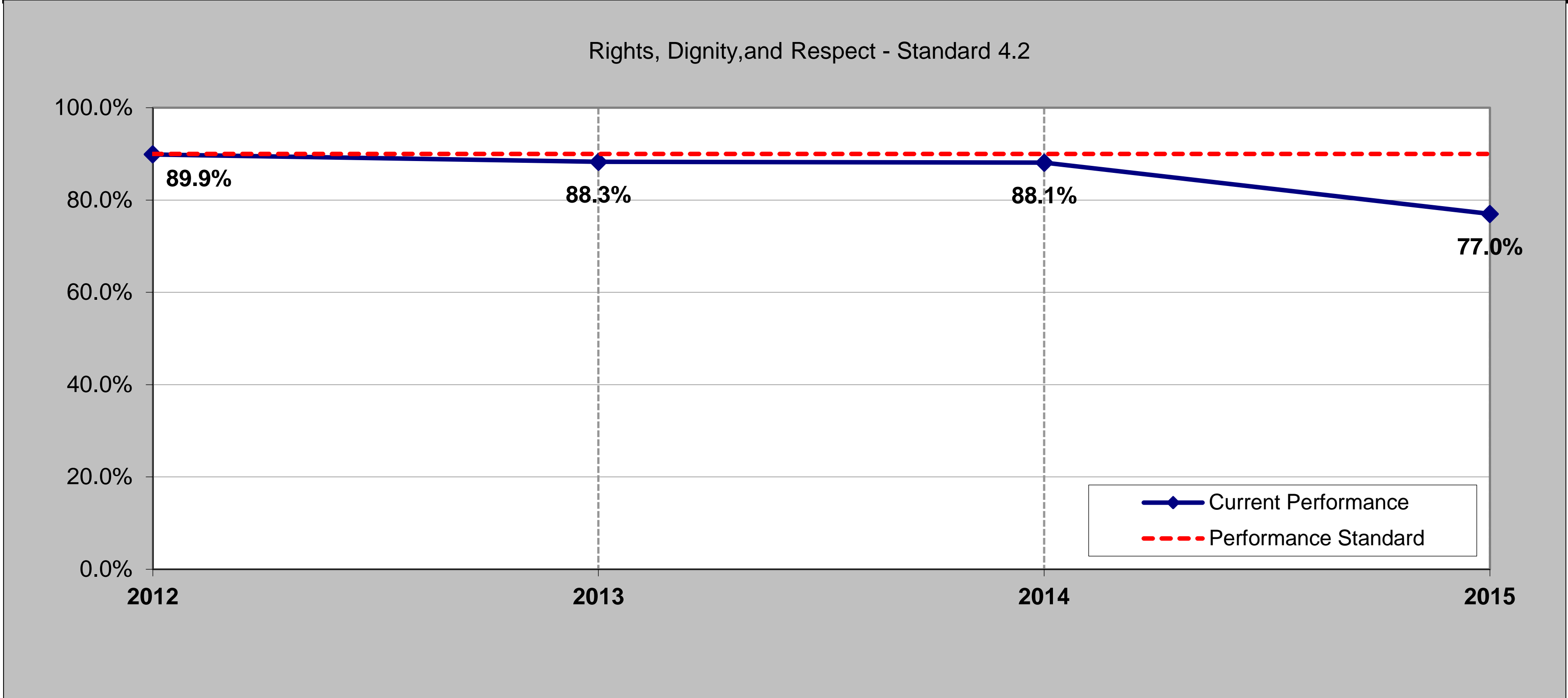
Standard 33: Recovery

33.2 Consumers reporting staff believed they could grow, change and recover
33.2 Consumers reporting staff supported their recovery efforts
33.6 Consumers reporting providers offered peer recovery groups

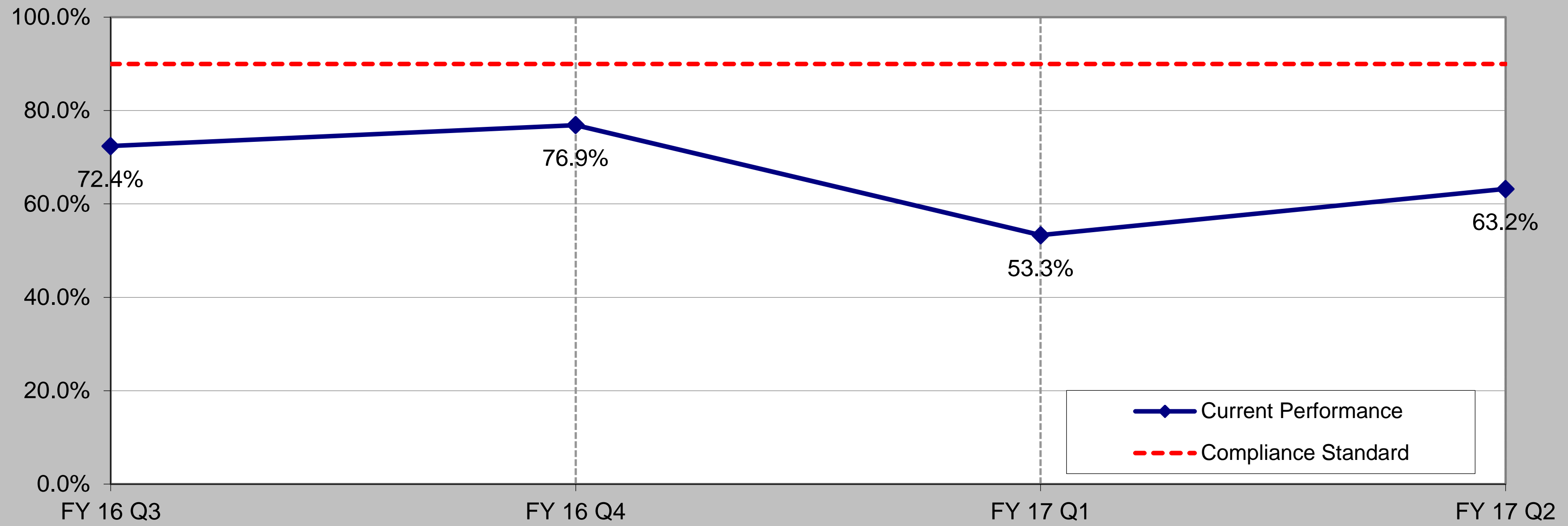
Standard 1	
Measurement	Domain averages of positive responses to the statements in the quality and appropriateness domain
Standard	Performance: at or above 85%
Data Sources	Adult Mental Health and Well Being Survey
Current Level	87.9% (1068 out of 1215)



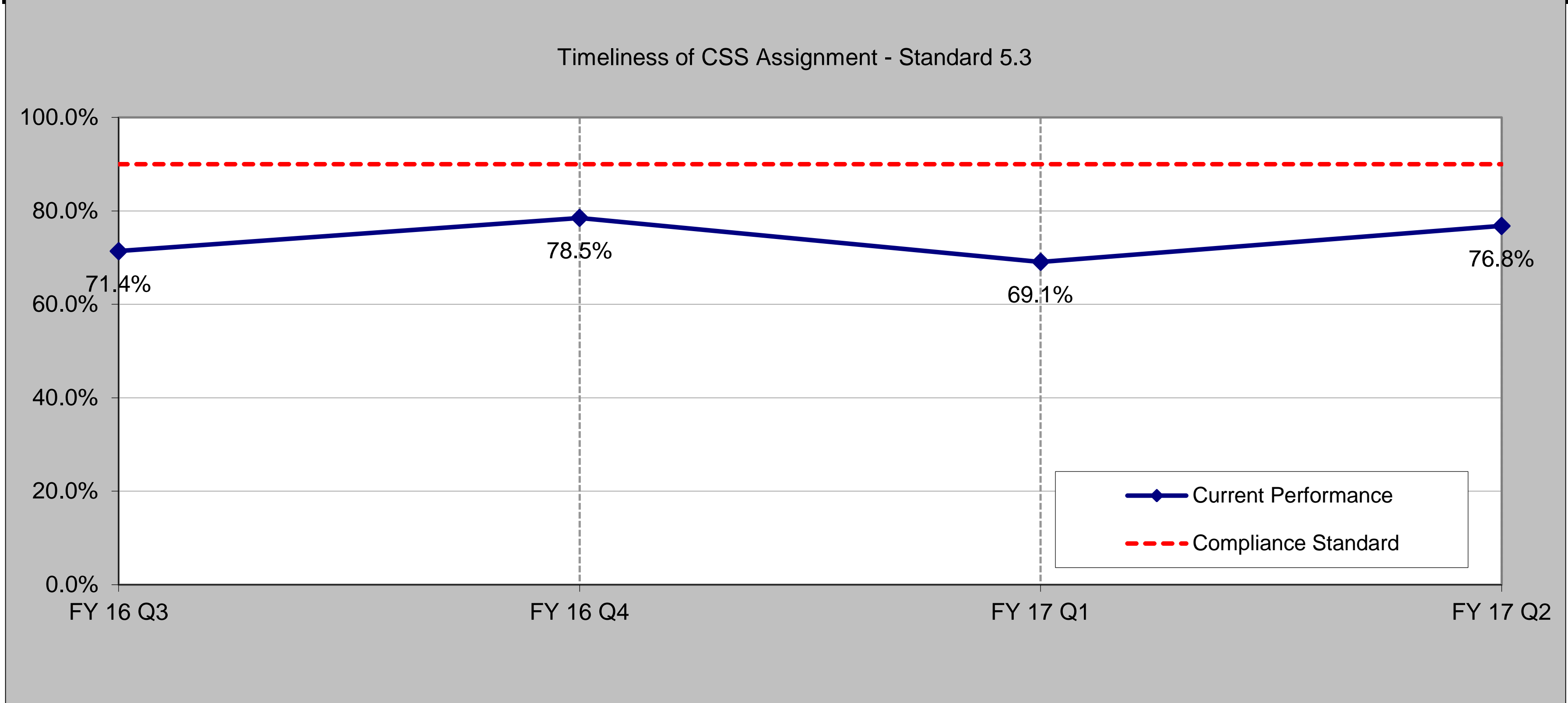
Standard 4.2	
Measurement	Domain averages of positive responses to the statements in the quality and appropriateness domain
Standard	Performance: at or above 90%
Data Sources	Adult Mental Health and Well Being Survey
Current Level	77.0% (935 out of 1215)



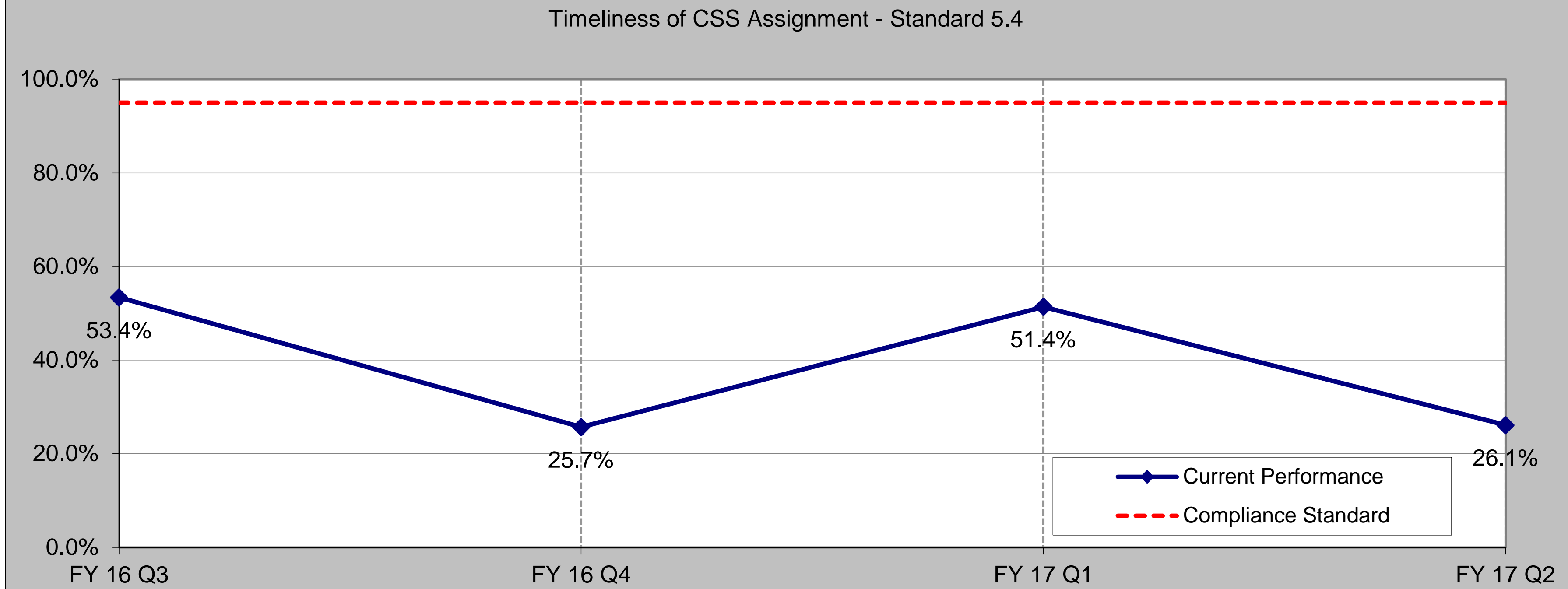
Standard 5.2	
Measurement	Percentage of all hospitalized class members assigned a worker within 2 working days of referral
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data (APS Healthcare)
Current Level	Compliance: 63.2% (12 out of 19)



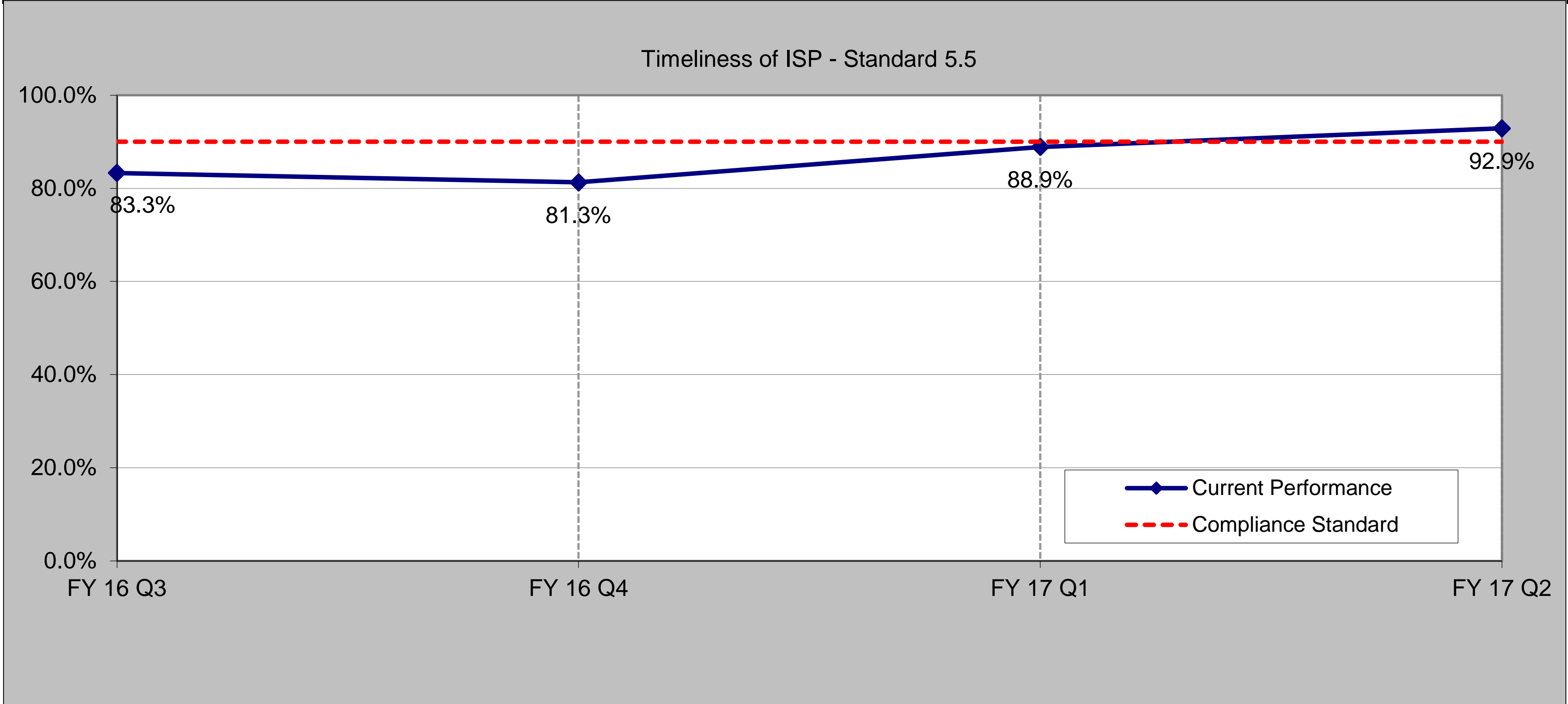
Standard 5.3	
Measurement	Percentage of all non-hospitalized class members who were assigned a worker within 3 working days of referral
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	Compliance: 76.8% (53 out of 69)



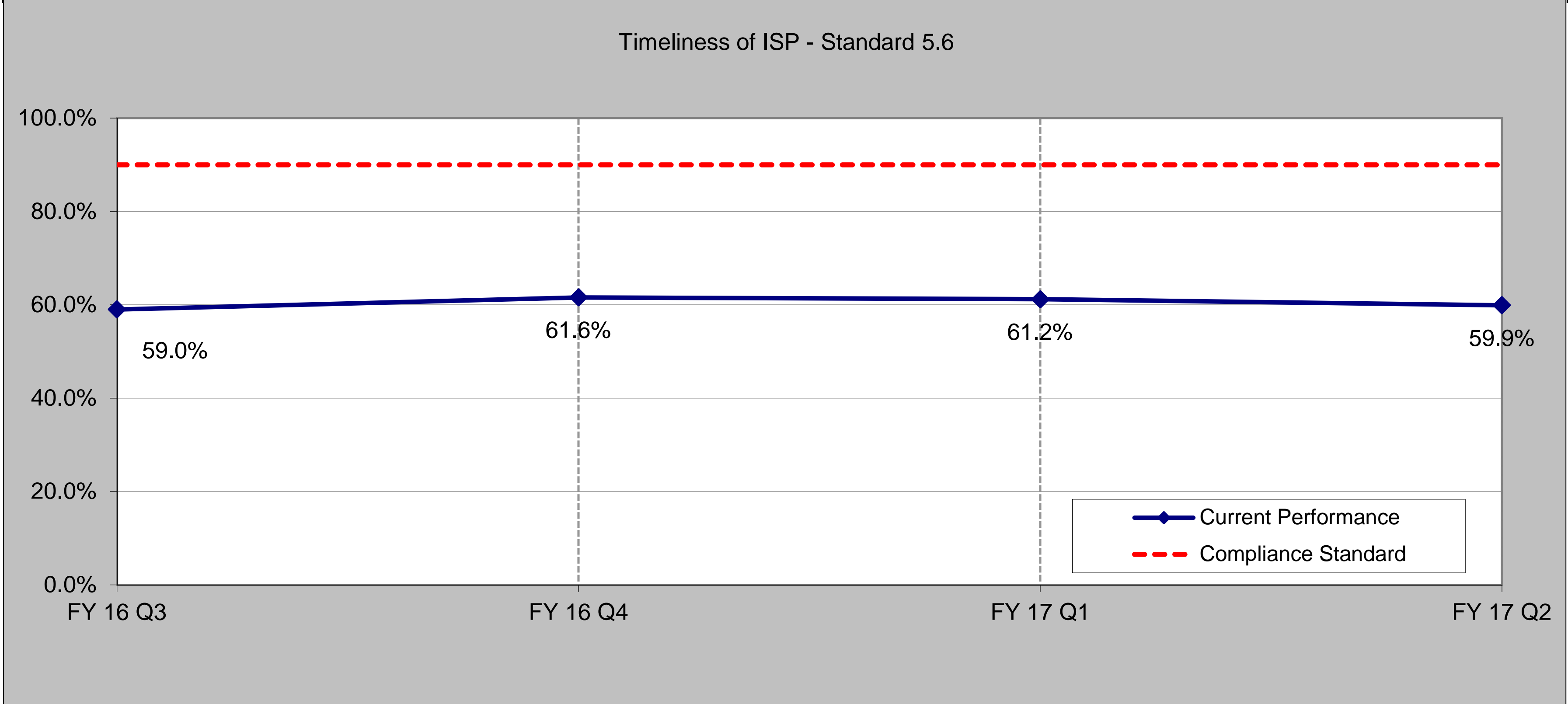
Standard 5.4	
Measurement	Of the class members who were not assigned on time, percentage of these clients who were assigned a community support worker within 7 working days
Standard	Performance: 100%
	Compliance: 95%
Data Source	ISP RDS Data (APS Healthcare)
Current Level	Compliance: 26.1% (6 out of 23)

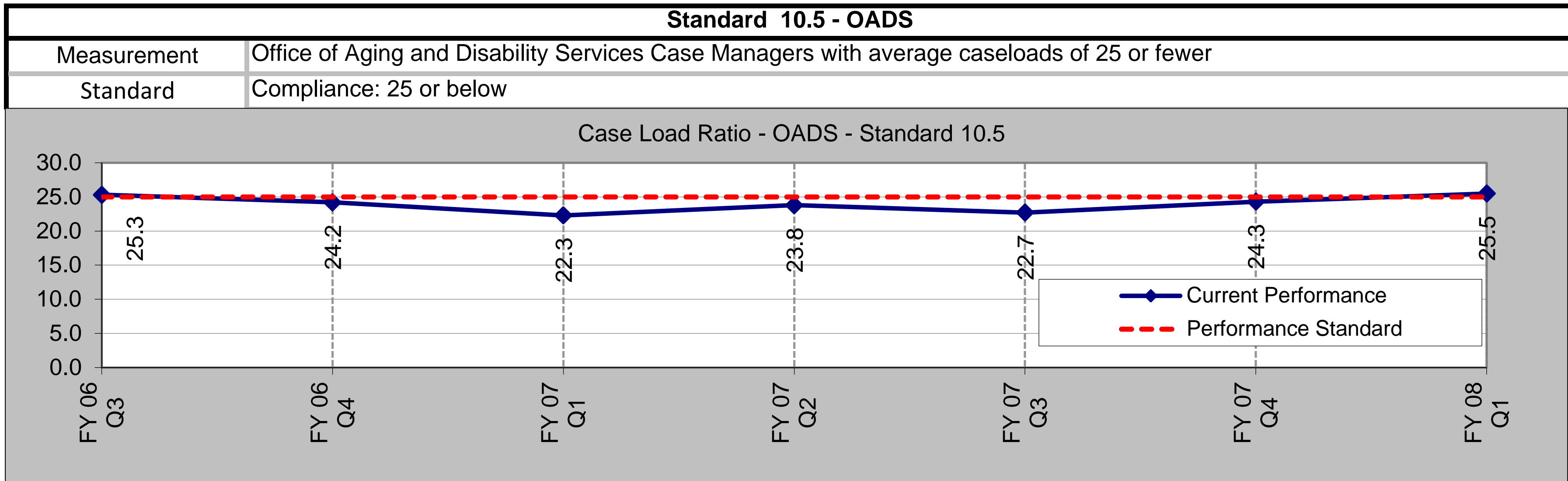


Standard 5.5	
Measurement	Percent of class members whose ISP completed within 30 days
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data (APS Healthcare)
Current Level	Compliance: 92.9% (13 out of 14)



Standard 5.6	
Measurement	90 day class member ISP reviews completed within specified timeframe
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data (APS Healthcare)
Current Level	Compliance: 56.9% (272 out of 478)

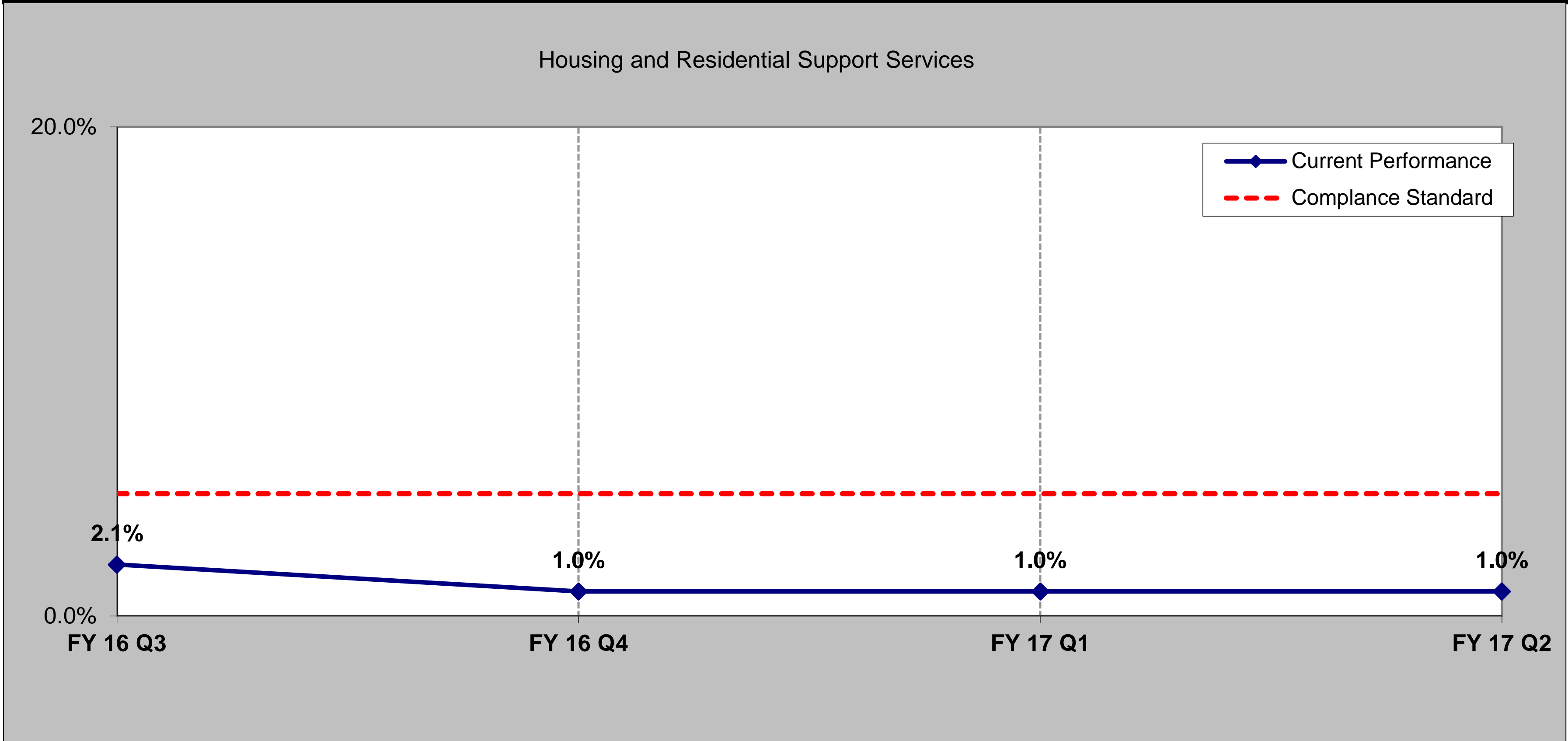




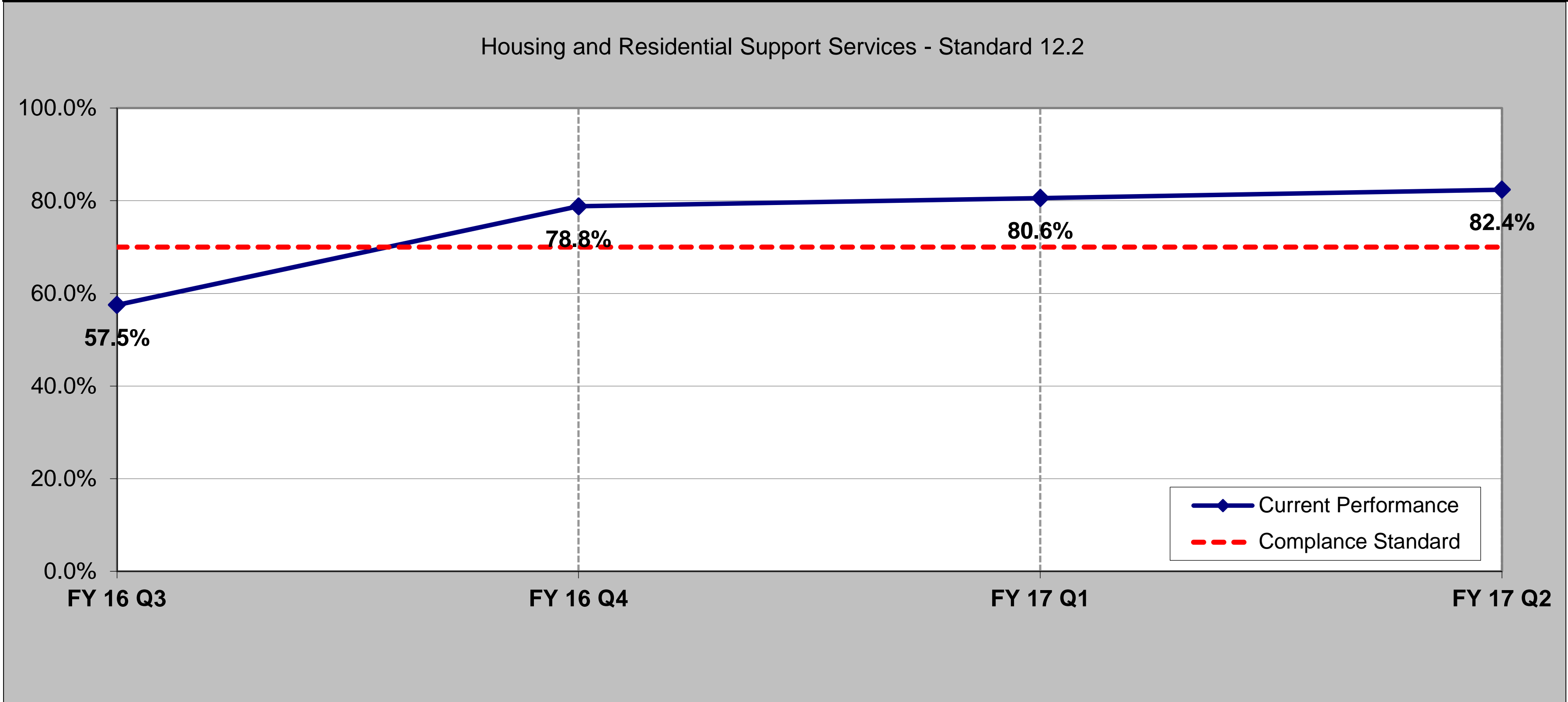
Standard 10.5 - OADS	
Measurement	Office of Aging and Disability Services Case Managers with average caseloads of 25 or fewer
Standard	Compliance: 25 or below

Standard 10.5 - OADS	
Measurement	Office of Aging and Disability Services Case Managers with average caseload of 25 or fewer
Standard	Compliance: 90% of all OADS Case Managers with Class Member Public Wards
Data Sources	MAPSIS Case Counts for Workers with Class Member Public Wards
Current Level	100% (26 out of 26)

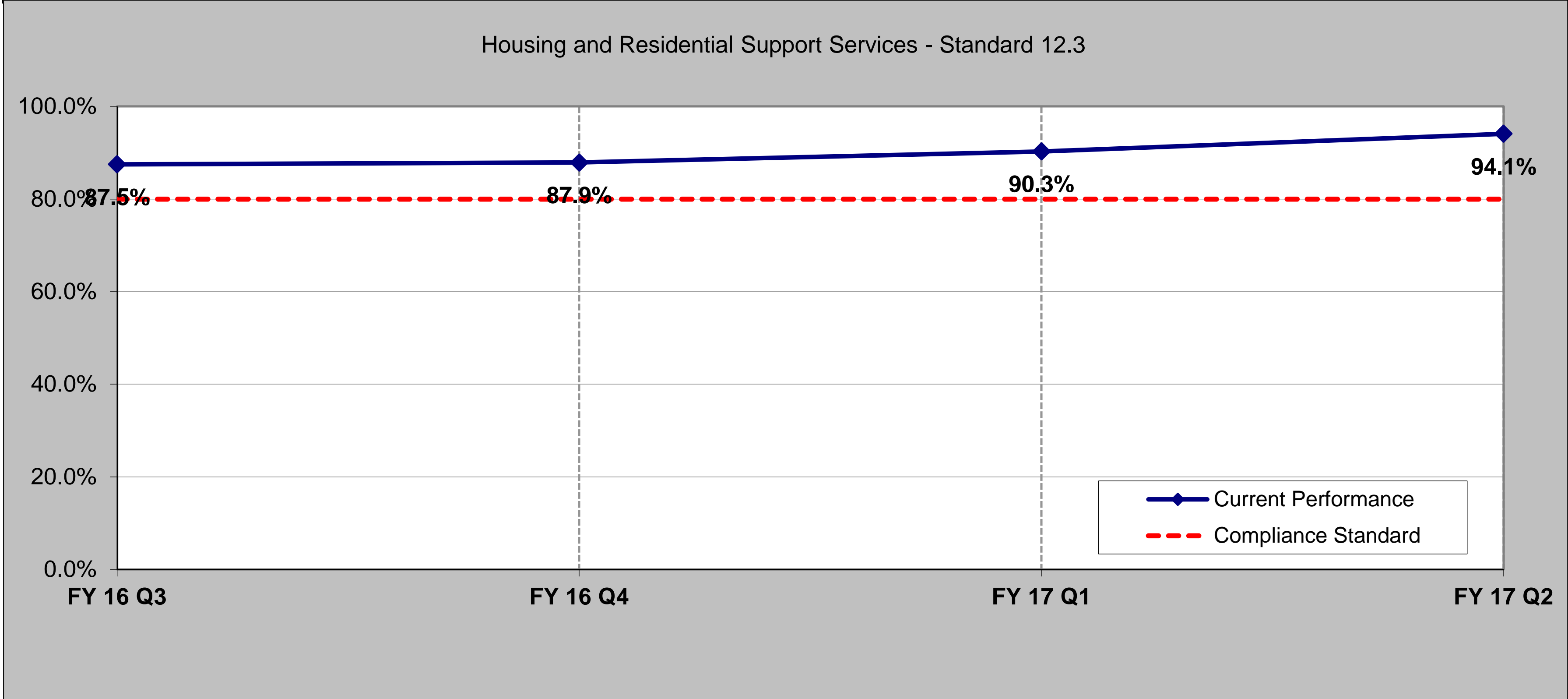
Standard 12.1	
Measurement	Class members in the community with ISPs with unmet residential support needs
Standard	Compliance: 5% or fewer (3 out of 4 quarters)
Data Sources	ISP RDS Data
Current Level	1% (5 out of 533)



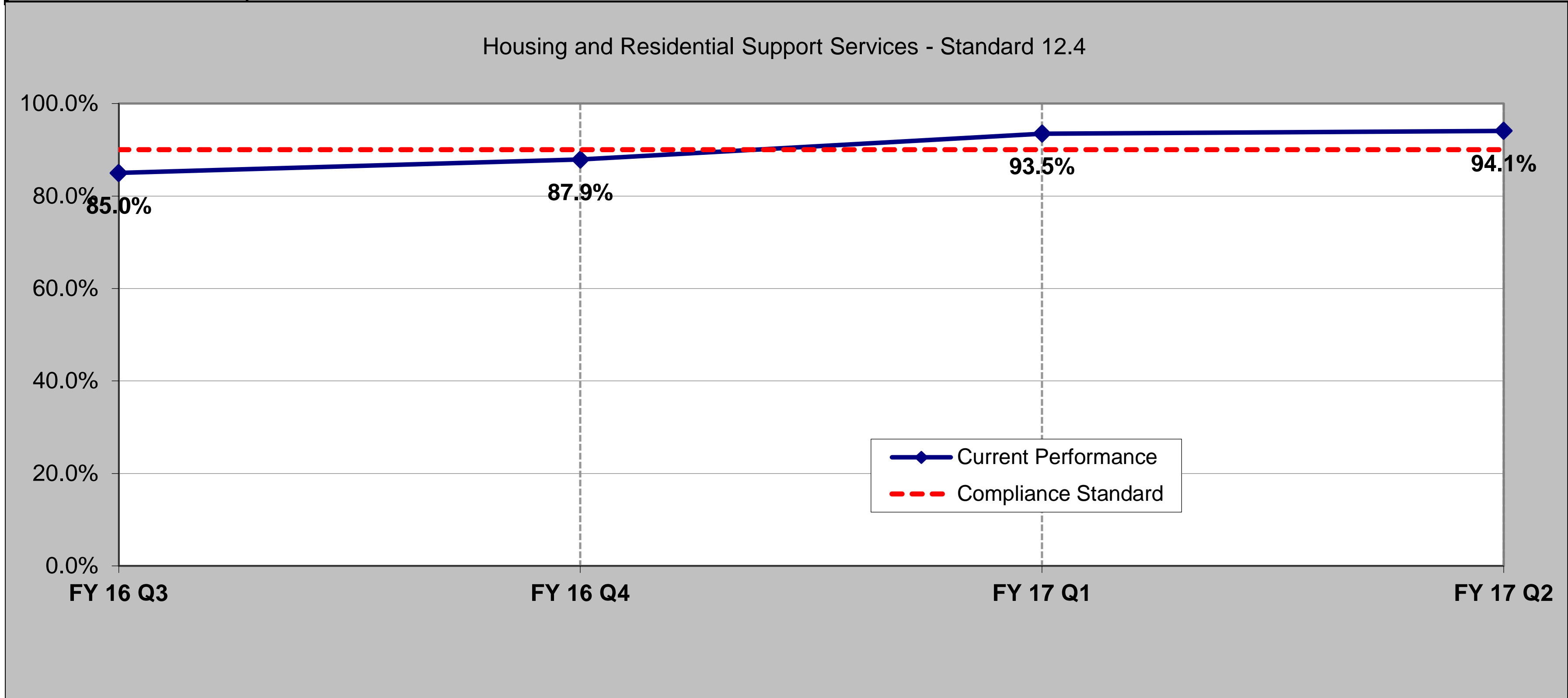
Standard 12.2	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge not impeded due to lack of residential supports)
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Sources	Riverview Psychiatric Center Discharge Data
Current Level	82.4% (Lack of residental supports did not impede discharge for 28 out of 34 patients within 7 days)



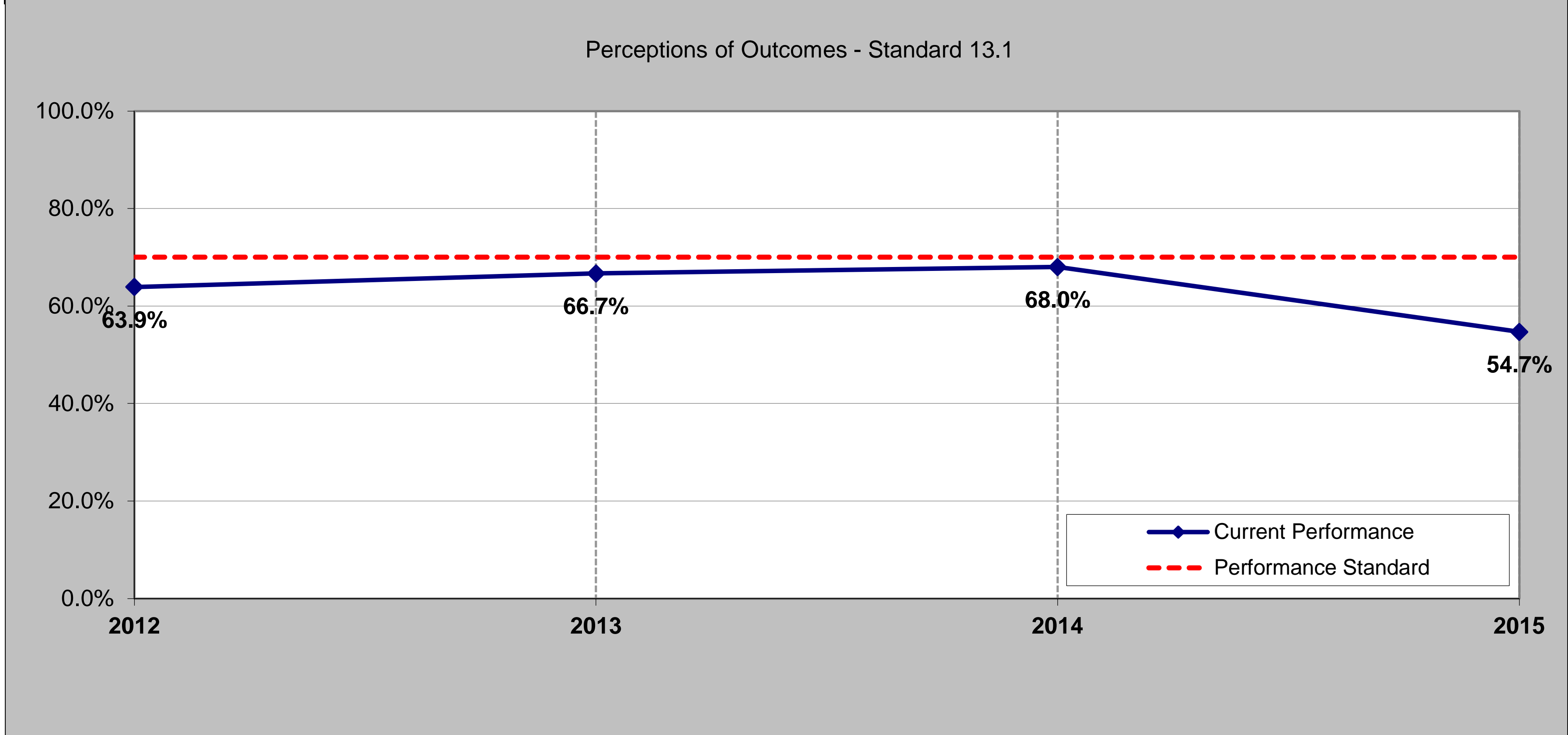
Standard 12.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge not impeded due to lack of residential supports)
Standard	Performance: 96 % (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Sources	Riverview Psychiatric Center Discharge Data
Current Level	94.1% (Lack of residental supports did not impede discharge for 32 out of 34 patients within 30 days)



Standard 12.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge not impeded due to lack of residential supports)
Standard	Performance: 100 % (within 45 days of that determination)
	Compliance: 95% (within 45 days of that determination)
Data Sources	Riverview Psychiatric Center Discharge Data
Current Level	94.1% (Lack of residental supports did not impede discharge for 32 out of 34 patients within 45 days)

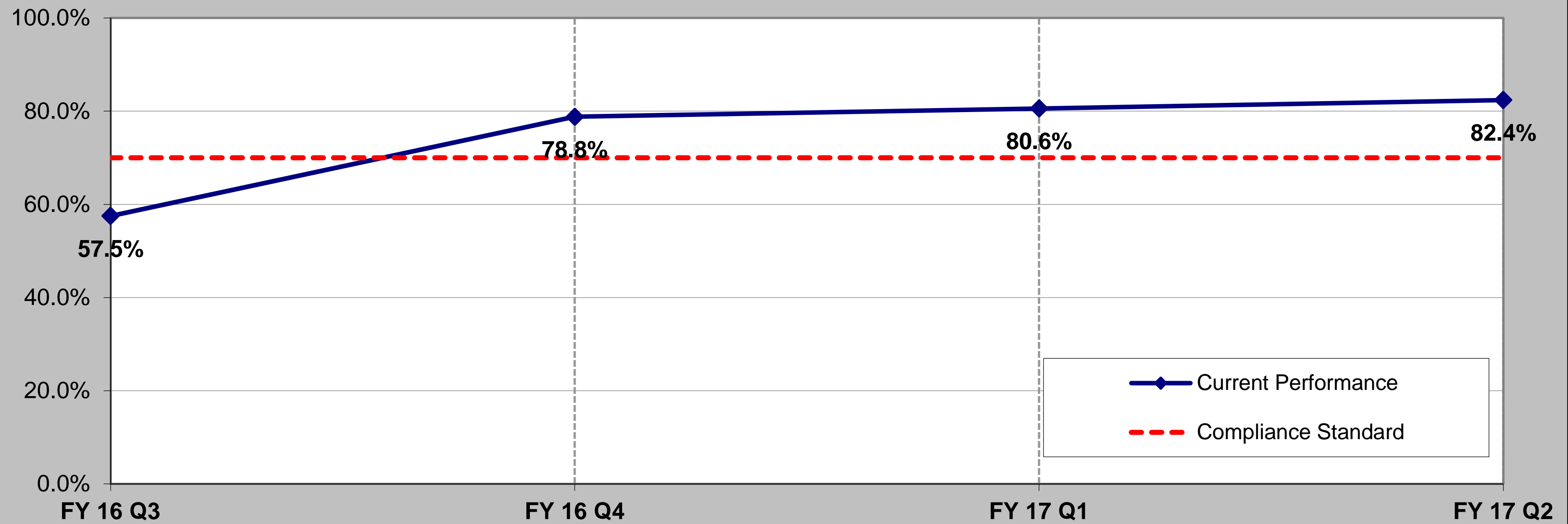


Standard 13.1	
Measurement	Average of positive responses to the Living Situation questions in the Perception of Outcomes domain
Standard	Performance: at or above 70%
Data Sources	Adult Mental Health and Well Being Survey
Current Level	54.7% (664 out of 1215)

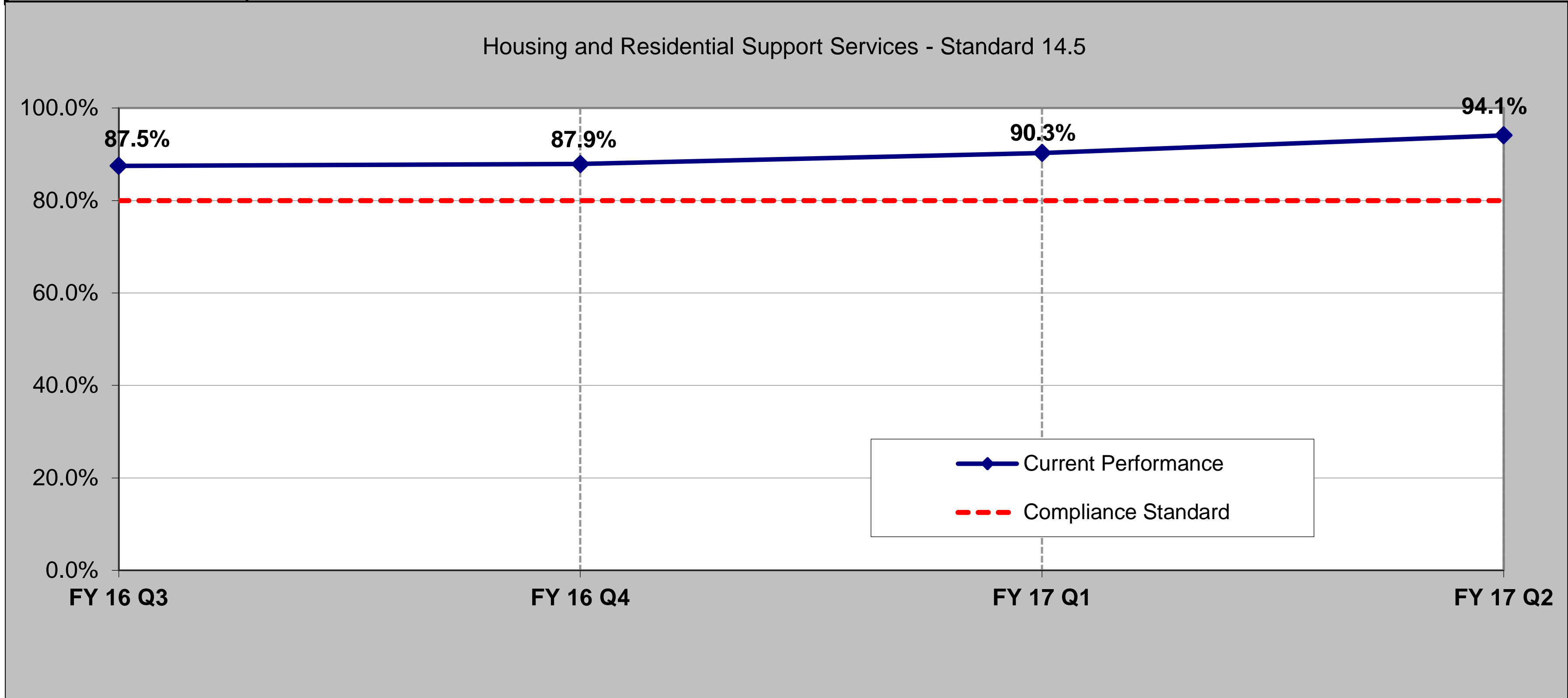


DIG survey data is collected the year prior to which it is reported

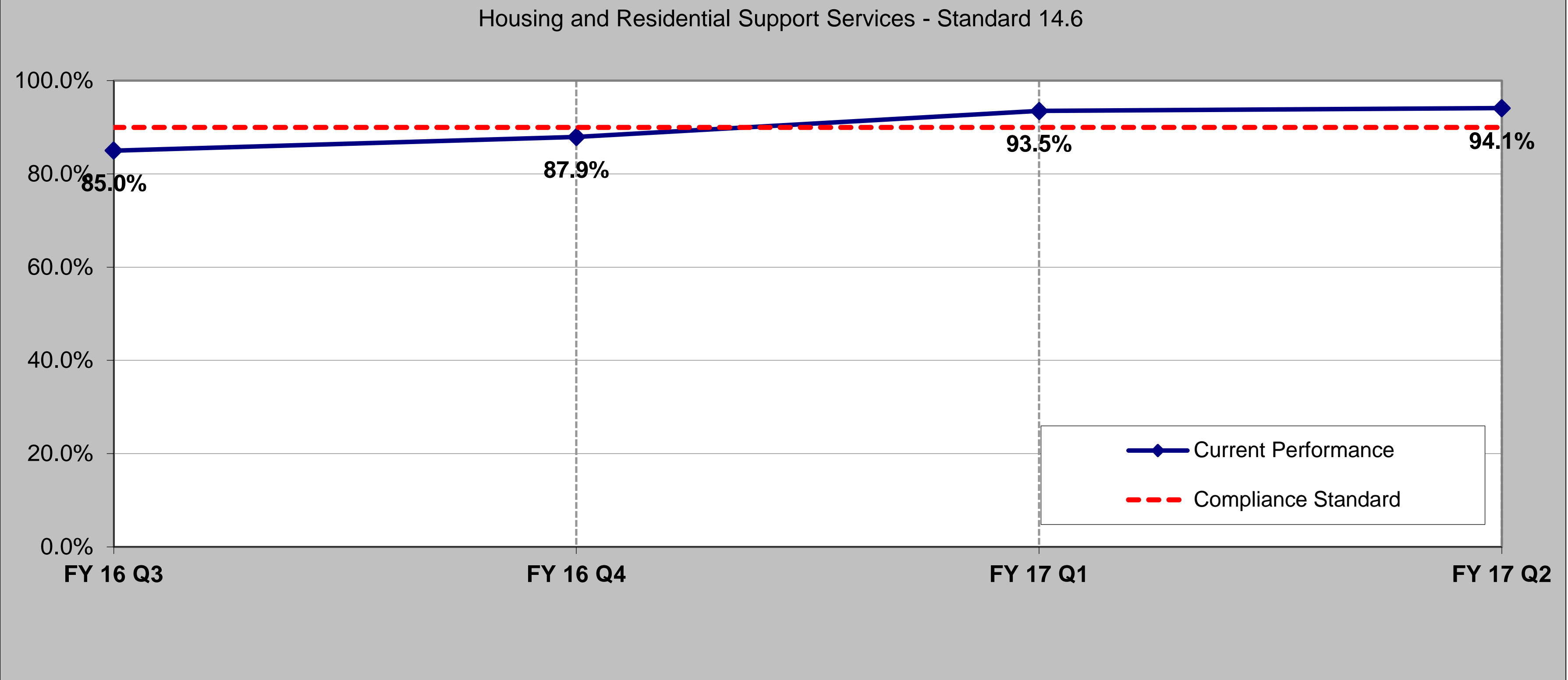
Standard 14.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Compliance: 70% (within 7 days of that determination)
	Performance: 75% (within 7 days of that determination)
Data Sources	Riverview Psychiatric Center Discharge Data
Current Level	82.4% (Lack of residental supports did not impede discharge for 28 out of 34 patients within 7 days)



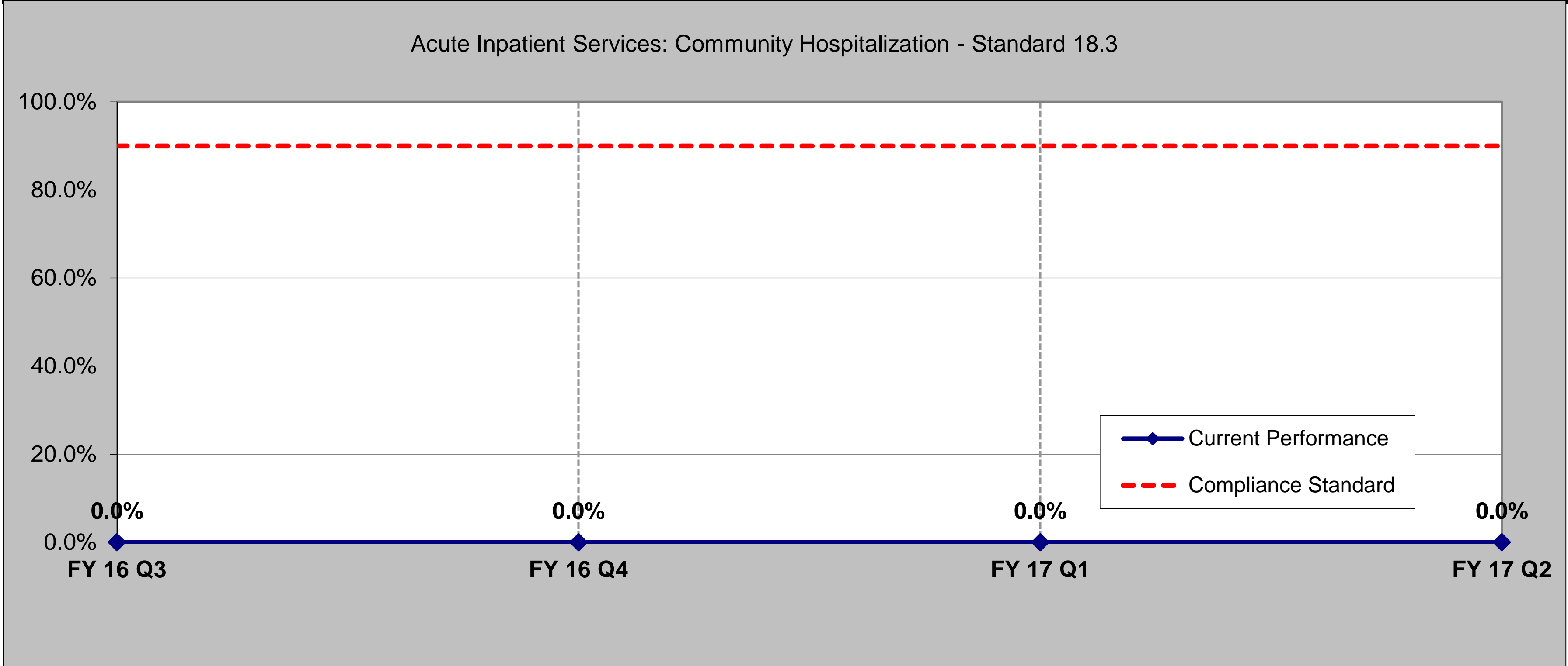
Standard 14.5	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Compliance: 80% (within 30 days of that determination)
	Performance: 96% (within 30 days of that determination)
Data Sources	Riverview Psychiatric Center Discharge Data
Current Level	94.1% (Lack of residental supports did not impede discharge for 32 out of 34 patients within 30 days)



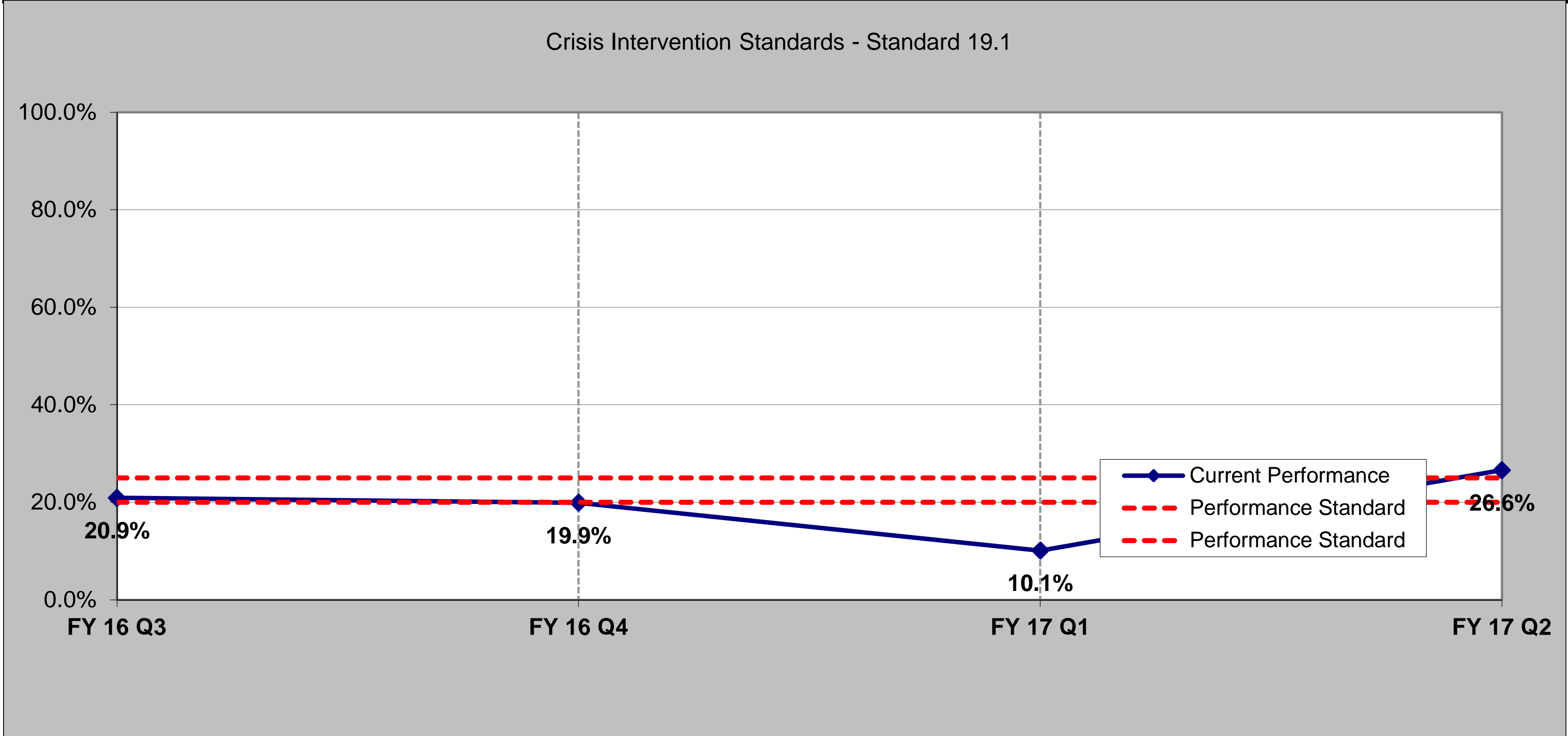
Standard 14.6	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Compliance: 90% (within 45 days of that determination)
	Performance: 100% (within 45 days of that determination)
Data Sources	Riverview Psychiatric Center Discharge Data
Current Level	94.1% (Lack of residental supports did not impede discharge for 32 out of 34 patients within 30 days)



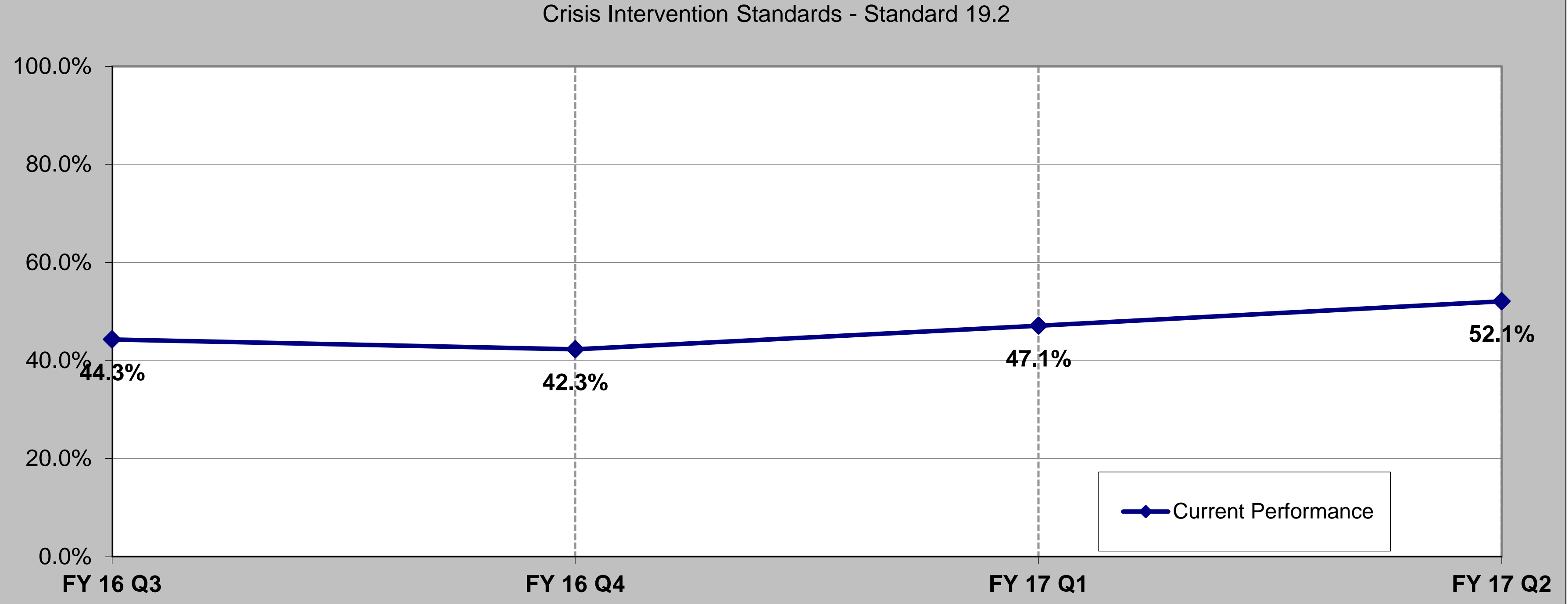
Standard 18.3	
Measurement	CI/ICI/ICM/ACT worker participated in hospital treatment and discharge planning
Standard	Compliance: 90%
Data Sources	UR Databases/EIS
Current Level	0.0% (0 out of 0) (No Data Being Entered by SAMHS)



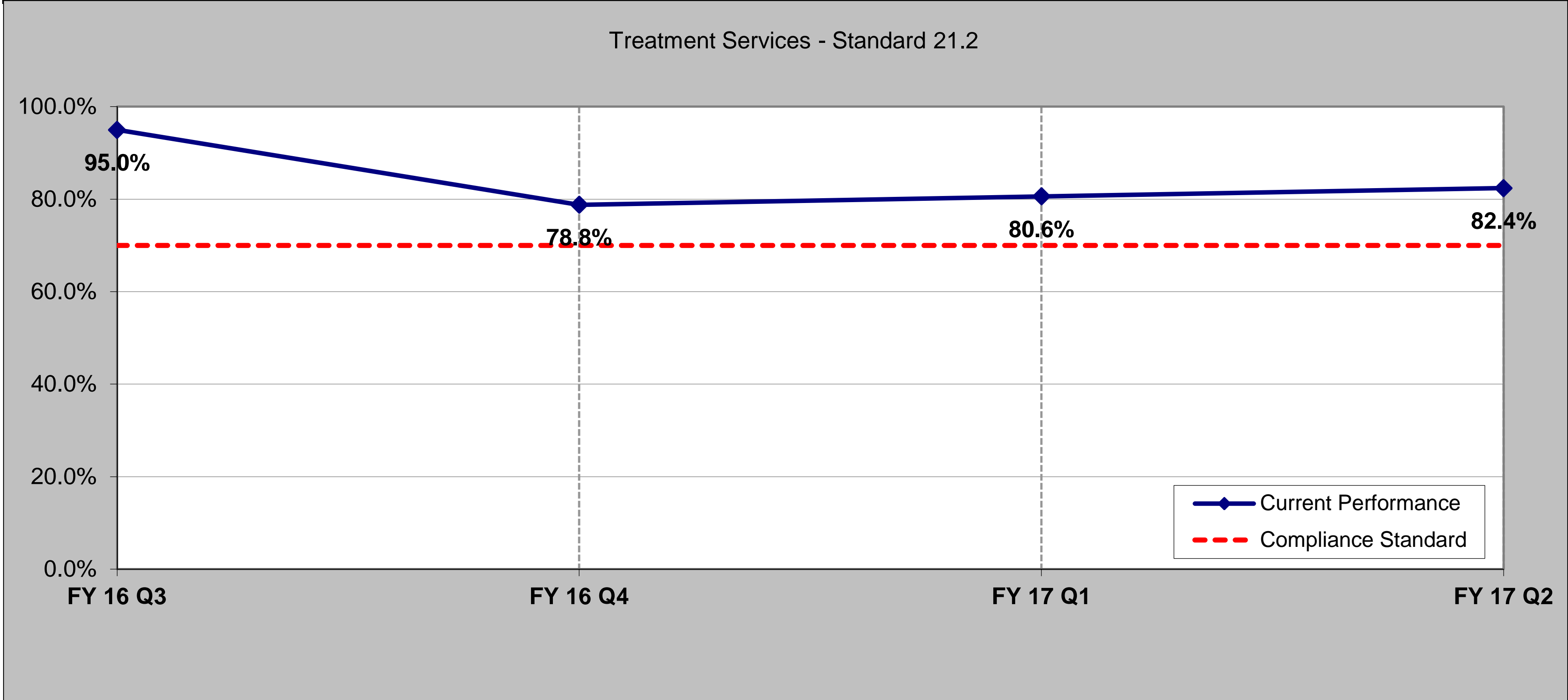
Standard 19.1	
Measurement	Face to face crisis contacts that result in hospitalizations
Standard	Compliance: No more than 20 - 25% are hospitalized as a result of crisis intervention.
Data Sources	Quarterly Crisis Contract Performance Data (both voluntary and involuntary hospitalization)
Current Level	56.1% (1940 out of 3460)



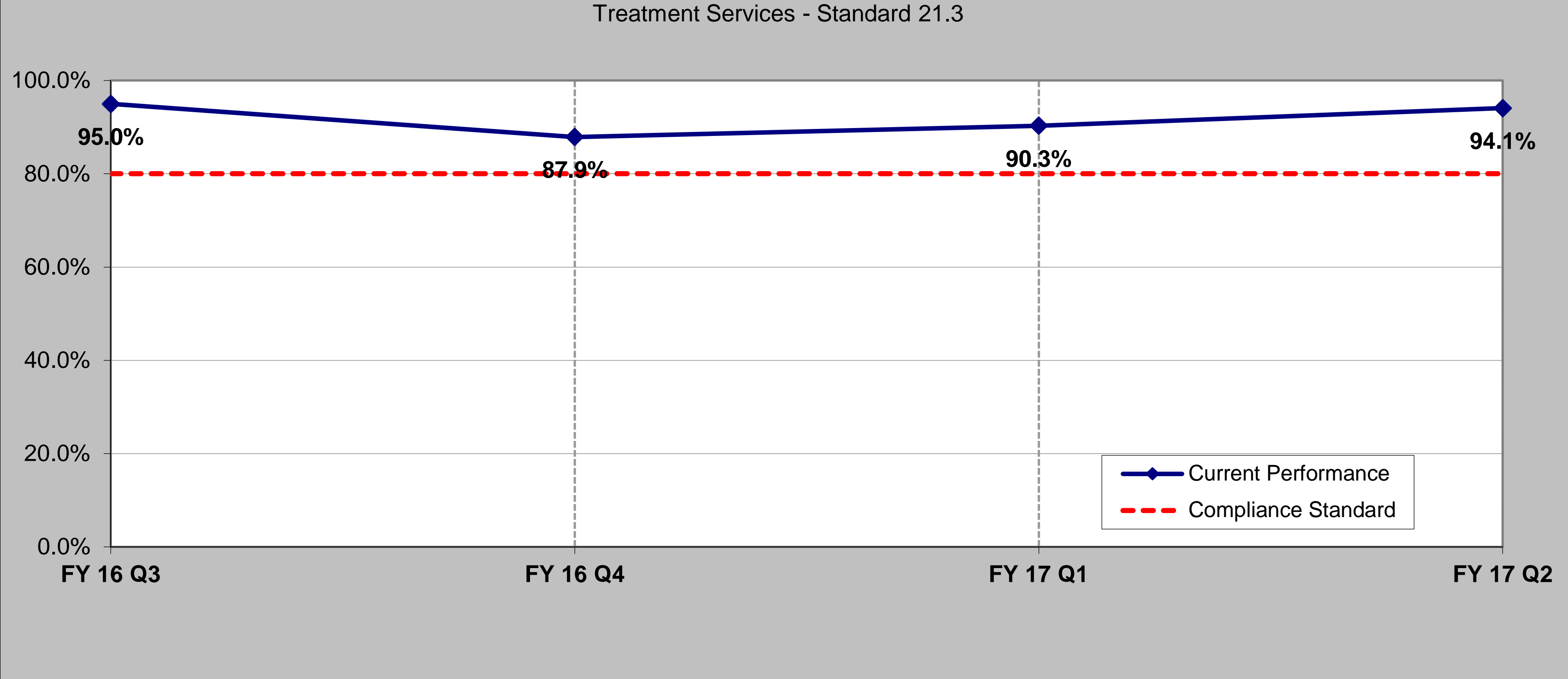
Standard 19.2	
Measurement	Face to face crisis contacts that result in follow-up and/or referral to community based services
Standard	To Be Established
Data Sources	Quarterly Crisis Contract Performance Data
Current Level	52.1% (1801 out of 3460)



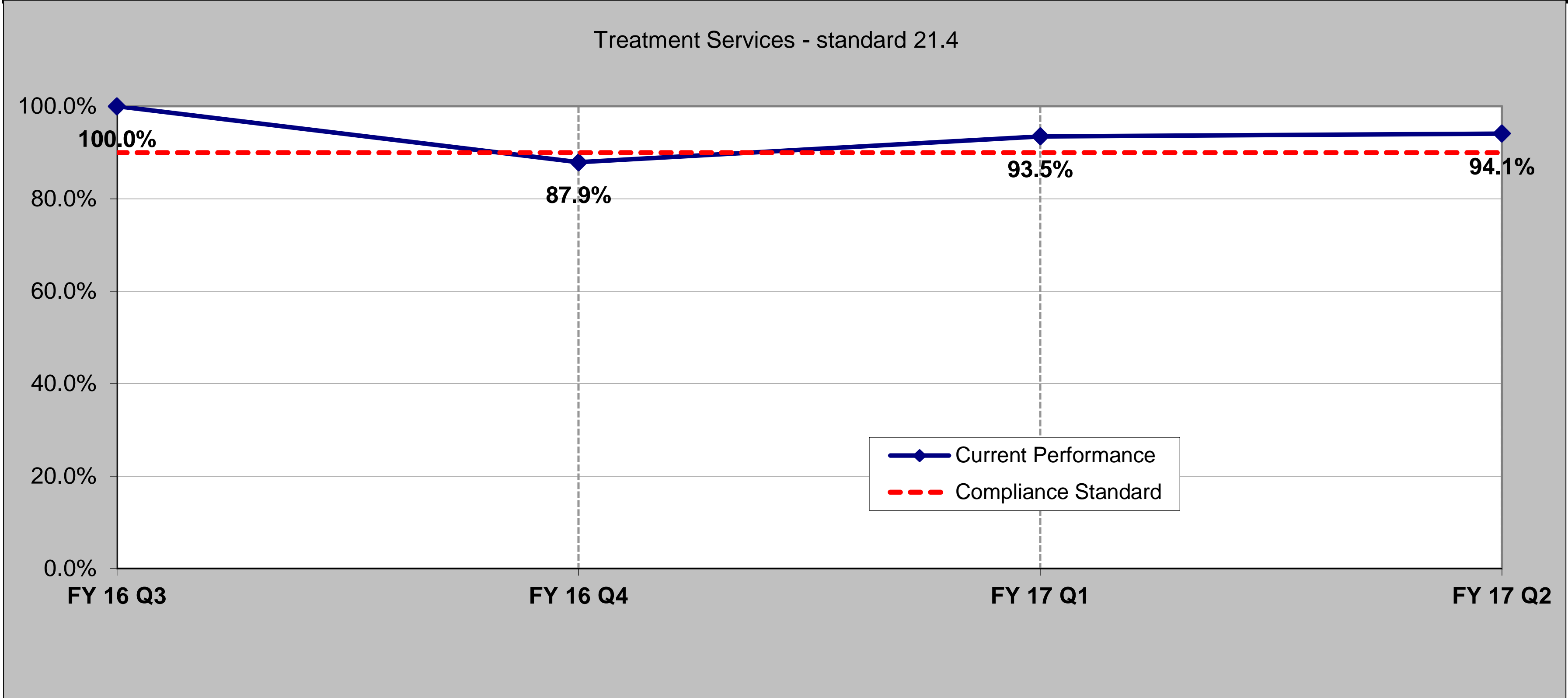
Standard 21.2	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge not impeded due to lack of mental health treatment)
Standard	Compliance: 70% (within 30 days of that determination)
Data Sources	Riverview Psychiatric Center Discharge Data
Current Level	82.4% (28 out of 34)



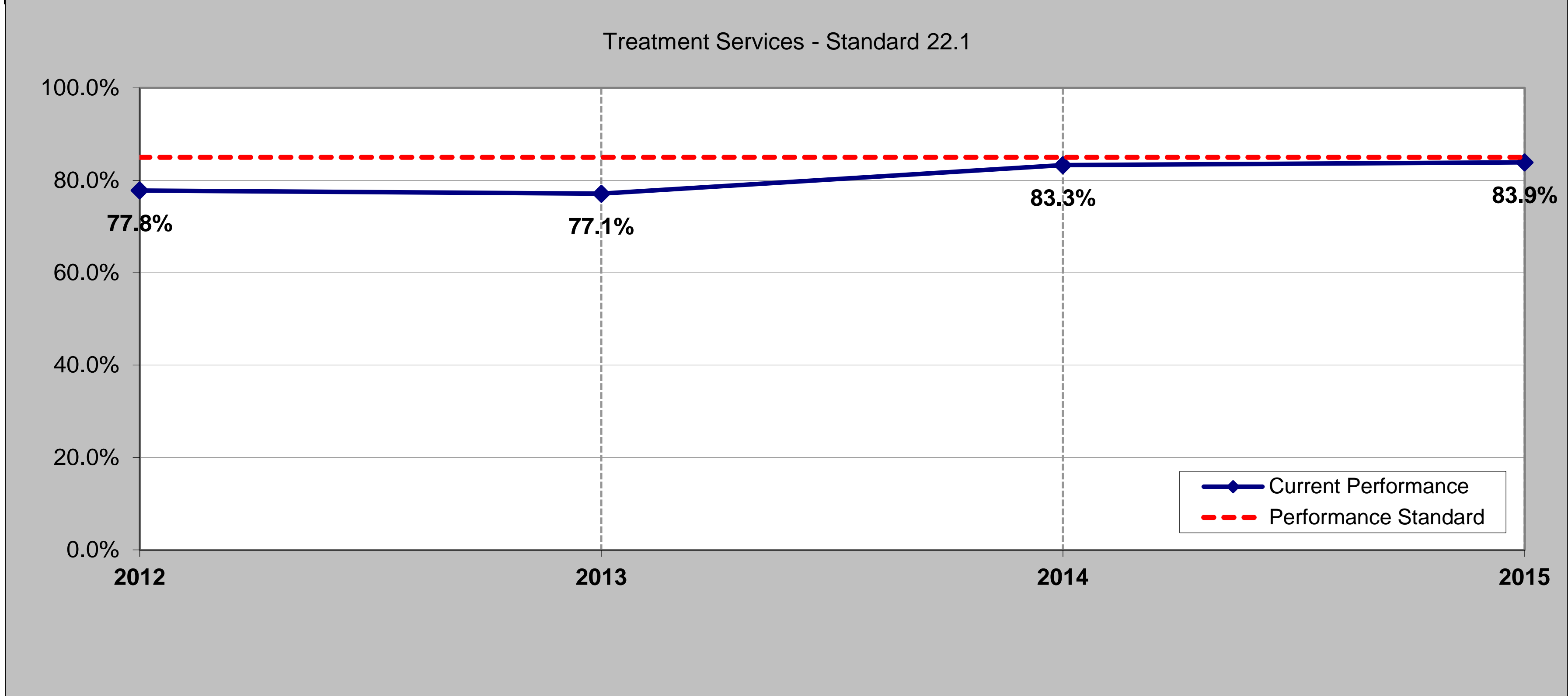
Standard 21.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge not impeded due to lack of mental health treatment)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Sources	Riverview Psychiatric Center Discharge Data
Current Level	94.1% (32 out of 34)



Standard 21.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge not impeded due to lack of mental health treatment)
Standard	Performance: 100% (within 45 days of that determination)
	Compliance: 90% (within 45 days of that determination)
Data Sources	Riverview Psychiatric Center Discharge Data
Current Level	94.1% (32 out of 34)

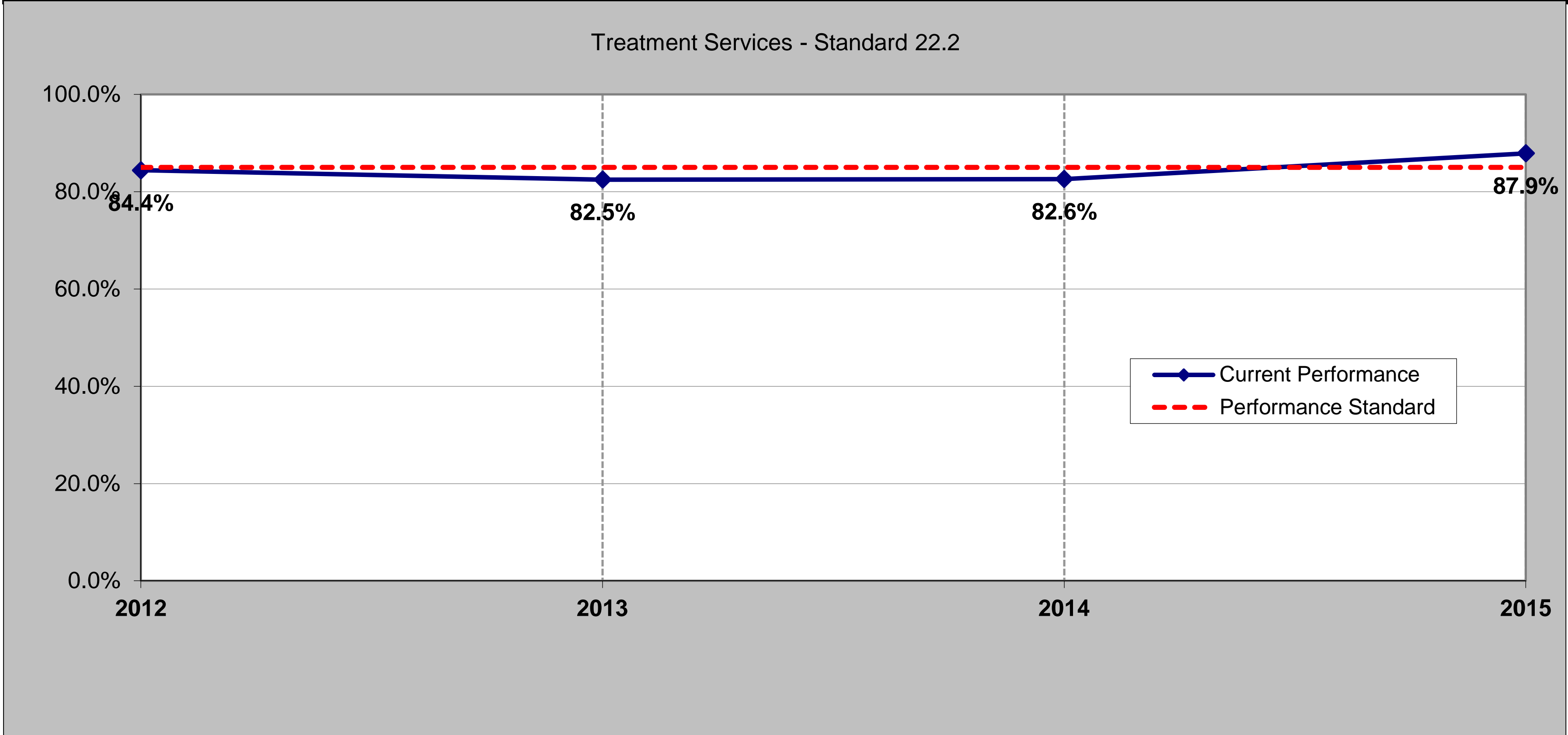


Standard 22.1	
Measurement	Domain average of positive responese tin the Perception of access domain
Standard	Performance: at or above 85% (SAMHS conducts review, takes action when falls below defined levels)
Data Sources	Adult Mental Health and Well Being Survey
Current Level	83.9% (1019 out of 1215)



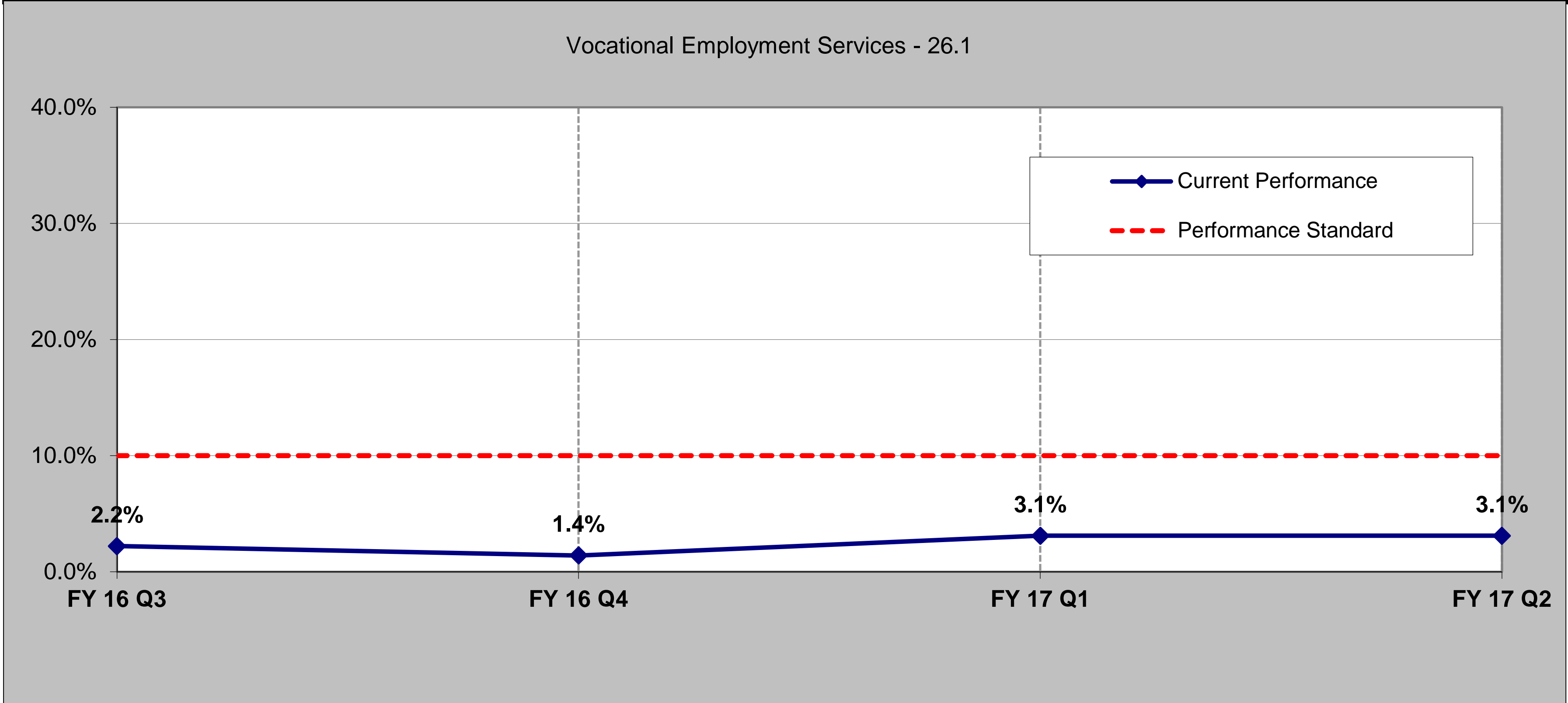
DIG survey data is collected the year prior to which it is reported

Standard 22.2	
Measurement	Domain average of positive responese tin the General Statisfication of access domain
Standard	Performance: at or above 85% (SAMHS conducts review, takes action when falls below defined levels)
Data Sources	Adult Mental Health and Well Being Survey
Current Level	87.9% (1068 out of 1215)

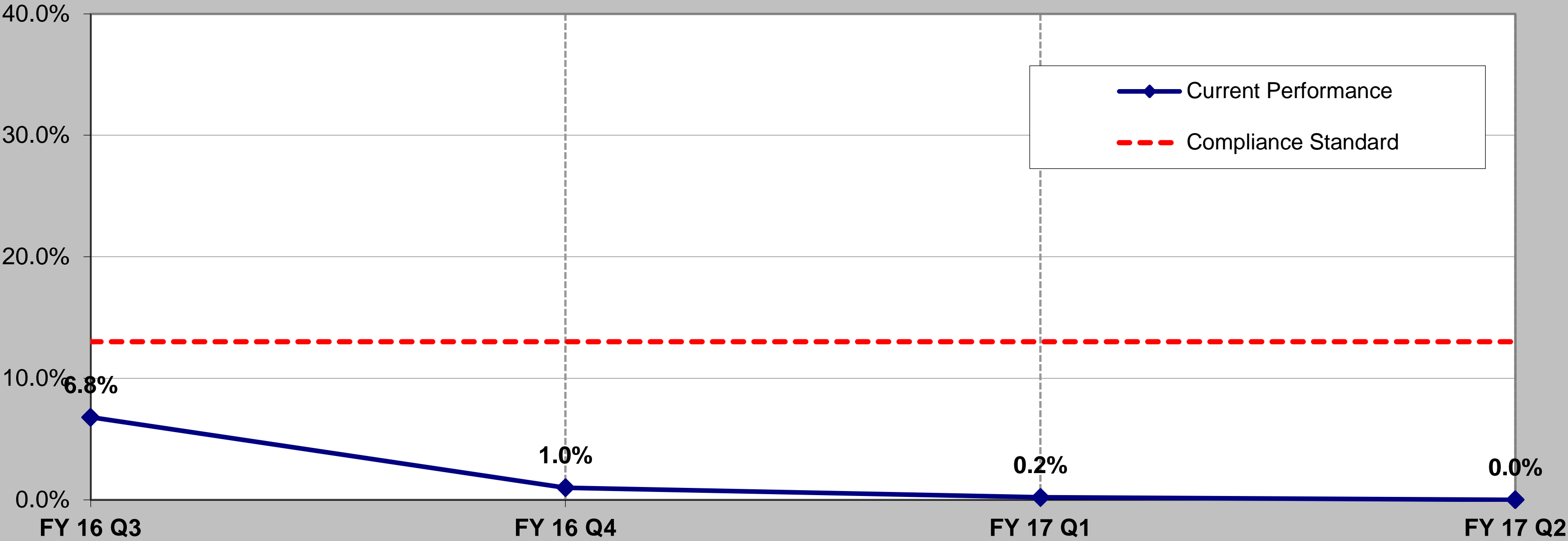


DIG survey data is collected the year prior to which it is reported

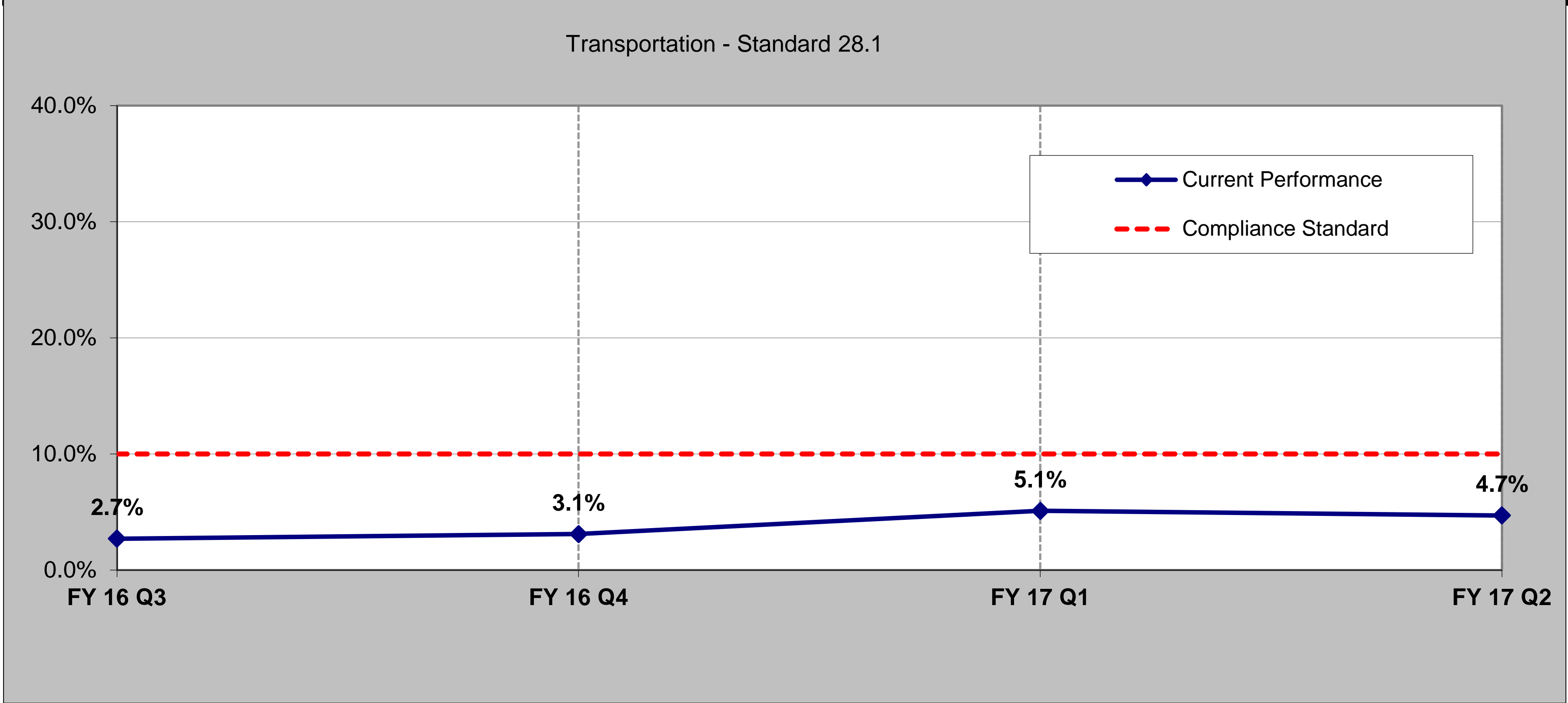
Standard 26.1	
Measurement	Class members with ISP identified unmet vocational/employment support needs
Standard	Performace: 10% or fewer
Data Sources	ISP RDS Data
Current Level	3.1% (15 out of 533)



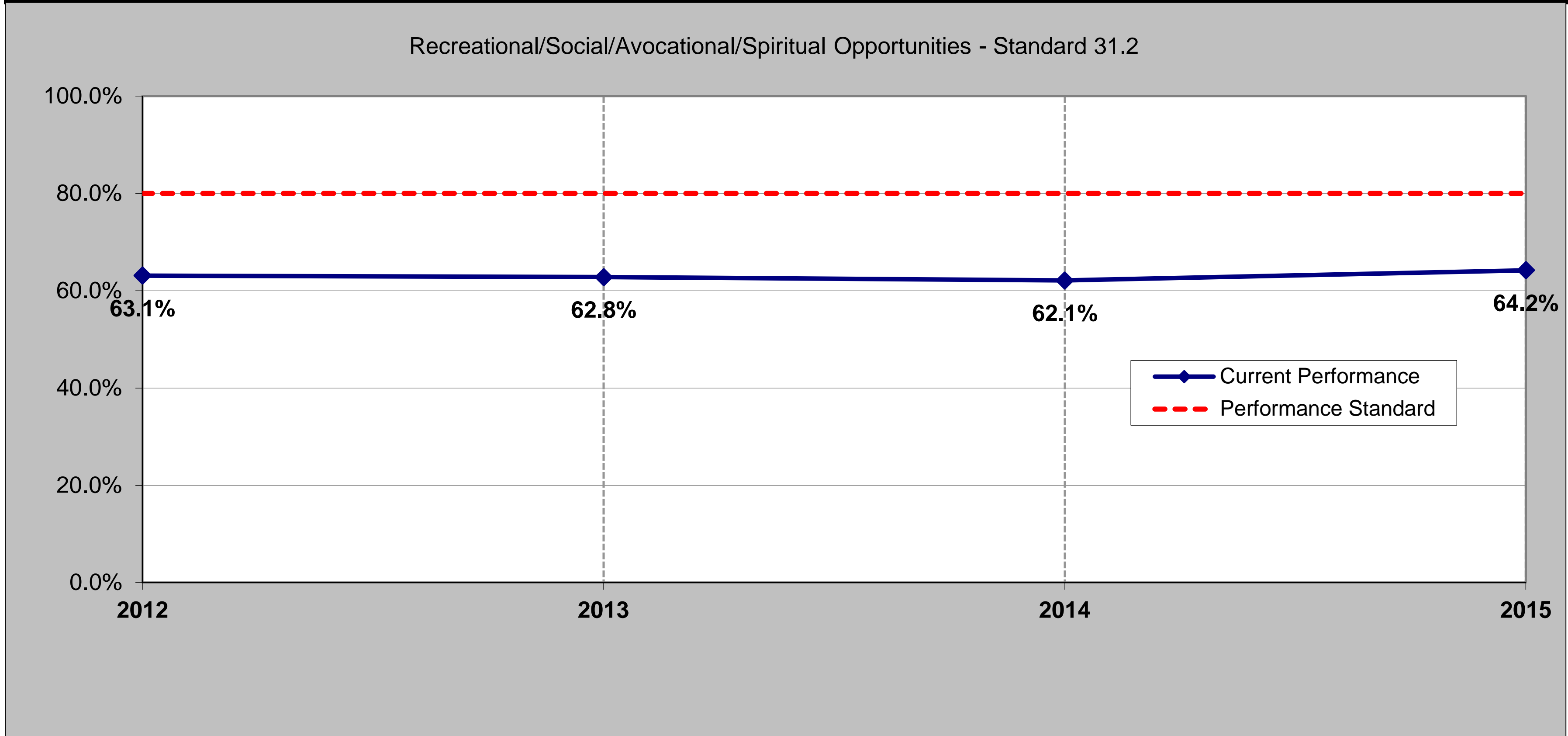
Standard 26.2	
Measurement	Class members employed in competitive employment in community
Standard	Performance: 15% of class members employed in competitive employment
Data Sources	ISP RDS Data
Current Level	0.0% (1 out of 533)



Standard 28.1	
Measurement	Percentage of class members with ISP identified unmet transportation needs
Standard	Compliance: 10% or fewer (3 vout of 4 quarters)
Data Sources	ISP RDS Data
Current Level	4.7% (25 out of 533)

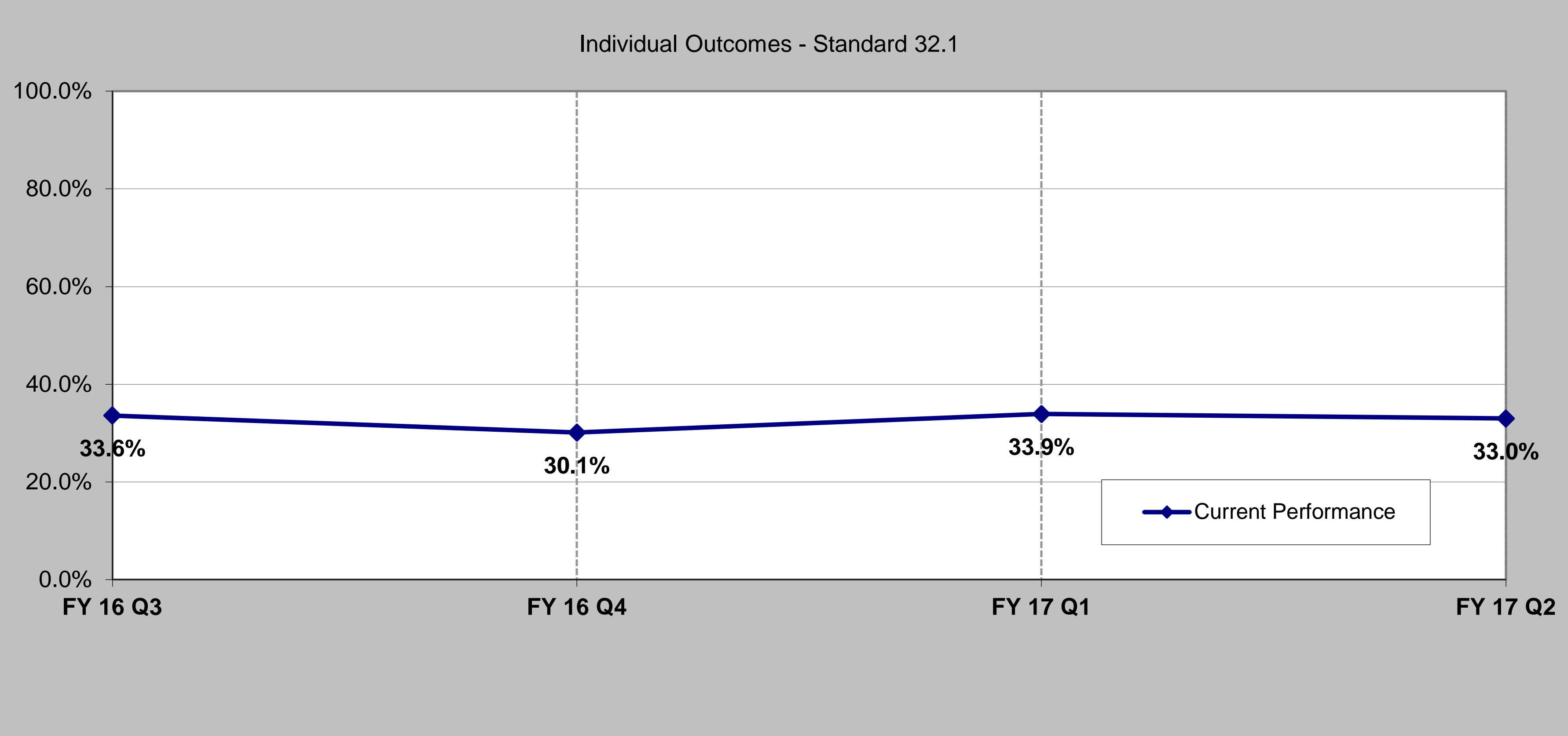


Standard 31.2	
Measurement	Domain average of positive respones in the Social Connectedness domain
Standard	Performance: at or above 65%
Data Sources	Adult Mental Health and Well Being Survey
Current Level	62.7% (760 out of 1215)



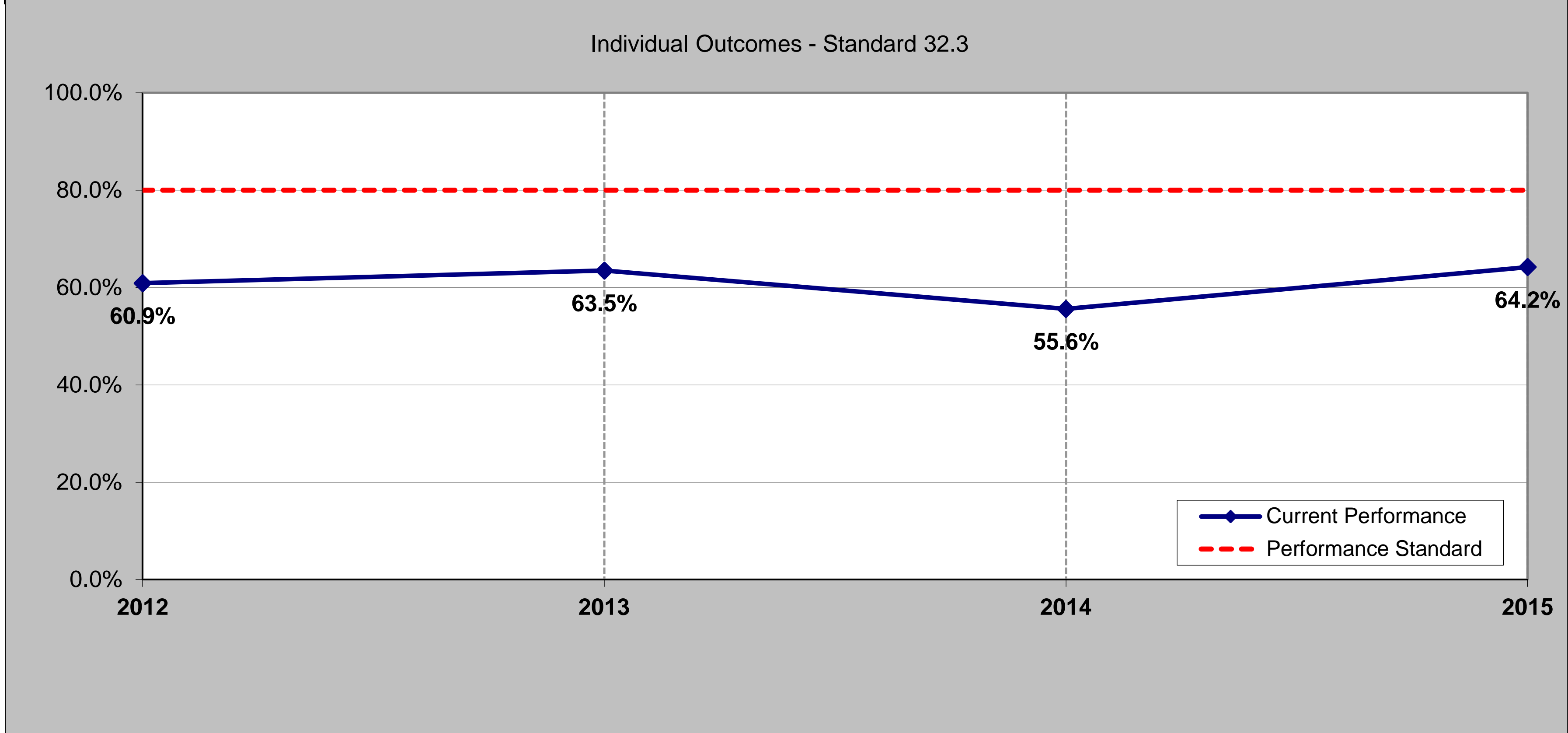
DIG survey data is collected the year prior to which it is reported

Standard 32.1	
Measurement	Class Members demonstrating functional improvement on LOCUS between baseline and 12 month re-certification
Standard	Performance:To be established
Data Sources	Enrollment Data (Based on overall composite score)
Current Level	33.0% (377 out of 1142)



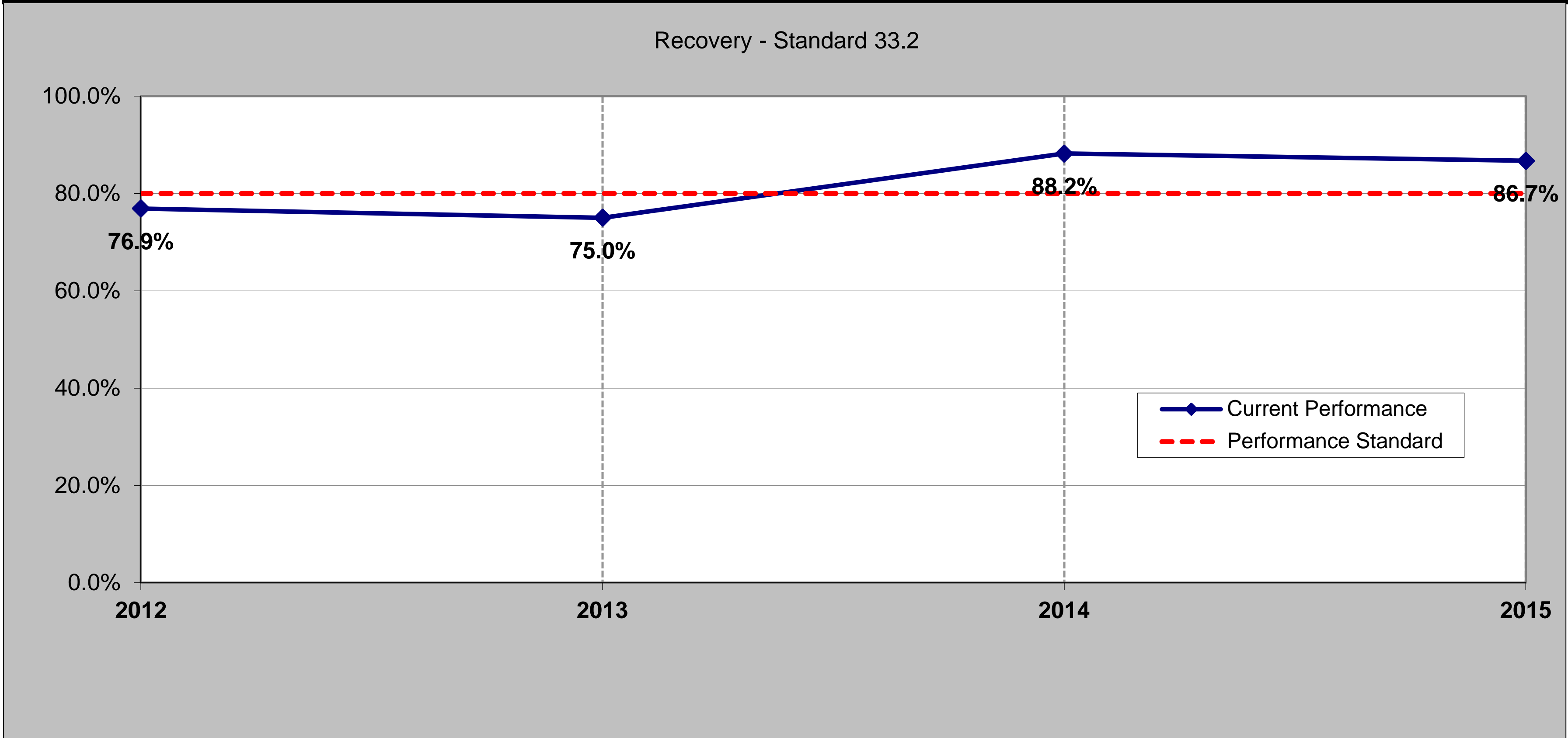
Standard 32.2	
Measurement	Class Members who have maintained level of functioning between baseline and 12 month re-certification
Standard	Performance:To be established
Data Sources	Enrollment Data (Based on overall composite score)
Current Level	34.1% (389 out of 1142)

Standard 32.3	
Measurement	Domain average of positive respones in the fuctional outcomes domain
Standard	Performance: at or above 80%
Data Sources	Adult Mental Health and Well Being Survey
Current Level	54.6% (663 out of 1215)



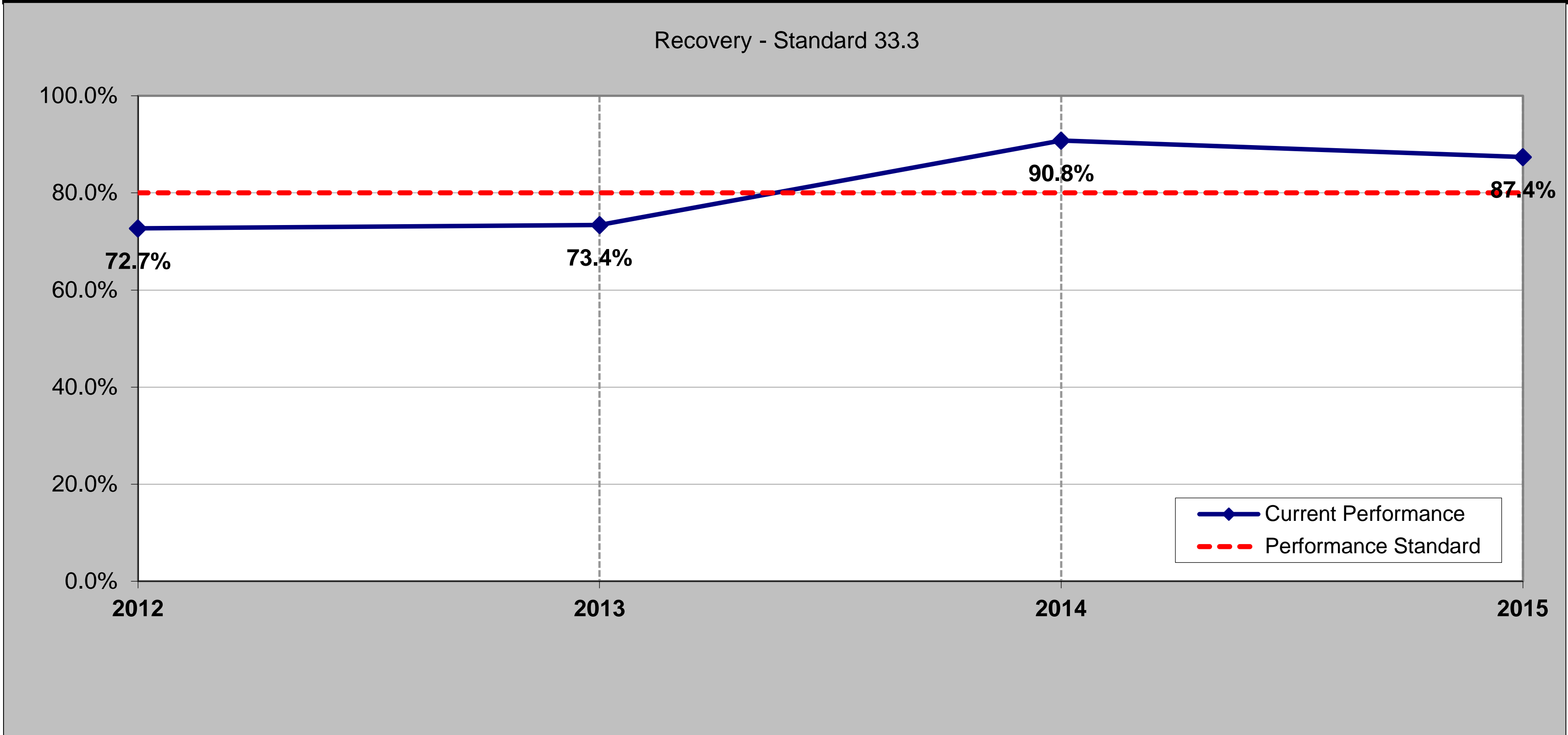
DIG survey data is collected the year prior to which it is reported

Standard 33.2	
Measurement	Consumers reporting that agency staff believe that they can grow, change and recover
Standard	Performance:80%
Data Sources	Adult Mental Health and Well Being Survey
Current Level	86.7% (1054 out of 1215)



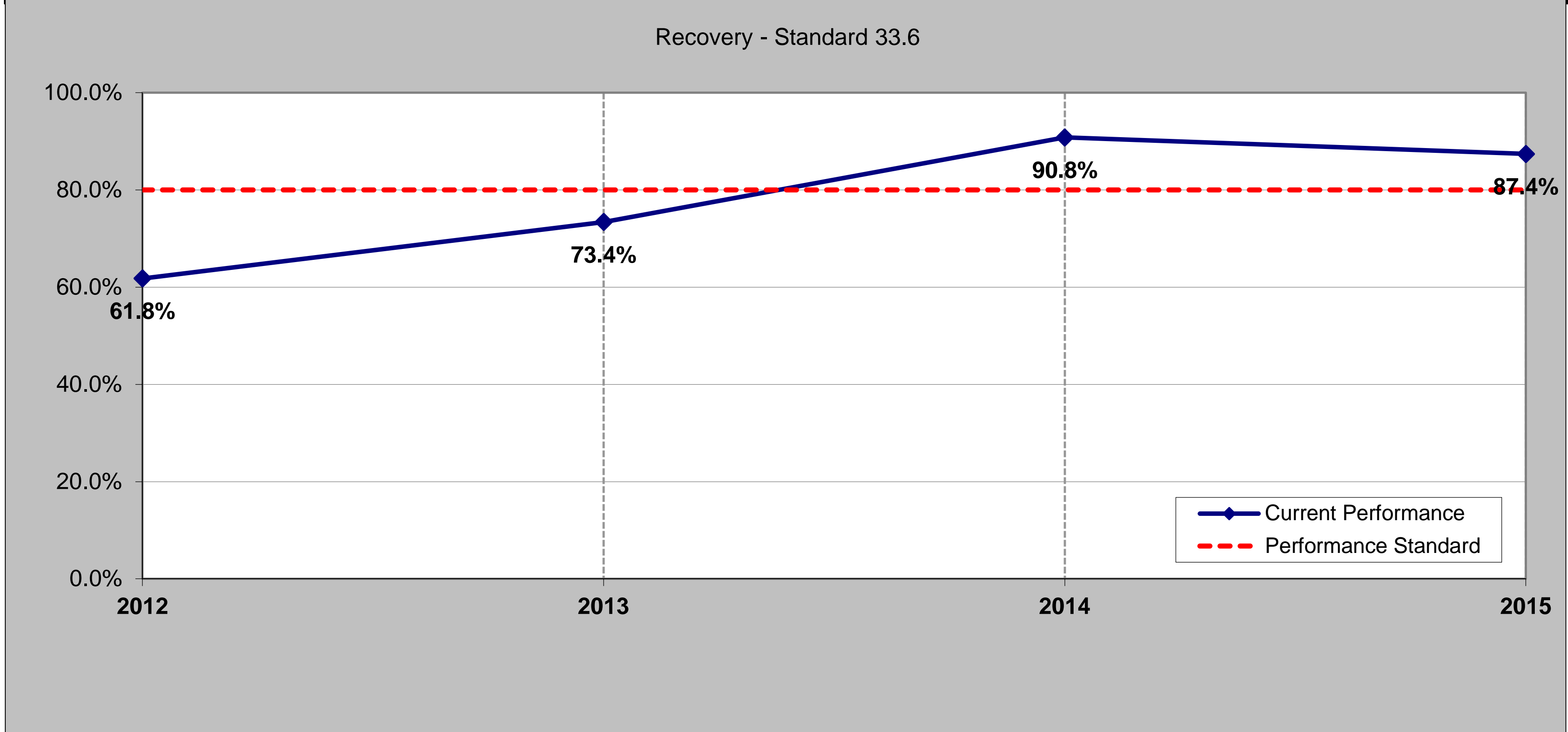
DIG survey data is collected the year prior to which it is reported

Standard 33.3	
Measurement	Consumers reporting that agency services and staff supported their recovery and wellness efforts and beliefs
Standard	Performance:80%
Data Sources	Adult Mental Health and Well Being Survey
Current Level	87.4% (1062 out of 1215)



DIG survey data is collected the year prior to which it is reported

Standard 33.6	
Measurement	Consumers reporting that service providers offered mutual support or recovery-oriented groups run by peers
Standard	Performance:80%
Data Sources	Adult Mental Health and Well Being Survey
Current Level	87.4% (1062 out of 1215)



DIG survey data is collected the year prior to which it is reported

Adult Mental Health Services
An Office of the Department of Health and Human Services
Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Consent Decree Performance
and Quality Improvement
Standard 5
Report for: 2017 Q2
(October, November, December 2016)
(Class Members)

	Measurement		
Method 1	Percent of class members requesting a worker who were assigned one.		
	2016 Q3	100.0%	(204 of 204)
	2016 Q4	100.0%	(162 of 162)
	2017 Q1	100.0%	(112 of 112)
	2017 Q2	100.0%	(88 of 88)
Method 2	Percent of hospitalized class members who were assigned a worker within 2 days.		
	2016 Q3	72.4%	(21 of 29)
	2016 Q4	76.9%	(10 of 13)
	2017 Q1	53.3%	(8 of 15)
	2017 Q2	63.2%	(12 of 19)
Method 3	Percent of non-hospitalized class members assigned a worker within 3 days.		
	2016 Q3	71.4%	(125 of 175)
	2016 Q4	78.5%	(117 of 149)
	2017 Q1	69.1%	(67 of 97)
	2017 Q2	76.8%	(53 of 69)
Method 4	Percent of class members in hospital or community not assigned on time but were assigned within 1-7 additional days.		
	2016 Q3	53.4%	(31 of 58)
	2016 Q4	25.7%	(9 of 35)
	2017 Q1	51.4%	(19 of 37)
	2017 Q2	26.1%	(6 of 23)
Method 5	ISP completed within 30 days of service request.		
	2016 Q3	83.3%	(55 of 66)
	2016 Q4	81.3%	(39 of 48)
	2017 Q1	88.9%	(24 of 27)
	2017 Q2	92.9%	(13 of 14)
Method 6	90 Day ISP review completed within specified timeframe.		
	2016 Q3	59.0%	(585 of 991)
	2016 Q4	61.6%	(628 of 1,019)
	2017 Q1	61.2%	(553 of 903)
	2017 Q2	56.9%	(272 of 478)

As of: Jan 17, 2017 Run By: Julia.Mason

Starting with Fiscal Year 2009, Quarter 1 (July, August, September 2008) all calculations are based on 'working days' to time of assignment. The first three quarters were re-calculated using this new formula.

For questions, contact the DHHS Data Management Group.

Performance Indicators and Quality Improvement Standards

APPENDIX: ADULT MENTAL HEALTH DATA SOURCES

Adult Health and Well- Survey:

Data Type/Method: Handout Survey
Target Population: All people who receive a Community Integration or Behavioral Health Home Service, ACT and Community Rehabilitation Services.
Approximate Sample Size Responses: 1215

The Maine DHHS/SAMHS consumer survey is from a new model, entitled *Perception of Care*, developed by the New York Office of Alcoholism and Substance Abuse, which replaced the National Mental Health Statistics Improvement survey. "The NY-OASAS Perception of Care model bases their survey on a modular survey developed by federal Substance Abuse and Mental Health Services Administration to assess performance across mental health and substance abuse service system.[1]
[1] Doucette, A. (2008). *Modular Survey: Addressing the Need to Measure Quality.* Rockville, MD: SAMHSA."

The survey was administered in late August 2015. The survey was designed to assess consumer experiences and satisfaction with their services and support in four primary domains: 1) Access to Services; 2) Quality and Appropriateness; 3) General Satisfaction; and 4) Outcomes. Additional questions were added regarding employment.

The survey for 2016 is being contracted out.

Community Hospital Utilization Review Summary:

This activity is no longer required as of December 13, 2016 by Order of Daniel E. Wathen, Court Master.

Community Support Enrollment Data:

Data Type/Method: Demographic, clinical and diagnostic data for all consumers in Adult Mental Health Community Support Services (Community Integration, ACT, Community Rehabilitation Services and Behavioral Health Homes) maintained and reported from the Department's EIS (Enterprise Information System). Data is collected by Kepro as part of its prior authorization process and entered into EIS twice a month.
Target Population: Adult Mental Health Consumers receiving Community Support - approximately 18,385 of whom approximately 1200 are class members.

Community Support Services Census/Staffing Data:

Data Type/Method: Provider Completed Survey; Completed by supervisors of Assertive Community Treatment (ACT), Community Integration (CI), Community Rehabilitation Services (CRS) and Behavioral Health Homes (BHH).
Target Population: Consumers receiving CI/ACT/CRS/BHH from DHHS/SAMHS contracted agencies.
Approximate Sample Size: Collected from all providers of these services on a quarterly basis.

OMS data specialists collect census/staffing data quarterly from contracted agencies that provide ACT, CI, CRS and BHH services. This data source provides a snapshot of case management staff vacancies as well as consumer to worker ratios.

Grievance Tracking Data:

This activity is no longer required as of December 13, 2016 by Order of Daniel E. Wathen, Court Master.

Class Member Treatment Planning Review:

Data Type/Method: Service Review/Document Review
Target Population: Class Members receiving Community Support Services (ACT, CI, CRS and BHH)
Approximate Sample Size: The sample size is 50 per quarter, utilizing the random sampling methodology as previously developed. This review allows the SAMHS Division of Quality Management the opportunity to assess and develop a new system of document reviews, not solely focused on treatment planning, that can be implemented across program areas and provide data for a wider group of individuals utilizing mental health services.

Two Quality Management Specialists now carry responsibility for this review of class members receiving Community Support Services. Data collected as part of the review is captured regionally and entered into a database within EIS. The Treatment Planning Review focuses on: education and the use of authorizations, assessment of domains, incorporation of strengths and barriers, crisis planning, needed resources including the identification of unmet needs and service agreements.

Individualized Support Plan (ISP) Resource Data Summary (ISP RDS) tracking System:

Data Type/Method: ISP RDS submitted by Community Support providers and collected by Kepro (formally APS Healthcare) as a component of their authorization process. Data is then entered into EIS twice a month.
Target Population: Adult Mental Health Consumers who receive Community Support Services (ACT, CI, CRS and BHH).

The data is collected in Kepro, sent to SAMHS and reported through the DHHS Enterprise Information System (EIS). The ISP RDS captures ISP completion dates. The ISP RDS also captures data on the current housing/living situation of the person receiving services as well as the current vocational/employment statuses. Needed resources are tracked and include the following categories: Mental Health Services, Peer, Recovery and Support Services, Substance Abuse Services, Housing Resources, Health Care Resources, Legal Resources, Financial Resources, Educational Resources, Vocational Resources, Living Skills Resources, Transportation Resources, Personal Growth Resources and Other. The ISP RDS calculates unmet needs data by comparing current 90 day reviews to previous 90 days reviews. See Section 6 for other changes to the RDS.

Quarterly Contract Performance Measures Data:

Data Type/Method: Performance Measures
Target Population: All consumers receiving DHHS/SAMHS contracted services.
Approximate Sample Size: All consumers receiving DHHS/SAMHS contracted services.

Performance measures are in all mental health direct services contracts. There are also some performance measures in the indirect services contracts. The contract performance measures are being monitored by the Field Service Managers.

Department of Health and Human Services (DHHS)
Office of Substance Abuse and Mental Health Services (SAMHS)
Report on Unmet Needs and Quality Improvement Initiatives
February 1, 2017

Attached Report:

Statewide Report of Unmet Resource Needs for Fiscal Year 2016 Quarter 2

Population Covered:

- Persons receiving Community Integration (CI), Community Rehabilitation Services (CRS), Assertive Community Treatment (ACT) and Behavioral Health Homes (BHH)
- Class and non-class members

Data Sources:

Enrollment data and RDS (resource data summary) data collected by APS Healthcare, with data fed into and reported from the DHHS EIS data system

Unmet Resource Need Definition

Unmet resource needs are defined by 'Table 1. Response Times and Unmet Resource Needs' found on page 17 of the approved DHHS/OAMHS Adult Mental Health Services Plan of October 13, 2006. Unmet resource needs noted in the tables were found to be 'unmet' at some point within the quarter and may have been met at the time of the report.

Quality Improvement Measures

The Office of Substance Abuse and Mental Health Services is undertaking a series of quality improvement measures to address unmet needs among the covered population for the Consent Decree.

The improvement measures are designed to address both specific and generic unmet needs of consumers using the established array of needs:

A. Mental Health Services
B. Mental Health Crisis Planning
C. Peer, Recovery and Support
D. Substance Abuse Services
E. Housing
F. Health Care
G. Legal
H. Financial Security
I. Education
J. Vocational/Employment
K. Living Skills
L. Transportation
M. Personal Growth/Community

Ongoing Quality Improvement Initiatives

Contract Performance Measures. SAMHS has instituted contract performance measures for all direct services which include but are not limited to Community Integration, ACT, Community Rehabilitation Services, Behavioral Health Homes, Daily Living Support Services, Skills Development, Medication Management and Residential Treatment. Where appropriate, the measures are in alignment with standards under the Consent Decree Plan.
Identified Need: A, B, C, D, E, J, K, L.

Mental Health Rehabilitation Technician- SAMHS, Muskie School, providers and consumers have formed a group to redesign the certification of the Mental Health Rehabilitation Technician/Community. The group has worked over the last two years to come up with ways to redesign the certification. Different pathways are being considered for people to obtain their MHRT/C certification, including but not limited to those with a MHRT/1 and peers who have training as Certified Intentional Peer Support person. The redesign group received feedback from the academic community regarding implementation into their programs. The redesign is now undergoing internal review at SAMHS to determine what basic skills and knowledge are required to begin serving consumers. The redesign group also has developed a web-based training **Maine Mental Health System 101** for those with clinical degrees who wish to provide services as a MHRT/C. This initiative continues to move forward but has not been formalized.
Identified Need: A, B, C, D, E, F, G, H, I, J, K, L, M

Consent Decree Process Improvement Quality Improvement Initiative
A staff member has been designated to oversee management of the Waitlist for CI services. This person has worked with SAMHS staff to identify strengths and weaknesses. This person is working in conjunction with SAMHS staff to make changes to the system to better manage the Waitlist. Agencies are being sent their Waitlists directly from Kepro. A form was developed for agencies to report to the Field Service Managers and Field Service Specialist regarding each consumer and their status regarding wait time, when someone is choosing to stay on that agency's waitlist, who is in service, who is not in service, what is their start date, who has been discharged, who has rescheduled appointments and any other explanations. SAMHS staff also has been meeting with agencies to discuss ways of more efficiently managing their waitlist. There has been discussion with agencies regarding open access. Some agencies are providing open access certain hours of the day or certain days of the week.
The Waitlist decreased from 341 to 105 persons waiting from 1/1/2016 to 12/30/2016. SAMHS will continue to work with agencies to lower the Waitlist.
SAMHS is working on several initiatives to increase employment including working with the Office of MaineCare to receive accurate data. SAMHS is also working with the Department of Labor to in developing programs to assist consumers to obtain the skills they will need to find employment.
SAMHS has developed a new tool to review charts that will target the compliance with the 90 day review of an ISP.
Identified Need: A, B

SAMHS Quality Management Plan 2016-2019- A new Quality Management Plan is being developed that will better describe how and what data is being utilized to monitor and improve the adult mental health system. Identified Need: A,B,C,D,E,F,G,H,I,J,K,L,M

Adult Needs and Strengths Assessment (ANSA) - The ANSA has been used and entered into Enterprise Information System (EIS) by the residential providers for six years. Community Integration workers have just started entering the ANSA into EIS. SAMHS plans to eventually use the ANSA for all services. The ANSA has a field for intake, discharge, annual and 90 day review. The ANSA is a psychosocial and functional assessment including history of trauma and abuse, history of substance abuse, general health, medication needs, self-care potential, general capabilities, available support systems, living situation, employment status and skills, training needs, and other relevant capabilities and needs. There is also a field that distinguishes between forensic and non-forensic clients. Need: A, B, C, D, E, F, G, H, I, J, K, L, M

Resource Data Summary- Kepro has posted training materials on their website to assist providers in closing an unmet need when it is no longer needed without waiting for a 90 day review. SAMHS staff has been visiting agencies to help them identify true unmet needs. There has also been a discussion with the agencies regarding the necessity of closing an unmet need when it is no longer needed. Kepro now has a system to delete the reporting of an unmet need of those who have received a service that is registered, prior authorized or auto authorized by them, when the RDS isn't closed by an agency. All of these efforts will provide SAMHS with a more accurate picture of unmet needs.
Identified Need: A, B, C, D, E, F, G, H, I, J, K, L, M

Section 17- The amendments to Section 17 of the MaineCare rules went into effect on April 8, 2016. The amendments changed the eligibility requirements for Community Integration Service and impose a new seven (7) day requirement for face-to-face contact with the consumer. SAMHS worked with Kepro to capture data for compliance with the seven (7) day face-to-face requirement. Kepro is currently sending the data in the monthly report. SAMHS will monitor this measure and will be developing a performance measure. Persons who don't meet the new eligibility criteria were given up to 120 days as a transition period. If a person is unable to transition to a different service they were given an extra 90 days. All class members will receive Community Integration regardless of eligibility. Identified Need: A, C

Section 65- The Club House service has been moved out of Day Support in Section 17 to Section 65. SAMHS wanted anyone with a mental health diagnosis to be able to receive pre-employment and employment services through the Club House.

Substance Abuse and Mental Health Services
41 Anthony Ave, Augusta, ME 04333
Tel: (207)-287-4243 or (207)-287-4250
http://www.maine.gov/dhhs/mh/index.shtml

Statewide Report of Unmet Resource Needs for Fiscal Year 2017 Quarter 1

July, August, September, 2016

Purpose of Report:

This report examines:

a.) level of unmet resource needs for 14 categories
b.) geographical variations in the reports of unmet resource needs
c.) trends across quarters

Data for this report is compiled from individuals who indicate a need on their ISP (individualized support plan) for a resource that is not available within prescribed timeframes. Some needs classified as unmet may have subsequently been met before the end of the quarter. Compiled data is based on:

- the client's address
- completed RDS (Resource Data Summary) reports by case managers (CI, ACT, CRS and BHH)
- both class members and non-class members

Data collection and reporting:

Enrollment and RDS data is entered by providers into APS Healthcare's CareConnection at the time of the Initial Prior Authorization (PA) request and at all Continuing Stay Reviews. Data is then fed to the EIS Database on a monthly basis.

Unmet resource need data is reported and reviewed one quarter after the quarter ends as this method gives a more accurate picture of unmet resource needs.

Statewide data is reported first, followed by individual CSN reports.

As of Sept 19, 2011 all "other" categories within each major resource need category were no longer an available option for reporting within APS CareConnections. There remains one stand alone "other resource need" category for those resources that are not available within any other category. As a result of this change, OAMHS will no longer be reporting on those "other" categories within each resource need category.

Report of Unmet Resource Needs

Statewide
(Class Members and Non-Class Member)

Fiscal Year 2017 Quarter 2
(Oct, Nov, Dec 2016)

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Distinct Clients with a RDS	11,627	10,533	8,946	4,915

7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	14	6	18	22
7a-iii Dialectical Behavioral Therapy	30	20	48	36
7a-iv Family Psycho-Educational Treatment	10	9	20	17
7a-v Group Counseling	28	29	59	63
7a-vi Individual Counseling	170	91	386	234
7a-vii Inpatient Psychiatric Facility	4	3	2	2
7a-viii Intensive Case Management	65	35	74	63
7a-x Psychiatric Medication Management	204	133	366	242
Total Unmet Resource Needs	525	326	973	679
Distinct Clients with Unmet Resource Needs	446	264	787	550
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	145	101	266	195
7b-ii Mental Health Advance Directives	22	19	51	43
Total Unmet Resource Needs	167	120	317	238
Distinct Clients with Unmet Resource Needs	159	111	305	226
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	30	13	45	42
7c-ii Recovery Workbook Group	1	2	4	4
7c-iii Social Club	69	41	139	104
7c-iv Peer-Run Trauma Recovery Group	27	26	46	41
7c-v Wellness Recovery and Action Planning	29	21	49	36
7c-vi Family Support	107	73	191	137
Total Unmet Resource Needs	263	176	474	364
Distinct Clients with Unmet Resource Needs	221	146	380	300
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	33	22	63	46
7d-ii Residential Treatment Substance Abuse Services	8	4	10	12
Total Unmet Resource Needs	41	26	73	58
Distinct Clients with Unmet Resource Needs	40	26	72	56
7e. Housing				
7e-i Supported Apartment	73	50	97	83
7e-ii Community Residential Facility	19	10	28	20
7e-iii Residential Treatment Facility (group home)	11	5	11	13
7e-iv Assisted Living Facility	31	13	39	35
7e-v Nursing Home	3	2	4	7
7e-vi Residential Crisis Unit	2	1	1	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	520	284	825	636
Total Unmet Resource Needs	659	365	1,005	794
Distinct Clients with Unmet Resource Needs	612	330	942	744

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7f. Health Care				
7f-i Dental Services	398	223	624	519
7f-ii Eye Care Services	144	81	269	197
7f-iii Hearing Services	26	18	60	41
7f-iv Physical Therapy	25	10	55	43
7f-v Physician/Medical Services	203	117	305	255
Total Unmet Resource Needs	796	449	1,313	1,055
Distinct Clients with Unmet Resource Needs	587	322	913	755
7g. Legal				
7g-i Advocate	47	23	117	59
7g-ii Guardian (private)	5	2	14	9
7g-iii Guardian (public)	4	3	7	6
Total Unmet Resource Needs	56	28	138	74
Distinct Clients with Unmet Resource Needs	56	28	136	73
7h. Financial Security				
7h-i Assistance with Managing Money	337	175	559	446
7h-ii Assistance with Securing Public Benefits	151	83	291	225
7h-iii Representative Payee	27	20	42	35
Total Unmet Resource Needs	515	278	892	706
Distinct Clients with Unmet Resource Needs	443	230	733	587
7i. Education				
7i-i Adult Education (other than GED)	62	33	128	72
7i-ii GED	41	21	66	45
7i-iii Literacy Assistance	21	9	35	29
7i-iv Post High School Education	58	32	111	77
7i-v Tuition Reimbursement	8	5	25	14
Total Unmet Resource Needs	190	100	365	237
Distinct Clients with Unmet Resource Needs	167	85	308	207
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	20	12	38	24
7j-ii Club House and/or Peer Vocational Support	11	7	21	14
7j-iii Competitive Employment (no supports)	52	24	92	54
7j-iv Supported Employment	31	18	69	42
7j-v Vocational Rehabilitation	107	68	192	156
Total Unmet Resource Needs	221	129	412	290
Distinct Clients with Unmet Resource Needs	194	116	352	260
7k. Living Skills				
7k-i Daily Living Support Services	84	65	190	135
7k-ii Day Support Services	13	10	24	22
7k-iii Occupational Therapy	6	3	11	10
7k-iv Skills Development Services	49	31	80	74
Total Unmet Resource Needs	152	109	305	241
Distinct Clients with Unmet Resource Needs	134	96	265	214
7l. Transportation				
7l-i Transportation to ISP-Identified Services	268	158	450	350
7-ii Transportation to Other ISP Activities	150	85	256	184
7-iii After Hours Transportation	111	62	184	150
Total Unmet Resource Needs	529	305	890	684
Distinct Clients with Unmet Resource Needs	325	197	559	456

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7m. Personal Growth/Community				
7m-i Avocational Activities	15	9	32	26
7m. Personal Growth/Community				
7m-ii Recreation Activities	92	53	184	134
7m-iii Social Activities	225	136	420	335
7m-iv Spiritual Activities	36	13	85	61
Total Unmet Resource Needs	368	211	721	556
Distinct Clients with Unmet Resource Needs	266	159	492	392
Other Resources				
Other Resources	158	88	212	185
Total Unmet Resource Needs	158	88	212	185
Distinct Clients with Unmet Resource Needs	158	88	212	185

Statewide Totals				
Total Unmet Resource Needs	4,640	2,710	8,090	6,161
Distinct Clients With any Unmet Resource Need	1,676	892	2,505	2,101
Distinct Clients with a RDS	8,946	4,915	11,627	10,533

Report Run: Jan 17, 2017

For questions, contact the DHHS Data Management Group.

Report of Unmet Resource Needs

Statewide
(Class Members Only)

Fiscal Year 20161 Quarter 2
(Oct, Nov, Dec 2016)

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Distinct Clients with a RDS	1,138	1,089	975	533
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	3	5	3	1
7a-iii Dialectical Behavioral Therapy	0	3	0	0
7a-iv Family Psycho-Educational Treatment	1	1	1	0
7a-v Group Counseling	3	2	1	1
7a-vi Individual Counseling	19	12	11	2
7a-vii Inpatient Psychiatric Facility	0	0	0	1
7a-viii Intensive Case Management	5	8	10	6
7a-x Psychiatric Medication Management	22	16	19	9
Total Unmet Resource Needs	53	47	45	20
Distinct Clients with Unmet Resource Needs	44	38	38	17
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	7	10	9	8
7b-ii Mental Health Advance Directives	2	3	4	3
Total Unmet Resource Needs	9	13	13	11
Distinct Clients with Unmet Resource Needs	8	11	11	8
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	5	2	2	1
7c-ii Recovery Workbook Group	1	1	1	0
7c-iii Social Club	10	9	7	2
7c-iv Peer-Run Trauma Recovery Group	1	1	1	0
7c-v Wellness Recovery and Action Planning	3	4	2	0
7c-vi Family Support	5	6	9	3
Total Unmet Resource Needs	25	23	22	6
Distinct Clients with Unmet Resource Needs	19	18	16	5
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	4	1	3	4
7d-ii Residential Treatment Substance Abuse Services	2	0	1	0
Total Unmet Resource Needs	6	1	4	4
Distinct Clients with Unmet Resource Needs	6	1	4	4
7e. Housing				
7e-i Supported Apartment	12	13	13	8
7e-ii Community Residential Facility	4	4	5	3
7e-iii Residential Treatment Facility (group home)	3	2	2	1
7e-iv Assisted Living Facility	6	6	7	1
7e-v Nursing Home	1	0	0	0

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7e-vi Residential Crisis Unit	0	0	1	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	47	43	37	17
Total Unmet Resource Needs	73	68	65	31
Distinct Clients with Unmet Resource Needs	62	57	53	22
7f. Health Care				
7f-i Dental Services	42	33	30	20
7f-ii Eye Care Services	13	8	6	7
7f-iii Hearing Services	3	3	2	1
7f-iv Physical Therapy	1	0	1	0
7f-v Physician/Medical Services	12	11	12	6
Total Unmet Resource Needs	71	55	51	34
Distinct Clients with Unmet Resource Needs	53	46	42	26
7g. Legal				
7g-i Advocate	4	4	3	2
7g-ii Guardian (private)	0	2	1	0
7g-iii Guardian (public)	2	2	1	2
Total Unmet Resource Needs	6	8	5	4
Distinct Clients with Unmet Resource Needs	6	8	5	4
7h. Financial Security				
7h-i Assistance with Managing Money	19	12	14	11
7h-ii Assistance with Securing Public Benefits	15	8	5	3
7h-iii Representative Payee	5	5	2	1
Total Unmet Resource Needs	39	25	21	15
Distinct Clients with Unmet Resource Needs	32	21	20	13
7i. Education				
7i-i Adult Education (other than GED)	2	3	4	3
7i-ii GED	1	1	1	0
7i-iii Literacy Assistance	2	1	0	0
7i-iv Post High School Education	3	3	4	3
7i-v Tuition Reimbursement	2	1	1	0
Total Unmet Resource Needs	10	9	10	6
Distinct Clients with Unmet Resource Needs	10	8	9	5
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	5	4	4	2
7j-ii Club House and/or Peer Vocational Support	4	3	2	0
7j-iii Competitive Employment (no supports)	6	3	2	1
7j-iv Supported Employment	5	5	4	2
7j-v Vocational Rehabilitation	12	12	8	4
Total Unmet Resource Needs	32	27	20	9
Distinct Clients with Unmet Resource Needs	27	22	16	7
7k. Living Skills				
7k-i Daily Living Support Services	8	4	4	3
7k-ii Day Support Services	2	1	0	0
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	4	3	2	1

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Total Unmet Resource Needs	14	8	6	4
Distinct Clients with Unmet Resource Needs	12	8	6	4
7l. Transportation				
7l-i Transportation to ISP-Identified Services	17	14	17	12
7-ii Transportation to Other ISP Activities	16	11	12	6
7-iii After Hours Transportation	13	10	9	7
Total Unmet Resource Needs	46	35	38	25
Distinct Clients with Unmet Resource Needs	29	25	26	16
7m. Personal Growth/Community				
7m-i Avocational Activities	2	2	2	0
7m-ii Recreation Activities	12	8	8	7
7m-iii Social Activities	23	20	19	9
7m-iv Spiritual Activities	3	3	3	2
Total Unmet Resource Needs	40	33	32	18
Distinct Clients with Unmet Resource Needs	28	24	22	11
Other Resources				
Other Resources	16	14	20	8
Total Unmet Resource Needs	16	14	20	8
Distinct Clients with Unmet Resource Needs	16	14	20	8

Statewide Totals				
Total Unmet Resource Needs	440	366	352	195
Distinct Clients With any Unmet Resource Need	185	165	156	74
Distinct Clients with a RDS	1,138	1,089	975	533

Report Run: Jan 17, 2017

For questions, contact the DHHS Data Management Group.

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2017 Quarter 2
(Oct, Nov, Dec 2016)

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Distinct Clients with a RDS	485	443	337	176
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	1	3	2	1
7a-iii Dialectical Behavioral Therapy	2	3	0	0
7a-iv Family Psycho-Educational Treatment	1	0	0	0
7a-v Group Counseling	10	11	3	9
7a-vi Individual Counseling	20	11	4	3
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	4	2	1	0
7a-x Psychiatric Medication Management	20	24	23	19
Total Unmet Resource Needs	58	54	33	32
Distinct Clients with Unmet Resource Needs	45	41	28	26
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	24	16	13	17
7b-ii Mental Health Advance Directives	0	0	0	1
Total Unmet Resource Needs	24	16	13	18
Distinct Clients with Unmet Resource Needs	24	16	13	17
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	0	0	0	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	11	7	5	4
7c-iv Peer-Run Trauma Recovery Group	4	6	1	7
7c-v Wellness Recovery and Action Planning	1	1	0	1
7c-vi Family Support	5	9	11	9
Total Unmet Resource Needs	21	23	17	21
Distinct Clients with Unmet Resource Needs	20	22	17	16
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	6	5	1	3
7d-ii Residential Treatment Substance Abuse Services	0	2	1	0
Total Unmet Resource Needs	6	7	2	3
Distinct Clients with Unmet Resource Needs	6	7	2	3
7e. Housing				
7e-i Supported Apartment	5	4	6	6
7e-ii Community Residential Facility	0	0	0	0
7e-iii Residential Treatment Facility (group home)	0	1	0	0
7e-iv Assisted Living Facility	3	2	2	1
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	28	25	13	12
Total Unmet Resource Needs	36	32	21	19
Distinct Clients with Unmet Resource Needs	32	30	20	17

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7f. Health Care				
7f-i Dental Services	26	19	9	9
7f-ii Eye Care Services	12	9	7	5
7f-iii Hearing Services	3	2	0	0
7f-iv Physical Therapy	1	2	1	0
7f-v Physician/Medical Services	13	12	12	5
Total Unmet Resource Needs	55	44	29	19
Distinct Clients with Unmet Resource Needs	41	39	25	13
7g. Legal				
7g-i Advocate	7	7	2	3
7g-ii Guardian (private)	1	0	0	0
7g-iii Guardian (public)	1	1	0	0
Total Unmet Resource Needs	9	8	2	3
Distinct Clients with Unmet Resource Needs	9	8	2	3
7h. Financial Security				
7h-i Assistance with Managing Money	35	39	22	18
7h-ii Assistance with Securing Public Benefits	28	22	6	6
7h-iii Representative Payee	1	0	0	3
Total Unmet Resource Needs	64	61	28	27
Distinct Clients with Unmet Resource Needs	54	52	26	20
7i. Education				
7i-i Adult Education (other than GED)	4	2	0	0
7i-ii GED	1	1	0	0
7i-iii Literacy Assistance	1	2	1	0
7i-iv Post High School Education	5	2	2	1
7i-v Tuition Reimbursement	0	0	0	0
Total Unmet Resource Needs	11	7	3	1
Distinct Clients with Unmet Resource Needs	11	7	3	1
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	2	3	0	0
7j-ii Club House and/or Peer Vocational Support	2	1	1	0
7j-iii Competitive Employment (no supports)	0	0	0	0
7j-iv Supported Employment	5	2	0	1
7j-v Vocational Rehabilitation	6	5	6	3
Total Unmet Resource Needs	15	11	7	4
Distinct Clients with Unmet Resource Needs	14	10	7	4
7k. Living Skills				
7k-i Daily Living Support Services	9	16	4	7
7k-ii Day Support Services	3	3	0	0
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	7	7	2	8
Total Unmet Resource Needs	19	26	6	15
Distinct Clients with Unmet Resource Needs	17	24	5	10
7l. Transportation				
7l-i Transportation to ISP-Identified Services	30	34	20	19
7-ii Transportation to Other ISP Activities	9	10	4	5
7-iii After Hours Transportation	18	22	12	8
Total Unmet Resource Needs	57	66	36	32
Distinct Clients with Unmet Resource Needs	43	48	28	24

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7m. Personal Growth/Community				
7m-i Avocational Activities	0	1	0	0
7m-ii Recreation Activities	8	7	3	1
7m-iii Social Activities	27	25	8	12
7m-iv Spiritual Activities	5	4	3	0
Total Unmet Resource Needs	40	37	14	13
Distinct Clients with Unmet Resource Needs	31	29	12	12
Other Resources				
Other Resources	15	15	9	3
Total Unmet Resource Needs	15	15	9	3
Distinct Clients with Unmet Resource Needs	15	15	9	3

CSN 1 Totals				
Total Unmet Resource Needs	430	407	220	210
Distinct Clients With any Unmet Resource Need	144	140	106	57
Distinct Clients with a RDS	485	443	337	176

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2017 Quarter 2
(Oct, Nov, Dec 2016)

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Distinct Clients with a RDS	2,079	1,883	1,459	890
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	4	4	1	1
7a-iii Dialectical Behavioral Therapy	5	3	5	2
7a-iv Family Psycho-Educational Treatment	2	2	1	1
7a-v Group Counseling	17	15	5	7
7a-vi Individual Counseling	87	74	52	31
7a-vii Inpatient Psychiatric Facility	1	0	1	0
7a-viii Intensive Case Management	12	11	10	6
7a-x Psychiatric Medication Management	72	58	43	31
Total Unmet Resource Needs	200	167	118	79
Distinct Clients with Unmet Resource Needs	165	136	103	63
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	50	34	34	21
7b-ii Mental Health Advance Directives	14	11	8	5
Total Unmet Resource Needs	64	45	42	26
Distinct Clients with Unmet Resource Needs	63	44	41	25
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	5	13	5	1
7c-ii Recovery Workbook Group	1	2	0	1
7c-iii Social Club	27	29	19	7
7c-iv Peer-Run Trauma Recovery Group	1	5	6	4
7c-v Wellness Recovery and Action Planning	21	12	12	11
7c-vi Family Support	23	17	13	10
Total Unmet Resource Needs	78	78	55	34
Distinct Clients with Unmet Resource Needs	73	67	46	31
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	22	18	12	7
7d-ii Residential Treatment Substance Abuse Services	1	1	2	1
Total Unmet Resource Needs	23	19	14	8
Distinct Clients with Unmet Resource Needs	23	18	13	8
7e. Housing				
7e-i Supported Apartment	23	16	14	5
7e-ii Community Residential Facility	4	2	1	0
7e-iii Residential Treatment Facility (group home)	3	2	2	0
7e-iv Assisted Living Facility	12	9	8	2
7e-v Nursing Home	1	0	0	0
7e-vi Residential Crisis Unit	1	0	1	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	198	142	116	58
Total Unmet Resource Needs	242	171	142	65
Distinct Clients with Unmet Resource Needs	225	162	137	62

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7f. Health Care				
7f-i Dental Services	106	94	76	48
7f-ii Eye Care Services	65	44	48	21
7f-iii Hearing Services	10	9	5	2
7f-iv Physical Therapy	8	10	6	0
7f-v Physician/Medical Services	53	45	47	30
Total Unmet Resource Needs	242	202	182	101
Distinct Clients with Unmet Resource Needs	172	137	121	75
7g. Legal				
7g-i Advocate	34	14	18	6
7g-ii Guardian (private)	9	5	4	2
7g-iii Guardian (public)	1	2	2	1
Total Unmet Resource Needs	44	21	24	9
Distinct Clients with Unmet Resource Needs	43	21	24	9
7h. Financial Security				
7h-i Assistance with Managing Money	135	103	83	43
7h-ii Assistance with Securing Public Benefits	72	58	46	24
7h-iii Representative Payee	6	5	8	4
Total Unmet Resource Needs	213	166	137	71
Distinct Clients with Unmet Resource Needs	181	140	121	61
7i. Education				
7i-i Adult Education (other than GED)	18	10	15	8
7i-ii GED	11	6	11	7
7i-iii Literacy Assistance	4	1	5	2
7i-iv Post High School Education	26	12	15	5
7i-v Tuition Reimbursement	4	2	2	2
Total Unmet Resource Needs	63	31	48	24
Distinct Clients with Unmet Resource Needs	58	29	45	21
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	6	2	4	2
7j-ii Club House and/or Peer Vocational Support	5	3	4	2
7j-iii Competitive Employment (no supports)	20	12	14	3
7j-iv Supported Employment	20	12	7	3
7j-v Vocational Rehabilitation	31	22	22	14
Total Unmet Resource Needs	82	51	51	24
Distinct Clients with Unmet Resource Needs	73	47	45	22
7k. Living Skills				
7k-i Daily Living Support Services	33	31	23	7
7k-ii Day Support Services	3	2	2	2
7k-iii Occupational Therapy	1	2	1	1
7k-iv Skills Development Services	10	13	11	5
Total Unmet Resource Needs	47	48	37	15
Distinct Clients with Unmet Resource Needs	44	44	33	14
7l. Transportation				
7l-i Transportation to ISP-Identified Services	81	66	59	40
7-ii Transportation to Other ISP Activities	45	33	29	19
7-iii After Hours Transportation	44	39	18	9
Total Unmet Resource Needs	170	138	106	68
Distinct Clients with Unmet Resource Needs	116	99	72	46

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7m. Personal Growth/Community				
7m-i Avocational Activities	7	5	6	4
7m-ii Recreation Activities	53	38	32	21
7m-iii Social Activities	101	88	74	40
7m-iv Spiritual Activities	10	12	10	3
Total Unmet Resource Needs	171	143	122	68
Distinct Clients with Unmet Resource Needs	118	94	82	48
Other Resources				
Other Resources	47	38	29	16
Total Unmet Resource Needs	47	38	29	16
Distinct Clients with Unmet Resource Needs	47	38	29	16

CSN 2 Totals				
Total Unmet Resource Needs	1,686	1,318	1,107	608
Distinct Clients With any Unmet Resource Need	556	457	333	182
Distinct Clients with a RDS	2,079	1,883	1,459	890

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2017 Quarter 2
(Oct, Nov, Dec 2016)

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Distinct Clients with a RDS	2,524	2,278	1,979	1,046
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	1	0	0	0
7a-iii Dialectical Behavioral Therapy	9	7	2	2
7a-iv Family Psycho-Educational Treatment	2	1	0	1
7a-v Group Counseling	8	5	1	2
7a-vi Individual Counseling	44	18	12	8
7a-vii Inpatient Psychiatric Facility	0	0	0	1
7a-viii Intensive Case Management	4	5	3	1
7a-x Psychiatric Medication Management	62	30	23	11
Total Unmet Resource Needs	130	66	41	26
Distinct Clients with Unmet Resource Needs	105	52	37	21
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	31	27	15	10
7b-ii Mental Health Advance Directives	5	5	2	3
Total Unmet Resource Needs	36	32	17	13
Distinct Clients with Unmet Resource Needs	35	29	15	10
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	3	2	1	1
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	8	5	5	2
7c-iv Peer-Run Trauma Recovery Group	2	0	0	1
7c-v Wellness Recovery and Action Planning	0	0	0	0
7c-vi Family Support	16	8	2	3
Total Unmet Resource Needs	29	15	8	7
Distinct Clients with Unmet Resource Needs	25	13	7	6
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	4	3	5	4
7d-ii Residential Treatment Substance Abuse Services	1	0	1	0
Total Unmet Resource Needs	5	3	6	4
Distinct Clients with Unmet Resource Needs	5	3	6	4
7e. Housing				
7e-i Supported Apartment	2	1	3	2
7e-ii Community Residential Facility	0	1	1	1
7e-iii Residential Treatment Facility (group home)	2	1	0	0
7e-iv Assisted Living Facility	4	5	4	1
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	87	80	43	25
Total Unmet Resource Needs	95	88	51	29
Distinct Clients with Unmet Resource Needs	93	85	48	27

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7f. Health Care				
7f-i Dental Services	81	61	38	19
7f-ii Eye Care Services	33	32	18	10
7f-iii Hearing Services	5	4	3	2
7f-iv Physical Therapy	6	5	3	0
7f-v Physician/Medical Services	51	55	37	17
Total Unmet Resource Needs	176	157	99	48
Distinct Clients with Unmet Resource Needs	121	106	70	34
7g. Legal				
7g-i Advocate	7	5	4	3
7g-ii Guardian (private)	0	2	1	0
7g-iii Guardian (public)	1	1	0	0
Total Unmet Resource Needs	8	8	5	3
Distinct Clients with Unmet Resource Needs	8	8	5	3
7h. Financial Security				
7h-i Assistance with Managing Money	59	56	40	22
7h-ii Assistance with Securing Public Benefits	28	22	9	11
7h-iii Representative Payee	7	8	5	2
Total Unmet Resource Needs	94	86	54	35
Distinct Clients with Unmet Resource Needs	83	74	47	30
7i. Education				
7i-i Adult Education (other than GED)	4	4	2	0
7i-ii GED	7	3	0	1
7i-iii Literacy Assistance	3	2	0	0
7i-iv Post High School Education	17	9	4	1
7i-v Tuition Reimbursement	4	1	0	0
Total Unmet Resource Needs	35	19	6	2
Distinct Clients with Unmet Resource Needs	27	17	6	2
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	2	1	2	0
7j-ii Club House and/or Peer Vocational Support	4	4	1	1
7j-iii Competitive Employment (no supports)	3	2	0	0
7j-iv Supported Employment	1	1	1	3
7j-v Vocational Rehabilitation	26	19	6	5
Total Unmet Resource Needs	36	27	10	9
Distinct Clients with Unmet Resource Needs	34	26	10	8
7k. Living Skills				
7k-i Daily Living Support Services	18	11	6	12
7k-ii Day Support Services	1	3	0	0
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	8	4	3	1
Total Unmet Resource Needs	27	18	9	13
Distinct Clients with Unmet Resource Needs	25	17	9	13
7l. Transportation				
7l-i Transportation to ISP-Identified Services	52	38	23	17
7-ii Transportation to Other ISP Activities	27	15	9	5
7-iii After Hours Transportation	9	6	6	5
Total Unmet Resource Needs	88	59	38	27
Distinct Clients with Unmet Resource Needs	61	43	28	22

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7m. Personal Growth/Community				
7m-i Avocational Activities	2	1	1	0
7m-ii Recreation Activities	13	15	5	4
7m-iii Social Activities	31	28	11	11
7m-iv Spiritual Activities	6	3	2	2
Total Unmet Resource Needs	52	47	19	17
Distinct Clients with Unmet Resource Needs	35	32	15	13
Other Resources				
Other Resources	20	14	7	5
Total Unmet Resource Needs	20	14	7	5
Distinct Clients with Unmet Resource Needs	20	14	7	5

CSN 3 Totals				
Total Unmet Resource Needs	831	639	370	238
Distinct Clients With any Unmet Resource Need	282	221	154	78
Distinct Clients with a RDS	2,524	2,278	1,979	1,046

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2017 Quarter 2
(Oct, Nov, Dec 2016)

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Distinct Clients with a RDS	1,014	908	757	432
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	8	7	7	1
7a-iii Dialectical Behavioral Therapy	9	3	4	3
7a-iv Family Psycho-Educational Treatment	4	5	4	2
7a-v Group Counseling	4	10	3	1
7a-vi Individual Counseling	51	27	18	16
7a-vii Inpatient Psychiatric Facility	1	1	1	1
7a-viii Intensive Case Management	6	5	4	1
7a-x Psychiatric Medication Management	46	21	15	12
Total Unmet Resource Needs	129	79	56	37
Distinct Clients with Unmet Resource Needs	95	60	43	27
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	45	28	19	16
7b-ii Mental Health Advance Directives	14	11	6	6
Total Unmet Resource Needs	59	39	25	22
Distinct Clients with Unmet Resource Needs	54	34	22	19
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	10	9	6	3
7c-ii Recovery Workbook Group	1	0	0	0
7c-iii Social Club	21	4	5	6
7c-iv Peer-Run Trauma Recovery Group	8	1	2	3
7c-v Wellness Recovery and Action Planning	11	5	0	2
7c-vi Family Support	32	11	6	9
Total Unmet Resource Needs	83	30	19	23
Distinct Clients with Unmet Resource Needs	50	22	15	16
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	10	6	4	1
7d-ii Residential Treatment Substance Abuse Services	0	0	0	0
Total Unmet Resource Needs	10	6	4	1
Distinct Clients with Unmet Resource Needs	10	6	4	1
7e. Housing				
7e-i Supported Apartment	8	6	6	3
7e-ii Community Residential Facility	4	2	2	0
7e-iii Residential Treatment Facility (group home)	4	3	3	0
7e-iv Assisted Living Facility	3	4	2	1
7e-v Nursing Home	0	1	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	69	51	45	26
Total Unmet Resource Needs	88	67	58	30
Distinct Clients with Unmet Resource Needs	78	61	54	29

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7f. Health Care				
7f-i Dental Services	60	48	34	17
7f-ii Eye Care Services	21	15	5	2
7f-iii Hearing Services	5	1	2	1
7f-iv Physical Therapy	6	5	1	1
7f-v Physician/Medical Services	36	24	16	10
Total Unmet Resource Needs	128	93	58	31
Distinct Clients with Unmet Resource Needs	88	69	44	24
7g. Legal				
7g-i Advocate	12	5	2	2
7g-ii Guardian (private)	1	1	0	0
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	13	6	2	2
Distinct Clients with Unmet Resource Needs	13	6	2	2
7h. Financial Security				
7h-i Assistance with Managing Money	63	41	28	22
7h-ii Assistance with Securing Public Benefits	36	22	10	15
7h-iii Representative Payee	4	3	3	5
Total Unmet Resource Needs	103	66	41	42
Distinct Clients with Unmet Resource Needs	69	49	32	29
7i. Education				
7i-i Adult Education (other than GED)	16	5	3	1
7i-ii GED	10	7	5	2
7i-iii Literacy Assistance	1	2	2	2
7i-iv Post High School Education	15	10	3	6
7i-v Tuition Reimbursement	7	3	0	1
Total Unmet Resource Needs	49	27	13	12
Distinct Clients with Unmet Resource Needs	35	26	13	11
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	11	4	2	4
7j-ii Club House and/or Peer Vocational Support	1	1	1	2
7j-iii Competitive Employment (no supports)	17	4	3	2
7j-iv Supported Employment	10	5	4	3
7j-v Vocational Rehabilitation	42	36	22	16
Total Unmet Resource Needs	81	50	32	27
Distinct Clients with Unmet Resource Needs	56	44	28	23
7k. Living Skills				
7k-i Daily Living Support Services	40	21	8	10
7k-ii Day Support Services	4	0	1	2
7k-iii Occupational Therapy	1	1	1	1
7k-iv Skills Development Services	13	11	8	3
Total Unmet Resource Needs	58	33	18	16
Distinct Clients with Unmet Resource Needs	46	33	16	16
7l. Transportation				
7l-i Transportation to ISP-Identified Services	59	44	45	24
7-ii Transportation to Other ISP Activities	41	22	32	15
7-iii After Hours Transportation	28	16	30	17
Total Unmet Resource Needs	128	82	107	56
Distinct Clients with Unmet Resource Needs	70	57	52	30

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7m. Personal Growth/Community				
7m-i Avocational Activities	13	10	3	2
7m-ii Recreation Activities	36	20	10	7
7m-iii Social Activities	59	44	23	16
7m-iv Spiritual Activities	8	2	3	2
Total Unmet Resource Needs	116	76	39	27
Distinct Clients with Unmet Resource Needs	66	49	26	19
Other Resources				
Other Resources	22	22	20	14
Total Unmet Resource Needs	22	22	20	14
Distinct Clients with Unmet Resource Needs	22	22	20	14

CSN 4 Totals				
Total Unmet Resource Needs	1,067	676	492	340
Distinct Clients With any Unmet Resource Need	223	169	139	84
Distinct Clients with a RDS	1,014	908	757	432

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2017 Quarter 2
(Oct, Nov, Dec 2016)

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Distinct Clients with a RDS	2,240	2,092	1,800	961
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	1	3	1	0
7a-iii Dialectical Behavioral Therapy	12	11	11	11
7a-iv Family Psycho-Educational Treatment	3	5	3	2
7a-v Group Counseling	13	16	12	7
7a-vi Individual Counseling	80	41	33	11
7a-vii Inpatient Psychiatric Facility	0	1	0	0
7a-viii Intensive Case Management	28	25	25	17
7a-x Psychiatric Medication Management	72	48	40	18
Total Unmet Resource Needs	209	150	125	66
Distinct Clients with Unmet Resource Needs	179	125	106	55
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	50	38	27	19
7b-ii Mental Health Advance Directives	7	8	1	2
Total Unmet Resource Needs	57	46	28	21
Distinct Clients with Unmet Resource Needs	56	45	28	21
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	9	5	8	4
7c-ii Recovery Workbook Group	1	0	0	0
7c-iii Social Club	35	28	11	7
7c-iv Peer-Run Trauma Recovery Group	18	18	10	5
7c-v Wellness Recovery and Action Planning	5	6	7	4
7c-vi Family Support	45	37	27	20
Total Unmet Resource Needs	113	94	63	40
Distinct Clients with Unmet Resource Needs	89	76	52	33
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	5	3	1	1
7d-ii Residential Treatment Substance Abuse Services	2	3	2	1
Total Unmet Resource Needs	7	6	3	2
Distinct Clients with Unmet Resource Needs	6	6	3	2
7e. Housing				
7e-i Supported Apartment	15	12	6	7
7e-ii Community Residential Facility	2	2	2	0
7e-iii Residential Treatment Facility (group home)	0	0	1	0
7e-iv Assisted Living Facility	1	3	3	0
7e-v Nursing Home	1	3	1	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	157	101	72	42
Total Unmet Resource Needs	176	121	85	49
Distinct Clients with Unmet Resource Needs	170	114	80	45

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7f. Health Care				
7f-i Dental Services	142	111	75	40
7f-ii Eye Care Services	78	52	30	19
7f-iii Hearing Services	26	18	9	6
7f-iv Physical Therapy	20	11	7	3
7f-v Physician/Medical Services	74	53	40	23
Total Unmet Resource Needs	340	245	161	91
Distinct Clients with Unmet Resource Needs	217	158	114	58
7g. Legal				
7g-i Advocate	36	14	10	4
7g-ii Guardian (private)	0	0	0	0
7g-iii Guardian (public)	2	0	1	0
Total Unmet Resource Needs	38	14	11	4
Distinct Clients with Unmet Resource Needs	38	14	11	4
7h. Financial Security				
7h-i Assistance with Managing Money	126	101	63	29
7h-ii Assistance with Securing Public Benefits	59	51	35	10
7h-iii Representative Payee	6	4	1	1
Total Unmet Resource Needs	191	156	99	40
Distinct Clients with Unmet Resource Needs	156	128	83	35
7i. Education				
7i-i Adult Education (other than GED)	45	26	16	5
7i-ii GED	25	18	13	5
7i-iii Literacy Assistance	15	9	6	1
7i-iv Post High School Education	18	20	10	5
7i-v Tuition Reimbursement	3	2	1	1
Total Unmet Resource Needs	106	75	46	17
Distinct Clients with Unmet Resource Needs	92	66	38	16
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	9	6	4	2
7j-ii Club House and/or Peer Vocational Support	5	3	1	1
7j-iii Competitive Employment (no supports)	18	12	10	5
7j-iv Supported Employment	18	9	7	3
7j-v Vocational Rehabilitation	40	33	13	14
Total Unmet Resource Needs	90	63	35	25
Distinct Clients with Unmet Resource Needs	83	55	32	24
7k. Living Skills				
7k-i Daily Living Support Services	41	28	13	13
7k-ii Day Support Services	7	11	7	4
7k-iii Occupational Therapy	5	5	2	1
7k-iv Skills Development Services	27	22	14	8
Total Unmet Resource Needs	80	66	36	26
Distinct Clients with Unmet Resource Needs	67	51	30	21
7l. Transportation				
7l-i Transportation to ISP-Identified Services	97	73	38	14
7-ii Transportation to Other ISP Activities	54	46	24	11
7-iii After Hours Transportation	39	30	18	8
Total Unmet Resource Needs	190	149	80	33
Distinct Clients with Unmet Resource Needs	110	85	45	16

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7m. Personal Growth/Community				
7m-i Avocational Activities	3	3	0	0
7m-ii Recreation Activities	38	26	21	10
7m-iii Social Activities	106	69	50	20
7m-iv Spiritual Activities	40	25	13	4
Total Unmet Resource Needs	187	123	84	34
Distinct Clients with Unmet Resource Needs	123	89	59	25
Other Resources				
Other Resources	34	26	23	6
Total Unmet Resource Needs	34	26	23	6
Distinct Clients with Unmet Resource Needs	34	26	23	6

CSN 5 Totals				
Total Unmet Resource Needs	1,818	1,334	879	454
Distinct Clients With any Unmet Resource Need	502	409	311	151
Distinct Clients with a RDS	2,240	2,092	1,800	961

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2017 Quarter 2
(Oct, Nov, Dec 2016)

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Distinct Clients with a RDS	2,104	1,970	1,756	994
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	1	1	1	2
7a-iii Dialectical Behavioral Therapy	7	7	3	2
7a-iv Family Psycho-Educational Treatment	5	3	1	2
7a-v Group Counseling	5	3	4	2
7a-vi Individual Counseling	64	43	37	13
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	13	10	15	8
7a-x Psychiatric Medication Management	56	39	38	31
Total Unmet Resource Needs	151	106	99	60
Distinct Clients with Unmet Resource Needs	120	88	83	50
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	32	26	25	11
7b-ii Mental Health Advance Directives	7	7	5	2
Total Unmet Resource Needs	39	33	30	13
Distinct Clients with Unmet Resource Needs	37	31	28	12
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	13	13	8	4
7c-ii Recovery Workbook Group	1	2	1	1
7c-iii Social Club	27	23	18	10
7c-iv Peer-Run Trauma Recovery Group	7	7	5	5
7c-v Wellness Recovery and Action Planning	5	5	4	2
7c-vi Family Support	38	29	28	13
Total Unmet Resource Needs	91	79	64	35
Distinct Clients with Unmet Resource Needs	72	60	53	30
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	6	4	6	5
7d-ii Residential Treatment Substance Abuse Services	6	6	2	2
Total Unmet Resource Needs	12	10	8	7
Distinct Clients with Unmet Resource Needs	12	9	8	7
7e. Housing				
7e-i Supported Apartment	36	36	28	20
7e-ii Community Residential Facility	14	10	11	8
7e-iii Residential Treatment Facility (group home)	0	2	4	4
7e-iv Assisted Living Facility	10	8	9	5
7e-v Nursing Home	1	3	2	1
7e-vi Residential Crisis Unit	0	0	1	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	189	171	172	90
Total Unmet Resource Needs	250	230	227	129
Distinct Clients with Unmet Resource Needs	235	213	206	110

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7f. Health Care				
7f-i Dental Services	139	120	119	69
7f-ii Eye Care Services	38	26	24	19
7f-iii Hearing Services	9	6	6	5
7f-iv Physical Therapy	6	5	5	4
7f-v Physician/Medical Services	36	35	33	22
Total Unmet Resource Needs	228	192	187	119
Distinct Clients with Unmet Resource Needs	175	156	153	90
7g. Legal				
7g-i Advocate	11	6	4	3
7g-ii Guardian (private)	2	0	0	0
7g-iii Guardian (public)	1	1	1	1
Total Unmet Resource Needs	14	7	5	4
Distinct Clients with Unmet Resource Needs	14	7	5	4
7h. Financial Security				
7h-i Assistance with Managing Money	69	54	59	27
7h-ii Assistance with Securing Public Benefits	29	22	25	8
7h-iii Representative Payee	10	5	2	2
Total Unmet Resource Needs	108	81	86	37
Distinct Clients with Unmet Resource Needs	93	71	76	34
7i. Education				
7i-i Adult Education (other than GED)	26	21	22	15
7i-ii GED	7	8	7	2
7i-iii Literacy Assistance	6	10	3	2
7i-iv Post High School Education	17	16	14	10
7i-v Tuition Reimbursement	3	4	3	1
Total Unmet Resource Needs	59	59	49	30
Distinct Clients with Unmet Resource Needs	52	46	43	22
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	2	5	3	4
7j-ii Club House and/or Peer Vocational Support	3	2	1	1
7j-iii Competitive Employment (no supports)	11	11	14	9
7j-iv Supported Employment	10	9	9	5
7j-v Vocational Rehabilitation	25	25	25	11
Total Unmet Resource Needs	51	52	52	30
Distinct Clients with Unmet Resource Needs	46	46	45	25
7k. Living Skills				
7k-i Daily Living Support Services	24	19	19	13
7k-ii Day Support Services	5	1	1	1
7k-iii Occupational Therapy	1	0	0	0
7k-iv Skills Development Services	6	7	4	2
Total Unmet Resource Needs	36	27	24	16
Distinct Clients with Unmet Resource Needs	33	27	24	16
7l. Transportation				
7l-i Transportation to ISP-Identified Services	75	60	58	32
7-ii Transportation to Other ISP Activities	54	39	36	22
7-iii After Hours Transportation	24	18	16	10
Total Unmet Resource Needs	153	117	110	64
Distinct Clients with Unmet Resource Needs	92	74	67	42

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7m. Personal Growth/Community				
7m-i Avocational Activities	3	3	2	1
7m-ii Recreation Activities	19	14	13	7
7m-iii Social Activities	51	50	36	24
7m-iv Spiritual Activities	9	7	3	2
Total Unmet Resource Needs	82	74	54	34
Distinct Clients with Unmet Resource Needs	64	58	46	29
Other Resources				
Other Resources	52	55	51	35
Total Unmet Resource Needs	52	55	51	35
Distinct Clients with Unmet Resource Needs	52	55	51	35

CSN 6 Totals				
Total Unmet Resource Needs	1,326	1,122	1,046	613
Distinct Clients With any Unmet Resource Need	526	490	459	259
Distinct Clients with a RDS	2,104	1,970	1,756	994

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2017 Quarter 2
(Oct, Nov, Dec 2016)

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Distinct Clients with a RDS	782	608	561	284
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	1	2	1	0
7a-iii Dialectical Behavioral Therapy	2	1	3	0
7a-iv Family Psycho-Educational Treatment	1	0	0	0
7a-v Group Counseling	0	0	0	1
7a-vi Individual Counseling	28	16	11	7
7a-vii Inpatient Psychiatric Facility	0	0	2	1
7a-viii Intensive Case Management	5	3	4	2
7a-x Psychiatric Medication Management	22	11	11	8
Total Unmet Resource Needs	59	33	32	19
Distinct Clients with Unmet Resource Needs	52	27	27	15
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	27	22	12	5
7b-ii Mental Health Advance Directives	3	1	0	0
Total Unmet Resource Needs	30	23	12	5
Distinct Clients with Unmet Resource Needs	28	23	12	5
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	4	0	2	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	5	6	5	3
7c-iv Peer-Run Trauma Recovery Group	3	4	3	1
7c-v Wellness Recovery and Action Planning	4	6	6	1
7c-vi Family Support	26	24	19	8
Total Unmet Resource Needs	42	40	35	13
Distinct Clients with Unmet Resource Needs	38	36	30	12
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	6	7	3	1
7d-ii Residential Treatment Substance Abuse Services	0	0	0	0
Total Unmet Resource Needs	6	7	3	1
Distinct Clients with Unmet Resource Needs	6	7	3	1
7e. Housing				
7e-i Supported Apartment	5	4	7	6
7e-ii Community Residential Facility	3	2	1	1
7e-iii Residential Treatment Facility (group home)	2	4	1	1
7e-iv Assisted Living Facility	3	2	1	2
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	65	45	42	23
Total Unmet Resource Needs	78	57	52	33
Distinct Clients with Unmet Resource Needs	73	54	47	30

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7f. Health Care				
7f-i Dental Services	47	50	38	15
7f-ii Eye Care Services	13	12	8	3
7f-iii Hearing Services	1	1	0	1
7f-iv Physical Therapy	5	4	0	1
7f-v Physician/Medical Services	28	24	16	9
Total Unmet Resource Needs	94	91	62	29
Distinct Clients with Unmet Resource Needs	69	67	49	22
7g. Legal				
7g-i Advocate	4	3	3	1
7g-ii Guardian (private)	0	0	0	0
7g-iii Guardian (public)	1	1	0	1
Total Unmet Resource Needs	5	4	3	2
Distinct Clients with Unmet Resource Needs	5	4	3	2
7h. Financial Security				
7h-i Assistance with Managing Money	43	35	26	7
7h-ii Assistance with Securing Public Benefits	25	22	14	9
7h-iii Representative Payee	6	8	6	3
Total Unmet Resource Needs	74	65	46	19
Distinct Clients with Unmet Resource Needs	59	50	36	14
7i. Education				
7i-i Adult Education (other than GED)	12	2	4	4
7i-ii GED	4	2	5	4
7i-iii Literacy Assistance	5	3	4	2
7i-iv Post High School Education	10	8	9	4
7i-v Tuition Reimbursement	1	2	2	0
Total Unmet Resource Needs	32	17	24	14
Distinct Clients with Unmet Resource Needs	26	14	18	12
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	2	2	4	0
7j-ii Club House and/or Peer Vocational Support	1	0	2	0
7j-iii Competitive Employment (no supports)	18	12	8	4
7j-iv Supported Employment	3	3	3	0
7j-v Vocational Rehabilitation	14	12	11	2
Total Unmet Resource Needs	38	29	28	6
Distinct Clients with Unmet Resource Needs	31	25	21	6
7k. Living Skills				
7k-i Daily Living Support Services	21	6	9	2
7k-ii Day Support Services	0	1	1	1
7k-iii Occupational Therapy	3	2	2	0
7k-iv Skills Development Services	7	9	5	3
Total Unmet Resource Needs	31	18	17	6
Distinct Clients with Unmet Resource Needs	26	13	12	4
7l. Transportation				
7l-i Transportation to ISP-Identified Services	41	25	17	9
7-ii Transportation to Other ISP Activities	18	14	12	6
7-iii After Hours Transportation	19	14	8	4
Total Unmet Resource Needs	78	53	37	19
Distinct Clients with Unmet Resource Needs	51	35	24	13

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7m. Personal Growth/Community				
7m-i Avocational Activities	4	3	3	2
7m-ii Recreation Activities	10	14	7	3
7m-iii Social Activities	28	22	17	9
7m-iv Spiritual Activities	6	7	1	0
Total Unmet Resource Needs	48	46	28	14
Distinct Clients with Unmet Resource Needs	36	32	20	9
Other Resources				
Other Resources	13	9	12	6
Total Unmet Resource Needs	13	9	12	6
Distinct Clients with Unmet Resource Needs	13	9	12	6

CSN 7 Totals				
Total Unmet Resource Needs	628	492	391	186
Distinct Clients With any Unmet Resource Need	184	142	121	56
Distinct Clients with a RDS	782	608	561	284

Report of Unmet Resource Needs

CSN Not Assigned

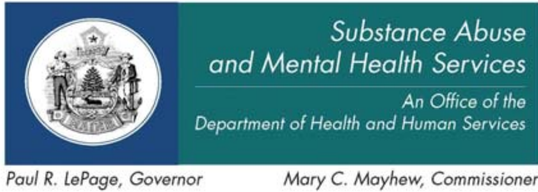
Fiscal Year 2017 Quarter 2
(Oct, Nov, Dec 2016)

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Distinct Clients with a RDS	399	351	297	132
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	1	2	1	1
7a-iii Dialectical Behavioral Therapy	2	1	2	0
7a-iv Family Psycho-Educational Treatment	2	1	1	1
7a-v Group Counseling	2	3	0	0
7a-vi Individual Counseling	12	4	3	2
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	2	2	3	0
7a-x Psychiatric Medication Management	16	11	11	3
Total Unmet Resource Needs	37	24	21	7
Distinct Clients with Unmet Resource Needs	26	21	19	7
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	7	4	0	2
7b-ii Mental Health Advance Directives	1	0	0	0
Total Unmet Resource Needs	8	4	0	2
Distinct Clients with Unmet Resource Needs	8	4	0	2
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	0	0	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	5	2	1	2
7c-iv Peer-Run Trauma Recovery Group	3	0	0	0
7c-v Wellness Recovery and Action Planning	2	1	0	0
7c-vi Family Support	6	2	1	1
Total Unmet Resource Needs	17	5	2	3
Distinct Clients with Unmet Resource Needs	13	4	1	2
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	4	0	1	0
7d-ii Residential Treatment Substance Abuse Services	0	0	0	0
Total Unmet Resource Needs	4	0	1	0
Distinct Clients with Unmet Resource Needs	4	0	1	0
7e. Housing				
7e-i Supported Apartment	3	4	3	1
7e-ii Community Residential Facility	1	1	1	0
7e-iii Residential Treatment Facility (group home)	0	0	0	0
7e-iv Assisted Living Facility	3	2	2	1
7e-v Nursing Home	1	0	0	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	32	21	17	8
Total Unmet Resource Needs	40	28	23	11
Distinct Clients with Unmet Resource Needs	36	25	20	10

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7f. Health Care				
7f-i Dental Services	23	16	9	6
7f-ii Eye Care Services	9	7	4	2
7f-iii Hearing Services	1	0	1	1
7f-iv Physical Therapy	3	1	2	1
7f-v Physician/Medical Services	14	7	2	1
Total Unmet Resource Needs	50	31	18	11
Distinct Clients with Unmet Resource Needs	30	23	11	6
7g. Legal				
7g-i Advocate	6	5	4	1
7g-ii Guardian (private)	1	1	0	0
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	7	6	4	1
Distinct Clients with Unmet Resource Needs	6	5	4	1
7h. Financial Security				
7h-i Assistance with Managing Money	29	17	16	7
7h-ii Assistance with Securing Public Benefits	14	6	6	0
7h-iii Representative Payee	2	2	2	0
Total Unmet Resource Needs	45	25	24	7
Distinct Clients with Unmet Resource Needs	38	23	22	7
7i. Education				
7i-i Adult Education (other than GED)	3	2	0	0
7i-ii GED	1	0	0	0
7i-iii Literacy Assistance	0	0	0	0
7i-iv Post High School Education	3	0	1	0
7i-v Tuition Reimbursement	3	0	0	0
Total Unmet Resource Needs	10	2	1	0
Distinct Clients with Unmet Resource Needs	7	2	1	0
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	4	1	1	0
7j-ii Club House and/or Peer Vocational Support	0	0	0	0
7j-iii Competitive Employment (no supports)	5	1	3	1
7j-iv Supported Employment	2	1	0	0
7j-v Vocational Rehabilitation	8	4	2	3
Total Unmet Resource Needs	19	7	6	4
Distinct Clients with Unmet Resource Needs	15	7	6	4
7k. Living Skills				
7k-i Daily Living Support Services	4	3	2	1
7k-ii Day Support Services	1	1	1	0
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	2	1	2	1
Total Unmet Resource Needs	7	5	5	2
Distinct Clients with Unmet Resource Needs	7	5	5	2
7l. Transportation				
7l-i Transportation to ISP-Identified Services	15	10	8	3
7-ii Transportation to Other ISP Activities	8	5	4	2
7-iii After Hours Transportation	3	5	3	1
Total Unmet Resource Needs	26	20	15	6
Distinct Clients with Unmet Resource Needs	16	15	9	4

	2016 Q3	2016 Q4	2017 Q1	2017 Q2
7m. Personal Growth/Community				
7m-i Avocational Activities	0	0	0	0
7m-ii Recreation Activities	7	0	1	0
7m-iii Social Activities	17	9	6	4
7m-iv Spiritual Activities	1	1	1	0
Total Unmet Resource Needs	25	10	8	4
Distinct Clients with Unmet Resource Needs	19	9	6	4
Other Resources				
Other Resources	9	6	7	3
Total Unmet Resource Needs	9	6	7	3
Distinct Clients with Unmet Resource Needs	9	6	7	3

CSN Not Assigned Totals				
Total Unmet Resource Needs	304	173	135	61
Distinct Clients With any Unmet Resource Need	88	73	53	25
Distinct Clients with a RDS	399	351	297	132



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Substance Abuse and Mental Health Services
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Bridging Recovery Assistance Program (BRAP)
Monitoring Report
Quarter 2 FY2017 (October, November, December 2016)

The Bridging Recovery Assistance Program (BRAP) has been established in recognition that recovery can only begin in a safe, healthy, and decent environment; a place one can call home. The Office of Substance Abuse and Adult Mental Health Services also recognizes that recovery is achieved on an individual basis which is not predicated by length of time but rather individual progress, successes and the necessity for rental assistance for persons with mental illness where length of assistance and amount of services are measured in need rather than in months.

BRAP is designed to assist individuals who have a psychiatric disability with housing costs until the individuals are awarded a Housing Choice Voucher (aka Section 8 Voucher), another federal subsidy, or until the individuals have an alternative housing placement. All units subsidized by BRAP funding must meet the U.S. Department of Housing and Urban Development's Housing Quality Standards and Fair Market Rents. Following the ***Housing First*** evidence-based program model, initial BRAP recipients are encouraged, but not required, to accept the provision of services to go hand in hand with the voucher.

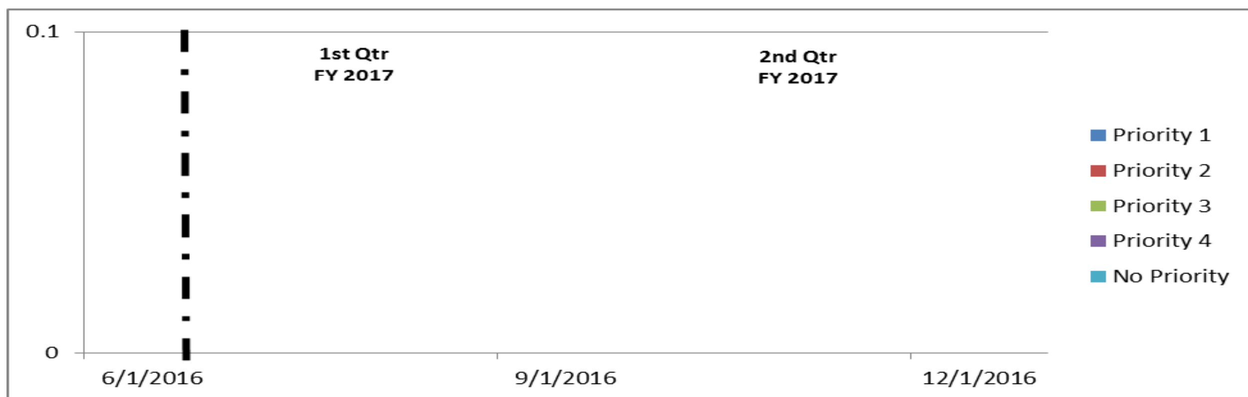
BRAP Waitlist

- Currently, there is no waitlist for the BRAP program. For this quarter, individuals who applied waited an average of 4-5 business days before being awarded a voucher and were able to start looking for housing.

BRAP Waitlist End of FY 2016 into FY 2017--Graph:
Detail by Priority Status to include those persons waiting longer than 90 Days, and showing change relative to last report.

Reporting Periods	16'-Mar	16'-Jun	16'-Sept	16'-Dec	% Change relative to Last Report
Total Number of Persons on Waitlist	77	0	0	0	No Change
Priority 1—Discharge from a psychiatric hospital, or State Funded Residential treatment facility	13	0	0	0	No Change
Priority 2—Homeless (HUD Transitional Definition)	53	0	0	0	No Change
Priority 3—Sub-standard Housing	2	0	0	0	No Change
Priority 4—Discharge from a Jail/Prison	9	0	0	0	No Change
Total number of persons on waitlist more than 90 days	43	0	0	0	No Change

Number of individuals on waitlist, as of December 31, 2016--Graph:
Last Qtr. FY 2016 to 2nd Qtr. FY 2017 Detail by Priority Status



Should reflect no waitlist at this time due to the ability to award vouchers within a reasonable timeframe of submission of application and funding availability.

BRAP Vouchers Awarded in 2nd Quarter of FY 2017

As of the close of the 2nd Quarter of FY 2017, a total of **312** new BRAP vouchers have been awarded.

Of those awarded, the total can be broken down into the priorities as follows:

- Priority #1: **62** individuals discharged from psychiatric hospitals or a state funded residential treatment facilities/PNMI have been awarded BRAP vouchers.
- Priority #2: **221** individuals who meet HUD's transitional homeless definition have been awarded BRAP vouchers.
- Priority #3: **18** individuals identified as living in sub-standard housing have been awarded BRAP vouchers.
- Priority #4: **4** individuals who were leaving a jail or prison have been awarded BRAP vouchers.
- No-Priority: **7** individuals who did not fit into specific program priorities but were coming from circumstances that warranted a situational waiver have been awarded BRAP vouchers.

Current BRAP Vouchers Awarded/Housed

The current BRAP census, as of December 31, 2016, shows a total of **1203** vouchers awarded, with **297** of those awarded but are looking for housing.

Of the **1203** individuals currently awarded vouchers, **906** are currently housed, the total can be broken down into the priorities as follows:

- Priority #1: **384** individuals discharged from psychiatric hospitals or a state funded residential treatment facilities/PNMI were awarded BRAP vouchers and are currently housed.

- Priority #2: **474** individuals who met HUD's transitional homeless definition were awarded BRAP vouchers and are currently housed.
- Priority #3: **23** individuals identified as living in sub-standard housing were awarded BRAP vouchers and are currently housed.
- Priority #4: **5** individuals who were leaving a jail or prison were awarded BRAP vouchers and are currently housed.
- No-Priority: **20** individuals who do not fit into specific program priorities but were coming from circumstances that warranted a situational waiver were awarded BRAP vouchers and are currently housed.

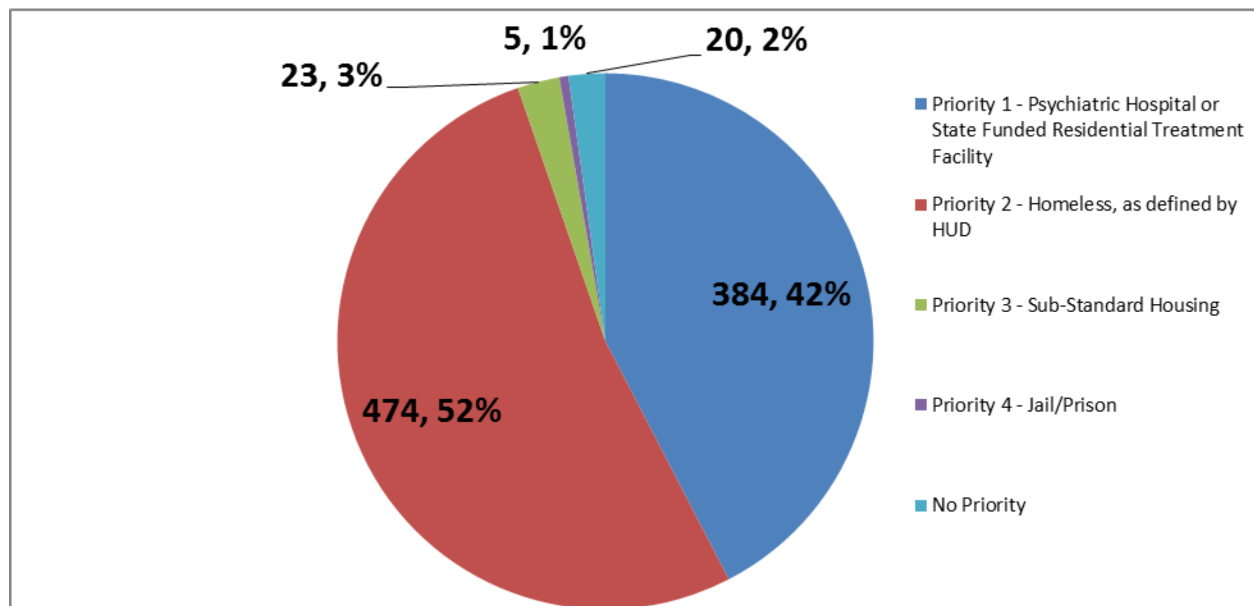
Current BRAP Census, as of December 31, 2016--Graph
Award detail by Priority Status, including persons in between apartments and never housed

BRAP Vouchers currently awarded, as of December 31, 2016	1203

Total number on BRAP Waitlist	0
Total number of persons Housed on BRAP	906
Priority 1 – Psych. Facility/PNMI	384
Priority 2 – Homeless (HUD)	474
Priority 3 – Substandard Housing	23
Priority 4 – Jail/Prison	5
No Priority	20

Total number of persons Awarded and looking for housing	297

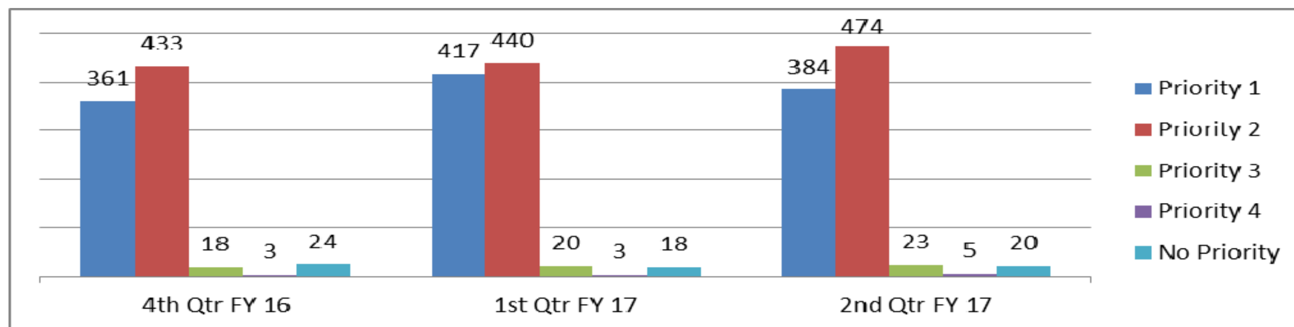
Current BRAP Census, as of December 31, 2016--Graph
Currently Housed detail by Priority Status



BRAP Vouchers Awarded/Housed Final Qtr. FY 2016 to 2nd Qtr. FY 2017--Graph: Detail by Priority Status, Individuals currently housed, and showing change relative to last report

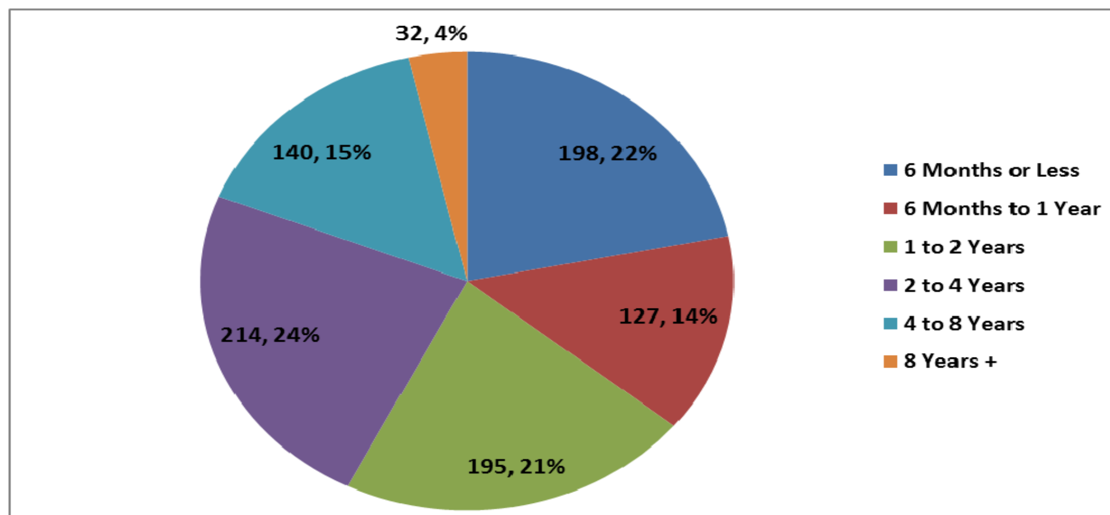
Reporting Periods	16'-June 4th Qtr. FY 16	16'-Sept 1st Qtr. FY 17	16'-Dec 2nd Qtr. FY 17	% Change relative to Last Report
Total Housed	839	898	906	.09% Up
Priority 1—Discharge from a psychiatric hospital, or State Funded Residential treatment facility	361	417	384	8% Down
Priority 2—Homeless (HUD Transitional Definition)	433	440	474	7% Up
Priority 3—Sub-standard Housing	18	20	23	15% Up
Priority 4—Discharge from a Jail/Prison	3	3	5	66% Up
No Priority-Waiver	24	18	20	11% Up

Number of individuals awarded and housed FY 2016 - FY 2017—Graph Detail by Priority



Length of Stay for those Housed on BRAP

The number of individuals housed on the BRAP program for longer than 24 months has decreased from 45% to 43% of the total persons housed on the program, with the shortest length of time housed being just under 1 month and with the longest amount of time staying housed on the program up to a period of 16 years or more.



Other Housing Programs

In addition to the BRAP program, SAMHS manages the PATH program, which is directed towards outreach, and which is responsible for engaging and enrolling literally homeless individuals into housing and mainstream resources with a focus on the literally homeless individuals who are eligible for Sec.13 and 17 in the Maine Care Manual and would be prioritized for BRAP and Shelter Plus Care.

Lastly, SAMHS administers a substantial number of Shelter Plus Care vouchers, funded by the U.S. Department of Housing and Urban Development, more than any other state on a per-capita basis. The census as of December 31, 2016 is 850. This program has seen significant growth over the last decade, which is the direct result of SAMHS aggressively applying for, and receiving, new grants annually. However, there has been no increase in HUD funding over the past two years, causing a zero increase in grants funded through the federal government. Because if this lack of additional funding, SAMHS is focusing vouchers, when they become available through turnover, on the Chronic and Long Term homeless populations throughout the state who generally qualify for this program.

The BRAP program was recently put out for RFP. The results of this RFP was a single provider selected to administer the program state wide.

Shalom House Inc., based in Portland, was the selected provider. Shalom has been the Centralized Administrative Agency for this program since inception and has selected each of our existing LAAs (Local Administrative Agencies) to continue to administer the program in each of their respective areas around the State of Maine.

****The changes to the eligibility of Sec.17 have had a significant effect on how many persons have accessed BRAP this past quarter. In light of this and to allow an avenue of access the program has created a BRAP enrollment form which allows a potential applicant to qualify for the program prior to actually receiving Sec. 17 services. This should prove to decrease any perceived barriers which may have resulted from the changes. Educating the community providers and potential applicants is a priority of SAMHS as well as our Providers.*

Class Member Treatment Planning Review

For the 2nd Quarterof Fiscal Year 2017

(October, November, December,2016)

		2016 Q3		2016 Q4		2017 Q1		2017 Q2	
Total Plans Reviewed		49		47		49		49	
I Releases									
1A	Does the record document that the agency has planned with and educated the consumer regarding releases of information at intake/initial treatment planning process?	100.0%	29 of 29	100.0%	16 of 16	90.9%	10 of 11	92.9%	13 of 14
1B	Does the record document that the agency has planned with and educated the consumer regarding releases of information during each treatment plan review?	100.0%	48 of 48	97.8%	45 of 46	89.8%	44 of 49	98.0%	48 of 49
1C	Does the record document that the consumer has a primary care physician (PCP)?	91.8%	45 of 49	87.2%	41 of 47	95.9%	47 of 49	98.0%	48 of 49
1D	If 1C. is yes, has there been an attempt to obtain releases signed by the consumer for the sharing of information with the PCP?	91.1%	41 of 45	90.2%	37 of 41	85.1%	40 of 47	87.5%	42 of 48
II Treatment Plan									
2A	Does the record document that the domains of housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional/psychological, and psychiatric were assessed with the consumer in treatment planning?	95.9%	47 of 49	95.7%	45 of 47	95.9%	47 of 49	95.9%	47 of 49
2B	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?	95.9%	47 of 49	97.9%	46 of 47	100.0%	48 of 48	98.0%	48 of 49
2C	Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?	95.9%	47 of 49	83.0%	39 of 47	93.6%	44 of 47	97.9%	47 of 48
2D	Does the record document that the individual's potential need for crisis intervention and resolution services was considered with the consumer during treatment planning?	95.9%	47 of 49	93.5%	43 of 46	98.0%	48 of 49	100.0%	49 of 49
2E	Does the record document that the consumer has a crisis plan?	51.0%	25 of 49	41.3%	19 of 46	71.4%	35 of 49	83.7%	41 of 49
2F	If 2E. is no, is the reason documented?	100.0%	24 of 24	100.0%	27 of 27	100.0%	14 of 14	100.0%	8 of 8
2G	If 2E. is yes, has the crisis plan been reviewed as required every three months?	88.0%	22 of 25	78.9%	15 of 19	77.1%	27 of 35	97.6%	40 of 41
2H	If 2E. is yes, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?	25.0%	2 of 8	400.0%	4 of 1	81.8%	9 of 11	100.0%	11 of 11
2I	Does the record document that the consumer has a mental health advance directive?	4.1%	2 of 49	8.5%	4 of 47	8.2%	4 of 49	16.3%	8 of 49

		2016 Q3		2016 Q4		2017 Q1		2017 Q2	
2J	If 2I. is yes, has the advance directive been reviewed at least annually by the CSW and consumer?	50.0%	1 of 2	25.0%	1 of 4	50.0%	2 of 4	75.0%	6 of 8
2K	If 2I. is no, is the reason why documented?	100.0%	47 of 47	100.0%	43 of 43	100.0%	45 of 45	100.0%	41 of 41
III Needed Resources									
3A	Does the record document that natural supports (family/friends) are being accessed as a resource?	91.8%	45 of 49	85.1%	40 of 47	85.7%	42 of 49	85.7%	42 of 49
3B	If 3A. is no, has the worker discussed with the consumer the consideration of natural supports as a resource?	100.0%	4 of 4	100.0%	7 of 7	100.0%	7 of 7	100.0%	7 of 7
3C	Does the record document that generic resources (those resources that anyone can access) are being accessed?	91.8%	45 of 49	91.5%	43 of 47	89.8%	44 of 49	95.9%	47 of 49
3D	If 3C. is no, has the worker discussed with the consumer the consideration of generic resources as a resource?	0.0%	0 of 4	0.0%	0 of 4	0.0%	0 of 5	0.0%	0 of 2
3E	Does the record document a resource need that has not been provided according to/within the expected response time?	14.3%	7 of 49	15.2%	7 of 46	16.3%	8 of 49	16.3%	8 of 49
3F	Does the treatment plan reflect interim planning?	71.4%	5 of 7	71.4%	5 of 7	62.5%	5 of 8	87.5%	7 of 8
3G	Does the record document that the treatment team reconvened after the unmet need was identified?	71.4%	5 of 7	71.4%	5 of 7	62.5%	5 of 8	87.5%	7 of 8
IV Service Agreements									
4A	Does the record document that service agreements are required for this plan? (see paragraph 69 protocol for definitions)	57.1%	28 of 49	59.6%	28 of 47	49.0%	24 of 49	40.8%	20 of 49
4B	If 4A. is yes, have service agreements been acquired?	71.4%	20 of 28	32.1%	9 of 28	54.2%	13 of 24	95.0%	19 of 20
4C	If 4A. is yes, are the service agreements current?	67.9%	19 of 28	32.1%	9 of 28	50.0%	12 of 24	95.0%	19 of 20
V Vocational Services									
5A	Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?	98.0%	48 of 49	91.5%	43 of 47	100.0%	49 of 49	100.0%	49 of 49
5B	Does the record document that the vocational domain is being addressed with the consumer at each 90 day treatment plan review?	89.8%	44 of 49	93.6%	44 of 47	95.8%	46 of 48	89.8%	44 of 49
VI Comments									
6A	Plan of correction requested?	26.5%	13 of 49	55.3%	26 of 47	42.6%	20 of 47	12.2%	6 of 49
6A.1.	Plan of correction for section 2A. (required when not all domains assessed) included?	200.0%	4 of 2	150.0%	3 of 2	300.0%	6 of 2	100.0%	2 of 2
6C	Plan of correction received?	84.6%	11 of 13	84.6%	22 of 26	95.0%	19 of 20	66.7%	4 of 6
6D	Were corrections made to the satisfaction of the CDC?	90.9%	10 of 11	100.0%	22 of 22	94.7%	18 of 19	75.0%	3 of 4

Report Run by:Julia.Mason

For questions, contact the DHHS Data Management Group.

Maine Department of Health and Human Services

Integrated Quarterly Crisis Report

STATEWIDE with GRAPHS

Oct 2016 - Dec 2016

I. Consumer Demographics (Unduplicated Counts - All Face-To-Face)

Gender	Children	Males	554	Females	611				
	Adults	Males	2,161	Females	2,187				
Age Range	Children	< 5	10	5 - 9	164	10 - 14	506	15-17	487
	Adults	18 - 21	478	22 - 35	1,248	36 - 60	2,081	>60	542
Payment Source	Children	MaineCare	784	Private Ins.	284	Uninsured	97	Medicare	2
	Adults	MaineCare	1,927	Private Ins.	794	Uninsured	1,171	Medicare	457

II. Summary Of All Crisis Contacts

	Children	Adults
a. Total number of telephone contacts	5,637	27,037
b. Total number of all Initial face-to-face contacts	1,044	3,514
c. Number in II.b. who are children/youth with Mental Retardation/Autism/Pervasive Dev. Disorder	113	
d. Number of face-to-face contacts that are ongoing support for crisis resolution/stabilization	123	1,242

III. Initial Crisis Contact Infomation

	Children		Adults	
a. Total number of Initial face-to-face contacts in which a wellness plan, crisis plan, ISP or advanced directive plan previously developed with the individual was used	78	7.5%	70	2.0%
b. Number of Initial face-to-face contacts who have a Community Support Worker (CI,CRS,ICM, ACT,TCM)	312	29.9%	868	24.7%
c. Number of Initial face-to-face contacts who have a Comm. Support Worker that was notified of crisis	273	87.5%	778	89.6%
d. SUM time in minutes for all Initial face-to-face contacts in II.b. from determination of need for face-to-face contact or when individual was ready and able to be seen to Initial face-to-face contact			105,965	30
e. Number of Initial face-to-face contacts in Emergency Department with final disp. within 8 hours			1,962	55.8%
f. Number of Initial face-to-face contacts not in Emergency Department with final disp. within 8 hours			1,222	34.8%

CHILDREN ONLY: Time from determination of need for face-to-face contact or when individual was ready and able to be seen to initial face to face contact.

Less Than 1 Hour.	872	1 to 2 Hours	135	2 to 4 Hours	31	More Than 4 Hours	6
Percent	83.5%	Percent	12.9%	Percent	3.0%	Percent	0.6%

CHILDREN ONLY: Time between completion of Initial face-to-face crisis assessment contact and final disposition/resolution of crisis

Less Than 3 Hours	527	3 to 6 Hours	406	6 to 8 Hours	34	8 to 14 Hours	37	> 14	40
Percent	50.5%	Percent	38.9%	Percent	3.3%	Percent	3.5%	Percen	3.8%

IV. Site Of Initial Face-To-Face Contacts

	Children		Adults	
a. Primary Care Residence (Home)	105	10.1%	317	9.0%
b. Family/Relative/Other Residence	56	5.4%	38	1.1%
c. Other Community Setting (Work, School, Police Dept, Public Place)	121	11.6%	131	3.7%
d. SNF, Nursing Home, Boarding Home	1	0.1%	20	0.6%
e. Residential Program (Congregate Community Residence, Apartment Program)	11	1.1%	62	1.8%
f. Homeless Shelter	0	0.0%	30	0.9%
g. Provider Office	20	1.9%	81	2.3%
h. Crisis Office	174	16.7%	465	13.2%
i. Emergency Department	551	52.8%	2,233	63.5%
j. Other Hospital Location	2	0.2%	91	2.6%
k. Incarcerated (Local Jail, State Prison, Juvenile Correction Facility)	3	0.3%	44	1.3%
Totals:	1,044	100%	3,512	100%

V. Crisis Resolution - Initial Encounters (Mutually Exclusive Exhaustive)

	Children		Adults	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	26	2.5%	245	7.0%
b. Crisis stabilization with referral to new provider for mental health/substance abuse follow up	208	19.9%	671	19.1%
c. Crisis stabilization with referral back to current provider for mental health/substane abuse follow up	405	38.8%	1,151	32.8%
d. Admission to Crisis Stabilization Unit	146	14.0%	369	10.5%
e. Inpatient Hospitalization Medical	8	0.8%	91	2.6%
f. Voluntary Psychiatric Hospitalization	249	23.9%	777	22.1%
g. Involuntary Psychiatric Hospitalization	1	0.1%	157	4.5%
h. Admission to Detox Unit	0	0.0%	49	1.4%
Totals:	1,043	100%	3,510	100%

QUARTERLY REPORT ON ORGANIZATIONAL PERFORMANCE EXCELLENCE

SECOND STATE FISCAL QUARTER 2017

October, November, December 2016

Rodney Bouffard
Superintendent
January 26, 2017

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Glossary of Terms, Acronyms & Abbreviations

ADC	Automated Dispensing Cabinets (for medications)
ADON	Assistant Director of Nursing
AOC	Administrator on Call
CCM	Continuation of Care Management (Social Work Services)
CCP	Continuation of Care Plan
CH/CON	Charges/Convicted
CMS	Centers for Medicare & Medicaid Services
CIVIL	Voluntary, No Criminal Justice Involvement
CIVIL-INVOL	Involuntary Civil Court Commitment (No Criminal Justice Involvement)
CoP	Community of Practice or Conditions of Participation (CMS)
CPI	Continuous Process (or Performance) Improvement
CPR	Cardio-Pulmonary Resuscitation
CSP	Comprehensive Service Plan
DCC	Involuntary District Court Committed
DCC-PTP	Involuntary District Court Committed, Progressive Treatment Plan
GAP	Goal, Assessment, Plan Documentation
HOC	Hand off Communication
IMD	Institute for Mental Disease
ICDCC	Involuntary Civil District Court Commitment
ICDCC-M	Involuntary Civil District Court Commitment, Court Ordered Medications
ICDCC-PTP	Involuntary Civil District Court Commitment, Progressive Treatment Plan
IC-PTP+M	Involuntary Commitment, Progressive Treatment Plan, Court Ordered Medications
ICRDCC	Involuntary Criminal District Court Commitment
INVOL CRIM	Involuntary Criminal Commitment
INVOL-CIV	Involuntary Civil Commitment
ISP	Individualized Service Plan
IST	Incompetent to Stand Trial
JAIL TRANS	A patient who has been transferred to RPC from jail.
JTF	A patient who has been transferred to RPC from jail.
LCSW	Licensed Clinical Social Worker
LEGHOLD	Legal Hold
LPN	Licensed Practical Nurse
MAR	Medication Administration Record
MHW	Mental Health Worker
MRDO	Medication Resistant Disease Organism (MRSA, VRE, C-Dif)
NASMHPD	National Association of State Mental Health Program Directors

NCR	Not Criminally Responsible
NOD	Nurse on Duty
NP	Nurse Practitioner
NPSG	National Patient Safety Goals (established by The Joint Commission)
NRI	NASMHPD Research Institute, Inc.
OPS	Outpatient Services Program (formally the ACT Team)
OT	Occupational Therapist
PA or PA-C	Physician's Assistant (Certified)
PCHDCC	Pending Court Hearing
PCHDCC+M	Pending Court Hearing for Court Ordered Medications
PPR	Periodic Performance Review – a self-assessment based upon TJC standards that are conducted annually by each department head.
PSD	Program Services Director
PTP	Progressive Treatment Plan
PRET	Pretrial Evaluation
R.A.C.E.	Rescue/Alarm/Confine/Extinguish
RN	Registered Nurse
RPC	Riverview Psychiatric Center
RT	Recreation Therapist
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SAMHS	Substance Abuse and Mental Health Services, Office of (Maine DHHS)
SBAR	Acronym for a model of concise communications first developed by the US Navy Submarine Command. S = Situation, B = Background, A = Assessment, R = Recommendation
SD	Standard Deviation – a measure of data variability. Staff Development.
Seclusion, Locked	Patient is placed in a secured room with the door locked.
Seclusion, Open	Patient is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
STAGE III	60 Day Forensic Evaluation
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
URI	Upper Respiratory Infection
UTI	Urinary Tract Infection
VOL	Voluntary – Self
VOL-OTHER	Voluntary – Others (Guardian)

Introduction

The Riverview Psychiatric Center Quarterly Report on Organizational Performance Excellence has been created to highlight the efforts of the hospital and its staff members to provide evidence of a commitment to patient recovery, safety in culture and practices, and fiscal accountability. The report is structured to reflect a philosophy and contemporary practices in addressing overall organizational performance in a systems improvement approach instead of a purely compliance approach. The structure of the report also reflects a focus on meaningful measures of organizational process improvement while maintaining measures of compliance that are mandated through regulatory and legal standards.

The methods of reporting are driven by a nationally accepted focused approach that seeks out areas for improvement that were clearly identified as performance priorities. The American Society for Quality, National Quality Forum, Baldrige National Quality Program and the National Patient Safety Foundation all recommend a systems-based approach where organizational improvement activities are focused on strategic priorities rather than compliance standards.

There are three major sections that make up this report:

The first section reflects compliance factors related to the Consent Decree and includes those performance measures described in the Order Adopting Compliance Standards dated October 29, 2007. Comparison data is not always available for the last month in the quarter and is included in the next report.

The second section describes the hospital's performance with regard to Joint Commission performance measures that are derived from the Hospital-Based Inpatient Psychiatric Services (HBIPS) that are reflected in The Joint Commissions quarterly ORYX Report and priority focus areas that are referenced in The Joint Commission standards:

I. Data Collection (PI.01.01.01)
II. Data Analysis (PI.02.01.01, PI.02.01.03)
III. Performance Improvement (PI.03.01.01)

The third section encompasses those departmental process improvement projects that are designed to improve the overall effectiveness and efficiency of the hospital's operations and contribute to the system's overall strategic performance excellence. Several departments and work areas have made significant progress in developing the concepts of this new methodology.

As with any change in how organizations operate, there are early adopters and those whose adoption of system changes is delayed. It is anticipated that over the next year, further contributors to this section of strategic performance excellence will be added as opportunities for improvement and methods of improving operational functions are defined.

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CONSENT DECREE

Consent Decree Plan

V1) The Consent Decree Plan, established pursuant to paragraphs 36, 37, 38, and 39 of the Settlement Agreement in Bates v. DHHS defines the role of Riverview Psychiatric Center in providing consumer-centered inpatient psychiatric care to Maine citizens with serious mental illness that meets constitutional, statutory, and regulatory standards.

The following elements outline the hospital's processes for ensuring substantial compliance with the provisions of the Settlement Agreement as stipulated in an Order Adopting Compliance Standards dated October 29, 2007.

Patient Rights

V2) Riverview produces documentation that patients are routinely informed of their rights upon admission in accordance with ¶ 150 of the Settlement Agreement;

Indicators	3Q2016	4Q2016	1Q2017	2Q2017
1. Patients are routinely informed of their rights upon admission.	95% 61/64	80% 39/50	95% 54/60	95% 57/60

Patients are informed of their rights and asked to sign that information has been provided to them. If they refuse, staff documents the refusal and signs, dates & times the refusal.

2Q2017: 1 patient refused.

V3) Grievance tracking data shows that the hospital responds to 90% of **Level II** grievances within five working days of the date of receipt or within a five-day extension.

Indicators	3Q2016	4Q2016	1Q2017	2Q2017
1. Level II grievances responded to by RPC on time.	N/A	N/A	0% 0/3	0% 0/4
2. Level I grievances responded to by RPC on time.	60% 46/77	89% 82/92	88% 86/98	83% 87/105

CONSENT DECREE

Admissions

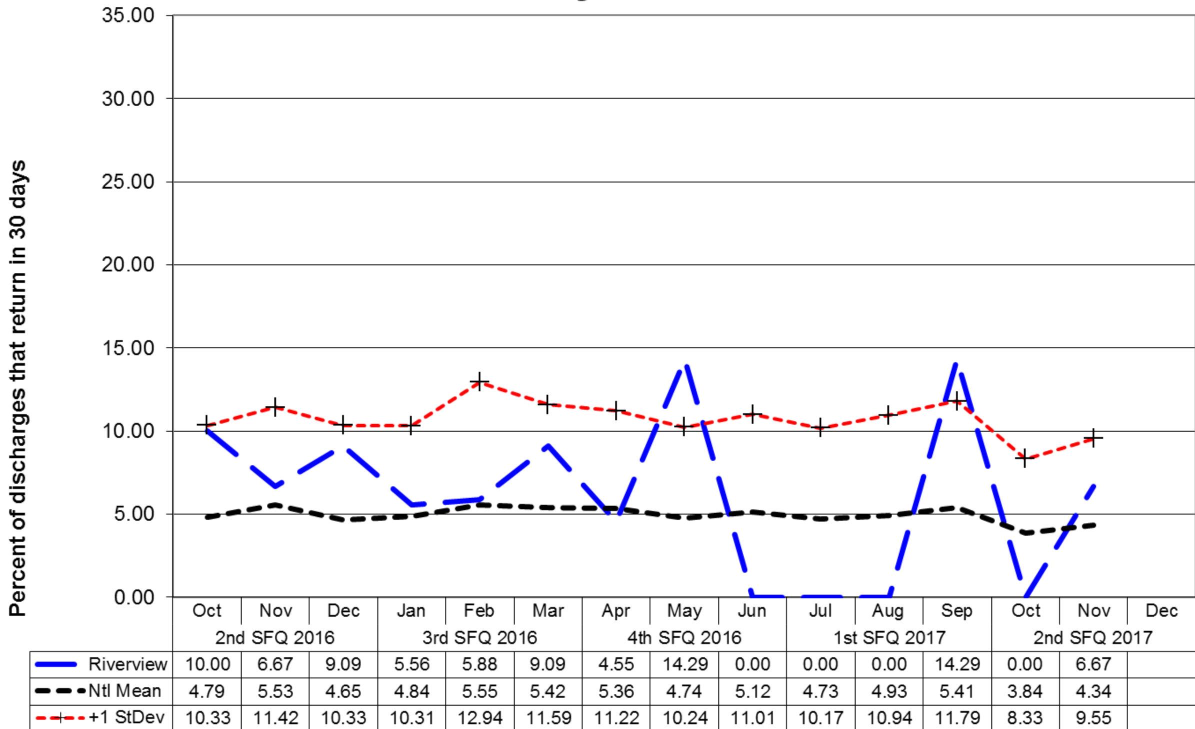
V4) Quarterly performance data shows that in 4 consecutive quarters, 95% of admissions to Riverview meet legal criteria:

ADMISSIONS	3Q2016	4Q2016	1Q2017	2Q2017	TOTAL
CIVIL:	**37**	**31**	**28**	**31**	**127**
VOL	1	1	0	0	**2**
INVOL (EIC)	7	4	6	9	**26**
DCC	29	25	22	20	**96**
DCC-PTP	0	1	0	2	**3**
FORENSIC:	**27**	**20**	**25**	**30**	**102**
60 DAY EVAL	13	2	8	14	**37**
JAIL TRANSFER	5	1	0	0	**6**
IST	3	8	13	7	**31**
NCR	6	9	4	9	**28**
TOTAL	**64**	**51**	**53**	**61**	**229**

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

CONSENT DECREE

V5) Quarterly performance data shows that in 3 out of 4 consecutive quarters, the % of readmissions within 30 days of discharge does not exceed one standard deviation from the national mean as reported by NASMHPD



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	10.00	6.67	9.09	5.56	5.88	9.09	4.55	14.29	0.00	0.00	0.00	14.29	0.00	6.67	
Ntl Mean	4.79	5.53	4.65	4.84	5.55	5.42	5.36	4.74	5.12	4.73	4.93	5.41	3.84	4.34	
+1 StDev	10.33	11.42	10.33	10.31	12.94	11.59	11.22	10.24	11.01	10.17	10.94	11.79	8.33	9.55	

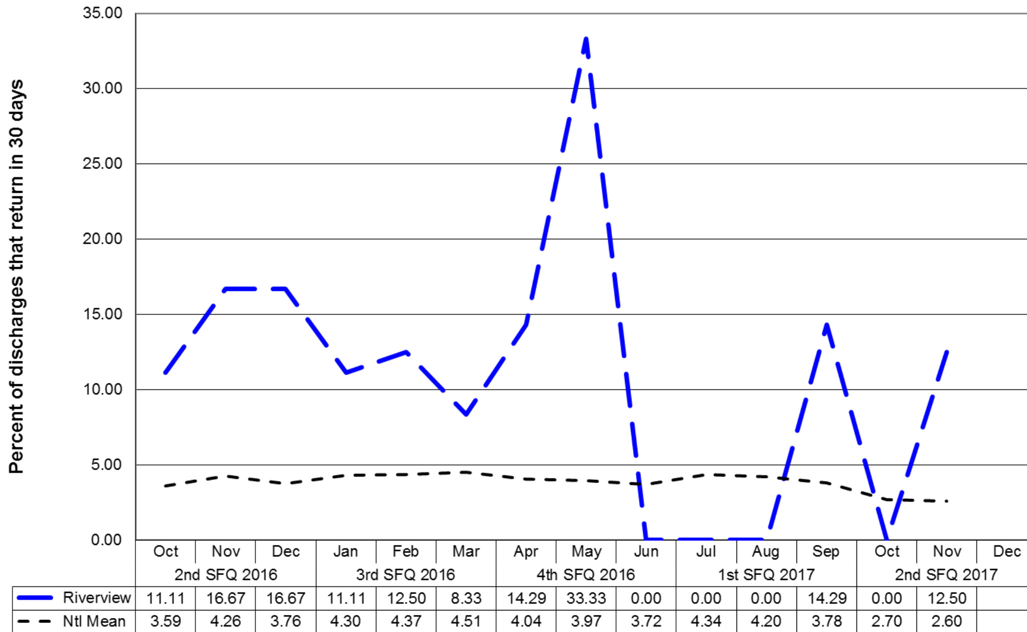
This graph depicts the percent of discharges from the facility that returned within 30 days of a discharge of the same patient from the same facility. For example; a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

Reasons for patient readmission are varied and may include decompensating or lack of compliance with a PTP. Specific causes for readmission are reviewed with each patient upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient granularity to determine trends for causes of readmission.

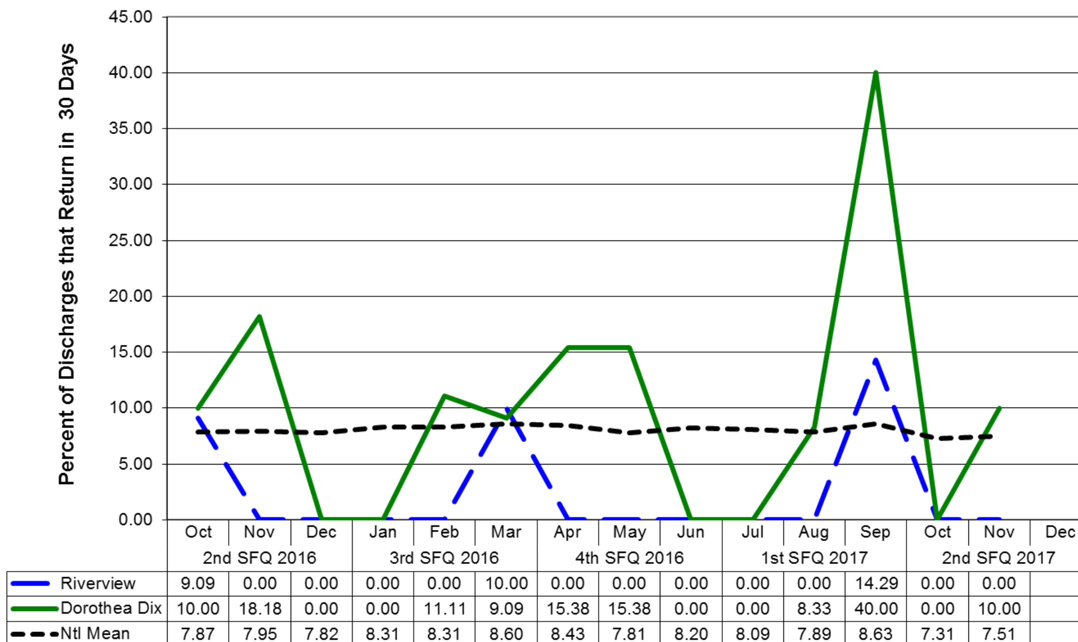
The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same patient from the same facility stratified by forensic or civil classifications. For example; a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

CONSENT DECREE



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	11.11	16.67	16.67	11.11	12.50	8.33	14.29	33.33	0.00	0.00	0.00	14.29	0.00	12.50	
Ntl Mean	3.59	4.26	3.76	4.30	4.37	4.51	4.04	3.97	3.72	4.34	4.20	3.78	2.70	2.60	



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	9.09	0.00	0.00	0.00	0.00	10.00	0.00	0.00	0.00	0.00	0.00	14.29	0.00	0.00	
Dorothea Dix	10.00	18.18	0.00	0.00	11.11	9.09	15.38	15.38	0.00	0.00	8.33	40.00	0.00	10.00	
Ntl Mean	7.87	7.95	7.82	8.31	8.31	8.60	8.43	7.81	8.20	8.09	7.89	8.63	7.31	7.51	

CONSENT DECREE

V6) Riverview documents, as part of the Performance Improvement & Quality Assurance process, that the Director of Social Work reviews all readmissions occurring within 60 days of the last discharge; and for each patient who spent fewer than 30 days in the community, evaluated the circumstances to determine whether the readmission indicated a need for resources or a change in treatment and discharge planning or a need for different resources and, where such a need or change was indicated, that corrective action was taken;

Review of Re-Admissions Occurring Within 60 Days:

Indicators	3Q2016	4Q2016	1Q2017	2Q2017
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge, and for each patient who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources; and, where such a need or change was indicated, that corrective action was taken.	100% 5/5	100% 4/4	100% 4/4	100% 6/6

2Q2017: Six patients were readmitted in the second quarter after spending less than 30 days in the community. Two clients from UK spent 2 and 4 days respectively at Maine General for medical issues and both were re-admitted. One re-admitted long-term NCR client was discharged back to a group home and was re-admitted for psychiatric and medical evaluation after 14 days in the community. One LK patient was readmitted after 27 days in the community and reported she "stopped taking medications and cannot deal with her house"

CONSENT DECREE

Reduction of Re-Hospitalization for Outpatient Services Programs (OPS) Patients

Indicators	1Q2017	2Q2017	3Q2017	4Q2017
1. The Program Service Director of the Outpatient Services Program will review all patient cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (group home, apartment, etc.) c. Geographic location of residence d. Community support network e. Patient demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with Outpatient Treatment	100% 2/2	100% 8/8		
2. Outpatient Services will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%		

2Q2017: Eight (8) patients returned to RPC: One for psychiatric symptoms and violation of court order, two for psychiatric symptoms, one for threatening behavior, one for psychiatric and medical, one for inadequate self-care and medical, one for elopement risk, and one for auditory hallucinations and anxiety. Six clients have returned to the community and two clients remain at RPC.

CONSENT DECREE

V7) Riverview certifies that no more than 5% of patients admitted in any year have a primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.

PATIENT ADMISSION DIAGNOSIS	3Q16	4Q16	1Q17	2Q17	TOTAL
ADJUSTMENT DISORDER WITH DISTURBANCE OF CONDUCT				1	**1**
ANTISOCIAL PERSONALITY DISORDER	1	1			**2**
ANXIETY DISORDER, UNSPECIFIED	1	1	1	2	**5**
ASPERGER'S SYNDROME				1	**1**
AUTISTIC DISORDER			1		**1**
BIPOLAR DISORD, CRNT EPISODE MANIC SEVER, W PSYCH FEATURES		1	1	3	**5**
BIPOLAR DISORD, CRNT EPISODE MANIC W/O PSYCH FEATURES, MILD			1		**1**
BIPOLAR DISORD, CRNT EPSD DEPRESS, SEVERE, W PSYCH FEATURES	3		1		**4**
BIPOLAR DISORDER, UNSPECIFIED	6	6	5	3	**20**
BIPOLAR II DISORDER	1			1	**2**
BORDERLINE PERSONALITY DISORDER	1	1			**2**
DELUSIONAL DISORDERS			1		**1**
DEMENTIA IN OTH DISEASES CLASSD ELSWHR W/ BEHAVIORAL DISTURB	1		1		**2**
GENERALIZED ANXIETY DISORDER				1	**1**
IMPULSE CONTROL DISORDER		1	1		**2**
MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED	2	1		3	**6**
MAJOR DEPRESSV DISORD, RECURRENT, SEVERE W/O PSYCH FEATURES		1			**1**
MAJOR DEPRESSV DISORD, SINGLE EPSD, SEVERE W PSYCH FEATURES	1				**1**
MAJOR DEPRESSV DISORDER, RECURRENT, SEVERE W/PSYCH FEATURES	1				**1**
MAJOR DEPRESSV DISORDER, RECURRENT, UNSPECIFIED		1	1	1	**3**
MANIC EPISODE W/O PSYCHOTIC SYMPTOMS, UNSPECIFIED			1		**1**

CONSENT DECREE

PATIENT ADMISSION DIAGNOSIS	3Q16	4Q16	1Q17	2Q17	TOTAL
MILD COGNITIVE IMPAIRMENT, SO STATED	1				**1**
MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION, UNSP				1	**1**
OTHER BIPOLAR DISORDER				1	**1**
OTHER DEPRESSIVE EPISODES	1				**1**
PARANOID PERSOANLITY DISORDER				1	**1**
PARANOID SCHIZOPHRENIA		4	4	4	**12**
POSTTRAUMATIC STRESS DISORDER-UNSPEC	3	3	1	4	**7**
RESIDUAL SCHIZOPHRENIA				1	**1**
SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE	14	12	8	12	**46**
SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE	2	1		1	**4**
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	3	2	4	8	**17**
SCHIZOPHRENIA, UNSPECIFIED	14	11	10	7	**42**
UNDIFFERENTIATED SCHIZOPHRENIA				1	**1**
UNSP PSYCHOSIS NOT DUE TO A SUB OR KNOWN PHYSIOL COND	8	4	5	3	**20**
UNSPECIFIED MOOD DISORDER (AFFECTIVE)	1		3	1	**5**
Total Admissions	**65**	**51**	**50**	**61**	**227**
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	**<1%**	**0%**	**<1%**	**0%**	**<1%**

CONSENT DECREE

Peer Supports

Quarterly performance data shows that in 3 out of 4 consecutive quarters:

V8) 100% of all patients have documented contact with a peer specialist during hospitalization;

V9) 80% of all treatment meetings involve a peer specialist.

Indicators	3Q2016	4Q2016	1Q2017	2Q2017
1. Attendance at Comprehensive Treatment Team meetings. (v9)	*91% 442/484	78% 430/550	87% 434/498	86% 440/511
2. Attendance at Service Integration meetings. (v8)	*86% 56/65	43% 20/46	74% 35/47	80% 35/44
3. Contact during admission. (v8)	100% 64/64	100% 51/51	100% 53/53	100% 61/61
4. Community Integration/Bridging Inpatient & OPS. Inpatient trips OPS	100% 26 204	100% 21 221	100% 23 216	100% 22 199
5. Peer Support will make a documented attempt to have patients fill out a survey before discharge or annually to evaluate the effectiveness of the peer support relationship during hospitalization.	46% 30/65	19% 9/48	4% 2/51	45% 26/58
6. Grievances responded to on time by Peer Support, within 1 day of receipt.	100% 77/77	89% 82/92	100% 96/96	100% 105/105
7. Peer Specialist will meet with resident's within 48 hours of admission and complete progress note to document meeting.	100% 64/64	100% 51/51	100% 53/53	100% 61/61
8. Each resident has documented contact with a peer supporter during their hospitalization (target is 100%).	100% 64/64	100% 51/51	100% 53/53	100% 61/61

CONSENT DECREE

Treatment Planning

V10) 95% of patients have a preliminary treatment and transition plan developed within 3 working days of admission;

Indicators	3Q2016	4Q2016	1Q2017	2Q2017
1. Service Integration Meeting and form completed by the end of the 3rd day.	100% 45/45	100% 45/45	100% 45/45	95% 43/45
2. Patient participation in Service Integration Meeting.	97% 44/45	95% 43/45	93% 42/45	95% 43/45
3. Social Worker participation in Service Integration Meeting.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
4. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	95% 43/45	93% 42/45	96% 43/45	93% 42/45
5. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and Social Worker role.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
6. Annual Psychosocial Assessment completed and current in chart.	100% 10/10	100% 10/10	80% 8/10	100% 10/10

2Q2017:

1. Two Service Integration meetings were not completed within 3 days on two direct admissions, one to the UK unit and one to the US unit. Both have been completed and are in the charts.
2. Two clients declined to meet for the Service Integration meeting and declined on follow up.
4. Three Comprehensive Psychosocial Assessments were not completed within the 7 day timeframe. They have been completed and are in the chart. Follow up was done with each individual social worker.

CONSENT DECREE

V11) 95% of patients also have individualized treatment plans in their records within 7 days thereafter;

Indicators	3Q2016	4Q2016	1Q2017	2Q2017
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all patients on assigned **CCM** caseload.	89% 40/45	91% 41/45	93% 42/45	100% 45/45
2. Treatment plans will have measurable goals and interventions listing patient strengths and areas of need related to transition to the community or transition back to a correctional facility.	100% 45/45	100% 45/45	100% 45/45	100% 45/45

2Q2017: All notes were in the charts. Two charts had a late progress note for the prior week, which was during Meditech audits. Staff continue to focus on reducing late entry notes.

CONSENT DECREE

V12) Riverview certifies that all treatment modalities required by ¶155 are available.

The treatment modalities listed below as listed in ¶155 are offered to all patients according to the individual patient's ability to participate in a safe and productive manner as determined by the treatment team and established in collaboration with the patient during the formulation of the individualized treatment plan.

	Provision of Services Normally by….			
Treatment Modality	**Medical Staff Psychology**	**Nursing**	**Social Services**	**Rehabilitation Services/ Treatment Mall**
Group and Individual Psychotherapy	X			
Psychopharmacological Therapy	X			
Social Services			X	
Physical Therapy				X
Occupational Therapy				X
ADL Skills Training		X		X
Recreational Therapy				X
Vocational/Educational Programs				X
Family Support Services and Education		X	X	X
Substance Abuse Services	X			
Sexual/Physical Abuse Counseling	X			
Introduction to Basic Principles of Health, Hygiene, and Nutrition		X		X

CONSENT DECREE

An evaluation of treatment planning and implementation, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:

V13) The treatment plans reflect:

- Screening of the patient's needs in all the domains listed in ¶61;
- Consideration of the patient's need for the services listed in ¶155;
- Treatment goals for each area of need identified, unless the patient chooses not, or is not yet ready, to address that treatment goal;
- Appropriate interventions to address treatment goals;
- Provision of services listed in ¶155 for which the patient has an assessed need;
- Treatment goals necessary to meet discharge criteria; and
- Assessments of whether the patient is clinically safe for discharge;

V14) The treatment provided is consistent with the individual treatment plans;

V15) If the record reflects limitations on a patient's rights listed in ¶159, those limitations were imposed consistent with the Rights of Recipients of Mental Health Services.

An abstraction of pertinent elements of a random selection of charts is periodically conducted to determine compliance with the compliance standards of the consent decree outlined in parts V13, V14, and V15.

This review of randomly selected charts revealed substantial compliance with the consent decree elements. Individual charts can be reviewed by authorized individuals to validate this chart review.

CONSENT DECREE

Medications

V16) Riverview certifies that the pharmacy computer database system for monitoring the use of psychoactive medications is in place and in use, and that the system as used meets the objectives of ¶168.

Riverview utilizes a Pyxis Medstation 4000 System for the dispensing of medications on each patient care unit. A total of six devices, one on each of the four main units and in each of the two special care units, provide access to all medications used for patient care, the pharmacy medication record, and allow review of dispensing and administration of pharmaceuticals.

A database program, HCS Medics, contains records of medication use for each patient and allows access by an after-hours remote pharmacy service to these records, to the Pyxis Medstation 4000 System. The purpose of this after-hours service is to maintain 24 hour coverage and pharmacy validation and verification services for prescribers.

Records of transactions are evaluated by the Director of Pharmacy and the Clinical Director to validate the appropriate utilization of all medication classes dispensed by the hospital. The Pharmacy and Therapeutics Committee, a multidisciplinary group of physicians, pharmacists, and other clinical staff, evaluate issues related to the prescribing, dispensing, and administration of all pharmaceuticals.

The system as described is capable of providing information to process reviewers on the status of medications management in the hospital and to ensure the appropriate use of psychoactive and other medications.

The effectiveness and accuracy of the Pyxis Medstation 4000 System is analyzed regularly through the conduct of process improvement and functional efficiency studies. These studies can be found in the Medication Management and Pharmacy Services sections of this report.

CONSENT DECREE

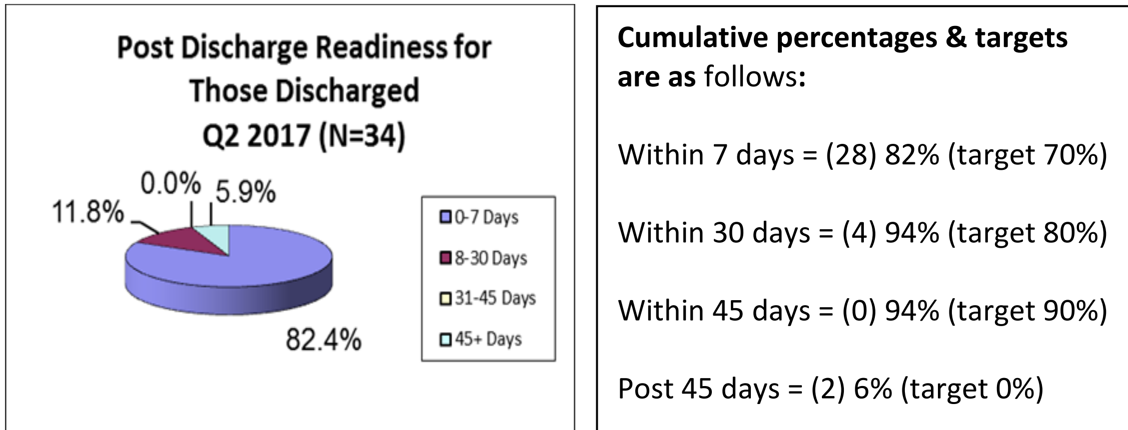
Discharges

Quarterly performance data shows that in 3 consecutive quarters:

V17) 70% of patients who remained ready for discharge were transitioned out of the hospital within 7 days of a determination that they had received maximum benefit from inpatient care;

V18) 80% of patients who remained ready for discharge were transitioned out of the hospital within 30 days of a determination that they had received maximum benefit from inpatient care;

V19) 90% of patients who remained ready for discharge were transitioned out of the hospital within 45 days of a determination that they had received maximum benefit from inpatient care (with certain patients excepted, by agreement of the parties and Court Master).



Cumulative percentages & targets are as follows:

Within 7 days = (28) 82% (target 70%)

Within 30 days = (4) 94% (target 80%)

Within 45 days = (0) 94% (target 90%)

Post 45 days = (2) 6% (target 0%)

Barriers to Discharge Following Clinical Readiness:

<table>
<tr><td><u>Residential Supports (0)</u>
No barriers in this area</td><td rowspan="3"><u>Housing (6)</u>
• 4 patients discharged within 30 days post clinical readiness (11, 18, and two at 20 days)
• 2 patients discharged 45+ days post clinical readiness (173 and 262 days)</td></tr>
<tr><td><u>Treatment Services (1)</u>
No barriers in this area</td></tr>
<tr><td><u>Other (0)</u>
No barriers in this area</td></tr>
</table>

CONSENT DECREE

The previous four quarters are displayed in the table below:

		Within 7 days	Within 30 days	Within 45 days	45+ days
Target >>		**70%**	**80%**	**90%**	**< 10%**
1Q2017	N=32	78.1%	87.5%	91%	9%
4Q2016	N=33	78.8%	87.9%	87.9%	12.1%
3Q2016	N=40	57.5%	72.5%	85.0%	10.7%
2Q2016	N=40	67.9%	85.7%	89.3%	10.7%

CONSENT DECREE

An evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:

V20) Treatment and discharge plans reflect interventions appropriate to address discharge and transition goals;

V20a) For patients who have been found not criminally responsible or not guilty by reason of insanity, appropriate interventions include timely reviews of progress toward the maximum levels allowed by court order; and the record reflects timely reviews of progress toward the maximum levels allowed by court order;

V21) Interventions to address discharge and transition planning goals are in fact being implemented;

V21a) For patients who have been found not criminally responsible or not guilty by reason of insanity, this means that, if the treatment team determines that the patient is ready for an increase in levels beyond those allowed by the current court order, Riverview is taking reasonable steps to support a court petition for an increase in levels.

Indicators	3Q2016	4Q2016	1Q2017	2Q2017
1. The Patient Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 13/13	100% 13/13	100% 13/13	100% 13/13
2. The Patient Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 13/13	100% 13/13	100% 13/13	100% 13/13
3. The Patient Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	92% 12/13	85% 11/13	85% 11/13	100% 13/13
4. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 13/13	100% 13/13	100% 13/13	100% 13/13

2Q2017:

3. The report was distributed each week electronically prior to the meeting. In addition, was available to distribute in hand at each meeting.

CONSENT DECREE

V22) The Department demonstrates that 95% of the annual reports for forensic patients are submitted to the Commissioner and forwarded to the court on time.

Indicators	3Q2016	4Q2016	1Q2017	2Q2017
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	14% 1/7	100% 2/2	67% 4/6	0% 0/5
2. The assigned **CCM** will review the new court order with the patient and document the meeting in a progress note or treatment team note.	100% 8/8	100% 3/3	100% 6/6	100% 4/4
3. Annual Reports (due in December) to the Commissioner for all inpatient NCR patients are submitted annually	100% 25/25	N/A	N/A	N/A

2Q2017:

1. All reports were completed within the 10 day timeframe.

3. Annual Reports are due this year in January 2017. A full report on the status of these reports will be completed in the quarter 3 report.

CONSENT DECREE

Staffing and Staff Training

V23) Riverview performance data shows that 95% of direct care staff have received 90% of their annual training.

Indicators	1Q2017	2Q2017	3Q2017	4Q2017	YTD
1. Riverview and Contract staff will attend CPR training bi-annually.	81% 65/80	89% 59/66			**85% 124/146**
2. Riverview and Contract staff will attend Annual training.	75% 135/179	47% 28/60			**68% 163/239**
3. Riverview and contract staff will attend MOAB training bi-annually	66% 52/79	68% 74/109			**67% 126/188**

2Q2017:

1. All staff members that are out of compliance have been notified.
2. All staff members that are out of compliance have been notified.
3. Due to staffing shortage and restructuring within the hospital, MOAB training was delayed for some staff. It is expected that the hospital will meet this standard next quarter. All staff members that are out of

CONSENT DECREE

Responsible Party: Susan Bundy, Director of Staff Development

I. Measure Name: Ongoing Education and Training

Measure Description: HR.01.05.03 requires that staff will participate in ongoing education and training to increase and maintain their competency.

Type of Measure: Performance Improvement

Goal: 90% of direct support staff will attend Collaborative Pro Active Solutions training by June 2017. Attendance will be tracked by Staffing and Organizational Development. Progress will be reported quarterly.

Progress: Collaborative Pro Active Solutions did not begin in November 2016 as expected due to other hospital priorities. RPC expects to make the training available in the next quarter.

II. Measure Name: Seclusion and Restraint Reduction

Measure Description: Because restraint and seclusion have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of the rights of an individual served, and even death, organizations continually explore ways to prevent, reduce, and strive to eliminate restraint and seclusion through effective performance improvement initiatives.

Type of Measure: Performance Improvement

Goal: RPC will decrease the use of seclusion and restraint by 50%.

FY 2017	Manual Holds	Mechanical Restraints	Locked Seclusion	Total Events Per Quarter
Quarter 1	91	6	42	**139**
Quarter 2	66	1	26	**93**
Quarter 3				
Quarter 4				
Total # of events	**157**	**7**	**68**	**232**

***Average # of events per month in FY2017 to date: 39**

CONSENT DECREE

FY 2016	Manual Holds	Mechanical Restraints	Locked Seclusion	Total Events Per Quarter
Quarter 1	95	6	75	**176**
Quarter 2	61	0	43	**104**
Quarter 3	108	0	72	**180**
Quarter 4	99	3	59	**161**
Total # of events	**363**	**9**	**249**	**621**

***Average # of events per month in FY2016: 52**

Action Plan:
Staff will receive initial and ongoing education training in the hospital approved Behavior Management Program and Recovery in Action to assist in establishing therapeutic relationships, so when a crisis begins, staff will be more influential and effective in preventing the use of seclusion and restraint.

Staff development will provide ongoing education to reinforce the organization's commitment to ensuring a caring, respectful, therapeutic environment. Data gathered through hospital performance measures will be analyzed to determine progress.

CONSENT DECREE

V24) Riverview certifies that 95% of professional staff have maintained professionally-required continuing education credits and have received the ten hours of annual cross-training required by ¶216;

DATE	HRS	TITLE	PRESENTER
1Q2016	4	July – September 2015	
2Q2016	19	October – December 2015	
3Q2016	14	January – March 2016	
4Q2016	21	April – June 2016	
1Q2017	8	July - September	
10/6/2016	1	Wellness & Disease Care: The Role of Herbal Therapies	Sarah Perry, PharmD
10/20/2016	1	Improving Quality of Care: The detection and prevention of clinical mistakes	TG Sriram, MD
12/8/2016	1	A Man from No-Where: A story about finding identity	Regana Sisson, MD George Davis MD
12/15/2016	1	The Man Who Hits Too Much	Dan Filene, MD
12/22/2016	1	Delusional Disorders -- Failures in Treatment	Randy Beal, PMHNP

CONSENT DECREE

V25) Riverview certifies that staffing ratios required by ¶202 are met, and makes available documentation that shows actual staffing for up to one recent month;

Staff Type	Consent Decree Ratio
General Medicine Physicians	1:75
Psychiatrists	1:25
Psychologists	1:25
Nursing	1:20
Social Workers	1:15
Mental Health Workers	1:6
Recreational/Occupational Therapists/Aides	1:8

With 92 beds, Riverview regularly meets or exceeds the staffing ratio requirements of the consent decree.

Staffing levels are most often determined by an analysis of unit acuity, individual monitoring needs of the patients who reside on specific units, and unit census.

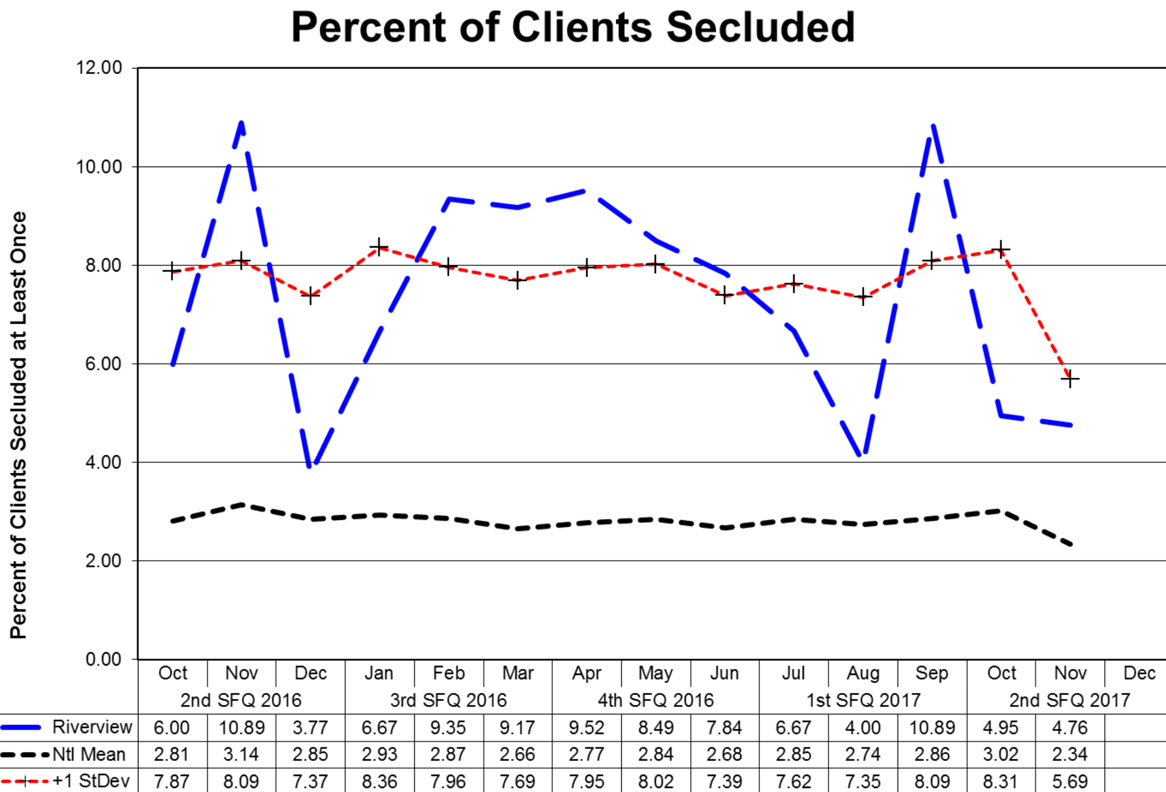
V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors consistent with their treatment plans.

Treatment teams regularly monitor the needs of individual patients and make recommendations for ongoing treatment modalities. Staffing levels are carefully monitored to ensure that all treatment goals, exercise needs, and outdoor activities are achievable. Staffing does not present a barrier to the fulfillment of patient needs. Staffing deficiencies that may periodically be present are rectified through utilization of overtime or mandated staff members.

CONSENT DECREE

Use of Seclusion and Restraints

V27) Quarterly performance data shows that, in 5 out of 6 quarters, total seclusion and restraint hours do not exceed one standard deviation from the national mean as reported by NASMHPD;

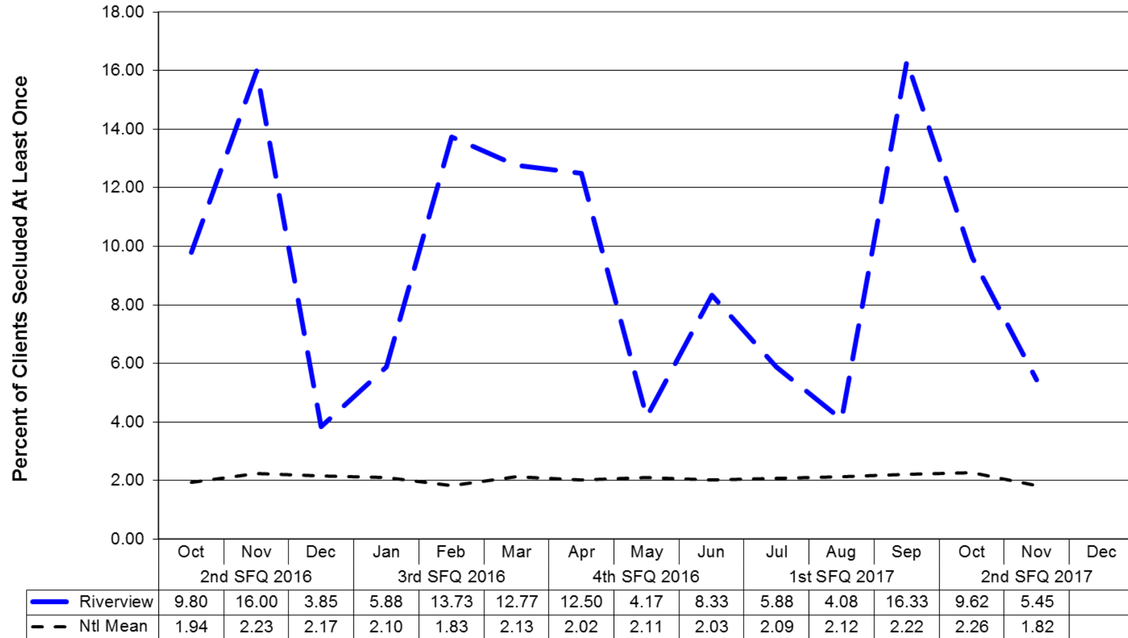


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	6.00	10.89	3.77	6.67	9.35	9.17	9.52	8.49	7.84	6.67	4.00	10.89	4.95	4.76	
Ntl Mean	2.81	3.14	2.85	2.93	2.87	2.66	2.77	2.84	2.68	2.85	2.74	2.86	3.02	2.34	
+1 StDev	7.87	8.09	7.37	8.36	7.96	7.69	7.95	8.02	7.39	7.62	7.35	8.09	8.31	5.69	

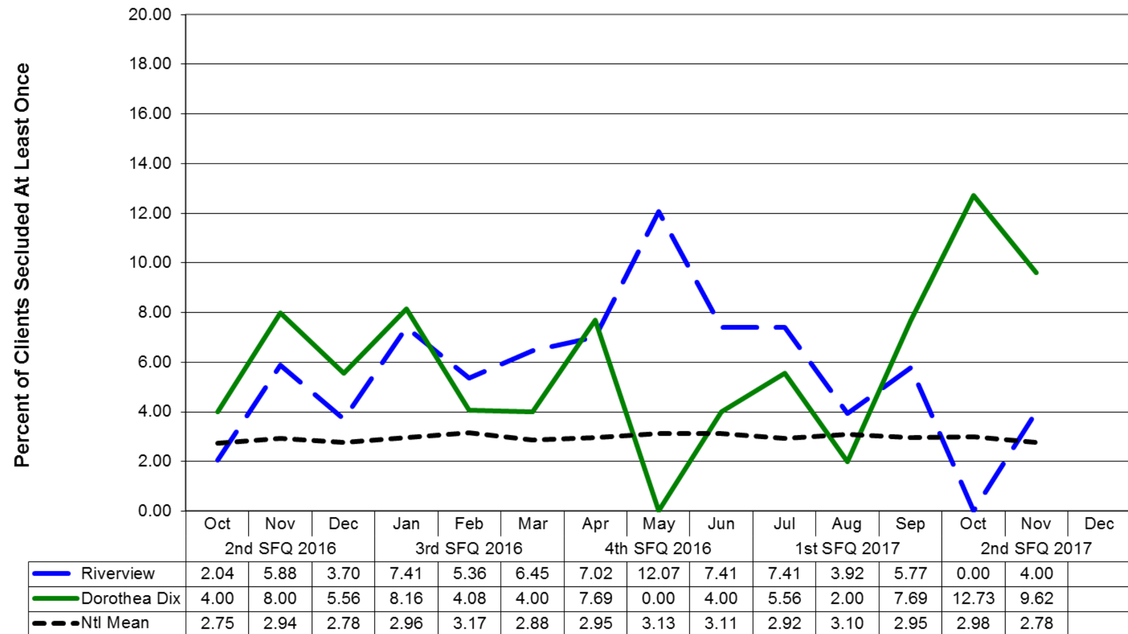
This graph depicts the percent of unique patients who were secluded at least once. For example, rates of 3.0 means that 3% of the unique patients served were secluded at least once.

The following graphs depict the percent of unique patients who were secluded at least once stratified by forensic or civil classifications. For example; rates of 3.0 means that 3% of the unique patients served were secluded at least once. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE

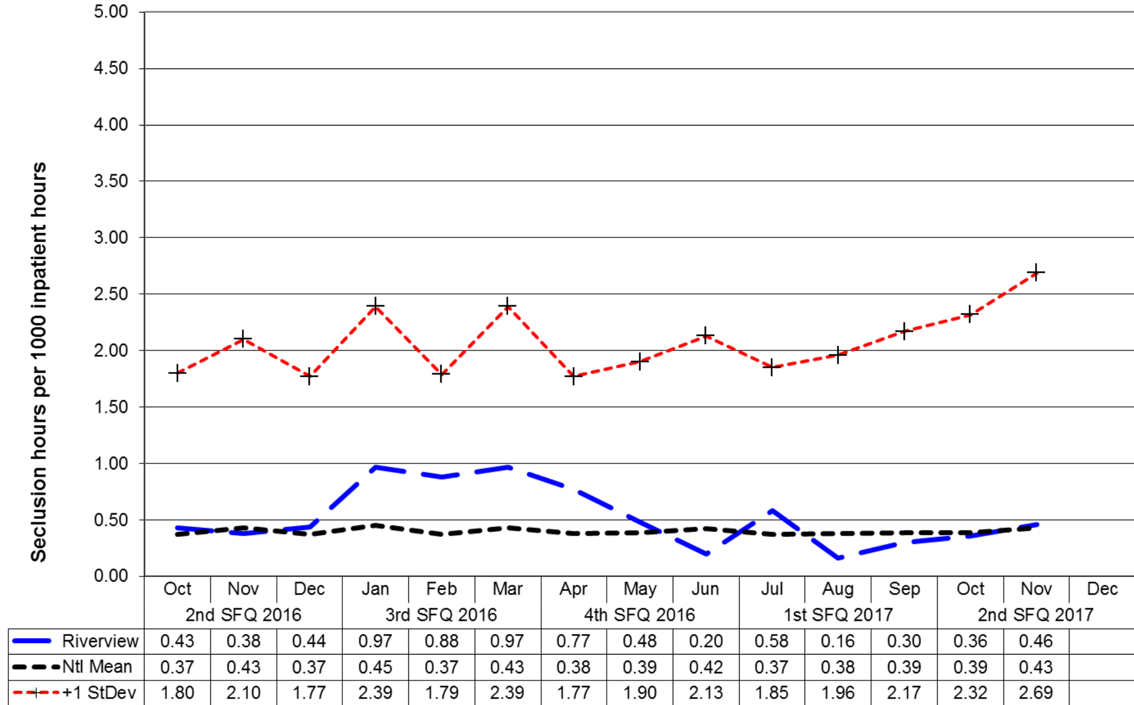


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	9.80	16.00	3.85	5.88	13.73	12.77	12.50	4.17	8.33	5.88	4.08	16.33	9.62	5.45	
Ntl Mean	1.94	2.23	2.17	2.10	1.83	2.13	2.02	2.11	2.03	2.09	2.12	2.22	2.26	1.82	



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	2.04	5.88	3.70	7.41	5.36	6.45	7.02	12.07	7.41	7.41	3.92	5.77	0.00	4.00	
Dorothea Dix	4.00	8.00	5.56	8.16	4.08	4.00	7.69	0.00	4.00	5.56	2.00	7.69	12.73	9.62	
Ntl Mean	2.75	2.94	2.78	2.96	3.17	2.88	2.95	3.13	3.11	2.92	3.10	2.95	2.98	2.78	

CONSENT DECREE



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.43	0.38	0.44	0.97	0.88	0.97	0.77	0.48	0.20	0.58	0.16	0.30	0.36	0.46	
Ntl Mean	0.37	0.43	0.37	0.45	0.37	0.43	0.38	0.39	0.42	0.37	0.38	0.39	0.39	0.43	
+1 StDev	1.80	2.10	1.77	2.39	1.79	2.39	1.77	1.90	2.13	1.85	1.96	2.17	2.32	2.69	

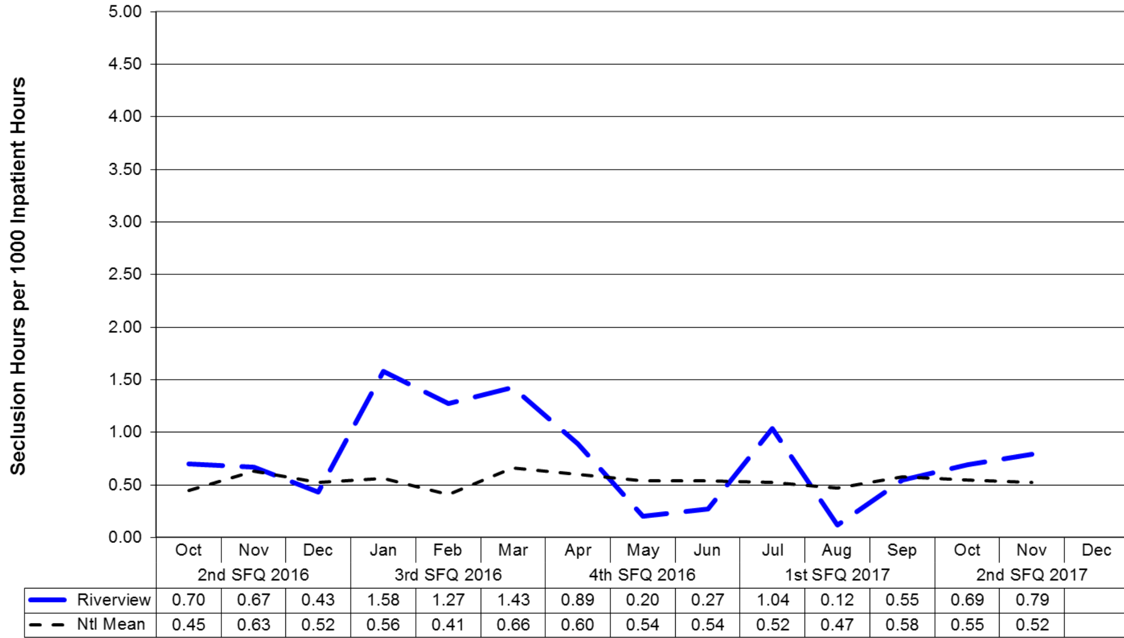
This graph depicts the number of hours patients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

The following graphs depict the number of hours patients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

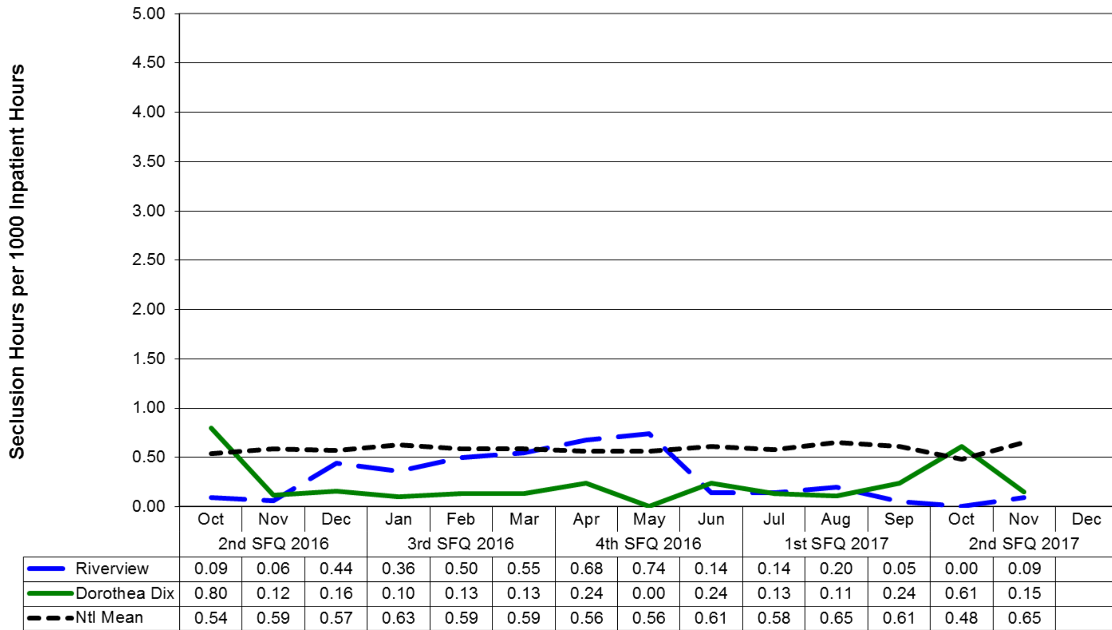
CONSENT DECREE

Seclusion Hours
Forensic Stratification



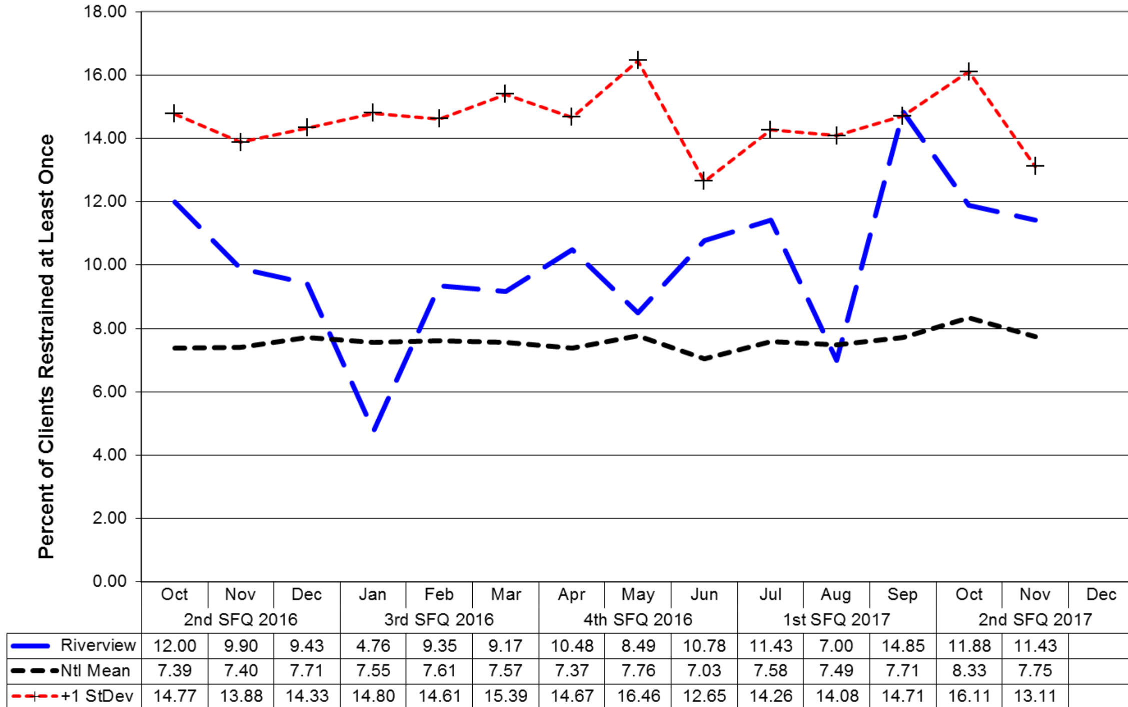
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.70	0.67	0.43	1.58	1.27	1.43	0.89	0.20	0.27	1.04	0.12	0.55	0.69	0.79	
Ntl Mean	0.45	0.63	0.52	0.56	0.41	0.66	0.60	0.54	0.54	0.52	0.47	0.58	0.55	0.52	

Seclusion Hours
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.09	0.06	0.44	0.36	0.50	0.55	0.68	0.74	0.14	0.14	0.20	0.05	0.00	0.09	
Dorothea Dix	0.80	0.12	0.16	0.10	0.13	0.13	0.24	0.00	0.24	0.13	0.11	0.24	0.61	0.15	
Ntl Mean	0.54	0.59	0.57	0.63	0.59	0.59	0.56	0.56	0.61	0.58	0.65	0.61	0.48	0.65	

CONSENT DECREE

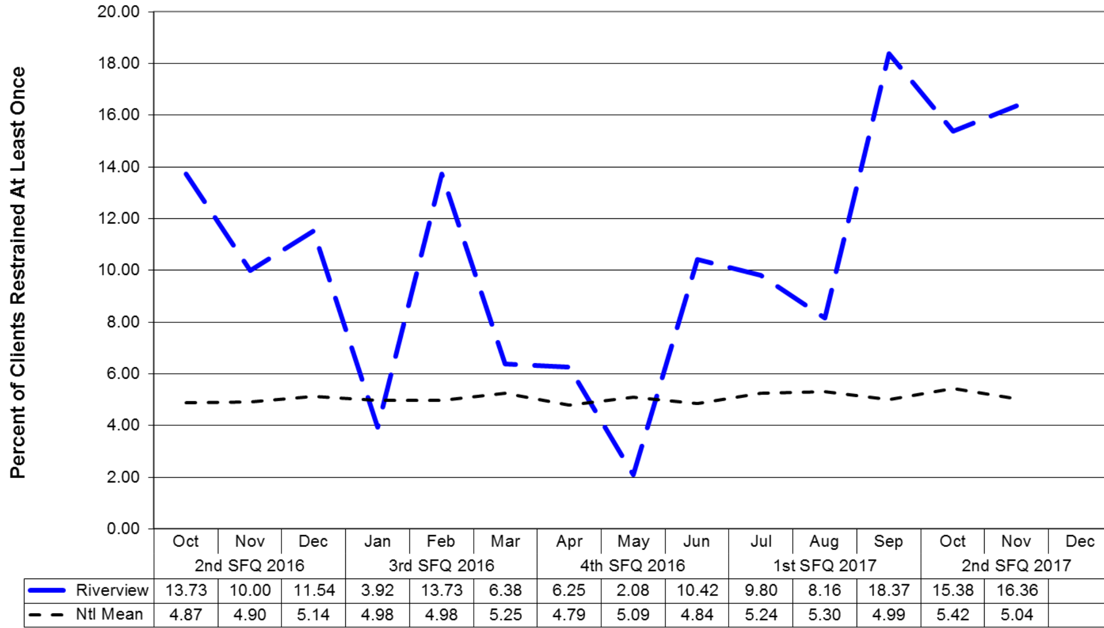


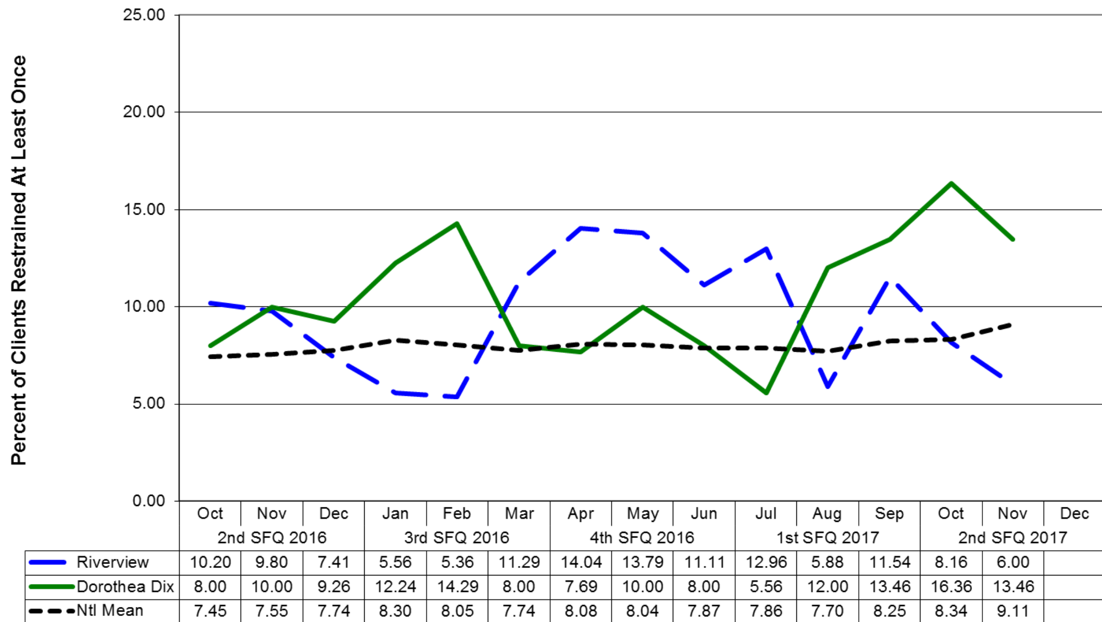
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	12.00	9.90	9.43	4.76	9.35	9.17	10.48	8.49	10.78	11.43	7.00	14.85	11.88	11.43	
Ntl Mean	7.39	7.40	7.71	7.55	7.61	7.57	7.37	7.76	7.03	7.58	7.49	7.71	8.33	7.75	
+1 StDev	14.77	13.88	14.33	14.80	14.61	15.39	14.67	16.46	12.65	14.26	14.08	14.71	16.11	13.11	

This graph depicts the percent of unique patients who were restrained at least once and includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique patients served were restrained at least once.

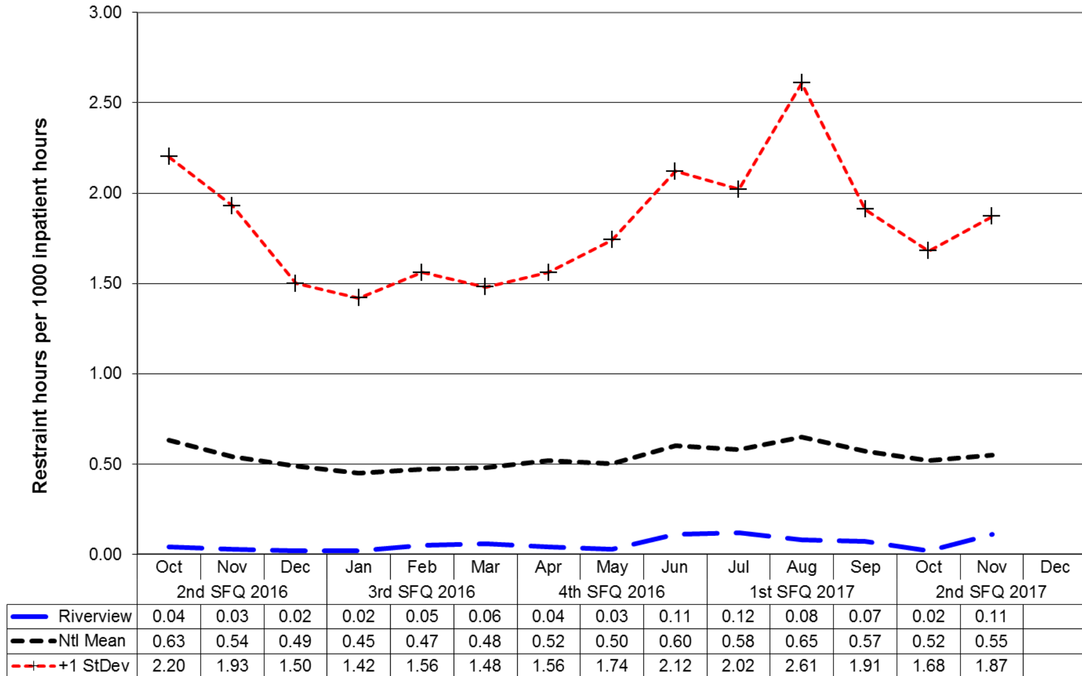
The following graphs depict the percent of unique patients who were restrained at least once stratified by forensic or civil classifications, and includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique patients served were restrained at least once. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE





CONSENT DECREE



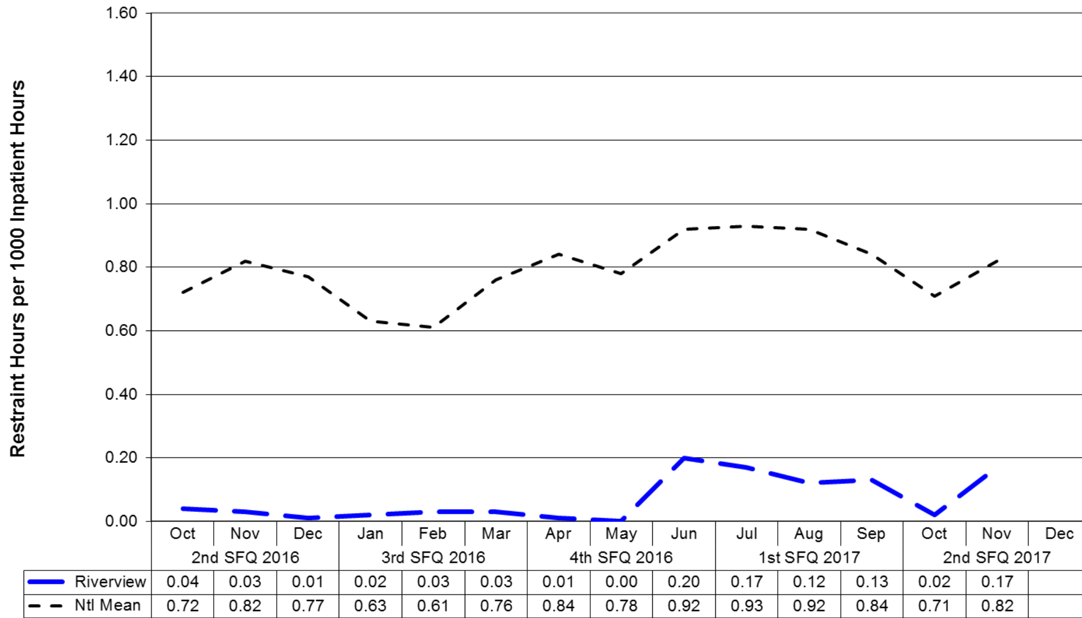
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.04	0.03	0.02	0.02	0.05	0.06	0.04	0.03	0.11	0.12	0.08	0.07	0.02	0.11	
Ntl Mean	0.63	0.54	0.49	0.45	0.47	0.48	0.52	0.50	0.60	0.58	0.65	0.57	0.52	0.55	
+1 StDev	2.20	1.93	1.50	1.42	1.56	1.48	1.56	1.74	2.12	2.02	2.61	1.91	1.68	1.87	

This graph depicts the number of hours patients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.

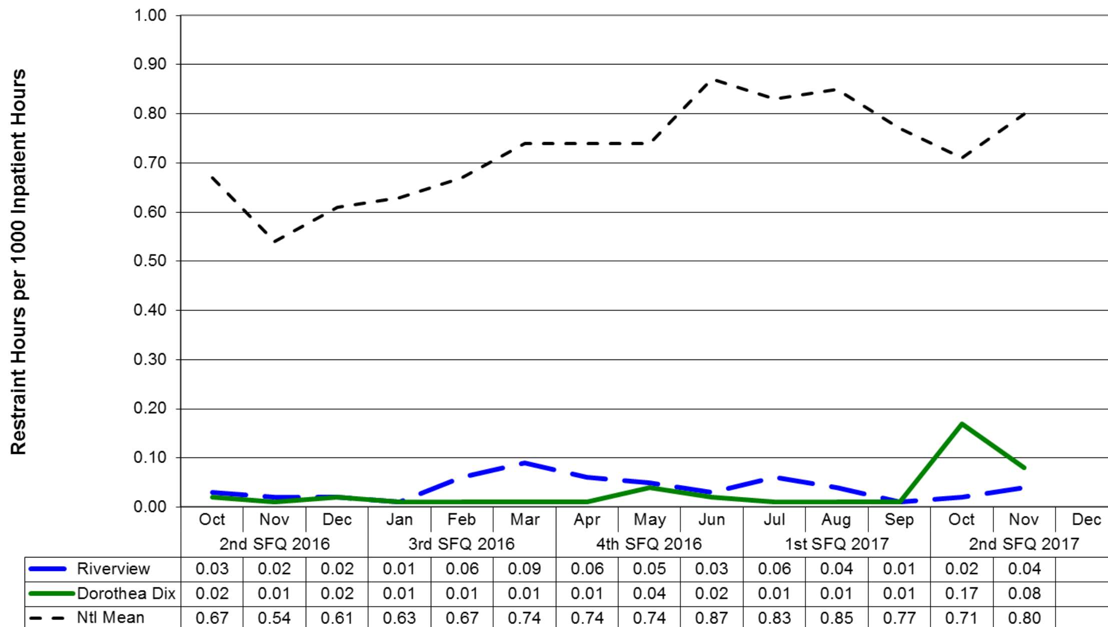
The following graphs depict the number of hours patients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

CONSENT DECREE



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.04	0.03	0.01	0.02	0.03	0.03	0.01	0.00	0.20	0.17	0.12	0.13	0.02	0.17	
Ntl Mean	0.72	0.82	0.77	0.63	0.61	0.76	0.84	0.78	0.92	0.93	0.92	0.84	0.71	0.82	



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.03	0.02	0.02	0.01	0.06	0.09	0.06	0.05	0.03	0.06	0.04	0.01	0.02	0.04	
Dorothea Dix	0.02	0.01	0.02	0.01	0.01	0.01	0.01	0.04	0.02	0.01	0.01	0.01	0.17	0.08	
Ntl Mean	0.67	0.54	0.61	0.63	0.67	0.74	0.74	0.74	0.87	0.83	0.85	0.77	0.71	0.80	

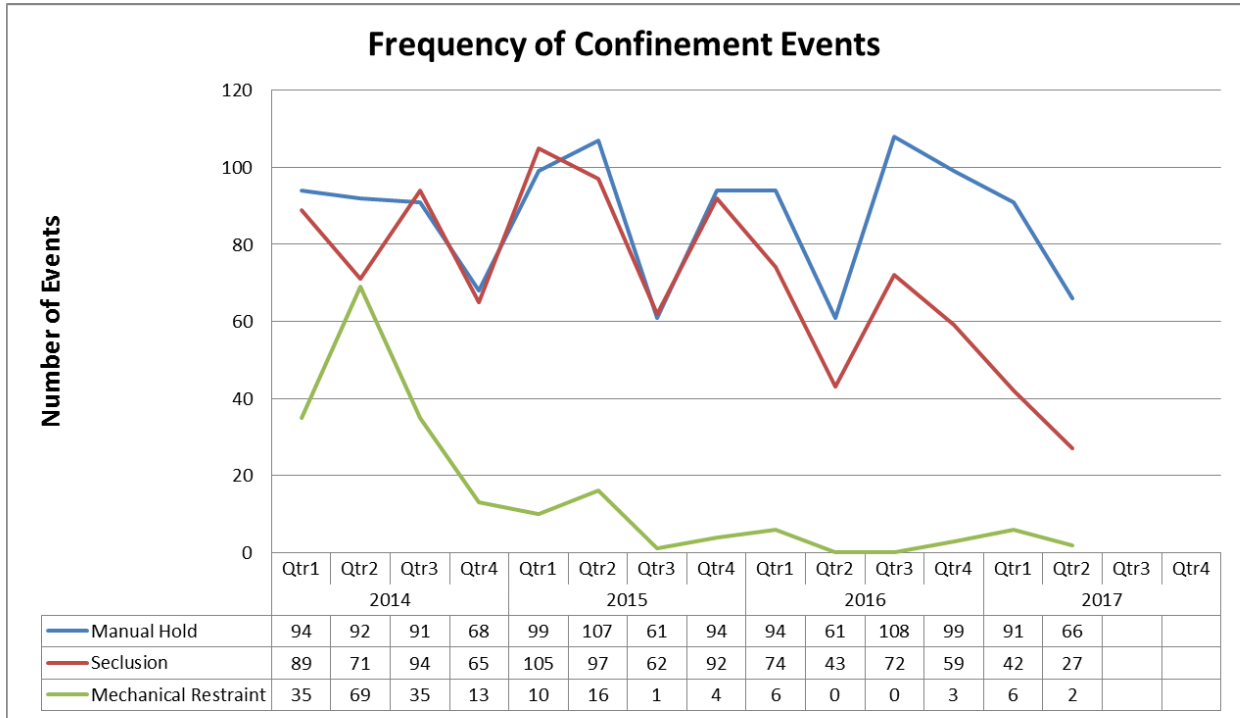
CONSENT DECREE

Confinement Event Detail
2Q2017

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR7878	14		8	22	23.40%	23.40%
MR7950	15		3	18	19.15%	42.55%
MR484	5		4	9	9.57%	52.13%
MR29	2		3	5	5.32%	57.45%
MR763	4		1	5	5.32%	62.77%
MR7820	3		2	5	5.32%	68.09%
MR657	3	1		4	4.26%	72.34%
MR7607	2		2	4	4.26%	76.60%
MR7973	3		1	4	4.26%	80.85%
MR4974	2		1	3	3.19%	84.04%
MR6466	3			3	3.19%	87.23%
MR7326	2			2	2.13%	89.36%
MR7127	1			1	1.06%	90.43%
MR7468	1			1	1.06%	91.49%
MR7871	1			1	1.06%	92.55%
MR7901	1			1	1.06%	93.62%
MR7932	1			1	1.06%	94.68%
MR7956	1			1	1.06%	95.74%
MR7980	1			1	1.06%	96.81%
MR7994	1			1	1.06%	97.87%
MR7794		1		1	1.06%	98.94%
MR85			1	1	1.06%	100.00%
	66	**2**	**26**	**94**	**100%**	

26% (22/86) of the average hospital population experienced some form of confinement event during 2Q2017. Five of these patients (6% of the average hospital population) accounted for 63% of the confinement events.

CONSENT DECREE



	2014				2015				2016				2017			
	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Manual Hold	94	92	91	68	99	107	61	94	94	61	108	99	91	66		
Seclusion	89	71	94	65	105	97	62	92	74	43	72	59	42	27		
Mechanical Restraint	35	69	35	13	10	16	1	4	6	0	0	3	6	2		

*Note: One seclusion was unlocked; therefore it was not included on the previous page.

CONSENT DECREE

V28) Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion events, seclusion was employed only when absolutely necessary to protect the patient from causing physical harm to self or others or for the management of violent behavior;

Factors of Causation Related to Seclusion Events:

	3Q2016	4Q2016	1Q2017	2Q2017	Total
Danger to Others/Self	42	57	40	27	**166**
Danger to Others	29	2			**31**
Danger to Self	1		2		**3**
% Dangerous Precipitation	100%	100%	100%	100%	**100%**
Total Events	**72**	**59**	**42**	**27**	**200**

V29) Riverview demonstrates that, based on a review of two quarters of data, for 95% of restraint events involving mechanical restraints, the restraint was used only when absolutely necessary to protect the patient from serious physical injury to self or others;

Factors of Causation Related to Mechanical Restraint Events:

	3Q2016	4Q2016	1Q2017	2Q2017	Total
Danger to Others/Self			6	2	**8**
Danger to Others					**0**
Danger to Self					**0**
% Dangerous Precipitation			100%	100%	**100%**
Total Events	**0**	**0**	**6**	**2**	**8**

V30) Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion and restraint events, the hospital achieved an acceptable rating for meeting the requirements of paragraphs 182 and 184 of the Settlement Agreement, in accordance with a methodology defined in **Attachments E-1 and E-2.**

See Pages 35-39

CONSENT DECREE

Confinement Events Management

2Q2017 Seclusion Events

(27) Events

Standard	Threshold	Compliance
1. The record reflects that seclusion was absolutely necessary to protect the patient from causing physical harm to self or others, or if the patient was examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption that significantly interferes with other patients' treatment.	95%	100%
2. The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%
3. The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	100%
4. The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%
5. The record reflects that, if the physician or physician extender was not immediately available to examine the patient, the patient was placed in seclusion following an examination by a nurse.	90%	100%
6. The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in seclusion, and if there is a delay, the reasons for the delay.	90%	100%
7. The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least 3 times per hour.)	90%	100%
8. Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
9. The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.	75%	100%
10. The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
11. The medical order states the conditions under which the patient may be sooner released.	85%	100%

CONSENT DECREE

12. The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
13. The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
14. The record includes a special check sheet that has been filled out to document reason for seclusion, description of behavior and the lesser restrictive alternatives considered.	85%	100%
15. The record reflects that the patient was released, unless clinically contraindicated, at least every 2 hours or as necessary for eating, drinking, bathing, toileting or special medical orders.	85%	100%
16. Reports of seclusion events were forwarded to Clinical Director and Patient Advocate.	90%	100%
17. The record reflects that, for persons with mental retardation, the regulations governing seclusion of patients with mental retardation were met.	85%	100%
18. The medical order for seclusion was not entered as a PRN order.	90%	100%
19. Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

CONSENT DECREE

Confinement Events Management

2Q2017 Mechanical Restraint Events

(2) Events

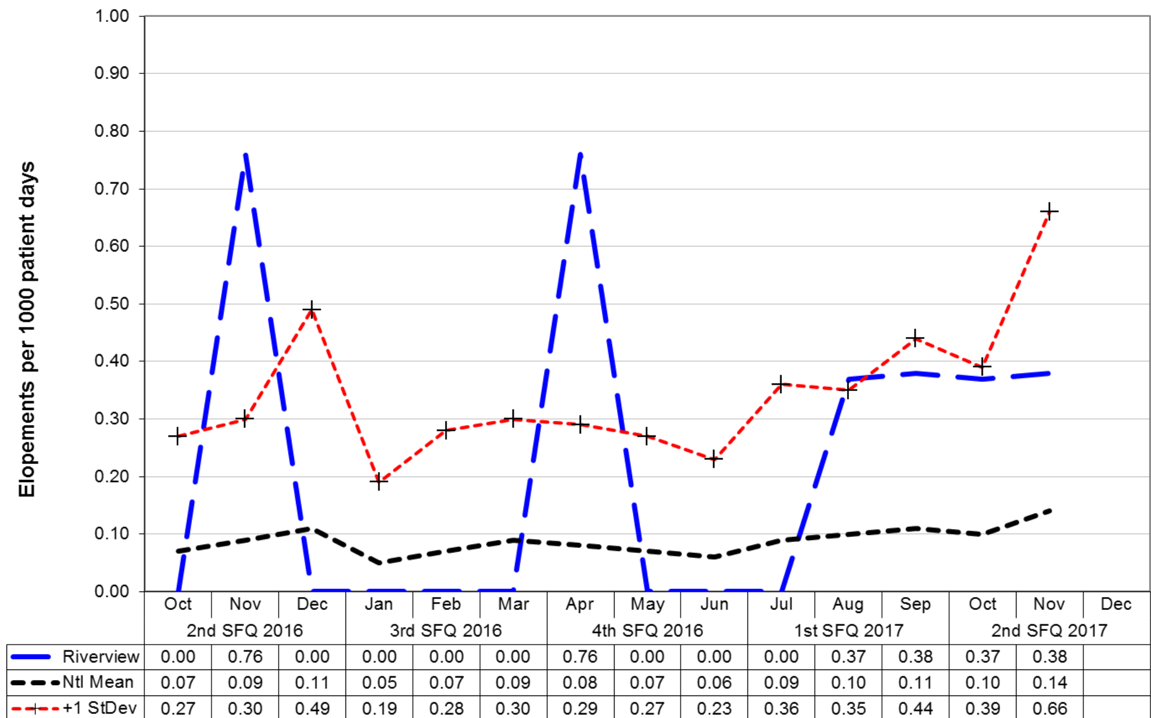
Standard	Threshold	Compliance
1. The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	100%
2. The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%
3. The record reflects that the decision to place the patient in restraint was made by a physician or physician extender	90%	100%
4. The decision to place the patient in restraint was entered in the patient's records as a medical order.	90%	100%
5. The record reflects that if a physician or physician extended was not immediately available to examine the patient, the patient was placed in restraint following an examination by a nurse.	90%	100%
6. The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in restraint, or, if there was a delay, the reasons for the delay.	90%	100%
7. The record reflects that the patient was kept under constant observation during restraint.	95%	100%
8. Individuals implementing restraint have been trained in techniques and alternatives.	90%	100%
9. The record reflects that reasonable efforts taken to notify guardian or designated representative as soon as possible that patient was placed in restraint.	75%	100%
10. The medical order states time of entry of order and that number of hours shall not exceed four.	90%	100%
11. The medical order shall state the conditions under which the patient may be sooner released.	85%	100%
12. The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	100%
13. The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	100%

CONSENT DECREE

14. The record includes a special check sheet that has been filled out to document the reason for the restraint, description of behavior and the lesser restrictive alternatives considered.	85%	100%
15. The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	100%
16. The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	100%
17. Copies of events were forwarded to Clinical Director and Patient Advocate.	90%	100%
18. For persons with mental retardation, the applicable regulations were met.	85%	100%
19. The record reflects that the order was not entered as a PRN order.	90%	100%
20. Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
21. A restraint event that exceeds 24 hours will be reviewed against the following requirement: If total consecutive hours in restraint, with renewals, exceeded 24 hours, the record reflects that the patient was medically assessed and treated for any injuries; that the order extending restraint beyond 24 hours was entered by Clinical Director (or if the Clinical Director is out of the hospital, by the individual acting in the Clinical Director's stead) following examination of the patient; and that the patient's guardian or representative has been notified.	90%	100%

Patient Elopements

V31) Quarterly performance data shows that, in 5 out of 6 quarters, the number of patient elopements does not exceed one standard deviation from the national mean as reported by NASMHPD.

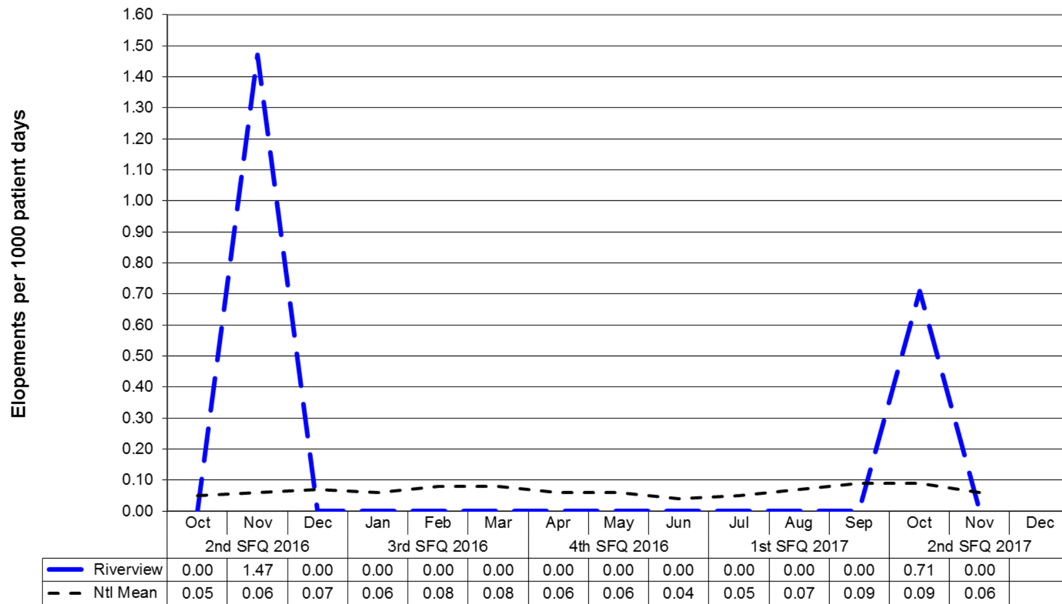


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.00	0.76	0.00	0.00	0.00	0.00	0.76	0.00	0.00	0.00	0.37	0.38	0.37	0.38	
Ntl Mean	0.07	0.09	0.11	0.05	0.07	0.09	0.08	0.07	0.06	0.09	0.10	0.11	0.10	0.14	
+1 StDev	0.27	0.30	0.49	0.19	0.28	0.30	0.29	0.27	0.23	0.36	0.35	0.44	0.39	0.66	

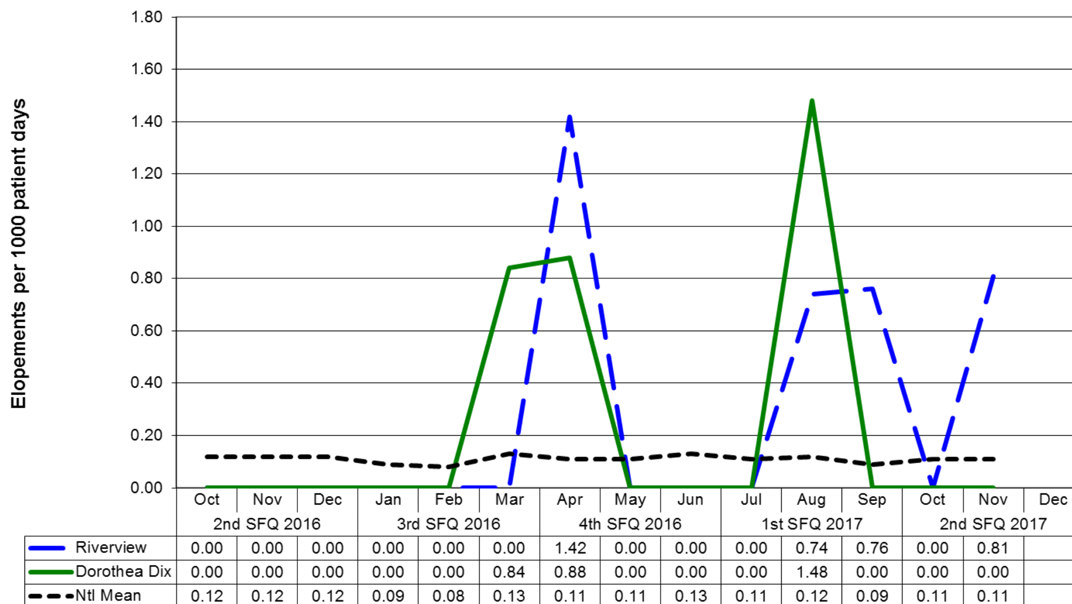
This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days. An elopement is defined as any time a patient is "absent from a location defined by the patient's privilege status regardless of the patient's leave or legal status."

The following graphs depict the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.00	1.47	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.71	0.00	
Ntl Mean	0.05	0.06	0.07	0.06	0.08	0.08	0.06	0.06	0.04	0.05	0.07	0.09	0.09	0.06	



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	1.42	0.00	0.00	0.00	0.74	0.76	0.00	0.81	
Dorothea Dix	0.00	0.00	0.00	0.00	0.00	0.84	0.88	0.00	0.00	0.00	1.48	0.00	0.00	0.00	
Ntl Mean	0.12	0.12	0.12	0.09	0.08	0.13	0.11	0.11	0.13	0.11	0.12	0.09	0.11	0.11	

CONSENT DECREE

Patient Injuries

V32) Quarterly performance data shows that, in 5 out of 6 quarters, the number of patient injuries does not exceed one standard deviation from the national mean as reported by NASMHPD.

The NASMHPD standards for measuring patient injuries differentiate between injuries that are considered reportable to the Joint Commission as a performance measure and those injuries that are of a less severe nature. While all injuries are currently reported internally, only certain types of injuries are documented and reported to NRI for inclusion in the performance measure analysis process.

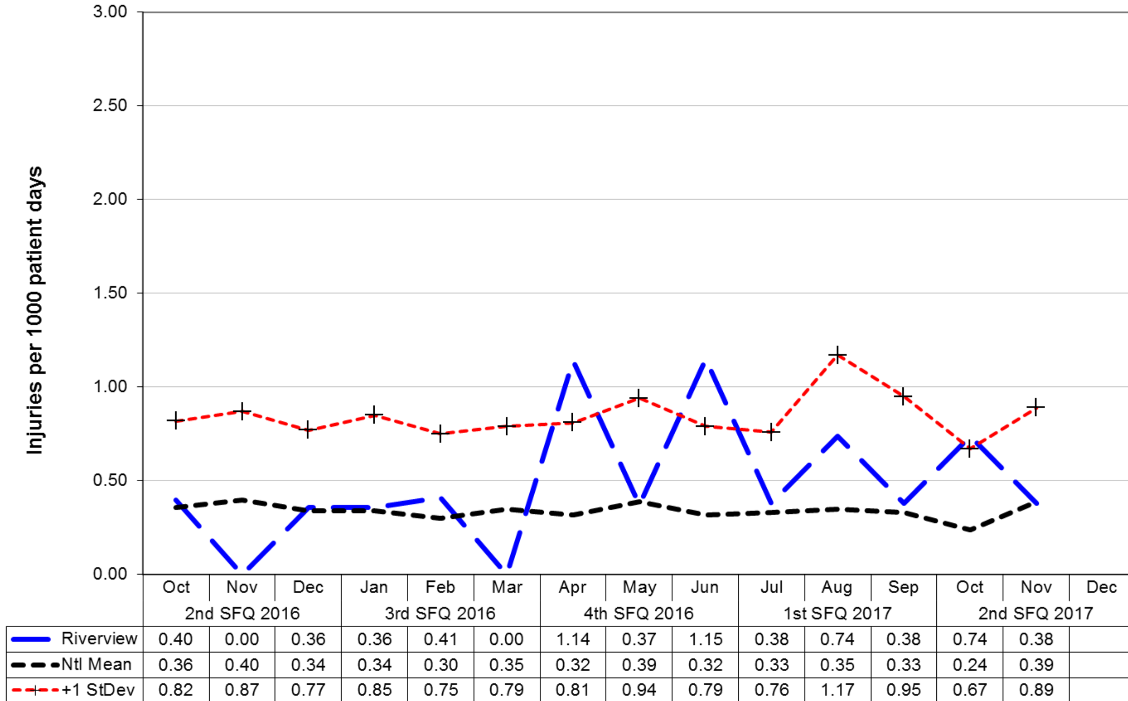
“Non-reportable” injuries include those that require: 1) No Treatment, or 2) Minor First Aid

Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

- No Treatment – The injury received by a patient may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid – The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed – The injury received is severe enough to require the treatment of the patient by a licensed practitioner, but does not require hospitalization.
- Hospitalization Required – The injury is so severe that it requires medical intervention and treatment as well as care of the injured patient at a general acute care medical ward within the facility or at a general acute care hospital outside the facility.
- Death Occurred – The injury received was so severe that if resulted in, or complications of the injury lead to, the termination of the life of the injured patient.

The comparative statistics graph only includes those events that are considered “Reportable” by NASMHPD.

CONSENT DECREE

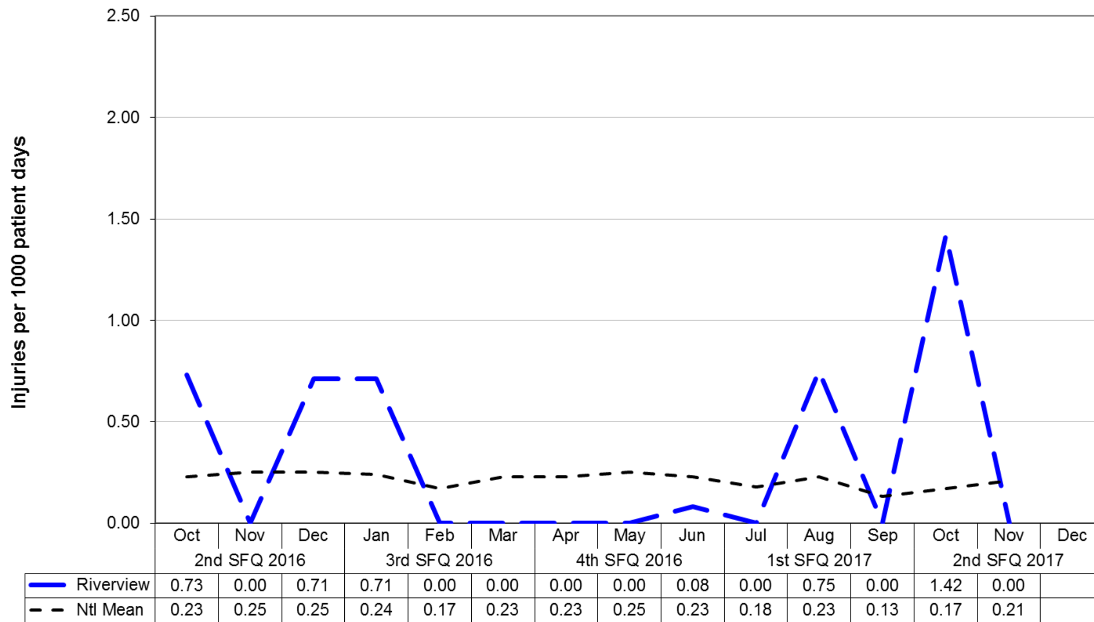


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.40	0.00	0.36	0.36	0.41	0.00	1.14	0.37	1.15	0.38	0.74	0.38	0.74	0.38	
Ntl Mean	0.36	0.40	0.34	0.34	0.30	0.35	0.32	0.39	0.32	0.33	0.35	0.33	0.24	0.39	
+1 StDev	0.82	0.87	0.77	0.85	0.75	0.79	0.81	0.94	0.79	0.76	1.17	0.95	0.67	0.89	

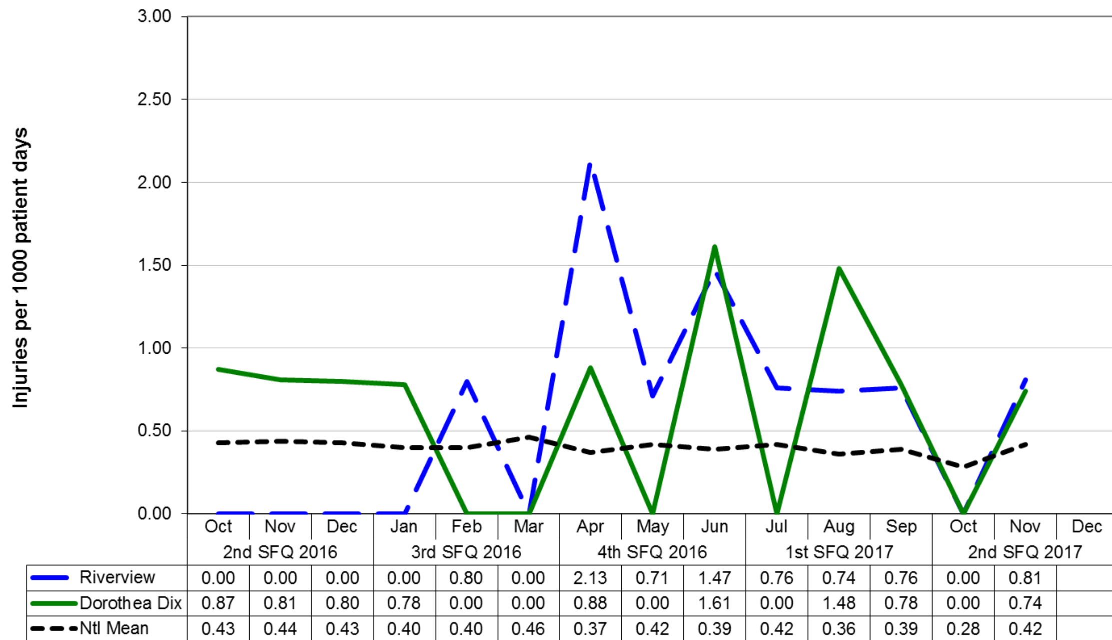
This graph depicts the number of patient injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

The following graphs depict the number of patient injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

CONSENT DECREE



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.73	0.00	0.71	0.71	0.00	0.00	0.00	0.00	0.08	0.00	0.75	0.00	1.42	0.00	
Ntl Mean	0.23	0.25	0.25	0.24	0.17	0.23	0.23	0.25	0.23	0.18	0.23	0.13	0.17	0.21	



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	0.00	0.00	0.00	0.00	0.80	0.00	2.13	0.71	1.47	0.76	0.74	0.76	0.00	0.81	
Dorothea Dix	0.87	0.81	0.80	0.78	0.00	0.00	0.88	0.00	1.61	0.00	1.48	0.78	0.00	0.74	
Ntl Mean	0.43	0.44	0.43	0.40	0.40	0.46	0.37	0.42	0.39	0.42	0.36	0.39	0.28	0.42	

CONSENT DECREE

Type and Cause of Injury by Month

Type - Cause	October	November	December	2Q2017
Accident	1	4	1	**6**
Assault (Patient to Patient)	1	3	2	**6**
Fall	2	1	1	**4**
Injury – Other				
Self-Injurious Behavior	6	2	2	**10**
Total	**10**	**10**	**6**	**26**

Severity of Injury by Month

Severity	October	November	December	2Q2017
No Treatment	6	1	1	**8**
Minor First Aid	2	9	4	**15**
Medical Intervention Required	2		1	**3**
Hospitalization Required				
Death Occurred				
Total	**10**	**10**	**6**	**26**

Due to changes in reporting standards related to "criminal" events as defined by the "State of Maine Rules for Reporting Sentinel Events", effective February 1, 2013, as defined the by "National Quality Forum 2011 List of Serious Reportable Events," the number of reportable "assaults" that occur as the result of patient interactions increased significantly. This change is due primarily as a result of the methods and rules related to data collection and abstraction.

Further information on Fall Reduction Strategies can be found under The Joint Commission Priority Focus Areas section of this report.

CONSENT DECREE

Patient Abuse, Neglect, Exploitation, Injury or Death

V33) Riverview certifies that it is reporting and responding to instances of patient abuse, neglect, exploitation, injury or death consistent with the requirements of ¶ 192-201 of the Settlement Agreement.

Type of Allegation	3Q2016	4Q2016	1Q2017	2Q2017	Total
Abuse Verbal	8	6	13	3	**30**
Abuse Physical	13	15	11	9	**48**
Abuse Sexual	11	17	17	3	**48**
Neglect	1	2	2	1	**6**
Coercion/Exploitation	6	8	2	5	**21**
Total	**39**	**48**	**45**	**21**	**153**

Riverview utilizes several vehicles to communicate concerns or allegations related to abuse, neglect, or exploitation:

1. Staff members complete an incident report upon becoming aware of an incident or an allegation of any form of abuse, neglect, or exploitation.
2. Patients have the option to complete a grievance or communicate allegations of abuse, neglect, or exploitation during any interaction with staff at all levels, Peer Support personnel, or the Patient Advocate(s).
3. Any allegation of abuse, neglect, or exploitation is reported both internally and externally to appropriate stakeholders, including:
   - Superintendent and/or AOC
   - Adult Protective Services
   - Guardian
   - Patient Advocate
4. Allegations are reported to the Risk Manager through the incident reporting system and fact-finding or investigations occur at multiple levels. The purpose of this investigation is to evaluate the event to determine if the allegations can be substantiated or not and to refer the incident to the patient's treatment team, hospital administration, or outside entities.
5. When appropriate to the allegation and circumstances, investigations involving law enforcement, family members, or human resources may be conducted.
6. The Human Rights Committee, a group consisting of consumers, family members, providers, and interested community members, and the Medical Executive Committee receive a report on the incident of alleged abuse, neglect, and exploitation monthly.

CONSENT DECREE

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with The Joint Commission in October 2016. The Hospital and the Out Patient Services were both fully accredited until October 2019.

V35) Riverview maintains its hospital license;

Riverview maintains its licensing status as required through the Maine Department of Health and Human Services Division of Licensing and Regulatory Services. The hospital is licensed through October 31, 2017. Out Patient Services is licensed until November 2, 2018.

V36) The hospital seeks CMS certification;

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance in eight areas by August 27, 2013. Plans are being developed to apply for certification.

V37) Riverview conducts quarterly monitoring of performance indicators in key areas of hospital administration, in accordance with the Consent Decree Plan, the accreditation standards of The Joint Commission, and according to a QAPI plan reviewed and approved by the Advisory Board each biennium, and demonstrates through quarterly reports that management uses that data to improve institutional performance, prioritize resources and evaluate strategic operations.

Riverview complies with this element of substantial compliance as evidenced by the current Integrated Plan for Performance Excellence, the data and reports presented in this document, the work of the Integrated Performance Excellence Committee, and sub-groups of this committee that are engaged in a transition to an improvement orientated methodology that is supported by The Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence. The Advisory Board approved the Integrated Plan for Performance Excellence in November 2016.

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

In 1987, The Joint Commission announced its *Agenda for Change,* which outlined a series of major steps designed to modernize the accreditation process. A key component of the *Agenda for Change* was the eventual introduction of standardized core performance measures into the accreditation process. As the vision to integrate performance measurement into accreditation became more focused, the name ORYX® was chosen for the entire initiative. The ORYX initiative became operational in March of 1999, when performance measurement systems began transmitting data to The Joint Commission on behalf of accredited hospitals and long term care organizations. Since that time, home care and behavioral healthcare organizations have been included in the ORYX initiative.

The initial phase of the ORYX initiative provided healthcare organizations a great degree of flexibility, offering greater than 100 measurement systems capable of meeting an accredited organization's internal measurement goals and The Joint Commission's ORYX requirements. This flexibility, however, also presented certain challenges. The most significant challenge was the lack of standardization of measure specifications across systems. Although many ORYX measures appeared to be similar, valid comparisons could only be made between health care organizations using the same measures that were designed and collected based on standard specifications. The availability of over 8,000 disparate ORYX measures also limited the size of some comparison groups and hindered statistically valid data analyses. To address these challenges, standardized sets of valid, reliable, and evidence-based quality measures have been implemented by The Joint Commission for use within the ORYX initiative.

Hospital-Based Inpatient Psychiatric Services (HBIPS) Core Measure Set

Driven by an overwhelming request from the field, The Joint Commission was approached in late 2003 by the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI) to work together to identify and implement a set of core performance measures for hospital-based inpatient psychiatric services. Project activities were launched in March 2004. At this time, a diverse panel of stakeholders convened to discuss and recommend an overarching initial framework for the identification of HBIPS core performance measures. The Technical Advisory Panel (TAP) was established in March 2005 consisting of many prominent experts in the field.

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The first meeting of the TAP was held May 2005 and a framework and priorities for performance measures was established for an initial set of core measures. The framework consisted of seven domains:

- Assessment
- Treatment Planning and Implementation
- Hope and Empowerment
- Patient Driven Care
- Patient Safety
- Continuity and Transition of Care
- Outcomes

The current HBIPS standards reflected in this report are designed to reflect these core domains in the delivery of psychiatric care.

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Admissions Screening (HBIPS 1)

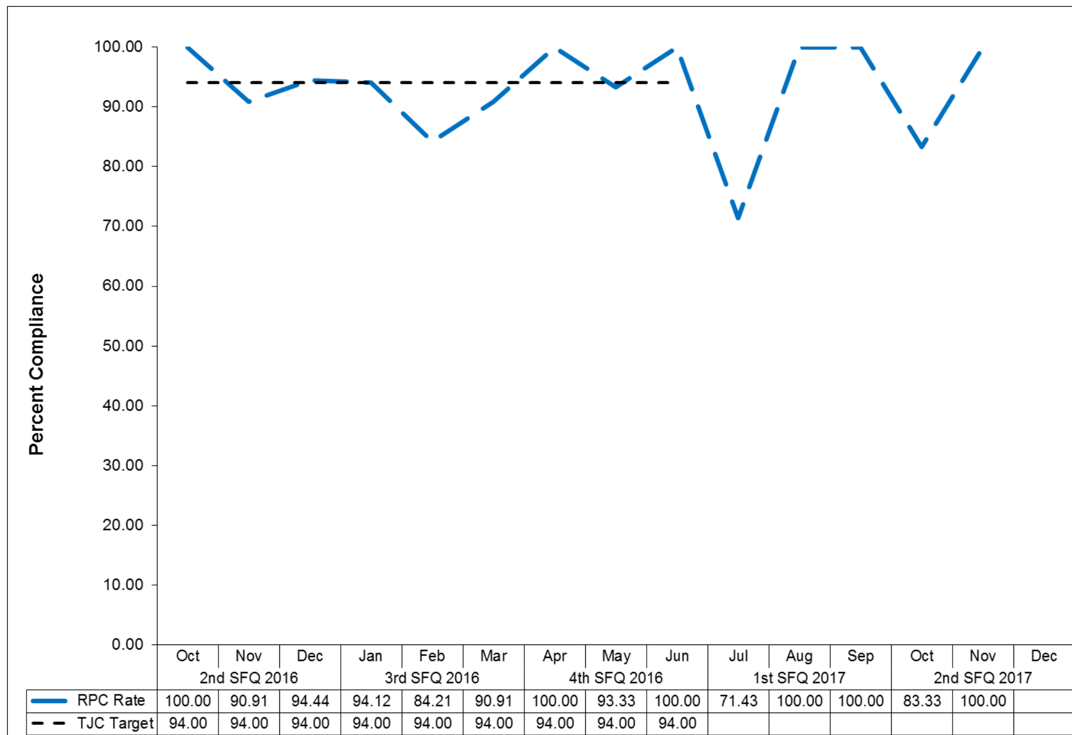
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

Patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of admission for all of the following: risk of violence to self or others, substance use, psychological trauma history, and patient strengths.

Rationale

Substantial evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004; NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients' strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals' community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.



	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
RPC Rate	100.00	90.91	94.44	94.12	84.21	90.91	100.00	93.33	100.00	71.43	100.00	100.00	83.33	100.00	
TJC Target	94.00	94.00	94.00	94.00	94.00	94.00	94.00	94.00	94.00						

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Physical Restraint (HBIPS 2)

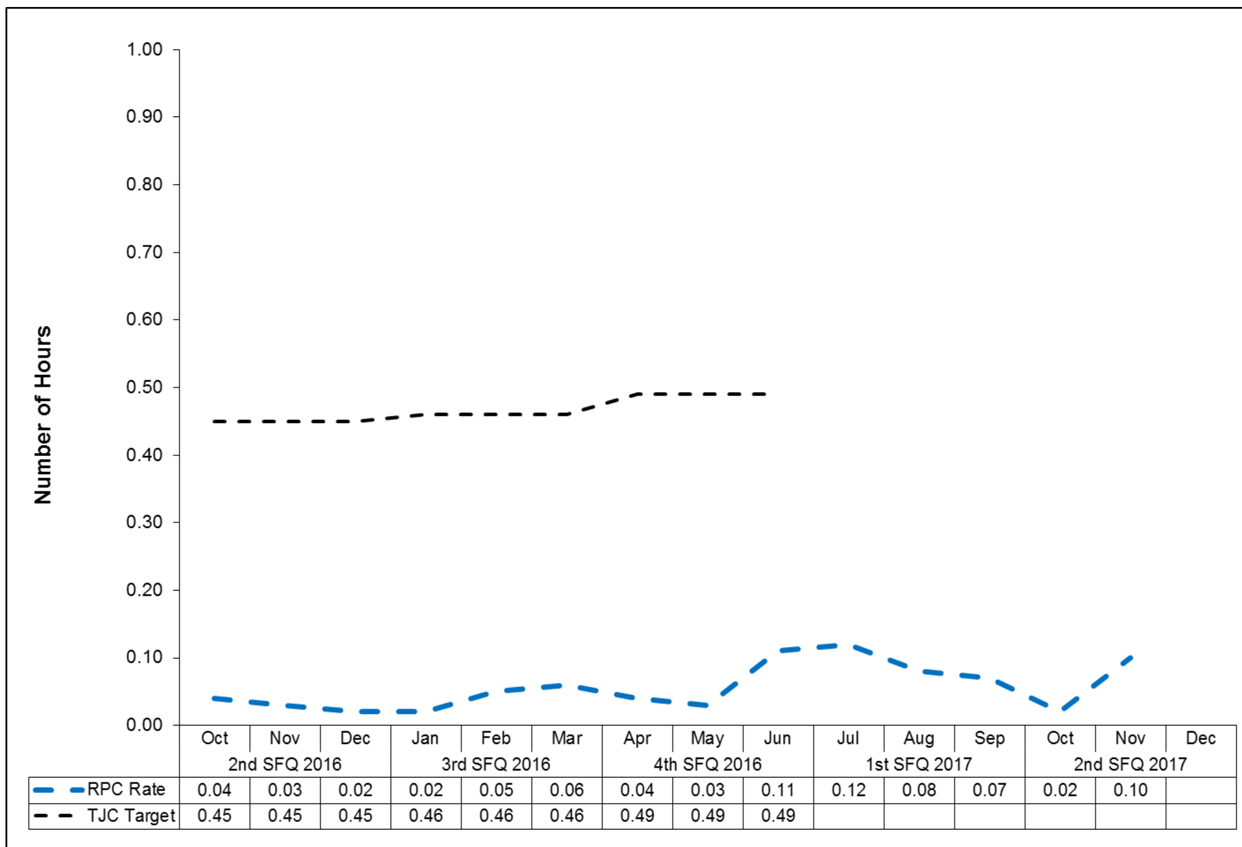
Hours of Use

Description

The total number of hours that all patients, admitted to a hospital-based inpatient psychiatric setting, were maintained in physical restraint.

Rationale

Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
RPC Rate	0.04	0.03	0.02	0.02	0.05	0.06	0.04	0.03	0.11	0.12	0.08	0.07	0.02	0.10	
TJC Target	0.45	0.45	0.45	0.46	0.46	0.46	0.49	0.49	0.49						

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Seclusion (HBIPS 3)

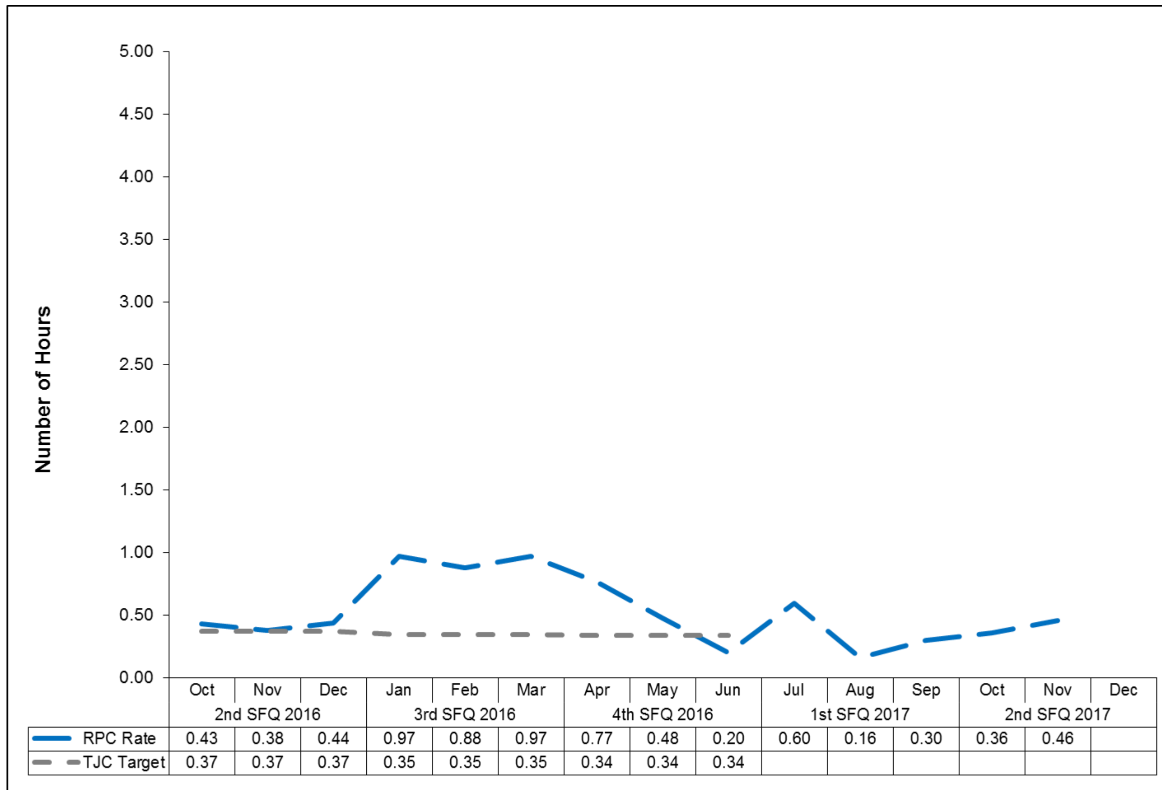
Hours of Use

Description

The total number of hours that all patients, admitted to a hospital-based inpatient psychiatric setting, were held in seclusion.

Rationale

Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
RPC Rate	0.43	0.38	0.44	0.97	0.88	0.97	0.77	0.48	0.20	0.60	0.16	0.30	0.36	0.46	
TJC Target	0.37	0.37	0.37	0.35	0.35	0.35	0.34	0.34	0.34						

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Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications.

Rationale

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in *treatment resistant* patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients *without* a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl & Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

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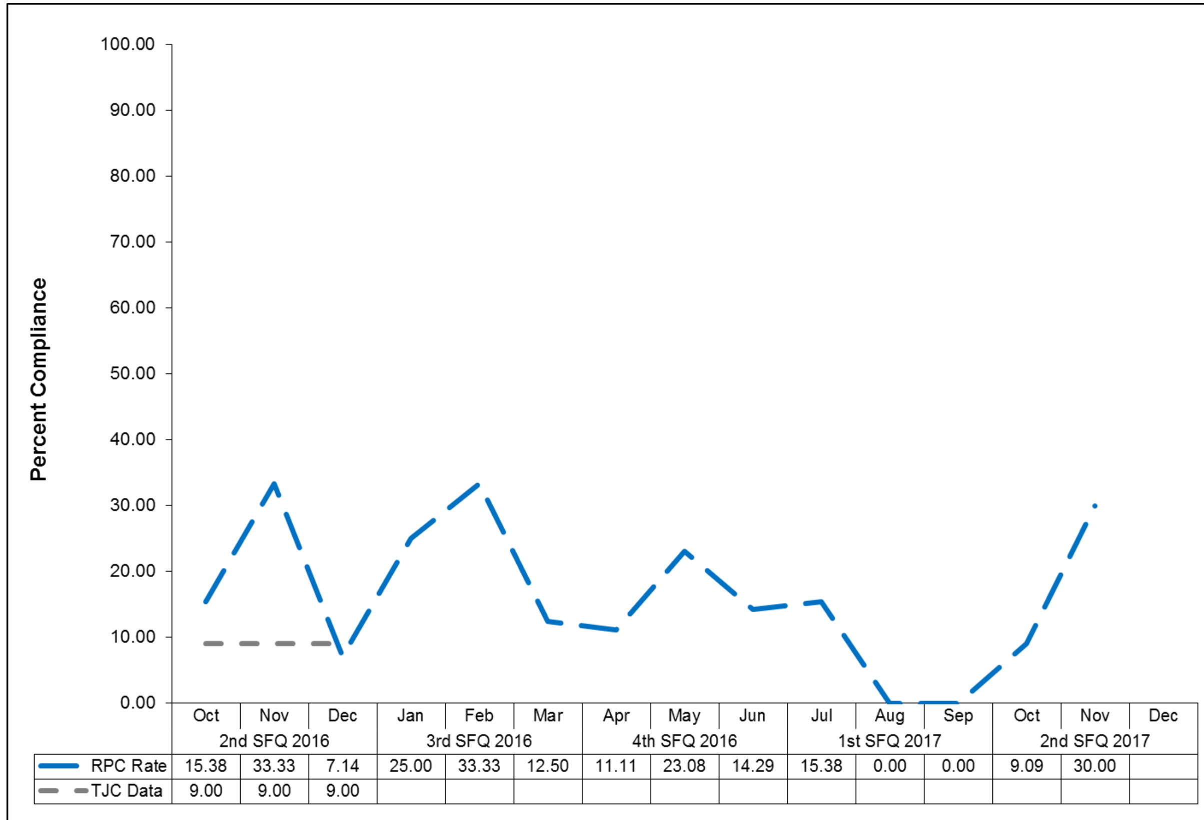
Multiple Antipsychotic Medications on Discharge (HBIPS 4)



Note: The Joint Commission discontinued this measure effective 6/30/2016.

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.

Rationale

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in *treatment resistant* patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients *without* a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

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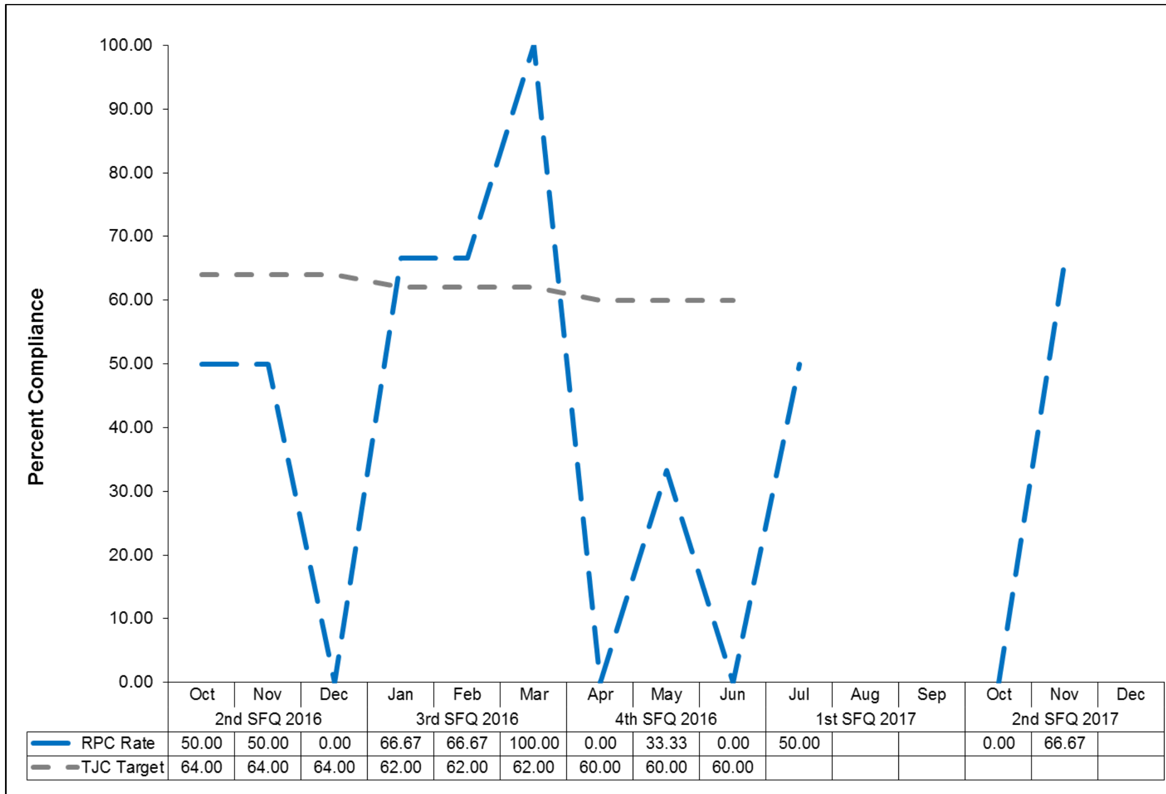
Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



Note: no patients were prescribed multiple antipsychotics in August or September 2016.

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Contract Performance Indicators

TJC LD.04.03.09 The same level of care should be delivered to patients regardless of whether services are provided directly by the hospital or through contractual agreement. Leaders provide oversight to make sure that care, treatment, and services provided directly are safe and effective. Likewise, leaders must also oversee contracted services to make sure that they are provided safely and effectively.

2Q2017 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Rodney Bouffard Superintendent	One indicator did not meet standard: Attendance by Peer Support Staff at Treatment Team Meetings. All other indicators met standards.
Community Dental, Region II	Dr. Joanna Gratton Clinical Director	All indicators met or exceeded standards.
Comprehensive Pharmacy Services	Dr. Joanna Gratton Clinical Director	All indicators met standards.
Comtec Security	Richard Levesque Director of Support Services	All indicators met standards.
Cummins Northeast	Richard Levesque Director of Support Services	All indicators met standards
Disability Rights Center	Rodney Bouffard Superintendent	All indicators met standards.
G & E Roofing	Richard Levesque Director of Support Services	All indicators exceeded standards.
Goodspeed & O'Donnell	Dr. Joanna Gratton Clinical Director	No services were provided during this timeframe.
Liberty Healthcare – After Hours Coverage	Dr. Joanna Gratton Clinical Director	All indicators exceeded standards.
Liberty Healthcare – Physician Staffing	Dr. Joanna Gratton Clinical Director	All indicators met or exceeded standards.
Main Security Surveillance	Richard Levesque Director of Support Services	All indicators met standards.
Maine General Community Care/HealthReach	Dr. Joanna Gratton Clinical Director	All indicators met standards.
Maine General Medical Center Laboratory Services	Dr. Joanna Gratton Clinical Director	All indicators met standards.

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Contractor	Program Administrator	Summary of Performance
MD-IT Transcription Service	Samantha Brockway Medical Records Administrator	All indicators met standards.
Mechanical Services	Richard Levesque Director of Support Services	All indicators met standards.
Medical Staffing and Services of Maine	Dr. Joanna Gratton Clinical Director	All indicators met standards.
Motivational Services	Dr. Joanna Gratton Clinical Director	All indicators met or exceeded standards.
Norris	Richard Levesque Director of Support Services	All indicators met standards.
Occupational Therapy Consultation and Rehabilitation Services	Janet Barrett Director of Rehabilitation	All indicators met or exceeded standards.
Otis Elevator	Richard Levesque Director of Support Services	All indicators exceeded standards.
Pine Tree Legal Assistance	Dr. Joanna Gratton Clinical Director	No services were provided during this timeframe.
Project Staffing	Cindy Michaud Business Services Manager	All indicators exceeded standards.
Protection One	Richard Levesque Director of Support Services	No services were provided during this timeframe.
Securitas Security Services	Philip Tricarico Safety Compliance Officer	All indicators met or exceeded standards.
UniFirst Corporation	Richard Levesque Director of Support Services	Two indicators did not meet standards: Timely linen pickup and delivery, and infection control measures taken at the provider’s facility. One indicator met standards.
Waste Management	Debora Proctor Executive Housekeeper	All indicators met standards.
Worldwide Travel Staffing	Renee Pfingst Director of Nursing	All indicators met standards.

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Adverse Reactions to Sedation or Anesthesia

TJC PI.01.01.01 EP6: The hospital collects data on the following: adverse events related to using moderate or deep sedation or anesthesia. (See also LD.04.04.01, EP 2)

Capital Community Clinic - Dental Clinic

Dental Clinic Timeout/Identification of Patient

Indicators	3Q2016	4Q2016	1Q2017	2Q2017	YTD
National Patent Safety Goals Goal 1: Improve the accuracy of Patient Identification. Capital Community Dental Clinic assures accurate patient identification by: asking the patient to state his/her name and date of birth. A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the Dental Assistant.	Jan 100% 5/5	Apr N/A	July N/A	Oct 100% 4/4	**100% 20/20**
	Feb 100% 3/3	May N/A	Aug N/A	Nov N/A	
	Mar N/A	June N/A	Sept 100% 7/7	Dec 100% 1/1	
	Total 100% 8/8	**Total N/A**	**Total 100% 7/7**	**Total 100% 5/5**	

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Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	3Q2016	4Q2016	1Q2017	2Q2017	YTD
1. All patients with tooth extractions will be assessed and have teaching post procedure on the following topics, as provided by the Dentist or Dental Assistant: • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The patient, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. Post dental extraction patients will receive a follow-up phone call from the clinic within 24 hours of procedure to assess for post procedure complications	Jan 100% 5/5	Apr N/A	July N/A	Oct 100% 4/4	**100%** **20/20**
	Feb 100% 3/3	May N/A	Aug N/A	Nov N/A	
	Mar N/A	June N/A	Sept 100% 7/7	Dec 100% 1/1	
	Total **100%** **8/8**	**Total** **N/A**	**Total** **100%** **7/7**	**Total** **100%** **5/5**	

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Healthcare Acquired Infections Monitoring and Management

NPSG.07.03.01 Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.

Infection Control

Responsible Party: Rebecca Eastman, Infection Control RN

I. Measure Name: Hospital Associated Infection (HAI) Rate

Measure Description: Monitor and Measure of Hospital Associated Infections

Measure Type: Quality Assurance

Results							
Target	**Unit**	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Within 1 STDV of the Mean	Hospital Associated Infection Rate	FY 2016 1 STDV within the mean	16 HAI/IC Rate 2.65	19 HAI/IC Rate 3.78			HAI/IC 3.12
Actual Outcome			>1 STDV within the mean	>1 STDV within the mean			1 STDV within the mean

A Hospital Acquired Infection (HAI) is any infection present, incubating or exposed to more than 72 hours after admission (unless the patient is off hospital grounds during that time) or declared by a physician, a physician's assistant or advanced practice nurse to be a HAI.

A Present on Admission (POA) infection is any infection present, incubating or exposed to prior to admission; while on pass; during off-site medical, dental, or surgical care; by a visitor, any prophylaxis treatment of a condition or treatment of a condition for which the patient has a history of chronic infection no matter how long the patient has been hospitalized; or declared by the physician, physician's assistant, or advanced practice nurse to be a community acquired infection.

An Idiosyncratic Infection is any infection that occurs after admission and is the result of the patient's action toward himself or herself.

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Infections:

Lower Kennebec:
Dental Abscess (HAI)
Hidradenitis Suppurativa (HAI)

Lower Saco:
Conjunctivitis (HAI)
Dental Abscess (HAI)
Dental Abscess (HAI)
Infected Right Leg (HAI)
Human Bite Prophylaxis (POA)

Upper Saco:
Monilial Vaginitis (HAI)
Cellulitis of Ear Canal (HAI)
Otitis Media and Externa (HAI)
Paronychia of Toes (HAI)
Cellulitis/Folliculitis (HAI)
Strep Throat (HAI)
Pneumonia (HAI)
Blepharitis (HAI)

Upper Kennebec:
Dental Pain (HAI)
Urinary Tract Infection (POA)
Otitis Externa (HAI)
Wound Cellulitis (POA)
Cellulitis of Right Foot (HAI)
Pneumonia (POA)
Pharyngitis with Fever (HAI)
Urinary Tract Infection (HAI)

Data Analysis:
Total Infections: 23
HAI: 19
POA: 4
Idiosyncratic Infections: 0

Plan: Ongoing surveillance

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

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II. Measure Name: Employee Hand Hygiene Rate

Measure Description:

- Staff will observe the hand hygiene practice of nurses as they pass medications. (10 observations per month)
- Staff will do ten (10) hand hygiene observations per month (before & after patient contact) in the milieu on the **7AM-7PM shift.**
- Staff will do ten (10) hand hygiene observations per month (before & after patient contact) in the milieu on the **7PM-7AM shift**

Measure Type: Performance Improvement

<table>
<tr><th colspan="8">Results</th></tr>
<tr><th></th><th>Unit</th><th>Baseline</th><th>1Q2017</th><th>2Q2017</th><th>3Q2016</th><th>4Q2017</th><th>YTD</th></tr>
<tr><td>Target</td><td rowspan="2">Employee Hand Hygiene Compliance</td><td rowspan="2">69%
FY 2016</td><td>>90%</td><td>>90%</td><td>>90%</td><td>>90%</td><td>>90%</td></tr>
<tr><td>Actual</td><td>99%</td><td>96%</td><td></td><td></td><td>98%</td></tr>
</table>

Data:

Upper Saco Meds – 100%
Upper Saco Milieu 7AM-7PM – 100%
Upper Saco Milieu 7PM-7AM – 100%

Upper Kennebec Meds –100%
Upper Kennebec Milieu 7AM-7PM – 100%
Upper Kennebec Milieu 7PM-7AM – 100%

Lower Kennebec Meds – 83%
Lower Kennebec Milieu 7AM-7PM – 100%
Lower Kennebec Milieu 7PM-7AM – 100%

Lower Saco Meds – 100%
Lower Saco Milieu 7AM-7PM –100%
Lower Saco Milieu 7PM-7AM – 100%

Plan: Continue to monitor and measure.

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III. Measure Name: Assisting Patients with Daily Hygiene

Measure Description: Staff offer hand gel to patients prior to breakfast, lunch, and dinner, ten (10) days per month.

Measure Type: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Employee Hand Hygiene Compliance	88% FY 2016	>90%	>90%	>90%	>90%	**>90%**
Actual			98%	94%			**96%**

Data:
The mean compliance rate for October 2016 is 99%.
The mean compliance rate for November 2016 is 82%.
The mean compliance rate for December 2016 is 100%.

Plan: Continue to monitor and measure.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

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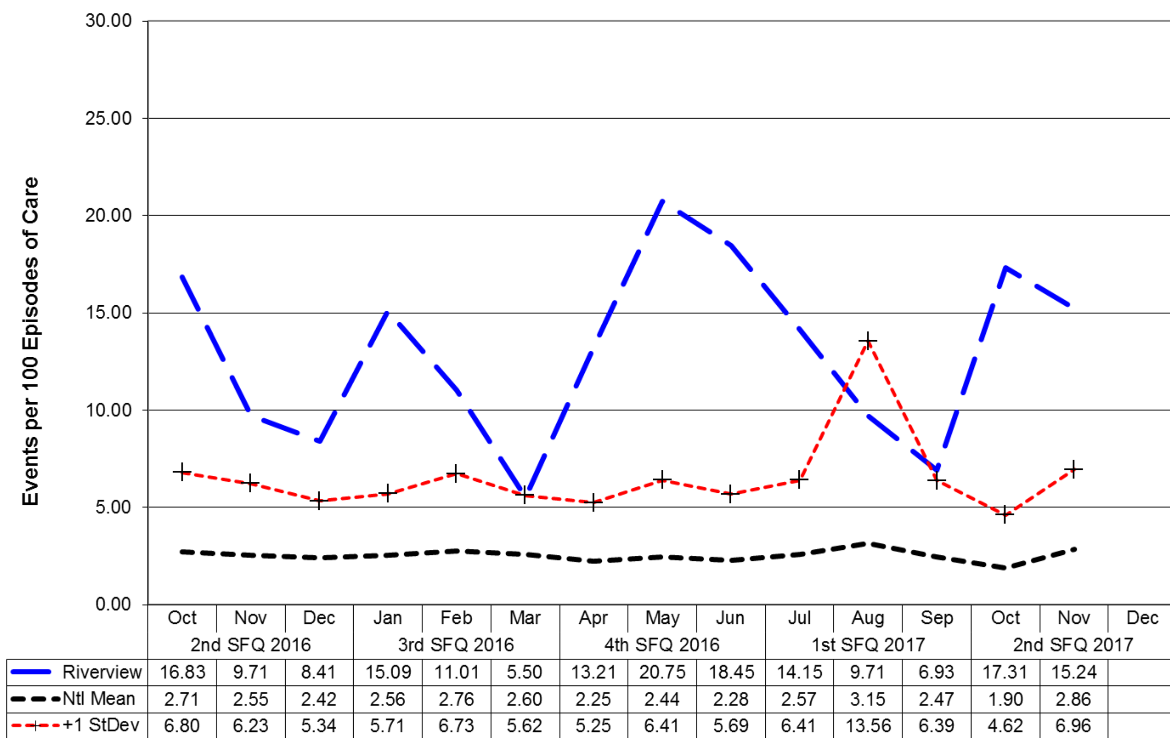
Medication Errors and Adverse Reactions

TJC PI.01.01.01 EP14: The hospital collects data on the following: Significant medication errors. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)

TJC PI.01.01.01 EP15: The hospital collects data on the following: Significant adverse drug reactions. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	16.83	9.71	8.41	15.09	11.01	5.50	13.21	20.75	18.45	14.15	9.71	6.93	17.31	15.24	
Ntl Mean	2.71	2.55	2.42	2.56	2.76	2.60	2.25	2.44	2.28	2.57	3.15	2.47	1.90	2.86	
+1 StDev	6.80	6.23	5.34	5.71	6.73	5.62	5.25	6.41	5.69	6.41	13.56	6.39	4.62	6.96	

This graph depicts the number of medication error events that occurred for every 100 episodes of care (duplicated patient count). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

The following graphs depict the number of medication error events that occurred for every 100 episodes of care (duplicated patient count) stratified by forensic or civil classifications. For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care. The hospital-wide results from Dorothea Dix are compared to the civil population results at Riverview due to the homogeneous nature of these two sample groups.

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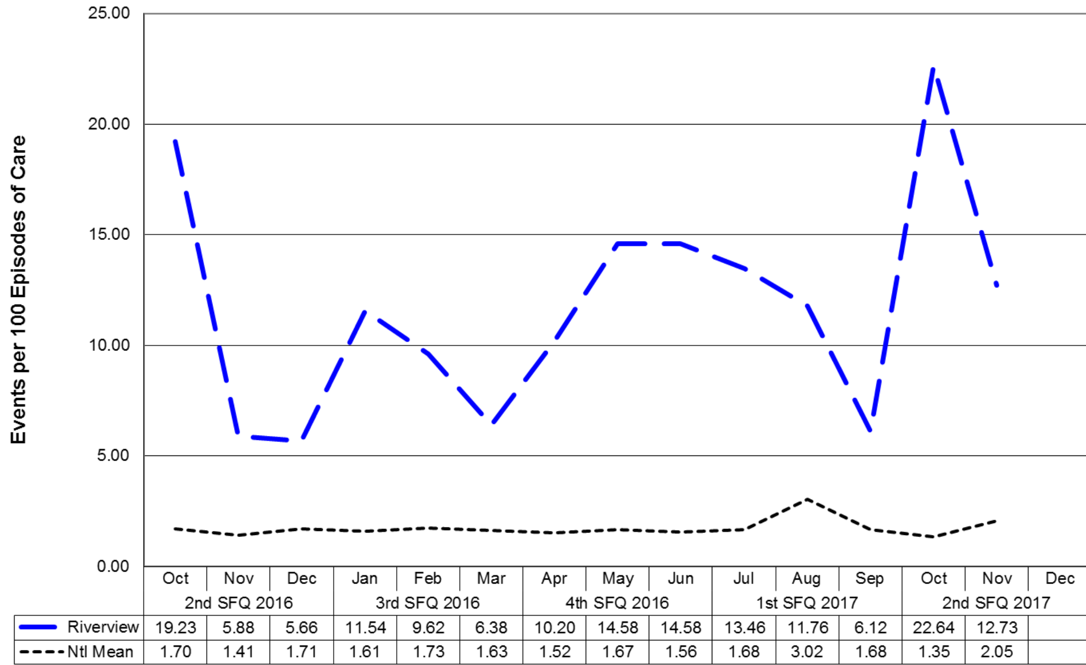
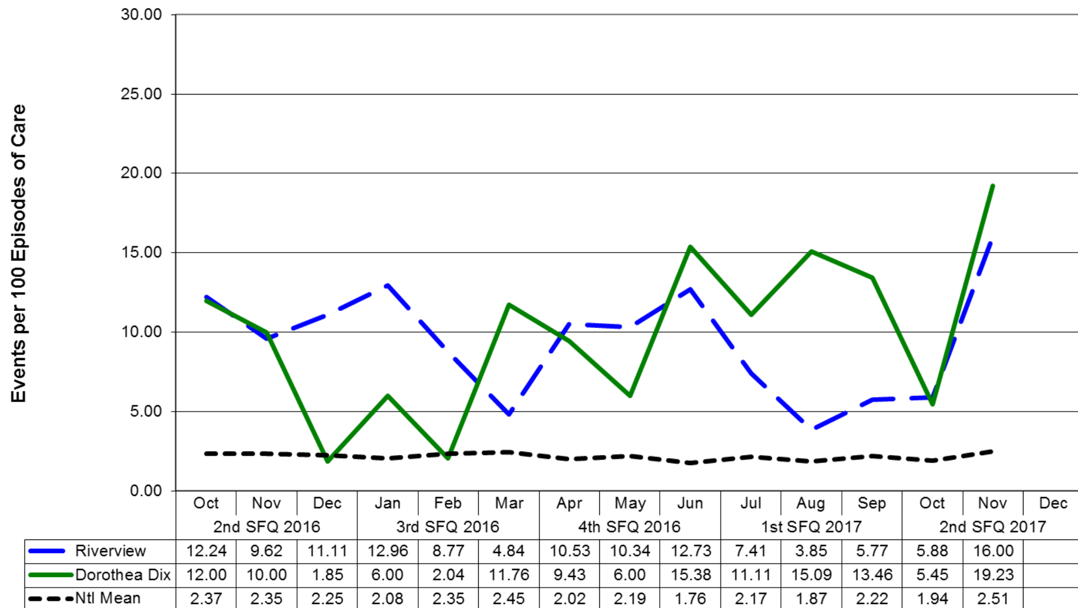


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	19.23	5.88	5.66	11.54	9.62	6.38	10.20	14.58	14.58	13.46	11.76	6.12	22.64	12.73	
Ntl Mean	1.70	1.41	1.71	1.61	1.73	1.63	1.52	1.67	1.56	1.68	3.02	1.68	1.35	2.05	



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	12.24	9.62	11.11	12.96	8.77	4.84	10.53	10.34	12.73	7.41	3.85	5.77	5.88	16.00	
Dorothea Dix	12.00	10.00	1.85	6.00	2.04	11.76	9.43	6.00	15.38	11.11	15.09	13.46	5.45	19.23	
Ntl Mean	2.37	2.35	2.25	2.08	2.35	2.45	2.02	2.19	1.76	2.17	1.87	2.22	1.94	2.51	

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Medication Variances

Medication variances are classified according to four major areas related to the area of service delivery. The error must have resulted in some form of variance in the desired treatment or outcome of care. A variance in treatment may involve one incident but multiple medications; each medication variance is counted separately irrespective of whether it involves one error event or many. Medication error classifications include:

Prescribing: An error of prescribing occurs when there is an incorrect selection of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber. Errors may occur due to improper evaluation of indications, contraindications, known allergies, existing drug therapy and other factors. Illegible prescriptions or medication orders that lead to patient level errors are also defined as errors of prescribing in identifying and ordering the appropriate medication to be used in the care of the patient.

Dispensing: An error of dispensing occurs when the incorrect drug, drug dose or concentration, dosage form, or quantity is formulated and delivered for use to the point of intended use.

Administration: An error of administration occurs when there is an incorrect selection and administration of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber.

Complex: An error which resulted from two or more distinct errors of different types is classified as a complex error.

Review, Reporting and Follow-up Process:
The Medication Variances Process Review Team (PRT) meets weekly to evaluate the causation factors related to the medication variances reported on the units and in the pharmacy and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and patient care practices. The team consists of the Clinical Director (or designee), the Director of Nursing (or designee), the Director of Pharmacy (or designee), and the Clinical Risk Manager or the Performance Improvement Manager.

The activities and recommendations of the Medication Variances PRT are reported monthly to the Integrated Performance Excellence Committee.

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Administration Process

Medication Errors Related to Staffing Effectiveness

Date	Omit	Type of Error	Float	New	O/T	Unit	Staff Mix		
							RN	LPN	MHW
10/4/2016	Y	OMISSION X28	NA	NA	NA	LS	4	1	6
10/4/2016	Y	OMISSION X2	N	N	N	LS	2	1	4
10/7/2016	Y	OMISSION X2	N	N	N	US	3	1	4
10/8/2016	Y	OMISSON X1	N	N	N	US	2	0	4
10/9/2016	N	WRONG TIME X1				LS	2	0	4
10/14/2016	Y	OMISSION X1	Y	N	N	LK	3	1	7
10/17/2016	Y	OMISSION X1	Y	N	N	LS	2	1	6
10/17/2016	Y	OMISSION X1	Y	N	N	LS	3	1	6
10/21/2016	Y	OMISSTION X1	N	N	N	LS	3	0	6
10/24/2016	N	WRONG DOSE X1	N	N	N	US	2	1	4
10/26/2016	Y	OMISSION X1	Y	Y	N	LS	2	1	7
10/26/2016	N	EXTRA DOSE X1	N	Y	N	US	2	0	4
10/27/2016	N	WRONG TIME X1	N	N	N	UK	1	0	3
10/27/2016	N	EXTRA DOSE X1	Y	N	N	US	4	0	4
10/27/2016	Y	OMISSION X1	N	N	N	LS	4	0	6
10/30/2016	N	WRONG TIME X1	N	N	N	LK	3	1	7
11/2/2016	N	EXPIRED DRUG X23	Y	N	N	US	2	0	3
11/3/2016	Y	OMISSION X1	Y		N	US	2	0	3
11/3/2016	Y	OMISSION X1	N	N	N	UK	2	1	3
11/4/2016	Y	OMISSION X1	Y	N	N	LK	3	0	9
11/9/2016	Y	OMISSION X6	N	N	N	LS	3	1	11
11/9/2016	N	EXTRA DOSE X1	Y	N	N	LK	2	1	9
11/10/2016	Y	OMISSON X1	N	Y	N	LS	4	0	6
11/11/2016	N	WRONG SCHEDULE X1	N	N	N	UK	4	1	4
11/12/2016	N	WRONG MED X1	Y	N	N	US	2	0	4
11/14/2016	N	WRONG MED X1	N	N	N	LK	3	0	3
11/18/2016	N	WRONG DOSE X1	Y	N	N	UK	3	0	3
11/19/2016	Y	OMIT X1	Y	N	N	LK	2	0	6
11/19/2016	Y	OMIT X2	N	N	N	LS	3	0	7
11/23/2016	N	WRONG DOSE X1	N	N	N	LS	2	0	7
11/23/2016	N	WRONG TIME X1	N	N	N	US	2	1	5
11/24/2016	Y	OMIT X1	N	Y	N	LK	3	0	8
12/1/2016	N	WRONG TIME X2	Y	N	N	US	1	0	2
12/5/2016	Y	OMIT X3	N	N	N	US	2	1	5
12/5/2016	N	EXTRA DOSE X1	Y	N	N	LS	2	0	3
12/8/2016	N	WRONG TIME X1	N	N	N	UK	3	0	4
12/9/2016		OMIT X6				UK			

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

JOINT COMMISSION

12/15/2016	N	WRONG FORM				UK			
12/15/2016	N	WRONG TIME X1				LS			
12/16/2016	Y	OMIT X1	N	Y	N	UK	3	0	5
12/24/2016	N	WRONG TIME X1	Y	N	N	LK	2	0	4
Totals	**63**	**106**	**38**	**5**	**0**	**LS: 48**	**US: 37**	**LK: 8**	**UK: 13**
Percent	**59%**	**Total Errors**	**36%**	**5%**	**0%**	**45%**	**35%**	**8%**	**12%**

*Each dose of medication is documented as an individual variance (error)

Type of Error	# of Errors
Expired Drug	23
Extra Dose	4
Omission	63
Wrong Dose	3
Wrong Form	1
Wrong Med	2
Wrong Schedule	1
Wrong Time	9
Total	**106**

JOINT COMMISSION

Dispensing Process

Measure	Unit	Baseline 2016	Goal	1Q 2017	2Q 2017	3Q 2017	4Q 2017
1. Controlled Substance Loss Data: Daily Pyxis-CII Safe Compare Report.	All	0.19%	0% Target: Actual:	0% 0%	0% 0%		
2. Controlled Substance Loss Data: Monthly CII Safe Vendor Receipt Report.	Rx	0	0 Target: 0 Actual: 0	0 0	0 0		
3. Controlled Substance Loss Data: Monthly Pyxis Controlled Drug Discrepancies.	All	0/mo	Target: 0 Actual: 0	0 0 (0/mo)	0 0 (0/mo)		
4. Medication Management Monitoring: Measures of drug reactions, adverse drug events, and other management data.	Rx	10/year	Target: 0 Actual: 0	0 10	0 2		
5. Medication Management Monitoring: Resource Documentation Reports of Clinical Interventions.	Rx	136/ quarter	100% Target: Actual:	100% 167	100% 129		
6. Psychiatric Emergency Process: Monthly audit of all psych emergency measures against 8 criteria.	All	100%	100% Target: Actual:	100% 100%	100% 96%		
7. Operational Audit: Monthly audit of 3 operational indicators from CPS contract.	Rx	100%	100% Target: Actual:	100% 100%	100% TBD		

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Inpatient Consumer Survey

TJC PI.01.01.01 EP16: The hospital collects data on the following: Patient perception of the safety and quality of care, treatment, and services.

The **Inpatient Consumer Survey (ICS)** is a standardized national survey of customer satisfaction. The National Association of State Mental Health Program Directors Research Institute (NRI) collects data from state psychiatric hospitals throughout the country in an effort to compare the results of patient satisfaction in six areas or domains of focus. These domains include Outcomes, Dignity, Rights, Participation, Environment, and Empowerment.

Inpatient Consumer Survey (ICS) has been recently endorsed by NQF, under the Patient Outcomes Phase 3: Child Health and Mental Health Project, as an outcome measure to assess the results, and thereby improve care provided to people with mental illness. The endorsement supports the ICS as a scientifically sound and meaningful measure to help standardize performance measures and assures quality of care.

Rate of Response for the Inpatient Consumer Survey:

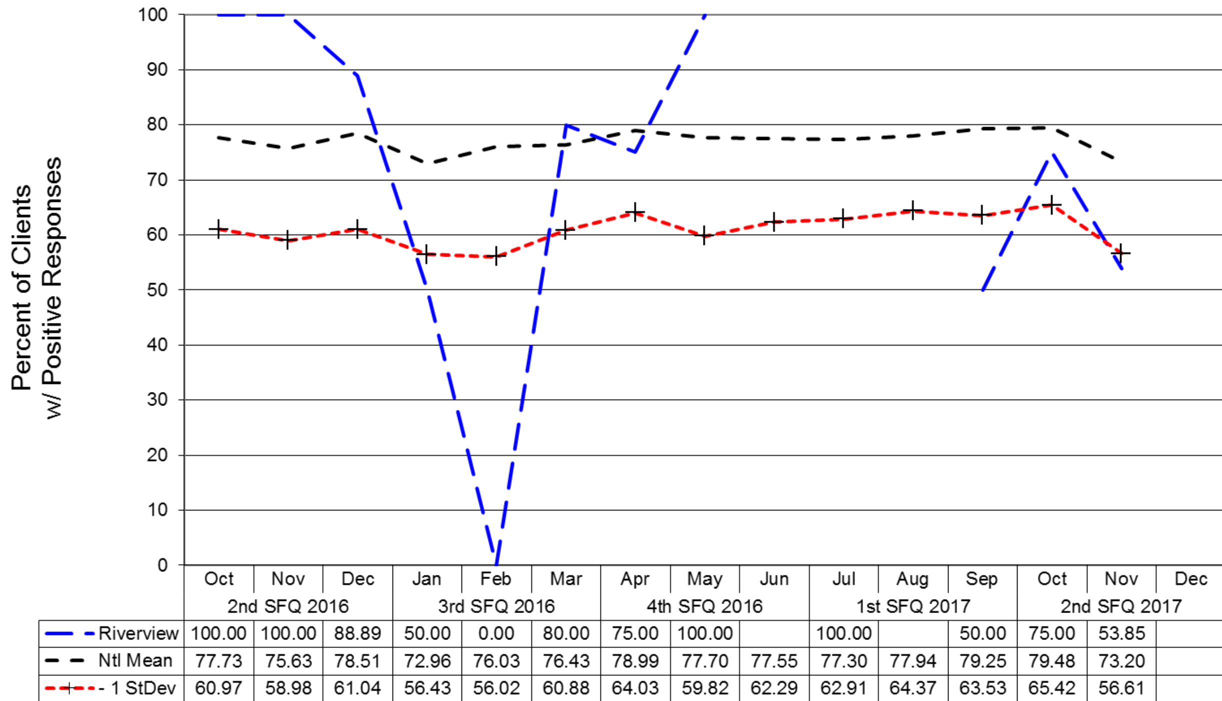
Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic patients, the process of administering the inpatient survey is difficult to administer. Whenever possible, Peer Support staff work to gather information from patients on their perception of the care provided to then while at Riverview Psychiatric Center.

The Peer Support group has identified a need to improve the overall response rate for the survey. This process improvement project is defined and described in the section on Patient Satisfaction Survey Return Rate of this report.

There is currently no aggregated date on a forensic stratification of responses to the survey.

Note: When the Riverview field is blank for a month it means that no patients responded to the survey questions on that page in that particular month.

JOINT COMMISSION



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	100.00	100.00	88.89	50.00	0.00	80.00	75.00	100.00		100.00		50.00	75.00	53.85	
Ntl Mean	77.73	75.63	78.51	72.96	76.03	76.43	78.99	77.70	77.55	77.30	77.94	79.25	79.48	73.20	
1 StDev	60.97	58.98	61.04	56.43	56.02	60.88	64.03	59.82	62.29	62.91	64.37	63.53	65.42	56.61	

Outcome Domain Questions:

1. I am better able to deal with crisis.
2. My symptoms are not bothering me as much.
3. I do better in social situations.
4. I deal more effectively with daily problems.

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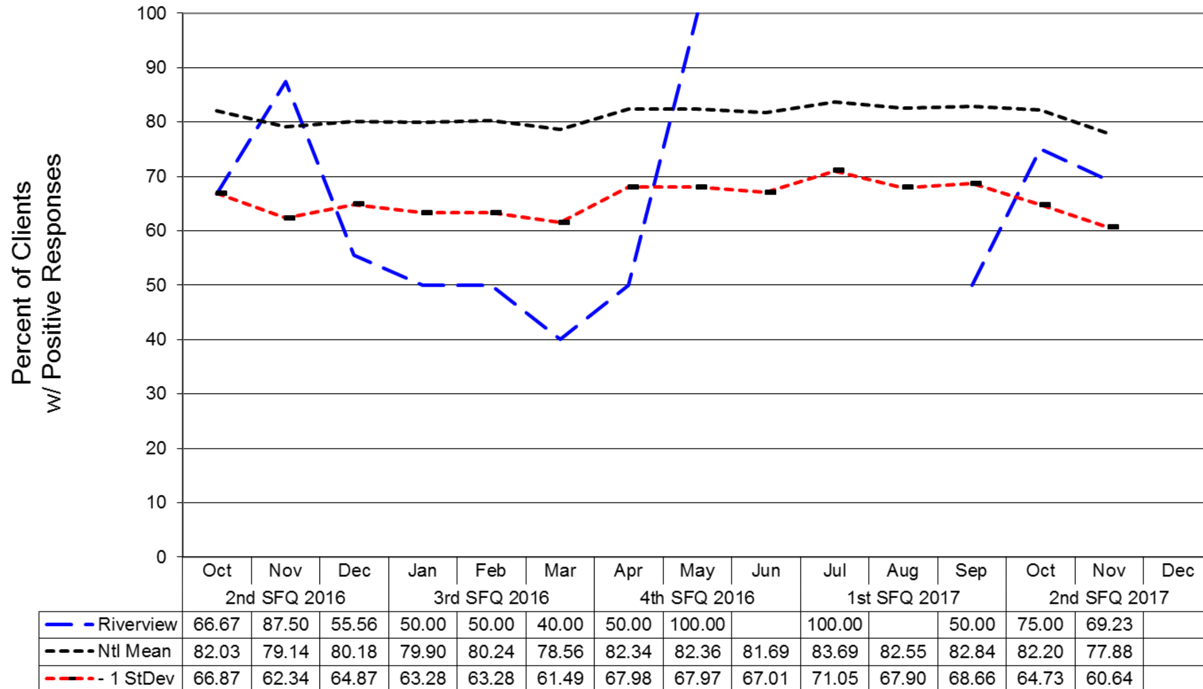

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	66.67	87.50	55.56	50.00	50.00	40.00	50.00	100.00		100.00		50.00	75.00	69.23	
Ntl Mean	82.03	79.14	80.18	79.90	80.24	78.56	82.34	82.36	81.69	83.69	82.55	82.84	82.20	77.88	
1 StDev	66.87	62.34	64.87	63.28	63.28	61.49	67.98	67.97	67.01	71.05	67.90	68.66	64.73	60.64	

Dignity Domain Questions:

1. I was treated with dignity and respect.
2. Staff here believed that I could grow, change and recover.
3. I felt comfortable asking questions about my treatment and medications.
4. I was encouraged to use self-help/support groups.

(Glossary of Terms, Acronyms & Abbreviations)

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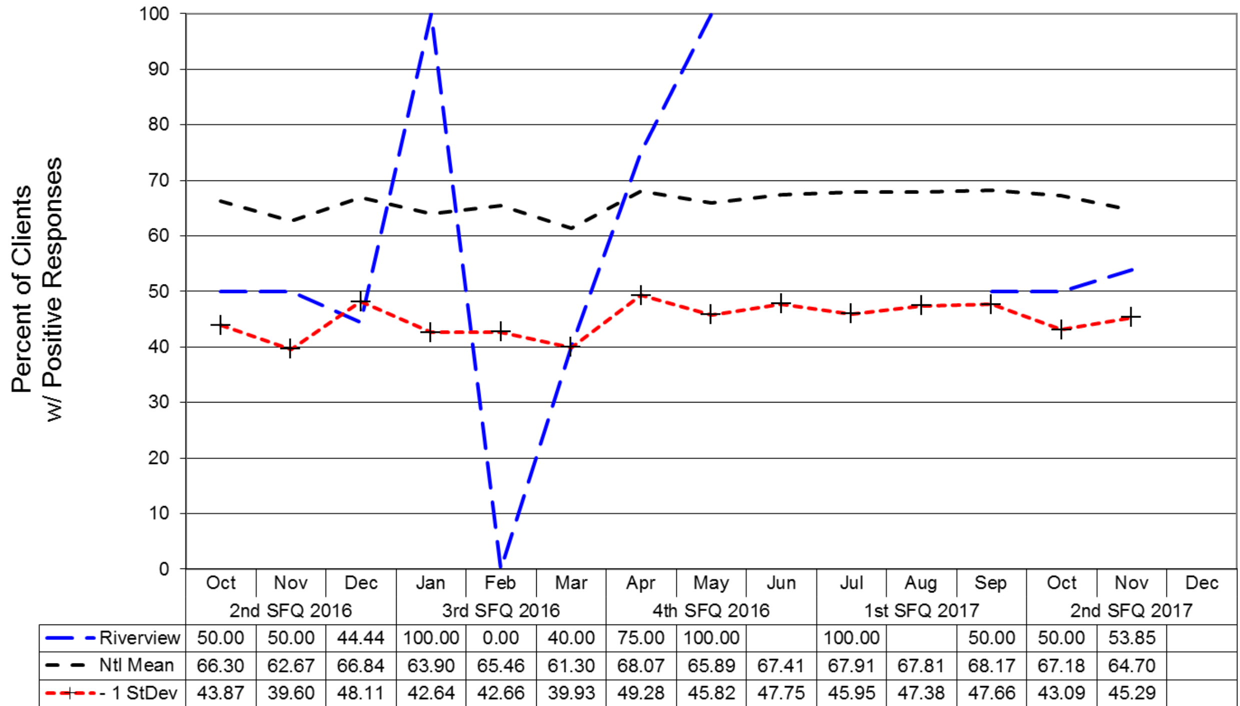
JOINT COMMISSION



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	50.00	50.00	44.44	100.00	0.00	40.00	75.00	100.00		100.00		50.00	50.00	53.85	
Ntl Mean	66.30	62.67	66.84	63.90	65.46	61.30	68.07	65.89	67.41	67.91	67.81	68.17	67.18	64.70	
1 StDev	43.87	39.60	48.11	42.64	42.66	39.93	49.28	45.82	47.75	45.95	47.38	47.66	43.09	45.29	

Rights Domain Questions:

1. I felt free to complain without fear of retaliation.
2. I felt safe to refuse medication or treatment during my hospital stay.
3. My complaints and grievances were addressed.

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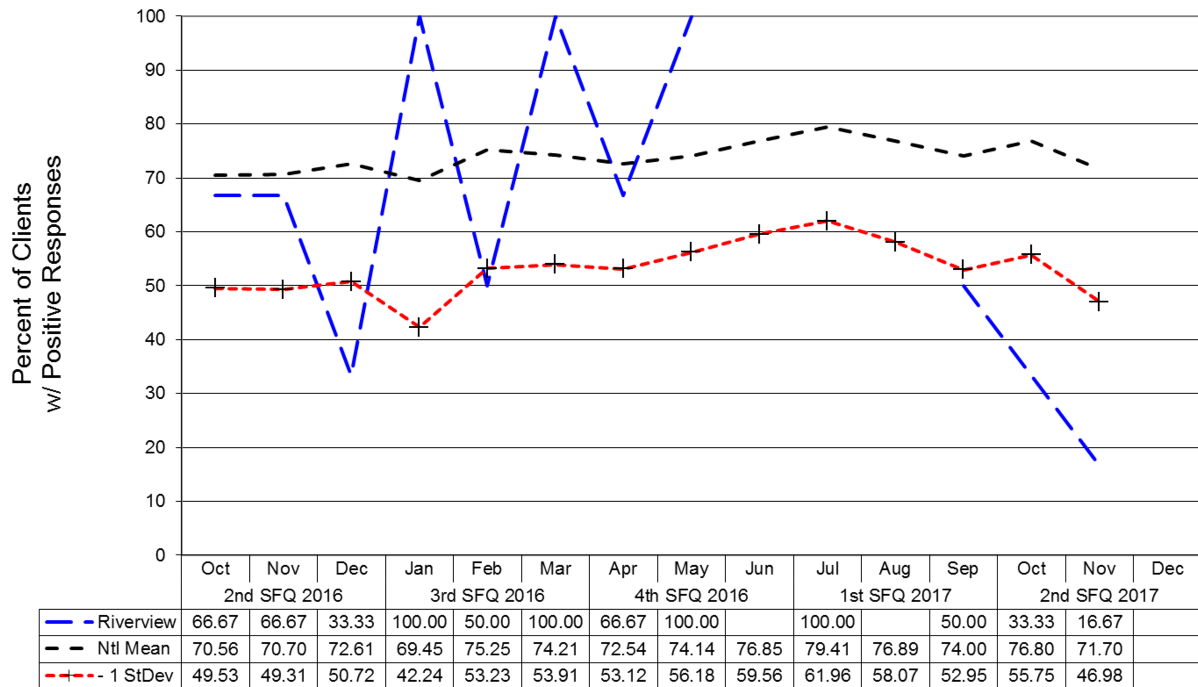
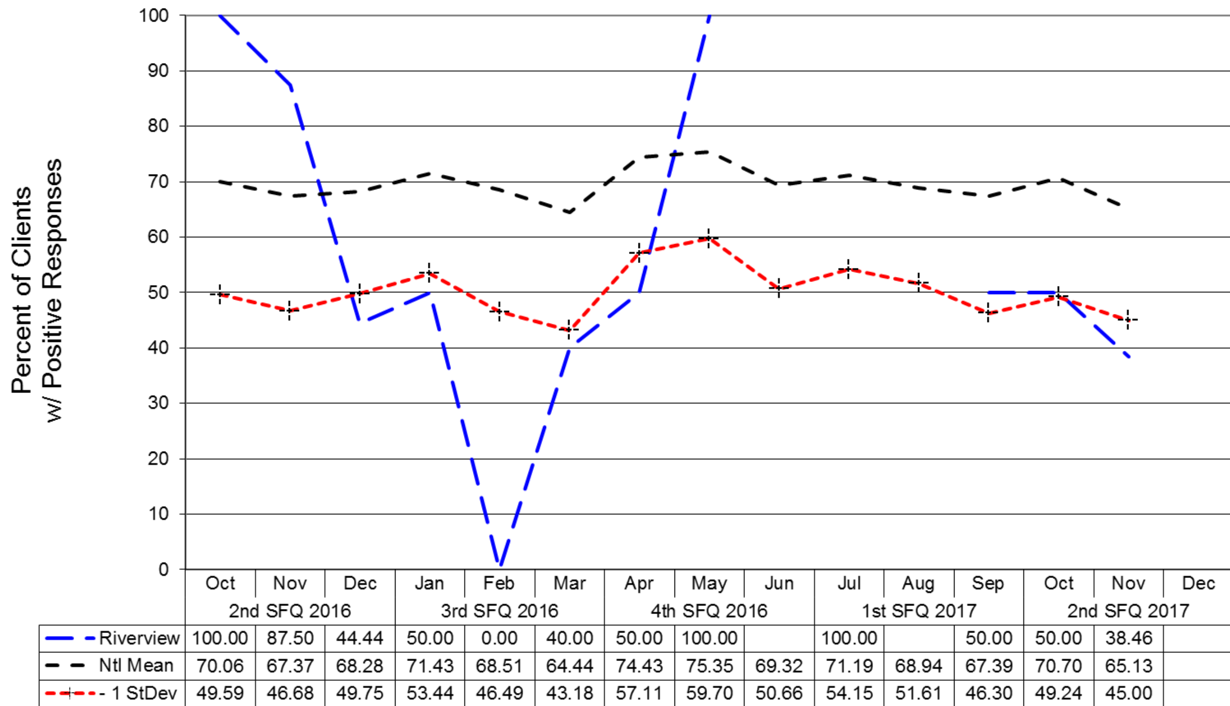


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	66.67	66.67	33.33	100.00	50.00	100.00	66.67	100.00		100.00		50.00	33.33	16.67	
Ntl Mean	70.56	70.70	72.61	69.45	75.25	74.21	72.54	74.14	76.85	79.41	76.89	74.00	76.80	71.70	
1 StDev	49.53	49.31	50.72	42.24	53.23	53.91	53.12	56.18	59.56	61.96	58.07	52.95	55.75	46.98	

Participation Domain Questions:

1. I participated in planning my discharge.
2. Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.
3. I had an opportunity to talk with my doctor or therapist from the community prior to discharge.

JOINT COMMISSION



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	100.00	87.50	44.44	50.00	0.00	40.00	50.00	100.00		100.00		50.00	50.00	38.46	
Ntl Mean	70.06	67.37	68.28	71.43	68.51	64.44	74.43	75.35	69.32	71.19	68.94	67.39	70.70	65.13	
1 StDev	49.59	46.68	49.75	53.44	46.49	43.18	57.11	59.70	50.66	54.15	51.61	46.30	49.24	45.00	

Environment Domain Questions:

1. The surroundings and atmosphere at the hospital helped me get better.
2. I felt I had enough privacy in the hospital.
3. I felt safe while I was in the hospital.
4. The hospital environment was clean and comfortable.

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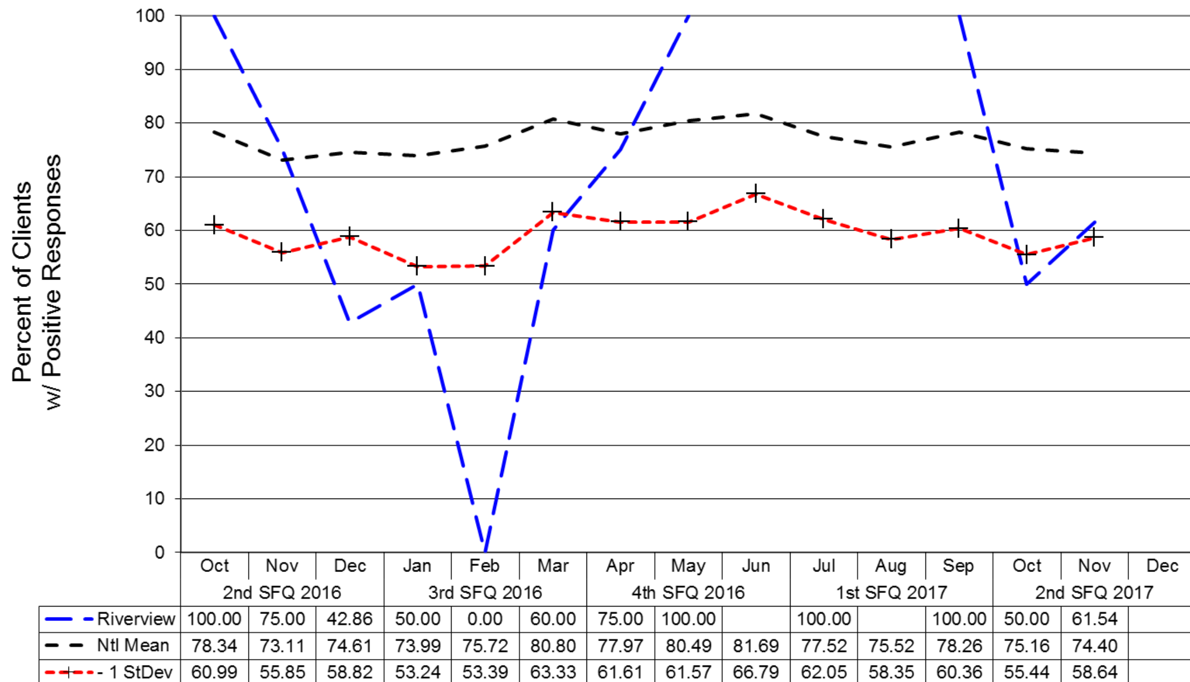


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017		
Riverview	100.00	75.00	42.86	50.00	0.00	60.00	75.00	100.00		100.00		100.00	50.00	61.54	
Ntl Mean	78.34	73.11	74.61	73.99	75.72	80.80	77.97	80.49	81.69	77.52	75.52	78.26	75.16	74.40	
1 StDev	60.99	55.85	58.82	53.24	53.39	63.33	61.61	61.57	66.79	62.05	58.35	60.36	55.44	58.64	

Empowerment Domain Questions:

1. I had a choice of treatment options.
2. My contact with my Doctor was helpful.
3. My contact with nurses and therapists was helpful.

JOINT COMMISSION

Fall Reduction Strategies

TJC PI.01.01.01 EP38: The hospital evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.

TJC PC.01.02.08: The hospital assesses and manages the patient's risks for falls.
EP01: The hospital assesses the patient's risk for falls based on the patient population and setting.
EP02: The hospital implements interventions to reduce falls based on the patient's assessed risk.

The Falls Risk Management Team has been created to be facilitated by a member of the team with data supplied by the Risk Manager. The role of this team is to conduct root cause analyses on each of the falls incidents and to identify trends and common contributing factors and to make recommendations for changes in the environment and process of care for those patients identified as having a high potential for falls. A * below indicates patient had both types of falls.

Type of Fall by Patient and Month

Fall Type	Patient	Oct	Nov	Dec	2Q2017
Un-Witnessed	MR7127		1		**1**
	MR5005	1			**1**
	MR7978		1		**1**
	MR7892*		1		**1**
	Totals	**1**	**3**	**0**	**4**
Fall Type	**Patient**	**Oct**	**Nov**	**Dec**	**2Q2017**
Witnessed	MR156	1			**1**
	MR2127	1	2	1	**4**
	MR5297		1		**1**
	MR7878	1			**1**
	MR7892*	1			**1**
	MR7959			1	**1**
	MR7980		1		**1**
	Totals	**4**	**4**	**2**	**10**

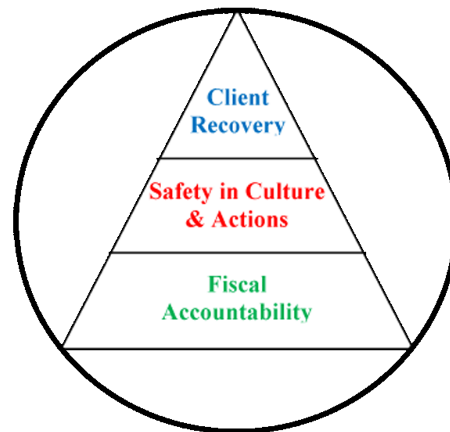
*Indicates that the patient had both un-witnessed and witnessed falls in the 2Q2017

STRATEGIC PERFORMANCE EXCELLENCE

Process Improvement Plans

Priority Focus Areas for Strategic Performance Excellence

In an effort to ensure that quality management methods used within the Maine Psychiatric Hospitals System are consistent with modern approaches of systems engineering, culture transformation, and process focused improvement strategies and in response to the evolution of Joint Commission methods to a more modern systems-based approach instead of compliance-based approach



Building a framework for patient recovery by ensuring fiscal accountability and a culture of organizational safety through the promotion of…

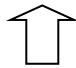
- The conviction that staff members are concerned with doing the right thing in support of patient rights and recovery;
- A philosophy that promotes an understanding that errors most often occur as a result of deficiencies in system design or deployment;
- Systems and processes that strive to evaluate and mitigate risks and identify the root cause of operational deficits or deficiencies without erroneously assigning blame to system stakeholders;
- The practice of engaging staff members and patients in the planning and implementing of organizational policy and protocol as a critical step in the development of a system that fulfills ethical and regulatory requirements while maintaining a practicable workflow;
- A cycle of improvement that aligns organizational performance objectives with key success factors determined by stakeholder defined strategic imperatives;
- Enhanced communications and collaborative relationships within and between cross-functional work teams to support organizational change and effective process improvement;
- Transitions of care practices where knowledge is freely shared to improve the safety of patients before, during, and after care;
- A just culture that supports the emotional and physical needs of staff members, patients, and family members that are impacted by serious, acute, and cumulative events.

STRATEGIC PERFORMANCE EXCELLENCE

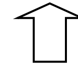
Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

Protect and enhance the health and well-being of Maine people
Promote independence and self sufficiency
Protect and care for those who are unable to care for themselves
Provide effective stewardship for the resources entrusted to the Department



Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas



Ensure and Promote Fiscal Accountability by…

Identifying and employing efficiency in operations and clinical practice
Promoting vigilance and accountability in fiscal decision-making.

Promote a Safety Culture by…

Improving Communication
Improving Staffing Capacity and Capability
Evaluating and Mitigating Errors and Risk Factors
Promoting Critical Thinking
Supporting the Engagement and Empowerment of Staff Members

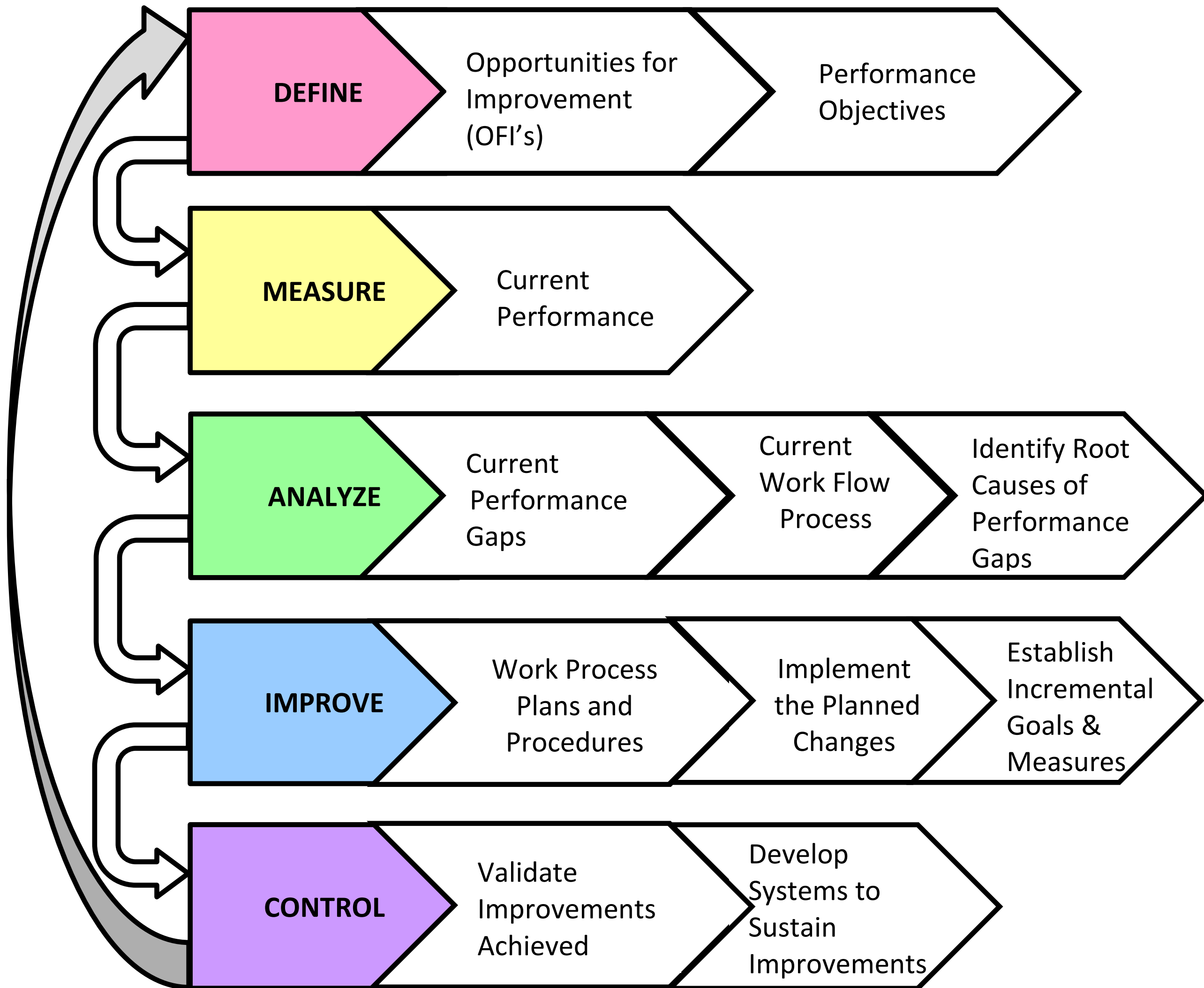
Enhance Patient Recovery by…

Develop Active Treatment Programs and Options for Patients
Supporting patients in their discovery of personal coping and improvement activities.

STRATEGIC PERFORMANCE EXCELLENCE

Each Department Determines Unique Opportunities and
Methods to Address the Hospital Goals

The Quarterly Report Consists of the Following:



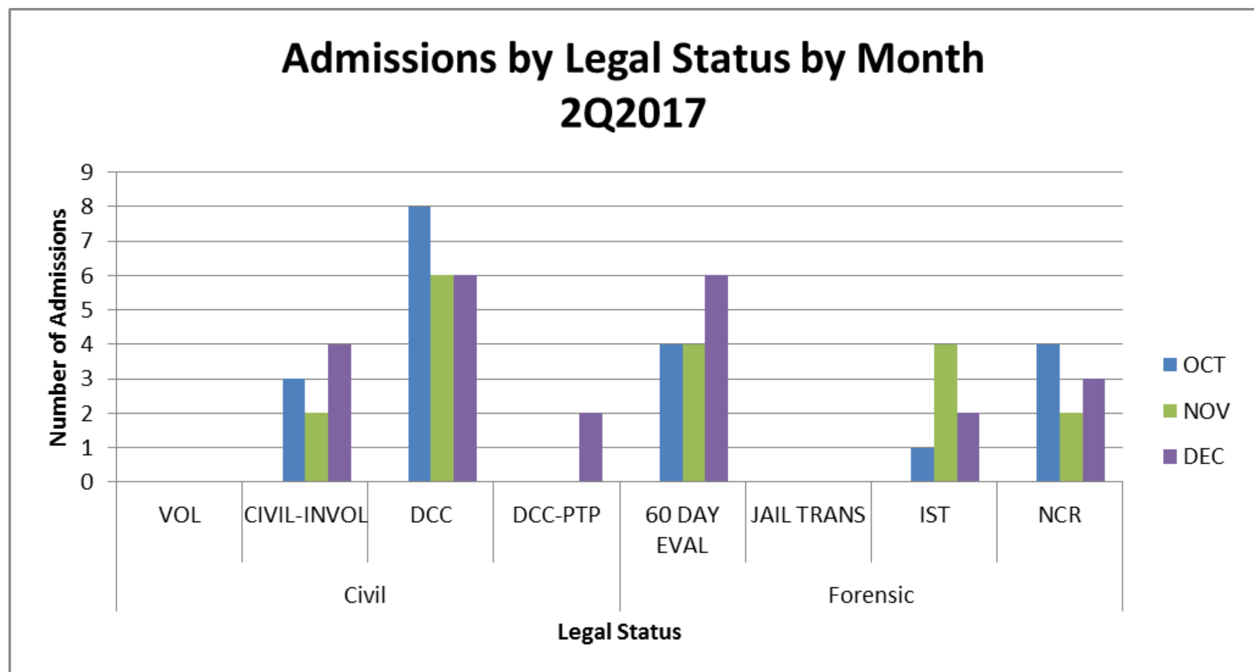
STRATEGIC PERFORMANCE EXCELLENCE

Admissions

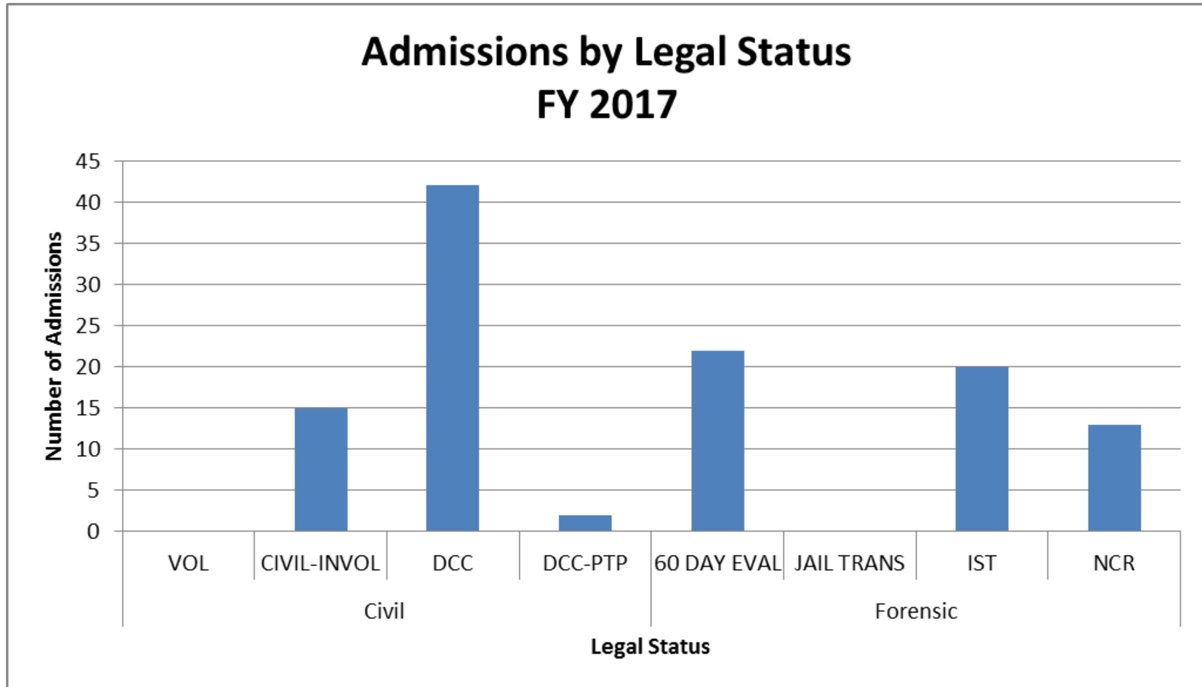
Responsible Party: Samantha Newman, RN, Admissions Nurse

Number of Admissions:

ADMISSIONS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**10**	**11**	**7**	**11**	**8**	**12**							**59**
VOL	0	0	0	0	0	0							**0**
CIVIL-INVOL	0	3	3	3	2	4							**15**
DCC	10	8	4	8	6	6							**42**
DCC-PTP	0	0	0	0	0	2							**2**
FORENSIC:	**10**	**9**	**6**	**9**	**10**	**11**							**25**
60 DAY EVAL	5	2	1	4	4	6							**22**
JAIL TRANS	0	0	0	0	0	0							**0**
IST	4	7	2	1	4	2							**20**
NCR	1	0	3	4	2	3							**13**
TOTAL	**20**	**20**	**13**	**20**	**18**	**23**							**84**



STRATEGIC PERFORMANCE EXCELLENCE

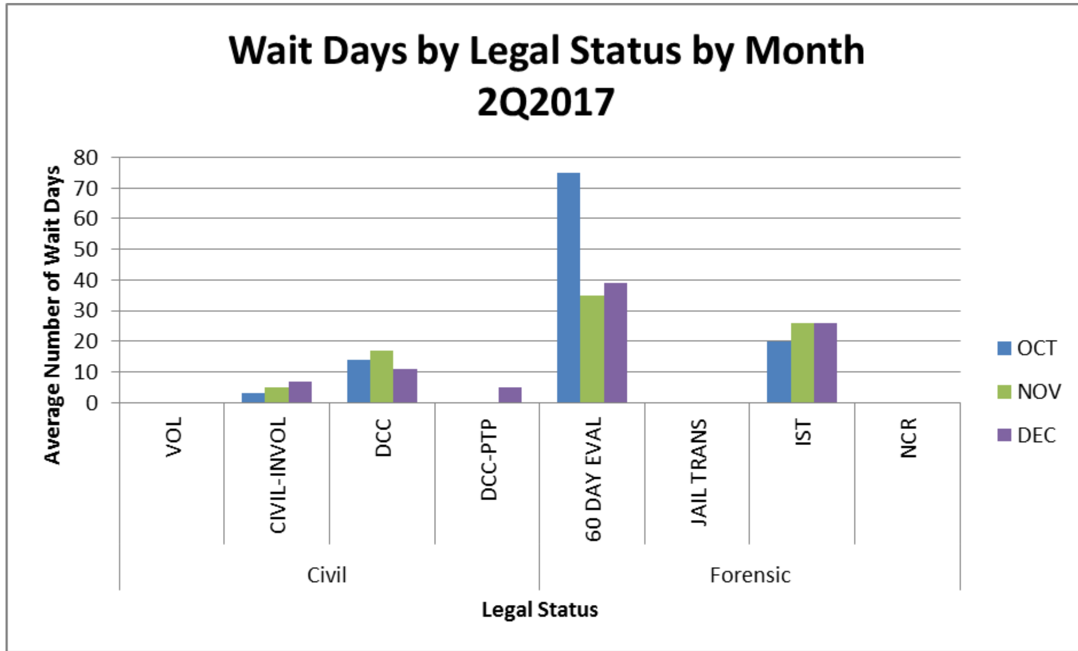


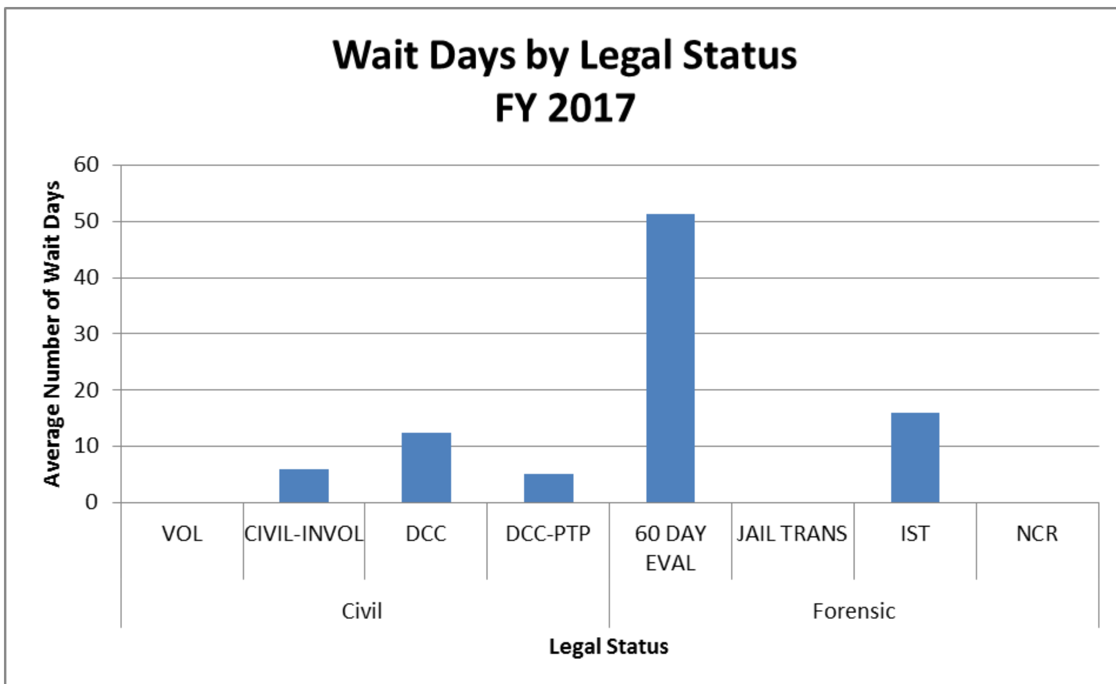
Average Number of Wait Days:

WAIT DAYS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**10**	**9**	**11**	**11**	**14**	**9**							**11**
VOL													
CIVIL-INVOL		4	11	3	5	7							**6**
DCC	10	12	10	14	17	11							**12**
DCC-PTP						5							**5**
FORENSIC:	**35**	**11**	**15**	**38**	**24**	**26**							**25**
60 DAY EVAL	64	32	63	75	35	39							**51**
JAIL TRANS													
IST	6	5	13	20	26	26							**16**
NCR	0		0	0	0	0							**0**
AVERAGE	**22**	**10**	**12**	**23**	**20**	**17**							**17**

*If a field is blank it means that there were no admissions for that legal status during that timeframe

STRATEGIC PERFORMANCE EXCELLENCE

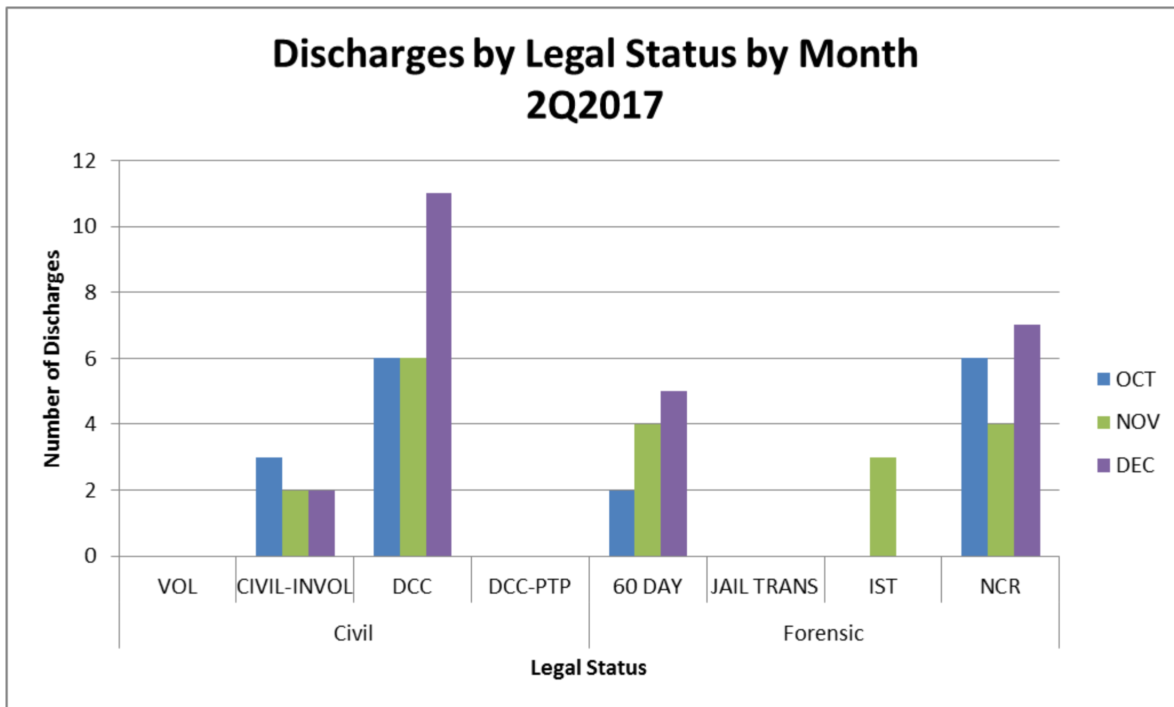




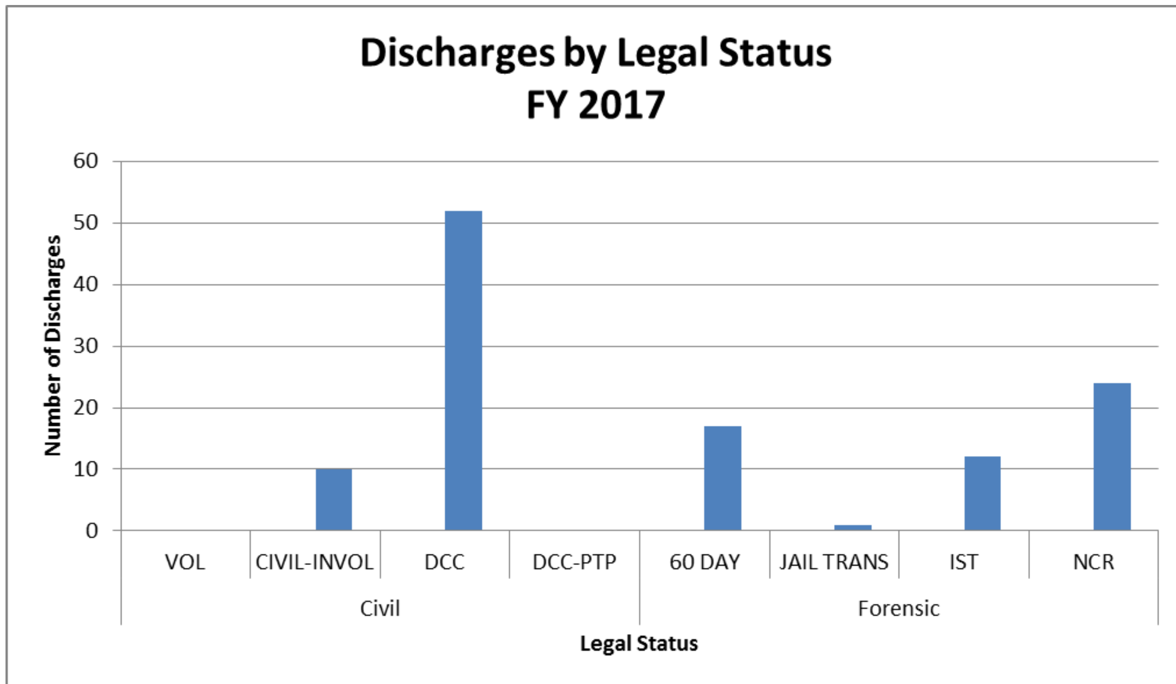
STRATEGIC PERFORMANCE EXCELLENCE

Number of Discharges:

DISCHARGES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**13**	**7**	**12**	**9**	**8**	**13**							**62**
VOL	0	0	0	0	0	0							**0**
CIVIL-INVOL	1	0	2	3	2	2							**10**
DCC	12	7	10	6	6	11							**52**
DCC-PTP	0	0	0	0	0	0							**0**
FORENSIC:	**10**	**8**	**5**	**8**	**11**	**12**							**23**
60 DAY	1	4	1	2	4	5							**17**
JAIL TRANS	1	0	0	0	0	0							**1**
IST	4	2	3	0	3	0							**12**
NCR	4	2	1	6	4	7							**24**
TOTAL	**23**	**15**	**17**	**17**	**19**	**25**							**85**



STRATEGIC PERFORMANCE EXCELLENCE

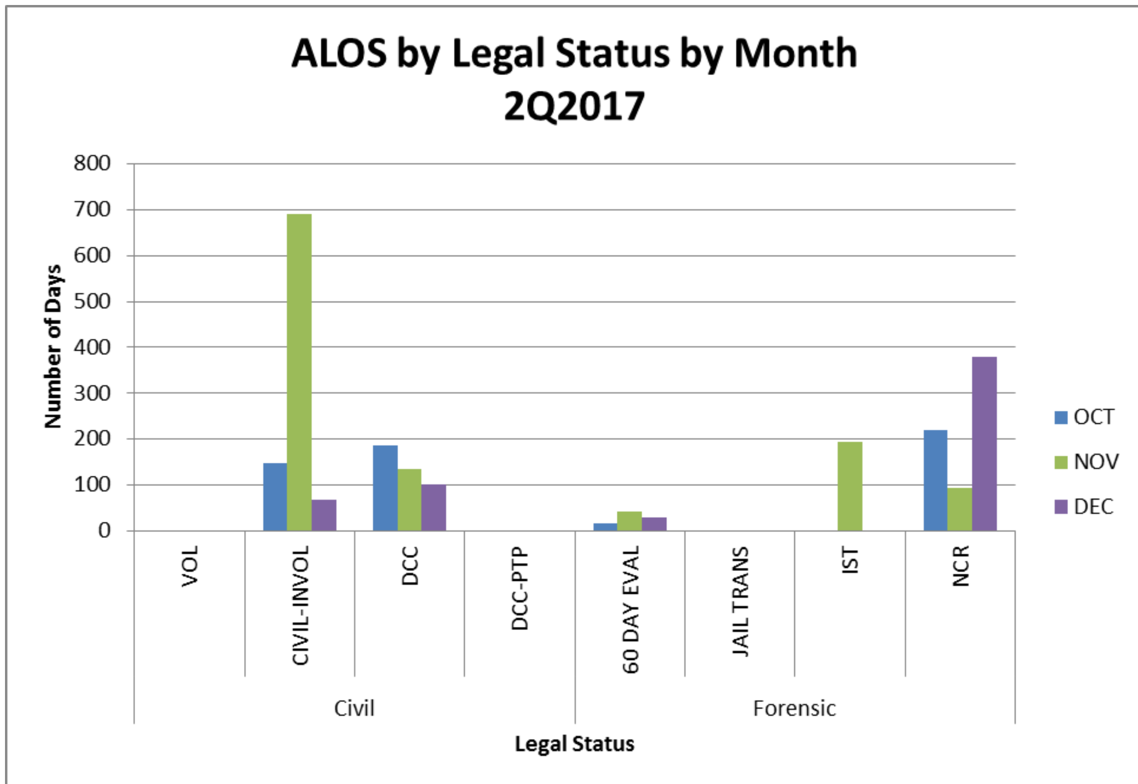


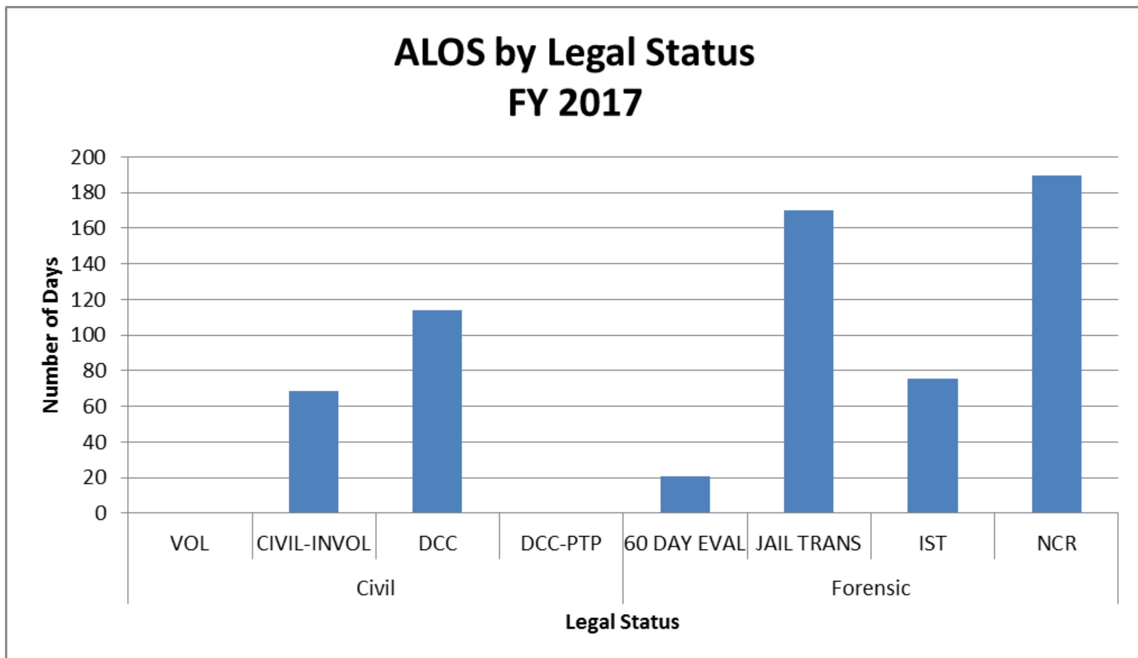
Average Length of Stay (Days):

ALOS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**99**	**79**	**145**	**174**	**273**	**97**							**108**
VOL													
CIVIL-INVOL	106		31	149	691	68							**69**
DCC	98	76	168	186	134	102							**114**
DCC-PTP													
FORENSIC:	**84**	**91**	**104**	**170**	**103**	**434**							**93**
60 DAY EVAL	9	30	23	18	43	30							**21**
JAIL TRANS	170												**170**
IST	107	33	86		194								**75**
NCR	58	273	238	220	94	379							**190**
AVERAGE	**92**	**85**	**133**	**172**	**174**	**162**							**103**

*If a field is blank it means that there were no discharges for that legal status during that timeframe

STRATEGIC PERFORMANCE EXCELLENCE





STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: NCR Admissions

Measure Description: Admittance of all NCR patients within 24 hours of referral

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	NCR referrals admitted within 24 hours	FY2014 75% 75/100	100%	100%	100%	100%	**100%**
Actual			100% 4/4	100% 9/9			**100% 13/13**

Data Analysis: There were nine NCR admissions this quarter. All were admitted the day of referral.

Action Plan: Continue to gather data on wait days for NCR admissions. Keep one bed available on the Forensic unit for NCR admissions when possible.

	Oct 2016	Nov 2016	Dec 2016	2Q2017
# of NCR Admissions	4	2	3	**9**
Average Wait Days	0	0	0	**0**

II. Measure Name: Jail Transfer Bed

Measure Description: Keep one Jail Transfer bed open and track length of stay and legal outcomes.

Type of Measure: Performance Improvement

	Oct 2016	Nov 2016	Dec 2016	2Q2017
# of Jail Transfer Admissions	0	0	0	**0**
# of Jail Transfer Discharges	0	0	0	**0**

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: There were no Jail Transfers admitted this quarter. Currently unable to have an open bed designated for jail transfers due to the large number of court ordered forensic patients.

III. Measure Name: Off Shift PA Admission Paperwork

Description: All required documentation will be complete and accurate for admissions on the off shifts by the PA.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Documentation complete and accurate for admissions on off shifts	FY2014 75% 75/100	100%	100%	100%	100%	**100%**
Actual			100% 3/3	100% 1/1			**100% 4/4**

Data Analysis: One off shift admission occurred this quarter and paperwork was completed accurately and timely.

Action Plan: Continue to monitor data so paperwork is completed accurately and timely.

STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Dental Clinic

Responsible Party: Dr. Ingrid Prikryl, DMD

I. Measure Name: Yearly Periodontal Charting

Measure Description: Complete a full mouth periodontal charting.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	% of recall appointments where full mouth periodontal charting was completed	FY 2016 51%	50%	55%	60%	65%	**70%**
Actual			33%	69%			**51%**

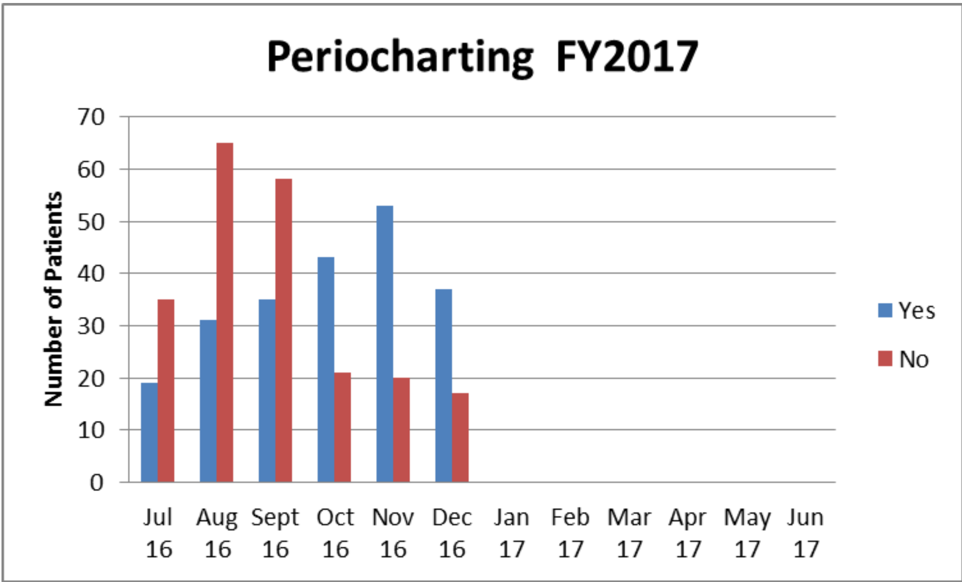
Data Analysis: To better report this measure, we will only measure periodontal charting on existing patients during their prophylactic recall appointments. Hygienist will note in the chart those patients that she is unable to chart because of limited chair time (i.e. patients with low function intellectual disability.)

October 2016: 43/64 = 67%
November 2016: 53/73 = 73%
December 2016: 37/54 = 68%

Action Plan: Charting to be completed by the hygienist during prophy appointments only and not during emergency or new patient appointments, in order to get a more accurate percentage.

Comments: Our periodontal charting has been improving but is still a work in progress.

STRATEGIC PERFORMANCE EXCELLENCE



II. Measure Name: Improving Oral Hygiene

Measure Description: Monitoring patients' oral hygiene and working to improve it

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Recall Hygiene Prophy	**New Measure**	50%	55%	60%	65%	**65%**
Actual			50%	44%			**47%**

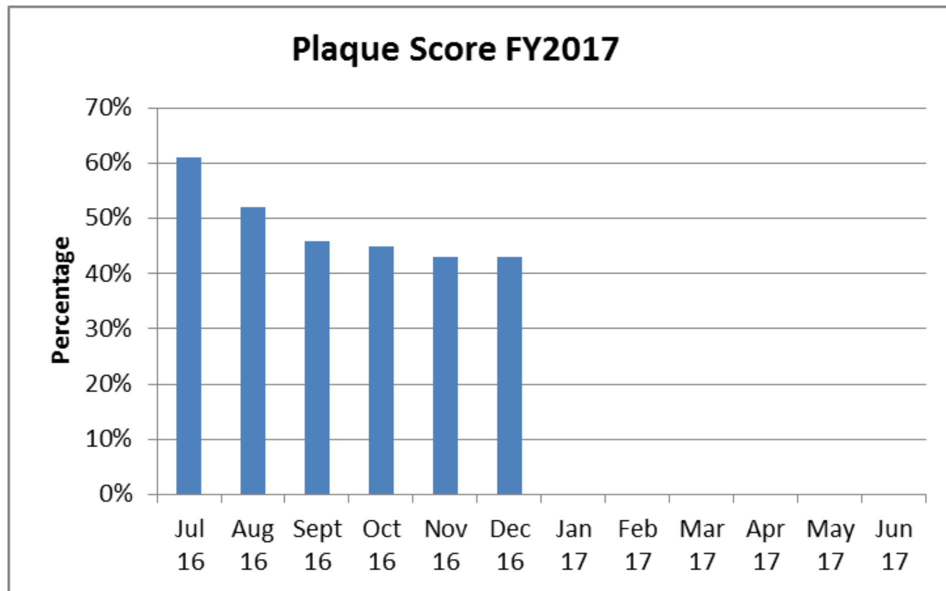
Data Analysis: Percentage of patients with Excellent or Good Hygiene were as follows: July 61%, August 52%, September 46%, October 45%, November 43%, December 46%. Goal is to stay above 65% and continuously improve to 75%.

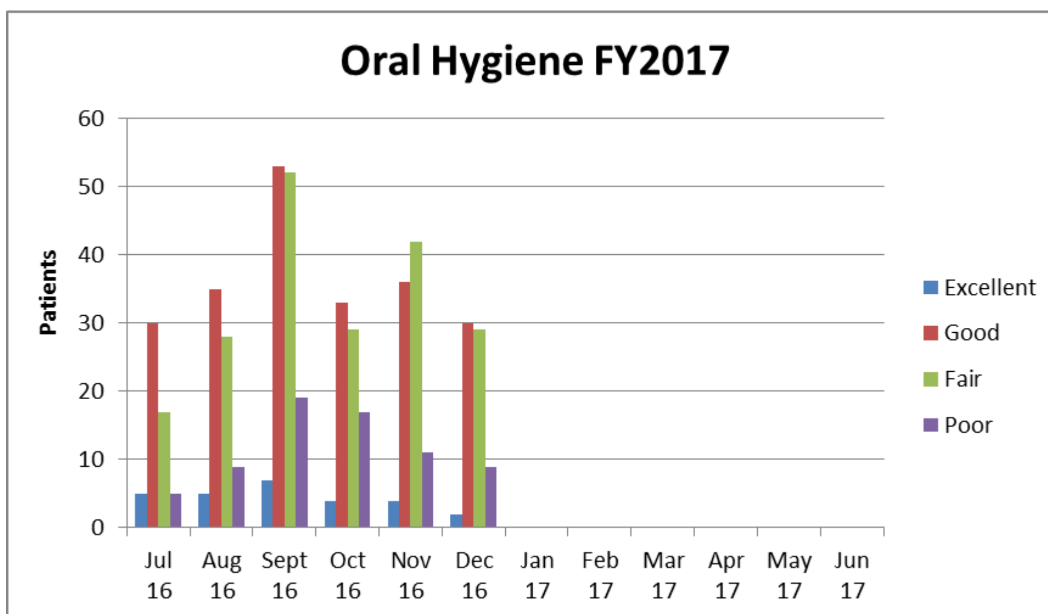
October 2016: 37/83 = 45%
November 2016: 40/93 = 43%
December 2016: 32/70 = 46%

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan: Plaque scores are measured/recorded on each patient and tallied during prophy recall appointments. Excellent, Good, Fair, and Poor are added up monthly. Excellent and good are added up and shown in a percentage. We would like the excellent/good to increase and fair/poor to decrease.

Comments: Trying to educate our patients on brushing DAILY and its importance for proper oral care and retention of teeth. Data is collected from daily collected plaque scores.





STRATEGIC PERFORMANCE EXCELLENCE

III. Measure Name: Next Visit

Measure Description: Writing Next Visit in progress note.

Type of Measure: Quality Assurance

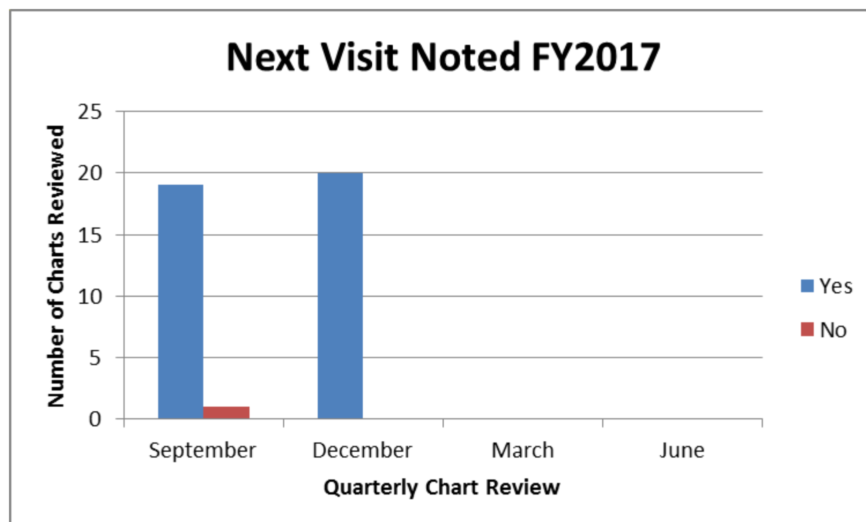
Results							
	Unit	Baseline	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Target	# of progress notes with next visit documented	FY2016 95%	90-100%	90-100%	100%	100%	**100%**
Actual			95%	100%			**98%**

Data Analysis: This continues to be a good quality assurance measure. Data collected from quarterly reviews by Community Dental; evaluate twenty random charts.

1Q2017	Yes: 19	No: 1
2Q2017	Yes: 20	No: 0

Action Plan: Write at the end of every progress note what the next visit is going to be even if it is a 3 MRC or denture adjustment as needed.

Comments: Data collected from quarterly reviews by Community Dental. Twenty random charts were evaluated.



STRATEGIC PERFORMANCE EXCELLENCE

IV. Measure Name: RMH and MEDS

Measure Description: Review medical history and medications at the start of each appointment.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Daily noted	FY2016 95%	90-100%	90-100%	100%	100%	**100%**
Actual			100%	100%			**100%**

Data Analysis: Continued QA from FY2016. Medical history and medication list will be reviewed at each appointment.

1Q2017	Yes: 20	No: 0
2Q2017	Yes: 20	No: 0

Action Plan: Review patient medical history and medication list at the start of each appointment.

Comments: Data collected from quarterly reviews by Community Dental. Twenty random charts were evaluated.

STRATEGIC PERFORMANCE EXCELLENCE

V. Measure Name: Blood Pressure

Measure Description: Blood pressure and pulse taken at each dental appointment

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Daily noted; Quarterly reviewed	90-100%	90-100%	90-100%	90-100%	90-100%	**90-100%**
Actual			95%	90%			**93%**

Data Analysis: All patients that are seen prior to restorations and prophy appointments; denture patients do not always have their blood pressure taken; especially on denture deliveries.

1Q2017	Yes: 19	No: 1
2Q2017	Yes: 18	No: 2

Action Plan: Take blood pressure and pulse at the start of all dental appointments. To withstand dental care, blood pressure should be less than 160/90. Need to discuss with hygienists that work on Friday that BP needs to be taken on all dental patients.

Comments: Data is collected from quarterly reviews by Community Dental. Twenty random charts were evaluated.

Capital Community Clinic
Medication Management Clinic

Responsible Party: Margaret Todd-Brown, RN

I. Measure Name: Medication Reconciliation

Measure Description: All patient medications will be reconciled at each medication management appointment, prior to the patient meeting with the provider.

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**FYTD**
Target	100% Reconciliation completed per patient visit.	FY2016 95%	100%	100%	100%	100%	**100%**
Actual			95% 18/19	88% 7/8			**93% 25/27**

Data Analysis: During this quarter, the Medication Clinic had eight patient contacts, and medication reconciliations were completed for seven of the contacts. It is unknown why the medication reconciliation was not completed for the 8th contact.

Action Plan: The clinic will continue to track this PI measure with the goal of reaching 100%.

STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Vital Signs

Measure Description: Staff will attempt to obtain vital signs on each patient to check on health status, known medical concerns, and potential medical side effects of medication regimen.

Measure Type: Performance Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**FYTD**
Target	Vitals will be attempted on 100% of patient visits.	FY2016 93%	100%	100%	100%	100%	**100%**
Actual			95% 18/19	100% 8/8			**96% 26/27**

Data Analysis: During this quarter, the Medication Clinic had 8 patient contacts. Vital signs were attempted for 8 patient visits.

Action Plan: The clinic will continue to track this PI measure with the goal of maintaining 100% Compliance.

STRATEGIC PERFORMANCE EXCELLENCE

Dietetic Services

Responsible Party: Kristen Piela, RDN, LDN, Dietetic Services Manager

I. Measure Name: Infection Control

Measure Description: The Dietetic Services Manager or designee will verify that Dietary staff have maintained proper sanitation processes for 18 specified pieces of foodservice equipment. A Sanitation Schedule and Checklist will be used to validate equipment is clean and sanitary. Dietary staff will be responsible for cleaning and documenting completion of each task. The supervisor will review sheets and complete a sanitation inspection weekly.

Type of Measure: Performance Improvement

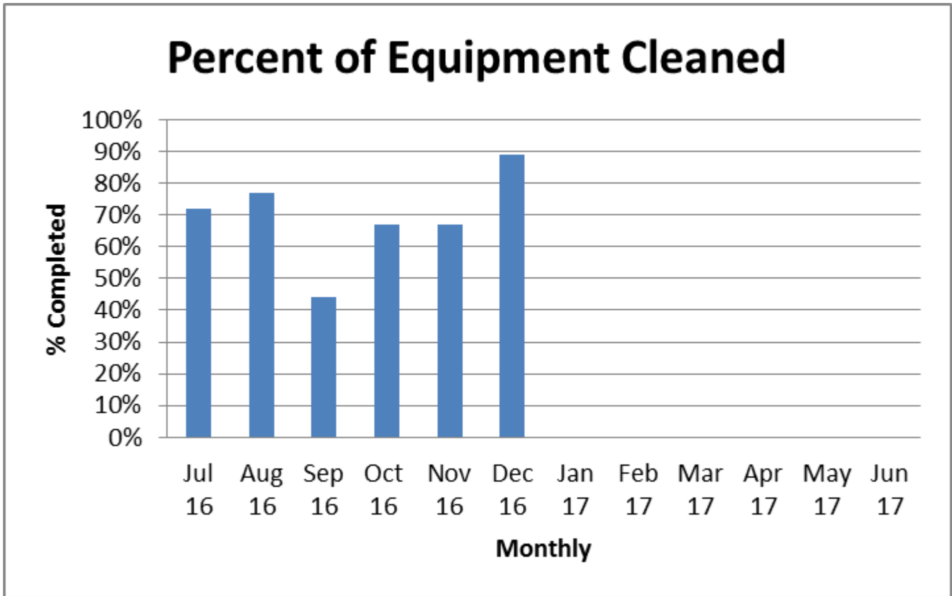
Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of Equipment Cleaned as Assigned	65% 1QFY17	70% 38/54	75% 41/54	80%	90%	**90% 195/216**
Actual			65% 35/54	74% 40/54			**69% 75/108**

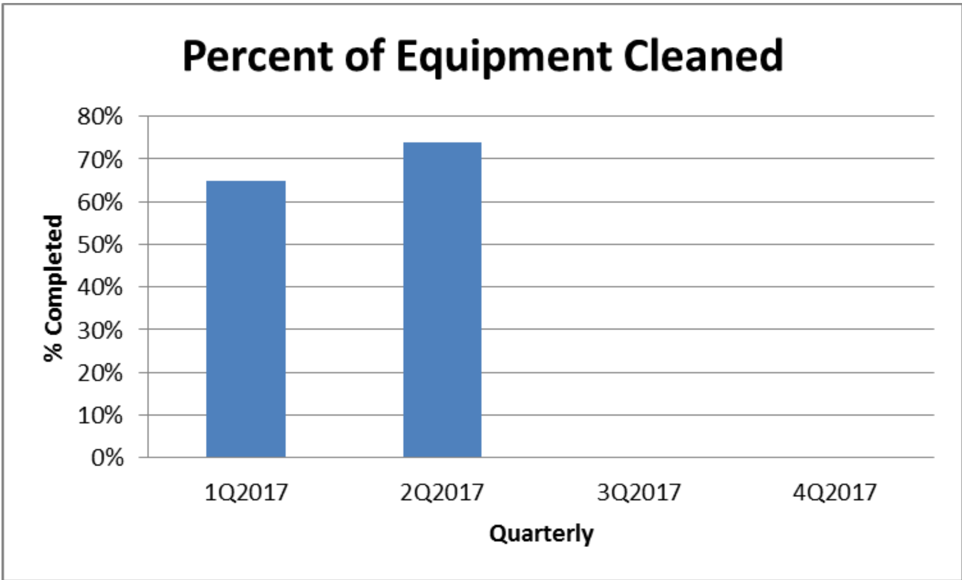
Data Analysis: The results this quarter indicate a baseline of 74%. The department will strive for continued improvement with a year-end goal at or above 90%. Data analysis by month indicates a high of 89% in December and a low of 67% in October and November. Two staff members were presented commendations for their diligence in completing the majority of the cleaning tasks for the first quarter. Six staff members cleaned the assigned equipment consistently throughout this quarter. Cooler #325 is the only piece of equipment that has not been cleaned extensively this quarter.

Action Plan:
The Dietetic Services Manager will provide a commendation to all staff members that consistently completed the assigned cleaning for the quarter, will review the daily staff schedule to assign the cleaning of each monitored piece of equipment to certain staff members as opposed to job classifications, and will assign a cook to clean cooler #325.

The Cook III's will: review the assignment schedule monthly to assure that staff are allotted time during their work day to complete their specific cleaning assignments, and will review and explain this report in a general staff meeting in the month of January.

STRATEGIC PERFORMANCE EXCELLENCE





STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Nutrition Screen Completion

Measure Description: Unit guidelines will be established that include parameters surrounding the distribution of nourishments. These guidelines will incorporate the latest USDA nutrition guide, *My Plate*, into a healthy dietary pattern for the patients on a daily basis. A team will be established to restructure the current Unit guidelines on the Lower Forensic Unit. This team will establish three set times to provide nourishments for patients daily. Nourishments will provide approximately 100 calories. Additionally, the food stocked daily on the units will include fresh fruits and vegetables, fresh cut fruit water, milk, tea, coffee and hot chocolate for consumption outside of nourishment times. This adjustment to the availability of nourishments will be measured through weight changes of patients on the unit using Body Mass Index (BMI) calculations; mean, minimum, maximum, median. Monthly weights on all patients will be documented in each patient's medical record.

Type of Measure: Performance Improvement

Data Analysis: Data was not available for collection this quarter. This Performance Improvement monitor has highlighted obstructions that must be amended in order to obtain accurate data for weight management analysis.

Action Plan: The Dietetic Services Manager will gather weights on all patients residing on the forensic side of the hospital to increase the sample size and will speak with the Nurse V's on the forensic units regarding the implementation of a nourishment regime that mirrors that of the lower forensic units and about the identification of line staff who would be most successful obtaining monthly weights from all patients. The Registered Dietitian will explain the significance and changes to this report in a general staff meeting in the month of January.

STRATEGIC PERFORMANCE EXCELLENCE

III. Measure Name: Nutrition Screen Accuracy

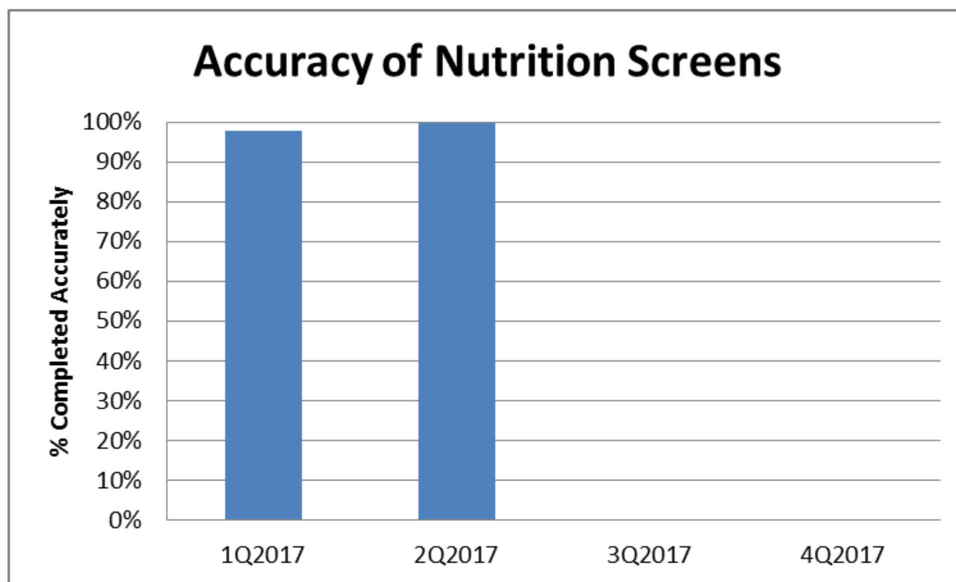
Measure Description: The Registered Dietitian will review every patient's Nursing Admission Data upon admission to assess ongoing compliance with the accuracy of the Nutrition Screen tool. This screen is utilized to attain nutrition indicators that necessitate dietary intervention.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of Nutrition screens completed accurately	FY 2016 93% 161/173	94% 47/50	95% 52/55	95%	96%	**96% 101/105**
Actual			98% 49/50	100% 55/55			**99% 104/105**

Data Analysis: These results indicate there has been a 2% improvement in the accuracy of the information gathered on the nutrition screen this quarter. The nutrition screen is completed by the nurse responsible for the admission.

Action Plan: Clinical Dietitian met with the primary admission nurse and thanked her for her attention and accuracy of the nutrition screen.



STRATEGIC PERFORMANCE EXCELLENCE

IV. Measure Name: Hand Hygiene Compliance

Measure Description: Supervisory staff including the Food Service Manager and Cook III's will observe all dietary employees as they return from break for proper hand hygiene.

Type of Measure: Quality Assurance

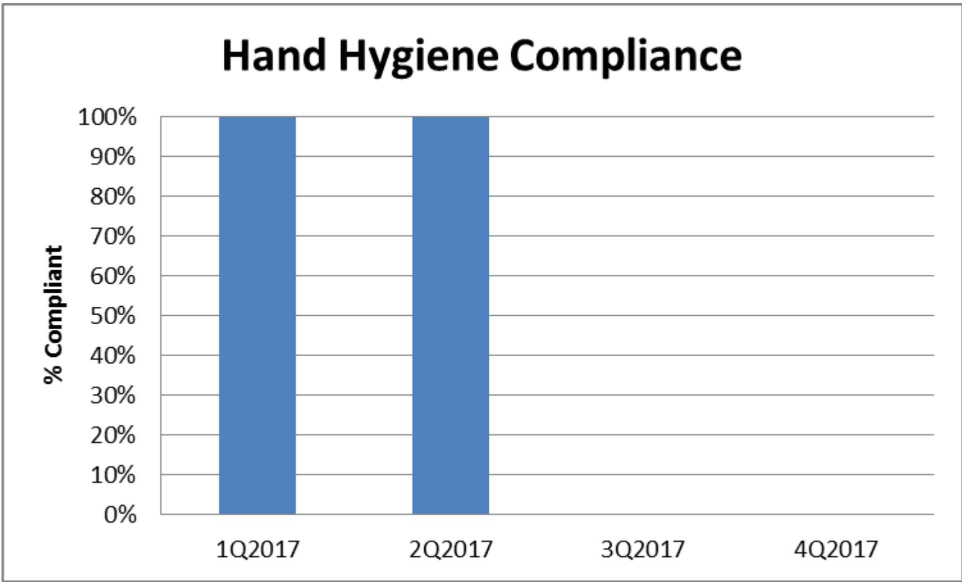
Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of Dietary employees washing hands after break	FY 2016 95.7%	95% 245/258	95% 221/232	95%	95%	**95% 465/490**
Actual			100% 258/258	100% 232/232			**100% 490/490**

Data Analysis: This monitor remains above 90%. The submitted data portray a 100% compliance rate. However, of the 14 dietary employees, 5 of them were observed on 0-10 occasions. Additionally, there were only one employee collecting the data.

Action Plan:

- Dietetic Services Manager reviewed this data with the Food Service Manager to determine why only one of the identified two employees is completing the data collection.
    - It was established that the second employee had not been informed of this expected task.
- Food Service Manager will observe the employees collecting the data to assure accuracy of the data collection process.
- Provide a review of the proper hand washing times and techniques as quarterly training.
- Encourage front line supervisors to promote hand hygiene with their staff throughout the day.
- Provide this Quality Assurance measure for review by staff to highlight the continued success.

STRATEGIC PERFORMANCE EXCELLENCE



Emergency Management

Responsible Party: Robert Patnaude, Emergency Management Coordinator

I. Measure Name: Communications Equipment/Two-way radios

Measure Description: The Joint Commission states the following in EM.02.02.01: "As part of its Emergency Operations Plan, the hospital prepares for how it will communicate during emergencies. *The hospital maintains reliable communications capabilities for the purpose of communicating response efforts to staff, patients, and external organizations."*

In the event of an unforeseen emergency which could impact the safety and security of patients, staff, and visitors, communications equipment, more specifically, two-way radios are a major solution to getting accurate information to and from staff in a timely manner. The objective of the Emergency Management Communications PI is to ensure compliance with The Joint Commission standard with the overall objective of ensuring that the two-way radio system is fully functional and that staff are proficient in its use.

Type of Measure: Performance Improvement

Methodology: Each month, the Emergency Management Coordinator or designee will perform a combination of partial and hospital-wide radio drills. Such drills will utilize a specific form to track the drills (see attached). In conjunction with the drills, environmental rounds will be conducted for the purpose of inspecting communications equipment. Any deficiencies shall have the appropriate corrective measure immediately instituted until compliance is met.

The numerator is the number of timely and appropriate responses by staff utilizing the two-way radios by assignments. The denominator will be the total number of two-way radios by assignments.

Baseline Data: To assure that critical emergency information is disseminated in a timely and accurate manner, **a minimum of 90%** compliance has been established. This data will be reported monthly to the Emergency Management Committee, IPEC, and the Environment of Care (EOC) Committee. Areas that fail to meet the threshold will be immediately reported to the aforementioned committees.

STRATEGIC PERFORMANCE EXCELLENCE

Results							
	Unit	Baseline	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Target	Percent of timely and appropriate responses	FY2016 90% 144/159	90%	90%	90%	90%	**90%**
Actual			98% 157/159	98% 157/159			**98% 314/318**

Data Analysis: With a significant amount of hands-on demonstrations, radio tests, and an increase in the use of radios, data showed that majority of the radios are being deployed in a timely manner and that staff is familiar with operating the radio.

Since September, Riverview's BERT Program was gone through a trial and error period with regard to the BERT radios. Every month, staff from all departments has been instructed on radio etiquette and protocol. Also during the months of October, November, and December, numerous departments received individualized training on two-way radio etiquette and protocol. Based on the occurrences listed here, the Emergency Management Coordinator felt that these occurrences augmented the objectives sought after during the typical monthly radio drills.

The BERT Program has also added (8) new radios to the patient-care units which has enhanced the communications abilities not only for BERT but for any event.

Special Note: So as not to skew the data for this quarter, EFFECTIVE January 1, 2017, information contained within the "AREAS/GROUPS MONITORED" will change to reflect the addition of and relocation of two-way radios. Along with the informational changes, Q3 data will reflect those changes.

Action Plan:

1. Continued tests and remedial training to staff along with supporting handouts as needed.
2. Increased surveillance of mass notification equipment such as alert pagers.
3. Investigate various media to notify staff to employ radios.

Comments: Over the course of the past (2) quarters, 98% of assigned radio equipment is placed into service in a timely manner. We attribute this success from our Action Plan and from units such as our Operations Center, Emergency Management, and Safety, which constantly monitors the use of the radios and provides immediate remedial instructions to our staff when deficiencies are discovered.

STRATEGIC PERFORMANCE EXCELLENCE

Areas/Groups Monitored N=Numerator D=Denominator	JULY 2016	AUG 2016	SEPT 2016	OCT 2016	NOV 2016	DEC 2016	JAN 2017	FEB 2017	MAR 2017	APR 2017	MAY 2017	JUNE 2017
Patient Care Areas/ # of radios												
Job Coach/1	1/1	1/1	***	1/1	1/1	1/1						
OPS/2	2/2	2/2	***	2/2	2/2	2/2						
Tx Mall, Clinic, Dietary, Med Rec/5	5/5*	5/5	***	5/5	5/5	5/5						
US, UK, LS, LSSCU, LK, LKSCU/10	9/ 10**	10/10	***	10/10	9/10**	10/10						
Support Services/ # of radios			***									
Administration/3	3/3	3/3	***	3/3	3/3	3/3						
Housekeeping/ 10	9/10*	10/10	***	10/10	10/10	9/10*						
Maintenance/14	14/14	14/14	***	14/14	14/14	14/14						
NOD/1	1/1	1/1	***	1/1	1/1	1/1						
Nursing Services/1	1/1	1/1	***	1/1	1/1	1/1						
Operations/1	1/1	1/1	***	1/1	1/1	1/1						
Security/4	4/4	4/4	***	4/4	4/4	4/4						
State Forensic Services/1	1/1	1/1	***	1/1	1/1	1/1						
Patient Care Areas	17/ 18	18/18	18/18	18/18	17/18	18/18						
Support Services	34/ 35	35/35	35/35	35/35	35/35	34/35						
Total	51/ 53	53/53	53/53	53/53	52/53	52/53						

*Some radio units not on duty due to shift assignment therefore given the same weight in order not to have a negative impact.

EMC: Emergency Management Coordinator

***1** One housekeeper reported that their radio was not working. The antenna needed to be replaced. After replacement, the test was performed as expected.

****2** LS-1 did not transmit since the radio was not seated in the charger properly. Remedial training was conducted reference to setting the radio into the slot of charger.

STRATEGIC PERFORMANCE EXCELLENCE

*****3** For the entire month of September, Riverview's new initiative was the BERT Program. During training to over 300 staff from all departments, staff was instructed on radio etiquette and protocol. Also during the month, numerous departments received individualized training on two-way radio etiquette and protocol. Based on the occurrences listed here, the Emergency Management Coordinator felt that these occurrences surpassed the objectives sought after during the typical monthly radio drills.

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Responsible Party: Janet Barrett CTRS, Director of Rehabilitation Services

I. Measure: Harbor Mall Hand-Off Communication (HOC)

Measure Description: To provide the exchange of patient-specific information between the patient care units and the Harbor Mall for the purpose of ensuring continuity of care and safety within designated time frames.

Type of Measure: Performance Improvement

Objectives	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	65% 309/479	69% 306/445			**67% 615/924**
SBAR information completed from the units to the Harbor Mall.	84% 403/479	86% 384/445			**85% 787/924**
Accuracy of information from the units.	76% 363/479	86% 383/445			**81% 746/924**
Overall Compliance	**75% 1075/1437**	**80% 1073/1335**			**77% 2148//2772**

Data Analysis: Overall compliance has increased this quarter, from 75% last quarter to 80% this quarter. Indicator one increased 4 points, from 65% to 69%; indicator two increased 2 points, from 84% to 86%; and indicator three increased 10 points, from 76% to 86%. The goal is to achieve and maintain 100% compliance for all indicators throughout four consecutive quarters.

Action Plan: Continue to monitor HOC sheets daily to encourage accuracy and a review of this information with the RN4 and RN5 from each unit, and to review and emphasize the HOC for importance of complete and accurate information, as pertaining to safety and continuity of care for patients. Maintain highlighted time statement at the bottom of each HOC to emphasize importance of returning HOC to the Harbor Mall by the designated time.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Responsible Party: Samantha Brockway, RHIT, Medical Records Administrator

Documentation and Timeliness:

Indicators	2Q2017 Findings	2Q2017 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements, and Medical Staff bylaws timeframes.	There were 61 discharges in the 2Q 2017. Of those, all were completed within 30 days.	100%	80%
Discharge summaries will be completed within 15 days of discharge.	Out of 61 discharge summaries, all were completed within 15 days of discharge.	100%	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	1 revised form, 1 deleted form, and 2 new forms in 2Q 2017 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	693 dictated reports were completed within 24 hours.	100%	90%

Summary: The indicators are based on the review of all discharged records. There was 100% compliance with 30 day record completion. Weekly "charts needing attention" lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 100% compliance with timely & accurate medical transcription services

Actions: Continue to monitor.

STRATEGIC PERFORMANCE EXCELLENCE

Confidentiality:

Indicators	2Q2017 Findings	2Q2017 Compliance	Threshold Percentile
All patient information released from the Health Information Department will meet all Joint Commission, State, Federal & HIPAA standards.	2,623 Requests for information (168 requests for patient information and 2,455 police checks) were released.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	All new employees/contract staff attended confidentiality/ HIPAA training.	100%	100%
Patient confidentiality/privacy issues tracked through incident reports.	0 privacy-related incident reports.		

Summary: The indicators are based on the review of all requests for information, orientation for all new employees/contract staff, and confidentiality/privacy-related incident reports.

No problems were found in 2Q2017 related to release of information from the Health Information Department and training of new employees/contract staff; however, compliance with current law and HIPAA regulations needs to be strictly adhered to requiring training, education, and policy development at all levels.

Actions: The above indicators will continue to be monitored.

STRATEGIC PERFORMANCE EXCELLENCE

Regulatory and Compliance Standards in Documentation

Ensuring Fiscal Responsibility in Documentation and Billing Practices

Indicator and Rationale for Selection	1Q2017	2Q2017	3Q2017	4Q2017
Identification Data	98% 54/55	100% 61/61		
Medical History, including chief complaint; HPI; past, social & family hx.; ROS, and physical exam w/in 24 hr. conclusion and plan	93% 55/55 4 Refused	100% 61/61 7 Refused		
Summary of patient's psychosocial needs as appropriate to the patients *	71% 39/55 16 +7 days	82% 50/61 11 > 7 days		
Psychiatric Evaluation in patient's record w/in 24 hrs. of admission	95% 52/55 1 +24 2 +60	100% 61/61		
Physician (TO/VO w/in 72 hr.)	96% 151/157	98% 127/130		
Evidence of appropriate informed consent	100% 55/55	100% 61/61		
Clinical observations including the results of therapy.	100% 55/55	100% 61/61		
Nursing discharge Progress Note with time of discharge departure	95% 52/55	87% 53/61		
Consultation reports, when applicable	80% 99/123	100% 61/61		
Results of autopsy, when performed	N/A	N/A		
Advance Directive Status on admission and SW follow up after	93% 51/55	87% 53/61		
Notice of Privacy	100% 55/55	100% 61/61		
Chart Completion w/in 30 days of discharge date/discharge summary completed within 30 days	100% 55/55	100% 61/61		
Discharge Packet sent to follow up provider within 5 days of discharge.	98% 54/55	100% 61/61		

* The parameters for this measure will be changed to meet applicable goals as defined by the Director of Social Work. The current measure is more stringent than regulatory standards dictate.

STRATEGIC PERFORMANCE EXCELLENCE

Release of Information for Concealed Carry Permits:

Define:
The process of conducting background checks on applicants for concealed carry permits is the responsibility of the two State psychiatric hospitals. Patients admitted to private psychiatric hospitals, voluntarily or by court order, are not subject to this review. Delays in the processing of background checks has become problematic due to an increasing volume of applications and complaints received regarding delays in the processing of these requests

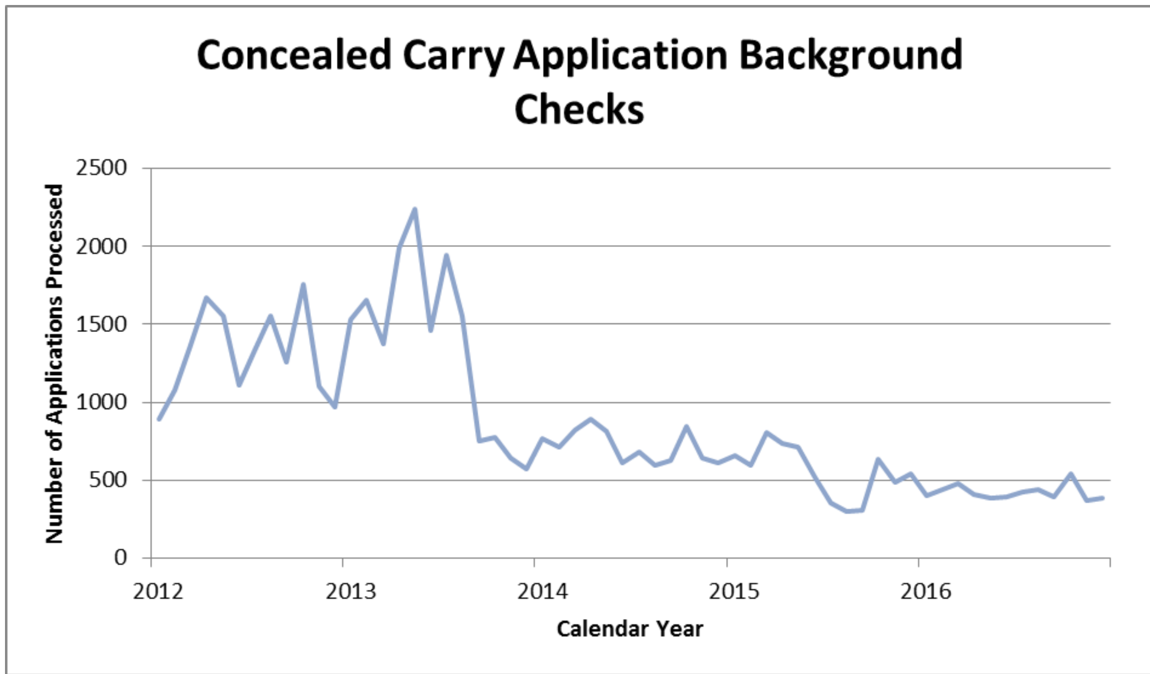
Analyze:
Data collected for the 2Q2017 showed that we received 1297 applications. This is a slight increase from last quarter, 1Q2017, when we received 1260 applications.

Improve:
The process has been streamlined as we have been working with the state police by eliminating the mailing of the applications from them to RPC and DDPC. RPC has reactivated the medical records email to receive lists of the applicants from the state police that include the DOB and any alias they may have had. This has cut down on paper as well as time taken sorting all the applications. OIT has also created a new patient index in which we are in the process of consolidating sources we search into this one system. Over time this will decrease time spent searching as we will no longer have to search several sources. This is ongoing.

Note: In July 2015, a new State of Maine law was approved effective October 2015. This law no longer requires citizens to have a concealed carry permit to carry a concealed weapon within the State of Maine. However, if citizens want to carry concealed outside Maine they will still need to apply for a concealed carry permit. We expect this to decrease the number of concealed carry permit applications we receive and process.

Year	**FY2017**												**Total**
Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	
# Applications Received	425	443	392	543	371	383							2557

STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

Housekeeping

Responsible Party: Debora Proctor, Housekeeping Supervisor

I. Measure Name: Patient Living Area

The Housekeeping Department will maintain an acceptable standard of cleanliness and sanitation in patient living areas.

Measure Description: The Housekeeping Supervisor or designee will perform a monthly inspection of the patient living area and record the findings on the Housekeeping Inspection Form. Any unit not meeting the threshold will be inspected every two weeks until compliance is met

Method of Monitoring: Inspection scores will be summarized monthly. Patient areas that fail to meet the threshold will be reported to the IPEC group, EOC, and the Director of Support Services. This report will include any actions taken.

Results:

Unit	Target	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Lower Saco	95%	93%	91%			**92%**
Upper Saco		93%	93%			**93%**
Lower Kennebec		91%	91%			**91%**
Upper Kennebec		86%	93%			**90%**
Overall Average		**91%**	**92%**			**92%**

Data Analysis: The Housekeeping Supervisor inspected units monthly. Improvements will be expected in the dusting and floor cleaning areas.

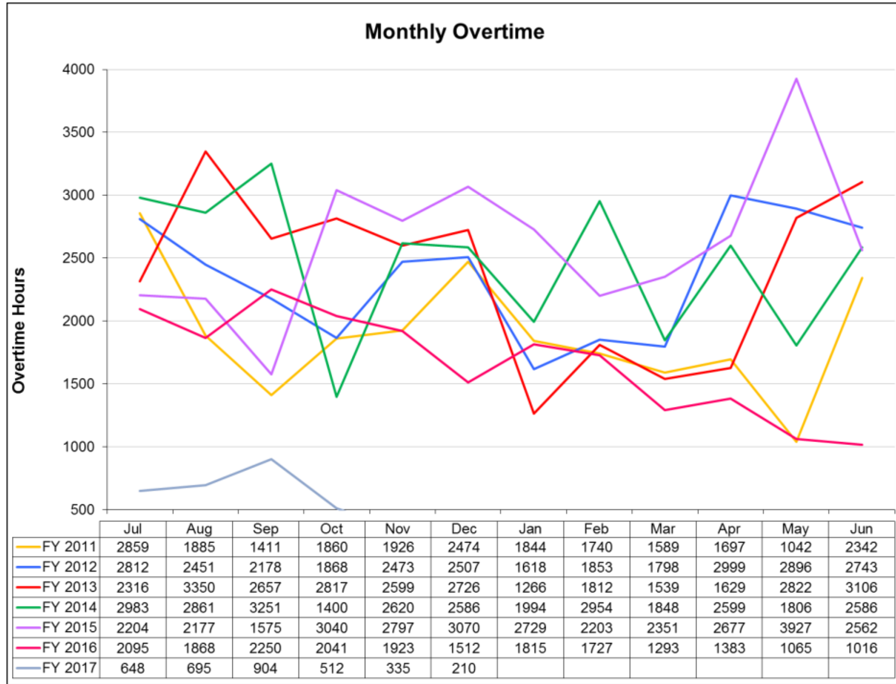
Action Plan: The Housekeeping Supervisor will continue to do monthly inspections to assure that cleanliness of the environment continues to improve.

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

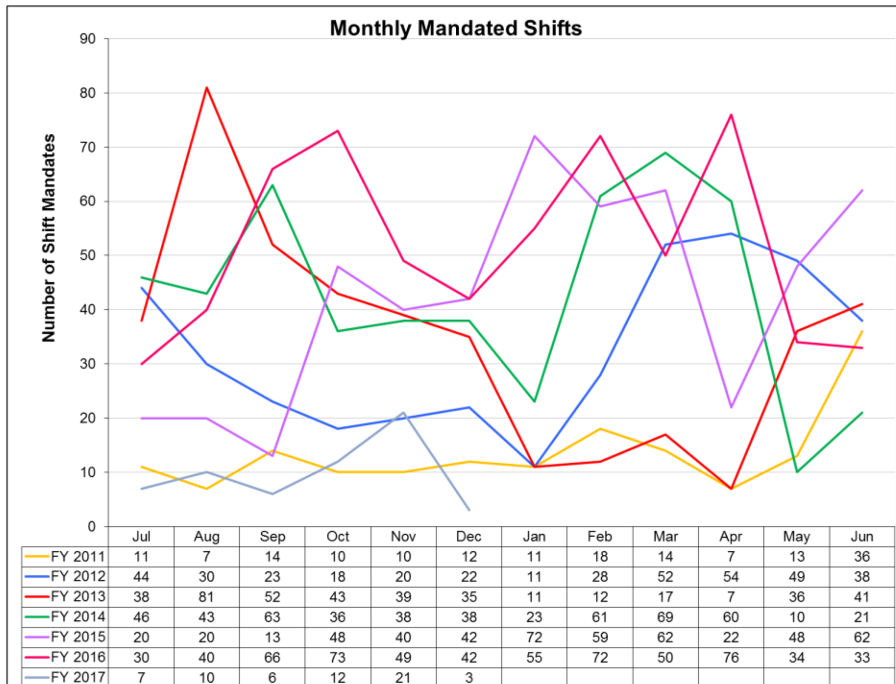
STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Person Responsible: Aimee Rice, Human Resources Manager



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2011	2859	1885	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2012	2812	2451	2178	1868	2473	2507	1618	1853	1798	2999	2896	2743
FY 2013	2316	3350	2657	2817	2599	2726	1266	1812	1539	1629	2822	3106
FY 2014	2983	2861	3251	1400	2620	2586	1994	2954	1848	2599	1806	2586
FY 2015	2204	2177	1575	3040	2797	3070	2729	2203	2351	2677	3927	2562
FY 2016	2095	1868	2250	2041	1923	1512	1815	1727	1293	1383	1065	1016
FY 2017	648	695	904	512	335	210						



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY 2013	38	81	52	43	39	35	11	12	17	7	36	41
FY 2014	46	43	63	36	38	38	23	61	69	60	10	21
FY 2015	20	20	13	48	40	42	72	59	62	22	48	62
FY 2016	30	40	66	73	49	42	55	72	50	76	34	33
FY 2017	7	10	6	12	21	3						

STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: License Reviews

Measure Description: Ensuring that licenses/registry entries are verified via the appropriate source prior to hire for all licensed (or potentially licensed) new hires.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percentage Licenses Reviewed	FY 2014 98%	100%	100%	100%	100%	**100%**
Actual			100% 20/20	100% 15/15			**100% 35/35**

Data Analysis: During 2Q2017, there were 31 new hires. Of those, 15 were licensed, or potentially licensed. License and CNA Registry checks were performed prior to hire on all 15.

Action Plan: No action is needed at this time.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff

Responsible Party: Dr. Joanna Gratton, Clinical Director

Quality Improvement Plan
2016-2017

As specified in Article Seven of the Medical Staff Bylaws, the improvement and assurance of medical staff quality and performance is of paramount importance to the hospital. This plan insures that the standards of patient care are consistent across all clinical services and all specialties and categories of responsible practitioners. Through a combination of internal and external peer review, indicator monitoring, focused case reviews of adverse outcomes or sentinel events, routine case reviews of patients with less than optimal outcomes, and the establishment of performance improvement teams when clinical process problems arise, the medical staff will insure quality surveillance and intervention activities appropriate to the volume and complexity of Riverview's clinical workload. Medical Staff Quality Improvement efforts will be fully integrated with the hospital-wide Integrated Performance Excellence Committee (IPEC) so that information can be sent to and received from other clinical and administrative units of the hospital. The Clinical Director, assisted by the President of the Medical Staff, will serve as the primary liaison between the MEC and IPEC. Oversight of the Medical Staff Performance Improvement Plan is primarily delegated to the Clinical Director in conjunction with the President of the Medical Staff, the Director of Integrated Quality and Informatics, the Superintendent, and ultimately to the Advisory Board.

The goal of the Medical Staff Quality Improvement Plan is to provide care that is:

Designed to improve clinical outcomes
Effective
Efficient
Patient centered
Equitable
Safe
Timely

To achieve this goal, medical staff members will participate in ongoing and systematic performance improvement efforts. The performance improvement efforts will focus on direct patient care processes and support processes that promote optimal patient outcomes. This is accomplished through peer review, clinical outcomes review, variance analysis, performance appraisals, and other appropriate quality improvement techniques.

STRATEGIC PERFORMANCE EXCELLENCE

1. **Peer Review Activities**:

   a. Regularly scheduled internal peer review by medical staff occurs on a quarterly basis at the Med Staff QA and PI Committee. The group of assembled clinicians will review case histories and treatment plans, and offer recommendations for possible changes in treatment plans, for any patient judged by the attending physician or psychologist, or others (including nursing, administration, the risk manager, or the Clinical Director) , and upon request, to not be exhibiting a satisfactory response to their medical, psychological, or psychiatric regimens. Our goal is to discuss a case quarterly. Detailed minutes of these reviews will be maintained, and the effectiveness of the reviews will be determined by recording feedback from the reviewed clinician as to the helpfulness of the recommendations, and by subsequent reports of any clinical improvements or changes noted in the patients discussed over time. Such intensive case reviews can also serve as the generator of new clinical monitors if frequent or systematic problem areas are uncovered.

      In addition all medical staff members (full and part-time) will have a minimum of six charts per year peer reviewed and rated for clinical pertinence of diagnosis and treatment as well as for documentation. These may include admission histories and physicals, discharge summaries, and progress notes. The results of these chart audits are available to the reviewed practitioners and trends will be monitored by the Clinical Director as part of performance review and credentialing decisions.

   b. Special internal peer review or focused review. At the direction of the Clinical Director a peer chart review is ordered for any significant adverse clinical event or significant unexpected variance. Examples would be a death, seclusion or restraint of one patient for eight or more continuous hours, patient elopement, the prescribing of three or more atypical antipsychotics for the same patient at the same time, or significant patient injury attributable to a medical intervention or error. This may be in conjunction with, lead to, or result from a Root Cause Analysis requested by the hospital Superintendent.

   c. External peer review occurs regularly through contracts with the Maine Medical Association and the Community Dental Clinic program. We plan to continue our recent tradition of assessment of the psychiatry service and the medical service by peers in those clinical areas based on random record assessment of 25 cases in each service through the Maine Medical Association (MMA). Our contract with MMA also allows for special focused peer reviews of any unexpected death or when there is a question of a significant departure from the standard of care. An outside dentist from Community Dental will also review 20 charts of the hospital dentist for clinical appropriateness quarterly.

STRATEGIC PERFORMANCE EXCELLENCE

2. MEC Subcommittee and IPEC Indicator Monitoring Activities:

The subcommittees of the MEC and the Integrated Performance Excellence Committee are the primary methods by which the medical staff monitor and analyze for trends all hospital-wide quality performance data as well as trends more specific to medical staff performance. The subcommittees, in turn, report their findings on a monthly basis to the Medical Executive Committee and to the Clinical Director for any needed action. The respective committees monitor the following indicators:

a. Integrated Performance Excellence Committee (this is not a subcommittee of the Medical Staff but the Clinical Director serves as a member and is the primary liaison to the Medical Executive Committee).
   - Psychiatric Emergencies
   - Seclusion and Restraint Events
   - Staff or Patient Injuries
   - Priority I Incident Reports
   - Other clinical/administrative department monitoring activity

b. Pharmacy and Therapeutics Committee:
   - Medication Errors Including Unapproved abbreviations
   - Adverse Drug Reactions
   - Pharmacy Interventions
   - Antibiotic Monitoring
   - Medication Use Evaluations
   - Psychiatric Emergency process

c. Medical Records Committee:
   - Chart Completion Rate/Delinquencies

d. Infection Control Committee:
   - Infection Rates (hospital acquired and community acquired)
   - Staff Vaccination Rates/Titers

e. Utilization Management Committee:
   - Insurance Denials

f. Med Staff QA & PI Committee:
   - Hospital-wide Core Measures and NASMHPD Data
   - Patient Satisfaction Surveys
   - Administrative concerns about quality
   - Special quality improvement monitors for the current year (see also the Appendix and number 6 below).
   - Reports from the Human Rights Committee regarding patient rights and safety issues
   - Specific case reviews

STRATEGIC PERFORMANCE EXCELLENCE

3. **Performance or Process Improvement Teams**:
When requested by or initiated by other disciplines or by hospital administration, or when performance issues are identified by the medical staff itself during its monitoring activities, the Clinical Director will appoint a medical staff member to an ad hoc performance improvement team. This is generally a multidisciplinary team looking at ways to improve hospital wide processes. Currently the following performance improvement teams involving medical staff are in existence or have recently completed their reviews:
    a. Review of treatment plans
    b. Review of mealtimes and fresh air breaks for whole hospital

4. **Miscellaneous Performance Improvement Activities**:
In addition to the formal monitoring and peer review activities described above, the Clinical Director is vigilant for methods to improve the delivery of clinical care in the hospital from interactions with, and feedback from, other discipline chiefs, from patients or from their complaints and grievances, and from community practitioners who interact with hospital medical staff. These interactions may result in reports to the Medical Executive Committee, in the creation of performance improvement teams, performance of a root-cause analysis, or counseling of individual practitioners.

5. **Reports of Practitioner-specific Data to Individual Practitioners**:
The office of the Clinical Director will provide confidential outcomes of practitioner-specific data to each medical staff member within 30 days of the end of the fiscal year. It will be placed in the confidential section of the practitioner's medical staff file and freely accessible during normal business hours. The office of the Clinical Director will notify all medical staff members when the data is available for review. Each medical staff member may discuss the data with the Clinical Director at any.

6. Upon the recommendation of the Clinical Director, upon recommendation of the MEC as a whole after a request from any member of the medical staff, from a recommendation of the Integrated Performance Excellence Committee, or upon recommendation of the Advisory Board, this plan may be amended with appropriate approvals at any time. Examples of when amendments might be necessary are the detection of new clinical problems requiring monitoring or when it is discovered that current monitors are consistently at or near target thresholds for six consecutive months. Should the number of active clinical monitors fall below four at any time, replacement monitors will be activated within two months of termination of the previous monitor (s). The Clinical Director, the Medical Staff President, and the MEC are jointly responsible for maintaining an active monitoring system at all times and to insure that all relevant clinical service

areas or services are involved in monitoring. The Director of Integrated Quality will also assist in assuring the ongoing presence of appropriate monitors.

Quality Improvement Reporting Schedule to Medical Executive Committee

Pharmacy & Therapeutics Committee:	Chair reports monthly
Medical Records Committee:	Chair reports monthly
Infection Control Committee:	Chair reports monthly
Utilization Management Committee:	Chair reports bimonthly
Med Staff QA and PI Committee:	Clinical Director reports monthly and to individual practitioners as necessary
Research Committee	Clinical Director reports bimonthly
CME Committee	Chair reports bimonthly
Human Rights Committee (Allegations of Abuse, Neglect and Exploitation)	Clinical Director reports monthly

STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: Polyantipsychotic Therapy

Measure Description: The use of two or more antipsychotic medications (polyantipsychotic therapy) is discouraged as current evidence suggests little to no added benefit with an increase in adverse effects when more than one antipsychotic is used. The Joint Commission Core (TJC) Measure HBIPS-5 requires that justification be provided when more than one antipsychotic is used. Three appropriate justifications are recognized: 1) Failure of 3 adequate monotherapy trials, 2) Plan to taper to monotherapy (cross taper) and 3) Augmentation of clozapine therapy. This measure aligns itself with the HBIPS-5 core measure and requires the attending psychiatrist to provide justification for using more than one antipsychotic. In addition to the justification, the clinical/pharmacological appropriateness is also evaluated.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Justified Polyantipsychotic Therapy	76% (2016)	90%	90%	90%	90%	**90%**
Actual			82%	52%			**67%**

Data Analysis: All medication profiles in the hospital are reviewed in each month of the quarter for antipsychotic medication orders. Attending psychiatrists are required to complete a Polyantipsychotic Therapy Justification Form when a patient is prescribed more than one antipsychotic.

Action Plan: This monitor will continue to be a process improvement parameter until we reach our goal of 90% overall. We will continue to monitor for appropriate justification of polyantipsychotic therapy. Pharmacy will continue alerting providers to provide justifications for polyantipsychotic therapy. Hopefully, these strategies will provide the necessary prompts to Medical Staff as reminders to address and provide justification for polyantipsychotic therapy.

Comments: 52% for the 2nd quarter is significantly lower that the baseline and prior quarter since the forms from four providers are not included in this report. Upon receipt of the completed Polyantipsychotic Therapy Justification Forms, the info will be reflected and noted in the third quarter report. We will be monitoring the completion of these parameters and reporting on them monthly to the Medical Staff Quality Assurance and Process Improvement Committee as well as quarterly in this report.

STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Metabolic Monitoring

Measure Description: Metabolic syndrome is a well-known side effect of second generation antipsychotics (SGAs). The majority of patients prescribed antipsychotics are prescribed an entity from the SGA sub-class. The purpose of this monitor is to ensure that we are monitoring, or attempting to monitor, SGA therapy appropriately for those patients prescribed SGAs.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Complete/Up-to-date Metabolic Parameters	69% (FY16)	75%	75%	75%	75%	**75%**
Actual			81%	16%			**49%**

Data Analysis: The pharmacy completed data collection of metabolic monitoring parameters for all patients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all patients included BMI (Body Mass Index) and BP (blood pressure) plus lab results including HDL cholesterol, triglycerides, fasting blood sugar, and hemoglobin A1c.

Action Plan: We will continue to monitor for metabolic syndrome in patients using SGA therapy. The patient's right to refuse assessment (weight, blood pressure and lab work) has been identified as a contributing factor to not being able to fully assess their metabolic status. The pharmacy has been updating a flow sheet for the medical service monthly to identify which patients are due for lab work to aid providers in this task.

Comments: We saw a significant decrease this quarter from 81% to 16%. This is due to prescribers and pharmacists not having readily retrievable access to labs. We are in the process of remedying this issue and will continue to monitor these parameters.

STRATEGIC PERFORMANCE EXCELLENCE

2Q2017	
# of patients with complete/up-to-date parameters	5
# of patients missing/not up-to-date parameters	25
# of patients meeting criteria for metabolic syndrome	7
# of patients without metabolic syndrome	7
# of patients unable to determine if have metabolic syndrome	16

III. Measure Name: Drug Safety Monitoring

Data Analysis: We have assessed a baseline group of patients with regards to the completion of their laboratory monitoring. Each month patients using lithium, valproic acid derivatives, carbamazepine or oxcarbazepine will be evaluated for completeness of their monitoring parameters as stated in the table above and reported to the Medical Staff Quality Assurance and Process Improvement Meeting so that missing parameters may be obtained.

Action Plan: Our plan is to continue to review patients using lithium, valproic acid derivatives, carbamazepine or oxcarbazepine for completeness of monitoring parameters. Our goal is 90% of patients will have complete parameters as specified in the above table over the next two quarters. An effort will be made to report the patient list and missing laboratory values monthly to aid in keeping this percentage at or above 90%.

Comments: At baseline in 1Q 2017, 26 patients were utilizing lithium, valproic acid derivatives, carbamazepine or oxcarbazepine with 11 patients (42%) not having up to date laboratory parameters. We will be monitoring the completion of these parameters and reporting on them monthly to the Medical Staff Quality Assurance and Process Improvement Committee as well as quarterly in this report.

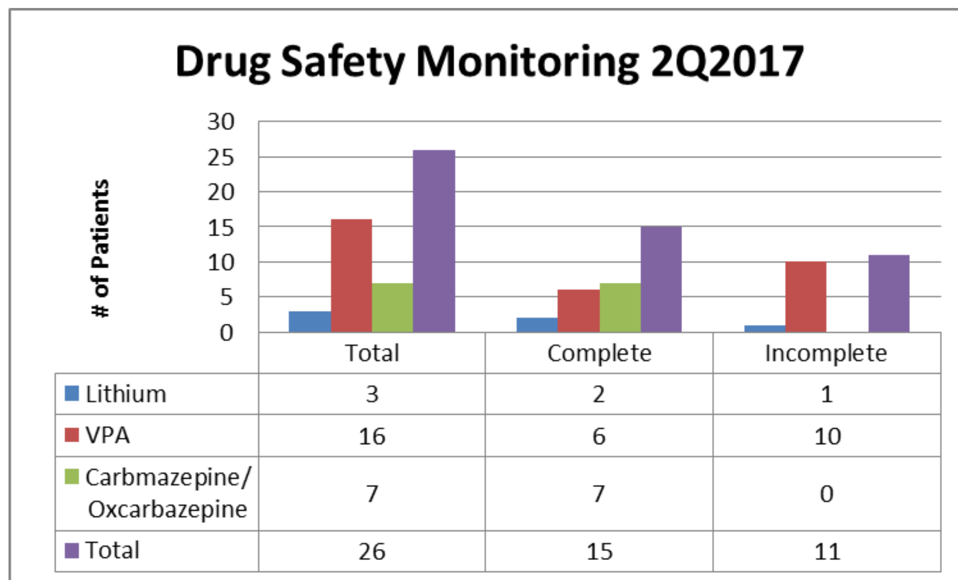
Laboratory Monitor	Lithium	VPA	Carbamazepine/ Oxcarbazepine
Baseline	• TSH • ECG (for clients >40 years of age) • Pregnancy test	• CBC • LFTs • Albumin • Sodium • Ammonia • Pregnancy Test	• CBC • LFTs • Albumin • Electrolytes • Pregnancy Test
Serum Levels	• At steady state • Every 3-6 months • As clinically indicated	• At steady state • As clinically indicated	• Two levels to establish dose, 4 weeks apart • As clinically indicated
Longitudinal Monitoring			
Every 3 months	• Once At 3months: ○ BUN ○ SCr ○ TSH	• Every 3 months for the 1st year of therapy: ○ Weight ○ CBC ○ LFTs ○ Albumin ○ Sodium	• Monthly for 3 months: ○ CBC ○ LFTs ○ Albumin ○ Electrolytes ○ BUN ○ SCr
Every 6 months	• BUN • SCr • TSH • Weight	---	---
Every 12 months	• Weight	• Weight • CBC • LFTs • Albumin • Sodium • BP* • Bone density* • FBG * • Fasting lipids*	• CBC • LFTs • Albumin • Electrolytes • BUN • SCr

***If there are clinical risk factors**
BP – blood pressure; BUN – blood urea nitrogen; CBC – complete blood count; ECG – echocardiogram; FBG – fasting blood glucose; FLP – fasting lipid profile; LFTs – liver function tests; SCr – serum creatinine; TSH – thyroid stimulating hormone; VPA – valproic acid and derivatives

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

STRATEGIC PERFORMANCE EXCELLENCE

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Complete/Up-to-date Laboratory Parameters	79% (FY2016)	90%	90%	90%	90%	**90%**
Actual			60%	42%			**51%**



	Total	Complete	Incomplete
Lithium	3	2	1
VPA	16	6	10
Carbmazepine/ Oxcarbazepine	7	7	0
Total	26	15	11

STRATEGIC PERFORMANCE EXCELLENCE

Nursing

Responsible Party: Renee Pfingst, RN, Director of Nursing

I. Measure Name: Mandate Occurrences

Definition: When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy. This creates difficulty for the employee who is required to unexpectedly stay at work up to 16 hours. It also creates a safety risk.

Type of Measure: Performance Improvement

Objective: Through collaboration among direct care staff and management, solutions will be identified to improve the staffing process in order to reduce and eventually eliminate mandate occurrences. This process will foster safety in culture and actions by improving communication, improving staffing capacity, mitigating risk factors, supporting the engagement and empowerment of staff. It will also enhance fiscal accountability by promoting accountability and employing efficiency in operations.

Methods of monitoring: Monitoring would be performed by:

- Staffing Office Database Tracking System
- Human Resources Department Payroll System

Methods of reporting: Reporting would occur by one or all of the following methods:

- Staffing Improvement Task Force
- Nursing Leadership
- Riverview Nursing Staff Communication

Unit: Mandate shift occurrences

Baseline: September 2013: Nurse Mandates 14 shifts, Mental Health Worker Mandates 49 shifts

STRATEGIC PERFORMANCE EXCELLENCE

Mandate Occurrences: When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.

	Baseline Sept 2013	3Q2016			4Q2016			1Q2017			2Q2017			Goal
		Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	
Nursing Mandates	14	11	8	10	11	8	10	1	0	0	4	5	1	0
Mental Health Worker (MHW) Mandates	49	62	41	32	62	41	32	6	10	6	8	16	2	0

Nursing mandates increased from 1 last quarter to 10 this quarter.
MHW mandates increased from 22 last quarter to 26 this quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

2Q2017 - Lower Saco

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	15/15	100%
2. STGs/ Interventions relate directly to content of GAP note	15/15	100%
3. Weekly Summary note completed	11/15	73%
4. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	5/15 10 N/A	100%
5. Multidisciplinary Teaching checklist active being completed	14/15	93%
6. Dental education Teaching checklist	15/15	100%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	15/15	100%
8. Annual Assessment completed	5/15 10 N/A	100%
9. Client's rights signed	15/15	100%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	15/15	100%
11. Informed Consent signed and dated	15/15	100%
12. STG Interventions are clear, simple behavioral actions for nurses	15/15	100%
13. STG for client is behavioral and measurable	15/15	100%
14. SRC monitor sheets completed	15 N/A	100%
15. Client debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	15 N/A	100%
16. Safety meeting held 72 hours after coercive event	15 N/A	100%
17. Treatment plan updated after every coercive event	15 N/A	100%
18. Staff debriefing completed within 24 hours of coercive event	15 N/A	100%

(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

2Q2017 - Upper Saco

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	15/15	100%
2. STGs/ Interventions relate directly to content of GAP note	15/15	100%
3. Weekly Summary note completed	14/15	93%
4. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	9/15	60%
5. Multidisciplinary Teaching checklist active being completed	9/15	60%
6. Dental education Teaching checklist	14/15	93%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	15/15	100%
8. Annual Assessment completed	7/15 8 N/A	100%
9. Client’s rights signed	14/15 1 Ref.	100%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	11/15 2 Ref	93%
11. Informed Consent signed and dated	15/15	100%
12. STG Interventions are clear, simple behavioral actions for nurses	15/15	100%
13. STG for client is behavioral and measurable	15/15	100%
14. SRC monitor sheets completed	1/15 14 N/A	100%
15. Client debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	1/15 14 N/A	100%
16. Safety meeting held 72 hours after coercive event	1/15 14 N/A	100%
17. Treatment plan updated after every coercive event	1/15 14 N/A	100%
18. Staff debriefing completed within 24 hours of coercive event	1/15 14 N/A	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

2Q2017 - Lower Kennebec

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	8/15	53%
2. STGs/ Interventions relate directly to content of GAP note.	12/15	80%
3. Weekly Summary note completed.	15/15	100%
4. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	3/15 11 N/A	93%
5. Multidisciplinary Teaching checklist active being completed	15/15	100%
6. Dental education Teaching checklist	15/15	100%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	15/15	100%
8. Annual Assessment completed.	13/15 2 N/A	100%
9. Client's rights signed.	13/15	87%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	15/15	100%
11. Informed Consent signed and dated	14/15	93%
12. STG Interventions are clear, simple behavioral actions for nurses	13/15	87%
13. STG for client is behavioral and measurable	10/15	67%
14. SRC monitor sheets completed	1/15 14 N/A	100%
15. Client debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	1/15 14 N/A	100%
16. Safety meeting held 72 hours after coercive event	1/15 14 N/A	100%
17. Treatment plan updated after every coercive event	1/15 14 N/A	100%
18. Staff debriefing completed within 24 hours of coercive event	1/15 14 N/A	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

2Q2017 - Upper Kennebec

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	11/15	73%
2. STGs/ Interventions relate directly to content of GAP note.	11/15	73%
3. Weekly Summary note completed.	14/15	93%
4. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	2/15 13 N/A	100%
5. Multidisciplinary Teaching checklist active being completed.	15/15	100%
6. Dental education Teaching checklist	15/15	100%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	15/15	100%
8. Annual Assessment completed.	14/15	93%
9. Client's rights signed.	14/15	93%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	14/15	93%
11. Informed Consent signed and dated	13/15	87%
12. STG Interventions are clear, simple behavioral actions for nurses	15/15	100%
13. STG for client is behavioral and measurable	15/15	100%
14. SRC monitor sheets completed	15 N/A	100%
15. Client debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	15 N/A	100%
16. Safety meeting held 72 hours after coercive event	15 N/A	100%
17. Treatment plan updated after every coercive event	15 N/A	100%
18. Staff debriefing completed within 24 hours of coercive event	15 N/A	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

2Q2017 Total – All Units

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	49/60	82%
2. STGs/ Interventions relate directly to content of GAP note	49/60	82%
3. Weekly Summary note completed	47/60	78%
4. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	14/60 45 N/A	98%
5. Multidisciplinary Teaching checklist active being completed	43/60	72%
6. Dental education Teaching checklist	59/60	98%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	59/60	98%
8. Annual Assessment completed	40/60 20 N/A	100%
9. Client's rights signed	56/60 1 Ref.	95%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	47/60	78%
11. Informed Consent signed and dated	59/60	98%
12. STG Interventions are clear, simple behavioral actions for nurses	58/60	97%
13. STG for client is behavioral and measurable	58/60	97%
14. SRC monitor sheets completed	2/60 58 N/A	100%
15. Client debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	2/60 58 N/A	100%
16. Safety meeting held 72 hours after coercive event	2/60 58 N/A	100%
17. Treatment plan updated after every coercive event	2/60 58 N/A	100%
18. Staff debriefing completed within 24 hours of coercive event	2/60 58 N/A	100%

STRATEGIC PERFORMANCE EXCELLENCE

Outpatient Services (OPS)

Responsible Party: Lisa Manwaring, PSD, Director

I. Measure Name: Admission Assessments

Measure Description: Within 5 business days of admission initial assessments from Psychiatry, Psychosocial, and Nursing will be complete and in the chart. All three will need to be present to count.

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**3Q2016**	**4Q2016**	**1Q2017**	**2Q2017**	**YTD**
Target	Percent of assessments completed on time	FY 2015 0% 0/4	75%	75%	75%	75%	**75%**
Actual			0% 0/4	25% 1/4	34% 2/6	42% 5/12	**31% 8/26**

Data Analysis: Two charts had one of the three assessments late by one day.

Action Plan: To review data results with the OPS staff to ensure compliance.

Comments: To provide education and admission packets with assessment reminders to help facilitate compliance.

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Responsible Party: Julia Duncan, Peer Support Coordinator

Indicator: Inpatient Consumer Survey Return Rate

Definition: There is a low number of satisfaction surveys completed and returned once offered to patients due to a number of factors.

Objective: To increase the number of surveys offered to patients, as well as increase the return rate.

Those responsible for Monitoring: Peer Support Director and Peer Support Team Leader will be responsible for developing tracking tools to monitor survey due dates and surveys that are offered, refused, and completed. Peer Support Staff will be responsible for offering surveys to patients and tracking them until the responsibility can be assigned to one person.

Methods of Monitoring:

- Biweekly supervision check-ins
- Monthly tracking sheets/reports submitted for review

Methods of Reporting:

- Patient Satisfaction Survey Tracking Sheet
- Completed surveys entered into spreadsheet/database

Unit: All patient care/residential units

Baseline: Determined from previous year's data.

Quarterly Targets: Quarterly targets vary based on unit baseline with the end target being 50%.

STRATEGIC PERFORMANCE EXCELLENCE

Survey Return Rate	Unit	Baseline	Target	3Q2016	4Q2016	1Q2017	2Q2017	YTD
The inpatient consumer survey is the primary tool for collecting data on how patients feel about the services they are provided at the hospital.	**LK**	15%	50%	64% 7/11	9% 1/11	8% 1/13	50% 4/8	**30% 13/43**
	LS	5%	50%	13% 2/16	0% 0/10	0% 0/12	90% 9/10	**22% 11/48**
	UK	45%	50%	19% 5/26	13% 3/22	0% 0/18	25% 6/24	**15% 14/90**
	US	30%	50%	0% 0/5	12% 1/8	16% 1/6	44% 7/16	**26% 9/35**
	Overall			**24% 14/58**	**10% 5/51**	**4% 2/49**	**45% 26/58**	**22% 47/216**

Comments: Percentages are calculated based on the number of people eligible to receive a survey vs. the number of people who completed the surveys.

Inpatient Consumer Survey Results

#	Indicators	3Q 2016	4Q 2016	1Q 2017	2Q 2017	YTD Average
1	I am better able to deal with crisis.	53%	70%	75%	70%	**67%**
2	My symptoms are not bothering me as much.	64%	65%	75%	68%	**68%**
3	The medications I am taking help me control symptoms that used to bother me.	42%	65%	38%	68%	**53%**
4	I do better in social situations.	56%	70%	63%	65%	**64%**
5	I deal more effectively with daily problems.	64%	64%	38%	69%	**59%**
6	I was treated with dignity and respect.	56%	65%	50%	68%	**60%**
7	Staff here believed that I could grow, change and recover.	56%	70%	50%	70%	**62%**
8	I felt comfortable asking questions about my treatment and medications.	72%	70%	75%	68%	**71%**
9	I was encouraged to use self-help/support groups.	58%	70%	75%	69%	**68%**
10	I was given information about how to manage my medication side effects.	64%	70%	25%	58%	**54%**
11	My other medical conditions were treated.	64%	55%	88%	63%	**68%**
12	I felt this hospital stay was necessary.	58%	40%	38%	54%	**48%**
13	I felt free to complain without fear of retaliation.	44%	70%	38%	59%	**53%**

STRATEGIC PERFORMANCE EXCELLENCE

14	I felt safe to refuse medication or treatment during my hospital stay.	47%	60%	88%	57%	**63%**
15	My complaints and grievances were addressed.	47%	88%	63%	63%	**65%**
16	I participated in planning my discharge.	72%	88%	88%	57%	**76%**
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	53%	75%	38%	54%	**55%**
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	56%	60%	50%	55%	**55%**
19	The surroundings and atmosphere at the hospital helped me get better.	50%	65%	38%	56%	**52%**
20	I felt I had enough privacy in the hospital.	58%	60%	38%	58%	**54%**
21	I felt safe while I was in the hospital.	61%	65%	75%	63%	**66%**
22	The hospital environment was clean and comfortable.	56%	65%	88%	68%	**69%**
23	Staff were sensitive to my cultural background.	44%	69%	63%	67%	**61%**
24	My family and/or friends were able to visit me.	58%	75%	25%	67%	**56%**
25	I had a choice of treatment options.	44%	75%	38%	67%	**56%**
26	My contact with my doctor was helpful.	58%	70%	88%	65%	**70%**
27	My contact with nurses and therapists was helpful.	67%	75%	75%	71%	**72%**
28	If I had a choice of hospitals, I would still choose this one.	53%	45%	50%	59%	**52%**
29	Did anyone tell you about your rights?	50%	88%	38%	69%	**61%**
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	44%	69%	38%	61%	**53%**
31	Do you know someone who can help you get what you want or stand up for your rights?	50%	81%	88%	70%	**72%**
32	My pain was managed.	50%	69%	88%	68%	**69%**
	Overall Score	**55%**	**68%**	**59%**	**64%**	**62%**

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Responsible Party: Michael Migliore, Director of Pharmacy

I. Measure Name: Controlled Substance Loss Data

Measure Description: Daily and monthly comparison of Pyxis vs CII Safe Transaction Report.

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2016**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Pharmacy	0.19%	0%	0%	0%	0%	0%
Actual			0%	0%			0%

Data Analysis: All of the controlled substances have been accounted for, resulting in a 0% loss of controlled substances for the second quarter.

Action Plan: Continue to remain vigilant and educate staff on proper automated dispensing cabinet procedures to avoid the creation of discrepancies.

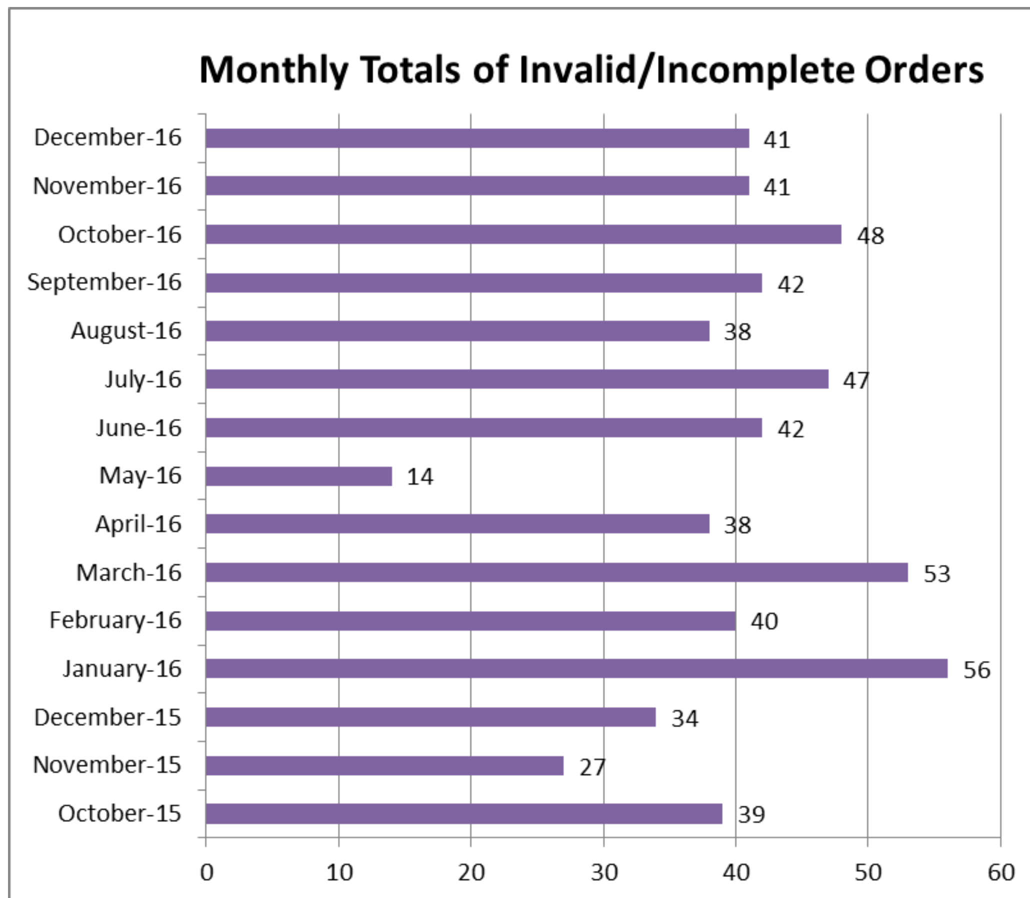
Comments: The action plan continues to provide favorable results.

STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Invalid Orders

Measure Description: Incomplete/Invalid Orders.

Type of Measure: Performance Improvement



Background: With a zero tolerance policy for invalid orders, every prescribed order must contain the drug name, strength, administration route, dosing frequency, provider signature, order time and date, accurate allergy and adverse drug reaction information, and indication. Receiving an invalid order by the staff pharmacist requires documentation, copying and returning the invalid order to the prescriber for remediation, as well as contacting and informing the unit of the invalided order.

Data Analysis: For the 2nd quarter, the number of invalid orders is in the forty range. October reported 48 invalid/incomplete orders with 41 in November and 41 in December. Missing

indications, allergies and adverse drug reactions were the highest findings. This information continues to be reported at the monthly Pharmacy and Therapeutics Committee meeting.

Action Plan: The need to track incomplete orders after the initiation of the new EHR system in 2017 will become obsolete since the conversion will forbid providers to proceed to initiate an order that is not complete.

III. Measure Name: Veriform Medication Room Audits

Measure Description: Comprehensive Unit Compliance Audits

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2016**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	All	100%	100%	100%	100%	100%	**100%**
Actual			100%	100%			**100%**

Data Analysis: The pharmacy medication room audits for all units have been completed for quarter two without completion deficiencies.

Action Plan: No deficiencies were noted with pharmacy's completion of the medication room audits. Pharmacy staff will continue to operate to maintain 100% completion and will continue reporting any noted deficiencies to nursing staff.

Comments: Continuous monitoring of the Medication room audits and approval by the responsible individuals has again provided satisfactory results for this quarter. Excellent communication and cooperation with interdepartmental administration is the key to this favorable report.

STRATEGIC PERFORMANCE EXCELLENCE

IV. Measure Name: Fiscal Accountability

Measure Description: Monthly Tracking of Dispensed Discharge Prescriptions

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline Avg. FY2016**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Actual	All	$5,479 for 361 Rx's	$6870 for 344 Rx's	$5503 For 311 Rx's			$12,373 For 655 Rx's

Data Analysis: Riverview Psychiatric Center's Extended Hospital Pharmacy license permits it to dispense medication to both inpatients and outpatients. The majority of the outpatient prescriptions are for a 7-day supply of discharge medications. Administrative approval is required when a greater than 7 day supply is needed. Discharge prescriptions serve to cover the patient's needs until they are able to obtain medications in the community.

Action Plan: Efforts to coordinate advance discharge planning to mimic the process currently in place at Dorothea Dix Psychiatric Center will permit patients to obtain prescription coverage prior to discharge and result in decreased pharmacy expenditures as well as a reduction in the volume of outpatient prescriptions provided by the pharmacy.

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	Baseline Avg. FY2016	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
$ spent	$5,479	$6870	$5503			$12,373
# RX's	361	344	311			655
$ per Rx	$15.18	$19.97	$17.69			$18.89

Comments: The second quarter reported similar total prescription costs as the baseline/quarter 2016 and also reported a lower than average number of Rx's. The cost of a 2nd quarter prescription was $17.69, a $2.28 decrease from 1st quarter. Formulary management, providing the most cost effective medications, and utilizing wholesaler and buying group resources are providing favorable results regarding the expense of discharge patient medications.

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

(Occupational Therapy, Therapeutic Recreation, Vocational Services, Chaplaincy, Patient Education)

Responsible Party: Janet Barrett, CTRS, Director of Rehabilitation Services

I. Measure Name: Recreational Therapy Assessment

Measure Description: Improving health outcomes/patient care. In order to receive effective treatment, all patients admitted to RPC will take part in a Recreational Therapy Assessment within 7 days of admission. Each Recreation Therapist will then use this assessment to assist in the formulation of treatment interventions to assist patients in returning to a satisfying and meaningful life upon discharge. Target is to achieve and maintain an overall goal of 100% for 4 consecutive Quarters

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of Initial Rec Assessments within 7 days	85%	100%	100%	100%	100%	**100%**
Actual			88% 46/52	86% 47/56			**86% 93/108**

Data Analysis: Of the 56 admissions, 8 of the patients did not have their initial assessment completed within the 7 day timeframe. Factors that contributed to not achieving a 100% where 3 of the assessments were late secondary to a holiday weekend falling within the 7 day window. Eight of the eight assessments not completed timely were one day late.

Action Plan: Meet with the Recreation Therapists and develop a tracking system for admissions to ensure all assessments are completed in the allotted time frame.

STRATEGIC PERFORMANCE EXCELLENCE

Safety & Security

Responsible Party: Philip Tricarico, Safety Officer

I. Measure Name: Contraband/Prohibited Items

Measure Description: Contraband/prohibited items found during front Lobby screening done by security staff of patients and visitors, to create and foster a safe environment for all staff, patients, and visitors.

"Contraband" is a term used to describe ant items that are illegal to possess / use by statute. RPC knowledge of possession / use of such item(s) on RPC property may involve law enforcement notification / intervention. Contraband as identified in statute "means any tool or other item that may be used to facilitate of section 755, a dangerous weapon or a scheduled drug as defined in section 1101, subsection 11, unless in the case of a patient at a state hospital. As used in this section, "state hospital" means the Riverview Psychiatric Center. A person is guilty of trafficking in contraband in a state hospital if:

1. That person intentionally conveys or attempts to convey a dangerous weapon to any patient at a state hospital. Violation of this paragraph is a Class C crime.
2. That person intentionally conveys or attempts to convey contraband, other than a dangerous weapon to any patient at a state hospital. Violation of this paragraph is a Class D crime.
3. Being a patient at a state hospital, that person intentionally makes, obtains or possesses contraband Violation of this paragraph is a Class D crime.

"Prohibited" is a term used to describe any items that are not illegal to possess / use. But are not permitted for entry into the secure areas in the RPC building or permitted for possession / use on RPC grounds. Unless specified otherwise by stature or hospital policy. Some prohibited items may be secured in a locked vehicle or at security.

Objective: Through inspection, observation, and aggressive incident management, an effective management process would limit or eliminate the likelihood that a safety/security incident would occur. This process would ultimately create and foster a safe environment for all staff, clients, and visitors.

Those Responsible for Monitoring: Monitoring would be performed by Safety Officer, Security Site-Manager, Security Officers, Operations Supervisor, Operations staff, Director of Support Services, Director of Environmental Services, Environmental Services staff, Supervisors, and frontline staff.

STRATEGIC PERFORMANCE EXCELLENCE

Methods of Monitoring:

- Direct observation
- Cameras
- Front Lobby security screening of patients and visitors.

Methods of Reporting: Reporting would occur by one or all of the following methods;

- Daily Activity Reports (DAR's)
- Incident Reporting System (IR's)

Unit: Hospital Wide
Baseline: -5% reduction of contraband / prohibited found each Q
Goal: Baseline – 5% each Q

Results						
	Baseline	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD % Met**
Target	3089	New Measure	3089-5% = 2935	2534-5% = 2407		**100%**
Actual		3089	2534			**100%**

2Q2017: This is a new measure for FY2017. We have met our goal for this Quarter. Although we are tracking 17 different categories of contraband and prohibited items, for the purpose of this indicator I am only reporting the items that pose the greatest risk/hazard to the patients and facility. Being a new CPI this is a work in progress. We may change some of the items and reporting format to better suite our needs. For instance, keys and cellphones account for a very large share of items held. However, almost every visitor has these two items so Security specifically asks for and looks for them. Therefore, the risk of them getting by Security is very minimal. Matches and lighters are easy to be missed in a screening. Therefore they will be reported for this CPI. The same goes for drugs. If any of these items gets past Security it could have serious consequences for our patients and facility. We are also including known failures, incidents where an item should be held by Security but somehow got through. We are utilizing incident reports to record failures. IR's eliminate any bias or hearsay information. We had a net decrease in the 4 items we are tracking (weapons, drugs, lighters and chain wallets). The data also points to Wednesday being the busiest day of the week for contraband/prohibited items. This can be explained by the District Court cases heard here. We get a noticeable increase in outside visitors on this day.

Weapons: 24
Lighters: 97
Drugs (prescription and other): 4
Chain Wallets: 360

Event	Date	Time	Location	Disposition	Comments
There were no reported incidents of contraband/prohibited items getting past Security.					

II. Measure Name: Grounds Safety/Security Incidents

Measure Description: Safety/Security incidents occurring on the grounds at Riverview. Grounds being defined as "*outside the building footprint of the facility, being the secured yards, parking lots, pathways surrounding the footprint, unsecured exterior doors, and lawns.* Incidents being defined as, "*Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches.* These incidents shall also include "*near misses, being of which if they had gone unnoticed, could have resulted in injury, an accident, or unwanted event".*

Objective: Through inspection, observation, and aggressive incident management, an effective management process would limit or eliminate the likelihood that a safety/security incident would occur. This process would ultimately create and foster a safe environment for all staff, clients, and visitors.

Those Responsible for Monitoring: Monitoring would be performed by Safety Officer, Security Site-Manager, Security Officers, Operations Supervisor, Operations staff, Director of Support Services, Director of Environmental Services, Environmental Services staff, Supervisors, and frontline staff.

Methods of Monitoring: Monitoring would be performed by;
- Direct observation
- Cameras
- Patrol media such as "Vision System"
- Assigned foot patrol

STRATEGIC PERFORMANCE EXCELLENCE

Methods of Reporting: Reporting would occur by one or all of the following methods; Daily Activity Reports (DAR's)

- Incident Reporting System (IR's)
- Web-based media such as the Vision System

Results						
	Baseline	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	10	2	2	2	2	**8**
Actual		2	0			**2**

The 2Q 2017 Target was (2). Our actual number was (0). We absolutely exceeded our goal! We have not had any issues this quarter with state owned pickup trucks and the contraband they frequently contained. We have been working with Capitol Police, Fleet Management and the Department of Conservation (agency the trucks are assigned to). There has been significant improvement in how often we are finding contraband items in these trucks. We will continue to work with all parties as we seek to resolve this issue. Although we had no issues this quarter a new system was implemented, by maintenance, for checking cars in and out. We will monitor and remain vigilant as we all get used to the new system. The past two quarters have presented a new problem to us. The locks and chains on the dumpsters have been cut or damaged to the point of not being usable. We will continue to monitor this and look for solutions. We are pleased that in all of the events, our Security staff or clinical staff had discovered/processed the event before there was a negative impact to the patients. The reporting, which follows below, continues to provide a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our aggressive rounds by Securitas continue to prove its worth with regard to Security's presence and patrol techniques. The stability and longevity of our Security staff along with its cohesiveness with the Clinical component of the hospital has proven to be most effective in our management of practices.

Event	Date	Time	Location	Disposition	Comments
No incidents to report this quarter.					