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

Department of Health and Human Services
Substance Abuse and Mental Health Services
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-2595; Fax: (207) 287-4334
TTY Users: Dial 711 (Maine Relay)

May 1, 2016

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

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

Dear Justice Walthen:

Enclosed, pursuant to paragraph 280 of the Settlement Agreement, please find the Substance Abuse and Adult Mental Health Services Quarterly Report for the quarter ending Dec 31, 2015.

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
Daniel J. Eccher, Assistant Attorney General
Mary C. Mahew, Commissioner DHHS

Department of Health & Human Services, Office of Adult Mental Health Services
Bates v. DHHS Consent Decree
Jan., Feb., March 3nd Quarter, SFY 2016
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 3nd quarter of state fiscal year 2016, covering the period January, February and March 2016. A link to the PDF version of each document is provided on the SAMHS website.

		DESCRIPTION
1	**Cover Letter, Quarterly Report:** May 2016 *Section 1*	Letter to Dan Wathen, Court Master, submitting the Quarterly Report pursuant to paragraph 280 of the Settlement Agreement for the quarter ending March 31, 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 19 specific performance and quality improvement standards (many are multi-part) 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)

		DESCRIPTION
		concerning consumers (class members and non-class members) who 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	**Community Hospital Utilization Review** *Section 10*	Aggregate report of Utilization Review (UR) of all persons with MaineCare or without insurance coverage admitted into emergency involuntary, community hospital based beds. UR data is reported one quarter behind to allow sufficient time for reviews and data entry to be completed.
11	**Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital** *Section 11*	Report drawn from UR data that details, by hospital, the percentage of ISPs obtained, ISPs consistent with the hospital treatment and discharge plan, and case manager involvement in hospital treatment and discharge planning. UR data is reported one quarter behind to allow sufficient time for reviews and data entry to be completed.
12	**DHHS Integrated Child/Adult Quarterly Crisis Report** *Section 12*	Aggregate quarterly report of crisis data submitted by crisis providers to the Office of Quality Improvement on a monthly basis.
13	**Riverview Psychiatric Center Performance Improvement Report** *Section 13*	Reports on Riverview's compliance with specific indicators re: performance and quality; recording findings, problem, status, and actions for the specified quarter.
14	**APS Healthcare Reports** *Section 14*	For members on the Community Integration waitlist who were authorized for this service, how long they waited. These reports count the number of days from the date the CFSN was opened to the date the service was authorized. The reports are run 2 quarters behind, therefore, those who were entered on the waitlist will have started the service.

Summary of new Initiatives at SAMHS

The Office of Substance Abuse and Mental Health Services (SAMHS) is currently in the process of hiring a staff member to, among other duties, analyze and manage the Waitlist system. The Waitlist has improved dramatically from January 2015 to January 2016 as represented by a **40**% overall reduction in persons waiting for services; however, the data still shows that a significant number of consumers are remaining on the Waitlist well beyond the assignment times for community integration services specified in the Settlement Agreement. SAMHS will continue to analyze and improve the Waitlist system over the coming months with the goal of achieving substantial compliance. This process includes an analysis of the existing system, as well the relationships and business processes between: APS HealthCare, the Provider Community, SAMHS, and the consumers themselves.

The Behavioral Health Home (BHH) initiative has blossomed as there are currently 4,386 members in the program, 27 Behavioral Health locations with 70 sites. The Office of MaineCare Services started accepting applications on April 1, 2016 to promote additional capacity in the BHH program. The start date for new BHHOs will be July 21, 2016.

New rules governing Section 17 went into effect on April 8, 2016. SAMHS and the Office of the Attorney General will be working on a proposal to reconcile the days to assignment (2 days for class members who are hospitalized, 3 days for class members in the community and 7 days for non-class members) with the changes in Section 17 of the MaineCare Benefits Manual, which now require a 7-day referral to service standard. With these rule changes, we intend to negotiate an amendment to the Settlement Agreement to align the required assignment times to the rule change in Section 17.

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

	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 May2016* And *Unmet Needs by CSN for FY16 Q2 found in Section 7.*
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 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. The Draft Quality Improvement plan for 2016-2019 is being revised to align with the changes at SAMHS.
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 submitted funding requests to meet all identified needs under the Consent Decree, both through the supplemental budget and the next biennial budget, with support of the Governor ; and the Legislature enacted a budget including all requests. These funds are now part of the base budget instead of having to be submitted as budget requests for additional grant funds.
II.2	Demonstrate reliability of unmet needs data based on evaluation	See *Cover: Unmet Needs and Quality Improvement Initiatives May 2016* and the *Performance and Quality Improvement Standards: May 2016* 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 identifying, 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 unmet needs *(Amended language 9/29/09)*	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.
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	The Annual Report for 2015 will be submitted next quarter.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs May 2016* and the *Performance and Quality Improvement Standards: May 2016* for examples of the Department Utilizing the QM system.
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 II.4 above for examples of how quality management data was used to support budget requests for systems improvement. Unmet need reports have been used to identify where additional funds are needed for delivery of services.
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 32 of 32 agencies had protocol/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. SAMHS distributed the survey in Augusta 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.
IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.

	hearing is to be held or if parties concur.	
IV.5	90% hospitalized class members assigned worker within 2 days of request - *must be met for 3 out of 4* quarters	See attached *Performance and Quality Improvement Standards: May 2016,* Standard 5-2. This standard has not been met for the past 4 quarters.
IV.6	90% non-hospitalized class members assigned worker within 3 days of request - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2016,* Standard 5-3. This standard has not been met for the past 4 quarters.
IV.7	95% of class members in hospital or community not assigned within 2 or 3 days, assigned within an additional 7 days - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2016,* Standard 5-4. This standard has not been met for the past 4 quarters.
IV.8	90% of class members enrolled in CSS with initial ISP completed within 30 days of enrollment - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2016,* 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 - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2016,* 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.
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.
IV.12	Certify in quarterly reports that DHHS is meeting its obligation re: quarterly mailings	On December 10, 2014, the court approved an amendment to a Stipulated Order that requires monitoring of class member addresses. If the percentage of unverified addresses exceeds 15%, the court master will review the efforts and make necessary recommendations. A list of class member's addresses is available to the court master, plaintiff's counsel and the court upon request.
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - *must be met for 3 out of 4 quarters*	See Section 9 *Class Member Treatment Planning Review*, Question 2A. This standard has been met in 3 of the last 4 quarters. The percentage for this quarter is 95.9%.
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be met for 3 out of 4 quarters*	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 - *must be met for 3 out of 4 quarters*	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.16	QM system documents that SAMHS requires corrective action by the provider	See Section 9 *Class Member Treatment Planning Review,* Question 6.a.1 that addresses plans of

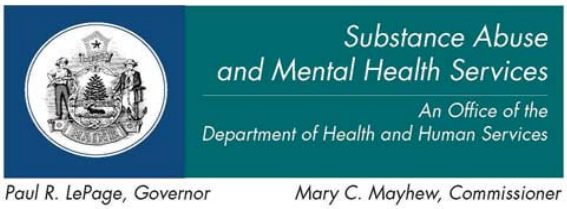
	agency when document review reveals not all domains assessed	correction. Corrective action taken when all domains were not assessed.
IV.17	In 90% of ISPs reviewed, interim plans developed when resource needs not available within expected response times - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2016,* Standard 8-2 and *Class Member Treatment Plan Review*, Question 3F. This standard has not been met in the last 4 quarters.
IV.18	90% of ISPs review included service agreement/treatment plan - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2016,* Standard 9-1 and *Class Member Treatment Plan Review*, Questions 4B & C. This standard has not been met in the last 4 quarters.
IV.19	90% of ACT/ICI/CI providers statewide 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.	Standard 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*	ICMs' work is focused on community forensic and outreach services. Individual ICMs no longer carry caseloads. Should this change in the future, SAMHS will resume reporting on caseload ratios.
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: May 2016,* Standard 10-5. This standard has been met in FY 15 Q2, Q3, Q4 and FY 16 Q1, Q2 and Q3
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: May 2016,* Standard 12-1 Standard met for the FY08 Q4; FY09 Q1,Q3, and Q4; FY10; FY11; FY12, FY13;FY 14, and FY 15, and FY16 Q1, Q2 and Q3
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 **and**	Unmet residential supports needs for non-class members do not exceed 15 percentage points of the same for Class Members. See attached report Consent Decree Compliance Standards IV.23 and IV.43
	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	See attached *Performance and Quality Improvement Standards: May 2016,* Standards 12-2, 12-3 and 12-4 Standard 12.2 and 12.4 were not met Q3 FY16.

	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)	
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**	See attached *Performance and Quality Improvement Standards: May 2016,* Standard 14-1 Standard met in FY 14 Q3 and 32 out of the last 37 quarters.
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 court master)	See attached *Performance and Quality Improvement Standards: May 2016,* Standard 14-4, 14-5 & 14-6 Standard 14-4 met since the beginning of FY09, except for FY10 Q3, FY15 Q4 and FY 16 Q1, Q2 and Q3. Standard 14-5 met FY09 Q2; Q3; and Q4; FY10 Q2 and Q4; FY11;FY12, FY13, FY 14, FY 15, and FY 16 Q1, Q2 and Q3 Standard 14-6 met FY09 Q2 and Q4; FY10 Q2; and Q4; FY11, FY12, FY13, and FY 14, FY 15 Q1 and Q4; and FY 16 Q1, Q2 and Q3 was not met.
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Standard no longer reported per amendment dated May 8, 2014.
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	See attached *Performance and Quality Improvement Standards: May 2016,* Standard 16-1 and *Community Hospital Utilization Review – Class Members 1st Quarter of Fiscal Year 2016.* IN FY13 Q1: 100% (19 of 19) Q2: 92.9% (13 of 14) Q3: 86.7% (13 of 15) Q4: 90.0% (18 of 20) IN FY14 Q1: 27.3%(3 of 11) Q2: 76.5% (13 of 17) Q3: 84.6 % (11 of 13) Q4: 100.0 % (12 of 12) IN FY15 Q1: 100.0%%(12 of 12) Q2: 77.8 (14 of 18) Q3: 95.5% (21 of 22) Q4: 86.7% (13 of 15) IN FY16 Q1: 79.2 (19 of 24) Q2: 94.4 (17 of 18) Q3: 87% (7of 8)
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	All involuntary hospital contracts are in place.

	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	
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	SAMHS reviews emergency involuntary admissions at the following hospitals: Maine General Medical Center, Spring Harbor, St. Mary's, Mid-Coast Hospital, Southern Maine Medical Center, PenBay Medical Center, Maine Medical Center/P6 and Acadia. Only 4 hospitals were reviewed this quarter due to staffing shortages. See Standard IV.33 below regarding corrective actions.
IV.32	Licensing reviews of hospitals include an evaluation of compliance with patient rights and require a plan of correction to address any deficiencies.	22 Complaints Received 11 Complaints investigated 2 Substantiated 1 Plan of correction sought 2 Rights of Recipients Violations found
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	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
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%)	See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members2nd[t] Quarter of Fiscal Year 2016.* The report displaying data by hospital for community hospitals accepting emergency involuntary clients is shared quarterly by posting reports on the CSN section of the Office's website. Standard 18.1 has been met once in the past 4 quarters. Standard 18.2 has been met for the past 4 quarters. Standard 18.3 has been met for the past 3 out of 4 quarters. Only 4 hospitals were reviewed this quarter due staffing shortages.
IV.35	No more than 20-25% of face-to-face crisis contacts result in hospitalization – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2016*, Standard 19-1 and *Adult Mental Health Quarterly Crisis Report 2nd Quarter, State Fiscal Year 2016 Summary Report*. Standard met In FY12,FY13, FY14 Q1, Q3, Q2 slightly above standard (26.3%), Q4 slightly above standard (26.1%), FY 15 Q1, Q3 and Q4, and slightly above standard in Q2 (25.6%); standard met in FY 16 Q1, Q2 and Q3
IV.36	90% of crisis phone calls requiring face-to-face assessments are responded to within an	See attached *Adult Mental Health Quarterly Crisis Report 3rd Quarter, State Fiscal Year 2016 Summary*

	average of 30 minutes from the end of the phone call – *must be met for 3 out of 4 quarters* 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	*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 30 minutes from the end of the phone call – this standard was met FY12, FY13, FY14 Q1, Q2, Q4. FY 15 Q2, Q3, Q4 and FY 16 Q1, Q2 and Q3
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 – *must be met for 3 out of 4 quarters*	See attached *Adult Mental Health Quarterly Crisis Report 3rd Quarter, State Fiscal Year 2016 Summary Report.* Standard has been met since FY08 Q2 until FY 15 Q1 (87.2%), Q2 (87.7%), Q3 (86.8%), Q4 (86.7%) and in FY 16 Q1 (88.6%). Standard met FY 16 Q2 (90.2%), FY 16 Q3 (90.5%)
IV.38	90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2016,* Standard 19-4 and *Adult Mental Health Quarterly Crisis Report 3rd Quarter, State Fiscal Year 2016 Summary Report*. Standard met 3 of the last 4 quarters.
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).
IV.42	5% or fewer class members have unmet needs for mental health treatment services – *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: May 2016,* Standard 21-1 This standard has not been met for the last 3 quarters but was met for Q3 FY16.
IV.43	**EITHER** quarterly unmet mental health treatment needs for one year for qualified 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 mental health treatment needs for non-class members do not exceed 15 percentage points of the same for Class Members. See attached 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: May 2016*, Standards 21-2, 21-3 and 21-4 Standard met since the beginning of FY08
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	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
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*	See attached *Performance and Quality Improvement Standards: May 2016*, Standard 28 This standard has been consistently met since FY08.
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	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
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.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.50	The department documents the number and types of mental health informational 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.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.



Consent Decree Performance and Quality Improvement Standards: May 2016

The attached compliance and performance standards are primarily for use in monitoring, evaluation and quality assurance of the areas covered by the Consent Decree pertaining to the community mental health system. The standards are intended to offer the parties and the court master a means of measuring system function and improvement over time and the Department's work towards compliance. If the percentage is within .5% of standard, the standard is considered met.

All standards utilizing RDS/enrollment data, inclusive of unmet need data, are reported one quarter behind (for example, reporting 3rd quarter data in the 4th quarter).

Reporting includes, where pertinent, discussion of the data and recommendations.

Definitions:	What the standard is intending to measure.
Standard Title:	How the standard is being measured.
Measure Method:	The most recent data available for the Standard.
Performance Standard:	Standard set as a component of the Department's approved Adult Mental Health Services Plan dated October 13, 2006.
Compliance Standard:	Standard set as a component of the Department's approved standards for defining substantial compliance approved October 29, 2007.

Calendar and Fiscal Year Definitions:

CY: Calendar Year - January 1 - December 31.
FY: Fiscal Year - State Fiscal Year July 1 - June 30.

DHHS Office of Substance Abuse and Mental Health Services

Compliance and Performance Standards: Summary Sheet
January - March 2016

Standard 1. Rights Dignity and Respect

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

Standard 2. Rights Dignity and Respect

Consent Decree Performance and Quality Improvement Standards: November 2015

Standard 3. Rights Dignity and Respect

1. No longer reported per amendment dated May 8, 2014. Report available upon request.
2. No longer reported per amendment dated May 8, 2014. Report available upon request.

Standard 4. Rights Dignity and Respect

1. Deleted: Amendment request to delete approved 01/19/2011
1a. Deleted: Amendment request to delete approved 01/19/2011
1b. Deleted: Amendment request to delete approved 01/19/2011
2. Consumers given information about their rights

Standard 5. Timeliness of ISP and CI/CSS Assignment

1. Class members requesting a worker who were assigned one.
2. Hospitalized class members assigned a worker in 2 days.
3. Non-hospitalized class members assigned a worker in 3 days.
4. Class members not assigned on time, but within 1-7 extra days.

6. 90 day ISP review completed within specified time frame
7. Initial ISPs not developed w/in 30 days, but within 60 days.
8. ISPs not reviewed within 90 days, but within 120 days.

Standard 7. CI/CSS/ Individualized Support Planning

1a. No longer reported per amendment dated May 8, 2014. Report available upon request.
1b. No longer reported per amendment dated May 8, 2014. Report available upon request.
1c. No longer reported per amendment dated May 8, 2014. Report available upon request.
1d. No longer reported per amendment dated May 8, 2014. Report available upon request.

Standard 8. CI/CSS Individualized Support Planning

1. ISP team reconvened after an unmet need was identified
2. ISPs reviewed with unmet needs with established interim plans.

Standard 9. ISP Service Agreements

ISPs that require Service Agreements that have current Service Agreements

Compliance and Performance Standards: Summary Sheet
January - March 2016

Standard 10. Case Load Ratios

1. No longer reported per amendment dated May 8, 2014. Report available upon request.
2. No longer reported per amendment dated May 8, 2014. Report available upon request.
3. Intensive Community Integration Statewide Case Load Ratio - deleted: ICI is no longer a service offered by MaineCare.
4. Intensive Case Management Statewide Case Load Ratio
5. OES Public Ward Case Management Case Load Ratio

Standard 11. CI/CSS Individualized Support Planning

No longer reported per amendment dated May 8, 2014. Report available upon request.

Standard 12. Housing & Residential Support Services

1. Class Members with ISPs, with unmet Residential Support Needs
2. Lack of Residential Support impedes Riverview discharge within 7 days of determination of readiness for discharge.
3. Lack of Residential Support impedes discharge within 30 days of determination.
4. Lack of Residential Support impedes discharge within 45 days of determination.

Standard 13. Housing & Residential Support Services

1. Average of positive responses in the Adult Mental Health and Well Being Survey Perception of Outcomes domain
2. Deleted: Amendment request to delete approved 01/19/2011

Standard 14. Housing & Residential Support Services

1. Class members with unmet housing resource needs.
2. Respondents who were homeless over 12 month period.
3. Deleted: Amendment request to delete approved 01/19/2011
4. Lack of housing impedes Riverview discharge within 7 days of determination of readiness for discharge
5. Lack of housing impedes Riverview discharge within 30 days of determination
6. Lack of housing impedes Riverview discharge within 45 days of determination

Standard 15. Housing & Residential Services

No longer reported per amendment dated May 8, 2014. Report available upon request.

Standard 16. Acute Inpatient Services (Class Member Involuntary Admissions)

Inpatient admissions reasonably near community residence.

Compliance and Performance Standards: Summary Sheet
January - March 2016

Standard 17. Acute Inpatient Services (Class Member Involuntary Admissions)

1. No longer reported per amendment dated May 8, 2014. Report available upon request.
2. No longer reported per amendment dated May 8, 2014. Report available upon request.

2a. No longer reported per amendment dated May 8, 2014. Report available upon request.

3. No longer reported per amendment dated May 8, 2014. Report available upon request.

3a. No longer reported per amendment dated May 8, 2014. Report available upon request.

4. No longer reported per amendment dated May 8, 2014. Report available upon request.

4a. No longer reported per amendment dated May 8, 2014. Report available upon request.

5. No longer reported per amendment dated May 8, 2014. Report available upon request.

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

1. Admissions for whom hospital obtained ISP
2. Treatment and Discharge plans consistent with ISP
3. CI/ICM/ACT worker participated in treatment and discharge planning

Standard 19. Crisis intervention Services

1. Face to face crisis contacts that result in hospitalizations.
2. Face to face crisis contacts resulting in follow up and/or referral to community services
3. Face to face crisis contacts using pre-developed crisis plan.
4. Face to face crisis contacts in which CI worker was notified of crisis.

Standard 20. Crisis Intervention Services

1. Deleted: Amendment request to delete approved 01/19/2011
2. Deleted: Amendment request to delete approved 01/19/2011

Standard 21. Treatment Services

1. Class Members with unmet mental health treatment needs.
2. Lack of MH Tx impedes Riverview discharge within 7 days of determination of readiness for discharge
3. Lack of MH Tx impedes Riverview discharge within 30 days of determination.
4. Lack of MH Tx impedes Riverview discharge within 45 days of determination
5. No longer reported per amendment dated May 8, 2014. Report available upon request.

Standard 22. Treatment Services

1. Average of positive responses in the Adult Mental Health and Well Being Survey Perception of Access domain
2. Average of positive responses in the Adult Mental Health and Well Being survey General Satisfaction domain

Standard 23. Family Support Services

1. No longer reported per amendment dated May 8, 2014. Report available upon request.
2. No longer reported per amendment dated May 8, 2014. Report available upon request.

Compliance and Performance Standards: Summary Sheet
January - March 2016

Standard 24. Family Support Services

1. No longer reported per amendment dated May 8, 2014. Report available upon request.
2. No longer reported per amendment dated May 8, 2014. Report available upon request.
3. Deleted: Family participants reporting satisfaction with respite services in the community - NAMI closed its respite programs as of January 2010

Standard 25. Family Support Services

1. No longer reported per amendment dated May 8, 2014. Report available upon request.
2. No longer reported per amendment dated May 8, 2014. Report available upon request.

Standard 26. Vocational Employment Services

1. Class members with ISPs - Unmet vocational/employment Needs.
2. Class Members in competitive employment in the community.
3. Consumers in supported or competitive employment in the community.

Standard 27. Vocational Employment Services

1. Deleted: Amendment request to delete approved 01/19/2011
2. Deleted: Amendment request to delete approved 01/19/2011

Standard 28. Transportation

Class Members with ISPs - Unmet transportation needs.

Standard 29. Transportation

1. Deleted: Amendment request to delete approved 01/19/2011
2. Deleted: Amendment request to delete approved 01/19/2011

Standard 30. Rec/Soc/Avocational/Spiritual Opportunities

1. No longer reported per amendment dated May 8, 2014. Report available upon request.
2. No longer reported per amendment dated May 8, 2014. Report available upon request.

Standard 31. Rec/Soc/Avoc/Spirtual

1. ISP identified class member unmet needs in recreational/social/avocational/spiritual areas Social Connectedness domain
3. Deleted: Amendment request to delete approved 01/19/2011

Standard 32. Individual Outcomes

1. Consumers with improvement in LOCUS (Baseline to Follow-up)
2. Consumers who have maintained functioning (Baseline to Follow-up)
3. Consumers reporting positively on functional outcomes.

Compliance and Performance Standards: Summary Sheet
January - March 2016

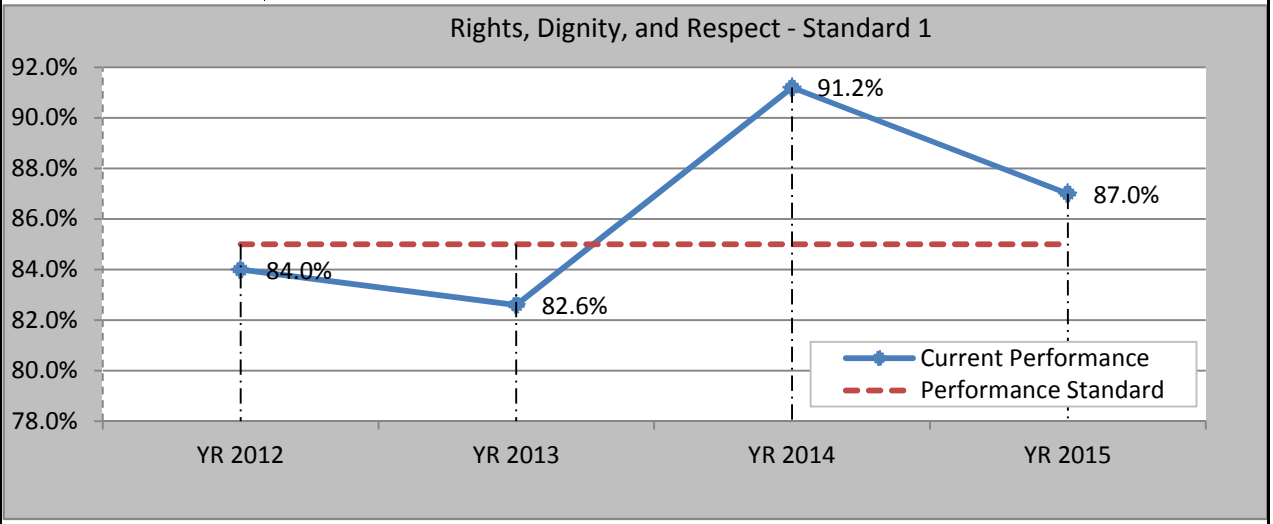
Standard 33. Recovery

1. No longer reported per amendment dated May 8, 2014. Report available upon request.
2. Consumers reporting staff believed they could grow, change, recover
3. Consumers reporting staff supported their recovery efforts
4. Deleted: Consumers reporting that providers offered learning opportunities: questions eliminated with 2007 Adult Mental Health and Well Being Survey
5. Consumers reporting providers stressed natural supports/friendships
6. Consumers reporting providers offered peer recovery groups.

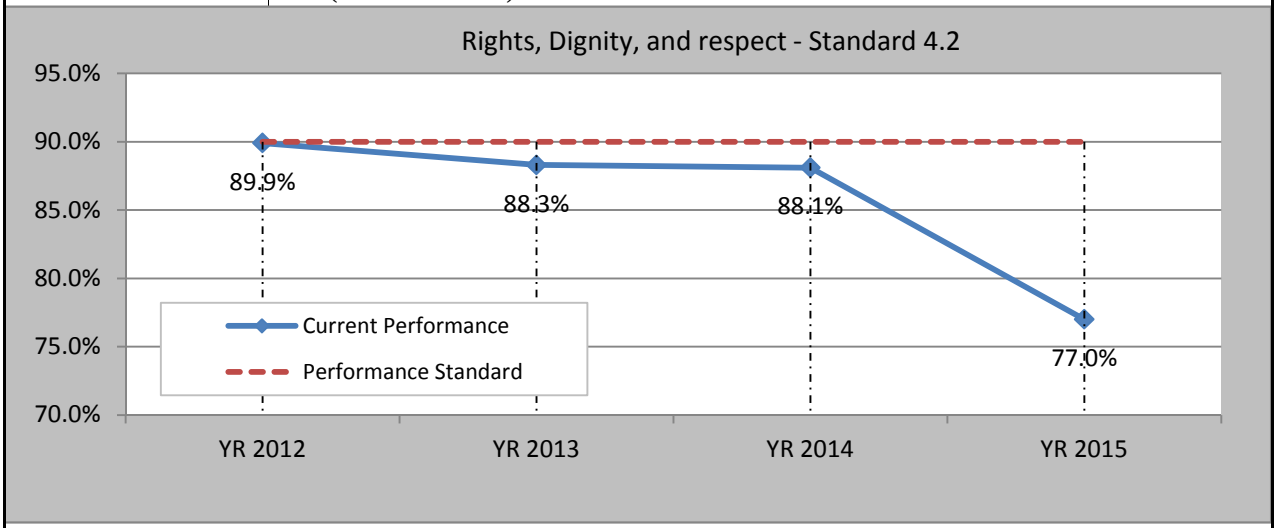
Standard 34. Public Education

1. No longer reported per amendment dated May 8, 2014. Report available upon request.
2. No longer reported per amendment dated May 8, 2014. Report available upon request.

DHHS Office of Substance Abuse and Mental Health Services	
Rights, Dignity, and Respect	
Standard 1 - Treated with respect for their individuality	
Standard 1	
Measurement	Domain average of positive responses to the statements in the quality and appropriateness domain.
Standard	Performance: at or above 85%
Data Source	Adult Mental Health and Well Being Survey
Current Level	87% (1068 out of 1215)



Standard 4 - Class Members are informed of their rights	
Standard 4.2	
Measurement	Percent of consumers reporting they were given information about their rights.
Standard	Performance: 90%
Data Source	Adult Mental Health and Well Being Survey Q22
Current Level	77% (935 out of 1215)

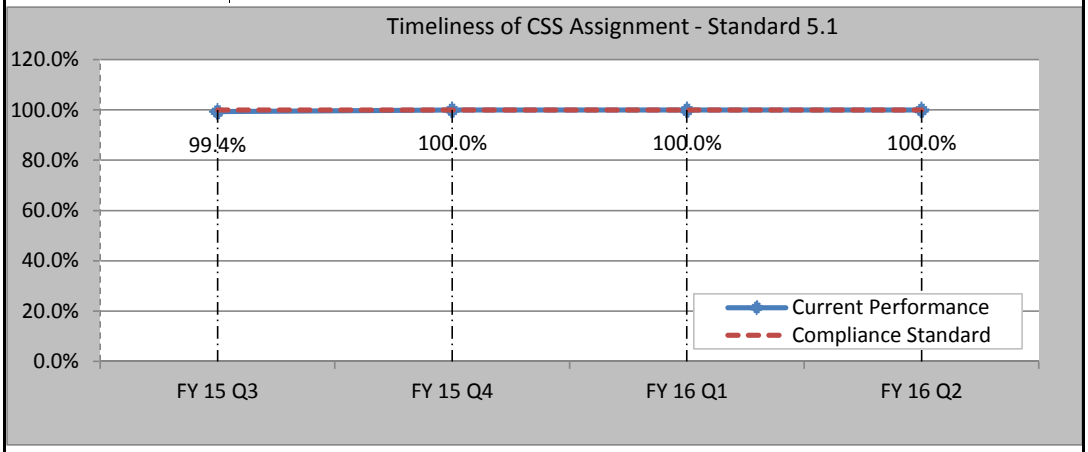


DHHS Office of Substance Abuse and Mental Health Services

Community Support Services: Community Integration, Community Rehabilitation Services, Assertive Community Treatment and Adult Behavioral Health Homes

Individualized Support Planning

Standard 5.1	
Measurement	Percentage of Class Members requesting a worker who were assigned one.
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	100% (165 of 165)

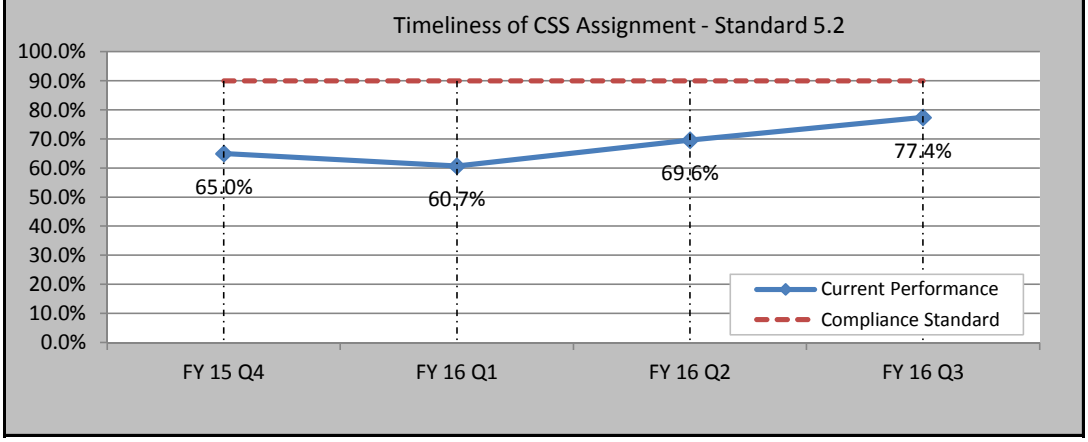


Disscussion of Standard 5.1:

The denominator for this measure is all class members, hospitalized or not who received community support service and it also includes any contact for service notifications (CFSN) for community support services that are not filled o discharged by the 10th of the month of the subsequent quarter.

For SFY2016, quarter 2, there were 142 non-hospitalized class members and 23 hospitalized class members assigned workers. There were 0 class members who remained on the wait list and who were not served.

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	Adult Mental Health and Well Being Survey Q22
Current Level	77.4% (24 out of 31)

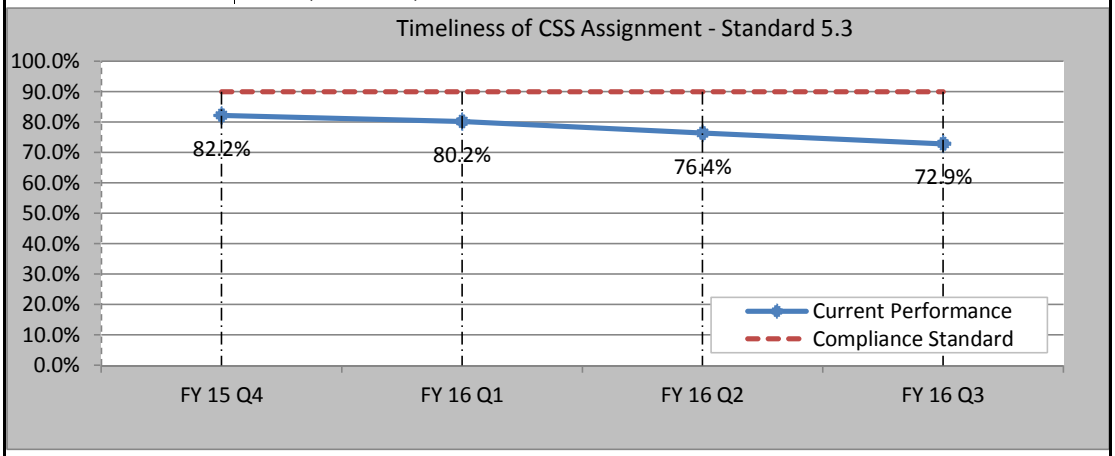


DHHS Office of Substance Abuse and Mental Health Services

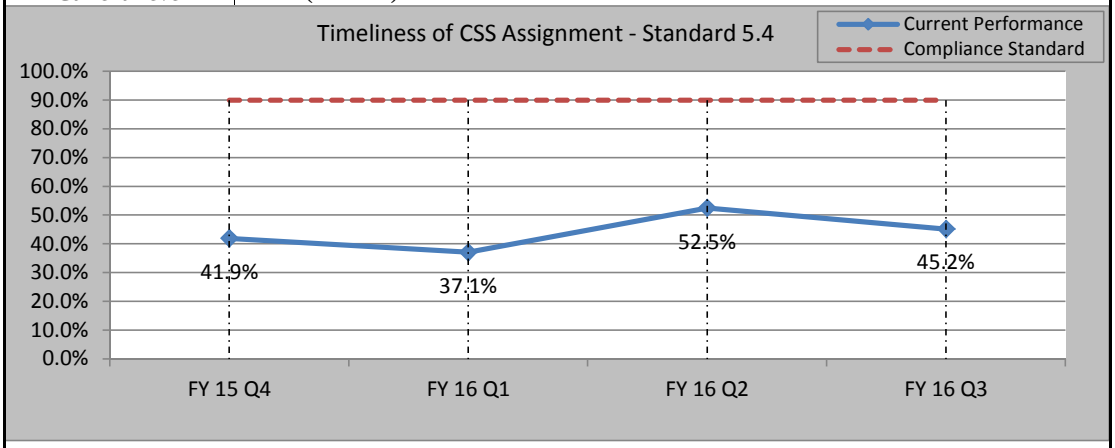
Community Support Services: Community Integration, Community Rehabilitation Services, Assertive Community Treatment and Adult Behavioral Health Homes

Individualized Support Planning

Standard 5.3	
Measurement	Percentage of all non-hospitalized Class Members assigned a worker within 3 working days of referral.
Standard	Performance: 100% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	72.9% (148 of 203)



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
Current Level	45.2% (28 of 62)



Discussion of Standard 5.4:

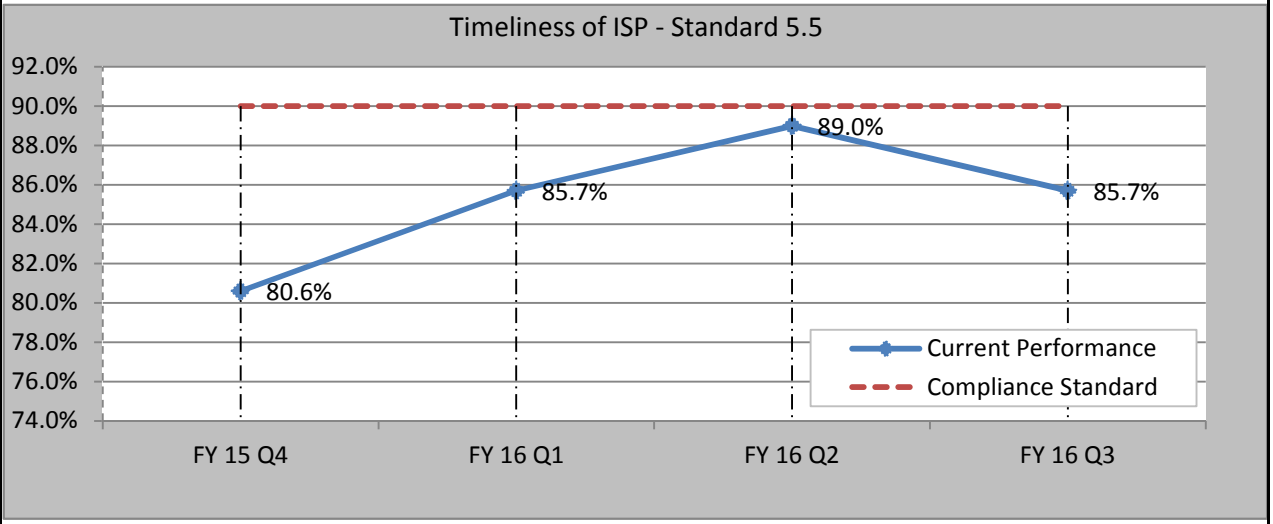
This standard looks at all Class Members (both hospitalized and not) who did not receive a community support worker on time, but did receive a worker within 7 working days. For example, for the current quarter, standard 5.2 shows 23 - 16 = 7 class members not receiving a worker within 2 days and standard 5.3 shows 142 - 100 = 42 class members not receiving a worker within 3 days. Standard 5.4 reports on the 7 + 42 = 49 class members not served on time. Of these 49, 13 received the service within 7 working days.

DHHS Office of Substance Abuse and Mental Health Services

Community Integration / Community Support Services / Individualized Support Planning

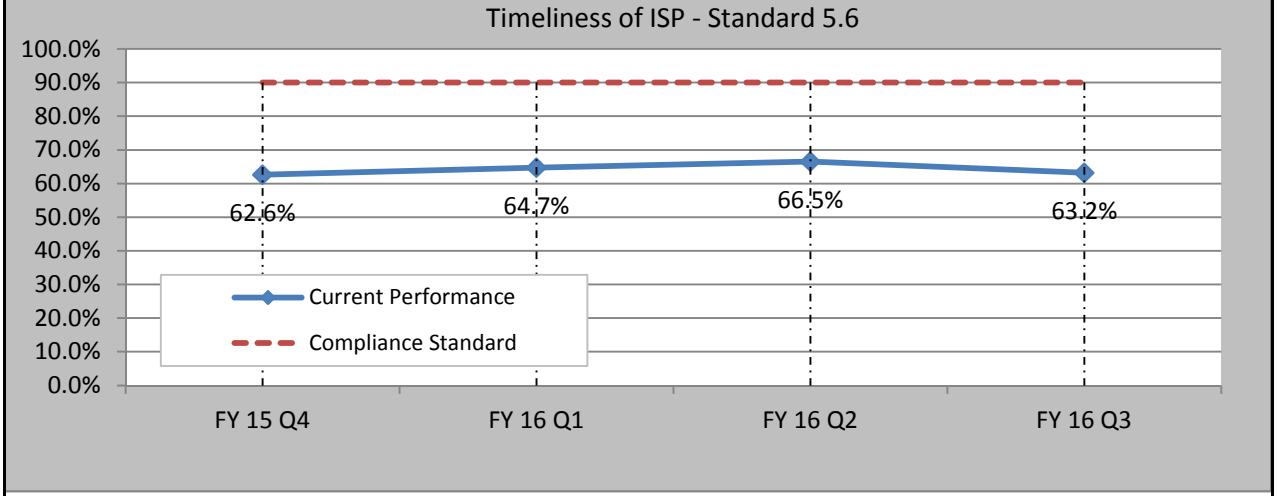
Standard 5.5

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
Current Level	85.7% (42 out of49)

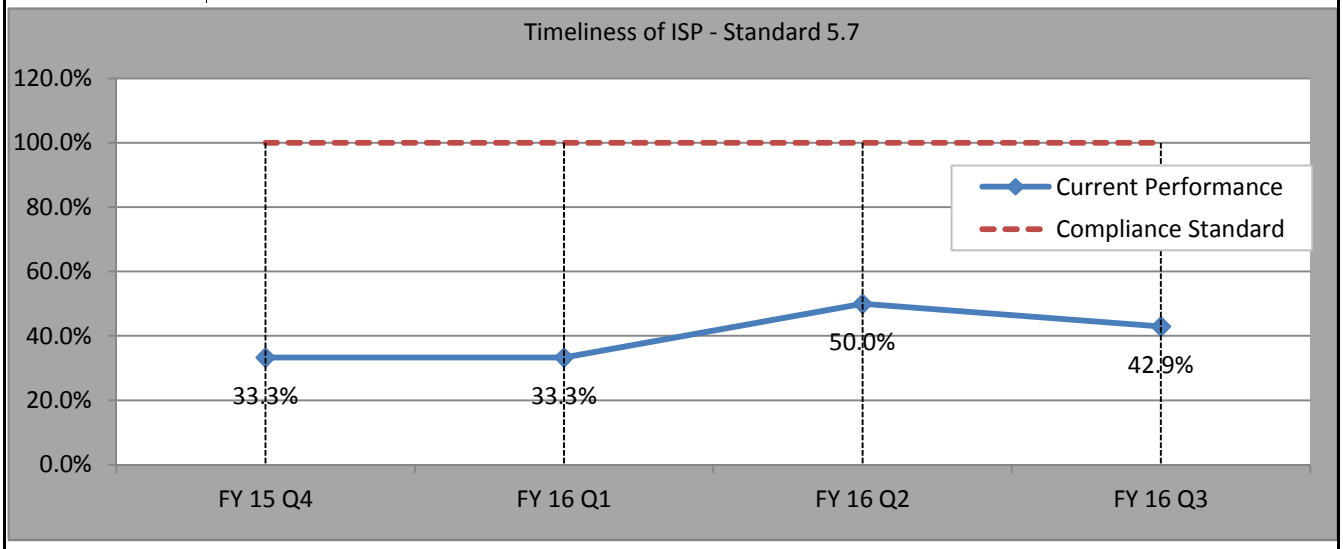


Standard 5.6

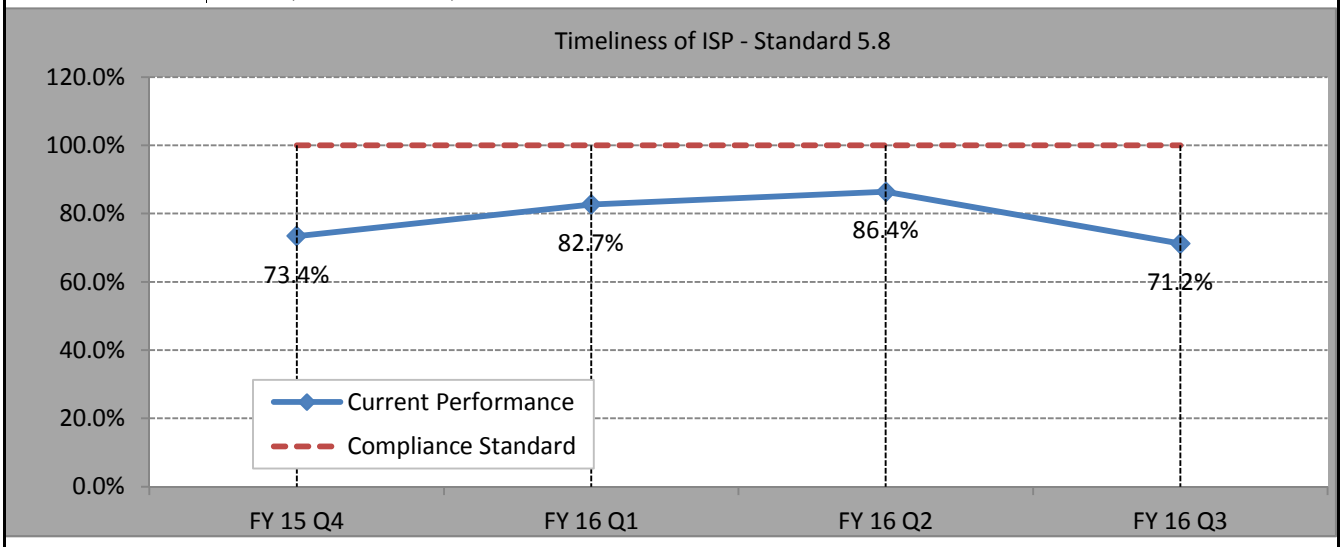
Measurement	90 day class member Isp reviews completed within specified timeframe.
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	63.2% (470 out of 744)



DHHS Office of Substance Abuse and Mental Health Services	
Community Integration / Community Support Services / Individualized Support Planning	
Standard 5.7	
Measurement	Initial class member ISPs not developed within 30 days, but were developed within 60 working days.
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	42.9% (3 out of 7)



Standard 5.8	
Measurement	Initial class member ISPs not developed within 90 days, but were developed within 120 working days.
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	71.2% (195 out of 274)



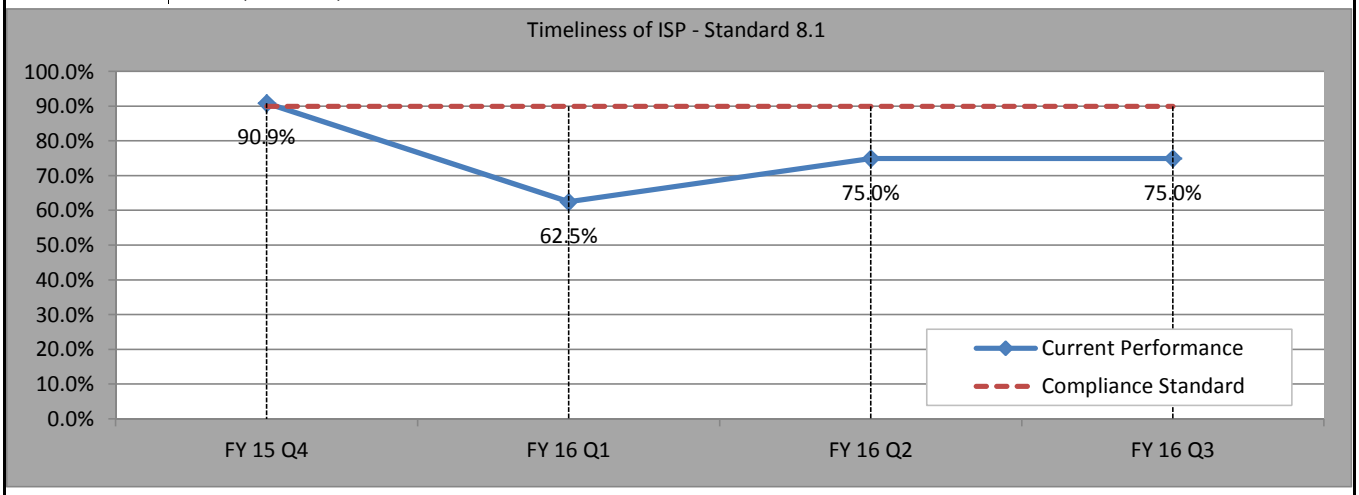
Discussion: Standards 5.1 - 5.8: Field Quality Managers have completed additional agency trainings around assignment times. Assignment time performance measures are now included in Rider E of agency contracts. Data Quality Management Team will identify outliers for follow up by the treatment team and provider agencies driving these numbers. Consent Decree Process Improvement has also been deployed within seven agencies to collaberate around resolution to these issues.

DHHS Office of Substance Abuse and Mental Health Services

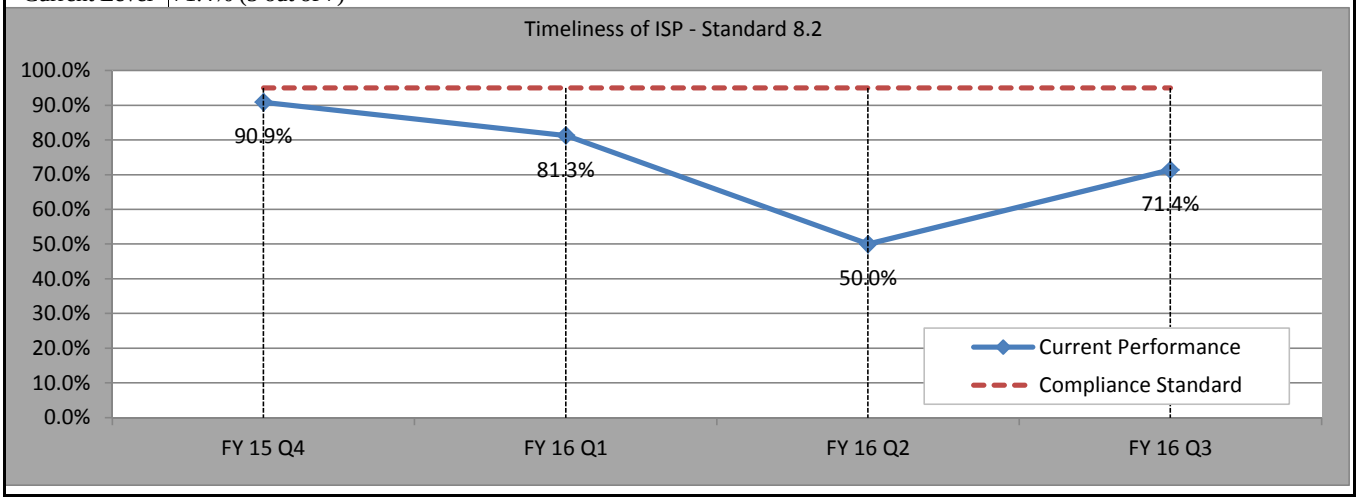
Community Integration / Community Support Services / Individualized Support Planning

Standard 8 - Services based on needs of class member rather than only available services.

Standard 8.1	
Measurement	ISPs reviewed in which there is evidence that the ISP team reconvened after an unmet need was identified
Standard	Performance: 90%
Data Source	ISP RDS Data
Current Level	75.0% (6 out of 8)



Standard 8.2	
Measurement	ISPs reviewed with identified unmet needs in which interim plans are established.
Standard	Performance: 95% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	71.4% (5 out of 7)

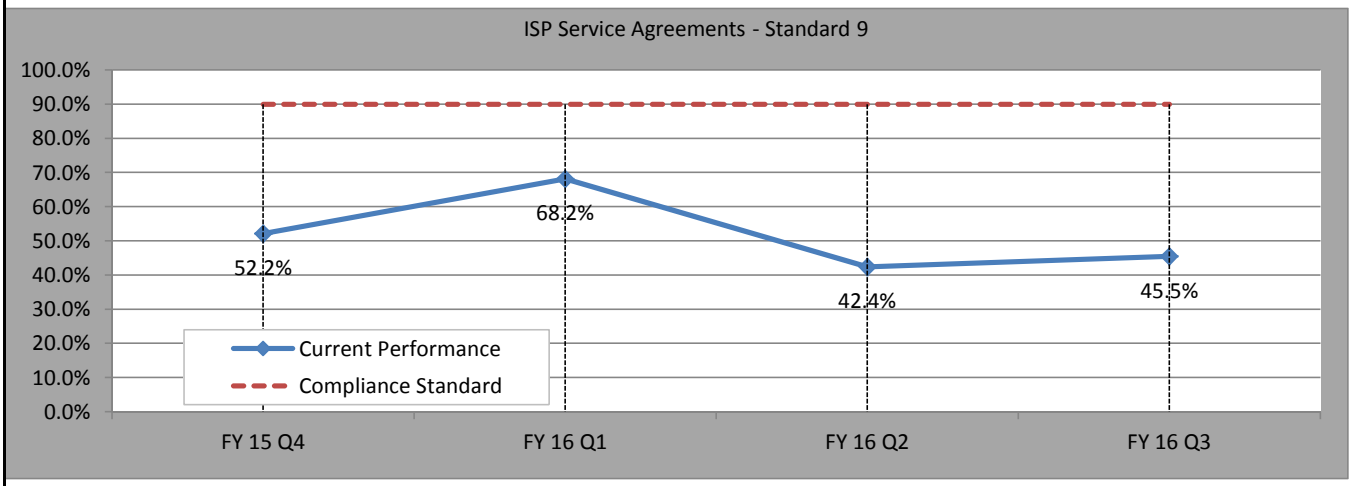


DHHS Office of Substance Abuse and Mental Health Services

Community Integration / Community Support Services / Individualized Support Planning

Standard 9 - Services to be delivered by an agency funded or licensed by the state

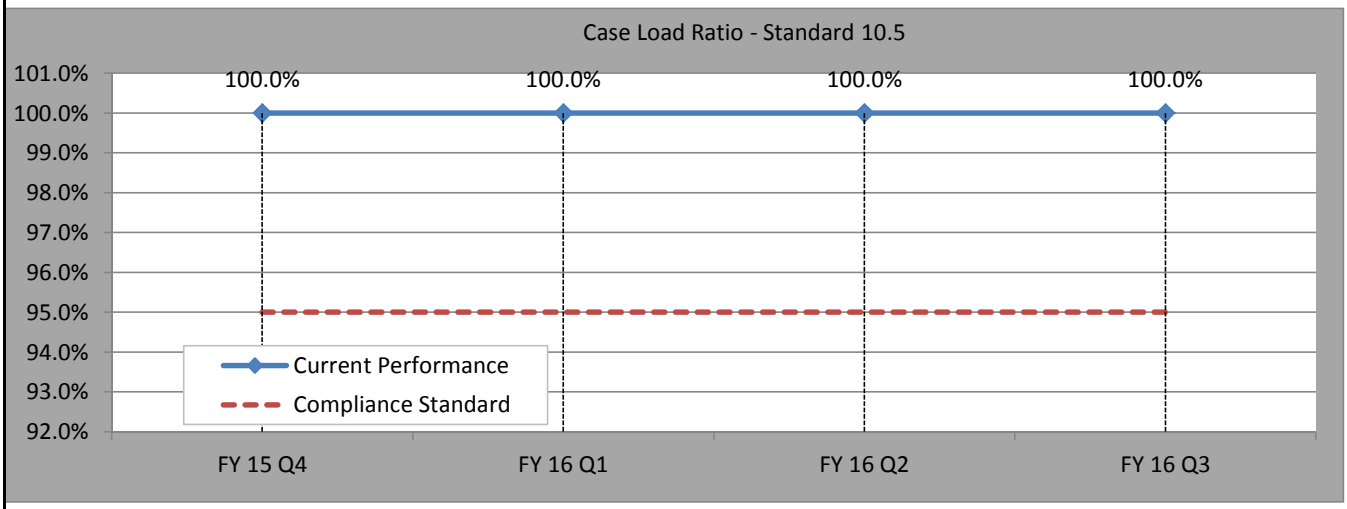
Standard 9	
Measurement	ISPs with services identified and with a treatment plan signed by each provider.**
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning review
Current Level	45.5% (15 out of 33)



Discussion:

Standards 8.1, 8.2, and 9 - Field Quality Managers continue to perform document reviews and work with the agencies around unmet needs and service agreements.

DHHS Office of Substance Abuse and Mental Health Services	
Community Integration / Community Support Services / Individualized Support Planning	
Standard 9 - Services to be delivered by an agency funded or licensed by the state	
Standard 10.4 - ICM	
Measurement	Intensive Case Managers with average caseloads of 16 or fewer.
Standard	Compliance: 90% of all ICM Workers with Class Member caseloads
	CMs focus on outreach with individuals in forensic facilities. ICMs no longer carry traditional caseloads. In the future, if ICMs carry caseloads, OAMHS will resume reporting caseload ratios.
Standard 10.5 - OADS	
Measurement	Office of Aging and Disability Services Case Managers with average caseload of 40 or fewer.
Standard	Compliance: 90% of all OADS Case Managers with Class Member Public Wards
Data Source	MAPSIS Case Counts for Workers with Class Members Public Wards
Current Level	100% (26 out of 26)



Discussion:

Standard 10.5 - Per amendment dated December 10, 2014 average case load was changed from 25 to 40.

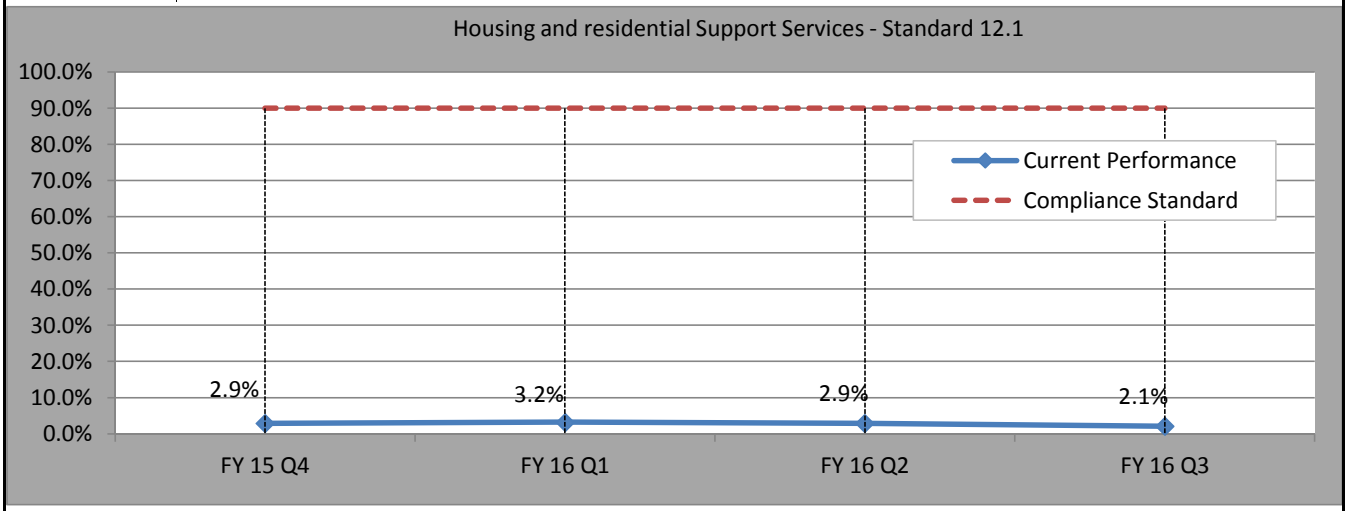
DHHS Office of Substance Abuse and Mental Health Services

Community Resources and treatment Services Housing and Residential

Standard 12 - Residental Support Services adequate to meet ISP needs of those ready for discharge.

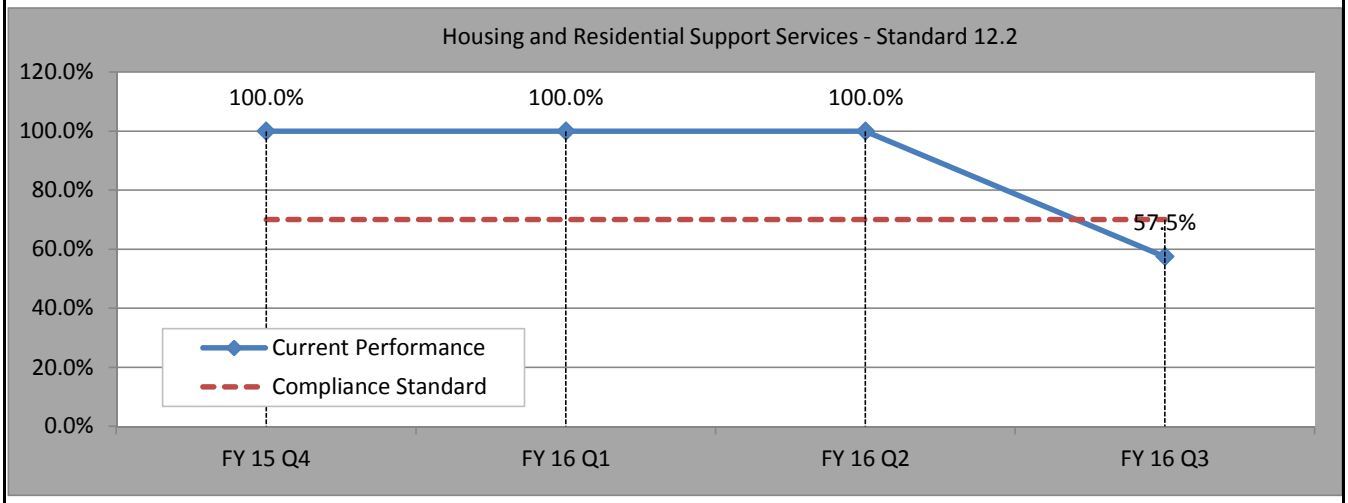
Standard 12.1

Measurement	Class members in community with ISPs with unmet residential support needs.
Standard	Compliance: 5% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data and Quality Improvement
Current Level	2.1% (18 out of 825)



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 is not impeded due to lack of residential support services)
	Performance: Performance: 75% (within 7 days of that determination5%)
Standard	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	57.5% FY16 Q3 (Lack of residential supports did not impede discharge for 23out of 40 patients within 7 days)

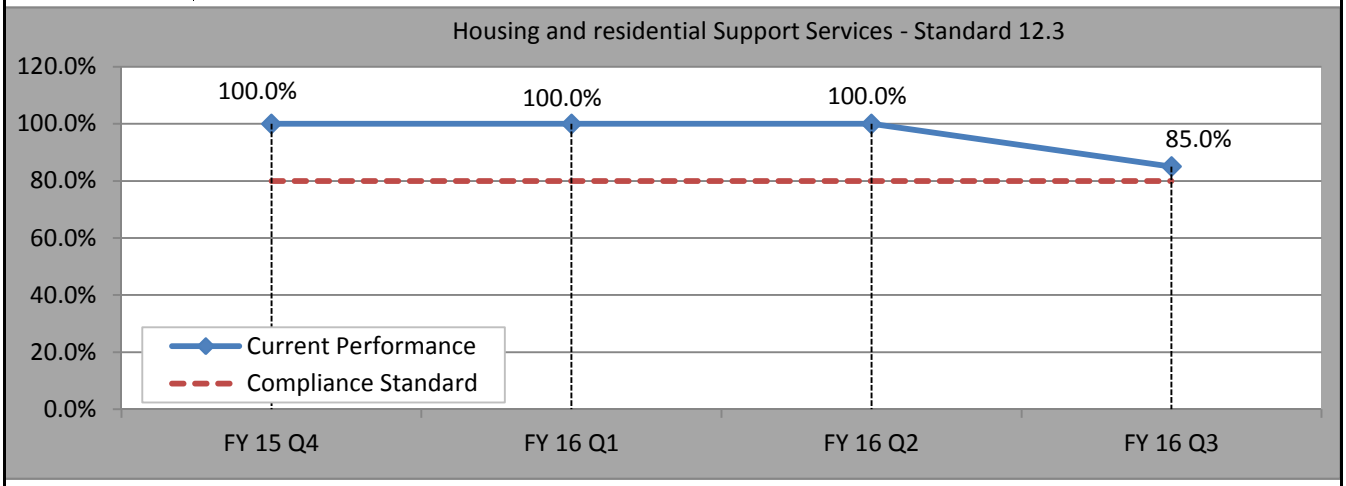


DHHS Office of Substance Abuse and Mental Health Services

Community Resources and treatment Services Housing and Residential

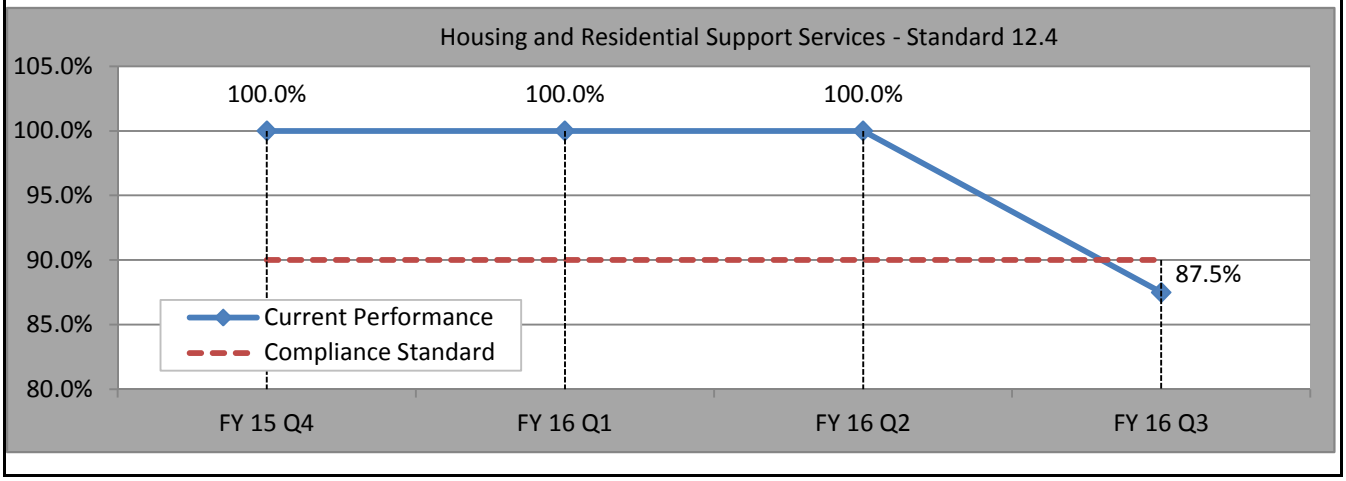
Standard 12.3

Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30
Standard	Performance: Performance: 96% (within 30 days of that determination5%) Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	85.0% (34 out of 40) FY16 Q3 (Lack of residential supports did not impede discharge for any patients within 30 days)



Standard 12.4

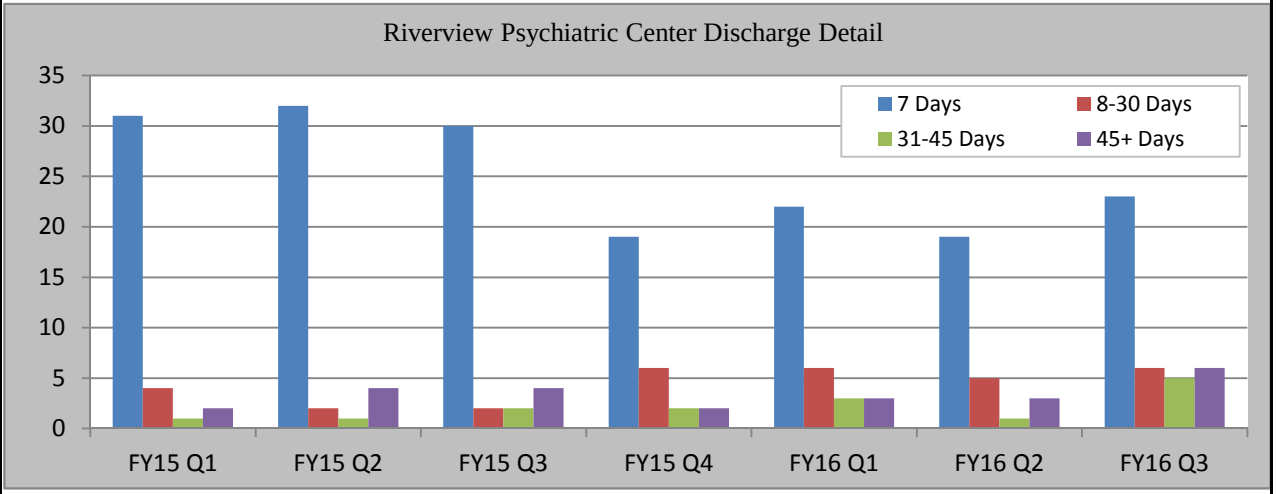
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: Performance: 100% (within 45 days of that determination5%) Compliance: 90% (within 45 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	87.5% (35 out of 40) FY16 Q3 (Lack of residential supports did not impede discharge for any patients within 45 days)



DHHS Office of Substance Abuse and Mental Health Services

Community Resources and Treatment Services

Housing and Residential



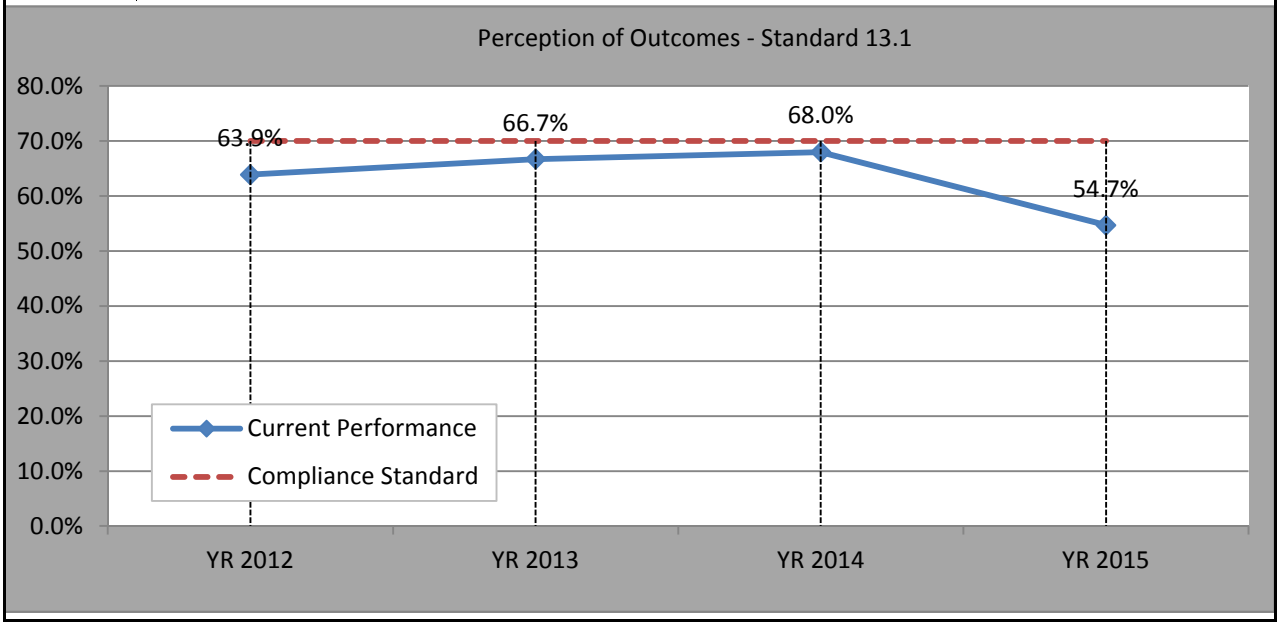
Riverview Psychiatric Center Discharge Detail to amplify data presented in Standards 12.2, 12.3, 12.4:

40 Civil Patients discharged in quarter
23 discharged at 7 days (57.5%)
6 discharged 8-30 days (15%)
5 discharged 31-45 days (12.5%)
6 discharged post 45 days (15%)

Residential Supports did not impede discharge for any patients post clinical readiness for discharge

Standard 13.1

Measuremen	Domain average of positive responses to the questions in the Perception of Outcomes domain
Standard	Performance: at or above 70%
Data Source	Adult Mental health and Well Being Survey
Current Leve	54.7% (664 of 1215)



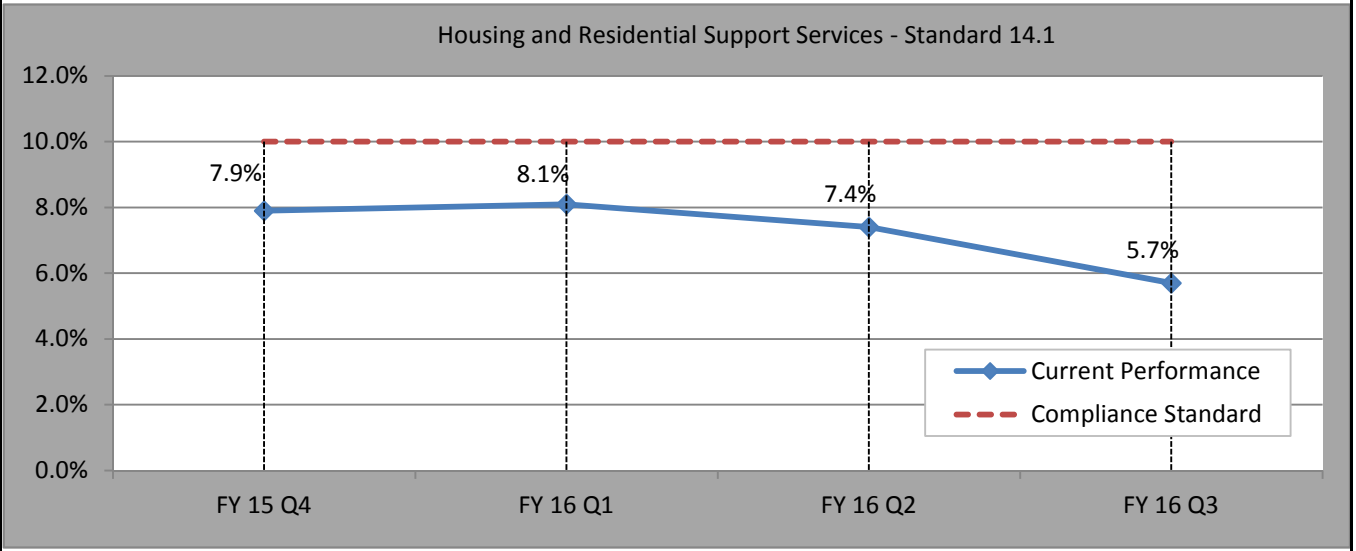
DHHS Office of Substance Abuse and Mental Health Services

Community Resources and treatment Services Housing and Residential

Standard 14 - Demonstrate an array of housing alternatives available to meet class member needs.

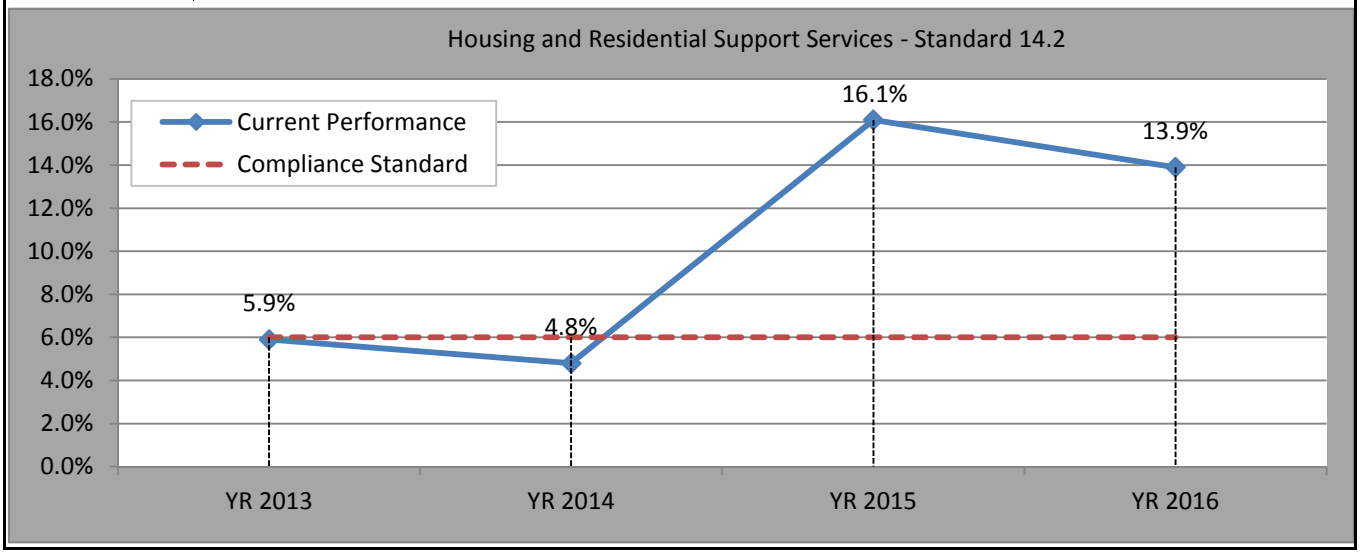
Standard 14.1

Measurement	Class members in community with ISPs with unmet housing needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	5.7% (47 out of 825)

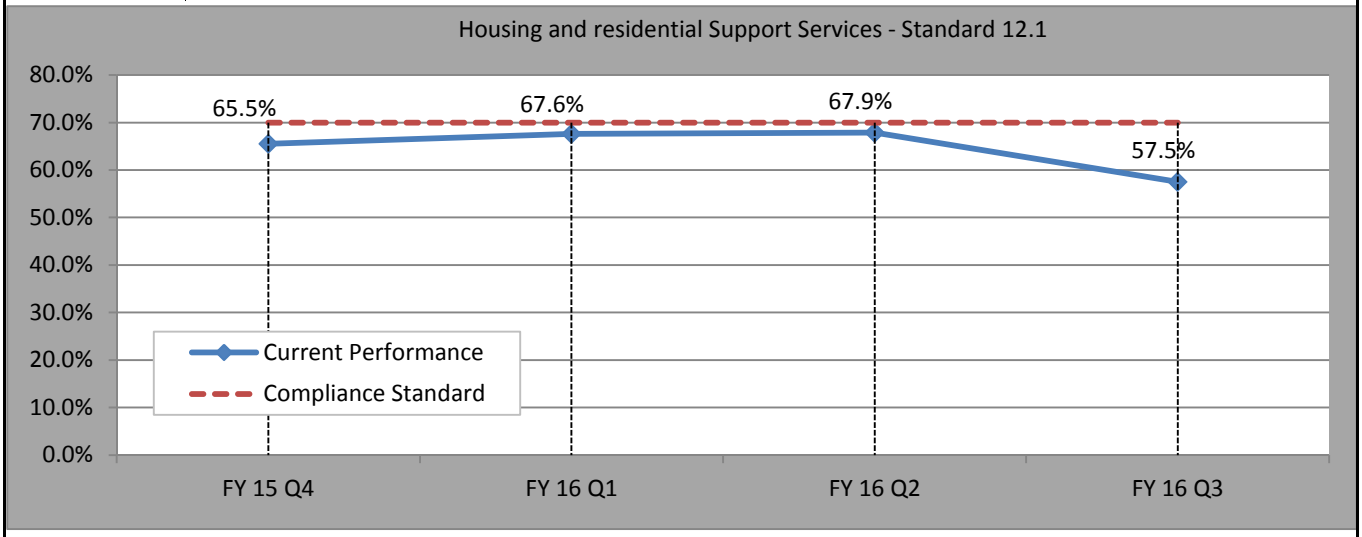


Standard 14.2

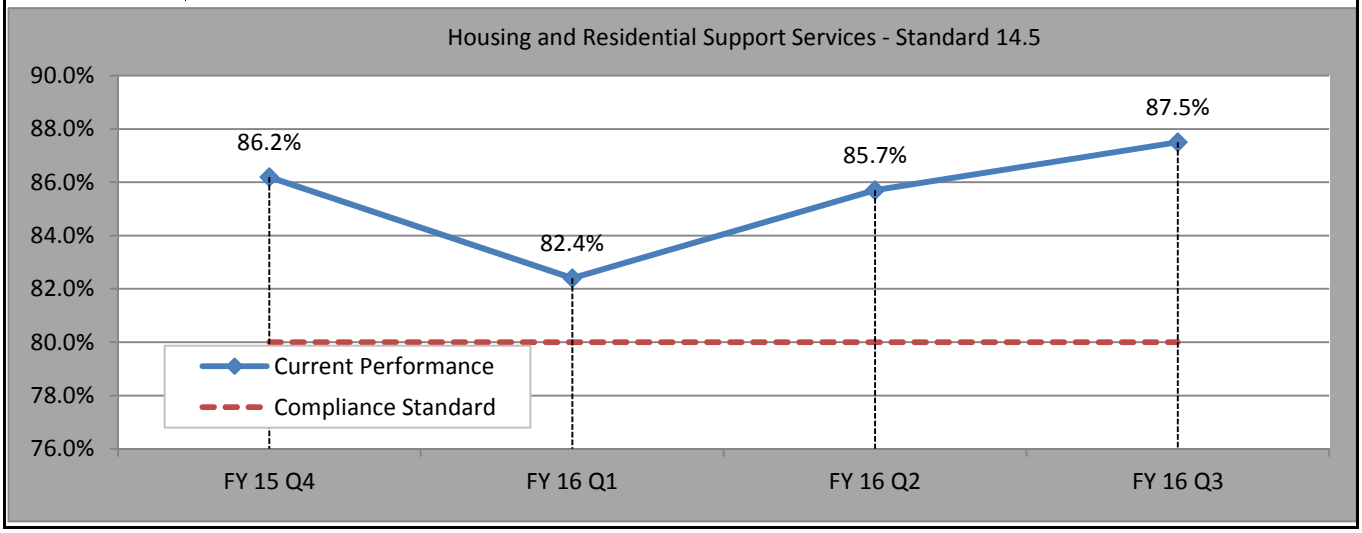
Measurement	Percentage of respondents who experienced homelessness over 12-month period.
Standard	Performance: 6% or fewer
Data Source	Adult Mental Health and Well Being Survey, living situation data
Current Level	13.9% (169 out of 1215)



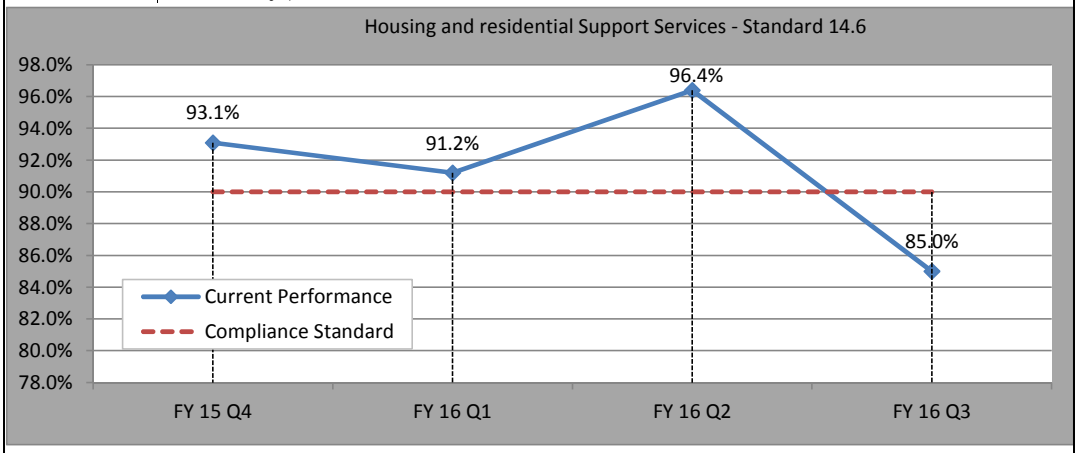
DHHS Office of Substance Abuse and Mental Health Services	
Community Resources and Treatment Services Housing and Residential	
Standard 14.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	57.5% FY 16 Q3 (Lack of housing alternatives did not impede discharge for 23 out of 40 patients within 7 days)

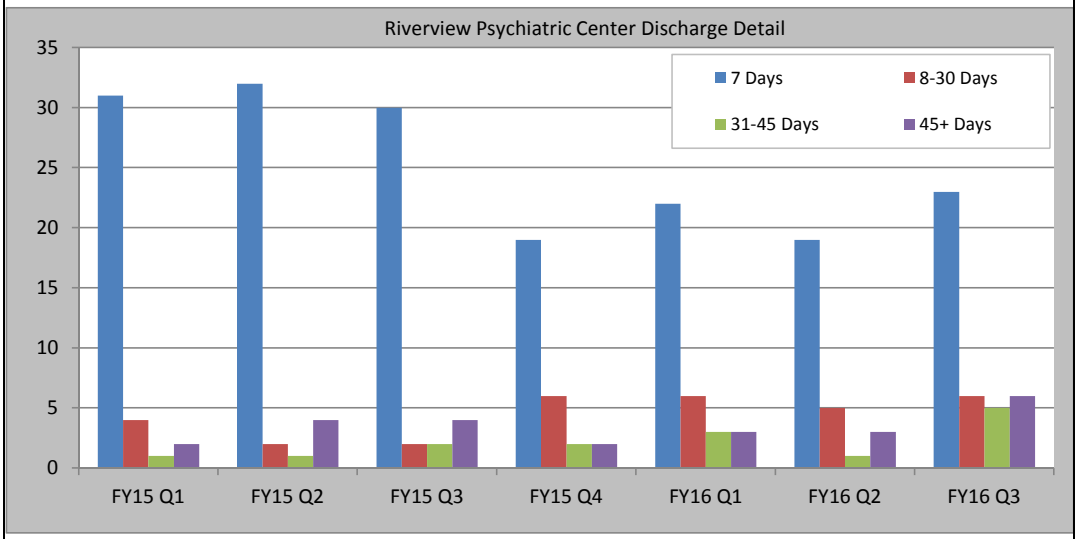


Standard 14.5	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Perfomance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	87.5% FY16 Q3 (Lack of residential supports did not impede discharge for 35 out of 40 patients within 30 days)



DHHS Office of Substance Abuse and Mental Health Services	
Community Resources and Treatment Services	
Housing and Residential	
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	Performance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	85.0% FY 16 Q3 (Lacck of housing alternatives did not impede discharge for 34 out of 40 patients within 45 days)





<u>40 Civil Patients discharged in quarter</u>
23 discharged at 7 days (57.5%)
6 discharged 8-30 days (15%)
5 discharged 31-45 days (12.5%)
6 discharged post 45 days (15%)

<u>Housing Alternatives impeded discharge for 13 patients (32%)</u>

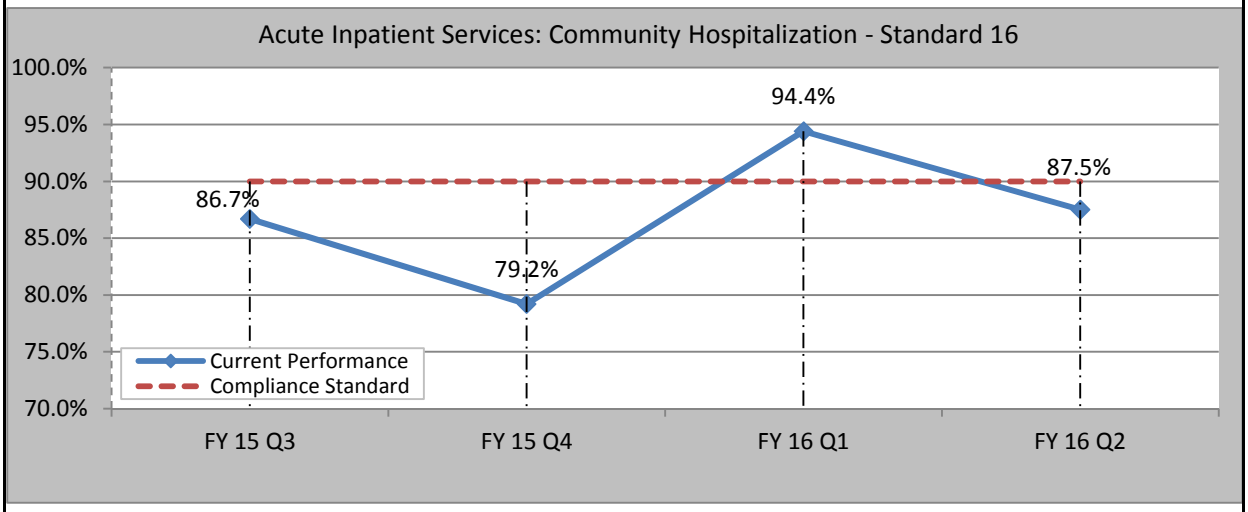
5 patients discharged within 8-30 days post clinical readiness for discharge
2 patient discharged 31- 45 days post clinical readiness for discharge
6 patient discharged greater than 45 days post clinical readiness for discharge

DHHS Office of Substance Abuse and Mental Health Services

Community Resources and treatment Services Acute Inpatient Services: Involuntary Community Hospitalization

Standard 16 - Psychiatric Hospitalization reasonably near an individual's local community.

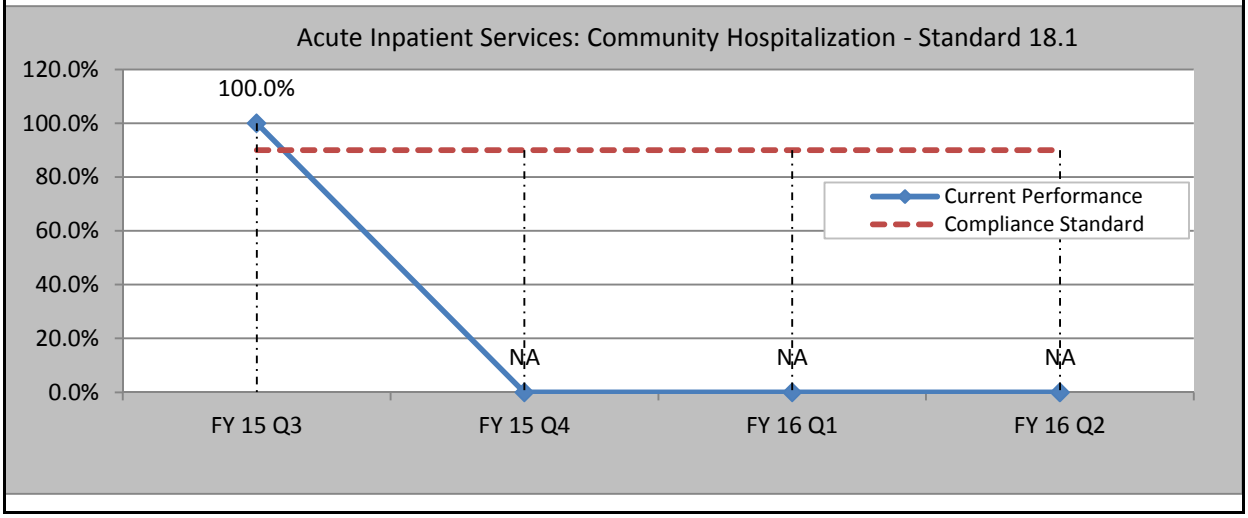
Standard 16	
Measurement	Class Member admissions determined to be reasonably near an individual's local community of residence.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	87.5% (7 out of 8)



Reasonably Near is defined by Attachment C to the October 29, 2007 approved Compliance Standards.

Standard 18 - Continuity of Treatment is maintained during hospitalization in community inpatient settings

Standard 18.1	
Measurement	Class members admitted with ISPs for whom hospital obtained ISP.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	0.0% (0 out of 6)

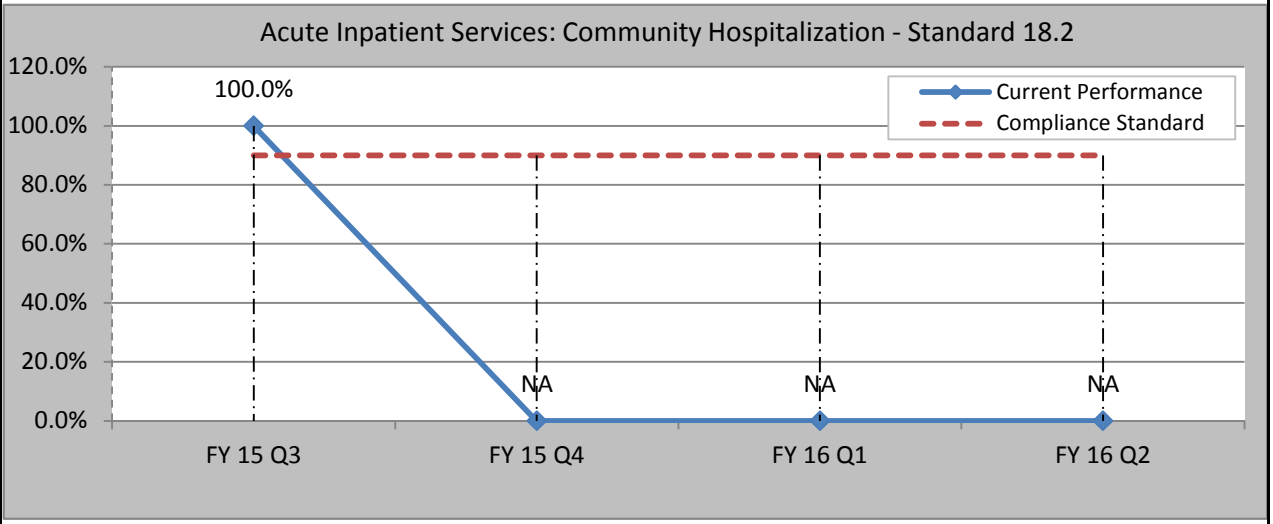


DHHS Office of Substance Abuse and Mental Health Services

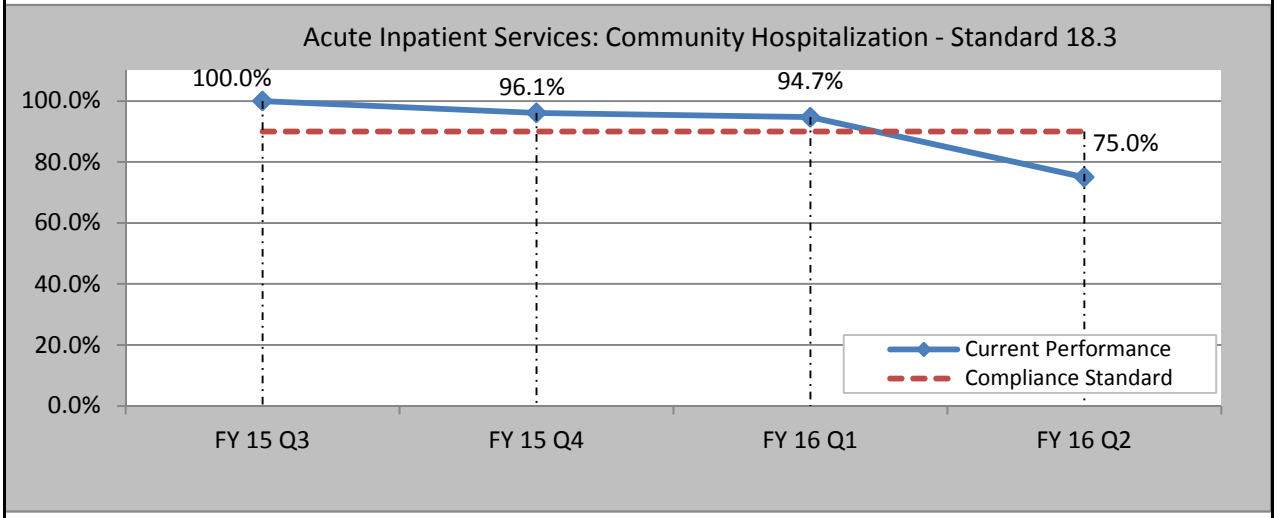
Community Resources and treatment Services Acute Inpatient Services: Involuntary Community Hospitalization

Standard 18 - Continuity of Treatment is maintained during hospitalization in community inpatient settings

Standard 18.2	
Measurement	Treatment and discharge plan were determined to be consistent with ISP goals and objectives.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	NA



Standard 18.3	
Measurement	CI/ICI/ICM/ACT worker participated in hospital treatment and discharge planning.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	75.0% (2 out of 2)



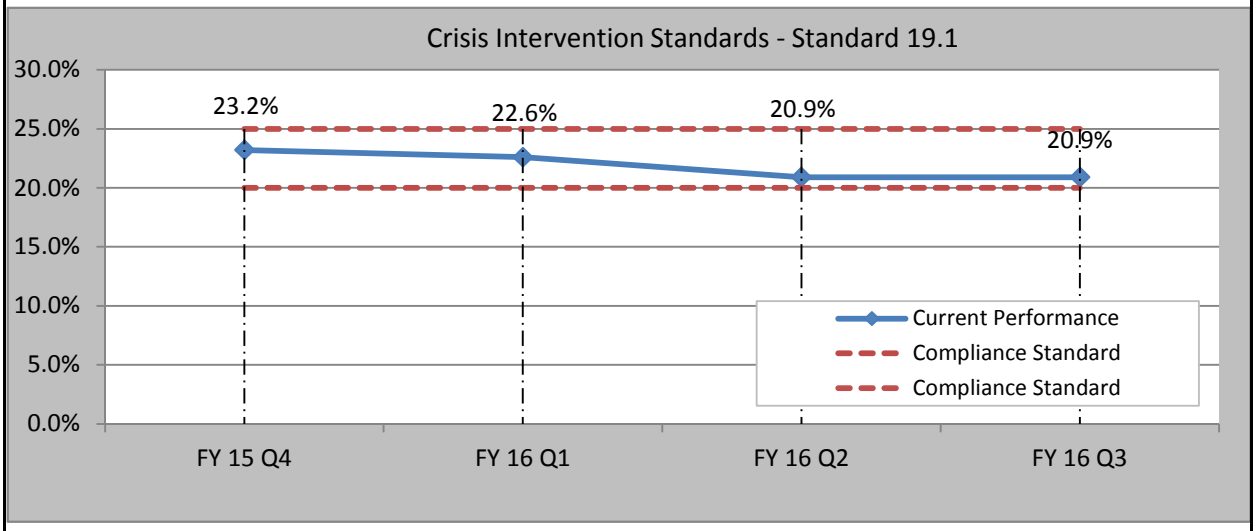
DHHS Office of Substance Abuse and Mental Health Services

Community Resources and treatment Services Acute Crisis Intervention Services

Standard 19 - Crisis services are effective an meet Settlement Agreement Standards

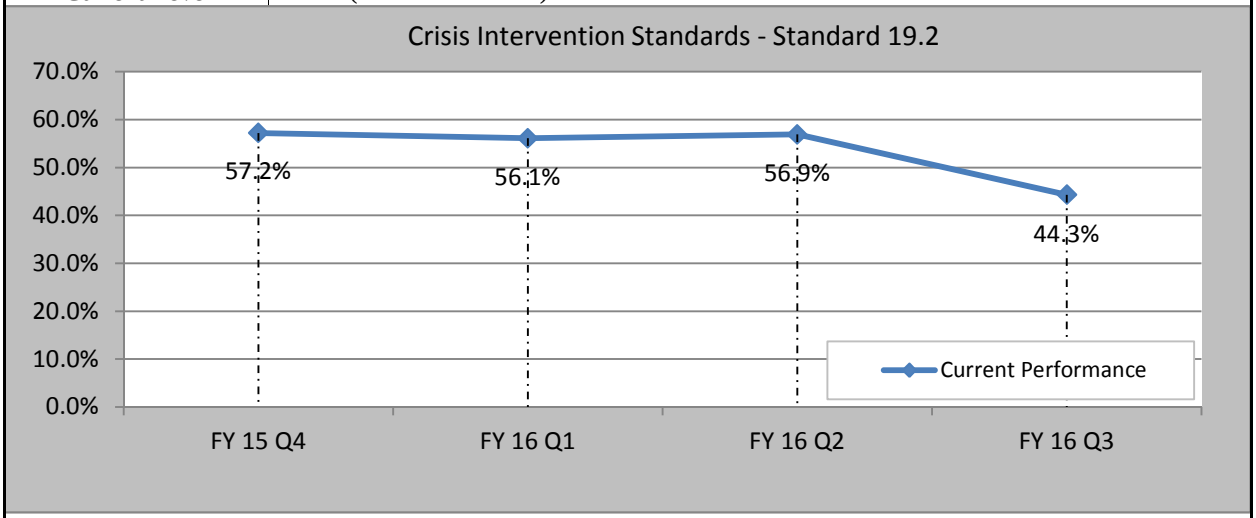
Standard 19.1

Measurement	Face to face crisis contacts that result in hospitalizations.
Standard	Performance: No more than 20-25% are hospitalized as result of crisis intervention.
Data Source	Quarterly Crisis Contract Performance Data and Quality Improvement
Current Level	20.9% (834 out of 3974)



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 Source	Quarterly Crisis Contract Performance Data
Current Level	44.3% (1759 out of 3974)



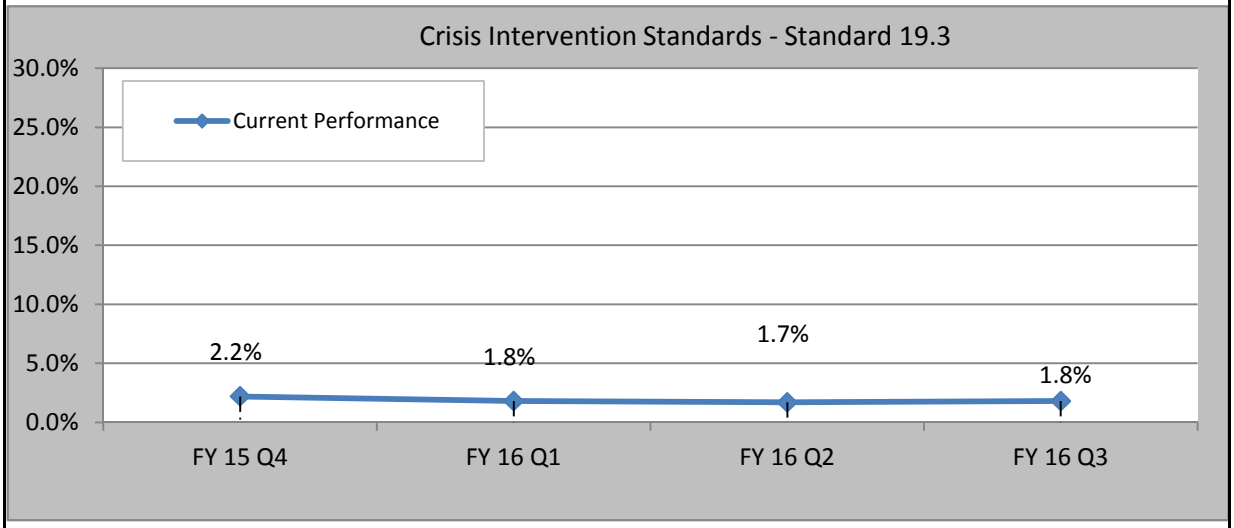
DHHS Office of Substance Abuse and Mental Health Services

Community Resources and Treatment Services

Crisis Intervention Services

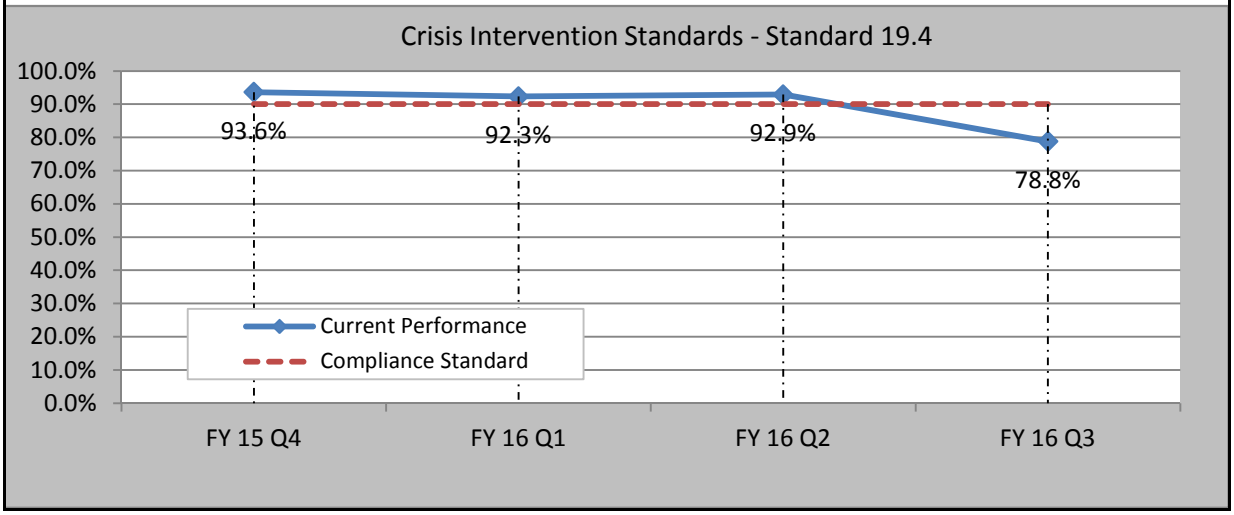
Standard 19.3

Measurement	Face to face crisis contacts in which client has a CI worker and worker was notified about the crisis.
Standard	To Be Established
Data Source	Quarterly Crisis Contract Performance Data
Current Level	1.8% (74 out of 3974)



Standard 19.4

Measurement	Face to face crisis contacts that result in follow-up and/or referral to community based services.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	Quarterly Crisis Contract Performance Data
Current Level	78.8% (790 out of 1003)



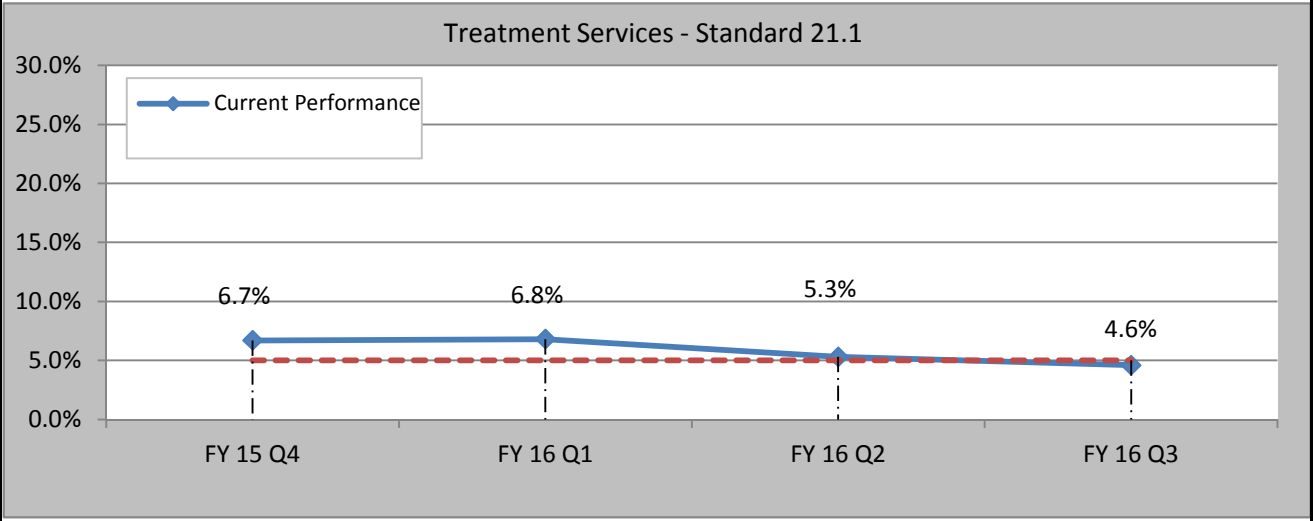
DHHS Office of Substance Abuse and Mental Health Services

Community Resources and Treatment Services

Standard 21 - An array of mental health treatment services are available and sufficient to meet ISP needs of class members and the needs of hospitalized class members ready for discharge.

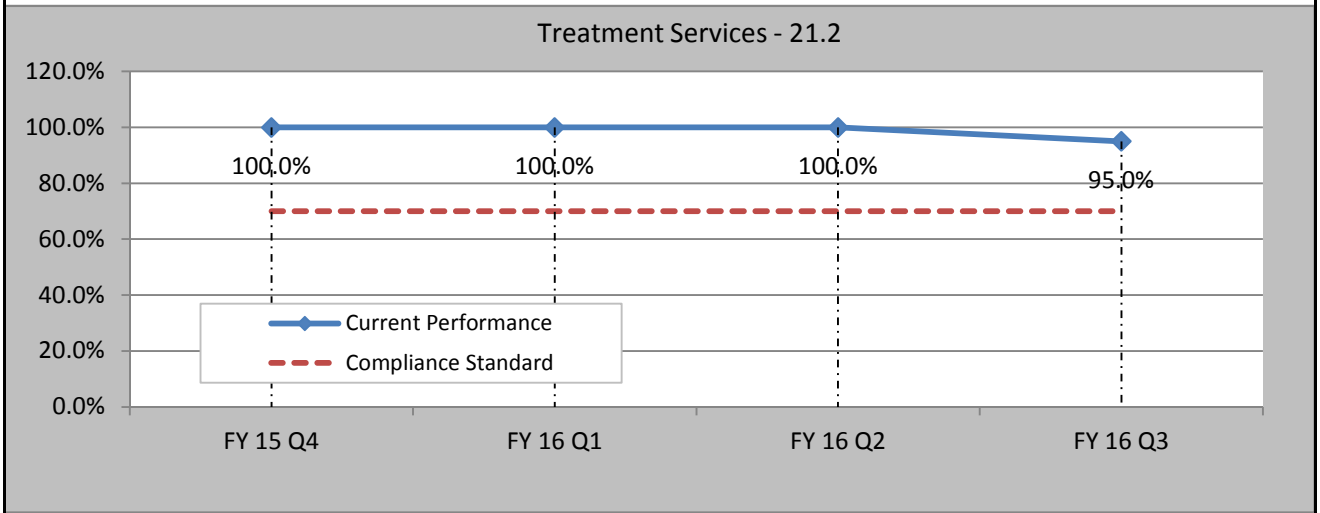
Standard 21.1

Measurement	Class members with ISPs with unmet mental health treatment needs.
Standard	Compliance: 5% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	4.6% (38 out of 825)

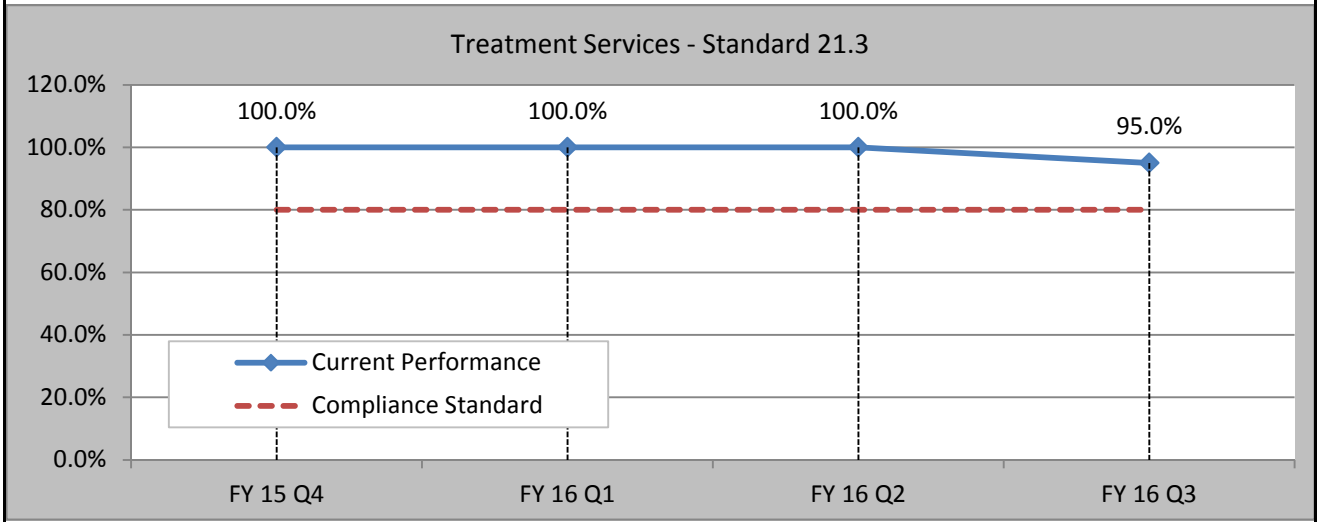


Standard 21.2

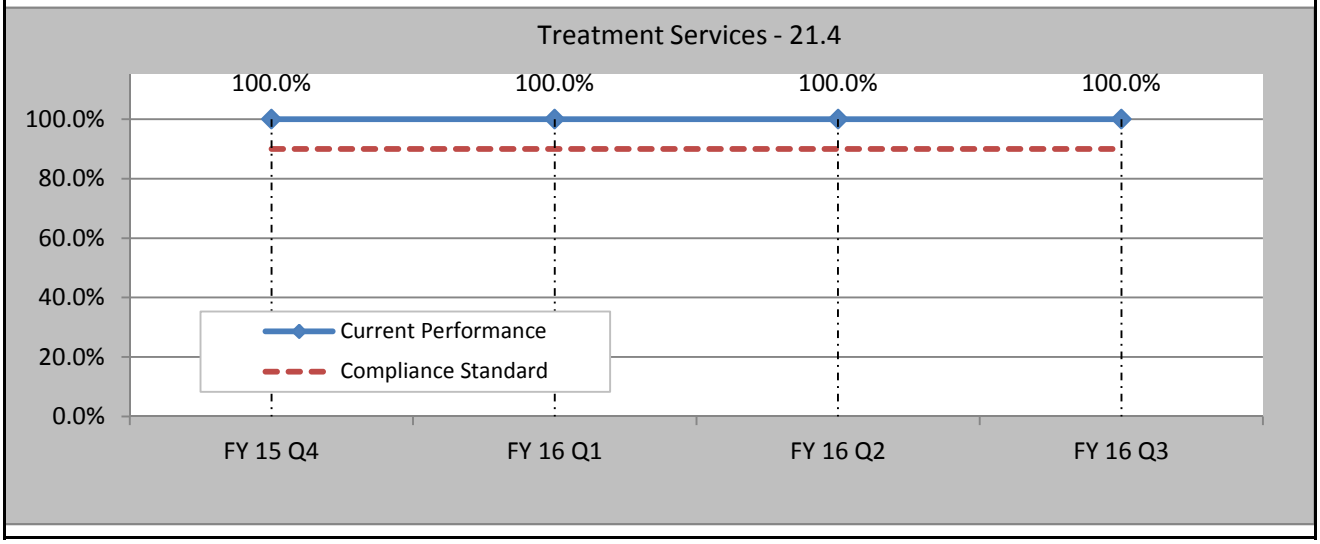
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination.
Standard	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	95% FY16 Q3 (Lack of mental health treatment did not impede discharge for any patients within 7 days)



DHHS Office of Substance Abuse and Mental Health Services	
Community Resources and Treatment Services	
Standard 21.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination.
Standard	Performance: 96% (within 30 days of that determination) Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	95% FY16 Q3 (Lack of mental health treatment did not impede discharge for any patients within 30 days)



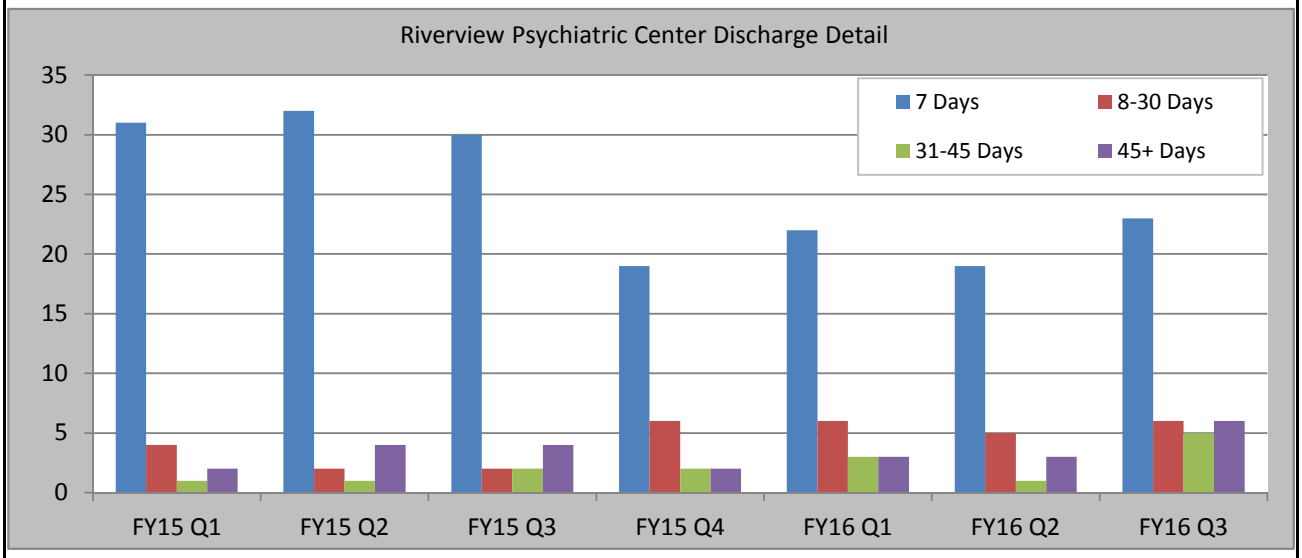
Standard 21.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination.
Standard	Performance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100% FY16 Q3 (Lack of mental health treatment did not impede discharge for any patients within 45 days)



DHHS Office of Substance Abuse and Mental Health Services

Community Resources and Treatment Services

Treatment Services



Riverview Psychiatric Center Discharge Detail to amplify data presented in Standards 12.2, 12.3, 12.4:

<u>40 Civil Patients discharged in quarter</u>
23 discharged at 7 days (57.5%)
6 discharged 8-30 days (15%)
5 discharged 31-45 days (12.5%)
6 discharged post 45 days (15%)

<u>Treatment services did not impede discharge for any patient post clinical readiness for discharge.</u>

DHHS Office of Substance Abuse and Mental Health Services

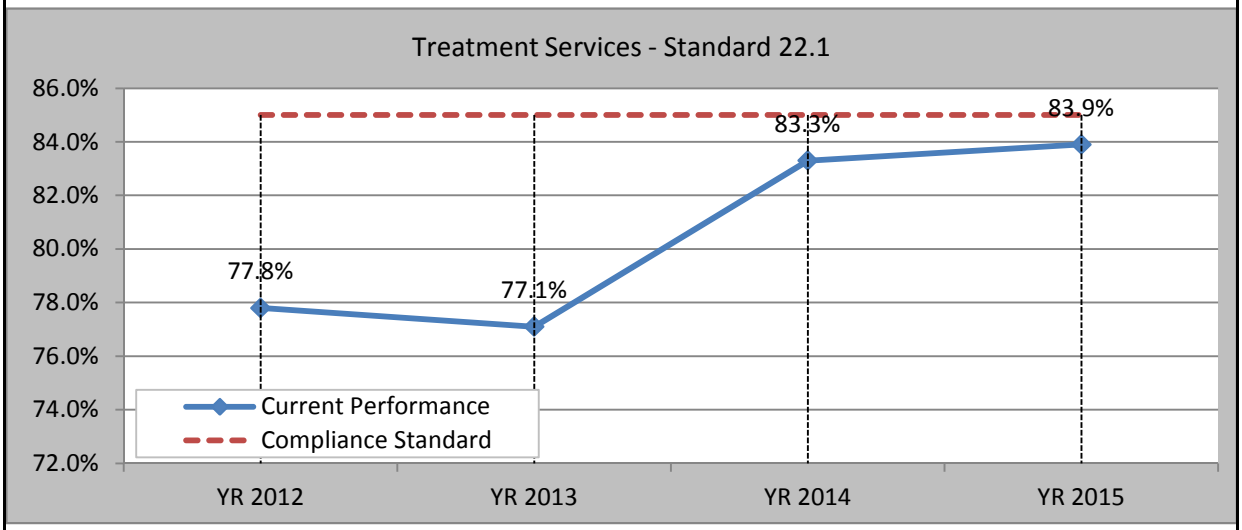
Community Resources and Treatment Services

Treatment Services

Standard 22 - Class members satisfied with access and quality of MH treatment services received.

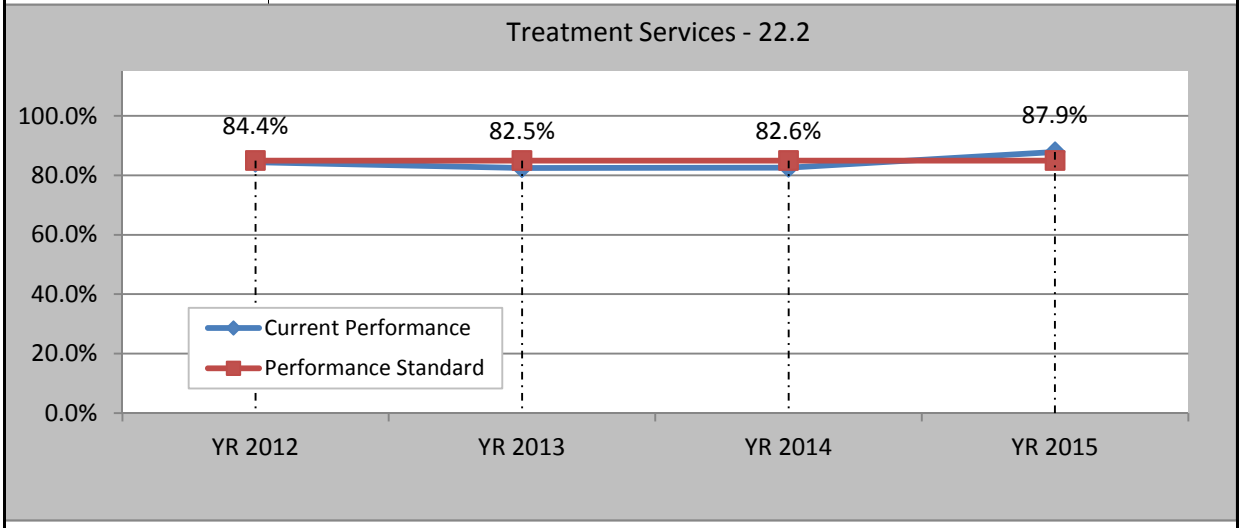
Standard 22.1

Measurement	Domain average of positive responses in the Perception of access domain.
Standard	Performance: At or above 85% Compliance: OAMHS conducts review, takes action if results fall below defined leavels.
Data Source	Adult Mental Health and Well Being Survey
Current Level	83.9%



Standard 22.2

Measurement	Domain average of positive responses in the General Satisfaction domain.
Standard	Performance: at or above 85%
Data Source	Adult Mental Health and Well Being Survey
Current Level	87.9%



DHHS Office of Substance Abuse and Mental Health Services

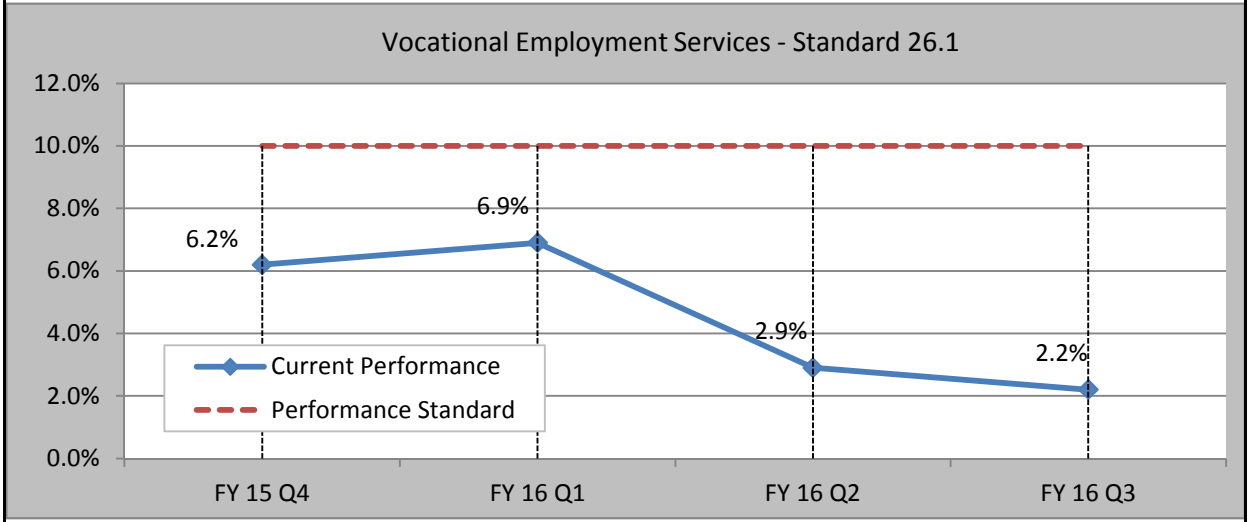
Community Resources and Treatment Services

Vocational Employment Services

Standard 26 - Reasonable efforts to provide array of vocational opportunities to meet ISP needs

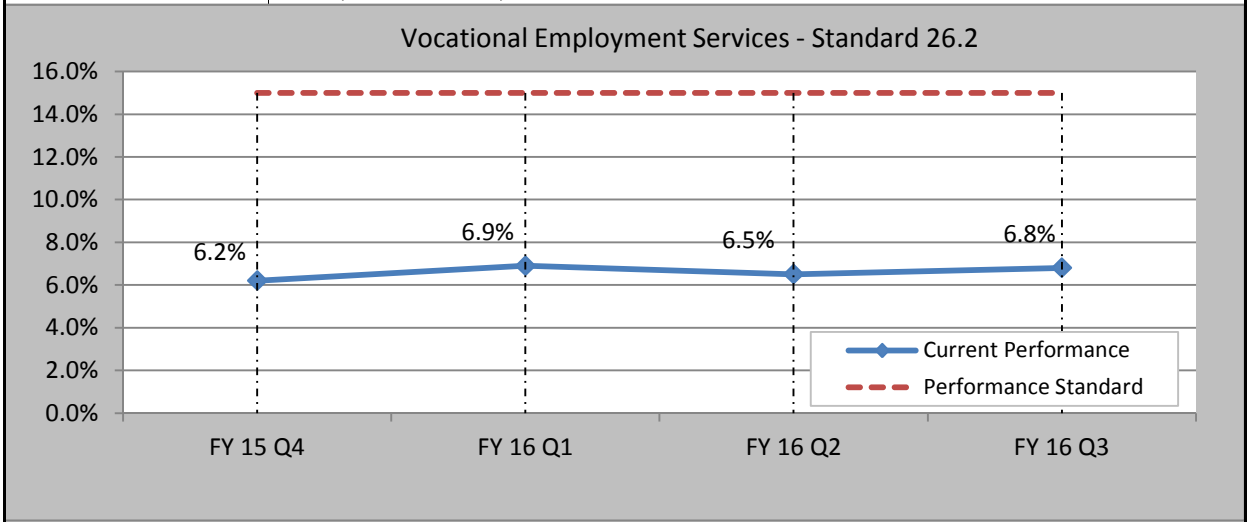
Standard 26.1

Measurement	Class members with ISP identified unmet vocational/employment support needs.
Standard	Performance: 10% or fewer
Data Source	ISP RDS Data
Current Level	2.2% (18 out of 825)

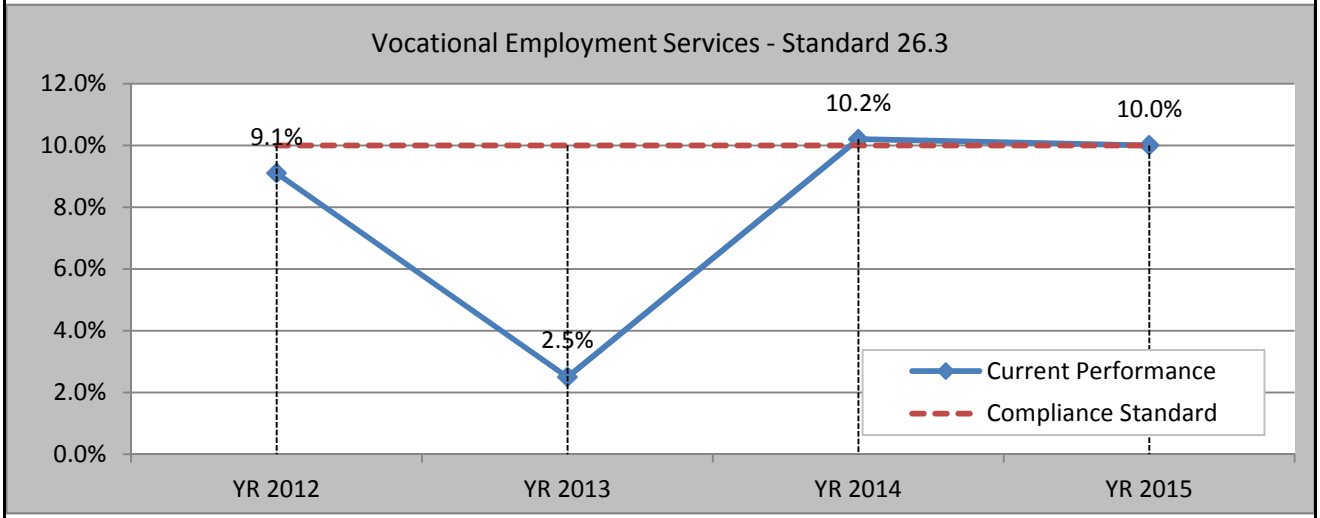


Standard 26.2

Measurement	Domain average of positive responses in the General Satisfaction domain.
Standard	Performance: 15% of class members employed in competitive employment.
Data Source	ISP RDS Data
Current Level	6.8% (83 out of 1229)



DHHS Office of Substance Abuse and Mental Health Services	
Community Resources and Treatment Services	
Vocational Employment Services	
Standard 26.3	
Measurement	Consumers under age 62 in supported and competitive employment (part or full time)
Standard	Performance: 15% in either competitive or supported employment Compliance: If number falls below 10%, Department conducts further review and takes apporopriate action.
Data Source	Adult Mental Health and Well Being Survey
Current Level	10% (98 out of 981)



Discussion:

This standard factored out those persons responding to the Adult Mental Health and Well Being Survey employment questions who are 62 and older.

DHHS Office of Substance Abuse and Mental Health Services

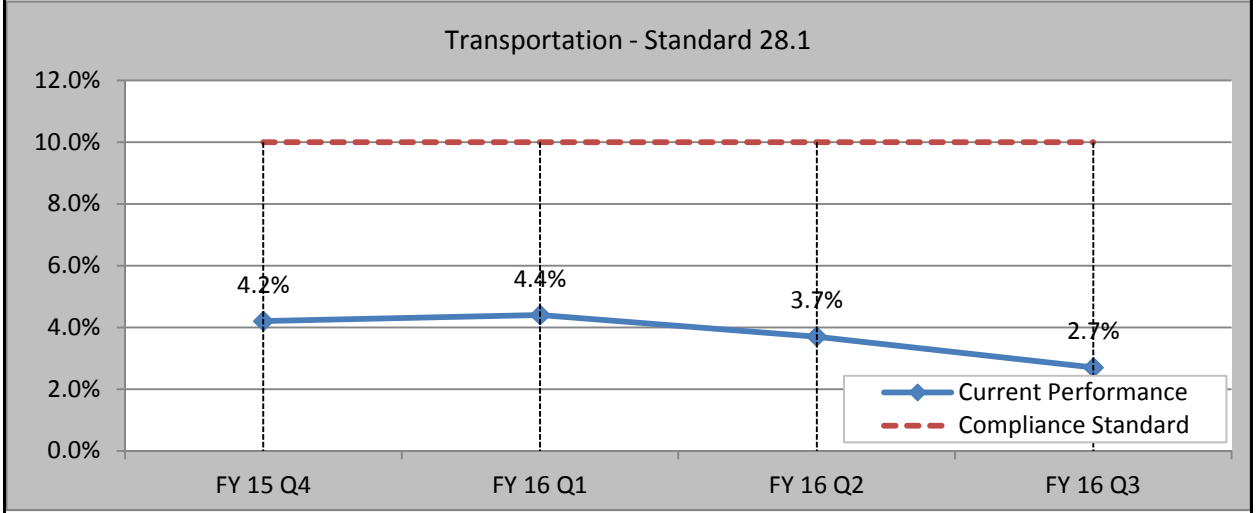
Community Resources and Treatment Services

Transportation

Standard 28 - Reasonable efforts to identify and resolve transportation problems that may limit access to services.

Standard 28.1

Measurement	Percentage of class members with ISP identified unmet transportation needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	2.7% (22 out of 825)



Discussion:

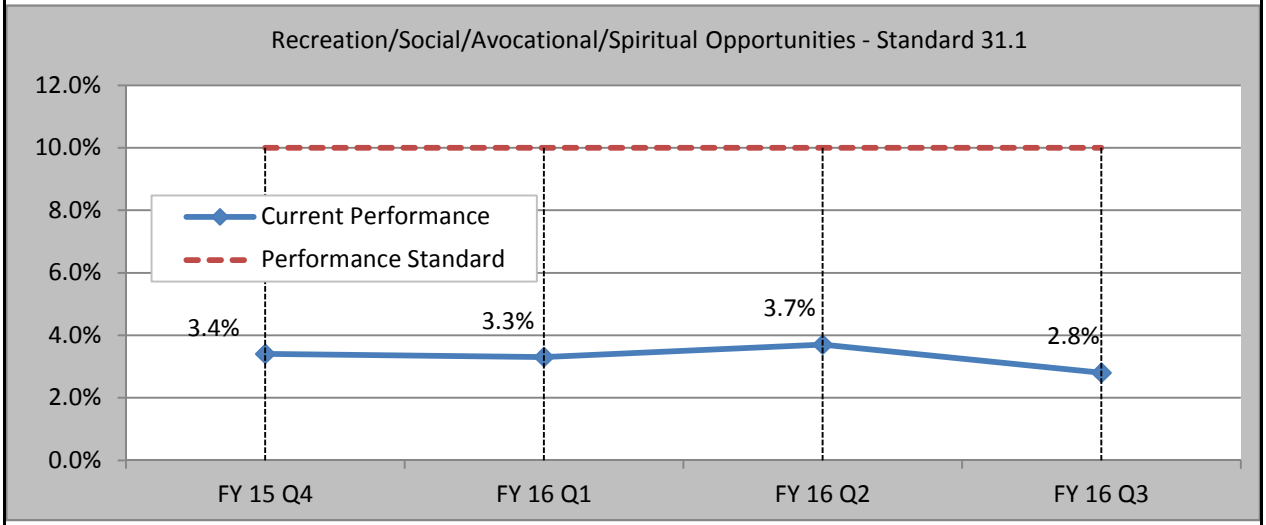
This standard factored out those persons responding to the Adult Mental Health and Well Being Survey employment questions who are 62 and older.

DHHS Office of Substance Abuse and Mental Health Services

Standard 31 - Class member involvement in personal growth activities and community life

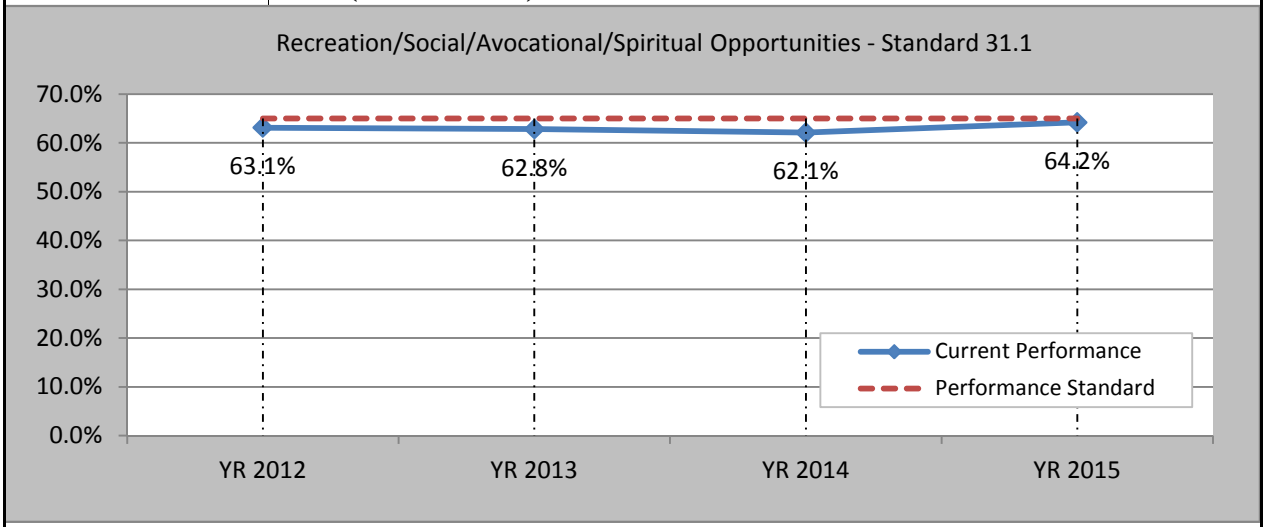
Standard 31.1

Measurement	ISP identified class member unmet needs in recreational, social, avocational, and spiritual areas.
Standard	Performance: 10% or fewer
Data Source	ISP RDS Data
Current Level	2.8% (23 out of 825)



Standard 31.2

Measurement	Domain average of positive responses in the Social Connectedness domain.
Standard	Performance: At or above 65%
Data Source	
Current Level	64.2% (780 out of 1215)



DHHS Office of Substance Abuse and Mental Health Services

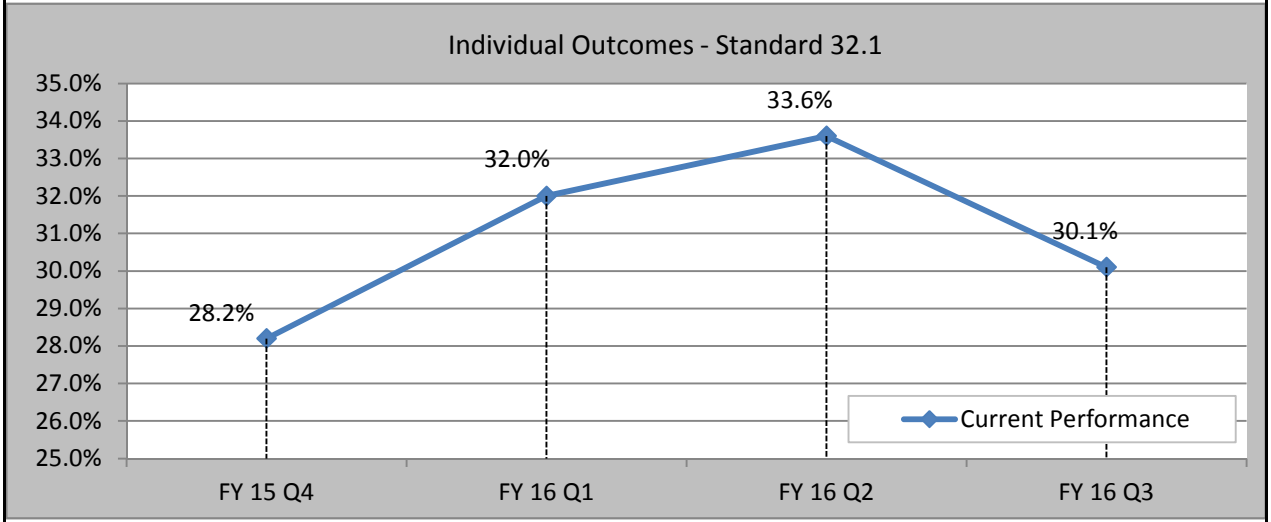
System Outcomes: Supporting the Recovery of Adults with Mental Illness

Recovery

Standard 32 - Functional improvements in the lives of class members receiving services

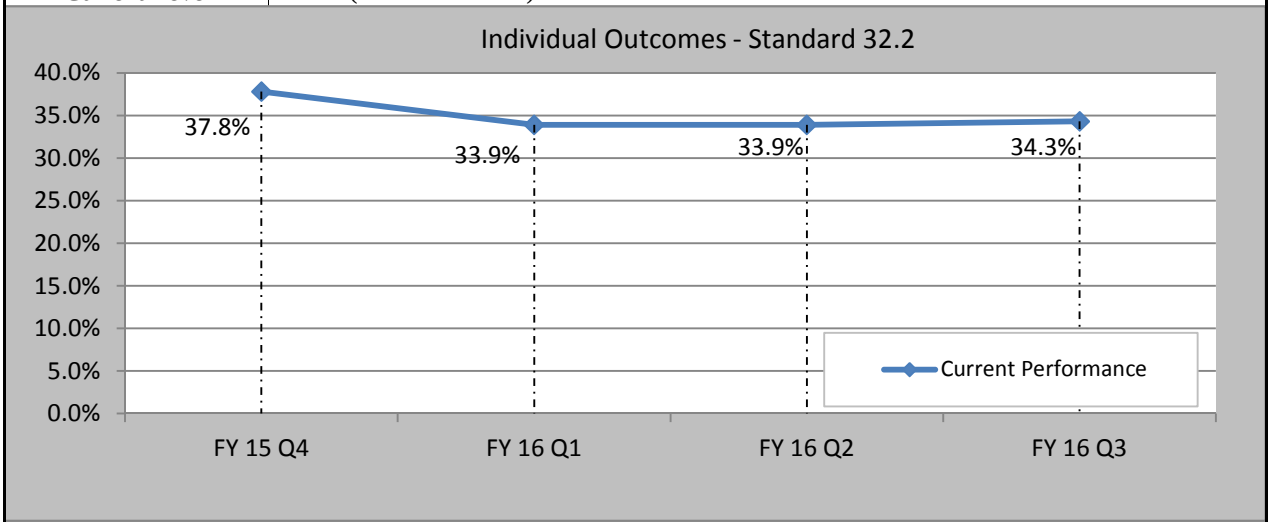
Standard 32.1

Measurement	Class members demonstrating functional improvement on LOCUS between baseline and 12 month re-certification
Standard	Standard to be established.
Data Source	Enrollment data (Based on overall composite score)
Current Level	30.1% (370 out of 1228)

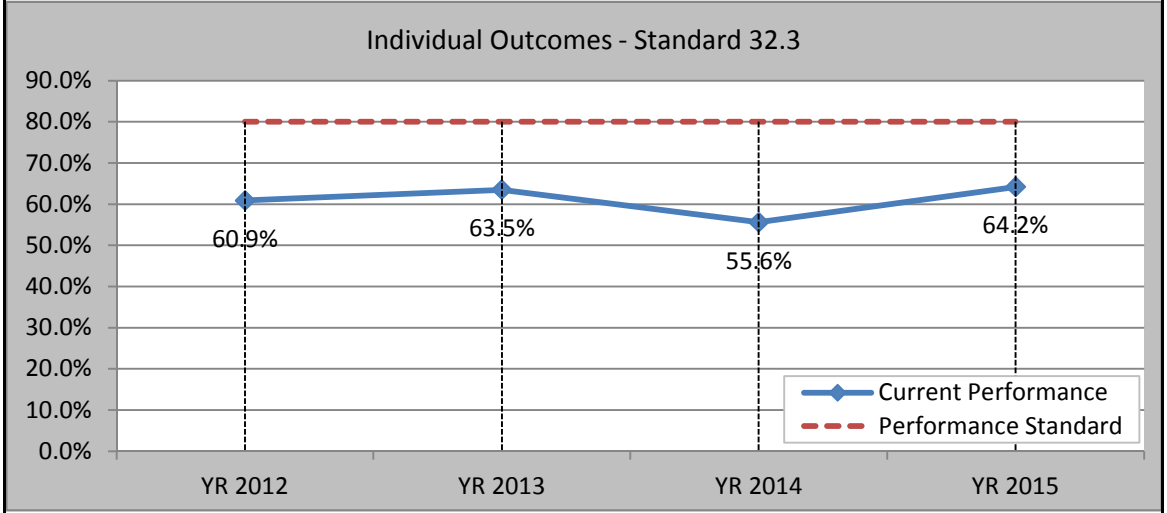


Standard 32.2

Measurement	How the standard is measured.
Standard	
Data Source	Enrollment data (Based on overall composite score)
Current Level	34.3% (421 out of 1228)



DHHS Office of Substance Abuse and Mental Health Services	
System Outcomes: Supporting the Recovery of Adults with Mental Illness	
Recovery	
Standard 32.3	
Measurement	Consumers reporting positively on functional outcomes on Adult Mental Health and Well Being Survey outcome items.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	64.2%



DHHS Office of Substance Abuse and Mental Health Services

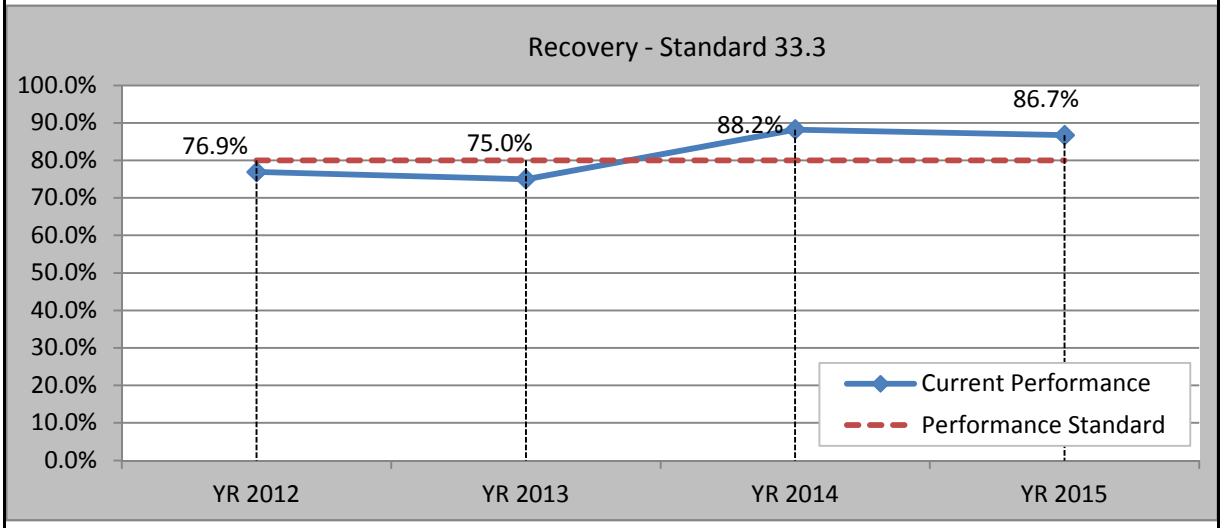
System Outcomes: Supporting the Recovery of Adults with Mental Illness

Recovery

Standard 33 - Demonstrate that consumers are supported in their recovery process

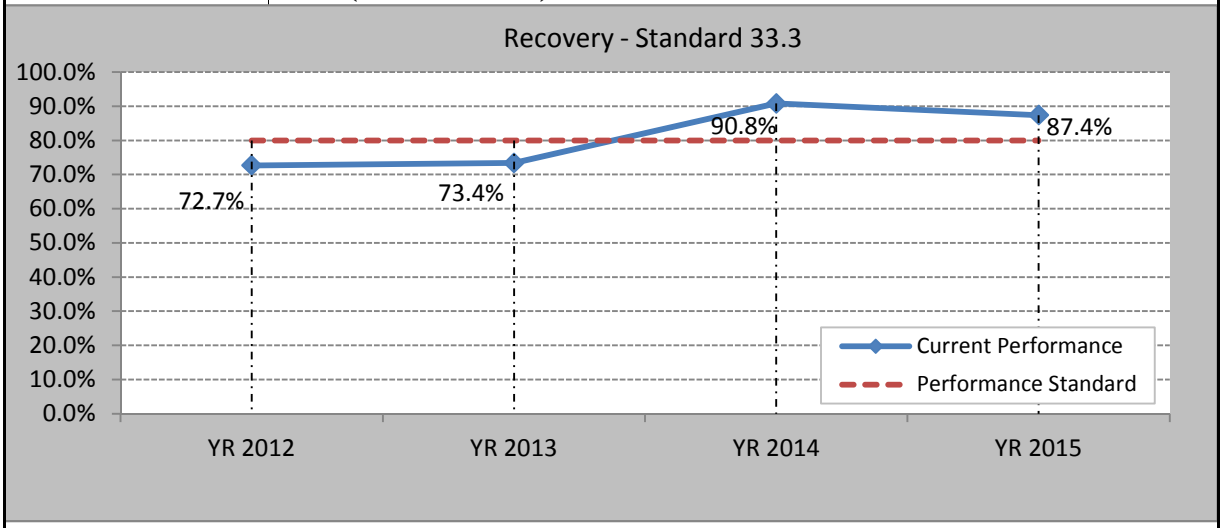
Standard 33.2

Measurement	Consumers reporting that agency staff believe that they can grow, change and recover.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	86.7%

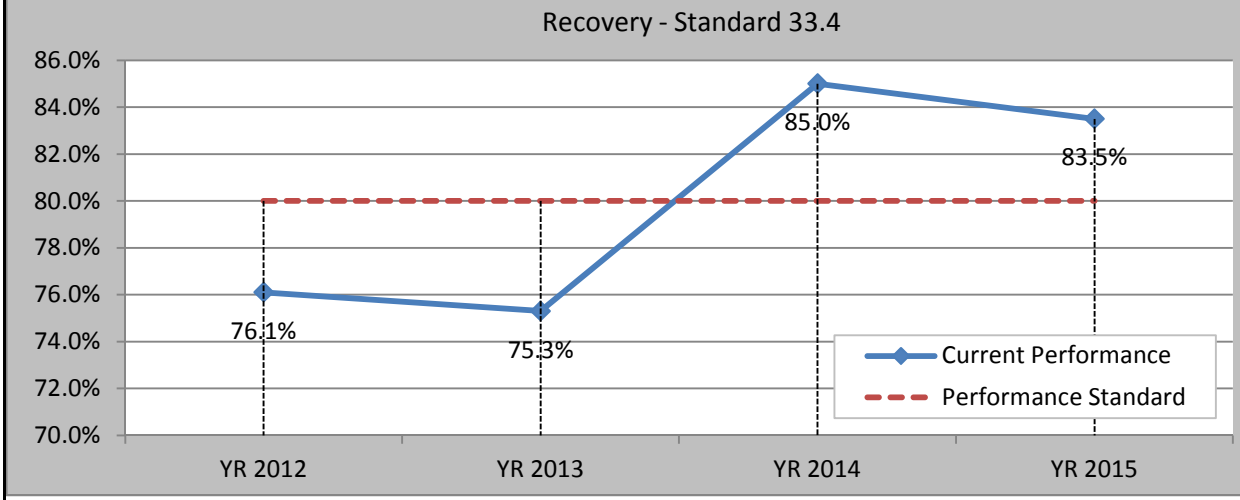


Standard 33.3

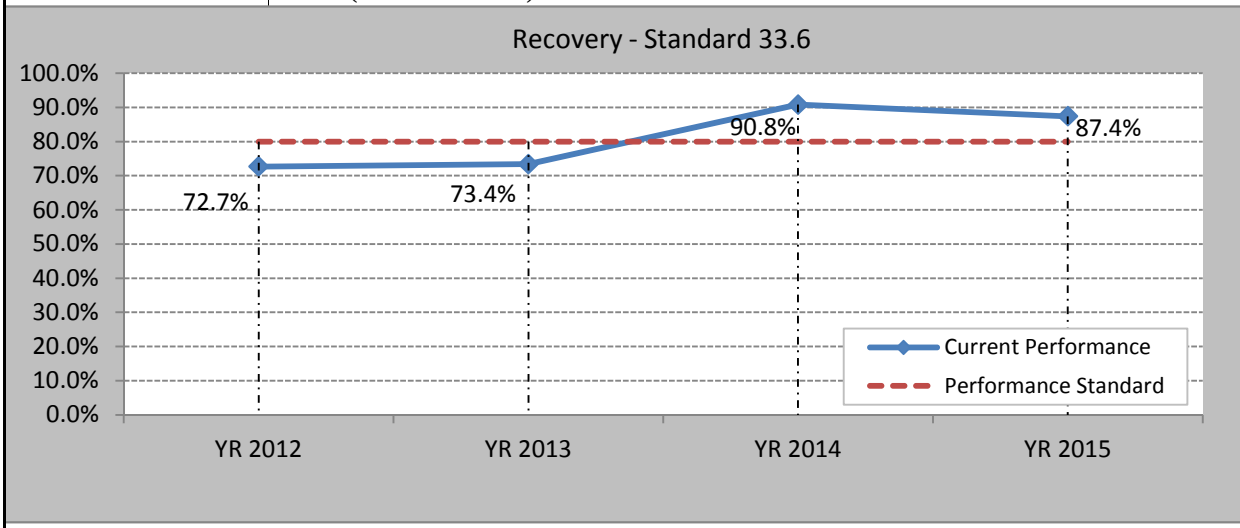
Measurement	Consumers reporting that agency services and staff supported their recovery and wellness efforts and beliefs.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey Q15
Current Level	87.4% (1062 out of 1215)

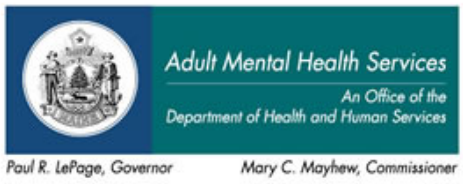


DHHS Office of Substance Abuse and Mental Health Services	
System Outcomes: Supporting the Recovery of Adults with Mental Illness	
Recovery	
Standard 33.4	
Measurement	Consumers reporting that providers offered opportunities to learn skills to strengthen and maintain wellness.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	83.5% (1014 out of 1215)



Standard 33.6	
Measurement	Consumers reporting that service providers offered mutual support or recovery-oriented groups run by peers.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey Q16
Current Level	87.4% (536 out of 1215)





Consent Decree Performance and Quality

Standard 5

Report for: 2016 Q2
(October, November, December2015)
(Class Members)

Measurement

Method 1	Percent of class members requesting a worker who were assigned one.		
	2015 Q3	100.0%	(141 of 141)
	2015 Q4	100.0%	(170 of 170)
	2016 Q1	100.0%	(166 of 166)
	2016 Q2	100.0%	(179 of 179)

Method 2	Percent of hospitalized class members who were assigned a worker within 2 days.		
	2015 Q3	65.2%	(15 of 23)
	2015 Q4	63.6%	(14 of 22)
	2016 Q1	56.3%	(18 of 32)
	2016 Q2	68.0%	(17 of 25)

Method 3	Percent of non-hospitalized class members assigned a worker within 3 days.		
	2015 Q3	78.8%	(93 of 118)
	2015 Q4	81.8%	(121 of 148)
	2016 Q1	79.1%	(106 of 134)
	2016 Q2	75.3%	(116 of 154)

Method 4	Percent of class members in hospital or community not assigned on time but were assigned within 1-7 additional days.		
	2015 Q3	51.5%	(17 of 33)
	2015 Q4	42.9%	(15 of 35)
	2016 Q1	31.0%	(13 of 42)
	2016 Q2	52.2%	(24 of 46)

Method 5	ISP completed within 30 days of service request.		
	2015 Q3	78.0%	(39 of 50)
	2015 Q4	77.0%	(47 of 61)
	2016 Q1	88.5%	(54 of 61)
	2016 Q2	87.9%	(58 of 66)

Method 6	90 Day ISP review completed within specified timeframe.		
	2015 Q3	66.4%	(651 of 980)
	2015 Q4	65.6%	(681 of 1,038)
	2016 Q1	66.4%	(738 of 1,112)
	2016 Q2	65.0%	(656 of 1,009)

Method 7	Initial ISPs not developed within 30 days, but were developed within 60 days.		
	2015 Q3	27.3%	(3 of 11)
	2015 Q4	21.4%	(3 of 14)
	2016 Q1	42.9%	(3 of 7)
	2016 Q2	62.5%	(5 of 8)

Method 8	ISPs that were not reviewed within 90 days, but were reviewed within 120 days.		
	2015 Q3	77.8%	(256 of 329)
	2015 Q4	81.8%	(292 of 357)
	2016 Q1	89.3%	(334 of 374)
	2016 Q2	78.8%	(278 of 353)

As of: Apr 5, 2016 Run By: Lee.Richardson

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.

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

Community Hospital Utilization Review Summary:

Data Type/Method: Service Review/Document Review
Target Population: Individuals admitted to community inpatient psychiatric hospitals on an emergency involuntary basis.
Approximate Sample Size: 105 per quarter; FY16 Q2 50

The Regional Utilization Review Nurses perform clinical reviews of all individuals who were involuntarily admitted who have MaineCare or do not have a payer source. Utilization Review Nurses review all community discharges for appropriateness of the admission, including: compliance with active treatment guidelines; whether medical necessity was established; Blue Paper process completed; and patients rights were maintained, etc. The data collected as part of the clinical review is entered into EIS. This quarter due to staffing shortages only four (4) hospitals were reviewed.

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 APS Healthcare as part of its prior authorization process and fed into EIS twice a month.
Target Population: Adult Mental Health Consumers receiving Community Support approximately 18,900 with 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.

OCQI 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:

Data Type/Method: Information pertaining to Level II and Level III Grievances.

Target Population: Consumers receiving any community based mental health service licensed, contracted or funded by DHHS and consumers who are patients at Riverview Psychiatric Center or Dorothea Dix Psychiatric Center.

The Data Tracking System contains grievances and rights violations for consumers in Adult Mental Health Services. The data system tracks the type of grievance, remedies, resolution and timeliness.

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: As of the 3rd quarter FY11, sample size has been decreased to 50 per quarter, utilizing the random sampling methodology as previously developed. This allows the new SAMHS Division of Quality Management the time 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 APS Healthcare as a component of their authorization process. Data is then fed 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 APS Healthcare, 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.

Department of Health and Human Services (DHHS)
Office of Substance Abuse and Mental Health Services (SAMHS)
Report on Unmet Needs and Quality Improvement Initiatives
May 1, 2016

Attached Report:

Statewide Report of Unmet Resource Needs for Fiscal Year 2016 Quarter 3

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

SAMHS Website – Redesign. The redesign has begun and the expectation is that the home page of the website will have a completely different look. It will be easier to navigate for everyone. Each page of the current website will be evaluated for update to date information, correct links and overall content. Many pages will be retained on the new website while others may be archived. This will allow the website to be accessible and efficient but without losing any prior information. All aspects of the new site should be rolled-out in December 2016.
Identified Need: A, B, C, D, E, F, G, H, I, J, K, L,M

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. SAMHS will be reviewing all measures before implementing FY17 contracts.
Identified Need: A, B, C, D, E, J, K, L.

Contract Review Initiative. The staff at the Office of Continuous Quality Improvement has continued to ensure up-to-date, accurate service encounter data A query tool was built to help SAMHS identify service utilization patterns across three sources of funding. Also, a tool was built to assist providers in sending their data to SAMHS. This entire project has been completed but needs constant monitoring.
Identified Need: A, B, D, E, I, J, 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 several months to come up with ways to redesign the certification. They are currently working on the Competencies required to be certified. Different pathways are being looked at for people to obtain their MHRT/C including but not limited to MHRT/1and peers with Certified Intentional Peer Support Service training. The new requirements will be gradually implemented in order for the schools to change their curriculum. This initiative continues to move forward but hasn't 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 manager is going to be hired (interviews started) to oversee the Consent Decree and to perform an analysis on the Waitlist system. The manager will work with SAMHS staff to identify strengths and weaknesses. This person will then provide feedback to SAMHS staff and work with them to reform the system. Currently agencies are getting their Waitlists directly from APS Healthcare. The agencies are to respond to the Field Service Managers and Field Service Specialist regarding each consumer and their status regarding wait time, choosing to stay on that agencies waitlist, those who are in service, those who are not in service-what is their start date, those discharged, those rescheduling appointments or other explanation. The Waitlist has decreased by 48% from 4/3/15-4/8/16.
Identified Need: A, B

SAMHS Quality Management Plan 2016-2019- The **DRAFT** Quality Management Plan is being completely reviewed and changes are being made as appropriate reflecting the new structure of SAMHS. The QM Plan should be finalized August 2016. Identified Need:
A,B,C,D,E,F,G,H,I,J,K,L,M

AMHI Consent Decree-History, Requirements and Related Topics- A new Power Point was developed to provide in depth assistance to agencies regarding the history, the requirements and other related topics. This Power Point can be found at the link below along with other relevant topics. http://www.maine.gov/dhhs/samhs/resources.shtml
Identified Need: A, B, C, E, G, I, J

Adult Needs and Strengths Assessment (ANSA)- The ANSA is currently being used by the residential providers and the data is being submitted through a portal in Enterprise Information Systems (EIS). The ANSA has a field for intake, discharge, annual and 90 day review. There is a field that distinguishes between forensic and non-forensic clients. SAMHS is slowly implementing a pilot across services. All pilot agencies are now able to submit their data. This pilot is to help SAMHS determine the correct level of care of each consumer.
A, B, C, D, E, F, G, H, I, J, K, L, M

Resource Data Summary- A combined project with SAMHS, APS Healthcare and providers to assess what would be helpful for providers in entering and discharging unmet needs in APS Healthcare. APS has recently posted training materials on their website to assist providers in closing an unmet need when it is no longer needed without waiting. SAMHS and APS have worked out a system to delete the reporting of an unmet need of those who have received the service but were not closed by the agency. This will provide SAMHS with a true picture of unmet needs for those that receive services that are entered into APS Healthcare.
A, B, C, D, E, F, G, H, I, J, K, L, M

Section 17- The new rules for Section 17 went into effect on April 8, 2016. SAMHS has been working with APS Healthcare to capture the seven (7) day face to face requirement. Persons who don't meet the eligibility will be given 120 days transition period. If a person is unable to transition to a different service they will be given an extra 90 days. All class members will receive Community Integration regardless of eligibility. There will be Phase II and possibly Phase III changes to Section 17.
A, C

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

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 2016 Quarter 3

January, February, March, 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.

Adult Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

Statewide

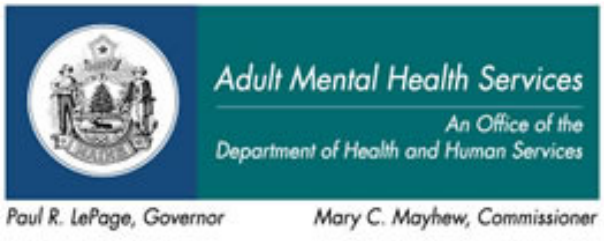
(Class Members and Non-Class Member)

Fiscal Year 2016 Quarter 3

(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	10,619	11,724	11,479	8,580
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	48	50	33	13
7a-iii Dialectical Behavioral Therapy	89	86	71	38
7a-iv Family Psycho-Educational Treatment	23	33	27	16
7a-v Group Counseling	71	82	77	48
7a-vi Individual Counseling	662	816	759	316
7a-vii Inpatient Psychiatric Facility	7	9	7	1
7a-viii Intensive Case Management	88	103	105	55
7a-x Psychiatric Medication Management	609	681	593	288
Total Unmet Resource Needs	1,597	1,860	1,672	775
Distinct Clients with Unmet Resource Needs	1,169	1,354	1,228	618
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	311	422	347	204
7b-ii Mental Health Advance Directives	79	82	65	40
Total Unmet Resource Needs	390	504	412	244
Distinct Clients with Unmet Resource Needs	359	471	390	234
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	63	70	60	32
7c-ii Recovery Workbook Group	5	6	9	2
7c-iii Social Club	183	204	169	120
7c-iv Peer-Run Trauma Recovery Group	47	58	66	38
7c-v Wellness Recovery and Action Planning	46	61	59	46
7c-vi Family Support	158	223	214	163
Total Unmet Resource Needs	502	622	577	401
Distinct Clients with Unmet Resource Needs	388	475	449	322
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	95	114	89	42
7d-ii Residential Treatment Substance Abuse Services	18	21	17	9

Report Run: Apr 26, 2016



Report of Unmet Resource Needs

Statewide

(Class Members and Non-Class Member)

Fiscal Year 2016 Quarter 3

(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	10,619	11,724	11,479	8,580
Total Unmet Resource Needs	113	135	106	51
Distinct Clients with Unmet Resource Needs	108	129	100	50
7e. Housing				
7e-i Supported Apartment	114	128	127	78
7e-ii Community Residential Facility	34	43	37	23
7e-iii Residential Treatment Facility (group home)	19	25	16	7
7e-iv Assisted Living Facility	47	49	37	29
7e-v Nursing Home	4	3	3	4
7e-vi Residential Crisis Unit	0	1	0	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	847	970	953	627
Total Unmet Resource Needs	1,065	1,219	1,173	769
Distinct Clients with Unmet Resource Needs	994	1,121	1,098	719
7f. Health Care				
7f-i Dental Services	647	699	698	476
7f-ii Eye Care Services	246	298	310	203
7f-iii Hearing Services	47	69	68	44
7f-iv Physical Therapy	54	68	56	41
7f-v Physician/Medical Services	358	426	372	219
Total Unmet Resource Needs	1,352	1,560	1,504	983
Distinct Clients with Unmet Resource Needs	982	1,087	1,041	690
7g. Legal				
7g-i Advocate	136	142	128	94
7g-ii Guardian (private)	25	22	20	13
7g-iii Guardian (public)	14	10	10	6
Total Unmet Resource Needs	175	174	158	113
Distinct Clients with Unmet Resource Needs	166	168	152	111
7h. Financial Security				

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Report of Unmet Resource Needs

Statewide

(Class Members and Non-Class Member)

Fiscal Year 2016 Quarter 3

(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	10,619	11,724	11,479	8,580
7h-i Assistance with Managing Money	619	680	618	422
7h-ii Assistance with Securing Public Benefits	346	384	322	229
7h-iii Representative Payee	52	61	48	33
Total Unmet Resource Needs	1,017	1,125	988	684
Distinct Clients with Unmet Resource Needs	851	940	824	561
7i. Education				
7i-i Adult Education (other than GED)	103	138	125	105
7i-ii GED	78	92	83	55
7i-iii Literacy Assistance	38	50	49	28
7i-iv Post High School Education	111	113	110	86
7i-v Tuition Reimbursement	15	19	21	22
Total Unmet Resource Needs	345	412	388	296
Distinct Clients with Unmet Resource Needs	297	352	323	246
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	42	51	56	32
7j-ii Club House and/or Peer Vocational Support	36	38	33	18
7j-iii Competitive Employment (no supports)	79	86	87	72
7j-iv Supported Employment	63	71	75	60
7j-v Vocational Rehabilitation	274	278	250	154
Total Unmet Resource Needs	494	524	501	336
Distinct Clients with Unmet Resource Needs	428	442	436	282
7k. Living Skills				
7k-i Daily Living Support Services	301	349	290	158
7k-ii Day Support Services	37	47	39	17
7k-iii Occupational Therapy	15	20	17	10
7k-iv Skills Development Services	90	118	108	66
Total Unmet Resource Needs	443	534	454	251

Report Run: Apr 26, 2016

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Report of Unmet Resource Needs

Statewide
(Class Members and Non-Class Member)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	10,619	11,724	11,479	8,580
Distinct Clients with Unmet Resource Needs	391	463	400	216
7l. Transportation				
7l-i Transportation to ISP-Identified Services	492	570	495	354
7-ii Transportation to Other ISP Activities	263	317	278	211
7-iii After Hours Transportation	189	222	193	154
Total Unmet Resource Needs	944	1,109	966	719
Distinct Clients with Unmet Resource Needs	628	712	626	442
7m. Personal Growth/Community				
7m-i Avocational Activities	28	36	30	26
7m. Personal Growth/Community				
7m-ii Recreation Activities	202	231	198	160
7m-iii Social Activities	436	496	472	340
7m-iv Spiritual Activities	85	105	103	71
Total Unmet Resource Needs	751	868	803	597
Distinct Clients with Unmet Resource Needs	521	598	559	403
Other Resources				
Other Resources	175	184	188	176
Total Unmet Resource Needs	175	184	188	176
Distinct Clients with Unmet Resource Needs	175	184	188	176
Statewide Totals				
Total Unmet Resource Needs	9,363	10,830	9,890	6,395
Distinct Clients With any Unmet Resource Need	2,838	3,093	2,939	1,931
Distinct Clients with a RDS	10,619	11,724	11,479	8,580

Report Run: Apr 26, 2016

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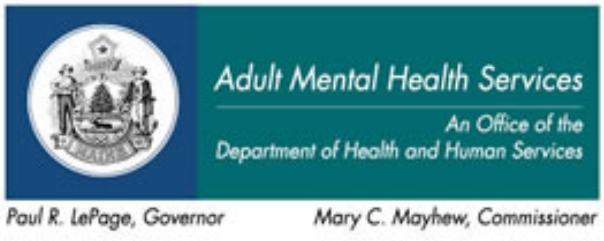
Report of Unmet Resource Needs

Statewide
(Class Members Only)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,101	1,171	1,129	825
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	7	6	2	2
7a-iii Dialectical Behavioral Therapy	3	2	0	0
7a-iv Family Psycho-Educational Treatment	2	2	2	1
7a-v Group Counseling	5	3	2	3
7a-vi Individual Counseling	34	46	33	18
7a-vii Inpatient Psychiatric Facility	1	1	0	0
7a-viii Intensive Case Management	7	6	10	3
7a-x Psychiatric Medication Management	46	43	29	19
Total Unmet Resource Needs	105	109	78	46
Distinct Clients with Unmet Resource Needs	74	80	60	38
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	14	19	13	7
7b-ii Mental Health Advance Directives	7	6	2	2
Total Unmet Resource Needs	21	25	15	9
Distinct Clients with Unmet Resource Needs	19	22	14	8
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	8	9	3	4
7c-ii Recovery Workbook Group	0	1	2	1
7c-iii Social Club	10	15	12	8
7c-iv Peer-Run Trauma Recovery Group	3	3	1	1
7c-v Wellness Recovery and Action Planning	2	6	2	3
7c-vi Family Support	5	6	6	5
Total Unmet Resource Needs	28	40	26	22
Distinct Clients with Unmet Resource Needs	21	28	19	16
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	6	9	5	3
7d-ii Residential Treatment Substance Abuse Services	3	3	3	2

Report Run: Apr 26, 2016



Report of Unmet Resource Needs

Statewide
(Class Members Only)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,101	1,171	1,129	825
Total Unmet Resource Needs	9	12	8	5
Distinct Clients with Unmet Resource Needs	9	12	8	5
7e. Housing				
7e-i Supported Apartment	15	19	14	8
7e-ii Community Residential Facility	7	6	8	3
7e-iii Residential Treatment Facility (group home)	5	6	4	2
7e-iv Assisted Living Facility	6	7	7	5
7e-v Nursing Home	0	0	1	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	68	75	65	35
Total Unmet Resource Needs	101	113	99	54
Distinct Clients with Unmet Resource Needs	88	95	83	47
7f. Health Care				
7f-i Dental Services	50	51	50	33
7f-ii Eye Care Services	11	13	12	10
7f-iii Hearing Services	2	4	2	3
7f-iv Physical Therapy	1	2	2	0
7f-v Physician/Medical Services	28	26	23	10
Total Unmet Resource Needs	92	96	89	56
Distinct Clients with Unmet Resource Needs	81	79	70	42
7g. Legal				
7g-i Advocate	9	8	7	4
7g-ii Guardian (private)	2	1	0	0
7g-iii Guardian (public)	6	4	4	2
Total Unmet Resource Needs	17	13	11	6
Distinct Clients with Unmet Resource Needs	14	13	11	6
7h. Financial Security				

Report Run: Apr 26, 2016

Adult Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

Statewide
(Class Members Only)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,101	1,171	1,129	825
7h-i Assistance with Managing Money	23	29	18	15
7h-ii Assistance with Securing Public Benefits	19	23	14	14
7h-iii Representative Payee	10	12	8	4
Total Unmet Resource Needs	52	64	40	33
Distinct Clients with Unmet Resource Needs	43	54	34	26
7i. Education				
7i-i Adult Education (other than GED)	2	1	3	2
7i-ii GED	3	5	3	0
7i-iii Literacy Assistance	3	2	2	2
7i-iv Post High School Education	5	6	5	3
7i-v Tuition Reimbursement	1	2	2	1
Total Unmet Resource Needs	14	16	15	8
Distinct Clients with Unmet Resource Needs	11	12	13	8
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	2	4	4
7j-ii Club House and/or Peer Vocational Support	5	6	7	3
7j-iii Competitive Employment (no supports)	6	4	4	5
7j-iv Supported Employment	10	7	7	3
7j-v Vocational Rehabilitation	12	12	16	8
Total Unmet Resource Needs	34	31	38	23
Distinct Clients with Unmet Resource Needs	28	25	33	18
7k. Living Skills				
7k-i Daily Living Support Services	23	29	17	7
7k-ii Day Support Services	3	4	5	1
7k-iii Occupational Therapy	2	0	1	0
7k-iv Skills Development Services	8	8	8	4
Total Unmet Resource Needs	36	41	31	12

Report Run: Apr 26, 2016

Adult Mental Health Services
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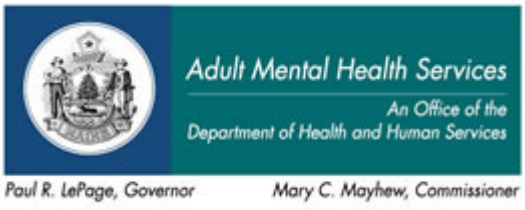
Report of Unmet Resource Needs

Statewide
(Class Members Only)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,101	1,171	1,129	825
Distinct Clients with Unmet Resource Needs	28	34	24	10
7l. Transportation				
7l-i Transportation to ISP-Identified Services	23	32	22	12
7-ii Transportation to Other ISP Activities	17	18	17	15
7-iii After Hours Transportation	21	20	21	10
Total Unmet Resource Needs	61	70	60	37
Distinct Clients with Unmet Resource Needs	46	52	42	22
7m. Personal Growth/Community				
7m-i Avocational Activities	1	1	1	1
7m. Personal Growth/Community				
7m-ii Recreation Activities	12	14	16	10
7m-iii Social Activities	32	33	35	19
7m-iv Spiritual Activities	2	3	3	3
Total Unmet Resource Needs	47	51	55	33
Distinct Clients with Unmet Resource Needs	37	39	42	23
Other Resources				
Other Resources	16	11	11	14
Total Unmet Resource Needs	16	11	11	14
Distinct Clients with Unmet Resource Needs	16	11	11	14
Statewide Totals				
Total Unmet Resource Needs	633	692	576	358
Distinct Clients With any Unmet Resource Need	262	265	234	141
Distinct Clients with a RDS	1,101	1,171	1,129	825

Report Run: Apr 26, 2016



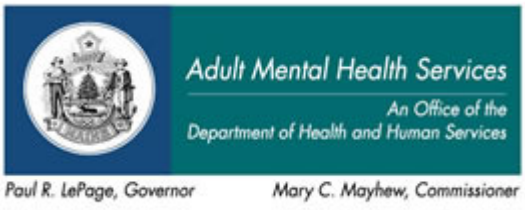
Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	401	467	442	381
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	3	2	1	0
7a-iii Dialectical Behavioral Therapy	4	7	3	1
7a-iv Family Psycho-Educational Treatment	1	2	1	0
7a-v Group Counseling	5	8	8	10
7a-vi Individual Counseling	26	29	24	18
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	2	1	0	3
7a-x Psychiatric Medication Management	25	23	19	15
Total Unmet Resource Needs	66	72	56	47
Distinct Clients with Unmet Resource Needs	55	54	47	36
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	19	22	14	20
7b-ii Mental Health Advance Directives	1	1	1	0
Total Unmet Resource Needs	20	23	15	20
Distinct Clients with Unmet Resource Needs	19	22	15	20
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	1	0	0
7c-ii Recovery Workbook Group	0	1	1	0
7c-iii Social Club	16	16	9	10
7c-iv Peer-Run Trauma Recovery Group	0	1	2	4
7c-v Wellness Recovery and Action Planning	1	2	1	1
7c-vi Family Support	8	10	6	5
Total Unmet Resource Needs	26	31	19	20
Distinct Clients with Unmet Resource Needs	23	26	17	19
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	2	6	4	5

Report Run: Apr 26, 2016



Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	401	467	442	381
7d-ii Residential Treatment Substance Abuse Services	0	3	1	0
Total Unmet Resource Needs	2	9	5	5
Distinct Clients with Unmet Resource Needs	2	6	4	5
7e. Housing				
7e-i Supported Apartment	9	9	7	4
7e-ii Community Residential Facility	1	2	0	0
7e-iii Residential Treatment Facility (group home)	1	1	1	0
7e-iv Assisted Living Facility	2	4	4	3
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	1	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	24	25	30	23
Total Unmet Resource Needs	37	42	42	30
Distinct Clients with Unmet Resource Needs	33	35	38	27
7f. Health Care				
7f-i Dental Services	23	22	21	23
7f-ii Eye Care Services	9	11	10	10
7f-iii Hearing Services	1	2	1	3
7f-iv Physical Therapy	4	3	3	0
7f-v Physician/Medical Services	14	15	13	11
Total Unmet Resource Needs	51	53	48	47
Distinct Clients with Unmet Resource Needs	35	37	34	35
7g. Legal				
7g-i Advocate	10	9	6	7
7g-ii Guardian (private)	1	1	1	0
7g-iii Guardian (public)	0	0	1	1
Total Unmet Resource Needs	11	10	8	8
Distinct Clients with Unmet Resource Needs	11	10	7	8

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	401	467	442	381
7h. Financial Security				
7h-i Assistance with Managing Money	26	26	30	30
7h-ii Assistance with Securing Public Benefits	21	25	30	25
7h-iii Representative Payee	0	0	1	1
Total Unmet Resource Needs	47	51	61	56
Distinct Clients with Unmet Resource Needs	42	43	51	48
7i. Education				
7i-i Adult Education (other than GED)	3	1	3	3
7i-ii GED	3	5	3	1
7i-iii Literacy Assistance	2	2	2	1
7i-iv Post High School Education	7	5	6	5
7i-v Tuition Reimbursement	2	0	1	0
Total Unmet Resource Needs	17	13	15	10
Distinct Clients with Unmet Resource Needs	13	13	13	10
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	2	2	3	1
7j-ii Club House and/or Peer Vocational Support	1	1	1	2
7j-iii Competitive Employment (no supports)	2	2	4	0
7j-iv Supported Employment	3	3	4	5
7j-v Vocational Rehabilitation	12	6	7	5
Total Unmet Resource Needs	20	14	19	13
Distinct Clients with Unmet Resource Needs	18	13	17	12
7k. Living Skills				
7k-i Daily Living Support Services	10	11	8	9
7k-ii Day Support Services	4	7	4	3
7k-iii Occupational Therapy	0	2	1	0
7k-iv Skills Development Services	9	10	6	6

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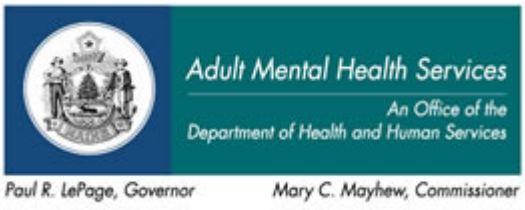

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	401	467	442	381
Total Unmet Resource Needs	23	30	19	18
Distinct Clients with Unmet Resource Needs	21	26	18	16
7l. Transportation				
7l-i Transportation to ISP-Identified Services	24	24	26	26
7-ii Transportation to Other ISP Activities	6	6	8	9
7-iii After Hours Transportation	17	15	14	17
Total Unmet Resource Needs	47	45	48	52
Distinct Clients with Unmet Resource Needs	36	34	36	38
7m. Personal Growth/Community				
7m-i Avocational Activities	1	0	0	0
7m-ii Recreation Activities	9	11	6	7
7m-iii Social Activities	30	28	25	24
7m-iv Spiritual Activities	4	5	5	5
Total Unmet Resource Needs	44	44	36	36
Distinct Clients with Unmet Resource Needs	36	31	28	28
Other Resources				
Other Resources	12	12	14	14
Total Unmet Resource Needs	12	12	14	14
Distinct Clients with Unmet Resource Needs	12	12	14	14
CSN 1 Totals				
Total Unmet Resource Needs	423	449	405	376
Distinct Clients With any Unmet Resource Need	143	148	142	124
Distinct Clients with a RDS	401	467	442	381

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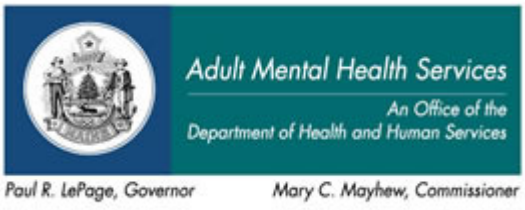

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,826	2,090	2,067	1,592
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	3	3	3
7a-iii Dialectical Behavioral Therapy	5	5	5	5
7a-iv Family Psycho-Educational Treatment	2	3	1	1
7a-v Group Counseling	19	23	15	13
7a-vi Individual Counseling	117	146	140	63
7a-vii Inpatient Psychiatric Facility	2	3	4	0
7a-viii Intensive Case Management	14	21	24	8
7a-x Psychiatric Medication Management	91	110	91	50
Total Unmet Resource Needs	252	314	283	143
Distinct Clients with Unmet Resource Needs	188	233	211	118
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	56	91	69	37
7b-ii Mental Health Advance Directives	15	18	14	10
Total Unmet Resource Needs	71	109	83	47
Distinct Clients with Unmet Resource Needs	64	98	82	46
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	6	6	9	3
7c-ii Recovery Workbook Group	1	1	1	0
7c-iii Social Club	32	38	33	24
7c-iv Peer-Run Trauma Recovery Group	5	5	6	0
7c-v Wellness Recovery and Action Planning	16	15	21	20
7c-vi Family Support	24	29	35	21
Total Unmet Resource Needs	84	94	105	68
Distinct Clients with Unmet Resource Needs	69	76	85	64
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	21	32	28	12

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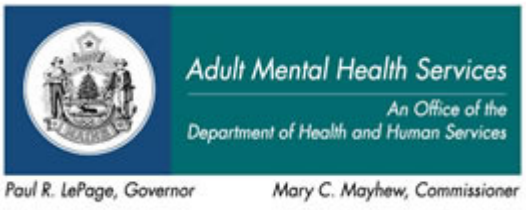

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,826	2,090	2,067	1,592
7d-ii Residential Treatment Substance Abuse Services	5	5	5	1
Total Unmet Resource Needs	26	37	33	13
Distinct Clients with Unmet Resource Needs	23	35	30	13
7e. Housing				
7e-i Supported Apartment	19	19	21	22
7e-ii Community Residential Facility	5	7	4	4
7e-iii Residential Treatment Facility (group home)	3	3	2	1
7e-iv Assisted Living Facility	14	10	10	11
7e-v Nursing Home	0	0	0	1
7e-vi Residential Crisis Unit	0	0	0	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	155	175	173	136
Total Unmet Resource Needs	196	214	210	176
Distinct Clients with Unmet Resource Needs	182	198	201	160
7f. Health Care				
7f-i Dental Services	76	105	109	70
7f-ii Eye Care Services	35	49	60	46
7f-iii Hearing Services	4	8	9	8
7f-iv Physical Therapy	9	10	8	4
7f-v Physician/Medical Services	57	65	58	31
Total Unmet Resource Needs	181	237	244	159
Distinct Clients with Unmet Resource Needs	131	171	171	115
7g. Legal				
7g-i Advocate	23	33	36	20
7g-ii Guardian (private)	14	14	11	8
7g-iii Guardian (public)	3	1	1	1
Total Unmet Resource Needs	40	48	48	29
Distinct Clients with Unmet Resource Needs	38	46	48	29

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,826	2,090	2,067	1,592
7h. Financial Security				
7h-i Assistance with Managing Money	107	135	123	86
7h-ii Assistance with Securing Public Benefits	61	81	65	54
7h-iii Representative Payee	8	10	6	5
Total Unmet Resource Needs	176	226	194	145
Distinct Clients with Unmet Resource Needs	145	186	163	124
7i. Education				
7i-i Adult Education (other than GED)	12	15	11	12
7i-ii GED	7	13	13	9
7i-iii Literacy Assistance	4	6	3	2
7i-iv Post High School Education	20	23	25	19
7i-v Tuition Reimbursement	3	5	5	3
Total Unmet Resource Needs	46	62	57	45
Distinct Clients with Unmet Resource Needs	41	55	52	41
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	10	10	10	6
7j-ii Club House and/or Peer Vocational Support	6	10	9	5
7j-iii Competitive Employment (no supports)	11	15	19	14
7j-iv Supported Employment	12	15	15	18
7j-v Vocational Rehabilitation	34	28	30	23
Total Unmet Resource Needs	73	78	83	66
Distinct Clients with Unmet Resource Needs	58	65	73	58
7k. Living Skills				
7k-i Daily Living Support Services	33	42	43	26
7k-ii Day Support Services	2	2	2	1
7k-iii Occupational Therapy	1	1	2	1
7k-iv Skills Development Services	17	20	19	8

Report Run: Apr 26, 2016

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,826	2,090	2,067	1,592
Total Unmet Resource Needs	53	65	66	36
Distinct Clients with Unmet Resource Needs	46	59	60	35
7l. Transportation				
7l-i Transportation to ISP-Identified Services	78	85	68	59
7-ii Transportation to Other ISP Activities	40	44	42	32
7-iii After Hours Transportation	33	43	37	38
Total Unmet Resource Needs	151	172	147	129
Distinct Clients with Unmet Resource Needs	98	119	104	90
7m. Personal Growth/Community				
7m-i Avocational Activities	11	9	5	6
7m-ii Recreation Activities	51	48	52	47
7m-iii Social Activities	88	94	103	83
7m-iv Spiritual Activities	17	16	10	8
Total Unmet Resource Needs	167	167	170	144
Distinct Clients with Unmet Resource Needs	109	122	121	99
Other Resources				
Other Resources	26	30	36	36
Total Unmet Resource Needs	26	30	36	36
Distinct Clients with Unmet Resource Needs	26	30	36	36
CSN 2 Totals				
Total Unmet Resource Needs	1,542	1,853	1,759	1,236
Distinct Clients With any Unmet Resource Need	457	544	525	423
Distinct Clients with a RDS	1,826	2,090	2,067	1,592

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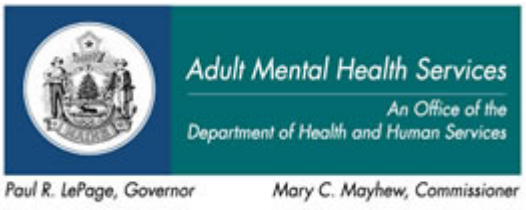

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,160	2,477	2,411	1,908
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	6	2	1	0
7a-iii Dialectical Behavioral Therapy	4	8	8	5
7a-iv Family Psycho-Educational Treatment	3	2	2	1
7a-v Group Counseling	7	4	7	6
7a-vi Individual Counseling	88	116	102	34
7a-vii Inpatient Psychiatric Facility	3	4	1	0
7a-viii Intensive Case Management	10	12	5	4
7a-x Psychiatric Medication Management	111	125	100	47
Total Unmet Resource Needs	232	273	226	97
Distinct Clients with Unmet Resource Needs	169	195	160	76
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	61	70	57	22
7b-ii Mental Health Advance Directives	19	24	18	3
Total Unmet Resource Needs	80	94	75	25
Distinct Clients with Unmet Resource Needs	71	85	67	24
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	4	7	3	1
7c-ii Recovery Workbook Group	1	0	1	0
7c-iii Social Club	15	27	13	6
7c-iv Peer-Run Trauma Recovery Group	5	6	6	0
7c-v Wellness Recovery and Action Planning	1	0	1	0
7c-vi Family Support	13	17	14	11
Total Unmet Resource Needs	39	57	38	18
Distinct Clients with Unmet Resource Needs	31	48	32	17
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	10	14	9	3

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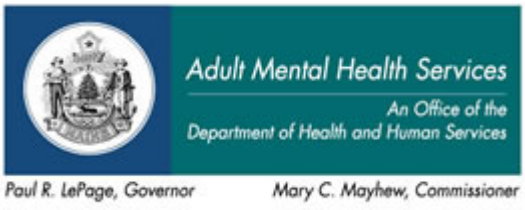

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,160	2,477	2,411	1,908
7d-ii Residential Treatment Substance Abuse Services	3	1	1	1
Total Unmet Resource Needs	13	15	10	4
Distinct Clients with Unmet Resource Needs	12	15	10	4
7e. Housing				
7e-i Supported Apartment	9	8	4	1
7e-ii Community Residential Facility	3	4	2	0
7e-iii Residential Treatment Facility (group home)	2	5	2	2
7e-iv Assisted Living Facility	8	9	6	3
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)	126	158	138	69
Total Unmet Resource Needs	148	185	152	75
Distinct Clients with Unmet Resource Needs	140	176	152	75
7f. Health Care				
7f-i Dental Services	75	104	105	56
7f-ii Eye Care Services	29	41	44	20
7f-iii Hearing Services	7	10	10	1
7f-iv Physical Therapy	4	11	7	5
7f-v Physician/Medical Services	56	87	66	33
Total Unmet Resource Needs	171	253	232	115
Distinct Clients with Unmet Resource Needs	127	179	161	83
7g. Legal				
7g-i Advocate	7	5	6	7
7g-ii Guardian (private)	2	0	0	0
7g-iii Guardian (public)	3	3	2	1
Total Unmet Resource Needs	12	8	8	8
Distinct Clients with Unmet Resource Needs	12	8	8	8

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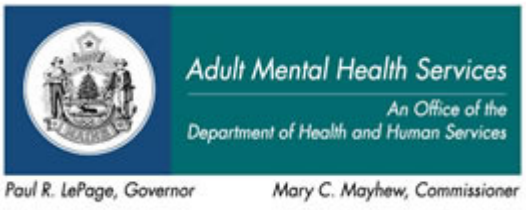

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,160	2,477	2,411	1,908
7h. Financial Security				
7h-i Assistance with Managing Money	92	96	82	43
7h-ii Assistance with Securing Public Benefits	42	49	36	18
7h-iii Representative Payee	13	17	11	5
Total Unmet Resource Needs	147	162	129	66
Distinct Clients with Unmet Resource Needs	125	138	113	59
7i. Education				
7i-i Adult Education (other than GED)	9	15	9	2
7i-ii GED	7	8	9	7
7i-iii Literacy Assistance	4	9	6	3
7i-iv Post High School Education	17	15	21	11
7i-v Tuition Reimbursement	3	2	3	4
Total Unmet Resource Needs	40	49	48	27
Distinct Clients with Unmet Resource Needs	33	41	40	20
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	0	1	1	1
7j-ii Club House and/or Peer Vocational Support	11	10	7	2
7j-iii Competitive Employment (no supports)	7	2	4	2
7j-iv Supported Employment	3	4	3	1
7j-v Vocational Rehabilitation	27	34	30	23
Total Unmet Resource Needs	48	51	45	29
Distinct Clients with Unmet Resource Needs	45	44	42	27
7k. Living Skills				
7k-i Daily Living Support Services	49	62	49	12
7k-ii Day Support Services	1	3	3	0
7k-iii Occupational Therapy	0	1	2	0
7k-iv Skills Development Services	9	11	10	8

Report Run: Apr 26, 2016

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,160	2,477	2,411	1,908
Total Unmet Resource Needs	59	77	64	20
Distinct Clients with Unmet Resource Needs	56	70	59	19
7l. Transportation				
7l-i Transportation to ISP-Identified Services	72	88	76	40
7-ii Transportation to Other ISP Activities	42	49	44	22
7-iii After Hours Transportation	17	16	17	6
Total Unmet Resource Needs	131	153	137	68
Distinct Clients with Unmet Resource Needs	91	106	92	46
7m. Personal Growth/Community				
7m-i Avocational Activities	4	4	4	2
7m-ii Recreation Activities	15	29	17	10
7m-iii Social Activities	34	58	47	22
7m-iv Spiritual Activities	2	5	8	6
Total Unmet Resource Needs	55	96	76	40
Distinct Clients with Unmet Resource Needs	40	65	54	26
Other Resources				
Other Resources	10	9	20	16
Total Unmet Resource Needs	10	9	20	16
Distinct Clients with Unmet Resource Needs	10	9	20	16
CSN 3 Totals				
Total Unmet Resource Needs	1,185	1,482	1,260	608
Distinct Clients With any Unmet Resource Need	401	460	409	214
Distinct Clients with a RDS	2,160	2,477	2,411	1,908

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	961	1,019	970	721
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	18	22	16	6
7a-iii Dialectical Behavioral Therapy	6	9	9	9
7a-iv Family Psycho-Educational Treatment	7	11	7	4
7a-v Group Counseling	7	7	7	4
7a-vi Individual Counseling	71	98	85	42
7a-vii Inpatient Psychiatric Facility	0	1	0	1
7a-viii Intensive Case Management	13	17	14	5
7a-x Psychiatric Medication Management	65	98	74	41
Total Unmet Resource Needs	187	263	212	112
Distinct Clients with Unmet Resource Needs	117	159	137	80
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	44	69	57	42
7b-ii Mental Health Advance Directives	17	17	14	12
Total Unmet Resource Needs	61	86	71	54
Distinct Clients with Unmet Resource Needs	58	82	65	49
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	9	10	11	10
7c-ii Recovery Workbook Group	1	1	2	1
7c-iii Social Club	22	30	24	21
7c-iv Peer-Run Trauma Recovery Group	8	10	10	8
7c-v Wellness Recovery and Action Planning	8	15	9	11
7c-vi Family Support	26	56	38	29
Total Unmet Resource Needs	74	122	94	80
Distinct Clients with Unmet Resource Needs	50	81	61	47
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	16	20	16	10

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	961	1,019	970	721
7d-ii Residential Treatment Substance Abuse Services	2	1	1	0
Total Unmet Resource Needs	18	21	17	10
Distinct Clients with Unmet Resource Needs	18	21	17	10
7e. Housing				
7e-i Supported Apartment	14	16	14	8
7e-ii Community Residential Facility	2	4	5	2
7e-iii Residential Treatment Facility (group home)	5	8	4	2
7e-iv Assisted Living Facility	2	5	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)	70	95	78	52
Total Unmet Resource Needs	93	128	103	65
Distinct Clients with Unmet Resource Needs	85	110	91	57
7f. Health Care				
7f-i Dental Services	60	71	67	52
7f-ii Eye Care Services	18	25	27	20
7f-iii Hearing Services	3	6	7	5
7f-iv Physical Therapy	4	5	6	6
7f-v Physician/Medical Services	34	41	38	29
Total Unmet Resource Needs	119	148	145	112
Distinct Clients with Unmet Resource Needs	88	104	97	75
7g. Legal				
7g-i Advocate	12	15	10	10
7g-ii Guardian (private)	0	0	1	1
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	12	15	11	11
Distinct Clients with Unmet Resource Needs	12	15	11	11

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	961	1,019	970	721
7h. Financial Security				
7h-i Assistance with Managing Money	53	75	56	56
7h-ii Assistance with Securing Public Benefits	39	42	40	33
7h-iii Representative Payee	4	6	3	4
Total Unmet Resource Needs	96	123	99	93
Distinct Clients with Unmet Resource Needs	70	94	73	62
7i. Education				
7i-i Adult Education (other than GED)	9	14	15	16
7i-ii GED	9	11	8	5
7i-iii Literacy Assistance	3	3	1	1
7i-iv Post High School Education	16	18	16	13
7i-v Tuition Reimbursement	3	8	7	7
Total Unmet Resource Needs	40	54	47	42
Distinct Clients with Unmet Resource Needs	32	42	35	28
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	11	17	17	11
7j-ii Club House and/or Peer Vocational Support	2	2	4	1
7j-iii Competitive Employment (no supports)	9	11	11	14
7j-iv Supported Employment	8	15	11	9
7j-v Vocational Rehabilitation	53	64	53	32
Total Unmet Resource Needs	83	109	96	67
Distinct Clients with Unmet Resource Needs	63	77	68	43
7k. Living Skills				
7k-i Daily Living Support Services	44	66	55	35
7k-ii Day Support Services	5	9	10	4
7k-iii Occupational Therapy	4	6	4	1
7k-iv Skills Development Services	12	17	16	12

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	961	1,019	970	721
Total Unmet Resource Needs	65	98	85	52
Distinct Clients with Unmet Resource Needs	56	81	69	40
7l. Transportation				
7l-i Transportation to ISP-Identified Services	68	73	66	45
7-ii Transportation to Other ISP Activities	41	51	44	34
7-iii After Hours Transportation	18	24	18	24
Total Unmet Resource Needs	127	148	128	103
Distinct Clients with Unmet Resource Needs	75	81	74	55
7m. Personal Growth/Community				
7m-i Avocational Activities	2	7	10	13
7m-ii Recreation Activities	29	42	37	34
7m-iii Social Activities	49	67	64	55
7m-iv Spiritual Activities	13	14	14	8
Total Unmet Resource Needs	93	130	125	110
Distinct Clients with Unmet Resource Needs	56	76	73	62
Other Resources				
Other Resources	19	25	20	21
Total Unmet Resource Needs	19	25	20	21
Distinct Clients with Unmet Resource Needs	19	25	20	21
CSN 4 Totals				
Total Unmet Resource Needs	1,087	1,470	1,253	932
Distinct Clients With any Unmet Resource Need	251	294	259	182
Distinct Clients with a RDS	961	1,019	970	721

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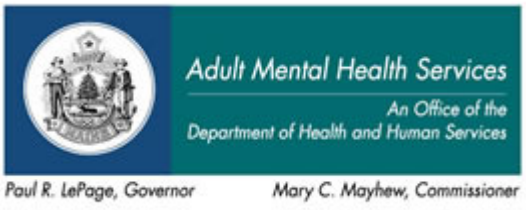

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,031	2,285	2,237	1,634
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	6	9	5	2
7a-iii Dialectical Behavioral Therapy	38	28	28	9
7a-iv Family Psycho-Educational Treatment	2	3	5	3
7a-v Group Counseling	19	22	22	7
7a-vi Individual Counseling	162	184	181	69
7a-vii Inpatient Psychiatric Facility	0	0	1	0
7a-viii Intensive Case Management	13	15	25	17
7a-x Psychiatric Medication Management	140	135	126	63
Total Unmet Resource Needs	380	396	393	170
Distinct Clients with Unmet Resource Needs	289	312	308	143
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	51	68	61	37
7b-ii Mental Health Advance Directives	12	13	8	7
Total Unmet Resource Needs	63	81	69	44
Distinct Clients with Unmet Resource Needs	60	79	67	43
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	15	18	14	5
7c-ii Recovery Workbook Group	1	1	2	0
7c-iii Social Club	45	43	47	30
7c-iv Peer-Run Trauma Recovery Group	13	17	22	15
7c-v Wellness Recovery and Action Planning	8	7	6	4
7c-vi Family Support	50	41	44	41
Total Unmet Resource Needs	132	127	135	95
Distinct Clients with Unmet Resource Needs	101	95	103	75
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	19	14	8	3

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Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,031	2,285	2,237	1,634
7d-ii Residential Treatment Substance Abuse Services	1	2	2	2
Total Unmet Resource Needs	20	16	10	5
Distinct Clients with Unmet Resource Needs	20	15	9	4
7e. Housing				
7e-i Supported Apartment	17	21	22	9
7e-ii Community Residential Facility	4	5	6	2
7e-iii Residential Treatment Facility (group home)	2	1	2	1
7e-iv Assisted Living Facility	1	3	2	2
7e-v Nursing Home	1	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	172	185	180	136
Total Unmet Resource Needs	197	215	212	150
Distinct Clients with Unmet Resource Needs	185	201	197	144
7f. Health Care				
7f-i Dental Services	165	158	151	105
7f-ii Eye Care Services	75	78	72	61
7f-iii Hearing Services	17	25	25	18
7f-iv Physical Therapy	20	19	20	16
7f-v Physician/Medical Services	88	88	80	62
Total Unmet Resource Needs	365	368	348	262
Distinct Clients with Unmet Resource Needs	256	249	228	170
7g. Legal				
7g-i Advocate	53	43	35	30
7g-ii Guardian (private)	3	2	2	0
7g-iii Guardian (public)	2	1	2	1
Total Unmet Resource Needs	58	46	39	31
Distinct Clients with Unmet Resource Needs	56	45	38	31

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Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,031	2,285	2,237	1,634
7h. Financial Security				
7h-i Assistance with Managing Money	138	136	150	101
7h-ii Assistance with Securing Public Benefits	91	93	80	47
7h-iii Representative Payee	8	6	5	5
Total Unmet Resource Needs	237	235	235	153
Distinct Clients with Unmet Resource Needs	192	194	189	125
7i. Education				
7i-i Adult Education (other than GED)	36	42	39	36
7i-ii GED	27	31	27	25
7i-iii Literacy Assistance	13	11	15	14
7i-iv Post High School Education	27	21	16	14
7i-v Tuition Reimbursement	2	3	2	2
Total Unmet Resource Needs	105	108	99	91
Distinct Clients with Unmet Resource Needs	91	91	81	78
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	8	9	9	8
7j-ii Club House and/or Peer Vocational Support	9	10	7	6
7j-iii Competitive Employment (no supports)	21	17	20	15
7j-iv Supported Employment	19	15	21	15
7j-v Vocational Rehabilitation	71	63	51	35
Total Unmet Resource Needs	128	114	108	79
Distinct Clients with Unmet Resource Needs	116	101	100	73
7k. Living Skills				
7k-i Daily Living Support Services	82	92	69	38
7k-ii Day Support Services	12	12	11	6
7k-iii Occupational Therapy	4	4	4	5
7k-iv Skills Development Services	19	32	34	22

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Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,031	2,285	2,237	1,634
Total Unmet Resource Needs	117	140	118	71
Distinct Clients with Unmet Resource Needs	106	125	102	59
7l. Transportation				
7l-i Transportation to ISP-Identified Services	95	108	97	79
7-ii Transportation to Other ISP Activities	53	57	52	50
7-iii After Hours Transportation	37	44	40	35
Total Unmet Resource Needs	185	209	189	164
Distinct Clients with Unmet Resource Needs	120	133	116	89
7m. Personal Growth/Community				
7m-i Avocational Activities	3	6	4	1
7m-ii Recreation Activities	47	48	46	32
7m-iii Social Activities	104	115	112	82
7m-iv Spiritual Activities	26	32	34	32
Total Unmet Resource Needs	180	201	196	147
Distinct Clients with Unmet Resource Needs	127	138	133	96
Other Resources				
Other Resources	49	42	32	24
Total Unmet Resource Needs	49	42	32	24
Distinct Clients with Unmet Resource Needs	49	42	32	24
CSN 5 Totals				
Total Unmet Resource Needs	2,216	2,298	2,183	1,486
Distinct Clients With any Unmet Resource Need	606	636	606	377
Distinct Clients with a RDS	2,031	2,285	2,237	1,634

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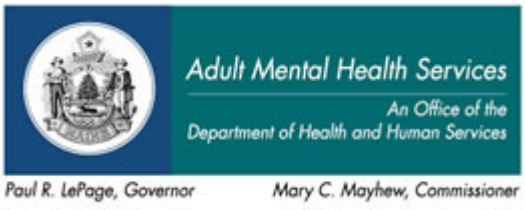

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,996	2,131	2,129	1,641
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	6	7	2	0
7a-iii Dialectical Behavioral Therapy	12	15	7	6
7a-iv Family Psycho-Educational Treatment	4	6	7	5
7a-v Group Counseling	8	14	13	5
7a-vi Individual Counseling	109	129	137	60
7a-vii Inpatient Psychiatric Facility	0	1	1	0
7a-viii Intensive Case Management	25	23	22	13
7a-x Psychiatric Medication Management	84	102	102	50
Total Unmet Resource Needs	248	297	291	139
Distinct Clients with Unmet Resource Needs	185	226	214	110
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	32	52	41	26
7b-ii Mental Health Advance Directives	8	5	6	7
Total Unmet Resource Needs	40	57	47	33
Distinct Clients with Unmet Resource Needs	35	55	45	31
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	17	15	16	10
7c-ii Recovery Workbook Group	1	2	2	1
7c-iii Social Club	28	30	24	22
7c-iv Peer-Run Trauma Recovery Group	7	10	12	7
7c-v Wellness Recovery and Action Planning	4	7	10	4
7c-vi Family Support	18	44	45	40
Total Unmet Resource Needs	75	108	109	84
Distinct Clients with Unmet Resource Needs	60	88	90	69
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	10	10	8	4

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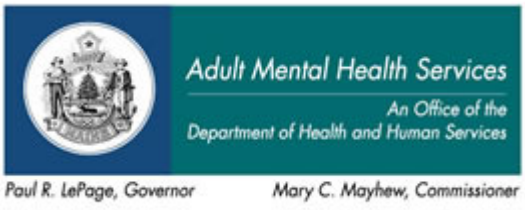

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,996	2,131	2,129	1,641
7d-ii Residential Treatment Substance Abuse Services	4	8	7	5
Total Unmet Resource Needs	14	18	15	9
Distinct Clients with Unmet Resource Needs	14	18	14	9
7e. Housing				
7e-i Supported Apartment	25	32	35	29
7e-ii Community Residential Facility	12	14	15	11
7e-iii Residential Treatment Facility (group home)	3	5	3	0
7e-iv Assisted Living Facility	13	12	8	6
7e-v Nursing Home	2	2	2	2
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	186	206	235	158
Total Unmet Resource Needs	241	271	298	206
Distinct Clients with Unmet Resource Needs	231	250	278	195
7f. Health Care				
7f-i Dental Services	147	155	160	121
7f-ii Eye Care Services	39	57	57	35
7f-iii Hearing Services	6	8	10	8
7f-iv Physical Therapy	6	9	8	6
7f-v Physician/Medical Services	53	69	67	28
Total Unmet Resource Needs	251	298	302	198
Distinct Clients with Unmet Resource Needs	192	206	212	148
7g. Legal				
7g-i Advocate	10	18	11	9
7g-ii Guardian (private)	1	2	1	2
7g-iii Guardian (public)	1	2	1	1
Total Unmet Resource Needs	12	22	13	12
Distinct Clients with Unmet Resource Needs	12	22	13	12

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Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,996	2,131	2,129	1,641
7h. Financial Security				
7h-i Assistance with Managing Money	86	93	92	62
7h-ii Assistance with Securing Public Benefits	38	42	29	26
7h-iii Representative Payee	5	9	11	9
Total Unmet Resource Needs	129	144	132	97
Distinct Clients with Unmet Resource Needs	118	128	119	83
7i. Education				
7i-i Adult Education (other than GED)	21	34	32	28
7i-ii GED	14	18	17	7
7i-iii Literacy Assistance	7	12	16	4
7i-iv Post High School Education	12	14	10	15
7i-v Tuition Reimbursement	1	1	2	2
Total Unmet Resource Needs	55	79	77	56
Distinct Clients with Unmet Resource Needs	50	71	66	50
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	6	7	10	2
7j-ii Club House and/or Peer Vocational Support	2	2	2	2
7j-iii Competitive Employment (no supports)	17	20	15	13
7j-iv Supported Employment	11	14	15	9
7j-v Vocational Rehabilitation	38	50	53	23
Total Unmet Resource Needs	74	93	95	49
Distinct Clients with Unmet Resource Needs	66	85	85	44
7k. Living Skills				
7k-i Daily Living Support Services	39	36	33	21
7k-ii Day Support Services	11	11	7	2
7k-iii Occupational Therapy	1	1	1	1
7k-iv Skills Development Services	16	15	10	5

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Adult Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,996	2,131	2,129	1,641
Total Unmet Resource Needs	67	63	51	29
Distinct Clients with Unmet Resource Needs	57	52	48	26
7l. Transportation				
7l-i Transportation to ISP-Identified Services	75	112	96	75
7-ii Transportation to Other ISP Activities	46	75	65	54
7-iii After Hours Transportation	25	40	39	25
Total Unmet Resource Needs	146	227	200	154
Distinct Clients with Unmet Resource Needs	97	135	122	90
7m. Personal Growth/Community				
7m-i Avocational Activities	1	2	3	2
7m-ii Recreation Activities	23	21	20	18
7m-iii Social Activities	65	77	71	50
7m-iv Spiritual Activities	11	21	22	8
Total Unmet Resource Needs	100	121	116	78
Distinct Clients with Unmet Resource Needs	77	93	91	60
Other Resources				
Other Resources	27	32	42	48
Total Unmet Resource Needs	27	32	42	48
Distinct Clients with Unmet Resource Needs	27	32	42	48
CSN 6 Totals				
Total Unmet Resource Needs	1,479	1,830	1,788	1,192
Distinct Clients With any Unmet Resource Need	577	619	637	444
Distinct Clients with a RDS	1,996	2,131	2,129	1,641

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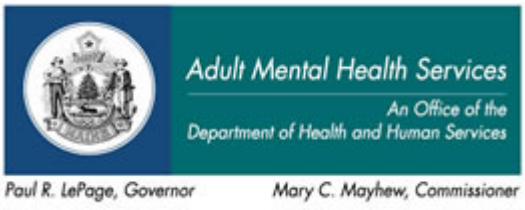

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	809	803	796	476
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	5	3	4	1
7a-iii Dialectical Behavioral Therapy	17	11	7	1
7a-iv Family Psycho-Educational Treatment	4	5	4	1
7a-v Group Counseling	4	0	0	0
7a-vi Individual Counseling	62	78	64	22
7a-vii Inpatient Psychiatric Facility	2	0	0	0
7a-viii Intensive Case Management	8	10	12	3
7a-x Psychiatric Medication Management	66	62	61	14
Total Unmet Resource Needs	168	169	152	42
Distinct Clients with Unmet Resource Needs	113	119	108	36
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	37	34	37	15
7b-ii Mental Health Advance Directives	4	3	3	1
Total Unmet Resource Needs	41	37	40	16
Distinct Clients with Unmet Resource Needs	38	34	37	16
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	8	9	4	2
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	13	12	15	3
7c-iv Peer-Run Trauma Recovery Group	8	8	8	2
7c-v Wellness Recovery and Action Planning	6	11	8	4
7c-vi Family Support	12	15	24	12
Total Unmet Resource Needs	47	55	59	23
Distinct Clients with Unmet Resource Needs	35	43	47	21
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	11	14	11	2

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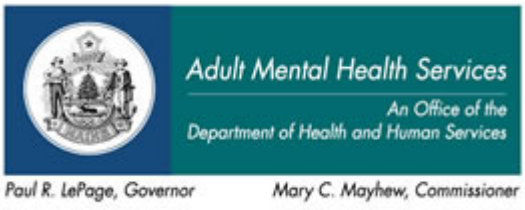

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	809	803	796	476
7d-ii Residential Treatment Substance Abuse Services	3	1	0	0
Total Unmet Resource Needs	14	15	11	2
Distinct Clients with Unmet Resource Needs	13	15	11	2
7e. Housing				
7e-i Supported Apartment	16	17	16	3
7e-ii Community Residential Facility	3	3	3	3
7e-iii Residential Treatment Facility (group home)	3	2	2	1
7e-iv Assisted Living Facility	6	4	3	3
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)	82	90	89	34
Total Unmet Resource Needs	110	116	113	44
Distinct Clients with Unmet Resource Needs	98	108	104	40
7f. Health Care				
7f-i Dental Services	72	54	62	39
7f-ii Eye Care Services	24	20	27	6
7f-iii Hearing Services	4	3	2	1
7f-iv Physical Therapy	3	6	3	2
7f-v Physician/Medical Services	41	43	36	18
Total Unmet Resource Needs	144	126	130	66
Distinct Clients with Unmet Resource Needs	108	95	100	49
7g. Legal				
7g-i Advocate	11	9	15	4
7g-ii Guardian (private)	1	0	0	0
7g-iii Guardian (public)	5	3	3	1
Total Unmet Resource Needs	17	12	18	5
Distinct Clients with Unmet Resource Needs	15	12	18	5

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Adult Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	809	803	796	476
7h. Financial Security				
7h-i Assistance with Managing Money	85	79	54	30
7h-ii Assistance with Securing Public Benefits	36	29	24	19
7h-iii Representative Payee	10	8	9	4
Total Unmet Resource Needs	131	116	87	53
Distinct Clients with Unmet Resource Needs	113	100	74	41
7i. Education				
7i-i Adult Education (other than GED)	6	9	8	6
7i-ii GED	7	4	4	1
7i-iii Literacy Assistance	4	5	5	3
7i-iv Post High School Education	7	10	15	6
7i-v Tuition Reimbursement	1	0	1	2
Total Unmet Resource Needs	25	28	33	18
Distinct Clients with Unmet Resource Needs	22	24	25	14
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	3	3	4	1
7j-ii Club House and/or Peer Vocational Support	4	3	3	0
7j-iii Competitive Employment (no supports)	10	15	11	10
7j-iv Supported Employment	3	1	3	3
7j-v Vocational Rehabilitation	27	20	18	7
Total Unmet Resource Needs	47	42	39	21
Distinct Clients with Unmet Resource Needs	41	39	36	18
7k. Living Skills				
7k-i Daily Living Support Services	30	25	23	12
7k-ii Day Support Services	1	0	0	0
7k-iii Occupational Therapy	3	4	3	2
7k-iv Skills Development Services	7	9	10	4

Report Run: Apr 26, 2016

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

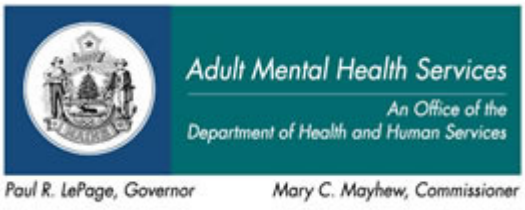
Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	809	803	796	476
Total Unmet Resource Needs	41	38	36	18
Distinct Clients with Unmet Resource Needs	33	33	32	14
7l. Transportation				
7l-i Transportation to ISP-Identified Services	60	54	47	22
7-ii Transportation to Other ISP Activities	28	22	17	6
7-iii After Hours Transportation	33	32	23	7
Total Unmet Resource Needs	121	108	87	35
Distinct Clients with Unmet Resource Needs	84	76	61	26
7m. Personal Growth/Community				
7m-i Avocational Activities	5	6	4	2
7m-ii Recreation Activities	19	21	16	8
7m-iii Social Activities	44	34	32	14
7m-iv Spiritual Activities	7	6	7	3
Total Unmet Resource Needs	75	67	59	27
Distinct Clients with Unmet Resource Needs	53	46	40	20
Other Resources				
Other Resources	19	22	15	10
Total Unmet Resource Needs	19	22	15	10
Distinct Clients with Unmet Resource Needs	19	22	15	10
CSN 7 Totals				
Total Unmet Resource Needs	1,000	951	879	380
Distinct Clients With any Unmet Resource Need	282	272	259	113
Distinct Clients with a RDS	809	803	796	476

Report Run: Apr 26, 2016



Report of Unmet Resource Needs

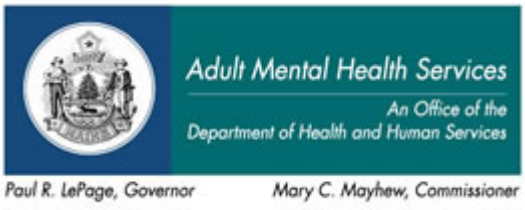
CSN Not Assigned

Fiscal Year 2016 Quarter 3

(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	435	452	427	227
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	2	1	1
7a-iii Dialectical Behavioral Therapy	3	3	4	2
7a-iv Family Psycho-Educational Treatment	0	1	0	1
7a-v Group Counseling	2	4	5	3
7a-vi Individual Counseling	27	36	26	8
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	3	4	3	2
7a-x Psychiatric Medication Management	27	26	20	8
Total Unmet Resource Needs	64	76	59	25
Distinct Clients with Unmet Resource Needs	53	56	43	19
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	11	16	11	5
7b-ii Mental Health Advance Directives	3	1	1	0
Total Unmet Resource Needs	14	17	12	5
Distinct Clients with Unmet Resource Needs	14	16	12	5
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	3	4	3	1
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	12	8	4	4
7c-iv Peer-Run Trauma Recovery Group	1	1	0	2
7c-v Wellness Recovery and Action Planning	2	4	3	2
7c-vi Family Support	7	11	8	4
Total Unmet Resource Needs	25	28	18	13
Distinct Clients with Unmet Resource Needs	19	18	14	10
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	6	4	5	3

Report Run: Apr 26, 2016



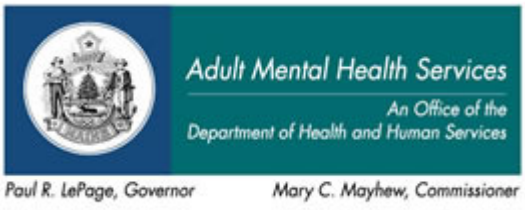
Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	435	452	427	227
7d-ii Residential Treatment Substance Abuse Services	0	0	0	0
Total Unmet Resource Needs	6	4	5	3
Distinct Clients with Unmet Resource Needs	6	4	5	3
7e. Housing				
7e-i Supported Apartment	5	6	8	2
7e-ii Community Residential Facility	4	4	2	1
7e-iii Residential Treatment Facility (group home)	0	0	0	0
7e-iv Assisted Living Facility	1	2	2	0
7e-v Nursing Home	1	0	1	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	32	36	30	19
Total Unmet Resource Needs	43	48	43	23
Distinct Clients with Unmet Resource Needs	40	43	37	21
7f. Health Care				
7f-i Dental Services	29	30	23	10
7f-ii Eye Care Services	17	17	13	5
7f-iii Hearing Services	5	7	4	0
7f-iv Physical Therapy	4	5	1	2
7f-v Physician/Medical Services	15	18	14	7
Total Unmet Resource Needs	70	77	55	24
Distinct Clients with Unmet Resource Needs	45	46	38	15
7g. Legal				
7g-i Advocate	10	10	9	7
7g-ii Guardian (private)	3	3	4	2
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	13	13	13	9
Distinct Clients with Unmet Resource Needs	10	10	9	7

Report Run: Apr 26, 2016



Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2016 Quarter 3

(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	435	452	427	227
7h. Financial Security				
7h-i Assistance with Managing Money	32	40	31	14
7h-ii Assistance with Securing Public Benefits	18	23	18	7
7h-iii Representative Payee	4	5	2	0
Total Unmet Resource Needs	54	68	51	21
Distinct Clients with Unmet Resource Needs	46	57	42	19
7i. Education				
7i-i Adult Education (other than GED)	7	8	8	2
7i-ii GED	4	2	2	0
7i-iii Literacy Assistance	1	2	1	0
7i-iv Post High School Education	5	7	1	3
7i-v Tuition Reimbursement	0	0	0	2
Total Unmet Resource Needs	17	19	12	7
Distinct Clients with Unmet Resource Needs	15	15	11	5
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	2	2	2	2
7j-ii Club House and/or Peer Vocational Support	1	0	0	0
7j-iii Competitive Employment (no supports)	2	4	3	4
7j-iv Supported Employment	4	4	3	0
7j-v Vocational Rehabilitation	12	13	8	6
Total Unmet Resource Needs	21	23	16	12
Distinct Clients with Unmet Resource Needs	21	18	15	7
7k. Living Skills				
7k-i Daily Living Support Services	14	15	10	5
7k-ii Day Support Services	1	3	2	1
7k-iii Occupational Therapy	2	1	0	0
7k-iv Skills Development Services	1	4	3	1

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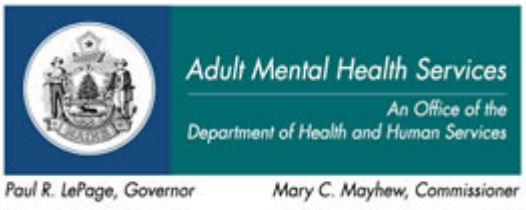


Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2016 Quarter 3

(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	435	452	427	227
Total Unmet Resource Needs	18	23	15	7
Distinct Clients with Unmet Resource Needs	16	17	12	7
7l. Transportation				
7l-i Transportation to ISP-Identified Services	20	26	19	8
7-ii Transportation to Other ISP Activities	7	13	6	4
7-iii After Hours Transportation	9	8	5	2
Total Unmet Resource Needs	36	47	30	14
Distinct Clients with Unmet Resource Needs	27	28	21	8
7m. Personal Growth/Community				
7m-i Avocational Activities	1	2	0	0
7m-ii Recreation Activities	9	11	4	4
7m-iii Social Activities	22	23	18	10
7m-iv Spiritual Activities	5	6	3	1
Total Unmet Resource Needs	37	42	25	15
Distinct Clients with Unmet Resource Needs	23	27	19	12
Other Resources				
Other Resources	13	12	9	7
Total Unmet Resource Needs	13	12	9	7
Distinct Clients with Unmet Resource Needs	13	12	9	7
CSN Not Assigned Totals				
Total Unmet Resource Needs	431	497	363	185
Distinct Clients With any Unmet Resource Need	121	120	102	54
Distinct Clients with a RDS	435	452	427	227

Report Run: Apr 26, 2016

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

Department of Health and Human Services
Substance Abuse and Mental Health Services
32 Blossom Lane, Marquardt Building, 2nd Floor
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-4243; Fax: (207) 287-1022
TTY Users: Dial 711 (Maine Relay)

Bridging Recovery Assistance Program (BRAP)
Monitoring Report
Quarter 3 FY2016 (January, February, March 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. There is not a single housing market in the country where a person receiving Social Security as his or her sole income source can afford to rent even a modest one-bedroom apartment. According to a report issued by the Technical Assistance Collaborative,[1] in Maine, 95 percent of a person's SSI standard monthly payment is needed to pay for the average one-bedroom apartment statewide. In Cumberland County the amount is 94 percent and Sagadahoc 98 percent. In the City of Portland 115 percent of a person's SSI is necessary to pay for the average one-bedroom apartment, and in the KEYS area (Kittery, Elliot, York and South Berwick) 110 percent.

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.

The BRAP program has recently gone through the RFP process and has been placed in contract with the chosen BRAP program provider recipient.

The monitoring of the Bridging Rental Assistance Program (BRAP) is the responsibility of the Maine's Department of Health and Human Services' Office of Substance Abuse and Adult Mental Health Services (SAMHS) and particularly the Data, Quality Management, and Resource Development team.

BRAP Waitlist

The bullets below highlight some of the details regarding the 77 persons who are currently waiting for a BRAP voucher: The percentage terms reflect the percentage of relative change compared to the last report.

- Priority 1: 13 BRAP applicants who were discharged from a psychiatric hospital within the last 6 months are waiting for BRAP services. Typically, Riverview and Dorothea Dix consumers are not waiting more than 3 business days from the date of a completed application to receiving a BRAP voucher.
- Priority #2: 53 BRAP applicants who meet HUD's definition of Transitional Homelessnes are waiting for BRAP services.

[1] Cooper, E., O'Hara, A, Siner, N., and Zovistoski, A. Priced Out In 2012: The Housing Crisis for People with Disabilities. Technical Assistance Collaborative Inc. Consortium for Citizens with Disabilities, Housing Task Force. 2013.

- Priority #3: 2 BRAP applicants identified as living in sub-standard housing (Substandard Housing). Statewide priority 3 waiting for BRAP services is 8 persons.
- Priority #4: 9 BRAP applicants identified as having left a DHHS funded community residential facility within the past six months are waiting for BRAP services.
- Currently, 43 individuals have been on the waitlist for BRAP services for more than 90 day, this reflects the maximum use of funds available, many of these individuals are looking for units to rent with voucher in hand..

BRAP Vouchers Awarded

Since BRAP's inception, there has been a total of 3,262 BRAP vouchers awarded, which are broken down as follows:

- Priority #1: 1605 individuals discharged from psychiatric hospitals have been awarded BRAP vouchers
- Priority #2: 1531 individuals who meet HUD's transitional homeless definition have been awarded BRAP vouchers
- Priority #3: 53 individuals identified as living in sub-standard housing have been awarded BRAP vouchers
- Priority #4: 293 individuals who were leaving a DHHS funded living facility have been awarded BRAP vouchers.

Note that, since BRAP's inception, 25 vouchers have been awarded to persons with no priority assigned to them. In the third quarter of fiscal year 2016, a total of 232 BRAP vouchers were awarded.

The BRAP census as of March 31,2016 was 864 vouchers, with 209 voucher which have been awarded and are currently seeking housing.

Additional funding of $1,233,947 was added to the BRAP budget of $5,372,414, which brings the total FY16 BRAP budget to $6,606,361, which will allow for an additional 150-200 additional vouchers in FY16. SAMHS is working closely with community providers and councils in order to direct these vouchers to those most in need as well as those leaving State funded Hospitals and Residential Facilities.

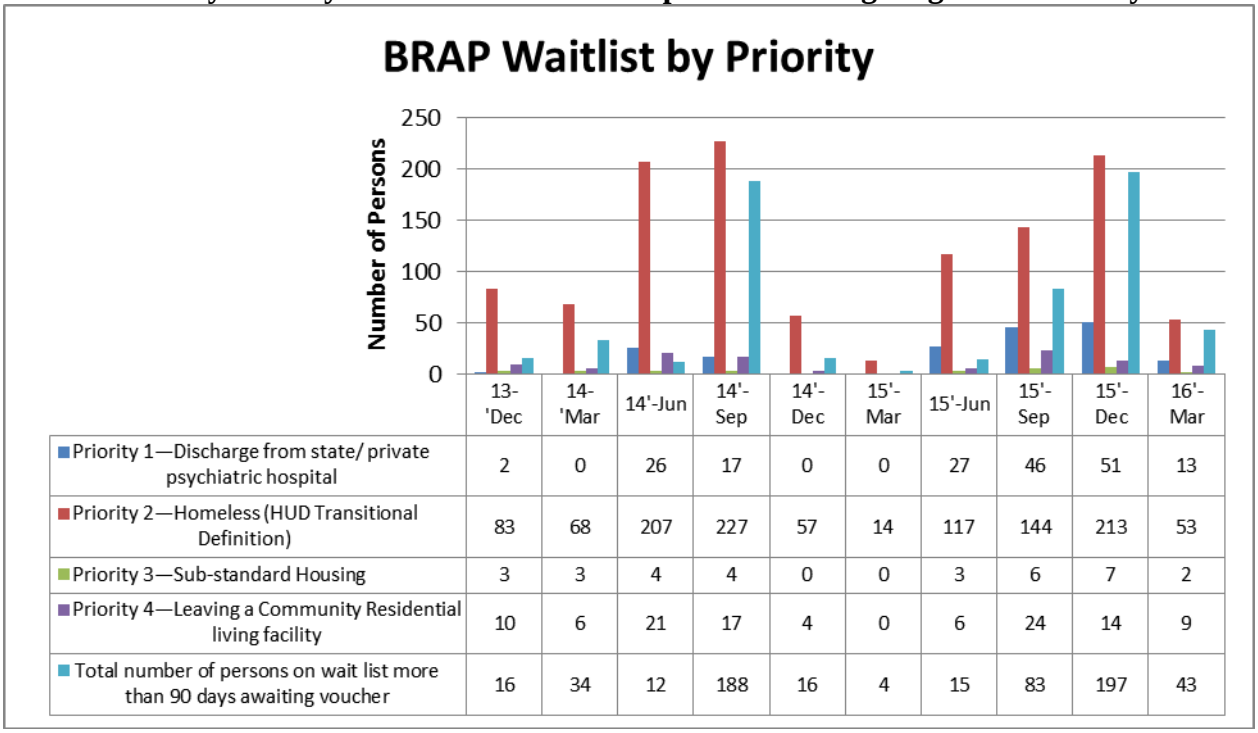
The number of individuals on the BRAP program for 24 months or more remains steady at 50% of the entire BRAP program. This is seen as a direct result of decades of federal and state cuts to low-income and supportive housing programs, including persons who will not qualify for Section 8 due to a criminal history. The lack of availability of these resources, particularly Section 8 at the federal level, has translated to an increased amount of pressure on state programs such as BRAP, to pick up where these programs have left off.

Other Housing Programs

In addition, the PATH program, also managed by SAMHS, is being directed to outreach, engage and enroll literally homeless individuals into housing and mainstream resources with a focus on the literally unsheltered 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.
The PATH program will be going out to RFP within the next few months.

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 March 31, 2016 is 1,007 vouchers, of which 43 of these voucher holders are awarded and currently seeking housing. 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 three years, causing a zero increase in grants funded through HUD. SAMHS is focusing vouchers, when they become available through turnover, on the Chronic and Long Term homeless populations who generally qualify for this program.

BRAP Waitlist Status--Graph:
Detail by Priority Status to include those persons waiting longer than 90 Days

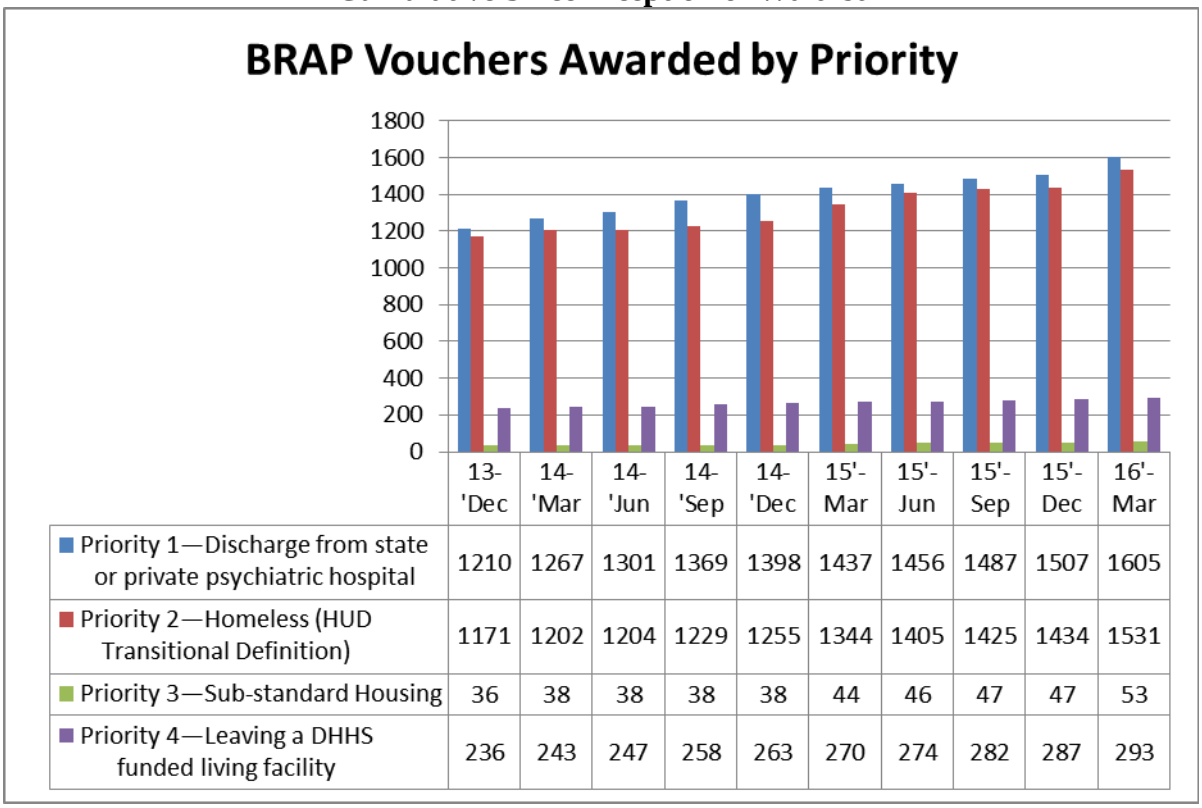


	13-'Dec	14-'Mar	14'-Jun	14'-Sep	14'-Dec	15'-Mar	15'-Jun	15'-Sep	15'-Dec	16'-Mar
Priority 1—Discharge from state/ private psychiatric hospital	2	0	26	17	0	0	27	46	51	13
Priority 2—Homeless (HUD Transitional Definition)	83	68	207	227	57	14	117	144	213	53
Priority 3—Sub-standard Housing	3	3	4	4	0	0	3	6	7	2
Priority 4—Leaving a Community Residential living facility	10	6	21	17	4	0	6	24	14	9
Total number of persons on wait list more than 90 days awaiting voucher	16	34	12	188	16	4	15	83	197	43

BRAP Vouchers Awarded—Table:
Detail by Priority Status to include those persons waiting longer than 90 Days

Reporting Period	13-'Dec	14-'Mar	14'-Jun	14'-Sep	14'-Dec	15'-Mar	15'-Jun	15'-Sep	15'-Dec	16'-Mar	% Change relative to Last Report
Total number of persons waiting for BRAP	98	77	260	266	61	93	154	220	287	77	-73%
Priority 1—Discharge from state/ private psychiatric hospital	2	0	26	17	0	0	27	46	51	13	-75%
Priority 2—Homeless (HUD Transitional Definition)	83	68	207	227	57	14	117	144	213	53	-75%
Priority 3—Sub-standard Housing	3	3	4	4	0	0	3	6	7	2	-71%
Priority 4—Leaving a Community Residential living facility	10	6	21	17	4	0	6	24	14	9	-36%
Total number of persons on wait list more than 90 days awaiting voucher	16	34	12	188	16	4	15	83	197	43	-78%

BRAP Awards—Graph and Table
Cumulative Since Inception of Waitlist



	13-'Dec	14-'Mar	14-'Jun	14-'Sep	14-'Dec	15'-Mar	15'-Jun	15'-Sep	15'-Dec	16'-Mar
Priority 1—Discharge from state or private psychiatric hospital	1210	1267	1301	1369	1398	1437	1456	1487	1507	1605
Priority 2—Homeless (HUD Transitional Definition)	1171	1202	1204	1229	1255	1344	1405	1425	1434	1531
Priority 3—Sub-standard Housing	36	38	38	38	38	44	46	47	47	53
Priority 4—Leaving a DHHS funded living facility	236	243	247	258	263	270	274	282	287	293

BRAP Awards—Table
Cumulative Percent Change Since Inception of Waitlist

Reporting Periods	13-'Dec	14-'Mar	14-'Jun	14-'Sep	14-'Dec	15'-Mar	15'-Jun	15'-Sep	15'-Dec	16'-Mar	% Change relative to Last Report
Cumulative number of persons awarded BRAP	2668	2767	2808	2914	2974	3116	3203	3262	3297	3506	6.34%
Priority 1—Discharge from state or private psychiatric hospital	1210	1267	1301	1369	1398	1437	1456	1487	1507	1605	6.50%
Priority 2—Homeless (HUD Transitional Definition)	1171	1202	1204	1229	1255	1344	1405	1425	1434	1531	6.76%
Priority 3—Sub-standard Housing	36	38	38	38	38	44	46	47	47	53	12.77%
Priority 4—Leaving a DHHS funded living facility	236	243	247	258	263	270	274	282	287	293	2.09%

Substance Abuse and Mental Health Services
An Office of the Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Class Member Treatment Planning Review

For the 2nd Quarterof Fiscal Year 2016

(October, November, December,2015)

		2015 Q3		2015 Q4		2016 Q1		2016 Q2	
Total Plans Reviewed		45		49		50		50	
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%	5 of 5	83.3%	15 of 18	100.0%	9 of 9	92.6%	25 of 27
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%	45 of 45	87.8%	43 of 49	100.0%	48 of 48	93.5%	43 of 46
1C	Does the record document that the consumer has a primary care physician (PCP)?	93.3%	42 of 45	93.8%	45 of 48	90.0%	45 of 50	90.0%	45 of 50
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?	97.6%	41 of 42	77.8%	35 of 45	88.9%	40 of 45	86.7%	39 of 45
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?	100.0%	45 of 45	78.7%	37 of 47	100.0%	49 of 49	100.0%	50 of 50
2B	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?	97.8%	44 of 45	97.9%	46 of 47	100.0%	50 of 50	100.0%	50 of 50
2C	Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?	97.7%	43 of 44	100.0%	47 of 47	91.8%	45 of 49	100.0%	50 of 50

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?	100.0%	45 of 45	85.7%	42 of 49	100.0%	50 of 50	98.0%	49 of 50
2E	Does the record document that the consumer has a crisis plan?	64.4%	29 of 45	40.8%	20 of 49	66.0%	33 of 50	90.0%	45 of 50
2F	If 2E. is no, is the reason documented?	100.0%	16 of 16	100.0%	29 of 29	100.0%	17 of 17	100.0%	5 of 5
2G	If 2E. is yes, has the crisis plan been reviewed as required every three months?	93.1%	27 of 29	80.0%	16 of 20	93.9%	31 of 33	84.4%	38 of 45
2H	If 2E. is yes, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?	100.0%	7 of 7	-200.0%	4 of -2	500.0%	5 of 1	90.9%	10 of 11
2I	Does the record document that the consumer has a mental health advance directive?	17.8%	8 of 45	6.3%	3 of 48	4.0%	2 of 50	8.0%	4 of 50
2J	If 2I. is yes, has the advance directive been reviewed at least annually by the CSW and consumer?	62.5%	5 of 8	100.0%	3 of 3	50.0%	1 of 2	50.0%	2 of 4
2K	If 2I. is no, is the reason why documented?	100.0%	37 of 37	100.0%	45 of 45	100.0%	48 of 48	100.0%	46 of 46
III Needed Resources									
3A	Does the record document that natural supports (family/friends) are being accessed as a resource?	91.1%	41 of 45	93.8%	45 of 48	90.0%	45 of 50	86.0%	43 of 50
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%	3 of 3	100.0%	5 of 5	100.0%	7 of 7
3C	Does the record document that generic resources (those resources that anyone can access) are being accessed?	95.6%	43 of 45	89.6%	43 of 48	94.0%	47 of 50	94.0%	47 of 50
3D	If 3C. is no, has the worker discussed with the consumer the consideration of generic resources as a resource?	0.0%	0 of 2	0.0%	0 of 5	0.0%	0 of 3	0.0%	0 of 3
3E	Does the record document a resource need that has not been provided according to/within the expected response time?	11.1%	5 of 45	24.4%	11 of 45	32.0%	16 of 50	16.0%	8 of 50
3F	Does the treatment plan reflect interim planning?	80.0%	4 of 5	90.9%	10 of 11	81.3%	13 of 16	50.0%	4 of 8
3G	Does the record document that the treatment team reconvened after the unmet need was identified?	80.0%	4 of 5	90.9%	10 of 11	62.5%	10 of 16	75.0%	6 of 8

IV Service Agreements									
4A	Does the record document that service agreements are required for this plan? (see paragraph 69 protocol for definitions)	55.6%	25 of 45	46.9%	23 of 49	44.0%	22 of 50	66.0%	33 of 50
4B	If 4A. is yes, have service agreements been acquired?	80.0%	20 of 25	52.2%	12 of 23	68.2%	15 of 22	45.5%	15 of 33
4C	If 4A. is yes, are the service agreements current?	80.0%	20 of 25	52.2%	12 of 23	68.2%	15 of 22	45.5%	15 of 33
V Vocational Services									
5A	Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?	100.0%	45 of 45	81.3%	39 of 48	100.0%	50 of 50	98.0%	49 of 50
5B	Does the record document that the vocational domain is being addressed with the consumer at each 90 day treatment plan review?	86.7%	39 of 45	79.6%	39 of 49	91.8%	45 of 49	94.0%	47 of 50
VI Comments									
6A	Plan of correction requested?	17.8%	8 of 45	51.0%	25 of 49	26.0%	13 of 50	42.0%	21 of 50
6A.1.	Plan of correction for section 2A. (required when not all domains assessed) included?	N/A	0 of 0	120.0%	12 of 10	N/A	1 of 0	N/A	1 of 0
6C	Plan of correction received?	100.0%	8 of 8	96.0%	24 of 25	76.9%	10 of 13	71.4%	15 of 21
6D	Were corrections made to the satisfaction of the CDC?	100.0%	8 of 8	100.0%	24 of 24	100.0%	10 of 10	100.0%	15 of 15

Report Run by:Lee.Richardson

Report Run on:Apr 7, 2016 at 10:08:07 AM

Adult Mental Health Services
An Office of the Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Community Hospital Utilization Review for Involuntary Admissions

For the 2nd Quarter of Fiscal Year 2016

(October, November, December, 2015)

	2015 Q3	2015 Q4	2016 Q1	2016 Q2
Total Admissions	16	24	18	8
Hospital				
Hospitalized in Local Area	87.5% (14 of 16)	79.2% (19 of 24)	94.4% (17 of 18)	87.5% (7 of 8)
Hospitalization Made Voluntary	31.2% (5 of 16)	58.3% (14 of 24)	27.8% (5 of 18)	87.5% (7 of 8)
Quality Care				
Active Treatment Within Guidelines	100.0% (16 of 16)	100.0% (24 of 24)	100.0% (18 of 18)	100.0% (8 of 8)
Individual Service Plans				
Receiving Case Management Services	6.2% (1 of 16)	37.5% (9 of 24)	33.3% (6 of 18)	25.0% (2 of 8)
Case Manager Involved with Discharge Planning	100.0% (1 of 1)	100.0% (9 of 9)	100.0% (6 of 6)	100.0% (2 of 2)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (1 of 1)	100.0% (9 of 9)	100.0% (6 of 6)	100.0% (2 of 2)
Hospital Obtained ISP when authorized	100.0% (1 of 1)	0.0% (0 of 9)	0.0% (0 of 6)	0.0% (0 of 2)
Treatment and Discharge Plan Consistant with ISP	100.0% (1 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)

Report Run: Apr 5, 2016

For questions, contact the Data Specialist Team at the Office of Adult Mental Health Services

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

Community Hospital Utilization Review for Involuntary Admissions

Class Member and Non Class Member

For the 2nd Quarter of Fiscal Year 2016

(October, November, December, 2015)

	2015 Q3	2015 Q4	2016 Q1	2016 Q2
Total Admissions	99	113	95	50
Hospital				
Hospitalized in Local Area	93.9% (93 of 99)	88.5% (100 of 113)	91.6% (87 of 95)	90.0% (45 of 50)
Hospitalization Made Voluntary	71.7% (71 of 99)	77.9% (88 of 113)	63.2% (60 of 95)	78.0% (39 of 50)
Quality Care				
Active Treatment Within Guidelines	100.0% (99 of 99)	100.0% (113 of 113)	100.0% (95 of 95)	100.0% (50 of 50)
Individual Service Plans				
Receiving Case Management Services	18.2% (18 of 99)	23.0% (26 of 113)	20.0% (19 of 95)	16.0% (8 of 50)
Case Manager Involved with Discharge Planning	100.0% (18 of 18)	96.2% (25 of 26)	94.7% (18 of 19)	75.0% (6 of 8)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (18 of 18)	100.0% (26 of 26)	100.0% (19 of 19)	100.0% (8 of 8)
Hospital Obtained ISP when authorized	11.1% (2 of 18)	0.0% (0 of 26)	0.0% (0 of 19)	0.0% (0 of 8)
Treatment and Discharge Plan Consistant with ISP	100.0% (2 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)

Report Run: Apr 5, 2016

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Adult Mental Health Services
An Office of the Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Community Hospital Utilization Review for Involuntary Admissions

By Hospital

Class Members

For the 2nd Quarter of Fiscal Year 2016
(October, November, December, 2015)

	2015 Q3	2015 Q4	2016 Q1	2016 Q2
Number of Admissions	10	20	12	8
Involuntarily Admitted Clients who were Receiving CSS Services	1	8	5	2
Number of ISPs Hospitals were Authorized to Obtain	1	8	5	2
Number of ISPs Hospitals Obtained	1	0	0	0

FY QTR	Hospital	Admissions	Receiving Community Support Services	Hospital Obtained ISP when authorized	Treatment and Discharge Plan Consistant with ISP	Case Worker Involved with Treatment and Discharge Planning
2015 Q3	**Acadia**	1	0.0% (0 of 1)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
	Maine General - Augusta	1	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Southern Maine Medical Center	1	0.0% (0 of 1)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
	Spring Harbor	7	0.0% (0 of 7)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
2015 Q4	**Acadia**	2	0.0% (0 of 2)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
	Maine General - Augusta	1	100.0% (1 of 1)	100.0% (1 of 1)	NA (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	1	0.0% (0 of 1)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
	Southern Maine Medical Center	1	100.0% (1 of 1)	100.0% (1 of 1)	NA (0 of 0)	100.0% (1 of 1)
	Spring Harbor	15	40.0% (6 of 15)	100.0% (6 of 6)	NA (0 of 0)	100.0% (6 of 6)
2016 Q1	**Acadia**	2	50.0% (1 of 2)	100.0% (1 of 1)	NA (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	1	100.0% (1 of 1)	100.0% (1 of 1)	NA (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	2	50.0% (1 of 2)	100.0% (1 of 1)	NA (0 of 0)	100.0% (1 of 1)
	Spring Harbor	6	33.3% (2 of 6)	100.0% (2 of 2)	NA (0 of 0)	100.0% (2 of 2)
	St. Mary's	1	0.0% (0 of 1)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
2016 Q2	**PenBay Medical Center**	1	0.0% (0 of 1)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
	Spring Harbor	7	28.6% (2 of 7)	100.0% (2 of 2)	NA (0 of 0)	100.0% (2 of 2)

Report Run: Apr 5, 2016

For questions, contact the Data Specialist Team at the Office of Adult Mental Health Services

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

Community Hospital Utilization Review for Involuntary Admissions
By Hospital
Class Member and Non Class Member

For the 2nd Quarter of Fiscal Year 2016
(October, November, December, 2015)

	2015 Q3	2015 Q4	2016 Q1	2016 Q2
Number of Admissions	99	113	95	50
Involuntarily Admitted Clients who were Receiving CSS Services	18	26	19	8
Number of ISPs Hospitals were Authorized to Obtain	18	26	19	8
Number of ISPs Hospitals Obtained	2	0	0	0

FY QTR	Hospital	Admissions	Receiving Community Support Services	Hospital Obtained ISP when authorized	Treatment and Discharge Plan Consistant with ISP	Case Worker Involved with Treatment and Discharge Planning
2015 Q3	**Acadia**	19	26.3% (5 of 19)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	Maine General - Augusta	6	33.3% (2 of 6)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	Mid-coast Hospital	6	33.3% (2 of 6)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	PenBay Medical Center	4	0.0% (0 of 4)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	18	16.7% (3 of 18)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Spring Harbor	33	15.2% (5 of 33)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	St. Mary's	13	7.7% (1 of 13)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
2015 Q4	**Acadia**	16	31.2% (5 of 16)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	Maine General - Augusta	3	33.3% (1 of 3)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	6	16.7% (1 of 6)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	9	22.2% (2 of 9)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Spring Harbor	63	22.2% (14 of 63)	0.0% (0 of 14)	N/A (0 of 0)	92.9% (13 of 14)
	St. Mary's	14	21.4% (3 of 14)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
2016 Q1	**Acadia**	9	22.2% (2 of 9)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Augusta	8	12.5% (1 of 8)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Maine Medical Center	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	3	33.3% (1 of 3)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	5	20.0% (1 of 5)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	17	41.2% (7 of 17)	0.0% (0 of 7)	N/A (0 of 0)	85.7% (6 of 7)
	Spring Harbor	38	13.2% (5 of 38)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	St. Mary's	14	7.1% (1 of 14)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
2016 Q2	**Acadia**	2	50.0% (1 of 2)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	5	20.0% (1 of 5)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	7	0.0% (0 of 7)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	36	16.7% (6 of 36)	0.0% (0 of 6)	N/A (0 of 0)	66.7% (4 of 6)

Report Run: Apr 5, 2016
For questions, contact the Data Specialist Team at the Office of Adult Mental Health Services

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

Maine Department of Health and Human Services

Integrated Quarterly Crisis Report

STATEWIDE with GRAPHS

QTR3 (January, February and March) SYF16

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

Gender	Children	Males	661	Females	721				
	Adults	Males	2,500	Females	2,339				
Age Range	Children	< 5	8	5 - 9	143	10 - 14	634	15-17	597
	Adults	18 - 21	559	22 - 35	1,479	36 - 60	2,270	>60	531
Payment Source	Children	MaineCare	944	Private Ins.	355	Uninsured	83	Medicare	0
	Adults	MaineCare	2,378	Private Ins.	861	Uninsured	1,414	Medicare	186

II. Summary Of All Crisis Contacts

	Children	Adults
a. Total number of telephone contacts	7,827	24,627
b. Total number of all Initial face-to-face contacts	1,210	3,974
c. Number in II.b. who are children/youth with Mental Retardation/Autism/Pervasive Dev. Disorder	120	
d. Number of face-to-face contacts that are ongoing support for crisis resolution/stabilization	172	1,290

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	87	7.2%	74	1.9%
b. Number of Initial face-to-face contacts who have a Community Support Worker (CI,CRS,ICM, ACT,TCM)	368	30.4%	1,003	25.2%
c. Number of Initial face-to-face contacts who have a Comm. Support Worker that was notified of crisis	310	84.2%	790	78.8%
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			112,639	28
e. Number of Initial face-to-face contacts in Emergency Department with final disp. within 8 hours			2,281	57.4%
f. Number of Initial face-to-face contacts not in Emergency Department with final disp. within 8 hours			1,315	33.1%

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.	1014	1 to 2 Hours	156	2 to 4 Hours	37	More Than 4 Hours	3		
Percent	83.8%	Percent	12.9%	Percent	3.1%	Percent	0.2%		

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

Less Than 3 Hours	583	3 to 6 Hours	488	6 to 8 Hours	47	8 to 14 Hours	35	> 14	56
Percent	48.2%	Percent	40.3%	Percent	3.9%	Percent	2.9%	Percen	4.6%

IV. Site Of Initial Face-To-Face Contacts

	Children		Adults	
a. Primary Care Residence (Home)	146	12.1%	284	7.1%
b. Family/Relative/Other Residence	58	4.8%	38	1.0%
c. Other Community Setting (Work, School, Police Dept, Public Place)	147	12.1%	114	2.9%
d. SNF, Nursing Home, Boarding Home	0	0.0%	17	0.4%
e. Residential Program (Congregate Community Residence, Apartment Program)	8	0.7%	83	2.1%
f. Homeless Shelter	2	0.2%	25	0.6%
g. Provider Office	32	2.6%	134	3.4%
h. Crisis Office	185	15.3%	513	12.9%
i. Emergency Department	625	51.7%	2,570	64.7%
j. Other Hospital Location	6	0.5%	107	2.7%
k. Incarcerated (Local Jail, State Prison, Juvenile Correction Facility)	1	0.1%	89	2.2%
Totals:	1,210	100%	3,974	100%

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

	Children		Adults	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	16	1.3%	200	5.0%
b. Crisis stabilization with referral to new provider for mental health/substance abuse follow up	251	20.7%	755	19.0%
c. Crisis stabilization with referral back to current provider for mental health/substane abuse follow up	480	39.7%	1,339	33.7%
d. Admission to Crisis Stabilization Unit	178	14.7%	420	10.6%
e. Inpatient Hospitalization Medical	8	0.7%	160	4.0%
f. Voluntary Psychiatric Hospitalization	275	22.7%	834	21.0%
g. Involuntary Psychiatric Hospitalization	2	0.2%	157	4.0%
h. Admission to Detox Unit	0	0.0%	109	2.7%
Totals:	1,210	100%	3,974	100%

Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON ORGANIZATIONAL PERFORMANCE EXCELLENCE

THIRD STATE FISCAL QUARTER 2016

January, February, March 2016

Jay Harper
Superintendent
April 22, 2016

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Table of Contents

STRATEGIC PERFORMANCE EXCELLENCE

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

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	4Q2015	1Q2016	2Q2016	3Q2016
1. Patients are routinely informed of their rights upon admission.	100% 45/45	100% 79/79	80% 16/20	95% 61/64

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.

3Q2016: 26 signed, 30 declined, 4 lacked capacity, 1 not applicable.

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	4Q2015	1Q2016	2Q2016	3Q2016
1. Level II grievances responded to by RPC on time.	100% 1/1	100% 1/1	0% 0/0	0% 0/0
2. Level I grievances responded to by RPC on time.	52% 45/86	78% 129/165	51% 49/97	60% 46/77

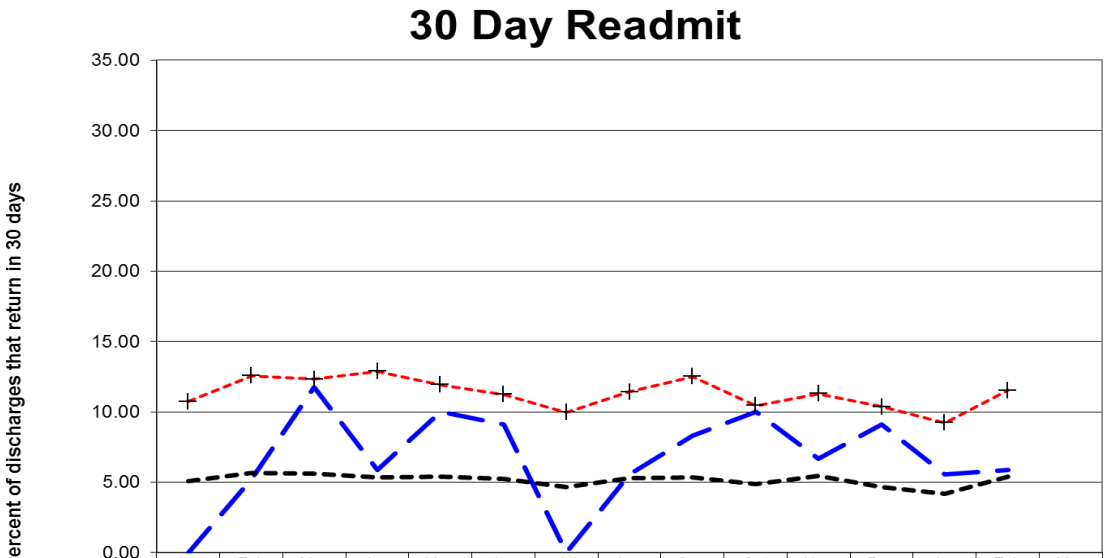
Admissions

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

ADMISSIONS	4Q2015	1Q2016	2Q2016	3Q2016	TOTAL
CIVIL:	**25**	**30**	**37**	**37**	**129**
VOL	1	2	1	1	**5**
INVOL	2	4	5	7	**18**
DCC	20	23	31	29	**103**
DCC-PTP	2	1	0	0	**3**
FORENSIC:	**20**	**34**	**21**	**27**	**102**
60 DAY EVAL	6	19	11	13	**49**
JAIL TRANSFER	0	2	1	5	**8**
IST	13	6	7	3	**29**
NCR	1	7	2	6	**16**
TOTAL	**45**	**64**	**58**	**64**	**231**

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



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.00	5.26	11.76	5.88	10.00	9.09	0.00	5.56	8.33	10.00	6.67	9.09	5.56	5.88	
Ntl Mean	5.07	5.68	5.59	5.33	5.38	5.24	4.67	5.27	5.34	4.85	5.44	4.63	4.19	5.40	
+1 StDev	10.74	12.57	12.32	12.87	11.93	11.24	9.97	11.41	12.51	10.43	11.28	10.35	9.22	11.52	

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.

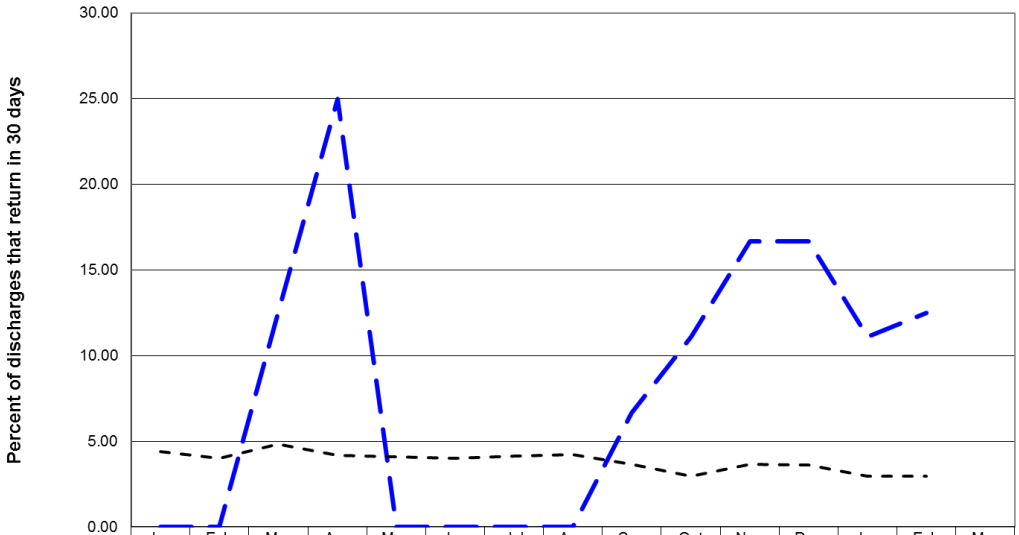
Reasons for patient readmission are varied and may include decompensating or lack of compliance with a PTP. Specific causes for readmission are reviewed with each patient upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient granularity to determine trends for causes of readmission. Between August 2013 and November 2014, the Lower Saco Unit was decertified; patients had to be discharged and readmitted in our Meditech Electronic Medical Record system whenever they transferred units within the hospital (either from or to Lower Saco), which caused them to show up as a 30 Day Readmission, even though they never left the hospital.

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.

CONSENT DECREE

30 Day Readmit

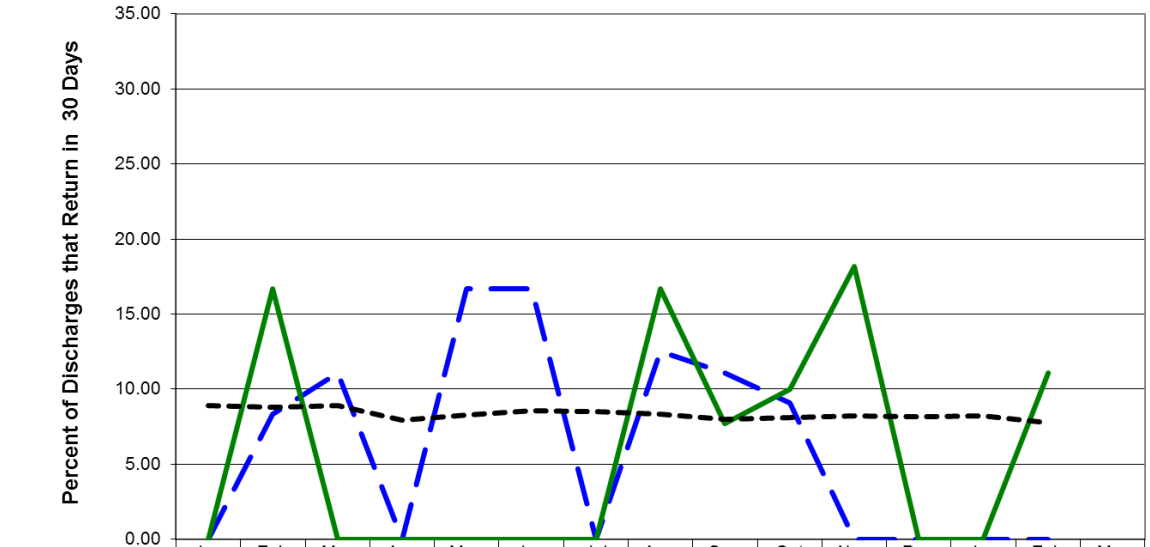
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.00	0.00	12.50	25.00	0.00	0.00	0.00	0.00	6.67	11.11	16.67	16.67	11.11	12.50	
Ntl Mean	4.41	4.02	4.84	4.19	4.11	4.02	4.14	4.22	3.64	2.95	3.65	3.63	2.98	2.97	

30 Day Readmit

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.00	8.33	11.11	0.00	16.67	16.67	0.00	12.50	11.11	9.09	0.00	0.00	0.00	0.00	
Dorothea Dix	0.00	16.67	0.00	0.00	0.00	0.00	0.00	16.67	7.69	10.00	18.18	0.00	0.00	11.11	
Ntl Mean	8.91	8.80	8.89	7.96	8.27	8.58	8.52	8.34	7.99	8.12	8.22	8.14	8.21	7.75	

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 READMISSION OCCURRING WITHIN 60 DAYS

Indicators	4Q2015	1Q2016	2Q2016	3Q2016
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% 2/2	100% 5/5	100% 4/4	100% 5/5

3Q2016: Five patients were re-admitted in 3Q2016. Of the 5 re-admitted, all spent less than 30 days in the community. Patient 1 spent 11 days in the community post discharge to a general hospital for a surgery and was re-admitted after completing rehabilitation. Patient 2 was discharged to a PMNI placement with the additional support of an OPS team. Patient became dis-regulated related to a complex medical issue affecting the psychiatric presentation and was re-admitted to the hospital after 14 days in the community. Patient 3 was a forensic discharge from an evaluation and re-admitted after 21 days for an IST evaluation. Patient 4 was a community discharge that stopped taking medications and refused service providers to enter the patient's residence and returned within 18 days of discharge. Patient 5 was a stage evaluation readmitted after court for discharge planning after 26 days.

CONSENT DECREE

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

Indicators	4Q15	1Q16	2Q16	3Q16
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% 1/1	100% 6/6	100% 2/2	100% 3/3
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%	100%	100%

3Q2016: Three patients returned to RPC; two patients remain at RPC and one has returned to the community. Patient 1 was medically compromised, patient 2 had homicidal inclination/anxiety, and patient 3had rapid decompensation on medication.

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	4Q15	1Q16	2Q16	3Q16	TOTAL
ADJUSTMENT DISORDER WITH DEPRESSED MOOD			1		**1**
ADJUSTMENT DISORDER W/ MIXED DISTURBANCE OF EMOTIONS & CONDUCT	1	1			**2**
ANTISOCIAL PERSONALITY		1		1	**2**
ATTENTION DEFICIT W/ HYPERACTIVITY		1			**1**
ANXIETY DISORDER, UNSPECIFIED				1	**1**
AUTISTIC DISORDER			1		**1**
BIPOLAR DISORD, CRNT EPISODE MANIC W/O PSYCH FEATURES, MILD			1		**1**
BIPOLAR DISORD, CRNT EPSD DEPRESS, SEVERE, W PSYCH FEATURES			1	3	**4**
BIPOLAR DISORDER, UNSPECIFIED		10	6	6	**22**
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE, SPEC W/ PSYCHOTIC BEHAV	1	1			**2**
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE, W/O PSYCHOTIC FEATURES	1	1			**2**
BIPOLAR I, REC EPIS OR CURRENT MANIC, IN PARTIAL OR UNSPEC REMISSION	1	1			**2**
BIPOLAR I, REC EPIS OR CURRENT MANIC, SEVERE, W/ PSYCHOTIC BEHAV		2			**2**
BIPOLAR II DISORDER				1	**1**
BORDERLINE PERSONALITY DISORDER				1	**1**
DELUSIONAL DISORDERS	1	1	1		**3**
DEMENTIA IN OTH DISEASES CLASSD ELSWHR W/ BEHAVIORAL DISTURB			1	1	**2**
DEPRESSIVE DISORDER NEC		3			**3**
DEPRESSIVE DISORDER-SEVERE	2				**2**
DEPRESSIVE DISORDER-UNSPEC		1			**1**
IMPULSE CONTROL DISORDER NOS	1				**1**
MAJOR DEPRESSV DISORDER, RECURRENT SEVERE W/PSYCH FEATURES			1		**1**
MAJOR DEPRESSV DISORD, SINGLE EPSD, SEVERE W PSYCH FEATURES				1	**1**

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

CONSENT DECREE

PATIENT ADMISSION DIAGNOSIS	4Q15	1Q16	2Q16	3Q16	TOTAL
MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED				2	**2**
MILD COGNITIVE IMPAIRMENT, SO STATED				1	**1**
OTHER DEPRESSIVE EPISODES				1	**1**
OTH PSYCH DISORDER NOT DUE TO A SUB OR KNOWN PHYSIOLOGICAL CONDITION			1		**1**
OTHER SCHIZOPHRENIA			2		**2**
OTHER SPEC PERVASIVE DEVELOPMENT DIS, CURRENT OR ACTIVE STATE	2				**2**
PARANOID SCHIZOPHRENIA			1		**1**
PARANOID SCHIZOPHRENIA-CHRONIC W/EXACERBATION					**0**
PARANOID SCHIZOPHRENIA-UNSPEC	1	1			**2**
POSTTRAUMATIC STRESS DISORDER	8	5	2	3	**18**
PSYCHOSIS NOS		4			**4**
RECURRENT DEPRESSIVE DISORDER-PSYCHOTIC	1	1			**2**
SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE			14	14	**28**
SCHIZOAFFECTIVE DISORDER, CHRONIC W/EXACER	17				**17**
SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE				2	**2**
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED		14	6	3	**23**
SCHIZOPHRENIA NOS-CHRONIC	5				**5**
SCHIZOPHRENIA, UNSPECIFIED	1	14	9	14	**38**
UNSPECIFIED ALCOHOL-INDUCED MENTAL DISORDERS	2				**2**
UNSPECIFIED MOOD DISORDER (EPISODIC)		2			**2**
UNSPECIFIED MODD DISORDER (AFFECTIVE)				1	**1**
UNSP PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSICAL COND			11	8	**19**
Total Admissions	**45**	**64**	**59**	**64**	**232**
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	**0%**	**0%**	**<1%**	**<1%**	**< 1%**

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	4Q2015	1Q2016	2Q2016	3Q2016
1. Attendance at Comprehensive Treatment Team meetings. (v9)	*96% 383/414	*89% 331/401	*86% 446/515	*91% 442/484
2. Attendance at Service Integration meetings. (v8)	66% 12/31	*97% 61/63	96% 47/49	*86% 56/65
3. Contact during admission. (v8)	100% 45/45	100% 64/64	100% 49/49	100% 64/64
4. Community Integration/Bridging Inpatient & OPS. Inpatient trips OPS	100% 25 142	100% 58 127	100% 91 131	100% 26 204
5. Peer Support will make an attempt to assist all patients in recognizing their personal medicine and filling out form.	100% 45/45	0% 0/64	82% 40/49	78% 50/64
6. 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.	62% 28/45	22% 14/63	41% 20/49	46% 30/65
7. Grievances responded to on time by Peer Support, within 1 day of receipt.	100% 86/86	100% 161/161	100% 97/97	100% 77/77
8. Peer Specialist will meet with resident's within 48 hours of admission and complete progress note to document meeting.	New Indicator Added FY 2016	100% 64/64	100% 49/49	100% 64/64
9. Each resident has documented contact with a peer supporter during their hospitalization (target is 100%).	New Indicator Added FY 2016	100% 64/64	100% 49/49	100% 64/64

Treatment Planning

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

Indicators	4Q2015	1Q2016	2Q2016	3Q2016
1. Service Integration Meeting and form completed by the end of the 3rd day.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
2. Patient participation in Service Integration Meeting.	95% 43/45	93% 42/45	95% 43/45	97% 44/45
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	97% 44/45	95% 43/45	95% 43/45
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	100% 10/10	100% 10/10

3Q2016:

2. One patient declined to meet for the Service Integration meeting and declined on follow up.

4. Two Comprehensive Psychosocial Assessments were not completed within the 7 day timeframe.

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

Indicators	4Q2015	1Q2016	2Q2016	3Q2016
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all patients on assigned **CCM** caseload.	100% 45/45	91% 41/45	96% 43/45	89% 40/45
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

3Q2016: During chart audits, four charts had a late progress note for the prior week. A meeting was held with the patient, but the note was a late entry. Issue was discussed with individual team members and support was given in supervision.

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.

Treatment Modality	Provision of Services Normally by….			
	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.

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.

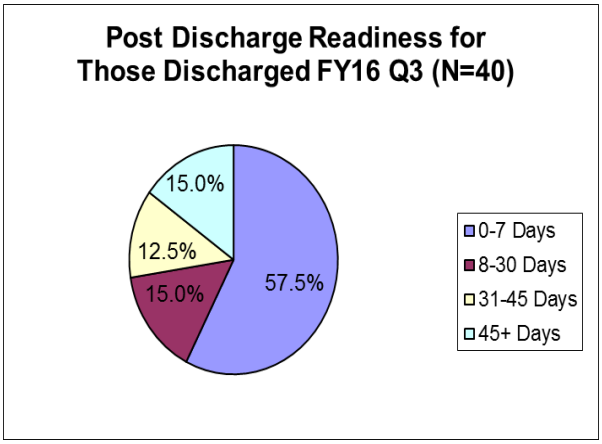
Discharges

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 = (23) 58% (target 70%)

Within 30 days = (6) 73% (target 80%)

Within 45 days = (5) 86% (target 90%)

Post 45 days = (6) 10.7% (target 0%)

Barriers to Discharge Following Clinical Readiness:

Residential Supports (0) No barriers in this area	Housing (13) • 5 patients discharged 8-30 days post clinical readiness (9, 14, 15, 16, 24 days) • 2 patient discharged 31-45 days post clinical readiness (34, 35 days) • 6 patients discharged 45+ days post clinical readiness (49, 51, 58, 65, 83, 145 days)
Treatment Services (2) Two patients were discharged at 36 and 45 days respectively with treatment service barriers (PTP)	
Other (0) No barriers in this area	

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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%**
2Q2016	N=40	67.9%	85.7%	89.3%	10.7%
1Q2016	N=34	64.7%	82.3%	91.1%	8.9%
4Q2015	N=29	65.6%	86.2%	93.1%	6.9%
3Q2015	N=38	78.9%	86.8%	89.4%	10.6%

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	4Q2015	1Q2016	2Q2016	3Q2016
1. The Patient Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 12/12	100% 12/12	100% 12/12	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% 12/12	100% 12/12	100% 12/12	100% 13/13
3. The Patient Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	92% 11/12	83% 10/12	92% 11/12	92% 12/13
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% 12/12	100% 12/12	92% 11/12	100% 13/13

3Q2016:

3. On one occasion the report was not sent out during the week, it was presented at the Wednesday Housing Meeting and a two week report was sent the following week.

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	4Q2015	1Q2016	2Q2016	3Q2016
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	66% 2/3	66% 2/3	0% 0/6	14% 1/7
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% 3/3	100% 3/3	100% 3/3	100% 8/8
3. Annual Reports (due in December) to the Commissioner for all inpatient NCR patients are submitted annually	N/A	N/A	0% 0/25	100% 25/25

3Q2016:

1. Seven Institutional Reports were done in the quarter. One of the reports was completed in the 10 business day timeframe. We continue to monitor the process and recognize that the complexities of these reports in some cases make it exceptionally challenging to complete in 10 days with the multi-disciplinary collaboration and input required for completion. All NCR patients that filed in the quarter have been on a docket or a pending docket in the proceeding months and have not had adverse outcomes due to this challenging deadline as all reports were filed within the guidelines and expectations of State Forensic Services and the Court.
2. All of the 25 NCR annual reports were completed in the 3rd quarter.

Staffing and Staff Training

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

Indicators	1Q2016	2Q2016	3Q2016	4Q2016	YTD
1. Riverview and Contract staff will attend CPR training bi-annually.	100% 55/55	100% 47/47	100% 41/41		100% 143/143
2. Riverview and Contract staff will attend Annual training.	86% 89/104	97% 56/58	80% 16/20		88% 161/182
3. Riverview and contract staff will attend MOAB training bi-annually	100% 28/28	100% 11/11	82% 94/115		86% 133/154

3Q2016:

2. Four employees are out of compliance for the quarter. Employees and their supervisors have been notified and corrective action is being taken.

3. Due to staff shortages, some employees due for MAOB recertification were unable to attend to ensure adequate unit coverage. The Hospital is developing a plan to ensure employees will be recertified in the imminent future.

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 Non Violent Communication and Motivational Interviewing training by June 2016. Attendance will be tracked by Staffing and Organizational Development. Progress will be reported quarterly.

Progress: To date, 216 out of 375 current employees have attended Non-Violent Communication (NVC) Training. 85 have attended eight hour NVC Training. 111 employees have attended Motivational Interviewing training to date.

Comments: Motivational Interviewing was offered in January and March 2016. Twenty-two staff attended.

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 2015	Manual Holds	Mechanical Restraints	Locked Seclusion	Total Events Per Quarter
Quarter 1	99	10	105	**214**
Quarter 2	107	16	97	**220**
Quarter 3	61	1	62	**124**
Quarter 4	94	4	92	**190**
Total # of events	**361**	**31**	**356**	**748**

***Average # of events per month in FY 2015: 62.3**

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				
Total # of events	**264**	**6**	**190**	**460**

***Average # of events per month in FY 2016 to date: 51**

Action Plan:

Staff will receive initial and ongoing education training in MOAB, Non Violent Communication, Motivational interviewing to assist in establish therapeutic relationships so that, 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.

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
4Q2015	17	April – June 2015	
1Q2016	4	July – September 2015	
2Q2016	19	October – December 2015	
1/7/2016	1	Health Effects of Physical Restraint of Psychiatric Patients	John Kootz, MD
1/14/2016	1	Which Symptoms are the Most Severe Amongst Psychiatric Inpatients with Histories of Psychosis? Who are Non-adherent with Medications? A new research study.	Graham Danzer, Psych Intern
1/19/2016	1	Medical Staff PI & QA Committee	William Nelson MD
1/21/2016	1	Promoting Equal Status for Women in Kenya	Sarah Malcolm, LMSW-CC
1/28/2016	1	Addressing the Elephant: Co-Occurring Disorders and Effective Treatment	James Given, LADC
2/4/2016	1	Name the Unnamable: Addressing Burnout Among Professional Caregivers in Mental Health Facility	James Weathersby, Chaplain
2/11/2016	1	Sensory Processing Styles: There's no "right" or "wrong"	Amy Walsh, MS OTR/L Jeremy Richardson, MOT OTR/L Maureen Martin, MOT OTR/L
2/25/2016	1	Eating Disorders: An overview of Anorexia and Bulimia	Sarah Perry, PharmD
3/3/2016	1	Sell v. United States: A look at the history and a review of the first Riverview case	Miriam Davidson, PMHNP
3/10/2016	1	Mindfulness at Riverview	Nancy Hathaway
3/17/2016	2	Team Presentation of an NCR Patient	Art DiRocco, PhD Elizabeth Houghton-Faryna, PsyD
3/24/2016	1	Exposure Therapy as a Transdiagnostic Treatment Procedure	Robert Brady, PhD
3/28/2016	1	Trauma Informed Care	Jessica Lloyd, Psych Intern

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.

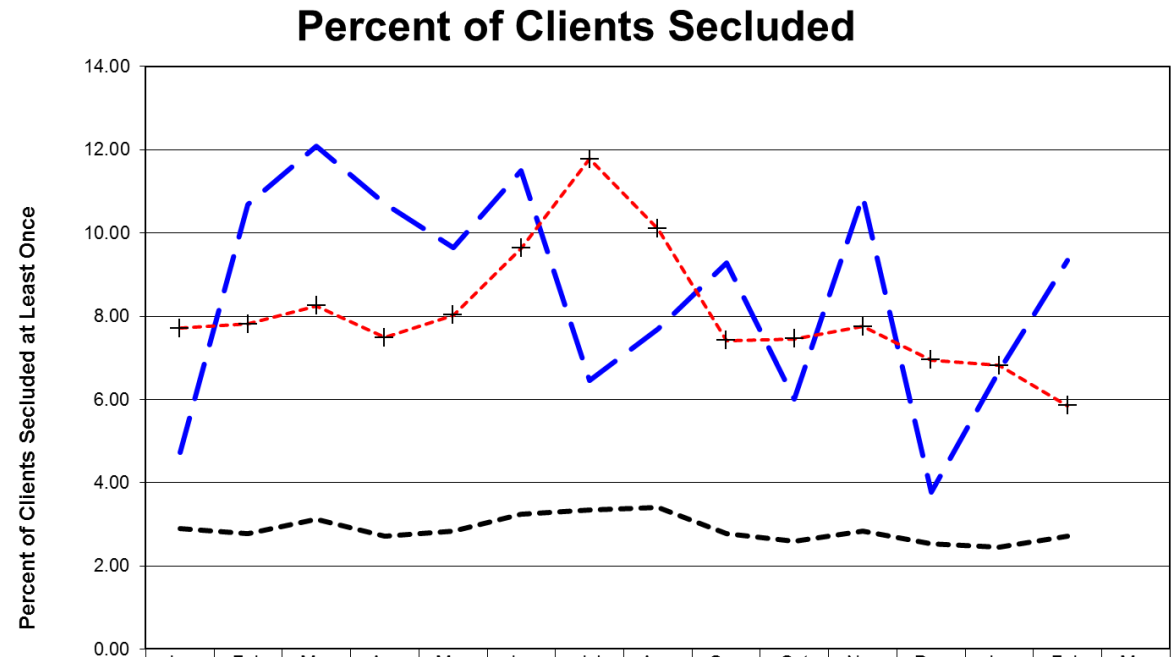
Staffing levels are most often determined by an analysis of unit acuity, individual monitoring needs of the patients who reside on specific units, and unit census.

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.

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;



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	4.72	10.68	12.09	10.71	9.64	11.49	6.45	7.69	9.28	6.00	10.89	3.77	6.67	9.35	
Ntl Mean	2.89	2.78	3.12	2.72	2.84	3.25	3.34	3.40	2.78	2.59	2.83	2.52	2.45	2.72	
+1 StDev	7.71	7.81	8.25	7.49	8.03	9.63	11.78	10.10	7.42	7.46	7.75	6.95	6.82	5.85	

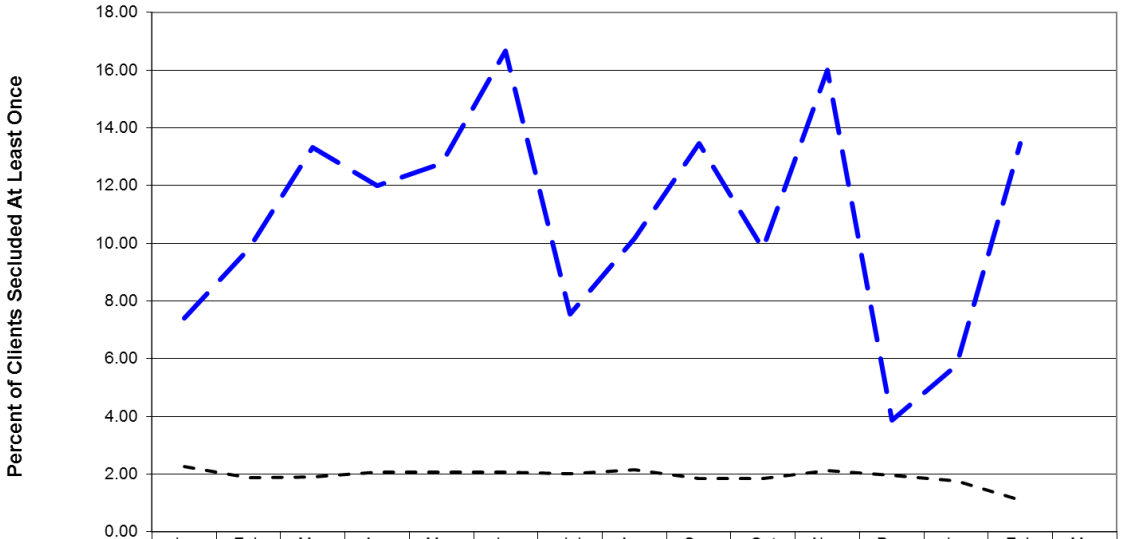
This graph depicts the percent of unique patients who were secluded at least once. For example, rates of 3.0 means that 3% of the unique patients served were secluded at least once.

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

Percent of Clients Secluded

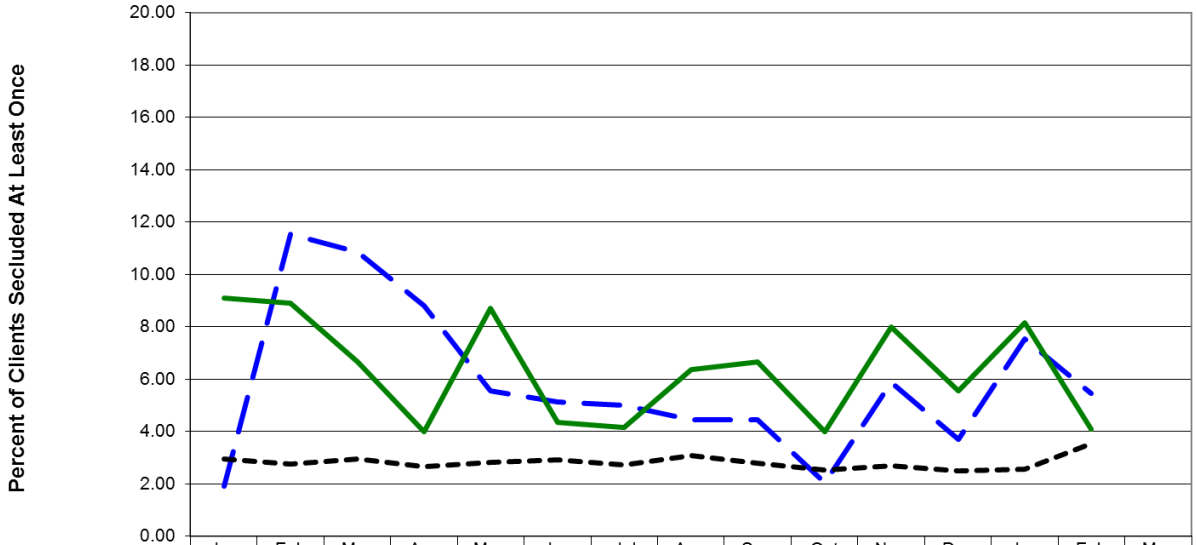
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	7.41	9.80	13.33	12.00	12.77	16.67	7.55	10.17	13.46	9.80	16.00	3.85	5.77	13.46	
Ntl Mean	2.25	1.86	1.89	2.08	2.08	2.07	2.01	2.14	1.84	1.84	2.11	1.96	1.76	1.11	

Percent of Clients Secluded

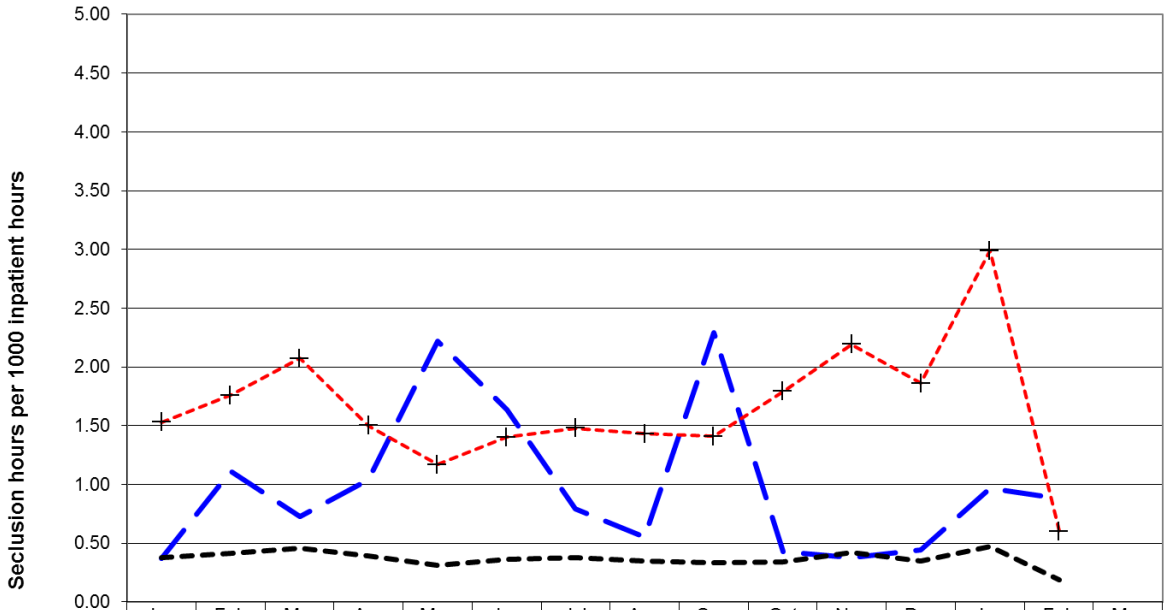
Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	1.92	11.54	10.87	8.82	5.56	5.13	5.00	4.44	4.44	2.04	5.88	3.70	7.55	5.45	
Dorothea Dix	9.09	8.89	6.67	4.00	8.70	4.35	4.17	6.38	6.67	4.00	8.00	5.56	8.16	4.08	
Ntl Mean	2.94	2.76	2.95	2.67	2.84	2.93	2.74	3.08	2.78	2.52	2.69	2.49	2.55	3.53	

CONSENT DECREE

Seclusion Hours



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.37	1.11	0.73	1.04	2.22	1.64	0.79	0.55	2.29	0.43	0.38	0.44	0.97	0.88	
Ntl Mean	0.38	0.41	0.46	0.39	0.31	0.36	0.38	0.35	0.33	0.34	0.42	0.35	0.47	0.19	
+1 StDev	1.53	1.76	2.07	1.50	1.17	1.40	1.48	1.43	1.41	1.79	2.19	1.86	2.99	0.60	

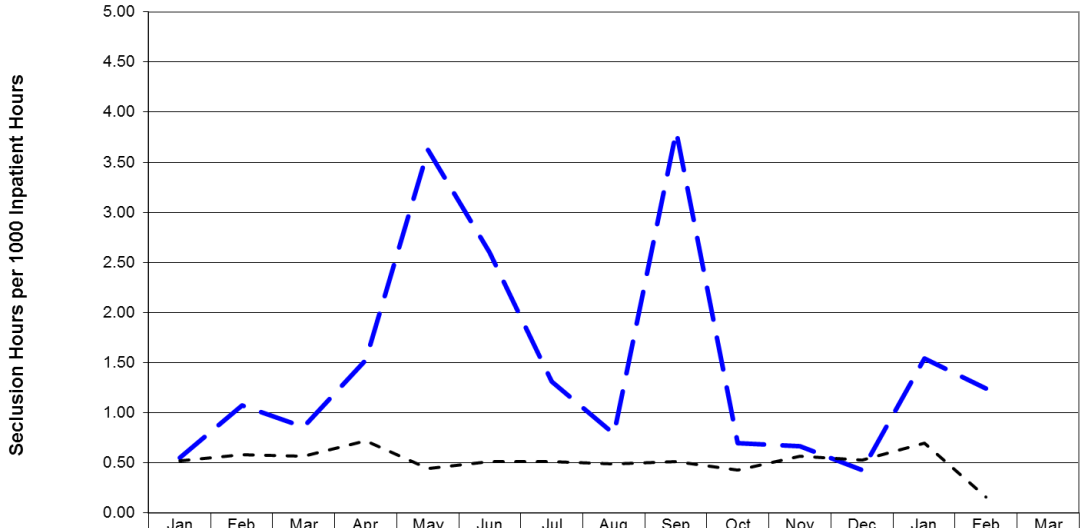
This graph depicts the number of hours patients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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.

CONSENT DECREE

Seclusion Hours

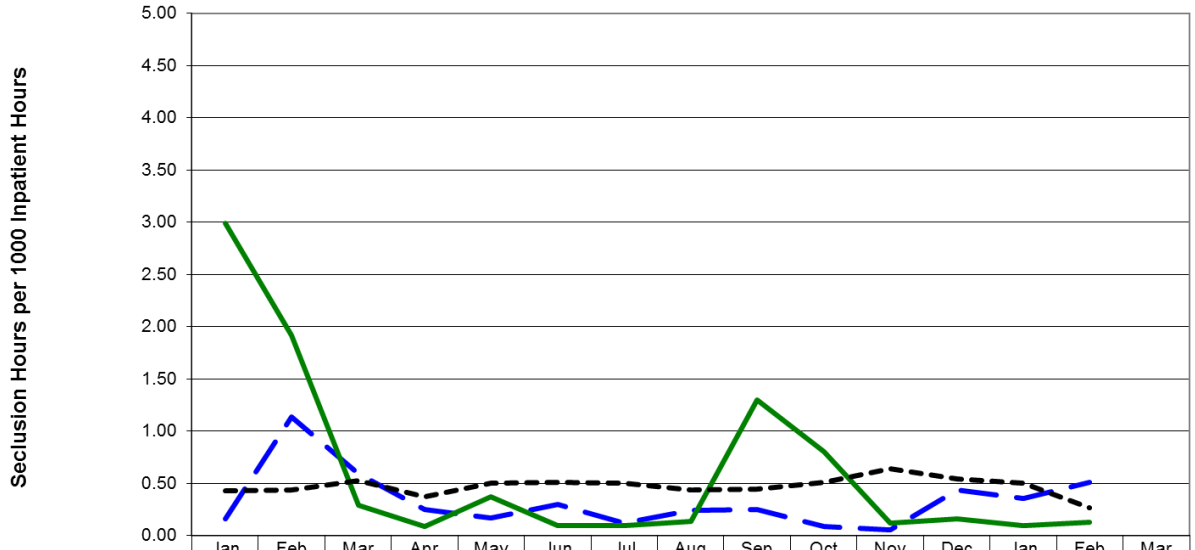
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.55	1.07	0.86	1.53	3.62	2.60	1.31	0.79	3.81	0.70	0.67	0.43	1.54	1.24	
Ntl Mean	0.52	0.58	0.57	0.72	0.44	0.51	0.51	0.49	0.51	0.43	0.57	0.53	0.70	0.16	

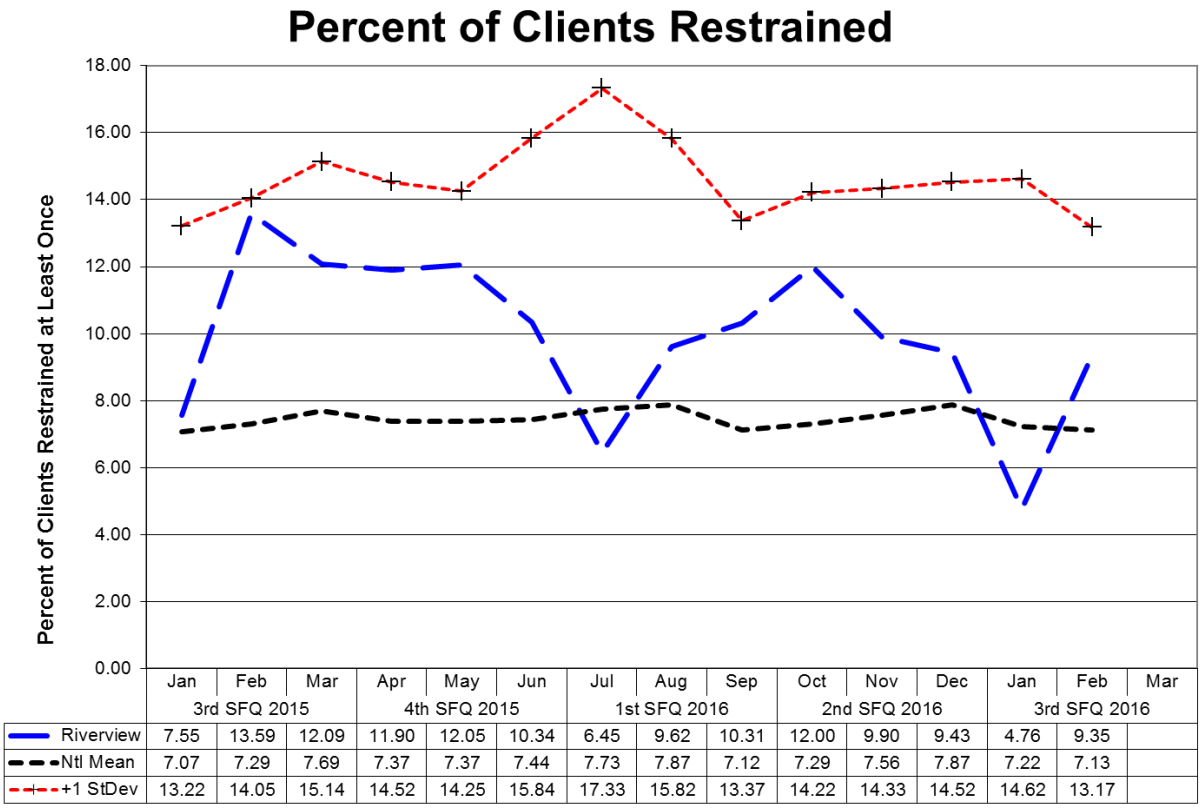
Seclusion Hours

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.16	1.14	0.59	0.25	0.17	0.30	0.12	0.24	0.25	0.09	0.06	0.44	0.36	0.51	
Dorothea Dix	2.99	1.92	0.29	0.09	0.37	0.10	0.10	0.14	1.30	0.80	0.12	0.16	0.10	0.13	
Ntl Mean	0.43	0.44	0.53	0.37	0.50	0.51	0.50	0.44	0.45	0.51	0.64	0.54	0.50	0.27	

CONSENT DECREE



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	7.55	13.59	12.09	11.90	12.05	10.34	6.45	9.62	10.31	12.00	9.90	9.43	4.76	9.35	
Ntl Mean	7.07	7.29	7.69	7.37	7.37	7.44	7.73	7.87	7.12	7.29	7.56	7.87	7.22	7.13	
+1 StDev	13.22	14.05	15.14	14.52	14.25	15.84	17.33	15.82	13.37	14.22	14.33	14.52	14.62	13.17	

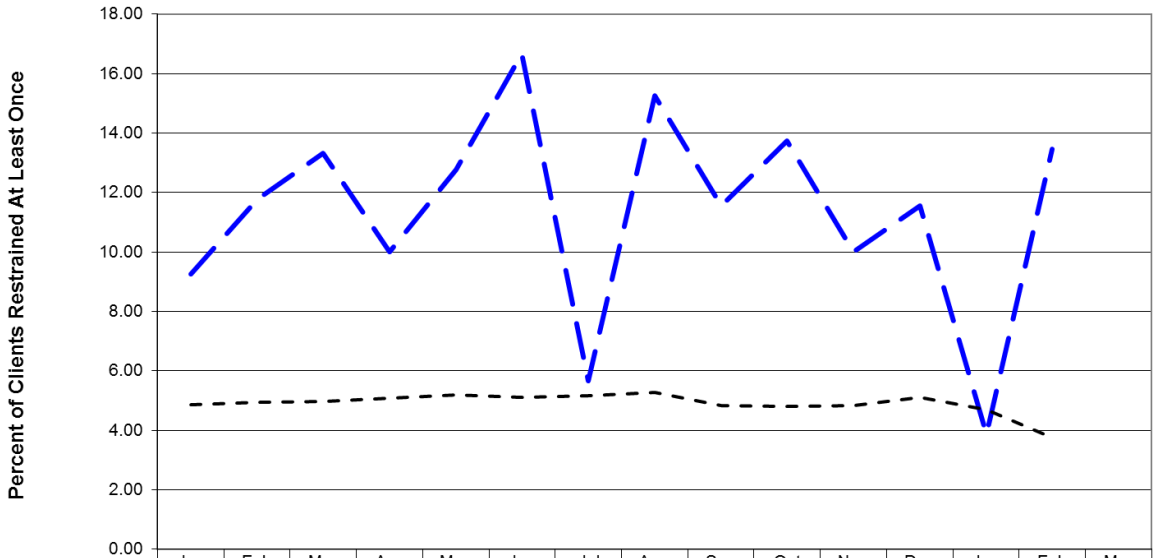
This graph depicts the percent of unique patients who were restrained at least once and includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique patients served were restrained at least once.

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

Percent of Clients Restrained

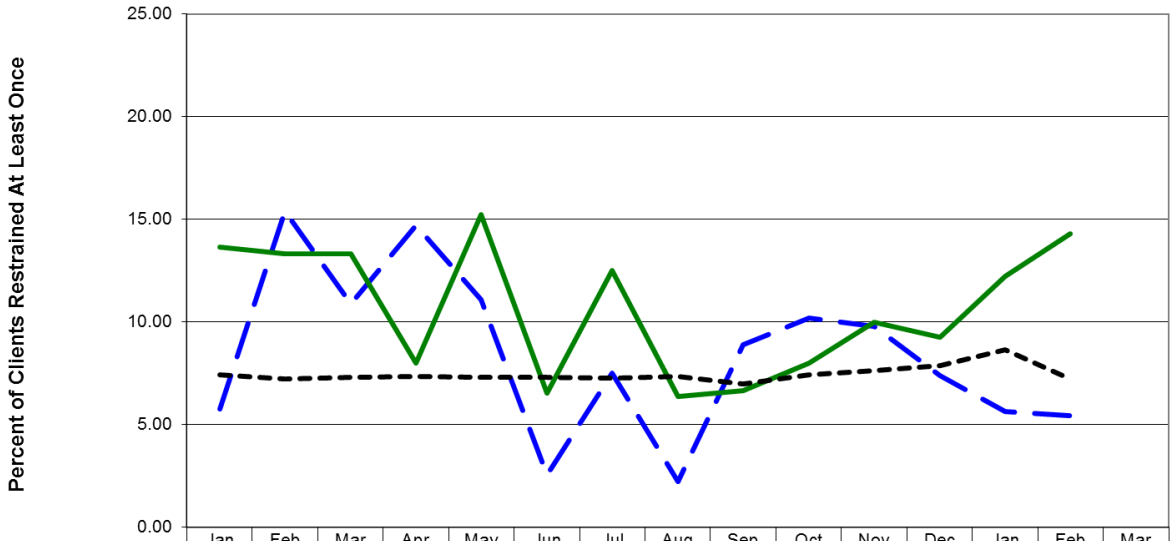
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	9.26	11.76	13.33	10.00	12.77	16.67	5.66	15.25	11.54	13.73	10.00	11.54	3.85	13.46	
Ntl Mean	4.85	4.93	4.96	5.07	5.18	5.12	5.17	5.27	4.83	4.80	4.84	5.11	4.69	3.76	

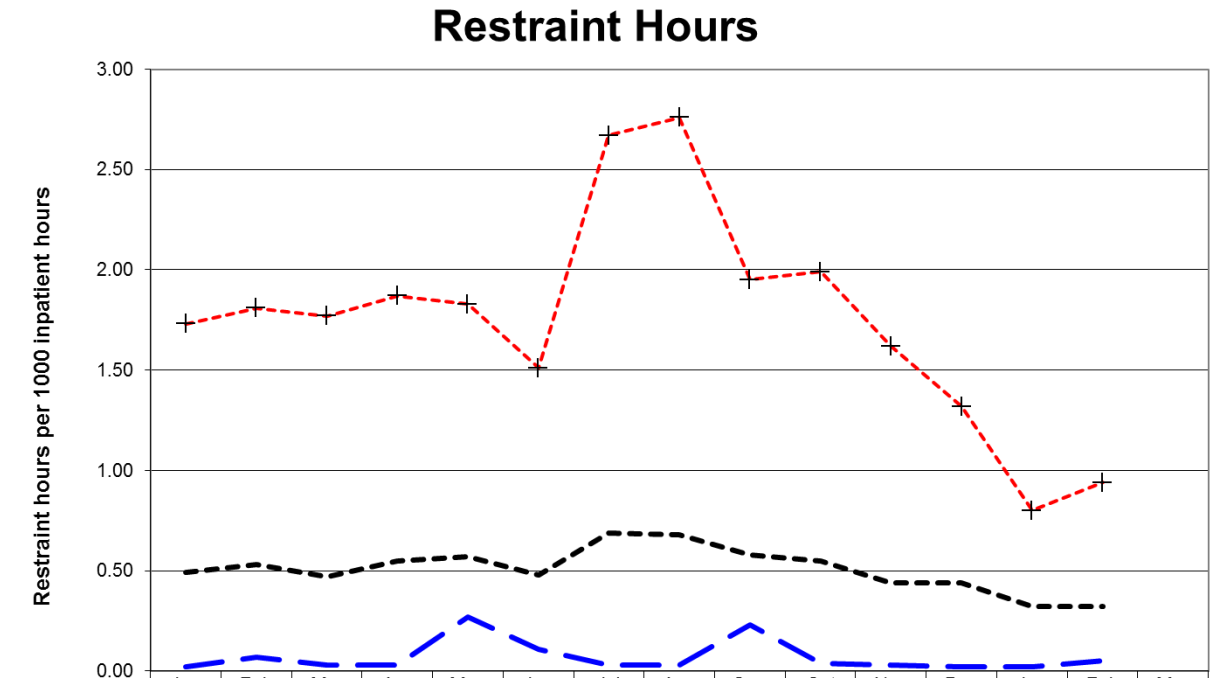
Percent of Clients Restrained

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	5.77	15.38	10.87	14.71	11.11	2.56	7.50	2.22	8.89	10.20	9.80	7.41	5.66	5.45	
Dorothea Dix	13.64	13.33	13.33	8.00	15.22	6.52	12.50	6.38	6.67	8.00	10.00	9.26	12.24	14.29	
Ntl Mean	7.45	7.22	7.33	7.36	7.32	7.31	7.28	7.34	6.98	7.43	7.62	7.90	8.67	7.24	

CONSENT DECREE



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.02	0.07	0.03	0.03	0.27	0.11	0.03	0.03	0.23	0.04	0.03	0.02	0.02	0.05	
Ntl Mean	0.49	0.53	0.47	0.55	0.57	0.48	0.69	0.68	0.58	0.55	0.44	0.44	0.32	0.32	
+1 StDev	1.73	1.81	1.77	1.87	1.83	1.51	2.67	2.76	1.95	1.99	1.62	1.32	0.80	0.94	

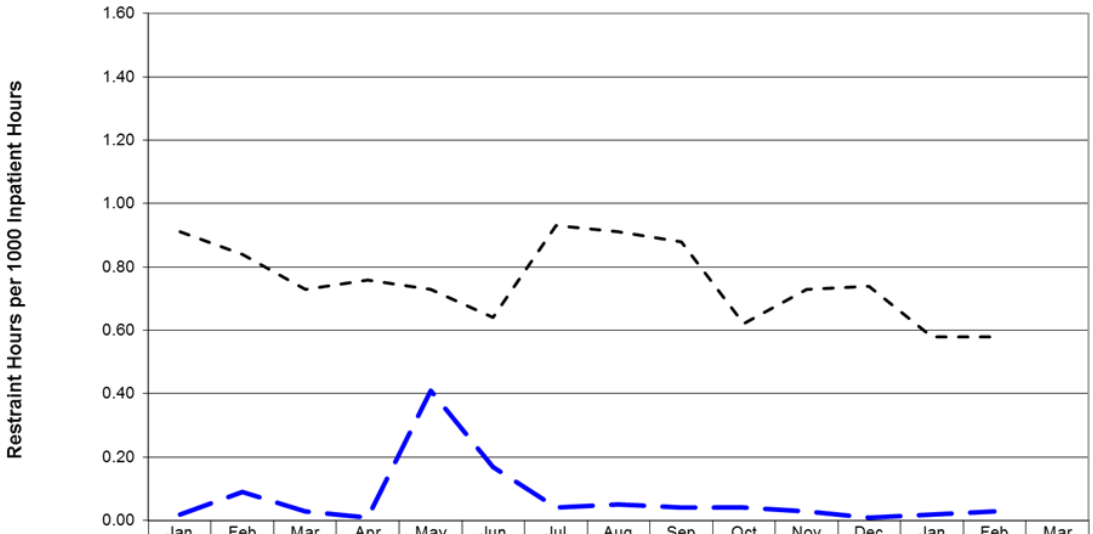
This graph depicts the number of hours patients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.

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.

CONSENT DECREE

Restraint Hours

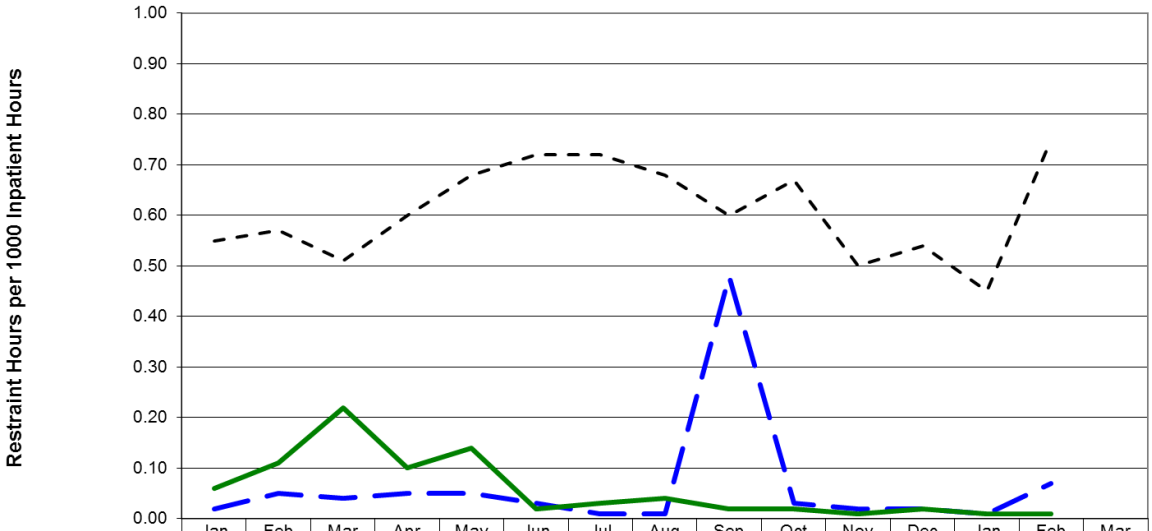
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.02	0.09	0.03	0.01	0.41	0.17	0.04	0.05	0.04	0.04	0.03	0.01	0.02	0.03	
Ntl Mean	0.91	0.84	0.73	0.76	0.73	0.64	0.93	0.91	0.88	0.62	0.73	0.74	0.58	0.58	

Restraint Hours

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.02	0.05	0.04	0.05	0.05	0.03	0.01	0.01	0.48	0.03	0.02	0.02	0.01	0.07	
Dorothea Dix	0.06	0.11	0.22	0.10	0.14	0.02	0.03	0.04	0.02	0.02	0.01	0.02	0.01	0.01	
Ntl Mean	0.55	0.57	0.51	0.60	0.68	0.72	0.72	0.68	0.60	0.67	0.50	0.54	0.45	0.75	

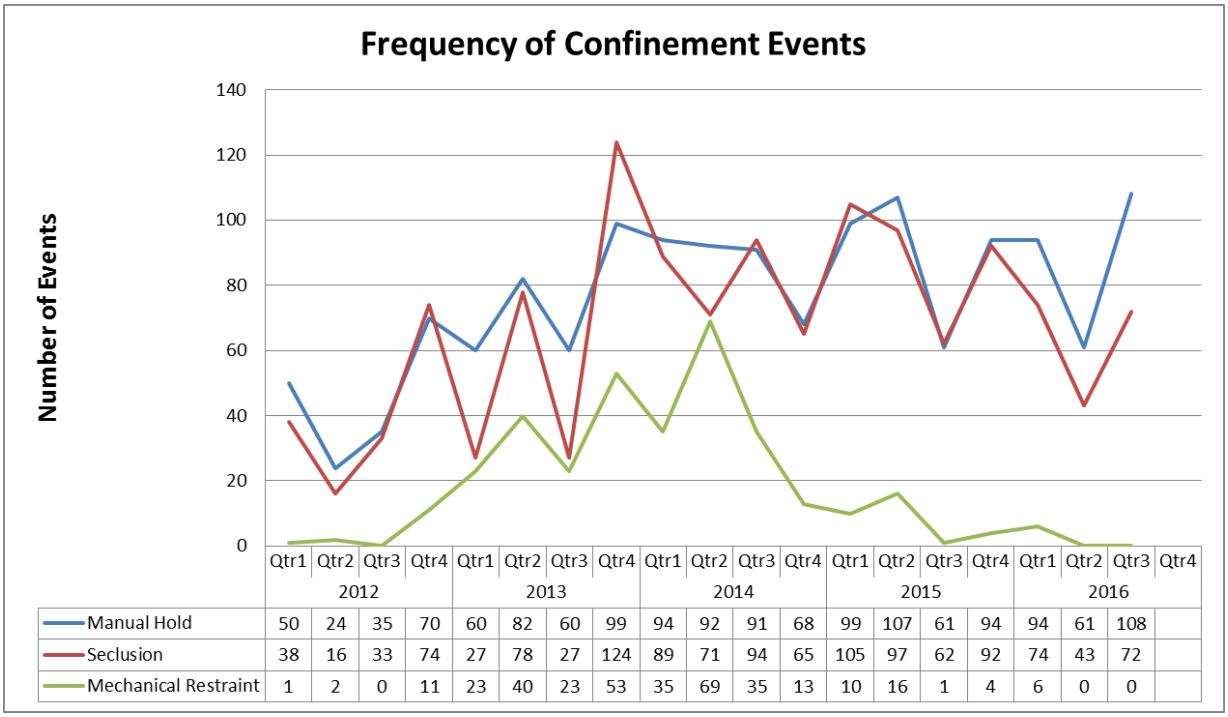
CONSENT DECREE

Confinement Event Detail
3Q2016

Patient	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR3374	25		21	**46**	**26%**	**26%**
MR7880	25		12	**37**	**21%**	**47%**
MR7127	15		4	**19**	**11%**	**57%**
MR763	5		6	**11**	**6%**	**63%**
MR5984	4		6	**10**	**6%**	**69%**
MR7736	5		3	**8**	**4%**	**73%**
MR7878	4		2	**6**	**3%**	**77%**
MR7879	3		3	**6**	**3%**	**80%**
MR7884	6			**6**	**3%**	**83%**
MR7893	3		3	**6**	**3%**	**87%**
MR7809	3		2	**5**	**3%**	**89%**
MR7768	2		2	**4**	**2%**	**92%**
MR1187	1		1	**2**	**1%**	**93%**
MR3827	1		1	**2**	**1%**	**94%**
MR5267	1		1	**2**	**1%**	**95%**
MR6714	2			**2**	**1%**	**96%**
MR7874	1		1	**2**	**1%**	**97%**
MR4647	1			**1**	**1%**	**98%**
MR6701			1	**1**	**1%**	**98%**
MR7375			1	**1**	**1%**	**99%**
MR7837	1			**1**	**1%**	**99%**
MR7871			1	**1**	**1%**	**100%**
MR7892			1	**1**	**1%**	**100%**
	108	**0**	**72**	**180**	**100%**	

28% (24/86) of the average hospital population experienced some form of confinement event during 3Q2016. Five of these patients (6% of the average hospital population) accounted for 69% of the containment events.

CONSENT DECREE



	Qtr1 2012	Qtr2 2012	Qtr3 2012	Qtr4 2012	Qtr1 2013	Qtr2 2013	Qtr3 2013	Qtr4 2013	Qtr1 2014	Qtr2 2014	Qtr3 2014	Qtr4 2014	Qtr1 2015	Qtr2 2015	Qtr3 2015	Qtr4 2015	Qtr1 2016	Qtr2 2016	Qtr3 2016	Qtr4
Manual Hold	50	24	35	70	60	82	60	99	94	92	91	68	99	107	61	94	94	61	108	
Seclusion	38	16	33	74	27	78	27	124	89	71	94	65	105	97	62	92	74	43	72	
Mechanical Restraint	1	2	0	11	23	40	23	53	35	69	35	13	10	16	1	4	6	0	0	

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:

	4Q2015	1Q2016	2Q2016	3Q2016	Total
Danger to Others/Self	74	43	35	42	**194**
Danger to Others			23	29	**52**
Danger to Self				1	**1**
% Dangerous Participation	100%	100%	100%	100%	**100%**
Total Events	**74**	**43**	**58**	**72**	**247**

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:

	4Q2015	1Q2016	2Q2016	3Q2016	Total
Danger to Others/Self	6				**6**
Danger to Others					**0**
Danger to Self					**0**
% Dangerous Participation	100%	100%	100%	100%	**100%**
Total Events	**6**	**0**	**0**	**0**	**6**

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

Seclusion Events (72) Events

Standard	Threshold	Compliance
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%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%
The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	99%
The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	99%
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%
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%
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%
Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
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%

Confinement Events Management

Seclusion Events, Continued (72) Events

Standard	Threshold	Compliance
The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
The medical order states the conditions under which the patient may be sooner released.	85%	100%
The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
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%
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%
Reports of seclusion events were forwarded to Clinical Director and Patient Advocate.	90%	100%
The record reflects that, for persons with mental retardation, the regulations governing seclusion of patients with mental retardation were met.	85%	100%
The medical order for seclusion was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events (0) Events

Standard	Threshold	Compliance
The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	N/A
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	N/A
The record reflects that the decision to place the patient in restraint was made by a physician or physician extender	90%	N/A
The decision to place the patient in restraint was entered in the patient's records as a medical order.	90%	N/A
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%	N/A
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%	N/A
The record reflects that the patient was kept under constant observation during restraint.	95%	N/A
Individuals implementing restraint have been trained in techniques and alternatives.	90%	N/A
The record reflects that reasonable efforts taken to notify guardian or designated representative as soon as possible that patient was placed in restraint.	75%	N/A
The medical order states time of entry of order and that number of hours shall not exceed four.	90%	N/A
The medical order shall state the conditions under which the patient may be sooner released.	85%	N/A

CONSENT DECREE

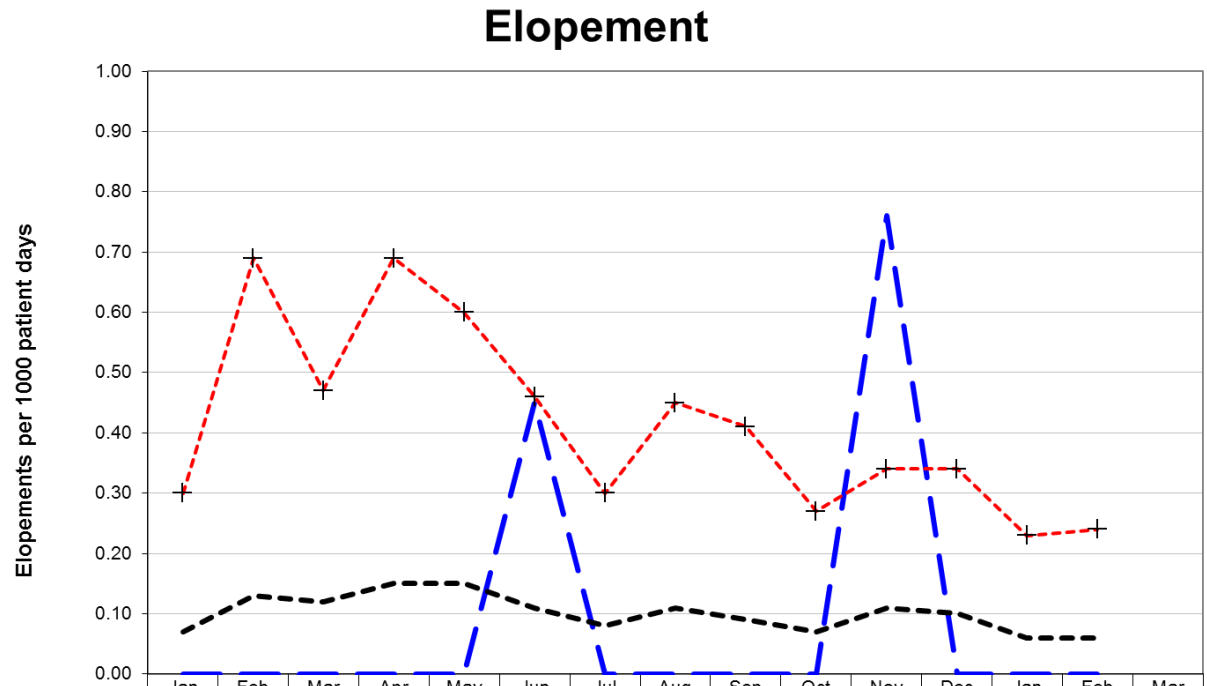
Confinement Events Management

Mechanical Restraint Events, Continued (0) Events

Standard	Threshold	Compliance
The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	N/A
The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	N/A
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%	N/A
The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	N/A
The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	N/A
Copies of events were forwarded to Clinical Director and Patient Advocate.	90%	N/A
For persons with mental retardation, the applicable regulations were met.	85%	N/A
The record reflects that the order was not entered as a PRN order.	90%	N/A
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
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%	N/A

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.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.00	0.45	0.00	0.00	0.00	0.00	0.76	0.00	0.00	0.00	
Ntl Mean	0.07	0.13	0.12	0.15	0.15	0.11	0.08	0.11	0.09	0.07	0.11	0.10	0.06	0.06	
+1 StDev	0.30	0.69	0.47	0.69	0.60	0.46	0.30	0.45	0.41	0.27	0.34	0.34	0.23	0.24	

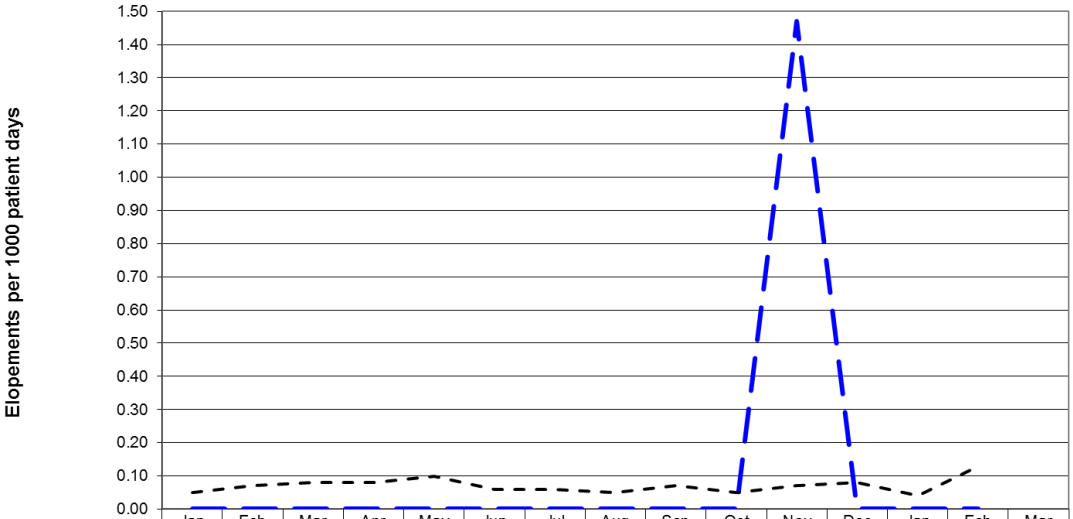
This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days. An elopement is defined as any time a patient is "absent from a location defined by the patient's privilege status regardless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

Elopement

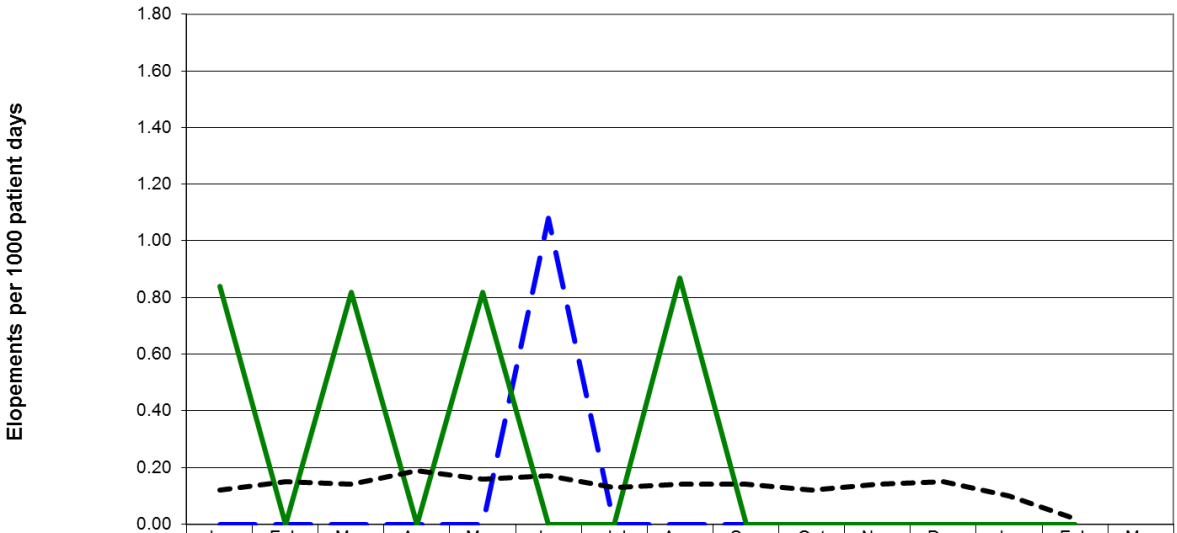
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.47	0.00	0.00	0.00	
Ntl Mean	0.05	0.07	0.08	0.08	0.10	0.06	0.06	0.05	0.07	0.05	0.07	0.08	0.04	0.13	

Elopement

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.00	1.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Dorothea Dix	0.84	0.00	0.82	0.00	0.82	0.00	0.00	0.87	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.12	0.15	0.14	0.19	0.16	0.17	0.13	0.14	0.14	0.12	0.14	0.15	0.10	0.02	

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

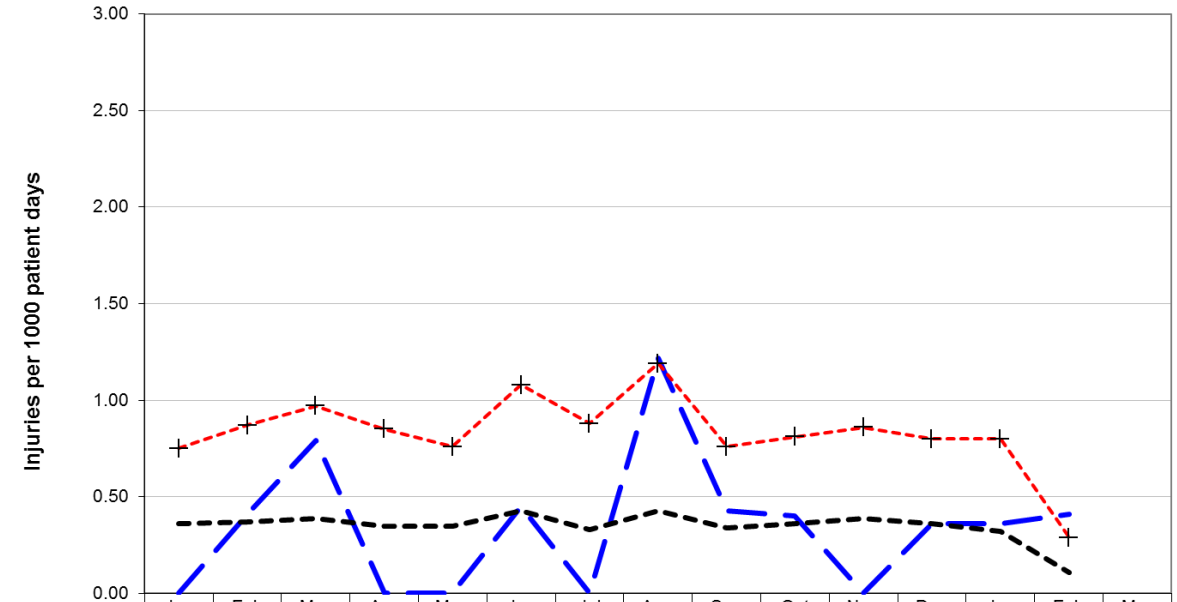
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

- 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

Client Injury Rate



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.00	0.41	0.79	0.00	0.00	0.45	0.00	1.22	0.43	0.40	0.00	0.36	0.36	0.41	
Ntl Mean	0.36	0.37	0.39	0.35	0.35	0.43	0.33	0.43	0.34	0.36	0.39	0.36	0.32	0.11	
+1 StDev	0.75	0.87	0.97	0.85	0.76	1.08	0.88	1.19	0.76	0.81	0.86	0.80	0.80	0.29	

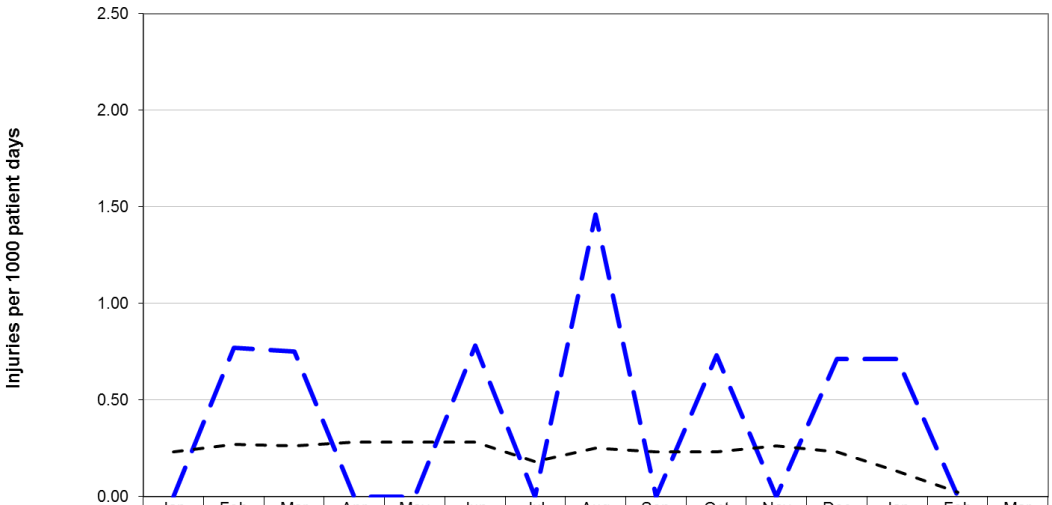
This graph depicts the number of patient injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

Client Injury Rate

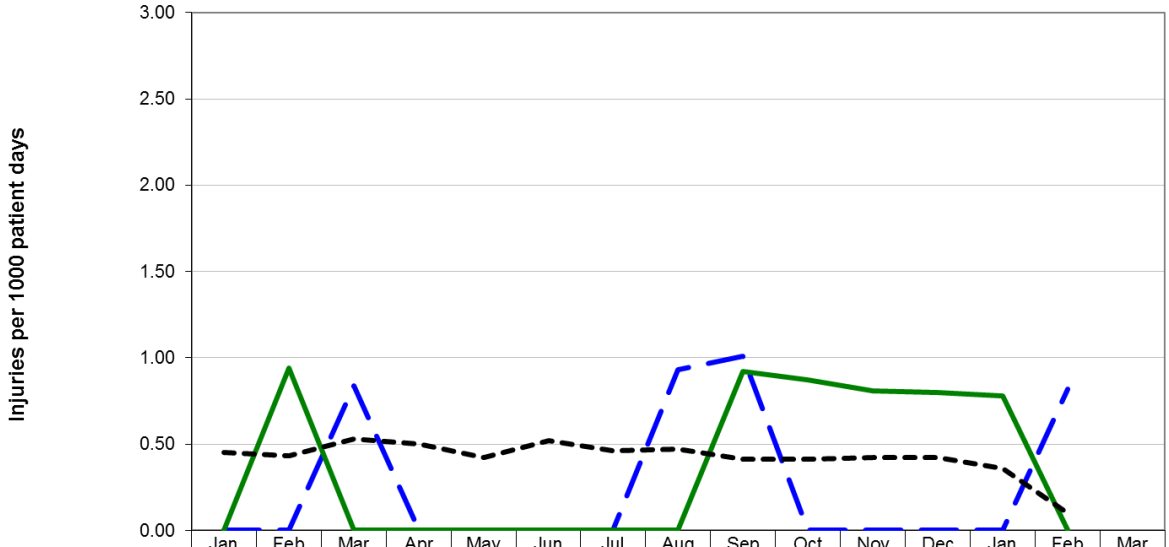
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.00	0.77	0.75	0.00	0.00	0.78	0.00	1.46	0.00	0.73	0.00	0.71	0.71	0.00	
Ntl Mean	0.23	0.27	0.26	0.28	0.28	0.28	0.18	0.25	0.23	0.23	0.26	0.23	0.13	0.02	

Client Injury Rate

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.00	0.00	0.84	0.00	0.00	0.00	0.00	0.93	1.01	0.00	0.00	0.00	0.00	0.82	
Dorothea Dix	0.00	0.94	0.00	0.00	0.00	0.00	0.00	0.00	0.92	0.87	0.81	0.80	0.78	0.00	
Ntl Mean	0.45	0.43	0.53	0.50	0.42	0.52	0.46	0.47	0.41	0.41	0.42	0.42	0.36	0.10	

CONSENT DECREE

Type and Cause of Injury by Month

Type - Cause	January	February	March	3Q2016
Accident – Fall	1	1	1	**3**
Accident – Other		1	4	**5**
Assault – Patient to Patient	2		1	**3**
Injury – Other		2	8	**10**
Self-Injurious Behavior	1			**1**
Total	**4**	**4**	**14**	**22**

Severity of Injury by Month

Severity	January	February	March	3Q2016
No Treatment	1	1	6	**8**
Minor First Aid	2	3	8	**13**
Medical Intervention Required	1			**1**
Hospitalization Required				
Death Occurred				
Total	**4**	**4**	**14**	**22**

Note: Previous quarterly report numbers may have been higher as they included data on incidents as well as injuries. This report has been modified to only include injuries. Per NASMHPD, injuries occur when harm or damage is done.

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.

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	4Q2015	1Q2016	2Q2016	3Q2016	Total
Abuse Verbal	5	8	11	8	**32**
Abuse Physical	9	14	11	13	**47**
Abuse Sexual	6	27	9	11	**53**
Neglect	0	3	2	1	**6**
Coercion/Exploitation	3	2	4	6	**15**
Total	**23**	**54**	**37**	**39**	**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.

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with The Joint Commission on in 2013 and is due for an upcoming reaccreditation visit in 2016. The hospital is currently completing its annual application for an accreditation visit in the fall of 2016.

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, 2016.

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 in 2016.

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 August 2015.

CONSENT DECREE

Recommendation from Court Master

February 9, 2016

Court Master Recommendation	Riverview Action
I recommend that Riverview implement unit based staffing on a pilot basis in one of the four units on or before April 4, 2016 with implementation on all other units to be completed on or before August 1, 2016.	The Upper Kennebec Unit moved to unit based staffing on April 4, 2016. The hospital has entered into a contract with Applied Management Services to assist in developing unit based/acuity based staffing models for the entire hospital. The contract has two components: first, an analysis of current staffing models and recommendations based on those findings and second installation of a software program that allows the hospital to monitor patient acuity and assign unit staff based on the acuity. Initial meetings with the vendor have occurred and the vendors software is being updated to work on State of Maine servers.
I recommend that the newly created positions for acuity specialists not be counted for purposes of determining compliance with the staffing ratios for mental health workers required by the Consent Decree. This change is designed to ensure that acuity specialists are assigned to their designated tasks and not used as substitutes for mental health workers	The Director of Nursing notified the staffing office of this change. Acuity Specialists are no longer counted for purposes of determining compliance with staffing ratios for mental health workers.
I recommend that an annual review of restrictive practices and the management system being used by the hospital be conducted by a fully independent consultant, with the report of the first review due on or before July 1, 2016. The scope of the review and the selection of the independent consultant to require the approval of the Court Master.	The hospital presented the Court Master with the name of a potential Vendor. After reviewing the proposal the Court Master declined permission and submitted the name of a consultant. The hospital is currently in negotiation with the proposed consultant.
I recommend that the mental health workers	Changes are in process to determine how to

who are most familiar with the patients be invited by the charge nurse on the unit to attend at least the initial portion of the treatment team meetings for those patients in order to provide input and observations, and that acuity specialists be invited to attend whenever it is deemed appropriate by the charge nurse. Current and relevant portions of the treatment plans, such as interventions, shall be maintained on the unit and reviewed with the charge nurse by the mental health workers assigned to those patients.	best use the knowledge of the mental health workers in the treatment team meetings. This is being reviewed and implemented on each unit in the hospital. Processes for ensuring that the most current treatment information is being made available to all staff on an ongoing basis.
I recommend that unit activity logs be maintained on each unit and that the logs be reviewed at least on a monthly basis to determine whether any limitation in a patient's access to treatment, services or outdoor areas has occurred.	Unit activity logs are maintained on each unit. Nurse educators are training staff on the required documentation regarding any limitations to treatment, services or outdoor activities.

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.

JOINT COMMISSION

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.

JOINT COMMISSION

Admissions Screening (HBIPS 1)

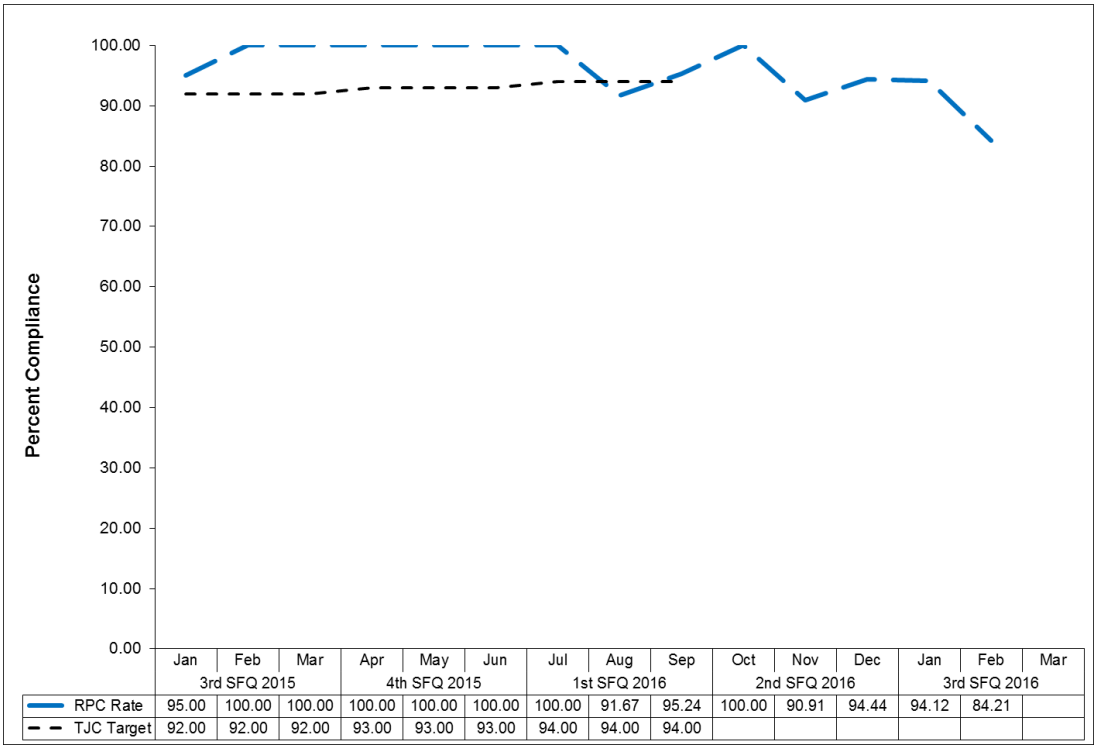
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

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.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
RPC Rate	95.00	100.00	100.00	100.00	100.00	100.00	100.00	91.67	95.24	100.00	90.91	94.44	94.12	84.21	
TJC Target	92.00	92.00	92.00	93.00	93.00	93.00	94.00	94.00	94.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

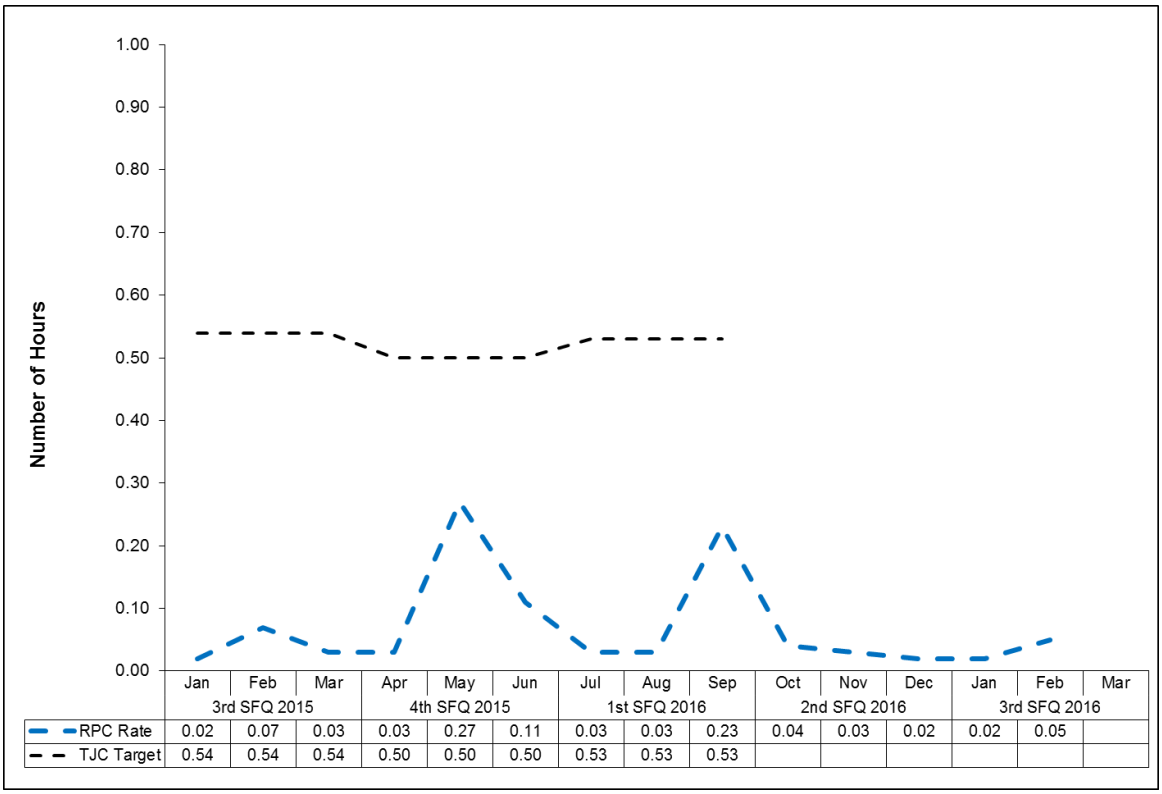
Hours of Use

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).



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
RPC Rate	0.02	0.07	0.03	0.03	0.27	0.11	0.03	0.03	0.23	0.04	0.03	0.02	0.02	0.05	
TJC Target	0.54	0.54	0.54	0.50	0.50	0.50	0.53	0.53	0.53						

JOINT COMMISSION

Seclusion (HBIPS 3)

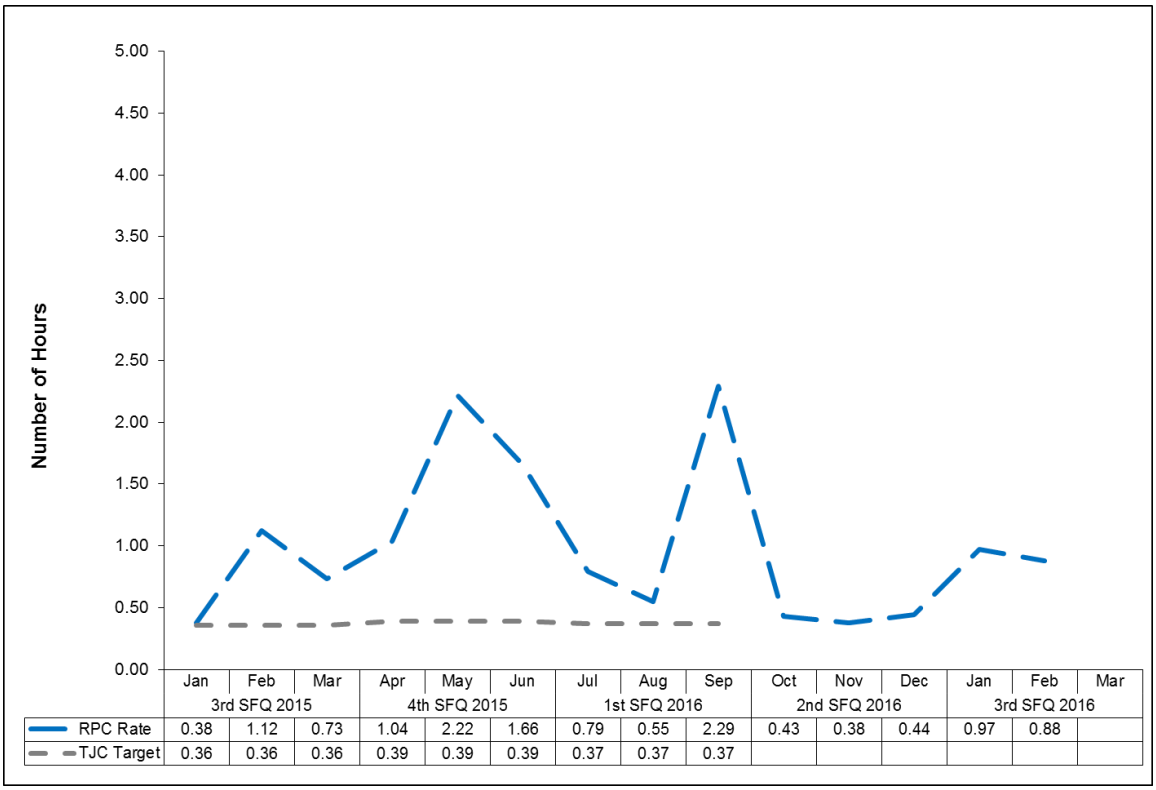
Hours of Use

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).



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
RPC Rate	0.38	1.12	0.73	1.04	2.22	1.66	0.79	0.55	2.29	0.43	0.38	0.44	0.97	0.88	
TJC Target	0.36	0.36	0.36	0.39	0.39	0.39	0.37	0.37	0.37						

JOINT COMMISSION

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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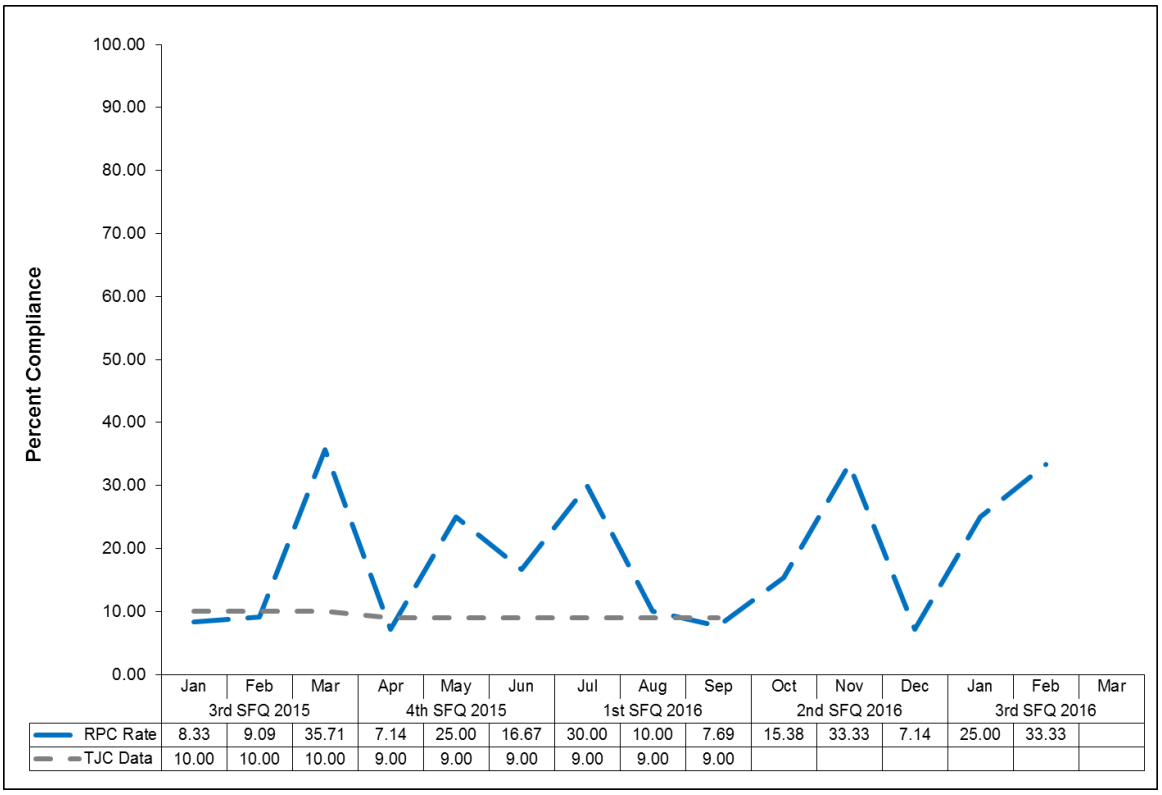
Multiple Antipsychotic Medications on Discharge (HBIPS 4)



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
RPC Rate	8.33	9.09	35.71	7.14	25.00	16.67	30.00	10.00	7.69	15.38	33.33	7.14	25.00	33.33	
TJC Data	10.00	10.00	10.00	9.00	9.00	9.00	9.00	9.00	9.00						

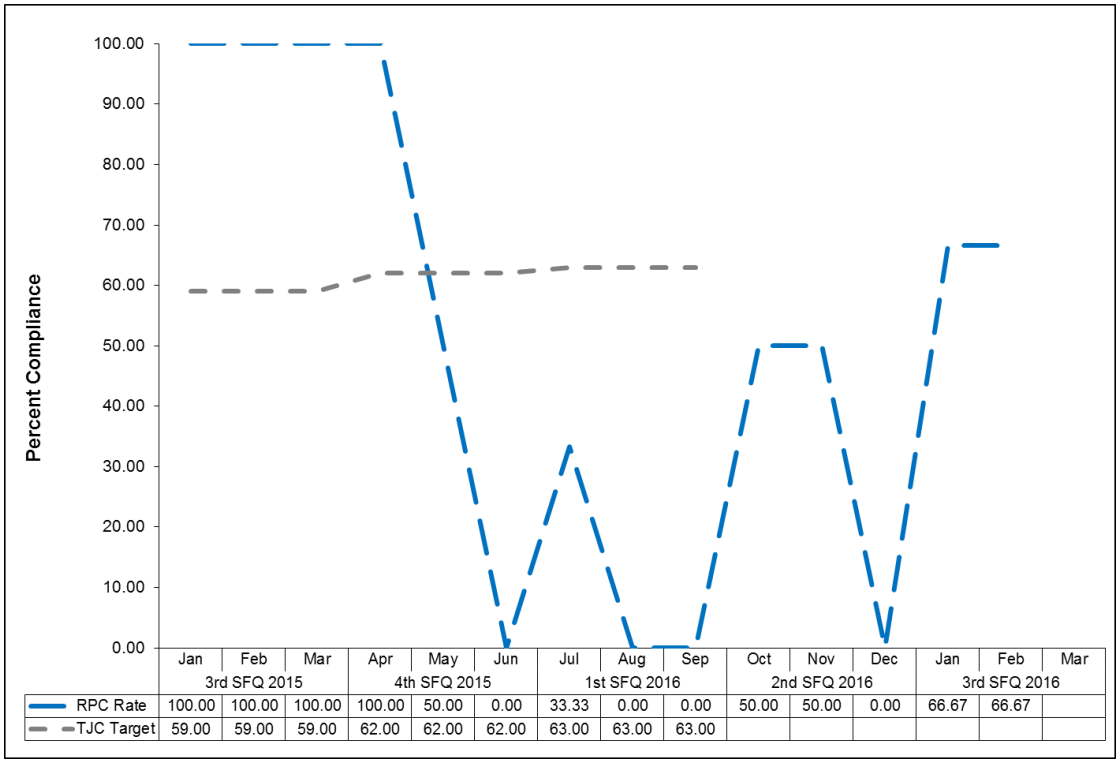
Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

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.

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



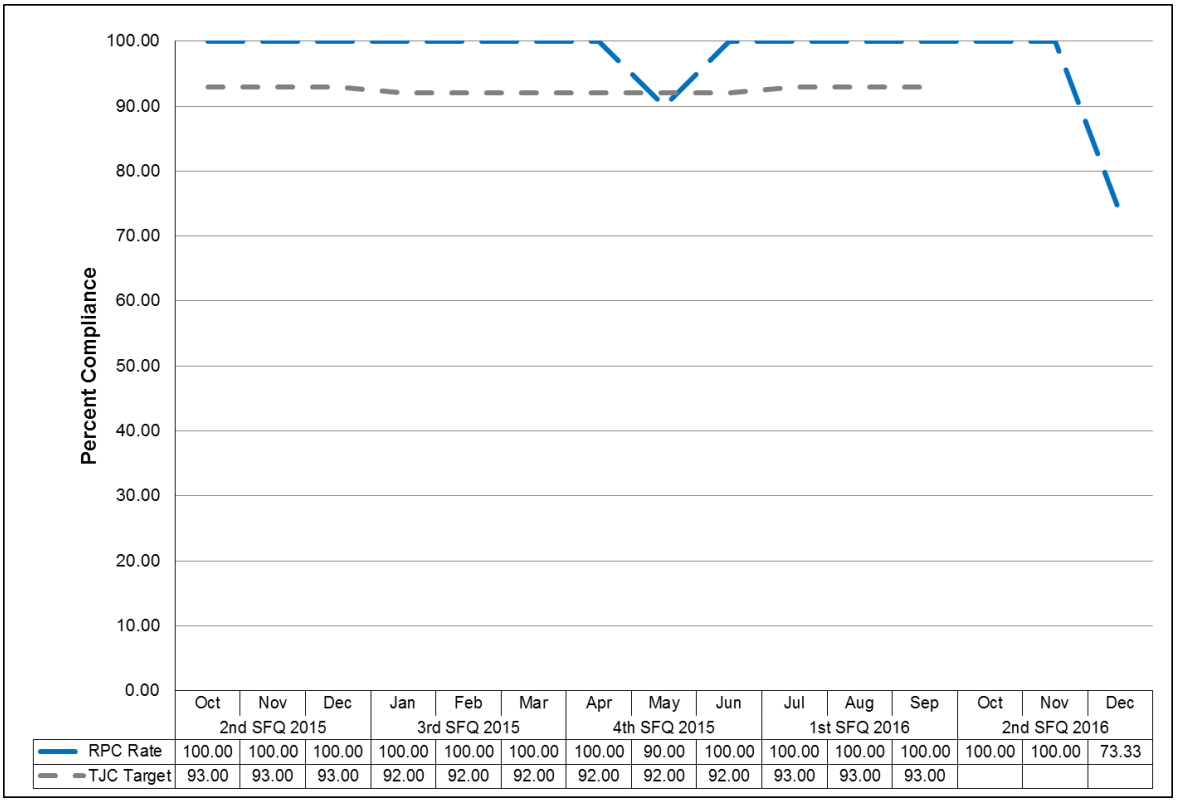
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
RPC Rate	100.00	100.00	100.00	100.00	50.00	0.00	33.33	0.00	0.00	50.00	50.00	0.00	66.67	66.67	
TJC Target	59.00	59.00	59.00	62.00	62.00	62.00	63.00	63.00	63.00						

JOINT COMMISSION

Post Discharge Continuing Care Plan (HBIPS 6)

Description
Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created.

Rationale
Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given the patient may not be available to the next level of care provider at the patient's initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the patient's treatment course during hospitalization, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AACP], 2001).



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
RPC Rate	100.00	100.00	100.00	100.00	100.00	100.00	100.00	90.00	100.00	100.00	100.00	100.00	100.00	100.00	73.33
TJC Target	93.00	93.00	93.00	92.00	92.00	92.00	92.00	92.00	92.00	93.00	93.00	93.00			

Note: The Joint Commission discontinued this measure effective 12/31/2015.

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

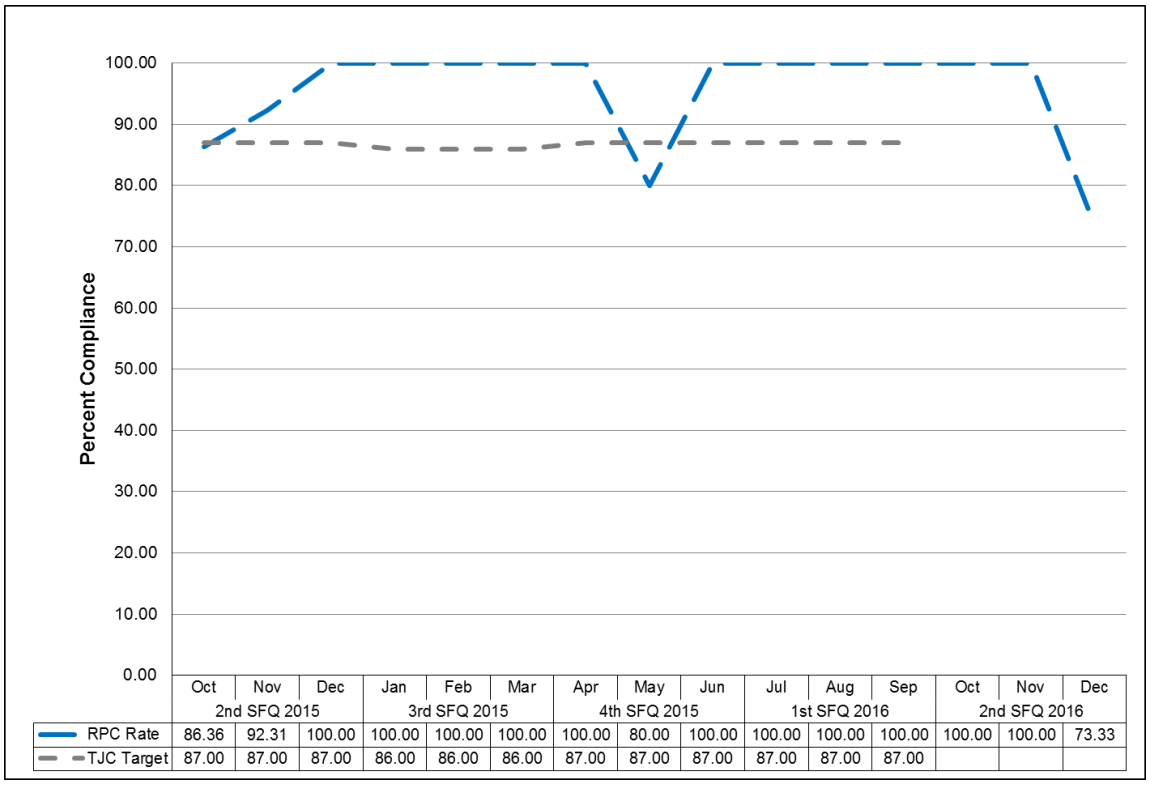
To Next Level of Care Provider on Discharge

Description

Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity.

Rationale

Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given the patient may not be available to the next level of care provider at the patient's initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the patient's treatment course during hospitalization, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AACP], 2001).



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
RPC Rate	86.36	92.31	100.00	100.00	100.00	100.00	100.00	80.00	100.00	100.00	100.00	100.00	100.00	100.00	73.33
TJC Target	87.00	87.00	87.00	86.00	86.00	86.00	87.00	87.00	87.00	87.00	87.00	87.00			

Note: The Joint Commission discontinued this measure effective 12/31/2015.

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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.

3Q2016 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Dr. William Nelson Clinical Director	All indicators met or exceeded standards.
Community Dental, Region II	Dr. William Nelson Clinical Director	All indicators met or exceeded standards.
Comprehensive Pharmacy Services	Dr. William Nelson 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.
Dartmouth Medical School	Jay Harper Superintendent	All indicators met standards.
Disability Rights Center	Jay Harper Superintendent	All indicators met standards.
G & E Roofing	Richard Levesque Director of Support Services	Indicator exceeded standards.
Goodspeed & O'Donnell	Dr. William Nelson Clinical Director	No services were provided during this timeframe.
Liberty Healthcare – After Hours Coverage	Dr. William Nelson Clinical Director	All indicators exceeded standards.
Liberty Healthcare – Physician Staffing	Dr. William Nelson Clinical Director	All indicators met standards.
Main Security Surveillance	Richard Levesque Director of Support Services	All indicators met standards.
Maine General Community Care/HealthReach	Dr. William Nelson Clinical Director	All indicators met standards.
Maine General Medical Center – Laboratory Services	Dr. William Nelson 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	No services were provided during this timeframe.
Medical Staffing and Services of Maine	Dr. William Nelson Clinical Director	All indicators met standards.
Motivational Services	Dr. William Nelson Clinical director	All indicators met or exceeded 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 met standards.
Pine Tree Legal Assistance	Dr. William Nelson Clinical Director	No services were provided during this timeframe.
Project Staffing	Cindy Michaud Business Services Manager	All indicators met or exceeded standards.
Protection One	Richard Levesque Director of Support Services	Indicator met standards.
Securitas Security Services	Philip Tricarico Safety Compliance Officer	All indicators met or exceeded standards.
UniFirst Corporation	Richard Levesque Director of Support Services	One indicator did not meet standards: The provider will submit monthly infection control measures reports. All other indicators met standards.
Waste Management	Debora Proctor Executive Housekeeper	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	4Q2015	1Q2016	2Q2016	3Q2016	Total
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.	**April** 100% 3/3 **May** N/A 0/0 **June** 100% 1/1 **Total** 100% 4/4	**July** 100% 3/3 **Aug** N/A 0/0 **Sept** N/A 0/0 **Total** 100% 3/3	**Oct** 100% 2/2 **Nov** 100% 1/1 **Dec** 100% 1/1 **Total** 100% 4/4	**Jan** 100% 5/5 **Feb** 100% 3/3 **Mar** N/A 0/0 **Total** 8/8	**100%** **19/19**

JOINT COMMISSION

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	4Q2015	1Q2016	2Q2016	3Q2016	Total
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. 3. 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	**April** 100% 3/3 **May** N/A 0/0 **June** 100% 1/1 **Total** 100% 4/4	**July** 100% 3/3 **Aug** N/A 0/0 **Sept** N/A 0/0 **Total** 100% 3/3	**Oct** 100% 2/2 **Nov** 100% 1/1 **Dec** 100% 1/1 **Total** 100% 4/4	**Jan** 100% 5/5 **Feb** 100% 3/3 **Mar** N/A 0/0 **Total** 8/8	**100%** **19/19**

JOINT COMMISSION

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**	**4Q2015**	**1Q2016**	**2Q2016**	**3Q2016**	**YTD**
Within 1 STDV of the Mean	Hospital Associated Infection Rate	FY 2014 1 STDV within the mean	4 HAI/IC Rate 0.83	12 HAI/IC Rate 1.4	7 HAI/IC Rate 1	11 HAI/IC Rate 1.2	HAI/IC 1.11
Actual Outcome			1 STDV within the mean	1 STDV within the mean	At 1 STDV	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) 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.

Infections:

Lower Kennebec:
Skin Infection (HAI)
Fungal Infection (POA)

Lower Kennebec SCU:
Urinary Tract Infection (HAI)
Urinary Tract Infection (HAI)

Lower Saco:
Chronic Sinusitis/Bronchitis (HAI)
Fungal Dermatitis (HAI)
Dental Abscess (POA)

Lower Saco SCU:
Cellulitis Leg and Toe (POA)
Foot Ulcer (HAI)

Upper Saco:
Erysipelas (HAI)

Upper Kennebec:
Otitis External (HAI)
Bacterial Vaginitis (HAI)
Ingrown Toenail (HAI)
Urinary Tract Infection (HAI)

Data Analysis:
Total Infections: 14
HAI: 11
POA: 3
Idiosyncratic Infections: 0

Plan: Ongoing surveillance

JOINT COMMISSION

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 **7-3 shift.**
- Staff will do ten (10) hand hygiene observations per month (before & after patient contact) in the milieu on the **3-11 shift**

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Employee Hand Hygiene Compliance	80% FY 2015	>90%	>90%	>90%	>90%	**>90%**
Actual			95%	No data available	42%		**69%**

Data:

Upper Saco Meds – no data
Upper Saco Milieu 7-3 – no data
Upper Saco Milieu 3-11 – no data

Upper Kennebec Meds –100%
Upper Kennebec Milieu 7-3 – 100%
Upper Kennebec Milieu 3-11 – 100%

Lower Kennebec Meds – 33%
Lower Kennebec Milieu 7-3 – 33%
Lower Kennebec Milieu 3-11 –no data

Lower Saco Meds – 50%
Lower Saco Milieu 7-3 –33%
Lower Saco Milieu 3-11 – 50%

Plan: Continue to monitor and measure.

JOINT COMMISSION

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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Employee Hand Hygiene Compliance	98% FY 2015	>90%	>90%	>90%	>90%	**>90%**
Actual			95%	No data available	81%		**88%**

Data:
The mean compliance rate for January 2016 is 78%.
The mean compliance rate for February 2016 is 97%.
The mean compliance rate for March 2016 is 67%.

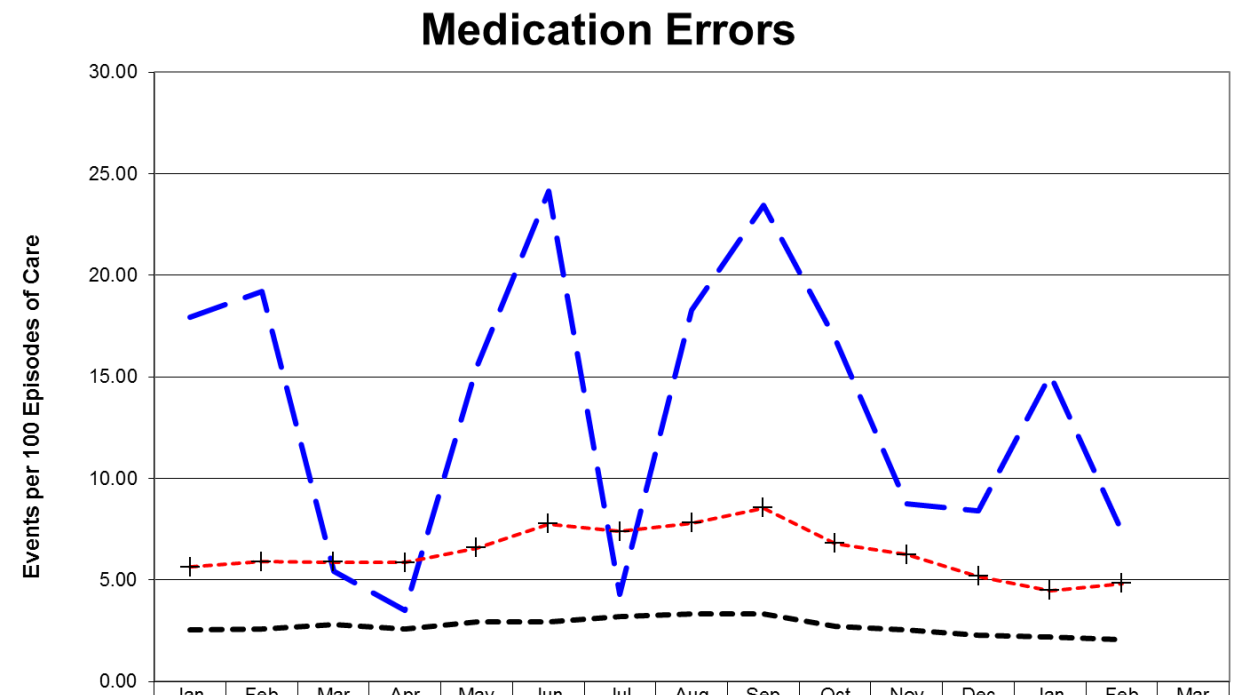
Plan: Continue to monitor and measure.

JOINT COMMISSION

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)



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	17.92	19.23	5.43	3.49	15.48	24.14	4.30	18.27	23.47	16.83	8.74	8.41	15.09	7.34	
Ntl Mean	2.54	2.60	2.80	2.59	2.92	2.94	3.19	3.32	3.34	2.72	2.54	2.30	2.19	2.07	
+1 StDev	5.63	5.91	5.88	5.86	6.59	7.77	7.38	7.80	8.54	6.80	6.26	5.17	4.49	4.84	

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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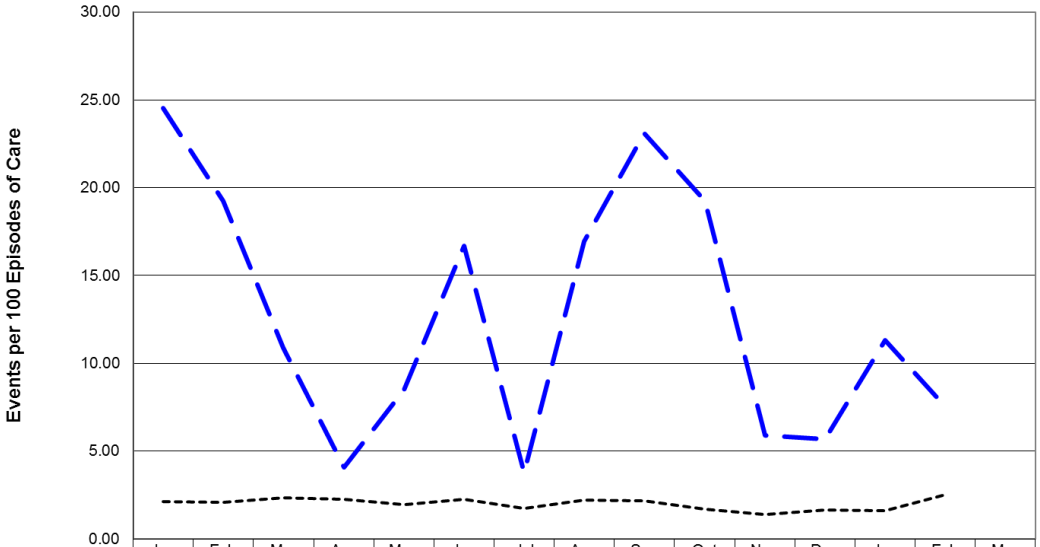
Medication Errors

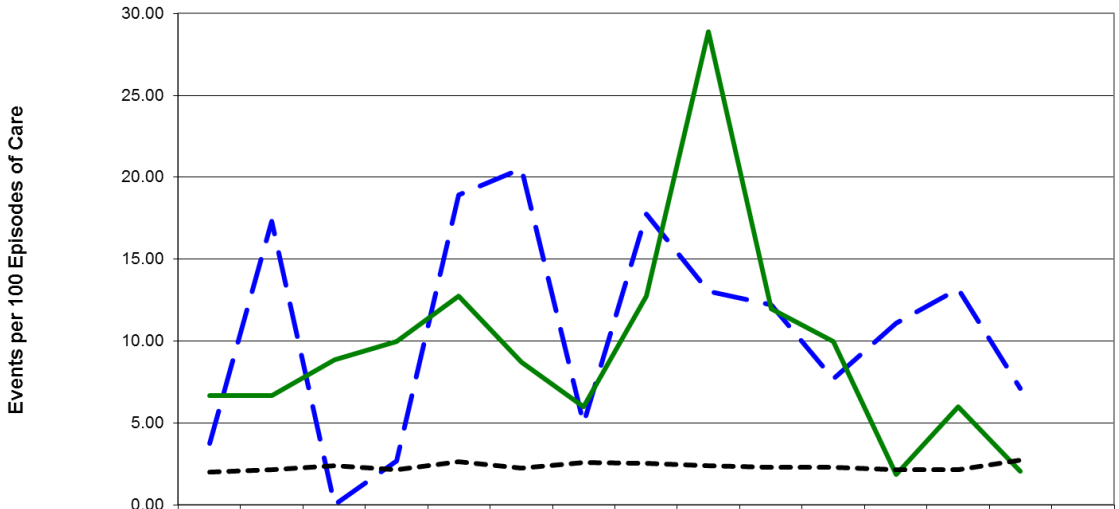
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	24.53	19.23	10.87	4.08	8.51	16.67	3.77	16.95	23.08	19.23	5.88	5.66	11.32	7.55	
Ntl Mean	2.13	2.09	2.33	2.25	1.97	2.25	1.74	2.20	2.18	1.69	1.38	1.63	1.60	2.51	

Medication Errors

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	3.77	17.31	0.00	2.70	18.92	20.51	5.00	17.78	13.04	12.24	7.69	11.11	13.21	7.14	
Dorothea Dix	6.67	6.67	8.89	10.00	12.77	8.70	6.00	12.77	28.89	12.00	10.00	1.85	6.00	2.04	
Ntl Mean	2.03	2.14	2.42	2.18	2.64	2.27	2.58	2.55	2.41	2.32	2.33	2.17	2.14	2.74	

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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.

JOINT COMMISSION

Administration Process

Medication Errors Related to Staffing Effectiveness

Date	Omit	Type of Error	Float	New	O/T	Unit	Staff Mix		
							RN	LPN	MHW
1/4/2016	N	WRONG TIME X1/PYXIS ERROR	N	N	N	UK	2	1	4
1/6/2016	N	WRONG TIME X1/GIVEN EARLY	Y	N	N	LSS	3	0	6
1/8/2016	Y	OMISSON X3	Y	N	N	LKM			
1/8/2016	N	EXTRA DOSE X1/NO CURRENT ORDER	N	N	N	US	3	1	5
1/15/2016	N	EXTRA DOSE X1/NO CURRENT ORDER	N	N	N	LSS	4	1	9
1/15/2016	N	EXTRA DOSE X1/NO CURRENT ORDER	N	N	N	US	3	1	5
1/15/2016	N	WRONG TIME/GIVEN LATE	N	N	Y	LKM	2	0	5
1/15/2016	N	WRONG TIME/GIVEN LATE	N	N	Y	LKM	2	0	5
1/16/2016	N	EXTRA DOSE X4/EXPIRED ORDER	N	N	N	UK	3	0	4
1/19/2016	Y	OMISSION X1	N	N	N	LKS	2	1	6
1/21/2016	Y	OMISSION X7	N	N	N	US	2	0	7
1/23/2016	N	EXTRA DOSE X 1	N	N	N	LSS	2	1	8
1/29/2016	Y	OMISSION X3	N	N	N	LKM	3	0	7
2/9/2016	N	WRONG TIME X1	Y	N	N	LKM	3	1	6
2/9/2016	Y	OMISSION X1	N	N	N	LKM	3	1	6
2/10/2016	N	WRONG TIME X5	N	N	N	LKSC			
2/11/2016	Y	OMISSION X1	Y	N	N	UK	3	1	4
2/15/2016	Y	OMISSION X5	Y	N	N	LSS	3	1	7
2/17/2016	Y	OMISSION X1	Y	N	N	LSS	3	1	8
2/20/2016	Y	OMISSON X1	N	N	N	LKS	**3**	1	7
2/23/2016	N	EXTRA DOSE X4/NO CURRENT ORDER	N	N	N	US	3	0	4
3/1/2016	N	WRONG TIME X1/GIVEN EARLY	N	N	N	LSM	2	0	4
3/9/2016	Y	OMISSION X1/IM BACKUP NOT GIVEN	N	N	N	UK	2	1	3
3/16/2016	N	WRONG DOSE X1	Y	N	N	LKM	4	0	7
3/18/2016	N	EXTRA DOSE X43/NO CURRENT ORDER	N	N	N	LSS	3	2	4

JOINT COMMISSION

3/22/2016	N	WRONG DOSE X1	N	N	N	LSS	3	1	4
3/23/2016	Y	OMISSION X2	N	N	N	UK	2	1	4
3/25/2016	N	EXTRA DOSE X2	N	Y	N	LSS	3	1	7
Totals	**26**		**13**	**2**	**2**	**LS: 56**	**US: 13**	**LK: 18**	**UK: 9**
Percent	**27%**	**96 Total Errors**	**14%**	**2%**	**2%**	**58%**	**14%**	**19%**	**9%**

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

Type of Error	**# of Errors**
Extra Dose	57
Omission	26
Wrong Dose	2
Wrong Time	11
Total	**96**

JOINT COMMISSION

Dispensing Process

Measure	Unit	Baseline 2015	Goal	4Q 2015	1Q 2015	2Q 2016	3Q 2016
1. Controlled Substance Loss Data: Daily Pyxis-CII Safe Compare Report.	All	0.19%	Target: Actual:	0% 0%	0% 0%	0% 0%	0% 0%
2. Controlled Substance Loss Data: Monthly CII Safe Vendor Receipt Report.	Rx	0 month	Target: Actual:	0 0	0 0	0 0	0 0
3. Controlled Substance Loss Data: Monthly Pyxis Controlled Drug discrepancies.	All	0 month	Target: Actual:	0 0	0 0	0 0	0 0
4. Medication Management Monitoring: Measures of drug reactions, adverse drug events and other management data.	Rx	8 year	Target: Actual:	0 3	0 0	0 0	0 1
5. Medication Management Monitoring: Resource Documentation Reports of Clinical Interventions.	Rx	99 Quarter/ 0 month	Target: Actual:	100% 56	100% 31	100% 144	100% 128
6. Psychiatric Emergency Process: Monthly audit of all psych emergencies measures against 9 criteria.	All	100%	Target: Actual:	100% 94%	100% 78%	100% 98%	100% 90%
7. Operational Audit: Monthly audit of 3 operational indicators from CPS contract.	Rx	100%	Target: Actual:	100% 100%	100% 100%	100% 100%	100% 100%

Note: Previous figures for Criteria #3 were reported on the number of discrepancies discovered in Pyxis. This number is not reflective of the number of controlled substances lost, but rather the number of times a simple mistake, such as a miscount, occurred. To ensure accuracy pharmacy staff reviewed past logs of controlled substances and found no substances unaccounted for.

JOINT COMMISSION

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:

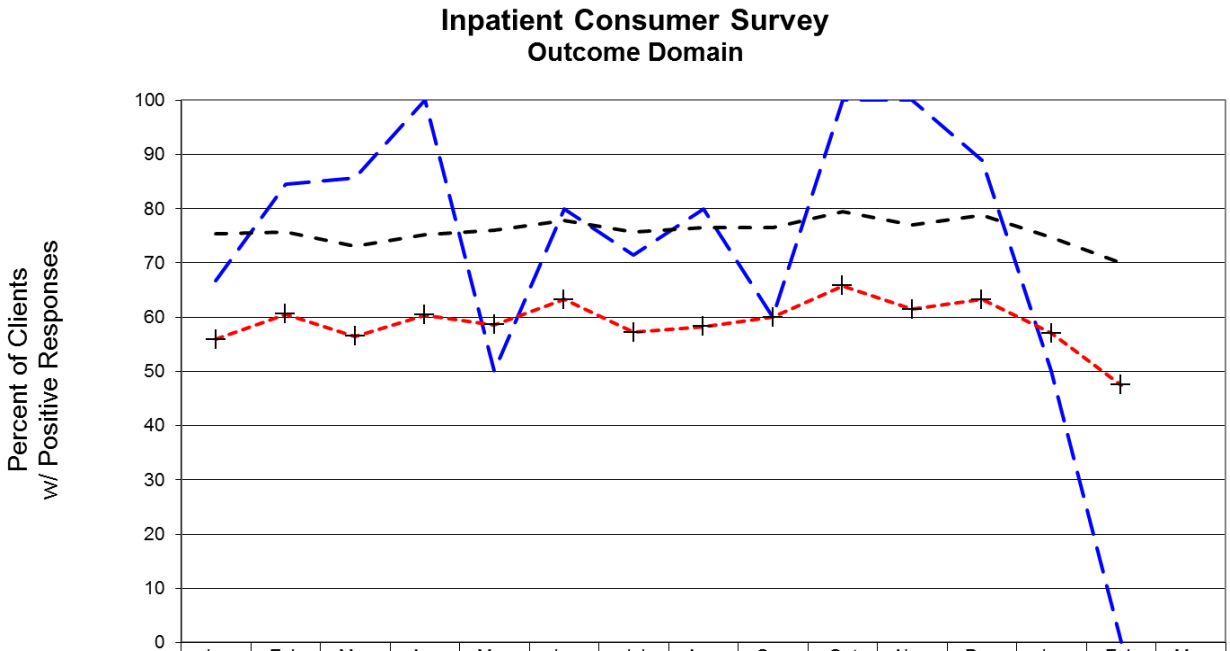
Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic patients, the process of administering the inpatient survey is difficult to administer. Whenever possible, Peer Support staff work to gather information from patients 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



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	66.67	84.62	85.71	100.00	50.00	80.00	71.43	80.00	60.00	100.00	100.00	88.89	50.00	0.00	
Ntl Mean	75.41	75.65	73.03	75.17	76.02	77.79	75.64	76.51	76.58	79.42	77.05	78.80	74.67	69.98	
- 1 StDev	55.90	60.56	56.49	60.44	58.59	63.30	57.20	58.28	60.00	65.78	61.46	63.23	57.09	47.53	

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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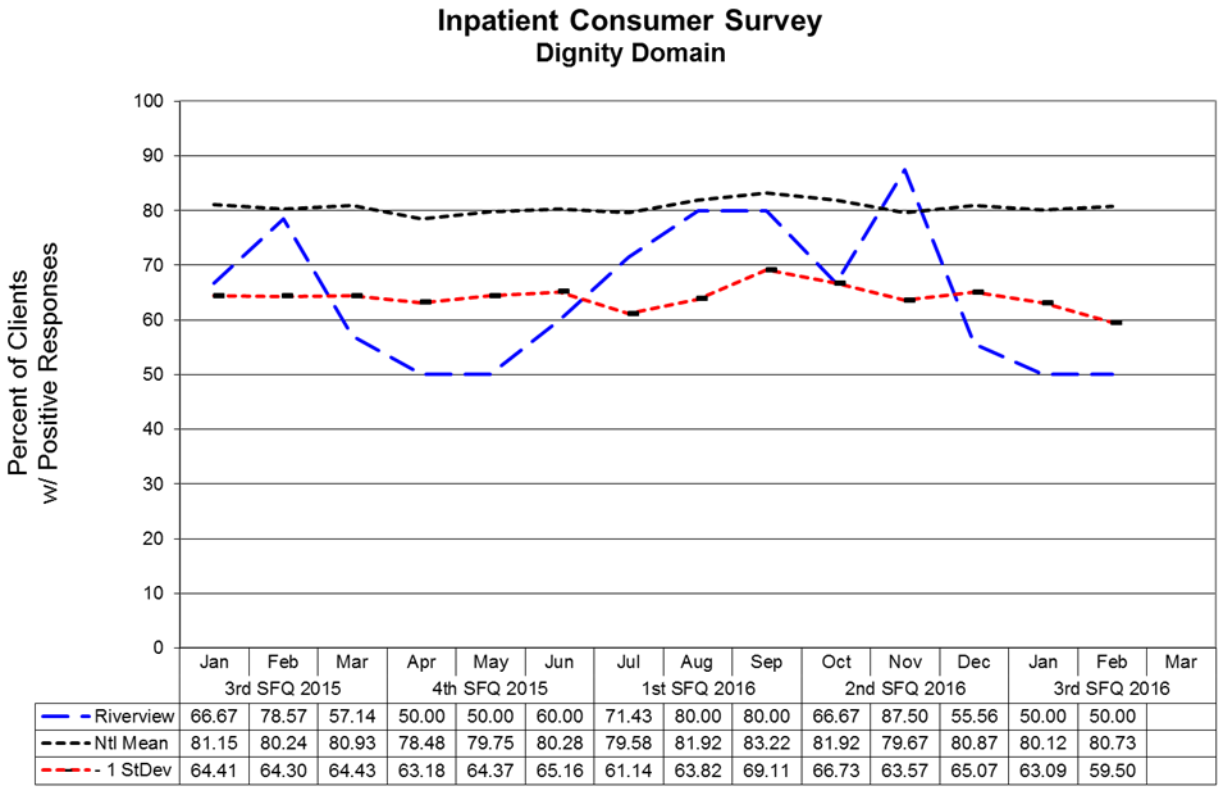

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	66.67	78.57	57.14	50.00	50.00	60.00	71.43	80.00	80.00	66.67	87.50	55.56	50.00	50.00	
Ntl Mean	81.15	80.24	80.93	78.48	79.75	80.28	79.58	81.92	83.22	81.92	79.67	80.87	80.12	80.73	
1 StDev	64.41	64.30	64.43	63.18	64.37	65.16	61.14	63.82	69.11	66.73	63.57	65.07	63.09	59.50	

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.

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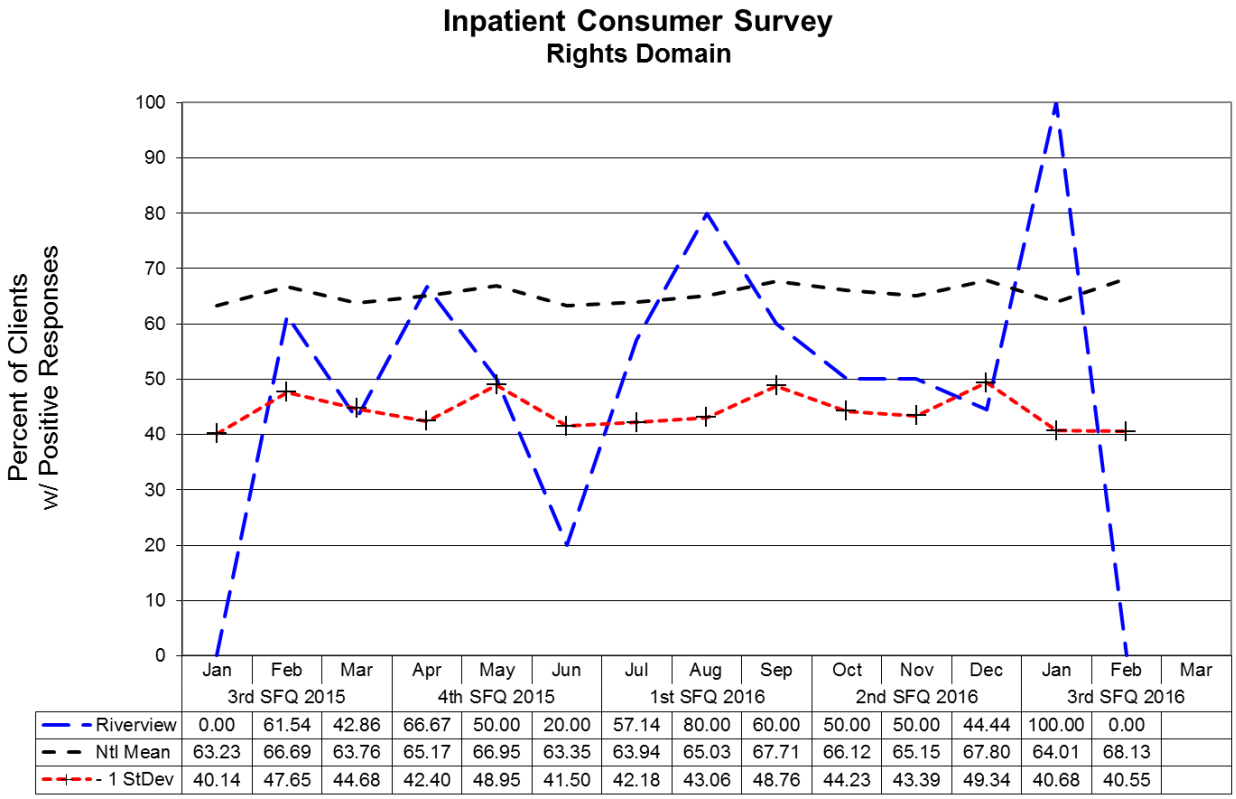
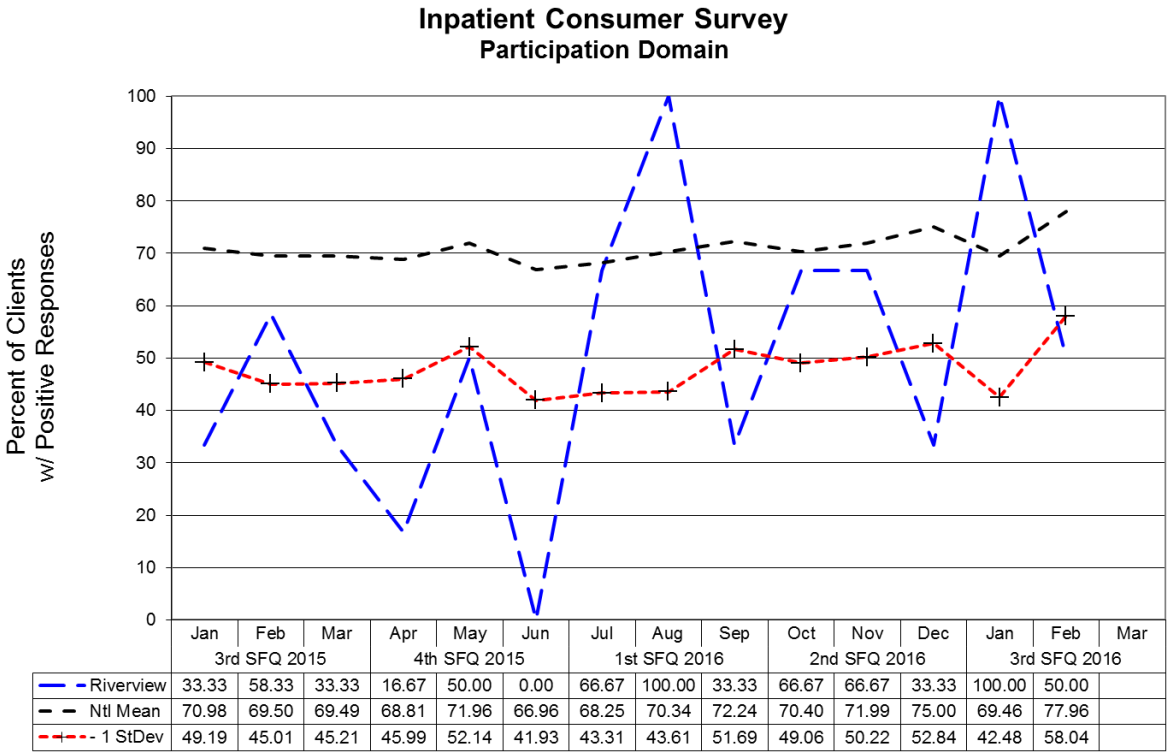


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	0.00	61.54	42.86	66.67	50.00	20.00	57.14	80.00	60.00	50.00	50.00	44.44	100.00	0.00	
Ntl Mean	63.23	66.69	63.76	65.17	66.95	63.35	63.94	65.03	67.71	66.12	65.15	67.80	64.01	68.13	
1 StDev	40.14	47.65	44.68	42.40	48.95	41.50	42.18	43.06	48.76	44.23	43.39	49.34	40.68	40.55	

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.

JOINT COMMISSION



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	33.33	58.33	33.33	16.67	50.00	0.00	66.67	100.00	33.33	66.67	66.67	33.33	100.00	50.00	
Ntl Mean	70.98	69.50	69.49	68.81	71.96	66.96	68.25	70.34	72.24	70.40	71.99	75.00	69.46	77.96	
1 StDev	49.19	45.01	45.21	45.99	52.14	41.93	43.31	43.61	51.69	49.06	50.22	52.84	42.48	58.04	

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.

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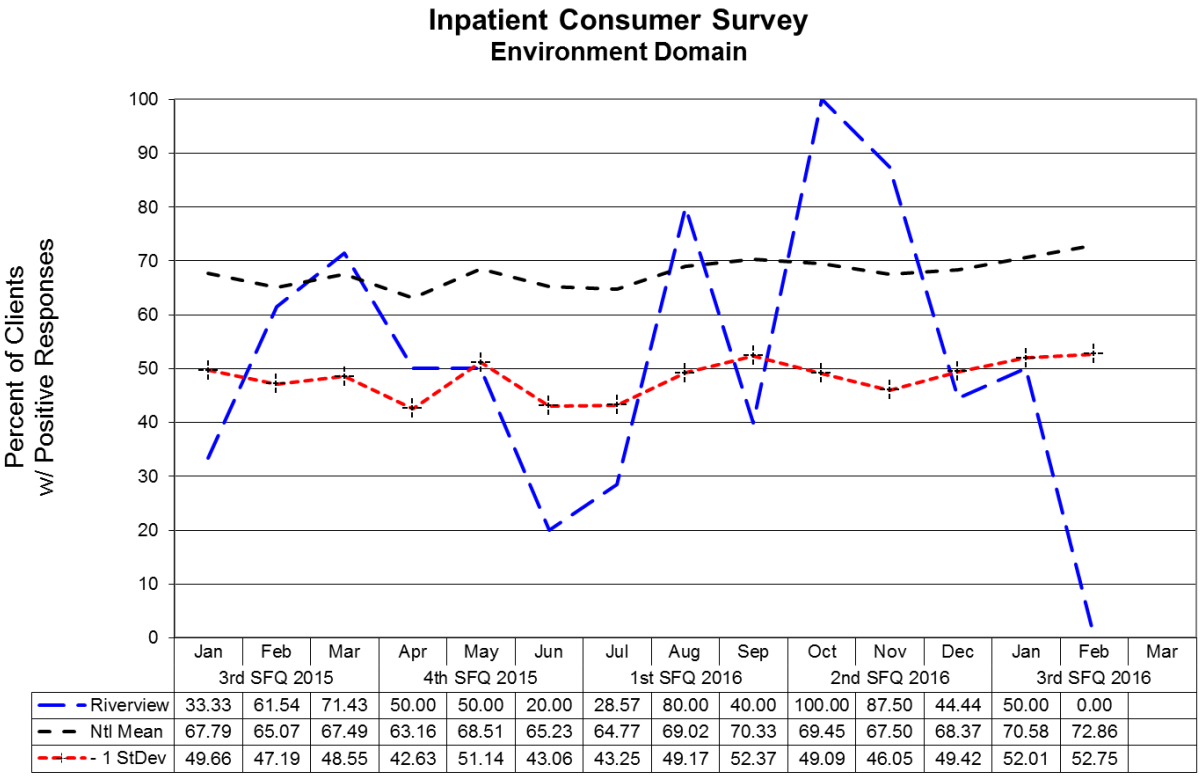

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	33.33	61.54	71.43	50.00	50.00	20.00	28.57	80.00	40.00	100.00	87.50	44.44	50.00	0.00	
Ntl Mean	67.79	65.07	67.49	63.16	68.51	65.23	64.77	69.02	70.33	69.45	67.50	68.37	70.58	72.86	
1 StDev	49.66	47.19	48.55	42.63	51.14	43.06	43.25	49.17	52.37	49.09	46.05	49.42	52.01	52.75	

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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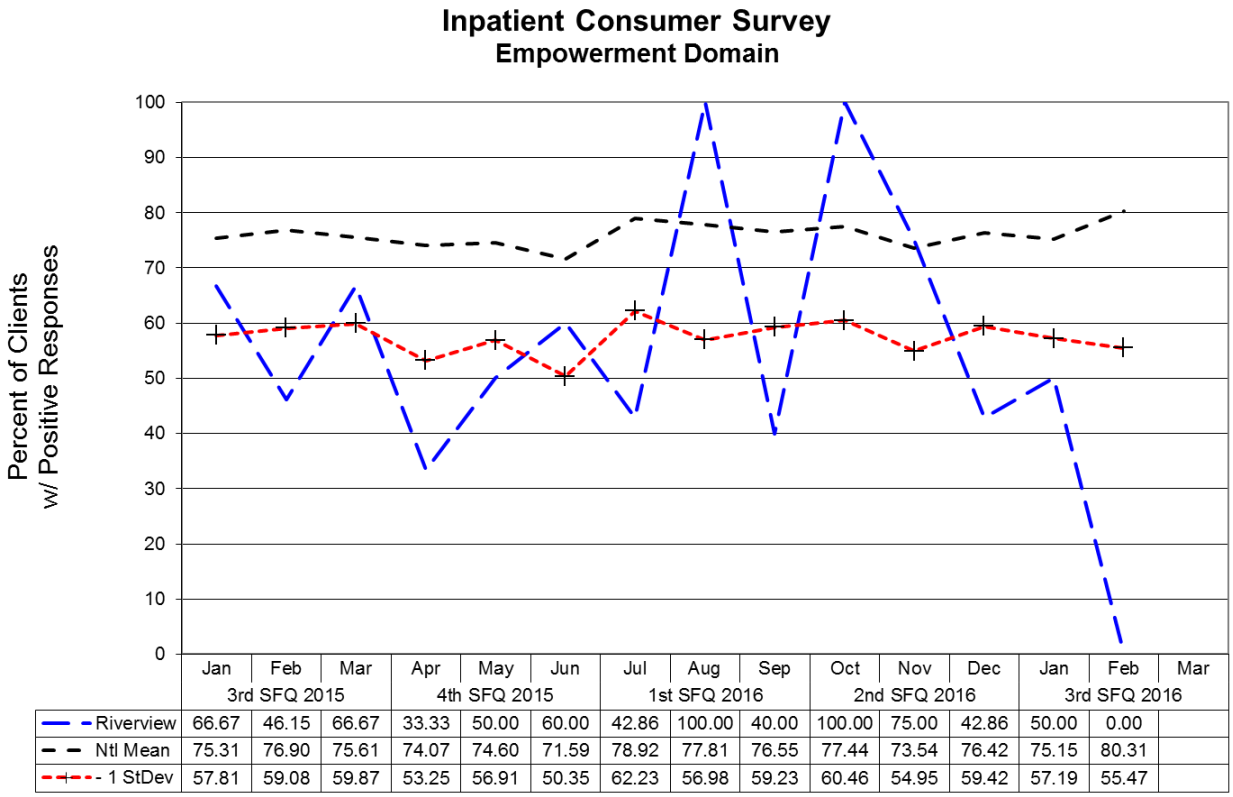


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016		
Riverview	66.67	46.15	66.67	33.33	50.00	60.00	42.86	100.00	40.00	100.00	75.00	42.86	50.00	0.00	
Ntl Mean	75.31	76.90	75.61	74.07	74.60	71.59	78.92	77.81	76.55	77.44	73.54	76.42	75.15	80.31	
- 1 StDev	57.81	59.08	59.87	53.25	56.91	50.35	62.23	56.98	59.23	60.46	54.95	59.42	57.19	55.47	

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.

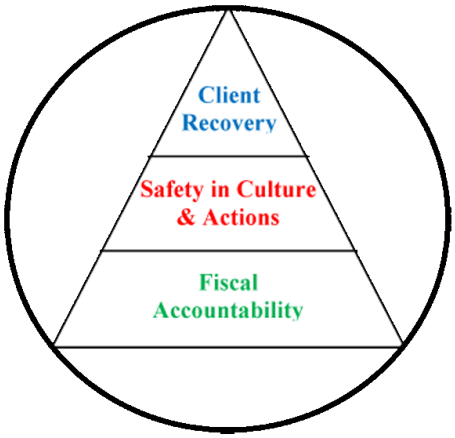
Type of Fall by Patient and Month:

Fall Type	Patient	Jan	Feb	Mar	Total
Unwitnessed	MR4647			1	**1**
	MR5984		1		**1**
	MR6963		1		**1**
	MR7375			1	**1**
	MR7837			1	**1**
	MR7847	1			**1**
	MR7852		1		**1**
	Totals	**1**	**3**	**3**	**7**
Fall Type	**Patient**	**Jan**	**Feb**	**Mar**	**Total**
Witnessed	MR113	2		1	3
	MR83		1		1
	MR635		1		1
	MR728		1		1
	MR6701		1		1
	MR6799	1			1
	MR7231		1		1
	MR7468			1	1
	MR7509	1			1
	MR7744	1			1
	Totals	**5**	**5**	**2**	**12**

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.

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

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

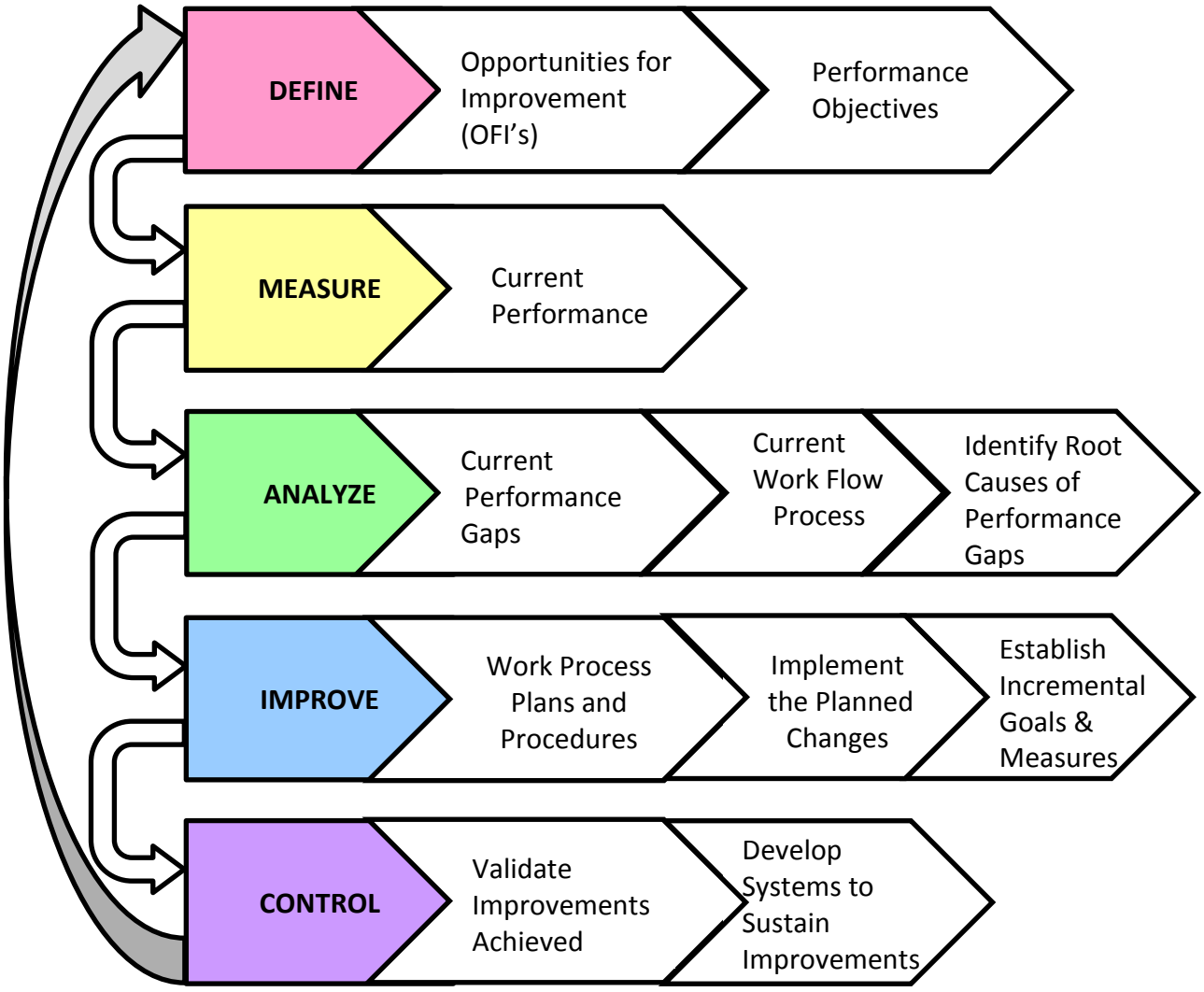
Enhance Patient Recovery by…
Develop Active Treatment Programs and Options for Patients
Supporting patients in their discovery of personal coping and improvement activities.

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

STRATEGIC PERFORMANCE EXCELLENCE

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

The Quarterly Report Consists of the Following:



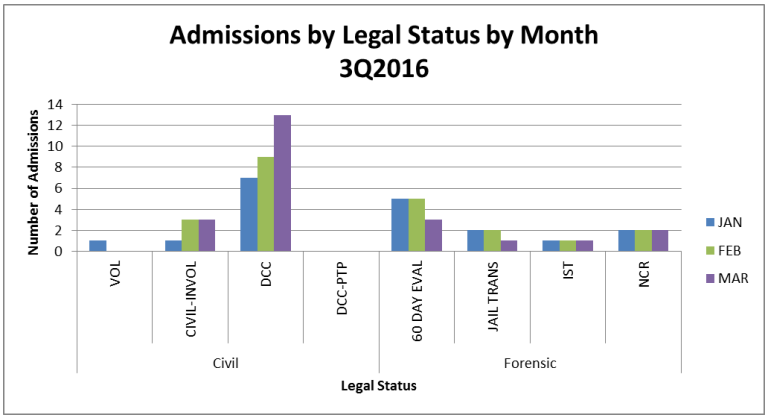
STRATEGIC PERFORMANCE EXCELLENCE

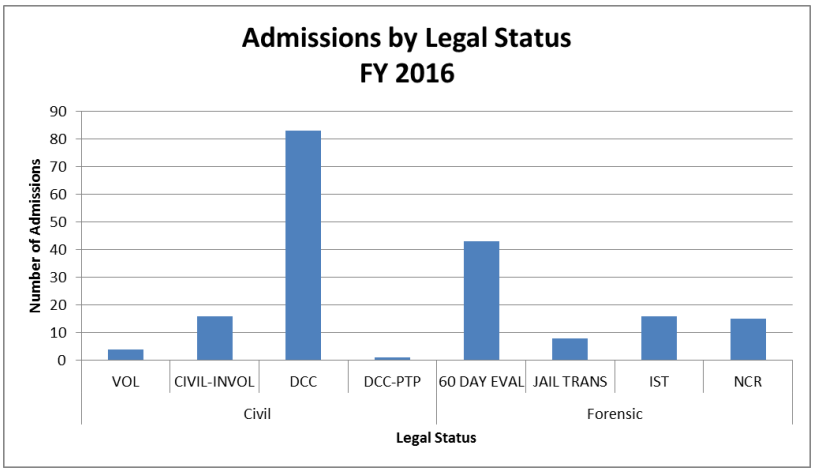
Admissions

Responsible Party: Jamie Meader, RN, Admissions Nurse

Number of Admissions:

ADMISSIONS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**7**	**13**	**10**	**15**	**14**	**8**	**9**	**12**	**16**				**104**
VOL	0	1	1	0	1	0	1	0	0				**4**
CIVIL-INVOL	0	2	2	1	4	0	1	3	3				**16**
DCC	7	9	7	14	9	8	7	9	13				**83**
DCC-PTP	0	1	0	0	0	0	0	0	0				**1**
FORENSIC:	**10**	**16**	**8**	**8**	**5**	**8**	**10**	**10**	**7**				**82**
60 DAY EVAL	8	8	3	2	2	7	5	5	3				**43**
JAIL TRANS	0	0	2	1	0	0	2	2	1				**8**
IST	0	4	2	3	3	1	1	1	1				**16**
NCR	2	4	1	2	0	0	2	2	2				**15**
TOTAL	**17**	**29**	**18**	**23**	**19**	**16**	**19**	**22**	**23**				**186**





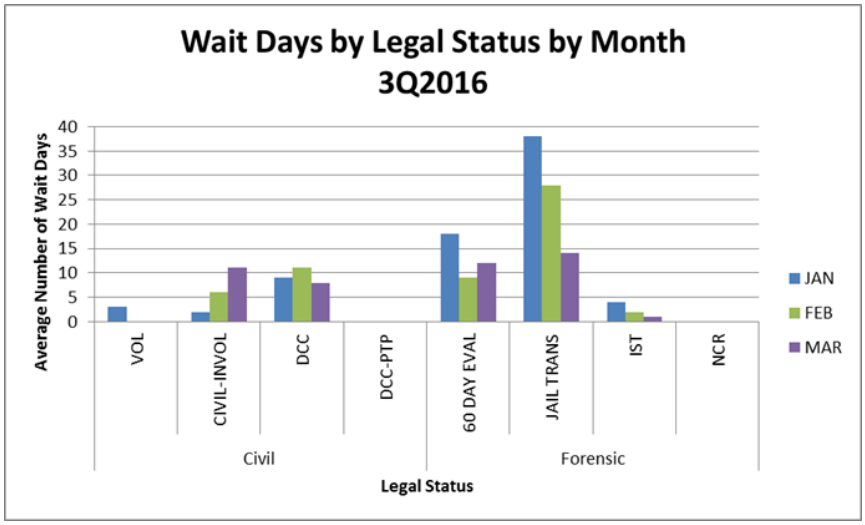
(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

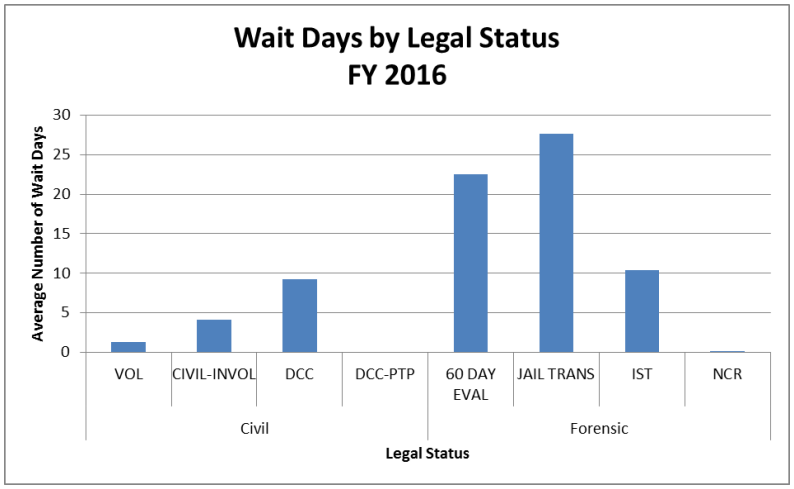
STRATEGIC PERFORMANCE EXCELLENCE

Average Number of Wait Days:

WAIT DAYS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**15**	**13**	**8**	**7**	**4**	**11**	**8**	**5**	**8**				**9**
VOL		1	1		0		3						**1**
CIVIL-INVOL		5	3	0	2		2	6	11				**4**
DCC	15	7	10	7	5	11	9	11	8				**9**
DCC-PTP		0											**0**
FORENSIC:	**53**	**18**	**19**	**15**	**14**	**22**	**17**	**10**	**7**				**19**
60 DAY EVAL	66	25	9	24	17		18	9	12				**23**
JAIL TRANS			46	12			38	28	14				**28**
IST		20	15	19	12		4	2	1				**10**
NCR	0	0	1	0			0	0	0				**0**
AVERAGE	**37**	**12**	**13**	**10**	**6**	**16**	**13**	**10**	**8**				**14**

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



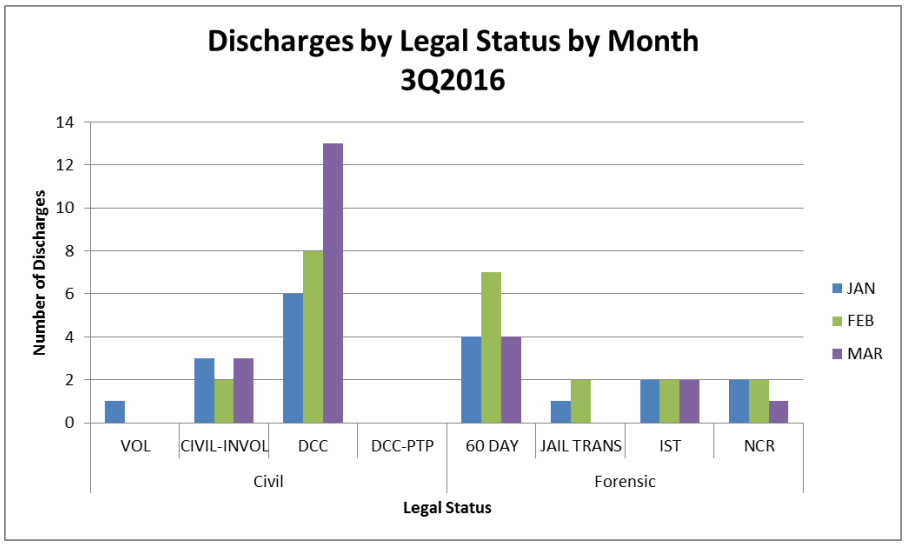


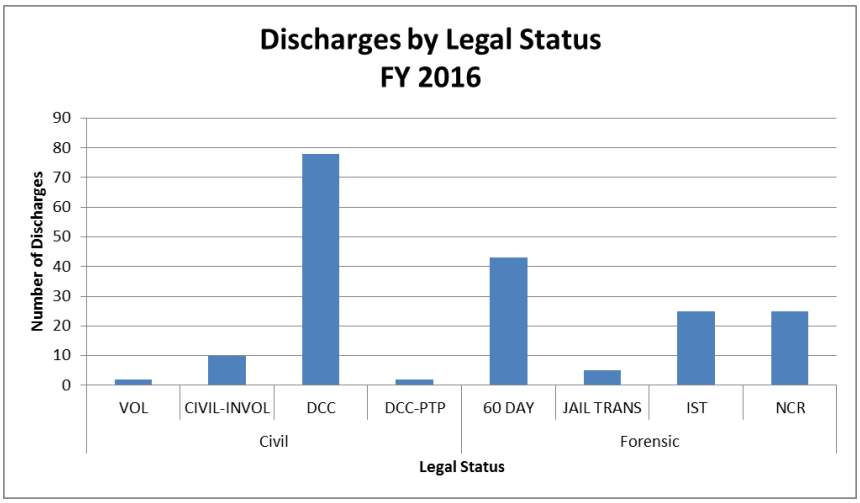
(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

STRATEGIC PERFORMANCE EXCELLENCE

Number of Discharges:

DISCHARGES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**8**	**8**	**11**	**11**	**6**	**12**	**10**	**10**	**16**				**92**
VOL	0	0	0	0	0	1	1	0	0				**2**
CIVIL-INVOL	1	0	0	1	0	0	3	2	3				**10**
DCC	6	8	11	9	6	11	6	8	13				**78**
DCC-PTP	1	0	0	1	0	0	0	0	0				**2**
FORENSIC:	**10**	**16**	**10**	**6**	**6**	**9**	**9**	**13**	**7**				**86**
60 DAY	3	10	5	3	3	4	4	7	4				**43**
JAIL TRANS	0	0	1	0	0	1	1	2	0				**5**
IST	5	5	4	1	2	2	2	2	2				**25**
NCR	2	1	0	2	13	2	2	2	1				**25**
TOTAL	**18**	**24**	**21**	**17**	**12**	**21**	**19**	**23**	**23**				**178**

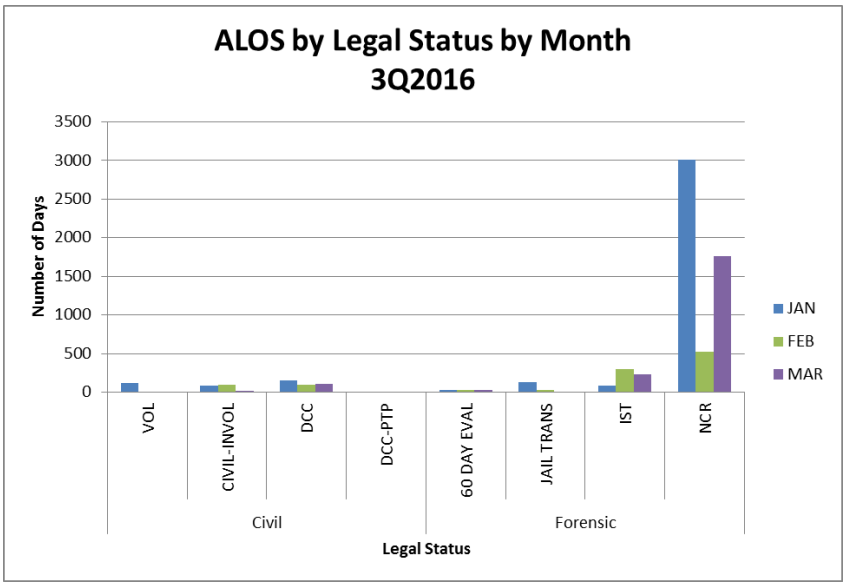


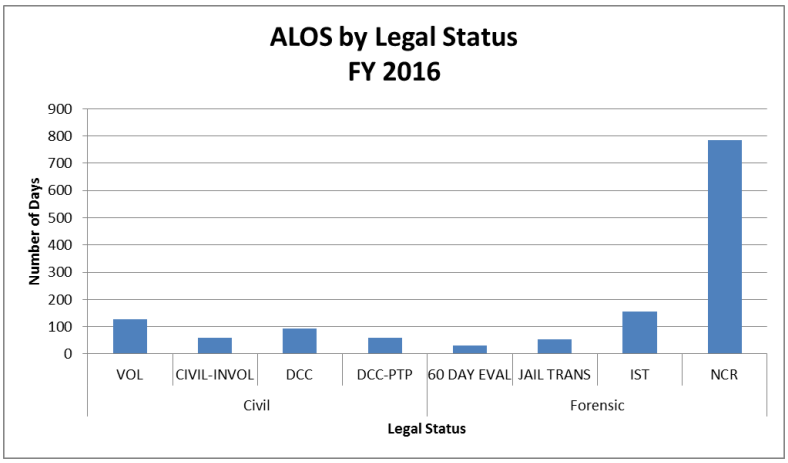


STRATEGIC PERFORMANCE EXCELLENCE

Average Length of Stay (Days):

ALOS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**64**	**70**	**83**	**65**	**74**	**122**	**129**	**98**	**87**				**88**
VOL						135	120						**128**
CIVIL-INVOL	23			64			88	97	21				**59**
DCC	71	70	83	67	74	121	147	98	102				**93**
DCC-PTP	61			60									**61**
FORENSIC:	**118**	**98**	**73**	**41**	**74**	**152**	**716**	**144**	**330**				**194**
60 DAY EVAL	24	27	28	26	50	30	29	28	25				**30**
JAIL TRANS			12			51	125	25					**53**
IST	74	252	146	50	108	161	90	295	227				**156**
NCR	371	31		59	80	438	3010	524	1757				**784**
AVERAGE	**94**	**88**	**78**	**57**	**74**	**135**	**407**	**124**	**161**				**135**





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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	NCR referrals admitted within 24 hours	N/A	100%	100%	100%	100%	**100%**
Actual			86% 6/7	100% 2/2	100% 6/6		**93% 14/15**

Data Analysis: Six NCR admissions occurred this quarter and all were admitted on 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 at all times.

	January 2016	**February 2016**	**March 2016**	**3Q2016**
# of NCR Admissions	2	2	2	**6 (Total)**
Wait Days	0	0	0	**0 (Average)**

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

Data Analysis: Five Jail Transfers were admitted this quarter.

- 1st JTF admitted in January waited 30 days for admission and had a LOS of 36 days. While in the hospital, an inpatient evaluation was ordered. Patient met with SFS and was returned to jail.

- 2nd JTF admitted in January waited 45 days for admission and had a LOS of 13 days. Patient was returned to jail and charges dismissed.
- 3rd JTF admitted in February waited 42 days for admission. While in the hospital an inpatient evaluation was ordered. Patient is currently still at RPC.
- 4th JTF admitted in February waited 13 days for admission and is currently still at RPC.
- 5th JTF admitted in March waited 14 days for admission and is currently still at RPC.

Action Plan: Continue to track data and keep one bed available for jail transfers.

	January 2016	February 2016	March 2016	3Q2016 Total
# of Jail Transfer (JTF) Admissions	2	2	1	**5**
# of Jail Transfer (JTF) Discharges	2	0	0	**2**

III. Measure Name: Off Shift PA Admission Paperwork

Measure 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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Documentation complete and accurate for admissions on off shifts	N/A	100%	100%	100%	100%	**100%**
Actual			100% 3/3	50% 1/2	N/A		**80% 4/5**

Data Analysis: No off shift admissions occurred this quarter.

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.

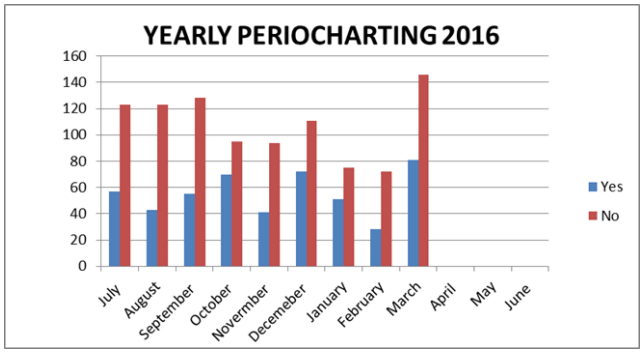
Type of Measure: Performance Improvement

	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	% of appointments where full mouth periodontal charting was completed	FY 2015 42%	50%	55%	60%	65%	**75%**
Actual			43%	61%	40%		**48%**

Data Analysis: There was a drop in Q3 periocharting because, an influx of emergency appointments in the doctors schedule, most of which were new patients of RPC that have never had a previous appointment. To better measure will only measure periocharting on existing patients during their prophy recall appointments.

Action Plan: Charting to be completed by the hygienist during prophy appointments ONLY and not during emergency or new patient appointments.

Comments: Would like to be at 65% by the next three month recall cycle and then at 75% after 12 month recall. This is a challenge because not all patients are able and/or willing to sit for periodontal charting.



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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Plaque Score Monthly	Fair (220-160)	Poor	Poor	Fair	Fair	**Fair**
Actual			221	248	150		**206 (Fair)**

Data Analysis: Smaller numbers demonstrate less plaque on our patients' teeth, therefore improved oral hygiene. The Q3 has decreased as we are only measuring prophy recall appointments.

Action Plan: Plaque scores should decrease in a 6 month cycle with proper oral hygiene instructions.

Comments: Trying to educate our patients on brushing DAILY and its importance for proper oral care and retention of teeth. Data collected from daily collected plaque scores as of the Q3 only on hygiene recall appointments.

III. Measure Name: Next Visit

Measure Description: Writing Next Visit in progress note.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	# of progress notes with next visit documented	66% FY 2015	70%	75%	80%	85%	**90%**
Actual			60%	95%	95%		**83%**

Data Analysis: FY2015 YTD was 66%; therefore, it has become a performance improvement measure. We would like this measure to be at 90 – 100%.

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; evaluate twenty random charts.

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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Daily noted	New implemented measure	70%	80%	90%	100%	
Actual			90%	95%	100%		**95%**

Data Analysis: As of the FY 2015 a new measure was implemented that the medical history and medication list be reviewed at each appointment.

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

Comments: Data collected from quarterly reviews by Community Dental; evaluate twenty random charts.

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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Daily noted; Quarterly reviewed	New implemented measure	90-100%	90-100%	90-100%	90-100%	**90-100%**
Actual			95%	95%	95%		**95%**

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.

Action Plan: Take blood pressure and pulse at the start of all dental appointments; quarterly charts reviewed.

Comments: To withstand dental care blood pressure should be less than 160/90.

Capital Community Clinic
Medication Management Clinic

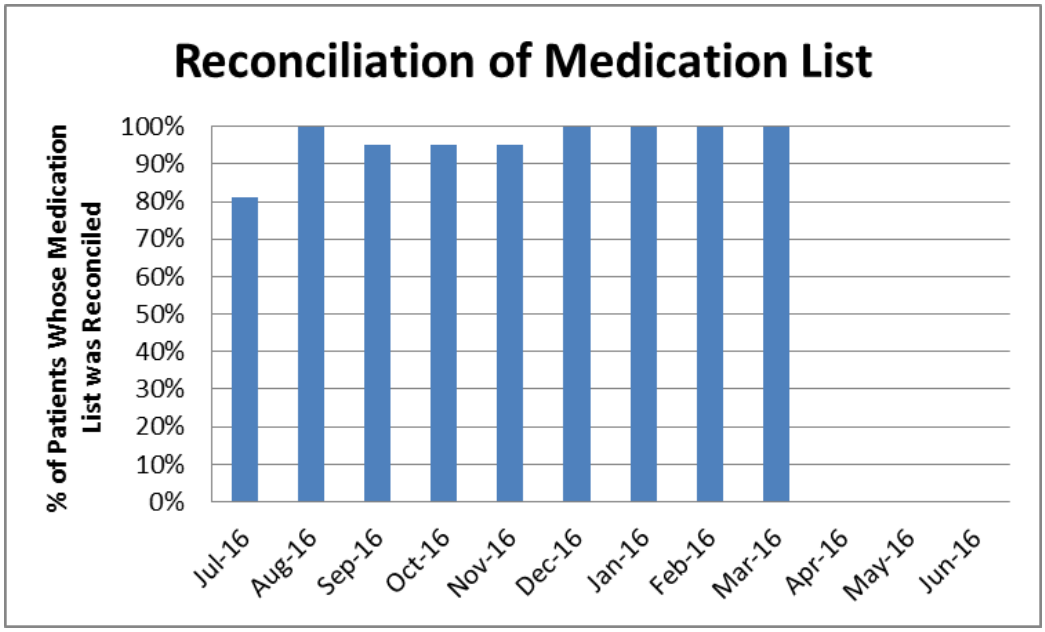
Responsible Party: Robin Weeks, Medical Assistant

I. Measure Name: Reconciliation of Outpatient Medication List

Measure Description: Each visit will cover reconciliation of medical & psychotropic medications with patients.

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**FYTD**
Target	Reconciliation completed per visit.	2Q2015 73%	100%	100%	100%	100%	**100%**
Actual			94% 59/63	97% 57/59	100% 46/46		**96% 162/168**



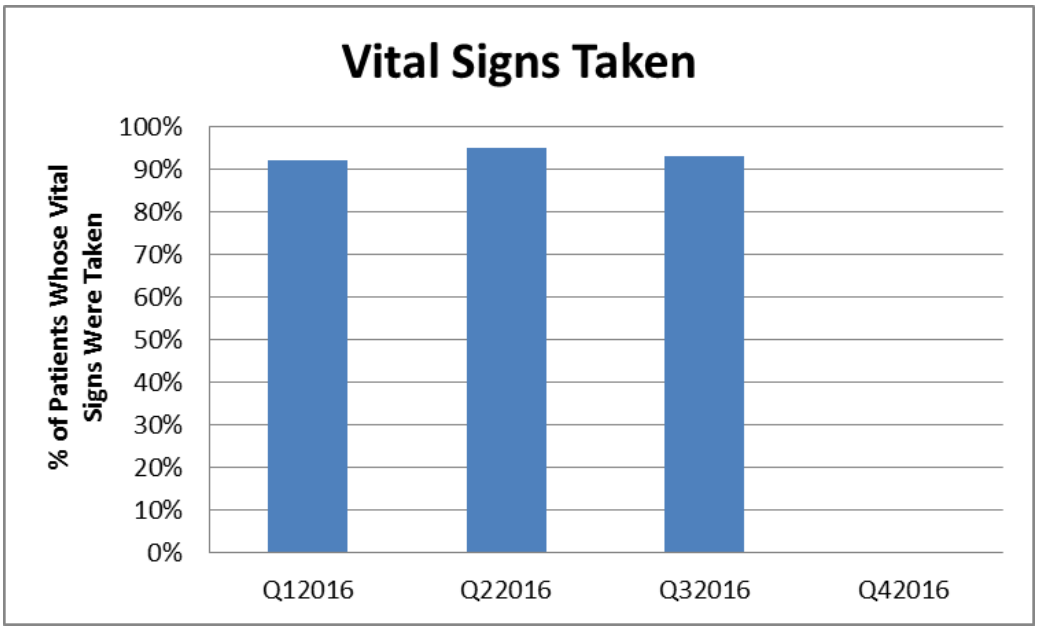
STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Vital Signs

Measure Description: Taking vital signs each visit will give us an idea of the effects of the prescribed medications and early detection of possible medical problems with the patient.

Measure Type: Quality Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**FYTD**
Target	Reconciliation completed per visit.	Q12015 73%	100%	100%	100%	100%	**100%**
Actual			92% 58/63	95% 56/59	93% 43/46		**93% 157/168**



STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela, Dietetic Services Manager

I. Measure Name: Nutrition Screen Completion

Measure Description: The Registered Dietitian will review each patient's Nursing Admission Data to assess ongoing compliance with the completion of the Nutrition Screen tool; within 24 hours of admission.

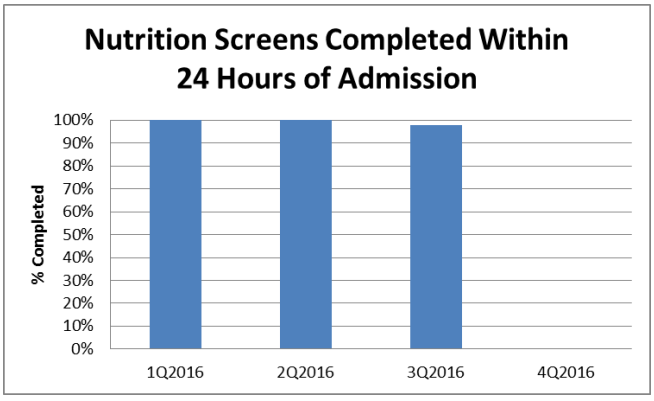
Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Nutrition screens completed on time	FY 2015 95%	95%	95%	95%	95%	**95%**
Actual			100% 60/60	100% 61/61	98% 62/63		**100% 183/184**

Data Analysis: Completion of the nutrition screens within 24 hours of admission has remained above target levels. This monitor began as an indicator in FY 2013.

Action Plan: To assure optimum care for our patients, this monitor will remain a quality assurance measure. As a follow up to this measure, there has been a performance improvement monitor developed to evaluate the accuracy of the screens being completed.

Comments: This is a multidisciplinary measure that has proven successful.



STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Nutrition Screen Accuracy

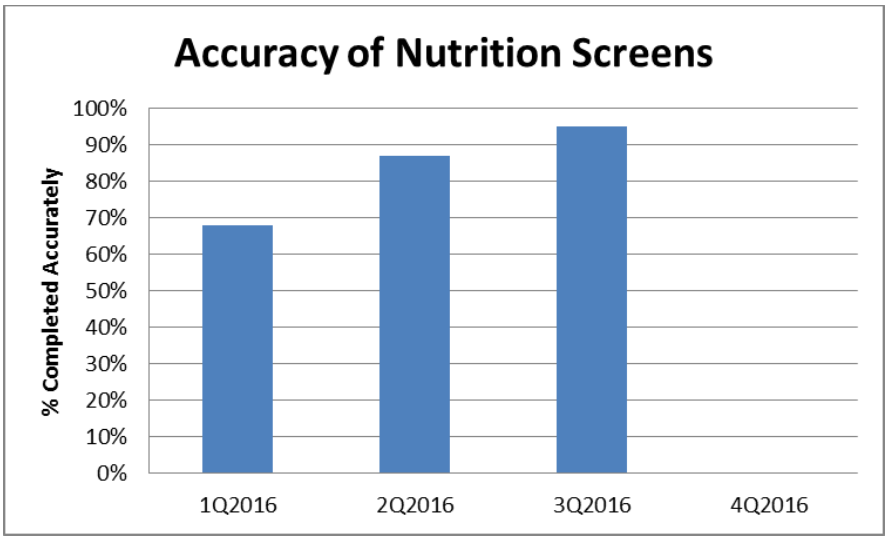
Measure Description: The Registered Dietitian will review every patient's Nursing Admission Data upon admission to assess ongoing compliance with the accuracy of the Nutrition Screen tool. This screen is utilized to attain nutrition indicators that necessitate dietary intervention.

Type of Measure: Performance Improvement

	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Nutrition screens completed accurately	FY 2016 Q1 68% 41/60	Baseline Established	95%	95%	95%	**95%**
Actual				87% 53/61	59/62 95%		**91% 112/123**

Data Analysis: These results indicate there has been an 8% improvement in the accuracy of the information gathered on the nutrition screen. The nutrition screen is completed by the nurse responsible for the admission. The diagnosis on the nutrition screen that was not identified on all three occasions was the "BMI>29.

Action Plan: Met with the admitting nurse responsible for this data collection. The omission was an oversight and will be assessed on incoming patients.



STRATEGIC PERFORMANCE EXCELLENCE

III. 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.

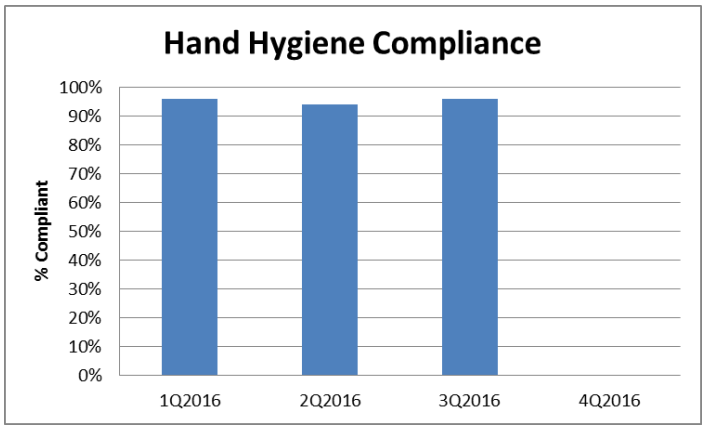
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Dietary employees washing hands after break	FY 2015 98% 338/346	95%	95%	95%	95%	**93%**
Actual			96% 343/356	94% 215/229	96% 276/288		**96% 834/873**

Data Analysis: The results of this quarter remain above 95%. There was a 2% increase in compliance. Total observations decreased by 59. One employee accounted for eight of the twelve times that handwashing wasn't observed. Two additional employees weren't observed washing their hands once within this rating period.

Action Plan:

- Continue to have front line supervisors monitor handwashing compliance after breaks.
- Provide a review of the proper hand washing times and techniques to staff member that is not consistently washing hands after breaks.
- Provide this Performance Improvement Measure to staff to highlight the continued success.



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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of timely and appropriate responses	FY2016 90% 144/159	90%	90%	90%	90%	**90%**
Actual			92% 147/159	96% 153/159	93% 148/159		**93% 448/477**

Data Analysis: With a significant amount of hands-on demonstrations, radio tests, and an increase in the use of radios, data showed that staff has become very familiar with operating the radio once the radios have been deployed. While the actual percentage of compliance is above the set threshold, what continues to be a critical issue is the fact that staff is not receiving the notification to employ the radios. The notification is going out, but either the pager is not on, the battery is dead, or the pager is not being monitored well appears to be the deficiency. We continue to investigate the most appropriate equipment such as non-battery dependent alert devices which are not so dependent on staff oversight.

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: 93% of assigned radio equipment is placed into service in a timely manner. Although this response adequately assures that the majority of occupants will receive timely and critical information, it still leaves a small population of staff who could be at harm's way if they do not receive critical information through mass notification. During the March test, one entire patient-care unit did not respond to the initial notification. Statistically, the overall numbers appears acceptable, but an entire unit not responding is a grave concern. Follow-up is planned to prevent a reoccurrence.

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

STRATEGIC PERFORMANCE EXCELLENCE

Areas/Groups Monitored N=Numerator D=Denominator	JUL 2015	AUG 2015	SEPT 2015	OCT 2015	NOV 2015	DEC 2015	JAN 2016	FEB 2016	MAR 2016	APR 2016	MAY 2016	JUNE 2016
Patient Care Areas/ # of radios												
Job Coach/1	1/1	1/1	1/1	1/1	1/1*	**0/1****	1/1*	1/1*	1/1*			
OPS/2	2/2	2/2	**1/2**	2/2	2/2*	2/2	2/2*	2/2	2/2*			
Tx Mall, Clinic, Dietary, Med Rec/5	5/5*	5/5	**3/5**	5/5	5/5*	**4/5**5**	5/5*	5/5	**4/5**5**			
US, UK, LS, LSSCU, LK, LKSCU/10	**9/10**	10/10	**8/10**	10/10	**7/10**3**	**9/10**	**9/10**3**	10/10	**7/10**3**			
Support Services/ # of radios												
Administration/3	3/3*	3/3	3/3	3/3	3/3*	3/3	3/3*	3/3	3/3*			
Housekeeping/ 10	**9/10**	10/10	**9/10**	**9/10*1**	10/10*	10/10	10/10	**9/10*9**	**5/10**8**			
Maintenance/14	14/14	14/14	**12/14**	14/14	14/14*	14/14	14/14	14/14	14/14*			
NOD/1	1/1	1/1	1/1	1/1	**0/1**4**	1/1*	1/1*	1/1*	1/1*			
Nursing Services/1	1/1	1/1	**0/1**	**0/1**2**	1/1*	**0/1**6**	1/1	1/1	1/1*			
Operations/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1*			
Security/4	4/4	4/4	4/4	4/4	4/4	4/4	4/4	4/4	4/4*			
State Forensic Services/1	1/1	1/1	**0/1**	1/1	1/1*	**0/1**7**	1/1	1/1	1/1*			
Patient Care Areas	**17/18**	**18/18**	**13/18**	**18/18**	**15/18**	**18/18**	**17/18**	**18/18**	**14/18**			
Support Services	**34/35**	**32/35**	**30/35**	**33/35**	**34/35**	**32/35**	**35/35**	**34/35**	**30/35**			
Total	**51/53**	**53/53**	**43/53**	**51/53**	**49/53**	**53/53**	**52/53**	**52/53**	**44/53**			

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

EMC: Emergency Management Coordinator

STRATEGIC PERFORMANCE EXCELLENCE

Key:

****1** Did not hear test due to radio being turned down. Remedial training held for staff.

****2** General staff in area were not aware that radio was assigned to that location. EMC educated staff.

****3** Operations had to call units. Staff did not respond to the Code Triage.

****4** Staff called Operations requesting the definition of "Code Triage". Upon further examination, the radio was dead. Not placed in charger properly. EMC educated staff.

****5** Operations called unit since staff did not respond to the "Code Triage". Pager for alert had a dead battery. EMC educated staff. Battery replaced.

****6** Operations had to call unit since staff did not respond to the "Code Triage". No means to receive message. Pager issued to Secretary. EMC educated staff.

****7** Operations had to call unit. Department Director only person in office. EMC to provide remedial training as requested.

****8** Housekeeping staff (Official shift start time of 0600) did not respond to the original test at 0606, but responded at the test done at 0615.

****9** One housekeeper reported that their radio was not working. After remedial training, the test was performed as expected.

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Responsible Party: Marcy Pepin, RN

I. Measure: Harbor Mall Hand-Off Communication

Objectives	1Q 2016	2Q 2016	3Q 2016	4Q 2016	Total FY2016
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	79% 44/56	93% 39/42	88% 37/42		**86% 120/140**
2. SBAR information completed from the units to the Harbor Mall.	79% 44/56	93% 39/42	86% 36/42		**85% 119/140**

Define: 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.

Measure: Indicator number one assessed as follows for the quarter: January 86%, February 79%, and March 100%. Indicator number two assessed as follows for quarter: January 93%, February 93%, and March 71%.

Analyze: For January, the specific time frame for being late was 3 minutes and 1 hour 15 minutes. For February, the specific time frame for being late was 5 minutes, 7 minutes, and 12 minutes. For March, all sheets turned in on time.

Improve: The results of the reports will be reviewed with the RN IVs from Lower Kennebec; Lower Saco; and Upper Saco and with the RN IIIs from UK. Data from the HOC sheets that did not arrive at the mall within the designated time-frame from the units will be reviewed. In addition, one morning or afternoon meeting with each unit to provide education regarding the importance of filling out the HOC sheets completely and submitting them to the Harbor Mall on time will be provided. We will maintain the statement at the bottom of the HOC reminding unit staff to turn the sheets in by 10 minutes after the hour to ensure that Harbor Mall leaders are made aware of any issues with the patients. This statement is highlighted in yellow.

Control: To continue to monitor the data and follow-up with any units(s) that may be having difficulties in developing or maintaining a process to meet the objectives above.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Responsible Party: Samantha Brockway, Medical Records Administrator

Documentation and Timeliness:

Indicators	3Q2016 Findings	3Q2016 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	65 charts for patients released during the quarter were sampled. 100% of the charts were completed within the required timeframe.	100%	80%
Discharge summaries will be completed within 15 days of discharge.	65 out of 65 discharge summaries were completed within 15 days of discharge.	100%	100%
Medical transcription will be timely and accurate.	Out of 741 dictated reports, 741 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	3Q2016 Findings	3Q2016 Compliance	Threshold Percentile
All patient information released from the Health Information Department will meet all Joint Commission, State, Federal & HIPAA standards.	2,546 requests for information (138 requests for patient information and 2,408 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 3Q2016 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 need 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

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

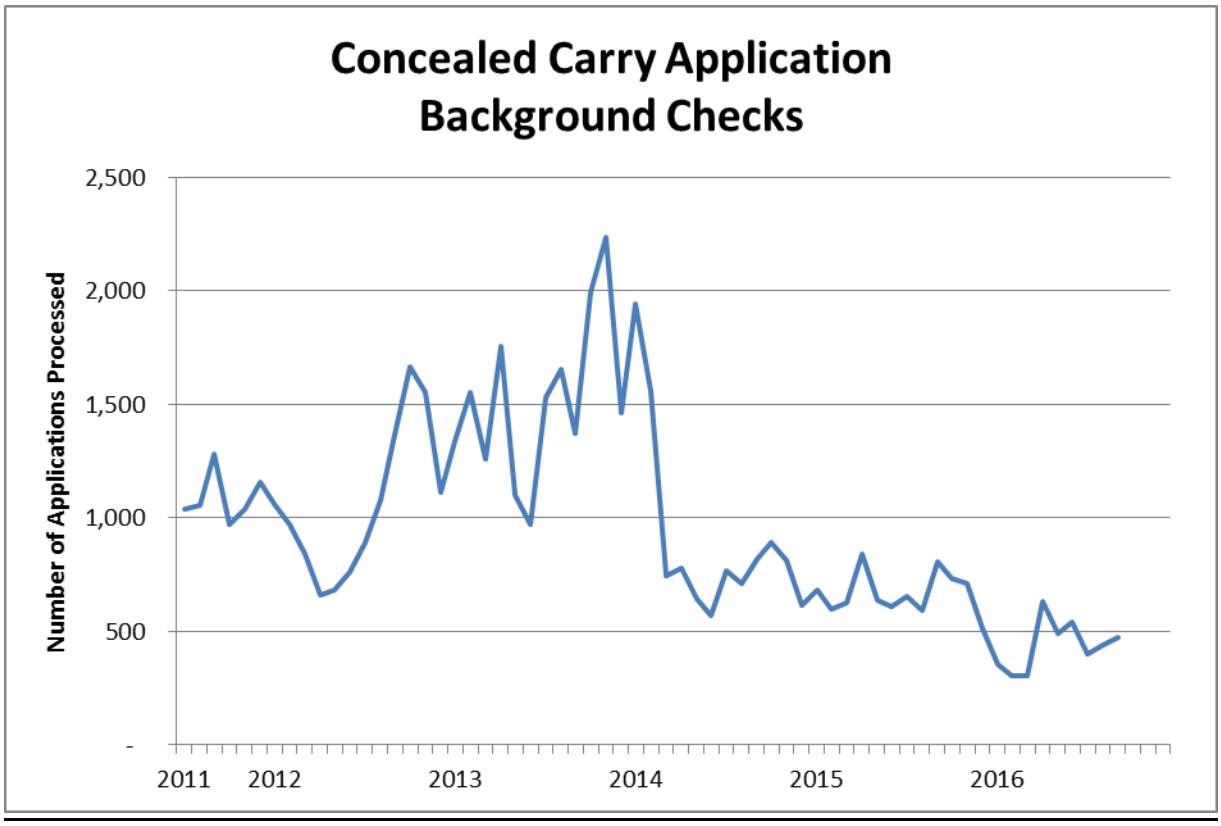
Analyze:
Data collected for the 3Q2016 showed that we received 1316 applications. This is a decrease from last quarter, 2Q2016, when we received 1665 applications.

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	FY 2015			FY2016								Total
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
# Applications Received	732	713	516	353	302	304	634	489	542	401	439	476	5901

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	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Lower Saco	85%	89%	94%	92%		**92%**
Upper Saco	85%	87%	88%	88%		**88%**
Lower Kennebec	85%	89%	90%	87%		**89%**
Upper Kennebec	85%	87%	89%	90%		**89%**
Overall Average	**85%**	**88%**	**90%**	**89%**		**90%**

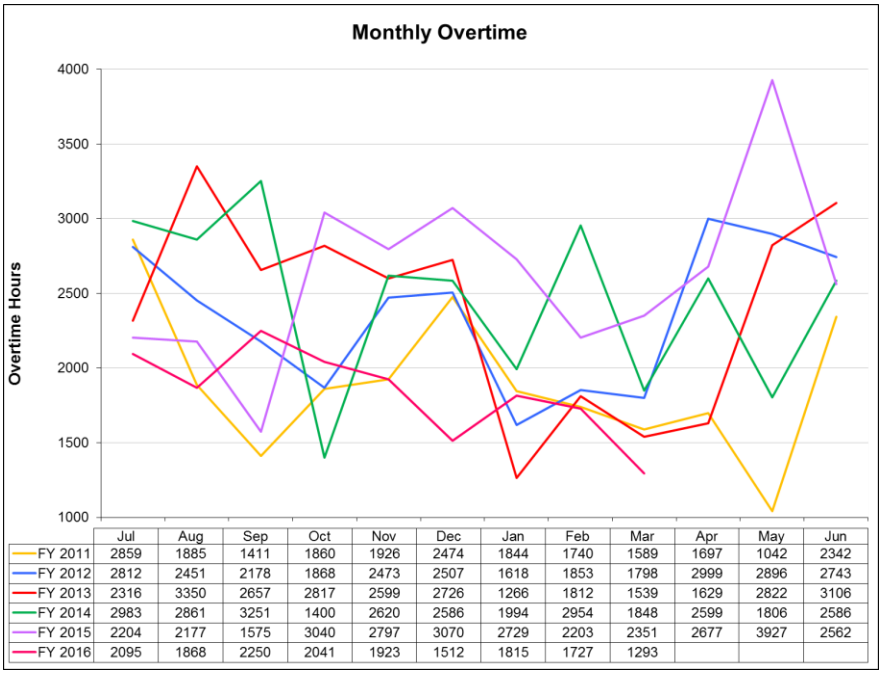
Data Analysis: The Housekeeping Supervisor inspected units monthly and found that window cleaning, dusting, and floor care in the nurse's station were consistent problem areas.

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

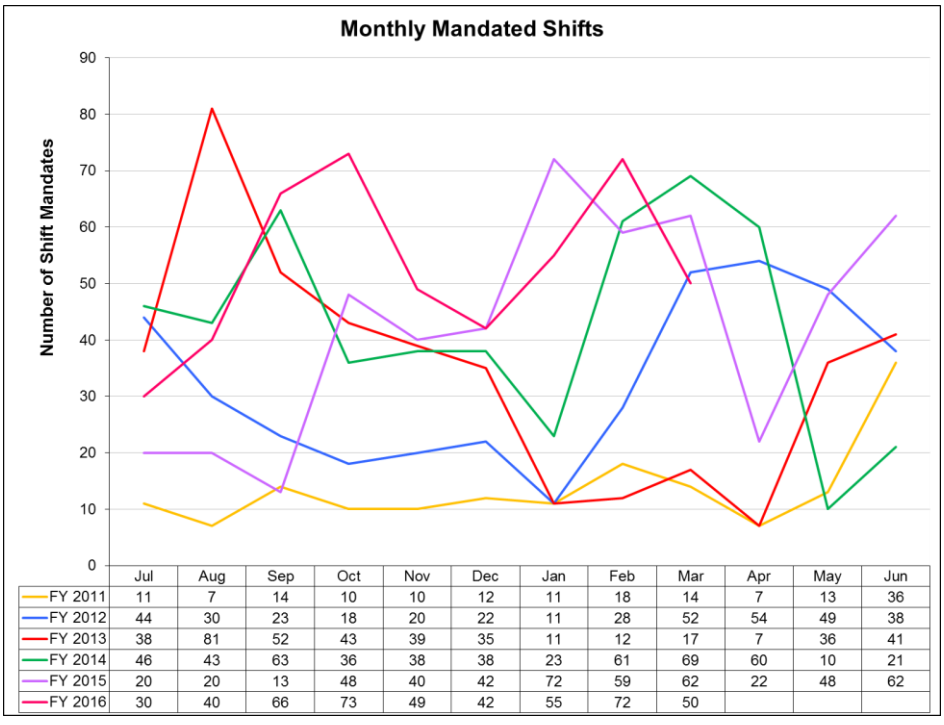
STRATEGIC PERFORMANCE EXCELLENCE

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			



	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			

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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percentage Licenses Reviewed	FY 2014 98%	100%	100%	100%	100%	**100%**
Actual			100% 19/19	100% 6/6	100% 28/28		**100% 53/53**

Data Analysis: During 3Q2016, there were 36 new hires. Of those, 28 were licensed, or potentially licensed. License and CNA Registry checks were performed prior to hire on all 28.

Action Plan: No action is needed at this time.

Medical Staff

Responsible Party: Dr. William Nelson, Acting Clinical Director

Quality Improvement Plan
2015-2016

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:

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

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.

1. **Peer Review Activities**:

   a. Regularly scheduled internal peer review by full time medical staff occurs on a monthly basis at the Peer Review and Quality Assurance 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 monthly. 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 one chart every other month 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.

   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 a biannual 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. An outside dentist from Community Dental will also review 20 charts of the hospital dentist for clinical appropriateness at least annually. Our contract with the Maine Medical

Association 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.

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
        - Clinical Pertinence of Documentation of Closed Records
    d. Infection Control Committee:
        - Infection Rates (hospital acquired and community acquired)
        - Staff Vaccination Rates/Titers
    e. Utilization Management Committee:
        - Admission Denials
        - Timeliness of Discharges After Denials
    f. Peer Review and Quality Assurance 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

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. Lower Saco Unit

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. This information will be available without the necessity of the practitioner requesting it. 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 time.

6. **Process to amend the quality improvement plan, including adding or deleting any monitors or processes:**
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
QA/PI/Peer Review 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: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Justified Polyantipsychotic Therapy	85% (2015)	90%	90%	90%	90%	**90%**
Actual			77%	69%	78%		**75%**

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. The percentage of justified polyantipsychotic therapy amongst those patients prescribed two or more antipsychotics is reported here. This quarter we regained ground in the number of patients on justifiable polyantipsychotic therapy. An analysis of the patients on polyantipsychotic therapy yielded the following results: An average of 27 percent of inpatients were prescribed two scheduled antipsychotics which has increased since last quarter. There has been a shift from scheduled polyantipsychotic therapy toward the use of more than one antipsychotic on an as needed basis only. In March, 17 of 23 patients on antipsychotic therapy were on one scheduled agent with another agent only as needed; while in January and February, totals were 8 of 23 and 9 of 20 respectively. We have seen an increase in number of patients with triple antipsychotic therapy from baseline average of 3 to a total of 5 patients in March. One patient had standing triple antipsychotic therapy; one patient with one scheduled agent and two as needed; and the remaining three had two scheduled agents and one as needed. Also notable is that 7 of 29 polyantipsychotic therapy patients in March were on clozapine therapy. All patients either had regimens which were deemed pharmacologically rational or were documented as being in the cross-taper process.

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan: This monitor was moved to Quality Assurance at the end of the second quarter. We will continue to monitor for appropriate justification of polyantipsychotic therapy. With the reorganization of the polyantipsychotic documentation process, numbers have improved from last quarter. Pharmacy has resumed alerting providers to provide justifications which may be partially responsible for this improvement as well.

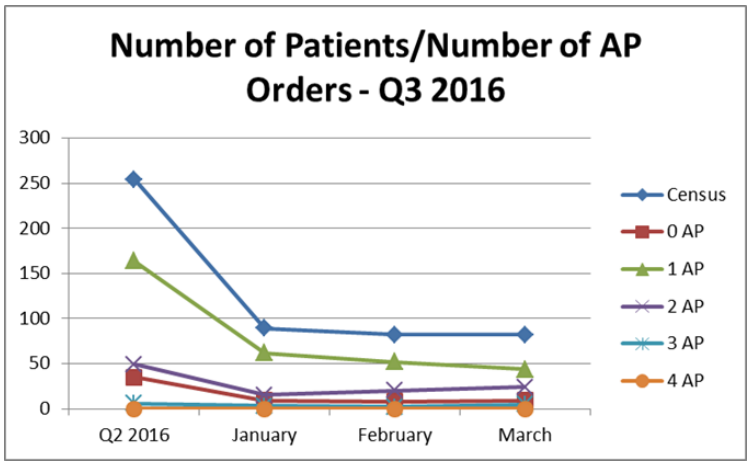
Comments: This quarter saw an improvement in the number of patients on polyantipsychotic therapy and an increase in documentation of justification for polyantipsychotic therapy. With the new staff becoming more familiar with the process as well as a transition from paper documentation sheets to an excel database, continued improvement is expected. Of note, most current polyantipsychotic therapy is due to the addition of another agent only on an as needed basis which are not typically carried over to discharge. Additionally, an increase in the institutions overall number of clozapine patients in this quarter may indicate a change in the characteristics of our current census.

Graph/Chart:

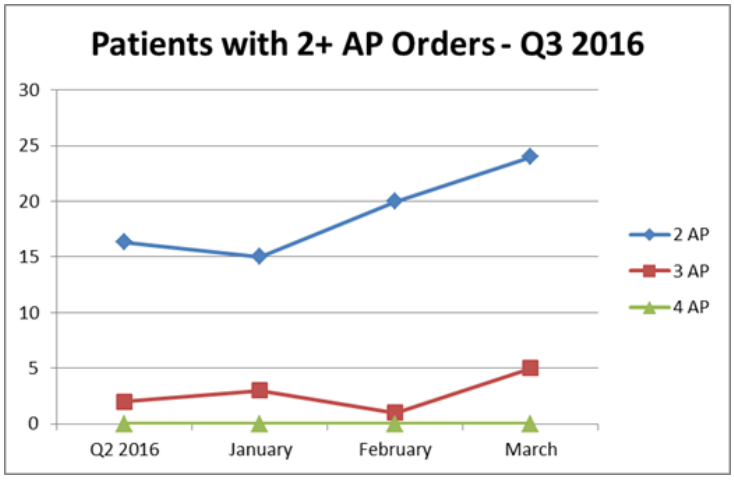
Q3 2016 Report	Q2 2016		January		February		March	
Census	254		89		82		82	
Antipsychotic Orders for Clients	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
No Antipsychotics	35	14	9	10	8	10	9	11
Mono-antipsychotic therapy	164	65	62	70	52	63	44	54
Two Antipsychotics	49	19	15	17	20	24	24	29
Three Antipsychotics	6	2	3	3	2	2	5	6
Four Antipsychotics	0	0	0	0	0	0	0	0
At least 1 antipsychotic	219	86	80	90	74	90	68	83
Total on Poly-antipsychotic therapy	55	22	18	20	22	27	29	35
Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics		25% (55/219)		23% (18/80)		30% (22/74)		43% (29/68)
More than 2 antipsychotics	6	3%	3	4%	2	3%	5	7%
Poly-Antipsychotic therapy breakdown	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
SGA + FGA	20	36	7	39	11	50	11	38
2 SGAs ("Pine" + "Done")	3	5	1	6	3	14	5	17
Other (2 antipsychotic regimens)	22	40	7	39	6	27	11	38
Other 2 Antipsychotic Regimen Details	1) Clozapine + Olanzapine		1) Clozapine + Olanzapine X3		1) Aripiprazole/Olanzapine		1) Aripiprazole/ Olanzapine X2	
	2) Olanzapine + Quetiapine		2) Clozapine + Quetiapine		2) Clozapine /Olanzapine		2) Clozapine/ Olanzapine X3	
	3) Risperidone + Aripiprazole		3) Haloperidol + Chlorpromazine		3) Clozapine /Quetiapine		3) Aripiprazole/ Paliperidone	
	4) Aripiprazole + Paliperidone		4) Aripiprazole + Olanzapine		4) Aripiprazole/ Paliperidone			
	5) Aripiprazole + Quetiapine		5) Aripiprazole + Paliperidone					
	6) Clozapine + Quetiapine							
	8) Aripiprazole + Olanzapine							
3+ Antipsychotic Regimens	3	1.60%	3	1.70%	2	2.70%	5	7.35%
	1) Clozapine + Olanzapine + Risperidone		1) Clozapine + Haloperidol + Olanzapine		1) Clozapine/Quetiapine/ Olanzapine		1) Clozapine/ Haloperidol/ Olanzapine	
	2) Clozapine + Haloperidol +Ziprasidone		2) Paliperidone + Quetiapine + Olanzapine		2) Clozapine/ Haloperidol/ Olanzapine		2) Clozapine/ Ziprasidone/ Haloperidol	
			3) Aripiprazole + Haloperidol + Olanzapine				3)Clozapine/ Quetiapine/ Olanzapine	
							4) Clozapine/ Quetiapine/ Chlorpromazine	
							5) Chlorpromazine/ Perphenazine/ Quetiapine	
Justifiable Poly-Antipsychotic Therapy	69% (38/55)		78% (14/18)		77% (17/22)		79% (23/29)	

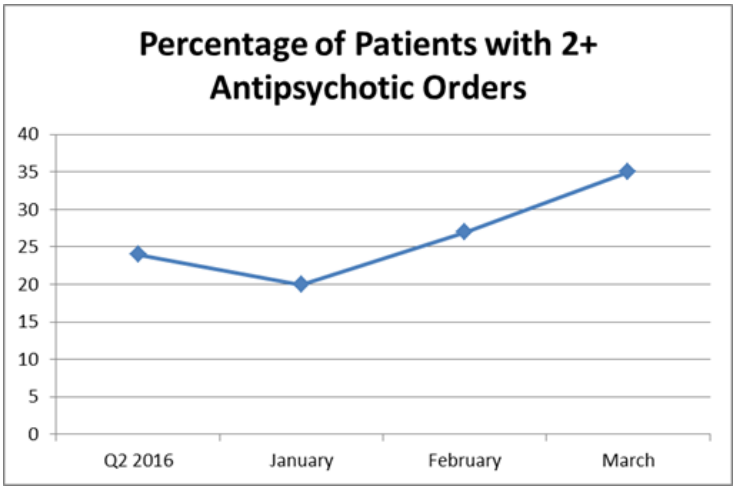
STRATEGIC PERFORMANCE EXCELLENCE

Census & Number of Patients with 0, 1, 2, 3 & 4 Orders for Antipsychotics:



Number of Patients with 2+ Antipsychotic orders per Month:





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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Complete/Up-to-date Metabolic Parameters	73%	75%	75%	75%	75%	**75%**
Actual			73%	63%	57%		**72%**

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 SGA therapy by monitoring for Metabolic Syndrome. The patient's right to refuse assessment (weight, blood pressure and lab work) has been

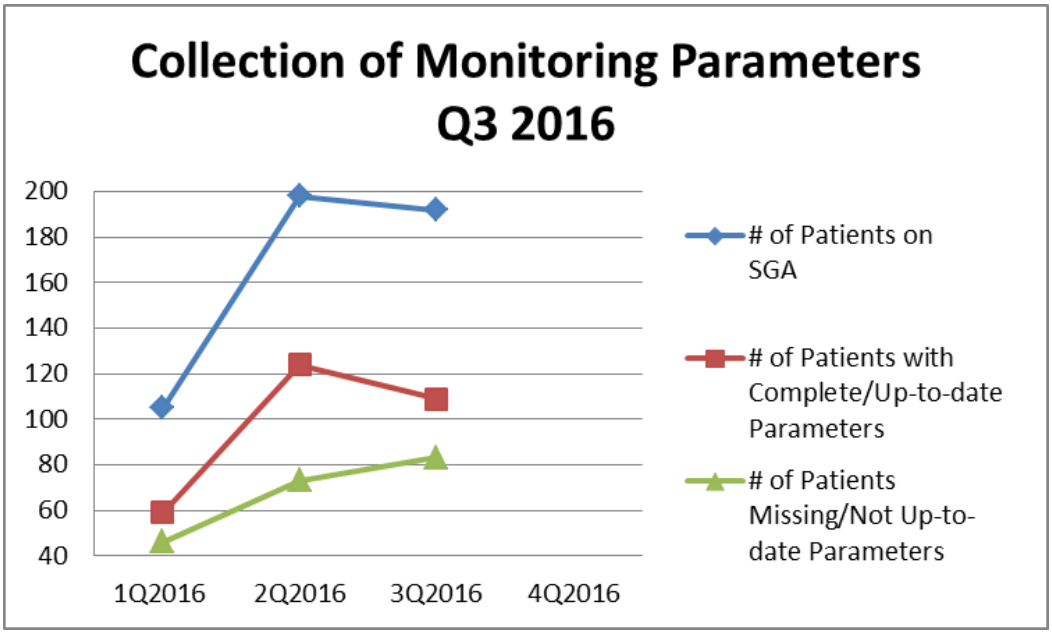
identified as a contributing factor to not being able to fully assess their metabolic status. Thus the goal of achieving 95% completed metabolic parameters is unrealistic and has been adjusted to a more reasonable goal of 75%. We have also started incorporating documentation of patient's refusals. This indicates that the provider is making the attempt to monitor the medication. In an attempt to streamline lab work, the Medical Staff has decided to incorporate lab work with the annual physical. This may impact this monitor going forward as data has been collected based on the most recent lab work and addition or changes in SGA therapy.

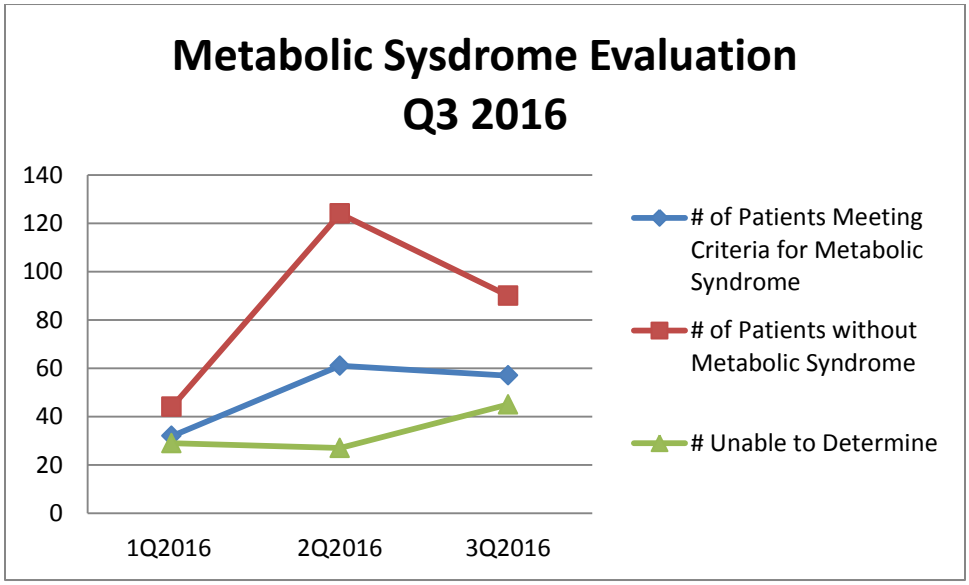
Comments: We saw a continued decrease this quarter to 57%, remaining below our goal of 75%. Of the patients that did not have complete/up-to-date parameters collected, 1% had documented refusals. For the majority of the patients, it is likely that their annual physical is not due and annual labs have not been ordered. Additionally, there has been some change over in medical staff in the last quarter. This may impact the results of this monitor negatively as the new providers become familiar with the system as well as the patients.

Graph/Chart:

	1Q2016	2Q2016	3Q2016	4Q2016
# of Patients on SGA	105	198	192	
# of Patients with Complete/Up-to-date Parameters	59 (56%)	124 (63%)	109 (57%)	
# of Patients Missing/Not Up-to-date Parameters	46 (44%)	74 (37%)	83 (43%)	
# of Patients Meeting Criteria for Metabolic Syndrome	32 (30%)	61 (31%)	57 (30%)	
# of Patients without Metabolic Syndrome	44 (42%)	124 (63%)	90 (47%)	
# Unable to Determine	29 (28%)	27 (14%)	45 (23%)	
Documented Refusals	0	27 (14%)	1 (.01%)	

STRATEGIC PERFORMANCE EXCELLENCE





III. Measure Name: Polytherapy

Measure Description: Polytherapy is defined as "combined treatment of multiple conditions with multiple medications." This differs from polypharmacy, the "treatment of a single condition with multiple medications from the same pharmacologic class or with the same mechanism of action" which our other monitor, Poly-antipsychotic therapy, addresses. Polypharmacy can lead to complex medication regimens and increases the chances of drug-drug interactions potentially negatively impacting or inhibiting another drug from exerting its intended therapeutic effect. When five or more medications are taken together there is almost a 100% chance of a drug-drug interaction. The purpose of this monitor is to evaluate polytherapy and actively discuss cases with the highest number of medications in an attempt to reduce polytherapy.

Type of Measure: Performance Improvement

Data Analysis: We have assessed a baseline group of patients with regards to their total number of medications prescribed and further broken it down to number of scheduled medications and number of PRN or "as needed" medications. Each month the patient medication profiles with the highest total number of medications for each unit will be reviewed at the Peer Review Committee to assess the potential for eliminating unnecessary medications. The number of actual profiles reviewed each month will be dependent on time constraints and presence/availability of the patient's Psychiatric and Medical providers.

Action Plan: Action Plan: Our plan is to continue to review patients with numerous medication orders at the monthly Peer Review Committee Meeting. An effort will be made to obtain more information on medication adherence and PRN usage for the patients reviewed. This monitor will be reported and discussed with the Medical Staff at the Peer Review and Pharmacy & Therapeutics (P&T) Committees.

Comments: Results this quarter continue to remain similar to previous quarters. The average number of agents has likely increased due to patient specific factors including an increased number of medically fragile patients. As the number of medications per patient seems to reflect our current population this measure is being transitioned from performance improvement to quality assurance for the upcoming quarters.

STRATEGIC PERFORMANCE EXCELLENCE

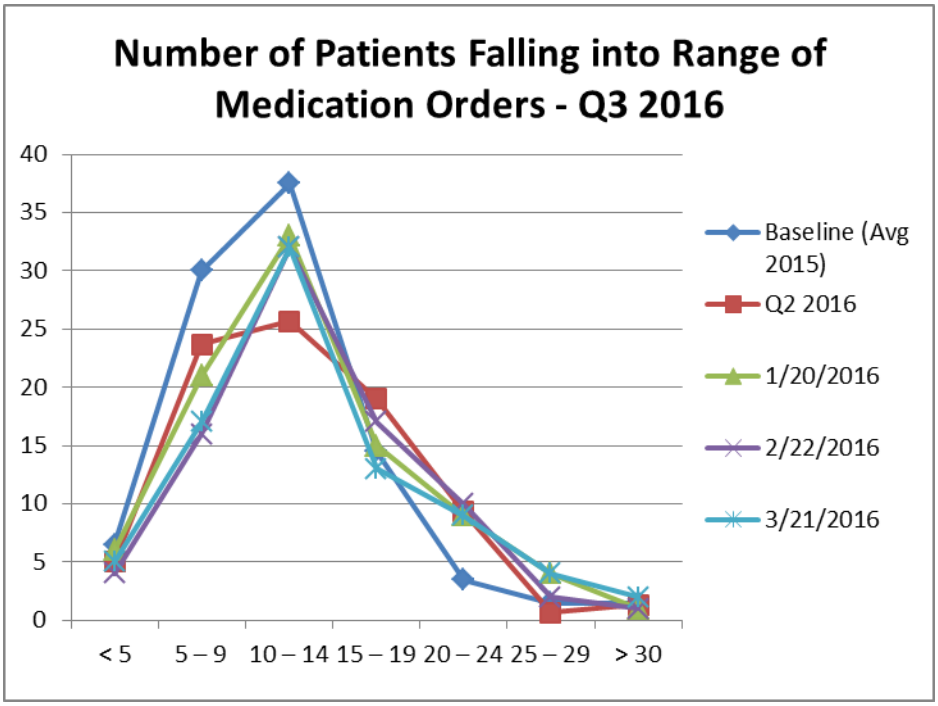
Graph/Chart:

	Baseline Average	Baseline Range	Q2 2016 Average	Q2 2016 Range	1/20/16 Average	1/20/16 Range	2/22/16 Average	2/22/16 Range	3/21/16 Average	3/21/16 Range
Total Orders	12.1	0-31	13	0-42	13	1-35	7	1-36	14	1-37
Scheduled	4.9	0-17	6	0-21	7	0-20	7	0-20	7	1-21
PRNs	5.9	0-19	7	0-23	7	1-20	14	1-21	8	0-21

Medication Number Range	Average Number of Patients (Baseline)	2Q2016 Average	1/20/16	2/22/16	3/21/16	3Q2016 Average
< 5	7	5	6	4	5	5
5 – 9	30	24	21	16	17	18
10 – 14	38	26	33	32	32	32
15 – 19	15	19	15	17	13	15
20 – 24	4	9	9	10	9	9
25 – 29	2	1	4	2	4	3
> 30	2	1	1	1	2	1

STRATEGIC PERFORMANCE EXCELLENCE

Number of Patients Falling in to Range of Medication Orders:



STRATEGIC PERFORMANCE EXCELLENCE

Nursing

Indicator: 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.

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.

Those responsible for monitoring: Monitoring will be performed by members of the Staffing Improvement Task Force which includes representation of Nurses and Mental Health Workers on all units, Staffing Office and Nursing Leadership.

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

Monthly Targets: 10% reduction monthly x4 from baseline

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.

	New Baseline Sept 2013	4Q2015			1Q2016			2Q2016			3Q2016			Goal
		Apr 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	
Nursing Mandates	14	2	4	6	2	1	8	11	8	10	3	1	5	10% reduction monthly x4 from baseline)
Mental Health Worker (MHW) Mandates	49	20	44	56	28	39	58	62	41	32	52	71	45	10% reduction monthly x4 from baseline)

Nursing mandates decreased from 29 last quarter to 9 this quarter.
MHW mandates increased from 135 last quarter to 168 this quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Outpatient Services (OPS)

Responsible Party: Lisa Manwaring, 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**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of assessments completed on time	FY 2015 0% 0/4	85%	85%	85%	85%	**85%**
Actual			0% 0/3	0% 0/5	0% 0/4		**0% 0/12**

Data Analysis: We had one chart with two assessments completed this quarter.

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.

Peer Support

Responsible Party: Samantha St. Pierre, 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%.

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

STRATEGIC PERFORMANCE EXCELLENCE

Survey Return Rate	Unit	Baseline	Target	1Q2016	2Q2016	3Q2016	4Q2016	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%	44% 7/16	23% 3/13	64% 7/11		**43% 17/40**
	LS	5%	50%	0% 0/21	54% 7/13	13% 2/16		**18% 9/50**
	UK	45%	50%	18% 3/17	25% 4/16	19% 5/26		**20% 12/59**
	US	30%	50%	88% 7/8	100% 7/7	0% 0/5		**70% 14/20**
	Overall							**31% 52/169**

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	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD Average
1	I am better able to deal with crisis.	69%	82%	53%		**68%**
2	My symptoms are not bothering me as much.	79%	77%	64%		**73%**
3	The medications I am taking help me control symptoms that used to bother me.	75%	70%	42%		**62%**
4	I do better in social situations.	71%	64%	56%		**64%**
5	I deal more effectively with daily problems.	73%	83%	64%		**73%**
6	I was treated with dignity and respect.	71%	65%	56%		**64%**
7	Staff here believed that I could grow, change and recover.	69%	62%	56%		**62%**
8	I felt comfortable asking questions about my treatment and medications.	68%	68%	72%		**69%**
9	I was encouraged to use self-help/support groups.	72%	75%	58%		**68%**
10	I was given information about how to manage my medication side effects.	68%	53%	64%		**62%**
11	My other medical conditions were treated.	65%	69%	64%		**66%**
12	I felt this hospital stay was necessary.	65%	48%	58%		**57%**

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

STRATEGIC PERFORMANCE EXCELLENCE

#	Indicators	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD Average
13	I felt free to complain without fear of retaliation.	69%	60%	44%		**58%**
14	I felt safe to refuse medication or treatment during my hospital stay.	62%	46%	47%		**52%**
15	My complaints and grievances were addressed.	63%	55%	47%		**55%**
16	I participated in planning my discharge.	75%	43%	72%		**63%**
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	63%	30%	53%		**49%**
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	63%	32%	56%		**50%**
19	The surroundings and atmosphere at the hospital helped me get better.	68%	63%	50%		**60%**
20	I felt I had enough privacy in the hospital.	64%	61%	58%		**61%**
21	I felt safe while I was in the hospital.	62%	62%	61%		**62%**
22	The hospital environment was clean and comfortable.	66%	63%	56%		**62%**
23	Staff were sensitive to my cultural background.	61%	52%	44%		**52%**
24	My family and/or friends were able to visit me.	69%	64%	58%		**64%**
25	I had a choice of treatment options.	64%	56%	44%		**55%**
26	My contact with my doctor was helpful.	66%	58%	58%		**61%**
27	My contact with nurses and therapists was helpful.	66%	64%	67%		**66%**
28	If I had a choice of hospitals, I would still choose this one.	55%	45%	53%		**51%**
29	Did anyone tell you about your rights?	71%	51%	50%		**57%**
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	63%	54%	44%		**54%**
31	Do you know someone who can help you get what you want or stand up for your rights?	74%	77%	50%		**67%**
32	My pain was managed.	62%	75%	50%		**62%**
	Overall Score	**67%**	**63%**	**55%**		**61%**

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 2015**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Pharmacy	0.19%	0%	0%	0%	0%	0%
Actual			0%	0%	0%		0%

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

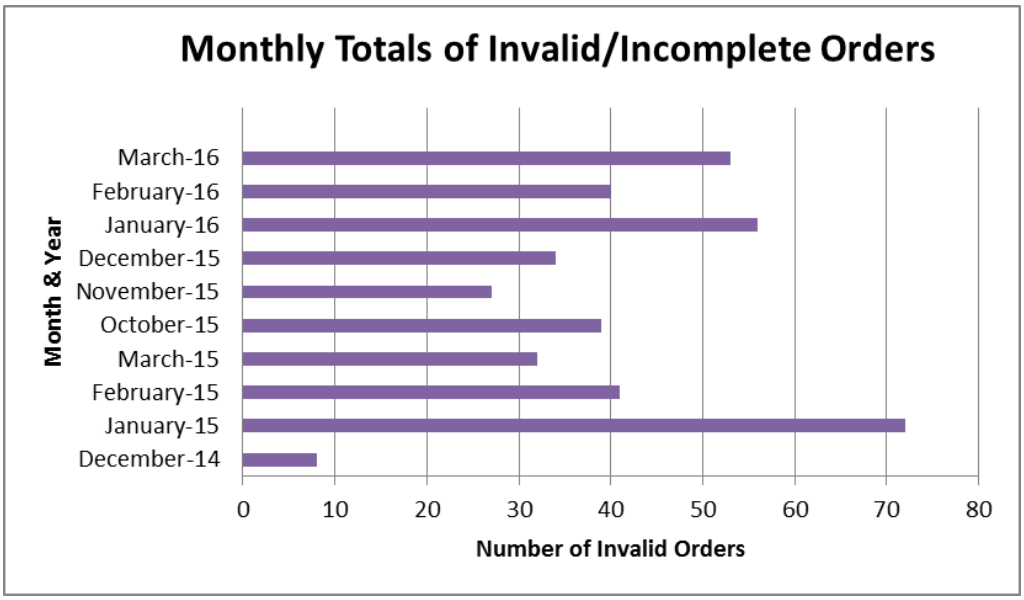
Action Plan: Remain vigilant and continue to educate staff on proper automated dispensing cabinet procedures to avoid the creation of discrepancies.

Comments: The action plan is providing the desired results.

II. **Measure Name: Invalid Orders**

Measure Description: Incomplete/Invalid Orders.

Type of Measure: Performance Improvement



*Data not available for April-September 2015

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.
The process for 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 third quarter the number of invalid orders has increased averaging 49 invalid orders per month up from last quarter average of 33. Statistically one number higher than the baseline of 48 indicates additional room for improvement. Missing indications was the primary reason for incomplete orders followed by allergies and adverse drug reaction information on the order forms.

Action Plan: Rapid contact, resolution and awareness to the prescriber are an ongoing process to decrease the number of incomplete orders and provide excellent patient care. With the implementation of the CoCentrix CPOE (computerized physician order entry) system, due to arrive in June of this year, prescribers will be unable to process orders without filling in all the required fields. CPOE will eliminate incomplete orders.

III. **Measure Name: Veriform Medication Room Audits**

Measure Description: Comprehensive Unit Compliance Audits

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2015**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	All	100%	100%	100%	100%	100%	**100%**
Actual			100%	100%	100%		**100%**

Data Analysis: The medication room audits have been concluded for quarter three without completion deficiencies.

Audit Compliance Findings: The Pharmacy Medication Room Audits for all the units have been completed for the third quarter.

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: Medication room audits must be approved by the Nurse Unit Manager in a timely fashion. There are instances when the approvals have exceeded their required time limit and pharmacy has been diligent in their efforts to rectifying these occurrences by resending the requests and delivering hard copies to the responsible individuals.

STRATEGIC PERFORMANCE EXCELLENCE

IV. **Measure Name: Fiscal Accountability**

Measure Description: Monthly Tracking of Dispensed Discharge Prescriptions

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2015**	**4Q 2015**	**1Q 2016**	**2Q 2016**	**3Q 2016**	**YTD**
Actual	All	$15764 for 861 Rx's	$5266 for 261 Rx's	$5281 for 368 Rx's	$3719 for 312 Rx's	$7679 for 461 Rx's	**$21,945 for 1402 Rx's**

Data Analysis: Riverview Psychiatric Center has an Extended Hospital Pharmacy license, meaning it can dispense to both in and outpatients. The majority of the outpatient prescriptions are for a 7-day supply of discharge medications. Special approval is required from administration when a great than 7 day supply is needed. The discharge prescriptions serve to cover the patient's needs until they are able to obtain medications in the community.

Action Plan: Advance discharge planning would permit patients to obtain prescription coverage prior to discharge resulting in decreased pharmacy expenditures and a reduction in the volume of outpatient prescriptions provided by the pharmacy.

Comments: Calculating from the baseline figure of $15,764 for 861 Rx's equals $18.30 per Rx, and the YTD figure of $21945.86 for 1402 Rx's equals $15.65 per Rx. Subtracting YTD from baseline results in a $2.65 decrease per Rx to date. Additionally, in keeping drug costs down, monitoring and purchasing pharmaceuticals that are on preferred GPO pricing lists will provide a decrease in expenditures.

STRATEGIC PERFORMANCE EXCELLENCE

Psychology

Responsible Party: Arthur DiRocco, Ph.D., Director of Psychology

I. Measure Name: Outpatient Readiness Scale (ORS)

Measure Description: The ORS will be completed for those patients who reside in the community and are receiving services through OPS. Target is 90%of outpatients will have ORS completed and updated every 6 months.

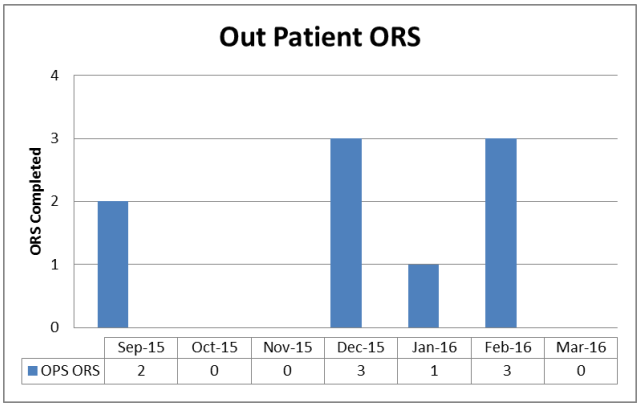
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of OPS recipients evaluated with ORS	1Q2016 4%	90%	90%	90%	90%	**90%**
Actual			4% 2/47	11% 5/47	15% 7/47		**10% 14/141**

Data Analysis: This is a new initiative and will require training and follow-up with the OPS treatment team. Preliminary efforts have helped produce modest results in the first month. Baseline was measured from September 2015 to December 2015. The start of this initiative was mid-February 2016.

Action Plan: Psychology staff who work with the OPS treatment team will prompt the team to complete the ORS on each OPS recipient.

Comments: Plans are in place to assess patients on a more frequent basis as staff become more familiar with the assessment instrument. Our expectation is to double the number evaluated by the close of the next quarter.



STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Treatment Plan Improvement Initiative

Measure Description: Patient treatment plans identifying psychological interventions will contain one or more of the following criteria: clear operational definitions, baseline data (e.g., excess or deficiency), and desired, measurable outcomes. Target is within 4 months 90% of all treatment plans developed with psychologist input will contain key features of proposed model intervention plans.

Type of Measure: Performance improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of treatment plans which meet new standard	2Q2016 20%	90%	90%	90%	90%	**90%**
Actual				20% 2/10	25% 3/12		**23% 5/22**

Data Analysis: This is a new initiative and will require training and formative feedback to achieve desired level of thoroughness and conformity with desired standards. Baseline was measured from September 2015 to February 2016. The start of this initiative was February 15, 2016.

Action Plan: Psychology staff will work collaboratively in both an intra- and inter-disciplinary manner to achieve clear and practical behavior plans.

Comments: Individual treatment plans (10 to 12) were accessed at random from on-line unit entries and examined for elements consistent with this initiative. Future efforts will be made to ensure that patients with identified psychological treatment needs will have a corresponding treatment plan.

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: Occupational Therapy Service Orders

Measure Description: Improving health outcomes/patient care. In order to receive effective treatment, all patients receiving Occupational Therapy Services have a doctor's order and referral sheet completed before services are initiated.

Methodology: Each quarter Rehabilitation Services Director will audit the Occupational Therapy Referral Log and review the list of all patients receiving services to ensure a doctor's order for the service has been written and a referral to OT was completed before the patient began receiving services.

The numerator will be the number of OT Service referrals that include the required MD order, the denominator will be the total number of OT Service referrals received.

Goal: To achieve and maintain an overall goal of 100% for 4 consecutive Quarters

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient receiving OT services has an MD order	FY 2015 97%	100%	100%	100%	100%	**100%**
Actual			100% 25/25	100% 29/29	100% 25/25		**100% 79/79**

Data Analysis: In review of Occupational Therapy Services Log all patients referred for services from January 1, to March 31, 2016 had both the referral sheet completed as well at the doctor's order attached to it.

Action Plan: Review the results of the audit with Occupational Therapy staff.

STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Vocational Services Documentation

Measure Description: Improving health outcomes/patient care. In order to receive effective treatment, all patients engaged in the Vocational Rehabilitation Program will have updated treatment plans and weekly documentation on the progress towards addressing the intervention outlines in the treatment plan.

Methodology: Each quarter Rehabilitation Services Director will audit the charts of the patients involved in the Vocational Rehabilitation Program to review treatment plans and progress notes to ensure they are being completed in a timely manner and updated on a regular basis.

The numerator will be the number of patient charts with the required documentation and the denominator will be the total number of patients in the Vocational Rehabilitation Program.

Goal: To achieve and maintain an overall goal of 100% for 4 consecutive Quarters

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient working in the Voc. Rehab. Program has the required documentation	60%	100%	100%	100%	100%	**100%**
Actual			50% 6/12	91% 29/32	97% 29/30		**76%** **25/33**

Data Analysis: Charts were audited using the Rehab. Services –Vocational Services tool. There was only 1 chart in which a weekly note was not done on time.

Action Plan: Continue with the monthly audits to assist with attaining the goal of 100% so that the Vocational documentation can reach the goal of 4 consecutive quarters of 100%.

STRATEGIC PERFORMANCE EXCELLENCE

Safety & Security

Responsible Party: Philip Tricarico, Safety Officer

I. 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".

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**Total**
Target	# of Incidents	*Baseline of 10	2	4	2	2	**9**
Actual			4	2	1		**7**

3Q2016: The Q3 Target was (2). Our actual number was (1). We 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. 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.

Safety & Security Incidents:

Event	Date	Time	Location	Disposition	Comments
1. Safety Concern (Staff member vehicle with contraband in the bed)	2/8/16	1116	Staff Parking Lot	Staff member moved truck to another lot, off grounds.	Staff member with multiple contraband and dangerous items in the bed of their truck. Items included long steel cable, rope, hack saw & blades and large pipe wrenches.

APS Healthcare

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Quarterly Report 60a for Members on MaineCare Waitlist for CI

Report Dates: 10/01/2015 To 12/31/2015 **Report Run Date: 4/12/2016**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection "Date worker assigned". The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a wait list for service. The CFSN is used in conjunction with the date of assignment to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare funds.

What This Report Measures: For members on the CI wait list who were authorized for the service, how long they waited. This report counts the number of days from the date the CFSN was opened to the date the service was authorized. The report is run 2 quarters ago so nearly everyone who was entered on the wait list will have started the service. If someone on the MaineCare waitlist is authorized for the state-funded service, it is counted as being authorized for the service.

Number of people who were authorized for CI from the MaineCare wait list during the quarter 518

For those who received the service:

Average number of days waiting: 13 days

Percent waiting 30 days or less: 84.6%

Percent waiting 90 days or less: 99.8%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
AMHI Class N	490	486	4	411	78	1	14
AMHI Class Y	28	27	1	27	1	0	6
Totals	**518**	**513**	**5**	**438**	**79**	**1**	**13**

District	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
District 1	70	70	0	44	25	1	28
District 2	102	100	2	77	25	0	18
District 3	87	86	1	80	7	0	10
District 4	45	45	0	39	6	0	9
District 5	146	145	1	135	11	0	9
District 6	47	46	1	44	3	0	5
District 7	12	12	0	11	1	0	13
District 8	6	6	0	5	1	0	7
Unknown	3	3	0	3	0	0	6
Totals	**518**	**513**	**5**	**438**	**79**	**1**	**13**

APS Healthcare

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
Alternative Wellness Services	11	11	0	11	0	0	6
Assistance Plus	47	46	1	47	0	0	1
Catholic Charities Maine	82	81	1	66	16	0	18
Charlotte White Center	19	19	0	17	2	0	6
Common Ties	61	60	1	58	3	0	9
Community Care	24	23	1	23	1	0	6
Community Health & Counseling Services	21	21	0	19	2	0	8
Counseling Services Inc.	27	27	0	21	6	0	17
Health Affiliates Maine	1	1	0	1	0	0	22
Kennebec Behavioral Health	87	87	0	71	16	0	15
Learning Works	2	2	0	2	0	0	3
MAS Home Care of Maine	2	2	0	1	1	0	29
Mid Coast Mental Health	27	27	0	26	1	0	5
Northern Lighthouse	1	1	0	1	0	0	0
Providence	3	3	0	3	0	0	10
Smart Child & Family Services	4	4	0	3	1	0	19
Sweetser	35	35	0	14	20	1	40
The Opportunity Alliance	64	63	1	54	10	0	13
Totals	**518**	**513**	**5**	**438**	**79**	**1**	**13**

APS Healthcare

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Quarterly Report 60b for People on State-funded Waitlist for CI

Report Dates: 10/01/2015 To 12/31/2015 **Report Run Date: 4/12/2016**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection "Date worker assigned". The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a wait list for service. The CFSN is used in conjunction with the date of assignment to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare funds.

What This Report Measures: For members on the State-funded CI wait list who were authorized for the service, how long they waited. This report counts the number of days from the date the CFSN was opened to the date the service was authorized. The report is run 2 quarters ago so nearly everyone who was entered on the wait list will have started the service. If someone on the state-funded waitlist is authorized for the MaineCare service, it is counted as being authorized for the service.

Number of people who were authorized for CI from the state-funded wait list during the quarter: 237

For those who received the service:

Average number of days waiting: 16 days

Percent waiting 30 days or less: 81.4%

Percent waiting 90 days or less: 98.3%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
AMHI Class N	230	34	196	188	38	4	16
AMHI Class Y	7	1	6	5	2	0	24
Totals	**237**	**35**	**202**	**193**	**40**	**4**	**16**

District	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
District 1	26	3	23	12	10	4	44
District 2	61	13	48	43	18	0	21
District 3	48	3	45	45	3	0	10
District 4	23	4	19	18	5	0	15
District 5	34	9	25	31	3	0	10
District 6	32	0	32	31	1	0	5
District 7	1	1	0	1	0	0	0
District 8	3	1	2	3	0	0	12
Unknown	9	1	8	9	0	0	4
Totals	**237**	**35**	**202**	**193**	**40**	**4**	**16**

APS Healthcare

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
Assistance Plus	21	5	16	21	0	0	6
Catholic Charities Maine	7	1	6	3	4	0	43
Charlotte White Center	4	0	4	4	0	0	3
Common Ties	39	3	36	39	0	0	8
Community Care	26	1	25	26	0	0	4
Community Counseling Center	7	0	7	3	4	0	30
Community Health & Counseling Services	2	0	2	2	0	0	11
Cornerstone Behavioral Healthcare	1	0	1	1	0	0	0
Counseling Services Inc.	22	2	20	10	11	1	37
Kennebec Behavioral Health	20	6	14	17	3	0	14
Learning Works	1	0	1	0	0	1	106
Life by Design	1	1	0	1	0	0	15
Mid Coast Mental Health	19	3	16	15	4	0	12
Smart Child & Family Services	3	0	3	2	0	1	66
Sweetser	20	3	17	17	3	0	15
The Opportunity Alliance	31	9	22	24	6	1	17
Tri-County Mental Health	13	1	12	8	5	0	23
Totals	**237**	**35**	**202**	**193**	**40**	**4**	**16**

APS Healthcare

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Report 67

Non-Hospitalized Members Assigned to Any Community Support Service (CI,CRS,ACT or Adult BHH) within 3 and 7 Working Days (Includes MaineCare members and Courtesy Reviews done by APS)

Report Dates: 10/01/2015 To 12/31/2015 **Run Date: 04/12/2016**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Non-hospitalized member -** MaineCare member who is not in an inpatient psychiatric facility at the time of application for services. This is indicated by the member not having an open authorization for inpatient psychiatric services on the day a CFSN is completed or on the day the member is referred for CI services.
- **Community support services:** Community support services is a group of mental health services providing support in the community to persons with serious mental illness. It includes CI, CRS, ACT and Adult Behavioral Health Homes
- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Adult Assertive Community Treatment (ACT)** provides individualized intensive integrated community-based services that are delivered by a multi-disciplinary team of practitioners who are available twenty-four(24) hours a day.
- **Behavioral Health Home (BHH)** is a service designed to integrate the systems of care of behavioral health and physical health.
- **Community Rehabilitation Services (CRS)** are delivered by a team, with primary case management for each member assigned to one team member.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection “Date worker assigned”. The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a waiting list for service. When there is a CFSN, it is used in conjunction with the start date of the service to determine the number of days the member waited.
- **Referral Date** is a field in CareConnection that the Provider may fill in when a member applies for a service. If the member is not put on a waiting list, (i.e. no CFSN) the referral date is used with the date of assignment to determine the number of days the member waited.
- **Courtesy Review -** APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.

What This Report Measures: The number of non-hospitalized members authorized for any type of community support services and whether they a.) were assigned to a case manager within 3 working days, b.) Waited 4 - 7 working days to be assigned or c.) waited longer than 8 days but were eventually assigned to a case manager.

Total number of non-hospitalized members admitted to any community support service: 2,491

Total assigned within 3 working days: 1,680	% assigned within 3 working days: 67%
Total assigned in 4 - 7 working days: 230	% assigned in 4 -7 working days: 9%
Total assigned within 7 working days: 1,910	% assigned within 7 working days: 77%
Total assigned after 8 or more working days: 581	% assigned after 8 or more working days: 23%

Service	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
H0040 - Adult Assertive Community Treatment - ACT	18	6	37	61
H2015 - Community Integration (CI)	1,339	185	410	1,934
H2018 - Community Rehabilitation Services (CRS)	5	1	2	8
T2022HB - Behavioral Health Homes - Adult	318	38	132	488
Total	**1,680**	**230**	**581**	**2,491**

Gender	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Female	1,047	144	371	1,562
Male	633	86	210	929
Total	**1,680**	**230**	**581**	**2,491**

Adult Age Groups	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
18-20	92	9	26	127
21-24	119	20	43	182
25-64	1,387	187	487	2,061
65-74	66	11	19	96
Over 75 Years Old	16	3	6	25
Total	**1,680**	**230**	**581**	**2,491**

AMHI Class	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	1,580	220	549	2,349
AMHI Class Y	100	10	32	142
Total	**1,680**	**230**	**581**	**2,491**

District	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	178	36	108	322
District 2/ Cumberland County	238	37	172	447
District 3/ Androscoggin, Franklin, and Oxford Counties	348	34	115	497
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	129	29	35	193
District 5/ Somerset and Kennebec Counties	382	51	87	520
District 6/ Piscataquis and Penobscot Counties	262	28	30	320
District 7/ Washington and Hancock Counties	59	2	13	74
District 8/ Aroostook County	72	10	18	100
Unknown	12	3	3	18
Total	**1,680**	**230**	**581**	**2,491**

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	34	9	9	52
Allies	18	0	0	18
Alternative Services	22	0	3	25
Alternative Wellness Services	28	15	9	52
AngleZ Behavioral Health Services-17 ACM	14	0	3	17
Aroostook Mental Health Services	36	3	2	41
Ascentria Care Alliance	21	1	2	24
Assistance Plus	43	1	8	52
Break of Day, Inc	16	1	2	19
Bright Future Healthier You	27	0	1	28
Broadreach Family & Community Services	15	1	1	17
Catholic Charities Maine	26	19	45	90
Central Maine Family Counseling	10	0	1	11
Charlotte White Center	12	6	4	22
Choices	10	0	0	10
Common Ties	27	16	30	73
Community Care	27	3	7	37
Community Counseling Center	47	7	36	90
Community Health & Counseling Services	102	7	16	125
Cornerstone Behavioral Healthcare	15	1	1	17
Counseling Services Inc.	94	15	77	186
Crisis and Counseling Centers	1	0	0	1
Direct Community Care	6	0	2	8
Dirigo Counseling Clinic	28	1	0	29
Employment Specialist of Maine	1	2	1	4
Evergreen Behavioral Services	19	0	1	20
Facing Change	26	0	0	26
Fellowship Health Resources	1	0	0	1
Fullcircle Supports Inc	27	2	3	32
Gateway Community Services LLC	18	0	2	20
Graham Behavioral Services	12	0	1	13
Healing Hearts LLC	9	0	0	9
Health Affiliates Maine	140	0	4	144
HealthReach network	2	1	3	6
Healthy Healing Counseling Inc	46	1	2	49
Higher Ground Services	6	1	0	7
Kennebec Behavioral Health	76	15	55	146
Learning Works	15	4	10	29
Life by Design	30	3	7	40
Maine Behavioral Health Organization	56	1	4	61
Maine Immigrant and Refugee Services	9	4	7	20
Maine Vocational & Rehabilitation Assoc.	11	2	2	15
Manna Inc	3	0	1	4
MAS Home Care of Maine	18	5	5	28
Merrymeeting	1	4	3	8
Mid Coast Mental Health	20	3	10	33
Motivational Services	15	3	0	18
Northeast Occupational Exchange	28	0	8	36
Northern Lighthouse	3	0	1	4
Northern Maine General	0	0	1	1

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Ocean Way Mental Health Agency	7	2	2	11
OHI	11	2	0	13
Oxford County Mental Health Services	13	3	2	18
Paramount Behavioral Services,Inc	15	2	0	17
Partnerships for Nonprofits, dba Reach	7	0	0	7
Penobscot Community Health Center	7	0	0	7
Protea Integrated Health & Wellness	88	2	3	93
Providence	10	6	12	28
Riverview	1	0	0	1
Rumford Group Homes	12	0	0	12
Sequel Care of Maine	9	0	6	15
Shalom House	12	1	3	16
Sinfonia Family Services	2	0	0	2
Smart Child & Family Services	6	2	10	18
Spurwink	1	0	1	2
St. Andre Homes	1	1	2	4
Sunrise Opportunities	3	0	0	3
Sweetser	92	28	31	151
The Opportunity Alliance	48	11	62	121
The Umbrella Agency	6	0	0	6
Tri-County Mental Health	47	12	55	114
Volunteers of America	2	1	2	5
York County Shelter Program	9	0	0	9
Total	**1,680**	**230**	**581**	**2,491**

APS Healthcare

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Report 69

Hospitalized Members Assigned to Any Community Support Service (CI,CRS,ACT or Adult BHH) within 3 and 7 Working Days (Includes MaineCare members and Courtesy Reviews done by APS)

Report Dates: 10/01/2015 To 12/31/2015 **Run Date: 04/12/2016**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Hospitalized member -** MaineCare member who is in an inpatient psychiatric facility at the time of application for services. This is indicated by the member having an open authorization for inpatient psychiatric services at the time a CFSN authorization is entered into CareConection or on the day that the member is referred for CI services.
- **Community support services:** Community support services is a group of mental health services providing support in the community to persons with serious mental illness. It includes CI, CRS, ACT and Adult Behavioral Health Homes
- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Adult Assertive Community Treatment (ACT)** provides individualized intensive integrated community-based services that are delivered by a multi-disciplinary team of practitioners who are available twenty-four(24) hours a day.
- **Behavioral Health Home (BHH)** is a service designed to integrate the systems of care of behavioral health and physical health.
- **Community Rehabilitation Services (CRS)** are delivered by a team, with primary case management for each member assigned to one team member.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection “Date worker assigned”. The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a waiting list for service. When there is a CFSN, it is used in conjunction with the start date of the service to determine the number of days the member waited.
- **Referral Date** is a field in CareConnection that the Provider may fill in when a member applies for a service. If the member is not put on a waiting list, (i.e. no CFSN) the referral date is used with the date of assignment to determine the number of days the member waited.
- **Courtesy Review -** APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.

What This Report Measures: The number of hospitalized members authorized for any type of community support services and whether they a.) were assigned to a case manager within 2 working days, b.) Waited 3 - 7 working days to be assigned or c.) waited longer than 8 days but were eventually assigned to a case manager.

Total number of non-hospitalized members admitted to any community support service: 66

Total assigned within 2 working days: 43	% assigned within 2 working days: 65%
Total assigned in 3 - 7 working days: 8	% assigned in 3 -7 working days:12 %
Total assigned within 7 working days: 51	% assigned within 7 working days: 77%
Total assigned after 8 or more working days: 15	% assigned after 8 or more working days: 23%

Service	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
H0040 - Adult Assertive Community Treatment - ACT	8	2	5	15
H2015 - Community Integration (CI)	20	3	3	26
H2018 - Community Rehabilitation Services (CRS)	1	1	1	3
T2022HB - Behavioral Health Homes - Adult	14	2	6	22
Total	**43**	**8**	**15**	**66**

Gender	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Female	17	4	5	26
Male	26	4	10	40
Total	**43**	**8**	**15**	**66**

AMHI Class	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	27	5	11	43
AMHI Class Y	16	3	4	23
Total	**43**	**8**	**15**	**66**

District	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	5	0	1	6
District 2/ Cumberland County	6	0	5	11
District 3/ Androscoggin, Franklin, and Oxford Counties	2	1	2	5
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	1	1	1	3
District 5/ Somerset and Kennebec Counties	16	4	3	23
District 6/ Piscataquis and Penobscot Counties	9	0	2	11
District 7/ Washington and Hancock Counties	2	2	1	5
District 8/ Aroostook County	1	0	0	1
Unknown	1	0	0	1
Total	**43**	**8**	**15**	**66**

Providers	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	9	1	0	10
Aroostook Mental Health Services	2	0	0	2
Catholic Charities Maine	2	0	2	4
Common Ties	0	0	1	1
Community Care	1	0	0	1
Community Counseling Center	0	0	3	3
Community Health & Counseling Services	2	2	2	6
Counseling Services Inc.	4	0	1	5
Fullcircle Supports Inc	3	0	0	3
Graham Behavioral Services	1	1	0	2
HealthReach network	1	1	0	2
Healthy Healing Counseling Inc	1	0	0	1
Kennebec Behavioral Health	3	1	1	5
Maine Vocational & Rehabilitation Assoc.	1	0	0	1
Motivational Services	3	1	1	5
Northeast Occupational Exchange	2	0	0	2
OHI	1	0	0	1
Sweetser	3	0	0	3
Tri-County Mental Health	2	1	2	5
Volunteers of America	1	0	2	3
York County Shelter Program	1	0	0	1
Total	**43**	**8**	**15**	**66**