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 The Certification Request was withdrawn May 14, 2010.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.