Department of Health and Human Service
Office of Adult Mental Health Services
Fourth Quarter State Fiscal Year 2011 (April, May and June 2011)
Report on Compliance Plan Standards: Community
August 1, 2011

	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 July 2011* and *Unmet Needs by CSN for FY'11 Q3 (January, February, March 2011)*
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	All vocational components of the October 2006 Plan were completed in March 2010 and the Department will be seeking certification within the 1st quarter of FY2012.
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 The Certification Request was withdrawn May 14, 2010.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.
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	Unmet needs reports are posted on the OAMHS CSN website on a quarterly basis in order to inform discussions and recommendations to the Department for meeting unmet needs. Budget submissions to the Governor and the Legislature are in part built on data regarding unmet needs. This is reflected in the financial documents submitted to DAFS.
II.2	Demonstrate reliability of unmet needs data based on evaluation	

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 DHHS submission of the budget for FY2012/2013 included the requested funding suggested by the Court Master, a total of an additional $4.6 million for services and $1 million for BRAP. This was discussed with the Court Master.
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)*	Both the Commissioner and the Director of the DHHS Office of Adult Mental Health Services testified in favor of the additional funding noted in II,3 above. The final outcome of the legislative session was that for FY'12 and FY'13, funding for BRAP has been included. However, the approximately $4.6 million for other services was funded for FY'12 only with a report due to the legislature in January 2012 to demonstrate the continuing need for FY 2013.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	*MaineCare and Grant Expenditures Report for FY10* emailed to Court Master and Plaintiff's Counsel on 2/16/11.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs by CSN July 2011* 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 OAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Based on contract reviews done in the 3rd quarter of FY'11, 100 % of the agencies reviewed in OAMHS Field Service Offices (Bangor, Augusta, Portland) have protocols/procedures in place for client notification of rights, with documentation in provider files maintained within the regional offices. Based in licensing surveys, 100% of licensed mental health agencies have protocols/policies in place for client notification of the *Rights of Recipients.*
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 2010 DIG Survey was 88.6%, slightly below the standard of 90%. The data was shared with the CCSM

IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension	Standard met Calendar Years 2006, 2007, 2008 and 2009; the 1st and 3rd quarters of calendar year (CY) 2010 (data not available for the 2nd quarter); and the 2nd quarter CY'11 (no Level II grievances reported in the 1st quarter of CY 2011) See attached *Performance and Quality Improvement Standards: July 2011*, Standard 2
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if hearing is to be held or if parties concur.	Reporting began in the 1st quarter of calendar year 2008. The standard has been met, when there was a level III grievance, at 100% through the 2nd quarter of calendar year (CY) 2011 (data not available for the 2nd quarter CY10).
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: July 2011*, Standard 5-2.
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: July 2011*, Standard 5-3.
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: July 2011*, Standard 5-4.
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*	The standard was met for the 3rd and 4th quarters FY'08, all 4 quarters of FY'09 and FY'10, and the 1st, 2nd and 3rd quarters of FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 5-5
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: July 2011*, Standard 5-6.
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. As the data has been consistent over time and the feedback and interaction with providers had lessened greatly, reports are now created quarterly and available to providers upon request. Providers were notified of this change on May 18, 2011.
IV.11	Data collected once a year shows that no > 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	Once-a-year report (completed January 2011) showed that 1.8% of class members enrolled in CS did not have their ISP reviewed before the next annual review. Those not completed appear to be data errors between APS Healthcare and EIS.
IV.12	Certify in quarterly reports that DHHS is meeting its obligation re: quarterly mailings	On May 14, 2010, the court approved a Stipulated Order that requires mailings to be done only semi-annually in 2010, moving to annually in 2011 and thereafter, as long as the number of unverified addresses remains at or

		below 15%. The most recent class member mailing occurred in December 2010. The percentage of unverified addresses at that time remained below 15% at 10.8%. The next mailing will be in November 2011.
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - *must be met for 3 out of 4 quarters*	Standard met for all quarters of FY'10 and FY'11. See attached *Class Member Treatment Planning Review*, Question 2A
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be met for 3 out of 4 quarters*	Standard has been met continuously since the first quarter of FY'08. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 7-1a and *Class Member Treatment Planning Review*, Question 2B
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 met for all quarters of FY'09, FY'10, and FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 7-1c (does the consumer have a crisis plan) and *Class Member Treatment Planning Review*, Question 2F
IV.16	QM system documents that OAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	See attached *Class Member Treatment Planning Review*, Question 6.a.1 that addresses plans of correction.
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: July 2011*, Standard 8-2 and *Class Member Treatment Plan Review*, Question 3F.
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: July 2011*, Standard 9-1 and *Class Member Treatment Plan Review*, Questions 4B & C.
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.	Community Integration -- standard met since the 2nd quarter FY'08. ACT – standard met for the 2nd, 3rd and 4th quarters FY'10 and the 1st, 2nd and 4th quarters FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 10.1 and 10-2
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, OAMHS will resume reporting on caseload ratios.
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads	In this last legislative session, 1 new caseworker line was approved for the Office of Elder Services (OES).

	(pg 10) *must be met for 3 out of 4 quarters*	The position will be available in the fall. This should help to reduce caseload size. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 10-5.
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**	Standard met for the 4th quarter FY'08; the 1st, 3rd and 4th quarters of FY'09; all quarters of FY'10; and the 1st, 2nd and 3rd quarters of FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 12-1
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, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status **and**	Unmet residential support need data for the past year (FY'10 Q4, FY'11 Q's 1, 2 and 3) shows that unmet residential support needs for non-class members did not exceed by 15 percentage points those of class members. • Q4: class members 6.04%, non-class members 4.66% • Q1: class members 5.25%, non-class members 4.47% • Q2: class members 4.76%, non-class members 4.06% • Q3: class members 5.01%, non-class members 3.9%
IV.24	Meet RPC discharge standards (below); **or** if not met document reasons and demonstrate that failure not due to lack of residential support services • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	Standard met for 4 quarters of FY'08, FY'09, FY'10 and FY'11 See attached *Performance and Quality Improvement Standards: July2011*, Standards 12-2, 12-3 and 12-4
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**	Standard met for quarters 3 and 4 FY'09 and 1st, 2nd and 3rd quarters of FY'10. Percentage for the 4th quarter FY'10 was 10.8%, just above the standard. Standard met for the 1st, 2nd and 3rd quarters FY'11 (10.5%, 10.2% and 8.3%). See attached *Performance and Quality Improvement Standards: July 2011*, Standard 14-1
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	Standard 14-4 met for all quarters of FY'09; the 1st, 2nd and 4th quarters of FY'10; and all quarters of FY'11 Standard 14-5 met for the 2nd, 3rd and 4th quarters FY'09; the 2nd and 4th quarters of FY'10; and all quarters of FY'11 Standard 14-6 met for the 2nd and 4th quarters FY'09; the 2nd and 4th quarters FY'10; and all of FY'11.

	exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: April 2011*, Standard 14-4, 14-5 & 14-6
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Standard met 2007, 2008, 2009 and 2010 (annual review). Results reported in *Performance and Quality Improvement Standards: January 2010 Report*, Standard 15-1
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	In FY'10: 1st quarter 88.2% (15 of 17); 2nd quarter 81.8% (9 of 11); 3rd quarter 82.4% (14 of 17); and 4th quarter 90.9% (20 of 22). In FY'11, 88% (22 of 25) in the 1st quarter; 75% (9 of 12) in the 2nd quarter; and 78.9% (15 of 19) in the 3rd quarter. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 16-1 and *Community Hospital Utilization Review – Class Members 3rd Quarter of Fiscal Year 2011*.
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	See IV.30 below
IV.30	Evaluates compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	With the curtailment in FY 2010 and the elimination of funding for involuntary hospitalizations other than MaineCare in FY 2011, there currently are no contracts with hospitals in place. After some discussion as to how to proceed, it was determined that OAMHS will seek to establish agreements with the hospitals covering the key issues. A draft agreement was finalized with the Attorney General's Office and has been shared with MaineGeneral Hospital. Once the agreement is completed with MaineGeneral, OAMHS will use the finalized agreement as the basis for each of the other hospital agreements. Despite not having agreements in place, OAMHS is continuing the process with hospitals that it has historically performed – no objections have been received from the hospitals. The Office continues to perform reviews for involuntary hospitalizations with our Field Office Nurses.
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	OAMHS reviews emergency involuntary admissions at the following hospitals: MaineGeneral, Spring Harbor, St. Mary's, Mid-Coast Hospital, Southern Maine Medical Center, PenBay Medical Center, and Acadia. 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.	4th Quarter FY'11: No Rights of Recipients violations.
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	Standards met for FY'08, FY'09, and FY'10; and 1st, 2nd and 3rd quarters FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standards 17-2a, 17-3a and 17-4a and *Community Hospital Utilization Review – Class Members 3rd Quarter of Fiscal Year 2011*.
IV.34	QM system documents that if hospitals have fallen below the performance standard for any of the following, OAMHS 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 *Performance and Quality Improvement Standards: July 2011*, Standards 18-1, 18-2 and 18-3 for data by hospital. 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. See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members 3rd Quarter of Fiscal Year 2011*.
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*	Standard met for the 1st Quarter of FY'11, with the 2nd and 3rd quarters' results being slightly above the standard at 26%. In FY'10, standard met for the 1st quarter: slightly above at 25.7% for the 3rd quarter and 26% for the 4th quarter. Beginning with the 1st quarter of FY'09, the hospitalization rate has generally run between 1 to 3 percentage points higher than the standard. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 19-1 and *Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2011 Summary Report*.
IV.36	90% of crisis phone calls requiring face-to-face assessments are responded to within an average of 30 minutes from the end of the phone call – *must be met for 3 out of 4 quarters*	Starting with July 2008 reporting from providers, OAMHS 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 for the third quarter of FY'11 was 36.7 minutes. See attached *Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2011 Summary*

		Report.
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*	Standard has been met since the 2nd quarter of FY'08. See attached *Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2011 Summary Report.*
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*	Standard has been met since the 1st quarter of FY'08. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 19-4 and *Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2011 Summary Report.*
IV.39	Compliance Standard deleted per amendment request approved January 19, 2011.	
IV.40	Department has implemented the components of the CD plan related to vocational services	As of quarter 3 FY'10, 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)*	2010 Adult Health and Well-Being Survey: 10% of consumers in supported and competitive employment (full or part time). See attached *2010 Adult Health and Well-being Survey*
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: July 2011*, Standard 21-1
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, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet mental health treatment need data for the past year (FY'10 Q4, FY'11 Q's 1, 2 and 3) shows that unmet mental health treatment needs for non-class members did not exceed by 15 percentage points those of class members. • Q4: class members 17.09%, non-class members 16.09% • Q1: class members 16.1%, non-class members 17.81% • Q2: class members 15.37%, non-class members 18.85% • Q3: class members 13.93%, non-class members 18.01%
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	2010 Adult Health and Well-Being Survey: 77.6% domain average of positive responses.

	Domain is at or above 85%) *(Amended language 1/19/11)* **and**	
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)	Standard met for 4 quarters of FY'08, FY'09, FY'10 and FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standards 21-2, 21-3 and 21-4
IV.46	OAMHS lists in quarterly reports the programs sponsored that are designed to improve quality of life and community inclusion, including support of peer centers, social clubs, community connections training, wellness programs and leadership and advocacy training programs – list must cover prescribed topics and audiences that fit parameters of ¶105.	See attached *Performance and Quality Improvement Standards: July 2011*, Standard 30
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*	Standard met for all quarters of FY'08, FY'09 and FY'10; and the 1st, 2nd and 3rd quarters of FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 28
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	See attached *Performance and Quality Improvement Standards: July 2011*, Standard 23-1 and 23-2
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.	100% of contracts include this requirement. Annual contract reviews completed in the 3rd quarter of FY'11 in all 3 regions addressed this standard with documentation contained in contract files maintained by the regional office.
IV.50	Lists in quarterly reports the number and types of mental health informational workshops, forums and presentations geared to general public that are designed to reduce myths/stigma and foster community integration (cover prescribed list and fit audience parameters)	See attached *Performance and Quality Improvement Standards: July 2011*, Standard 34 and attached *Public Education Report April-June 2011.*