Department of Health & Human Services, Office of Adult Mental Health Services
Bates v. DHHS Consent Decree
April, May, June 2014: 4th Quarter, SFY 2014
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 fourth quarter of state fiscal year 2014, covering the period from April through June, 2014. A link to the PDF version of each document is provided on the SAMHS website.

	DOCUMENT	DESCRIPTION
1	**Cover Letter, Quarterly Report:** August, 2014 *Section 1* Microsoft Word or Adobe PDF	Letter to Dan Wathen, Court Master, submitting the Quarterly Report pursuant to paragraph 280 of the Settlement Agreement for the quarter ending June 30, 2014.
2	**Report on Compliance Plan Standards: Community** *Section 2* Microsoft Word or Adobe PDF	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* Adobe PDF	Details the status of the Department's compliance with 34 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	**Public Education – Standard 34.1** *Section 4* Excel Version or Adobe PDF	Amplifies Standard 34.1 of the Performance and Quality Improvement Standards above, detailing the mental health workshops, forums, and presentations made, including levels of participation
5	**Performance Quality and Improvement Standards, Appendix: Adult Mental Health Data Sources** *Section 5* Microsoft Word or Adobe PDF **Consent Decree Performance and Quality Improvement Standard 5.** *Section 5A*	Lists and describes all of the data sources used for measuring and reporting the Department's compliance on the Performance and Quality Improvement Standards. 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.
6	**Cover: Unmet Needs and Quality**	Provides a brief introduction to the unmet needs report as well as

	DOCUMENT	DESCRIPTION
	Improvement Initiative *Section 6* Microsoft Word or Adobe PDF	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* Adobe PDF	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) 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* Microsoft Word or Adobe PDF	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* Adobe PDF	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: Class Members** *Section 10* Adobe PDF	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: Class** *Section 11* Adobe PDF	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* Adobe PDF	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.

	DOCUMENT	DESCRIPTION
	Microsoft Word or Adobe PDF	
14	**APS Healthcare Reports** *Section 14* Adobe PDF	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.
15	**Consent Decree Compliance Standards IV.23 and IV.43** *Section 15* Adobe PDF*	Yearly report that documents the percentage differences of unmet needs for residential services and unmet needs for mental health treatment between Class and Non Class members.

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

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August 1, 2014

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

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

Dear Dan:

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 June 30, 2014.

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

Sincerely,

Guy R. Cousins
Director of Substance Abuse and Mental Health Services

cc: Helen Bailey, Esq.
Phyllis Gardiner, Assistant Attorney General
Kathy Greason, Assistant Attorney General
Mary C. Mayhew, Commissioner DHHS

Department of Health and Human Service
Office of Substance Abuse and Mental Health Services
Third Quarter State Fiscal Year 2014
Report on Compliance Plan Standards: Community
August 1, 2014

	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 August 2014* and *Unmet Needs by CSN for FY14 Q3. 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. A new quality improvement plan for 2013-2018 is being developed.
II.1	Provide documentation that unmet needs data and information (data source list page 4 of compliance plan) is used in planning for resource development and preparing budget requests	Unmet needs reports are posted on the SAMHS 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	See *Cover: Unmet Needs and Quality Improvement Initiatives August 2014* and the *Performance and Quality Improvement Standards: August 2014* for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data. SAMHS is reviewing the reliability of the unmet needs data. From this review, a plan will be developed to provider training and technical assistance on identifying, recording and implementing services for unmet needs.
II.3	Submission of budget proposals for adult	The Director of SAMHS provides the Court Master

	mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs *(Amended language 9/29/09)*	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	MaineCare and Grant Expenditure Report for FY 13 provided in the May 2014 report.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs August 2014* and the *Performance and Quality Improvement Standards: August 2014* 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 standards II.3 and II.4 above for examples of how quality management data was used to support budget requests for systems improvement.
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 24 of 24 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 2013 DIG Survey was 88.3%. These data are posted on the SAMHS website and provided to the Consumer Council of Maine. SAMHS met to address the methodology used for the survey and to boost consumer participation in the survey to be distributed in the fall of 2014.
IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension.	Grievances have been responded to consistently over time. During the fourth quarter there was 10 Level II grievances filed; 10 responded to within the 5 day period.
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. Standard has been consistently addressed. There have been no Level III grievances filed in FY14.
IV.5	90% hospitalized class members assigned	See attached *Performance and Quality Improvement*

	worker within 2 days of request - *must be met for 3 out of 4* quarters	*Standards: August 2014* 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: August 2014,* 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: August 2014,* 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: August 2014,* 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: August 2014,* 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. 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. Providers are notified when reports are run. Some do request copies. Feedback has been minimal.
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	The 2013 data analysis indicates that out of 1,432 records for review, that 127 (8.9%) 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 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%. Percentage of unverified addresses for the December 2013 mailing remained below 15%. Most recent mailing was completed December 2013 and the report was provided in the February report.
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 4 out of the 4 quarters. The current percentage is 100.0%.
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: August 2014,* Standard 7-1a and *Class Member Treatment Planning Review,* Question 2B

		Standard has been met continuously since the first quarter of FY08.
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*	See attached *Performance and Quality Improvement Standards: August 2014,* Standard 7-1c (does the consumer have a crisis plan) and *Class Member Treatment Planning Review,* Question 2F Standard met since the beginning of FY09
IV.16	QM system documents that SAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	See Section 9 *Class Member Treatment Planning Review,* Question 6.a.1 that addresses plans of correction. In 0.0 % of cases, SAMHS required a correction action plan from providers.
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: August 2014,* Standard 8-2 and *Class Member Treatment Plan Review,* Question 3F. This standard has been met in 2 out of 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: August 2014,* Standard 9-1 and *Class Member Treatment Plan Review,* Questions 4B & C. This standard has not been met in the past 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.	See attached *Performance and Quality Improvement Standards: August 2014,* Standard 10.1 and 10-2 Community Integration -- standard met since the 2nd quarter FY08. ACT – standard met for the 2nd, 3rd and 4th quarters FY10; the 1st, 2nd and 4th quarters FY11; FY 12, FY13, and FY14
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: August 2014,* Standard 10-5. This standard has not been met in the last 4 quarters.
IV.21	Independent review of the ISP process finds that ISPs met a reasonable level of compliance as defined in Attachment B of the Compliance Plan	
IV.22	5% or fewer class members have ISP-identified unmet residential support - *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: August 2014,* Standard 12-1 Standard met for the 4th quarter FY08; the 1st, 3rd and 4th quarters of FY09; all quarters of FY10 and FY11; all 4 quarters of FY12, FY13; and 1st, 2nd and 3rd quarters FY 14.

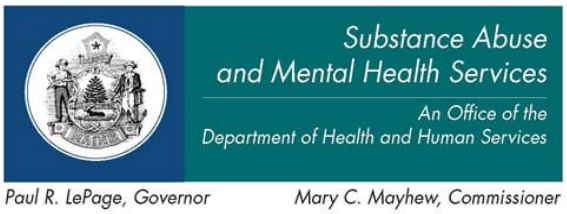
IV.23	**EITHER** quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status **and**	Unmet residential supports do not exceed 15 percentage points of Class Members. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.24	Meet RPC discharge standards (below); **or** if not met document reasons and demonstrate that failure not due to lack of residential support services • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: August 2014,* Standards 12-2, 12-3 and 12-4 Standard met since the beginning of FY08.
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: August 2014,* Standard 14-1 Standard met in FY 2014 Q3 and 25 out of the last 29 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: August 2014,* Standard 14-4, 14-5 & 14-6 Standard 14-4 met since the beginning of FY09, except for Q3 FY10. Standard 14-5 met for the 2nd, 3rd and 4th quarters FY09; the 2nd and 4th quarters of FY10; FY11; FY12 FY13 and FY 14. Standard 14-6 met for the 2nd and 4th quarters FY09; the 2nd and 4th quarters FY10; FY11; FY12, FY13, and FY 14.
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Results reported in *Performance and Quality Improvement Standards: July 2010 Report,* Standard 15-1 This standard has been met since 2007. SAMHS submitted an amendment request to the court master to modify this requirement on November 23, 2011. The court master approved SAMHS' request to hold the 2011 annual review in abeyance pending a decision on the amendment request.
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: August 2014,* Standard 16-1 and *Community Hospital Utilization Review – Class Members 3rd Quarter of Fiscal Year 2014.*

		In FY12: 76.2% (16 of 21) in the 1st quarter, 63.6% (14 of 22) in the 2nd quarter, 77.8% (7 of 9) in the 3rd quarter, 73.7% (14 of 19) in the 4th quarter IN FY13: 100% (19 of 19) in the 1st quarter 92.9% (13 of 14) in the 2nd quarter 86.7% (13 of 15) in the 3rd quarter 90.0% (18 of 20) in the 4th quarter IN FY 14: 27.3%(3 of 11) in the 1st quarter 76.5% (13 of 17) in the 2nd quarter 84.6 % (11 of 13) in the 3rd quarter
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	See IV.30 below
IV.30	Evaluates compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	All involuntary hospital contracts are in place.
IV.31	UR Nurses review all involuntary admissions funded by DHHS, take corrective action when they identify deficiencies and send notices of any violations to the licensing division and to the hospital	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. 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.	15 Complaints Received 10 Complaints investigated 2 Substantiated 2 Plan of correction sought 1 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	See attached *Performance and Quality Improvement Standards: August 2014*, Standards 17-2a, 17-3a and 17-4a and *Community Hospital Utilization Review – Class Members 3rd Quarter of Fiscal Year 2014.* Standards met for FY08, FY09, FY10, FY11, and FY12 Standards met for FY13, and 1st, 2nd and 3rd Quarter FY 14
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	See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members 3rd Quarter of Fiscal Year 2014.* 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.

	• obtaining ISPs (90%) • creating treatment and discharge plan consistent with ISPs (90%) • involving CIWs in treatment and discharge planning (90%)	Standard 18.1 has not been met for the past 4 quarters. Standard 18.2 has been met for the past 4 quarters Standard 18.3 has been met for the past 4 quarters
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: August 2013,* Standard 19-1 and *Adult Mental Health Quarterly Crisis Report Fourth Quarter, State Fiscal Year 2014 Summary Report*. In FY11, standard met for the 1st quarter, with the 2nd (25.6%), 3rd (26.2%) and 4th (26.4%) quarters' results being slightly above the standard. In FY12, standard met all 4 quarters. In FY 13, standard met all 4 quarters. In FY 14, standard met 1st quarter, 2nd quarter slightly above standard (26.3%), met 3rd quarter and 4th quarter slightly above standard (26.1%)
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*	See attached *Adult Mental Health Quarterly Crisis Report Fourth Quarter, State Fiscal Year 2014 Summary Report*. Starting with July 2008 reporting from providers, SAMHS collects data on the total number of minutes for the response time (calculated from the determination of need for face to face contact or when the individual is ready and able to be seen to when the individual is actually seen) and figures an average. Average statewide calls requiring face to face assessments are responded to within an average of 30 minutes from the end of the phone call was met for all 4 Quarters in FY12, 4 quarters in FY13 and 1st and 2nd quarter of FY14. Standard not met 3rd quarter FY14. Standard met FY14 Q4.
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 Fourth Quarter, State Fiscal Year 2014 Summary Report*. Standard has been met since the 2nd quarter of FY08.
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: August 2013,* Standard 19-4 and *Adult Mental Health Quarterly Crisis Report Fourth Quarter, State Fiscal Year 2014 Summary Report*. Standard not met 3 out of 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 quarter 3 FY10, 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	2013 Adult Health and Well-Being Survey: 2.5 % of consumers in supported and competitive employment (full or part time).

	shows that the number of consumers under age 62 and employed in supportive or competitive employment falls below 10%. *(Amended language 1/19/11)*	
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: August 2014*, Standard 21-1 This standard has not been met for the prior 4 quarters.
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 do not exceed 15 percentage points of 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**	2013 Adult Health and Well-Being Survey: 77.1% 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: August 2014*, Standards 21-2, 21-3 and 21-4 Standard met since the beginning of FY08
IV.46	SAMHS 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: August 2014*, 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*	See attached *Performance and Quality Improvement Standards: August 2014*, 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	See attached *Performance and Quality Improvement Standards: August 2014*, Standard 23-1 and 23-2. NAMI Maine is the provider of the family support services.

	on page 16 of the Compliance Plan	
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. Documentation is maintained by the regional offices.
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: August 2014*, Standard 34.1 and attached *Public Education Report for the past quarter*.



Consent Decree Performance and Quality Improvement Standards: August 2014

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.

Starting fiscal year 2012, quarter 3, standard 5.1, 5.2, 5.3 and 5.4 will now be calculated by APS Healthcare.

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:

Standard Title:	What the standard is intending to measure.
Measure Method:	How the standard is being measured.
Standard has been me	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.

Compliance and Performance Standards: Summary Sheet
April - June 2014

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

Response to Level II Grievances within 5 days

Standard 3. Rights Dignity and Respect

1. Number of Level II Grievances filed/unduplicated # of people.
2. Number of substantiated Level II Grievances

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.
5. ISP completed within 30 days of service request.
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. ISPs reflect the strengths of the consumer?
1b. ISPs consider need for crisis intervention and resolution services?
1c. Does the consumer have a crisis plan?
1d. Has the crisis plan been reviewed every 3 months?

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
April - June 2014

Standard 10. Case Load Ratios

1. ACT Statewide Case Load Ratio
2. Community Integration Statewide Case Load Ratio
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

Paragraph 74. Needs of Class Members not in Service

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

Class members in homes with more than 8 beds in which class member's choice to reside in the facility is documented.

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

Inpatient admissions reasonably near community residence.

Compliance and Performance Standards: Summary Sheet
April - June 2014

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

1. Admission to community inpatient units with blue paper on file.
2. Blue paper was completed and in accordance with terms.

2a. Corrective action by UR Nurse when Blue paper not complete

3. Admissions in which 24 hour certification completed.

3a. Corrective action by UR Nurse when 24 hour certification not complete

4. Admission in which patients' rights were maintained

4a. Corrective action by UR Nurse when rights not maintained

5. Admissions for which medical necessity has been established.

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.Class Members use an array of Mental Health Services

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. An array of family support services as per settlement agreement
2. Number and distribution of family support services provided

Compliance and Performance Standards: Summary Sheet
April - June 2014

Standard 24. Family Support Services

1. Counseling group participants reporting satisfaction with services
2. Program participants reporting satisfaction with education programs
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. Agency contracts with referral mechanism to family support
2. Families reporting satisfaction with referral process.

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. Number of Social Clubs/peer center participants.
2. Number of other peer support programs

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
April - June 2014

Standard 33. Recovery

1. Consumers reporting staff helped them to take charge of managing illness.
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.

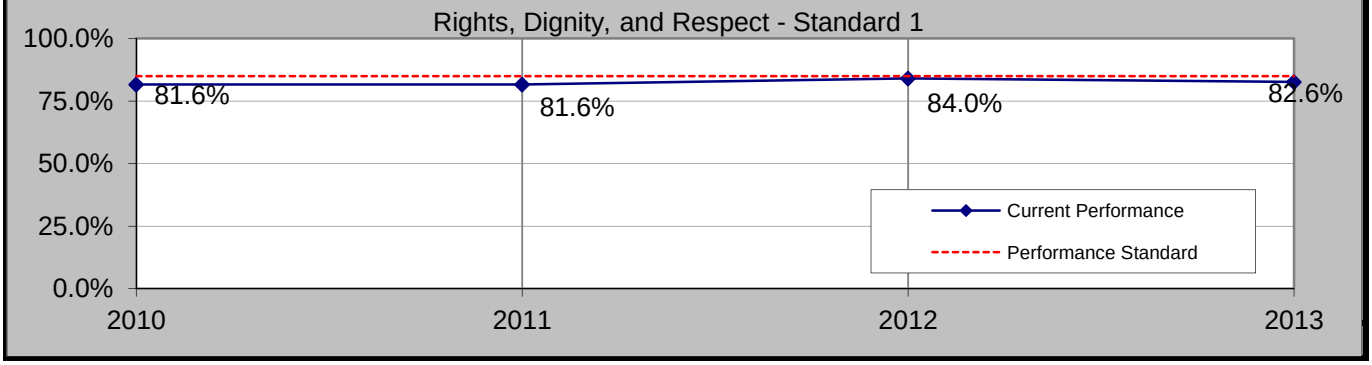
Standard 34. Public Education

1. # MH workshops, forums and presentations geared to public participation.
2. #, type of information packets, publications, and press releases distributed to public.

Rights, Dignity, and Respect

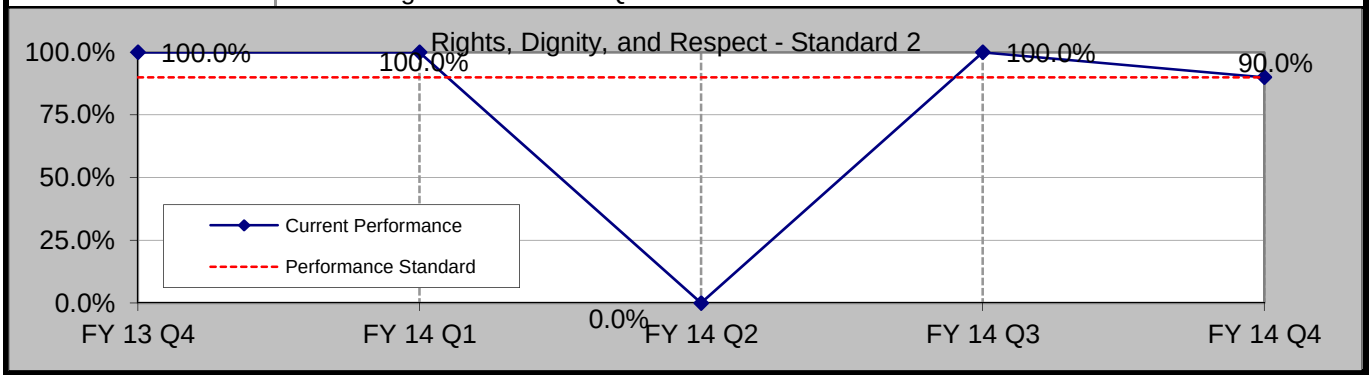
Standard 1 - Treated with respect for their individuality

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	82.6 %



Standard 2 - Grievances are addressed in a timely manner

Standard 2	
Measurement	Response to Level II Grievances within 5 days or agreed upon extension
Standard	Performance: 90% Within 5 days or during extension
Data Source	DHHS Grievance Tracking System
Current Level	10 level II grievances FY14 Q4

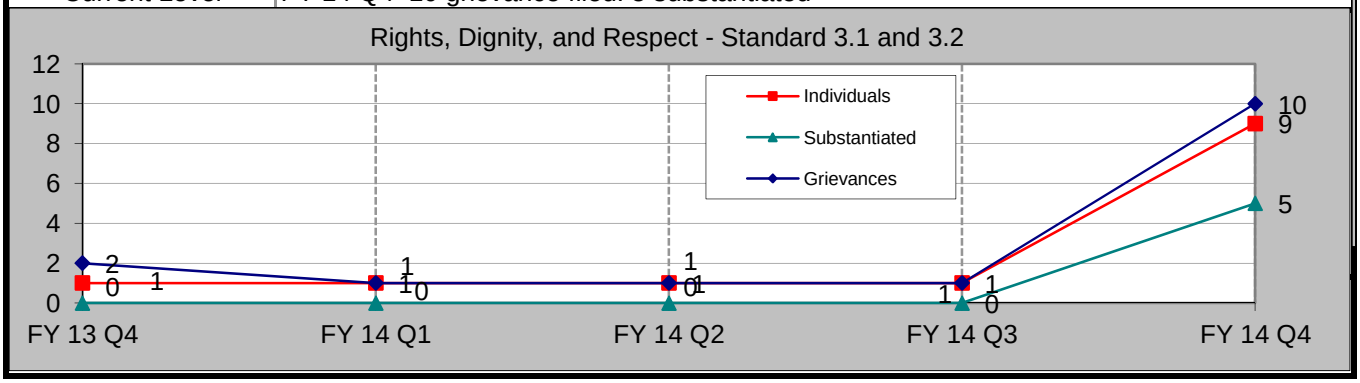


Rights, Dignity, and Respect

Standard 3 - Demonstrate rights are respected and maintained

Standard 3.1	
Measurement	Number of Level II grievances filed and number unduplicated people
Standard	No numerical standards necessary, ongoing monitoring of grievance trends.
Data Source	DHHS Grievance Tracking System
Current Level	FY 14 Q4 10 grievance filed. 9 individuals

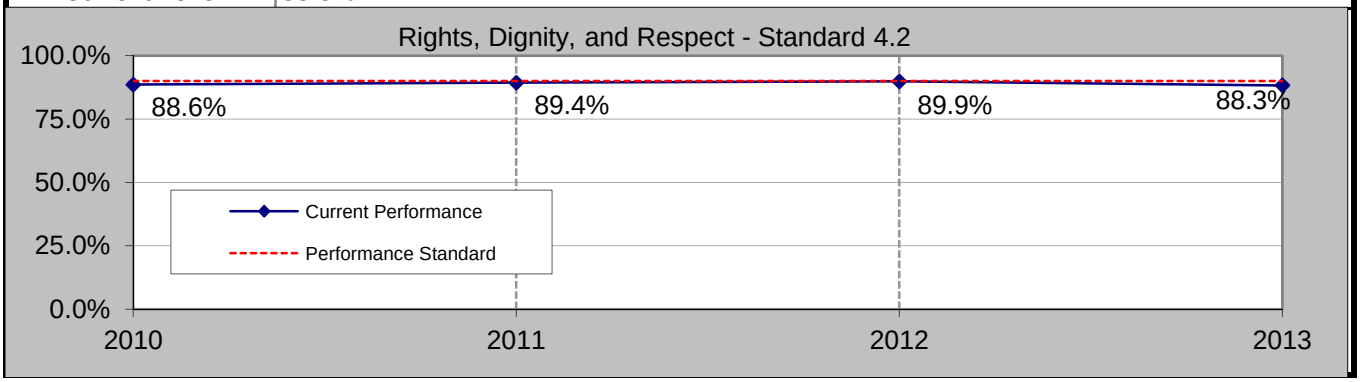
Standard 3.2	
Measurement	Number of Level II grievances filed where violation is substantiated
Standard	No numerical standards necessary, ongoing monitoring of grievance trends.
Data Source	DHHS Grievance Tracking System
Current Level	FY 14 Q4 10 grievance filed. 5 substantiated



Rights, Dignity, and Respect

Standard 4 - Class Members are informed of their rights

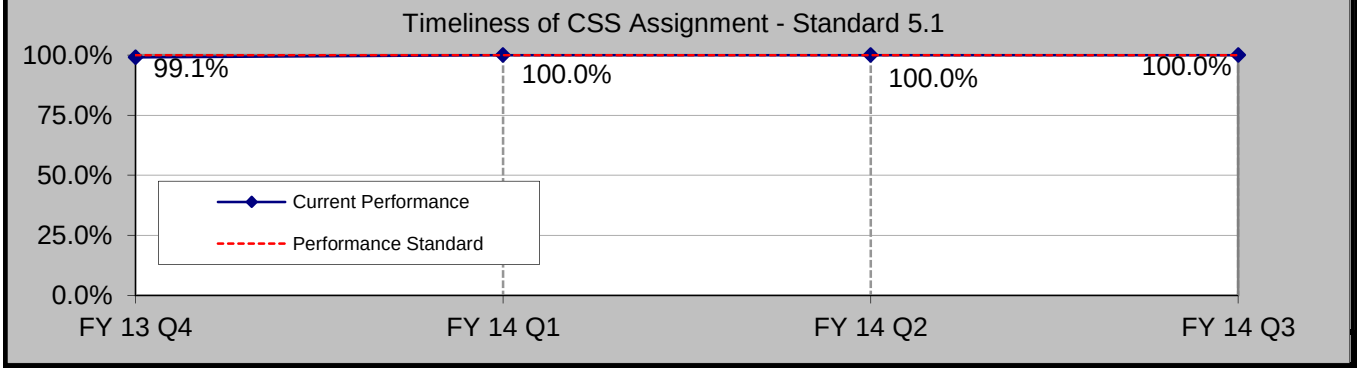
Standard 4.2	
Measurement	Percent of consumers reporting they were given information about their rights.
Standard	Performance: 90%
	Compliance: See explanation below.
Data Source	Adult Mental Health and Well Being Survey Q22
Current Level	88.3%



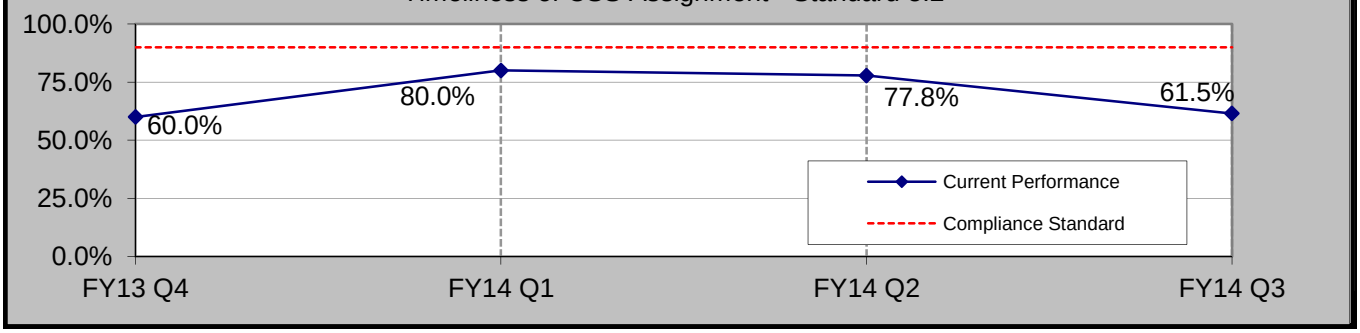
Community Integration / Community Support Services / Individualized Support Planning

Standard 5 - Prompt Assignment of CI/ACT Workers, ISP Timeframes/Attendees at ISP Meetings

Standard 5.1	
Measurement	Percentage of class members requesting a worker who were assigned one.
Standard	Performance: 100%
Data Source	APS Healthcare
Current Level	100.0% (94 out of 94)

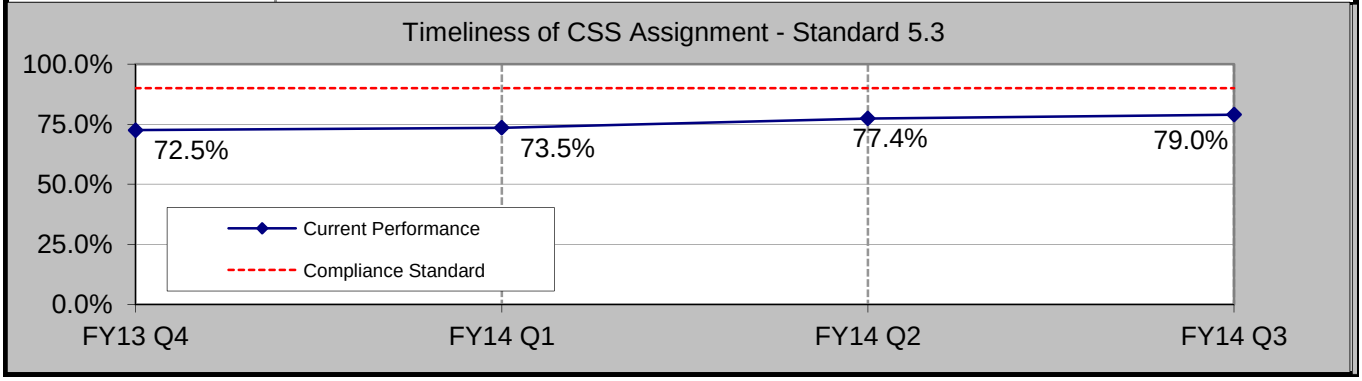


Standard 5.2	
Measurement	Percentage of hospitalized class members who were a assigned a worker within 2 working days.
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	APS Healthcare
Current Level	61.5% (8 out of 13)

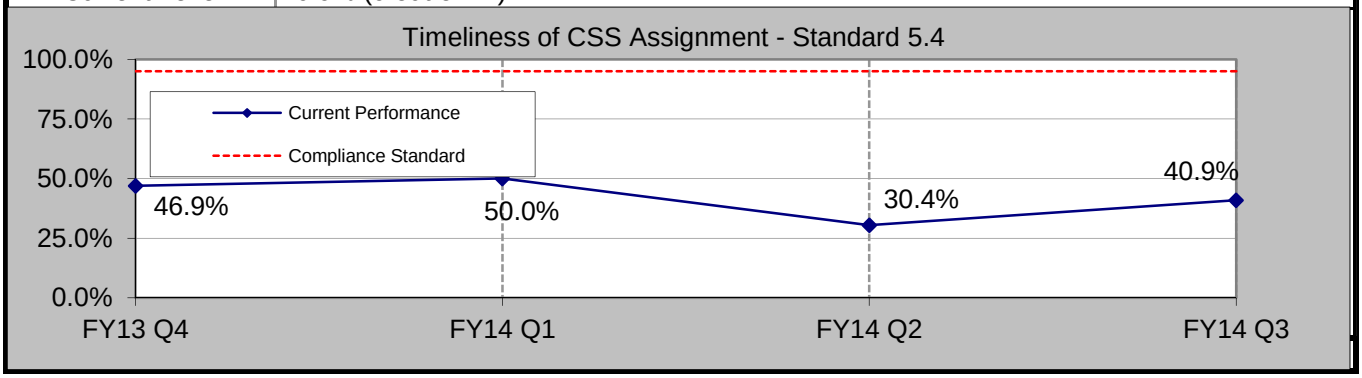


Community Integration / Community Support Services / Individualized Support Planning

Standard 5.3	
Measurement	Percent of non-hospitalized class members assigned a worker within 3 working days.
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	APS Healthcare
Current Level	79.0% (64 out of 81)



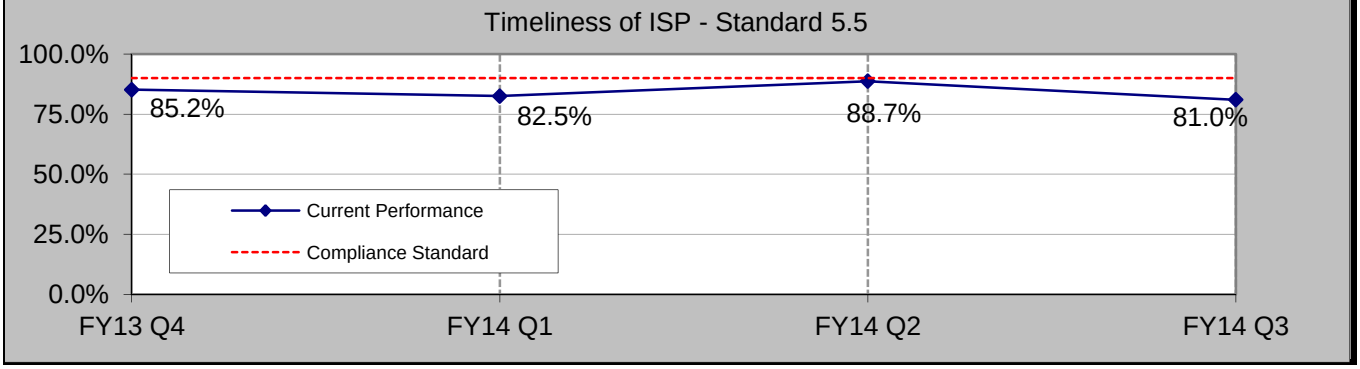
Standard 5.4	
Measurement	Percent of class members in hospital or community not assigned on time but were assigned within an additional 7 working days.
Standard	Performance: 100% Compliance: 95%
Data Source	APS Healthcare
Current Level	40.9% (9 out of 22)



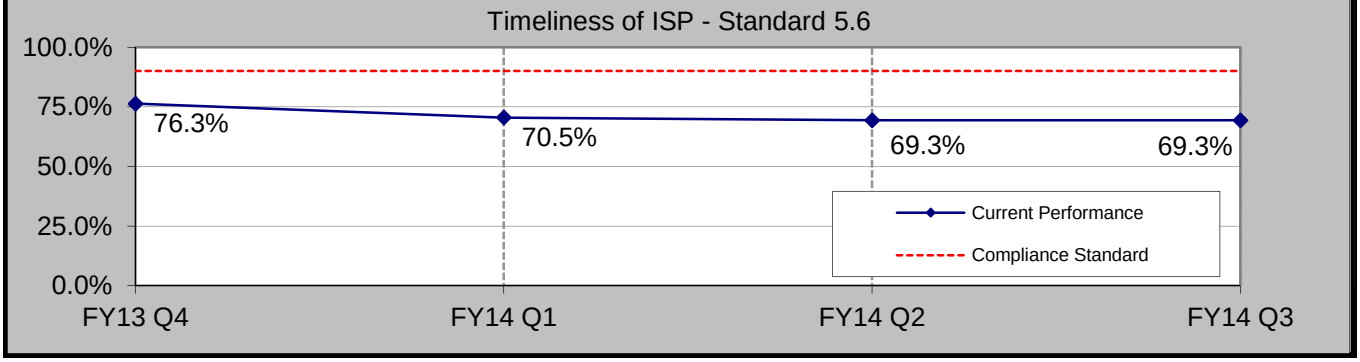
Standards 5.1 -5.4 – Calculations are now based on days from Contact for Service Notification to date of assignment. The first 3 quarters have been re-calculated using this formula.

Community Integration / Community Support Services / Individualized Support Planning

Standard 5.5	
Measurement	Class member ISPs completed within 30 days of service request
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	81.0% (34 out of 42)

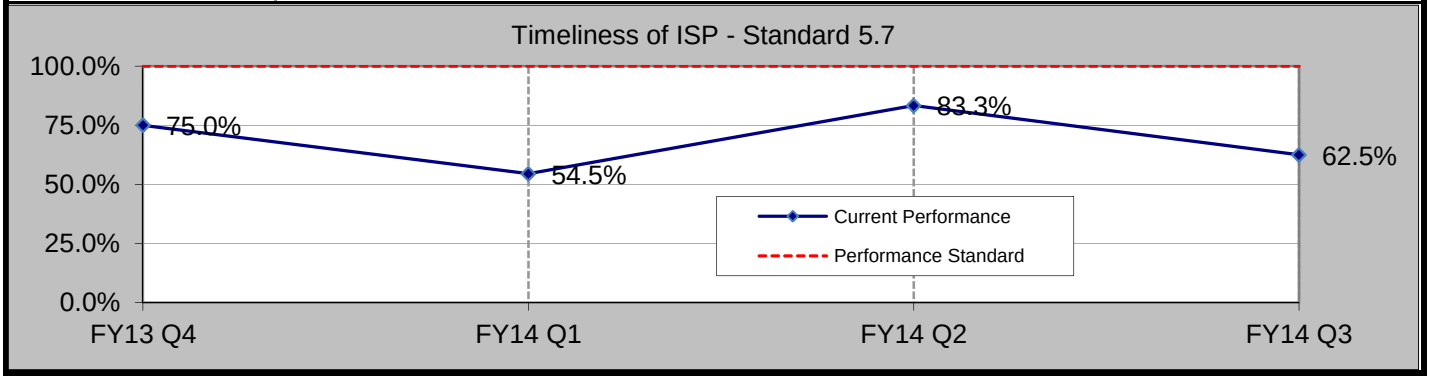


Standard 5.6	
Measurement	90 day class member ISP reviews completed within specified timeframe.
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	69.3% (738 out of 921)

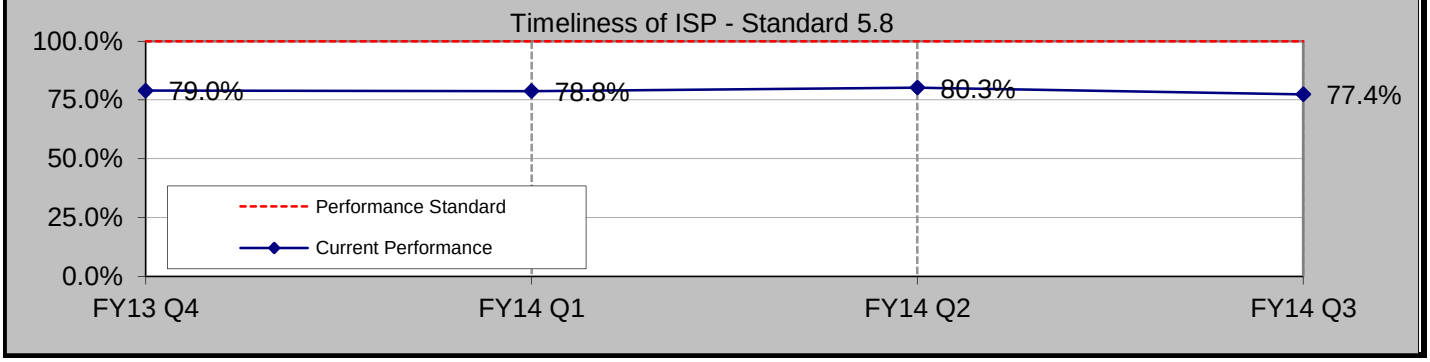


Community Integration / Community Support Services / Individualized Support Planning

Standard 5.7	
Measurement	Initial class member ISPs not developed within 30 days, but were developed within 60 working
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	62.5% (5 out of 8)



Standard 5.8	
Measurement	Class member ISPs that were not reviewed within 90 days but were reviewed within 120 working
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	77.4% (219 out of 283)



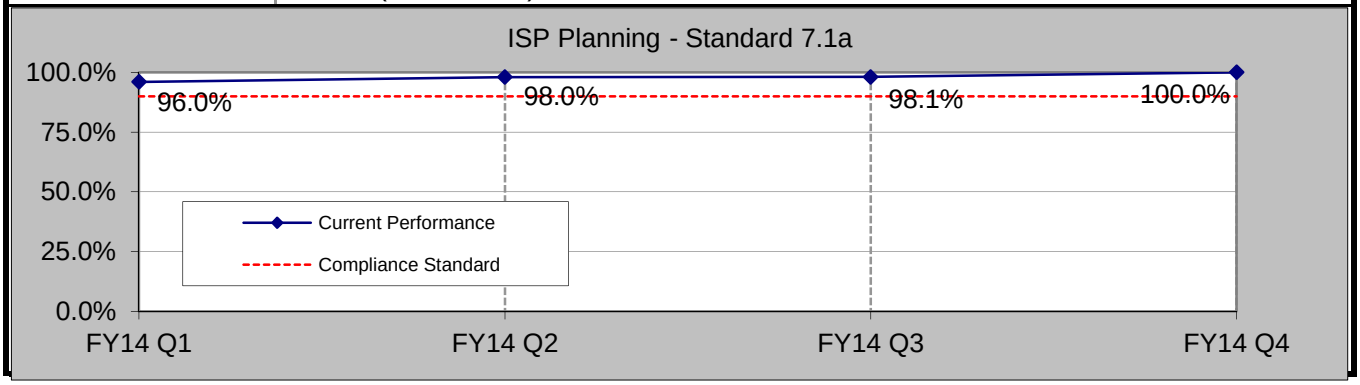
Discussion:

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.

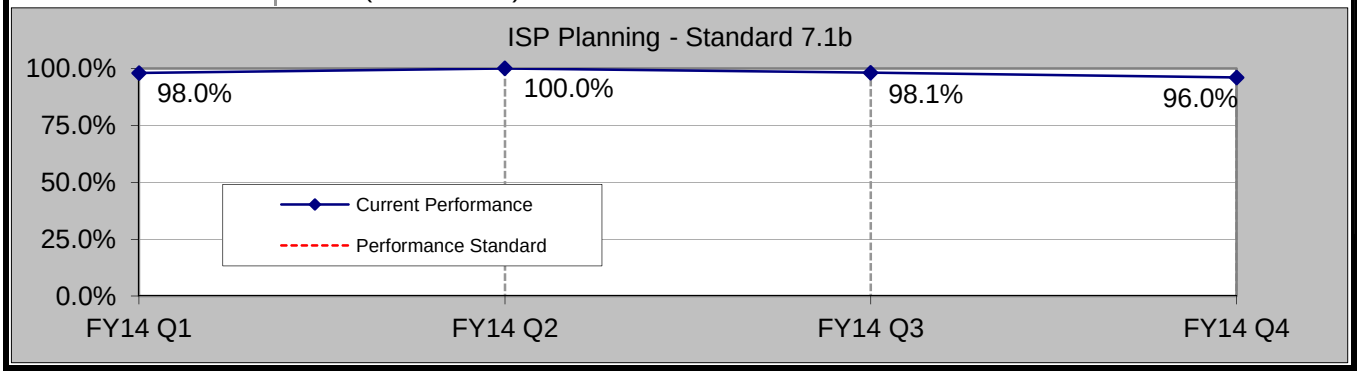
Community Integration / Community Support Services / Individualized Support Planning

Standard 7 - ISPs are based on class members' strengths & needs

Standard 7.1a	
Measurement	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?
Standard	Performance: 95% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	100.0% (51 out of 51)

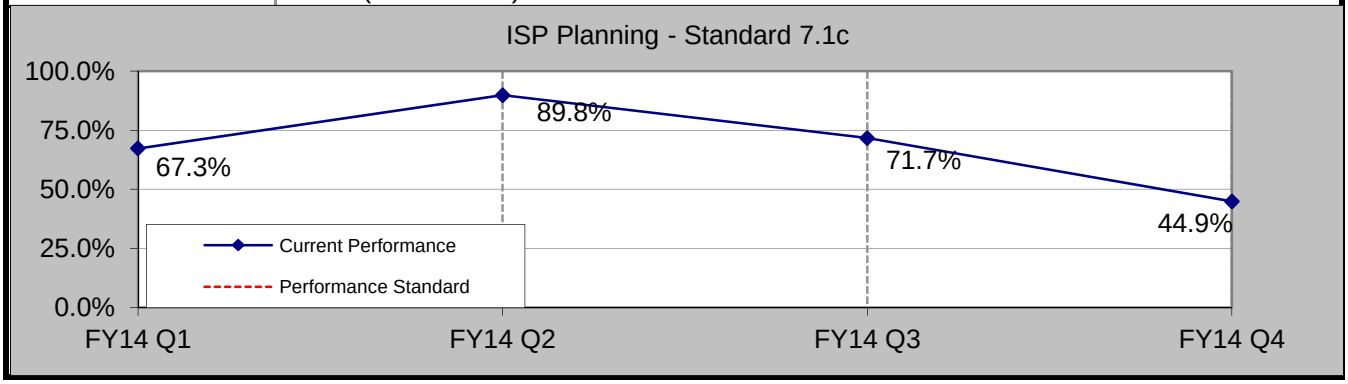


Standard 7.1b	
Measurement	Does record document the individual's potential need for crisis intervention and resolution services was considered during treatment planning?
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	96.0% (48 out of 50)

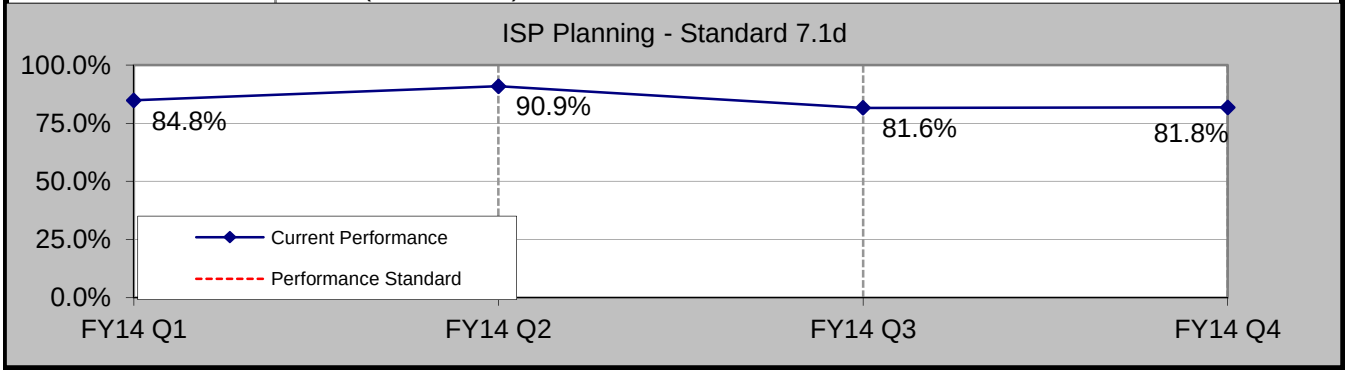


Community Integration / Community Support Services / Individualized Support Planning

Standard 7.1c	
Measurement	Does the record document that the consumer has a crisis plan?
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	44.9% (22 out of 49)



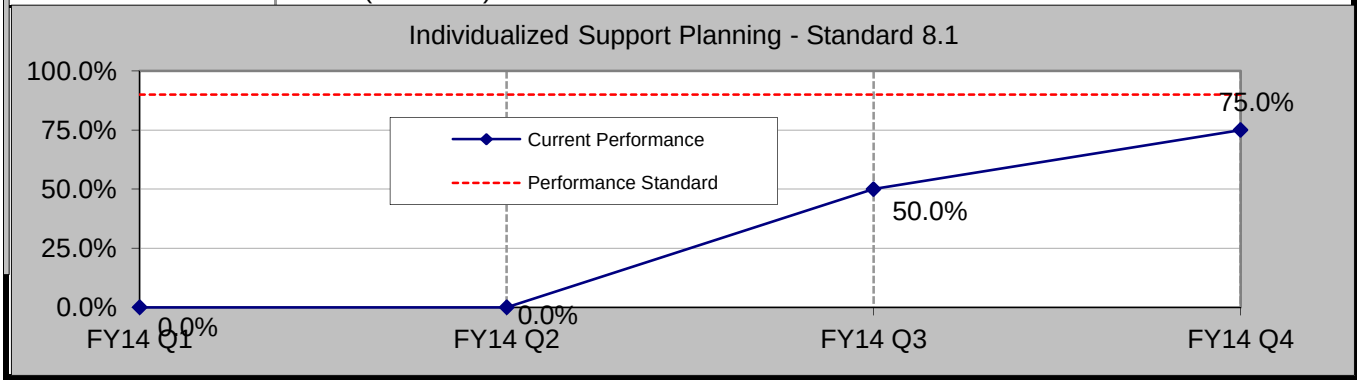
Standard 7.1d	
Measurement	If the consumer has a crisis plan, "has the crisis plan been reviewed as required, every 3 months?"
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	81.8% (18 out of 22)



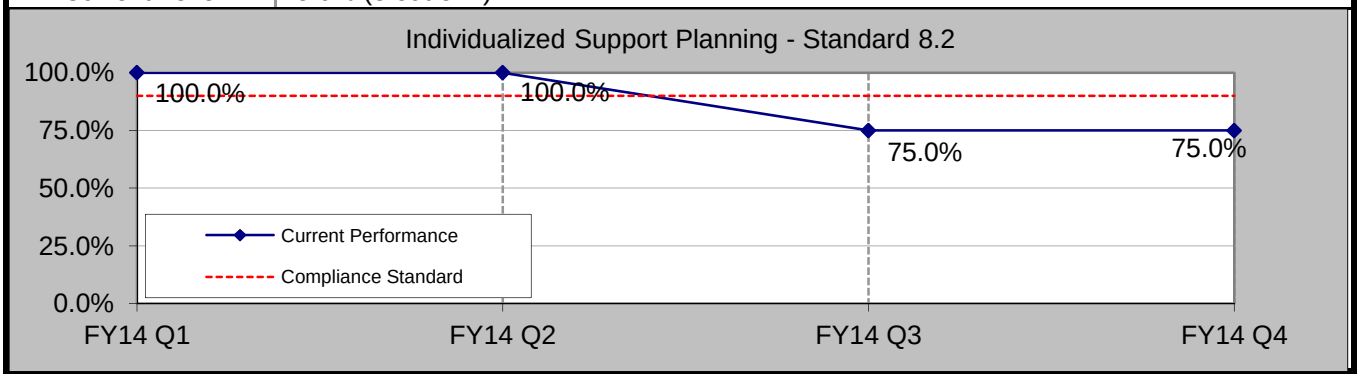
Community Integration / Community Support Services / Individualized Support Planning

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	Class Member Treatment Planning Review
Current Level	75.0% (3 out of 4)



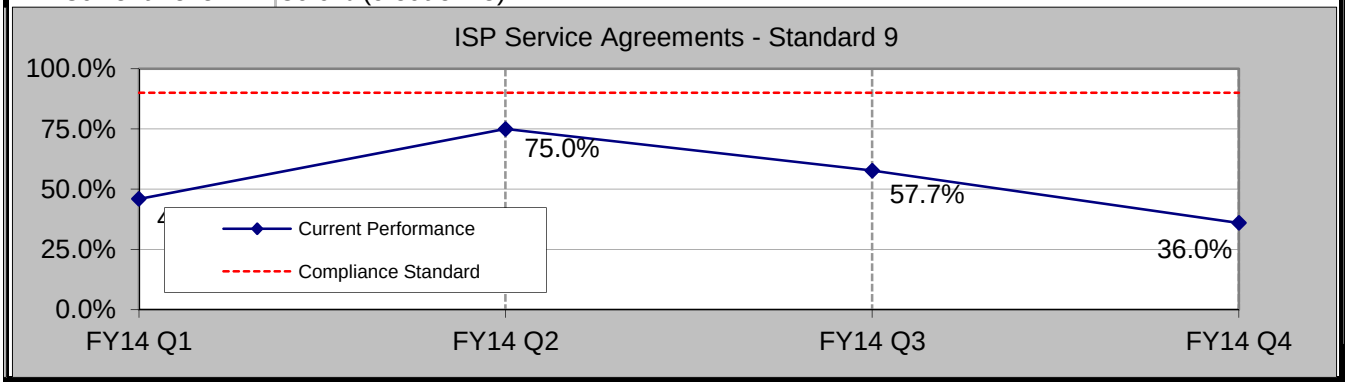
Standard 8.2	
Measurement	ISPs reviewed with identified unmet needs in which interim plans are established.
Standard	Performance: 95% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	75.0% (3 out of 4)



Community Integration / Community Support Services / Individualized Support Planning

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

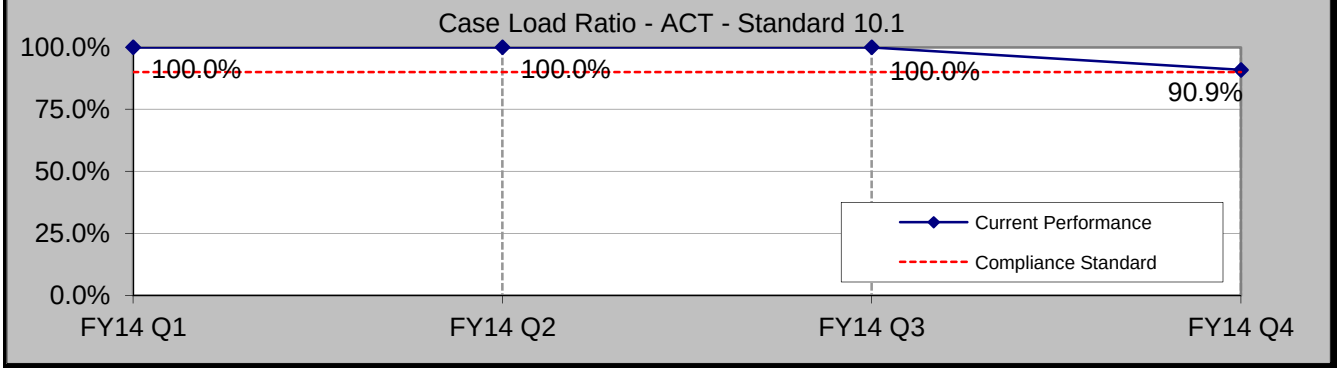
Standard 9	
Measurement	ISPs with services identified and with a treatment plan signed by each provider.**
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	36.0% (9 out of 25)



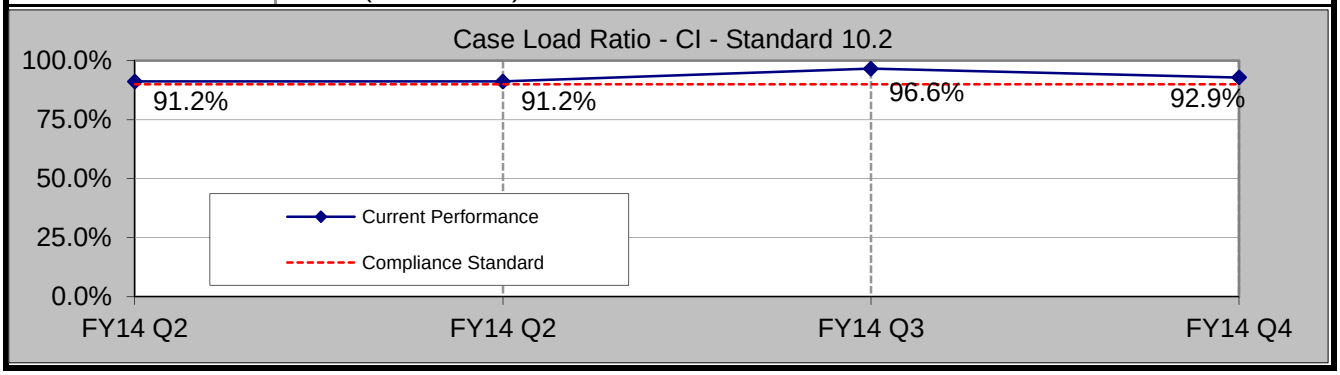
Community Integration / Community Support Services / Individualized Support Planning

Standard 10 - Case Load Ratio

Standard 10.1 - ACT	
Measurement	ACT Providers with average caseloads of 10 or fewer.
Standard	Compliance: 90% of all ACT Teams
Data Source	Agency Community Support Census/Staffing Ratio Database
Current Level	90.9% (10 out of 11)



Standard 10.2 - CI	
Measurement	Community Integration Providers with average caseloads of 40 or fewer.
Standard	Compliance: 90% of all CIW Providers
Data Source	Agency Community Support Census/Staffing Ratio Database
Current Level	92.9% (52 out of 56)



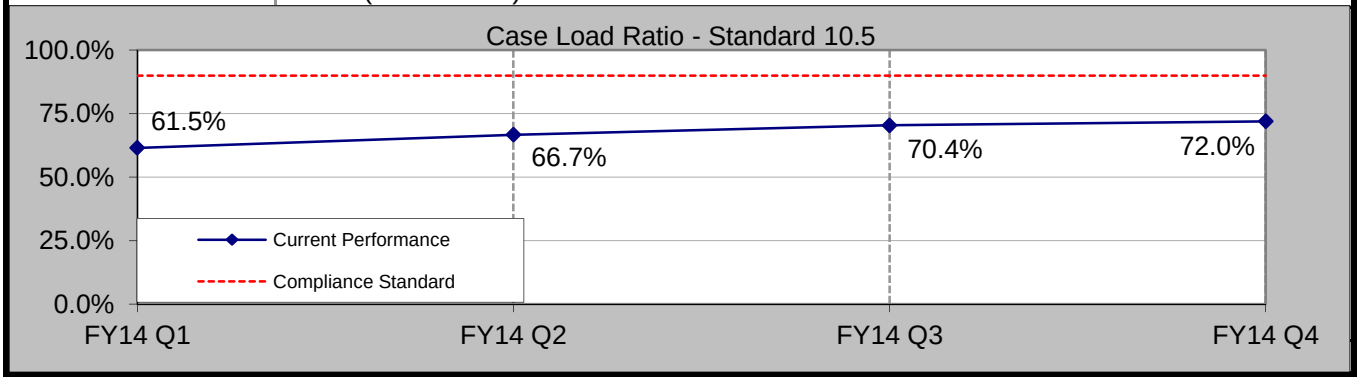
Discussion;

Standard 10.2: The volume of clients is growing by 10% every year and 10 new agencies have begun providing case management services and reporting case load ratio data within the last 6 months. This volume increase in clients and initial reporting for many agencies may cause the percentage do drop slightly. Low performing agencies will be monitored and corrective action taken if case load ratios do not stabilize.

Community Integration / Community Support Services / Individualized Support Planning

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
	ICMs 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 25 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	72.0% (18 out of 25)



Community Integration / Community Support Services / Individualized Support Planning

Standard 11 - Needs of Class Members not in service considered in system design and services

Standard 11.1	
Measurement	Number of class members who do not receive services from a community support worker identifying resource needs in an ISP-related domain area.
Standard	No numerical standard.
Data Source	Paragraph 74 Protocol
Current Level	See tables below

Standard 11.2	
Measurement	Number of unmet needs in each ISP-related domain for class members who do not receive services from a community support worker.
Standard	No numerical standard.
Data Source	Paragraph 74 Protocol
Current Level	See tables below

The total of unique individuals for all regions may not equal the total unique individuals for the State as an individual may make a request of a CDC in more than one region.

Number of contacts with resource needs Jan 1 - Mar 31, 2014				
	Region 1	Region 2	Region 3	Total
Unique Individuals:	8	5	11	24
Unmet Needs:	0	4	11	15

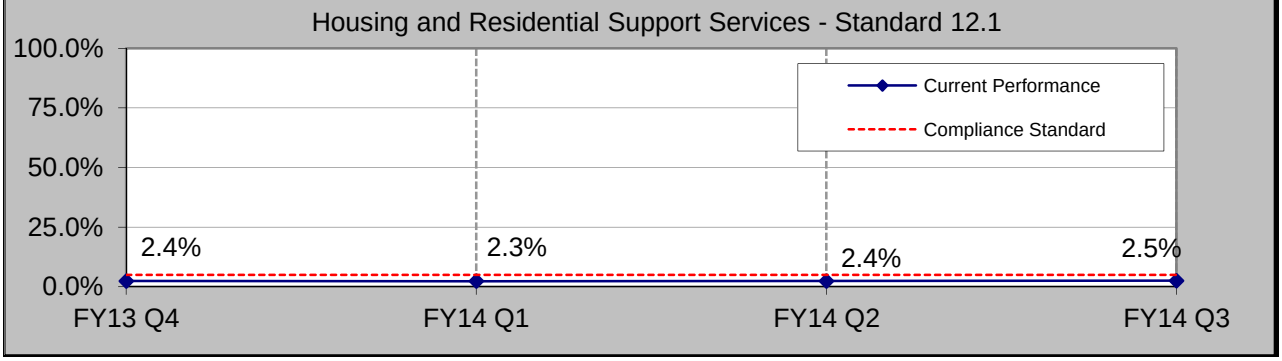
Unmet Needs by Domain Jan 1 - Mar 31, 2014	
ISP Domain Areas	**State**
Mental Health Services	0
MH Crisis Planning Resources	0
Peer, Recovery & Support Resources	0
Substance Abuse Services	0
Housing Resources	15
Health Care Resources	0
Legal Resources	0
Financial Security Resources	0
Education Resources	0
Vocation Employment Resources	0
Living Skills Resources	0
Transportation Resources	0
Personal Growth/Community Participation Resources	0
Total	0

Unmet needs have increased due to a more complete collection of the data.

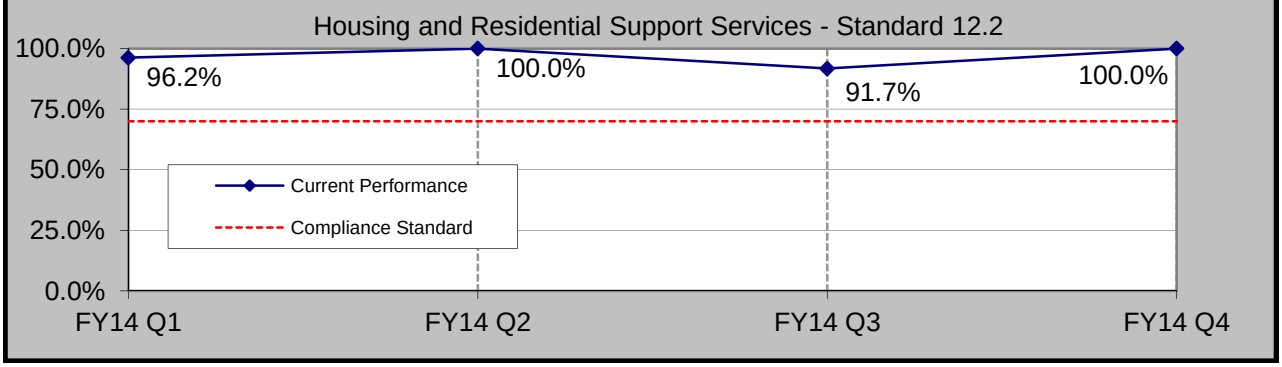
Community Resources and Treatment Services
Housing and Residential

Standard 12 - Residential 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
Current Level	2.5% (25 out of 1005)

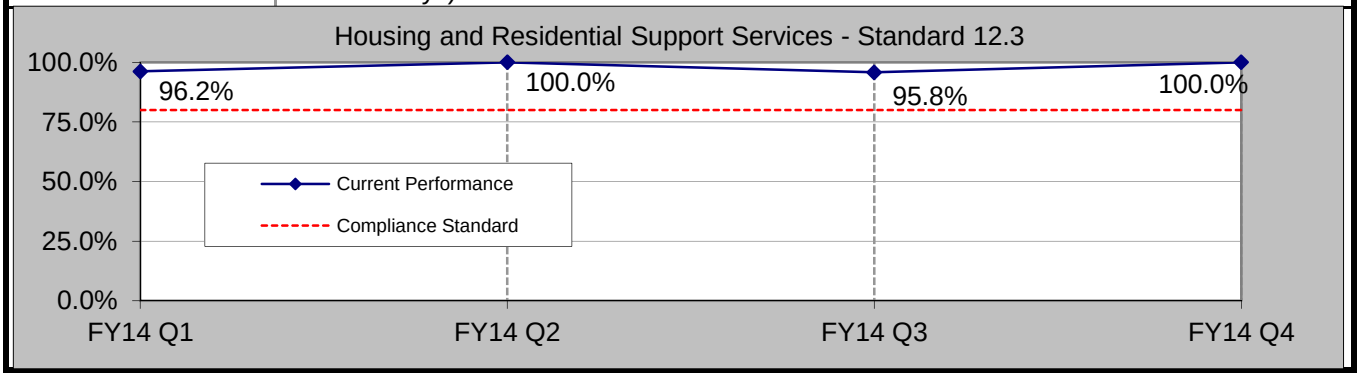


Standard 12.2	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 Q4 (Lack of residential supports did not impede discharge for any patients within 7 days)

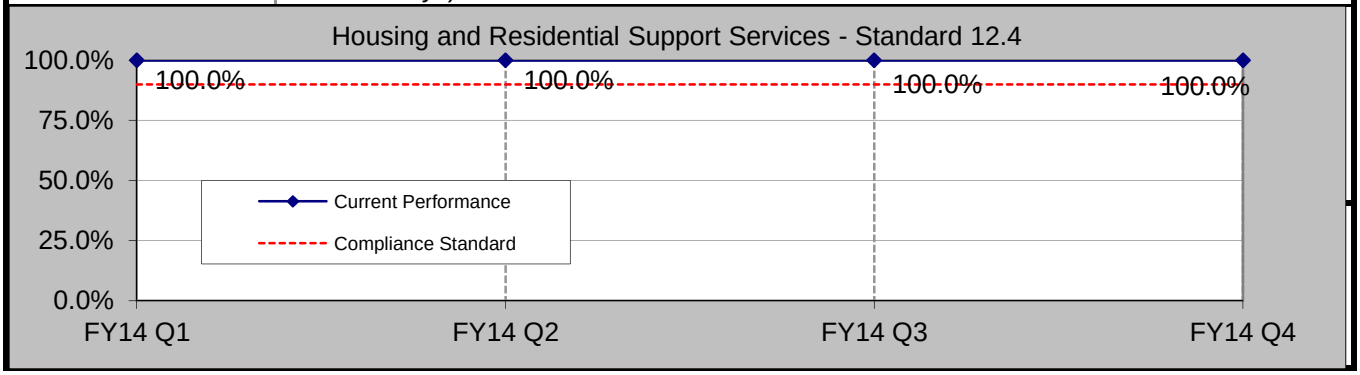


Community Resources and Treatment Services
Housing and Residential

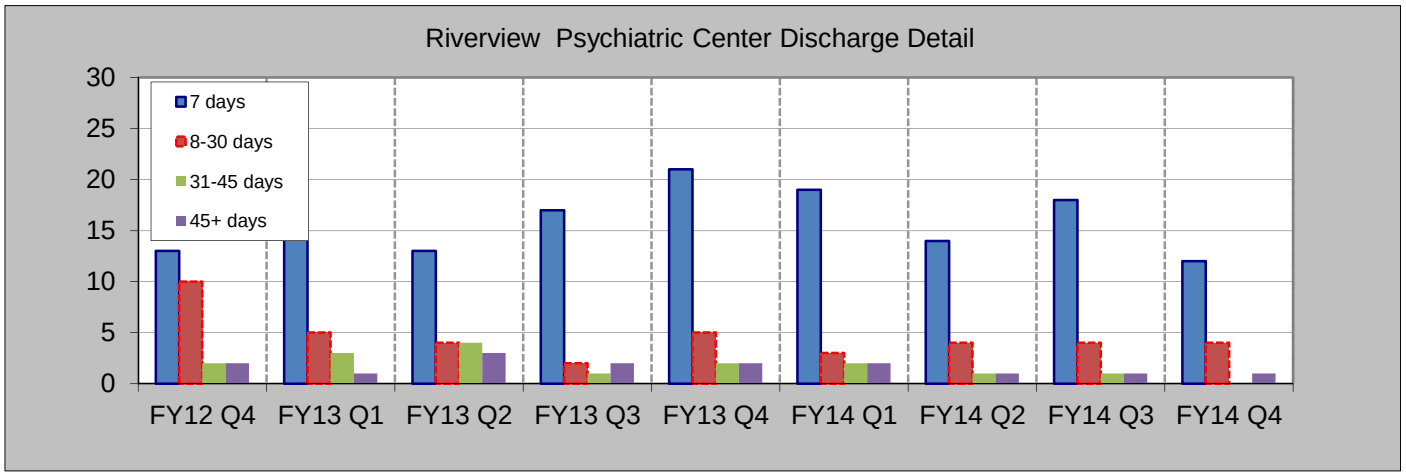
Standard 12.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 Q4 (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	Perfomance: 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	100.0% FY14 Q4 (Lack of residential supports did not impede discharge any patients within 45 days)



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:

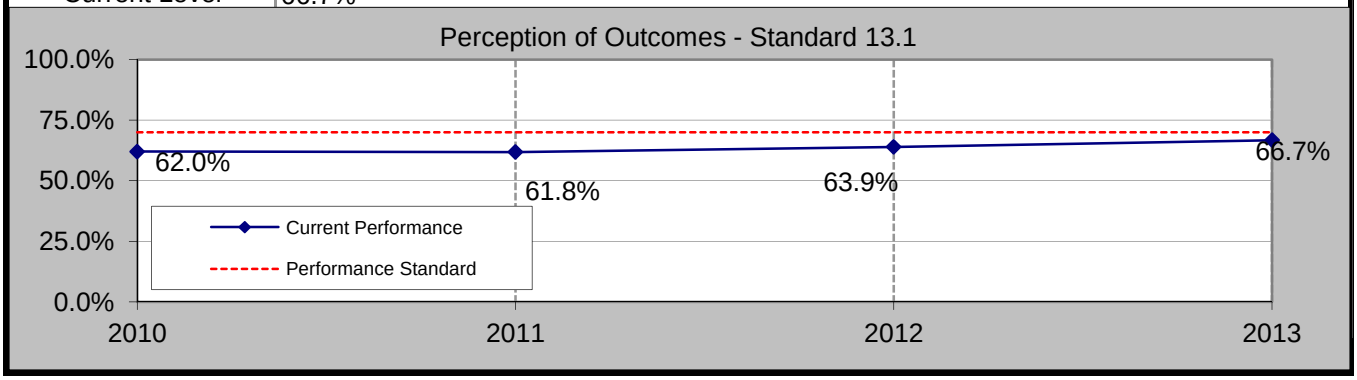
17 Civil Patients discharged in quarter

12 discharged at 7 days (70.6%)
4 discharged 8-30 days (23.5%)
1 discharged post 45 days (5.9%)

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

Community Resources and Treatment Services
Housing and Residential

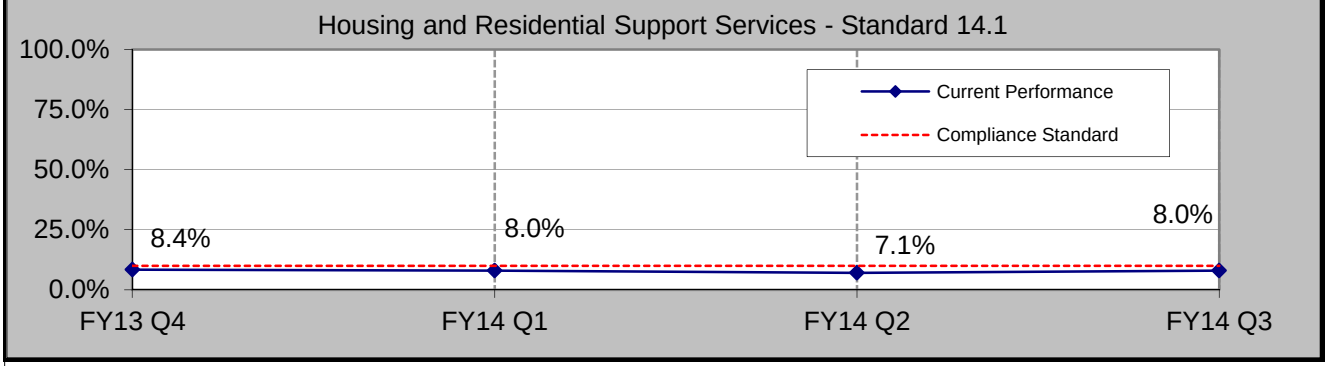
Standard 13.1	
Measurement	Domain average of positive responses to the questions in the Perception of Outcomes domain
Standard	Performance: at or above 70%
Data Source	Adult Mental Health and Well Being Survey
Current Level	66.7%



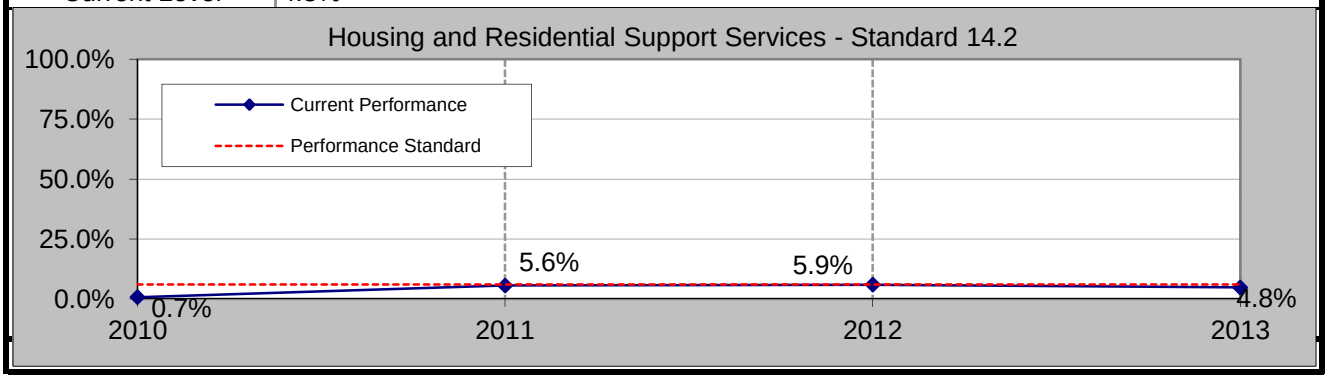
Community Resources and Treatment Services
Housing and Residential

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

Standard 14.1	
Measurement	Class members with ISPs with unmet housing needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	8.0% (80 out of 1005)

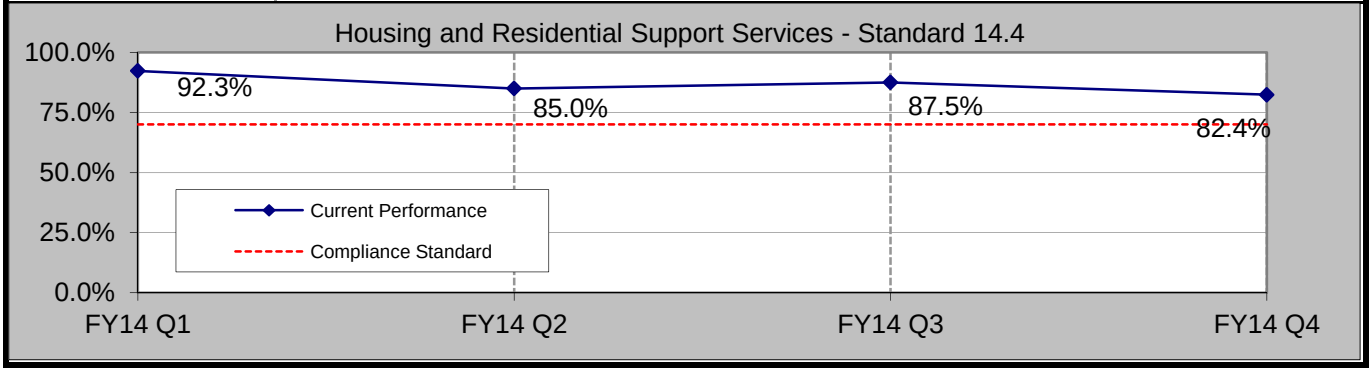


Standard 14.2	
Measurement	Percentage of respondents who experienced homelessness over 12-month period.
Standard	Performance: 6% or fewer
Data Source	Adult Mental Health and Well Being Survey, living situation data
Current Level	4.8%



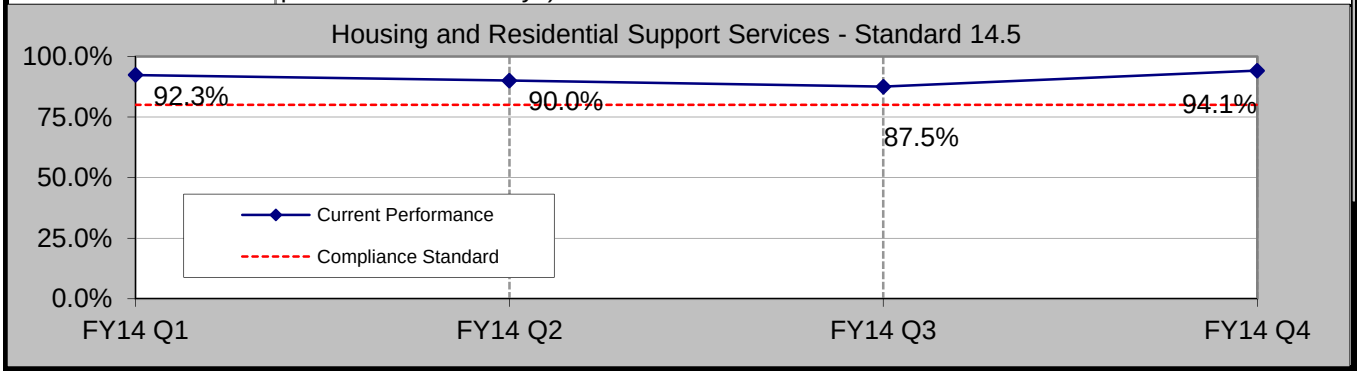
Community Resources and Treatment Services
Housing and Residential

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	82.4% FY14 Q4. (Lack of housing alternatives did not impede discharge for 14 out of 17 patients within 7 days)

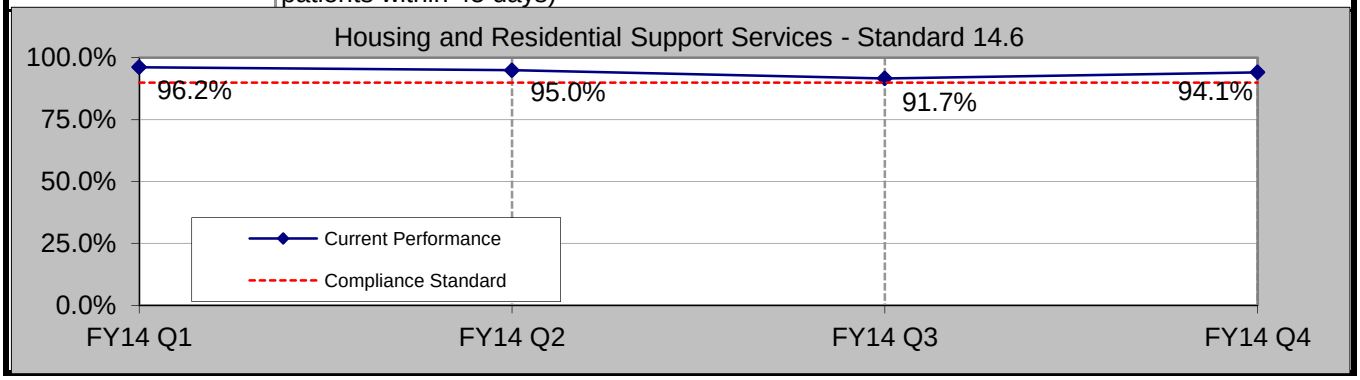


Community Resources and Treatment Services
Housing and Residential

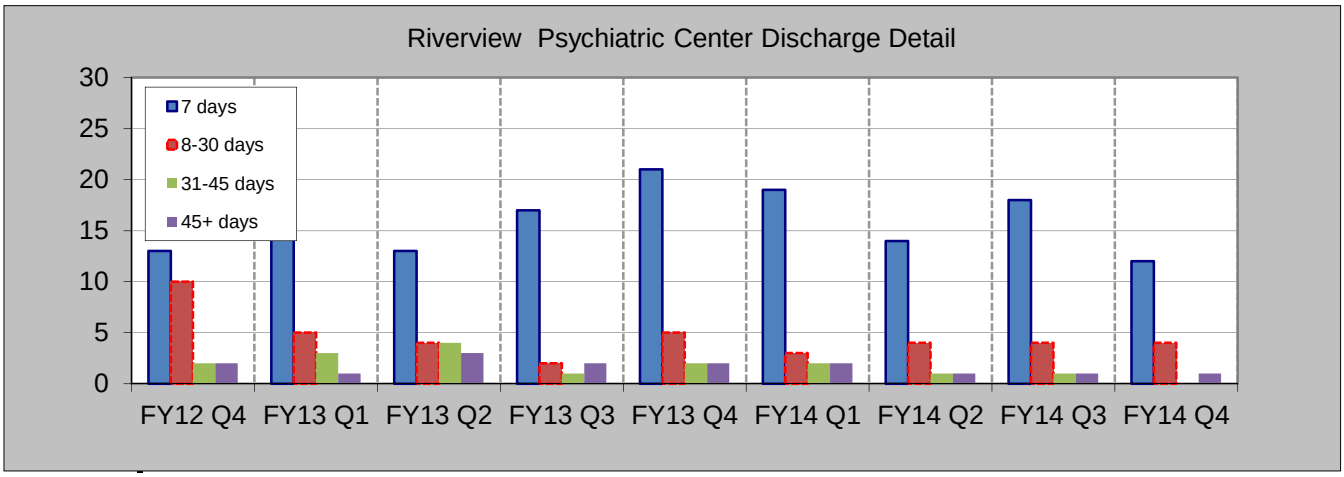
Standard 14.5	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	94.1% FY14 Q4 (Lack of housing alternatives did not impede discharge for 16 out of 17 patients within 30 days)



Standard 14.6	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	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	94.1% FY14 Q1 (Lack of housing alternatives did not impede discharge for 16 out of 17 patients within 45 days)



Community Resources and Treatment Services
Housing and Residential



17 Civil Patients discharged in quarter

12 discharged at 7 days (70.6%)
4 discharged 8-30 days (23.5%)
1 discharged post 45 days (5.9%)

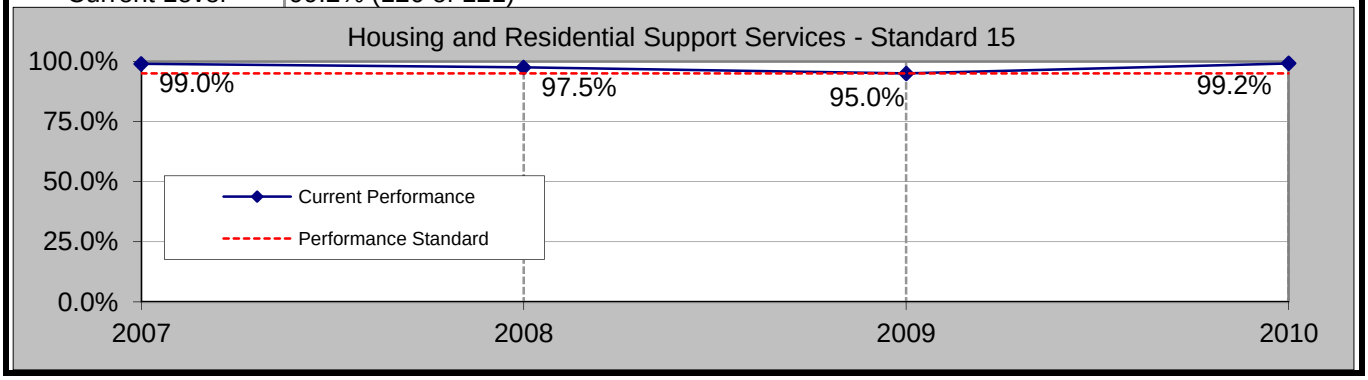
Housing Alternatives impeded discharge for 3 patients (17.6%)

2 patient discharged within 7-30 days post clinical readiness for discharge
1 patient discharged greater than 45 days post clinical readiness for discharge

Community Resources and Treatment Services
Housing and Residential

Standard 15 - Housing where community services are located / Homes with more than 8 beds

Standard 15	
Measurement	Class members residing in homes with more than 8 beds in which the class member chooses to reside in that facility is documented.
Standard	Performance: 95%
Data Source	Paragraph 96 Annual Review
Current Level	99.2% (120 of 121)

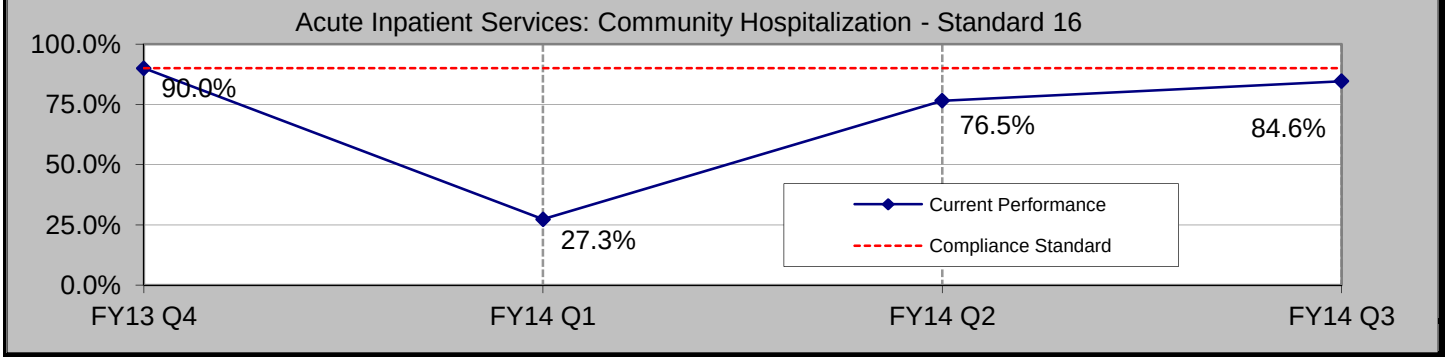


The protocol for obtaining the informed consent of Class Members to live in homes with greater than 8 beds (Settlement Agreement Paragraph 96) is followed annually to track data for this standard. SAMHS submitted an amendment request to modify this requirement on November 23, 2011. While the request is being reviewed, SAMHS was granted permission to hold the 2011 review in abeyance until a decision is made.

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% (3 out of 4 quarters)
Data Source	UR Database/EIS
Current Level	84.6% (11 out of 13)



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

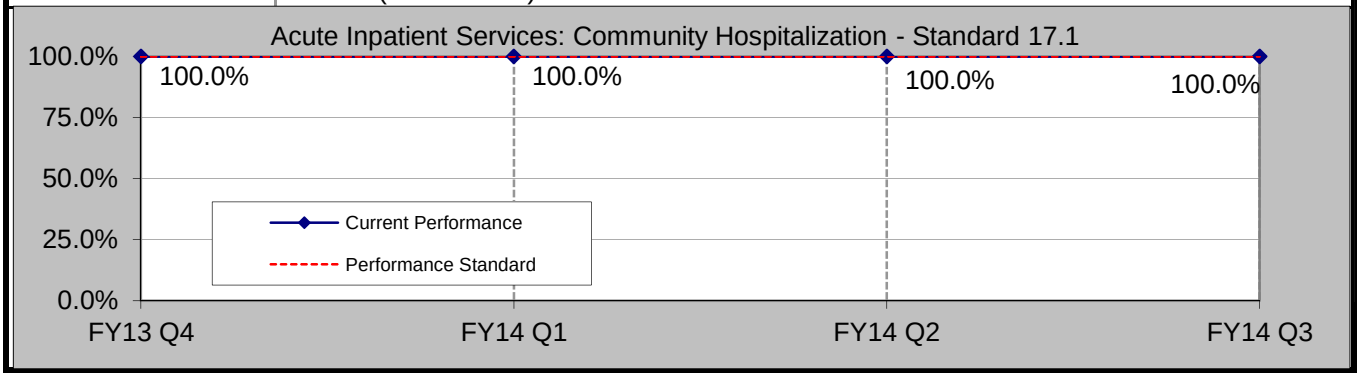
Discussion:

Standard 16 FY14 Q1: Data has been double checked manually and percentage reported is accurate. Persons needing hospitalization during the quarter were placed in the nearest **available** hospital bed. This could result in admissions outside the individual's catchment area. Measure will continue to be monitored to verify if a reflection of larger trend or an anomaly.

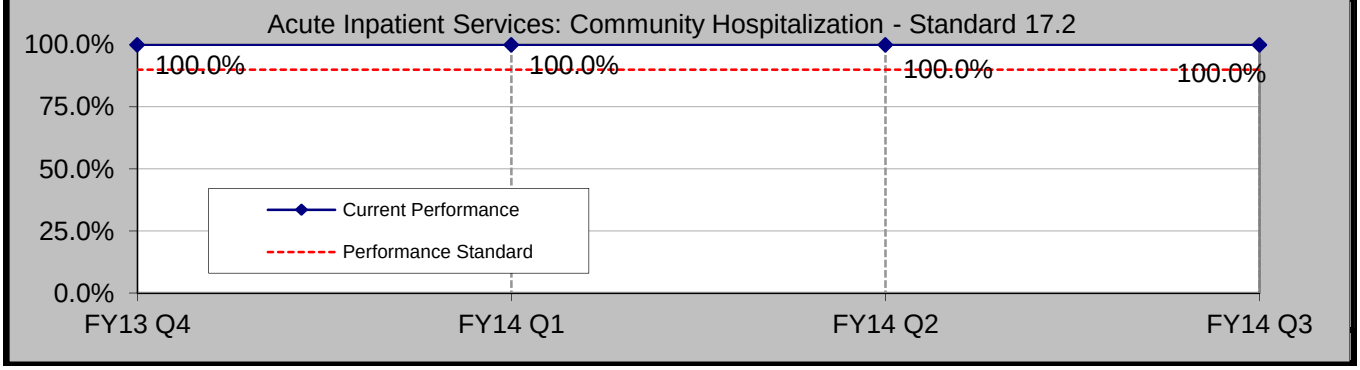
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

Standard 17 - Class member admissions to community involuntary inpatient units are in accordance with law and meet medical necessity critieria

Standard 17.1	
Measurement	Class member involuntary admissions to community inpatient units have blue paper on file.
Standard	Performance: 100%
Data Source	UR Database/EIS
Current Level	100.0% (13 out of 13)

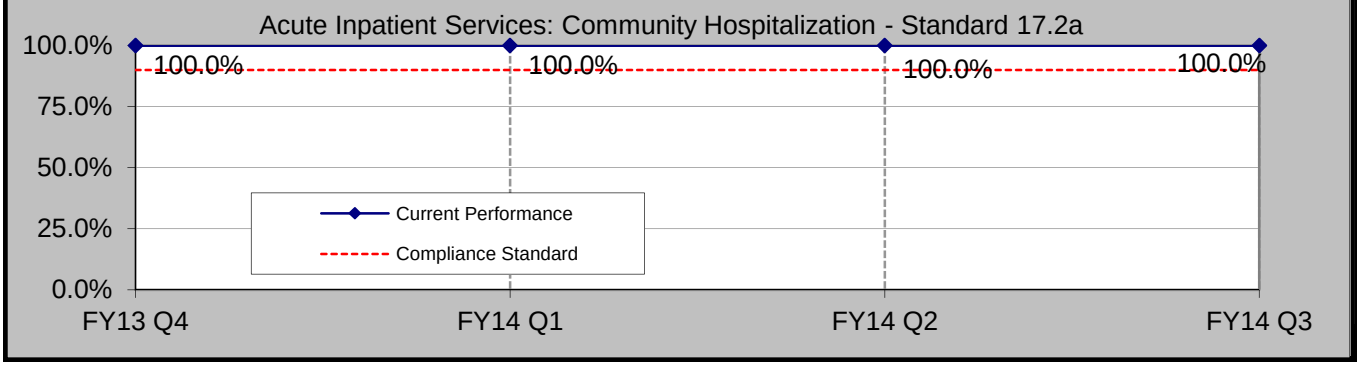


Standard 17.2	
Measurement	Blue paper was completed and in accordance with terms.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (13 out of 13)

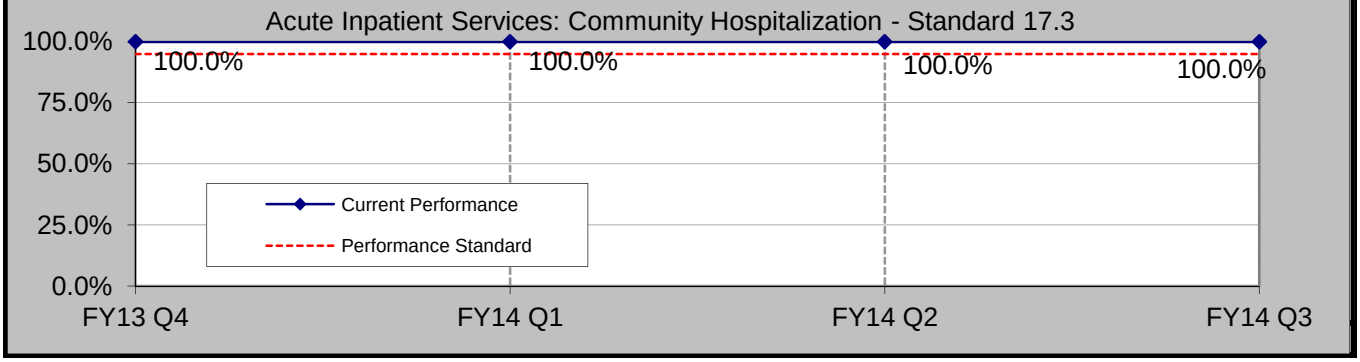


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

Standard 17.2a	
Measurement	Corrective action taken by UR nurse where blue paper not completed in accordance with terms.
Standard	Performance: 95%
	Compliance:90%
Data Source	UR Database/EIS
Current Level	100.0% (All blue papers reported as completed and in accordance with terms)

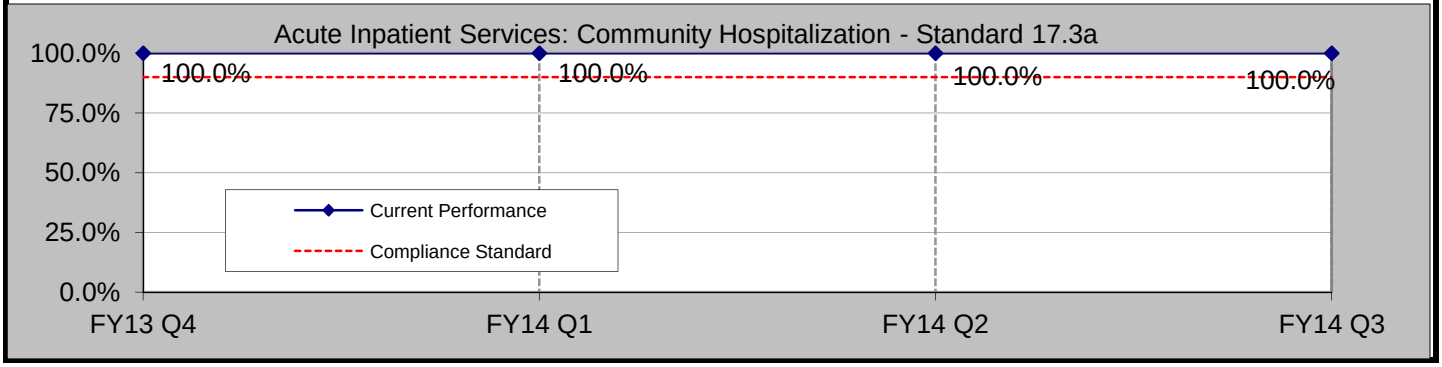


Standard 17.3	
Measurement	Class member involuntary admissions to community inpatient units in which 24 hour certification was completed.
Standard	Performance: 95%
Data Source	UR Database/EIS
Current Level	100.0% (12 out of 12)

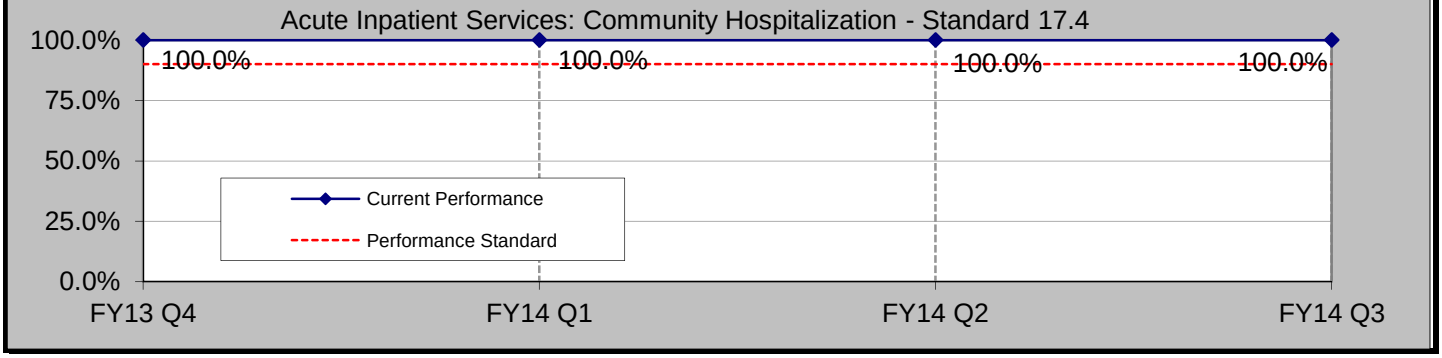


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

Standard 17.3a	
Measurement	Corrective action taken by UR nurse where 24 hour certification was not completed.
Standard	Performance: 100% Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (All 24 hr certifications reported as completed)

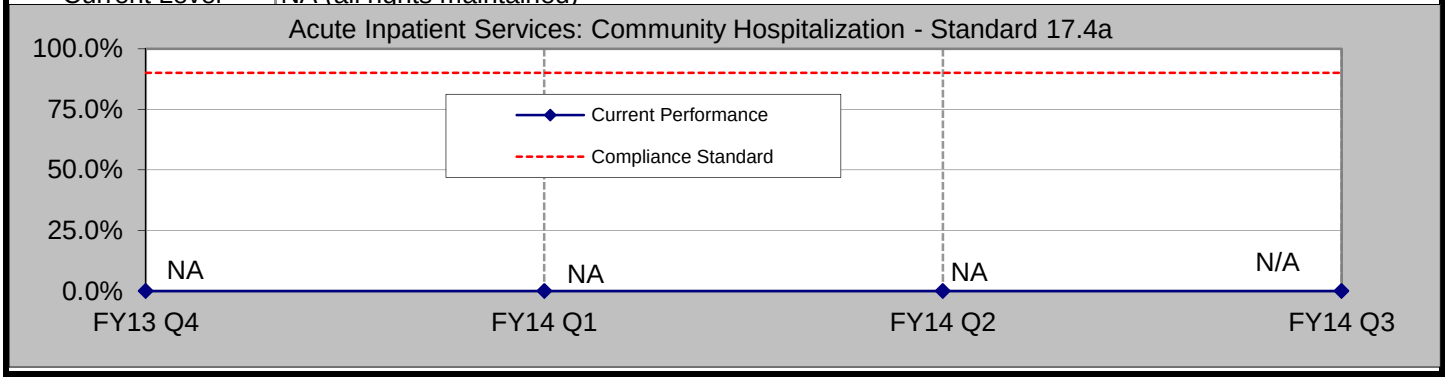


Standard 17.4	
Measurement	Class member involuntary admissions to community inpatient units in which patients' rights were maintained.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (13 out of 13)

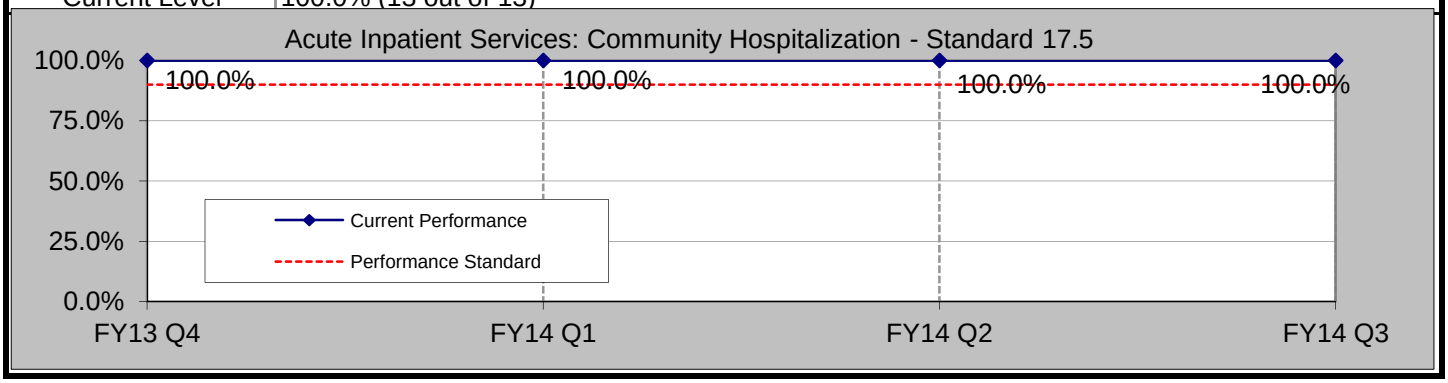


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

Standard 17.4a	
Measurement	Corrective action taken by UR nurse where documentation showed patients' rights not maintained.
Standard	Performance: 90% Compliance: 90%
Data Source	UR Database/EIS
Current Level	NA (all rights maintained)



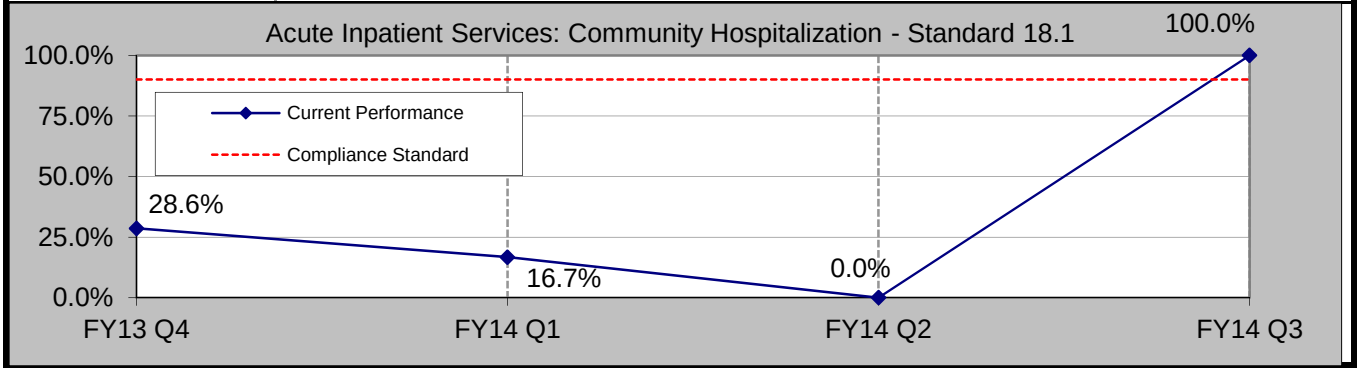
Standard 17.5	
Measurement	Class member involuntary admissions for which medical necessity has been established.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (13 out of 13)



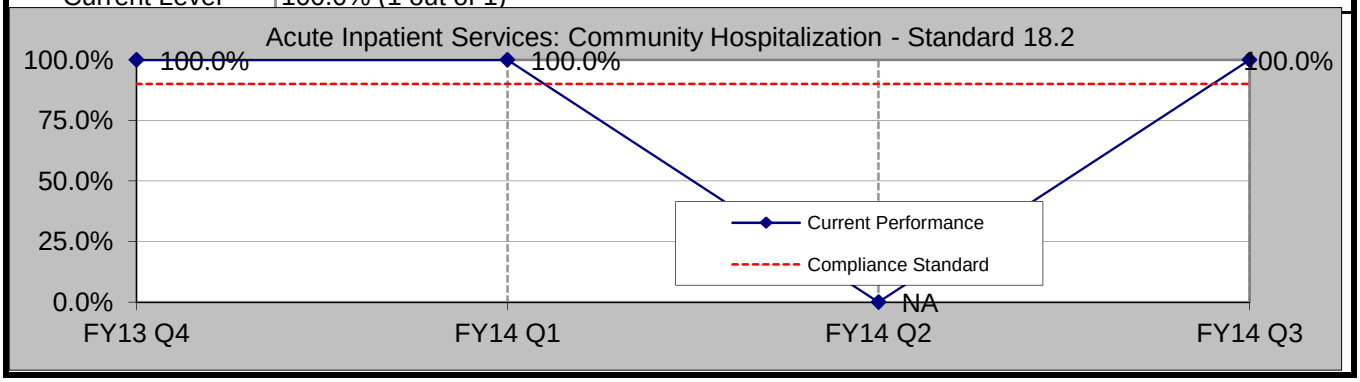
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

Standard 18.1	
Measurement	Class members admitted with ISPs for whom hospital obtained ISP.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (1 out of 1)

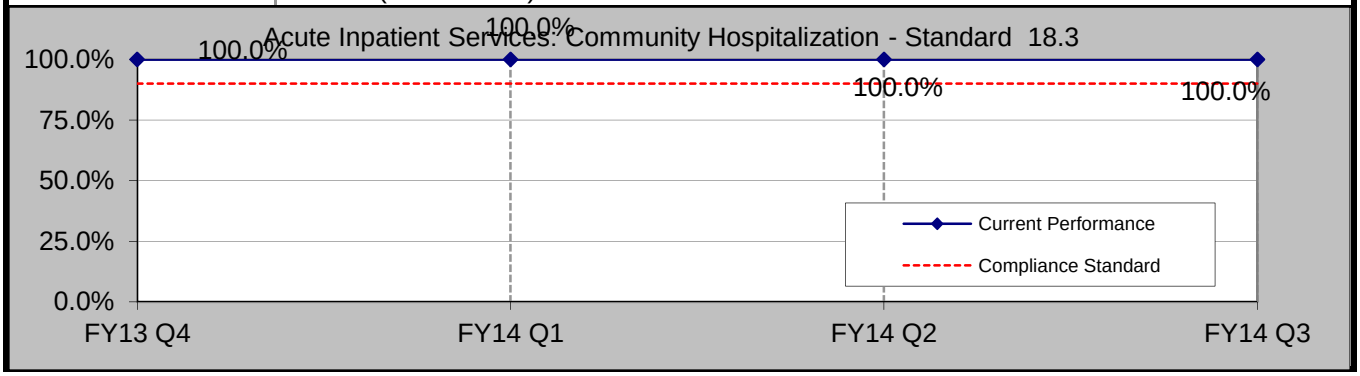


Standard 18.2	
Measurement	Treatment and discharge plan were determined to be consistent with ISP goals and objectives.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (1 out of 1)



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

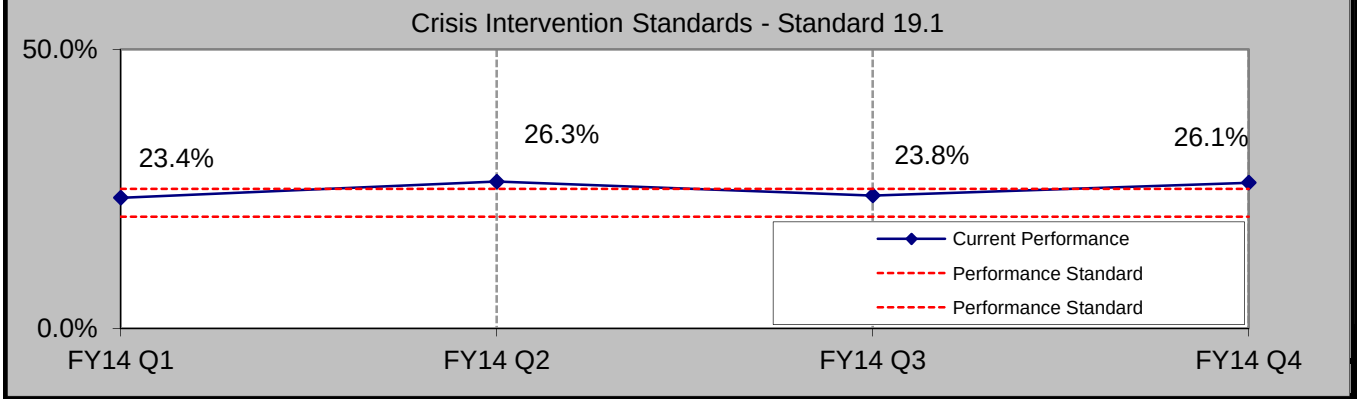
Standard 18.3	
Measurement	CI/ICI/ICM/ACT worker participated in hospital treatment and discharge planning.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (10 out of 10)



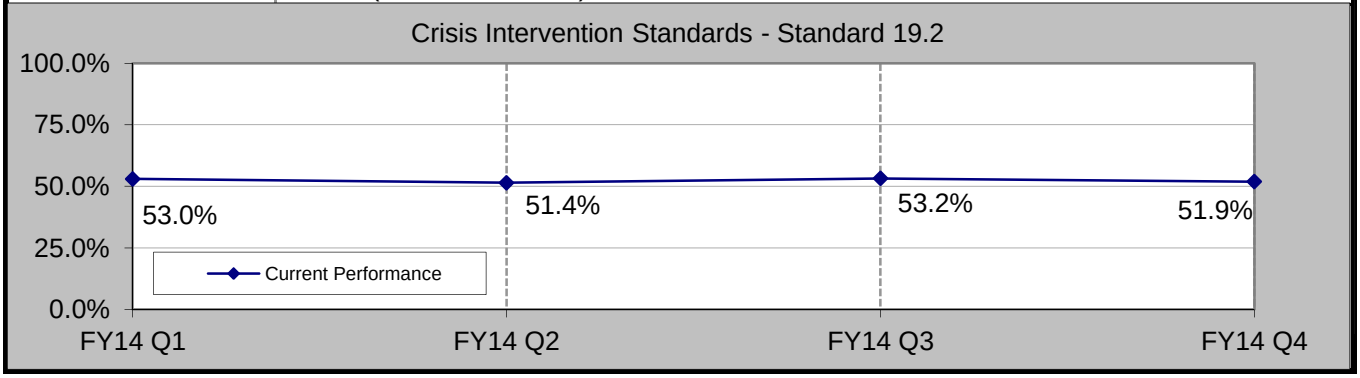
Community Resources and Treatment Services
Crisis Intervention Services

Standard 19 - Crisis services are effective and 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
Current Level	26.1% (1031 out of 3956)

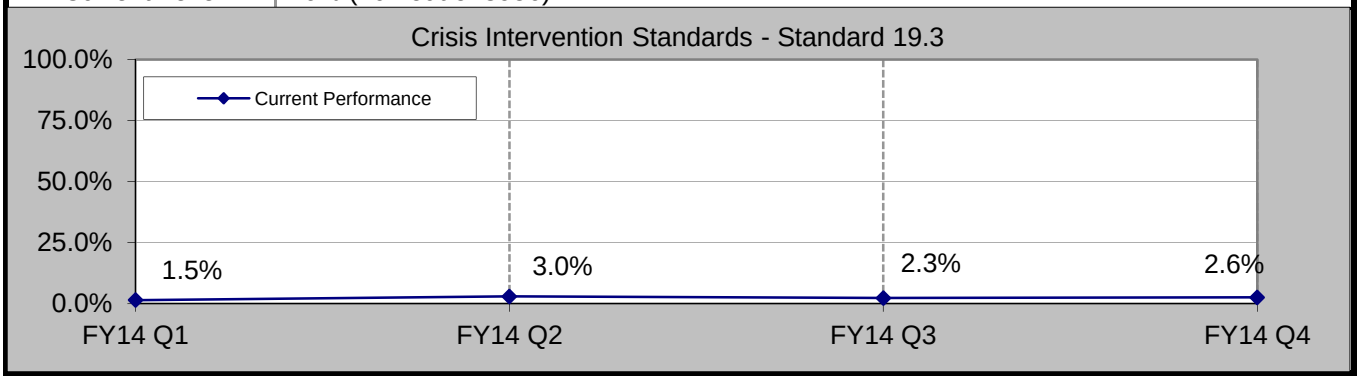


Standard 19.2	
Measurement	Face to face crisis contacts that result in follow-up and/or referral to community based services.
Standard	To Be Established
Data Source	Quarterly Crisis Contract Performance Data
Current Level	51.9 % (2689 out of 3956)

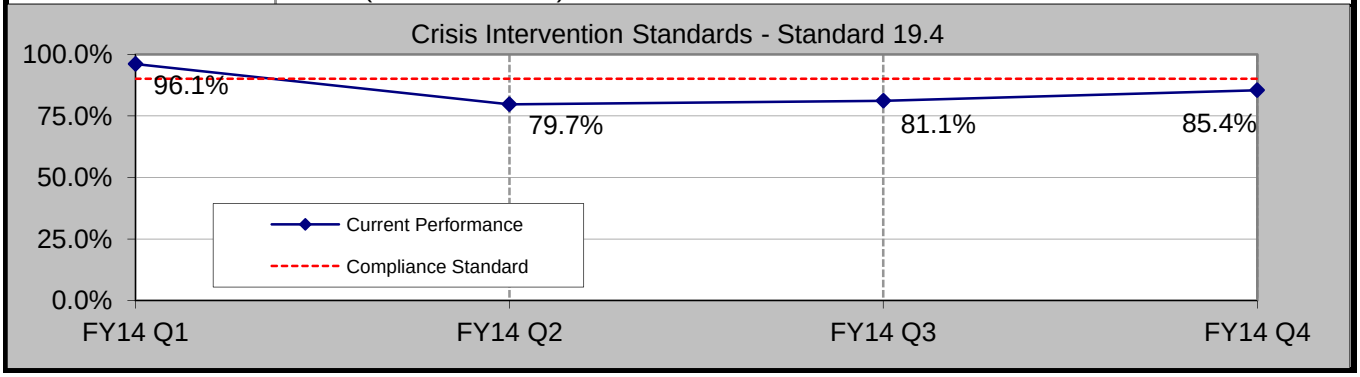


Community Resources and Treatment Services
Crisis Intervention Services

Standard 19.3	
Measurement	Face to face crisis contacts in which a previously developed crisis plan was available and used.
Standard	To Be Established
Data Source	Quarterly Crisis Contract Performance Data
Current Level	2.6% (104 out of 3956)



Standard 19.4	
Measurement	Face to face crisis contacts in which client has a CI worker and worker was notified about the crisis.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	Quarterly Crisis Contract Performance Data
Current Level	85.4% (999 out of 1170)



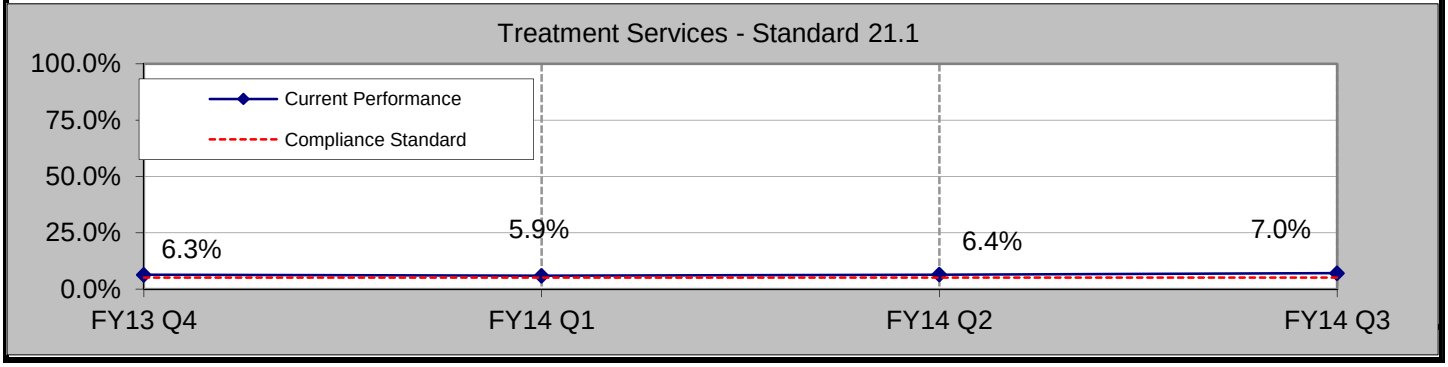
Discussion:

Standard 19.4: The department recently modified the reporting tool and process for capturing this data and is currently working with providers to collect more accurate data. Continue to monitor.

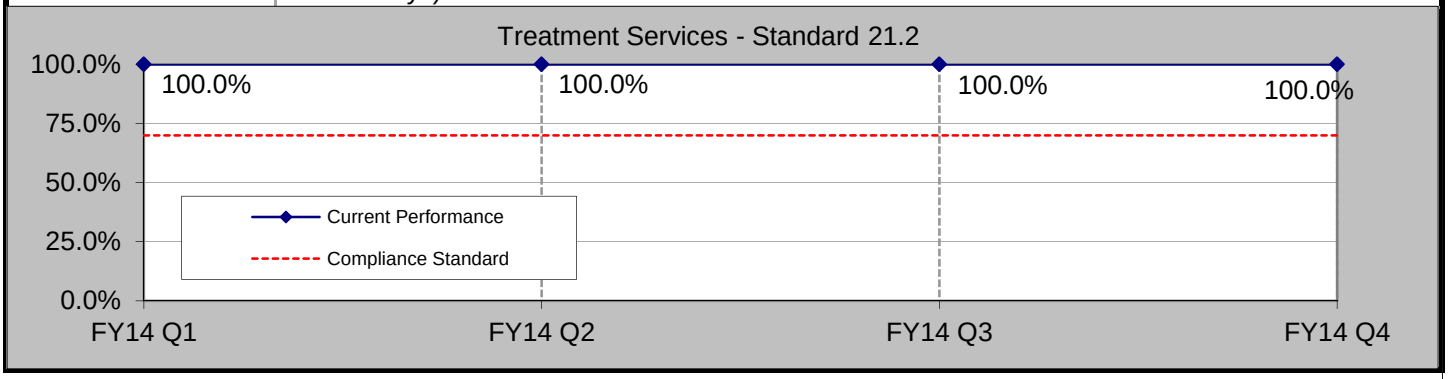
Community Resources and Treatment Services
Treatment Services

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	7.0% (70 out of 1005)

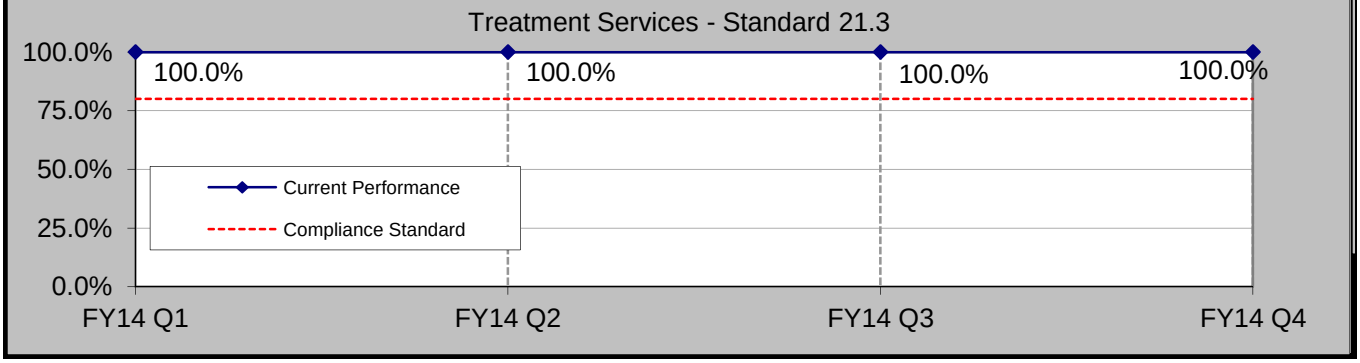


Standard 21.2	
measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 Q4 (Lack of mental health treatment did not impede discharge for any patients within 7 days)

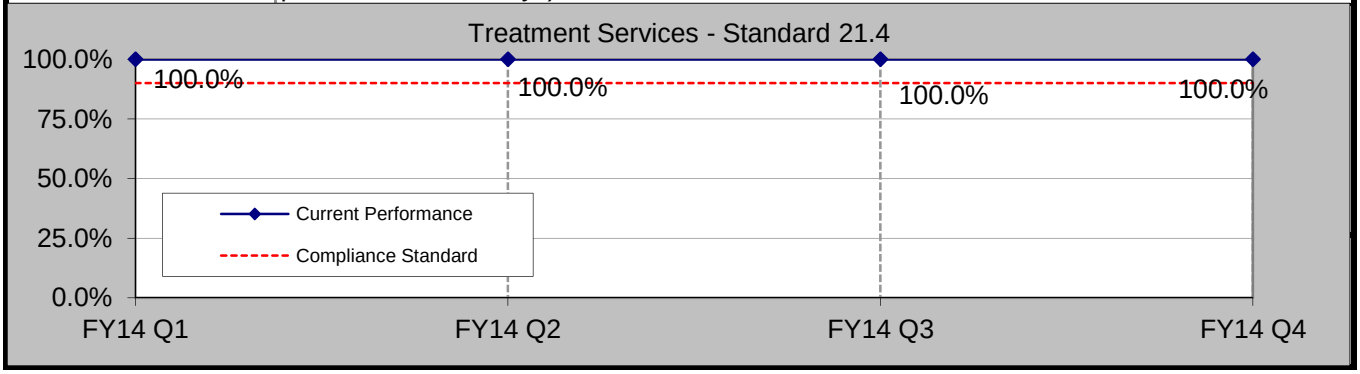


Community Resources and Treatment Services
Treatment Services

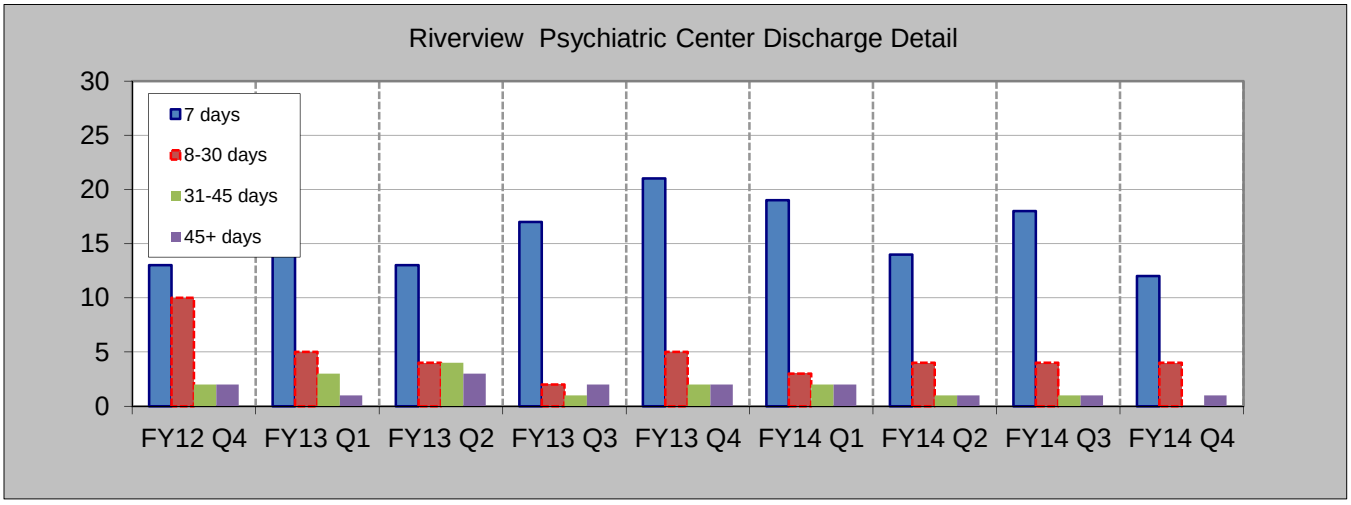
Standard 21.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination
Standard	Performance: 96% (within 30 days of that determination) Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 Q4 (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 45 days of that determination
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	100.0% FY14 Q4 (Lack of mental health treatment did not impede discharge for any patients within 45 days)



Community Resources and Treatment Services
Treatment Services



Riverview Psychiatric Center Discharge Detail to amplify data presented in Standards 21.2,21.3,21.4

17 Civil Patients discharged in quarter

12 discharged at 7 days (70.6%)
4 discharged 8-30 days (23.5%)
1 discharged post 45 days (5.9%)

Treatment services did not impede discharge for any patient post clinical readiness for discharge.

Community Resources and Treatment Services
Treatment Services

Standard 21.5	
Measurement	MaineCare data demonstrates by mental health service category that class members use an array of mental health treatment services.
Standard	No Numerical Standard Necessry
Data Source	Paid Claims data

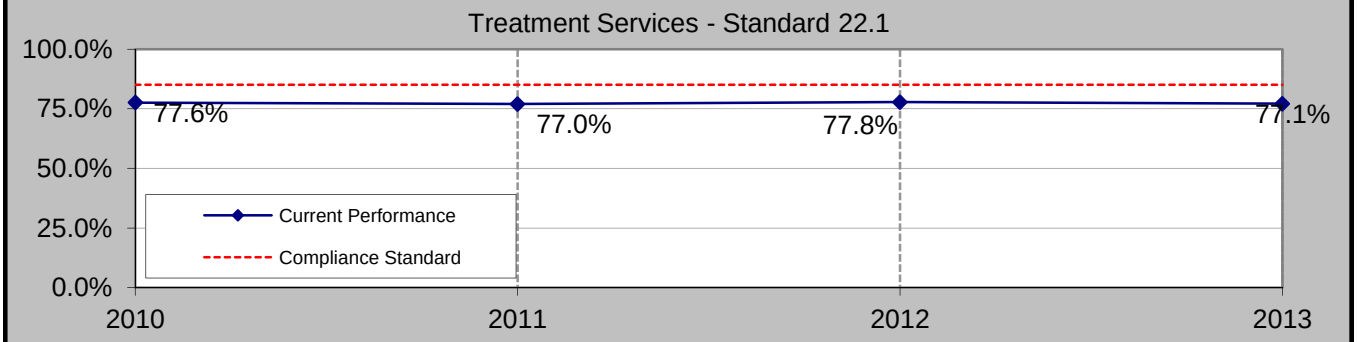
MaineCare Data FY 2013			
Mental Health Treatment Services Received	**Total Number**	**Total Number of Class Members**	**Percent of Class Members**
Assertive Community Treatment	863	285	33.0%
Community Integration	14,670	1,170	8.0%
Communty Rehabilitation	185	64	34.6%
Crisis Services	5,186	543	10.5%
Crisis Residential (CSU)	2,049	479	23.4%
Day Support/Day Treatment	1,138	126	11.1%
Medication Management	12,608	558	4.4%
Outpatient (Comp Assess&Therapy)	23,716	538	2.3%
Residential	884	310	35.1%
Skills Development	502	49	9.8%
Daily Living Supports	1,924	229	11.9%
***Total Unduplicated Count**	**36,553**	**1,758**	**4.8%**

*Total unduplicated counts will not be the sum of the total numbers. Members often receive more than one type of service.

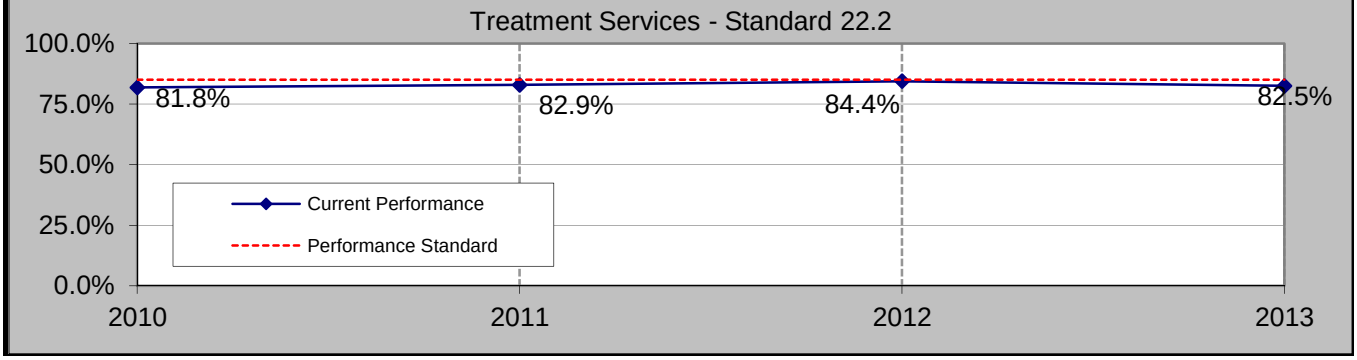
Community Resources and Treatment Services
Treatment Services

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 levels.
Data Source	Adult Mental Health and Well Being Survey
Current Level	77.1%



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	82.5%



Community Resources and Treatment Services
Family Support Services

Standard 23 - An array of family support services are available as per Settlement Agreement

Standard 23.1	
Measurement	Number of education programs developed and delivered meeting Settlement Agreement requirements
Standard	No standard necessary
Data Source	NAMI
Current Level	3 family to family classes: Q3 FY 14

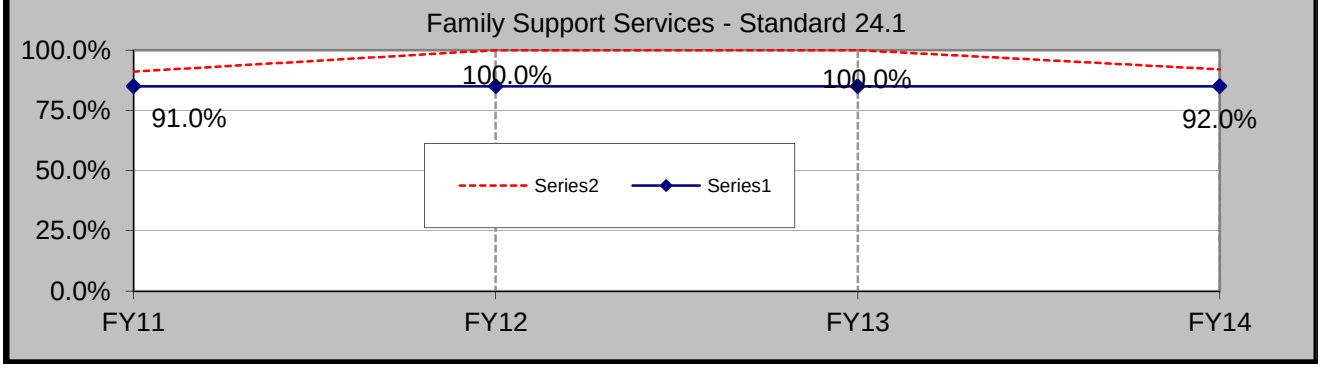
Standard 23.2	
Measurement	Number and distribution of family support services provided
Standard	No standard necessary
Data Source	NAMI
Current Level	45 family support groups, 18 sites: Q3 FY 14

Note: Contracted agencies are allowed one month after the end of the quarter to submit performance indicator data.

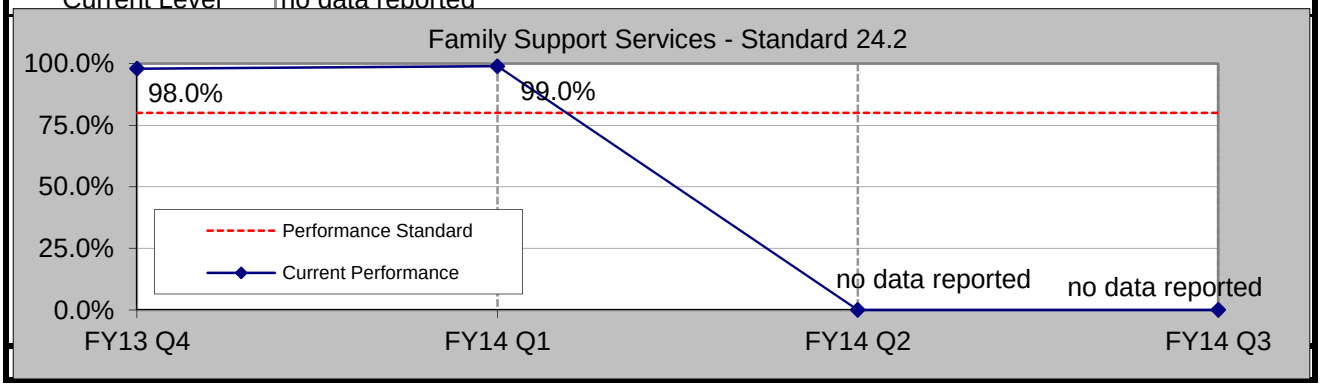
Community Resources and Treatment Services
Family Support Services

Standard 24 - Consumer/family satisfaction with family support, information and referral services

Standard 24.1	
Measurement	Percentage of support group and group counseling participants reporting satisfaction with services.
Standard	Performance: 85%
Data Source	NAMI
Current Level	92.0%



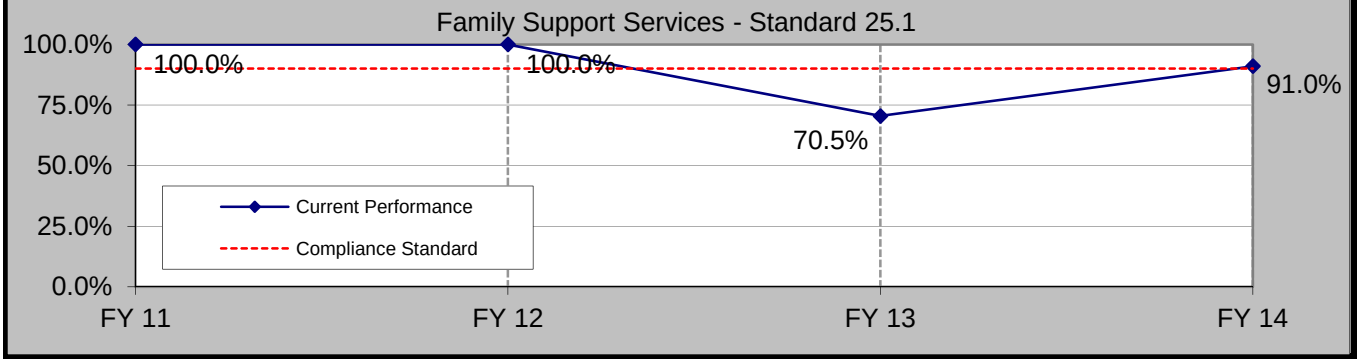
Standard 24.2	
Measurement	Percentage of program participants reporting satisfaction with education programs.
Standard	Performance: 80%
Data Source	NAMI
Current Level	no data reported



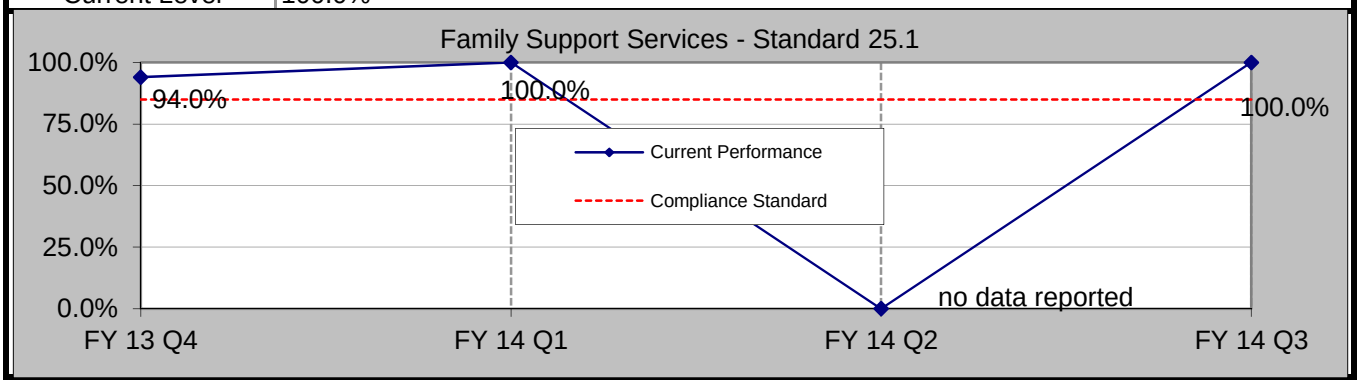
Community Resources and Treatment Services
Family Support Services

Standard 25 - Agencies are referring family members to family support groups

Standard 25.1	
Measurement	Agency contracts reviewed with documented evidence of referral mechanism to family support services.
Standard	Compliance: 90%
Data Source	Contract Reviews
Current Level	91.0% (121 of 133)



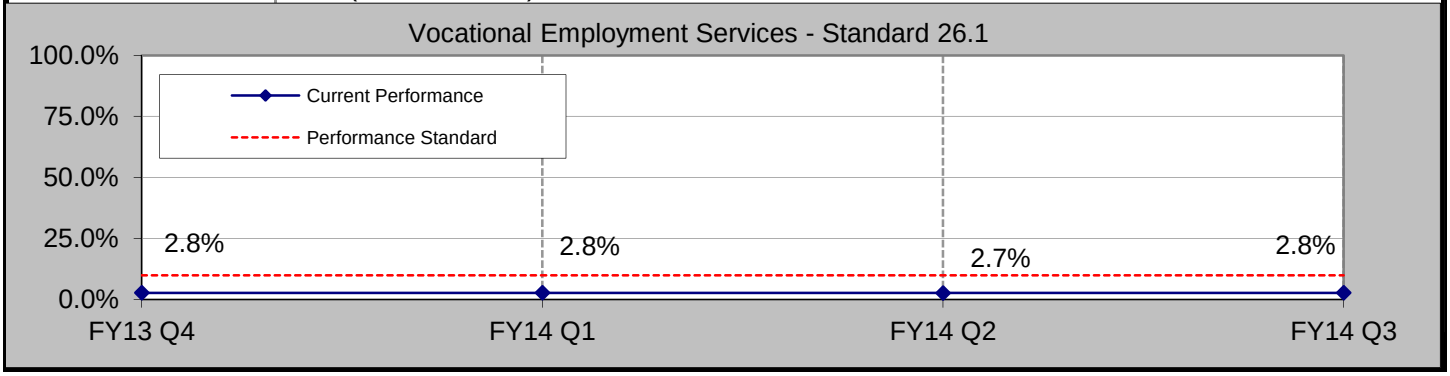
Standard 25.2	
Measurement	Families receiving referrals for family support services reporting satisfaction with referral process.
Standard	Performance: 85%
Data Source	NAMI
Current Level	100.0%



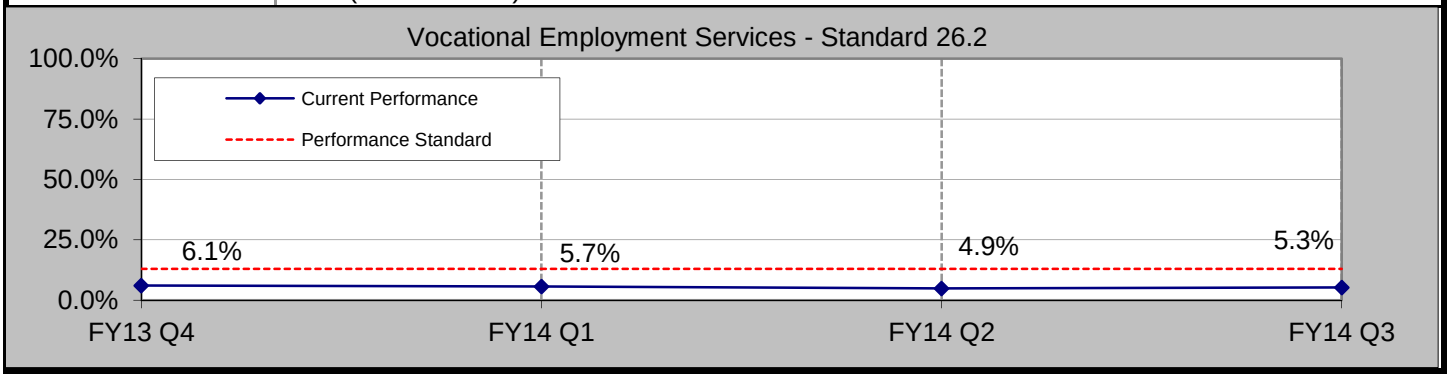
Community Resources and Treatment Services
Vocational Employment Services

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	2.8% (28 out of 1005)

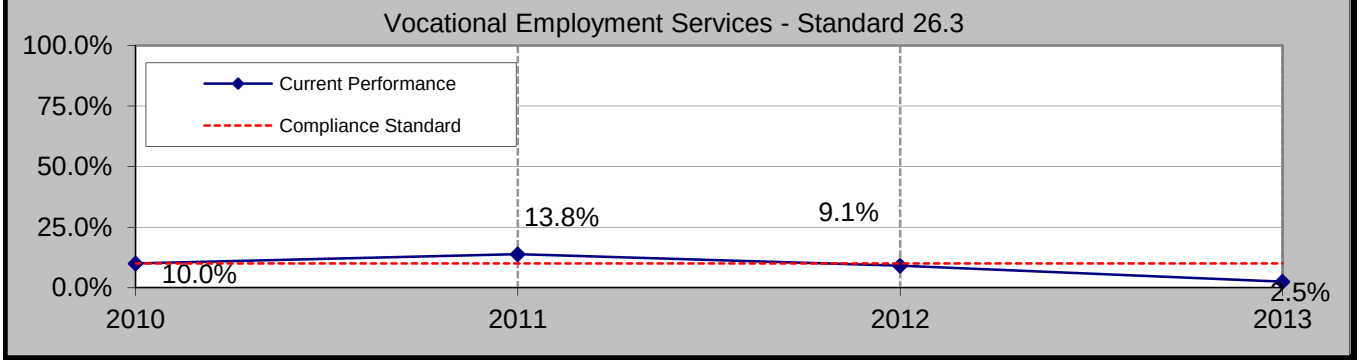


Standard 26.2	
Measurement	Class members younger than age 62 in competitive employment in the community.
Standard	Performance: 15% of class members employed in competitive employment. Compliance: 13% or Baseline (10.8%).
Data Source	ISP RDS Data
Current Level	5.3% (45 out of 845)



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 appropriate action.
Data Source	Adult Mental Health and Well Being Survey
Current Level	2.5%



Discussion:

This standard factored out those persons responding to the Adult Mental Health and Well Being Survey employment questions who are 62 and older, indicated they were retired or indicated they were not looking for work

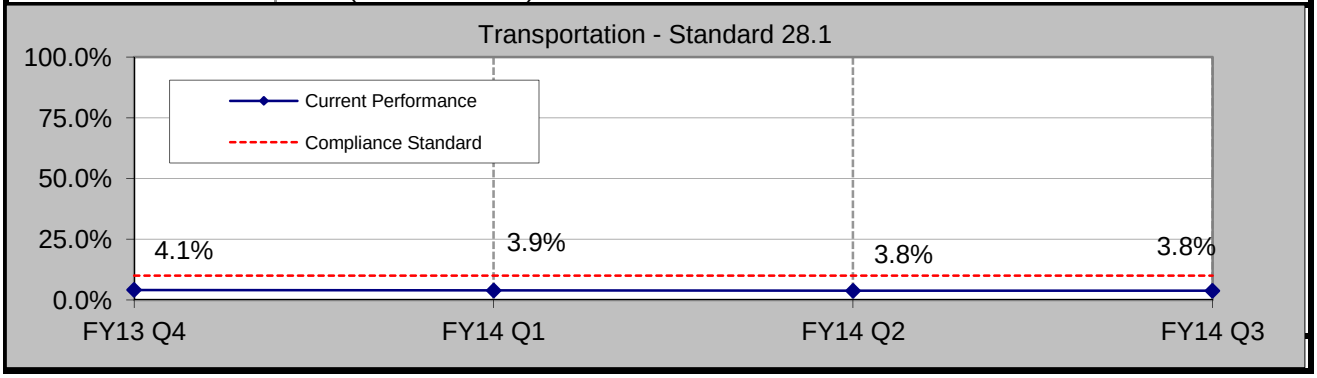
The response rate for the Adult Mental Health survey was very low in 2012 and the department is currently working on a plan to have a higher response rate.

Standard 26.3: Vocational performance standard has been discussed during fidelity reviews. The job of the vocational specialist to involve client has also been discussed.

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	3.8% (38 out of 1005)



Standard 30 - Department has sponsored programs for leisure skills and avocational skills.

Standard 30.1	
Measurement	Number of social clubs/peer centers and participants by region.
Standard	Qualitative evaluation; no numerical standard required.
Data Source	Treatment and Recovery
Current Level	34509 total visits, 1014 unduplicated clients (14 of 14 social clubs/peer centers reporting for FY 14 Q3.)

Standard 30.2	
Measurement	Number of other peer support programs and participation.
Standard	Qualitative evaluation; no numerical standard required.
Data Source	Treatment and Recovery
Current Level	14 Peer Support programs statewide during FY 2014 Q3. (includes social clubs/peer centers): Participation data is not collected for the Statewide Initiatives noted below.

Peer Support Groups funded by DHHS FY2014 Q3:

Peer Centers and Social Clubs:

Center for Life Enrichment -- Kittery, Common Connections -- Saco, Friends Together -- Jay, Harmony Support Center -- Sanford, Harvest Social Club -- Caribou, LINC -- Augusta, 100 Pine Street -- Lewiston, Sweetser Peer Center -- Brunswick, Together Place -- Bangor, Valley Social Club -- Madawaska, Waterville Social Club -- Waterville

Club Houses: Capitol Club House -- Augusta, High Hopes -- Waterville, LA Clubhouse -- Lewiston
Unlimited Solutions Clubhouse -- Bangor

Statewide:

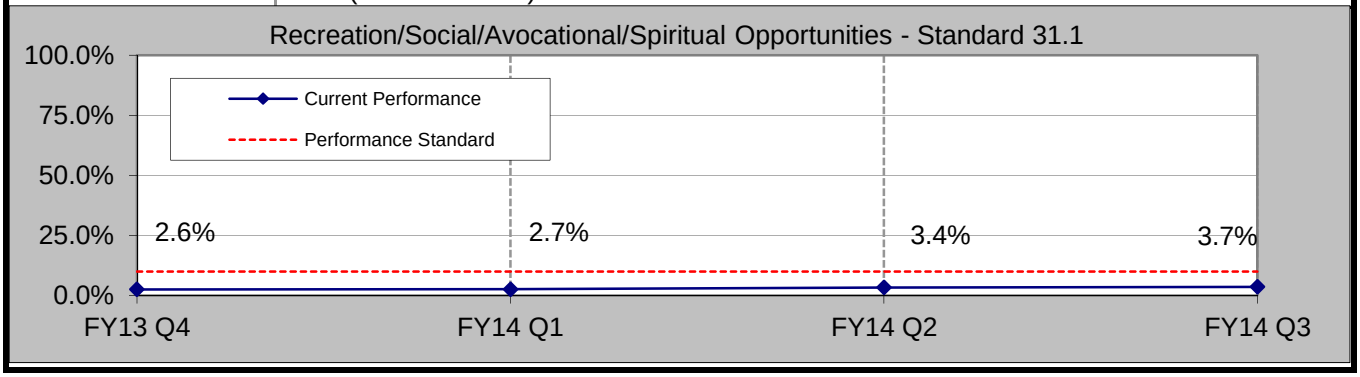
Community Connections: Community based recreational opportunities and leisure planning
MAPSRC (Maine Association of Psychosocial Rehabilitation Centers)

NAMI Support Groups primarily attended by consumers:

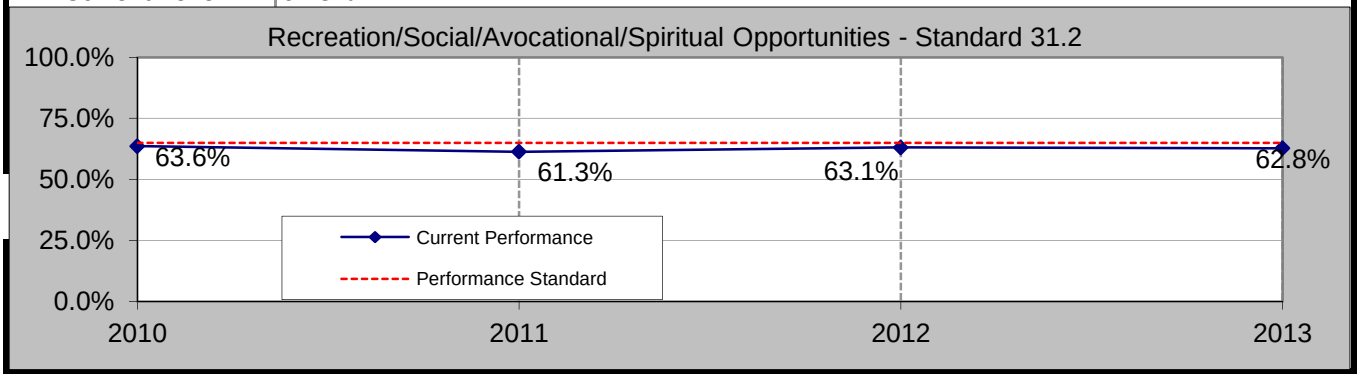
Augusta, Bangor, Biddeford, Damariscotta, Dover Foxcroft, Ellsworth, Farmington, Harrington, Houlton, Lewiston, Machias, Norway, Rockland, Sanford, South Paris, and Waterville.

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	3.7% (37 out of 1005)



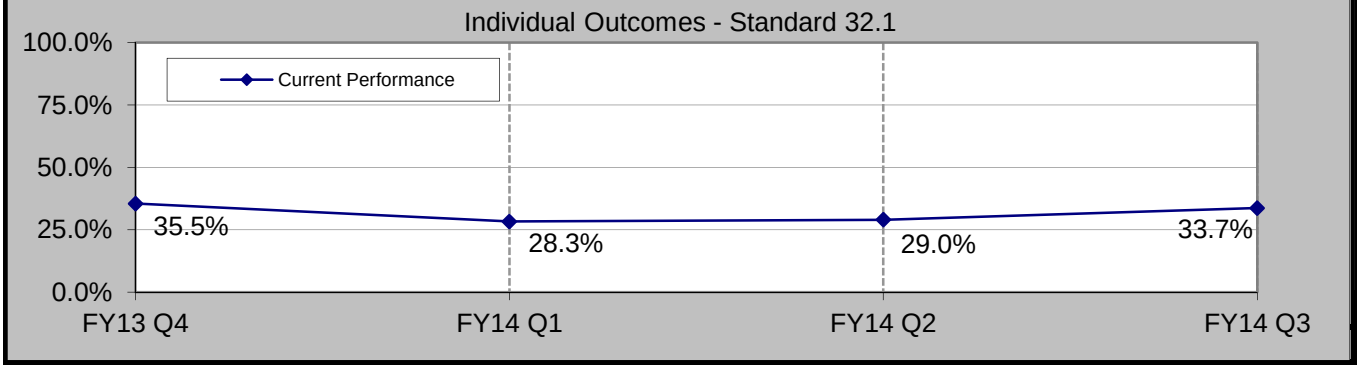
Standard 31.2	
Measurement	Domain average of positive responses in the Social Connectedness domain
Standard	Performance: At or above 65%
Data Source	Adult Mental Health and Well Being Survey
Current Level	62.8%



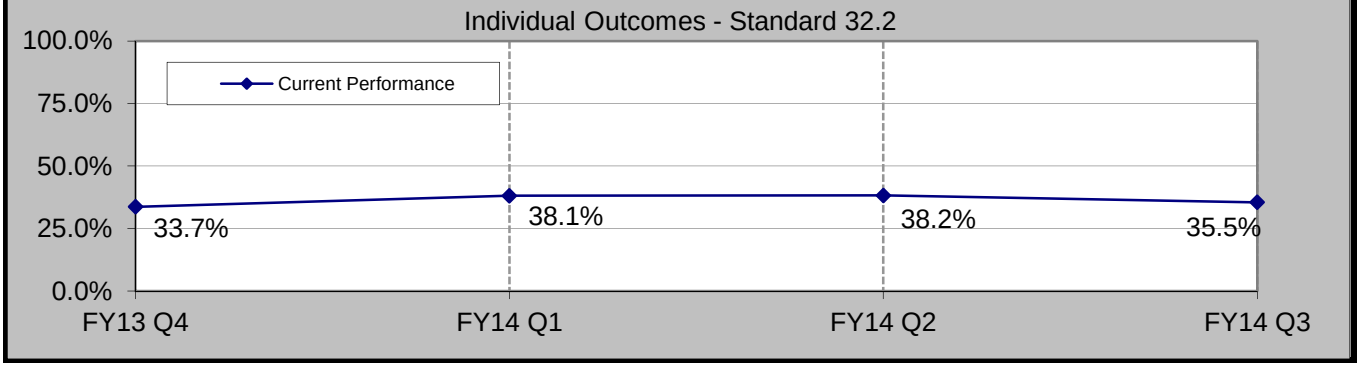
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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	33.7% (127 out of 377)

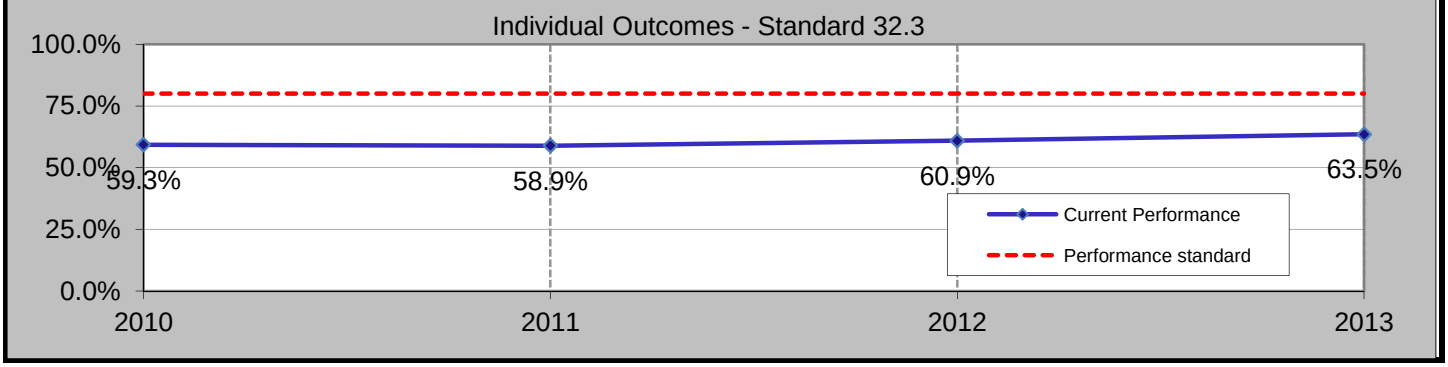


Standard 32.2	
Measurement	Class Members who have maintained level of functioning between baseline and 12 month re-certification.
Standard	Standard to be established.
Data Source	Enrollment data (Based on overall composite score.)
Current Level	35.5% (134 out of 377)



System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

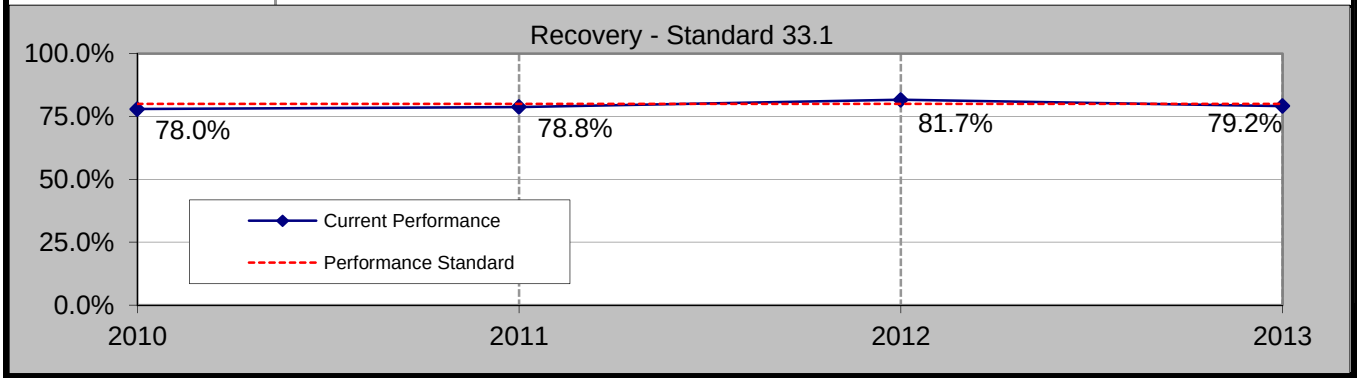
Standard 32.3	
Measurement	Consumers reporting positively on functional outcomes on Adult Mental Health and Well Being Survey outcome items.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	63.5%



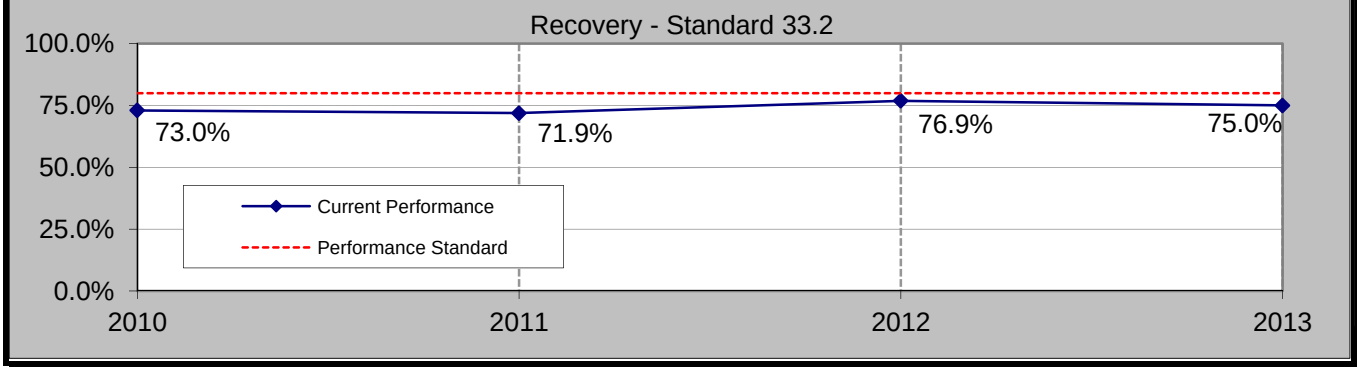
System Outcomes: Supporting the Recovery of Adults with Mental Illness
Recovery

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

Standard 33.1	
Measurement	Consumer reporting that agency staff helped them obtain information needed to take charge of managing illness.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	79.2%



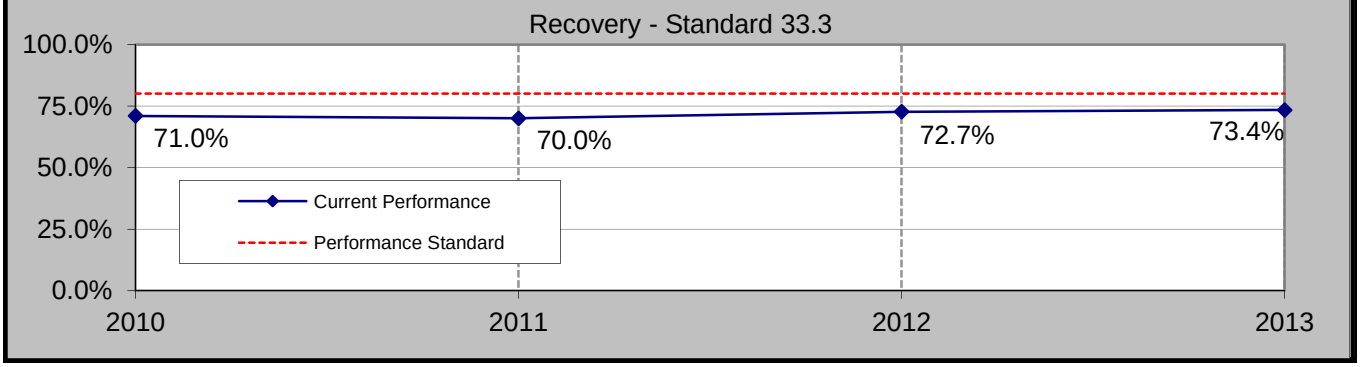
Standard 33.2	
Measurement	Consumers reporting that agency staff believe that they can grow, change and recover
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	75.0%



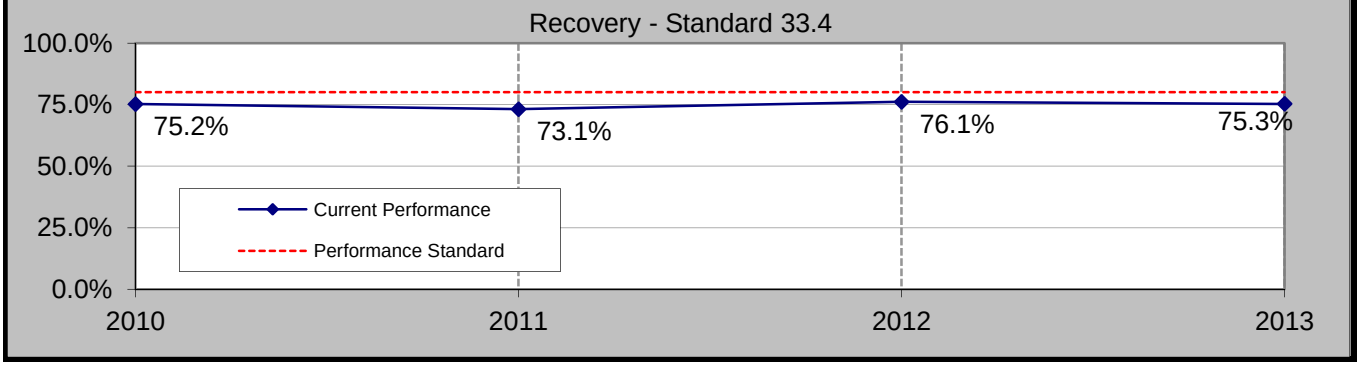
System Outcomes: Supporting the Recovery of Adults with Mental Illness

Recovery

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	73.4%

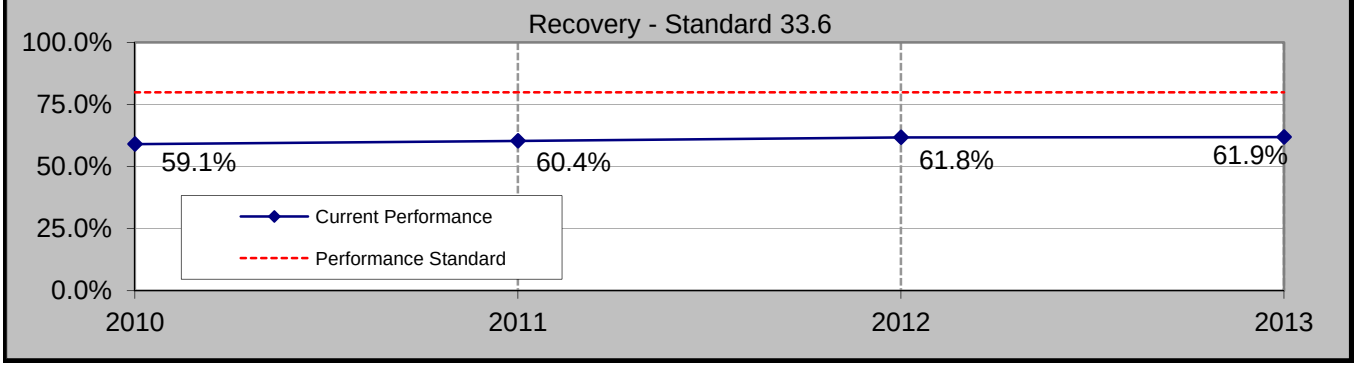


Standard 33.4	
Measurement	Consumers reporting that providers offered opportunities to learn skills to strengthen and maintain wellness.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey Q16
Current Level	75.3%



System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

Standard 33.6	
Measurement	Consumers reporting that service providers offered mutual support or recovery-oriented groups run by peers.
Standard	Performance: 80%
Source	Adult Mental Health and Well Being Survey
Current Level	61.9%



System Outcomes: Supporting the Recovery of Adults with Mental Illness
Public Education

Standard 34.1	
Measurement	# of mental health workshops, forums, and presentations geared toward general public and level of participation.
Standard	Qualitative evaluation required, no numerical standard necessary.
Data Source	NAMI
Current Level	35 FY14 Q3

Standard 34.2	
Measurement	Number and type of info packets, publications, press releases, etc. distributed to public audiences.
Standard	Qualitative evaluation required, no numerical standard necessary.
Data Source	NAMI
Current Level	3412 FY14 Q3

Public Education- Standard 34
April - June 2014

Note: Contracted agencies are allowed one month after the quarter to submit performance indicator data.
As a result, NAMI Maine is submitting performance indicator data for January-March 2014

Measure Method One:

Name, Date & Location of Public Education Program	Audience: Public Service Agency	Audience: RPC and/or DDPC staff	Audience: Community Members	Audience: Other (Please Specify)	Total # of Participants	Topic: Addressing Myths & Stigma	Topic: Promoting Community Integration	Topic: Rights of MH Consumers and/or their Families	Topic: Other (Please Specify)	Total # Presentations/ # Participants This Quarter
Family-to-Family 12-week course (Waterville October 24 - January 16, 2014)			X	Family Members	9	X	X	X	Communication, problem solving, empathy workshops; current research; advocacy; medications and other treatments; recovery; how to cope with worry and stress; dealing with crisis.	**3 *Family-to-Family* 12-week education courses to 44 participants**
Family-to-Family 12-week course (Westbrook 1/17/14 - 4/1/14)			X	Family Members	20	X	X	X	workshops; current research; advocacy; medications and other treatments; recovery; how to cope with worry and stress; dealing with crisis.	
Family-to-Family 12-week course (Bangor 3/13/14 - 5/29/14)			X	Family Members	15	X	X	X	workshops; current research; advocacy; medications and other treatments; recovery; how to cope with worry and stress; dealing with crisis.	
Mental Health Presentation (Beal College, Bangor 2/11/14)			X	College Students	9	X	X	X	Mental health services and family and peer perspectives	**8 *Mental Health/NAMI 101* presentations to 244 participants**
Mental Health Presentation (RPC, Augusta 3/7/14)				Riverview patients	5	X	X	X		
Mental Health Presentation (AARP, Portland 3/18/14)			X	AARP members	20	X	X		Mental health services and family and peer perspectives	
Self Injurious Behavior and Depression (Camden 2/27/14)			X		140				Self Injurious Behavior and Depression	

PenBay Medical Grand Rounds (Rockport 3/4/14)				Medical staff	35				General information and awareness panel	**244 participants**
Hall-Dale High School Mental Health Presentations (Hallowell 1/24/14)				High School Students	15	X			General MH and recovery information	
Hall-Dale High School Mental Health Presentations (Hallowell 1/24/14)				High School Students	10	X				
Mental Health Presentation (Portland 3/6/14)			X		10	X				
Suicide Prevention Gatekeeper Training (Unity 1/10/14)	X		X	School staff	40	X	X			**8 *Gatekeeper* Trainings to 205 participants**
Suicide Prevention Gatekeeper Training (Augusta 1/21/14)	X		X	School staff	25	X	X			
Suicide Prevention Gatekeeper Training (Portland 1/28/14)	X		X	School staff	21	X	X			
Suicide Prevention Gatekeeper Training (Ellsworth 3/3/14)	X		X	School staff	30	X	X			
Suicide Prevention Gatekeeper Training (Rockland 3/6/14)	X		X	School staff	20	X	X			
Suicide Prevention Gatekeeper Training (Augusta 3/11/14)	X		X	School staff	23	X	X			
Suicide Prevention Gatekeeper Training (Rockport 3/18/14)	X		X	School staff	15	X	X			
Suicide Prevention Gatekeeper Training (Caribou 3/20/14)	X		X	School staff	31	X	X			
Suicide Assessment Training for Clinicians (Rockland 1/17/14)	X			Private practice counselors	24	X	X	X		**3 *Clinical Assessment* trainings for 55 participants**
Suicide Assessment Training for Clinicians (Rockland 2/10/14)	X			Private practice and primary care staff	15	X	X	X		
Suicide Assessment Training for Clinicians (Portland 2/25/14)	X			Private practice and primary care staff	16	X	X	X		
Suicide Prevention Training of the Trainer (Lewiston 1/13/14)	X		X	School staff	22	X	X		Training school/agency staff and community members to present Suicide Awareness sessions	
Suicide Prevention Training of the Trainer (Augusta 2/6/14)	X		X	School staff	16	X	X		Training school/agency staff and community members to present Suicide Awareness sessions	

Suicide Prevention Training of the Trainer (Ellsworth 3/4/14)	X		X	School staff	32	X	X		Training school/agency staff and community members to present Suicide Awareness sessions	**6 *Training of the Trainer* trainings for 147 participants**
Suicide Prevention Training of the Trainer (Caribou 3/21/14)	X		X	School staff	43	X	X		Training school/agency staff and community members to present Suicide Awareness sessions	
Suicide Prevention Training of the Trainer (Augusta 3/24/14)	X		X	School staff	23	X	X		Training school/agency staff and community members to present Suicide Awareness sessions	
Suicide Prevention Training of the Trainer (Rockport 3/28/14)	X		X	School staff	11	X	X		Training school/agency staff and community members to present Suicide Awareness sessions	
Lifelines (Bangor 1/7/14)				School staff	5	X				**2 *Lifelines* trainings for 15 participants**
Lifelines (Hallowell 3/10/14)				School staff	10	X				
Franklin County Crisis Intervention Team Program January 6,7,8,9,10 University of Maine-Farmington	X			Evergreen Behavioral staff (2)	10	X	X	X		**5 *CIT* trainings for 129 participants**
Lincoln/Sagadahoc CIT Program March 3-March 7 Two Bridges Regional Jail, Wiscassett	X				26	X	X	X		
Somerset CIT Program March17-March 21 Somerset County Jail, Madison	X				23	X	X	X		
Cumberland County CIT Program March 31-April 4 Cumberland County Jail, Portland	X				23	X	X	X		
Basic Law Enforcement Class March 25, 2014 Maine Criminal Justice Academy, Vassalboro	X				47	X	X	X		

Performance Indicators and Quality Improvement Standards

APPENDIX: ADULT MENTAL HEALTH DATA SOURCES

Adult Health and Well- Survey (Data Infrastructure Grant):

Data Type/Method: Mail Survey
Target Population: All people who receive a publicly-funded mental health service where eligibility includes having a serious mental illness (SMI).
Approximate Sample Size (responses): 1300-1500

The Maine DHHS/SAMHS consumer survey is an adapted version of the National Mental Health Statistics Improvement (MHSIP) Consumer Survey that was specifically designed for use by adult recipients of mental health services. The survey is administered by mail in the summer. It is currently used by all State Mental Health Authorities across the country and will allow for state-to-state comparisons of satisfaction trends. 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.

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: 150 per quarter.

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.

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 Intensive Case Management) 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.
Approximate Sample Size: 1500 class members of the total consumers enrolled in Community Support.

Community Support Services Census/Staffing Data:

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

SAMHS data specialists collect census/staffing data quarterly from contracted agencies that provide ACT and CI 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)
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.

Quality Management Specialists, one in each region, 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 on and 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, and CRS).

The data is maintained and reported on through the DHHS Enterprise Information System (EIS). The ISP RDS captures ISP completion dates and consumer demographic data. The ISP RDS also captures data on the current housing/living situation of the person receiving services as well as the current vocational and 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.

Quarterly Contract Performance Indicator Data:

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

The Quarterly Contract Performance Indicator System was implemented in July of 1998 at which time common performance indicators and reporting requirements were included in all contracts with provider agencies. Specific indicators were developed for each of the Adult Mental Health services areas. As of July 2008, most QA/QI contract performance indicators were deleted as much of the data is now being collected by APS Healthcare. Some specific service areas, for example crisis services and peer services, continue to have specific indicators within their contracts that they must report on quarterly.

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

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

Consent Decree Performance and Quality Improvement Standard 5

Report for: 2014 Q3
(January, February, March 2014)
(Class Members)

Measurement			
Method 1	Percent of class members requesting a worker who were assigned o		
	2013 Q4	99.1%	(111 of 112)
	2014 Q1	100.0%	(120 of 120)
	2014 Q2	100.0%	(102 of 102)
	2014 Q3	100.0%	(94 of 94)
Method 2	Percent of hospitalized class members who were assigned a worker		
	2013 Q4	60.0%	(6 of 10)
	2014 Q1	80.0%	(8 of 10)
	2014 Q2	77.8%	(7 of 9)
	2014 Q3	61.5%	(8 of 13)
Method 3	Percent of non-hospitalized class members assigned a worker within		
	2013 Q4	72.5%	(74 of 102)
	2014 Q1	73.5%	(83 of 113)
	2014 Q2	77.4%	(72 of 93)
	2014 Q3	79.0%	(64 of 81)
Method 4	Percent of class members in hospital or community not assigned on		
	2013 Q4	46.9%	(13 of 29)
	2014 Q1	50.0%	(20 of 43)
	2014 Q2	30.4%	(17 of 34)
	2014 Q3	40.9%	(9 of 22)
Method 5	ISP completed within 30 days of service request.		
	2013 Q4	80.7%	(46 of 57)
	2014 Q1	79.7%	(55 of 69)
	2014 Q2	89.5%	(51 of 57)
	2014 Q3	81.0%	(34 of 42)
Method 6	90 Day ISP review completed within specified timeframe.		
	2013 Q4	67.6%	(712 of 1,053)
	2014 Q1	68.2%	(759 of 1,113)
	2014 Q2	71.0%	(789 of 1,111)
	2014 Q3	69.3%	(638 of 921)
Method 7	Initial ISPs not developed within 30 days, but were developed within		
	2013 Q4	54.5%	(6 of 11)
	2014 Q1	42.9%	(6 of 14)
	2014 Q2	83.3%	(5 of 6)
	2014 Q3	62.5%	(5 of 8)

Method 8	ISPs that were not reviewed within 90 days, but were reviewed with		
	2013 Q4	79.5%	(271 of 341)
	2014 Q1	80.8%	(286 of 354)
	2014 Q2	91.3%	(294 of 322)
	2014 Q3	77.4%	(219 of 283)

As of: Jul 11, 2014 Run By: Brandi.Giguere

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.

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services (DHHS)
Office of Substance Abuse and Mental Health Services (SAMHS)
Report on Unmet Needs and Quality Improvement Initiatives
August, 2014

Attached Report:

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 3

Population Covered:

- Persons receiving Community Integration (CI), Community Rehabilitation (CRS) and Assertive Community Treatment (ACT) services
- 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

Crisis Reports. At the directive of the Commissioner, SAMHS revised its Crisis Reports and required individual encounter reporting as of July 1, 2013. All of the prior crisis data variables continued to be reported but now on an individual level. Providers will still report the aggregate number of telephone calls they receive. SAMHS staff worked with the Maine Crisis Network providers to create variables for the crisis screening/assessment reasons for face to face encounters. Meetings were held with providers and technical assistance has been provided by the Data and Quality Management staff. Outcomes include withholding two contract incentive payments due to providers not meeting standards.
Identified Need: A,B,D

Critical Incident Reporting. SAMHS had three systems and portals for providers to report on critical incidents involving consumers. These systems and portals are a legacy from the merger of Adult Mental Health Services and the Office of Substance Abuse. The rollout of a streamlined Critical Incident reporting process took place in October with training and a go live date which occurred in November. Critical Incidents are now received through a dedicated email address, fax, and with phone support. We are currently building a web access portal and will begin testing late in the third quarter with implementation ready for roll-out in the new fiscal year 15.
Identified Need: A,B,D,E,F,G,

SAMHS Website - Reports. During the first week of July, SAMHS started posting APS, Crisis Management, and Waitlist reports on its website. Providers are notified these reports at each monthly stakeholder calls. In addition, providers were notified by email when the initial reports were posted. Generally reports are posted each Thursday.
Identified Need: A,B,C,D,E,F,I,J,K

SAMHS Website – Redesign. A taskforce has been formed to design and implement a new SAMHS website. SAMHS currently has the legacy websites for Adult Mental Health Services and Office of Substance Abuse. Changes to the website will be incremental based on a schedule that is being developed. Early estimates are that given the resources available it will take 9-12 months for all aspects of the new site to be rolled-out in January 2015.
Identified Need: A, B, C, D, E, F,G, H, I, J, K, L,M

Agency Score Card. Within 30 days after the submission of the quarterly report to the Court Master, the Data/Quality Manager will meet with the prevention, intervention, treatment and recovery managers to review standards deficiencies noted in the report. The managers will review issues to determine corrective actions. Once the managers meet, an agency score card listing all measures will be sent to field service teams to develop corrective action steps for meeting the standards. The agency score card and corrective actions steps will be sent to SAMHS management, field service teams and will be posted in the Data/Quality Management area of the SAMHS office.
Identified Need: A, B, C, D, E, F, G, H, I, J, K, L, M

Commissioner's Unmet Needs Workgroup. Commissioner Mayhew has appointed a workgroup to examine the performance and compliance standards under the approved Consent Decree Plan and

SAMHS's ability to meet the compliance standards. The workgroup has reviewed data from FY2006 to the present to determine patterns of compliance with the standards. The data have been analyzed and recommendations have been made to the Commissioner, Court Master, and Plaintiffs' Attorney.
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 five services areas for FY13 contracts and fourteen services areas for FY14 contracts. Where appropriate, the measures are in alignment with standards under the Consent Decree Plan. In a meeting with the DHHS Office of Quality Management, we agreed on a three year schedule for full implementation of measures; year one will be to validate the measures, year two to establish baselines, year 3 to test full implementation. At that point the measures will be put into Maine Care rule as well as being standardized for all SAMHS provider contracts.
Identified Need: A, B, C, D

Housing Quality Survey. Quality Management staff have undertaken inspections of housing for mental health residents in the state where there are three or fewer beds. The certified reviewers are using a standardized HUD housing form (Housing Quality Survey). In FY14, a questionnaire about consumer satisfaction with housing and services will be included.
Identified Need: A,E,K,M

Community Rehabilitation Services Survey. A face to face survey of clients who receive CRS services was conducted in February 2013. Interviews with 126 consumers were conducted and chart reviews were performed for an additional 10 consumers who were not available to be interviewed. The purpose of the survey was to determine whether residents understood the service delivery parameters of the CRS services as related to linkages to housing services. Seventy-five percent of leases indicated there were no linkages between housing and services however 59% of treatment plans mandated that a linkage be in place. The consumers perceived a seamless/no barriers transition from PNMI funded beds to CRS services. Hence there was no disruption in consumer services and care but did not allow consumers to control the choice over where to reside. All providers and consumers were educated about the separation of services from housing as part of the survey process. A report of the findings was presented to the monthly meeting with the Court Master in March 2013.
Identified Need: E, H, K

Contract Review Initiative. The Data/Quality Management staff are working with field service teams to ensure they have up-to-date, accurate service encounter data when they review progress toward meeting contract goals and establishing benchmarks for new contracts. A set of encounter data variables has been identified and was tested in FY13. A review of the process occurred in early FY14 to determine which data to include for expansion of this initiative to all SAMHS contractors. SAMHS has built SQL query tools to help office staff identify service utilization patterns across three sources of funding.
Identified Need: A, B, D, E, I, J, L

Mental Health Rehabilitation/Crisis Service Provider Review. The Mental Health Rehabilitation/ Crisis Service Provider (MHRT/CSP) certification was developed by the crisis providers (Maine Crisis Network) over the past several years in collaboration with DHHS—adult mental health and children's behavioral health and the Muskie School. The MHRT/CSP is now ready to be implemented with providers. A review team consisting of two representatives from the

Maine Crisis Network, two representatives from Children's Behavioral Health and two representatives from SAMHS will work together to conduct reviews at contracted agencies. Muskie staff collected the data and has produced a summary report which is in review at this time.
Identified Need: B

NIATx Quality Improvement Initiative. NIATx has been deployed in seven provider agencies to address wait list and time to assignment issues in provider agencies. SAMHS has contracted with a NIATx trainer who is providing on-site training and technical assistance. The model involves targeted changes using a rapid improvement methodology. A SAMHS central office NIATx team has been formed and has been trained in using the model with employees. The Data/Quality Management Office is addressing the data needs for providers and central office staff to ensure they have the necessary data/quality management tools to measure their successes. One outcome of this initiative is that APS Health Care now sends an email reminder to the provider agency staff for all clients on a waitlist over 30 days. Another outcome is that APS Healthcare reporting methods were revised to more accurately reflect the consent decree requirements for 5.2 – 5.4.
Identified Need: A,B

SAMHS Quality Management Plan 2013-2018. A team in the Data and Quality Management division is undertaking the development of a new SAMHS comprehensive quality management plan for 2013-2018. The team members are engaging with division leaders in the four pillars of SAMHS services (prevention, intervention, treatment and recovery) to develop profiles of programs, specific initiatives, evidence based or promising practice services being offered and standardized performance measures. The scope of the final plan will be inclusive of all SAMHS services and the required Consent Decree services will be imbedded within the larger document. There has been significant progress on the plan this quarter.
Identified Need: A,B,C,D,E,F,G,H,I,J,K,L,M

Wait List Tables and Graphs. On a weekly basis, the Data/Management staff update tables and graphs of number of people on wait lists for CI, ACT and DLSS. Also, graphs for time to assignment are produced that provide further information on these three services. Two new reports were developed and distributed as of 7/1/13. The first report is by service, by provider which lists number on waitlist by agency, and the length of time on the waitlist. The second report is a YTD comparison with the prior year for Community Integration services. These reports are sent to management and field service staff to monitor trends in services over the past six months. The Data Quality Management team is now producing an internal report to the Treatment team of the top ten persons on the waitlists. This report, containing PHI, will generate a discussion between the Treatment team and provider agency to follow up on these specific outliers.
Identified Need: A

Substance Abuse and Mental Health Services
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Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 3

Jan, Feb, Mar, 2014

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, and CRS)
- both class members and non-class members

Data collection and reporting:

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

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

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

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

Report Run: Jul 10, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q3

Table 1: Distinct People with a Resource Data Summary (RDS) by CSN

CSN	Counties	Distinct People
CSN 1	Aroostook	375
CSN 2	Hancock, Penobscot, Piscataquis & Washington	1,600
CSN 3	Kennebec & Somerset	1,795
CSN 4	Knox, Lincoln, Sagadahoc & Waldo	754
CSN 5	Androscoggin, Franklin & Oxford	1,826
CSN 6	Cumberland	1,825
CSN 7	York	530
Not Assigned	No legal address	324
Statewide		9,029

Table 2: Distinct People and Unmet Resource Needs across four Quarters

	2013 Q4			2014 Q1			2014 Q2			2014 Q3		
	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
CSN 1	130	385	33.8%	133	406	32.8%	139	423	32.9%	123	375	32.8%
CSN 2	431	1,868	23.1%	471	1,889	24.9%	473	1,825	25.9%	425	1,600	26.6%
CSN 3	380	2,102	18.1%	384	2,081	18.5%	362	2,083	17.4%	298	1,795	16.6%
CSN 4	217	836	26.0%	214	803	26.7%	203	856	23.7%	181	754	24.0%
CSN 5	623	2,038	30.6%	639	2,018	31.7%	620	2,086	29.7%	578	1,826	31.7%
CSN 6	640	2,097	30.5%	657	2,099	31.3%	663	2,057	32.2%	573	1,825	31.4%
CSN 7	192	574	33.4%	161	528	30.5%	205	588	34.9%	191	530	36.0%
N/A	120	412	29.1%	119	411	29.0%	107	419	25.5%	92	324	28.4%
Total	2,733	10,312	26.5%	2,778	10,235	27.1%	2,772	10,337	26.8%	2,461	9,029	27.3%

Report Run: Jul 10, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q3

Graph 1: Number of Unmet Resource Needs by Category over four Quarters

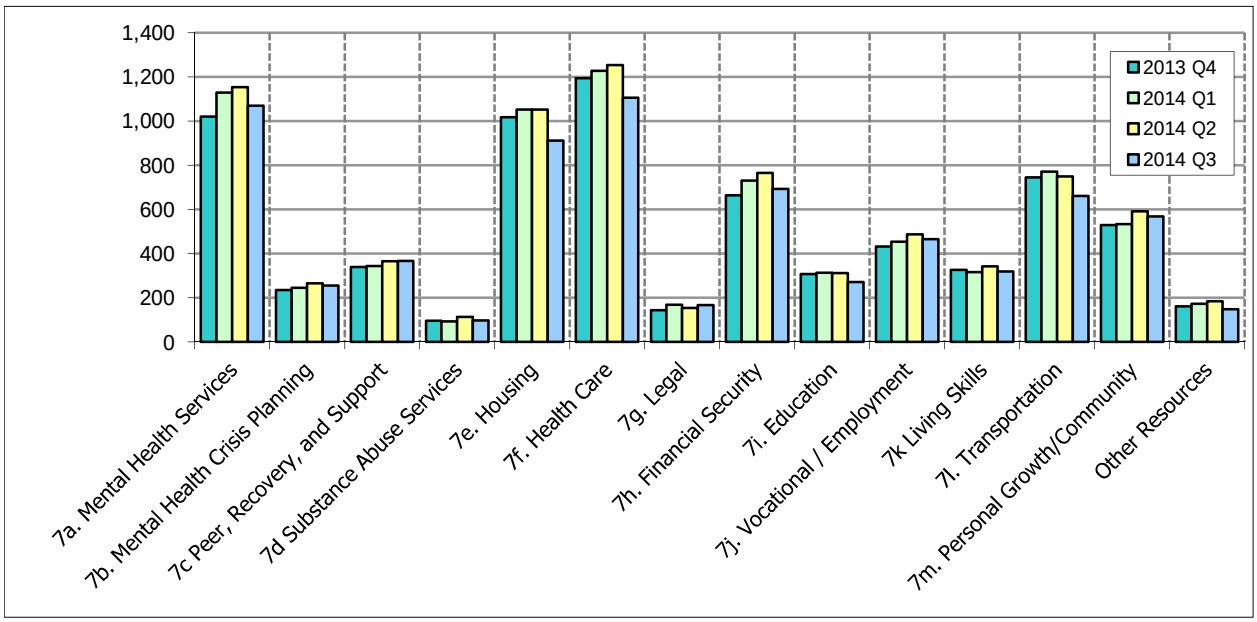

Table 3: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q4	2014 Q1	2014 Q2	2014 Q3
7a. Mental Health Services	1,020	1,129	1,153	1,069
7b. Mental Health Crisis Planning	235	245	266	255
7c Peer, Recovery, and Support	339	344	365	367
7d Substance Abuse Services	96	93	113	98
7e. Housing	1,017	1,052	1,053	912
7f. Health Care	1,195	1,227	1,254	1,106
7g. Legal	144	169	154	167
7h. Financial Security	664	730	766	693
7i. Education	308	314	312	272
7j. Vocational / Employment	432	454	488	466
7k Living Skills	326	317	343	319
7l. Transportation	745	771	749	661
7m. Personal Growth/Community	530	533	592	568
Other Resources	162	173	184	149
Total Statewide Unmet Needs	7,213	7,551	7,792	7,102

Report Run: Jul 10, 2014

Substance Abuse and 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

Statewide

(All CSNs)

Fiscal Year 2014 Quarter 3

(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	10,312	10,235	10,337	9,029
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	62	64	79	68
7a-iii Dialectical Behavioral Therapy	40	40	44	47
7a-iv Family Psycho-Educational Treatment	16	18	11	11
7a-v Group Counseling	34	44	53	41
7a-vi Individual Counseling	415	491	520	453
7a-vii Inpatient Psychiatric Facility	6	6	6	7
7a-viii Intensive Case Management	24	32	37	36
7a-x Psychiatric Medication Management	485	498	482	474
Total Unmet Resource Needs	1,020	1,129	1,153	1,069
Distinct Clients with Unmet Resource Needs	863	909	945	875
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	179	188	212	201
7b-ii Mental Health Advance Directives	56	57	54	54
Total Unmet Resource Needs	235	245	266	255
Distinct Clients with Unmet Resource Needs	220	224	244	235
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	40	41	40	45
7c-ii Recovery Workbook Group	4	7	5	7
7c-iii Social Club	110	114	121	123
7c-iv Peer-Run Trauma Recovery Group	34	32	42	34
7c-v Wellness Recovery and Action Planning	24	32	35	35
7c-vi Family Support	127	118	122	123
Total Unmet Resource Needs	339	344	365	367
Distinct Clients with Unmet Resource Needs	279	279	293	286
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	78	76	97	87
7d-ii Residential Treatment Substance Abuse Services	18	17	16	11
Total Unmet Resource Needs	96	93	113	98
Distinct Clients with Unmet Resource Needs	94	90	110	97

Report Run: Jul 10, 2014

Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

Statewide

(All CSNs)

Fiscal Year 2014 Quarter 3

(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	10,312	10,235	10,337	9,029
7e. Housing				
7e-i Supported Apartment	116	114	127	103
7e-ii Community Residential Facility	35	41	33	28
7e-iii Residential Treatment Facility (group home)	13	13	17	14
7e-iv Assisted Living Facility	42	49	56	48
7e-v Nursing Home	4	6	4	5
7e-vi Residential Crisis Unit	2	1	2	2
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	805	828	814	712
Total Unmet Resource Needs	1,017	1,052	1,053	912
Distinct Clients with Unmet Resource Needs	938	961	962	834
7f. Health Care				
7f-i Dental Services	616	633	638	557
7f-ii Eye Care Services	232	234	251	229
7f-iii Hearing Services	62	53	50	41
7f-iv Physical Therapy	38	42	41	38
7f-v Physician/Medical Services	247	265	274	241
Total Unmet Resource Needs	1,195	1,227	1,254	1,106
Distinct Clients with Unmet Resource Needs	922	927	936	816
7g. Legal				
7g-i Advocate	93	113	109	120
7g-ii Guardian (private)	40	41	34	38
7g-iii Guardian (public)	11	15	11	9
Total Unmet Resource Needs	144	169	154	167
Distinct Clients with Unmet Resource Needs	136	159	145	160
7h. Financial Security				
7h-i Assistance with Managing Money	368	409	413	371
7h-ii Assistance with Securing Public Benefits	254	270	304	272
7h-iii Representative Payee	42	51	49	50
Total Unmet Resource Needs	664	730	766	693
Distinct Clients with Unmet Resource Needs	592	645	671	597

Report Run: Jul 10, 2014

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

Statewide

(All CSNs)

Fiscal Year 2014 Quarter 3

(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	10,312	10,235	10,337	9,029
7i. Education				
7i-i Adult Education (other than GED)	67	66	67	52
7i-ii GED	86	89	77	80
7i-iii Literacy Assistance	29	27	27	27
7i-iv Post High School Education	102	115	120	95
7i-v Tuition Reimbursement	24	17	21	18
Total Unmet Resource Needs	308	314	312	272
Distinct Clients with Unmet Resource Needs	285	297	291	245
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	43	37	43	52
7j-ii Club House and/or Peer Vocational Support	26	38	44	42
7j-iii Competitive Employment (no supports)	66	68	72	72
7j-iv Supported Employment	41	48	54	51
7j-v Vocational Rehabilitation	256	263	275	249
Total Unmet Resource Needs	432	454	488	466
Distinct Clients with Unmet Resource Needs	381	396	420	390
7k. Living Skills				
7k-i Daily Living Support Services	221	217	224	208
7k-ii Day Support Services	32	24	26	23
7k-iii Occupational Therapy	9	14	11	9
7k-iv Skills Development Services	64	62	82	79
Total Unmet Resource Needs	326	317	343	319
Distinct Clients with Unmet Resource Needs	304	294	313	290
7l. Transportation				
7l-i Transportation to ISP-Identified Services	362	383	390	352
7-ii Transportation to Other ISP Activities	197	205	196	155
7-iii After Hours Transportation	186	183	163	154
Total Unmet Resource Needs	745	771	749	661
Distinct Clients with Unmet Resource Needs	529	532	537	474
7m. Personal Growth/Community				
7m-i Avocational Activities	24	27	31	30

Report Run: Jul 10, 2014

Substance Abuse and 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

Statewide

(All CSNs)

Fiscal Year 2014 Quarter 3

(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	10,312	10,235	10,337	9,029
7m. Personal Growth/Community				
7m-ii Recreation Activities	142	135	158	155
7m-iii Social Activities	316	309	337	324
7m-iv Spiritual Activities	48	62	66	59
Total Unmet Resource Needs	530	533	592	568
Distinct Clients with Unmet Resource Needs	396	387	427	392
Other Resources				
Other Resources	162	173	184	149
Total Unmet Resource Needs	162	173	184	149
Distinct Clients with Unmet Resource Needs	162	173	184	149
Statewide Totals				
Total Unmet Resource Needs	7,213	7,551	7,792	7,102
Distinct Clients With any Unmet Resource Need	2,733	2,778	2,772	2,461
Distinct Clients with a RDS	10,312	10,235	10,337	9,029

Report Run: Jul 10, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q3

CSN 1 - Aroostook

Table 1: Distinct People and Unmet Resource Needs across four Quarters

2013 Q4			2014 Q1			2014 Q2			2014 Q3		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
130	385	33.8%	133	406	32.8%	139	423	32.9%	123	375	32.8%

Graph 1: Number of Unmet Resource Needs by Category over four Quarters

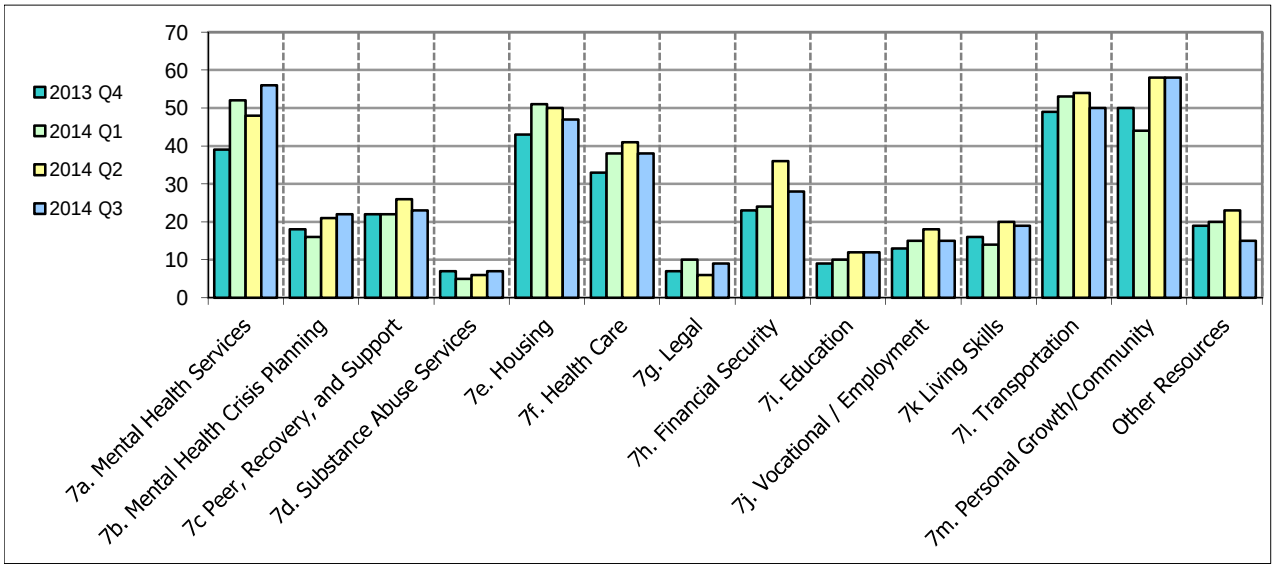

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q4	2014 Q1	2014 Q2	2014 Q3
7a. Mental Health Services	39	52	48	56
7b. Mental Health Crisis Planning	18	16	21	22
7c Peer, Recovery, and Support	22	22	26	23
7d. Substance Abuse Services	7	5	6	7
7e. Housing	43	51	50	47
7f. Health Care	33	38	41	38
7g. Legal	7	10	6	9
7h. Financial Security	23	24	36	28
7i. Education	9	10	12	12
7j. Vocational / Employment	13	15	18	15
7k Living Skills	16	14	20	19
7l. Transportation	49	53	54	50
7m. Personal Growth/Community	50	44	58	58
Other Resources	19	20	23	15
Total CSN 1 Unmet Needs	348	374	419	399

Report Run: Jul 10, 2014

Substance Abuse and 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 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	385	406	423	375
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	0	0	0	2
7a-iii Dialectical Behavioral Therapy	7	4	4	3
7a-iv Family Psycho-Educational Treatment	1	0	0	0
7a-v Group Counseling	2	6	4	4
7a-vi Individual Counseling	7	13	15	15
7a-vii Inpatient Psychiatric Facility	0	1	0	0
7a-viii Intensive Case Management	0	0	1	1
7a-x Psychiatric Medication Management	22	28	24	31
Total Unmet Resource Needs	39	52	48	56
Distinct Clients with Unmet Resource Needs	35	44	39	47
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	14	11	17	18
7b-ii Mental Health Advance Directives	4	5	4	4
Total Unmet Resource Needs	18	16	21	22
Distinct Clients with Unmet Resource Needs	17	13	19	20
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	0	1	1	1
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	13	16	20	18
7c-iv Peer-Run Trauma Recovery Group	2	1	2	2
7c-v Wellness Recovery and Action Planning	2	2	2	2
7c-vi Family Support	5	2	1	0
Total Unmet Resource Needs	22	22	26	23
Distinct Clients with Unmet Resource Needs	20	21	24	21
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	7	5	6	7
7d-ii Residential Treatment Substance Abuse Services	0	0	0	0
Total Unmet Resource Needs	7	5	6	7
Distinct Clients with Unmet Resource Needs	7	5	6	7

Report Run: Jul 10, 2014

Substance Abuse and 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 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	385	406	423	375
7e. Housing				
7e-i Supported Apartment	9	10	14	10
7e-ii Community Residential Facility	2	2	1	2
7e-iii Residential Treatment Facility (group home)	2	3	2	2
7e-iv Assisted Living Facility	2	4	6	5
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	28	32	27	28
Total Unmet Resource Needs	43	51	50	47
Distinct Clients with Unmet Resource Needs	36	41	39	39
7f. Health Care				
7f-i Dental Services	14	17	17	18
7f-ii Eye Care Services	3	7	8	9
7f-iii Hearing Services	1	1	2	0
7f-iv Physical Therapy	2	1	0	2
7f-v Physician/Medical Services	13	12	14	9
Total Unmet Resource Needs	33	38	41	38
Distinct Clients with Unmet Resource Needs	30	30	30	27
7g. Legal				
7g-i Advocate	6	6	4	6
7g-ii Guardian (private)	1	3	1	2
7g-iii Guardian (public)	0	1	1	1
Total Unmet Resource Needs	7	10	6	9
Distinct Clients with Unmet Resource Needs	6	9	6	9
7h. Financial Security				
7h-i Assistance with Managing Money	13	13	15	11
7h-ii Assistance with Securing Public Benefits	10	11	21	16
7h-iii Representative Payee	0	0	0	1
Total Unmet Resource Needs	23	24	36	28
Distinct Clients with Unmet Resource Needs	22	24	33	24

Report Run: Jul 10, 2014

Substance Abuse and 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 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	385	406	423	375
7i. Education				
7i-i Adult Education (other than GED)	1	0	0	0
7i-ii GED	3	4	4	5
7i-iii Literacy Assistance	1	1	2	1
7i-iv Post High School Education	3	4	5	5
7i-v Tuition Reimbursement	1	1	1	1
Total Unmet Resource Needs	9	10	12	12
Distinct Clients with Unmet Resource Needs	9	10	12	12
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	0	2	2	3
7j-ii Club House and/or Peer Vocational Support	1	1	1	0
7j-iii Competitive Employment (no supports)	1	0	1	1
7j-iv Supported Employment	2	3	6	4
7j-v Vocational Rehabilitation	9	9	8	7
Total Unmet Resource Needs	13	15	18	15
Distinct Clients with Unmet Resource Needs	12	13	15	13
7k. Living Skills				
7k-i Daily Living Support Services	5	6	9	7
7k-ii Day Support Services	3	0	0	0
7k-iii Occupational Therapy	0	0	0	1
7k-iv Skills Development Services	8	8	11	11
Total Unmet Resource Needs	16	14	20	19
Distinct Clients with Unmet Resource Needs	15	12	17	16
7l. Transportation				
7l-i Transportation to ISP-Identified Services	25	28	29	26
7-ii Transportation to Other ISP Activities	11	10	11	9
7-iii After Hours Transportation	13	15	14	15
Total Unmet Resource Needs	49	53	54	50
Distinct Clients with Unmet Resource Needs	36	37	38	35
7m. Personal Growth/Community				
7m-i Avocational Activities	0	2	4	5

Report Run: Jul 10, 2014

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CSN 1
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Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	385	406	423	375
7m. Personal Growth/Community				
7m-ii Recreation Activities	16	9	13	16
7m-iii Social Activities	32	29	36	34
7m-iv Spiritual Activities	2	4	5	3
Total Unmet Resource Needs	50	44	58	58
Distinct Clients with Unmet Resource Needs	39	33	44	39
Other Resources				
Other Resources	19	20	23	15
Total Unmet Resource Needs	19	20	23	15
Distinct Clients with Unmet Resource Needs	19	20	23	15
CSN 1 Totals				
Total Unmet Resource Needs	348	374	419	399
Distinct Clients With any Unmet Resource Need	130	133	139	123
Distinct Clients with a RDS	385	406	423	375

Report Run: Jul 10, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q3

CSN 2 - Hancock, Washington, Penobscot, Piscataquis

Table 1: Distinct People and Unmet Resource Needs across four Quarters

2013 Q4			2014 Q1			2014 Q2			2014 Q3		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
431	1,868	23.1%	471	1,889	24.9%	473	1,825	25.9%	425	1,600	26.6%

Graph 1: Number of Unmet Resource Needs by Category over four Quarters

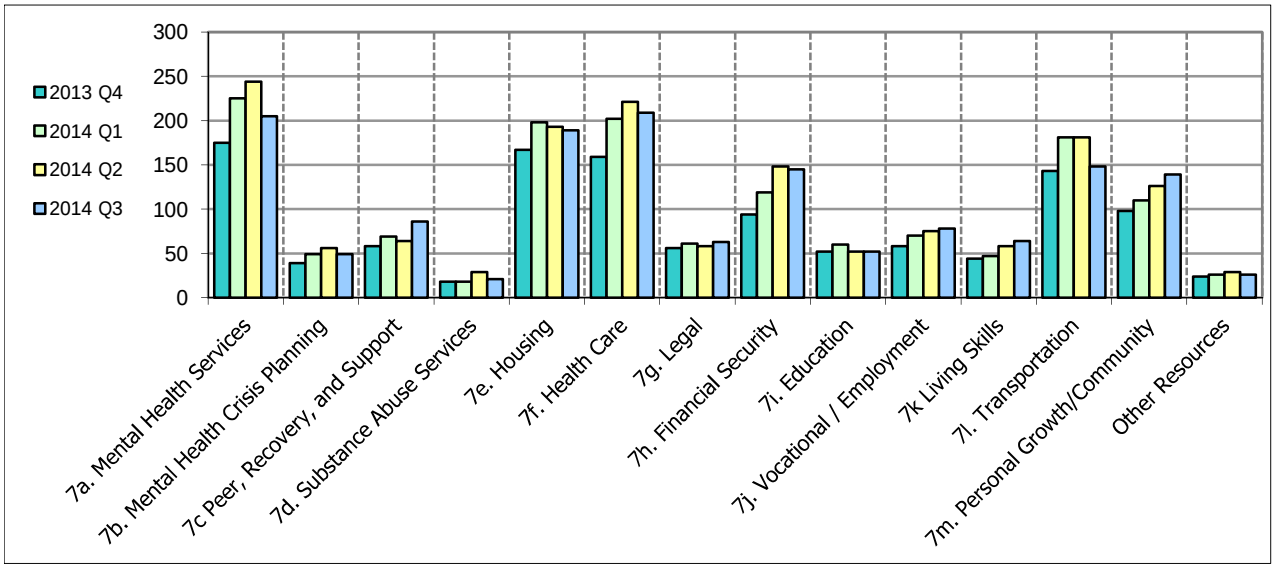

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q4	2014 Q1	2014 Q2	2014 Q3
7a. Mental Health Services	175	225	244	205
7b. Mental Health Crisis Planning	39	49	56	49
7c Peer, Recovery, and Support	58	69	64	86
7d. Substance Abuse Services	18	18	29	21
7e. Housing	167	198	193	189
7f. Health Care	159	202	221	209
7g. Legal	56	61	58	63
7h. Financial Security	94	119	148	145
7i. Education	52	60	52	52
7j. Vocational / Employment	58	70	75	78
7k Living Skills	44	47	58	64
7l. Transportation	143	181	181	148
7m. Personal Growth/Community	98	110	126	139
Other Resources	24	26	29	26
Total CSN 2 Unmet Needs	1,185	1,435	1,534	1,474

Report Run: Jul 10, 2014

Substance Abuse and 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 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	1,868	1,889	1,825	1,600
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	3	3	7	5
7a-iii Dialectical Behavioral Therapy	2	3	1	3
7a-iv Family Psycho-Educational Treatment	6	6	4	3
7a-v Group Counseling	7	7	13	13
7a-vi Individual Counseling	74	107	122	92
7a-vii Inpatient Psychiatric Facility	0	0	1	1
7a-viii Intensive Case Management	1	5	8	9
7a-x Psychiatric Medication Management	82	94	88	79
Total Unmet Resource Needs	175	225	244	205
Distinct Clients with Unmet Resource Needs	133	158	174	144
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	35	42	50	40
7b-ii Mental Health Advance Directives	4	7	6	9
Total Unmet Resource Needs	39	49	56	49
Distinct Clients with Unmet Resource Needs	37	45	52	45
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	7	6	5	8
7c-ii Recovery Workbook Group	1	1	0	1
7c-iii Social Club	13	17	15	24
7c-iv Peer-Run Trauma Recovery Group	11	9	10	9
7c-v Wellness Recovery and Action Planning	6	9	9	11
7c-vi Family Support	20	27	25	33
Total Unmet Resource Needs	58	69	64	86
Distinct Clients with Unmet Resource Needs	41	49	51	60
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	15	17	27	20
7d-ii Residential Treatment Substance Abuse Services	3	1	2	1
Total Unmet Resource Needs	18	18	29	21
Distinct Clients with Unmet Resource Needs	16	18	27	21

Report Run: Jul 10, 2014

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	1,868	1,889	1,825	1,600
7e. Housing				
7e-i Supported Apartment	17	27	21	15
7e-ii Community Residential Facility	4	6	4	6
7e-iii Residential Treatment Facility (group home)	0	0	0	1
7e-iv Assisted Living Facility	7	9	13	12
7e-v Nursing Home	0	0	0	1
7e-vi Residential Crisis Unit	0	0	1	2
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	139	156	154	152
Total Unmet Resource Needs	167	198	193	189
Distinct Clients with Unmet Resource Needs	157	185	180	173
7f. Health Care				
7f-i Dental Services	66	84	91	85
7f-ii Eye Care Services	33	43	46	52
7f-iii Hearing Services	4	7	7	7
7f-iv Physical Therapy	7	9	11	11
7f-v Physician/Medical Services	49	59	66	54
Total Unmet Resource Needs	159	202	221	209
Distinct Clients with Unmet Resource Needs	121	145	160	148
7g. Legal				
7g-i Advocate	23	27	31	31
7g-ii Guardian (private)	31	30	25	29
7g-iii Guardian (public)	2	4	2	3
Total Unmet Resource Needs	56	61	58	63
Distinct Clients with Unmet Resource Needs	52	57	52	59
7h. Financial Security				
7h-i Assistance with Managing Money	48	70	79	84
7h-ii Assistance with Securing Public Benefits	41	41	59	51
7h-iii Representative Payee	5	8	10	10
Total Unmet Resource Needs	94	119	148	145
Distinct Clients with Unmet Resource Needs	82	103	119	119

Report Run: Jul 10, 2014

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Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	1,868	1,889	1,825	1,600
7i. Education				
7i-i Adult Education (other than GED)	9	10	7	8
7i-ii GED	5	7	5	6
7i-iii Literacy Assistance	3	4	3	2
7i-iv Post High School Education	26	29	29	28
7i-v Tuition Reimbursement	9	10	8	8
Total Unmet Resource Needs	52	60	52	52
Distinct Clients with Unmet Resource Needs	48	56	49	47
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	9	8	11	10
7j-ii Club House and/or Peer Vocational Support	2	3	4	10
7j-iii Competitive Employment (no supports)	18	22	20	17
7j-iv Supported Employment	7	7	7	9
7j-v Vocational Rehabilitation	22	30	33	32
Total Unmet Resource Needs	58	70	75	78
Distinct Clients with Unmet Resource Needs	49	57	60	62
7k. Living Skills				
7k-i Daily Living Support Services	30	32	34	36
7k-ii Day Support Services	4	3	3	3
7k-iii Occupational Therapy	1	3	2	2
7k-iv Skills Development Services	9	9	19	23
Total Unmet Resource Needs	44	47	58	64
Distinct Clients with Unmet Resource Needs	38	41	51	52
7l. Transportation				
7l-i Transportation to ISP-Identified Services	64	85	91	79
7-ii Transportation to Other ISP Activities	35	47	42	32
7-iii After Hours Transportation	44	49	48	37
Total Unmet Resource Needs	143	181	181	148
Distinct Clients with Unmet Resource Needs	93	111	119	99
7m. Personal Growth/Community				
7m-i Avocational Activities	8	10	10	11

Report Run: Jul 10, 2014

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Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	1,868	1,889	1,825	1,600
7m. Personal Growth/Community				
7m-ii Recreation Activities	31	31	41	47
7m-iii Social Activities	54	57	62	70
7m-iv Spiritual Activities	5	12	13	11
Total Unmet Resource Needs	98	110	126	139
Distinct Clients with Unmet Resource Needs	68	73	84	88
Other Resources				
Other Resources	24	26	29	26
Total Unmet Resource Needs	24	26	29	26
Distinct Clients with Unmet Resource Needs	24	26	29	26
CSN 2 Totals				
Total Unmet Resource Needs	1,185	1,435	1,534	1,474
Distinct Clients With any Unmet Resource Need	431	471	473	425
Distinct Clients with a RDS	1,868	1,889	1,825	1,600

Report Run: Jul 10, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q3

CSN 3 - Kennebec and Somerset

Table 1: Distinct People and Unmet Resource Needs across four Quarters

2013 Q4			2014 Q1			2014 Q2			2014 Q3		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
380	2,102	18.1%	384	2,081	18.5%	362	2,083	17.4%	298	1,795	16.6%

Graph 1: Number of Unmet Resource Needs by Category over four Quarters

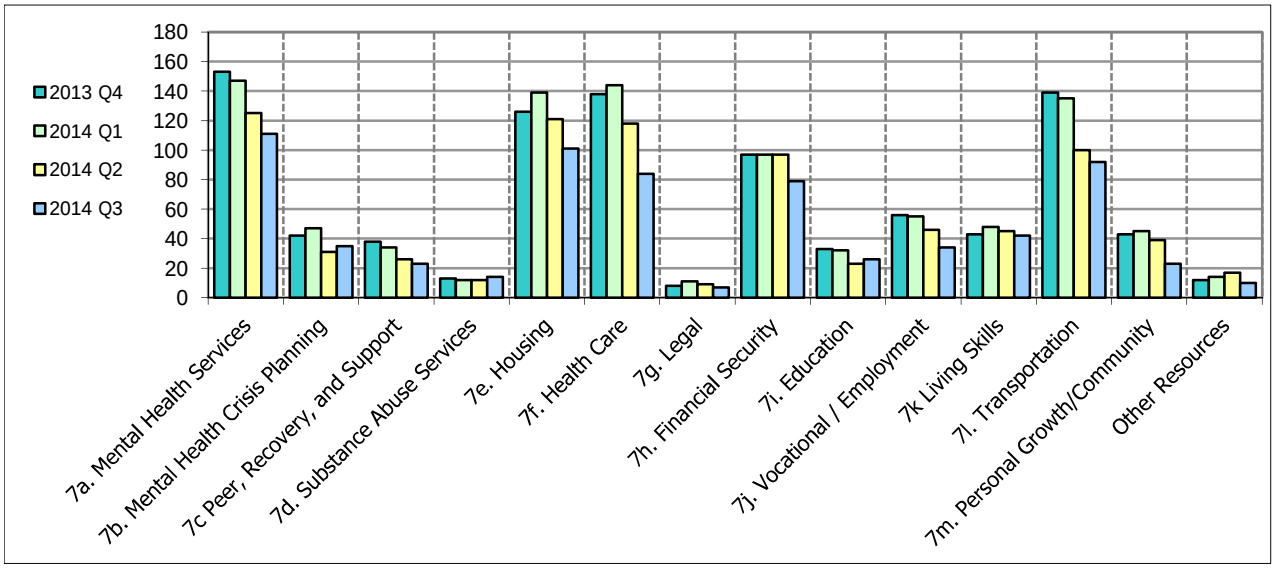

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q4	2014 Q1	2014 Q2	2014 Q3
7a. Mental Health Services	153	147	125	111
7b. Mental Health Crisis Planning	42	47	31	35
7c Peer, Recovery, and Support	38	34	26	23
7d. Substance Abuse Services	13	12	12	14
7e. Housing	126	139	121	101
7f. Health Care	138	144	118	84
7g. Legal	8	11	9	7
7h. Financial Security	97	97	97	79
7i. Education	33	32	23	26
7j. Vocational / Employment	56	55	46	34
7k Living Skills	43	48	45	42
7l. Transportation	139	135	100	92
7m. Personal Growth/Community	43	45	39	23
Other Resources	12	14	17	10
Total CSN 3 Unmet Needs	941	960	809	681

Report Run: Jul 10, 2014

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,102	2,081	2,083	1,795
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	4	3	2
7a-iii Dialectical Behavioral Therapy	3	2	2	2
7a-iv Family Psycho-Educational Treatment	1	1	1	1
7a-v Group Counseling	5	5	1	1
7a-vi Individual Counseling	67	63	47	45
7a-vii Inpatient Psychiatric Facility	1	1	1	2
7a-viii Intensive Case Management	2	2	1	0
7a-x Psychiatric Medication Management	72	69	69	58
Total Unmet Resource Needs	153	147	125	111
Distinct Clients with Unmet Resource Needs	113	107	95	83
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	32	33	22	26
7b-ii Mental Health Advance Directives	10	14	9	9
Total Unmet Resource Needs	42	47	31	35
Distinct Clients with Unmet Resource Needs	37	41	27	30
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	4	3	4	3
7c-ii Recovery Workbook Group	1	2	0	0
7c-iii Social Club	12	9	5	3
7c-iv Peer-Run Trauma Recovery Group	1	2	2	1
7c-v Wellness Recovery and Action Planning	1	2	2	3
7c-vi Family Support	19	16	13	13
Total Unmet Resource Needs	38	34	26	23
Distinct Clients with Unmet Resource Needs	34	29	21	21
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	10	9	10	11
7d-ii Residential Treatment Substance Abuse Services	3	3	2	3
Total Unmet Resource Needs	13	12	12	14
Distinct Clients with Unmet Resource Needs	13	12	12	13

Report Run: Jul 10, 2014

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CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,102	2,081	2,083	1,795
7e. Housing				
7e-i Supported Apartment	7	7	9	8
7e-ii Community Residential Facility	4	9	4	2
7e-iii Residential Treatment Facility (group home)	1	1	1	0
7e-iv Assisted Living Facility	1	2	3	5
7e-v Nursing Home	0	0	0	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	113	120	104	85
Total Unmet Resource Needs	126	139	121	101
Distinct Clients with Unmet Resource Needs	121	133	117	96
7f. Health Care				
7f-i Dental Services	66	70	61	38
7f-ii Eye Care Services	26	29	24	17
7f-iii Hearing Services	12	10	8	5
7f-iv Physical Therapy	4	4	2	1
7f-v Physician/Medical Services	30	31	23	23
Total Unmet Resource Needs	138	144	118	84
Distinct Clients with Unmet Resource Needs	112	115	101	71
7g. Legal				
7g-i Advocate	5	6	5	4
7g-ii Guardian (private)	1	1	1	2
7g-iii Guardian (public)	2	4	3	1
Total Unmet Resource Needs	8	11	9	7
Distinct Clients with Unmet Resource Needs	6	9	7	6
7h. Financial Security				
7h-i Assistance with Managing Money	37	41	40	34
7h-ii Assistance with Securing Public Benefits	52	47	50	36
7h-iii Representative Payee	8	9	7	9
Total Unmet Resource Needs	97	97	97	79
Distinct Clients with Unmet Resource Needs	87	91	91	68

Report Run: Jul 10, 2014

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,102	2,081	2,083	1,795
7i. Education				
7i-i Adult Education (other than GED)	6	5	5	3
7i-ii GED	10	9	8	9
7i-iii Literacy Assistance	7	7	3	4
7i-iv Post High School Education	8	9	5	8
7i-v Tuition Reimbursement	2	2	2	2
Total Unmet Resource Needs	33	32	23	26
Distinct Clients with Unmet Resource Needs	30	29	21	25
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	3	3	2	2
7j-ii Club House and/or Peer Vocational Support	11	9	10	5
7j-iii Competitive Employment (no supports)	2	3	3	3
7j-iv Supported Employment	4	4	3	2
7j-v Vocational Rehabilitation	36	36	28	22
Total Unmet Resource Needs	56	55	46	34
Distinct Clients with Unmet Resource Needs	50	48	43	32
7k. Living Skills				
7k-i Daily Living Support Services	39	39	36	33
7k-ii Day Support Services	2	1	2	2
7k-iii Occupational Therapy	0	1	0	0
7k-iv Skills Development Services	2	7	7	7
Total Unmet Resource Needs	43	48	45	42
Distinct Clients with Unmet Resource Needs	43	47	44	41
7l. Transportation				
7l-i Transportation to ISP-Identified Services	85	83	65	62
7-ii Transportation to Other ISP Activities	31	30	20	17
7-iii After Hours Transportation	23	22	15	13
Total Unmet Resource Needs	139	135	100	92
Distinct Clients with Unmet Resource Needs	102	99	82	73
7m. Personal Growth/Community				
7m-i Avocational Activities	0	0	1	1

Report Run: Jul 10, 2014

Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,102	2,081	2,083	1,795
7m. Personal Growth/Community				
7m-ii Recreation Activities	5	7	5	2
7m-iii Social Activities	36	36	31	20
7m-iv Spiritual Activities	2	2	2	0
Total Unmet Resource Needs	43	45	39	23
Distinct Clients with Unmet Resource Needs	39	39	33	21
Other Resources				
Other Resources	12	14	17	10
Total Unmet Resource Needs	12	14	17	10
Distinct Clients with Unmet Resource Needs	12	14	17	10
CSN 3 Totals				
Total Unmet Resource Needs	941	960	809	681
Distinct Clients With any Unmet Resource Need	380	384	362	298
Distinct Clients with a RDS	2,102	2,081	2,083	1,795

Report Run: Jul 10, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q3

CSN 4 - Knox, Lincoln, Sagadahoc, Waldo

Table 1: Distinct People and Unmet Resource Needs across four Quarters

2013 Q4			2014 Q1			2014 Q2			2014 Q3		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
217	836	26.0%	214	803	26.7%	203	856	23.7%	181	754	24.0%

Graph 1: Number of Unmet Resource Needs by Category over four Quarters

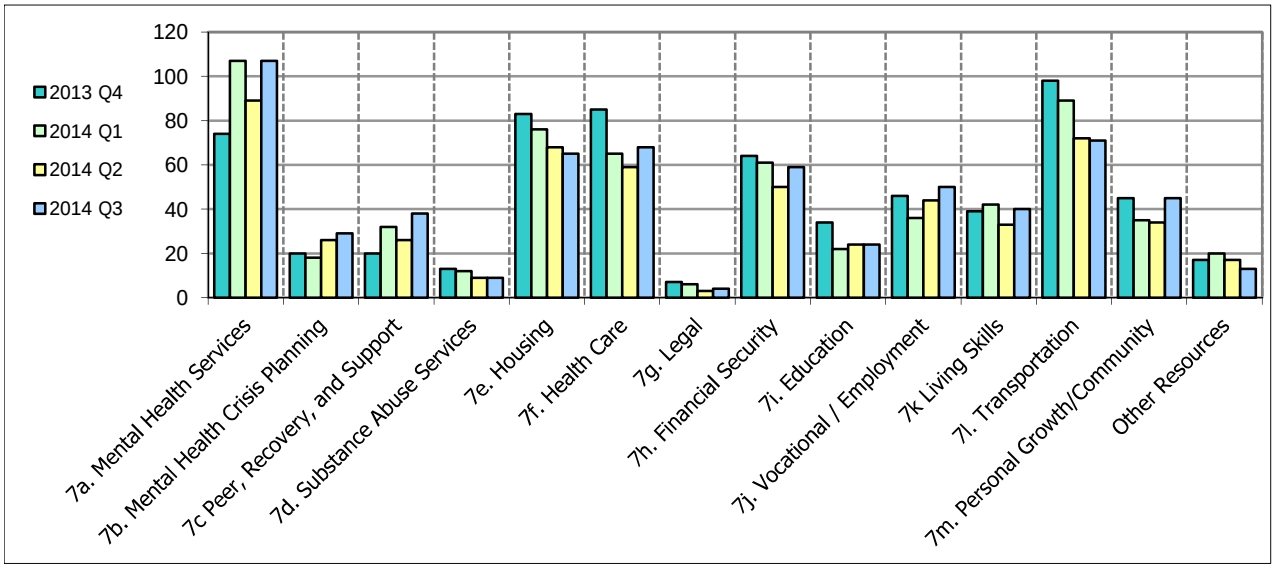

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q4	2014 Q1	2014 Q2	2014 Q3
7a. Mental Health Services	74	107	89	107
7b. Mental Health Crisis Planning	20	18	26	29
7c Peer, Recovery, and Support	20	32	26	38
7d. Substance Abuse Services	13	12	9	9
7e. Housing	83	76	68	65
7f. Health Care	85	65	59	68
7g. Legal	7	6	3	4
7h. Financial Security	64	61	50	59
7i. Education	34	22	24	24
7j. Vocational / Employment	46	36	44	50
7k Living Skills	39	42	33	40
7l. Transportation	98	89	72	71
7m. Personal Growth/Community	45	35	34	45
Other Resources	17	20	17	13
Total CSN 4 Unmet Needs	645	621	554	622

Report Run: Jul 10, 2014

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	836	803	856	754
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	3	2	10	12
7a-iii Dialectical Behavioral Therapy	0	3	0	2
7a-iv Family Psycho-Educational Treatment	0	1	1	1
7a-v Group Counseling	1	3	4	3
7a-vi Individual Counseling	41	47	36	45
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	2	3	3	3
7a-x Psychiatric Medication Management	27	48	35	41
Total Unmet Resource Needs	74	107	89	107
Distinct Clients with Unmet Resource Needs	61	85	71	78
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	14	14	20	28
7b-ii Mental Health Advance Directives	6	4	6	1
Total Unmet Resource Needs	20	18	26	29
Distinct Clients with Unmet Resource Needs	19	17	23	29
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	2	8	5	5
7c-ii Recovery Workbook Group	0	1	1	1
7c-iii Social Club	4	5	6	11
7c-iv Peer-Run Trauma Recovery Group	3	2	1	1
7c-v Wellness Recovery and Action Planning	0	2	3	2
7c-vi Family Support	11	14	10	18
Total Unmet Resource Needs	20	32	26	38
Distinct Clients with Unmet Resource Needs	19	27	18	29
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	11	10	8	9
7d-ii Residential Treatment Substance Abuse Services	2	2	1	0
Total Unmet Resource Needs	13	12	9	9
Distinct Clients with Unmet Resource Needs	13	12	9	9

Report Run: Jul 10, 2014

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	836	803	856	754
7e. Housing				
7e-i Supported Apartment	9	9	9	11
7e-ii Community Residential Facility	3	3	3	2
7e-iii Residential Treatment Facility (group home)	3	4	4	3
7e-iv Assisted Living Facility	7	5	5	2
7e-v Nursing Home	2	2	1	0
7e-vi Residential Crisis Unit	1	1	1	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	58	52	45	47
Total Unmet Resource Needs	83	76	68	65
Distinct Clients with Unmet Resource Needs	73	65	57	59
7f. Health Care				
7f-i Dental Services	45	37	36	35
7f-ii Eye Care Services	17	11	12	13
7f-iii Hearing Services	6	3	2	2
7f-iv Physical Therapy	1	1	0	3
7f-v Physician/Medical Services	16	13	9	15
Total Unmet Resource Needs	85	65	59	68
Distinct Clients with Unmet Resource Needs	68	51	47	54
7g. Legal				
7g-i Advocate	5	3	2	3
7g-ii Guardian (private)	2	3	1	1
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	7	6	3	4
Distinct Clients with Unmet Resource Needs	7	6	3	4
7h. Financial Security				
7h-i Assistance with Managing Money	36	33	29	30
7h-ii Assistance with Securing Public Benefits	21	20	18	26
7h-iii Representative Payee	7	8	3	3
Total Unmet Resource Needs	64	61	50	59
Distinct Clients with Unmet Resource Needs	56	47	44	48

Report Run: Jul 10, 2014

Substance Abuse and 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 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	836	803	856	754
7i. Education				
7i-i Adult Education (other than GED)	6	3	2	2
7i-ii GED	12	8	8	11
7i-iii Literacy Assistance	1	0	0	1
7i-iv Post High School Education	13	11	13	10
7i-v Tuition Reimbursement	2	0	1	0
Total Unmet Resource Needs	34	22	24	24
Distinct Clients with Unmet Resource Needs	33	22	22	23
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	4	4	5	6
7j-ii Club House and/or Peer Vocational Support	0	2	1	1
7j-iii Competitive Employment (no supports)	9	2	3	6
7j-iv Supported Employment	5	6	5	2
7j-v Vocational Rehabilitation	28	22	30	35
Total Unmet Resource Needs	46	36	44	50
Distinct Clients with Unmet Resource Needs	39	29	36	43
7k. Living Skills				
7k-i Daily Living Support Services	29	29	25	32
7k-ii Day Support Services	3	1	1	1
7k-iii Occupational Therapy	1	1	1	0
7k-iv Skills Development Services	6	11	6	7
Total Unmet Resource Needs	39	42	33	40
Distinct Clients with Unmet Resource Needs	35	37	30	36
7l. Transportation				
7l-i Transportation to ISP-Identified Services	52	48	39	40
7-ii Transportation to Other ISP Activities	33	27	20	21
7-iii After Hours Transportation	13	14	13	10
Total Unmet Resource Needs	98	89	72	71
Distinct Clients with Unmet Resource Needs	61	55	46	47
7m. Personal Growth/Community				
7m-i Avocational Activities	4	3	2	1

Report Run: Jul 10, 2014

Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	836	803	856	754
7m. Personal Growth/Community				
7m-ii Recreation Activities	11	9	9	14
7m-iii Social Activities	29	21	21	27
7m-iv Spiritual Activities	1	2	2	3
Total Unmet Resource Needs	45	35	34	45
Distinct Clients with Unmet Resource Needs	36	27	25	32
Other Resources				
Other Resources	17	20	17	13
Total Unmet Resource Needs	17	20	17	13
Distinct Clients with Unmet Resource Needs	17	20	17	13
CSN 4 Totals				
Total Unmet Resource Needs	645	621	554	622
Distinct Clients With any Unmet Resource Need	217	214	203	181
Distinct Clients with a RDS	836	803	856	754

Report Run: Jul 10, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q3

CSN 5 - Androscoggin, Franklin, Oxford (Includes: Bridgton, Harrison, Naples, Casco)

Table 1: Distinct People and Unmet Resource Needs across four Quarters

2013 Q4			2014 Q1			2014 Q2			2014 Q3		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
623	2,038	30.6%	639	2,018	31.7%	620	2,086	29.7%	578	1,826	31.7%

Graph 1: Number of Unmet Resource Needs by Category over four Quarters

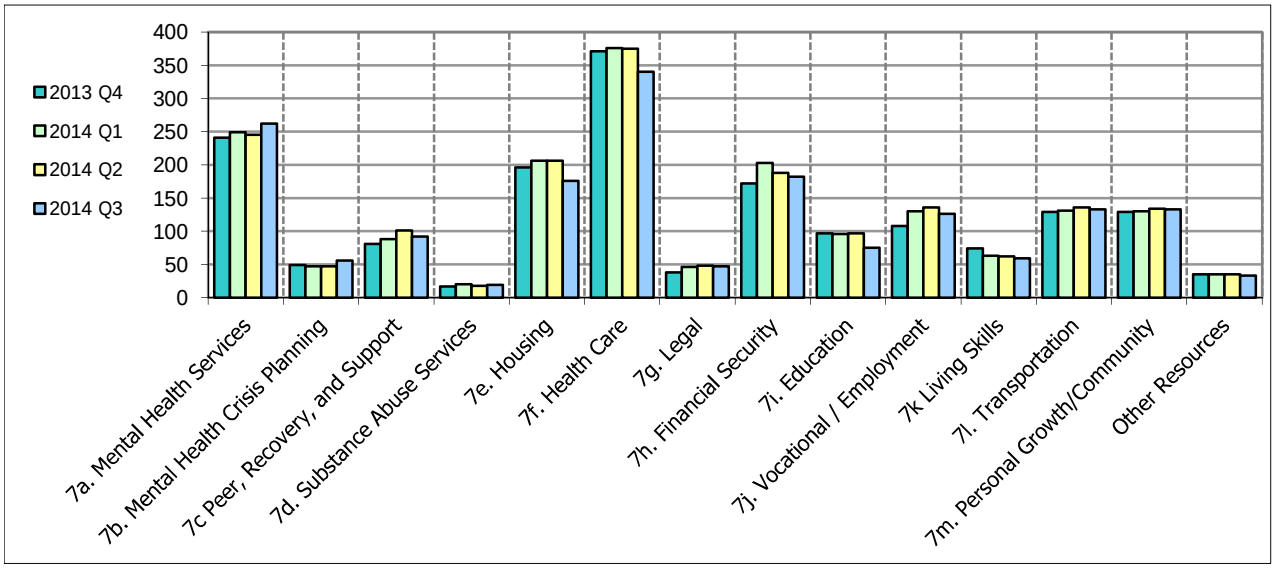

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q4	2014 Q1	2014 Q2	2014 Q3
7a. Mental Health Services	241	249	245	262
7b. Mental Health Crisis Planning	49	47	47	56
7c Peer, Recovery, and Support	81	88	101	92
7d. Substance Abuse Services	17	20	18	19
7e. Housing	196	206	206	176
7f. Health Care	371	376	375	340
7g. Legal	38	46	48	47
7h. Financial Security	172	203	188	182
7i. Education	97	96	97	75
7j. Vocational / Employment	108	130	136	126
7k Living Skills	74	63	62	59
7l. Transportation	129	131	136	133
7m. Personal Growth/Community	129	130	134	133
Other Resources	35	35	35	33
Total CSN 5 Unmet Needs	1,737	1,820	1,828	1,733

Report Run: Jul 10, 2014

Substance Abuse and 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 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,038	2,018	2,086	1,826
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	8	5	5	10
7a-iii Dialectical Behavioral Therapy	15	22	23	25
7a-iv Family Psycho-Educational Treatment	4	5	2	2
7a-v Group Counseling	5	8	9	7
7a-vi Individual Counseling	81	101	103	98
7a-vii Inpatient Psychiatric Facility	2	2	2	2
7a-viii Intensive Case Management	3	5	2	5
7a-x Psychiatric Medication Management	123	101	99	113
Total Unmet Resource Needs	241	249	245	262
Distinct Clients with Unmet Resource Needs	210	210	215	219
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	25	31	28	35
7b-ii Mental Health Advance Directives	24	16	19	21
Total Unmet Resource Needs	49	47	47	56
Distinct Clients with Unmet Resource Needs	47	45	43	52
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	10	11	8	10
7c-ii Recovery Workbook Group	1	2	3	3
7c-iii Social Club	21	29	32	32
7c-iv Peer-Run Trauma Recovery Group	3	7	8	7
7c-v Wellness Recovery and Action Planning	6	5	7	5
7c-vi Family Support	40	34	43	35
Total Unmet Resource Needs	81	88	101	92
Distinct Clients with Unmet Resource Needs	73	77	86	80
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	15	17	17	17
7d-ii Residential Treatment Substance Abuse Services	2	3	1	2
Total Unmet Resource Needs	17	20	18	19
Distinct Clients with Unmet Resource Needs	17	20	18	19

Report Run: Jul 10, 2014

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,038	2,018	2,086	1,826
7e. Housing				
7e-i Supported Apartment	14	13	16	13
7e-ii Community Residential Facility	3	3	4	2
7e-iii Residential Treatment Facility (group home)	2	2	1	3
7e-iv Assisted Living Facility	4	3	6	5
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	1	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	172	185	179	153
Total Unmet Resource Needs	196	206	206	176
Distinct Clients with Unmet Resource Needs	187	195	194	165
7f. Health Care				
7f-i Dental Services	196	193	199	171
7f-ii Eye Care Services	80	80	79	74
7f-iii Hearing Services	22	18	19	15
7f-iv Physical Therapy	13	14	12	9
7f-v Physician/Medical Services	60	71	66	71
Total Unmet Resource Needs	371	376	375	340
Distinct Clients with Unmet Resource Needs	270	270	268	239
7g. Legal				
7g-i Advocate	33	43	43	45
7g-ii Guardian (private)	1	0	2	1
7g-iii Guardian (public)	4	3	3	1
Total Unmet Resource Needs	38	46	48	47
Distinct Clients with Unmet Resource Needs	38	46	48	47
7h. Financial Security				
7h-i Assistance with Managing Money	108	131	120	105
7h-ii Assistance with Securing Public Benefits	56	64	60	66
7h-iii Representative Payee	8	8	8	11
Total Unmet Resource Needs	172	203	188	182
Distinct Clients with Unmet Resource Needs	157	186	172	165

Report Run: Jul 10, 2014

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,038	2,018	2,086	1,826
7i. Education				
7i-i Adult Education (other than GED)	24	23	24	16
7i-ii GED	32	39	32	26
7i-iii Literacy Assistance	8	5	10	8
7i-iv Post High School Education	25	26	26	20
7i-v Tuition Reimbursement	8	3	5	5
Total Unmet Resource Needs	97	96	97	75
Distinct Clients with Unmet Resource Needs	88	91	90	64
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	8	7	6	12
7j-ii Club House and/or Peer Vocational Support	8	10	15	16
7j-iii Competitive Employment (no supports)	9	12	10	11
7j-iv Supported Employment	10	12	18	15
7j-v Vocational Rehabilitation	73	89	87	72
Total Unmet Resource Needs	108	130	136	126
Distinct Clients with Unmet Resource Needs	99	119	121	106
7k. Living Skills				
7k-i Daily Living Support Services	55	44	46	43
7k-ii Day Support Services	8	9	6	5
7k-iii Occupational Therapy	3	3	2	2
7k-iv Skills Development Services	8	7	8	9
Total Unmet Resource Needs	74	63	62	59
Distinct Clients with Unmet Resource Needs	71	61	59	57
7l. Transportation				
7l-i Transportation to ISP-Identified Services	43	49	62	60
7-ii Transportation to Other ISP Activities	44	42	41	37
7-iii After Hours Transportation	42	40	33	36
Total Unmet Resource Needs	129	131	136	133
Distinct Clients with Unmet Resource Needs	92	94	102	90
7m. Personal Growth/Community				
7m-i Avocational Activities	3	4	3	3

Report Run: Jul 10, 2014

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,038	2,018	2,086	1,826
7m. Personal Growth/Community				
7m-ii Recreation Activities	34	34	33	27
7m-iii Social Activities	70	67	72	77
7m-iv Spiritual Activities	22	25	26	26
Total Unmet Resource Needs	129	130	134	133
Distinct Clients with Unmet Resource Needs	90	87	90	89
Other Resources				
Other Resources	35	35	35	33
Total Unmet Resource Needs	35	35	35	33
Distinct Clients with Unmet Resource Needs	35	35	35	33
CSN 5 Totals				
Total Unmet Resource Needs	1,737	1,820	1,828	1,733
Distinct Clients With any Unmet Resource Need	623	639	620	578
Distinct Clients with a RDS	2,038	2,018	2,086	1,826

Report Run: Jul 10, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q3

CSN 6 - Cumberland

Table 1: Distinct People and Unmet Resource Needs across four Quarters

2013 Q4			2014 Q1			2014 Q2			2014 Q3		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
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Graph 1: Number of Unmet Resource Needs by Category over four Quarters

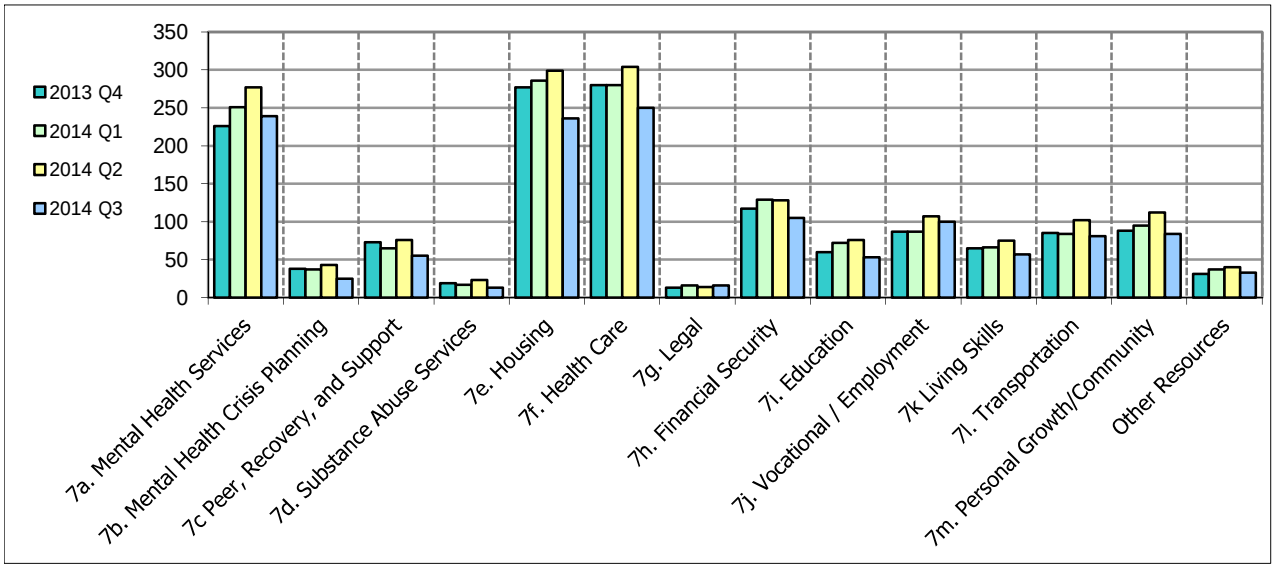

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q4	2014 Q1	2014 Q2	2014 Q3
7a. Mental Health Services	226	251	277	239
7b. Mental Health Crisis Planning	38	37	43	25
7c Peer, Recovery, and Support	73	65	76	55
7d. Substance Abuse Services	19	17	23	13
7e. Housing	277	286	299	236
7f. Health Care	280	280	304	250
7g. Legal	13	16	14	16
7h. Financial Security	117	129	128	105
7i. Education	60	72	76	53
7j. Vocational / Employment	87	87	107	100
7k Living Skills	65	66	75	57
7l. Transportation	85	84	102	81
7m. Personal Growth/Community	88	95	112	84
Other Resources	31	37	40	33
Total CSN 6 Unmet Needs	1,459	1,522	1,676	1,347

Report Run: Jul 10, 2014

Substance Abuse and 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 6
(Cumberland)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,097	2,099	2,057	1,825
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	35	37	40	31
7a-iii Dialectical Behavioral Therapy	4	4	3	3
7a-iv Family Psycho-Educational Treatment	2	2	3	3
7a-v Group Counseling	10	10	14	8
7a-vi Individual Counseling	76	95	103	88
7a-vii Inpatient Psychiatric Facility	1	1	1	1
7a-viii Intensive Case Management	13	15	15	16
7a-x Psychiatric Medication Management	85	87	98	89
Total Unmet Resource Needs	226	251	277	239
Distinct Clients with Unmet Resource Needs	182	189	208	182
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	32	31	38	23
7b-ii Mental Health Advance Directives	6	6	5	2
Total Unmet Resource Needs	38	37	43	25
Distinct Clients with Unmet Resource Needs	35	34	39	23
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	15	9	15	12
7c-ii Recovery Workbook Group	0	0	1	2
7c-iii Social Club	30	26	30	21
7c-iv Peer-Run Trauma Recovery Group	6	6	7	4
7c-v Wellness Recovery and Action Planning	7	9	8	5
7c-vi Family Support	15	15	15	11
Total Unmet Resource Needs	73	65	76	55
Distinct Clients with Unmet Resource Needs	55	46	55	39
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	13	11	16	9
7d-ii Residential Treatment Substance Abuse Services	6	6	7	4
Total Unmet Resource Needs	19	17	23	13
Distinct Clients with Unmet Resource Needs	19	15	23	13

Report Run: Jul 10, 2014

Substance Abuse and 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 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,097	2,099	2,057	1,825
7e. Housing				
7e-i Supported Apartment	44	38	44	35
7e-ii Community Residential Facility	15	13	11	9
7e-iii Residential Treatment Facility (group home)	4	3	8	5
7e-iv Assisted Living Facility	16	20	16	12
7e-v Nursing Home	2	3	2	2
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	196	209	218	173
Total Unmet Resource Needs	277	286	299	236
Distinct Clients with Unmet Resource Needs	247	253	267	212
7f. Health Care				
7f-i Dental Services	166	177	176	154
7f-ii Eye Care Services	48	41	55	46
7f-iii Hearing Services	12	10	9	9
7f-iv Physical Therapy	4	6	6	3
7f-v Physician/Medical Services	50	46	58	38
Total Unmet Resource Needs	280	280	304	250
Distinct Clients with Unmet Resource Needs	222	229	233	193
7g. Legal				
7g-i Advocate	10	14	12	13
7g-ii Guardian (private)	1	0	1	1
7g-iii Guardian (public)	2	2	1	2
Total Unmet Resource Needs	13	16	14	16
Distinct Clients with Unmet Resource Needs	13	16	14	16
7h. Financial Security				
7h-i Assistance with Managing Money	64	67	68	53
7h-ii Assistance with Securing Public Benefits	42	46	48	43
7h-iii Representative Payee	11	16	12	9
Total Unmet Resource Needs	117	129	128	105
Distinct Clients with Unmet Resource Needs	108	115	117	95

Report Run: Jul 10, 2014

Substance Abuse and 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 6
(Cumberland)

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,097	2,099	2,057	1,825
7i. Education				
7i-i Adult Education (other than GED)	16	19	20	16
7i-ii GED	13	19	18	16
7i-iii Literacy Assistance	7	6	6	7
7i-iv Post High School Education	23	27	29	12
7i-v Tuition Reimbursement	1	1	3	2
Total Unmet Resource Needs	60	72	76	53
Distinct Clients with Unmet Resource Needs	56	69	72	49
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	10	5	10	10
7j-ii Club House and/or Peer Vocational Support	3	4	5	3
7j-iii Competitive Employment (no supports)	16	21	23	22
7j-iv Supported Employment	7	11	9	14
7j-v Vocational Rehabilitation	51	46	60	51
Total Unmet Resource Needs	87	87	107	100
Distinct Clients with Unmet Resource Needs	76	76	93	84
7k. Living Skills				
7k-i Daily Living Support Services	36	42	41	33
7k-ii Day Support Services	8	6	8	6
7k-iii Occupational Therapy	2	4	4	2
7k-iv Skills Development Services	19	14	22	16
Total Unmet Resource Needs	65	66	75	57
Distinct Clients with Unmet Resource Needs	59	61	70	53
7l. Transportation				
7l-i Transportation to ISP-Identified Services	47	45	53	44
7-ii Transportation to Other ISP Activities	19	22	31	20
7-iii After Hours Transportation	19	17	18	17
Total Unmet Resource Needs	85	84	102	81
Distinct Clients with Unmet Resource Needs	70	70	77	64
7m. Personal Growth/Community				
7m-i Avocational Activities	3	3	3	3

Report Run: Jul 10, 2014

Substance Abuse and 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 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	2,097	2,099	2,057	1,825
7m. Personal Growth/Community				
7m-ii Recreation Activities	26	31	37	25
7m-iii Social Activities	50	52	65	50
7m-iv Spiritual Activities	9	9	7	6
Total Unmet Resource Needs	88	95	112	84
Distinct Clients with Unmet Resource Needs	69	71	86	65
Other Resources				
Other Resources	31	37	40	33
Total Unmet Resource Needs	31	37	40	33
Distinct Clients with Unmet Resource Needs	31	37	40	33
CSN 6 Totals				
Total Unmet Resource Needs	1,459	1,522	1,676	1,347
Distinct Clients With any Unmet Resource Need	640	657	663	573
Distinct Clients with a RDS	2,097	2,099	2,057	1,825

Report Run: Jul 10, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q3

CSN 7 - York

Table 1: Distinct People and Unmet Resource Needs across four Quarters

2013 Q4			2014 Q1			2014 Q2			2014 Q3		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
192	528	36.4%	161	588	27.4%	205	588	34.9%	191	530	36.0%

Graph 1: Number of Unmet Resource Needs by Category over four Quarters

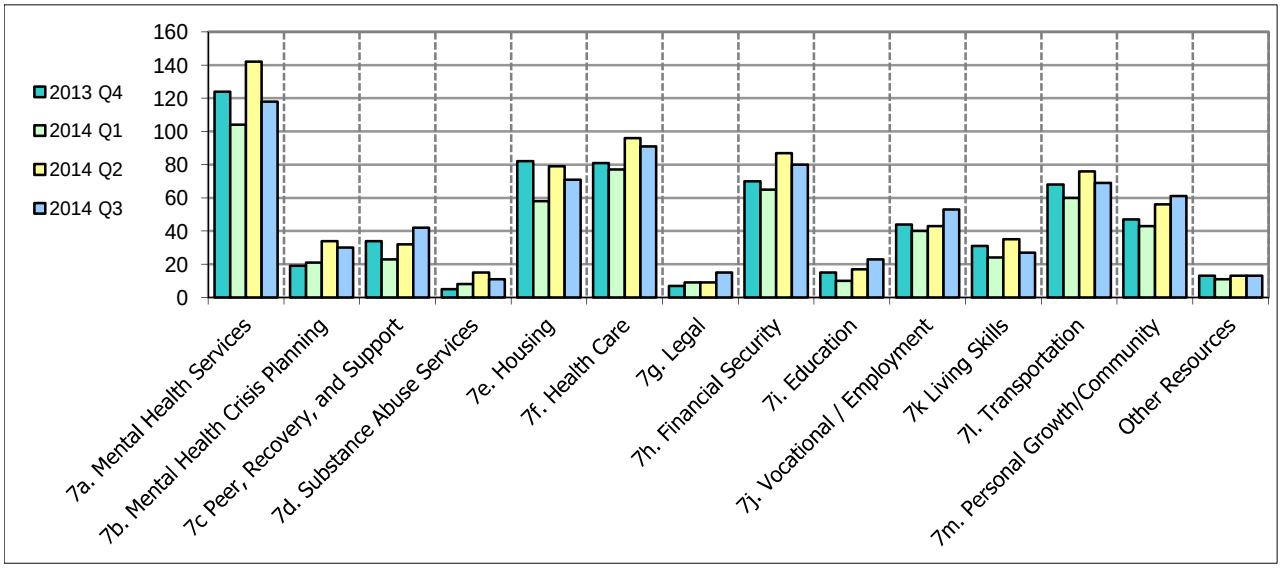

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q4	2014 Q1	2014 Q2	2014 Q3
7a. Mental Health Services	124	104	142	118
7b. Mental Health Crisis Planning	19	21	34	30
7c Peer, Recovery, and Support	34	23	32	42
7d. Substance Abuse Services	5	8	15	11
7e. Housing	82	58	79	71
7f. Health Care	81	77	96	91
7g. Legal	7	9	9	15
7h. Financial Security	70	65	87	80
7i. Education	15	10	17	23
7j. Vocational / Employment	44	40	43	53
7k Living Skills	31	24	35	27
7l. Transportation	68	60	76	69
7m. Personal Growth/Community	47	43	56	61
Other Resources	13	11	13	13
Total CSN 7 Unmet Needs	640	553	734	704

Report Run: Jul 10, 2014

Substance Abuse and 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 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	574	528	588	530
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	9	11	11	5
7a-iii Dialectical Behavioral Therapy	7	2	9	9
7a-iv Family Psycho-Educational Treatment	1	2	0	0
7a-v Group Counseling	3	3	5	4
7a-vi Individual Counseling	48	40	64	52
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	2	1	5	2
7a-x Psychiatric Medication Management	54	45	48	46
Total Unmet Resource Needs	124	104	142	118
Distinct Clients with Unmet Resource Needs	92	73	99	92
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	19	19	31	26
7b-ii Mental Health Advance Directives	0	2	3	4
Total Unmet Resource Needs	19	21	34	30
Distinct Clients with Unmet Resource Needs	19	20	33	28
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	2	3	2	6
7c-ii Recovery Workbook Group	1	1	0	0
7c-iii Social Club	11	9	11	12
7c-iv Peer-Run Trauma Recovery Group	6	3	7	7
7c-v Wellness Recovery and Action Planning	1	1	1	5
7c-vi Family Support	13	6	11	12
Total Unmet Resource Needs	34	23	32	42
Distinct Clients with Unmet Resource Needs	28	22	28	30
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	5	7	13	11
7d-ii Residential Treatment Substance Abuse Services	0	1	2	0
Total Unmet Resource Needs	5	8	15	11
Distinct Clients with Unmet Resource Needs	5	7	14	11

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	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	574	528	588	530
7e. Housing				
7e-i Supported Apartment	10	5	9	6
7e-ii Community Residential Facility	3	3	3	2
7e-iii Residential Treatment Facility (group home)	1	0	1	0
7e-iv Assisted Living Facility	2	3	3	4
7e-v Nursing Home	0	1	1	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	66	46	62	58
Total Unmet Resource Needs	82	58	79	71
Distinct Clients with Unmet Resource Needs	76	53	74	65
7f. Health Care				
7f-i Dental Services	38	31	41	41
7f-ii Eye Care Services	13	14	18	14
7f-iii Hearing Services	4	2	1	1
7f-iv Physical Therapy	6	6	8	8
7f-v Physician/Medical Services	20	24	28	27
Total Unmet Resource Needs	81	77	96	91
Distinct Clients with Unmet Resource Needs	61	53	68	62
7g. Legal				
7g-i Advocate	7	9	8	13
7g-ii Guardian (private)	0	0	0	1
7g-iii Guardian (public)	0	0	1	1
Total Unmet Resource Needs	7	9	9	15
Distinct Clients with Unmet Resource Needs	7	9	9	13
7h. Financial Security				
7h-i Assistance with Managing Money	46	36	44	46
7h-ii Assistance with Securing Public Benefits	22	27	35	27
7h-iii Representative Payee	2	2	8	7
Total Unmet Resource Needs	70	65	87	80
Distinct Clients with Unmet Resource Needs	55	51	68	63

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	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	574	528	588	530
7i. Education				
7i-i Adult Education (other than GED)	4	2	6	5
7i-ii GED	6	1	2	5
7i-iii Literacy Assistance	2	2	2	4
7i-iv Post High School Education	2	5	7	9
7i-v Tuition Reimbursement	1	0	0	0
Total Unmet Resource Needs	15	10	17	23
Distinct Clients with Unmet Resource Needs	13	9	15	18
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	8	7	6	8
7j-ii Club House and/or Peer Vocational Support	1	8	7	7
7j-iii Competitive Employment (no supports)	6	5	9	10
7j-iv Supported Employment	4	3	4	4
7j-v Vocational Rehabilitation	25	17	17	24
Total Unmet Resource Needs	44	40	43	53
Distinct Clients with Unmet Resource Needs	36	33	33	40
7k. Living Skills				
7k-i Daily Living Support Services	19	15	23	17
7k-ii Day Support Services	1	2	3	3
7k-iii Occupational Therapy	1	2	2	2
7k-iv Skills Development Services	10	5	7	5
Total Unmet Resource Needs	31	24	35	27
Distinct Clients with Unmet Resource Needs	30	22	28	24
7l. Transportation				
7l-i Transportation to ISP-Identified Services	30	30	39	34
7-ii Transportation to Other ISP Activities	16	14	22	15
7-iii After Hours Transportation	22	16	15	20
Total Unmet Resource Needs	68	60	76	69
Distinct Clients with Unmet Resource Needs	50	41	52	50
7m. Personal Growth/Community				
7m-i Avocational Activities	2	2	6	4

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	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	574	528	588	530
7m. Personal Growth/Community				
7m-ii Recreation Activities	9	8	13	17
7m-iii Social Activities	31	29	32	33
7m-iv Spiritual Activities	5	4	5	7
Total Unmet Resource Needs	47	43	56	61
Distinct Clients with Unmet Resource Needs	35	34	41	41
Other Resources				
Other Resources	13	11	13	13
Total Unmet Resource Needs	13	11	13	13
Distinct Clients with Unmet Resource Needs	13	11	13	13
CSN 7 Totals				
Total Unmet Resource Needs	640	553	734	704
Distinct Clients With any Unmet Resource Need	192	161	205	191
Distinct Clients with a RDS	574	528	588	530

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Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	412	411	419	324
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	2	3	1
7a-iii Dialectical Behavioral Therapy	2	0	2	0
7a-iv Family Psycho-Educational Treatment	1	1	0	1
7a-v Group Counseling	1	2	3	1
7a-vi Individual Counseling	21	25	30	18
7a-vii Inpatient Psychiatric Facility	2	1	1	1
7a-viii Intensive Case Management	1	1	2	0
7a-x Psychiatric Medication Management	20	26	21	17
Total Unmet Resource Needs	50	58	62	39
Distinct Clients with Unmet Resource Needs	37	43	44	30
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	8	7	6	5
7b-ii Mental Health Advance Directives	2	3	2	4
Total Unmet Resource Needs	10	10	8	9
Distinct Clients with Unmet Resource Needs	9	9	8	8
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	0	0	0	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	6	3	2	2
7c-iv Peer-Run Trauma Recovery Group	2	2	5	3
7c-v Wellness Recovery and Action Planning	1	2	3	2
7c-vi Family Support	4	4	4	1
Total Unmet Resource Needs	13	11	14	8
Distinct Clients with Unmet Resource Needs	9	8	10	6
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	2	0	0	3
7d-ii Residential Treatment Substance Abuse Services	2	1	1	1
Total Unmet Resource Needs	4	1	1	4
Distinct Clients with Unmet Resource Needs	4	1	1	4

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	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	412	411	419	324
7e. Housing				
7e-i Supported Apartment	6	5	5	5
7e-ii Community Residential Facility	1	2	3	3
7e-iii Residential Treatment Facility (group home)	0	0	0	0
7e-iv Assisted Living Facility	3	3	4	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)	33	28	25	16
Total Unmet Resource Needs	43	38	37	27
Distinct Clients with Unmet Resource Needs	41	36	34	25
7f. Health Care				
7f-i Dental Services	25	24	17	15
7f-ii Eye Care Services	12	9	9	4
7f-iii Hearing Services	1	2	2	2
7f-iv Physical Therapy	1	1	2	1
7f-v Physician/Medical Services	9	9	10	4
Total Unmet Resource Needs	48	45	40	26
Distinct Clients with Unmet Resource Needs	38	34	29	22
7g. Legal				
7g-i Advocate	4	5	4	5
7g-ii Guardian (private)	3	4	3	1
7g-iii Guardian (public)	1	1	0	0
Total Unmet Resource Needs	8	10	7	6
Distinct Clients with Unmet Resource Needs	7	7	6	6
7h. Financial Security				
7h-i Assistance with Managing Money	16	18	18	8
7h-ii Assistance with Securing Public Benefits	10	14	13	7
7h-iii Representative Payee	1	0	1	0
Total Unmet Resource Needs	27	32	32	15
Distinct Clients with Unmet Resource Needs	25	28	27	15

Report Run: Jul 10, 2014

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CSN Not Assigned

Fiscal Year 2014 Quarter 3
(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	412	411	419	324
7i. Education				
7i-i Adult Education (other than GED)	1	4	3	2
7i-ii GED	5	2	0	2
7i-iii Literacy Assistance	0	2	1	0
7i-iv Post High School Education	2	4	6	3
7i-v Tuition Reimbursement	0	0	1	0
Total Unmet Resource Needs	8	12	11	7
Distinct Clients with Unmet Resource Needs	8	11	10	7
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	1	1	1
7j-ii Club House and/or Peer Vocational Support	0	1	1	0
7j-iii Competitive Employment (no supports)	5	3	3	2
7j-iv Supported Employment	2	2	2	1
7j-v Vocational Rehabilitation	12	14	12	6
Total Unmet Resource Needs	20	21	19	10
Distinct Clients with Unmet Resource Needs	20	21	19	10
7k. Living Skills				
7k-i Daily Living Support Services	8	10	10	7
7k-ii Day Support Services	3	2	3	3
7k-iii Occupational Therapy	1	0	0	0
7k-iv Skills Development Services	2	1	2	1
Total Unmet Resource Needs	14	13	15	11
Distinct Clients with Unmet Resource Needs	13	13	14	11
7l. Transportation				
7l-i Transportation to ISP-Identified Services	16	15	12	7
7-ii Transportation to Other ISP Activities	8	13	9	4
7-iii After Hours Transportation	10	10	7	6
Total Unmet Resource Needs	34	38	28	17
Distinct Clients with Unmet Resource Needs	25	25	21	16
7m. Personal Growth/Community				
7m-i Avocational Activities	4	3	2	2

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(Jan, Feb, March 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Distinct Clients with a RDS	412	411	419	324
7m. Personal Growth/Community				
7m-ii Recreation Activities	10	6	7	7
7m-iii Social Activities	14	18	18	13
7m-iv Spiritual Activities	2	4	6	3
Total Unmet Resource Needs	30	31	33	25
Distinct Clients with Unmet Resource Needs	20	23	24	17
Other Resources				
Other Resources	11	10	10	6
Total Unmet Resource Needs	11	10	10	6
Distinct Clients with Unmet Resource Needs	11	10	10	6
CSN Not Assigned Totals				
Total Unmet Resource Needs	320	330	317	210
Distinct Clients With any Unmet Resource Need	120	119	107	92
Distinct Clients with a RDS	412	411	419	324

Report Run: Jul 10, 2014

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Bridging Rental Assistance Program (BRAP)
Monitoring Report
Quarter 4 FY2014 (April, May, June 2014)

The Bridging Rental 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 recognizes the necessity for rental assistance for persons with mental illness, particularly those being discharged from hospitals, group homes, homeless shelters,and places considered substandard for human habitation. 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, *Priced out in 2012* in Maine, 95% 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% and Sagadahoc 98%. In the City of Portland 115% 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%.

BRAP is designed to assist individuals who have a psychiatric disability with housing costs for up to 24 months or 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 a ***Housing First*** model, initial BRAP recipients are encouraged, but not required to accept the provision of services to go hand in hand with the voucher.

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

The bullets below highlight some of the details regarding persons who are currently waiting for a BRAP voucher: The percentage terms reflect the percentage of relative change compared to the last report. The BRAP program was frozen on May 20th with only Priority #1 persons being awarded coming out of Riverview or Dorothea Dix psychiatric centers.

- Priority #1 applicants (Discharge from a psychiatric hospital within the last 6 months). Riverview and Dorothea Dix consumers are typically not waiting more than 3 business days from the date of a completed application. Statewide priority 1 vouchers increased from 0 to 26.
- Priority #2 applicants (Homeless) have increased from 68 to 207 persons.
- Priority #3 applicants (Substandard Housing) increased from 3 to 4 persons.
- Priority #4 applicants (Community Residential Facility) increased from 6 to 21 persons.
- Persons on the waitlist greater than 90 days have decreased from 34 to 12 persons—a result of reaching out to each of these persons to determine interest in remaining on the waitlist for the program.

Since inception of the wait list, there has been a total of 2,808 BRAP vouchers awarded broken down as follows: Priority #1, 1,301; Priority #2, 1,204; Priority #3, 38; Priority #4, 247. Note that 18 vouchers have been awarded to persons with no priority. In the last quarter 41 vouchers were awarded—the reduction from pervious quarters is due to a partial freeze of new program vouchers in order to meet budgetary constraints in the close of FY14.

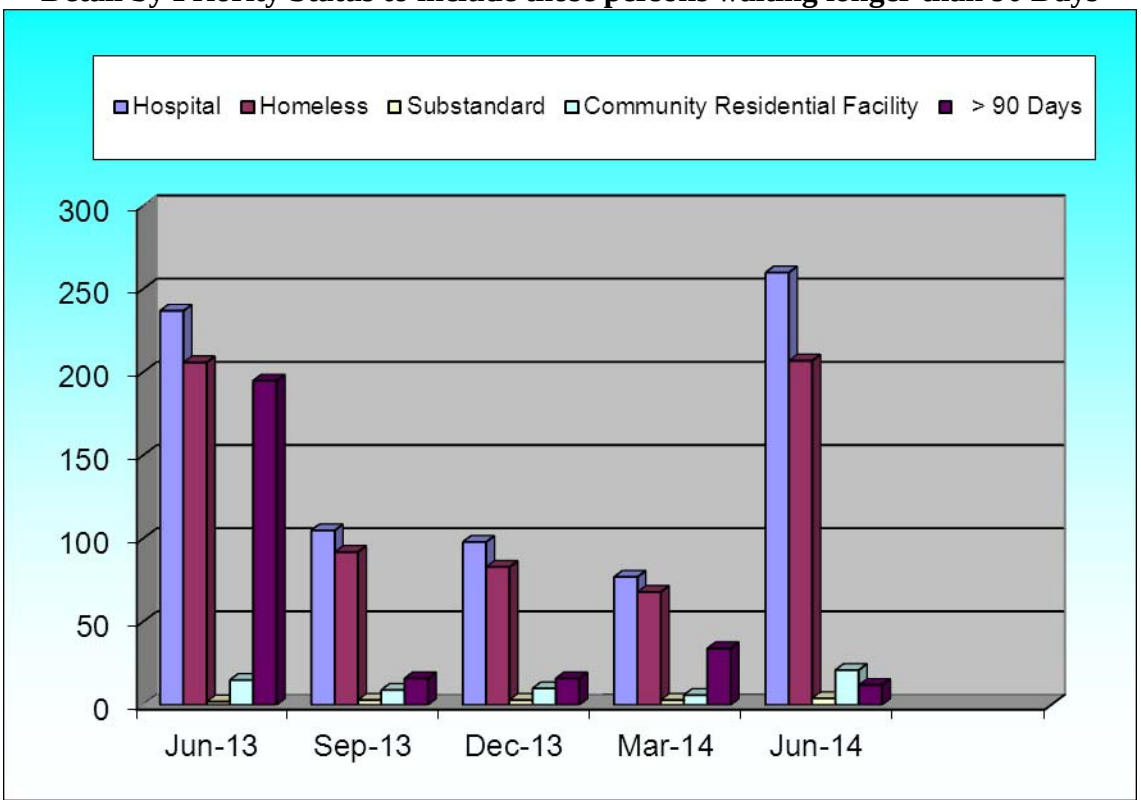
The BRAP census as of June 30, 2014 is 966 vouchers which is more in line with our targeted goal of 930 vouchers. The waitlist did spike in the last quarter as a result of the partial freeze of new BRAP vouchers beginning on May 20th. However, the number of persons waiting more than 90 days has substantially decreased as a result of contacting those individuals to determine ongoing interest in remaining on the program.

The overall BRAP budget for FY 15 is now a part of the baseline budget at SAMHS and remains at $5,372,414.00. Depending on regional demand for vouchers, we anticipate the census being able to support between 930 to 975 vouchers at any given time statewide.

The number of persons on the program for greater than 24 months remains steady at 50% of the entire program. This is principally a 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 criminal history. The lack of availability of these resources, particularly Section 8 at the federal level, has translated to increased pressures on state programs such as BRAP.

SAMHS administers a substantial number of Shelter Plus Care vouchers, more than any other state on a per-capita basis. The census increased by 164 vouchers, due to leveraging efforts, to 1,062 as of June 30, 2014. This program is funded by the U.S. Department of Housing and Urban Development and has seen significant growth over the last decade, the result of SAMHS aggressively applying for and receiving new grants each year. It should be noted that HUD has eliminated new project funding through an overall reduction of over 5% in this latest funding round.

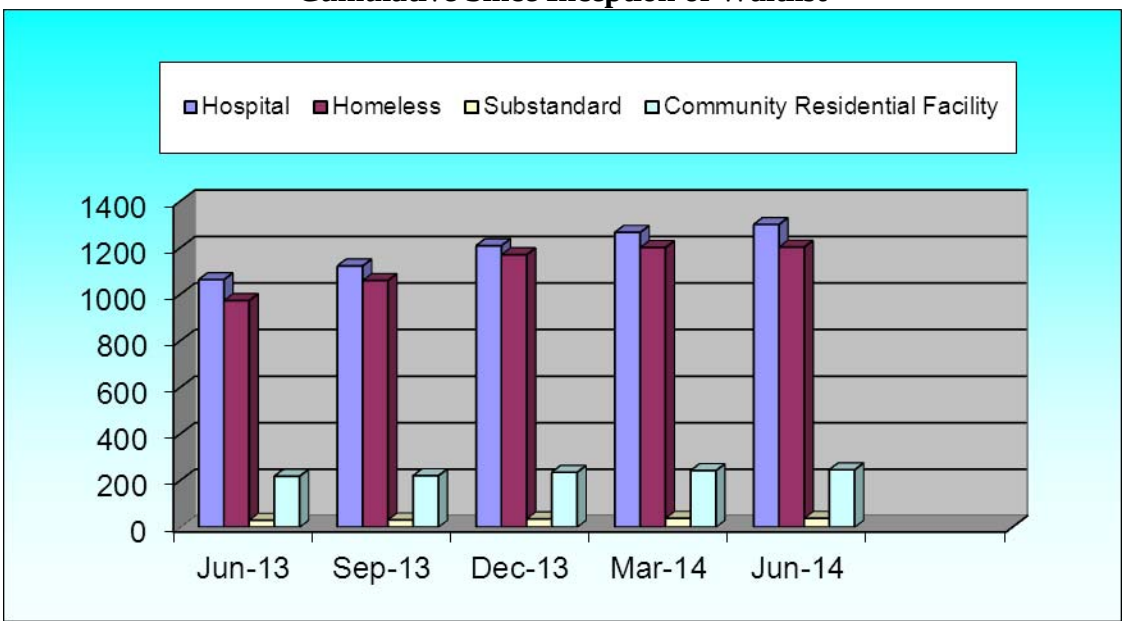
BRAP Waitlist Status--Graph:
Detail by Priority Status to include those persons waiting longer than 90 Days



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

Reporting Period	Jun-13	Sep-13	Dec-13	Mar-14	Jun-14	% Change relative to Last Report
Total number of persons waiting for BRAP	237	105	98	77	260	70%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	12	1	2	0	26	100%
Priority 2—Homeless (HUD Transitional Definition)	206	92	83	68	207	67%
Priority 3—Sub-standard Housing	2	3	3	3	4	25%
Priority 4—Leaving a Community Residential living facility	15	9	10	6	21	71%
Total number of persons on wait list more than 90 days awaiting voucher	195	16	16	34	12	-65%

BRAP Awards—Graph
Cumulative Since Inception of Waitlist



BRAP Awards—Table
Cumulative Since Inception of Waitlist

Reporting Periods	Jun-13	Sep-13	Dec-13	Mar-14	Jun-14	% Change relative to Last Report
Cumulative number of persons awarded BRAP	2300	2450	2668	2767	2808	1%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	1064	1123	1210	1267	1301	3%
Priority 2—Homeless (HUD Transitional Definition)	974	1060	1171	1202	1204	0%
Priority 3—Sub-standard Housing	30	31	36	38	38	0%
Priority 4—Leaving a DHHS funded living facility	219	221	236	243	247	2%

*Note: 18 persons awarded with no priority

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Class Member Treatment Planning Review

For the 4th Quarter of Fiscal Year 2014

(April, May, June, 2014)

		2014 Q1		2014 Q2		2014 Q3		2014 Q4	
Total Plans Reviewed		50		49		53		51	
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%	16 of 16	93.8%	15 of 16	100.0%	16 of 16	100.0%	12 of 12
1B	Does the record document that the agency has planned with and educated the consumer regarding releases of information during each treatment plan review?	80.4%	37 of 46	72.9%	35 of 48	88.2%	45 of 51	74.0%	37 of 50
1C	Does the record document that the consumer has a primary care physician (PCP)?	90.0%	45 of 50	98.0%	48 of 49	88.7%	47 of 53	96.1%	49 of 51
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?	80.0%	36 of 45	77.1%	37 of 48	83.0%	39 of 47	89.8%	44 of 49
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?	92.0%	46 of 50	100.0%	49 of 49	100.0%	51 of 51	100.0%	50 of 50
2B	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?	96.0%	48 of 50	98.0%	48 of 49	98.1%	51 of 52	100.0%	51 of 51
2C	Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?	94.0%	47 of 50	98.0%	48 of 49	98.1%	51 of 52	100.0%	51 of 51
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?	98.0%	49 of 50	100.0%	49 of 49	98.1%	52 of 53	96.0%	48 of 50
2E	Does the record document that the consumer has a crisis plan?	67.3%	33 of 49	89.8%	44 of 49	71.7%	38 of 53	44.9%	22 of 49
2F	If 2E. is no, is the reason documented?	100.0%	16 of 16	100.0%	5 of 5	100.0%	15 of 15	100.0%	27 of 27
2G	If 2E. is yes, has the crisis plan been reviewed as required every three months?	84.8%	28 of 33	90.9%	40 of 44	81.6%	31 of 38	81.8%	18 of 22
2H	If 2E. is yes, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?	100.0%	7 of 7	87.5%	7 of 8	40.0%	4 of 10	33.3%	1 of 3
2I	Does the record document that the consumer has a mental health advance directive?	4.1%	2 of 49	4.1%	2 of 49	3.8%	2 of 52	2.0%	1 of 51
2J	If 2I. is yes, has the advance directive been reviewed at least annually by the CSW and consumer?	0.0%	0 of 2	100.0%	2 of 2	0.0%	0 of 2	0.0%	0 of 1
2K	If 2I. is no, is the reason why documented?	100.0%	47 of 47	100.0%	47 of 47	100.0%	50 of 50	100.0%	50 of 50
III Needed Resources									
3A	Does the record document that natural supports (family/friends) are being accessed as a resource?	78.0%	39 of 50	100.0%	49 of 49	90.4%	47 of 52	98.0%	48 of 49

3B	If 3A. is no, has the worker discussed with the consumer the consideration of natural supports as a resource?	100.0%	11 of 11	N/A	0 of 0	100.0%	5 of 5	100.0%	1 of 1
3C	Does the record document that generic resources (those resources that anyone can access) are being accessed?	92.0%	46 of 50	100.0%	49 of 49	94.2%	49 of 52	100.0%	51 of 51
3D	If 3C. is no, has the worker discussed with the consumer the consideration of generic resources as a resource?	0.0%	0 of 4	N/A	0 of 0	0.0%	0 of 3	N/A	0 of 0
3E	Does the record document a resource need that has not been provided according to/within the expected response time?	2.0%	1 of 50	12.2%	6 of 49	7.7%	4 of 52	8.0%	4 of 50
3F	Does the treatment plan reflect interim planning?	100.0%	1 of 1	100.0%	6 of 6	75.0%	3 of 4	75.0%	3 of 4
3G	Does the record document that the treatment team reconvened after the unmet need was identified?	200.0%	2 of 1	100.0%	6 of 6	50.0%	2 of 4	75.0%	3 of 4
IV Service Agreements									
4A	Does the record document that service agreements are required for this plan? (see paragraph 69 protocol for definitions)	46.0%	23 of 50	57.1%	28 of 49	50.0%	26 of 52	51.0%	25 of 49
4B	If 4A. is yes, have service agreements been acquired?	56.5%	13 of 23	78.6%	22 of 28	80.8%	21 of 26	48.0%	12 of 25
4C	If 4A. is yes, are the service agreements current?	47.8%	11 of 23	75.0%	21 of 28	57.7%	15 of 26	36.0%	9 of 25
V Vocational Services									
5A	Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?	95.8%	46 of 48	100.0%	47 of 47	100.0%	52 of 52	100.0%	51 of 51
5B	Does the record document that the vocational domain is being addressed with the consumer at each 90 day treatment plan review?	89.6%	43 of 48	81.6%	40 of 49	94.2%	49 of 52	90.2%	46 of 51
VI Comments									
6A	Plan of correction requested?	52.0%	26 of 50	30.6%	15 of 49	40.4%	21 of 52	51.0%	26 of 51
6A.1.	Plan of correction for section 2A. (required when not all domains assessed) included?	75.0%	3 of 4	N/A	0 of 0	N/A	0 of 0	N/A	0 of 0
6C	Plan of correction received?	65.4%	17 of 26	86.7%	13 of 15	23.8%	5 of 21	26.9%	7 of 26
6D	Were corrections made to the satisfaction of the CDC?	100.0%	17 of 17	92.3%	12 of 13	100.0%	5 of 5	100.0%	7 of 7

Report Run by: Brandi.Giguere Report Run on: Jul 7, 2014 at 11:12:22 AM

Substance Abuse and 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

All Clients

For the 3rd Quarter of Fiscal Year 2014

(January, February, March, 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Total Admissions	123	119	115	75
Hospital				
Hospitalized in Local Area	84.6% (104 of 123)	84.0% (100 of 119)	80.9% (93 of 115)	78.7% (59 of 75)
Hospitalization Made Voluntary	71.5% (88 of 123)	81.5% (97 of 119)	80.9% (93 of 115)	78.7% (59 of 75)
Legal Status				
Blue Paper on File	99.2% (122 of 123)	100.0% (119 of 119)	100.0% (115 of 115)	100.0% (75 of 75)
Blue Paper Complete/Accurate	100.0% (122 of 122)	99.2% (118 of 119)	100.0% (115 of 115)	100.0% (75 of 75)
If not complete, Follow up per policy	N/A (0 of 0)	100.0% (1 of 1)	N/A (0 of 0)	N/A (0 of 0)
24 Hr. Certification Required	87.8% (108 of 123)	89.9% (107 of 119)	87.8% (101 of 115)	90.7% (68 of 75)
24 Hr. Certification on file	100.0% (108 of 108)	100.0% (107 of 107)	99.0% (100 of 101)	100.0% (68 of 68)
24 Hr. Certification Complete/Accurate	100.0% (108 of 108)	100.0% (107 of 107)	100.0% (100 of 100)	100.0% (68 of 68)
If not, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Quality Care				
Medical Necessity Established	100.0% (123 of 123)	99.2% (118 of 119)	100.0% (115 of 115)	100.0% (75 of 75)
Active Treatment Within Guidelines	100.0% (123 of 123)	100.0% (119 of 119)	100.0% (115 of 115)	100.0% (75 of 75)
Patient's Rights Maintained	98.4% (121 of 123)	97.5% (116 of 119)	99.1% (114 of 115)	100.0% (75 of 75)
If not maintained, follow up per policy	0.0% (0 of 1)	100.0% (3 of 3)	N/A (0 of 0)	N/A (0 of 0)
Inappropriate Use of Blue Paper	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Individual Service Plans				
Receiving Case Management Services	17.9% (22 of 123)	18.5% (22 of 119)	27.8% (32 of 115)	25.3% (19 of 75)
Case Manager Involved with Discharge Planning	100.0% (22 of 22)	95.5% (21 of 22)	100.0% (32 of 32)	100.0% (19 of 19)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (22 of 22)	100.0% (22 of 22)	100.0% (32 of 32)	100.0% (19 of 19)
Hospital Obtained ISP when authorized	18.2% (4 of 22)	18.2% (4 of 22)	6.2% (2 of 32)	5.3% (1 of 19)
Treatment and Discharge Plan Consistant with ISP	100.0% (4 of 4)	75.0% (3 of 4)	100.0% (2 of 2)	100.0% (1 of 1)

Report Run: Jul 16, 2014

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Substance Abuse and 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 Members

For the 3rd Quarter of Fiscal Year 2014

(January, February, March, 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Total Admissions	20	12	18	13
Hospital				
Hospitalized in Local Area	90.0% (18 of 20)	33.3% (4 of 12)	72.2% (13 of 18)	84.6% (11 of 13)
Hospitalization Made Voluntary	65.0% (13 of 20)	50.0% (6 of 12)	77.8% (14 of 18)	69.2% (9 of 13)
Legal Status				
Blue Paper on File	100.0% (20 of 20)	100.0% (12 of 12)	100.0% (18 of 18)	100.0% (13 of 13)
Blue Paper Complete/Accurate	100.0% (20 of 20)	100.0% (12 of 12)	100.0% (18 of 18)	100.0% (13 of 13)
If not complete, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
24 Hr. Certification Required	95.0% (19 of 20)	91.7% (11 of 12)	88.9% (16 of 18)	92.3% (12 of 13)
24 Hr. Certification on file	100.0% (19 of 19)	100.0% (11 of 11)	100.0% (16 of 16)	100.0% (12 of 12)
24 Hr. Certification Complete/Accurate	100.0% (19 of 19)	100.0% (11 of 11)	100.0% (16 of 16)	100.0% (12 of 12)
If not, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Quality Care				
Medical Necessity Established	100.0% (20 of 20)	100.0% (12 of 12)	100.0% (18 of 18)	100.0% (13 of 13)
Active Treatment Within Guidelines	100.0% (20 of 20)	100.0% (12 of 12)	100.0% (18 of 18)	100.0% (13 of 13)
Patient's Rights Maintained	100.0% (20 of 20)	100.0% (12 of 12)	94.4% (17 of 18)	100.0% (13 of 13)
If not maintained, follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Inappropriate Use of Blue Paper	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Individual Service Plans				
Receiving Case Management Services	35.0% (7 of 20)	50.0% (6 of 12)	72.2% (13 of 18)	76.9% (10 of 13)
Case Manager Involved with Discharge Planning	100.0% (7 of 7)	100.0% (6 of 6)	100.0% (13 of 13)	100.0% (10 of 10)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (7 of 7)	100.0% (6 of 6)	100.0% (13 of 13)	100.0% (10 of 10)
Hospital Obtained ISP when authorized	28.6% (2 of 7)	16.7% (1 of 6)	0.0% (0 of 13)	10.0% (1 of 10)
Treatment and Discharge Plan Consistant with ISP	100.0% (2 of 2)	100.0% (1 of 1)	N/A (0 of 0)	100.0% (1 of 1)

Report Run: Jul 16, 2014

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Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Community Hospital Utilization Review for Involuntary Admissions

Performance Standard 18-1,2,3 by Hospital: All Clients

For the 3rd Quarter of Fiscal Year 2014

(January, February, March, 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Number of Admissions	123	119	115	105
Involuntarily Admitted Clients who were Receiving CSS Services	22	22	32	27
Number of ISPs Hospitals were Authorized to Obtain	22	22	32	27
Number of ISPs Hospitals Obtained	4	4	2	1

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
2013 Q4	**Acadia**	17	17.6% (3 of 17)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Maine General - Waterville	14	28.6% (4 of 14)	100.0% (4 of 4)	100.0% (4 of 4)	100.0% (4 of 4)
	Mid-coast Hospital	4	25.0% (1 of 4)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	7	14.3% (1 of 7)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Select	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	11	18.2% (2 of 11)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Spring Harbor	54	14.8% (8 of 54)	0.0% (0 of 8)	N/A (0 of 0)	100.0% (8 of 8)
	St. Mary's	15	20.0% (3 of 15)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
2014 Q1	**Acadia**	22	13.6% (3 of 22)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Maine General - Waterville	8	37.5% (3 of 8)	100.0% (3 of 3)	100.0% (3 of 3)	100.0% (3 of 3)
	Mid-coast Hospital	12	8.3% (1 of 12)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	5	20.0% (1 of 5)	100.0% (1 of 1)	0.0% (0 of 1)	100.0% (1 of 1)
	Southern Maine Medical Center	21	14.3% (3 of 21)	0.0% (0 of 3)	N/A (0 of 0)	66.7% (2 of 3)
	Spring Harbor	41	24.4% (10 of 41)	0.0% (0 of 10)	N/A (0 of 0)	100.0% (10 of 10)
	St. Mary's	10	10.0% (1 of 10)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
2014 Q2	**Acadia**	37	32.4% (12 of 37)	0.0% (0 of 12)	N/A (0 of 0)	100.0% (12 of 12)
	Maine General - Augusta	11	18.2% (2 of 11)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	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	0.0% (0 of 3)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	PenBay Medical Center	9	11.1% (1 of 9)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	10	40.0% (4 of 10)	0.0% (0 of 4)	N/A (0 of 0)	100.0% (4 of 4)
	Spring Harbor	35	34.3% (12 of 35)	0.0% (0 of 12)	N/A (0 of 0)	100.0% (12 of 12)
	St. Mary's	9	0.0% (0 of 9)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
2014 Q3	**Acadia**	35	20.0% (7 of 35)	0.0% (0 of 7)	N/A (0 of 0)	100.0% (7 of 7)
	Maine General - Augusta	2	50.0% (1 of 2)	100.0% (1 of 1)	100.0% (1 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	7	42.9% (3 of 7)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	PenBay Medical Center	5	0.0% (0 of 5)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	6	0.0% (0 of 6)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	42	31.0% (13 of 42)	0.0% (0 of 13)	N/A (0 of 0)	100.0% (13 of 13)
	St. Mary's	8	37.5% (3 of 8)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)

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Community Hospital Utilization Review for Involuntary Admissions

Performance Standard 18-1,2,3 by Hospital: Class Members

For the 3rd Quarter of Fiscal Year 2014

(January, February, March, 2014)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Number of Admissions	20	12	18	13
Involuntarily Admitted Clients who were Receiving CSS Services	7	6	13	10
Number of ISPs Hospitals were Authorized to Obtain	7	6	13	10
Number of ISPs Hospitals Obtained	2	1	0	1

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
2013 Q4	**Acadia**	2	50.0% (1 of 2)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Maine General - Waterville	3	66.7% (2 of 3)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	PenBay Medical Center	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	12	33.3% (4 of 12)	0.0% (0 of 4)	N/A (0 of 0)	100.0% (4 of 4)
	St. Mary's	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
2014 Q1	**Acadia**	3	66.7% (2 of 3)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Waterville	1	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Mid-coast Hospital	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	PenBay Medical Center	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	5	60.0% (3 of 5)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
2014 Q2	**Acadia**	5	40.0% (2 of 5)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Augusta	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Maine Medical Center	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	3	66.7% (2 of 3)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Spring Harbor	7	100.0% (7 of 7)	0.0% (0 of 7)	N/A (0 of 0)	100.0% (7 of 7)
2014 Q3	**Acadia**	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Maine General - Augusta	1	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Mid-coast Hospital	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	7	71.4% (5 of 7)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	St. Mary's	2	100.0% (2 of 2)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)

Report Run: Jul 16, 2014

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Substance Abuse and Mental Health Services
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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)

August 1, 2014

Integrated Quarterly Crisis Report

The department has recently modified the reporting tool and process for collecting crisis data to more accurately reflect the performance in this standard. The department is currently working with the crisis providers to inform them of the standard and the importance of capturing accurate data.

All agencies providing crisis services received their incentive payments.

The Crisis program is currently under RFP process and is expected to be published this year.

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

Period From April 1, 2014 to June 30, 2014

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

Gender	Children	Males	718	Females	762				
	Adults	Males	2,324	Females	2,765				
Age Range	Children	< 5	13	5 - 9	204	10 - 14	642	15-17	621
	Adults	18 - 21	556	22 - 35	1,532	36 - 60	2,440	>60	561
Payment Source	Children	MaineCare	1,051	Private Ins.	356	Uninsured	71	Medicare	2
	Adults	MaineCare	2,566	Private Ins.	831	Uninsured	1,438	Medicare	254

II. Summary Of All Crisis Contacts

	Children	Adults
a. Total number of telephone contacts	7,242	36,064
b. Total number of all Initial face-to-face contacts	1,213	3,956
c. Number in II.b. who are children/youth with Mental Retardation/Autism/Pervasive Dev. Disorder	112	
d. Number of face-to-face contacts that are ongoing support for crisis resolution/stabilization	246	1,037

III. Initial Crisis Contact Information

	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	118	9.7%	104	2.6%
b. Number of Initial face-to-face contacts who have a Community Support Worker (CI,CRS,ICM, ACT,TCM)	492	40.6%	1,170	29.6%
c. Number of Initial face-to-face contacts who have a Comm. Support Worker that was notified of crisis	413	83.9%	999	85.4%
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			115,936	29
e. Number of Initial face-to-face contacts in Emergency Department with final disp. within 8 hours			2,075	52.5%
f. Number of Initial face-to-face contacts not in Emergency Department with final disp. within 8 hours			1,533	38.8%

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

Less Than 1 Hour.	1036	1 to 2 Hours	136	2 to 4 Hours	32	More Than 4 Hours	9	
Percent	85.4%	Percent	11.2%	Percent	2.6%	Percent	0.7%	

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

Less Than 3 Hours	492	3 to 6 Hours	546	6 to 8 Hours	40	8 to 14 Hours	36	> 14	99
Percent	40.6%	Percent	45.0%	Percent	3.3%	Percent	3.0%	Percen	8.2%

IV. Site Of Initial Face-To-Face Contacts

	Children		Adults	
a. Primary Care Residence (Home)	184	15.2%	385	9.7%
b. Family/Relative/Other Residence	41	3.4%	28	0.7%
c. Other Community Setting (Work, School, Police Dept, Public Place)	97	8.0%	135	3.4%
d. SNF, Nursing Home, Boarding Home	0	0.0%	14	0.4%
e. Residential Program (Congregate Community Residence, Apartment Program)	1	0.1%	53	1.3%
f. Homeless Shelter	1	0.1%	39	1.0%
g. Provider Office	48	4.0%	193	4.9%
h. Crisis Office	179	14.8%	572	14.5%
i. Emergency Department	651	53.7%	2,348	59.4%
j. Other Hospital Location	10	0.8%	110	2.8%
k. Incarcerated (Local Jail, State Prison, Juvenile Correction Facility)	1	0.1%	79	2.0%
Totals:	1,213	100%	3,956	100%

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

	Children		Adults	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	33	2.7%	215	5.4%
b. Crisis stabilization with referral to new provider for mental health/substance abuse follow-up	243	20.0%	760	19.2%
c. Crisis stabilization with referral back to current provider for mental health/substane abuse follow-up	444	36.6%	1,292	32.7%
d. Admission to Crisis Stabilization Unit	182	15.0%	515	13.0%
e. Inpatient Hospitalization Medical	4	0.3%	76	1.9%
f. Voluntary Psychiatric Hospitalization	301	24.8%	871	22.0%
g. Involuntary Psychiatric Hospitalization	6	0.5%	160	4.0%
h. Admission to Detox Unit	0	0.0%	67	1.7%
Totals:	1,213	100%	3,956	100%

Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE

FOURTH STATE FISCAL QUARTER 2014
April, May, June 2014

Robert J. Harper
Acting Superintendent

July 23, 2014

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Table of Contents

Table of Contents

Glossary of Terms, Acronyms & Abbreviations

ACT	Assertive Community Treatment
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 communications.
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
LCSW	Licensed Clinical Social Worker
LEGHOLD	Legal Hold
LPN	License Practical Nurse
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
MAR	Medication Administration Record
MHW	Mental Health Worker
MRDO	Medication Resistant Disease Organism (MRSA, VRE, C-Dif)
NAPPI	Non Abusive Psychological and Physical Intervention
NASMHPD	National Association of State Mental Health Program Directors
NCR	Not Criminally Responsible
NOD	Nurse on Duty
NP	Nurse Practitioner

Glossary of Terms, Acronyms & Abbreviations

NPSG	National Patient Safety Goals (established by the Joint Commission)
NRI	NASMHPD Research Institute, Inc.
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
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.
Seclusion, Locked	Client is placed in a secured room with the door locked.
Seclusion, Open	Client is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
STAGE III	60 Day Forensic Evaluation
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 staffs to provide evidence of a commitment to client recovery, safety in culture and practices and fiscal accountability. The report is structure 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 though regulatory and legal standards.

The methods of reporting are driven by a national 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 measure described in the Order Adopting Compliance Standards dated October 29, 2007. Comparison data is not always available for the last month in the quarter and is included in the next report.

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

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

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

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

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CONSENT DECREE

Consent Decree Plan

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

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

Client Rights

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. Clients are routinely informed of their rights upon admission	98% 52/55 2 refused	100% 45/45 (100%, 15/15 for Lower Saco)	100% 44/45 1 refused (100%, 15/15 for Lower Saco)	100% 26/32* (97%, 27/29 for Lower Saco**)

*3 refused, 3 lacked capacity
**1 refused, 1 not accounted for

Clients are informed of their rights and asked to sign that information has been provided to them. If they refuse, the staff documents the refusal and sign, date & time the refusal.

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	1Q2014	2Q2014	3Q2014	4Q2014
1. Level II grievances responded to by RPC on time.	50% 3/6	100% 1/1	N/A	100% 2/2
2. Level I grievances responded to by RPC on time.	98% 59/60	100% 61/61	97% 67/69	100% 51/51

CONSENT DECREE

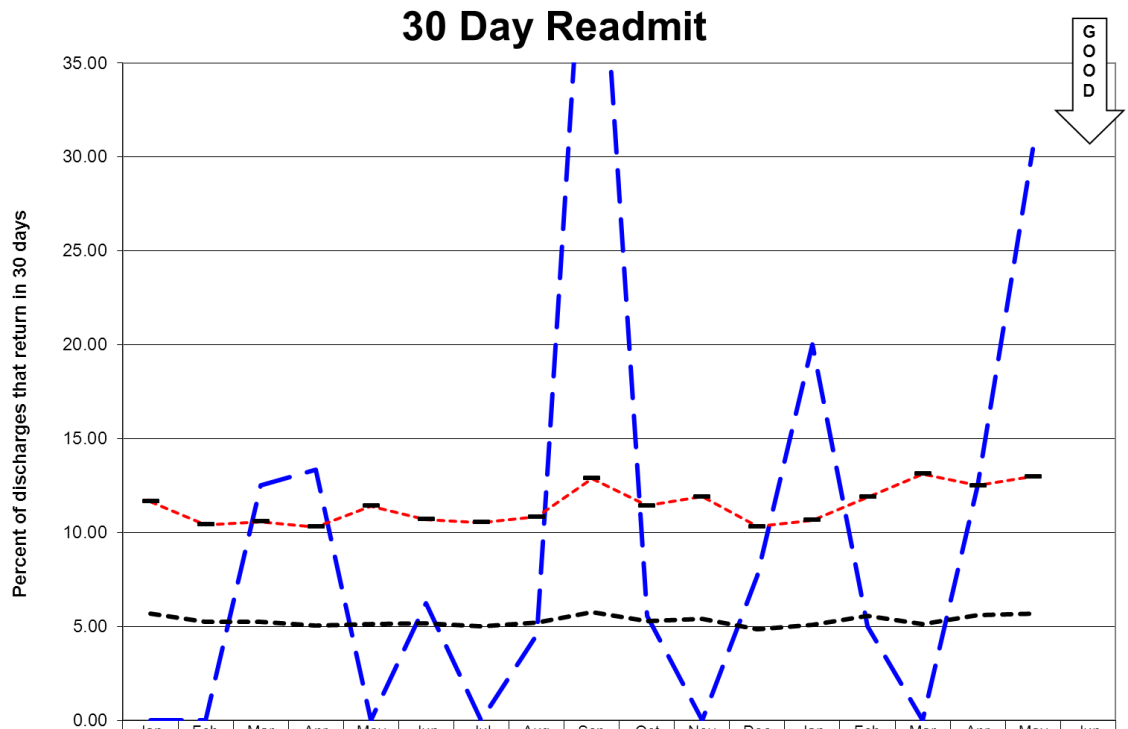
Admissions

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

Legal Status on Admission	1Q2014	2Q2014	3Q2014	4Q2014	Total
CIVIL				1	1
CIVIL-INVOL	1	3	2	1	7
DCC	29	14	29	24	96
DCC-PTP	1	1			2
Civil Total	**31**	**18**	**31**	**26**	**106**
CH/CON			1		1
IST	5	9	7	5	26
LEGHOLD			1	2	3
NCR		2	2		4
PRET		1			1
STAGE III	24	17	19	18	78
Forensic Total	**29**	**29**	**30**	**25**	**113**
GRAND TOTAL	**60**	**47**	**61**	**51**	**219**

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	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.00	0.00	12.50	13.33	0.00	6.25	0.00	4.55	50.00	5.56	0.00	7.69	20.00	5.00	0.00	12.50	30.43	
Ntl Mean	5.69	5.26	5.24	5.06	5.12	5.17	5.00	5.19	5.74	5.28	5.41	4.83	5.09	5.55	5.14	5.62	5.67	
+1 StDev	11.65	10.42	10.57	10.30	11.41	10.69	10.53	10.84	12.88	11.43	11.90	10.32	10.65	11.88	13.11	12.50	12.97	

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

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 client 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. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

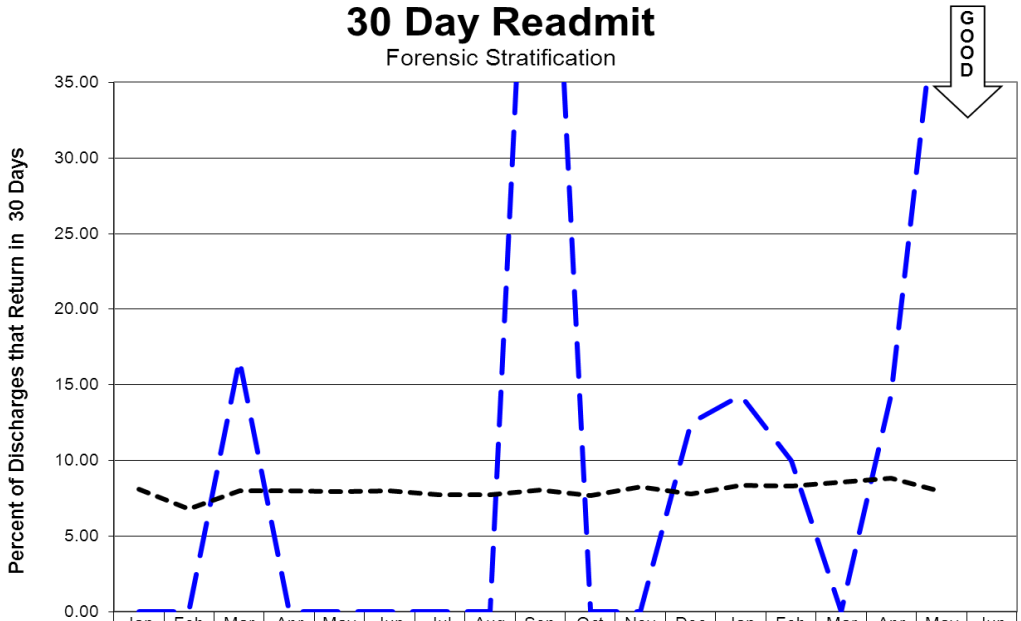
Reasons for client readmission are varied and may include decompensating or lack of compliance with a PTP to name a few. Specific causes for readmission are reviewed with each client upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient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

Please Note: In August 2013 the Lower Saco unit was decertified; patients had to be discharged and readmitted in our Meditech Electronic Medical Record System, even though they were not actually discharged from the hospital. This caused the numbers in August 2013 to increase. Starting in August 2013 and going forward anytime that a patient transfers units in the hospital (either from or to Lower Saco) we must now discharge them and readmit them in Meditech, which causes them to show up in this graph as a 30 Day Readmission, even though technically they never left the hospital.

CONSENT DECREE

30 Day Readmit

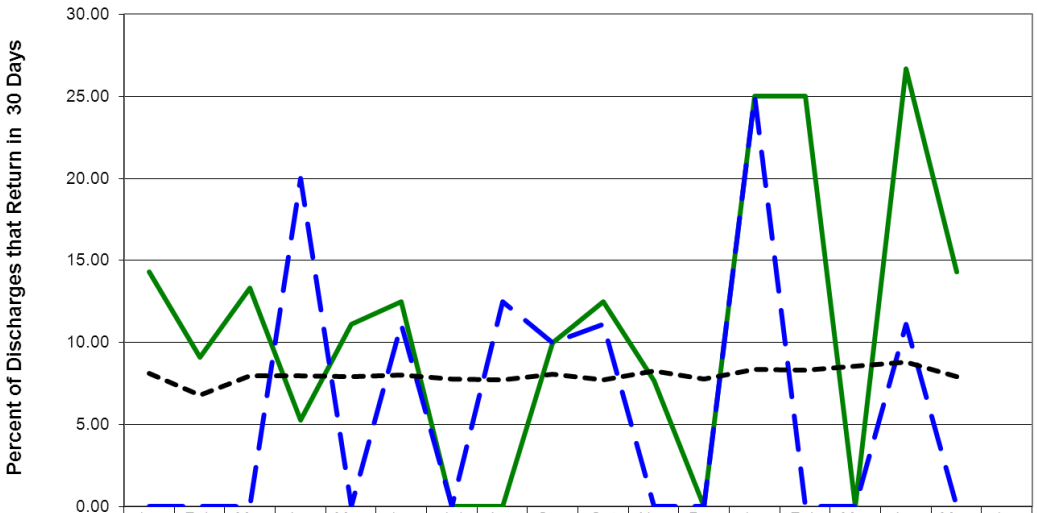
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.00	0.00	16.67	0.00	0.00	0.00	0.00	0.00	66.67	0.00	0.00	12.50	14.29	10.00	0.00	14.29	43.75	
National Mean	8.11	6.79	7.98	7.99	7.92	8.02	7.76	7.73	8.06	7.71	8.27	7.80	8.38	8.30	8.56	8.83	7.93	

30 Day Readmit

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Dorothea Dix	14.29	9.09	13.33	5.26	11.11	12.50	0.00	0.00	10.00	12.50	7.69	0.00	25.00	25.00	0.00	26.67	14.29	
Riverview	0.00	0.00	0.00	20.00	0.00	11.11	0.00	12.50	10.00	11.11	0.00	0.00	25.00	0.00	0.00	11.11	0.00	
National Mean	8.11	6.79	7.98	7.99	7.92	8.02	7.76	7.73	8.06	7.71	8.27	7.80	8.38	8.30	8.56	8.83	7.93	

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 client 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	1Q2014	2Q2014	3Q2014	4Q2014
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client 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. In cases where such a need or change was indicated that corrective action was taken.	100% 2/2	100% 1/1	N/A	100% 1/1

CONSENT DECREE

REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. The ACT Team Director will review all client 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 (i.e.: group home, apartment, etc) c. Geographic location of residence d. Community support network e. Client demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with ACT Team	100% 2 clients were returned to RPC for psychiatric instability,	100% 1 client was returned to RPC for psychiatric instability due to substance abuse relapse	100% 1 client was returned to DDPC for psychiatric instability, client remains in DDPC	100% 1 client returned to RPC for psychiatric instability from group home, remains in RPC on Upper Saco
2. ACT Team 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% Regular contact with DDPC treatment team	100% Attendance at all treatment team meetings and one morning rounds.

Current Quarter Summary:

1. Readmitted patient is male, age 43, socioeconomically disadvantaged, was living in the community in a group home for 8 months with one other psychiatric hospitalization, has little to no family support and is not able to adequately use resources that are available such as transportation, education. Patient was apparently medication adherent but smoking almost constantly. This patient had been attending appointments such as case management, medication management and peer support as scheduled with the RPC ACT Team and with the RPC Harbor Mall for group therapy.
2. The ACT Team and the Upper Saco Unit are working closely together to formulate a more lasting successful community placement that will likely include a neurological rehabilitation component to assist with this patient's access to structured, productive time spent in his residence. The Certified Therapeutic Recreation Specialist working with this patient was instrumental in developing this plan.

CONSENT DECREE

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

Client Admission Diagnoses	1Q14	2Q14	3Q14	4Q14	TOT
ADJUSTMENT DISORDER WITH DEPRESSED MOOD					0
ADJUSTMENT DISORDER WITH ANXIETY					0
ADJUST DISORDER WITH MIXED ANXIETY & DEPRESSED MOOD	2	1			3
ADJUSTMENT REACTION NOS	1				1
ALCOHOL ABUSE-IN REMISS					0
ANXIETY STATE NOS				3	3
ATTN DEFICIT W HYPERACT	1	1			2
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, UNSPECIFIED			1		1
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH			2		2
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPEC		3			3
BIPOLAR DISORDER, UNSPECIFIED	8	2	5	3	18
CATATONIA-UNSPECIFIED					0
DELUSIONAL DISORDER			1	2	3
DEPRESSIVE DISORDER NEC	6	3	4		13
DRUG ABUSE NEC-IN REMISS			1		1
FACTITIOUS DIS W PREDOMINANTLY PSYCHOLOGICAL SIGNS & SYMPTOM		1			1
FACTITIOUS ILL NEC/NOS		1			1
HEBEPHRENIA-UNSPEC		1			1
IMPULSE CONTROL DIS NOS		1			1
INTERMITT EXPLOSIVE DIS			1	1	2
MILD INTELLECTUAL DISABILITIES			1		1
OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER				1	1
OTH PERSISTENT MENTAL DIS DUE TO COND CLASS ELSEWHERE					0
PARANOID SCHIZO-CHRONIC	10	3	2	6	21
PARANOID SCHIZO-UNSPEC	1	1	4	1	7
PERSON FEIGNING ILLNESS	1	1			2
POSTTRAUMATIC STRESS DISORDER	4		5	1	10
PSYCHOSIS NOS	5	10	11	8	34
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	13	11	12	12	48
SCHIZOPHRENIA NOS-CHR			1	2	3
SCHIZOPHRENIA NEC-UNSPEC			1	1	2
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED		1		2	3
UNSPECIFIED EPISODIC MOOD DISORDER	8	5	9	8	30
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER					0
UNSPEC TRANSIENT MENTAL DIS IN COND CLASSIFIED ELSEWHERE		1			1
Total Admissions	60	47	61	51	219
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0.00%	0.00%	1.64%	0.00%	0.46%

Peer Supports

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

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

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. Attendance at Comprehensive Treatment Team meetings. (v9)	84% 408/488	86% 352/411	86% 395/458	89% 417/466
2. Attendance at Service Integration meetings. (v8)	95% 53/56	100% 41/41	86% 55/64	100% 46/46
3. Contact during admission. (v8)	100% 56/56	100% 57/57	100% 64/64	100% 62/62

Treatment Planning

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. Preliminary Continuity of Care meeting completed by end of 3rd day	100% 30/30	100% 30/30	100% 30/30	100% 30/30
2. Service Integration form completed by the end of the 3rd day	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3a. Client Participation in Preliminary Continuity of Care meeting.	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3b. CCM Participation in Preliminary Continuity of Care meeting.	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	93% 28/30	90% 27/30	100% 30/30	80% 24/30
4a.Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	96% 29/30	93% 28/30	93% 28/30	86% 26/30
4b. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and social worker role	96% 29/30	100% 30/30	100% 30/30	100% 30/30
4c. Annual Psychosocial Assessment completed and current in chart	100% 15/15	100% 15/15	100% 15/15	100% 15/15

Summary:
3c) The Peer Support department did not provide coverage to the units during a timeframe of training and staff absence. The Social Work Director addressed the issue with the Peer Support Director and the alerted the Superintendent to the coverage issue.
4a) We had four psych-social assessments that were not completed within the 7 day timeframe. The social work department temporarily had four vacancies concurrently and while all psych socials were completed they were not finished in the 7 day timeframe. Director continues to address the issue of unit coverage and staffing for the department.

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	96% 29/30	93% 28/30	86% 26/30	83% 25/30
2. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	100% 30/30	100% 30/30	96% 29/30	86% 26/30

Summary

1) Director addressed this issue with individual staff in supervision and with the entire team at group staff meeting.
2) Director addressed the issue with individual team members and as a group in staff meetings. The social work department continues to focus on this critical area of treatment planning.

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 clients according to the individual client's ability to participate in a safe and productive manner as determined by the treatment team and established in collaboration with the client 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			
Intro to Basic Principles of Health, Hygiene, and Nutrition		X		X

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

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

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

CONSENT DECREE

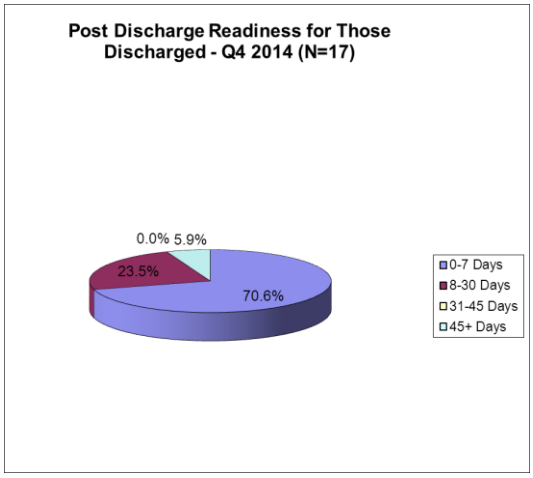
Discharges

Quarterly performance data shows that in 3 consecutive quarters:

V17) 70% of clients 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 clients 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 clients 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 clients excepted, by agreement of the parties and court master).



Cumulative percentages & targets are as follows:

Within 7 days = (12) 70.6% (target 70%)
Within 30 days = (16) 94.1% (target 80%)
Within 45 days = (16) 94.1% (target 90%)
Post 45 days = (1) 5.9% (target 0%)

Barriers to Discharge Following Clinical Readiness

Residential Supports (0)

No barriers in this area

Treatment Services (0) 0%

No barriers in this area

Housing (3) 17%

1 client discharged 15 days post clinical readiness/housing barrier
1 client discharged 27 days post clinical readiness/housing barrier
1 client discharged 49 days post clinical readiness/housing barrier

The previous four quarters are displayed in the table below

		Within 7 days	Within 30days	Within 45 days	45 +days
Target >>		70%	80%	90%	< 10%
3Q2014	N=24	73.1%	84.6%	92.3%	7.7%
2Q2014	N=20	73.1%	84.6%	92.3%	7.7%
1Q2014	N=26	73.1%	84.6%	92.3%	7.7%
4Q2013	N=30	70%	86.7%	93.3%	6.7%

CONSENT DECREE

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

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

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

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

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. The Client Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 12/12	100% 11/11	100% 9/9	91% 11/12
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 12/12	100% 11/11	100% 9/9	91% 11/12
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	91% 11/12	100% 11/11	100% 9/9	91% 11/12
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	91% 11/12	100% 11/11	100% 9/9	91% 11/12

Summary:

The last week in June the Director was absent on medical leave and the report was not generated. The housing meeting was held and discharge planning was discussed with the social workers and the gatekeepers.

CONSENT DECREE

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	12% 1/8	0% 0/4	0% 0/2	50% 3/6
2. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	100% 2/2	100% 4/4	100% 3/3	100% 4/4
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually		100% 92/92	N/A	N/A

Summary:

1) Six reports were filed at 1, 8, 9, 15, 17 and 23 days respectively three of which were outside of the 10 day standard.

CONSENT DECREE

Staffing and Staff Training

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014	2014 Total
1. Riverview and Contract staff will attend CPR training bi-annually.	*40/46 87%	*64/67 95.5%	55/58 94.8%	40/40 100%	94.3%
2. Riverview and Contract staff will attend NAPPI training annually.	*101/120	*137/157	*See #4. Below	*See # 4 Below	85%
3. Riverview and Contract staff will attend Annual training.	*11/25	*78/81	34/36 88%	*13/15 86%	78.5%
3. Riverview and Contract staff will attend MOAB training annually.	Changed to MOAB on 1/16/14	Changed to MOAB on 1/16/14	172/408 42%	234/416 56%	49%

1Q2014

1. Of the six employees who are not in compliance, two staff are on Workers Compensation status, two staff are on Family Medical Leave, one transferred and missed training due to family emergency, one is out of country. All are scheduled for next available training.
2. Of the nineteen employees who are not in compliance two are on Workers compensation leave, one is on LOA. Those remaining are scheduled for the next available training.
3. Of the eleven staff who are not in compliance; two staff are on Workers compensation, one is out of the country, and one has transferred to another department. Supervisors of remaining staff have been informed they are in non-compliance and corrective actions have been taken.

2Q2014

1. Three employees who are out of compliance are on leave status.
2. Eight of the employees are on leave status. The remaining twelve will be attending the next offered behavior management /physical intervention training.
3. The three the individuals who are not in compliance are on leave status.

3Q2014

1. The three employees who are out of compliance are on leave status.
2. RPC began using MOAB as their Behavior Management Program January 16th 2014. Since that time 197/197 (active) nurses and mental health workers have received.
3. One staff is on leave status, the other staff has been informed they are out of compliance and corrective action has been taken.

4Q2014

1. 100% of employees are compliant with CPR certification requirements.
2. Two out of 15 staff are non-compliant with Annual Mandatory Training Requirements. Corrective Action has been taken.
3. There are 234 employees who have received MOAB training, out of the total employees MOAB trained, 190 are unit staff. MOAB continues to be offered monthly.

CONSENT DECREE

Goal #1: SD will provide opportunities for employees to gain, develop and renew skills knowledge and aptitudes.

Objective: 100% of employees will be provided with an opportunity both formal and informal training and/or learning experiences that contribute to individual growth and improved performance in current position.

SD will survey staff annually and develop trainings to address training needs as identified by staff.

Current Status:

1Q2014:

Employee Education needs survey distributed to employees in March of 2013.

As a result of identified needs, the training entitled ***Personality Disorder Characteristics and Effective* Interventions** was developed and presented in August 2013.

August 19 & 26 2013, Susan C. Righthand, Ph.D, a nationally recognized speaker and consultant in the field of psychological assessment and treatment of sex offenders, conducted a *two part* training entitled: ***Working Effectively with Adult Sexual Offenders:*** *Characteristics, Assessment, and Interventions* available to all Riverview Psychiatric Center Employees.

August 20, 2013 Dr. Kenneth Beattie provided an in-service entitled: ***The Psychology of Working with Emotionally Challenging and Emotionally Challenged Clients.*** This training was developed in response to the Employee Education needs survey distributed to employees in March of 2013 and made available to all Riverview Psychiatric Center employees.

August 5, 2013, ***Single Wrist Restraint Application*** training was held to provide an opportunity to practice skills taught in the Initial NAPPI course provided to New Employees and NAPPI Recertification Class provided on a monthly basis through-out the year to Riverview Psychiatric Center employees. Over sixty unit staff attended.

2Q2014:

Patricia Deegan Ph D. provided ***Recovery Oriented Care*** training which included lessons from her own recovery from schizophrenia while teaching practical strategies for:

- Balancing the Dignity of Risk with the Duty to Care when supporting individual involvement in decision making.
- Navigating the Neglect/Overprotect Continuum, especially when folks appear to be making self-defeating choices.
- Practicing leadership-for-recovery in the workplace.

On January 18th, James Claiborn, Ph. D, provided training entitled ***Understanding Behavior and Treatment Planning*** in which participants learned:
How to identify, define, and describe behavior.
How to develop interventions that reinforce behavior we want to increase and extinguish behavior we want to decrease.

STAT Drills were offered throughout the month of November and December to provide staff with the opportunity to develop and enhance behavior intervention techniques and improve overall skill level when dealing with clients having difficulty maintaining positive behavior.

3Q2014:

Staff was provided training in Policy revisions and Regulatory standards in January 2014. Additionally Recovery Oriented Care and Personal Medicine training was rolled out at the end of March 2014.

4Q2014:

A variety of additional trainings were offered to staff during this quarter including; Recovery Principles/Personal Medicine, Power Statements, Documentation, ECG Testing and Application, Incident Reporting, Medication Administration, Conducting Mental Status Assessments, Patient Rights, Seclusion and Restraint policy and procedure, HIPAA,/Confidentiality.

Goal #2: SD will develop and implement a comprehensive mentoring program to assist new employees in gaining the skills necessary to do their job.

Objective: 100% of new Mental Health Workers will be paired with a mentor and will satisfactorily complete 12 competency areas on the unit orientation prior to being assigned regular duties requiring direct care of patients.

Current Status:

1Q2014:

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

2Q2014:

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

- In addition, mentor meetings were re-initiated to assist mentors in gaining, developing and renewing skills in which to increase new employees with the opportunity to learn specific job duties associated with their position and/or care of individuals receiving services.

3Q2014:

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

4Q2014:

All New employees were successfully paired with a mentor and completed all competencies as required.

CONSENT DECREE

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

DATE	HRS	TITLE	PRESENTER
DATE	HRS	TITLE	PRESENTER
3Q2012	14	January - March 2012	Winter Semester (see1Q13 Quarterly Report)
4Q2012	11	April – June 2012	Spring Semester (see1Q13 Quarterly Report)
1Q2013	3	July – September 2012	Summer Hiatus (see1Q13 Quarterly Report)
2Q2013	9	October – December 2012	Fall Semester (see2Q13 Quarterly Report)
3Q2013	11	January – March 2013	Winter Semester (see 3Q13 Quarterly Report)
4Q2013	12	April – June 2013	Spring Semester (see 4Q13 Quarterly Report)
1Q2014	5.5	July - September 2013	Summer Semester (see 1Q14 Quarterly Report)
2Q2014	7	October – December 2013	Fall Semester (see 2Q14 Quarterly Report)
3Q2014	15	January – March 2014	Winter Semester (see 3Q14 Quarterly Report)
4/3/2014	1	Black Swans in Psychiatry: Anticoagulation implications in the Psychiatric Setting	Miranda Cole, PharmD Elizabeth Dragatsi, RPh
4/10/2014	1	Neuropsychology in the Assessment of Adult ADHD: Why Bother?	Robert Roth, PhD
4/15/2014	1	Peer Review Committee	Brendan Kirby MD Miriam Davidson, PMHNP
4/17/2014	1	The Functionality of Behaviors	Randy Beal, PMHNP
4/24/2014	1	Addicted to Pain? The case of KR: Self-Injury, Naltrexone and Edogenous Opioids	Dan Filene, MD
5/1/2014	1	Riverview in Recovery	Jay Harper, Superintendent
5/8/2014	1	Holistic Perspective in Assessment: The Case of CS	Jennifer Heidler-Gary, PsyD
5/15/2014	1	Neuroinflammation in Schizophrenia	Doug Noordsy, MD
5/22/2014	1	When in Eoube About the Importance of Cultural Differences, Err on the Side of Discussion	Candice Claiborne, Psychology Intern
5/29/2014	1	Hypothyroidism at Riverview: Considering Variations in the Disease and Etiologies with 3 Recent Patients	George David, MD
6/4/2014	1	MOC	Jonathan Morris, MD
6/5/2014	1	Adult ADHD: Treatment can be life changing	Russell Kimball, PA-C
6/12/2014	1	Life Through a Persecutory Lens: Challenges and Inroads	Tatiana Gregor, EdD
6/19/2014	1	Why Not Clozapine?	Miranda Cole, PharmD
6/26/2014	1	Why a drum? Rhythm Therapy: An evaluation of current research, practices, and myths, and a proposal for research	John Kootz, MD
6/27/2014	6	Violence Risk Assessment	Ira Packer, PhD

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 clients who residing on specific units, and unit census.

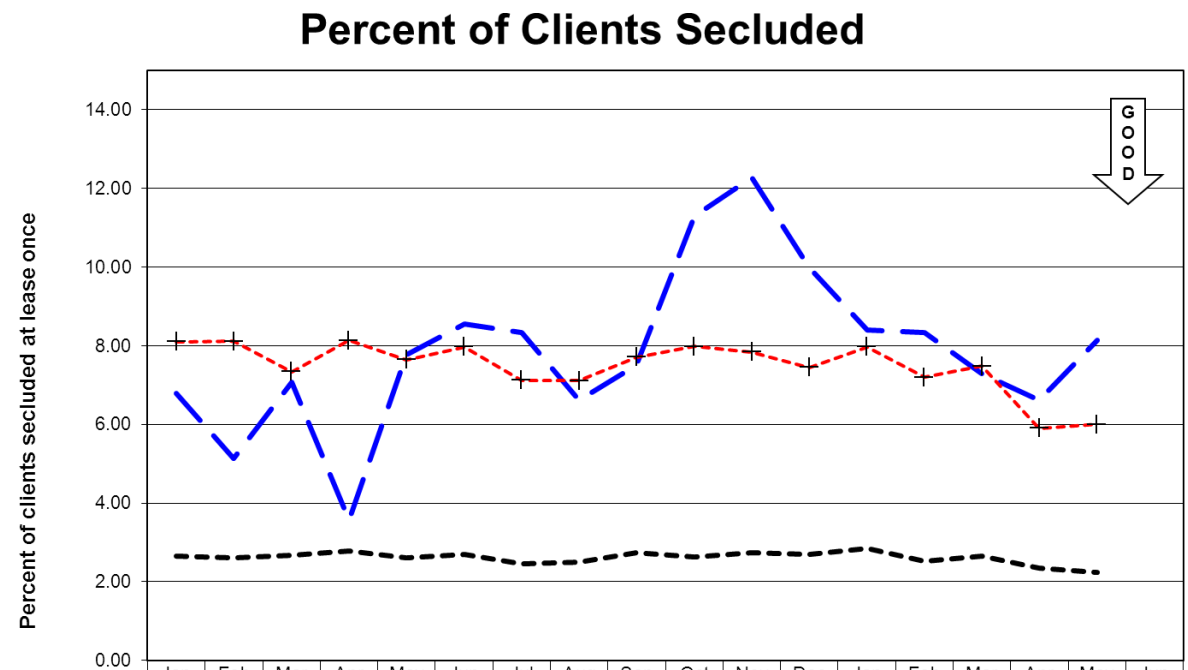
V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors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

Treatment teams regularly monitor the needs of individual clients 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 client needs. Staffing deficiencies that may periodically be present are rectified through utilization of overtime or mandated staff members.

CONSENT DECREE

Use of Seclusion and Restraints

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



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	6.78	5.13	7.08	3.57	7.76	8.55	8.33	6.61	7.50	11.30	12.28	10.00	8.40	8.33	7.30	6.62	8.15	
Ntl Mean	2.66	2.61	2.68	2.79	2.61	2.69	2.45	2.50	2.73	2.63	2.74	2.69	2.84	2.51	2.66	2.34	2.23	
+1 StDev	8.10	8.11	7.34	8.13	7.64	7.97	7.12	7.11	7.71	7.98	7.84	7.45	7.97	7.20	7.48	5.90	6.00	

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

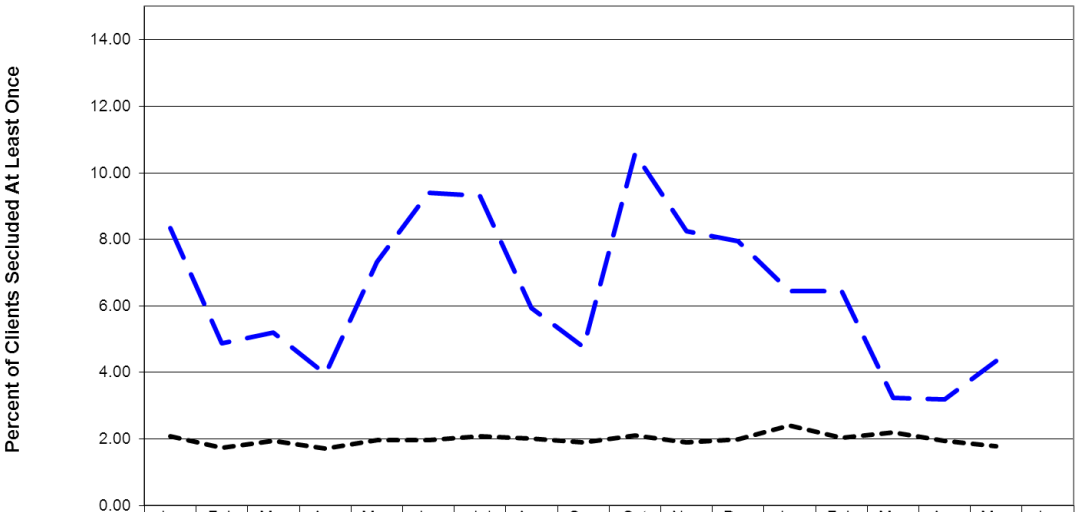
The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example; rates of 3.0 means that 3% of the unique clients served were secluded at least once.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Percent of Clients Secluded

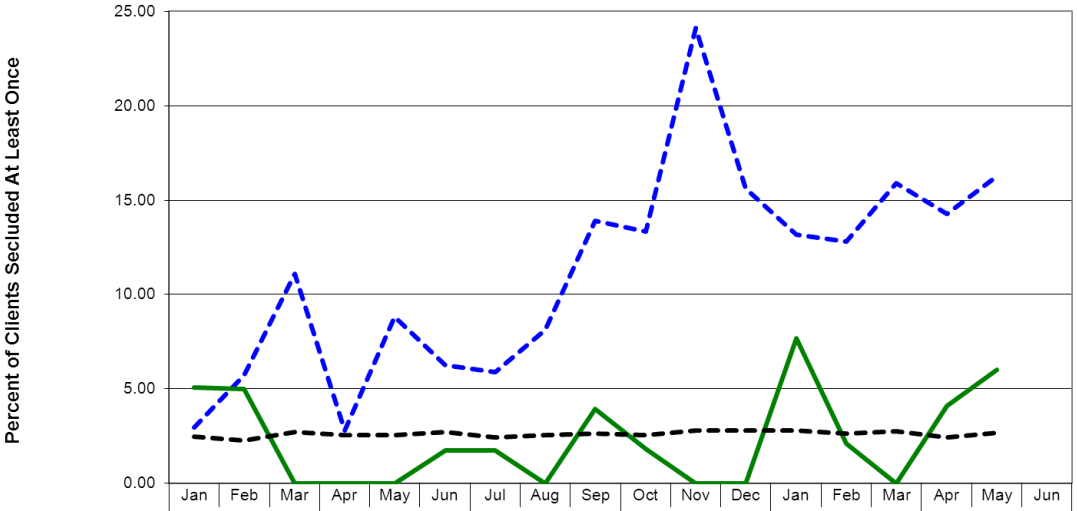
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	8.33	4.88	5.19	3.95	7.32	9.41	9.30	5.95	4.76	10.59	8.24	7.95	6.45	6.45	3.23	3.19	4.35	
Ntl Mean	2.09	1.73	1.95	1.72	1.97	1.97	2.08	2.01	1.89	2.10	1.89	1.98	2.40	2.04	2.21	1.95	1.79	

Percent of Clients Secluded

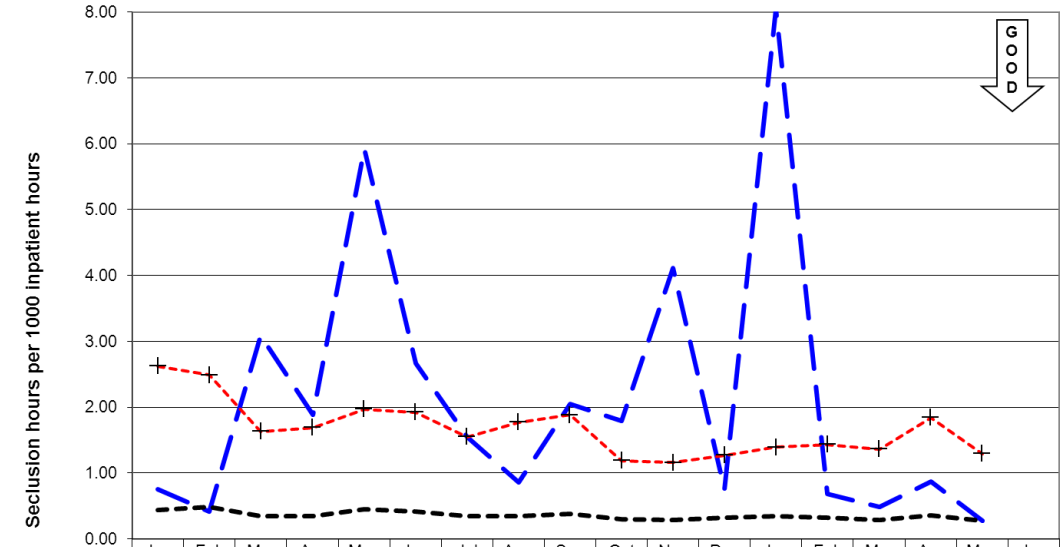
Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	2.94	5.71	11.11	2.78	8.82	6.25	5.88	8.11	13.89	13.33	24.14	15.62	13.16	12.82	15.91	14.29	16.28	
Dorothea Dix	5.08	5.00	0.00	0.00	0.00	1.75	1.72	0.00	3.92	1.82	0.00	0.00	7.69	2.08	0.00	4.08	6.00	
Ntl Mean	2.46	2.26	2.69	2.56	2.53	2.71	2.43	2.54	2.62	2.56	2.77	2.80	2.80	2.62	2.75	2.44	2.65	

CONSENT DECREE

Seclusion Hours



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.75	0.42	3.09	1.88	5.92	2.67	1.55	0.86	2.05	1.79	4.11	0.75	8.05	0.68	0.48	0.87	0.28	
Ntl Mean	0.44	0.48	0.34	0.34	0.45	0.41	0.35	0.34	0.38	0.30	0.29	0.32	0.34	0.32	0.29	0.36	0.27	
+1 StDev	2.62	2.49	1.63	1.69	1.97	1.92	1.55	1.77	1.88	1.19	1.16	1.27	1.39	1.43	1.36	1.84	1.29	

This graph depicts the number of hours clients 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 outlier values shown in May and June reflect the events related to a single individual during this period. This individual was in seclusion for extended periods of time due to extremely aggressive behaviors that are focused on staff. It was determined that the only way to effectively manage this client and create a safe environment for both the staff and other clients was to segregate him in an area away from other clients and to provide frequent support and interaction with staff in a manner that ensured the safety of the staff so engaged.

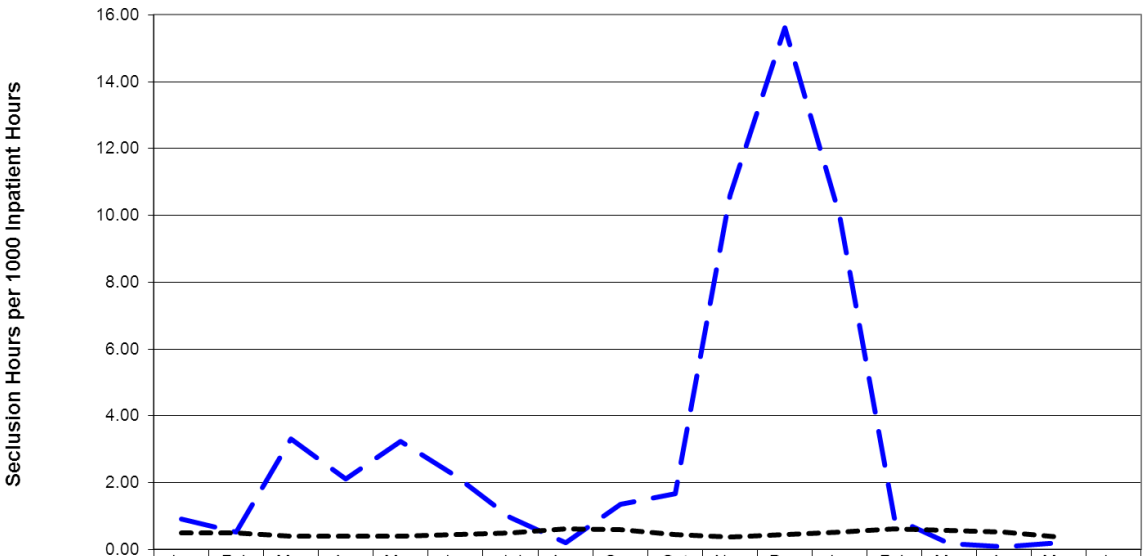
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Seclusion Hours

Forensic Stratification



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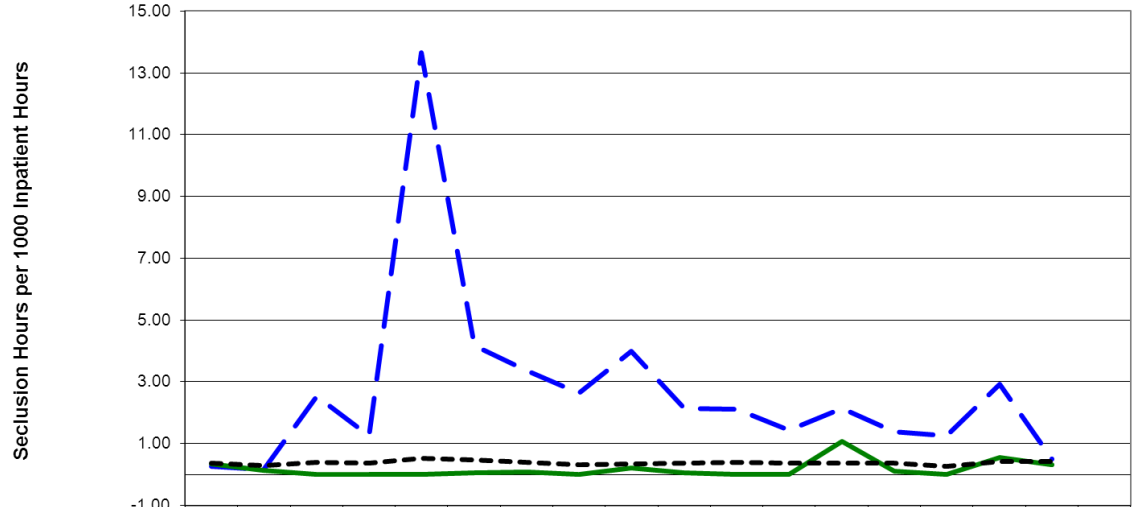
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.90	0.52	3.32	2.11	3.23	2.20	0.97	0.19	1.34	1.67	10.59	15.62	9.99	0.93	0.17	0.09	0.19	
Ntl Mean	0.50	0.50	0.39	0.40	0.40	0.45	0.50	0.61	0.60	0.44	0.37	0.45	0.51	0.61	0.56	0.51	0.38	

Seclusion Hours

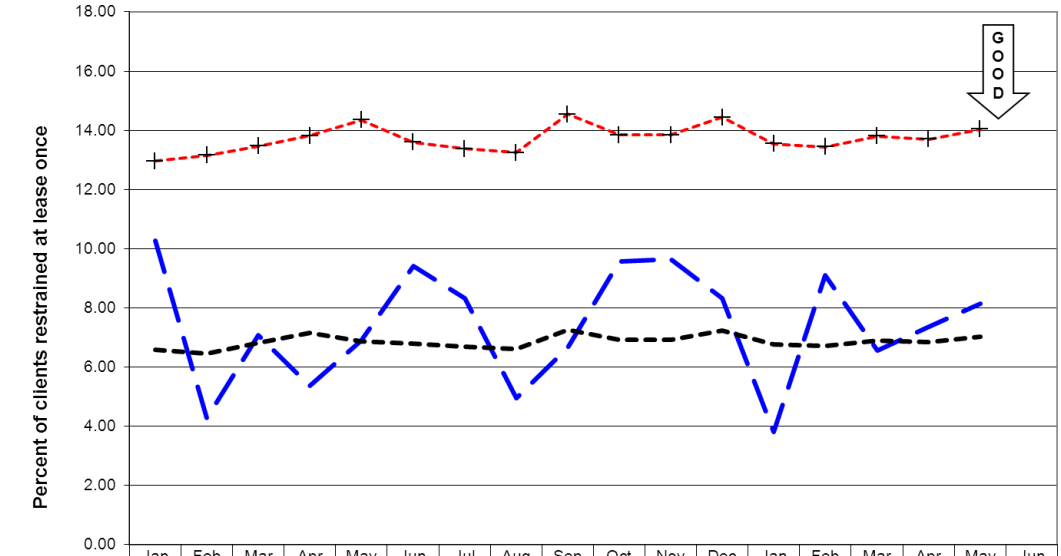
Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.26	0.16	2.53	1.26	13.65	4.18	3.37	2.63	3.98	2.14	2.12	1.43	2.14	1.38	1.26	2.92	0.49	
Dorothea Dix	0.35	0.13	0.00	0.00	0.00	0.06	0.09	0.00	0.22	0.05	0.00	0.00	1.08	0.10	0.00	0.56	0.31	
Ntl Mean	0.36	0.30	0.40	0.36	0.53	0.46	0.40	0.32	0.33	0.38	0.39	0.36	0.36	0.36	0.26	0.41	0.41	

CONSENT DECREE

Percent of Clients Restrained



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	10.26	4.27	7.08	5.36	6.90	9.40	8.33	4.96	6.67	9.57	9.65	8.33	3.82	9.09	6.57	7.35	8.15	
Ntl Mean	6.59	6.45	6.81	7.15	6.88	6.80	6.69	6.62	7.27	6.92	6.92	7.22	6.77	6.72	6.90	6.85	7.02	
+1 StDev	12.96	13.15	13.47	13.81	14.35	13.6	13.38	13.24	14.54	13.84	13.84	14.44	13.54	13.44	13.8	13.7	14.04	

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

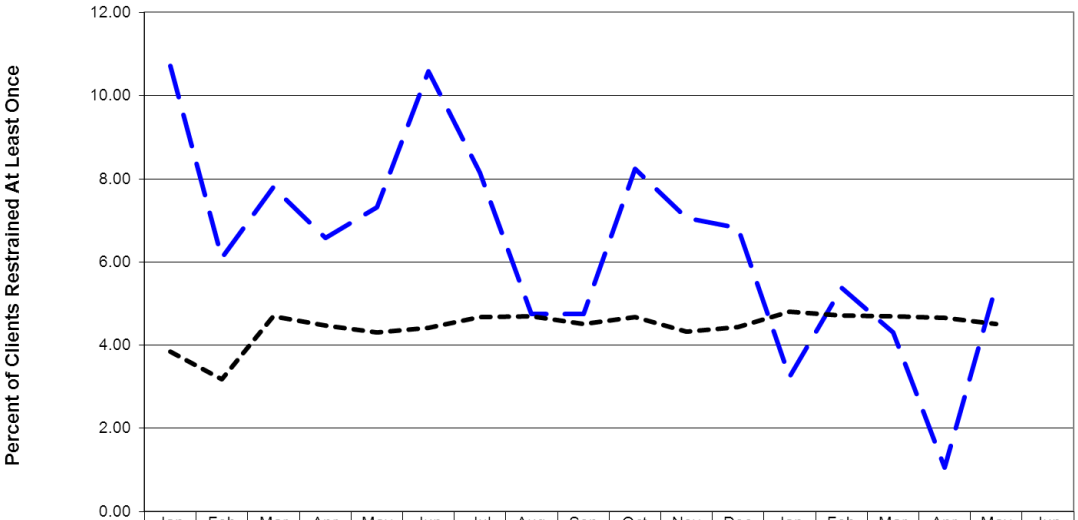
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Percent of Clients Restrained

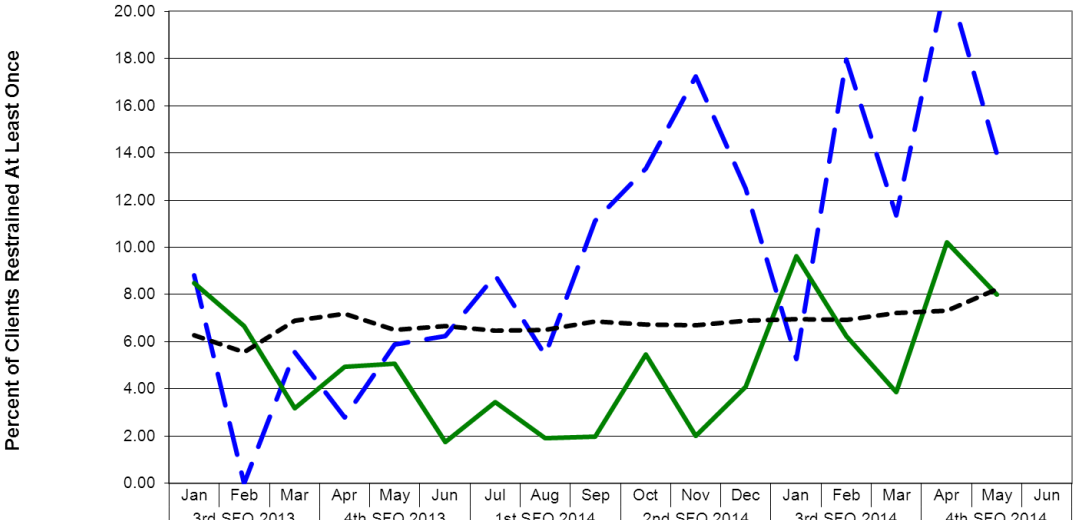
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	10.71	6.10	7.79	6.58	7.32	10.59	8.14	4.76	4.76	8.24	7.06	6.82	3.23	5.38	4.30	1.06	5.43	
Ntl Mean	3.85	3.19	4.70	4.48	4.30	4.42	4.68	4.70	4.51	4.67	4.32	4.44	4.80	4.71	4.70	4.66	4.51	

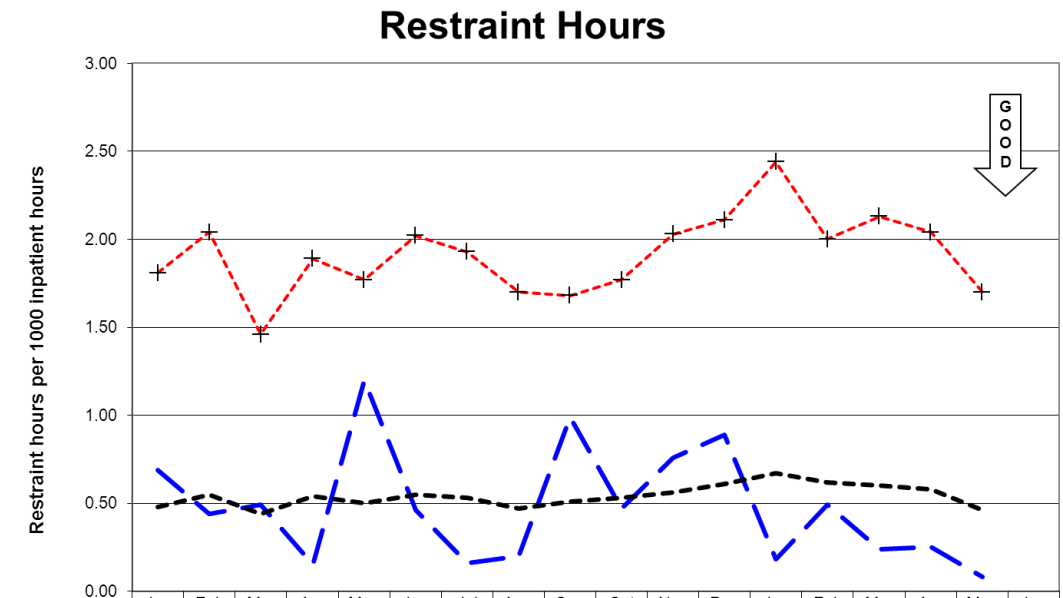
Percent of Clients Restrained

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	8.82	0.00	5.56	2.78	5.88	6.25	8.82	5.41	11.11	13.33	17.24	12.50	5.26	17.95	11.36	21.43	13.95	
Dorothea Dix	8.47	6.67	3.17	4.92	5.08	1.75	3.45	1.92	1.96	5.45	2.00	4.08	9.62	6.25	3.85	10.20	8.00	
Ntl Mean	6.27	5.55	6.90	7.18	6.50	6.66	6.46	6.49	6.85	6.72	6.70	6.89	6.96	6.91	7.20	7.30	8.21	

CONSENT DECREE



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.69	0.44	0.49	0.15	1.20	0.46	0.16	0.20	0.99	0.47	0.76	0.89	0.18	0.49	0.24	0.25	0.08	
Ntl Mean	0.48	0.55	0.44	0.54	0.50	0.55	0.53	0.47	0.51	0.53	0.56	0.61	0.67	0.62	0.60	0.58	0.46	
+1 StDev	1.81	2.04	1.46	1.89	1.77	2.02	1.93	1.70	1.68	1.77	2.03	2.11	2.44	2.00	2.13	2.04	1.70	

This graph depicts the number of hours clients 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.

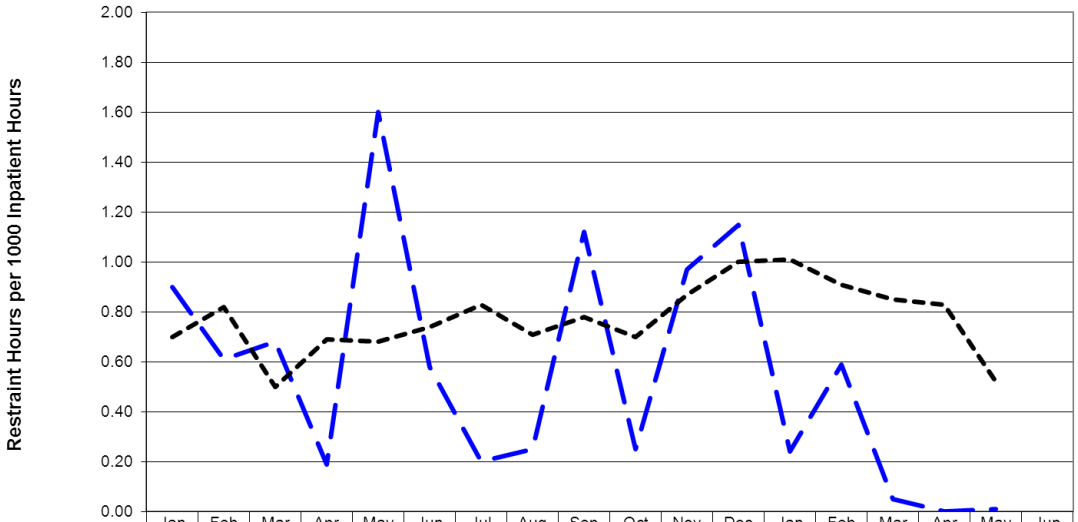
The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Restraint Hours

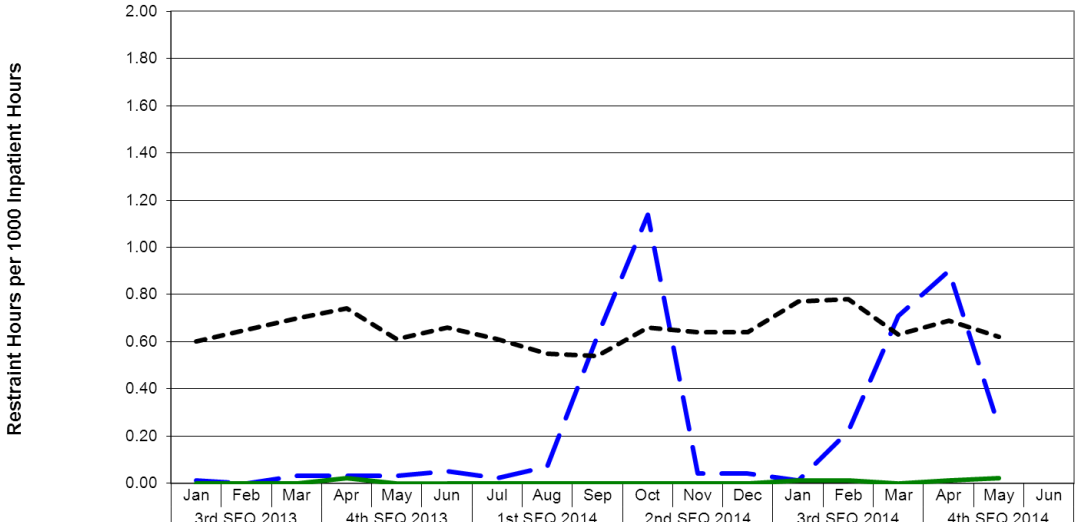
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.90	0.61	0.68	0.19	1.60	0.58	0.20	0.25	1.12	0.25	0.97	1.15	0.24	0.59	0.05	0.00	0.01	
Ntl Mean	0.70	0.82	0.50	0.69	0.68	0.74	0.83	0.71	0.78	0.70	0.87	1.00	1.01	0.91	0.85	0.83	0.52	

Restraint Hours

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.01	0.00	0.03	0.03	0.03	0.05	0.02	0.07	0.62	1.14	0.04	0.04	0.01	0.22	0.71	0.90	0.24	
Dorothea Dix	0.00	0.00	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.00	0.01	0.02	
Ntl Mean	0.60	0.65	0.70	0.74	0.61	0.66	0.61	0.55	0.54	0.66	0.64	0.64	0.77	0.78	0.63	0.69	0.62	

CONSENT DECREE

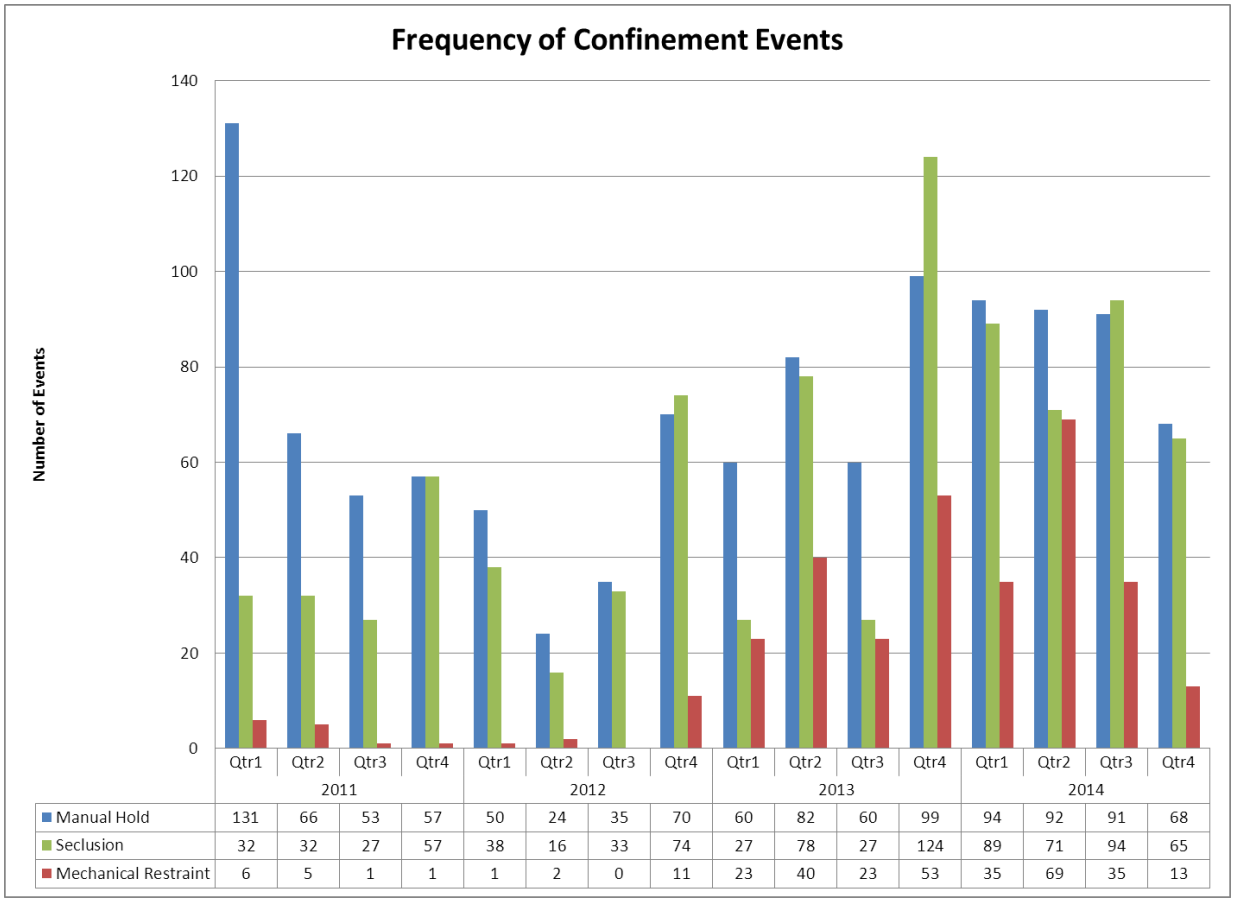
Confinement Event Detail

4th Quarter 2014

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR00007495	22	10	13	45	30.82%	30.82%
MR00002187	11		15	26	17.81%	48.63%
MR00007489	4	2	6	12	8.22%	56.85%
MR00005267	3		5	8	5.48%	62.33%
MR00000763	4		2	6	4.11%	66.44%
MR00007394	3		2	5	3.42%	69.86%
MR00007204	3		2	5	3.42%	73.29%
MR00007452	2		2	4	2.74%	76.03%
MR00007541	2		1	3	2.05%	78.08%
MR00003191	1		2	3	2.05%	80.14%
MR00007473	2		1	3	2.05%	82.19%
MR00006266	1		2	3	2.05%	84.25%
MR00000029	2		1	3	2.05%	86.30%
MR00006309	1	1		2	1.37%	87.67%
MR00007480	1		1	2	1.37%	89.04%
MR00007515	1		1	2	1.37%	90.41%
MR00007527	1		1	2	1.37%	91.78%
MR00005213			2	2	1.37%	93.15%
MR00007363			2	2	1.37%	94.52%
MR00007409	1			1	0.68%	95.21%
MR00007513	1			1	0.68%	95.89%
MR00007522	1			1	0.68%	96.58%
MR00007032	1			1	0.68%	97.26%
MR00000104			1	1	0.68%	97.95%
MR00005625			1	1	0.68%	98.63%
MR00001416			1	1	0.68%	99.32%
MR00006563			1	1	0.68%	100.00%
	68	**13**	**65**	**146**		

35% (27/78) of average hospital population experienced some form of confinement event during the 4th fiscal quarter 2014. Five of these clients (6% of the average hospital population) accounted for 66% of the containment events.

CONSENT DECREE



	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
	2011				2012				2013				2014			
Manual Hold	131	66	53	57	50	24	35	70	60	82	60	99	94	92	91	68
Seclusion	32	32	27	57	38	16	33	74	27	78	27	124	89	71	94	65
Mechanical Restraint	6	5	1	1	1	2	0	11	23	40	23	53	35	69	35	13

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

	4Q13	1Q14	2Q14	3Q14	4Q14
Danger to Others/Self	124	71	88	92	62
Danger to Others					3
Danger to Self					
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	124	71	88	92	65

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

	4Q13	1Q14	2Q14	3Q14	4Q14
Danger to Others/Self	53	29	51	35	12
Danger to Others					
Danger to Self			1		1
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	53	29	52	35	13

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 29 & 30

CONSENT DECREE

Confinement Events Management

Seclusion Events (65) 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%	100%
The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%
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%
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 medical director and advocate.	90%	100%
The record reflects that, for persons with mental retardation, the regulations governing seclusion of clients 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 (13) 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%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%
The record reflects that the decision to place the patient in restraint was made by a physician or physician extender	90%	100%
The decision to place the patient in restraint was entered in the patient's records as a medical order.	90%	100%
The record reflects that, if a physician or physician extended was not immediately available to examine the patient, the patient was placed in restraint following an examination by a nurse.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in restraint, or, if there was a delay, the reasons for the delay.	90%	100%
The record reflects that the patient was kept under constant observation during restraint.	95%	100%
Individuals implementing restraint have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts taken to notify guardian or designated representative as soon as possible that patient was placed in restraint.	75%	100%
The medical order states time of entry of order and that number of hours shall not exceed four.	90%	100%
The medical order shall state the conditions under which the patient may be sooner released.	85%	100%

Standard	Threshold	Compliance
The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	100%
The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document the reason for the restraint, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	100%
The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	100%
Copies of events were forwarded to medical director and advocate.	90%	100%
For persons with mental retardation, the applicable regulations were met.	85%	100%
The record reflects that the order 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
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 Medical Director (or if the Medical Director is out of the hospital, by the individual acting in the Medical Director's stead) following examination of the patient; and that the patient's guardian or representative has been notified.	90%	100%

Client Elopements

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

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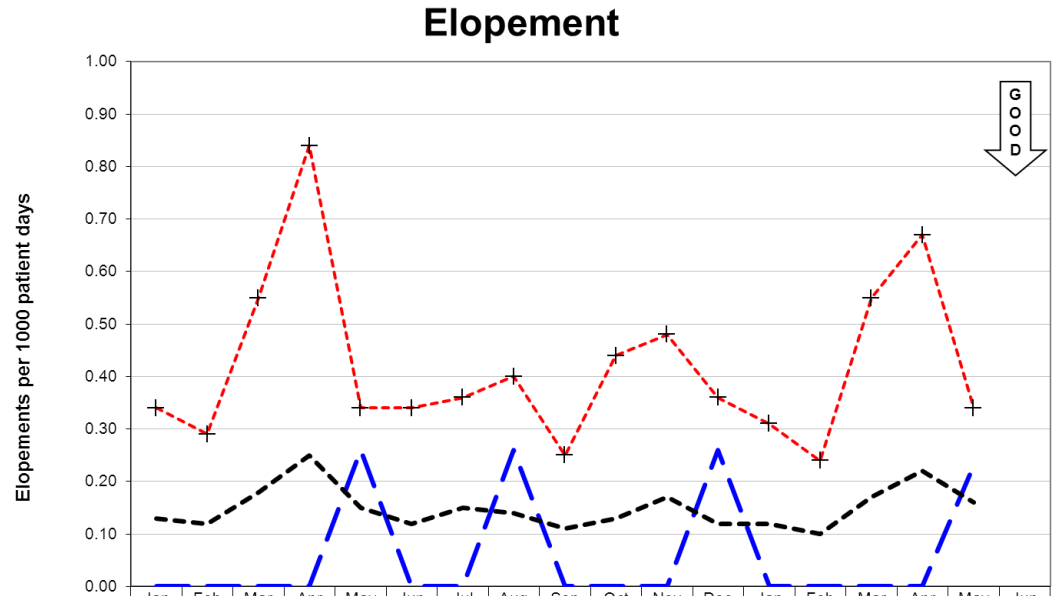


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.00	0.00	0.00	0.00	0.26	0.00	0.00	0.26	0.00	0.00	0.00	0.26	0.00	0.00	0.00	0.00	0.23	
Ntl Mean	0.13	0.12	0.18	0.25	0.15	0.12	0.15	0.14	0.11	0.13	0.17	0.12	0.12	0.10	0.17	0.22	0.16	
StDev	0.34	0.29	0.55	0.84	0.34	0.34	0.36	0.40	0.25	0.44	0.48	0.36	0.31	0.24	0.55	0.67	0.34	

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.

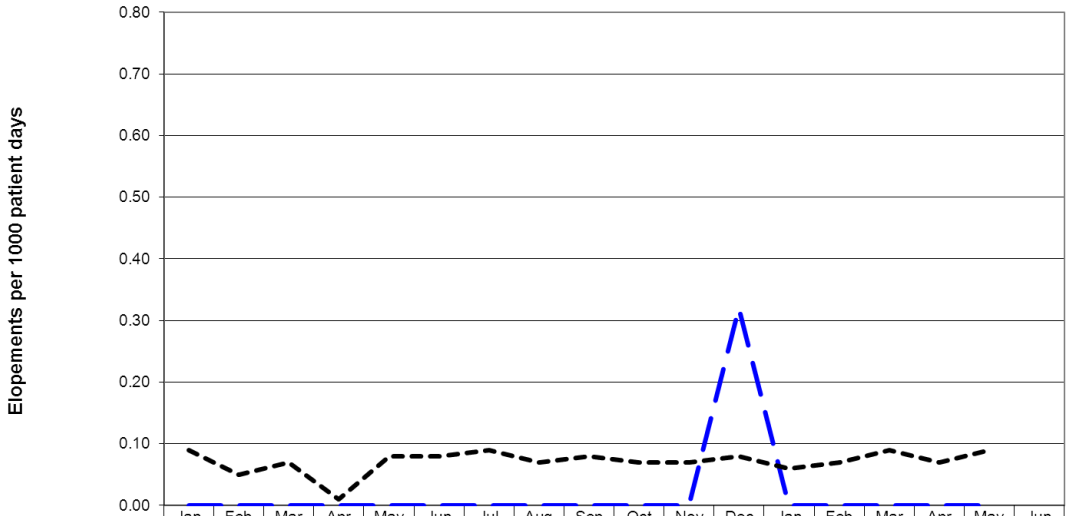
An elopement is defined as any time a client is “absent from a location defined by the client’s privilege status regardless of the client’s leave or legal status.”

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 the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

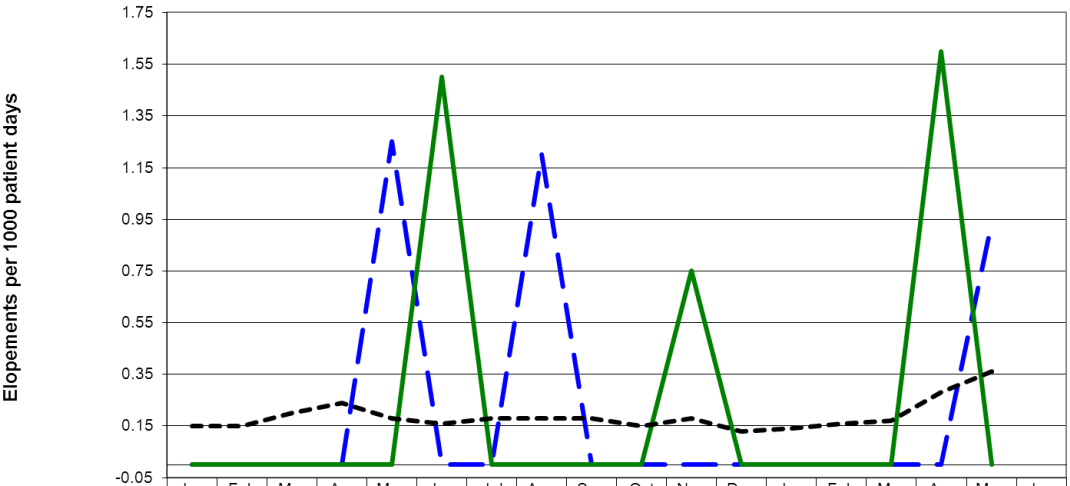
CONSENT DECREE

Elopement
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.32	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.09	0.05	0.07	0.01	0.08	0.08	0.09	0.07	0.08	0.07	0.07	0.08	0.06	0.07	0.09	0.07	0.09	

Elopement
Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.00	0.00	0.00	0.00	1.25	0.00	0.00	1.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.94	
Dorothea Dix	0.00	0.00	0.00	0.00	0.00	1.50	0.00	0.00	0.00	0.00	0.75	0.00	0.00	0.00	0.00	1.60	0.00	
Ntl Mean	0.15	0.15	0.20	0.24	0.18	0.16	0.18	0.18	0.18	0.15	0.18	0.13	0.14	0.16	0.17	0.28	0.36	

Client Injuries

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

The NASMHPD standards for measuring client 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

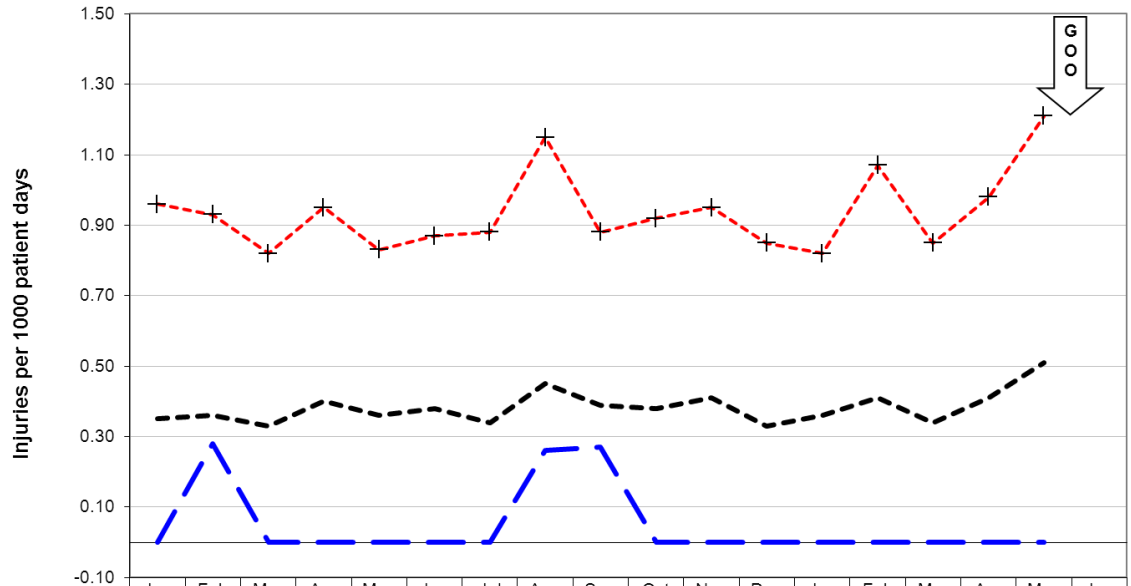
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

- No Treatment – The injury received by a client 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 client 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 client 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 client.

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	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.00	0.28	0.00	0.00	0.00	0.00	0.00	0.26	0.27	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.35	0.36	0.33	0.40	0.36	0.38	0.34	0.45	0.39	0.38	0.41	0.33	0.36	0.41	0.34	0.41	0.51	
+1 StDev	0.96	0.93	0.82	0.95	0.83	0.87	0.88	1.15	0.88	0.92	0.95	0.85	0.82	1.07	0.85	0.98	1.21	

This graph depicts the number of client 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.

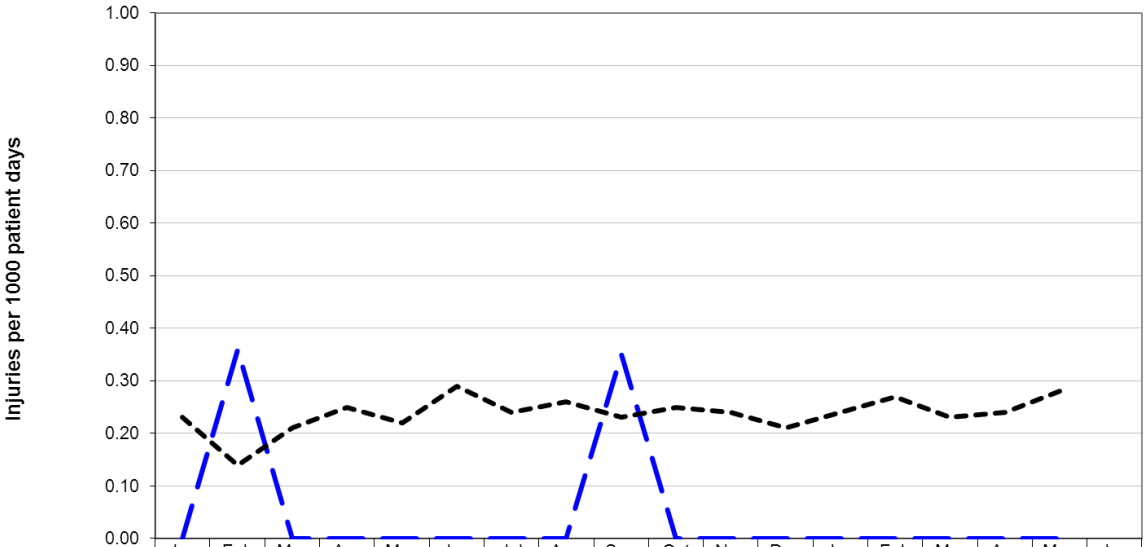
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Client Injury Rate

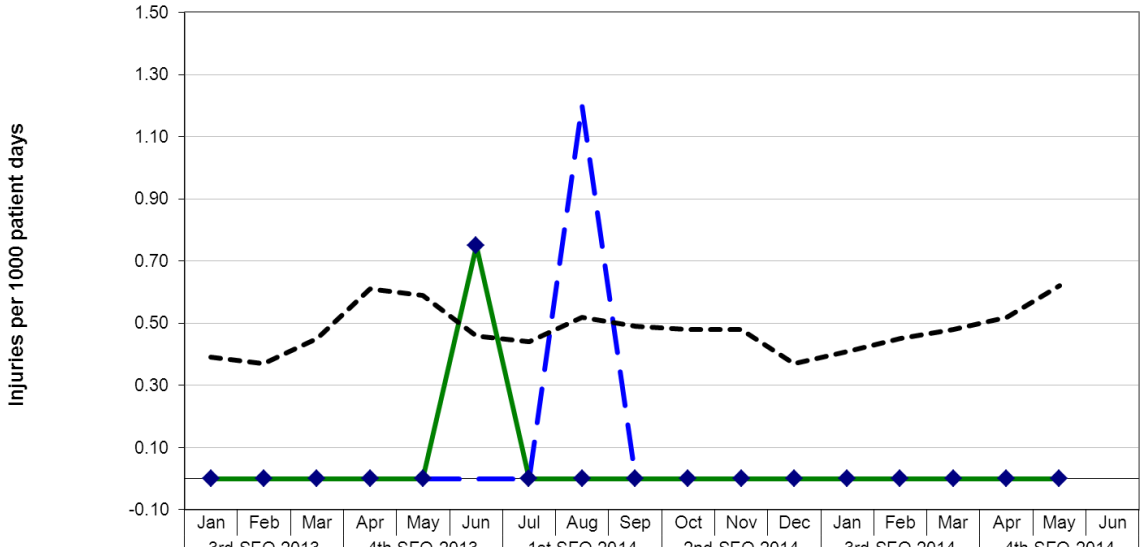
Forensic Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.00	0.36	0.00	0.00	0.00	0.00	0.00	0.00	0.35	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.23	0.14	0.21	0.25	0.22	0.29	0.24	0.26	0.23	0.25	0.24	0.21	0.24	0.27	0.23	0.24	0.28	

Client Injury Rate

Civil Stratification



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Dorothea Dix	0.00	0.00	0.00	0.00	0.00	0.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.39	0.37	0.45	0.61	0.59	0.46	0.44	0.52	0.49	0.48	0.48	0.37	0.41	0.45	0.48	0.52	0.62	

CONSENT DECREE

Severity of Injury by Month

Severity	APRIL	MAY	JUNE	4Q2014
No Treatment	34	40	30	**104**
Minor First Aid	1	2	2	**5**
Medical Intervention Required	2	0	1	**3**
Hospitalization Required	1	2	0	**3**
Death Occurred	0	0	0	**0**
Total	**38**	**44**	**33**	**115**

Type and Cause of Injury by Month

Type - Cause	APRIL	MAY	JUNE	4Q2014
Accident – Fall Unwitnessed	2	8	4	**14**
Accident – Fall Witnessed	1	5	7	**13**
Accident – Other	2	3	1	**6**
Assault – Client to Client	18	14	10	**42**
Self-Injurious Behavior	15	14	11	**40**
Total	**38**	**44**	**33**	**115**

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 client interactions increased significantly. This change is due primarily as a result of the methods and rules related to data collection and abstraction.

Falls continues to be the predominant cause of potentially injurious events not related to the assaults discussed previously. Fall incidents remain a focus of the hospital. None of the fall incidents required treatment of any kind but are address as to causation during the Falls Process Review Team Meeting held each month.

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	1Q2014	2Q2014	3Q2014	4Q2014
Abuse Physical	3	4	10	10
Abuse Sexual	4	2	5	15
Abuse Verbal	1	1	4	2
Coercion/Exploitation				
Neglect			1	

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. Clients 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 client advocates.
3. Any allegation of abuse, neglect, or exploitation is reported both internally and externally to appropriate stakeholders, include:
    - Superintendent and/or AOC
    - Adult Protective Services
    - Guardian
    - Client 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 client'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 incidence 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 November 11-13, 2013. A triennial accreditation survey is expected to occur in November 2016 or earlier.

The hospital had 10 Measures of Success to complete to maintain certification. Six have been successfully completed and the four others will be completed by annual recertification on November 2014.

V35) Riverview maintains its hospital license;

Riverview maintains licensing status as required through the Maine Department of Health and Human Services Division of Licensing and Regulatory Services.

V36) The hospital does not lose its CMS certification (for the entire hospital excluding Lower Saco SCU so long as Lower Saco SCU is a distinct part of the hospital for purposes of CMS certification) as a result of patient care issues;

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance by August 27, 2013. A revisit by CMS occurred on September 16th and 17th, 2013. The Medicare Provider Agreement will not be accepted unless CMS finds that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and that the hospital has fulfilled, or has made satisfactory arrangements to fulfill, all of its statutory and regulatory responsibilities of its previous agreement. See Section 1866(c) of the Social Security Act and 42 C.F.R.§489.57. Riverview had a CMS visit in May 2014 and the hospital's request for certification was denied. The hospital met seven of eight areas of deficiencies since the prior visit. Staff have undertaken additional efforts to address the one area of deficiency. A new application is being prepared for submission to CMS for certification of the hospital.

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 support by the Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence.

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

In 1987, The Joint Commission announced its *Agenda for Change,* which outlined a series of major steps designed to modernize the accreditation process. A key component of the *Agenda for Change* was the eventual introduction of standardized core performance measures into the accreditation process. As the vision to integrate performance measurement into accreditation became more focused, the name ORYX® was chosen for the entire initiative. The ORYX initi

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 healthcare 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.

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 HIBIPS standards reflected in this report a designed to reflect these core domains in the delivery of psychiatric care.

JOINT COMMISSION

Admissions Screening (HBIPS 1)

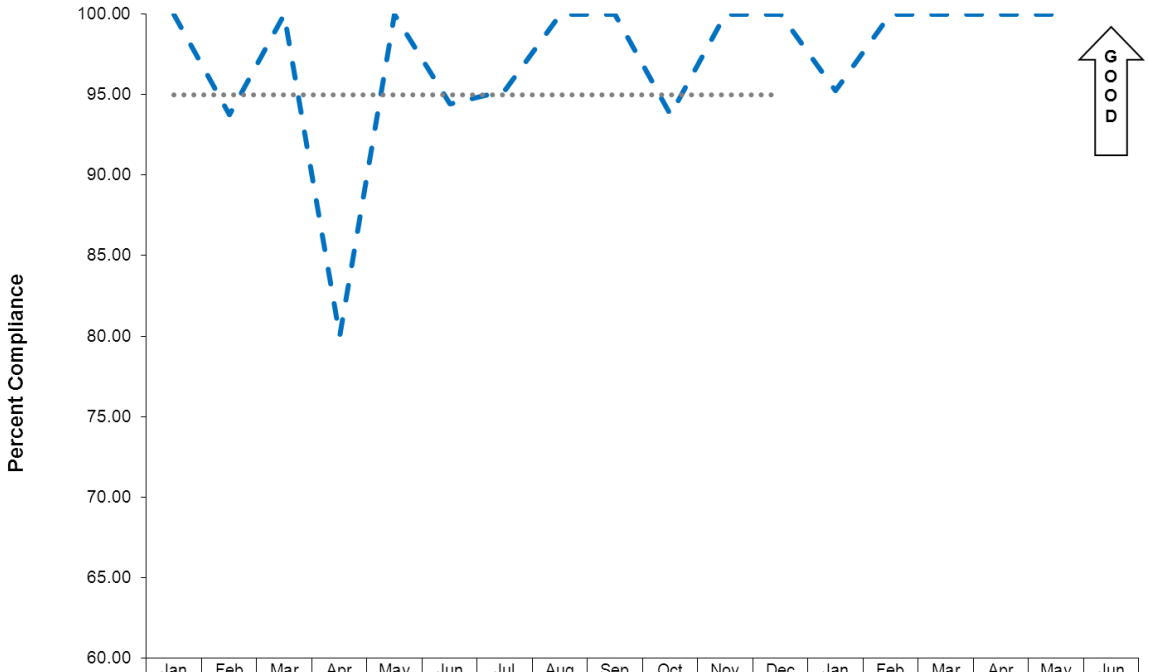
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

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	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
RPC Rate	100.00	93.75	100.00	80.00	100.00	94.44	95.25	100.00	100.00	93.75	100.00	100.00	95.24	100.00	100.00	100.00	100.00	
TJC Target	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

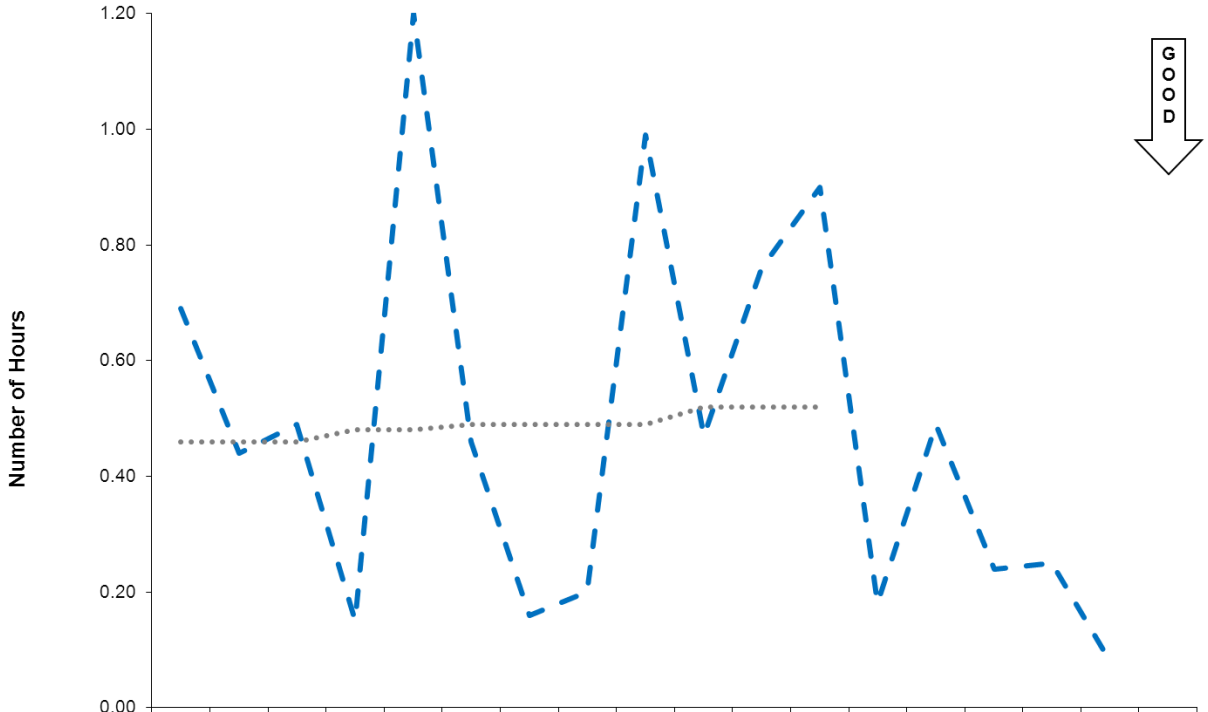
Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting was 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	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
RPC Rate	0.69	0.44	0.49	0.15	1.20	0.46	0.16	0.20	0.99	0.47	0.76	0.90	0.18	0.49	0.24	0.25	0.08	
TJC Target	0.46	0.46	0.46	0.48	0.48	0.49	0.49	0.49	0.49	0.52	0.52	0.52						

JOINT COMMISSION

Seclusion (HBIPS 3)

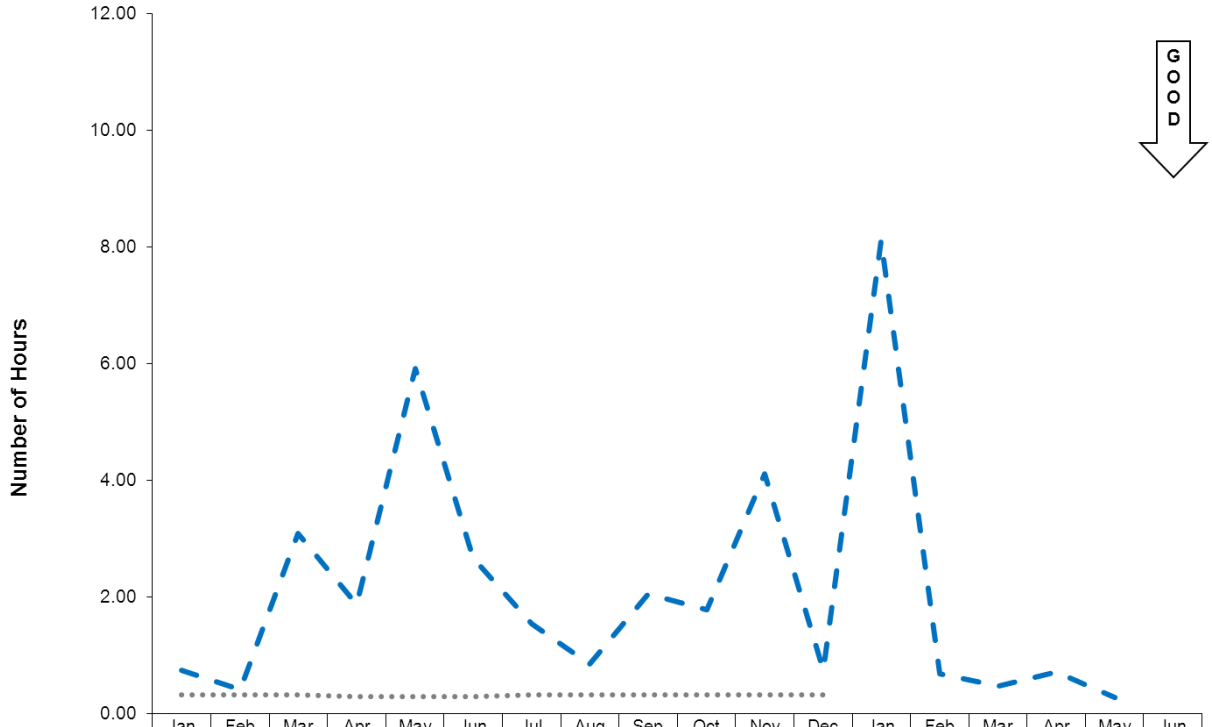
Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting was 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	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
RPC Rate	0.75	0.42	3.09	1.88	5.92	2.67	1.55	0.85	2.05	1.79	4.11	0.75	8.12	0.68	0.48	0.72	0.28	
TJC Target	0.32	0.32	0.32	0.30	0.30	0.30	0.33	0.33	0.33	0.32	0.32	0.32						

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

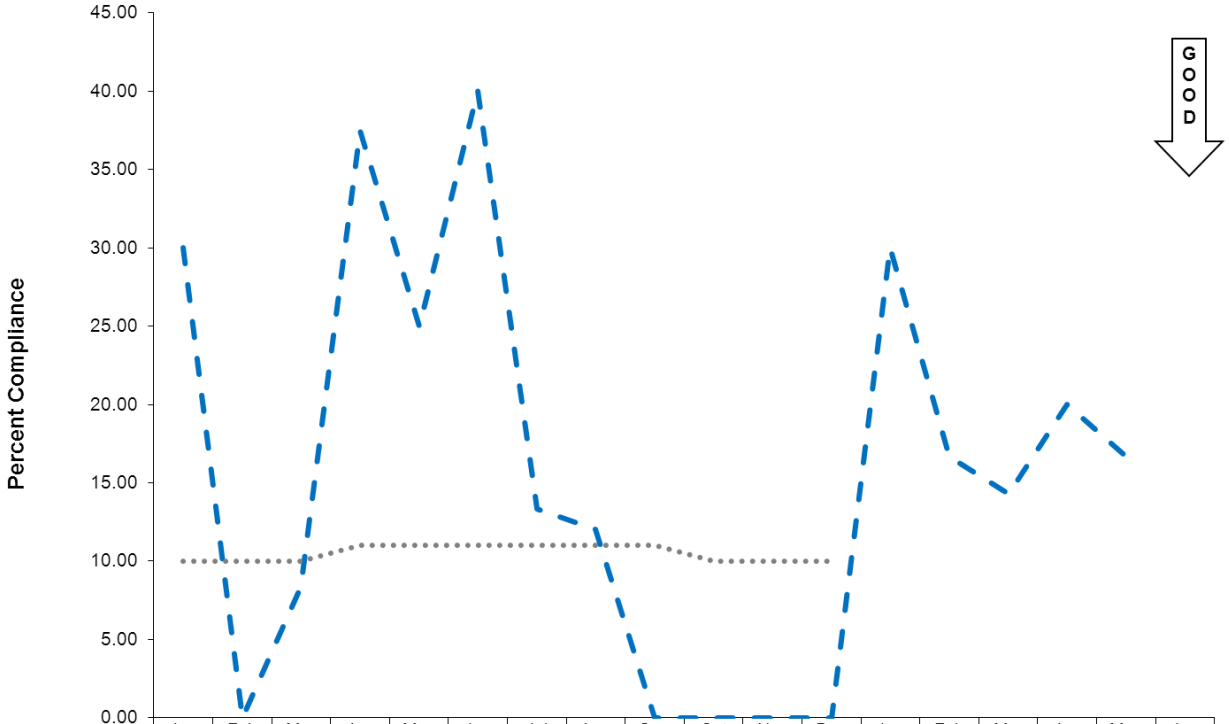
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

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.

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
RPC Rate	30.00	0.00	8.33	37.50	25.00	40.00	13.33	12.00	0.00	0.00	0.00	0.00	30.00	16.67	14.29	20.00	16.67	
TJC Data	10.00	10.00	10.00	11.00	11.00	11.00	11.00	11.00	11.00	10.00	10.00	10.00						

JOINT COMMISSION

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

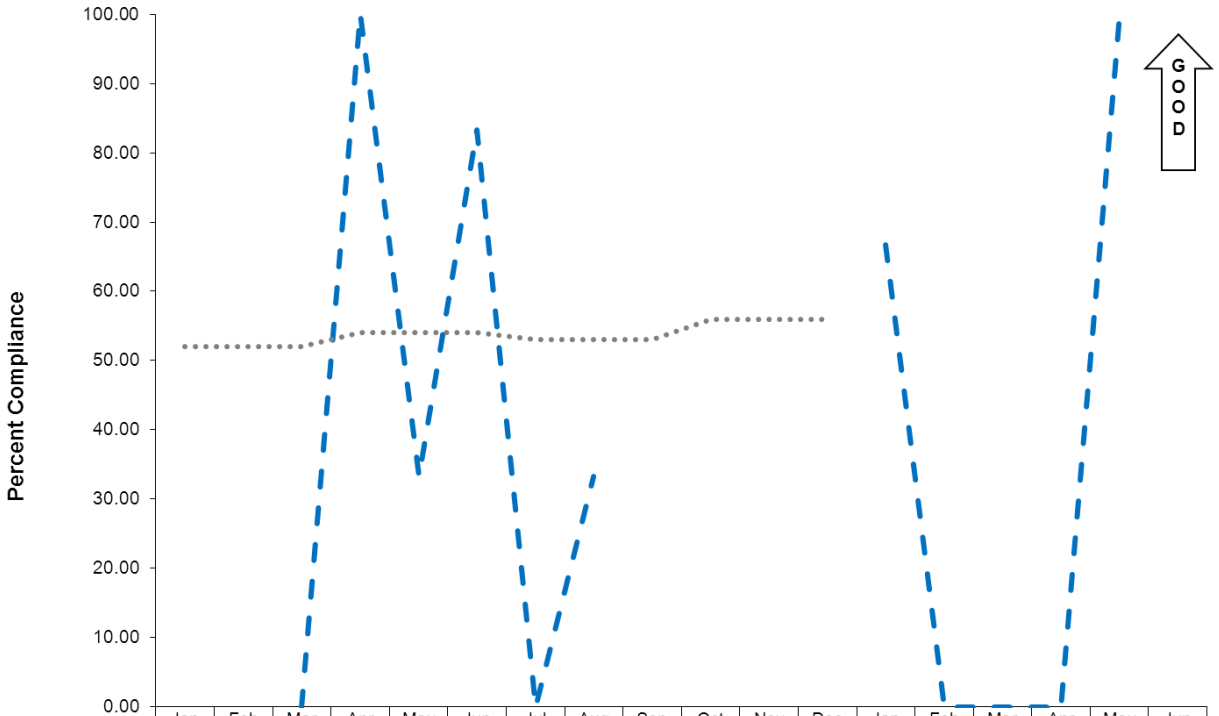
Rationale

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	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
RPC Rate	33.33		0.00	100.00	33.33	83.33	0.00	33.33					66.67	0.00	0.00	0.00	100.00	
TJC Target	52.00	52.00	52.00	54.00	54.00	54.00	53.00	53.00	53.00	56.00	56.00	56.00						

JOINT COMMISSION

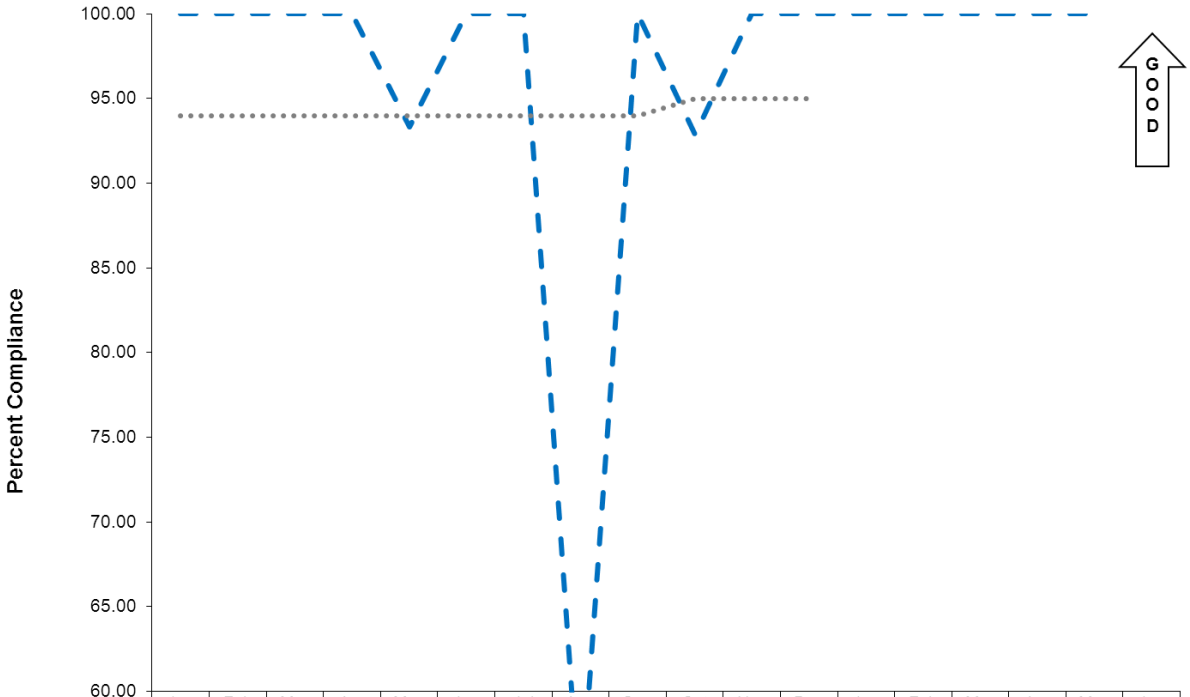
Post Discharge Continuing Care Plan (HBIPS 6)

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).



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
RPC Rate	100.00	100.00	100.00	100.00	93.33	100.00	100.00	52.94	100.00	92.86	100.00	100.00	100.00	100.00	100.00	100.00	100.00	
TJC Target	94.00	94.00	94.00	94.00	94.00	94.00	94.00	94.00	94.00	95.00	95.00	95.00						

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

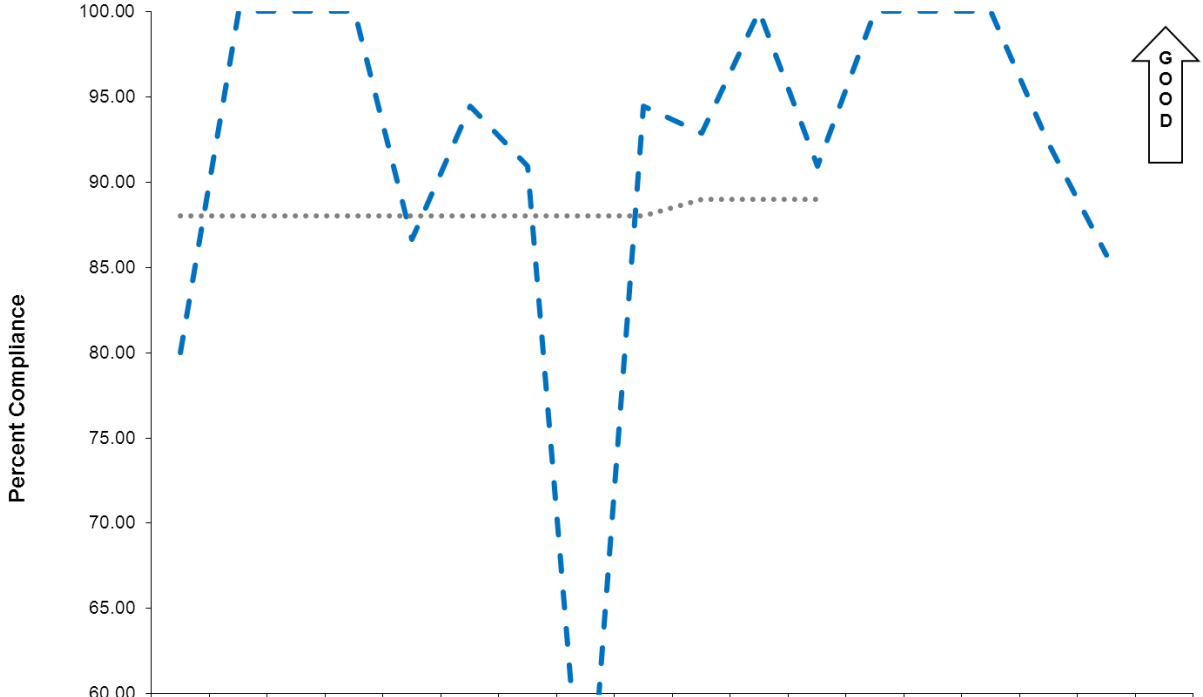
To Next Level of Care Provider on Discharge

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).



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
RPC Rate	80.00	100.00	100.00	100.00	86.67	94.44	90.91	50.00	94.44	92.86	100.00	90.91	100.00	100.00	100.00	92.31	85.71	
TJC Target	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	89.00	89.00	89.00						

JOINT COMMISSION

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.

Final Report of FY 2014 Clinical Contracts		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Stephanie George-Roy Director of Social Services	All indicators met or exceeded standards.
Community Dental, Region II	Dr. Brendan Kirby Medical Director	All indicators met standards.
Comprehensive Pharmacy Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
Dartmouth Medical School	Robert J. Harper Superintendent	All indicators met or exceeded standards.
Disability Rights Center	Robert J. Harper Superintendent	All indicators met standards.
Healthreach	Dr. Brendan Kirby Medical Director	All indicators met standards.
Liberty Healthcare – Physician Staffing	Dr. Brendan Kirby Medical Director	All indicators met standards.
MaineGeneral Medical Center – Laboratory Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
MD-IT	Amy Tasker Health Information Management Director	All indicators met standards.
Medical Staffing and Services of Maine, Inc.	Dr. Brendan Kirby Medical Director	All indicators met standards.
Motivational Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
NEMED	Rick Levesque Director of Support Services	All indicators met standards.
Occupational Therapy Consultation and Rehab Services	Janet Barrett Director of Rehabilitation	All indicators exceeded standards
Securitas Security Services	Robert Patnaude Director of Security	All indicators met or exceeded standards.

JOINT COMMISSION

Capital Community Clinic

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)

Dental Clinic Timeout/Identification of Client

Indicators	1Q2014	2Q2014	3Q2014	4Q2014	FY14 Total
National Patent Safety Goals Goal 1: Improve the accuracy of Client Identification. Capital Community Dental Clinic assures accurate client identification by: asking the client 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.	**July** 100% 6/6 **August** 100% 2/2 **September** 100% 4/4 **Total** 100% 12/12	**October** 100% 3/3 **November** 100% 1/1 **December** 100% 2/2 **Total** 100% 6/6	**January** 100% 2/2 **February** 100% 2/2 **March** 100% 7/7 **Total** 100% 11/11	**April** 100% 11/1 **May** N/A 0/0 **June** 100% 2/2 **Total** 100% 13/13	**Fiscal Year Total** 100% 42/42

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	1Q2014	2Q2014	3Q2014	4Q2014	FY14 Total
1. All clients 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 client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. 3. Post dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications	**July** 100% 6/6 **August** 100% 2/2 **September** 100% 4/4 **Total** 100% 12/12	**October** 100% 3/3 **November** 100% 1/1 **December** 100% 2/2 **Total** 100% 6/6	**January** 100% 2/2 **February** 100% 2/2 **March** 100% 7/7 **Total** 100% 11/11	**April** 100% 11/1 **May** N/A 0/0 **June** 100% 2/2 **Total** 100% 13/13	**Fiscal Year Total** 100% 42/42

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management

Upper Kennebec, Lower Kennebec, Upper Saco

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

Indicators	4Q14 Findings	4Q14 Compliance	Threshold Percentile
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	12/2.1	1 STDV within mean	1 STDV within the mean

Hospital Acquired Infection 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 HAI.

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

Idiosyncratic Infection is any infection that occurs after admission and is the result of the patient's action.

Lower Kennebec Unit
LLL Pneumonia (HAI)
Dental Infection/2 (CAI)
Pustula & Cystic Acne (CAI)
Prophylactic Treatment of Acute Sensitivity Rash/Chemical (HAI)
Tinea pedis/1 (HAI)
Tinea pedis/1 (CAI)
Tinea Versicolor (CAI)
Superficial Pressure Sore (CAI)
External Otitis Media (CAI)

Lower Kennebec Scu
Stage III Ulceration (HAI)
Monilial Intertrigo, possibly Vaginal Candida (CAI)

Upper Kennebec Unit
Carbuncle (CAI)
Gastoenteritis (CAI)

Upper Saco Unit
Inflammatory Nodule/possibly drained abscess (HAI)
UTI (CAI)
Dental Infection/3 (CAI)
Recurrent Aspiration Pneumonia – not counted
Otitis Media (HAI)
Viral Pneumonitis (HAI)
Recurrent C. difficile – not counted
Recurrent LLL Pneumonai – not counted
Cellulitis (HAI)
Tinea Pedis (HAI)
Intertrigo (self induced)
Superficial Abraison/Prophylactic Treatment (CAI)
Vaginal Yeast (CAI)
Superficial Bacterial Skin Infection (CAI)
S & S viral URI/3 (HAI)

Total Infection: 30
HAI: 12/2.1
CAI: 17
Idiosyncratic Infection: 1

JOINT COMMISSION

The fourth quarter hospital associated infection (HAI) rate is 2.1; and is within 1 standard deviation of the mean. Other than a small cluster of viral URI/LRI on Upper Saco in June, Infections were scattered throughout the hospital.

Plan: Continue total house surveillance

Lower Saco

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

Indicators	4Q14 Findings	4Q14 Compliance	Threshold Percentile
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	1.5	100%	1 SD within the mean

Hospital Acquired Infection 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 HAI.

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

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

Infections:
Acne Rosasea (CAI)
URI (HAI)
Candida/Thrush (HAI)
Severe Dental Decay (CAI)
Bilateral Conjunctivitis (HAI)
Tinea Corporis, Intertrigo & Tinea Pedis (HAI)
Recurrent Cellulitis – not counted
Blister Right Great Toe (CAI)

Total Infections: 7
CAI: 3
HAI: 4 – 1.5

Findings: The fourth quarter hospital associated infection rate is 1.5; and is within one standard deviation of the mean.

Plan: Continue surveillance

JOINT COMMISSION

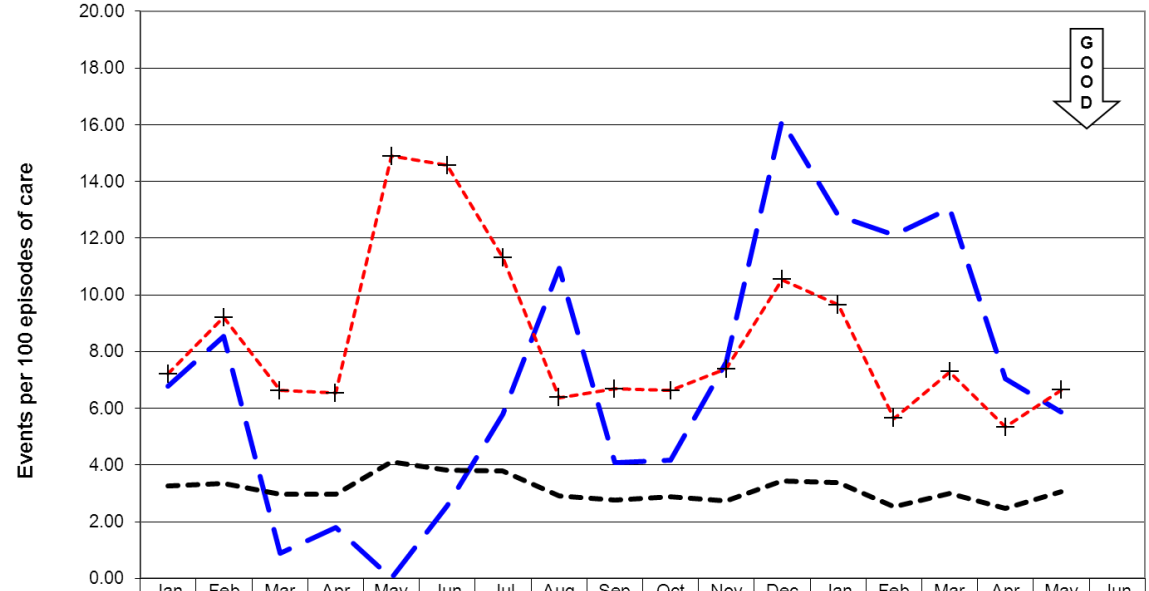
Medication Management

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)

Medication Errors



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	6.78	8.55	0.88	1.79	0.00	2.56	5.79	10.95	4.07	4.17	7.63	16.13	12.78	12.13	13.04	7.04	5.88	
Ntl Mean	3.26	3.34	2.98	2.97	4.12	3.81	3.80	2.91	2.77	2.88	2.74	3.45	3.39	2.52	2.99	2.46	3.07	
+1 StDev	7.21	9.20	6.62	6.53	14.89	14.56	11.31	6.37	6.69	6.62	7.38	10.53	9.64	5.65	7.28	5.33	6.64	

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

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 client level errors are also defined as errors of prescribing. in identifying and ordering the appropriate medication to be used in the care of the client.

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 client care practices. The team consists of the Medical 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

Medication Management - Administration Process
Medication Errors Related to Staffing Effectiveness

Date	OMIT	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
4-3-14	Y	Omission x1	N	N	N	LK	3 RN, 1 LPN, 7 MHW
4-4-14	Y	Omission x1	N	N	N	UK	2 RN, 0 LPN, 4 MHW
4-8-14	N	Wrong dose	Y	Y	N	LS	4 RN, 0 LPN, 6 MHW
4-12-14	N	Wrong dose	N	Y	N	US	3 RN, 0 LPN, 5 MHW
4-12-14	N	Wrong dose	N	N	N	LK	3 RN, 1 LPN, 7 MHW
4-17-14	N	Wrong med	N	N	N	LK	3 RN, 1 LPN, 7 MHW
4-20-14	N	Wrong med	N	N	N	LS	2 RN, 1 LPN, 8 MHW
4-26-14	N	Wrong time	Y	Y	N	LK	4 RN, 0 LPN, 7 MHW
4-26-14	N	Wrong time	N	N	N	UK	1 RN, 0 LPN, 3 MHW
4-27-14	N	Wrong dose x 4	N	N	N	LK	3 RN, 1 LPN, 7 MHW
4-25-14	N	Expired med	Y	Y	N	LS	2 RN, 0 LPN, 5 MHW
5-27-14	N	Wrong time	N	N	N	US	2.5 RN, 1 LPN, 3 MHW
5-30-14	N	Wrong med	N	N	N	LK	2 RN, 0 LPN, 5 MHW
5-27-14	N	Wrong dose	N	N	N	LK	3 RN, 1 LPN, 6 MHW
5-27-14	Y	Omission x1	Y	Y	N	UK	1 RN, 0 LPN, 3 MHW
5-28-14	Y	Omission x1	N	Y	N	LK	2 RN, 0 LPN, 5 MHW
6-17-14	N	Wrong time x 2 meds	Y	Y	N	US	3 RN, 0 LPN, 4 MHW
6-13-14	N	Wrong time	N	N	N	LS	3 RN, 0 LPN, 7 MHW
6-17-14	Y	Omission x 6	N	N	N	LK	3 RN, 0 LPN, 7 MHW
6-18-14	Y	Omission x 2	N	N	N	US	2 RN, 1 LPN, 4 MHW
6-25-14	N	Wrong time x 2	N	N	N	US	2 RNs, 1 LPN, 4 MHW
6-28-14	N	Wrong time	N	N	N	UK	3 RN, 0 LPN, 4 MHW
6-27-14	Y	Omission x 1	Y	Y	N	LK	4 RN, 0 LPN, 7 MHW

JOINT COMMISSION

Date	OMIT	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
6-27-14	Y	Omission x 1	Y	Y	N	LK	4 RN, 0 LPN, 7 MHW
6-27-14	N	Wrong time	N	N	N	UK	3 RN, 5 MHW
Totals	**14**		**8**	**10**	**0**	**LS: 4**	**US: 8**	**LK: 19**	**UK: 5**
Percent	**39%**		**22%**	**28%**	**0**	**11%**	**22%**	**53%**	**14%**

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

Summary

There were a total of 36 medication errors this quarter. 14 of the med errors were omissions, 8 errors were dose related, 10 errors involved wrong time, 3 were wrong medications given, and 1 was a medication given after the order had expired. 18 of the medication errors were committed by staff floating to another unit or by newly hired staff.

Actions

All nursing related medication errors were noted to have appropriate staffing levels. Medication errors are reviewed weekly with pharmacy, nursing administration and the Medical Director. New systems are being looked at to track as well as alert nurses to minimize medication errors by having pop up screens for when a medication is too soon to be given, etc. The RN IV or clinical manger on the unit reviews medication errors with staff assigned to their unit if an error is committed.

JOINT COMMISSION

Medication Management - Dispensing Process

Medication Management	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Controlled Substance Loss Data *Daily Pyxis-CII Safe Compare Report*	All		0%	0%	0%	0%	0%	10 discrepancies between Pyxis and CII transactions in Q4
Quarterly Results			0.3%	0%	2.5%	0.7%		
Monthly CII Safe Vendor Receipt	Rx	0	0	0	0	0	0	No discrepancies between CII Safe and vendor transactions for Q1,Q2,Q3, Q4
Quarterly Results			0	0	0	0		
Monthly Pyxis Controlled Drug discrepancies	All	11	0	0	0	0	0	Goal of "0" discrepancies involving controlled drugs dispensed from Pxyis
Quarterly Results			23	39	57	18		
Medication Management Monitoring Measures of drug reactions, adverse drug events and other management data	Rx	8/year	0	0	0	0		2 ADR's reported in Q4
Quarterly Results			1	2	4	2		
Resource Documentation Reports of Clinical Interventions	Rx	185 reports						100% of all clinical interventions documented
Quarterly Results			79	86	120	110		

JOINT COMMISSION

Medication Management	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Psychiatric Emergency Process Monthly audit of all psych emergencies measured against 9 criteria	All		N/A	N/A	100%	100%	100%	Goal of 100% compliance as measured by monthly audit tool *2/1/14 to 2/25/14,* *2/26/14 to 3/24/14, 3/24/14 to 5/19/14 and 5/20/14 to 6/30/14
Quarterly Results					77%, 97%, and 85%	94%		Decrease in % scoring resulted from 2 PE's not being communicated to Pharmacy.
Contract KPI's								
Operational Audit *Weekly audit of 3 operational indicators from CPS contract*	Rx		N/A	N/A	N/A	100%	100%	Goal of 100% compliance as measured by weekly audit tool for June 2014. *June 2, June 4, June 12 and June 20
Quarterly Results						100%		

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Department: Pharmacy Responsible Party: Garry Miller, R.Ph.

Lower Saco								
Medication Management	Unit	Baseline Oct 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Controlled Substance Loss Data Monthly CII Safe Transactions Report Generated and Reviewed	Lower Saco	100%	100%	100%	100%	100%	100%	Goal of 100% compliance in tracking CII safe transactions
Quarterly Results			100% (Oct)	100% (Nov & Dec)	100%	100%		
Monthly CII Safe Transactions Report Separately Maintained	Rx	100%	100%	100%	100%	100%	100%	Transaction Reports separately maintained for Lower Saco
Quarterly Results			100% (Oct)	100% (Nov & Dec)	100%	100%		
After-Hours Drug Access Monitoring Monitor daily after-hours drug distribution reports	Rx	100%	100%	100%	100%	100%	100%	Monitor daily after hours drug distribution reports to ensure compliance with policy
Quarterly Results			100% (Oct)	100% (Nov & Dec)	1	100%		

3/16/14: Called in my certified hospital NOD (Paul Courtemanche) at 0937 for issues on decertified unit, not directed to by AOC. Asked that Decertified unit's NOD (Mary Owen) contact me, did not attempt to do so until 1153 (2.5 hours later), rph already on site checking orders and unit dosing lactobacillus. Paul notified me that they took 2 cups of VPA from certified night closet for decertified unit via the inventory function (see Night Cabinet all station events report in pharmacy – Med removed by Patti Kantor at 0912 on 3/16/14) as the valproic acid stocked out on SLSCU, and needed lactobacillus again (client on SL).

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 client satisfaction in five areas or domains of focus. These domains include Outcomes, Dignity, Rights, Participation, and Environment.

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 clients, the process of administering the inpatient survey is difficult to administer. Whenever possible the peer support staff work to gather information from clients 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 Client Satisfaction Survey Return Rate of this report.

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

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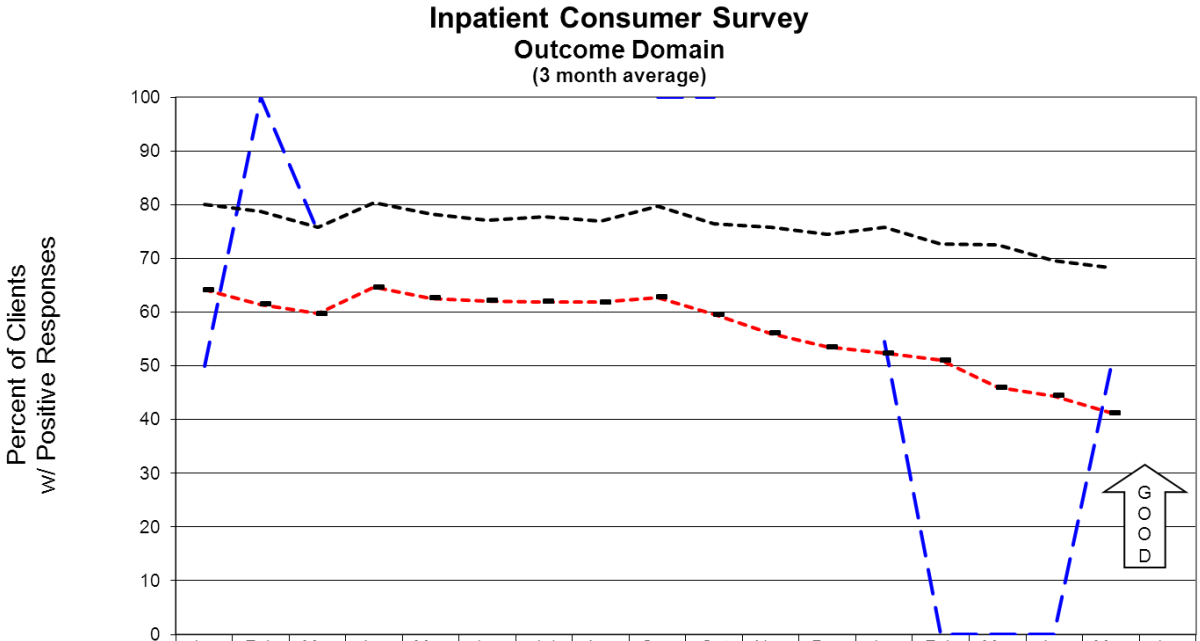
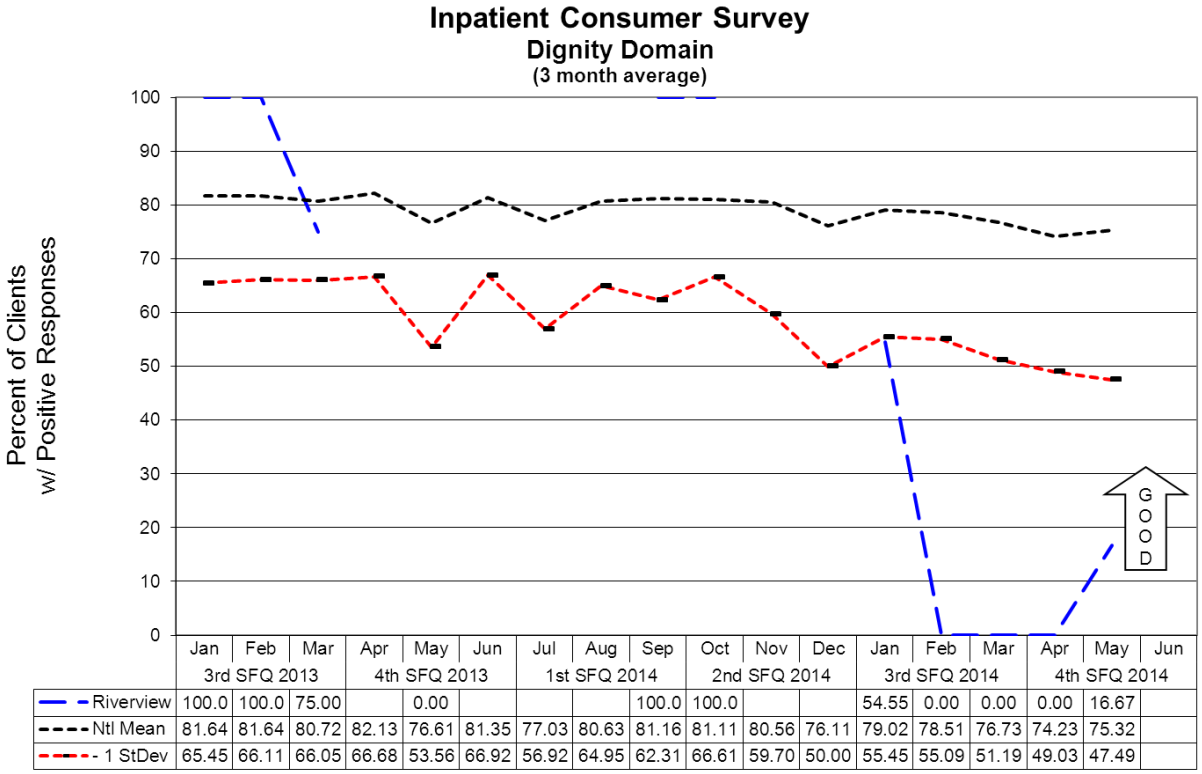


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	50.00	100.0	75.00		0.00				100.0	100.0			54.55	0.00	0.00	0.00	50.00	
Ntl Mean	80.08	78.74	75.84	80.44	78.30	77.06	77.70	77.02	79.66	76.53	75.76	74.46	75.84	72.62	72.49	69.52	68.24	
1 StDev	64.11	61.40	59.71	64.60	62.62	62.08	61.96	61.85	62.76	59.53	56.01	53.52	52.32	51.03	45.99	44.43	41.22	

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.

JOINT COMMISSION



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	100.0	100.0	75.00		0.00				100.0	100.0			54.55	0.00	0.00	0.00	16.67	
Ntl Mean	81.64	81.64	80.72	82.13	76.61	81.35	77.03	80.63	81.16	81.11	80.56	76.11	79.02	78.51	76.73	74.23	75.32	
- 1 StDev	65.45	66.11	66.05	66.68	53.56	66.92	56.92	64.95	62.31	66.61	59.70	50.00	55.45	55.09	51.19	49.03	47.49	

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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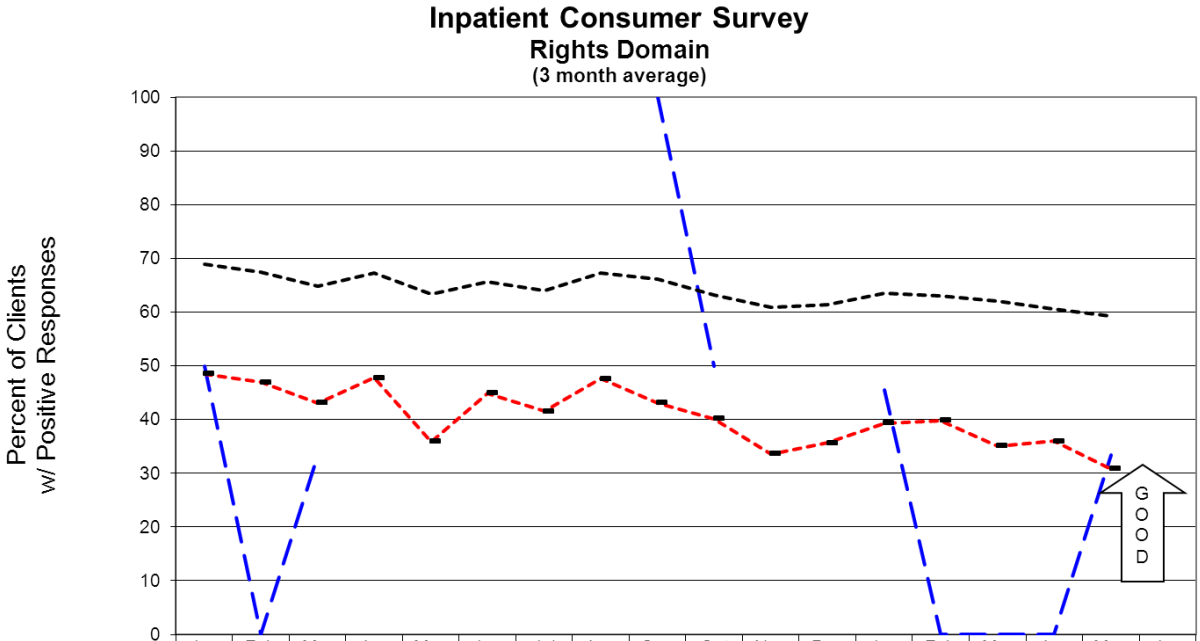

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	50.00	0.00	33.33		0.00				100.0	50.00			45.45	0.00	0.00	0.00	33.33	
Ntl Mean	68.89	67.51	64.81	67.23	63.34	65.61	63.95	67.27	66.19	63.20	60.89	61.45	63.52	63.01	62.04	60.53	59.30	
- 1 StDev	48.54	46.94	43.14	47.76	35.91	44.92	41.57	47.57	43.10	40.16	33.58	35.62	39.37	39.79	35.07	35.99	30.83	

Rights Domain Questions

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

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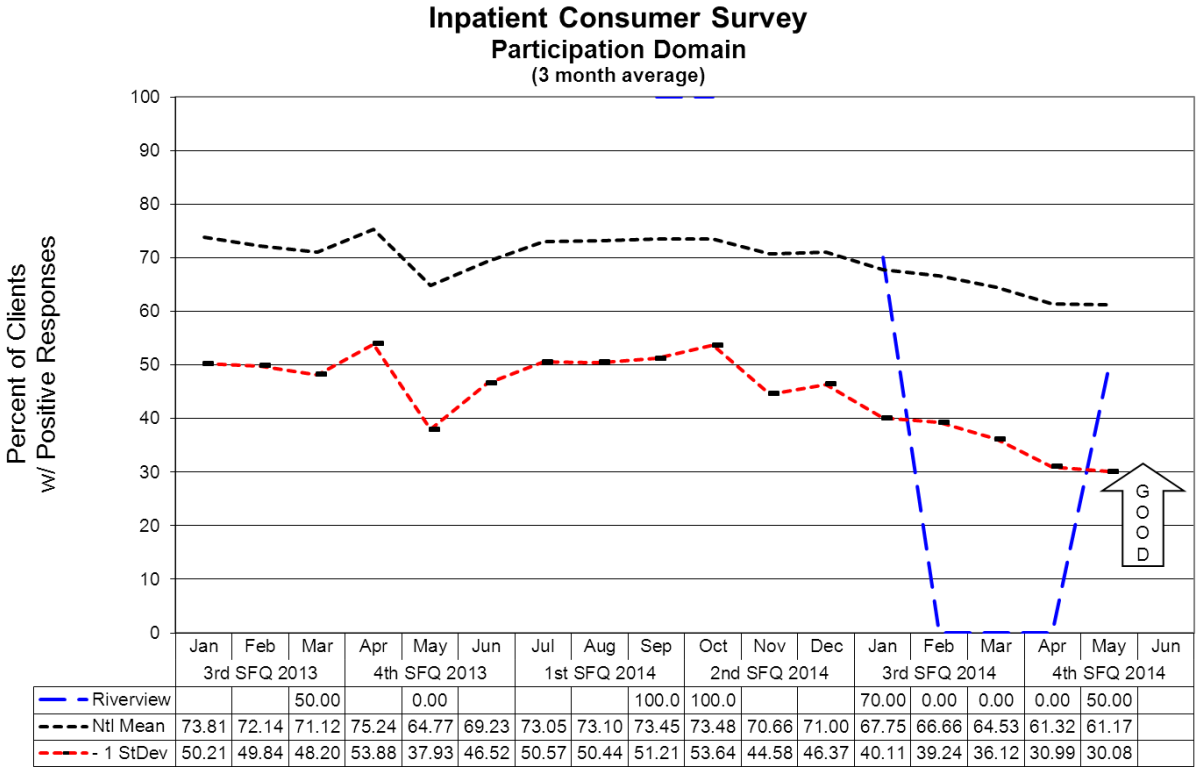
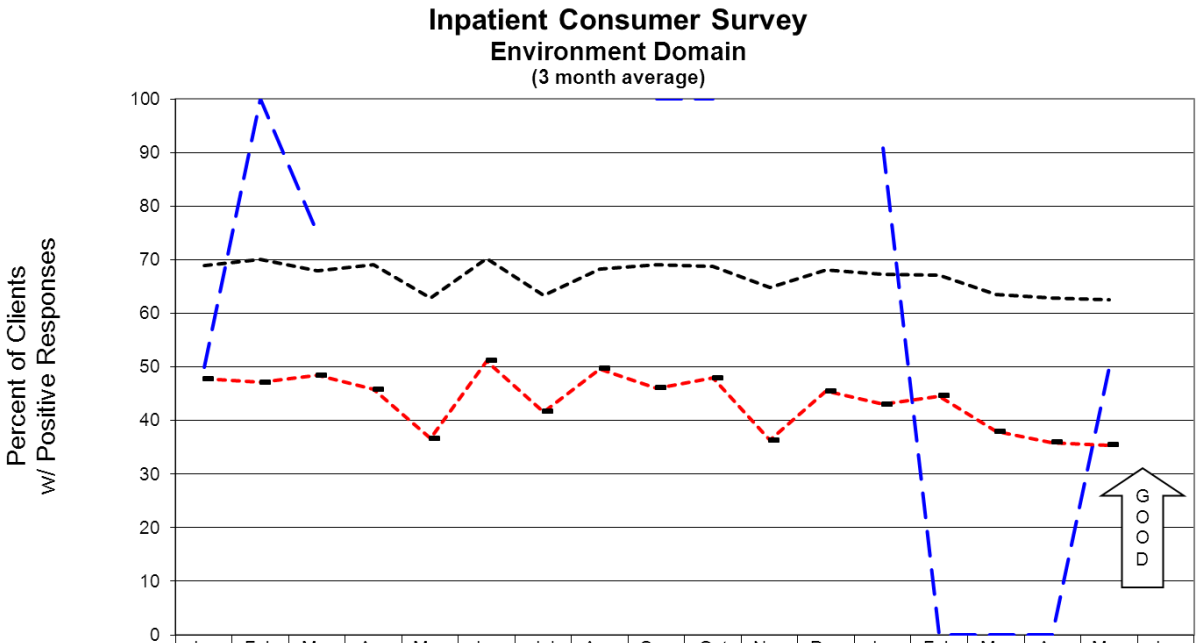


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview			50.00		0.00				100.0	100.0			70.00	0.00	0.00	0.00	50.00	
Ntl Mean	73.81	72.14	71.12	75.24	64.77	69.23	73.05	73.10	73.45	73.48	70.66	71.00	67.75	66.66	64.53	61.32	61.17	
- 1 StDev	50.21	49.84	48.20	53.88	37.93	46.52	50.57	50.44	51.21	53.64	44.58	46.37	40.11	39.24	36.12	30.99	30.08	

Participation Domain Questions

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

JOINT COMMISSION



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014		
Riverview	50.00	100.0	75.00		0.00				100.0	100.0			90.91	0.00	0.00	0.00	50.00	
Ntl Mean	68.86	70.00	67.99	69.06	62.93	70.31	63.35	68.22	69.05	68.81	64.83	68.08	67.23	67.09	63.55	62.82	62.53	
- 1 StDev	47.77	47.14	48.41	45.84	36.67	51.16	41.59	49.61	46.05	47.95	36.30	45.48	43.06	44.60	37.95	35.94	35.37	

Environment Domain

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.

JOINT COMMISSION

Pain Management

TJC **PC.01.02.07:** The hospital assesses and manages the patient's pain.

Indicator	1Q2014	2Q2014	3Q2014	4Q2014
Pre-administration	70%	74% 2774 of 3749	88% 3217 out of 3652	90% 2811 out of 3114
Post-administration	60%	63% 2362 of 3749	78% 2866 out of 3652	80% 2477 out of 3114

SUMMARY

Total number of PRN pain medications administered has decreased since last quarter (3114 compared to 3652). Both pre-assessment and post-assessment percentages have increased slightly; post-assessment being the area still needing improvement.

ACTIONS

Will meet with clinical managers to let them know that nursing needs to be more vigilant about assessing client pre and post administration of PRN pain medications. Will recommend having the oncoming shift check with the off going shift for any pain meds given that may need an assessment. Pharmacy is looking at future possibilities with Pyxis to see if a program can be installed that will alert nurses that an assessment is due/ needed.

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.

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 clients identified as having a high potential for falls.

Type of Fall by Client and Month

Fall Type	Client	APRIL	MAY	JUNE	4Q2014
Un-witnessed	MR00003191*		1	2	3
	MR00003120		2		2
	MR00000091	1			1
	MR00007509	1			1
	MR00007363*		1		1
	MR00007547		1		1
	MR00007291		1		1
	MR00007127		1		1
	MR00007502		1		1
	MR00007032			1	1
	MR00007480*			1	1
Witnessed	MR00003191*		1	3	4
	MR00007340	1			1
	MR00002313		1		1
	MR00007363*		1		1
	MR00007204		1		1
	MR00002127		1		1
	MR00007416			1	1
	MR00003374			1	1
	MR00000065			1	1
	MR00007480*			1	1

* Clients have experienced both witnessed and un-witnessed falls during the reporting quarter.

Review, Reporting and Follow-up Process

The Falls Assessment and Prevention Process Review Team (PRT) meets monthly to evaluate the causation factors related to the falls reported on the units and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices.

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

JOINT COMMISSION

Measures of Success

CTS.01.04.01
For organizations that serve adults with serious mental illness. The organization documents whether the adult has a psychiatric advance directive.

Responsible for Reporting: Director of Social Work/ACT Director

Corrective Action Taken:

WHO: The ACT Program Director is ultimately responsible for the corrective action and overall and ongoing compliance.

WHAT: Staff training was conducted in bi-weekly administrative meeting directing all case managers to use standard Disability Rights Psychiatric (Mental Health) Advanced Directive form and to date completion or declination to complete directive.

WHEN: Care, Treatment and Services issue was discussed with case managers in all-staff meeting 12-27-13, document to be used was copied and placed in admission and annual documentation folder.

HOW: The Program Director and Team Leader will perform bi-weekly reviews of charts to assess ongoing compliance, reporting findings to staff in bi-weekly administrative meetings.
Evaluation Method: Plan for assessing effectiveness of the corrective action taken:
• Sample size: Based on an ADC of 50, 30 records will be selected using random selection.
• Random sampling method used will be to identify six charts from 5 total shelves by selecting every other chart from right to left until 30 are identified.
• Frequency of the audit will be bi-weekly, reviewing six to eight charts per session, totaling up to 48 charts reviewed by the end of four months.
• Monitor for four consecutive months (expectation a minimum of 90% compliance)
• 30 = total number of charts reviewed for psychiatric advanced directives
• 28= total number of psychiatric advanced directives present in the chart or documented as having been offered but declined by client.
• The audit results will be reported by the program Director and Team Leader to the staff at each administrative meeting, the IPEC Committee, as well as to the Social Work Program Director.

RESULTS:

February	March	April	May	June
58%	82%	78%	79%	100%

JOINT COMMISSION

Measures of Success

CTS.02.02.07
The organization reassesses each individual served, as needed

Responsible for Reporting: Director of Social Work/ACT Director

Corrective Action Taken:

WHO: The ACT Program Director is ultimately responsible for the corrective action and overall ongoing compliance.

WHAT: Staff training was conducted in bi-weekly administrative meeting identifying the discovery of Annual Comprehensive Assessments being worded exactly the same as the previous year, and the necessity of writing new annual assessments for each client including any changes in progress or functioning. It was also identified that there was a missing Annual Comprehensive Assessment in one reviewed record, the standard of keeping at least the current and past year's Annual Comprehensive Evaluation was reiterated.

WHEN: This corrective action was also conducted in a bi-weekly administrative meeting on 12-27-13. No further procedures or policies were needed.

HOW: The Program Director and Team Leader will perform bi-weekly reviews of records to assess ongoing compliance, reporting findings to staff in bi-weekly administrative meetings for immediate correction, if indicated.
Evaluation Method: Plan for assessing effectiveness of the corrective action taken:
• Sample size: Based on an ADC of 50, 30 records will be selected using random selection.
• Random sampling method used will be to identify six charts from 5 total shelves by selecting every other chart from left to right until 30 are identified.
• Frequency of the audit will be bi-weekly, reviewing six to eight charts per session, totaling up to 48 charts reviewed by the end of four months.
• Monitor for four consecutive months (expectation a minimum of 90% compliance)
• 30 = total number of charts reviewed for presence and accuracy of Comprehensive Annual Assessment
• 28= minimum total number of Comprehensive Annual Assessments present in the chart and distinct from previous year.
• The audit results will be reported by the program Director and Team Leader to the staff at each administrative meeting, the IPEC Committee, as well as to the Social Work Program Director.

RESULTS:

February	March	April	May	June
83%	100%	78%	100%	90%

JOINT COMMISSION

Measures of Success

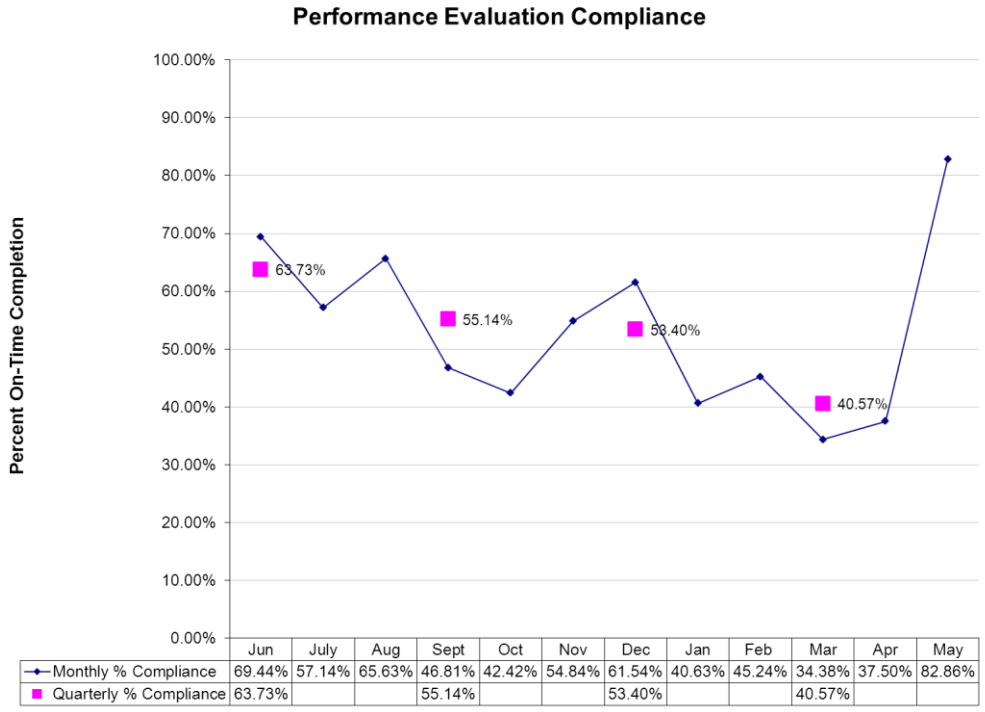
HR.01.06.01
Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation.

Responsible for Reporting: HR Director

RESULTS:

	12/2014	1/2014	2/2014	3/2014	4/2014	5/2014	**Total**
Performance evaluations completed on time (with competency assessment)	24	13	19	11	12	29	**108**
Total # of performance evaluations due (with competency assessment)	39	32	42	32	32	35	**212**
Evaluation Compliance	61.54%	41%	45.24%	34.38%	38%	82.86%	**50.94%**

*Data not yet available for June 2014



JOINT COMMISSION

Measures of Success

EC.02.01.01
The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

Responsible for Reporting: Director of Support Services

INDICATOR: Faucet Checks

FINDING: *EC.02.01.01 The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.*

OBJECTIVE: Have all bathrooms checked every 7 ½ minutes for patient safety (ligature) until faucets have been replaced with an approved anti-ligature model.

THOSE RESPONSIBLE FOR MONITORING: Clinical staff and Director of Support Services

METHODS OF MONITORING: Monitoring would be performed by:

- Direct observation for each bathroom by Clinical Staff

METHODS OF REPORTING: Reporting would occur by the following method:

- Daily activity bathroom faucet check sheets

THOSE RESPONSIBLE FOR REPORTING: Director of Support Services

UNIT: Number of actual checks / number of potential checks on all identified ligature problematic faucets on each patient unit.

Stated Goal: 90%

Bathroom Faucet Checks	Unit	February	March	April	May
The denominator is the total of potential checks for the month on all unit faucets in this patient area. The numerator is all faucets checked daily every 7 1/2 minutes. Any blanks on the faucet check sheet will count as a missed check. Monitoring of the checks will start January 2014 and continue for four months or until the faucets have been replaced.	# of actual checks / # of potential checks	100%	100%	100%	100%

JOINT COMMISSION

Measures of Success

ED.02.06.01
Interior spaces meet the need of the patient population and are safe and suitable to the care, treatment, and services provided.

Responsible for Reporting: Director of Support Services

INDICATOR: Bedroom Ligature / Oxygen Storage Assessments

FINDING: *EC.02.06.*01 *Interior spaces meet the need of the patient population and are safe and suitable to the care, treatment, and services provided.*

OBJECTIVE: (1) Have all bedrooms checked throughout the hospital for any ligature risks every month

(2) Check each unit for proper oxygen storage, ensuring that empty tanks are segregated from full tanks and labelled accordingly.

THOSE RESPONSIBLE FOR MONITORING: Director of Support Services

METHODS OF MONITORING: Monitoring would be performed by:

- Direct observation of each bedroom for any ligature risks
- Direct observation of proper storage of oxygen canisters

METHODS OF REPORTING: Reporting would occur by the following method:

- Monthly activity using the Bedroom Ligature / Oxygen Storage Assessment check sheets

Bedroom Ligature / Oxygen Storage Checks	Unit	Stated Goal	February	March	April	May
The Director of Support Services (or his designee) will perform monthly environment of care rounds (January 2014 thru April 2014) and assess ongoing compliance for both findings. The rounds consist of inspecting every patient room for oxygen tubing or other potential ligature evident in the room and ensuring the oxygen tanks are properly stored. The Director of Support Services will report findings to the monthly meeting of the Environment of Care Committee and the monthly meeting of IPEC (quality committee) under the "safety" agenda item.	Perform bedroom ligature / Oxygen Storage Assessments	100% of checks completed	100%	100%	100%	100%

JOINT COMMISSION

Measures of Success

MM.03.01.01
The hospital stores medications according to manufacturers' recommendations, or in the absence of such recommendations, according to a pharmacist's instructions.

Responsible for Reporting: Director of Nursing

The hospital stores medications according to the manufacturer's recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

Refrigerator temperatures are monitored on each unit for four consecutive months until 90% compliance is achieved.

Results:

February	March	April	May
99%	99%	100%	99%

JOINT COMMISSION

Measures of Success

PC.02.01.15
Care, treatment and services are provided to the patient in an interdisciplinary, collaborative manner.

Responsible for Reporting: Clinical Director

Results:

February	March	April	May
90%	90%	95%	90%

JOINT COMMISSION

Measures of Success

PC.02.03.03
The hospital helps the patient with his or her personal hygiene and grooming activities.

Responsible for Reporting: Director of Nursing

Hand Hygiene Measure: Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 30 days per month.

Results:

	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	Mean Rate
Lower Kennebec	68%	82%	61%	65%	96%	100%	79%
Lower Kennebec SCU	10%	18%	25%	95%	96%	94%	56%
Upper Kennebec	46%	46%	46%	100%	100%	100%	73%
Upper Saco	97%	94%	97%	100%	90%	96%	96%
Lower Saco	99%	38%	82%	97%	99%	97%	85%
Lower Saco SCU	14%	43%	1%	38%	96%	96%	48%
Mean Rate	**56%**	**54%**	**52%**	**83%**	**96%**	**97%**	**73%**

JOINT COMMISSION

Measures of Success

PC.03.03.29
Patients are debriefed after the use of restraint or seclusion for behavioral health purposes.

Responsible for Reporting: Superintendent

Results:

February	March	April	May
100%	100%	100%	100%

JOINT COMMISSION

Measures of Success

RC.01.02.01
Entries in the medical records are authenticated.

Responsible for Reporting: Clinical Director/Director of Nursing

Results:

February	March	April	May
96%	100%	100%	99%

PC.04.01.05
The hospital provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand.

Results:

February	March	April	May
96%	100%	99%	99%

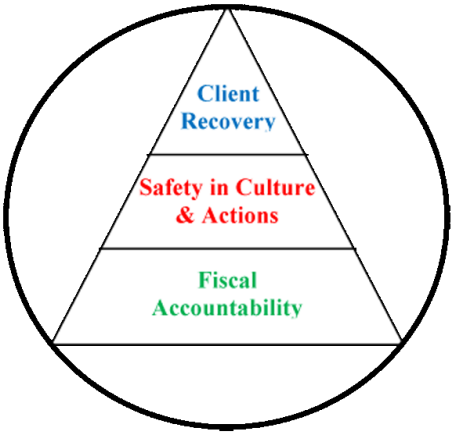
Summary: Indicators are based on 100% of progress notes created per month. Physicians' progress notes are audited to ensure authentication is occurring within 7 days of availability in the EMR per RPC's Medical Record Completion Policy (MS.3.20).

The indicators for the Discharge Instructions (consolidated aftercare form) are based on 100% of discharges occurring each month over 4 consecutive months.

STRATEGIC PERFORMANCE EXCELLENCE

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 client recovery by ensuring fiscal accountability and a culture of organizational safety through the promotion of…

- The conviction that staffs are concerned with doing the right thing in support of client 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 staffs and clients 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 clients before, during, and after care;
- A just culture that supports the emotional and physical needs of staffs, clients, and family members that are impacted by serious, acute, and cumulative events.

STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

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

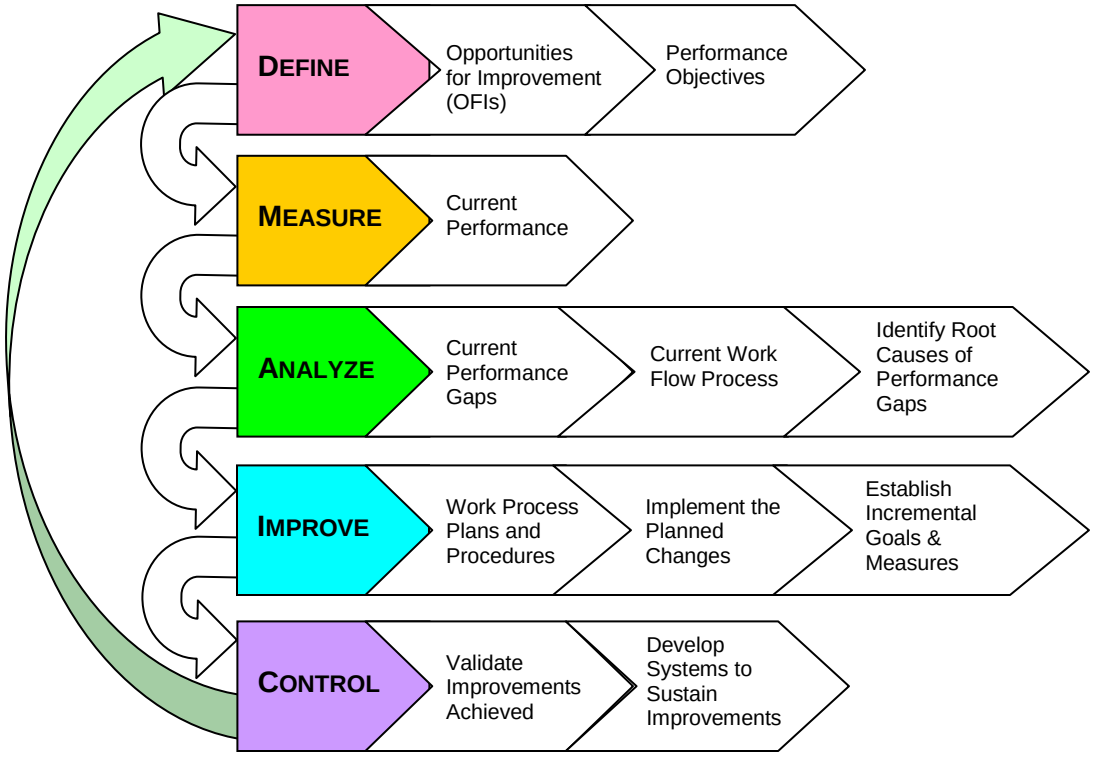
Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

Ensure and Promote Fiscal Accountability by…
Identifying and employing efficiency in operations and clinical practice
Promoting vigilance and accountability in fiscal decision-making.

Promote a Safety Culture by…
Improving Communication
Improving Staffing Capacity and Capability
Evaluating and Mitigating Errors and Risk Factors
Promoting Critical Thinking
Supporting the Engagement and Empowerment of Staffs

Enhance Client Recovery by…
Develop Active Treatment Programs and Options for Clients
Supporting clients in their discovery of personal coping and improvement activities.

Each Department Determines Unique Opportunities and Methods
to Address the Hospital Goals
The Quarterly Report Consists of the Following

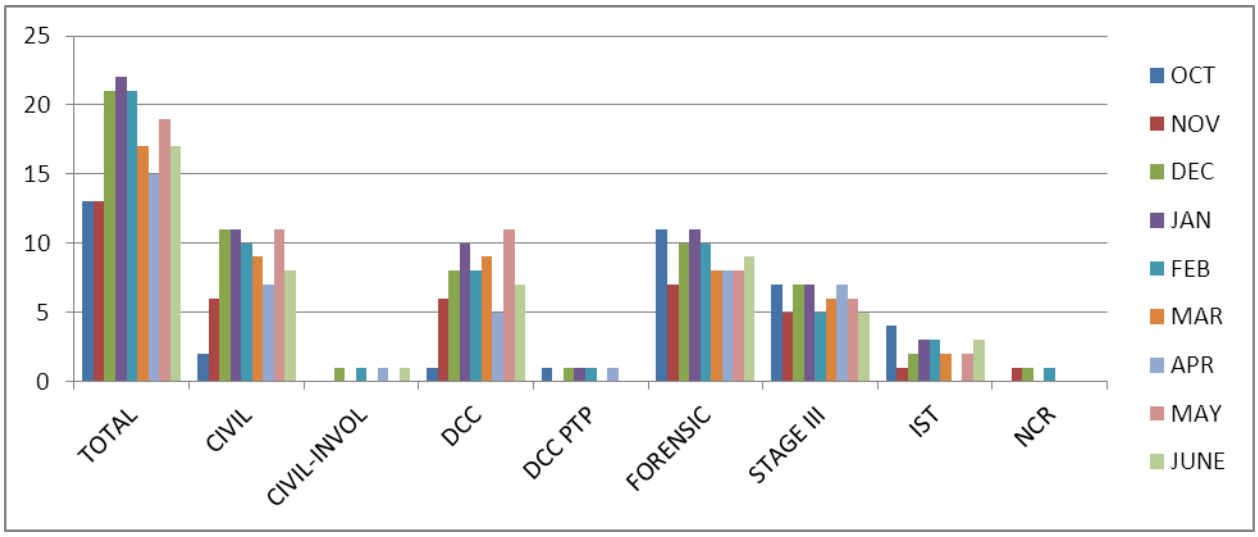


STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office Quarterly Report
4Q2014

Here is the Admissions data from the month of October 2013 through the month of June 2014. This data includes statistics on admissions, discharges, length of stay, and wait time. The data is broken down into different categories related to forensic, civil, district court commitment, in patient evaluations, incompetent to stand trial, not criminal responsible, involuntary civil and progressive treatment plan commitment. The Admissions Office continues to work with the IMHU program at the prison and has successfully referred and admitted 3 patients to this unit. The Admission Office is also working on a project related to the Convalescent Status of the NCR population.

Admission Data Graph



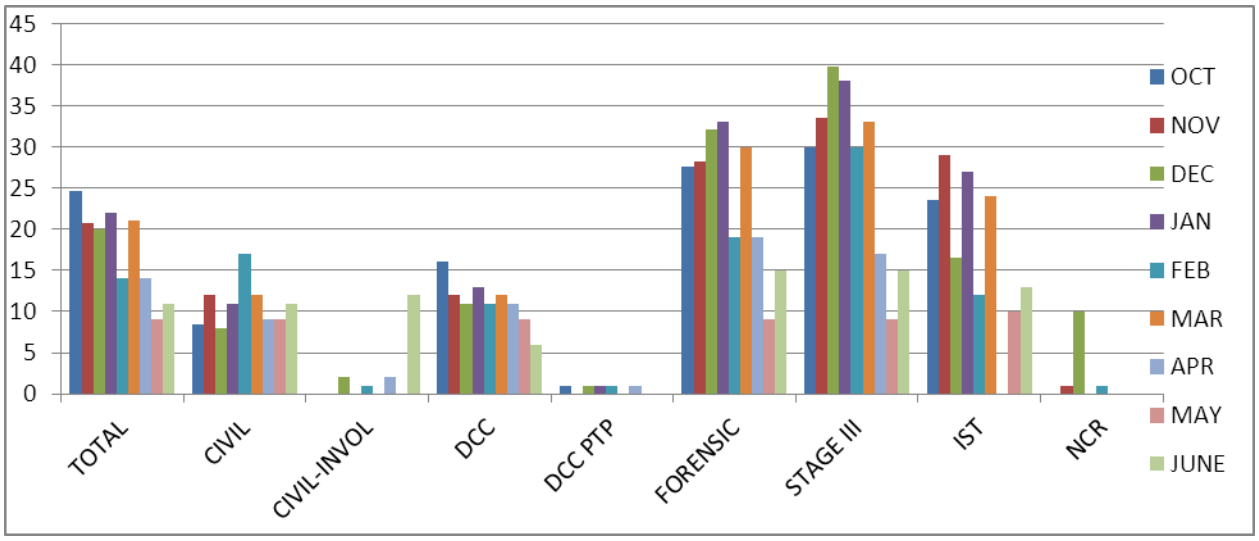
Admission Data

ADMISSIONS	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
TOTAL	13	13	21	22	21	17	15	19	17
CIVIL	2	6	11	11	10	9	7	11	8
CIVIL-INVOL	0	0	1	0	1	0	1	0	1
DCC	1	6	8	10	8	9	5	11	7
DCC PTP	1	0	1	1	1	0	1	0	0
FORENSIC	11	7	10	11	10	8	8	8	9
STAGE III	7	5	7	7	5	6	7	6	5
IST	4	1	2	3	3	2	0	2	3
NCR	0	1	1	0	1	0	0	0	0

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office Quarterly Report, continued.

Wait List Graph



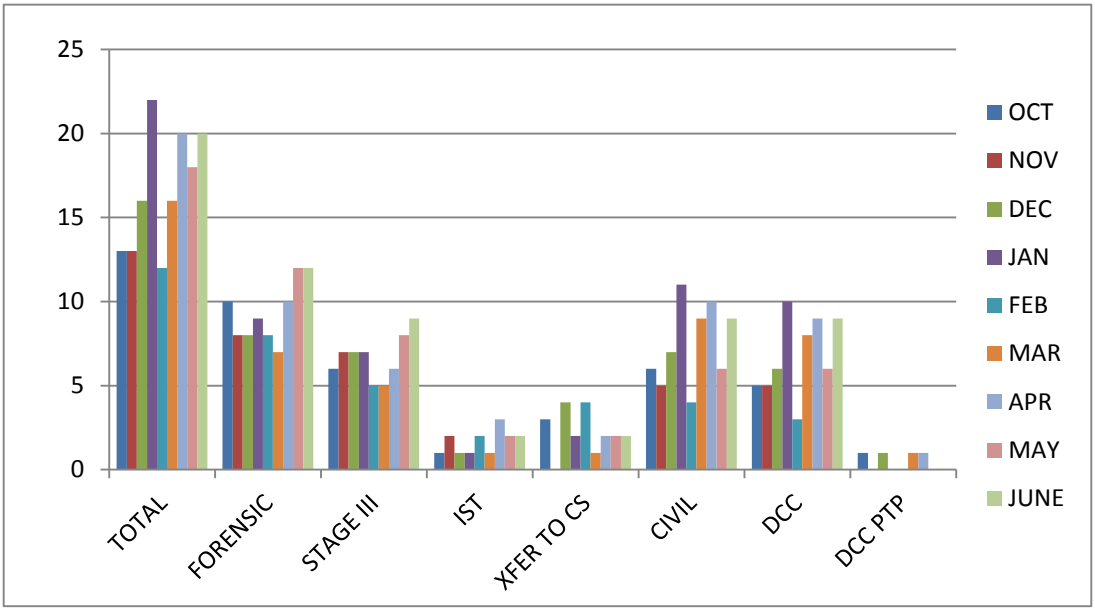
Wait List Data

WAIT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
TOTAL	25	21	20	22	14	21	14	9	11
CIVIL	9	12	8	11	17	12	9	9	11
CIVIL-INVOL	0	0	2	0	1	0	2	0	12
DCC	16	12	11	13	11	12	11	9	6
DCC PTP	1	0	1	1	1	0	1	0	0
FORENSIC	28	28	32	33	19	30	19	9	15
STAGE III	30	34	40	38	30	33	17	9	15
IST	24	29	17	27	12	24	0	10	13
NCR	0	1	10	0	1	0	0	0	0

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office Quarterly Report, continued.

Discharge Graph



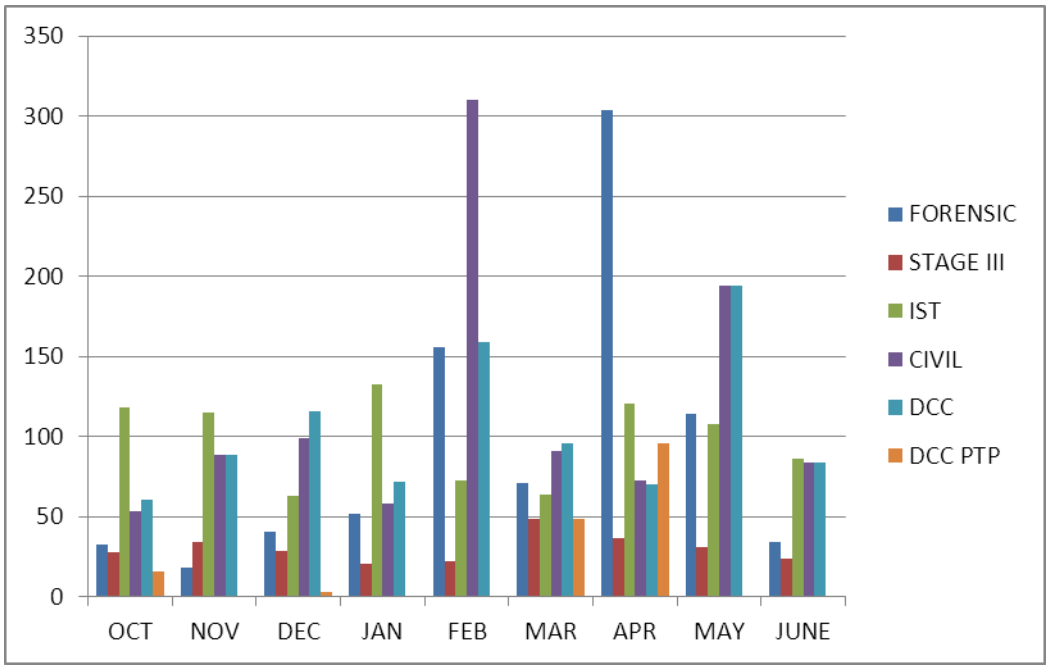
Discharge Data

DISCHARGES	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
TOTAL	13	13	16	22	12	16	20	18	20
FORENSIC	10	8	8	9	8	7	10	12	12
STAGE III	6	7	7	7	5	5	6	8	9
IST	1	2	1	1	2	1	3	2	2
XFER TO CS	3	0	4	2	4	1	2	2	2
CIVIL	6	5	7	11	4	9	10	6	9
DCC	5	5	6	10	3	8	9	6	9
DCC PTP	1	0	1	0	0	1	1	0	0

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office Quarterly Report, continued.

Length of Stay Graph



Length of Stay Data

LOS	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
FORENSIC	33	18	41	52	156	71	304	114	34
STAGE III	28	34	29	21	22	49	37	31	24
IST	118	115	63	133	73	64	121	108	86
CIVIL	53	89	99	58	310	91	73	194	84
DCC	61	89	116	72	159	96	70	194	84
DCC PTP	16	0	3	0	0	49	96	0	0

STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic

2014/2015 Plan

I. Performance Indicators:

- Patient Satisfaction Survey
  - Ask pt. to fill out after each appointment to evaluate procedure and dental staff
- Staff / Case Manager Survey
  - Ask to fill out yearly per patient to evaluate the dental clinic as a whole
- Plaque Score evaluate patients oral hygiene at each appointment
  - Aid with oral hygiene education
  - Aid to discuss with staff and caretakers
  - Monitor at home hygiene
- Periodontal charting
  - Complete periodontal charting yearly to evaluate periodontal status

II. Quality Assurance Measures:

- Formulate a yearly treatment
  - Cross out/date treatment as completed
  - Write NV at the end of each progress note
- Take blood pressure and pulse at the start of each dental appointment
- Signed consent for all RCTs and EXTs
  - Completed by patient, dentist and assistant
- Time out taken prior to ALL extractions
  - Dentist initials time out and writes the initials of the assistant
- Patient re-identified by date of birth at the start of each appointment
- Goal of eliminating wait list for patients in pain
  - Blocking out daily slots for emergency appointment
  - Goal of 30 appointments per month (if not needed fill with routine care)

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions

Hand Hygiene Compliance: In an effort to monitor, sustain and improve hand hygiene compliance, the Dietary department measures its results through observations of Dietary staff when returning from a scheduled break.

	1st Quarter 2014			2nd Quarter 2014			3rd Quarter 2014			4th Quarter 2014			
Baseline	Target – Baseline	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 12%	Findings	Compliance	Target – Q3 + 12%	Findings	Compliance	Goal
85%	85%	16/30	53%	65%	33/57	58%	70%	55/66	83%	82%	99/ 187	53%	80-90%

Data:
99 compliant observations /187 hand hygiene observations =53% hand hygiene compliance rate

Summary:

- Hand hygiene compliance has decreased by 30%.
- Hand hygiene observations have increased; 66 observations last quarter to 187 observations this first quarter.
- Assigned additional staff to observe Hand Hygiene practices which increased the total number of observations thus increased validity of the compliance rate.
- Updated hand hygiene signage and placed them in different locations.

Action Plan:

- Continue use of the current Hand Hygiene Tool.
- Encourage employees to adhere to hand hygiene via verbal interaction/reminders.
- The Food Service Manager will present this quarterly report at the departmental staff meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions							
Nutrition Screen Completion: In an effort to monitor, improve and sustain timely completion of the nutrition screen for all admissions to RPC; decertified unit. The Registered Dietitian will review each Nutrition Screen within the Initial Nursing Admission Data. This screen will be completed by Nursing within 24 hours of admission.							
2nd Quarter 2014	**3rd Quarter 2014**			**4th Quarter 2014**			
Established Baseline	**Jan-March 2014 Target – Q2 + 1%**	**Findings**	**Compliance**	**April-June 2014 Target – Q3 + 0%**	**Findings**	**Compliance**	**Goal**
100% 26/26		60/63	95%	95%	57/59	96.6%	95-100%

Data:
57 Nutrition screens completed w/in 24 hours of admission
59 Total Admissions = 96.6% of nutrition screens completed within 24 hours of admission

Summary:

- The Registered Dietitian reviewed the nutrition screens of the 63 client admissions for this quarter.
- Upon review, the RD discovered 2 nutrition screens incomplete.
- One incomplete nutrition screens was documented on the Lower Kennebec unit; one was documented on the Lower Saco unit.
- RD spoke with a nurse on each unit prior to the 24 hour deadline to facilitate possible completion of the screen.

Action Plan:

- RD will continue correspondence with nursing staff regarding the discovery of incomplete nutrition screens and request completion, as appropriate.
- Present quarterly report at departmental staff meeting and IPEC meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

INDICATOR

GROUNDS SAFETY/SECURITY INCIDENTS

DEFINITION

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

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

THOSE RESPONSIBLE FOR MONITORING: Monitoring would be performed by Safety Officer, Security Site-Manager, Security Officers, Operations Supervisor, Operations staff, Director of Support Services, Director of Environmental Services, Environmental Services staff, Supervisors, and frontline staff.

METHODS OF MONITORING: Monitoring would be performed by;

- Direct observation
- Cameras
- Patrol media such as "Vision System"
- Assigned foot patrol

METHODS OF REPORTING: Reporting would occur by one or all of the following methods;

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

UNIT: Hospital grounds as defined above

BASELINE: 5% each Q

2014 Q1-Q4 TARGETS: Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

Department: Safety & Security Responsible Party: Bob Patnaude Safety Officer

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q4/14 Target Actual	Q1/15 Target Actual	Q2/15 Target Actual	Q3/15 Target Actual	Q4/15 Target Actual	Goal
Grounds Safety & Security Incidents Safety/Security incidents occurring on the grounds at Riverview, which include "*Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches*	# of Incidents	* Baseline of 10	(10) -5% (6)	(6) -5%	Q1 Actual -5%	Q2 Actual -5%	Q3 Actual -5%	Baseline -5%

SUMMARY OF EVENTS

The Q4 Target was (10). Our actual number was (6); although we were just shy of the goal, it was a decrease this quarter. Overall, for the entire year, our actual number of events was 20% less than the hoped for Target amount. 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 Organization. We feel that 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 Security continues to prove its' worth with regard to Security's presence and patrol techniques. The stability and longevity of our Security staff along with its' cohesiveness with the Clinical component of the hospital has proven to be most effective in our management of practices.

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
1. Safety Concern (State vehicle unlocked)	04/18/14	0156hrs.	State vehicle parking lot	Vehicle secured	1. Security discovered during outside patrol. 2. Lock mechanism malfunctioned. 3. Safety and NOD notified. 4. SEC IR # 647 completed
2. Security Concern (Exterior door ajar)	05/09/14	1825hrs.	Exterior Door	Door secured by Security	1. Security discovered during security tour. 2. Security checked entire area. 3. Safety and NOD notified. 4. SEC IR # 650 completed.

STRATEGIC PERFORMANCE EXCELLENCE

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
3. Safety Concern (Building material on ground)	06/14/14	2000hrs.	Saco Yard	Material to Operations to alert Maintenance	1. MHW alerted Security. 2. Security secured material and took to Ops. 3. Safety, Maintenance, and NOD notified. 4. SEC IR # 657 completed.
4. Safety Concern (Vehicle key in staff lot)	06/19/14	1050hrs.	Staff Parking Lot	1. Turned in to Operations. 2. Email sent	1. Employee discovered and turned into Security. 2. Safety, Operations, notified 3. Email sent to staff to claim. 4. SEC IR # 661 completed.
5. Security Concern (Suspicious individual presented in Main Lobby)	06/20/14	1500hrs.	Main Lobby	Capitol Police called to respond and investigate	1. Suspicious person came to lobby. When approached, became upset and fled. 2. Operations notified Capitol Police. Individual gone on arrival. 3. Safety and NOD notified. 4. SEC IR # 633 completed.
6. Safety Concern (Metal can discovered in State Vehicle)	06/27/14	1753hrs.	State Vehicle	1. Security investigated 2. Removed item. 3. Last known operator's supervisor notified by Safety.	1. Security discovered during vehicle checks. 2. Removed items. 3. Safety and NOD notified. 4. Safety sent email to last known operator's supervisor for follow-up. 3. SEC IR # 669 completed.

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Objectives	1Q2014	2Q2014	3Q2014	4Q2014
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	71% 30/41	69% 29/42	79% 33/42	71% 30/42
2. SBAR information completed from the units to the Harbor Mall.	86% 36/42	88% 37/42	81% 34/42	79% 33/42

Unit: All three units January, February, and March 2014
Accountability Area: Harbor Mall
Aspect: Harbor Mall Hand-off Communication
Overall Compliance: 80%

DEFINE

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

MEASURE

Indicator number one has decreased from 79% last quarter to 71% for this quarter. Indicator number two has decreased from 81% last quarter to 79% this quarter.

ANALYZE

Overall compliance has maintained at 79% for last quarter and this quarter. For indicator number one the designated time for the sheets to be received is not in compliance. The amount of time the sheets are late has decreased. Continue to concentrate on both indicators to improve current performance gaps.

IMPROVE

I met with the Nurse IV on US to review November's data since they had the most HOC sheets that were not received on time or not received at all.

CONTROL

The plan is to continue to monitor the data and follow up with any unit(s) who may be having difficulties in developing a consistent system that works for them to meet the objectives. I will review the results of this quarterly report at Nursing Leadership.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Documentation and Timeliness

Upper Saco, Lower Kennebec, Upper Kennebec

Indicators	4Q14 Findings	4Q14 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 35 discharges in quarter 4 2014. Of those, 35 were completed by 30 days.	100%	80%
Discharge summaries will be completed within 15 days of discharge.	35 out of 35 discharge summaries were completed within 15 days of discharge during quarter 4 2014.	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	6 forms were approved/ revised in quarter 4 2014 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 809 dictated reports, 809 were completed within 24 hours.	100%	90%

Summary: The indicators are based on the review of all discharged records. There was 100% compliance with 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

Health Information Technology (Medical Records)

Documentation and Timeliness

Lower Saco

Indicators	4Q14 Findings	4Q14 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 32 discharges in quarter 4 2014. Of those, 32 were completed by 30 days.	100%	80%
Discharge summaries will be completed within 15 days of discharge.	32 out of 32 discharge summaries were completed within 15 days of discharge during quarter 4 2014.	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	6 forms were approved/ revised in quarter 4 2014 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 809 dictated reports, 809 were completed within 24 hours.	100%	90%

Summary: The indicators are based on the review of all discharged records. There was 100% compliance with 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

Health Information Technology (Medical Records)

Confidentiality

Indicators	4Q14 Findings	4Q14 Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	4674 requests for information (108 requests for client information and 4494 police checks) were released for quarter 4 2014.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	New employees/contract staff in quarter 4 2014.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident report during quarter 4 2014.	100%	100%

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 quarter 4 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

Health Information Technology (Medical Records)

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. Clients 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 4th quarter 2014 showed that we received 2325 applications. This is a decrease from last quarter (3rd quarter 2014) when we received 5168 applications.

Improve

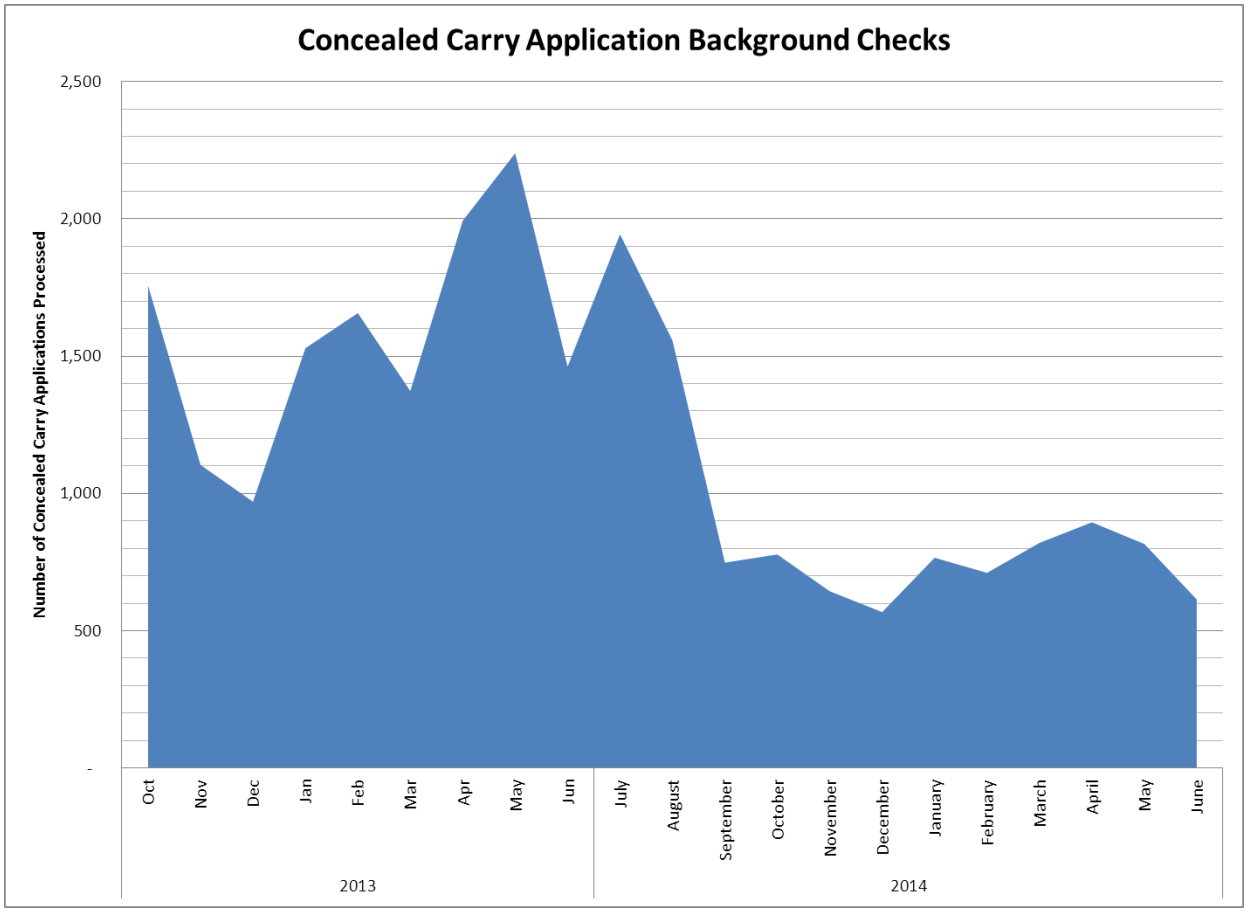
The process has been streamlined as we have been working with the state police by eliminating the mailing of the applications from them to RPC and DDPC. RPC has reactivated the medical records email to receive lists of the applicants from the state police that include the DOB and any alias they may have had. This has cut down on paper as well as time taken sorting all the applications. Due to the change in how we process the applications, we no longer have data on the Max and Avg Receipt Delay and Processing Time.

NOTE: At the end of the reporting period, there were 0 police checks outstanding for Riverview Psychiatric Center. We are now processing requests for concealed weapons checks via an emailed listing from the State Police.

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.

FY 2014	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
# Applications Received	1944	1557	748	778	644	568	766	711	820	895	816	614

STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Define

Completion of performance evaluations according to scheduled due dates continues to be problematic.

Measure

Current results are consistently below the 85% average quarterly performance goal.

Analyze

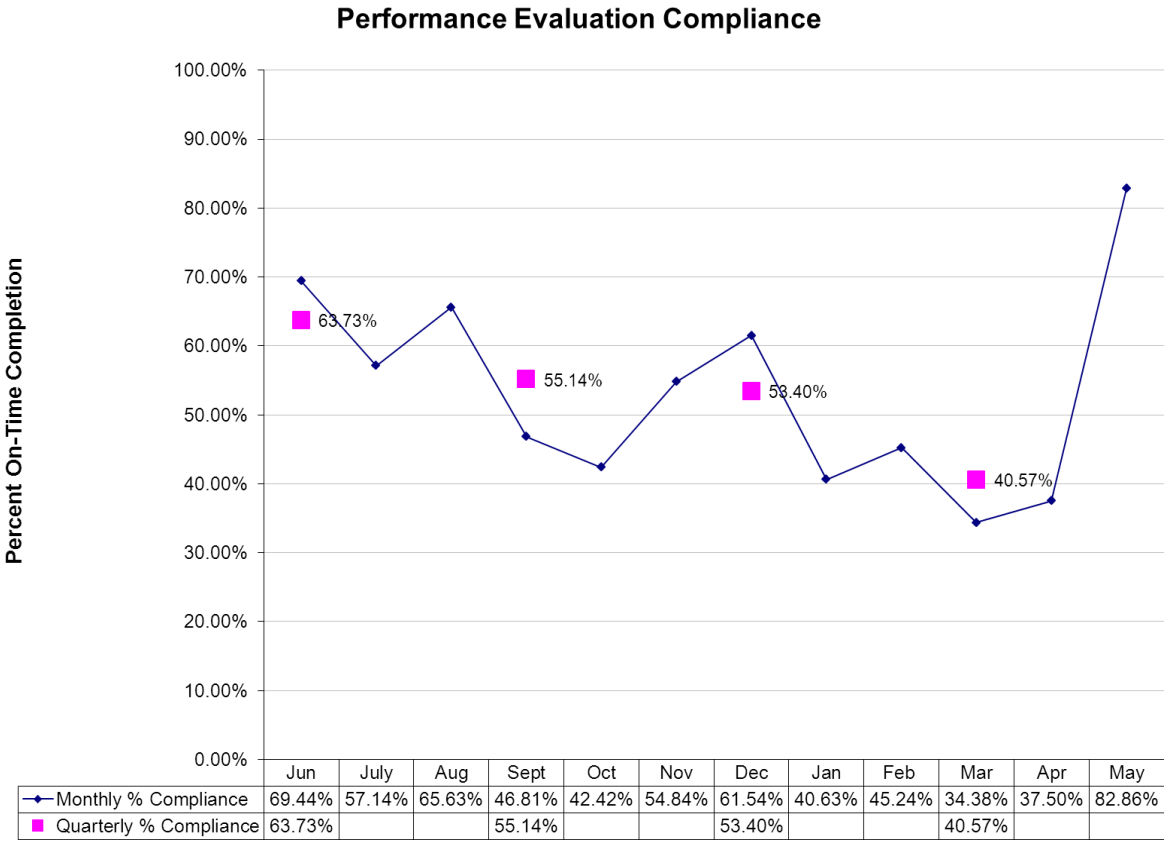
A thorough analysis of the root causes for lack of compliance with this performance standard is indicated.

Improve

In the interim, the Personnel Director has begun the process of reporting to hospital leadership the status of performance evaluation completion at least monthly so follow-up with responsible parties can be accomplished.

Control

Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.

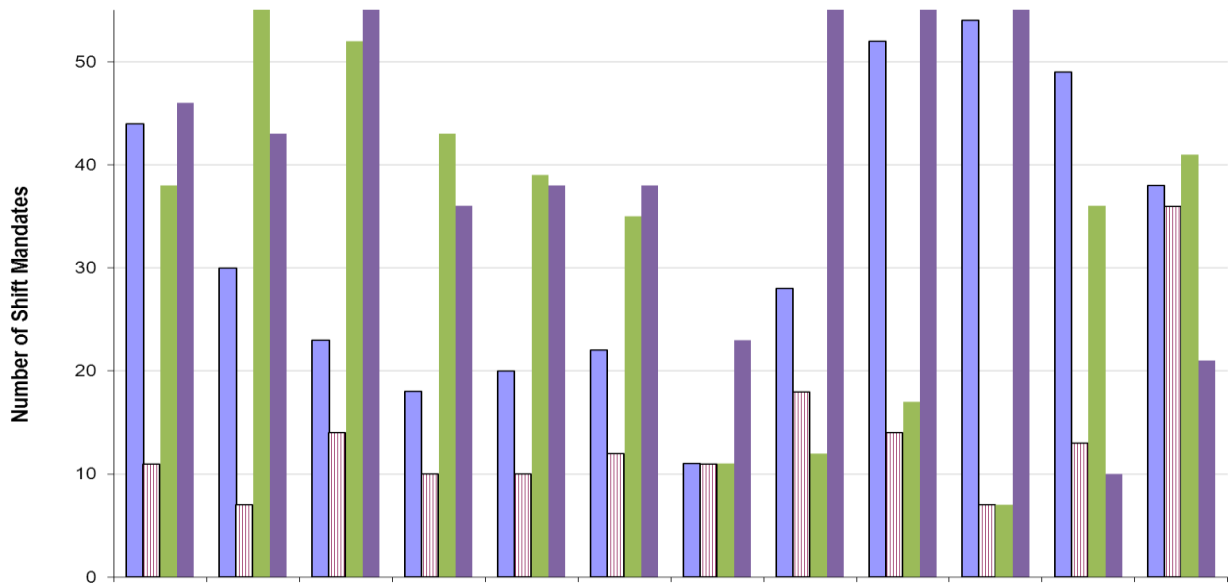


	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Monthly % Compliance	69.44%	57.14%	65.63%	46.81%	42.42%	54.84%	61.54%	40.63%	45.24%	34.38%	37.50%	82.86%
Quarterly % Compliance	63.73%			55.14%			53.40%			40.57%		

*Data not yet available for June 2014

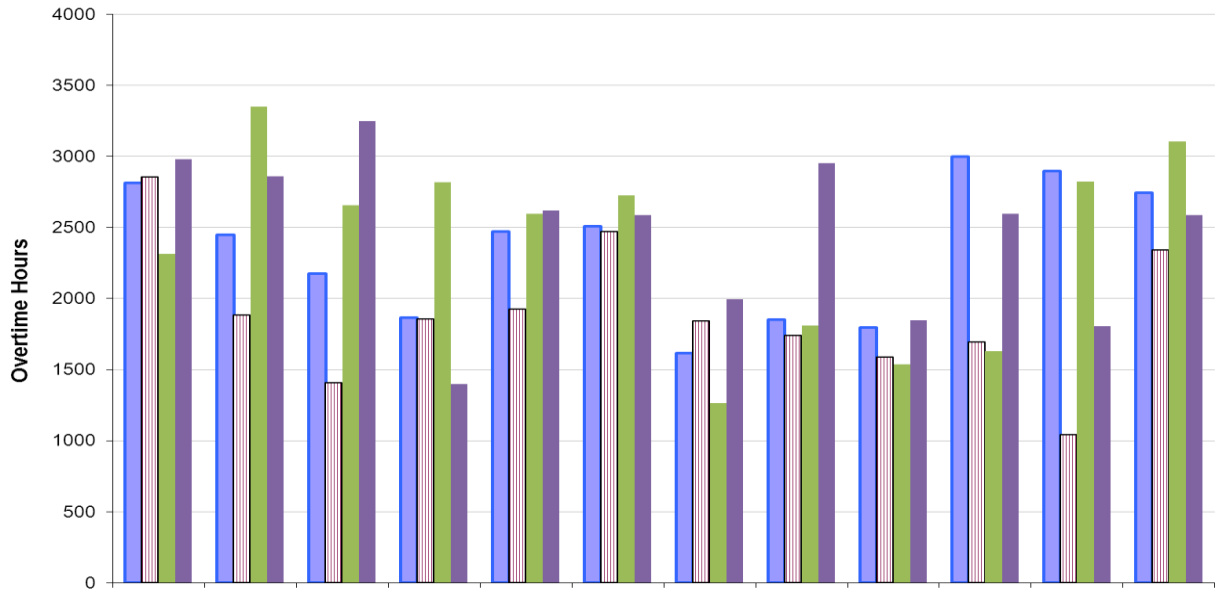
STRATEGIC PERFORMANCE EXCELLENCE

Monthly Mandated Shifts



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY 2011	11	7	14	10	10	12	11	18	14	7	13	36
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

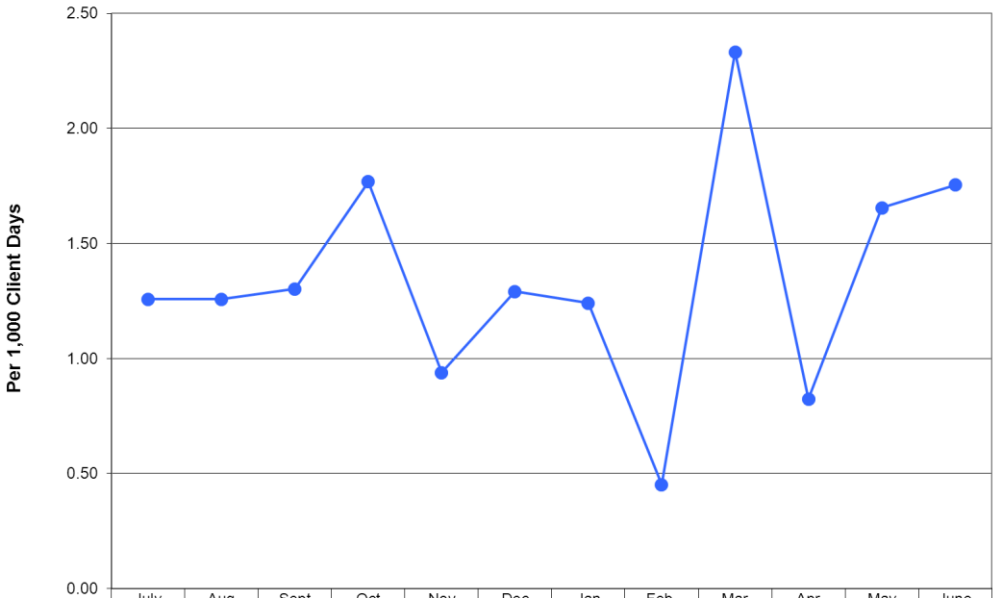
Monthly Overtime



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	2812	2451	2178	1868	2473	2507	1618	1853	1798	2999	2896	2743
FY 2011	2859	1885	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2013	2316	3350	2657	2817	2599	2726	1266	1812	1539	1629	2822	3106
FY 2014	2983	2861	3251	1400.25	2620.25	2586	1994	2953.5	1847.5	2598.75	1805.5	2586

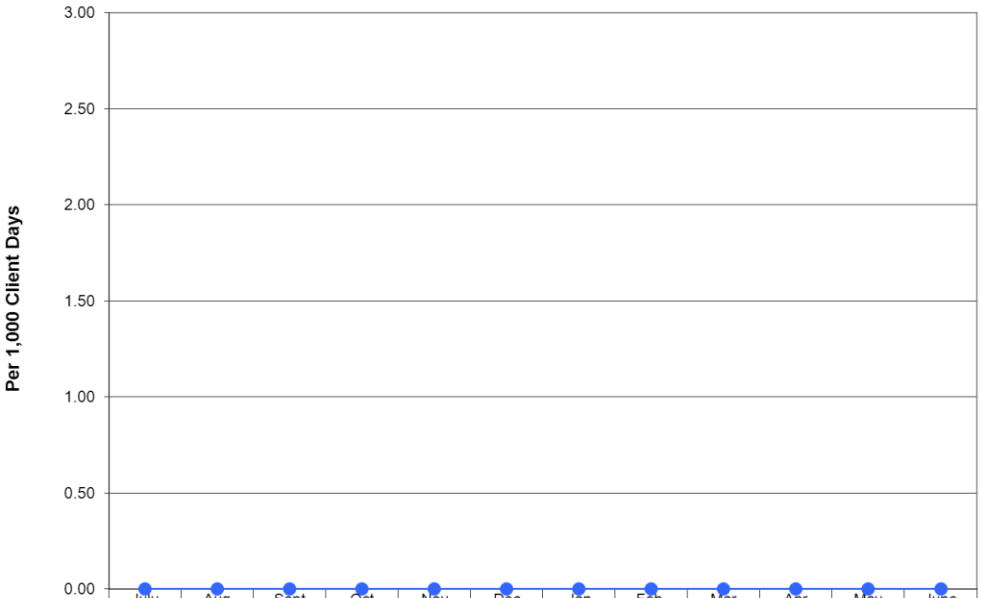
STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Lost Time Ratio	1.26	1.26	1.30	1.77	0.94	1.29	1.24	0.45	2.33	0.82	1.65	1.75

Reportable (Lost Time & Medical) Non-Direct Care Staff Injuries



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Series1	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Poly Antipsychotic Medication Monitoring

	April	May	June
Census	100	97	94
Antipsychotic Orders for Clients			
No Antipsychotics	23	18 (19%)	14 (15%)
Mono-antipsychotic therapy	55	56 (58%)	57 (61%)
Two Antipsychotics	18	20 (21%)	18 (19%)
Three Antipsychotics	3	0	3 (3%)
Four Antipsychotics	1	3 (3%)	2 (2%)
At least 1 antipsychotic	77	79 (81%)	80 (85%)
Total on Poly-antipsychotic therapy	22	23 (24%)	23 (24%)
Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics	29% (22/77)	29% (23/79)	29% (23/80)
More than 2 antipsychotics	4	3 (3%)	5 (5%)
Poly-Antipsychotic therapy breakdown			
SGA + FGA	8 (36%)	15 (65%)	11 (48%)
2 SGAs ("Pine" + "Done")	6 (27%)	3 (13%)	4 (17%)
Other (2 antipsychotic regimens)	4 (18%)	2 (9%)	3 (13%)
Other 2 Antipsychotic Regimen Details	1) Aripiprazole + ziprasidone 2) Olanzapine + quetiapine 3) Loxapine + chlorpromazine 4) Clozapine + olanzapine	1) Lurasidone + aripiprazole 2) Paliperidone + ziprasidone	1) Olanzapine + quetiapine 2) Loxapine + haloperidol 3) Paliperidone + ziprasidone
3+ Antipsychotic Regimens	1) Fluphenazine + loxapine + quetiapine 2) Haloperidol + paliperidone + risperidone 3) Asenapine + chlorpromazine + ziprasidone 4) Haloperidol + risperidone + olanzapine + quetiapine	1) Clozapine + haloperidol + paliperidone + risperidone 2) Quetiapine + haloperidol + paliperidone + risperidone 3) Haloperidol + risperidone + olanzapine + quetiapine	1)Olanzapine + perphenazine + chlorpomazine 2)Paliperidone + haloperidol + olanzapine (x2) 3)Quetiapine + haloperidol + paliperidone + risperidone 4)Haloperidol + risperidone + olanzapine + quetiapine

***Justifiable Poly-Antipsychotic Therapy**	82%	87%	87%
Decreases in number of concurrent antipsychotic orders	2AP → 1AP: 5 3AP → 2AP: 1 3AP → 1AP: 1	2AP → 1AP: 6 4AP → 1AP: 1	4AP→ 3AP: 2 3A → 2AP: 1

SGA = Second Generation Antipsychotic; FGA = First Generation Antipsychotic; "Pines" = clozapine, olanzapine, quetiapine, asenapine; "Dones" = risperidone, paliperidone, ziprasidone, lurasidone, iloperidone; prn = as needed; AP = Antipsychotic

Data Collection

All medication profiles in the hospital were reviewed for the months of April, May and June. We were particularly interested in the proportion of patients who were receiving more than one antipsychotic medication, since practice guidelines by the American Psychiatric Association clearly discourage this practice. When a case of polypharmacy was encountered we further required the prescriber to justify the practice based on pre-agreed upon clinical elements required to make the justification.

Findings

Over the quarter we found that about 79% of patients were receiving at least one antipsychotic medication. Of these patients, about 29%, a two percent decrease from last quarter (31%), were receiving more than one such agent, and by definition was a case of polypharmacy. Within this overall percentage we noted that the individual percentages for all months were 29. We did see an increase in the number of patients on 3 and 4 antipsychotics. However, this quarter also evaluated the number of patients that had a decrease in the number of concurrent antipsychotic orders. In April, 7 patients had a decrease in the number of antipsychotics concurrently ordered, May also had 7 patients and June had 3, for a total of 17 patients.

Analysis

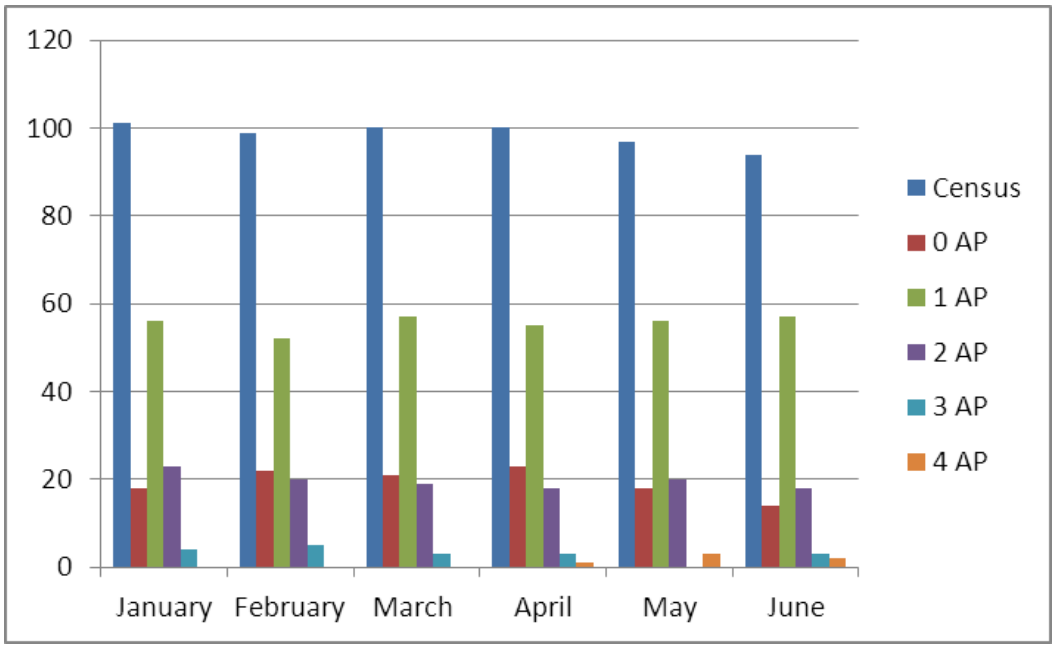
We are just below our target of 90% justified for the quarter at 85%. This is a decrease from last quarter but is likely due to changes in collecting the data prospectively. We have also implemented an electronic justification form that is emailed to prescribers who have a new admission on more than one antipsychotic or write a new order resulting in poly-antipsychotic therapy for a patient. The patients with active orders for 4 antipsychotics have all had at least one antipsychotic discontinued. At the time of this report, there are no patients on 4 antipsychotics.

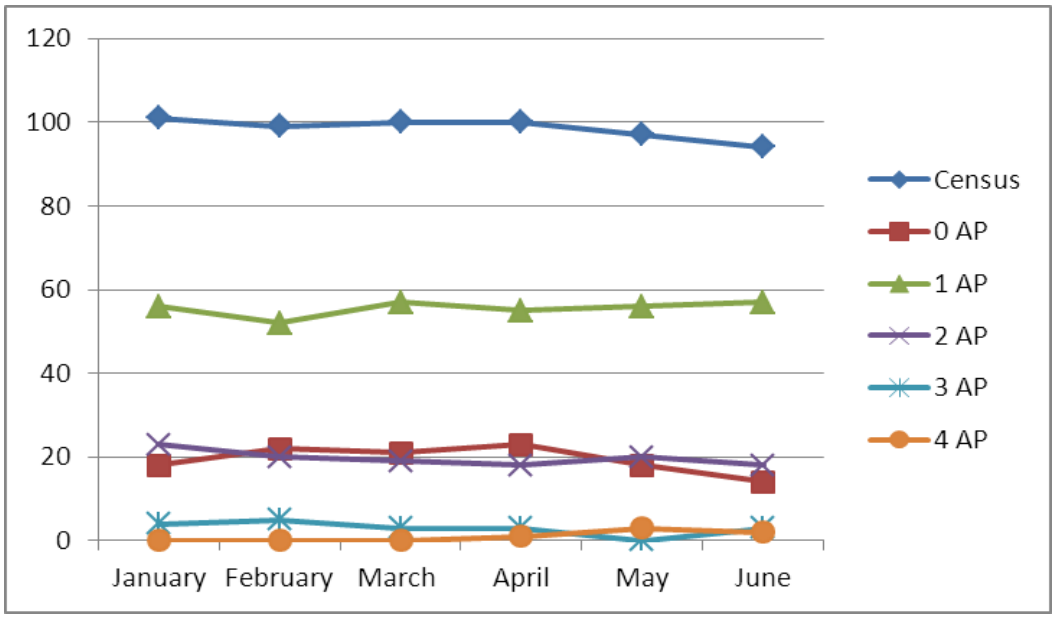
Plan

We will continue this monitor for another quarter since appropriate antipsychotic prescribing is both a common task in the hospital as well as one fraught with many potential negative sequellae. We will continue to prospectively gather data on polyantipsychotic therapy and follow-up with prescribers regarding the documented plan of action. We will continue to give feedback to medical staff and to look closely at all cases where it has been difficult to wean the client off high doses of multiple drugs.

STRATEGIC PERFORMANCE EXCELLENCE

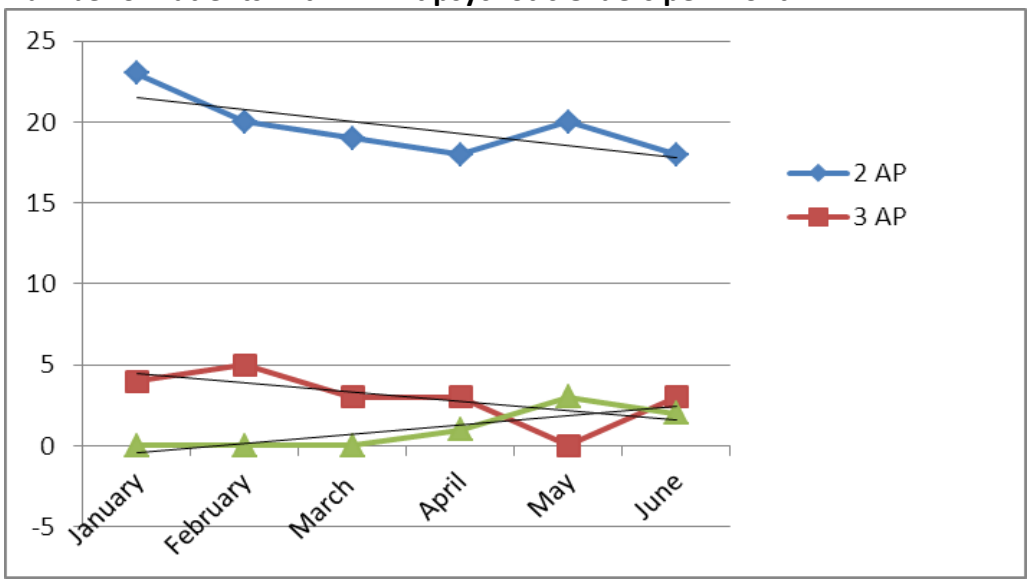
Census & Number of Patients with 0, 1, 2, 3, & 4 Orders for Antipsychotics





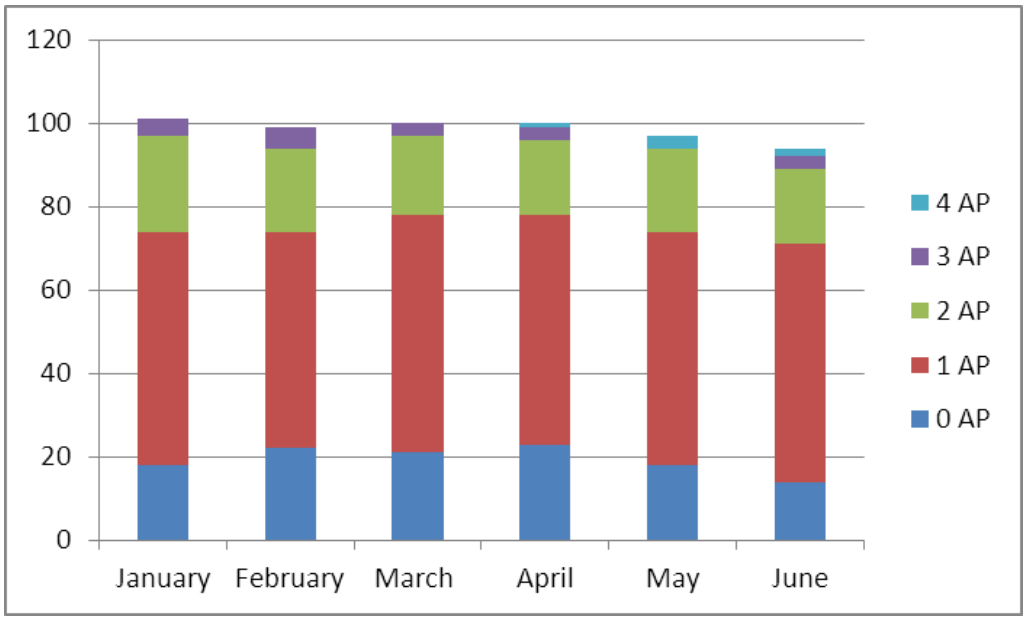
STRATEGIC PERFORMANCE EXCELLENCE

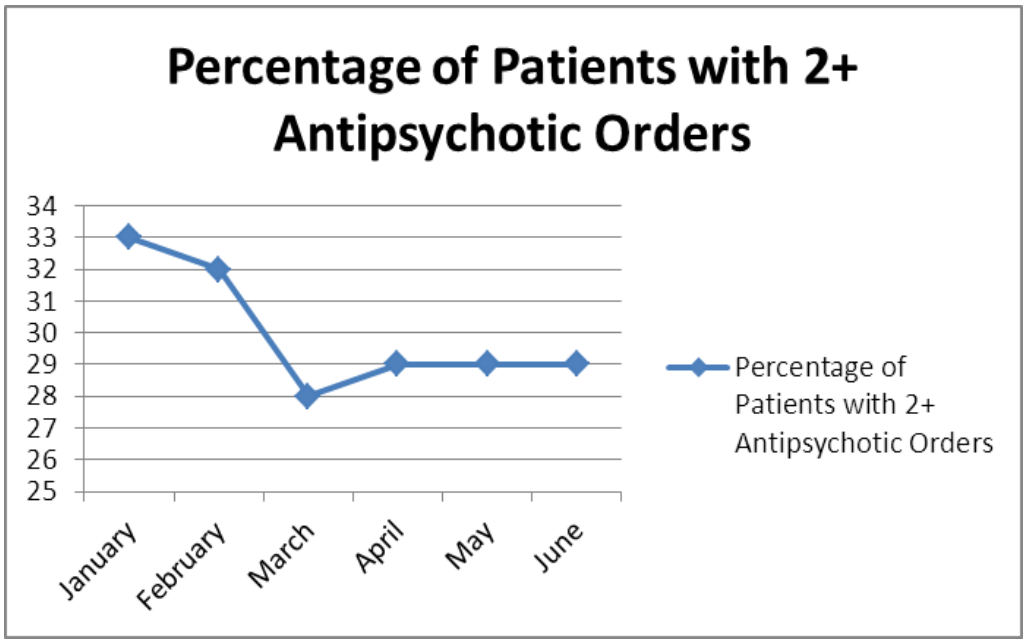
Number of Patients with 2+ Antipsychotic Orders per Month



STRATEGIC PERFORMANCE EXCELLENCE

Number of Concurrent Antipsychotic Orders Per Patient Per Month





STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Antibiotic Use Monitoring

Data Collection

During the quarter the antibiotic monitoring form consisting of a special doctor's order sheet with details of the antibiotic indication, drug, and strength, and giving agreed upon prescribing guidelines was fully implemented. Adherence to utilization of the form and the clinical appropriateness of indications for the antibiotic orders are gathered at the end of each month and the summary is provided at the following months' Pharmacy and Therapeutics (P&T) Committee. The Peer Review Team has been identified.

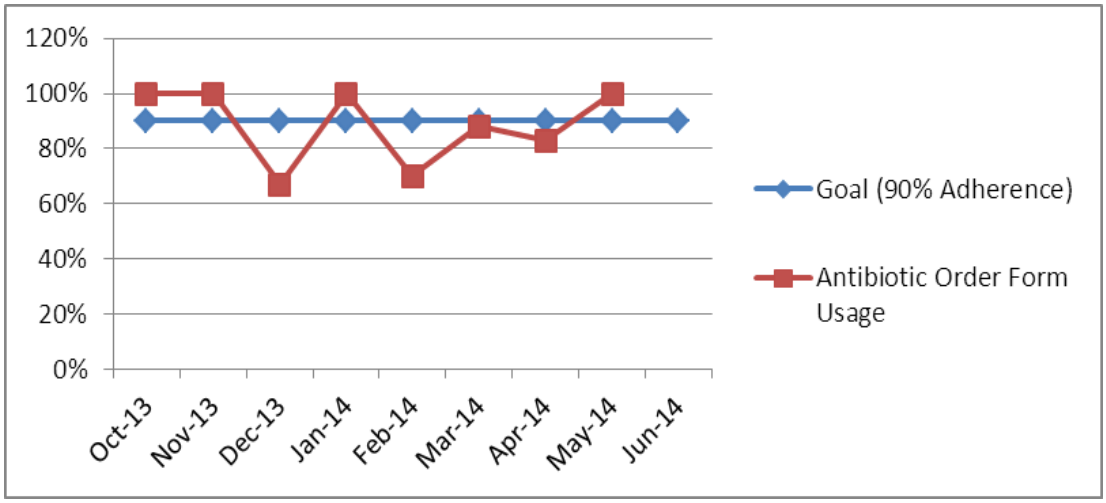
Findings

During the monitoring period there was an adherence rate of 90%. However, not all of the individual months had an adherence rate of 90% or greater. The adherence rate for April was 88%, May 83% and June 100%. The adherence rate for the quarter is an improvement from the previous quarter, adherence rate of 86%. The orders for April have been presented at the Pharmacy and Therapeutic (P&T) Committee. The May and June results will be presented at the July P&T Committee Meeting. Once again the non-adherence to the form is by after hour/on-call prescribers. There have been many new additions to the on-call roster and the non-adherence may be due to unfamiliarity with the process. Education will be provided to those prescribers that do not utilize the form.

Medical Staff Performance Improvement Indicator: Antibiotic Stewardship

Goal: 90% Adherence to Antibiotic Order Form for 4 Consecutive Months

	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Goal (90% Adherence)	90%	90%	90%	90%	90%	90%	90%	90%
Antibiotic Order Form Usage	100%	100%	67%	100%	70%	88%	83%	100%



STRATEGIC PERFORMANCE EXCELLENCE

Plan

The Peer Review team will evaluate the appropriateness of each antibiotic order. The team will also, on an ongoing basis, review the clinical guidelines and make recommendations for changes. Other trends identified by the team will be reported as necessary. A summary will be presented at each P&T Committee Meeting. Our threshold for this monitor is that 90% of all antibiotic orders will meet clinical guidelines as developed by the Medical Executive Committee.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Metabolic Monitoring of Atypical Antipsychotics

Data Collection

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. Also collected were the dates of the last tests and the names of the atypical drugs each patlient was receiving. This information is posted on the physician's shared drive and presented monthly at the Pharmacy and Therapeutics (P&T) Committee Meeting

Findings

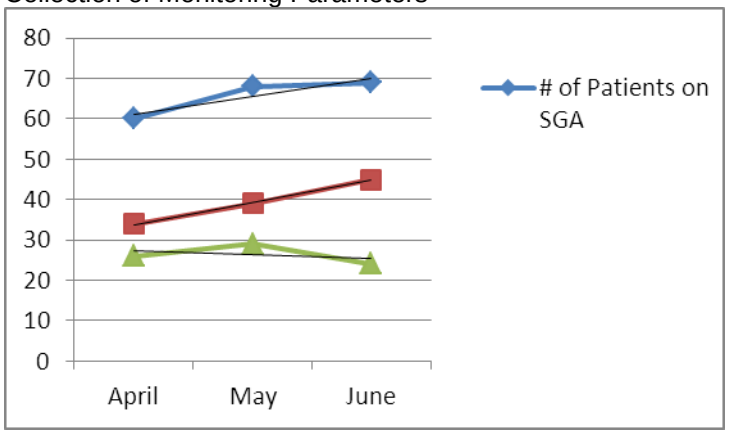
During the monitoring period there were 60, 68 and 69 clients receiving at least one atypical antipsychotic agent, respectively. Data was completely recorded for all desired data elements for about 60% of patients prescribed second generation antipsychotics for the quarter. Fourteen percent Twenty-three percent of patients were missing enough data elements that their metabolic status was unable to be determined. This is a decrease from last quarter's 23%. Missing data elements were primarily related to lab studies, mostly due to refusal of clients to obtain blood work.

Medical Staff Performance Improvement Indicator:

Metabolic Monitoring 2014

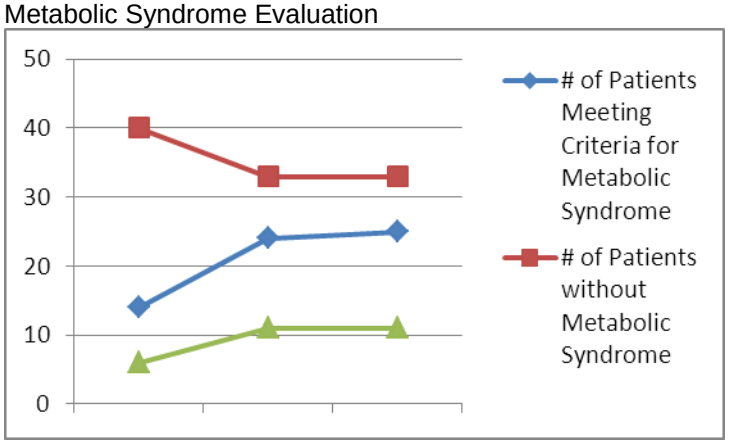
	April	May	June
# of Patients on SGA	60	68	69
# of Patients with Complete/Up-to-date Parameters	34 (57%)	39 (57%)	45 (65%)
# of Patients Missing/ Not Up-to-date Parameters	26 (43%)	29 (43%)	24 (35%)
# of Patients Meeting Criteria for Metabolic Syndrome	14 (23%)	24 (35%)	25 (36%)
# of Patients without Metabolic Syndrome	40 (67%)	33 (49%)	33 (48%)
# Unable to Determine	6 (10%)	11 (16%)	11(16%)

Collection of Monitoring Parameters



STRATEGIC PERFORMANCE EXCELLENCE

Metabolic Syndrome Evaluation



Analysis

At 60% we are still below our target of 95% of clients on atypical antipsychotics having a complete metabolic profile available to the pharmacist and to the medical staff. This was primarily due to missing laboratory values in the data base due to refusals.

Plan

Going forward, our plan will be to review the recommended metabolic monitoring frequency for each client to optimize the monitoring and prevent unnecessary lab work. We will continue to monitor the data elements of metabolic monitoring for each client prescribed a second generation antipsychotic. We will also continue to refine and improve our data entry. We will explore the concept of a metabolic clinic to better assess, identify, monitor, educate and treat clients at risk for metabolic syndrome. We will work to develop a schedule for blood draws for monitoring. We will utilize the APA and ADA guidelines to determine each client's recommended frequency of monitoring. We will explore the literature to determine action steps once a client is identified as having metabolic syndrome. We are also planning to provide education on Metabolic Syndrome to the Medical Staff in an attempt to increase awareness.

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

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

August 2012: Nurse Mandates 24 shifts, Mental Health Worker Mandates 53 shifts

MONTHLY TARGETS

Baseline –10% each month

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Mandates

Staffing Improvement Task Force

		Mandate Occurrences – Nurses	Mandate Occurrences – Mental Health Workers
		When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.
	Unit	# of shifts	# of shifts
	Baseline– August 2012	24	53
1Q2014	July 2013	5	51
	August 2013	3	30
	September 2013	20	98
2Q2014	October 2013	4	32
	November 2013	8	30
	December 2013	9	29
3Q2014	January 2014	3	20
	February 2014	12	49
	March 2014	15	54
4Q2014	April 2014	20	36
	May 2014	1	13
	June 2014	8	14
Total FY2014		**108**	**456**
	Goal	16 (10% reduction monthly x4 from baseline)	35 (10% reduction monthly x4 from baseline)
	Comments	Due to posting openings out 30 days we have a significant drop in mandates	This also is R/T staff picking up OT and therefore choosing when to do OT

Nursing mandates were down this quarter from 30 last quarter to 29 this quarter. MHW mandates were also down from 123 last quarter to 63 this quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

INDICATOR

Client Satisfaction Survey Return Rate

DEFINITION

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

OBJECTIVE

To increase the number of surveys offered to clients, as well as increase the return rate.

THOSE RESPONSIBLE FOR MONITORING

Peer Services 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. Full-time peer support staff will be responsible for offering surveys to clients 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

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

UNIT

All client care/residential units

BASELINE

Determined from previous year's data.

QUARTERLY TARGETS

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

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Inpatient Client Survey – Improving the Rate of Return

Department: Peer Support Responsible Party: Chris Monahan

Strategic Objectives								
Client Recovery	Unit	Baseline	FY14 Q1	FY14 Q2	FY14 Q3	FY14 Q4	Goal	Comments
CSS Return Rate	LK	15%	5%	18%	10%	12%	50%	
The client satisfaction survey is the primary tool for collecting data on how clients feel about the services they are provided at the hospital. Data collection has been low on all units and the way in which the surveys are administered has challenges based on the unit operations and performance of the peer support worker.	LS	5%	4%	8%	10%	0%	50%	*Percentages are calculated based on number of people eligible to receive a survey vs. the number of people who completed the surveys.*
	UK	45%	39%	47%	50%	12%	50%	
	US	30%	100%	33%	30%	100%	50%	

STRATEGIC PERFORMANCE EXCELLENCE

Summary of Inpatient Client Survey Results

#	Indicators	1Q2014 Findings	2Q2014 Findings	3Q2014 Findings	4Q2014 Findings	Average Score
1	I am better able to deal with crisis.	70%	69%	73%	59%	68%
2	My symptoms are not bothering me as much.	78%	71%	63%	59%	68%
3	The medications I am taking help me control symptoms that used to bother me.	65%	75%	83%	59%	71%
4	I do better in social situations.	69%	73%	65%	53%	65%
5	I deal more effectively with daily problems.	70%	69%	68%	53%	65%
6	I was treated with dignity and respect.	70%	75%	73%	63%	70%
7	Staff here believed that I could grow, change and recover.	73%	69%	80%	63%	71%
8	I felt comfortable asking questions about my treatment and medications.	63%	69%	70%	56%	65%
9	I was encouraged to use self-help/support groups.	65%	77%	70%	66%	70%
10	I was given information about how to manage my medication side effects.	65%	63%	65%	47%	60%
11	My other medical conditions were treated.	63%	71%	75%	57%	67%
12	I felt this hospital stay was necessary.	63%	63%	65%	44%	59%
13	I felt free to complain without fear of retaliation.	60%	53%	50%	47%	53%
14	I felt safe to refuse medication or treatment during my hospital stay.	39%	63%	55%	56%	53%
15	My complaints and grievances were addressed.	58%	65%	68%	56%	62%
16	I participated in planning my discharge.	67%	73%	65%	72%	69%
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	58%	73%	65%	63%	65%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	72%	71%	63%	59%	66%
19	The surroundings and atmosphere at the hospital helped me get better.	68%	69%	65%	66%	67%
20	I felt I had enough privacy in the hospital.	68%	71%	63%	63%	66%
21	I felt safe while I was in the hospital.	65%	75%	75%	59%	69%
22	The hospital environment was clean and comfortable.	73%	75%	78%	59%	71%
23	Staff were sensitive to my cultural background.	63%	83%	55%	59%	65%
24	My family and/or friends were able to visit me.	78%	77%	78%	59%	73%
25	I had a choice of treatment options.	58%	73%	60%	50%	60%
26	My contact with my doctor was helpful.	70%	77%	68%	47%	66%
27	My contact with nurses and therapists was helpful.	60%	79%	78%	66%	71%
28	If I had a choice of hospitals, I would still choose this one.	58%	69%	48%	56%	58%
29	Did anyone tell you about your rights?	58%	71%	63%	59%	63%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	60%	67%	45%	47%	55%
31	Do you know someone who can help you get what you want or stand up for your rights?	58%	71%	70%	69%	67%
32	My pain was managed.	64%	65%	65%	59%	63%
	Overall Score	**64%**	**71%**	**66%**	**58%**	**65%**

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

The IPEC reporting reflects three major areas of focus for performance improvement that have pharmacy specific indicators: **Safety in Culture and Actions, Fiscal Accountability and Medication Management** (see Medication Management – Dispensing Process)**.** The pharmacy specific indicators for each of the priority focus areas utilizes measurable and objective data that is trended and analyzed to support performance improvement efforts and medication safety, as well as, ensure regulatory compliance and best practice in key areas.

Safety in Culture and Actions

RPC's primary medication distribution system uses the Pyxis Medstations to provide an electronic "closed loop" system to dispense medications for patients. Within the Pyxis system, key data elements are reported, trended and analyzed to ensure medication safety and regulatory compliance are maintained. *Pyxis Discrepancies* created by nursing staff are monitored daily and analyzed by Pharmacy with follow up to Nursing as needed for resolution. A monthly summary is provided to the Nursing-Pharmacy Committee for further review and discussion of trends and ideas to minimize the occurrence of discrepancies by Nursing. *Pyxis Overrides of Controlled Drugs* by nursing staff is another indicator that is closely monitored and trended with follow up for resolution as needed. A monthly summary is also reviewed by the Nursing-Pharmacy Committee for action steps. The goal with each of these indicators is to minimize the occurrence of either discrepancies or overrides by action steps to address performance issues via education or system changes which help satisfy TJC requirements for monitoring the effectiveness of the Medication Management system. *Veriform Medication Room Audits* are performed on each medication room to determine compliance with established medication storage procedures and requirements. The results of the audits are shared with the nursing managers for their respective corrective actions or staff education.

Fiscal Accountability

The *Discharge Prescriptions* indicator tracks the cost and number of prescription drugs dispensed to patients at discharge. This baseline data will be used to determine the best approach to implement steps to decrease this expense. The lack of a resource to perform insurance verification and research prior authorizations needed so clinicians' can make timely and informed prescribing decisions is believed to be inherent in the discharge process. Without this resource, RPC is obliged to provide discharge medications to prevent a gap in medication coverage as the patient is being transitioned to another facility. The plan of correction is to explore options and propose a resolution to RPC's Medical Director.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Pharmacy

Responsible Party: Garry Miller, R.Ph.

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Pyxis CII Safe Comparison *Daily and monthly comparison of Pyxis vs CII Safe transactions*	Rx		0%	0%	0%	0%		2 discrepancies between Pyxis and CII Safe transactions during Q4
Quarterly Results			0.3%	0%	2.5%	0.7%		
Veriform Medication Room Audits *Monthly comprehensive audits of criteria*	All	97%	100%	100%	100%	100%	90%	Overall compliance is 98% for Q1,Q2,Q3 and Q4
Quarterly Results			98%	98%	98%	97%		
Pyxis Discrepancies *Monthly monitoring and trending of Pxyis discrepancies.*	All	63/mo	50	50	50	50	50/mo	Trending of monthly data was significantly increased for Q2 and Q3 vs Q1
Quarterly Results			226 (75/mo)	403 (134/mo)	389 (130/mo)	452 (150/mo)		
Pyxis Overrides – Controlled Drugs *Monthly monitoring and trending of Pyxis overrides for Controlled Drugs*	All	15/month	10	10	10	10	10	Target goal is 10/month
Quarterly Results			65	53	114	116		
Fiscal Accountability	Unit	2013 Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions *Monitoring and Tracking of dispensed Discharge Prescriptions*	Rx	$8440 334 drugs	$5262 418 drugs	$4184 252 drugs	$2679 359 drugs	$3867 341 drugs		Significant costs are incurred in providing discharge drugs.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services

Define

Client participation in on-unit groups and utilization of resources to relieve distress is variable but should be promoted to encourage activities that support recovery and the development of skills necessary for successful community integration.

Measure

The program services team will measure the current status of program participation and resource utilization to identify a baseline for each of the four units.

Analyze

Analysis of the barriers to utilization will be conducted in an attempt to determine causation factors for limited participation.

Improve

Strategies for encouraging increased participation in on-unit groups and the utilization of resources to relieve distress will be identified in a collaborative manner with client and staff participation.

Control

Ongoing review of utilization of programs and resources will be conducted to determine whether unit practice has changed and improvements are sustainable.

INDICATOR	Baseline	Quarterly Improvement Target	Improvement Objective
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**			**14**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**			
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**			
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended.**			**100%**
5. **The client can identify distress tolerance tools on the unit**			**100%**
6. **The client is able to can identify his or her primary staff.**			**100%**

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	Main/SCU 5 7	85% 100%	Days/Even. 7 / 7 = 14
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	6 Avg.		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	6 Avg		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	17/30	56%	100%
5. **The client can identify distress tolerance tools on the unit**	24/30	80%	100%
6. **The client is able to state who his primary staff is**	24/30	80%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

LK has improved in consistency of unit groups and attendance. Acuity has been a factor in the sporadic attendance. We continue to look at ways to decrease the acuity as well as increase client interest/participation in unit groups. Recovery RNs added to the staffing pattern is one way that we hope to be able to offer more on unit groups for clients as well as some further training for staff. Acuity Specialists on the unit will also free up some staff for group participation.

ACTIONS

We will continue to try to increase not only client participation in groups but also in relating the client's Recovery Goals to the groups offered and documenting on the group participation and progress towards goals as well.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 7 7	100%	 7 / 7 = 14 7 / 7 = 14
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	4/6	70%	N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	5/6	85%	N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	8/10	80%	100%
5. **The client can identify distress tolerance tools on the unit (re named coping tools)**	9/10	90%	100%
6. **The client is able to state who his primary staff is**	8/10	80%	100%

EVALUATION OF EFFECTIVENESS

On unit groups are offered once on day shift and once on evenings daily by RN. The percentage of treatment plans increased this quarter from 40% to 80%. The unit acuity has decreased over the last quarter. Regular assigned nurses for the day shift have had a decrease over the last quarter.

ISSUES

Consistent group leaders on the day shift have become an issue leading to participation in the on unit groups. Treatment plans also need work reflecting the on unit groups.

ACTIONS

Upper Kennebec is working on getting regularly assigned day nurses to help with consistent day on unit groups. Treatment plans are also being addressed to reflect the on unit groups.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	Main/SCU 36 / 12 27 / 10	 100% 100%	 7 / 7 = 14 7 / 7 = 14
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)	4.0 / 1.5		N/A
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)	3.5 / 1		N/A
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	10	100%	100%
5. The client can identify distress tolerance tools on the unit	30/30	100%	100%
6. The client is able to state who his primary staff is	30/30	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

The Lower Saco unit on-unit groups by MHWS and professional staff is on-going and well established. Documentation in the Meditech has improved. This treatment effort continues to be reflected in the treatment plans. The on-unit groups have been a regular part of each client's daily activity and are incorporated in their Rx plans. A high level of acuity on any given day can negatively impact levels of attendance and interest. Recreational Therapy staff members are more consistent in documenting participation and nursing staff have improved documentation over the past quarter. Only an occasional new client may need to be reminded about available tools/activities to help relieve distress.

ACTIONS

RT staff members are very important in providing diversion and therapy groups to Lower Saco clients, which needs to be maintained. The unit is offering many more groups weekly than the threshold; The acuity specialist positions have helped address acuity situations and further improved overall quality of groups.

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STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 14 9	 100% 100%	 Days/ Even. 7 / 7 = 14
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	1.5avg./15grps		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	4avg./10grps		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	4	40%	100%
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	100%
6. **The client is able to state who his primary staff is**	30/30	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

There continues to be a need to better reflect this on-unit treatment effort in the treatment plans. Nearly all of the clients on Upper Saco attend the hospital treatment mall with a high level of participation and attendance with off-unit treatment. Off unit groups are reflected in the treatment plans and are a regular part of physician orders. As in previous reports, there needs to be increased effort at reflecting on-unit groups in the treatment plans, especially for weekends and for clients not regularly attending the hospital treatment mall.

ACTIONS

Newly admitted clients quickly become familiar with distress tolerance tools (MP3 players, cards, exercise machines, etc.) and how to access them. They also know their assigned primary staff. Additional efforts need to be made to get all on-unit offered groups in individual treatment plans. Continued efforts are being made to offer groups to those clients that have less activity at the hospital treatment mall. Treatment planning for on-unit groups and follow-up documentation issues are being identified with the new nursing leader.

STRATEGIC PERFORMANCE EXCELLENCE

Psychology Department

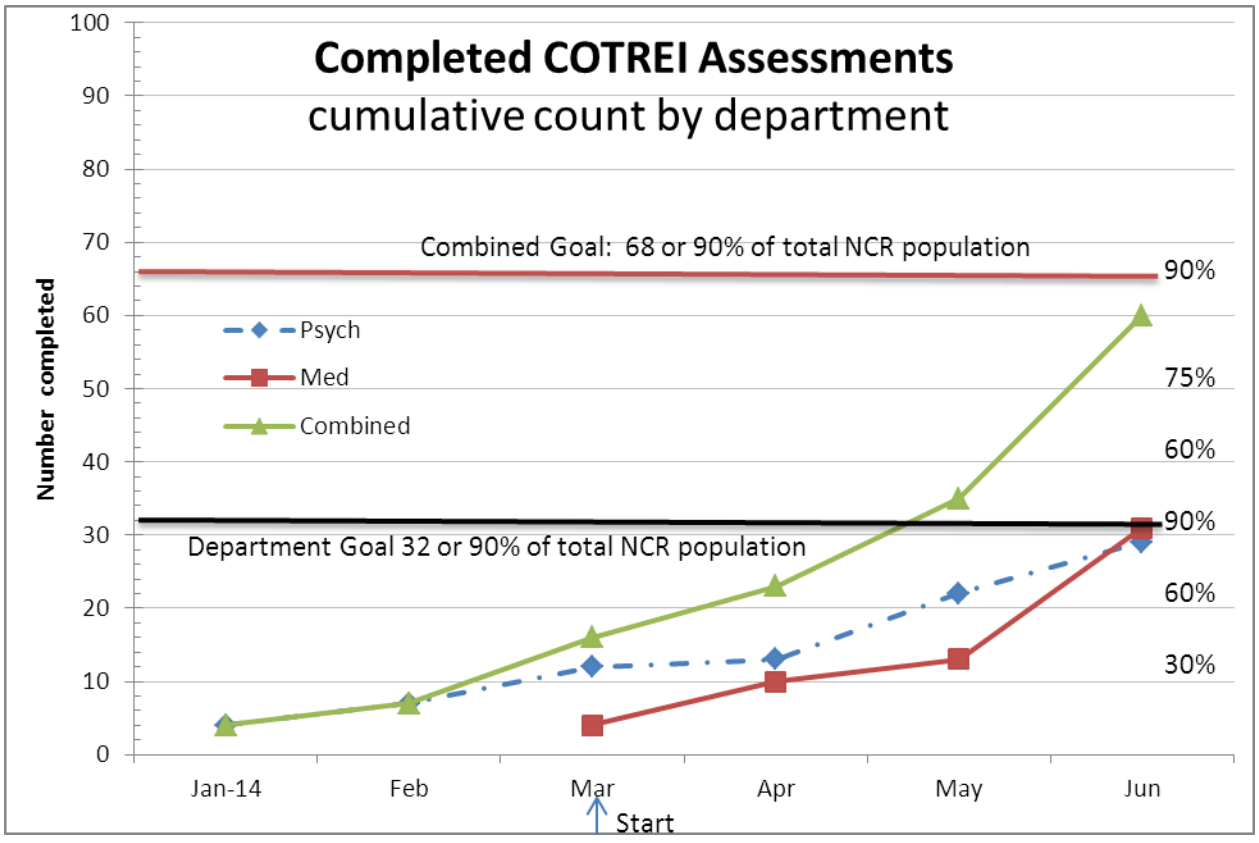
Department: Psychology Services Responsible Party: Arthur DiRocco, PhD

Current Psychology Performance Improvement Goal

The psychology department engaged in performance improvement activity involving the assessment of at least 90% of all patients residing at RPC who have been adjudicated as not criminally responsible (NCR) by the Court. Beginning in April 1st, 2014 to July 1st, 2014 members of the psychology and medical department completed a total of 60 assessments of the 68 individuals identified as NCR. This represents an 88% completion rate for the combined departments. Psychology completed 29 out of 32 for a completion rate of 91% of the targeted goal. Medical completed 31 out of 32 for a completion rate of 97% of the targeted goal. The data collected from these assessments will be used to assist the treatment team to identify treatment needs and to measure outcomes for this population of patients.

Medical Staff Performance Improvement Activity

Target Goal: 90% completion of COTREI assessments of NCR patients in 4 months



COTREI: Community Outpatient Treatment Readiness Evaluation Instrument

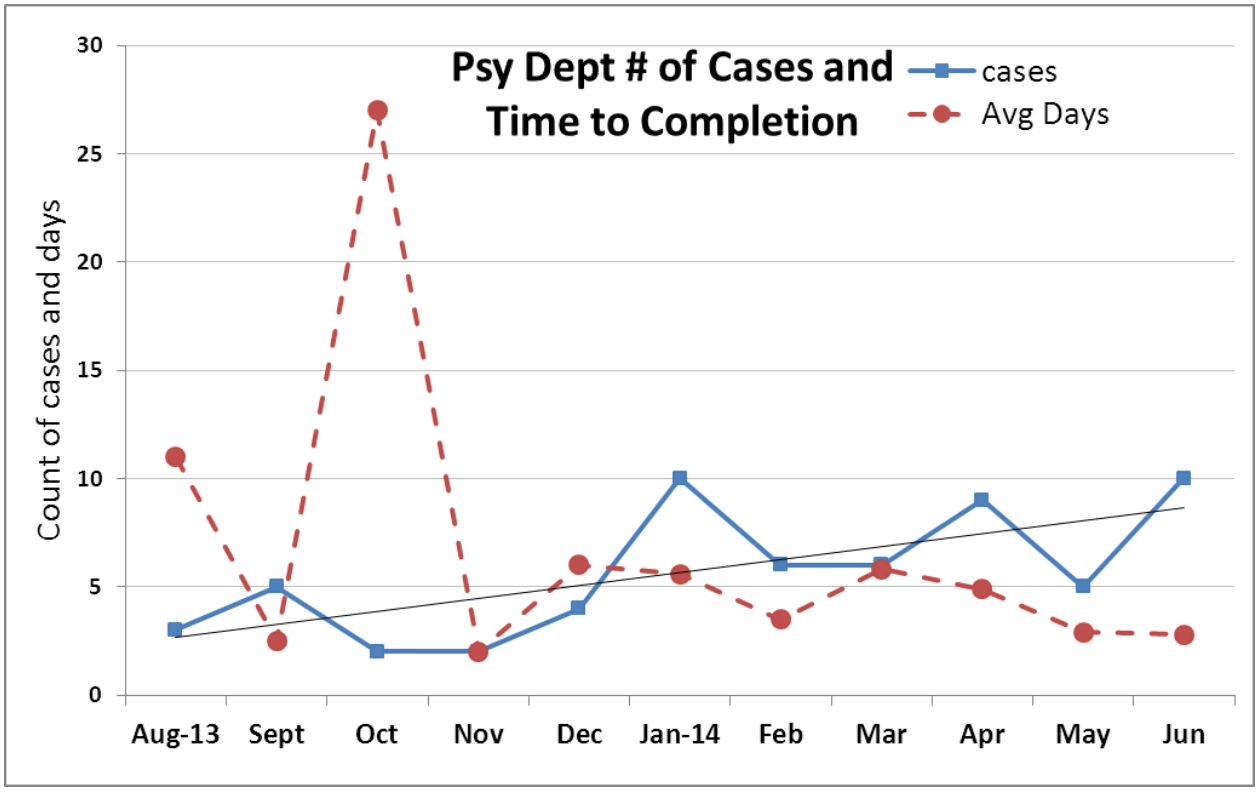
STRATEGIC PERFORMANCE EXCELLENCE

Psychology Department

Successful Performance Improvement Plan

A previous department effort to improve delivery of psychological services was conducted over the first two quarters of 2014; i.e., January to July 2014. The aim of that program was to increase the number of cases which were completed by the department and to decrease the waiting time between referral and completion of the case. The first goal was to increase the number of cases (August 2013 to December 2013) from an average of 3 per month to a target of 6 cases per month or by a factor of 2. The base rate for waiting time for completion of services the previous 5 months (August to December) was 10.6 days. Since January 2014 the number of waiting days has dropped to an average of 4.5 days while the number of cases completed has grown to an average of 7 per month. Goals of 1st two quarters have been met.

Psychology Staff Performance Improvement Activity
Target Goal: Improve efficiency and speed of services



STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Vocational Incentive Program Treatment Plans *The objective of this improvement project is to ensure vocational treatment plans are initiated on all clients within 5 days of beginning work and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.*	55%	92%	95%	98%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	All charts reviewed had a current plan and documentation was present.
Quarterly Results		95%	88%	93%	100%		

Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Recreational Therapy Assessments & Treatment Plans *The objective of this improvement project is to ensure that Recreational Therapy assessments are completed within 7 days of admission and that a treatment plan is initiated after the assessment and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.*	75%	85%	90%	95%	100%	The treatment plans will be reviewed more regularly and updated at each client treatment team meeting or if there is any change in client status	All plans updated and documentation in the chart for this quarter.
Quarterly Results		85%	91%	100%	100%		

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery & Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Occupational Therapy referrals and doctors orders. *The objective of this improvement project is to ensure each client receiving Occupational Therapy Services from RPC OT staff has a doctor's order as well as a referral form completed prior to the initiation of services.*	33%	50% 39 of 43	75% 13 of 16	100% 22 of 23	100% 14 of 14	To increase the percentage of referrals and doctor's orders by 25 % each quarter until we attain 100% compliance .	1 patient had services initiated prior to the order physically being received by Rehab. Dept but OT reviewed the order in the patient chart prior to starting services as they had been made aware of the order by MD.
Quarterly Results		91%	81%	96%	100%		

Report Number: 27 and 28

Non-Hospitalized Members Assigned to Community Integration Service (CI) within 3 and 7 Working Days

(Includes MaineCare members and Courtesy Reviews done by APS)

Report Dates: 01/01/2014 To 03/31/2014

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 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 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 tme 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 Community Integration (CI) and whether they a.) were assigned to a case manager in the CI service within 3 working days, b.) Waited 4 - 7 working days to be assigned to a CI worker or c.) waited longer than 8 days but were eventually assigned to the CI service.

Total number of non-hospitalized members applying for CI: 1,975

Total assigned within 3 working days: 1,263

Total assigned in 4 - 7 working days: 217

Total assigned within 7 working days: 1,480

Total assigned after 8 or more working days: 495

% assigned within 3 working days: 64%

% assigned in 4 -7 working days: 11%

% assigned within 7 working days: 75%

% assigned after 8 or more working days: 25%

Gender	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Female	812	137	316	1,265
Male	451	80	179	710
Total	**1,263**	**217**	**495**	**1,975**

Adult Age Groups	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
18-20	101	17	30	148
21-24	104	16	56	176
25-64	1,008	175	390	1,573
65-74	38	7	15	60
Over 75 Years Old	12	2	4	18
Total	**1,263**	**217**	**495**	**1,975**

APS Healthcare

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

AMHI Class	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	1,199	212	483	1,894
AMHI Class Y	64	5	12	81
Total	**1,263**	**217**	**495**	**1,975**

District	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	100	27	42	169
District 2/ Cumberland County	215	56	128	399
District 3/ Androscoggin, Franklin, and Oxford Counties	322	40	86	448
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	104	15	65	184
District 5/ Somerset and Kennebec Counties	225	25	53	303
District 6/ Piscataquis and Penobscot Counties	182	36	76	294
District 7/ Washington and Hancock Counties	46	7	19	72
District 8/ Aroostook County	57	8	22	87
Unknown	12	3	4	19
Total	**1,263**	**217**	**495**	**1,975**

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	10	0	2	12
Allies	6	9	11	26
Alternative Services	18	0	0	18
Alternative Wellness Services	4	1	0	5
Aroostook Mental Health Services	34	3	3	40
Assistance Plus	34	2	9	45
Behavior Health Solutions for Me	4	0	0	4
Break of Day, Inc	2	2	10	14
Broadreach Family & Community Services	17	2	0	19
Catholic Charities Maine	35	18	44	97
Charlotte White Center	5	3	17	25
Choices	10	0	0	10
Common Ties	77	17	15	109
Community Care	10	0	7	17
Community Counseling Center	49	16	34	99
Community Health & Counseling Services	92	15	30	137
Connections for Kids	2	1	0	3
Cornerstone Behavioral Healthcare - CM	30	3	2	35
Counseling Services Inc.	58	28	26	112
Direct Community Care	12	4	1	17
Dirigo Counseling Clinic	10	4	0	14
Employment Specialist of Maine	3	4	7	14
Evergreen Behavioral Services	3	0	0	3
Fullcircle Supports Inc	32	1	2	35
Graham Behavioral Services	12	2	1	15
Harbor Family Services	0	0	2	2
Healing Hearts LLC	4	0	1	5
Health Affiliates Maine	143	0	5	148
Higher Ground Services	14	1	1	16
Kennebec Behavioral Health	69	1	9	79
Life by Design	13	2	9	24
Lutheran Social Services	3	0	1	4
Maine Behavioral Health Organization	55	3	2	60
Maine Vocational & Rehabilitation Assoc.	6	5	2	13
Manna Inc	5	1	2	8

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Merrymeeting Behavioral Health Associates-Adult Case Mgmt	8	2	1	11
Mid Coast Mental Health	18	0	29	47
Motivational Services	4	0	1	5
Northeast Occupational Exchange	26	10	34	70
Northern Maine General - Community Support	2	0	3	5
Ocean Way Mental Health Agency	6	0	0	6
OHI	3	4	6	13
Oxford County Mental Health Services	12	0	5	17
Port Resources-Sec 17	2	0	0	2
Rumford Group Homes	12	0	0	12
Sequel Care of Maine	9	1	0	10
Shalom House	12	1	1	14
Smart Child & Family Services	8	4	2	14
Somali Bantu Youth Association of Maine	6	0	4	10
St. Andre Homes	10	3	7	20
Stepping Stones	19	2	0	21
Sunrise Opportunities	5	0	0	5
Sweetser	87	13	45	145
The Opportunity Alliance	49	14	36	99
Tri-County Mental Health	81	14	62	157
UCP VI	0	1	3	4
York County Shelter Program	3	0	1	4
Total	**1,263**	**217**	**495**	**1,975**

APS Healthcare

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

Report Number: 29 and 30

Hospitalized Members Assigned to Community Integration Service (CI) within 2 and 7 Working Days

(Includes MaineCare members and Courtesy Reviews done by APS)

Report Dates: 01/01/2014 To 03/31/2014

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 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 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 tme of admission, but is expected

What This Report Measures: The number of hospitalized members authorized for Community Integration (CI) and whether they a.) were assigned to a case manager in the CI service within 2 working days, b.) Waited 3-7 working days be assigned a CI worker, or c.) waited longer than 8 days but were eventually assigned to the service

Total number of hospitalized members applying for CI: 44

Total assigned within 2 working days: 27	% assigned within 2 working days: 61%
Total assigned in 3 - 7 working days: 8	% assigned in 3 -7 working days:18 %
Total assigned within 7 working days: 35	% assigned within 7 working days: 80%
Total assigned after 8 or more working days: 9	% assigned after 8 or more working days: 20%

Gender	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Female	13	3	4	20
Male	14	5	5	24
Total	**27**	**8**	**9**	**44**

AMHI Class	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	19	4	8	31
AMHI Class Y	8	4	1	13
Total	**27**	**8**	**9**	**44**

District	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	3	2	1	6
District 2/ Cumberland County	6	1	2	9
District 3/ Androscoggin, Franklin, and Oxford Counties	3	2	3	8
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	1	0	0	1
District 5/ Somerset and Kennebec Counties	6	0	2	8
District 6/ Piscataquis and Penobscot Counties	7	3	1	11
District 8/ Aroostook County	1	0	0	1
Total	**27**	**8**	**9**	**44**

Providers	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	2	1	1	4
Alternative Services	0	0	1	1
Aroostook Mental Health Services	1	0	0	1
Assistance Plus	3	0	0	3
Catholic Charities Maine	4	0	0	4
Common Ties	0	1	1	2
Community Care	1	0	0	1
Community Health & Counseling Services	2	2	0	4
Counseling Services Inc.	1	2	0	3
Graham Behavioral Services	2	0	0	2
Health Affiliates Maine	1	0	1	2
Kennebec Behavioral Health	2	1	2	5
Maine Vocational & Rehabilitation Assoc.	1	0	0	1
Mid Coast Mental Health	1	0	0	1
Motivational Services	0	0	1	1
Northeast Occupational Exchange	1	0	0	1
Shalom House	4	1	0	5
Sweetser	0	0	1	1
The Opportunity Alliance	0	0	1	1
Tri-County Mental Health	1	0	0	1
Total	**27**	**8**	**9**	**44**

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: 01/01/2014 To 03/31/2014 **Report Run Date: 7/24/2014**

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

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 752

For those who received the service: Average number of days waiting: 12 days

Percent waiting 30 days or less: 88% Percent waiting 90 days or less: 99%

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	716	710	6	627	82	7	12
AMHI Class Y	36	34	2	35	1	0	5
Totals	**752**	**744**	**8**	**662**	**83**	**7**	**12**

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	76	75	1	70	6	0	9
District 2	254	251	3	227	25	2	11
District 3	109	108	1	103	6	0	8
District 4	33	32	1	27	6	0	15
District 5	124	124	0	103	16	5	15
District 6	95	94	1	81	14	0	10
District 7	30	30	0	25	5	0	16
District 8	25	25	0	20	5	0	15
Unknown	6	5	1	6	0	0	6
Totals	**752**	**744**	**8**	**662**	**83**	**7**	**12**

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	52	52	0	44	7	1	10
Catholic Charities Maine	97	96	1	94	3	0	8
Common Ties	60	59	1	60	0	0	4
Community Care	17	16	1	13	4	0	13
Community Counseling Center	66	65	1	60	4	2	14
Community Health & Counseling Services	95	95	0	79	16	0	12
Counseling Services Inc.	84	83	1	75	9	0	11
Direct Community Care	8	8	0	7	1	0	9
Healing Hearts LLC	2	2	0	2	0	0	0
Higher Ground Services	8	8	0	8	0	0	6
Kennebec Behavioral Health	50	50	0	37	9	4	21
Life by Design	19	19	0	14	5	0	19
Mid Coast Mental Health	20	18	2	14	6	0	19
Motivational Services	1	1	0	1	0	0	0
OHI	2	2	0	2	0	0	4
Shalom House	7	7	0	7	0	0	2
Sweetser	16	16	0	12	4	0	22
The Opportunity Alliance	109	108	1	104	5	0	8
Tri-County Mental Health	35	35	0	26	9	0	21
UCP VI	4	4	0	3	1	0	15
Totals	**752**	**744**	**8**	**662**	**83**	**7**	**12**

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: 01/01/2014 To 03/31/2014 **Report Run Date: 7/24/2014**

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

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: 124

For those who received the service: Average number of days waiting: 31 days

Percent waiting 30 days or less: 65% Percent waiting 90 days or less: 87%

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	121	20	101	78	27	16	32
AMHI Class Y	3	1	2	3	0	0	11
Totals	**124**	**21**	**103**	**81**	**27**	**16**	**31**

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	23	3	20	7	10	6	52
District 2	18	3	15	7	2	9	74
District 3	32	5	27	26	6	0	15
District 4	21	3	18	14	6	1	25
District 5	14	5	9	13	1	0	14
District 6	10	1	9	9	1	0	6
District 7	4	1	3	3	1	0	13
District 8	2	0	2	2	0	0	17
Totals	**124**	**21**	**103**	**81**	**27**	**16**	**31**

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	11	3	8	10	1	0	9
Common Ties	15	5	10	11	4	0	16
Community Care	5	0	5	3	2	0	20
Community Counseling Center	1	1	0	1	0	0	17
Community Health & Counseling Services	2	1	1	2	0	0	0
Cornerstone Behavioral Healthcare - CM	7	1	6	7	0	0	1
Counseling Services Inc.	17	1	16	2	9	6	67
Kennebec Behavioral Health	10	3	7	9	1	0	15
Life by Design	2	0	2	2	0	0	17
Mid Coast Mental Health	10	2	8	6	3	1	33
Shalom House	1	0	1	1	0	0	0
Smart Child & Family Services	4	1	3	3	1	0	14
Sweetser	17	0	17	12	5	0	19
The Opportunity Alliance	11	2	9	1	1	9	113
Tri-County Mental Health	10	1	9	10	0	0	12
York County Shelter Program	1	0	1	1	0	0	0
Totals	**124**	**21**	**103**	**81**	**27**	**16**	**31**

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

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

Consent Decree Compliance Standards IV.23 and IV.43

Report for: 2014 Q3
(January, February, March 2014)

Total Residential Support Unmet Needs (From 7K Living Skills Resources)

	2013 Q4		2014 Q1		2014 Q2		2014 Q3	
% of Total Unmet Needs For Class Members	32	5.04%	30	5.13%	32	5.28%	29	5.41%
% of Total Unmet Needs For Non-Class Members	299	4.55%	287	4.12%	311	4.33%	290	4.42%
% of Total Unmet Needs For All Clients	331	4.59%	317	4.20%	343	4.40%	319	4.49%
How much higher is percent of Non-Class unmet needs than Class Member unmet needs.		-0.49%		-1.01%		-0.95%		-0.99%

Total Mental Health Treatment Unmet Needs (From 7A Mental Health Services)

	2013 Q4		2014 Q1		2014 Q2		2014 Q3	
% of Total Unmet Needs For Class Members	92	14.49%	88	15.04%	98	16.17%	85	15.86%
% of Total Unmet Needs For Non-Class Members	928	14.11%	1041	14.94%	1055	14.68%	984	14.99%
% of Total Unmet Needs For All Clients	1020	14.14%	1129	14.95%	1153	14.80%	1069	15.05%
How much higher is percent of Non-Class unmet needs than Class Member unmet needs.		-0.38%		-0.10%		-1.49%		-0.87%

Total Number of Unmet Needs (From All Categories)

	2013 Q4	2014 Q1	2014 Q2	2014 Q3
Unmet Needs for Class Members	**635**	**585**	**606**	**536**
Unmet Needs for Non Class Members	**6578**	**6966**	**7186**	**6566**
Unmet Needs for All Clients	**7213**	**7551**	**7792**	**7102**

Report Run: July 14, 2014

This report factors in all unmet needs in these categories. One client may have multiple needs in one category. This report does not reflect individual clients.