Department of Health & Human Services, Office of Adult Mental Health Services
Bates v. DHHS Consent Decree
April, May, June 4th Quarter, SFY 2016
CONSENT DECREE REPORT

SUMMARY
(Section 1A)

The DHHS Office of Substance Abuse and Mental Health Services is required to report to the Court quarterly regarding compliance and progress toward meeting specific standards as delineated in the Bates v. DHHS Consent Decree Settlement Agreement, the Consent Decree Plan of October 2006, and the Compliance Standards approved October 29, 2007. The following documents are submitted as the Quarterly Progress Report for the 3nd quarter of state fiscal year 2016, covering the period January, February and March 2016. A link to the PDF version of each document is provided on the SAMHS website.

		DESCRIPTION
1	**Cover Letter, Quarterly Report:** May 2016 *Section 1*	Letter to Dan Wathen, Court Master, submitting the Quarterly Report pursuant to paragraph 280 of the Settlement Agreement for the quarter ending July 31, 2016.
2	**Report on Compliance Plan Standards: Community** *Section 2*	Lists and updates the information pertaining to standards approved in October 2007 for evaluating and measuring DHHS compliance with the terms and principles of the Settlement Agreement.
3	**Performance and Quality Improvement Standards** *Section 3*	Details the status of the Department's compliance with 19 specific performance and quality improvement standards (many are multi-part) required by the Consent Decree October 2006 Plan for this reporting quarter. Reporting includes the baseline, current level, performance standard, and compliance standard for each, including graphs.
4	**Consent Decree Performance and Quality Improvement Standard 5.** *Section 4*	Aggregate report of assignment time to service and completion time of Individual Support Plans (ISPs). Data gathered from Contact for Service Notifications, Prior Authorizations, and Continued Stay Requests via APS Care Connections.
5	**Performance Quality and Improvement Standards, Appendix: Adult Mental Health Data Sources** *Section 5*	Lists and describes all of the data sources used for measuring and reporting the Department's compliance on the Performance and Quality Improvement Standards.
6	**Cover: Unmet Needs and Quality Improvement Initiative** *Section 6*	Provides a brief introduction to the unmet needs report as well as some definitions of the data, initial findings and next steps. Also includes information on the quality improvement initiatives undertaken by SAMHS.
7	**Unmet Needs by CSN** *Section 7*	Quarterly report drawn from the Enterprise Information System (EIS) by CSN (based on client zip code), from resource need data entered by community support case managers (CI, ACT, CRS, and BHH)

		DESCRIPTION
		concerning consumers (class members and non-class members) who indicate a need for a resource that is not immediately available. Providers are required to enter the information electronically upon enrollment of a client in Community Support Services and update the information from their clients' Individual Service Plans (ISPs) every 90 days via an RDS (Resource Data Summary) entered as a component of prior authorization and continuing stay requests made to APS Healthcare via their online system, CareConnections.
8	**BRAP Waitlist Monitoring Report,** *Section 8*	Describes status of the DHHS Bridging Rental Assistance Program's (BRAP) waitlist, focusing on the numbers served over time by priority status.
9	**Class Member Treatment Planning Review** *Section 9*	Aggregate report of document reviews completed on a random sample of class member ISPs by Consent Decree Coordinators following a standardized protocol.
10	**Community Hospital Utilization Review** *Section 10*	Aggregate report of Utilization Review (UR) of all persons with MaineCare or without insurance coverage admitted into emergency involuntary, community hospital based beds. UR data is reported one quarter behind to allow sufficient time for reviews and data entry to be completed.
11	**Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital** *Section 11*	Report drawn from UR data that details, by hospital, the percentage of ISPs obtained, ISPs consistent with the hospital treatment and discharge plan, and case manager involvement in hospital treatment and discharge planning. UR data is reported one quarter behind to allow sufficient time for reviews and data entry to be completed.
12	**DHHS Integrated Child/Adult Quarterly Crisis Report** *Section 12*	Aggregate quarterly report of crisis data submitted by crisis providers to the Office of Quality Improvement on a monthly basis.
13	**Riverview Psychiatric Center Performance Improvement Report** *Section 13*	Reports on Riverview's compliance with specific indicators re: performance and quality; recording findings, problem, status, and actions for the specified quarter.
14	**APS Healthcare Reports** *Section 14*	For members on the Community Integration waitlist who were authorized for this service, how long they waited. These reports count the number of days from the date the CFSN was opened to the date the service was authorized. The reports are run 2 quarters behind, therefore, those who were entered on the waitlist will have started the service.

Summary of new Initiatives at SAMHS

The Office of Substance Abuse and Mental Health Services (SAMHS) has hired Phyllis Powell to manage the Waitlist and assist in contract compliance efforts. The Waitlist has improved dramatically from July 2015 to July 2016 as represented by a **74**% overall reduction in persons waiting for services; however, the data continues to indicate need for improvement in this key metric. SAMHS will continue to analyze and improve the Waitlist system over the coming months. This process includes an analysis of the existing system, as well the relationships and business processes by and between: KeyPro (formerly APS HealthCare), the Provider Community, SAMHS, and the consumers themselves.

The Behavioral Health Home (BHH) initiative has blossomed as of March 31st there were 4,536 members in the program, consisting of 27 Behavioral Health locations with 70 sites. We anticipate additional growth of the BHH program as the Office of MaineCare Services opened up new applications on April 1, 2016 to promote additional capacity. The approval date for new BHHOs was July 21, 2016 and it is expected that the programs will be able to admit consumers is early fall.

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

We expect to have our first look at the data regarding the 7-day referral to service standard in August. This data will be influenced through October of 2016 by the additional time allowed for consumers to transition to more appropriate levels of care—under the Emergency Rules.

Several members of SAMHS, in conjunction with Providers, Consumers, and Disability Rights Maine have been working on the development of a Discharge Planning Protocol from the state psychiatric hospitals to the community. This project has also included protocol discussions in moving from the Residential Treatment portfolio to more independent living in the community.

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, 2016

Daniel E. Wathen, Esq.
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RE: *Bates v. DHHS* – Quarterly Progress Report

Dear Justice Walthen:

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

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

Sincerely,

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

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

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

	Compliance Standard	Report/Update
I.1	Implementation of all the system development steps in October 2006 Plan	As of March 2010, all 119 original components of the system development portion of the Consent Decree Plan of October 2006 have been accomplished or deleted per amendment.
I.2	Certify that a system is in place for identifying unmet needs	See attached *Cover: Unmet Needs August2016* And *Unmet Needs by CSN for FY16 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 Plan is being developed and is expected to be ready by the next Quarterly Report.
II.1	Provide documentation that unmet needs data and information (data source list page 4 of compliance plan) is used in planning for resource development and preparing budget requests	Department is in the process of submitting funding requests to meet all identified needs under the Consent Decree, for the next biennial budget. All funds are now part of the base budget.
II.2	Demonstrate reliability of unmet needs data based on evaluation	See *Cover: Unmet Needs and Quality Improvement Initiatives May 2016* and the *Performance and Quality Improvement Standards: August 2016* for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data. SAMHS continues to review the reliability of the unmet needs data to ensure proper identifying, recording and implementation of services for unmet needs. See Section 6.
II.3	Submission of budget proposals for adult mental health services given to Governor,	The Director of SAMHS provides the Court Master with an updated projection of needs and associated costs as

	with pertinent supporting documentation showing requests for funding to address unmet needs *(Amended language 9/29/09)*	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	Under development
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs August 2016* and the *Performance and Quality Improvement Standards: August 2016* for examples of the Department Utilizing the QM system Performance measures are in all direct service contracts.
III.1a	Document through quarterly or annual reports the data collected and activities to assure reliability (including ability of EIS to produce accurate data)	This quarterly report documents significant data collection and review activities of the SAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	See compliance standard II.4 above for examples of how quality management data was used to support budget requests for systems improvement. Unmet need reports have been used to identify where additional funds are needed for delivery of services.
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Contract and licensing reviews are conducted as licenses expire. A report from DLRS is available; during the last quarter 33 of 33 agencies had protocol/procedures in place for client notification of rights.
IV.2	If results from the DIG Survey fall below levels established for Performance and Quality Improvement Standard 4.2, 90% of consumers report they were given information about their rights, the Department: (i) consults with the Consumer Council System of Maine (CCSM); (ii) takes corrective action a determined necessary by CCSM; and (iii) develops that corrective action in consultation with CCSM. *(Amended language 1/19/11)*	The percentage for standard 4.2 from the 2015 DIG Survey was 77%. These data are posted on the SAMHS website and provided to the Consumer Council of Maine. SAMHS distributed the survey in August 2015 and the recipients had until November 30, 2015 to return the survey. The survey is based on the model Perception of Care developed by the New York Office of Alcoholism and Substance Abuse. See longer explanation in Section 5.
IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if hearing is to be held or if parties concur.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.

IV.5	90% hospitalized class members assigned worker within 2 days of request - *must be met for 3 out of 4* quarters	See attached *Performance and Quality Improvement Standards: August 2016,* Standard 5-2. This standard has not been met for the past 4 quarters.
IV.6	90% non-hospitalized class members assigned worker within 3 days of request - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: August 2016,* Standard 5-3. This standard has not been met for the past 4 quarters.
IV.7	95% of class members in hospital or community not assigned within 2 or 3 days, assigned within an additional 7 days - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: August 2016,* Standard 5-4. This standard has not been met for the past 4 quarters.
IV.8	90% of class members enrolled in CSS with initial ISP completed within 30 days of enrollment - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: August 2016,* Standard 5-5. This standard has not been met for the past 4 quarters.
IV.9	90% of class members had their 90 day ISP review(s) completed within that time period - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: August 2016,* Standard 5-6. This standard has not been met for the past 4 quarters
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. The data has been consistent over time and since May 2011, reports are created quarterly and available to providers upon request.
IV.11	Data collected once a year shows that no more than 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	The 2015 data analysis indicates that out of 1,441 records for review, 173 (12.0%) did not have an ISP review within the prescribed time frame. The Quality Services Specialist has been giving technical support to agencies where class members enrolled in CS did not have their ISP reviewed before the next annual review.
IV.12	Certify in quarterly reports that DHHS is meeting its obligation re: quarterly mailings	On December 10, 2014, the court approved an amendment to a Stipulated Order that requires monitoring of class member addresses. If the percentage of unverified addresses exceeds 15%, the court master will review the efforts and make necessary recommendations. A list of class member's addresses is available to the court master, plaintiff's counsel and the court upon request.
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - *must be met for 3 out of 4 quarters*	See Section 9 *Class Member Treatment Planning Review*, Question 2A. This standard has been met in 3 of the last 4 quarters. The percentage for this quarter is 95.9%.
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be met for 3 out of 4 quarters*	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.15	90% of ISPs reviewed have a crisis plan or documentation as to why one wasn't developed - *must be met for 3 out of 4 quarters*	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.16	QM system documents that SAMHS	See Section 9 *Class Member Treatment Planning*

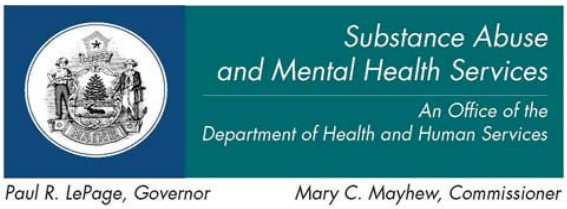
	requires corrective action by the provider agency when document review reveals not all domains assessed	*Review*, Question 6.a.1 that addresses plans of correction. Corrective action taken when all domains were not assessed.
IV.17	In 90% of ISPs reviewed, interim plans developed when resource needs not available within expected response times - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: August 2016,* Standard 8-2 and *Class Member Treatment Plan Review,* Question 3F. This standard has been met 1quarter 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 2016,* Standard 9-1 and *Class Member Treatment Plan Review,* Questions 4B & C. This standard has not been met for the last 4 quarters.
IV.19	90% of ACT/ICI/CI providers statewide meet prescribed case load ratios - *must be met for 3 out of 4 quarters* Note: As of 7/1/08, ICI is no longer a service provided by DHHS.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - *must be met for 3 out of 4 quarters*	ICMs' work is focused on community forensic and outreach services. Individual ICMs no longer carry caseloads. Should this change in the future, SAMHS will resume reporting on caseload ratios.
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: August 2016,* Standard 10-5. This standard has been met in FY 15 Q2, Q3, Q4 and FY 16 Q1, Q2, Q3 and Q4
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 2016,* Standard 12-1 Standard met for the FY08 Q4; FY09 Q1,Q3, and Q4; FY10; FY11; FY12, FY13;FY 14, and FY 15, and FY16 Q1, Q2 and Q3
IV.23	**EITHER** quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet residential supports needs for non-class members do not exceed 15 percentage points of the same for Class Members. See attached report Consent Decree Compliance Standards IV.23 and IV.43
	Meet RPC discharge standards (below); **or** if not met document reasons and demonstrate that failure not due to lack of	See attached *Performance and Quality Improvement Standards: August 2016,* Standards 12-2, 12-3 and 12-4

	residential support services • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	Standard 12.2 and 12.4 were not met Q3 FY16.
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 2016,* Standard 14-1 Standard has been met for the last 4 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 2016,* Standard 14-4, 14-5 & 14-6 Standard 14-4 met since the beginning of FY09, except for FY10 Q3, FY15 Q4 and FY 16 Q1, Q2 and Q3. Standard 14-5 met FY09 Q2; Q3; and Q4; FY10 Q2 and Q4; FY11;FY12, FY13, FY 14, FY 15, and FY 16 Standard 14-6 met FY09 Q2 and Q4; FY10 Q2; and Q4; FY11, FY12, FY13, and FY 14, FY 15 Q1 and Q4; and FY 16 Q1, Q2
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Standard no longer reported per amendment dated May 8, 2014.
IV.28	90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in attachment C to the Compliance Plan	See attached *Performance and Quality Improvement Standards: August 2016,* Standard 16-1 and *Community Hospital Utilization Review – Class Members 1st Quarter of Fiscal Year 2016.* IN FY13 Q1: 100% (19 of 19) Q2: 92.9% (13 of 14) Q3: 86.7% (13 of 15) Q4: 90.0% (18 of 20) IN FY14 Q1: 27.3%(3 of 11) Q2: 76.5% (13 of 17) Q3: 84.6 % (11 of 13) Q4: 100.0 % (12 of 12) IN FY15 Q1: 100.0%%(12 of 12) Q2: 77.8 (14 of 18) Q3: 95.5% (21 of 22) Q4: 86.7% (13 of 15) IN FY16 Q1: 79.2 (19 of 24) Q2: 94.4 (17 of 18) Q3: Not completed (See Section 5)
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	See IV.30 below
IV.30	Evaluates compliance with all legal requirements for involuntary clients and	All involuntary hospital contracts are in place.

	with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	
IV.31	UR Nurses review all involuntary admissions funded by DHHS, take corrective action when they identify deficiencies and send notices of any violations to the licensing division and to the hospital	SAMHS reviews emergency involuntary admissions at the following hospitals: Maine General Medical Center, Spring Harbor, St. Mary's, Mid-Coast Hospital, Southern Maine Medical Center, PenBay Medical Center, Maine Medical Center/P6 and Acadia. No hospitals were reviewed this quarter due to staffing. SAMHS is in the process of hiring. 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.	7 Complaints Received 4 Complaints investigated 2 Substantiated 1 Plan of correction sought 2 Rights of Recipients Violations found
IV.33	• 90% of the time corrective action was taken when blue papers were not completed in accordance with terms • 90% of the time corrective action was taken when 24 hour certifications were not completed in accordance with terms • 90% of the time corrective action was taken when patient rights were not maintained	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.34	QM system documents that if hospitals have fallen below the performance standard for any of the following, SAMHS made the information public through CSNs, addressed in contract reviews with hospitals and CSS providers, and took appropriate corrective action to enforce responsibilities • obtaining ISPs (90%) • creating treatment and discharge plan consistent with ISPs (90%) • involving CIWs in treatment and discharge planning (90%)	See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members2nd[t] Quarter of Fiscal Year 2016.* The report displaying data by hospital for community hospitals accepting emergency involuntary clients is shared quarterly by posting reports on the CSN section of the Office's website. Standard 18.1 has been met once in the past 3 quarters. Standard 18.2 has been met for the past 3 quarters. Standard 18.3 has been met for the past 2 out of 4 quarters. No hospitals were reviewed this quarter due to staffing. SAMHS working toward hiring a UR nurse.
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 2016*, Standard 19-1 and *Adult Mental Health Quarterly Crisis Report 4th Quarter, State Fiscal Year 2016 Summary Report*. Standard met In FY12,FY13, FY14, FY 15, FY16 Q1, Q2 and Q3, Q4 slightly below at 19.9%.
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	See attached *Adult Mental Health Quarterly Crisis Report 3rd Quarter, State Fiscal Year 2016 Summary Report.*

	phone call – *must be met for 3 out of 4 quarters* Per amendment dated May 8,2014 the standard now reads as follows: 90% of crisis calls requiring face-to-face assessments are responded to within an average of 60 minutes from the end of the phone call	Starting with July 2008 reporting from providers, SAMHS collects data on the total number of minutes for the response time (calculated from the determination of need for face to face contact or when the individual is ready and able to be seen to when the individual is actually seen) and figures an average. Average statewide calls requiring face to face assessments are responded to within an average of 30 minutes from the end of the phone call – this standard was met FY12, FY13, FY14 Q1, Q2, Q4. FY 15 Q2, Q3, Q4 and FY 16
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 4th Quarter, State Fiscal Year 2016 Summary Report*. Standard has been met since FY08 Q2 until FY 15 Q1 (87.2%), Q2 (87.7%), Q3 (86.8%), Q4 (86.7%) and in FY 16 Q1 (88.6%). Standard met FY 16 Q2 (90.2%), FY 16 Q3 (90.5%). Standard not met FY16 Q4
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 2016*, Standard 19-4 and *Adult Mental Health Quarterly Crisis Report 4th Quarter, State Fiscal Year 2016 Summary Report*. Standard met 3 of the last 4 quarters.
IV.39	Compliance Standard deleted 1/19/2011.	
IV.40	Department has implemented the components of the CD plan related to vocational services	As of FY10, Q3, the Department has implemented all components of the CD Plan related to Vocational Services.
IV.41	QM system shows that the Department conducts further review and takes appropriate corrective action if PS 26.3 data shows that the number of consumers under age 62 and employed in supportive or competitive employment falls below 10%. *(Amended language 1/19/11)*	2015 Adult Health and Well-Being Survey: 10 % of consumers in supported and competitive employment (full or part time).
IV.42	5% or fewer class members have unmet needs for mental health treatment services – *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: August 2016,* Standard 21-1 This standard has not been met for the last 3 quarters but was met for Q3 FY16.
IV.43	**EITHER** quarterly unmet mental health treatment needs for one year for qualified non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet mental health treatment needs for non-class members do not exceed 15 percentage points of the same for Class Members. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.44	QM documentation shows that the	2015 Adult Health and Well-Being Survey: 83.9%

	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**	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 2016*, Standards 21-2, 21-3 and 21-4 Standard 12.2 met since the beginning of FY08 Standard 12.3 met since the beginning of FY08 Standard 12.4 met since the beginning of FY08 except FY16 Q3
IV.46	The department documents the programs it has sponsored that are designed to improve quality of life and community inclusion for class members, including support of peer centers, social clubs, community connections training, wellness programs, and leadership and advocacy training programs. Standard amended per amendment dated May 8, 2014	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: August 2016*, Standard 28 This standard has been consistently met since FY08.
IV.48	Provide documentation in quarterly reports of funding, developing, recruiting, and supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.49	Certify that all contracts with providers include a requirement to refer family members to family support services, and produce documentation that contract reviews include evaluation of compliance with this requirement.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.50	The department documents the number and types of mental health informational workshops, forums, and presentations geared toward the general public that are designed to reduce myths and stigma of mental illness and to foster community integration or persons with mental illness.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.



Consent Decree Performance and Quality Improvement Standards: August 2016

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

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

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

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

Calendar and Fiscal Year Definitions:

CY: Calendar Year - January 1 - December 31.

FY: Fiscal Year - State Fiscal Year July 1 - June 30.

DHHS Office of Substance Abuse and Mental Health Services

Compliance and Performance Standards: Summary Sheet
April - June 2016

Standard 1. Rights Dignity and Respect

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

Standard 2. Rights Dignity and Respect

Consent Decree Performance and Quality Improvement Standards: November 2015

Standard 3. Rights Dignity and Respect

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

Standard 4. Rights Dignity and Respect

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

Standard 5. Timeliness of ISP and CI/CSS Assignment

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

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

Standard 7. CI/CSS/ Individualized Support Planning

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

Standard 8. CI/CSS Individualized Support Planning

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

Standard 9. ISP Service Agreements

ISPs that require Service Agreements that have current Service Agreements

DHHS Office of Substance Abuse and Mental Health Services

Compliance and Performance Standards: Summary Sheet
April - June 2016

Standard 10. Case Load Ratios

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

Standard 11. CI/CSS Individualized Support Planning

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

Standard 12. Housing & Residential Support Services

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

Standard 13. Housing & Residential Support Services

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

Standard 14. Housing & Residential Support Services

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

Standard 15. Housing & Residential Services

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

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

Inpatient admissions reasonably near community residence.

DHHS Office of Substance Abuse and Mental Health Services

Compliance and Performance Standards: Summary Sheet
April - June 2016

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

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

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

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

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

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

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

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

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

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

Standard 19. Crisis intervention Services

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

Standard 20. Crisis Intervention Services

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

Standard 21. Treatment Services

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

Standard 22. Treatment Services

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

Standard 23. Family Support Services

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

DHHS Office of Substance Abuse and Mental Health Services

Compliance and Performance Standards: Summary Sheet
April - June 2016

Standard 24. Family Support Services

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

Standard 25. Family Support Services

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

Standard 26. Vocational Employment Services

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

Standard 27. Vocational Employment Services

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

Standard 28. Transportation

Class Members with ISPs - Unmet transportation needs.

Standard 29. Transportation

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

Standard 30. Rec/Soc/Avocational/Spiritual Opportunities

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

Standard 31. Rec/Soc/Avoc/Spirtual

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

Standard 32. Individual Outcomes

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

DHHS Office of Substance Abuse and Mental Health Services

Compliance and Performance Standards: Summary Sheet
April - June 2016

Standard 33. Recovery

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

Standard 34. Public Education

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

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Consent Decree Performance and Quality Improvement Standard 5

Report for: 2016 Q4
(September, December 2015, March 2016)
(Class Members)

Measurement			
Method 1	Percent of class members requesting a worker who were assigned one.		
	2015 Q4	100.0%	(209 of 209)
	2016 Q1	100.0%	(159 of 159)
	2016 Q2	100.0%	(166 of 166)
	2016 Q3	100.0%	(256 of 256)
Method 2	Percent of hospitalized class members who were assigned a worker within 2 days.		
	2015 Q4	52.0%	(13 of 25)
	2016 Q1	50.0%	(8 of 16)
	2016 Q2	72.0%	(18 of 25)
	2016 Q3	77.1%	(27 of 35)
Method 3	Percent of non-hospitalized class members assigned a worker within 3 days.		
	2015 Q4	80.0%	(132 of 165)
	2016 Q1	80.4%	(115 of 143)
	2016 Q2	76.6%	(108 of 141)
	2016 Q3	71.0%	(157 of 221)
Method 4	Percent of class members in hospital or community not assigned on time but were assigned within 1-7 additional days.		
	2015 Q4	45.2%	(19 of 42)
	2016 Q1	25.0%	(9 of 36)
	2016 Q2	52.5%	(21 of 40)
	2016 Q3	48.6%	(35 of 72)
Method 5	ISP completed within 30 days of service request.		
	2015 Q4	81.5%	(44 of 54)
	2016 Q1	92.5%	(49 of 53)
	2016 Q2	89.0%	(65 of 73)
	2016 Q3	85.0%	(51 of 60)
Method 6	90 Day ISP review completed within specified timeframe.		
	2015 Q4	67.5%	(692 of 1,025)
	2016 Q1	61.1%	(596 of 976)
	2016 Q2	69.8%	(634 of 908)
	2016 Q3	69.8%	(630 of 903)

Method 7	Initial ISPs not developed within 30 days, but were developed within 60 days.		
	2015 Q4	30.0%	(3 of 10)
	2016 Q1	50.0%	(2 of 4)
	2016 Q2	75.0%	(6 of 8)
	2016 Q3	66.7%	(6 of 9)

Method 8	ISPs that were not reviewed within 90 days, but were reviewed within 120 days.		
	2015 Q4	88.0%	(293 of 333)
	2016 Q1	65.3%	(248 of 380)
	2016 Q2	94.2%	(258 of 274)
	2016 Q3	94.1%	(257 of 273)

As of: July 13, 2016 Run By: Lee Richardson

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

Performance Indicators and Quality Improvement Standards

APPENDIX: ADULT MENTAL HEALTH DATA SOURCES

Adult Health and Well- Survey:

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

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

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

Community Hospital Utilization Review Summary:

Data Type/Method: Service Review/Document Review
Target Population: Individuals admitted to community inpatient psychiatric hospitals on an emergency involuntary basis.
Approximate Sample Size: 105 per quarter; FY16 Q2 0 Lack of staff, SAMHS is working toward hiring a UR nurse

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

Community Support Enrollment Data:

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

Community Support Services Census/Staffing Data:

Data Type/Method: Provider Completed Survey; Completed by supervisors of Assertive Community Treatment (ACT), Community Integration (CI), Community Rehabilitation Services (CRS) and Behavioral Health Homes (BHH).

Target Population: Consumers receiving CI/ACT/CRS/BHH from DHHS/SAMHS contracted agencies.

Approximate Sample Size: Collected from all providers of these services on a quarterly basis.

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

Grievance Tracking Data:

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

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

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

Class Member Treatment Planning Review:

Data Type/Method: Service Review/Document Review

Target Population: Class Members receiving Community Support Services (ACT, CI, CRS and BHH)

Approximate Sample Size: The sample size is 50 per quarter, utilizing the random sampling methodology as previously developed. This review allows the SAMHS Division of Quality Management the opportunity to assess and develop a new system of document reviews, not solely focused on treatment planning, that can be implemented across program areas and provide data for a wider group of individuals utilizing mental health services.

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

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

Data Type/Method: ISP RDS submitted by Community Support providers and collected by APS Healthcare as a component of their authorization process. Data is then entered into EIS twice a month.

Target Population: Adult Mental Health Consumers who receive Community Support Services (ACT, CI, CRS and BHH).

The data is collected in APS Healthcare, sent to SAMHS and reported through the DHHS Enterprise Information System (EIS). The ISP RDS captures ISP completion dates. The ISP RDS also captures data on the current housing/living situation of the person receiving services as well as the current

vocational/employment statuses. Needed resources are tracked and include the following categories: Mental Health Services, Peer, Recovery and Support Services, Substance Abuse Services, Housing Resources, Health Care Resources, Legal Resources, Financial Resources, Educational Resources, Vocational Resources, Living Skills Resources, Transportation Resources, Personal Growth Resources and Other. The ISP RDS calculates unmet needs data by comparing current 90 day reviews to previous 90 days reviews. See Section 6 for other changes to the RDS.

Quarterly Contract Performance Measures Data:

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

Performance measures are in all mental health direct services contracts. There are also some performance measures in the indirect services contracts.

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

Attached Report:

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

Population Covered:

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

Data Sources:

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

Unmet Resource Need Definition

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

Quality Improvement Measures

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

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

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

Ongoing Quality Improvement Initiatives

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

Contract Performance Measures. SAMHS has instituted contract performance measures for all direct services which include but are not limited to Community Integration, ACT, Community Rehabilitation Services, Behavioral Health Homes, Daily Living Support Services, Skills Development, Medication Management and Residential Treatment. Where appropriate, the measures are in alignment with standards under the Consent Decree Plan. SAMHS will be reviewing all measures before implementing FY17 contracts.
Identified Need: A, B, C, D, E, J, K, L.

Contract Review Initiative. The staff at the Office of Continuous Quality Improvement has continued to ensure up-to-date, accurate service encounter data. A query tool was built to help SAMHS identify service utilization patterns across three sources of funding federal funds, state funds and Consent Decree funds. Also there was a tool developed to make it easier for providers to submit their data to SAMHS. This entire project has been completed but needs constant monitoring.
Identified Need: A, B, D, E, I, J, L

Mental Health Rehabilitation Technician- SAMHS, Muskie School, providers and consumers have formed a group to redesign the certification of the Mental Health Rehabilitation Technician/Community. The group has worked over the last year to come up with ways to redesign the certification. They are currently working on the Competencies required to be certified. Different pathways are being considered for people to obtain their MHRT/C certification, including but not limited to those with a MHRT/1 and peers who have training as Certified Intentional Peer Support person. The redesign group met with academic entities and asked these entities to give them feedback by 7/1/16. The redesign group also has developed a web-based training **Maine Mental Health System 101** for those with clinical degrees who wish to provide services as a MHRT/C. This initiative continues to move forward but has not been formalized.
Identified Need: A, B, C, D, E, F, G, H, I, J, K, L, M

Consent Decree Process Improvement Quality Improvement Initiative
A staff member has been designated to oversee management of the Waitlist for CI services. This person has worked with SAMHS staff to identify strengths and weaknesses. This person is working in conjunction with SAMHS staff to make changes to the system to better manage the Waitlist. Currently, agencies are getting their Waitlists directly from APS Healthcare. The agencies are to respond to the Field Service Managers and Field Service Specialist regarding each consumer and their status regarding wait time, who is choosing to stay on that agency's waitlist, who is in service, who is not in service, what is their start date, who has been discharged, who has rescheduled appointments and any other explanation. The Waitlist has decreased by 74% from 6/29/15-7/6/16.
Identified Need: A, B

SAMHS Quality Management Plan 2016-2019- A new Quality Management Plan is being developed that will better describe how (and what) data is being utilized to monitor and improve the adult mental health system. A draft is expected to be available for review by October 1, 2016.
Identified Need: A,B,C,D,E,F,G,H,I,J,K,L,M

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

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

Resource Data Summary- A combined project with SAMHS, APS Healthcare and providers to assess what would be helpful for providers in entering and discharging unmet needs in APS Healthcare. APS has recently posted training materials on their website to assist providers in closing an unmet need when it is no longer needed without waiting for a 90 day review. SAMHS and APS have worked on a system to delete the reporting of an unmet need of those who have received the service but were not closed by the agency. This will provide SAMHS with a more accurate picture of unmet needs.
Identified Need: A, B, C, D, E, F, G, H, I, J, K, L, M

Section 17- The amendments to Section 17 of the MaineCare rules went into effect on April 8, 2016. The amendments changed the eligibility requirements for Community Integration Service and impose a new seven (7) day requirement for face-to-face contact with the consumer. SAMHS has been working with APS Healthcare to capture compliance with the seven (7) day face-to-face requirement. Persons who don't meet the new eligibility criteria will be given up to 120 days as a transition period. If a person is unable to transition to a different service they will be given an extra 90 days. All class members will receive Community Integration regardless of eligibility. SAMHS will see the first data from the seven (7) day requirement for face-to-face contact in late August 2016.
Identified Need: A, C

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

Substance Abuse and Mental Health Services
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http://www.maine.gov/dhhs/mh/index.shtml

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

January, February, March, 2016

Purpose of Report:

This report examines:

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

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

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

Data collection and reporting:

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

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

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

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

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Report of Unmet Resource Needs

Statewide

(Class Members and Non-Class Member)

Fiscal Year 2016 Quarter 3

(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	10,664	11,783	11,600	11,296
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	48	50	33	18
7a-iii Dialectical Behavioral Therapy	89	86	71	47
7a-iv Family Psycho-Educational Treatment	23	33	27	20
7a-v Group Counseling	71	82	77	58
7a-vi Individual Counseling	662	816	763	375
7a-vii Inpatient Psychiatric Facility	7	9	7	2
7a-viii Intensive Case Management	88	103	105	70
7a-x Psychiatric Medication Management	609	681	595	357
Total Unmet Resource Needs	1,597	1,860	1,678	947
Distinct Clients with Unmet Resource Needs	1,169	1,354	1,233	766
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	311	422	347	260
7b-ii Mental Health Advance Directives	79	82	65	50
Total Unmet Resource Needs	390	504	412	310
Distinct Clients with Unmet Resource Needs	359	471	390	298
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	63	70	60	45
7c-ii Recovery Workbook Group	5	6	9	4
7c-iii Social Club	183	204	169	137
7c-iv Peer-Run Trauma Recovery Group	47	58	66	43
7c-v Wellness Recovery and Action Planning	46	61	59	49
7c-vi Family Support	158	224	215	185
Total Unmet Resource Needs	502	623	578	463
Distinct Clients with Unmet Resource Needs	388	476	450	370
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	95	115	91	62
7d-ii Residential Treatment Substance Abuse Services	18	21	17	10

Report Run: July 11, 2016

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

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

Report of Unmet Resource Needs

Statewide
(Class Members and Non-Class Member)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	10,619	11,724	11,479	8,580
Total Unmet Resource Needs	113	136	108	72
Distinct Clients with Unmet Resource Needs	108	130	102	71
7e. Housing				
7e-i Supported Apartment	114	128	127	97
7e-ii Community Residential Facility	34	43	37	28
7e-iii Residential Treatment Facility (group home)	19	25	16	11
7e-iv Assisted Living Facility	47	49	37	39
7e-v Nursing Home	4	3	3	4
7e-vi Residential Crisis Unit	0	1	0	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	847	971	954	809
Total Unmet Resource Needs	1,065	1,220	1,174	989
Distinct Clients with Unmet Resource Needs	994	1,122	1,099	926
7f. Health Care				
7f-i Dental Services	648	699	699	615
7f-ii Eye Care Services	246	298	311	262
7f-iii Hearing Services	47	69	68	59
7f-iv Physical Therapy	54	68	56	54
7f-v Physician/Medical Services	358	427	373	296
Total Unmet Resource Needs	1,353	1,561	1,507	1,286
Distinct Clients with Unmet Resource Needs	983	1,088	1,043	896
7g. Legal				
7g-i Advocate	136	142	128	115
7g-ii Guardian (private)	25	22	20	14
7g-iii Guardian (public)	14	10	10	7
Total Unmet Resource Needs	175	174	158	136
Distinct Clients with Unmet Resource Needs	166	168	152	134
7h. Financial Security				

Report Run: Apr 26, 2016

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

Report of Unmet Resource Needs

Statewide
(Class Members and Non-Class Member)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	10,664	11,783	11,600	11,296
7h-i Assistance with Managing Money	619	680	619	546
7h-ii Assistance with Securing Public Benefits	347	384	322	286
7h-iii Representative Payee	52	61	48	41
Total Unmet Resource Needs	1,018	1,125	989	873
Distinct Clients with Unmet Resource Needs	852	940	824	717
7i. Education				
7i-i Adult Education (other than GED)	103	138	125	126
7i-ii GED	78	92	83	66
7i-iii Literacy Assistance	38	50	49	33
7i-iv Post High School Education	111	113	110	105
7i-v Tuition Reimbursement	15	19	21	24
Total Unmet Resource Needs	345	412	388	354
Distinct Clients with Unmet Resource Needs	297	352	323	299
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	42	52	56	38
7j-ii Club House and/or Peer Vocational Support	36	38	33	21
7j-iii Competitive Employment (no supports)	79	86	87	90
7j-iv Supported Employment	63	71	75	68
7j-v Vocational Rehabilitation	275	278	250	187
Total Unmet Resource Needs	495	525	501	404
Distinct Clients with Unmet Resource Needs	429	443	436	345
7k. Living Skills				
7k-i Daily Living Support Services	301	349	290	188
7k-ii Day Support Services	37	47	39	24
7k-iii Occupational Therapy	15	20	17	11
7k-iv Skills Development Services	90	118	108	80
Total Unmet Resource Needs	443	534	454	303

Report Run: July 11, 2016

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

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

Report of Unmet Resource Needs

Statewide
(Class Members and Non-Class Member)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	10,664	11,783	11,600	11,296
Distinct Clients with Unmet Resource Needs	391	463	400	263
7l. Transportation				
7l-i Transportation to ISP-Identified Services	492	570	495	439
7-ii Transportation to Other ISP Activities	263	317	278	250
7-iii After Hours Transportation	189	223	193	180
Total Unmet Resource Needs	944	1,110	966	869
Distinct Clients with Unmet Resource Needs	628	713	626	546
7m. Personal Growth/Community				
7m-i Avocational Activities	28	36	30	32
7m. Personal Growth/Community				
7m-ii Recreation Activities	202	231	198	182
7m-iii Social Activities	437	498	472	415
7m-iv Spiritual Activities	85	105	103	83
Total Unmet Resource Needs	752	870	803	712
Distinct Clients with Unmet Resource Needs	522	600	559	486
Other Resources				
Other Resources	175	184	188	209
Total Unmet Resource Needs	175	184	188	209
Distinct Clients with Unmet Resource Needs	175	184	188	209
Statewide Totals				
Total Unmet Resource Needs	9,367	10,838	9,904	7,927
Distinct Clients With any Unmet Resource Need	2,840	3,097	2,946	2,454
Distinct Clients with a RDS	10,664	11,783	11,600	11,296

Report Run: July 11, 2016

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

Report of Unmet Resource Needs

Statewide
(Class Members Only)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,117	1,187	1,151	1,111
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	8	7	4	3
7a-iii Dialectical Behavioral Therapy	3	2	0	0
7a-iv Family Psycho-Educational Treatment	2	2	3	1
7a-v Group Counseling	6	3	2	3
7a-vi Individual Counseling	35	47	35	18
7a-vii Inpatient Psychiatric Facility	1	1	0	0
7a-viii Intensive Case Management	7	6	11	4
7a-x Psychiatric Medication Management	47	44	30	22
Total Unmet Resource Needs	109	112	85	51
Distinct Clients with Unmet Resource Needs	77	83	63	43
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	15	21	15	7
7b-ii Mental Health Advance Directives	7	6	2	2
Total Unmet Resource Needs	22	27	17	9
Distinct Clients with Unmet Resource Needs	20	24	16	8
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	8	9	4	4
7c-ii Recovery Workbook Group	0	1	2	1
7c-iii Social Club	10	15	12	10
7c-iv Peer-Run Trauma Recovery Group	3	3	1	1
7c-v Wellness Recovery and Action Planning	2	6	2	3
7c-vi Family Support	5	6	6	5
Total Unmet Resource Needs	28	40	27	24
Distinct Clients with Unmet Resource Needs	21	28	20	18
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	6	9	5	4
7d-ii Residential Treatment Substance Abuse Services	3	3	3	2

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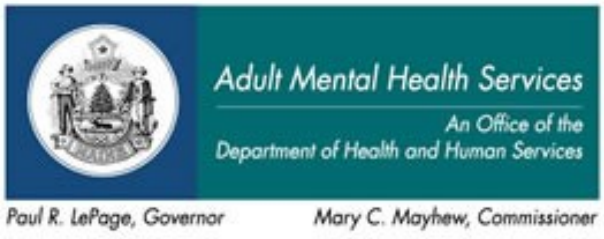

Report of Unmet Resource Needs

Statewide

(Class Members Only)

Fiscal Year 2016 Quarter 3

(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,117	1,187	1,151	1,111
Total Unmet Resource Needs	9	12	8	6
Distinct Clients with Unmet Resource Needs	9	12	8	6
7e. Housing				
7e-i Supported Apartment	15	20	14	12
7e-ii Community Residential Facility	7	6	8	4
7e-iii Residential Treatment Facility (group home)	5	6	4	3
7e-iv Assisted Living Facility	6	8	8	6
7e-v Nursing Home	0	0	1	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	69	77	68	47
Total Unmet Resource Needs	102	117	104	73
Distinct Clients with Unmet Resource Needs	89	97	86	62
7f. Health Care				
7f-i Dental Services	51	52	51	42
7f-ii Eye Care Services	12	14	13	13
7f-iii Hearing Services	2	4	2	3
7f-iv Physical Therapy	1	2	2	1
7f-v Physician/Medical Services	29	27	24	12
Total Unmet Resource Needs	95	99	92	71
Distinct Clients with Unmet Resource Needs	82	80	71	53
7g. Legal				
7g-i Advocate	9	8	7	4
7g-ii Guardian (private)	2	1	0	0
7g-iii Guardian (public)	6	4	4	2
Total Unmet Resource Needs	17	13	11	6
Distinct Clients with Unmet Resource Needs	14	13	11	6
7h. Financial Security				

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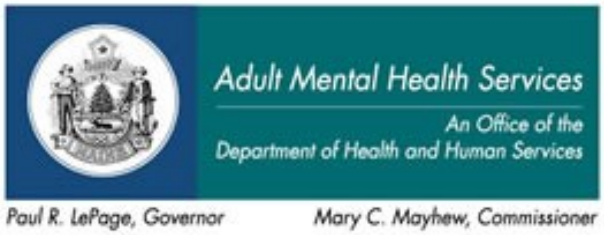


Report of Unmet Resource Needs

Statewide

(Class Members Only)

Fiscal Year 2016 Quarter 3

(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,117	1,187	1,151	1,111
7h-i Assistance with Managing Money	23	29	18	18
7h-ii Assistance with Securing Public Benefits	20	24	15	15
7h-iii Representative Payee	10	12	8	5
Total Unmet Resource Needs	53	65	41	38
Distinct Clients with Unmet Resource Needs	44	55	35	31
7i. Education				
7i-i Adult Education (other than GED)	2	1	3	2
7i-ii GED	4	6	5	1
7i-iii Literacy Assistance	3	2	2	2
7i-iv Post High School Education	5	6	5	3
7i-v Tuition Reimbursement	1	2	2	2
Total Unmet Resource Needs	15	17	17	10
Distinct Clients with Unmet Resource Needs	12	13	15	10
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	2	4	5
7j-ii Club House and/or Peer Vocational Support	5	6	7	4
7j-iii Competitive Employment (no supports)	6	4	4	6
7j-iv Supported Employment	10	7	8	5
7j-v Vocational Rehabilitation	14	13	18	12
Total Unmet Resource Needs	36	32	41	32
Distinct Clients with Unmet Resource Needs	30	26	35	27
7k. Living Skills				
7k-i Daily Living Support Services	24	31	19	7
7k-ii Day Support Services	3	4	5	2
7k-iii Occupational Therapy	2	0	1	0
7k-iv Skills Development Services	9	8	8	4
Total Unmet Resource Needs	38	43	33	13

Report Run: July 11, 2016

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

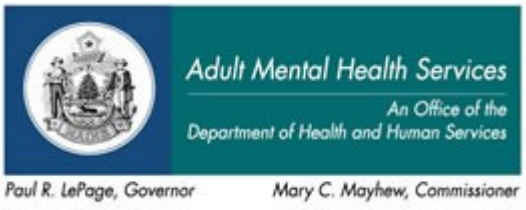
Report of Unmet Resource Needs

Statewide
(Class Members Only)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,117	1,187	1,151	1,111
Distinct Clients with Unmet Resource Needs	28	34	24	10
7l. Transportation				
7l-i Transportation to ISP-Identified Services	26	34	24	17
7-ii Transportation to Other ISP Activities	19	20	19	16
7-iii After Hours Transportation	21	20	21	12
Total Unmet Resource Needs	66	74	64	45
Distinct Clients with Unmet Resource Needs	49	54	44	28
7m. Personal Growth/Community				
7m-i Avocational Activities	1	1	1	2
7m. Personal Growth/Community				
7m-ii Recreation Activities	13	15	18	11
7m-iii Social Activities	35	35	38	22
7m-iv Spiritual Activities	2	3	3	3
Total Unmet Resource Needs	51	54	60	38
Distinct Clients with Unmet Resource Needs	40	41	45	27
Other Resources				
Other Resources	16	11	11	16
Total Unmet Resource Needs	16	11	11	16
Distinct Clients with Unmet Resource Needs	16	11	11	16
Statewide Totals				
Total Unmet Resource Needs	657	716	611	432
Distinct Clients With any Unmet Resource Need	267	269	238	182
Distinct Clients with a RDS	1,117	1,187	1,151	1,111

Report Run: July 11, 2016



Report of Unmet Resource Needs

CSN 1
(Aroostook)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	403	469	446	478
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	3	2	1	2
7a-iii Dialectical Behavioral Therapy	4	7	3	2
7a-iv Family Psycho-Educational Treatment	1	2	1	2
7a-v Group Counseling	5	8	8	11
7a-vi Individual Counseling	25	28	24	20
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	2	1	0	3
7a-x Psychiatric Medication Management	24	23	19	20
Total Unmet Resource Needs	64	71	56	60
Distinct Clients with Unmet Resource Needs	54	53	47	44
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	19	22	14	25
7b-ii Mental Health Advance Directives	1	1	1	0
Total Unmet Resource Needs	20	23	15	25
Distinct Clients with Unmet Resource Needs	19	22	15	25
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	1	0	0
7c-ii Recovery Workbook Group	0	1	1	1
7c-iii Social Club	16	16	9	12
7c-iv Peer-Run Trauma Recovery Group	0	1	2	4
7c-v Wellness Recovery and Action Planning	1	2	1	1
7c-vi Family Support	8	10	6	5
Total Unmet Resource Needs	26	31	19	23
Distinct Clients with Unmet Resource Needs	23	26	17	21
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	2	6	4	6

Report Run: July 11, 2016

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

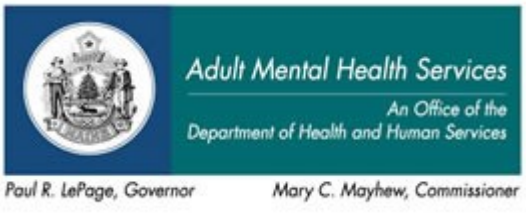
Report of Unmet Resource Needs

CSN 1
(Aroostook)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	403	469	446	478
7d-ii Residential Treatment Substance Abuse Services	0	3	1	0
Total Unmet Resource Needs	2	9	5	5
Distinct Clients with Unmet Resource Needs	2	6	4	5
7e. Housing				
7e-i Supported Apartment	9	9	7	6
7e-ii Community Residential Facility	1	2	0	0
7e-iii Residential Treatment Facility (group home)	1	1	1	0
7e-iv Assisted Living Facility	2	4	4	4
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	1	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	24	25	30	28
Total Unmet Resource Needs	37	42	42	38
Distinct Clients with Unmet Resource Needs	33	35	38	32
7f. Health Care				
7f-i Dental Services	23	22	21	27
7f-ii Eye Care Services	9	11	10	11
7f-iii Hearing Services	1	2	1	3
7f-iv Physical Therapy	4	3	3	0
7f-v Physician/Medical Services	14	15	13	14
Total Unmet Resource Needs	51	53	48	56
Distinct Clients with Unmet Resource Needs	35	37	34	41
7g. Legal				
7g-i Advocate	10	9	6	7
7g-ii Guardian (private)	1	1	1	1
7g-iii Guardian (public)	0	0	1	1
Total Unmet Resource Needs	11	10	8	9
Distinct Clients with Unmet Resource Needs	11	10	7	9

Report Run: Jul 11, 2016



Report of Unmet Resource Needs

CSN 1
(Aroostook)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	403	469	446	478
7h. Financial Security				
7h-i Assistance with Managing Money	26	26	30	36
7h-ii Assistance with Securing Public Benefits	21	25	30	29
7h-iii Representative Payee	0	0	1	1
Total Unmet Resource Needs	47	51	61	66
Distinct Clients with Unmet Resource Needs	42	43	51	55
7i. Education				
7i-i Adult Education (other than GED)	3	1	3	4
7i-ii GED	3	5	3	1
7i-iii Literacy Assistance	2	2	2	1
7i-iv Post High School Education	7	5	6	5
7i-v Tuition Reimbursement	2	0	1	0
Total Unmet Resource Needs	17	13	15	11
Distinct Clients with Unmet Resource Needs	13	13	13	11
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	2	2	3	2
7j-ii Club House and/or Peer Vocational Support	1	1	1	2
7j-iii Competitive Employment (no supports)	2	2	4	0
7j-iv Supported Employment	3	3	4	5
7j-v Vocational Rehabilitation	12	6	7	6
Total Unmet Resource Needs	20	14	19	15
Distinct Clients with Unmet Resource Needs	18	13	17	14
7k. Living Skills				
7k-i Daily Living Support Services	10	11	8	10
7k-ii Day Support Services	4	7	4	3
7k-iii Occupational Therapy	0	2	1	0
7k-iv Skills Development Services	9	10	6	8

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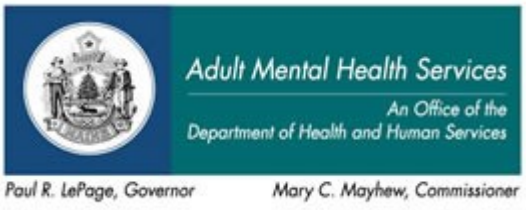

Report of Unmet Resource Needs

CSN 1
(Aroostook)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	403	469	446	478
Total Unmet Resource Needs	23	30	19	21
Distinct Clients with Unmet Resource Needs	21	26	18	18
7l. Transportation				
7l-i Transportation to ISP-Identified Services	24	24	26	31
7-ii Transportation to Other ISP Activities	6	6	8	10
7-iii After Hours Transportation	17	15	14	18
Total Unmet Resource Needs	47	45	48	59
Distinct Clients with Unmet Resource Needs	36	34	36	43
7m. Personal Growth / Community				
7m-i Avocational Activities	1	0	0	0
7m-ii Recreation Activities	9	11	6	9
7m-iii Social Activities	30	28	25	28
7m-iv Spiritual Activities	4	5	5	6
Total Unmet Resource Needs	44	44	36	43
Distinct Clients with Unmet Resource Needs	36	31	28	32
Other Resources				
Other Resources	12	12	14	15
Total Unmet Resource Needs	12	12	14	15
Distinct Clients with Unmet Resource Needs	12	12	14	15
CSN 1 Totals				
Total Unmet Resource Needs	421	448	405	447
Distinct Clients With any Unmet Resource Need	142	147	142	142
Distinct Clients with a RDS	403	469	446	478

Report Run: July 11, 2016

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,826	2,091	2,071	2,016
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	3	3	3
7a-iii Dialectical Behavioral Therapy	6	6	7	6
7a-iv Family Psycho-Educational Treatment	2	3	1	1
7a-v Group Counseling	20	24	16	16
7a-vi Individual Counseling	117	145	138	83
7a-vii Inpatient Psychiatric Facility	2	3	5	1
7a-viii Intensive Case Management	14	21	24	12
7a-x Psychiatric Medication Management	91	111	93	67
Total Unmet Resource Needs	254	316	287	189
Distinct Clients with Unmet Resource Needs	188	233	212	158
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	56	91	69	47
7b-ii Mental Health Advance Directives	16	19	13	12
Total Unmet Resource Needs	72	110	82	59
Distinct Clients with Unmet Resource Needs	65	99	81	58
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	6	6	9	5
7c-ii Recovery Workbook Group	1	1	1	0
7c-iii Social Club	31	37	32	25
7c-iv Peer-Run Trauma Recovery Group	5	5	6	1
7c-v Wellness Recovery and Action Planning	16	15	21	21
7c-vi Family Support	23	28	35	22
Total Unmet Resource Needs	82	92	104	74
Distinct Clients with Unmet Resource Needs	67	74	84	70
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	22	33	28	20

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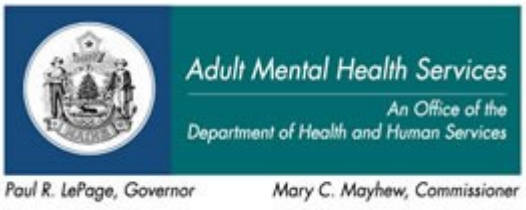


Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,826	2,091	2,071	2,016
7d-ii Residential Treatment Substance Abuse Services	5	5	5	1
Total Unmet Resource Needs	27	38	33	21
Distinct Clients with Unmet Resource Needs	24	36	30	21
7e. Housing				
7e-i Supported Apartment	18	18	21	23
7e-ii Community Residential Facility	5	7	4	4
7e-iii Residential Treatment Facility (group home)	4	4	2	3
7e-iv Assisted Living Facility	14	10	10	11
7e-v Nursing Home	0	0	0	1
7e-vi Residential Crisis Unit	0	0	0	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	154	175	173	188
Total Unmet Resource Needs	195	214	210	231
Distinct Clients with Unmet Resource Needs	182	198	201	215
7f. Health Care				
7f-i Dental Services	76	105	109	100
7f-ii Eye Care Services	34	48	59	63
7f-iii Hearing Services	4	8	9	10
7f-iv Physical Therapy	9	10	8	8
7f-v Physician/Medical Services	58	66	59	48
Total Unmet Resource Needs	181	237	244	229
Distinct Clients with Unmet Resource Needs	131	171	171	163
7g. Legal				
7g-i Advocate	23	33	37	32
7g-ii Guardian (private)	15	15	12	9
7g-iii Guardian (public)	3	1	1	1
Total Unmet Resource Needs	41	49	50	42
Distinct Clients with Unmet Resource Needs	38	46	49	41

Report Run: July 11, 2016

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,826	2,091	2,071	2,016
7h. Financial Security				
7h-i Assistance with Managing Money	105	132	120	126
7h-ii Assistance with Securing Public Benefits	62	82	65	68
7h-iii Representative Payee	8	10	6	5
Total Unmet Resource Needs	175	224	191	200
Distinct Clients with Unmet Resource Needs	144	184	161	172
7i. Education				
7i-i Adult Education (other than GED)	12	15	11	15
7i-ii GED	7	13	13	11
7i-iii Literacy Assistance	4	6	3	3
7i-iv Post High School Education	20	24	25	24
7i-v Tuition Reimbursement	3	5	5	3
Total Unmet Resource Needs	46	63	57	56
Distinct Clients with Unmet Resource Needs	41	56	52	52
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	10	10	10	6
7j-ii Club House and/or Peer Vocational Support	6	10	9	5
7j-iii Competitive Employment (no supports)	11	15	19	19
7j-iv Supported Employment	12	15	15	20
7j-v Vocational Rehabilitation	34	28	30	29
Total Unmet Resource Needs	73	78	83	79
Distinct Clients with Unmet Resource Needs	58	65	73	71
7k. Living Skills				
7k-i Daily Living Support Services	34	43	43	31
7k-ii Day Support Services	3	3	2	3
7k-iii Occupational Therapy	1	1	2	1
7k-iv Skills Development Services	17	20	19	9

Report Run: July 11, 2016

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	1,826	2,091	2,071	2,016
Total Unmet Resource Needs	55	67	66	44
Distinct Clients with Unmet Resource Needs	47	60	60	42
7l. Transportation				
7l-i Transportation to ISP-Identified Services	79	87	69	76
7-ii Transportation to Other ISP Activities	40	45	42	41
7-iii After Hours Transportation	33	43	36	42
Total Unmet Resource Needs	152	175	147	159
Distinct Clients with Unmet Resource Needs	99	121	104	111
7m. Personal Growth/Community				
7m-i Avocational Activities	11	9	5	7
7m-ii Recreation Activities	51	48	52	51
7m-iii Social Activities	87	93	101	97
7m-iv Spiritual Activities	17	16	10	9
Total Unmet Resource Needs	166	166	168	164
Distinct Clients with Unmet Resource Needs	108	121	119	114
Other Resources				
Other Resources	27	32	36	46
Total Unmet Resource Needs	27	32	38	46
Distinct Clients with Unmet Resource Needs	27	32	38	46
CSN 2 Totals				
Total Unmet Resource Needs	1,546	1,861	1,760	1,593
Distinct Clients With any Unmet Resource Need	456	544	527	543
Distinct Clients with a RDS	1,826	2,091	2,071	2,016

Report Run: July 11, 2016

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

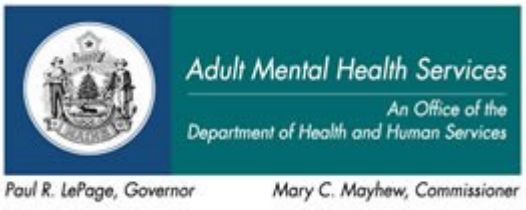
Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,198	2,530	2,486	2,471
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	6	2	1	0
7a-iii Dialectical Behavioral Therapy	4	8	8	8
7a-iv Family Psycho-Educational Treatment	2	1	1	1
7a-v Group Counseling	7	4	7	8
7a-vi Individual Counseling	88	116	102	44
7a-vii Inpatient Psychiatric Facility	3	4	1	0
7a-viii Intensive Case Management	9	11	4	3
7a-x Psychiatric Medication Management	111	124	101	60
Total Unmet Resource Needs	230	270	225	124
Distinct Clients with Unmet Resource Needs	169	195	161	100
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	60	70	57	32
7b-ii Mental Health Advance Directives	18	23	17	5
Total Unmet Resource Needs	78	93	74	37
Distinct Clients with Unmet Resource Needs	70	84	66	36
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	4	7	3	3
7c-ii Recovery Workbook Group	1	0	1	0
7c-iii Social Club	15	27	13	8
7c-iv Peer-Run Trauma Recovery Group	5	6	6	1
7c-v Wellness Recovery and Action Planning	1	0	1	0
7c-vi Family Support	12	16	15	16
Total Unmet Resource Needs	38	56	39	28
Distinct Clients with Unmet Resource Needs	30	47	33	24
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	9	13	9	4

Report Run: July 11, 2016



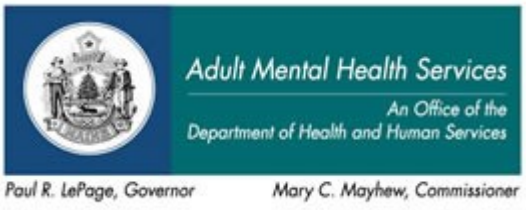
Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,198	2,530	2,486	2,471
7d-ii Residential Treatment Substance Abuse Services	3	1	1	1
Total Unmet Resource Needs	12	14	10	5
Distinct Clients with Unmet Resource Needs	11	14	10	5
7e. Housing				
7e-i Supported Apartment	9	8	4	2
7e-ii Community Residential Facility	3	4	2	0
7e-iii Residential Treatment Facility (group home)	2	5	2	3
7e-iv Assisted Living Facility	7	8	5	4
7e-v Nursing Home	0	1	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	126	157	139	86
Total Unmet Resource Needs	147	183	152	95
Distinct Clients with Unmet Resource Needs	139	174	152	93
7f. Health Care				
7f-i Dental Services	74	102	107	80
7f-ii Eye Care Services	29	41	45	32
7f-iii Hearing Services	7	10	10	5
7f-iv Physical Therapy	4	11	7	6
7f-v Physician/Medical Services	55	86	67	51
Total Unmet Resource Needs	169	250	236	174
Distinct Clients with Unmet Resource Needs	126	177	163	120
7g. Legal				
7g-i Advocate	8	6	6	7
7g-ii Guardian (private)	2	0	0	0
7g-iii Guardian (public)	3	3	2	1
Total Unmet Resource Needs	13	9	8	8
Distinct Clients with Unmet Resource Needs	13	9	8	8

Report Run: July 11, 2016



Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,198	2,530	2,486	2,471
7h. Financial Security				
7h-i Assistance with Managing Money	92	96	82	54
7h-ii Assistance with Securing Public Benefits	42	49	36	26
7h-iii Representative Payee	13	17	11	7
Total Unmet Resource Needs	147	162	129	87
Distinct Clients with Unmet Resource Needs	125	138	113	77
7i. Education				
7i-i Adult Education (other than GED)	9	15	9	4
7i-ii GED	7	8	9	7
7i-iii Literacy Assistance	4	9	6	3
7i-iv Post High School Education	17	15	21	16
7i-v Tuition Reimbursement	3	2	3	4
Total Unmet Resource Needs	40	49	48	34
Distinct Clients with Unmet Resource Needs	33	41	40	27
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	0	1	1	2
7j-ii Club House and/or Peer Vocational Support	11	10	7	3
7j-iii Competitive Employment (no supports)	7	2	4	3
7j-iv Supported Employment	3	4	3	1
7j-v Vocational Rehabilitation	27	34	30	27
Total Unmet Resource Needs	48	51	45	36
Distinct Clients with Unmet Resource Needs	45	44	42	34
7k. Living Skills				
7k-i Daily Living Support Services	48	61	49	17
7k-ii Day Support Services	1	3	3	1
7k-iii Occupational Therapy	0	1	2	0
7k-iv Skills Development Services	9	11	10	9

Report Run: July 11, 2016

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

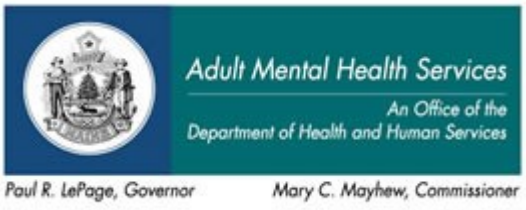
Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,198	2,530	2,486	2,471
Total Unmet Resource Needs	58	76	64	27
Distinct Clients with Unmet Resource Needs	55	69	59	25
7l. Transportation				
7l-i Transportation to ISP-Identified Services	70	86	75	50
7-ii Transportation to Other ISP Activities	41	48	44	27
7-iii After Hours Transportation	17	16	17	9
Total Unmet Resource Needs	128	150	136	86
Distinct Clients with Unmet Resource Needs	89	104	91	59
7m. Personal Growth/Community				
7m-i Avocational Activities	4	4	4	2
7m-ii Recreation Activities	15	29	17	13
7m-iii Social Activities	33	57	46	32
7m-iv Spiritual Activities	1	4	7	6
Total Unmet Resource Needs	53	94	74	53
Distinct Clients with Unmet Resource Needs	39	64	53	36
Other Resources				
Other Resources	10	9	20	21
Total Unmet Resource Needs	10	9	20	21
Distinct Clients with Unmet Resource Needs	10	9	20	21
CSN 3 Totals				
Total Unmet Resource Needs	1,171	1,466	1,260	815
Distinct Clients With any Unmet Resource Need	401	459	410	277
Distinct Clients with a RDS	2,198	2,530	2,486	2,471

Report Run: July 11, 2016



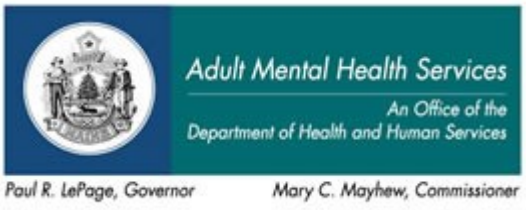
Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	976	1,031	991	985
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	18	22	16	9
7a-iii Dialectical Behavioral Therapy	6	9	9	9
7a-iv Family Psycho-Educational Treatment	7	11	7	5
7a-v Group Counseling	7	7	7	4
7a-vi Individual Counseling	71	99	84	46
7a-vii Inpatient Psychiatric Facility	0	1	0	1
7a-viii Intensive Case Management	13	17	14	5
7a-x Psychiatric Medication Management	67	99	74	44
Total Unmet Resource Needs	189	265	211	123
Distinct Clients with Unmet Resource Needs	119	160	136	89
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	44	70	57	45
7b-ii Mental Health Advance Directives	17	17	14	14
Total Unmet Resource Needs	61	87	71	59
Distinct Clients with Unmet Resource Needs	58	83	65	54
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	9	10	11	10
7c-ii Recovery Workbook Group	1	1	2	1
7c-iii Social Club	22	31	25	21
7c-iv Peer-Run Trauma Recovery Group	8	10	10	8
7c-v Wellness Recovery and Action Planning	8	16	10	11
7c-vi Family Support	26	57	38	31
Total Unmet Resource Needs	74	125	96	82
Distinct Clients with Unmet Resource Needs	50	82	61	49
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	15	20	17	10

Report Run: July 11, 2016



Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	976	1,031	991	985
7d-ii Residential Treatment Substance Abuse Services	2	1	1	0
Total Unmet Resource Needs	17	21	18	10
Distinct Clients with Unmet Resource Needs	17	21	18	10
7e. Housing				
7e-i Supported Apartment	14	17	15	8
7e-ii Community Residential Facility	2	5	6	3
7e-iii Residential Treatment Facility (group home)	5	8	4	3
7e-iv Assisted Living Facility	3	6	3	2
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	69	94	78	65
Total Unmet Resource Needs	93	130	106	81
Distinct Clients with Unmet Resource Needs	85	110	92	73
7f. Health Care				
7f-i Dental Services	60	71	67	60
7f-ii Eye Care Services	18	25	27	22
7f-iii Hearing Services	3	6	7	5
7f-iv Physical Therapy	4	5	6	7
7f-v Physician/Medical Services	34	41	38	35
Total Unmet Resource Needs	119	148	145	129
Distinct Clients with Unmet Resource Needs	88	104	97	86
7g. Legal				
7g-i Advocate	12	15	10	13
7g-ii Guardian (private)	0	0	1	1
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	12	15	11	14
Distinct Clients with Unmet Resource Needs	12	15	11	14

Report Run: July 11, 2016

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	976	1,031	991	985
7h. Financial Security				
7h-i Assistance with Managing Money	53	76	58	61
7h-ii Assistance with Securing Public Benefits	39	43	41	37
7h-iii Representative Payee	4	6	3	4
Total Unmet Resource Needs	96	125	102	102
Distinct Clients with Unmet Resource Needs	70	95	74	68
7i. Education				
7i-i Adult Education (other than GED)	9	14	15	16
7i-ii GED	9	11	8	10
7i-iii Literacy Assistance	3	3	1	1
7i-iv Post High School Education	16	18	16	15
7i-v Tuition Reimbursement	3	8	7	8
Total Unmet Resource Needs	40	54	47	50
Distinct Clients with Unmet Resource Needs	32	42	35	35
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	11	17	17	12
7j-ii Club House and/or Peer Vocational Support	2	2	4	1
7j-iii Competitive Employment (no supports)	9	11	11	16
7j-iv Supported Employment	8	15	11	10
7j-v Vocational Rehabilitation	54	64	54	40
Total Unmet Resource Needs	84	109	97	79
Distinct Clients with Unmet Resource Needs	64	77	69	53
7k. Living Skills				
7k-i Daily Living Support Services	44	67	57	38
7k-ii Day Support Services	5	10	11	4
7k-iii Occupational Therapy	4	6	4	1
7k-iv Skills Development Services	12	18	17	13

Report Run: July 11, 2016

Adult 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 2016 Quarter 3
(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	976	1,031	991	985
Total Unmet Resource Needs	65	101	89	56
Distinct Clients with Unmet Resource Needs	56	82	71	44
7l. Transportation				
7l-i Transportation to ISP-Identified Services	69	75	68	55
7-ii Transportation to Other ISP Activities	41	52	45	39
7-iii After Hours Transportation	18	26	19	26
Total Unmet Resource Needs	128	153	132	120
Distinct Clients with Unmet Resource Needs	76	84	76	66
7m. Personal Growth/Community				
7m-i Avocational Activities	2	7	10	13
7m-ii Recreation Activities	29	43	37	37
7m-iii Social Activities	49	68	65	59
7m-iv Spiritual Activities	13	14	14	8
Total Unmet Resource Needs	93	132	126	117
Distinct Clients with Unmet Resource Needs	56	77	74	66
Other Resources				
Other Resources	19	25	20	22
Total Unmet Resource Needs	19	25	20	22
Distinct Clients with Unmet Resource Needs	19	25	20	22
CSN 4 Totals				
Total Unmet Resource Needs	1,090	1,490	1,271	1,044
Distinct Clients With any Unmet Resource Need	253	294	259	213
Distinct Clients with a RDS	976	1,031	991	985

Report Run: July 11, 2016

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

Report of Unmet Resource Needs

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,053	2,306	2,273	2,182
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	6	9	5	2
7a-iii Dialectical Behavioral Therapy	38	28	28	12
7a-iv Family Psycho-Educational Treatment	2	3	5	3
7a-v Group Counseling	19	22	22	12
7a-vi Individual Counseling	163	186	183	76
7a-vii Inpatient Psychiatric Facility	0	0	1	0
7a-viii Intensive Case Management	13	15	25	25
7a-x Psychiatric Medication Management	140	135	125	73
Total Unmet Resource Needs	381	398	394	203
Distinct Clients with Unmet Resource Needs	289	313	309	174
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	52	69	63	50
7b-ii Mental Health Advance Directives	12	13	8	7
Total Unmet Resource Needs	64	82	71	57
Distinct Clients with Unmet Resource Needs	61	80	69	56
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	15	18	14	9
7c-ii Recovery Workbook Group	1	1	2	1
7c-iii Social Club	46	43	47	36
7c-iv Peer-Run Trauma Recovery Group	13	17	22	18
7c-v Wellness Recovery and Action Planning	8	7	6	4
7c-vi Family Support	50	41	45	44
Total Unmet Resource Needs	133	127	136	112
Distinct Clients with Unmet Resource Needs	101	95	104	87
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	19	15	8	7

Report Run: July 11, 2016

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

Report of Unmet Resource Needs

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,053	2,306	2,273	2,182
7d-ii Residential Treatment Substance Abuse Services	1	2	2	2
Total Unmet Resource Needs	20	17	10	9
Distinct Clients with Unmet Resource Needs	20	16	9	8
7e. Housing				
7e-i Supported Apartment	17	21	22	16
7e-ii Community Residential Facility	4	5	6	3
7e-iii Residential Treatment Facility (group home)	2	1	2	1
7e-iv Assisted Living Facility	1	3	2	2
7e-v Nursing Home	1	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	171	186	180	160
Total Unmet Resource Needs	196	216	212	182
Distinct Clients with Unmet Resource Needs	184	202	197	174
7f. Health Care				
7f-i Dental Services	167	159	151	138
7f-ii Eye Care Services	76	78	73	77
7f-iii Hearing Services	17	25	25	25
7f-iv Physical Therapy	20	19	20	20
7f-v Physician/Medical Services	87	88	79	75
Total Unmet Resource Needs	367	369	348	335
Distinct Clients with Unmet Resource Needs	257	250	228	213
7g. Legal				
7g-i Advocate	53	43	35	37
7g-ii Guardian (private)	3	2	2	0
7g-iii Guardian (public)	2	1	2	1
Total Unmet Resource Needs	58	46	39	39
Distinct Clients with Unmet Resource Needs	56	45	38	39

Report Run: July 11, 2016

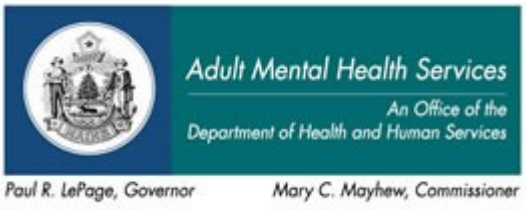
Adult Mental Health Services
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,053	2,306	2,273	2,182
7h. Financial Security				
7h-i Assistance with Managing Money	138	136	148	126
7h-ii Assistance with Securing Public Benefits	93	93	80	61
7h-iii Representative Payee	8	6	5	6
Total Unmet Resource Needs	239	235	233	193
Distinct Clients with Unmet Resource Needs	193	194	187	157
7i. Education				
7i-i Adult Education (other than GED)	36	42	39	45
7i-ii GED	27	31	27	25
7i-iii Literacy Assistance	13	11	15	15
7i-iv Post High School Education	27	20	15	15
7i-v Tuition Reimbursement	2	3	2	3
Total Unmet Resource Needs	105	107	98	103
Distinct Clients with Unmet Resource Needs	91	90	80	89
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	8	10	9	8
7j-ii Club House and/or Peer Vocational Support	9	10	7	6
7j-iii Competitive Employment (no supports)	21	17	20	19
7j-iv Supported Employment	19	15	21	19
7j-v Vocational Rehabilitation	71	63	51	39
Total Unmet Resource Needs	128	115	108	91
Distinct Clients with Unmet Resource Needs	116	102	100	84
7k. Living Skills				
7k-i Daily Living Support Services	80	90	66	40
7k-ii Day Support Services	12	12	11	7
7k-iii Occupational Therapy	4	4	4	5
7k-iv Skills Development Services	19	32	34	27

Report Run: July 11, 2016

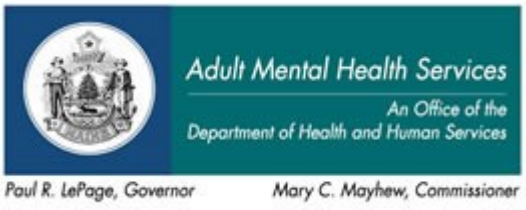


Report of Unmet Resource Needs

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,053	2,306	2,273	2,182
Total Unmet Resource Needs	115	138	115	79
Distinct Clients with Unmet Resource Needs	104	123	99	66
7l. Transportation				
7l-i Transportation to ISP-Identified Services	95	109	98	98
7-ii Transportation to Other ISP Activities	53	57	52	55
7-iii After Hours Transportation	37	44	40	40
Total Unmet Resource Needs	185	210	190	193
Distinct Clients with Unmet Resource Needs	120	134	117	112
7m. Personal Growth/Community				
7m-i Avocational Activities	3	6	4	3
7m-ii Recreation Activities	47	48	46	39
7m-iii Social Activities	105	116	112	107
7m-iv Spiritual Activities	26	32	34	39
Total Unmet Resource Needs	181	202	196	188
Distinct Clients with Unmet Resource Needs	128	139	133	124
Other Resources				
Other Resources	49	42	32	31
Total Unmet Resource Needs	49	42	32	31
Distinct Clients with Unmet Resource Needs	49	42	32	31
CSN 5 Totals				
Total Unmet Resource Needs	2,053	2,306	2,273	2,182
Distinct Clients With any Unmet Resource Need	606	638	608	490
Distinct Clients with a RDS	2,053	2,306	2,273	2,182

Report Run: July 11, 2016



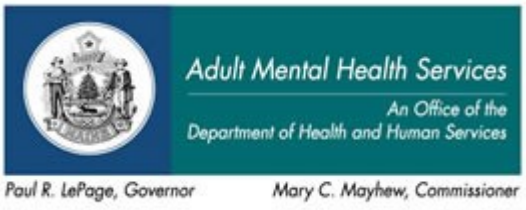
Report of Unmet Resource Needs

CSN 6
(Cumberland)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,002	2,140	2,135	2,097
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	6	7	2	0
7a-iii Dialectical Behavioral Therapy	12	15	7	6
7a-iv Family Psycho-Educational Treatment	4	6	7	5
7a-v Group Counseling	8	14	13	5
7a-vi Individual Counseling	108	128	136	68
7a-vii Inpatient Psychiatric Facility	0	1	0	0
7a-viii Intensive Case Management	25	23	21	13
7a-x Psychiatric Medication Management	83	101	101	59
Total Unmet Resource Needs	246	295	287	156
Distinct Clients with Unmet Resource Needs	184	225	212	126
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	32	52	41	31
7b-ii Mental Health Advance Directives	7	4	6	7
Total Unmet Resource Needs	39	56	47	38
Distinct Clients with Unmet Resource Needs	34	54	45	36
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	17	15	16	14
7c-ii Recovery Workbook Group	1	2	2	1
7c-iii Social Club	27	29	24	27
7c-iv Peer-Run Trauma Recovery Group	7	10	12	7
7c-v Wellness Recovery and Action Planning	3	6	10	5
7c-vi Family Support	18	44	45	42
Total Unmet Resource Needs	73	106	109	96
Distinct Clients with Unmet Resource Needs	60	88	90	77
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	10	10	9	7

Report Run: July 11, 2016



Report of Unmet Resource Needs

CSN 6
(Cumberland)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,002	2,140	2,135	2,097
7d-ii Residential Treatment Substance Abuse Services	4	8	7	6
Total Unmet Resource Needs	14	18	16	13
Distinct Clients with Unmet Resource Needs	14	18	15	13
7e. Housing				
7e-i Supported Apartment	26	33	35	35
7e-ii Community Residential Facility	12	14	15	14
7e-iii Residential Treatment Facility (group home)	2	4	3	0
7e-iv Assisted Living Facility	13	12	8	10
7e-v Nursing Home	2	2	2	2
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	185	208	236	196
Total Unmet Resource Needs	240	273	299	257
Distinct Clients with Unmet Resource Needs	230	253	279	242
7f. Health Care				
7f-i Dental Services	146	154	158	142
7f-ii Eye Care Services	38	56	56	39
7f-iii Hearing Services	6	8	10	9
7f-iv Physical Therapy	5	8	8	6
7f-v Physician/Medical Services	53	70	67	36
Total Unmet Resource Needs	248	296	299	232
Distinct Clients with Unmet Resource Needs	191	206	210	178
7g. Legal				
7g-i Advocate	10	18	11	9
7g-ii Guardian (private)	1	2	1	2
7g-iii Guardian (public)	1	2	1	1
Total Unmet Resource Needs	12	22	13	12
Distinct Clients with Unmet Resource Needs	12	22	13	12

Report Run: July 11, 2016

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,002	2,140	2,135	2,097
7h. Financial Security				
7h-i Assistance with Managing Money	85	91	92	72
7h-ii Assistance with Securing Public Benefits	39	43	30	30
7h-iii Representative Payee	5	9	11	10
Total Unmet Resource Needs	129	143	133	112
Distinct Clients with Unmet Resource Needs	118	127	120	97
7i. Education				
7i-i Adult Education (other than GED)	20	32	32	29
7i-ii GED	14	18	17	8
7i-iii Literacy Assistance	7	12	16	6
7i-iv Post High School Education	12	14	10	17
7i-v Tuition Reimbursement	1	1	2	3
Total Unmet Resource Needs	54	77	77	63
Distinct Clients with Unmet Resource Needs	49	69	66	56
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	6	7	10	2
7j-ii Club House and/or Peer Vocational Support	2	2	2	3
7j-iii Competitive Employment (no supports)	17	20	15	13
7j-iv Supported Employment	11	14	15	10
7j-v Vocational Rehabilitation	38	51	53	25
Total Unmet Resource Needs	74	94	95	54
Distinct Clients with Unmet Resource Needs	66	86	85	49
7k. Living Skills				
7k-i Daily Living Support Services	37	34	33	26
7k-ii Day Support Services	9	9	7	5
7k-iii Occupational Therapy	1	1	1	1
7k-iv Skills Development Services	15	14	10	6

Report Run: July 11, 2016

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

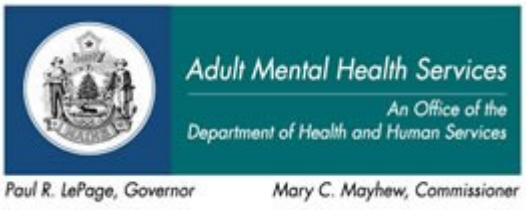
Report of Unmet Resource Needs

CSN 6
(Cumberland)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	2,002	2,140	2,135	2,097
Total Unmet Resource Needs	62	58	51	38
Distinct Clients with Unmet Resource Needs	55	50	48	35
7l. Transportation				
7l-i Transportation to ISP-Identified Services	74	110	95	79
7-ii Transportation to Other ISP Activities	45	73	65	56
7-iii After Hours Transportation	25	40	39	25
Total Unmet Resource Needs	144	223	199	160
Distinct Clients with Unmet Resource Needs	96	133	121	95
7m. Personal Growth/Community				
7m-i Avocational Activities	1	3	3	3
7m-ii Recreation Activities	22	20	20	20
7m-iii Social Activities	64	77	71	54
7m-iv Spiritual Activities	11	21	22	9
Total Unmet Resource Needs	98	121	116	86
Distinct Clients with Unmet Resource Needs	76	94	91	67
Other Resources				
Other Resources	27	33	43	53
Total Unmet Resource Needs	27	33	43	53
Distinct Clients with Unmet Resource Needs	27	33	43	53
CSN 6 Totals				
Total Unmet Resource Needs	2,002	2,140	2,135	2,097
Distinct Clients With any Unmet Resource Need	579	626	638	444
Distinct Clients with a RDS	2,002	2,140	2,135	2,097

Report Run: July 11, 2016



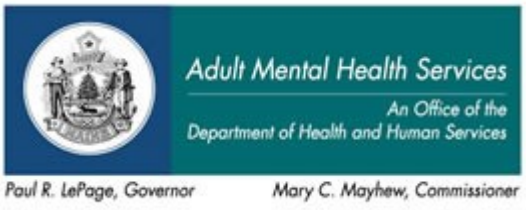
Report of Unmet Resource Needs

CSN 7
(York)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	804	797	805	711
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	5	3	4	1
7a-iii Dialectical Behavioral Therapy	17	11	7	2
7a-iv Family Psycho-Educational Treatment	4	5	4	1
7a-v Group Counseling	4	0	0	0
7a-vi Individual Counseling	62	77	67	27
7a-vii Inpatient Psychiatric Facility	2	0	0	0
7a-viii Intensive Case Management	8	10	13	5
7a-x Psychiatric Medication Management	67	62	63	20
Total Unmet Resource Needs	169	169	158	56
Distinct Clients with Unmet Resource Needs	114	118	113	48
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	36	32	36	25
7b-ii Mental Health Advance Directives	4	3	3	3
Total Unmet Resource Needs	40	35	39	28
Distinct Clients with Unmet Resource Needs	37	32	36	26
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	9	10	5	3
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	13	12	15	4
7c-iv Peer-Run Trauma Recovery Group	8	8	8	2
7c-v Wellness Recovery and Action Planning	6	11	8	5
7c-vi Family Support	12	15	23	20
Total Unmet Resource Needs	48	56	59	34
Distinct Clients with Unmet Resource Needs	36	44	47	31
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	11	13	12	6

Report Run: July 11, 2016



Report of Unmet Resource Needs

CSN 7
(York)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	804	797	805	711
7d-ii Residential Treatment Substance Abuse Services	3	1	0	0
Total Unmet Resource Needs	14	14	12	6
Distinct Clients with Unmet Resource Needs	13	14	12	6
7e. Housing				
7e-i Supported Apartment	15	16	16	5
7e-ii Community Residential Facility	3	3	3	3
7e-iii Residential Treatment Facility (group home)	3	2	2	1
7e-iv Assisted Living Facility	6	4	3	4
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)	83	89	88	57
Total Unmet Resource Needs	110	114	112	70
Distinct Clients with Unmet Resource Needs	98	106	103	64
7f. Health Care				
7f-i Dental Services	72	54	62	48
7f-ii Eye Care Services	24	20	27	12
7f-iii Hearing Services	4	3	2	1
7f-iv Physical Therapy	3	6	3	4
7f-v Physician/Medical Services	41	43	36	28
Total Unmet Resource Needs	144	126	130	93
Distinct Clients with Unmet Resource Needs	108	95	100	68
7g. Legal				
7g-i Advocate	11	9	14	5
7g-ii Guardian (private)	1	0	0	0
7g-iii Guardian (public)	5	3	3	1
Total Unmet Resource Needs	17	12	17	6
Distinct Clients with Unmet Resource Needs	15	12	17	6

Report Run: July 11, 2016

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

Report of Unmet Resource Needs

CSN 7
(York)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	804	797	805	711
7h. Financial Security				
7h-i Assistance with Managing Money	85	78	53	42
7h-ii Assistance with Securing Public Benefits	36	29	24	25
7h-iii Representative Payee	10	8	9	5
Total Unmet Resource Needs	131	115	86	72
Distinct Clients with Unmet Resource Needs	113	99	73	57
7i. Education				
7i-i Adult Education (other than GED)	6	9	8	10
7i-ii GED	7	4	4	3
7i-iii Literacy Assistance	4	5	5	4
7i-iv Post High School Education	7	10	14	9
7i-v Tuition Reimbursement	1	0	0	1
Total Unmet Resource Needs	25	28	31	27
Distinct Clients with Unmet Resource Needs	22	24	24	21
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	4	4	3	2
7j-ii Club House and/or Peer Vocational Support	4	3	3	1
7j-iii Competitive Employment (no supports)	10	15	11	16
7j-iv Supported Employment	3	1	3	3
7j-v Vocational Rehabilitation	28	20	18	13
Total Unmet Resource Needs	49	43	38	35
Distinct Clients with Unmet Resource Needs	43	40	35	28
7k. Living Skills				
7k-i Daily Living Support Services	31	26	25	19
7k-ii Day Support Services	1	0	0	0
7k-iii Occupational Therapy	3	4	3	3
7k-iv Skills Development Services	7	9	10	7

Report Run: July 11, 2016

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

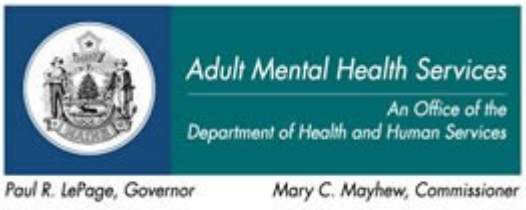
Report of Unmet Resource Needs

CSN 7
(York)

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	804	797	805	711
Total Unmet Resource Needs	42	39	38	29
Distinct Clients with Unmet Resource Needs	34	34	34	24
7l. Transportation				
7l-i Transportation to ISP-Identified Services	60	53	46	35
7-ii Transportation to Other ISP Activities	28	22	16	14
7-iii After Hours Transportation	33	32	23	16
Total Unmet Resource Needs	121	107	85	65
Distinct Clients with Unmet Resource Needs	84	75	60	44
7m. Personal Growth/Community				
7m-i Avocational Activities	5	6	4	4
7m-ii Recreation Activities	19	21	15	9
7m-iii Social Activities	45	34	31	24
7m-iv Spiritual Activities	7	6	7	5
Total Unmet Resource Needs	76	67	57	42
Distinct Clients with Unmet Resource Needs	54	46	39	31
Other Resources				
Other Resources	19	21	14	13
Total Unmet Resource Needs	19	21	14	13
Distinct Clients with Unmet Resource Needs	19	21	14	13
CSN 7 Totals				
Total Unmet Resource Needs	1,005	945	876	576
Distinct Clients With any Unmet Resource Need	283	268	261	164
Distinct Clients with a RDS	804	797	805	711

Report Run: July 11, 2016



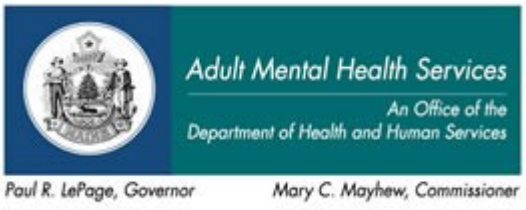
Report of Unmet Resource Needs

CSN Not Assigned

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	402	419	393	356
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	2	1	1
7a-iii Dialectical Behavioral Therapy	2	2	2	2
7a-iv Family Psycho-Educational Treatment	1	2	1	2
7a-v Group Counseling	1	3	4	2
7a-vi Individual Counseling	28	37	29	11
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	4	5	4	4
7a-x Psychiatric Medication Management	26	26	19	14
Total Unmet Resource Needs	64	77	60	36
Distinct Clients with Unmet Resource Needs	52	57	43	27
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	12	16	10	5
7b-ii Mental Health Advance Directives	4	2	3	2
Total Unmet Resource Needs	16	18	13	7
Distinct Clients with Unmet Resource Needs	15	17	13	7
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	2	3	2	1
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	13	9	4	4
7c-iv Peer-Run Trauma Recovery Group	1	1	0	2
7c-v Wellness Recovery and Action Planning	3	4	2	2
7c-vi Family Support	9	13	8	5
Total Unmet Resource Needs	28	30	16	14
Distinct Clients with Unmet Resource Needs	21	20	14	11
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	7	5	4	2

Report Run: July 11, 2016



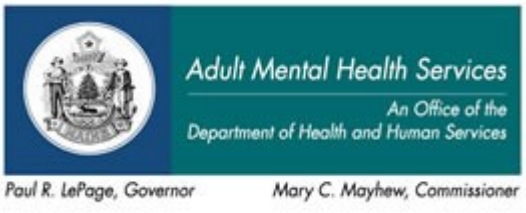
Report of Unmet Resource Needs

CSN Not Assigned

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	402	419	393	356
7d-ii Residential Treatment Substance Abuse Services	0	0	0	0
Total Unmet Resource Needs	7	5	4	2
Distinct Clients with Unmet Resource Needs	7	5	4	2
7e. Housing				
7e-i Supported Apartment	6	6	7	2
7e-ii Community Residential Facility	4	3	1	1
7e-iii Residential Treatment Facility (group home)	0	0	0	0
7e-iv Assisted Living Facility	1	2	2	2
7e-v Nursing Home	1	0	1	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	35	37	30	29
Total Unmet Resource Needs	47	48	41	35
Distinct Clients with Unmet Resource Needs	43	44	37	33
7f. Health Care				
7f-i Dental Services	30	32	24	20
7f-ii Eye Care Services	18	19	14	6
7f-iii Hearing Services	5	7	4	1
7f-iv Physical Therapy	5	6	1	2
7f-v Physician/Medical Services	16	18	14	9
Total Unmet Resource Needs	74	82	57	38
Distinct Clients with Unmet Resource Needs	47	48	40	27
7g. Legal				
7g-i Advocate	9	9	9	5
7g-ii Guardian (private)	2	2	3	1
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	11	11	12	6
Distinct Clients with Unmet Resource Needs	9	9	9	5

Report Run: July 11, 2016



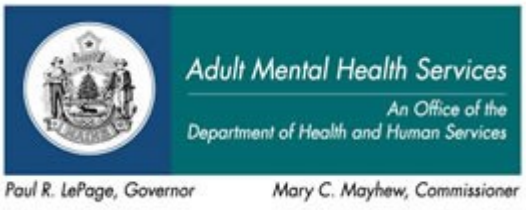
Report of Unmet Resource Needs

CSN Not Assigned

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

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	402	419	393	356
7h. Financial Security				
7h-i Assistance with Managing Money	35	45	36	29
7h-ii Assistance with Securing Public Benefits	15	20	16	10
7h-iii Representative Payee	4	5	2	2
Total Unmet Resource Needs	54	70	54	41
Distinct Clients with Unmet Resource Needs	47	60	45	34
7i. Education				
7i-i Adult Education (other than GED)	8	10	8	3
7i-ii GED	4	2	2	1
7i-iii Literacy Assistance	1	2	1	0
7i-iv Post High School Education	5	7	3	4
7i-v Tuition Reimbursement	0	0	1	2
Total Unmet Resource Needs	18	21	15	10
Distinct Clients with Unmet Resource Needs	16	17	13	8
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	1	3	3
7j-ii Club House and/or Peer Vocational Support	1	0	0	0
7j-iii Competitive Employment (no supports)	2	4	3	4
7j-iv Supported Employment	4	4	3	0
7j-v Vocational Rehabilitation	11	12	7	8
Total Unmet Resource Needs	19	21	16	15
Distinct Clients with Unmet Resource Needs	19	16	15	12
7k. Living Skills				
7k-i Daily Living Support Services	17	17	9	7
7k-ii Day Support Services	2	3	1	1
7k-iii Occupational Therapy	2	1	0	0
7k-iv Skills Development Services	2	4	2	1

Report Run: July 11, 2016



Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2016 Quarter 3

(Jan, Feb, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Distinct Clients with a RDS	402	419	393	356
Total Unmet Resource Needs	23	25	12	9
Distinct Clients with Unmet Resource Needs	19	19	11	9
7l. Transportation				
7l-i Transportation to ISP-Identified Services	21	26	18	15
7-ii Transportation to Other ISP Activities	9	14	6	8
7-iii After Hours Transportation	9	7	5	4
Total Unmet Resource Needs	39	47	29	27
Distinct Clients with Unmet Resource Needs	28	28	21	16
7m. Personal Growth/Community				
7m-i Avocational Activities	1	1	0	0
7m-ii Recreation Activities	10	11	5	4
7m-iii Social Activities	24	25	21	14
7m-iv Spiritual Activities	6	7	4	1
Total Unmet Resource Needs	41	44	30	19
Distinct Clients with Unmet Resource Needs	25	28	22	16
Other Resources				
Other Resources	12	10	7	8
Total Unmet Resource Needs	12	10	7	8
Distinct Clients with Unmet Resource Needs	12	10	7	8
CSN Not Assigned Totals				
Total Unmet Resource Needs	453	509	366	267
Distinct Clients With any Unmet Resource Need	120	121	101	84
Distinct Clients with a RDS	402	419	393	356

Report Run: July 11, 2016July 11

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

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

Bridging Recovery Assistance Program (BRAP)
Monitoring Report
Quarter 4 FY2016 (April, May, June 2016)

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

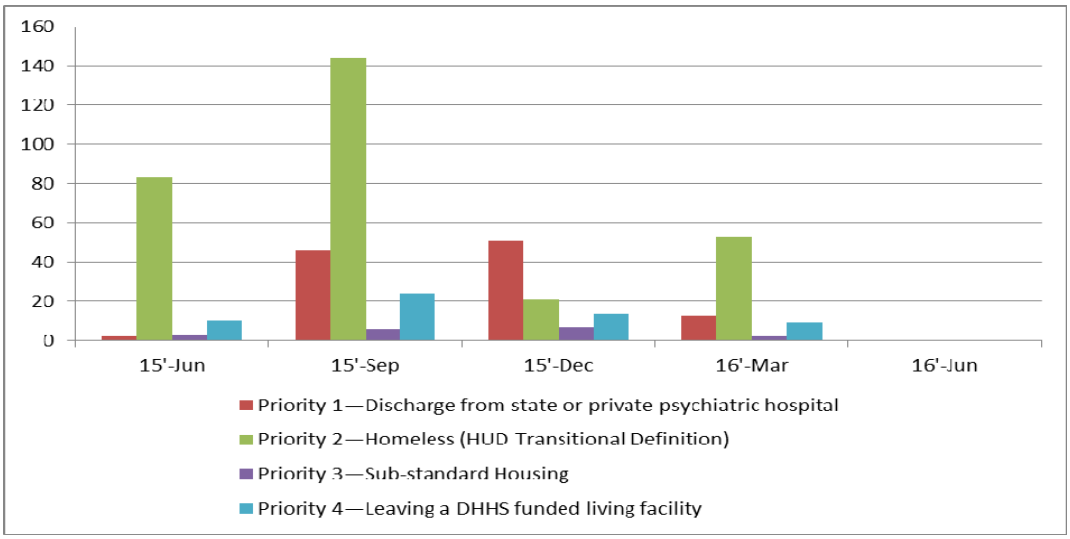
BRAP is designed to assist individuals who have a psychiatric disability with housing costs until the individuals are awarded a Housing Choice Voucher (aka Section 8 Voucher), another federal subsidy, or until the individuals have an alternative housing placement. All units subsidized by BRAP funding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

BRAP Waitlist

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

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

Reporting Periods	15'-Jun	15'-Sep	15'-Dec	16'-Mar	16'-Jun	% Change relative to Last Report
Total Number of Persons on Waitlist	154	220	287	77	0	-94.81%
Priority 1—Discharge from state or private psychiatric hospital	2	46	51	13	0	-92.31%
Priority 2—Homeless (HUD Transitional Definition)	83	144	21	53	0	-94.34%
Priority 3—Sub-standard Housing	3	6	7	2	0	
Priority 4—Leaving a DHHS funded living facility	10	24	14	9	0	
Total number of persons on waitlist more than 90 days	16	83	197	43	0	



***Should reflect no waitlist**

Current BRAP Vouchers Awarded

The BRAP census as of June 31, 2016 showed a total of 929 vouchers awarded, with 158 of those awarded but still looking for housing. Of those awarded, the total can be broken down into the priorities as follows:

- Priority #1: 361 individuals discharged from psychiatric hospitals have been awarded BRAP vouchers
- Priority #2: 433 individuals who meet HUD's transitional homeless definition have been awarded BRAP vouchers
- Priority #3: 18 individuals identified as living in sub-standard housing have been awarded BRAP vouchers
- Priority #4: 93 individuals who were leaving a DHHS funded living facility have been awarded BRAP vouchers.

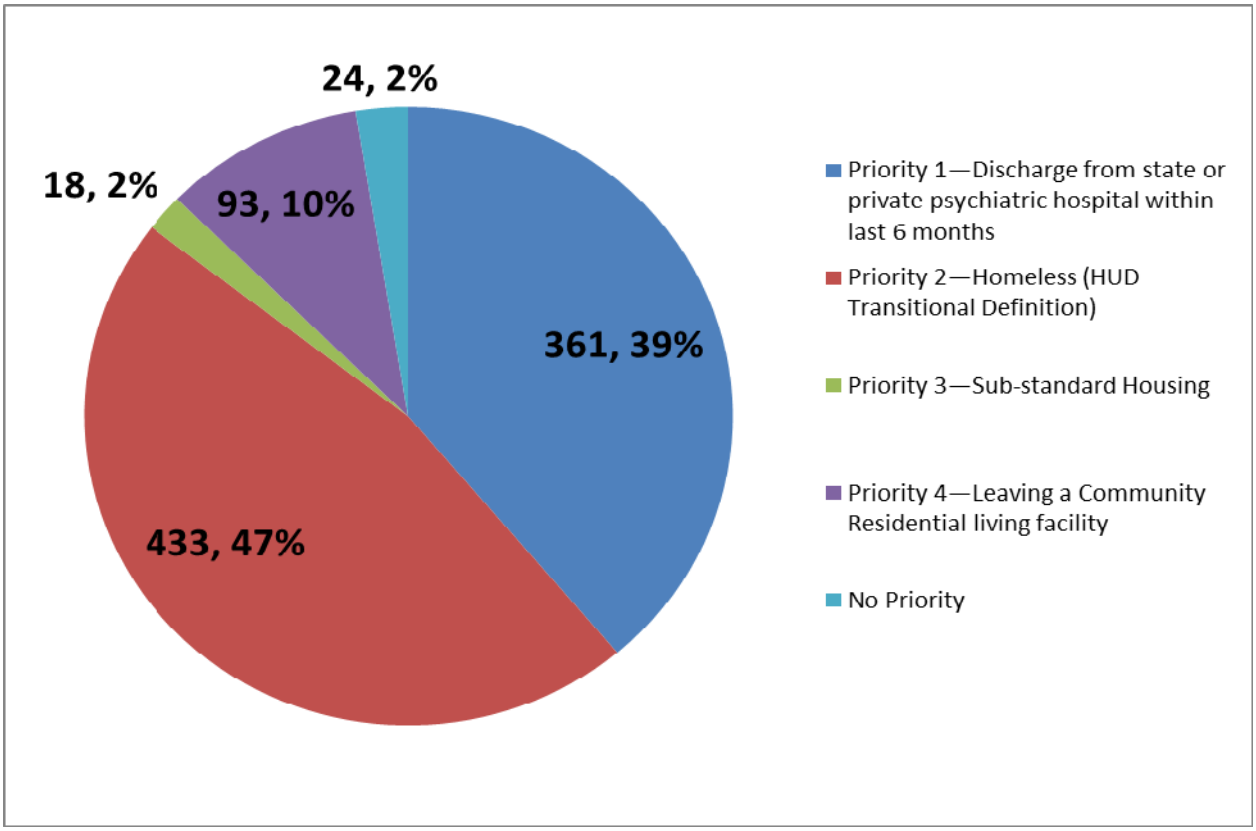
Note that only 24 vouchers were awarded this quarter to persons with no priority assigned to them. In the third quarter of fiscal year 2016, a total of 24 BRAP vouchers with no priorities were awarded.

Current BRAP Census--Graph:
Detail by Priority Status, including persons awarded but not housed

BRAP Census as of 6/30/16	**925**
Total number on BRAP Waitlist	**0**
Total number of persons Housed on BRAP	**929**
Priority 1	**361**
Priority 2	**433**
Priority 3	**18**
Priority 4	**93**
No Priority	**24**
Total number of persons Awarded but Never Housed	**158**

Current BRAP Census--Graph:
Detail by Percentage of Priority Status compared to all awarded and housed individuals

The number of individuals on the BRAP program for 24 months or more has decreased from 50% to 45% for, with the shortest length of time on the program being just over 2 months and with the longest program staying up to a period of 12 years.



Other Housing Programs

In addition, the PATH program, also managed by SAMHS, is being directed to outreach, engage and enroll literally homeless individuals into housing and mainstream resources with a focus on the literally homeless individuals who are eligible for Sec.13 and 17 in the Maine Care Manual and would be prioritized for BRAP and Shelter Plus Care.

Lastly, SAMHS administers a substantial number of Shelter Plus Care vouchers, funded by the U.S. Department of Housing and Urban Development, more than any other state on a per-capita basis. The census as of June 30, 2016 is 964. This program has seen significant growth over the last decade, which is the direct result of SAMHS aggressively applying for, and receiving, new grants annually.However, there has been no increase in HUD funding over the past two years, causing a zero increase in grants funded through HUD. SAMHS is focusing vouchers, when they become available through turnover, on the Chronic and Long Term homeless populations who generally qualify for this program.

Moving Forward

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

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

Other changes to the program include placing our #4 priority(applicants identified as having left a DHHS funded community residential facility within the past six months) into the #1priority (applicants who were discharded from a psychiatric hospital within the last 6 months) These two groups are now considered #1 priority

The addition of a new 4th priority --Applicant is being discharged within the next 30 days from a correctional facility (Jail/Prison); or has been adjudicated through a Mental Health treatment court and meets
Section 17 criteria and
(1) no subsequent residences have been identified; and
(2) they lack the resources and support networks needed to obtain access to housing.

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

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

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

Class Member Treatment Planning Review

For the 3nd Quarter of Fiscal Year 2016
(January, February, March 2016)

		2015 Q4	2016 Q1	2016 Q2	2016 Q3
Total Plans Reviewed		49	50	50	49
I Releases					
1A	Does the record document that the agency has planned with and educated the consumer regarding releases of information at intake/initial treatment planning process?	83.3% 15 of 18	100.0% 9 of 9	92.6% 25 of 27	100.0% 29 of 29
1B	Does the record document that the agency has planned with and educated the consumer regarding releases of information during each treatment plan review?	87.8% 43 of 49	100.0% 48 of 48	93.5% 43 of 46	100.0% 48 of 48
1C	Does the record document that the consumer has a primary care physician (PCP)?	93.8% 45 of 48	90.0% 45 of 50	90.0% 45 of 50	91.8% 45 of 49
1D	If 1C. is yes, has there been an attempt to obtain releases signed by the consumer for the sharing of information with the PCP?	77.8% 35 of 45	88.9% 40 of 45	86.7% 39 of 45	91.1% 41 of 45
II Treatment Plan					
2A	Does the record document that the domains of housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional/psychological, and psychiatric were assessed with the consumer in treatment planning?	78.7% 37 of 47	100.0% 49 of 49	100.0% 50 of 50	95.9% 47 of 49
2B	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?	97.9% 46 of 47	100.0% 50 of 50	100.0% 50 of 50	95.9% 47 of 49
2C	Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?	100.0% 47 of 47	91.8% 45 of 49	100.0% 50 of 50	95.9% 47 of 49

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?	85.7%	42 of 49	100.0%	50 of 50	98.0%	49 of 50	95.9%	47 of 49
2E	Does the record document that the consumer has a crisis plan?	40.8%	20 of 49	66.0%	33 of 50	90.0%	45 of 50	51.0%	25 of 49
2F	If 2E. is no, is the reason documented?	100.0%	29 of 29	100.0%	17 of 17	100.0%	5 of 5	100.0%	24 of 24
2G	If 2E. is yes, has the crisis plan been reviewed as required every three months?	80.0%	16 of 20	93.9%	31 of 33	84.4%	38 of 45	88.0%	22 of 25
2H	If 2E. is yes, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?	200.0%	4 of 2	500.0%	5 of 1	90.9%	10 of 11	25.0%	2 of 8
2I	Does the record document that the consumer has a mental health advance directive?	6.3%	3 of 48	4.0%	2 of 50	8.0%	4 of 50	4.1%	2 of 49
2J	If 2I. is yes, has the advance directive been reviewed at least annually by the CSW and consumer?	100.0%	3 of 3	50.0%	1 of 2	50.0%	2 of 4	50.0%	1 of 2
2K	If 2I. is no, is the reason why documented?	100.0%	45 of 45	100.0%	48 of 48	100.0%	46 of 46	100%	47 of 47
III Needed Resources									
3A	Does the record document that natural supports (family/friends) are being accessed as a resource?	93.8%	45 of 48	90.0%	45 of 50	86.0%	43 of 50	91.8%	45 of 49
3B	If 3A. is no, has the worker discussed with the consumer the consideration of natural supports as a resource?	100.0%	3 of 3	100.0%	5 of 5	100.0%	7 of 7	100.0%	4 of 4
3C	Does the record document that generic resources (those resources that anyone can access) are being accessed?	89.6%	43 of 48	94.0%	47 of 50	94.0%	47 of 50	91.8%	45 of 49
3D	If 3C. is no, has the worker discussed with the consumer the consideration of generic resources as a resource?	0.0%	0 of 5	0.0%	0 of 3	0.0%	0 of 3	0.0%	0 of 4
3E	Does the record document a resource need that has not been provided according to/within the expected response time?	24.4%	11 of 45	32.0%	16 of 50	16.0%	8 of 50	14.3%	7 of 49
3F	Does the treatment plan reflect interim planning?	90.9%	10 of 11	81.3%	13 of 16	50.0%	4 of 8	71.4%	5 of 7
3G	Does the record document that the treatment team reconvened after the unmet need was identified?	90.9%	10 of 11	62.5%	10 of 16	75.0%	6 of 8	71.4%	5 of 7

IV Service Agreements									
4A	Does the record document that service agreements are required for this plan? (see paragraph 69 protocol for definitions)	46.9%	23 of 49	44.0%	22 of 50	66.0%	33 of 50	57.1%	28 of 49
4B	If 4A. is yes, have service agreements been acquired?	52.2%	12 of 23	68.2%	15 of 22	45.5%	15 of 33	71.4%	20 of 28
4C	If 4A. is yes, are the service agreements current?	52.2%	12 of 23	68.2%	15 of 22	45.5%	15 of 33	67.9%	19 of 28
V Vocational Services									
5A	Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?	81.3%	39 of 48	100.0%	50 of 50	98.0%	49 of 50	98.0%	48 of 49
5B	Does the record document that the vocational domain is being addressed with the consumer at each 90 day treatment plan review?	79.6%	39 of 49	91.8%	45 of 49	94.0%	47 of 50	89.8%	44 of 49
VI Comments									
6A	Plan of correction requested?	51.0%	25 of 49	26.0%	13 of 50	42.0%	21 of 50	26.5%	13 of 49
6A.1.	Plan of correction for section 2A. (required when not all domains assessed) included?	120.0%	12 of 10	N/A	1 of 0	N/A	1 of 0	200%	4 of 2
6C	Plan of correction received?	96.0%	24 of 25	76.9%	10 of 13	71.4%	15 of 21	84.6%	11 of 13
6D	Were corrections made to the satisfaction of the CDC?	100.0%	24 of 24	100.0%	10 of 10	100.0%	15 of 15	90.9%	10 of 11

Report Run by:Lee.Richardson

Report Run on: Jul 13, 2016 at 12:23:02 PM

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

For the 3rd Quarter of Fiscal Year 2016

(January, February, March 2016)

	2015 Q4	2016 Q1	2016 Q2	2016 Q3*
Total Admissions	28	19	13	NA
Hospital				
Hospitalized in Local Area	82.1% (23 of 28)	94.7% (18 of 19)	84.6% (7 of 13)	NA
Hospitalization Made Voluntary	64.3% (18 of 28)	26.3% (5 of 19)	53.8% (7 of 13)	NA
Quality Care				
Active Treatment Within Guidelines	100.0% (28 of 28)	100.0% (19 of 19)	100.0% (13 of 13)	NA
Individual Service Plans				
Receiving Case Management Services	37.7% (10 of 28)	31.6% (6 of 19)	30.8% (4 of 13)	NA
Case Manager Involved with Discharge Planning	100.0% (10 of 10)	100.0% (6 of 6)	100.0% (4 of 4)	NA
Total Clients who Authorized Hospital to Obtain ISP	100.0% (10 of 10)	100.0% (6 of 6)	100.0% (4 of 4)	NA
Hospital Obtained ISP when authorized	0.0% (0 of 10)	0.0% (0 of 6)	0.0% (0 of 4)	NA
Treatment and Discharge Plan Consistant with ISP	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	NA

*NA = Data Not Available, as no data has been entered in the system that produces this report

Report Run: July 14, 2016

For questions, contact the Data Specialist Team at the Office of Substance Abuse and Mental Health Services

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

Community Hospital Utilization Review for Involuntary Admissions

Class Member and Non Class Member

For the 3rd Quarter of Fiscal Year 2016

(January, February, March 2016)

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

Report Run: Apr 5, 2016

For questions, contact the Data Specialist Team at the Office of Substance Abuse and Mental Health Services

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

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

Community Hospital Utilization Review for Involuntary Admissions

By Hospital - Class Members

For the 3rd Quarter of Fiscal Year 2016
(January, February, March 2016)

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

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

Report Run: July 14, 2016

For questions, contact the Data Specialist Team at the Office of Substance Abuse and Mental Health Services

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

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

Community Hospital Utilization Review for Involuntary Admissions

By Hospital

Class Member and Non Class Member

For the 3rd Quarter of Fiscal Year 2016

(January, February, March 2016)

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

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

Report Run: July 14, 2016

For questions, contact the Data Specialist Team at the Office of Substance Abuse and Mental Health Services

*NA = Data is Not Available for this quarter, due to no data entered into the reporting system.

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

QTR4 (April, May and June) SYF16

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

Gender	Children	Males	578	Females	592				
	Adults	Males	1,951	Females	1,998				
Age Range	Children	< 5	4	5 - 9	157	10 - 14	527	15-17	482
	Adults	18 - 21	426	22 - 35	1,207	36 - 60	1,880	>60	436
Payment Source	Children	MaineCare	847	Private Ins.	256	Uninsured	66	Medicare	1
	Adults	MaineCare	1,955	Private Ins.	699	Uninsured	1,146	Medicare	149

II. Summary Of All Crisis Contacts

	Children	Adults
a. Total number of telephone contacts	5,657	22,292
b. Total number of all Initial face-to-face contacts	1,028	3,311
c. Number in II.b. who are children/youth with Mental Retardation/Autism/Pervasive Dev. Disorder	131	
d. Number of face-to-face contacts that are ongoing support for crisis resolution/stabilization	134	901

III. Initial Crisis Contact Infomation

	Children		Adults	
a. Total number of Initial face-to-face contacts in which a wellness plan, crisis plan, ISP or advanced directive plan previously developed with the individual was used	72	7.0%	69	2.1%
b. Number of Initial face-to-face contacts who have a Community Support Worker (CI,CRS,ICM, ACT,TCM)	372	36.2%	822	24.8%
c. Number of Initial face-to-face contacts who have a Comm. Support Worker that was notified of crisis	353	94.9%	768	93.4%
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			101,716	31
e. Number of Initial face-to-face contacts in Emergency Department with final disp. within 8 hours			1,864	56.3%
f. Number of Initial face-to-face contacts not in Emergency Department with final disp. within 8 hours			1,087	32.8%

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.	869	1 to 2 Hours	136	2 to 4 Hours	21	More Than 4 Hours	1		
Percent	84.5%	Percent	13.2%	Percent	2.0%	Percent	0.1%		

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

Less Than 3 Hours	516	3 to 6 Hours	374	6 to 8 Hours	32	8 to 14 Hours	39	> 14	66
Percent	50.2%	Percent	36.4%	Percent	3.1%	Percent	3.8%	Percen	6.4%

IV. Site Of Initial Face-To-Face Contacts

	Children		Adults	
a. Primary Care Residence (Home)	137	13.3%	223	6.7%
b. Family/Relative/Other Residence	45	4.4%	44	1.3%
c. Other Community Setting (Work, School, Police Dept, Public Place)	84	8.2%	89	2.7%
d. SNF, Nursing Home, Boarding Home	0	0.0%	13	0.4%
e. Residential Program (Congregate Community Residence, Apartment Program)	11	1.1%	55	1.7%
f. Homeless Shelter	1	0.1%	23	0.7%
g. Provider Office	20	1.9%	85	2.6%
h. Crisis Office	160	15.6%	511	15.4%
i. Emergency Department	564	54.9%	2,162	65.3%
j. Other Hospital Location	4	0.4%	72	2.2%
k. Incarcerated (Local Jail, State Prison, Juvenile Correction Facility)	2	0.2%	33	1.0%
Totals:	1,028	100%	3,310	100%

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

	Children		Adults	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	27	2.6%	216	6.5%
b. Crisis stabilization with referral to new provider for mental health/substance abuse follow up	171	16.6%	654	19.8%
c. Crisis stabilization with referral back to current provider for mental health/substane abuse follow up	429	41.7%	1,017	30.7%
d. Admission to Crisis Stabilization Unit	127	12.4%	382	11.5%
e. Inpatient Hospitalization Medical	12	1.2%	169	5.1%
f. Voluntary Psychiatric Hospitalization	239	23.2%	634	19.1%
g. Involuntary Psychiatric Hospitalization	13	1.3%	150	4.5%
h. Admission to Detox Unit	10	1.0%	89	2.7%
Totals:	1,028	100%	3,311	100%

Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON ORGANIZATIONAL PERFORMANCE EXCELLENCE

FOURTH STATE FISCAL QUARTER 2016

April, May, June 2016

Rodney Bouffard
Superintendent
July 22, 2016

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Table of Contents

STRATEGIC PERFORMANCE EXCELLENCE

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Glossary of Terms, Acronyms & Abbreviations

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

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

Introduction

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

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

There are three major sections that make up this report:

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

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

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

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

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

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CONSENT DECREE

Consent Decree Plan

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

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

Patient Rights

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

Indicators	1Q2016	2Q2016	3Q2016	4Q2016
1. Patients are routinely informed of their rights upon admission.	100% 79/79	80% 16/20	95% 61/64	80% 39/50

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

4Q2016: 1 patient refused.

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

Indicators	1Q2016	2Q2016	3Q2016	4Q2016
1. Level II grievances responded to by RPC on time.	100% 1/1	0/0	0/0	0/0
2. Level I grievances responded to by RPC on time.	78% 129/165	51% 49/97	60% 46/77	89% 82/92

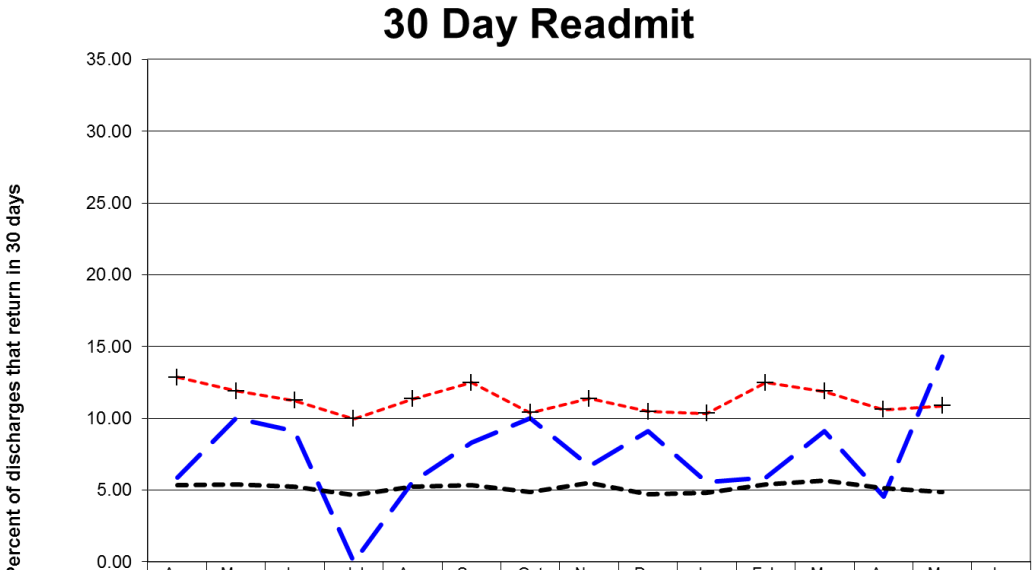
Admissions

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

ADMISSIONS	1Q2016	2Q2016	3Q2016	4Q2016	TOTAL
CIVIL:	**30**	**37**	**37**	**31**	**135**
VOL	2	1	1	1	**5**
INVOL	4	5	7	4	**20**
DCC	23	31	29	25	**108**
DCC-PTP	1	0	0	1	**2**
FORENSIC:	**34**	**21**	**27**	**20**	**102**
60 DAY EVAL	19	11	13	2	**45**
JAIL TRANSFER	2	1	5	1	**9**
IST	6	7	3	8	**24**
NCR	7	2	6	9	**24**
TOTAL	**64**	**58**	**64**	**51**	**237**

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	5.88	10.00	9.09	0.00	5.56	8.33	10.00	6.67	9.09	5.56	5.88	9.09	4.55	14.29	
Ntl Mean	5.33	5.38	5.26	4.67	5.23	5.33	4.84	5.48	4.73	4.83	5.42	5.64	5.11	4.86	
+1 StDev	12.85	11.91	11.25	9.96	11.35	12.48	10.40	11.36	10.47	10.33	12.48	11.88	10.61	10.87	

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

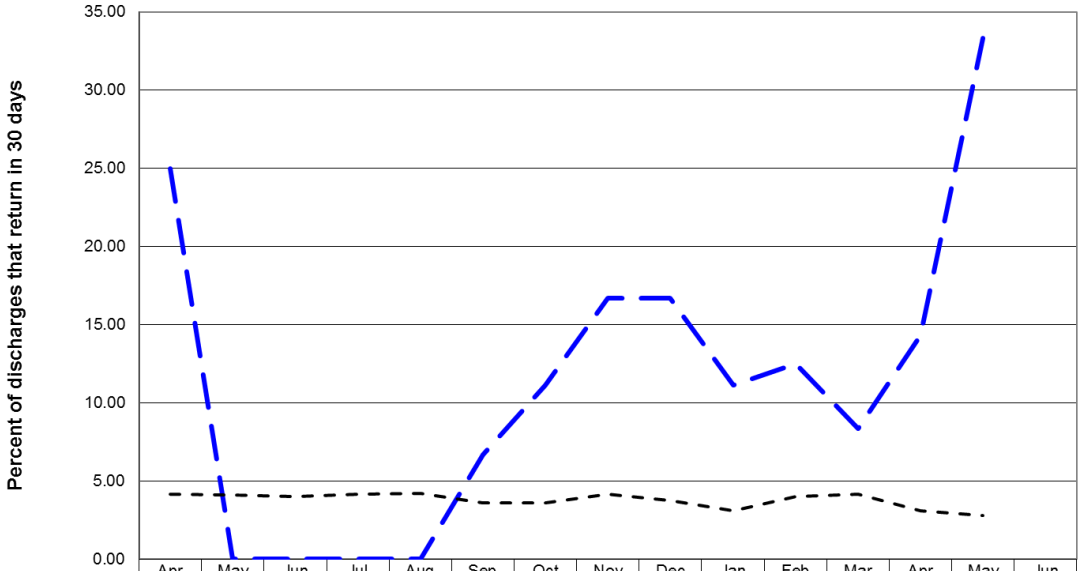
Reasons for patient readmission are varied and may include decompensating or lack of compliance with a PTP. Specific causes for readmission are reviewed with each patient upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient granularity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

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

CONSENT DECREE

30 Day Readmit

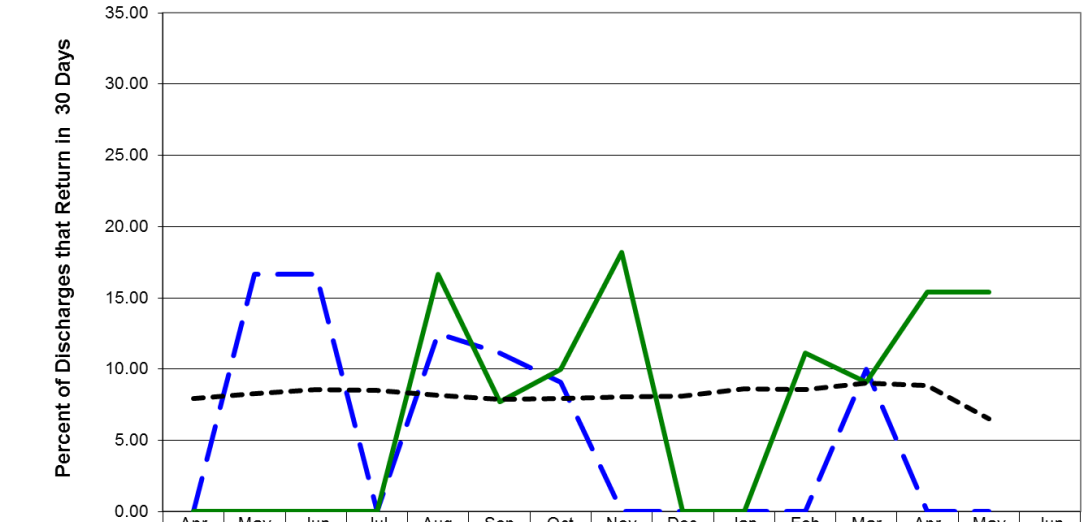
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	25.00	0.00	0.00	0.00	0.00	6.67	11.11	16.67	16.67	11.11	12.50	8.33	14.29	33.33	
Ntl Mean	4.17	4.11	4.01	4.16	4.22	3.58	3.60	4.15	3.76	3.08	4.00	4.15	3.11	2.79	

30 Day Readmit

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	16.67	16.67	0.00	12.50	11.11	9.09	0.00	0.00	0.00	0.00	10.00	0.00	0.00	
Dorothea Dix	0.00	0.00	0.00	0.00	16.67	7.69	10.00	18.18	0.00	0.00	11.11	9.09	15.38	15.38	
Ntl Mean	7.95	8.26	8.59	8.49	8.16	7.86	7.93	8.06	8.10	8.64	8.57	9.04	8.83	6.51	

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

REVIEW OF READMISSION OCCURRING WITHIN 60 DAYS

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

4Q2016: Four patients were re-admitted in 4Q2016. Of the 4 re-admitted, all spent less than 30 days in the community. Patient 1 spent 3 days at Maine General Medical Center for medical issues and was readmitted after three days. Patients 2, 3, and 4 were forensic discharges from inpatient evaluations and were each readmitted after 2 days, 22 days, and 25 days, respectively, for IST evaluations.

CONSENT DECREE

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

Indicators	1Q16	2Q16	3Q16	4Q16
1. The Program Service Director of the Outpatient Services Program will review all patient cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (group home, apartment, etc.) c. Geographic location of residence d. Community support network e. Patient demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with Outpatient Treatment	100% 6/6	100% 2/2	100% 3/3	100% 6/6
2. Outpatient Services will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%	100%	100%

4Q2016: 5 NCR patients and 1 PTP patient were returned to RPC; two patients remain at RPC and four have returned to the community. Patient 1 was medically compromised, patient 2 returned for a psychiatric and medical evaluation, patient 3 was returned for allegedly possessing child pornography, patient 4 for threatening to harm others and palming medications, patient 5 for suicidal thoughts, and patient 6 for alcohol use and eviction.

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

PATIENT ADMISSION DIAGNOSIS	1Q16	2Q16	3Q16	4Q16	TOTAL
ADJUSTMENT DISORDER W/ MIXED DISTURBANCE OF EMOTIONS & CONDUCT	1				**1**
ADJUSTMENT DISORDER WITH DEPRESSED MOOD		1			**1**
ANTISOCIAL PERSONALITY DISORDER	1		1	1	**3**
ANXIETY DISORDER, UNSPECIFIED			1	1	**2**
ATTENTION DEFICIT W/ HYPERACTIVITY	1				**1**
AUTISTIC DISORDER		1			**1**
BIPOLAR DISORD, CRNT EPISODE MANIC SEVER, W PSYCH FEATURES				1	**1**
BIPOLAR DISORD, CRNT EPISODE MANIC W/O PSYCH FEATURES, MILD		1			**1**
BIPOLAR DISORD, CRNT EPSD DEPRESS, SEVERE, W PSYCH FEATURES		1	3		**4**
BIPOLAR DISORDER, UNSPECIFIED	10	6	6	6	**28**
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE, SPEC W/ PSYCHOTIC BEHAV	1				**1**
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE, W/O PSYCHOTIC FEATURES	1				**1**
BIPOLAR I, REC EPIS OR CURRENT MANIC, IN PARTIAL OR UNSPEC REMISSION	1				**1**
BIPOLAR I, REC EPIS OR CURRENT MANIC, SEVERE, W/ PSYCHOTIC BEHAV	2				**2**
BIPOLAR II DISORDER			1		**1**
BORDERLINE PERSONALITY DISORDER			1	1	**2**
DELUSIONAL DISORDERS	1	1			**2**
DEMENTIA IN OTH DISEASES CLASSD ELSWHR W/ BEHAVIORAL DISTURB		1	1		**2**
DEPRESSIVE DISORDER NEC	3				**3**
DEPRESSIVE DISORDER-UNSPEC	1				**1**
IMPULSE CONTROL DISORDER				1	**1**
MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED			2	1	**3**

CONSENT DECREE

MAJOR DEPRESSV DISORD, RECURRENT, SEVERE W/O PSYCH FEATURES				1	**1**
MAJOR DEPRESSV DISORD, SINGLE EPSD, SEVERE W PSYCH FEATURES			1		**1**
MAJOR DEPRESSV DISORDER, RECURRENT, SEVERE W/PSYCH FEATURES		1	1		**2**
MAJOR DEPRESSV DISORDER, RECURRENT, UNSPECIFIED				1	**1**
MILD COGNITIVE IMPAIRMENT, SO STATED			1		**1**
OTH PSYCH DISORDER NOT DUE TO A SUB OR KNOWN PHYSIOLOGICAL CONDITION		1			**1**
OTHER DEPRESSIVE EPISODES			1		**1**
OTHER SCHIZOPHRENIA		2			**2**
PARANOID SCHIZOPHRENIA		1		4	**5**
PARANOID SCHIZOPHRENIA-UNSPEC	1				**1**
POSTTRAUMATIC STRESS DISORDER-UNSPEC	5	2	3	3	**13**
PSYCHOSIS NOS	4				**4**
RECURRENT DEPRESSIVE DISORDER-PSYCHOTIC	1				**1**
SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE		14	14	12	**40**
SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE			2	1	**3**
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	14	6	3	2	**25**
SCHIZOPHRENIA, UNSPECIFIED	14	9	14	11	**48**
UNSP PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSICAL COND		11	8	4	**23**
UNSPECIFIED MODD DISORDER (AFFECTIVE)			1		**1**
UNSPECIFIED MOOD DISORDER (EPISODIC)	2				**2**
Total Admissions	**64**	**59**	**65**	**51**	**239**
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	**0%**	**>1%**	**>1%**	**0%**	**>1%**

Peer Supports

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

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

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

Indicators	1Q2016	2Q2016	3Q2016	4Q2016
1. Attendance at Comprehensive Treatment Team meetings. (v9)	*89% 331/401	*86% 446/515	*91% 442/484	78% 430/550
2. Attendance at Service Integration meetings. (v8)	*97% 61/63	96% 47/49	*86% 56/65	43% 20/46
3. Contact during admission. (v8)	100% 64/64	100% 49/49	100% 64/64	100% 51/51
4. Community Integration/Bridging Inpatient & OPS. Inpatient trips OPS	100% 58 127	100% 91 131	100% 26 204	100% 21 221
5. Peer Support will make a documented attempt to have patients fill out a survey before discharge or annually to evaluate the effectiveness of the peer support relationship during hospitalization.	22% 14/63	41% 20/49	46% 30/65	19% 9/48
6. Grievances responded to on time by Peer Support, within 1 day of receipt.	100% 161/161	100% 97/97	100% 77/77	89% 82/92
7. Peer Specialist will meet with resident's within 48 hours of admission and complete progress note to document meeting.	100% 64/64	100% 49/49	100% 64/64	100% 51/51
8. Each resident has documented contact with a peer supporter during their hospitalization (target is 100%).	100% 64/64	100% 49/49	100% 64/64	100% 51/51

CONSENT DECREE

Treatment Planning

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

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

4Q2016:

2. Two patients declined to meet for the Service Integration Meeting and declined on follow up.

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

Indicators	1Q2016	2Q2016	3Q2016	4Q2016
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all patients on assigned **CCM** caseload.	91% 41/45	96% 43/45	89% 40/45	91% 41/45
2. Treatment plans will have measurable goals and interventions listing patient strengths and areas of need related to transition to the community or transition back to a correctional facility.	100% 45/45	100% 45/45	100% 45/45	100% 45/45

4Q2016: During chart audits, four charts had a late progress note for the prior week. A meeting was held with the patient, but the note was a late entry. The issue was discussed with individual team members and support was given in supervision. The primary contributing factor is three current social work position vacancies.

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

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

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

CONSENT DECREE

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

V13) The treatment plans reflect:

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

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

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

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

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

Medications

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

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

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

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

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

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

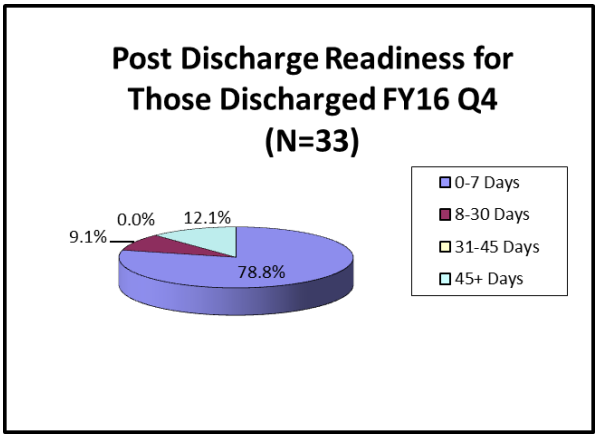
Discharges

Quarterly performance data shows that in 3 consecutive quarters:

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

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

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



Cumulative percentages & targets are as follows**:**

Within 7 days = (26) 79% (target 79%)

Within 30 days = (3) 88% (target 88%)

Within 45 days = (0) 88% (target 90%)

Post 45 days = (4) 12% (target 0%)

Barriers to Discharge Following Clinical Readiness:

Residential Supports (0) No barriers in this area	Housing (7) • 3 patients discharged (5, 13 and 23 days) post clinical readiness • 4 patients discharged 45+ days post clinical readiness (48, 49, 72, 114 days)
Treatment Services (1) One patient was discharged at 13 days with treatment service barriers (PTP)	
Other (0) No barriers in this area	

CONSENT DECREE

The previous four quarters are displayed in the table below:

		Within 7 days	Within 30 days	Within 45 days	45+ days
Target >>		**70%**	**80%**	**90%**	**< 10%**
3Q2016	N=40	57.5%	72.5%	85.0%	10.7%
2Q2016	N=40	67.9%	85.7%	89.3%	10.7%
1Q2016	N=34	64.7%	82.3%	91.1%	8.9%
4Q2015	N=29	65.6%	86.2%	93.1%	6.9%

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	1Q2016	2Q2016	3Q2016	4Q2016
1. The Patient Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 12/12	100% 12/12	100% 13/13	100% 13/13
2. The Patient Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 12/12	100% 12/12	100% 13/13	100% 13/13
3. The Patient Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	83% 10/12	92% 11/12	92% 12/13	85% 11/13
4. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 12/12	92% 11/12	100% 13/13	100% 13/13

4Q2016:

3. On two occasions the report was not sent out during the week, it was presented at the Wednesday Housing Meeting; on both occasions it was an issue with the database functioning.

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	1Q2016	2Q2016	3Q2016	4Q2016
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	66% 2/3	0% 0/6	14% 1/7	100% 2/2
2. The assigned **CCM** will review the new court order with the patient and document the meeting in a progress note or treatment team note.	100% 3/3	100% 3/3	100% 8/8	100% 3/3
3. Annual Reports (due in December) to the Commissioner for all inpatient NCR patients are submitted annually	N/A	0% 0/25	100% 25/25	N/A

Staffing and Staff Training

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

Indicators	1Q2016	2Q2016	3Q2016	4Q2016	YTD
1. Riverview and Contract staff will attend CPR training bi-annually.	100% 55/55	100% 47/47	100% 41/41	93% 39/42	98% 182/185
2. Riverview and Contract staff will attend Annual training.	86% 89/104	97% 56/58	80% 16/20	62% 58/93	80% 219/275
3. Riverview and contract staff will attend MOAB training bi-annually	100% 28/28	100% 11/11	82% 94/115	76% 152/200	81% 285/354

4Q2016:

1. Three out of 42 employees' CPR has expired. Corrective action has been taken to ensure compliance with this mandatory training component.
2. 35 employees are in need of completing their Annual Mandatory Quiz. Corrective action has been implemented.
3. 48 employees are still in need of MOAB as of January 2016. Due to staff shortages and unit coverage needs, some staff were unable to attend their annual recertification. Several staff in need of recertification have been scheduled to attend training in July 2016.

CONSENT DECREE

Responsible Party: Susan Bundy, Director of Staff Development

I. Measure Name: Ongoing Education and Training

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

Type of Measure: Performance Improvement

Goal: 90% of direct support staff will attend Non Violent Communication and Motivational Interviewing training by June 2016. Attendance will be tracked by Staffing and Organizational Development. Progress will be reported quarterly.

Progress: To date, 216 out of 375 current employees, 58%, have attended Non-Violent Communication (NVC) Training. 85 have attended the eight hour NVC Training. 111 employees have attended Motivational Interviewing training.

Comments: Non-Violent Communication and Motivational Interviewing were not offered this quarter.

II. Measure Name: Seclusion and Restraint Reduction

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

Type of Measure: Performance Improvement

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

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

***Average # of events per month in FY 2015: 62**

CONSENT DECREE

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

***Average # of events per month in FY 2016 to date: 52**

Action Plan:

Staff will receive initial and ongoing education training in MOAB, Non-Violent Communication, and Motivational Interviewing to assist in establishing therapeutic relationships so that when a crisis begins staff will be more influential and effective in preventing the use of seclusions and restraints.

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

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

DATE	HRS	TITLE	PRESENTER
4Q2015	17	April – June 2015	
1Q2016	4	July – September 2015	
2Q2016	19	October – December 2015	
3Q2016	14	January – March 2016	
4/7/2016	1	Beyond PTSD: Complex Trauma Caused by Childhood Interpersonal Abuse	Jessica Lloyd, Psychology Intern
4/14/2016	1	Mentalization Based Treatment	Daniel Price, MD
4/20/2016	1	Medical Staff QA & PI Committee	William Nelson, MD
4/21/2016	1.5	Equine Assisted Therapy - The EGALA Model	Hilary Spear, Rec Therapist Heidi Blodgett, Rec Therapist
4/28/2016	1	Treating the Not Guilty by Reason of Insanity Patient: Legal, Ethical and Clinical Issues	Alex de Nesnera, MD
5/12/2016	1	A case history and introduction to Punjabi Culture	Steven Macchione, Psychology Intern
5/17/2016	1	Medical Staff QA/PI Committee	William Nelson, MD
5/19/2016	1	A Complex Case Discussion	Noel Ngai, PsyD; Tatiana Gregor, EdD; Regana Sisson, MD; Maureen Martin, OT
5/26/2016	1	Fire-Setting: Who, Why and How	Brooke Hoffman, PsyD
6/2/2016	1	Hope in the Clinical Context: How Practicing Clinicians Define and Use Hope in Sessions	Brooke Hoffman, PsyD
6/9/2016	1	Precision Medicine: Clinical Applications of Pharmacogenomics	Sarah Perry, PharmD
6/16/2016	1.5	Dartmouth Review: Cultural Aspects of Psychotic Disorder	Regana Sisson, MD
6/17/2016	6	Evaluating the Validity of Miranda Waivers and the Trustworthiness of Confessions	Alen Goldstein, PhD, ABPP
6/23/2016	1	A Multi-Disciplinary Case Presentation	Graham Danzer, Psychology Intern
6/30/2016	1	Psychosis, Seizures or Both?	George Davis, MD

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

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

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

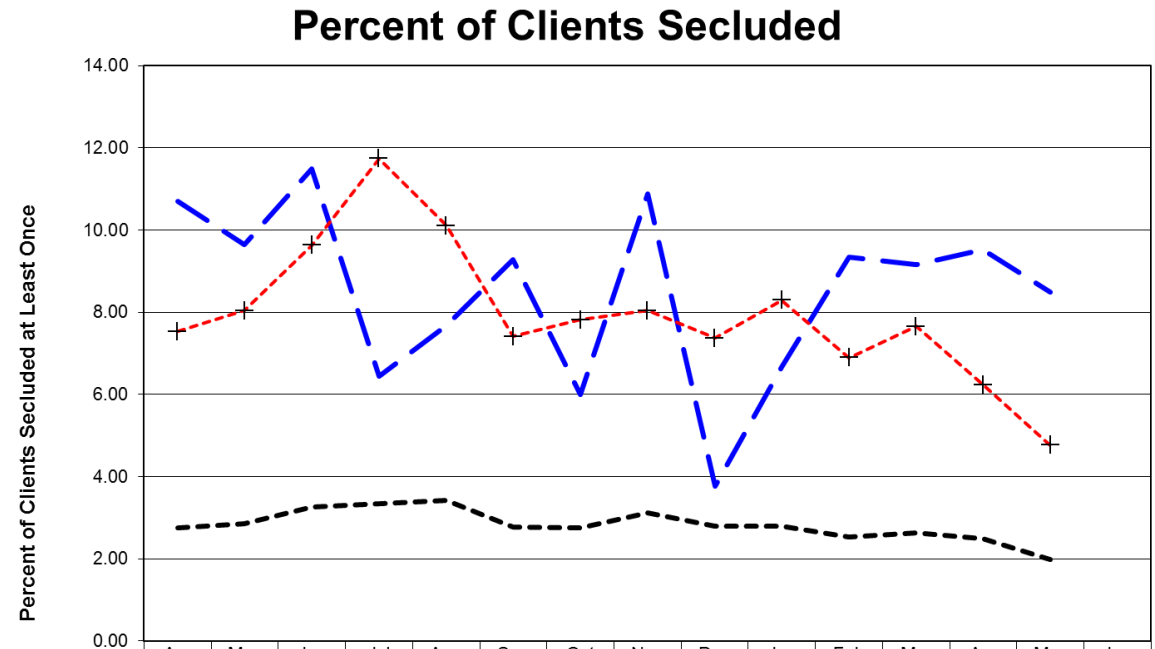
Staffing levels are most often determined by an analysis of unit acuity, individual monitoring needs of the patients who reside on specific units, and unit census.

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

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

Use of Seclusion and Restraints

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	10.71	9.64	11.49	6.45	7.69	9.28	6.00	10.89	3.77	6.67	9.35	9.17	9.52	8.49	
Ntl Mean	2.75	2.86	3.26	3.34	3.42	2.78	2.76	3.11	2.80	2.80	2.54	2.63	2.49	1.98	
+1 StDev	7.53	8.04	9.63	11.74	10.11	7.41	7.82	8.04	7.37	8.29	6.89	7.65	6.24	4.77	

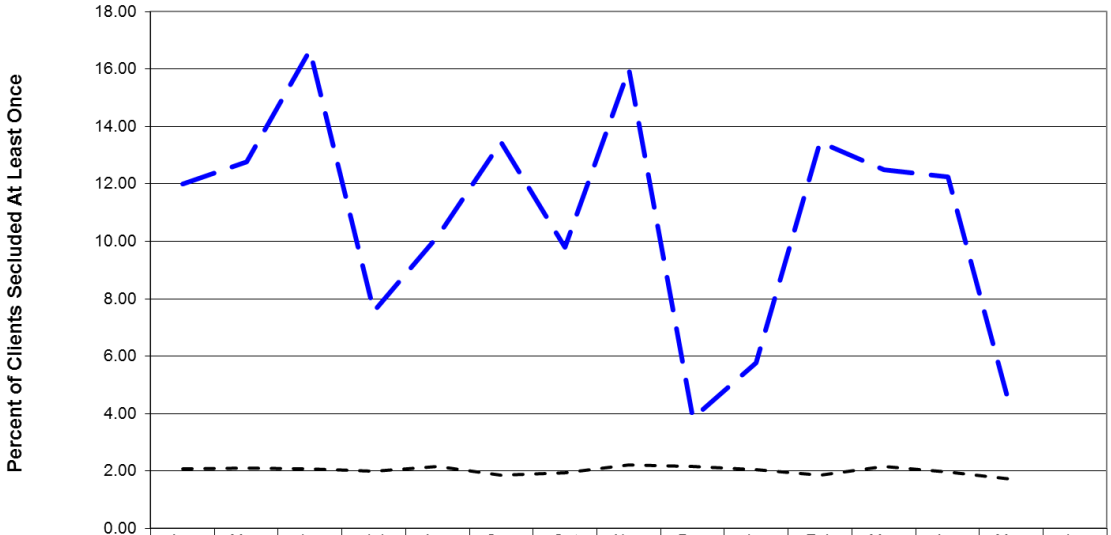
This graph depicts the percent of unique patients who were secluded at least once. For example, rates of 3.0 means that 3% of the unique patients served were secluded at least once.

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

CONSENT DECREE

Percent of Clients Secluded

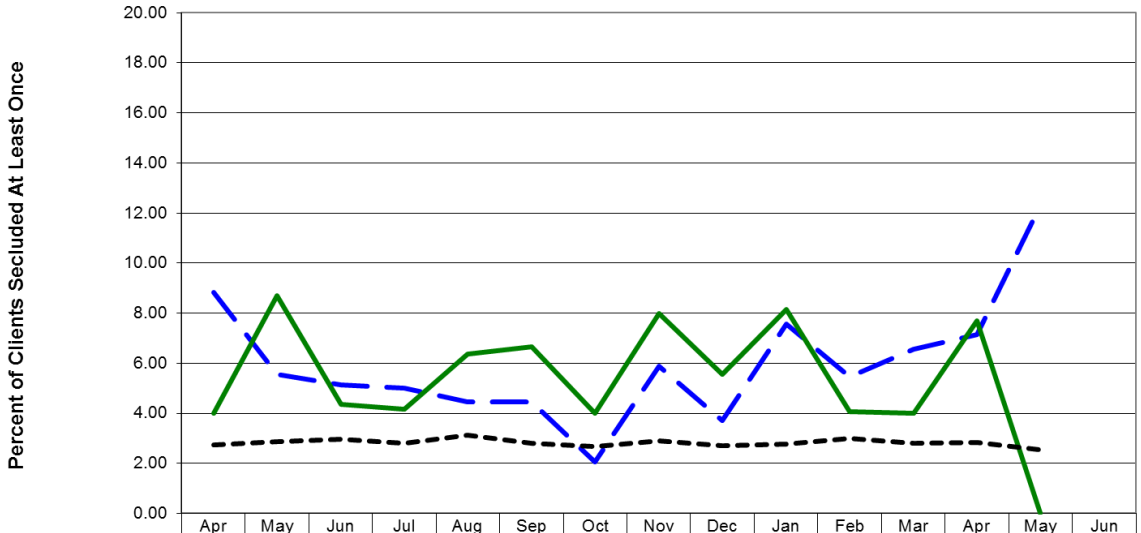
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	12.00	12.77	16.67	7.55	10.17	13.46	9.80	16.00	3.85	5.77	13.46	12.50	12.24	4.08	
Ntl Mean	2.09	2.10	2.07	2.00	2.15	1.86	1.94	2.21	2.15	2.06	1.85	2.16	1.98	1.73	

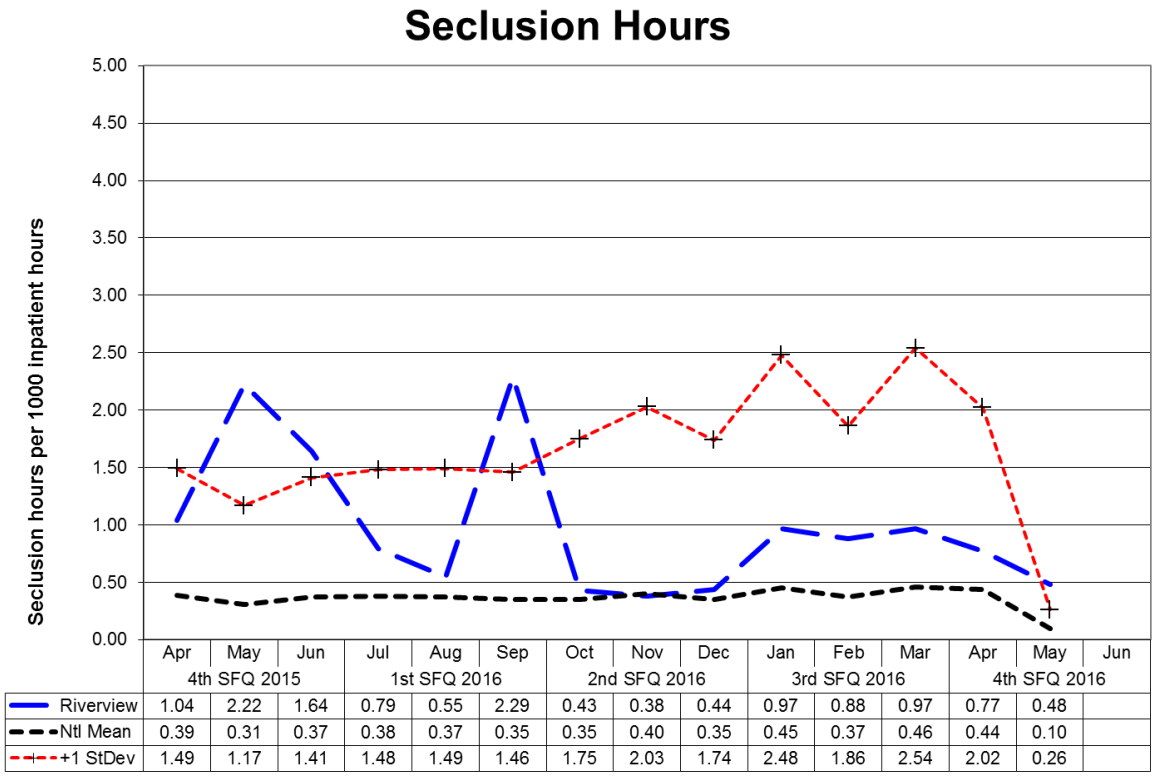
Percent of Clients Secluded

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	8.82	5.56	5.13	5.00	4.44	4.44	2.04	5.88	3.70	7.55	5.45	6.56	7.14	12.28	
Dorothea Dix	4.00	8.70	4.35	4.17	6.38	6.67	4.00	8.00	5.56	8.16	4.08	4.00	7.69	0.00	
Ntl Mean	2.73	2.87	2.97	2.79	3.14	2.81	2.66	2.90	2.72	2.78	2.98	2.79	2.84	2.55	

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	1.04	2.22	1.64	0.79	0.55	2.29	0.43	0.38	0.44	0.97	0.88	0.97	0.77	0.48	
Ntl Mean	0.39	0.31	0.37	0.38	0.37	0.35	0.35	0.40	0.35	0.45	0.37	0.46	0.44	0.10	
+1 StDev	1.49	1.17	1.41	1.48	1.49	1.46	1.75	2.03	1.74	2.48	1.86	2.54	2.02	0.26	

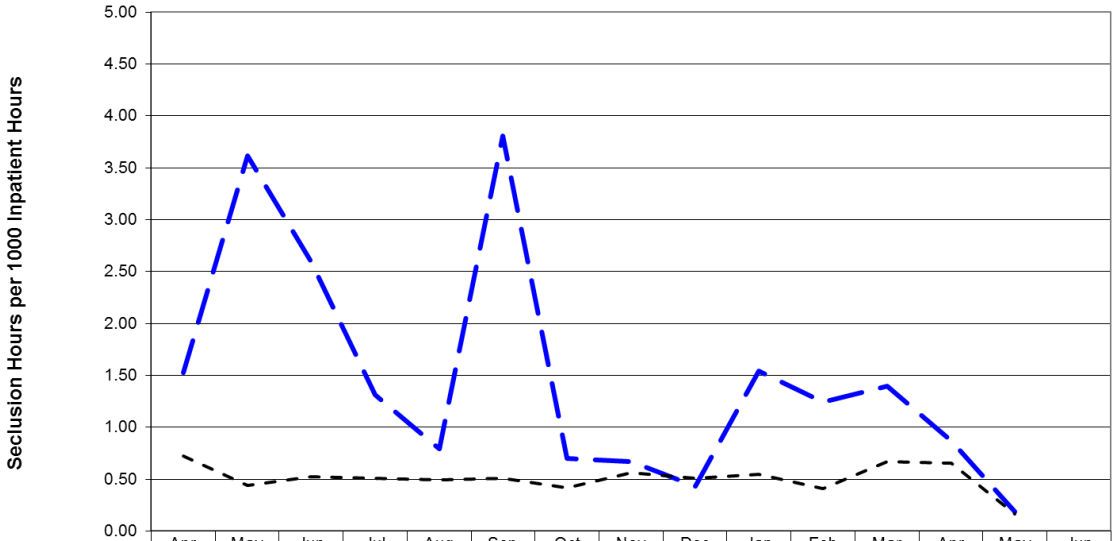
This graph depicts the number of hours patients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

CONSENT DECREE

Seclusion Hours

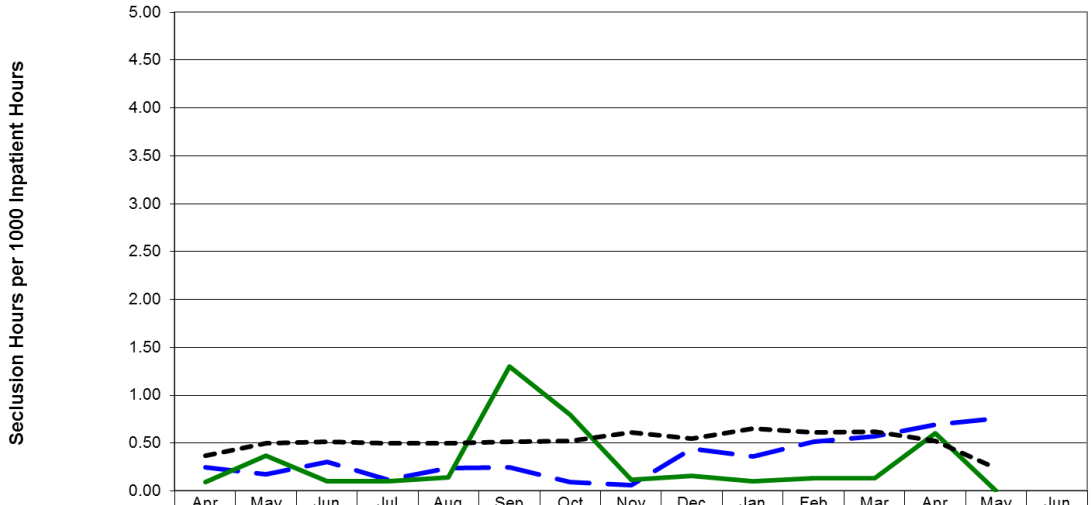
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	1.53	3.62	2.60	1.31	0.79	3.81	0.70	0.67	0.43	1.54	1.24	1.40	0.87	0.19	
Ntl Mean	0.72	0.44	0.52	0.51	0.49	0.51	0.42	0.56	0.51	0.55	0.41	0.67	0.65	0.16	

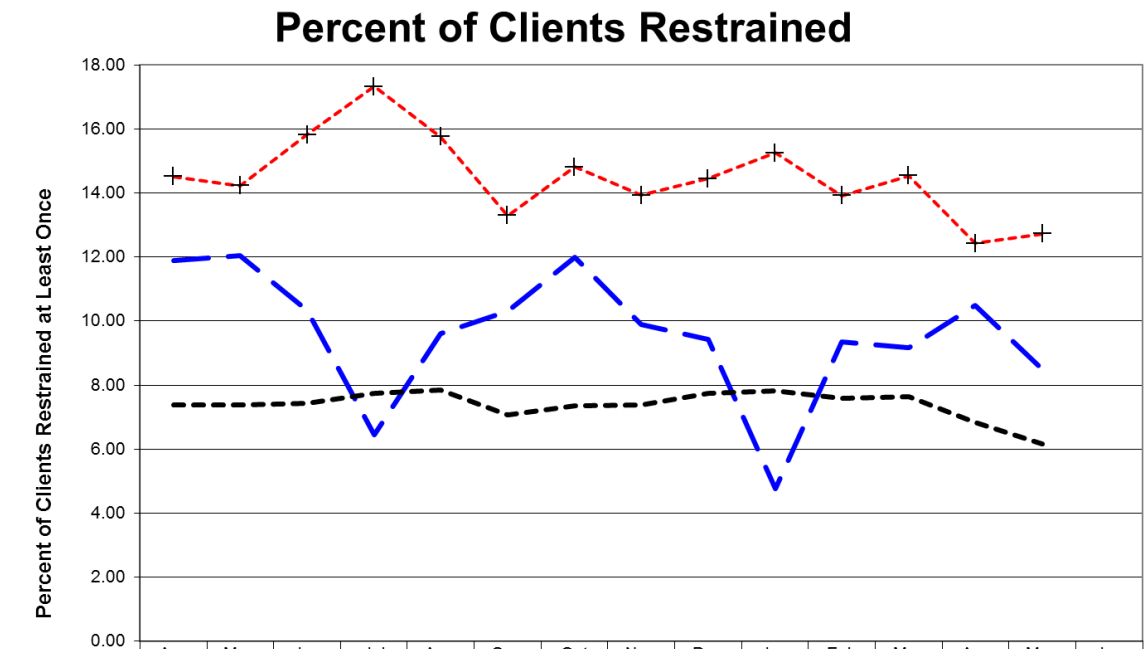
Seclusion Hours

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.25	0.17	0.30	0.12	0.24	0.25	0.09	0.06	0.44	0.36	0.51	0.57	0.69	0.76	
Dorothea Dix	0.09	0.37	0.10	0.10	0.14	1.30	0.80	0.12	0.16	0.10	0.13	0.13	0.60	0.00	
Ntl Mean	0.37	0.50	0.51	0.50	0.50	0.51	0.52	0.61	0.55	0.65	0.61	0.62	0.52	0.24	

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	11.90	12.05	10.34	6.45	9.62	10.31	12.00	9.90	9.43	4.76	9.35	9.17	10.48	8.49	
Ntl Mean	7.38	7.37	7.44	7.74	7.85	7.07	7.36	7.37	7.73	7.83	7.59	7.63	6.83	6.15	
+1 StDev	14.51	14.23	15.82	17.32	15.76	13.29	14.81	13.93	14.45	15.25	13.92	14.54	12.43	12.72	

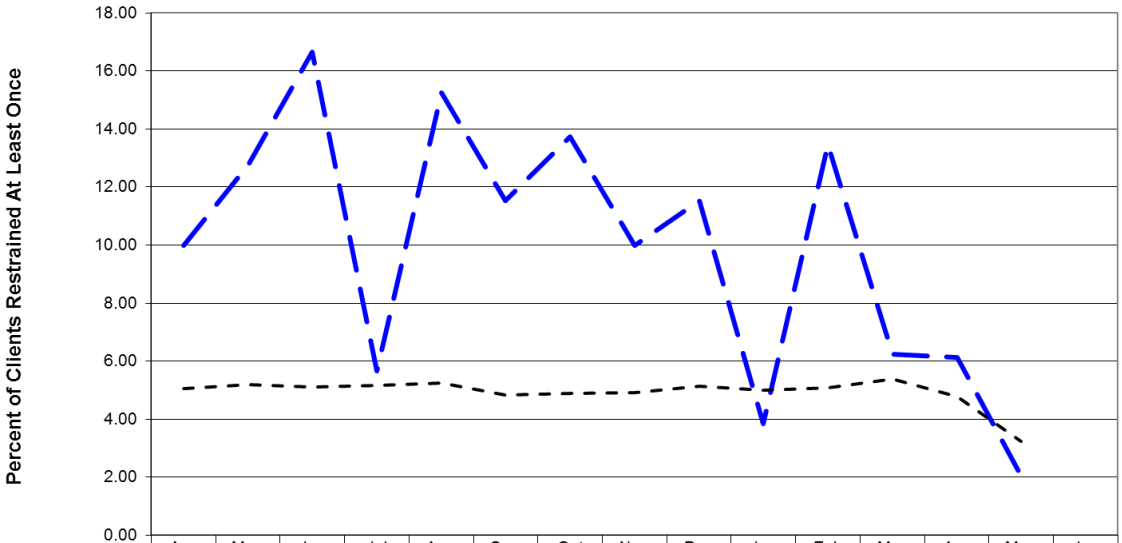
This graph depicts the percent of unique patients who were restrained at least once and includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique patients served were restrained at least once.

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

CONSENT DECREE

Percent of Clients Restrained

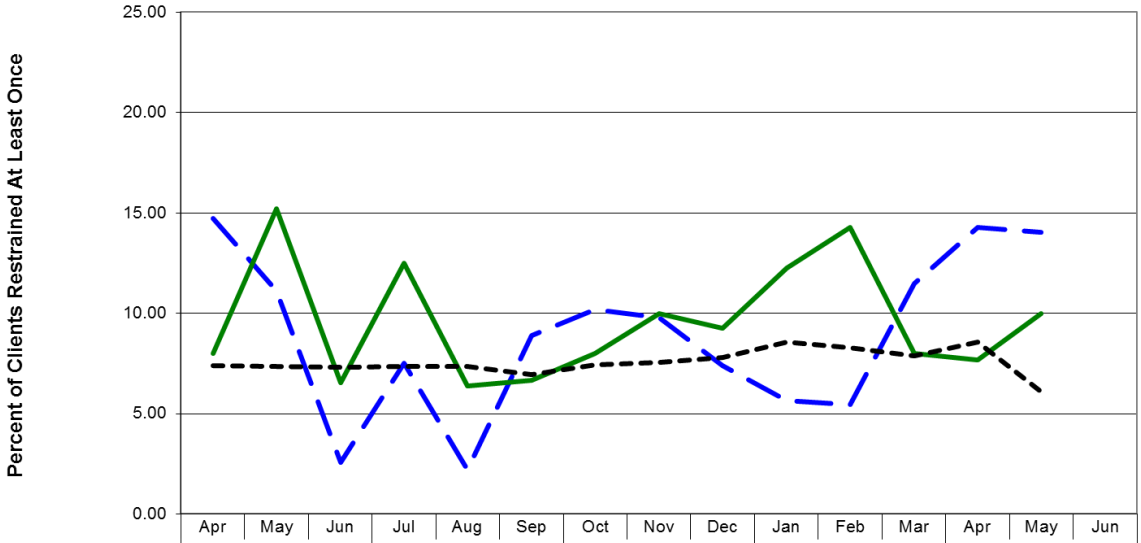
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	10.00	12.77	16.67	5.66	15.25	11.54	13.73	10.00	11.54	3.85	13.46	6.25	6.12	2.04	
Ntl Mean	5.05	5.18	5.10	5.16	5.25	4.84	4.89	4.92	5.14	4.99	5.07	5.39	4.77	3.24	

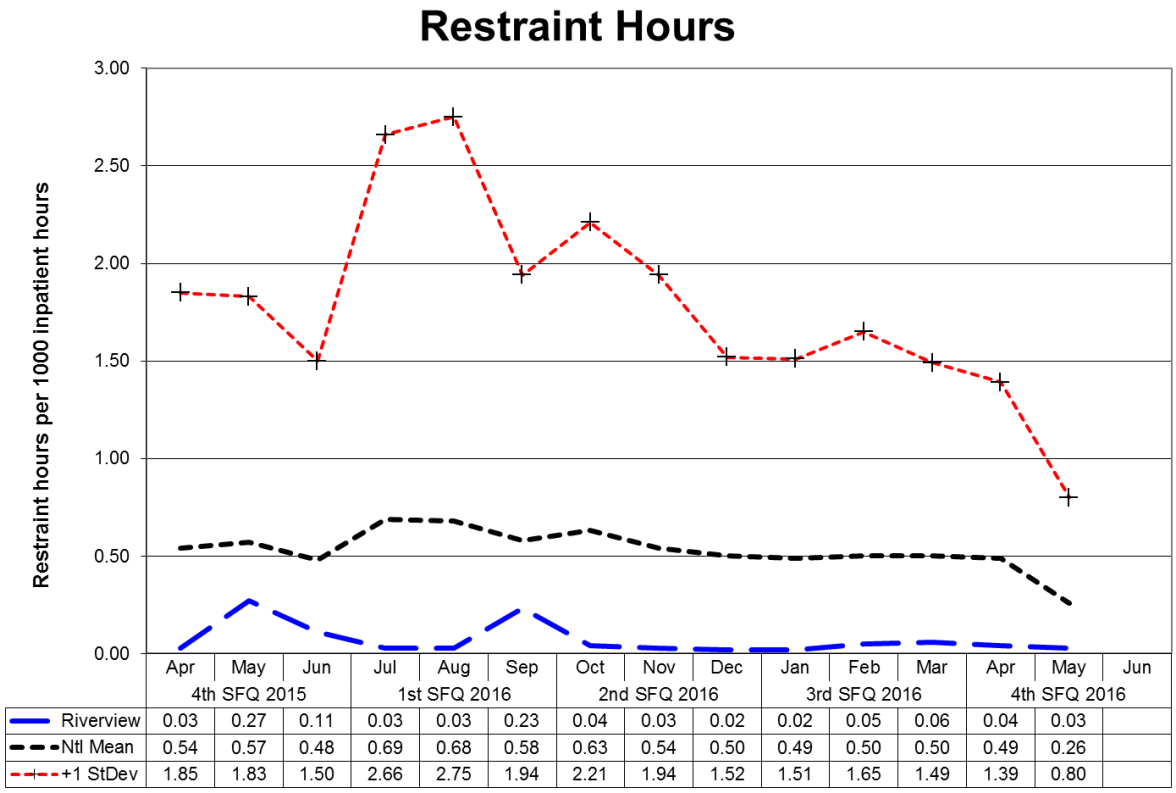
Percent of Clients Restrained

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	14.71	11.11	2.56	7.50	2.22	8.89	10.20	9.80	7.41	5.66	5.45	11.48	14.29	14.04	
Dorothea Dix	8.00	15.22	6.52	12.50	6.38	6.67	8.00	10.00	9.26	12.24	14.29	8.00	7.69	10.00	
Ntl Mean	7.40	7.33	7.32	7.34	7.35	6.96	7.45	7.54	7.81	8.55	8.27	7.86	8.56	6.09	

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.03	0.27	0.11	0.03	0.03	0.23	0.04	0.03	0.02	0.02	0.05	0.06	0.04	0.03	
Ntl Mean	0.54	0.57	0.48	0.69	0.68	0.58	0.63	0.54	0.50	0.49	0.50	0.50	0.49	0.26	
+1 StDev	1.85	1.83	1.50	2.66	2.75	1.94	2.21	1.94	1.52	1.51	1.65	1.49	1.39	0.80	

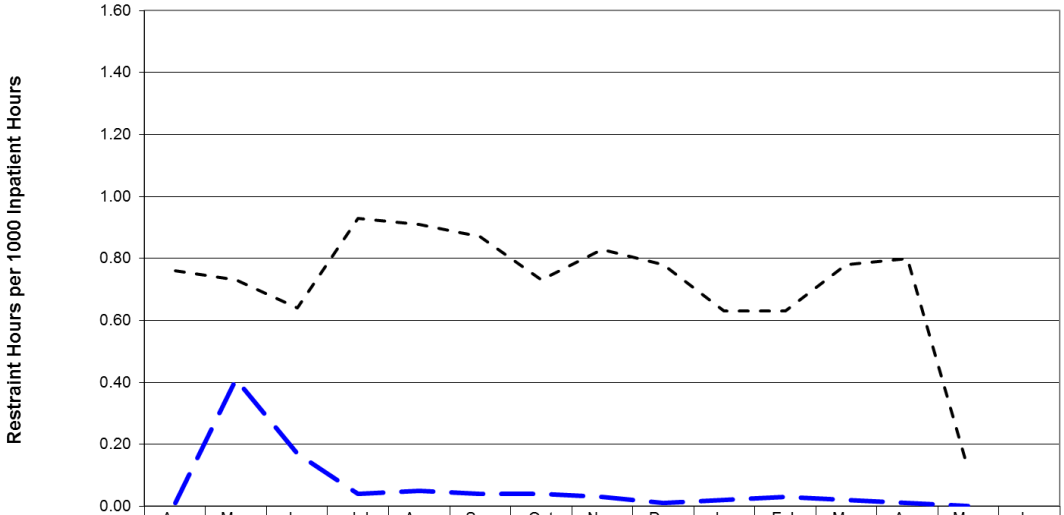
This graph depicts the number of hours patients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.

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

CONSENT DECREE

Restraint Hours

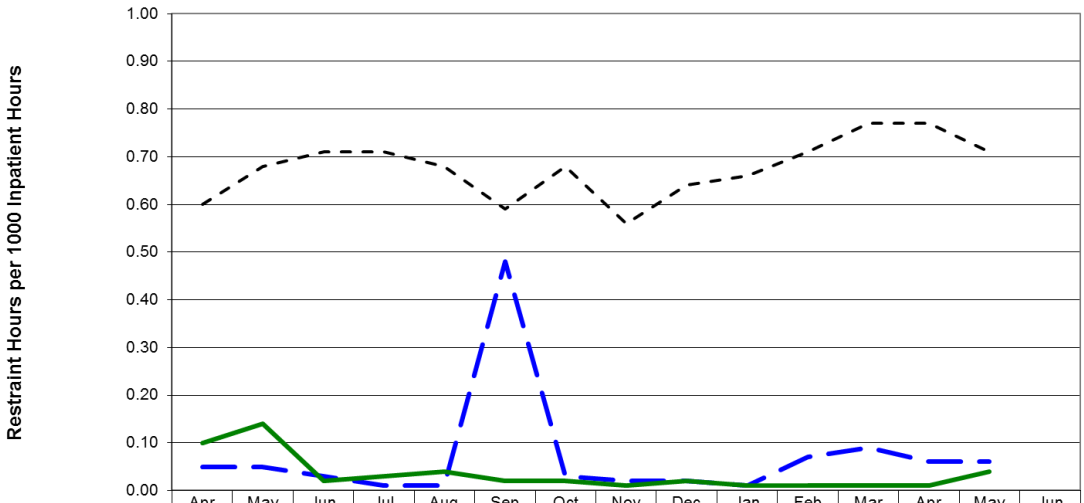
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.01	0.41	0.17	0.04	0.05	0.04	0.04	0.03	0.01	0.02	0.03	0.02	0.01	0.00	
Ntl Mean	0.76	0.73	0.64	0.93	0.91	0.87	0.73	0.83	0.78	0.63	0.63	0.78	0.80	0.12	

Restraint Hours

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.05	0.05	0.03	0.01	0.01	0.48	0.03	0.02	0.02	0.01	0.07	0.09	0.06	0.06	
Dorothea Dix	0.10	0.14	0.02	0.03	0.04	0.02	0.02	0.01	0.02	0.01	0.01	0.01	0.01	0.04	
Ntl Mean	0.60	0.68	0.71	0.71	0.68	0.59	0.68	0.56	0.64	0.66	0.71	0.77	0.77	0.71	

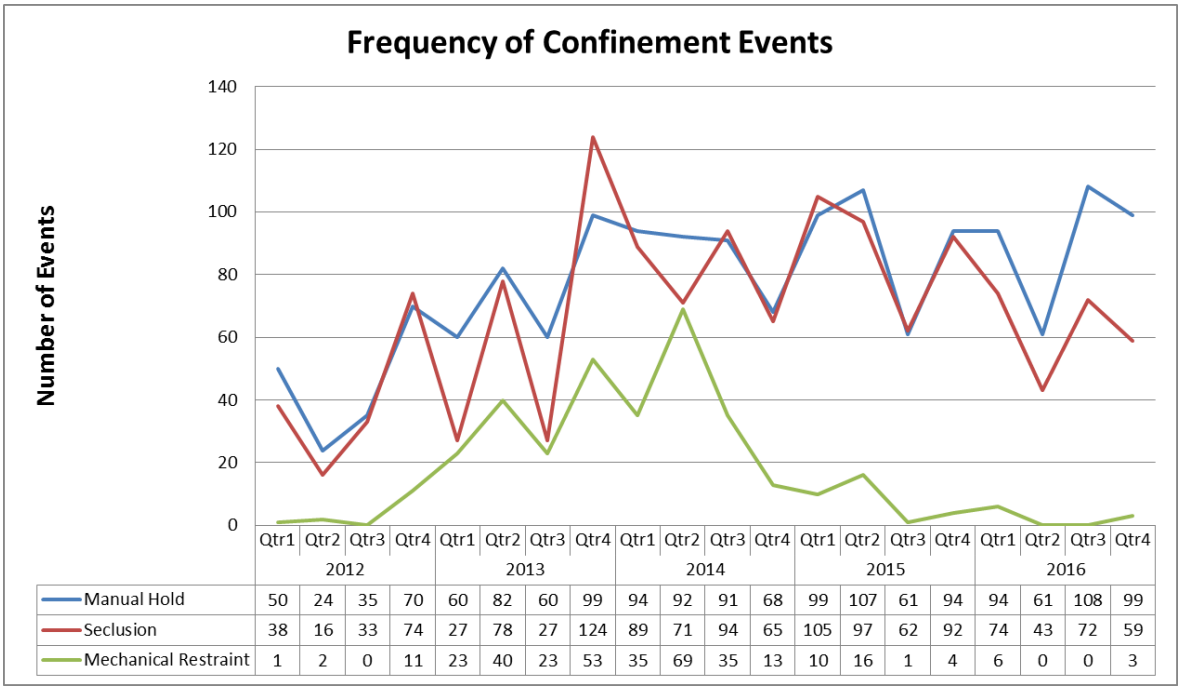
CONSENT DECREE

Confinement Event Detail
4Q2016

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR7880	35		17	52	32.30%	32.30%
MR7127	13		4	17	10.56%	42.86%
MR7878	11		6	17	10.56%	53.42%
MR657	7	3	1	11	6.83%	60.25%
MR7873	5		4	9	5.59%	65.84%
MR7893	3		4	7	4.35%	70.19%
MR4296	2		3	5	3.11%	73.29%
MR7794	2		3	5	3.11%	76.40%
MR7902	3		2	5	3.11%	79.50%
MR7899	2		2	4	2.48%	81.99%
MR7908	4			4	2.48%	84.47%
MR5984			3	3	1.86%	86.34%
MR5297	2		1	3	1.86%	88.20%
MR7315	1		2	3	1.86%	90.06%
MR7924	2		1	3	1.86%	91.93%
MR763	1		1	2	1.24%	93.17%
MR6714	1		1	2	1.24%	94.41%
MR161	1			1	0.62%	95.03%
MR3766			1	1	0.62%	95.65%
MR4647	1			1	0.62%	96.28%
MR5085	1			1	0.62%	96.90%
MR6314			1	1	0.62%	97.52%
MR7363			1	1	0.62%	98.14%
MR7607	1			1	0.62%	98.76%
MR7879			1	1	0.62%	99.38%
MR7915	1			1	0.62%	100.00%
	99	**3**	**59**	**161**		

30% (26/87) of the average hospital population experienced some form of confinement event during 4Q2016. Five of these patients (6% of the average hospital population) accounted for 70% of the confinement events.

CONSENT DECREE



	Qtr1 2012	Qtr2 2012	Qtr3 2012	Qtr4 2012	Qtr1 2013	Qtr2 2013	Qtr3 2013	Qtr4 2013	Qtr1 2014	Qtr2 2014	Qtr3 2014	Qtr4 2014	Qtr1 2015	Qtr2 2015	Qtr3 2015	Qtr4 2015	Qtr1 2016	Qtr2 2016	Qtr3 2016	Qtr4 2016
Manual Hold	50	24	35	70	60	82	60	99	94	92	91	68	99	107	61	94	94	61	108	99
Seclusion	38	16	33	74	27	78	27	124	89	71	94	65	105	97	62	92	74	43	72	59
Mechanical Restraint	1	2	0	11	23	40	23	53	35	69	35	13	10	16	1	4	6	0	0	3

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:

	1Q2016	2Q2016	3Q2016	4Q2016	Total
Danger to Others/Self	43	35	42	57	**177**
Danger to Others		23	29	2	**54**
Danger to Self			1		**1**
% Dangerous Participation	100%	100%	100%	100%	**100%**
Total Events	**43**	**58**	**72**	**59**	**232**

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:

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

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

See Pages 35-39

CONSENT DECREE

Confinement Events Management

Seclusion Events

(59) Events

Standard	Threshold	Compliance
1. The record reflects that seclusion was absolutely necessary to protect the patient from causing physical harm to self or others, or if the patient was examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption that significantly interferes with other patients' treatment.	95%	98%
2. The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	98%
3. The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	98%
4. The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	98%
5. The record reflects that, if the physician or physician extender was not immediately available to examine the patient, the patient was placed in seclusion following an examination by a nurse.	90%	100%
6. The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in seclusion, and if there is a delay, the reasons for the delay.	90%	100%
7. The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least 3 times per hour.)	90%	100%
8. Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
9. The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.	75%	100%
10. The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
11. The medical order states the conditions under which the patient may be sooner released.	85%	100%

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

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events

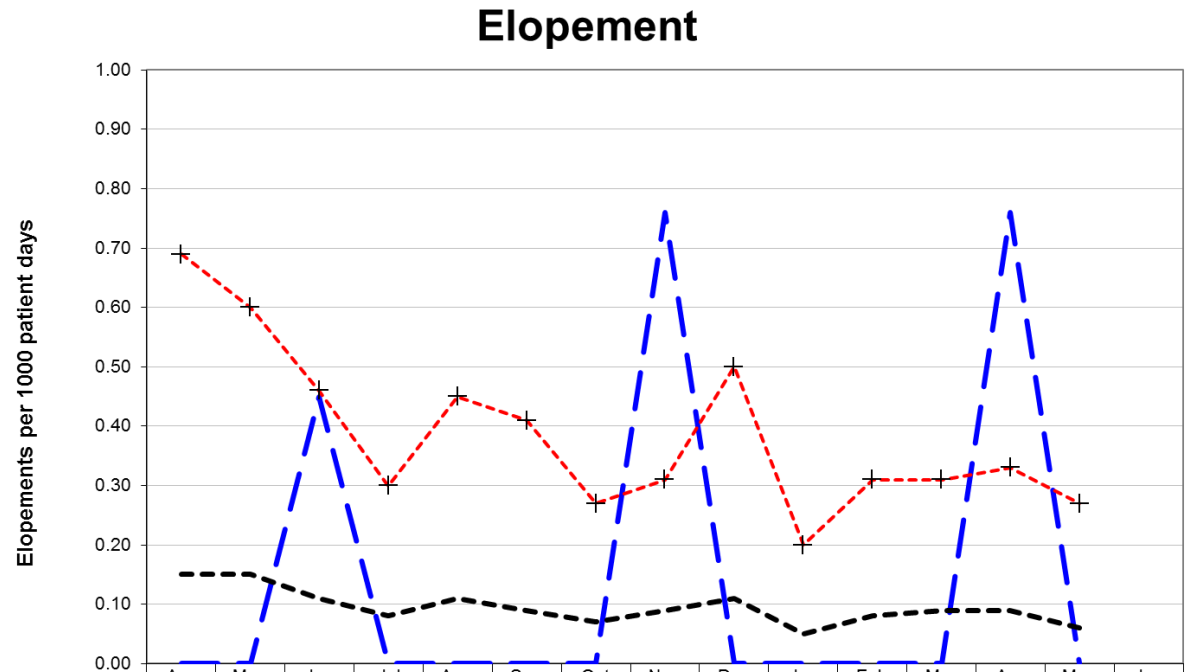
(3) Events

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

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

Patient Elopements

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	0.45	0.00	0.00	0.00	0.00	0.76	0.00	0.00	0.00	0.00	0.76	0.00	
Ntl Mean	0.15	0.15	0.11	0.08	0.11	0.09	0.07	0.09	0.11	0.05	0.08	0.09	0.09	0.06	
+1 StDev	0.69	0.60	0.46	0.30	0.45	0.41	0.27	0.31	0.50	0.20	0.31	0.31	0.33	0.27	

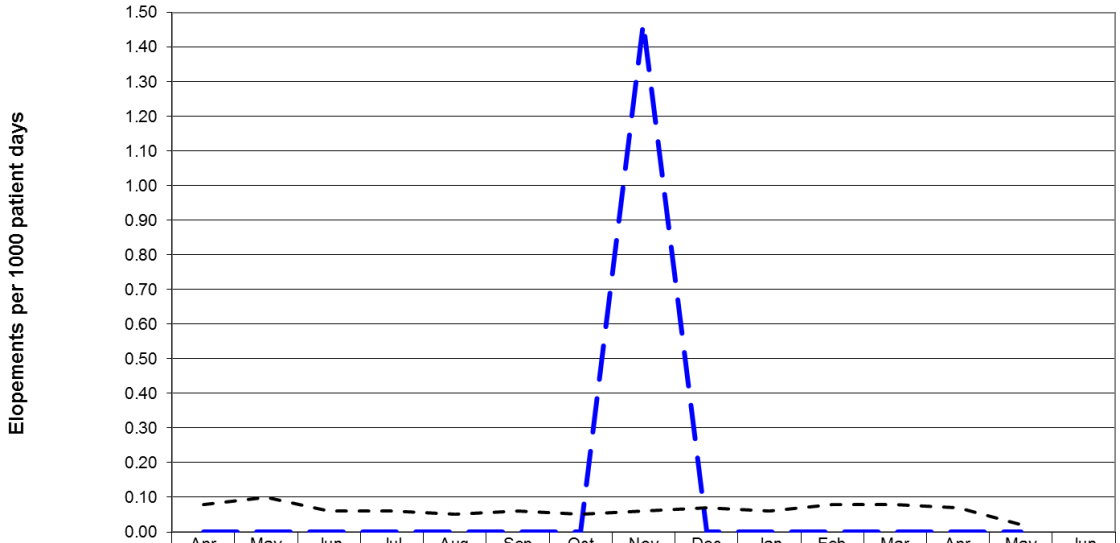
This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days. An elopement is defined as any time a patient is "absent from a location defined by the patient's privilege status regardless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

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

CONSENT DECREE

Elopement

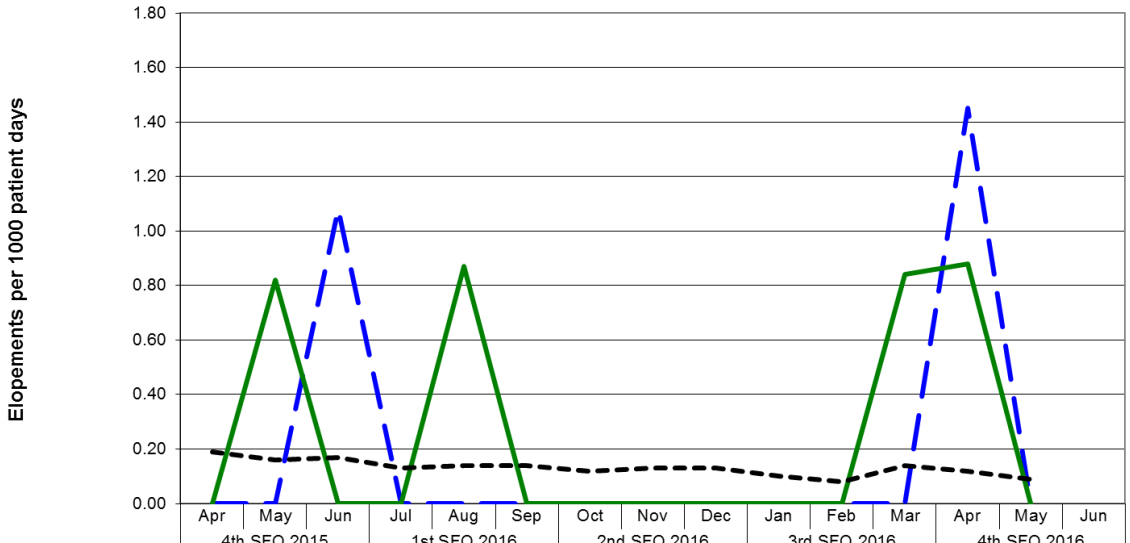
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.47	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.08	0.10	0.06	0.06	0.05	0.06	0.05	0.06	0.07	0.06	0.08	0.08	0.07	0.02	

Elopement

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	1.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.45	0.00	
Dorothea Dix	0.00	0.82	0.00	0.00	0.87	0.00	0.00	0.00	0.00	0.00	0.00	0.84	0.88	0.00	
Ntl Mean	0.19	0.16	0.17	0.13	0.14	0.14	0.12	0.13	0.13	0.10	0.08	0.14	0.12	0.09	

Patient Injuries

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

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

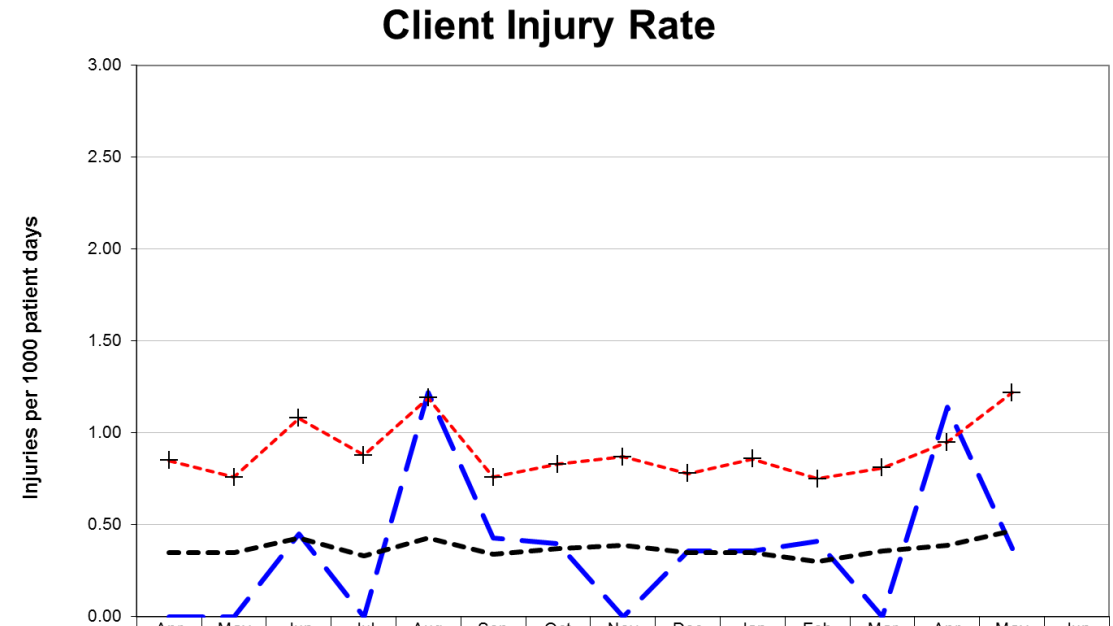
"Non-reportable" injuries include those that require: 1) No Treatment, or 2) Minor First Aid

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

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

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

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	0.45	0.00	1.22	0.43	0.40	0.00	0.36	0.36	0.41	0.00	1.14	0.37	
Ntl Mean	0.35	0.35	0.43	0.33	0.43	0.34	0.37	0.39	0.35	0.35	0.30	0.36	0.39	0.47	
+1 StDev	0.85	0.76	1.08	0.88	1.19	0.76	0.83	0.87	0.78	0.86	0.75	0.81	0.95	1.22	

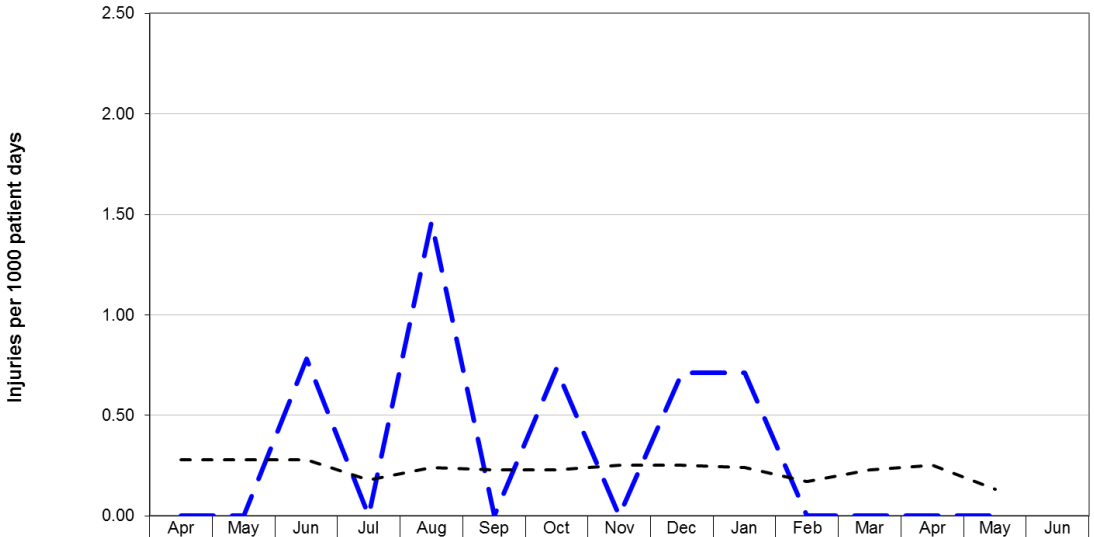
This graph depicts the number of patient injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

CONSENT DECREE

Client Injury Rate

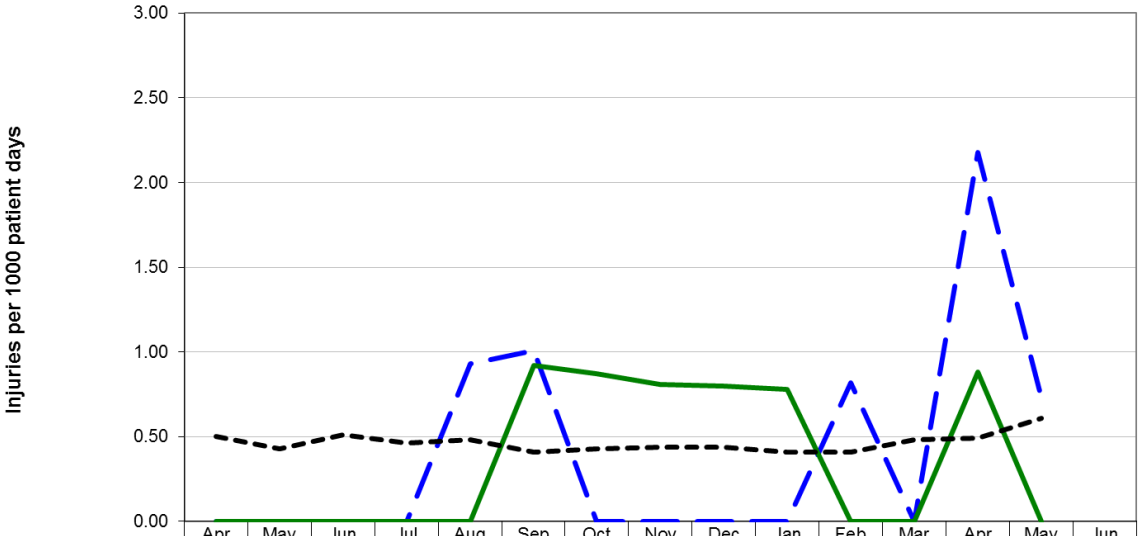
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	0.78	0.00	1.46	0.00	0.73	0.00	0.71	0.71	0.00	0.00	0.00	0.00	
Ntl Mean	0.28	0.28	0.28	0.18	0.24	0.23	0.23	0.25	0.25	0.24	0.17	0.23	0.25	0.13	

Client Injury Rate

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.93	1.01	0.00	0.00	0.00	0.00	0.82	0.00	2.18	0.73	
Dorothea Dix	0.00	0.00	0.00	0.00	0.00	0.92	0.87	0.81	0.80	0.78	0.00	0.00	0.88	0.00	
Ntl Mean	0.50	0.43	0.51	0.46	0.48	0.41	0.43	0.44	0.44	0.41	0.41	0.48	0.49	0.61	

CONSENT DECREE

Type and Cause of Injury by Month

Type - Cause	April	May	June	4Q2016
Accident	3	2	3	**8**
Assault (Patient to Patient)	2	2		**4**
Fall	5	1	3	**9**
Injury – Other	2	1	6	**9**
Self-Injurious Behavior	2	1	3	**6**
Total	**14**	**7**	**15**	**36**

Severity of Injury by Month

Severity	April	May	June	4Q2016
No Treatment	5	4	8	**17**
Minor First Aid	7	2	5	**14**
Medical Intervention Required	2	1	2	**5**
Hospitalization Required				
Death Occurred				
Total	**14**	**7**	**15**	**36**

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

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

Patient Abuse, Neglect, Exploitation, Injury or Death

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

Type of Allegation	1Q2016	2Q2016	3Q2016	4Q2016	Total
Abuse Verbal	8	11	8	6	**33**
Abuse Physical	14	11	13	15	**53**
Abuse Sexual	27	9	11	17	**64**
Neglect	3	2	1	2	**8**
Coercion/Exploitation	2	4	6	8	**20**
Total	**54**	**37**	**39**	**48**	**178**

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

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

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

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

V35) Riverview maintains its hospital license;

Riverview maintains its licensing status as required through the Maine Department of Health and Human Services Division of Licensing and Regulatory Services. The hospital is licensed through October 31, 2016.

V36) The hospital seeks CMS certification;

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

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

Riverview complies with this element of substantial compliance as evidenced by the current Integrated Plan for Performance Excellence, the data and reports presented in this document, the work of the Integrated Performance Excellence Committee, and sub-groups of this committee that are engaged in a transition to an improvement orientated methodology that is supported by The Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence. The Advisory Board approved the Integrated Plan for Performance Excellence in August 2015.

CONSENT DECREE

Recommendation from Court Master

February 9, 2016

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

CONSENT DECREE

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

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

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

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

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

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

JOINT COMMISSION

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

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

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

JOINT COMMISSION

Admissions Screening (HBIPS 1)

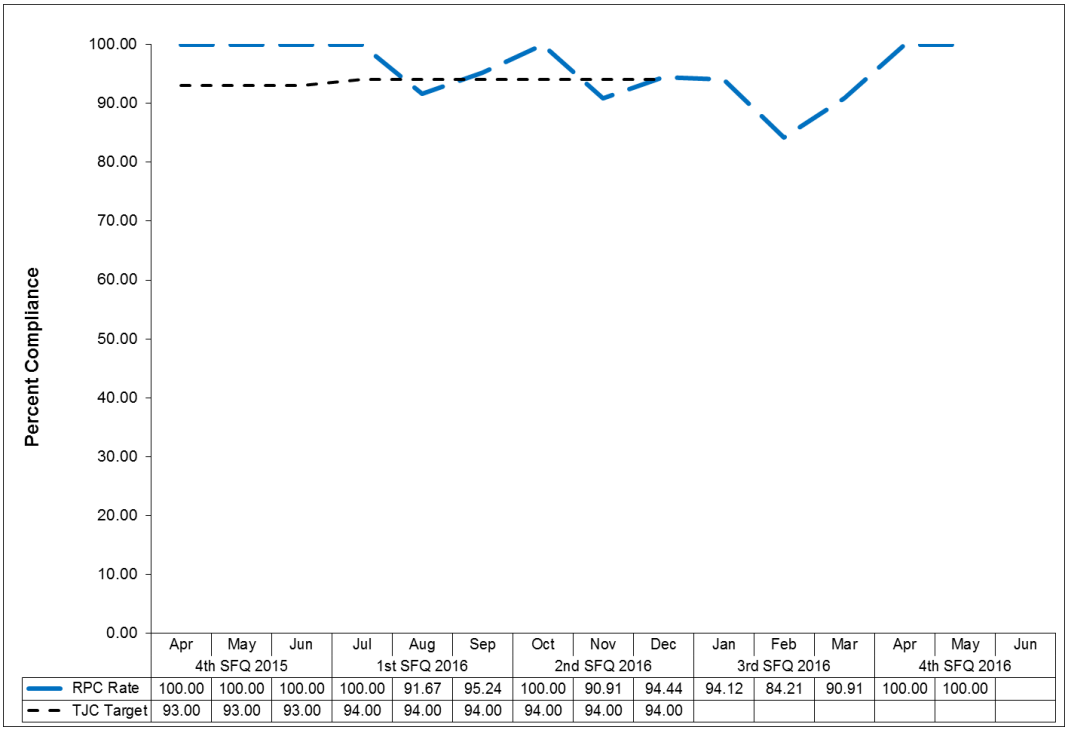
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

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

Rationale

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



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	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
RPC Rate	100.00	100.00	100.00	100.00	91.67	95.24	100.00	90.91	94.44	94.12	84.21	90.91	100.00	100.00	
TJC Target	93.00	93.00	93.00	94.00	94.00	94.00	94.00	94.00	94.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

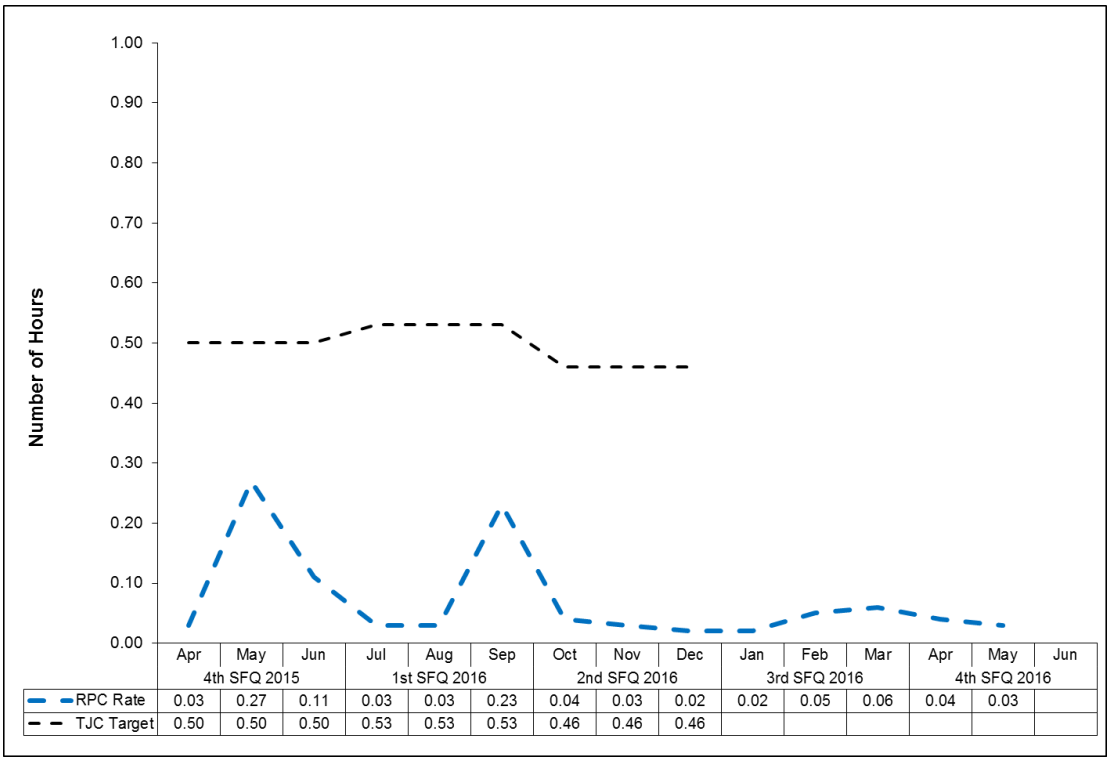
Hours of Use

Description

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

Rationale

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
RPC Rate	0.03	0.27	0.11	0.03	0.03	0.23	0.04	0.03	0.02	0.02	0.05	0.06	0.04	0.03	
TJC Target	0.50	0.50	0.50	0.53	0.53	0.53	0.46	0.46	0.46						

JOINT COMMISSION

Seclusion (HBIPS 3)

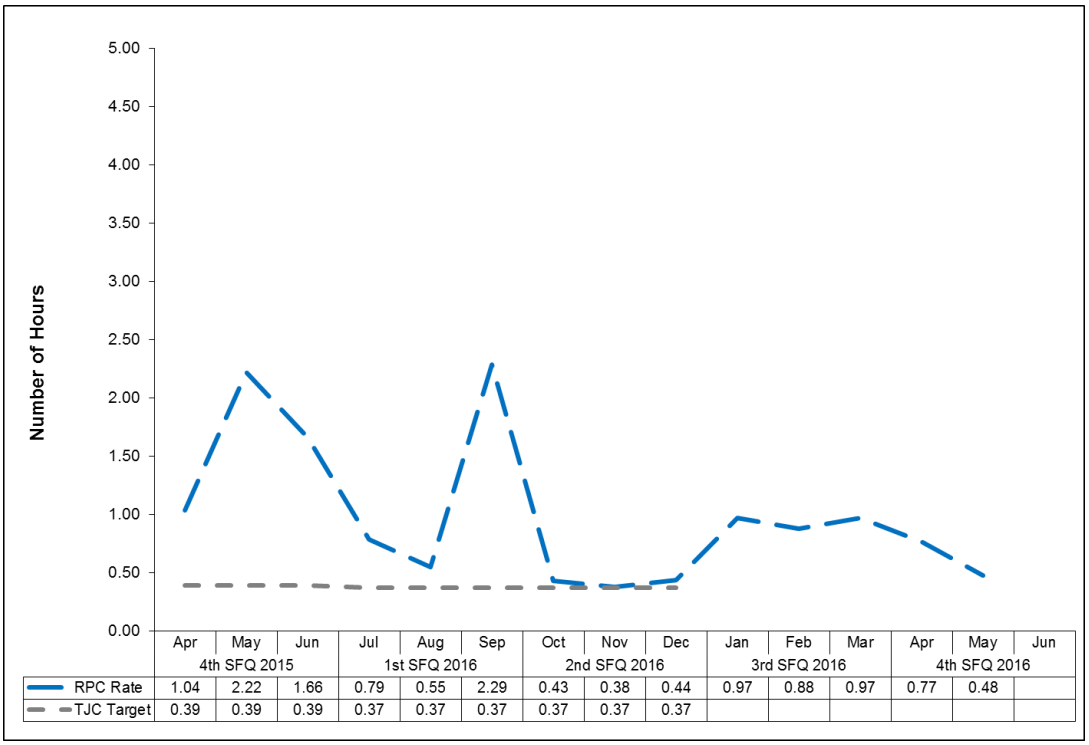
Hours of Use

Description

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

Rationale

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
RPC Rate	1.04	2.22	1.66	0.79	0.55	2.29	0.43	0.38	0.44	0.97	0.88	0.97	0.77	0.48	
TJC Target	0.39	0.39	0.39	0.37	0.37	0.37	0.37	0.37	0.37						

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

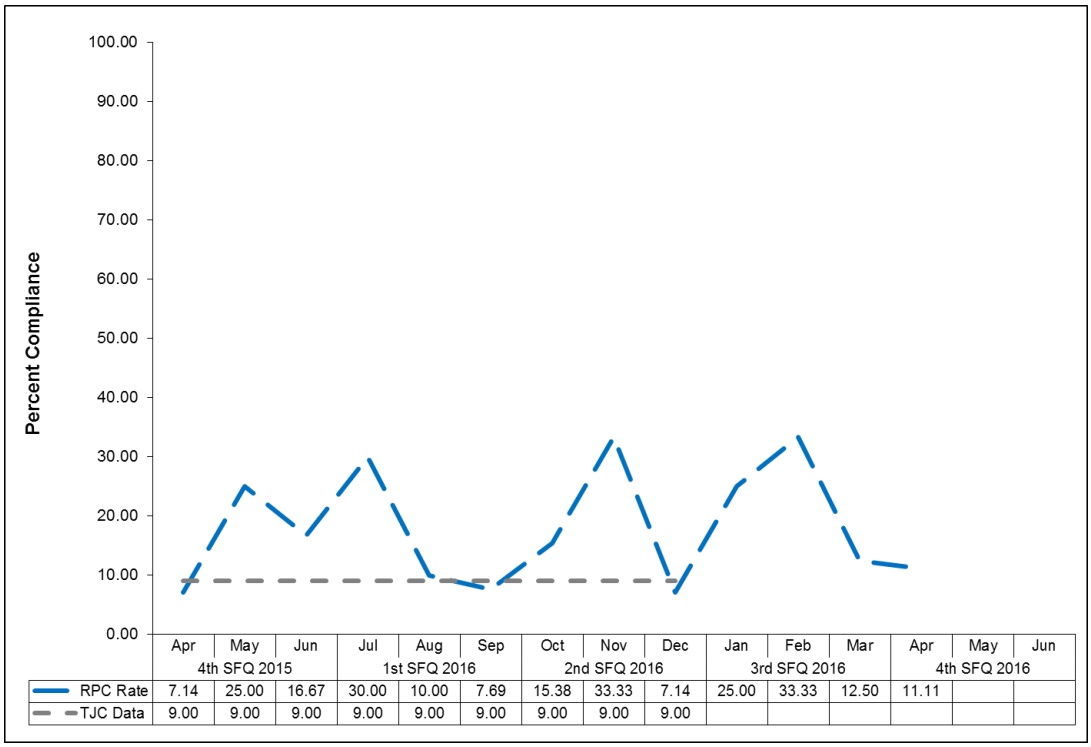
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications.

Rationale

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

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
RPC Rate	7.14	25.00	16.67	30.00	10.00	7.69	15.38	33.33	7.14	25.00	33.33	12.50	11.11		
TJC Data	9.00	9.00	9.00	9.00	9.00	9.00	9.00	9.00	9.00						

Note: no patients were prescribed multiple antipsychotics in May 2016.

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

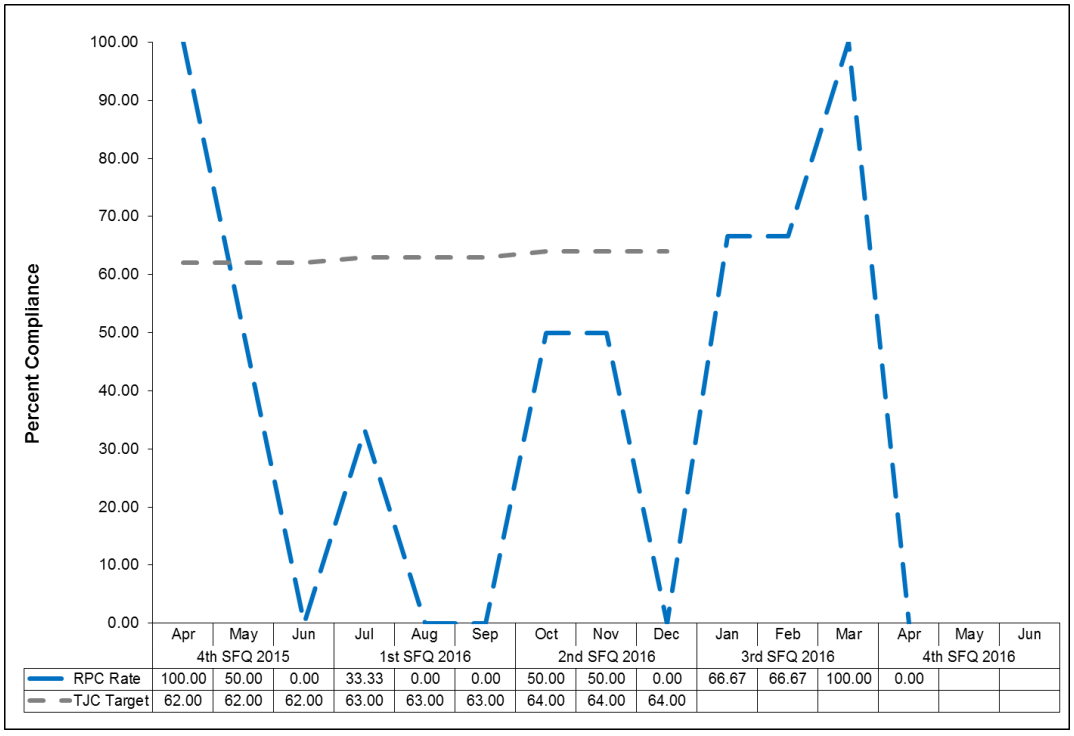
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.

Rationale

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

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
RPC Rate	100.00	50.00	0.00	33.33	0.00	0.00	50.00	50.00	0.00	66.67	66.67	100.00	0.00		
TJC Target	62.00	62.00	62.00	63.00	63.00	63.00	64.00	64.00	64.00						

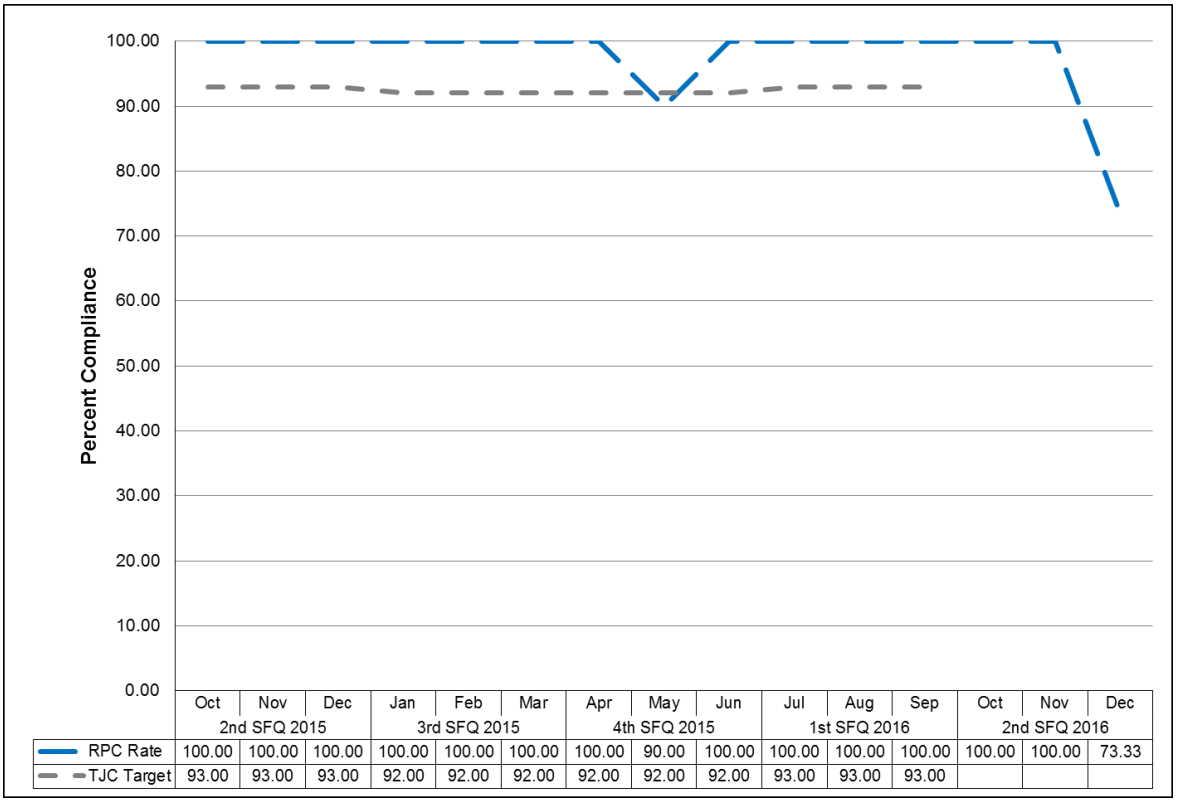
Note: no patients were prescribed multiple antipsychotics in May 2016.

JOINT COMMISSION

Post Discharge Continuing Care Plan (HBIPS 6)

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

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



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

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

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

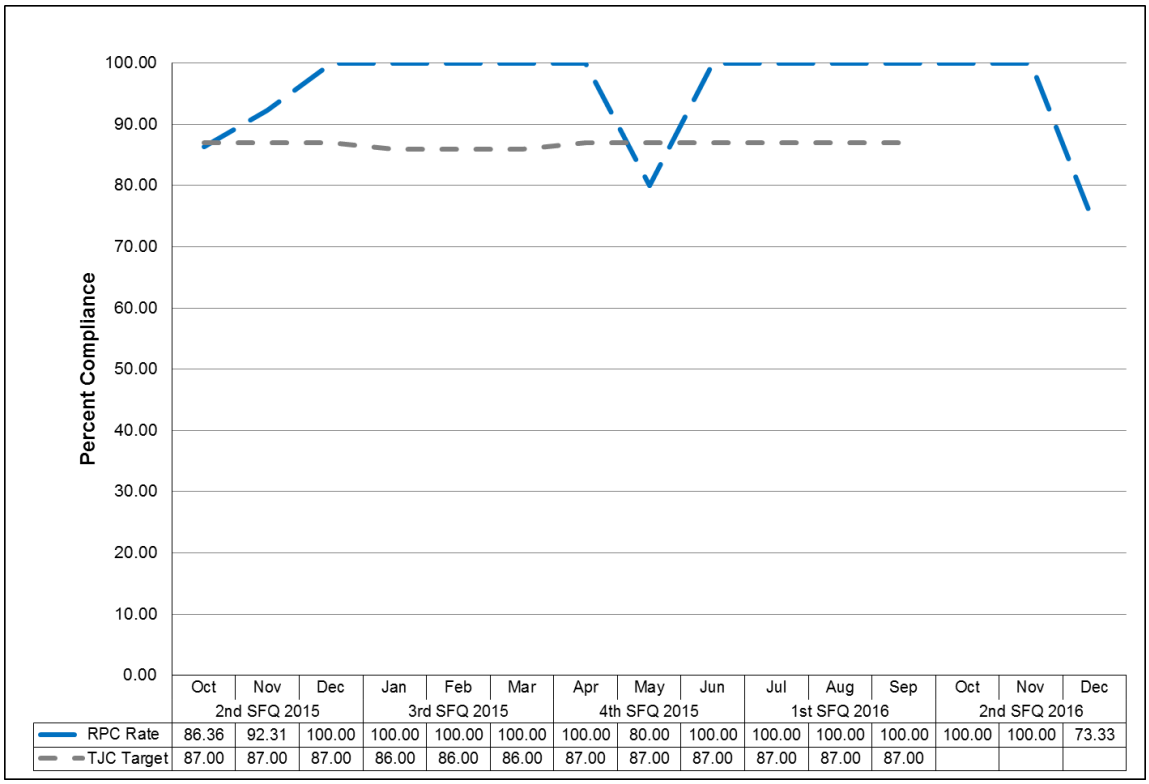
To Next Level of Care Provider on Discharge

Description

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

Rationale

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



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

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

JOINT COMMISSION

Contract Performance Indicators

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

4Q2016 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Rodney Bouffard Superintendent	One indicator did not meet standard: Attendance by Peer Support Staff at the Service Integration Meetings. All other indicators met standards.
Community Dental, Region II	Dr. William Nelson Acting Clinical Director	All indicators met or exceeded standards.
Comprehensive Pharmacy Services	Dr. William Nelson Acting Clinical Director	All indicators met standards.
Comtec Security	Richard Levesque Director of Support Services	All indicators met standards.
Cummins Northeast	Richard Levesque Director of Support Services	No services were provided during this timeframe.
Disability Rights Center	Rodney Bouffard Superintendent	All indicators met standards.
G & E Roofing	Richard Levesque Director of Support Services	No services were provided during this timeframe.
Goodspeed & O'Donnell	Dr. William Nelson Acting Clinical Director	No services were provided during this timeframe.
Liberty Healthcare – After Hours Coverage	Dr. William Nelson Acting Clinical Director	All indicators exceeded standards.
Liberty Healthcare – Physician Staffing	Dr. William Nelson Acting Clinical Director	All indicators met standards.
Main Security Surveillance	Richard Levesque Director of Support Services	All indicators met standards.
Maine General Community Care/HealthReach	Dr. William Nelson Acting Clinical Director	All indicators met standards.
Maine General Medical Center Laboratory Services	Dr. William Nelson Acting Clinical Director	All indicators met standards.

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

JOINT COMMISSION

Contractor	Program Administrator	Summary of Performance
MD-IT Transcription Service	Samantha Brockway Medical Records Administrator	All indicators met standards.
Mechanical Services	Richard Levesque Director of Support Services	All indicators met or exceeded standards.
Medical Staffing and Services of Maine	Dr. William Nelson Acting Clinical Director	All indicators met standards.
Motivational Services	Dr. William Nelson Acting Clinical Director	All indicators met or exceeded standards.
Occupational Therapy Consultation and Rehabilitation Services	Janet Barrett Director of Rehabilitation	All indicators met or exceeded standards.
Otis Elevator	Richard Levesque Director of Support Services	All indicators exceeded standards.
Pine Tree Legal Assistance	Dr. William Nelson Acting Clinical Director	No services were provided during this timeframe.
Project Staffing	Cindy Michaud Business Services Manager	All indicators met or exceeded standards.
Protection One	Richard Levesque Director of Support Services	No services were provided during this timeframe.
Securitas Security Services	Philip Tricarico Safety Compliance Officer	All indicators met or exceeded standards.
UniFirst Corporation	Richard Levesque Director of Support Services	All indicators met standards.
Waste Management	Debora Proctor Executive Housekeeper	All indicators met standards.

JOINT COMMISSION

Adverse Reactions to Sedation or Anesthesia

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

Capital Community Clinic - Dental Clinic

Dental Clinic Timeout/Identification of Patient

Indicators	1Q2016	2Q2016	3Q2016	4Q2016	Total
National Patent Safety Goals Goal 1: Improve the accuracy of Patient Identification. Capital Community Dental Clinic assures accurate patient identification by: asking the patient to state his/her name and date of birth. A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the Dental Assistant.	**July** 100% 3/3 **Aug** N/A 0/0 **Sept** N/A 0/0 **Total** 100% 3/3	**Oct** 100% 2/2 **Nov** 100% 1/1 **Dec** 100% 1/1 **Total** 100% 4/4	**Jan** 100% 5/5 **Feb** 100% 3/3 **Mar** N/A 0/0 **Total** 8/8	**Apr** N/A **May** N/A **June** N/A	**100%** **15/15**

Note: there were no extractions performed in 4Q2016.

JOINT COMMISSION

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	1Q2016	2Q2016	3Q2016	4Q2016	Total
1. All patients with tooth extractions will be assessed and have teaching post procedure on the following topics, as provided by the Dentist or Dental Assistant: • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The patient, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. 3. Post dental extraction patients will receive a follow-up phone call from the clinic within 24 hours of procedure to assess for post procedure complications	**July** 100% 3/3 **Aug** N/A 0/0 **Sept** N/A 0/0 **Total** 100% 3/3	**Oct** 100% 2/2 **Nov** 100% 1/1 **Dec** 100% 1/1 **Total** 100% 4/4	**Jan** 100% 5/5 **Feb** 100% 3/3 **Mar** N/A 0/0 **Total** 8/8	**Apr** N/A **May** N/A **June** N/A	**100%** **15/15**

Note: there were no extractions performed in 4Q2016.

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management

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

Infection Control

Responsible Party: Rebecca Eastman, Infection Control RN

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

Measure Description: Monitor and Measure of Hospital Associated Infections

Measure Type: Quality Assurance

Results							
Target	**Unit**	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Within 1 STDV of the Mean	Hospital Associated Infection Rate	FY 2014 1 STDV within the mean	12 HAI/IC Rate 1.4	7 HAI/IC Rate 1	11 HAI/IC Rate 1.2	5HAI/IC Rate 1	HAI/IC 1.125
Actual Outcome			1 STDV within the mean	At 1 STDV	1 STDV within the mean	1 STDV within the mean	

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

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

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

JOINT COMMISSION

Infections:

Lower Kennebec:
Bilateral toe infection (HAI)
URI (HAI)
URI (HAI)
Cellulitis (POA)

Lower Saco:
MRSA open abrasion/wound (HAI)
Dental Abscess (HAI)

Upper Kennebec:
Urinary Tract Bronchitis (HAI)

Data Analysis:
HAI: 6
POA: 1
Idiosyncratic Infections: 0
Total Infections: 7

Plan: Ongoing surveillance.

JOINT COMMISSION

II. Measure Name: Employee Hand Hygiene Rate

Measure Description:

- Staff will observe the hand hygiene practice of nurses as they pass medications. (10 observations per month)
- Staff will do ten (10) hand hygiene observations per month (before & after patient contact) in the milieu on the **7-3 shift.**
- Staff will do ten (10) hand hygiene observations per month (before & after patient contact) in the milieu on the **3-11 shift**

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Employee Hand Hygiene Compliance	80% FY 2015	>90%	>90%	>90%	>90%	**>90%**
Actual			95%	No data available	42%	76%	**71%**

Data:

Upper Saco Meds: 67%
Upper Saco Milieu 7-3: 97%
Upper Saco Milieu 3-11: 100%

Upper Kennebec Meds: 100%
Upper Kennebec Milieu 7-3: 100%
Upper Kennebec Milieu 3-11: 92%

Lower Kennebec Meds: 50%
Lower Kennebec Milieu 7-3: 65%
Lower Kennebec Milieu 3-11: 73%

Lower Saco Meds: 83%
Lower Saco Milieu 7-3: 83%
Lower Saco Milieu 3-11: 67%

Plan: Continue to monitor and measure. On the next report, the second and third measures will reflect the schedule changes and will read 7am-7pm and 7pm-7am respectively. Even though the data does not show an improvement, compliance has improved greatly in the second and third month of the 4Q2016.

JOINT COMMISSION

III. Measure Name: Assisting Patients with Daily Hygiene

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

Measure Type: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Employee Hand Hygiene Compliance	98% FY 2015	>90%	>90%	>90%	>90%	**>90%**
Actual			95%	No data available	81%	77%	**84%**

Data:
The mean compliance rate for April 2016 is 34%.
The mean compliance rate for May 2016 is 100%.
The mean compliance rate for June 2016 is 96%.

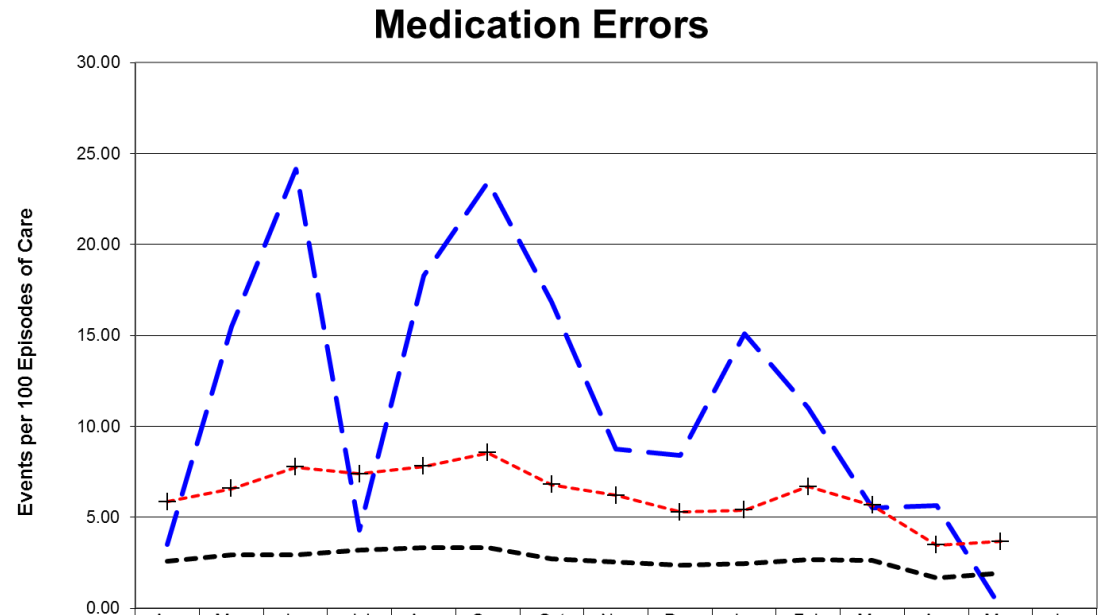
Plan: Continue to monitor and measure.

STRATEGIC PERFORMANCE EXCELLENCE

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)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	3.49	15.48	24.14	4.30	18.27	23.47	16.83	8.74	8.41	15.09	11.01	5.50	5.66	0.00	
Ntl Mean	2.59	2.92	2.94	3.19	3.32	3.34	2.71	2.54	2.36	2.46	2.69	2.62	1.67	1.93	
+1 StDev	5.86	6.59	7.77	7.38	7.80	8.54	6.80	6.20	5.28	5.39	6.69	5.66	3.48	3.68	

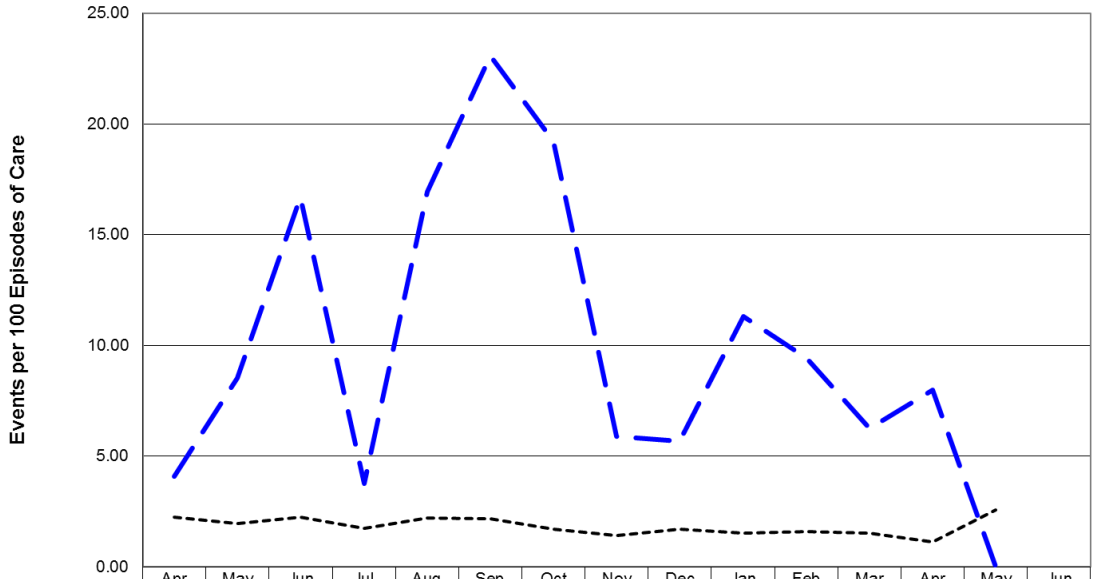
This graph depicts the number of medication error events that occurred for every 100 episodes of care (duplicated patient count). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

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

STRATEGIC PERFORMANCE EXCELLENCE

Medication Errors

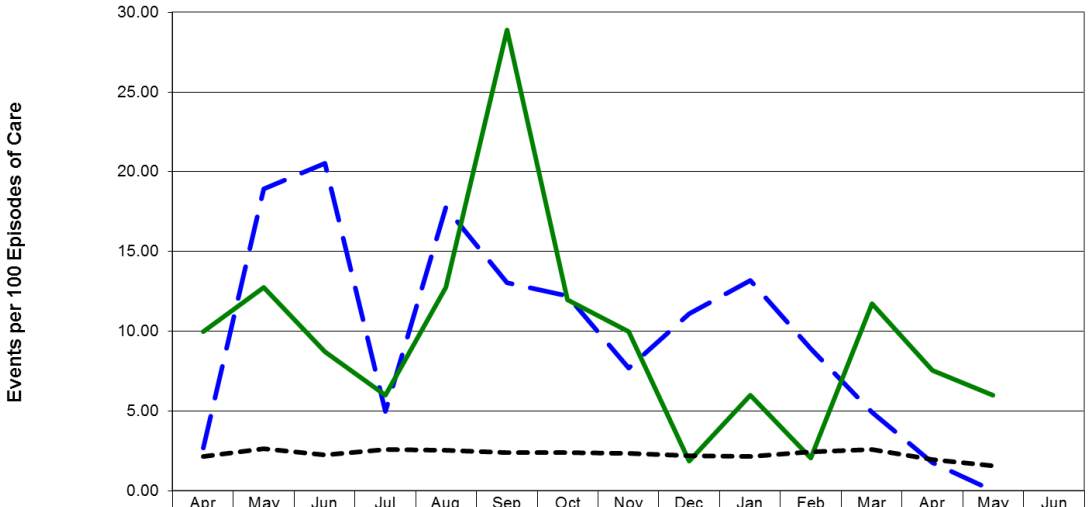
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	4.08	8.51	16.67	3.77	16.95	23.08	19.23	5.88	5.66	11.32	9.43	6.25	8.00	0.00	
Ntl Mean	2.25	1.97	2.25	1.74	2.20	2.18	1.70	1.41	1.70	1.53	1.61	1.53	1.13	2.56	

Medication Errors

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	2.70	18.92	20.51	5.00	17.78	13.04	12.24	7.69	11.11	13.21	8.93	4.92	1.79	0.00	
Dorothea Dix	10.00	12.77	8.70	6.00	12.77	28.89	12.00	10.00	1.85	6.00	2.04	11.76	7.55	6.00	
Ntl Mean	2.18	2.64	2.27	2.58	2.55	2.41	2.39	2.36	2.23	2.16	2.44	2.60	1.95	1.57	

STRATEGIC PERFORMANCE EXCELLENCE

Medication Variances

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

Prescribing

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

Dispensing

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

Administration

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

Complex

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

Review, Reporting and Follow-up Process:

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Administration Process

Medication Errors Related to Staffing Effectiveness

Date	Omit	Type of Error	Float	New	O/T	Unit	Staff Mix		
							RN	LPN	MHW
2/16/2016	N	GAVE PATIENT WRONG MEDS X3	N	N	N	UK	2	1	3
4/1/2016	Y	OMISSON X6	N	N	N	LSMAIN	3	1	6
4/3/2016	Y	OMISSION X1	N	N	N	LSMAIN	3	0	7
4/8/2016	Y	OMISSION X2	Y	N	N	LSMAIN	3	1	6
4/10/2016	Y	OMISSON X2	N	N	N	US	3	0	5
4/13/2016	N	GIVEN LATE WITHOUT ORDER	Y	N	N	LKMAIN	2	0	5
4/23/2016	Y	OMIT X3	N	N	N	US	3	0	4
4/26/2016	Y	OMIT X1	Y	N	N	LKMAIN	2	0	5
4/26/2016	N	WRONG FORM OF MEDICATION	N	N	N	LKMAIN	3	1	8
4/27/2016	Y	OMIT X1	Y	N	N	LKMAIN	3	1	7
4/27/2016	Y	OMIT X1	N	N	N	UK	2	0	4
4/28/2016	N	EXTRA DOSE X4	N	N	N	LKMAIN	3	1	7
4/30/2016	N	EXTRA DOSE X3	N	N	N	LKMAIN	2	0	6
5/4/2016	Y	OMIT X1	N	N	N	LKMAIN	3	1	8
5/5/2016	N	WRONG DOSE X1	N	N	N	US	2	1	4
5/7/2016	Y	OMIT X1	N	N	N	UK	3	0	4
5/12/2016	Y	OMIT X1	N	N	N	UK	2	1	4
5/13/2016	N	WRONG DOSE X1	N	N	N	LKMAIN	3	1	5
5/16/2016	Y	OMIT X3	N	N	N	LKSCU	1	0	4
5/17/2016	Y	OMIT X1	Y	N	N	LSSCU	3	1	5
5/17/2016	Y	OMIT X3	Y	N	N	US	3	1	4
5/18/2016	N	WRONG DOSE X2	Y	N	N	LSMAIN	3	0	7
5/21/2016	Y	OMIT X2	N	N	N	UK	3	1	2
5/21/2016	Y	OMIT X3	Y	N	N	LSMAIN	2	0	8
5/23/2016	N	GIVEN LATE WITHOUT ORDER X1	N	N	N	LSMAIN	3	1	7
5/25/2016	N	WRONG DOSE x2	N	N	N	US	2	0	4
5/25/2016	N	WRONG DOSE X2	N	N	N	US	2	1	4
5/28/2016	Y	OMIT X2	N	N	N	LSMAIN	2	1	6
6/8/2016	N	WRONG TIME X6	N	N	N	US	3	2	6
6/8/2016	N	WRONG DOSE X1	Y	N	N	LKSCU	3	1	7
6/15/2016	Y	OMIT X1	Y	N	N	LKSCU	3	0	6
6/18/2016	Y	OMIT X2	Y	N	N	UK	2	0	4
6/21/2016	N	WRONG TIME X3	Y	N	N	LSSCU	3	1	5

STRATEGIC PERFORMANCE EXCELLENCE

6/21/2016	N	EXPIRED DRUG X1	N	N	N	LKSCU	3	2	7
6/22/2016	Y	OMIT X1	N	Y	N	LKSCU	3	2	7
6/23/2016	N	WRONG FORM OF MEDICATION	N	N	N	UK	2	1	3
6/29/2016	N	WRONG DOSE X1	N	Y	N	UK	4	0	5
Totals	**40**		**21**	**2**	**0**	**LS: 23**	**US: 19**	**LK: 20**	**UK: 12**
Percent	**54%**	**74 Total Errors**	**28%**	**3%**	**0%**	**31%**	**26%**	**27%**	**16%**

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

Type of Error	# of Errors
Extra Dose	7
Late/No Order	2
Omission	40
Wrong Dose	10
Wrong Time	9
Wrong Medication	3
Wrong Form	2
Expired Medication	1
Total	**74**

STRATEGIC PERFORMANCE EXCELLENCE

Dispensing Process

Measure	Unit	Baseline 2015	Goal	1Q 2016	2Q 2016	3Q 2016	4Q 2016
1. Controlled Substance Loss Data: Daily Pyxis-CII Safe Compare Report.	All	0.19%	0% Target: Actual:	0% 0%	0% 0%	0% 0%	0% 0%
2. Controlled Substance Loss Data: Monthly CII Safe Vendor Receipt Report.	Rx	0	0 Target: 0 Actual: 0	0 0	0 0	0 0	0 0
3. Controlled Substance Loss Data: Monthly Pyxis Controlled Drug Discrepancies.	All	0/mo	Target: 0 Actual: 0	0 0 (0/mo)	0 0 (0/mo)	0 0 (0/mo)	0 0 (0/mo)
4. Medication Management Monitoring: Measures of drug reactions, adverse drug events, and other management data.	Rx	8/year	Target: 0 Actual: 0	0 0	0 0	0 1	0 9
5. Medication Management Monitoring: Resource Documentation Reports of Clinical Interventions.	Rx	99/ quarter	100% Target: Actual:	100% 31	100% 144	100% 128	100% 241
6. Psychiatric Emergency Process: Monthly audit of all psych emergency measures against 8 criteria.	All	100%	100% Target: Actual:	100% 78%	100% 98.4%	100% 90%	100% 80%*
7. Operational Audit: Monthly audit of 3 operational indicators from CPS contract.	Rx	100%	100% Target: Actual:	100% 100%	100% 100%	100% 100%	100% 100%

*During May/June 2016 part-time relief Pharmacists were unaware of the procedure and therefore the process was not completed. Four Psychiatric Emergencies from the 3Q2016 are included in this 4Q2016 quarter report.

STRATEGIC PERFORMANCE EXCELLENCE

Inpatient Consumer Survey

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

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

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

Rate of Response for the Inpatient Consumer Survey:

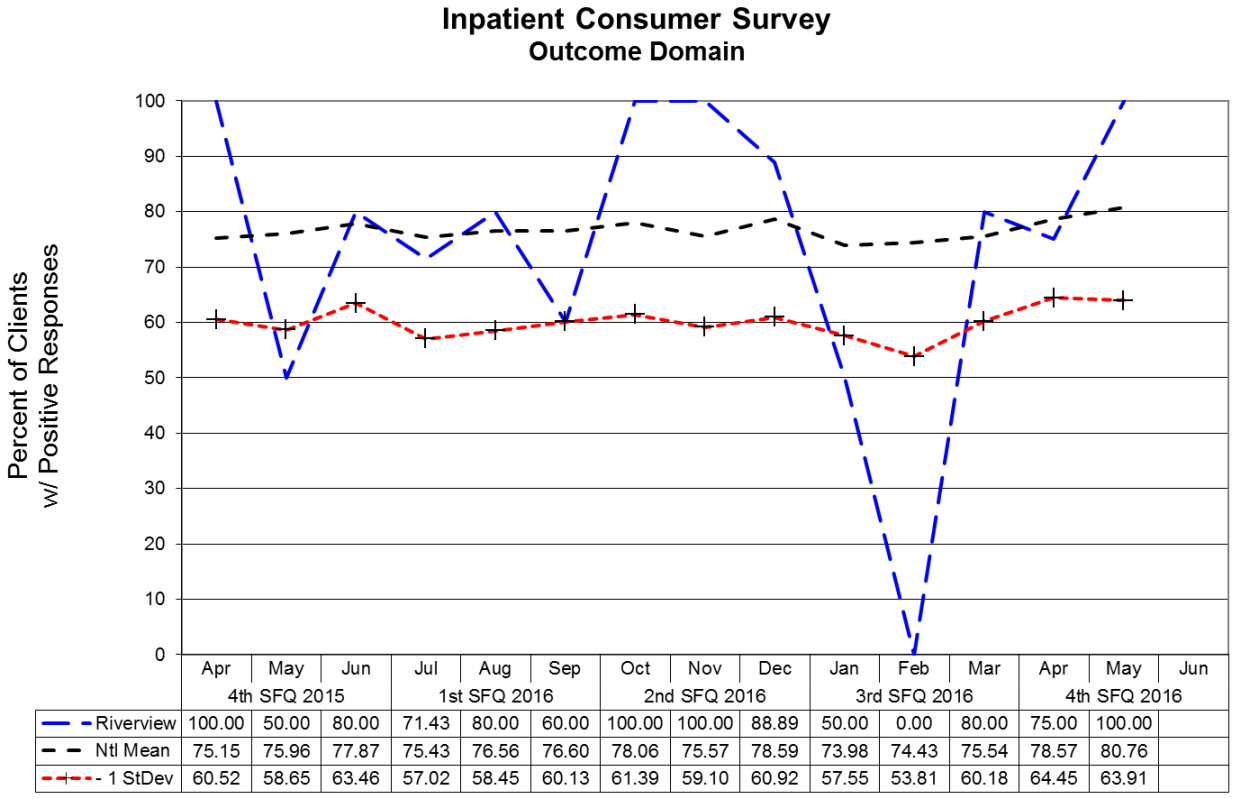
Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic patients, the process of administering the inpatient survey is difficult to administer. Whenever possible, Peer Support staff work to gather information from patients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

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

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

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

STRATEGIC PERFORMANCE EXCELLENCE

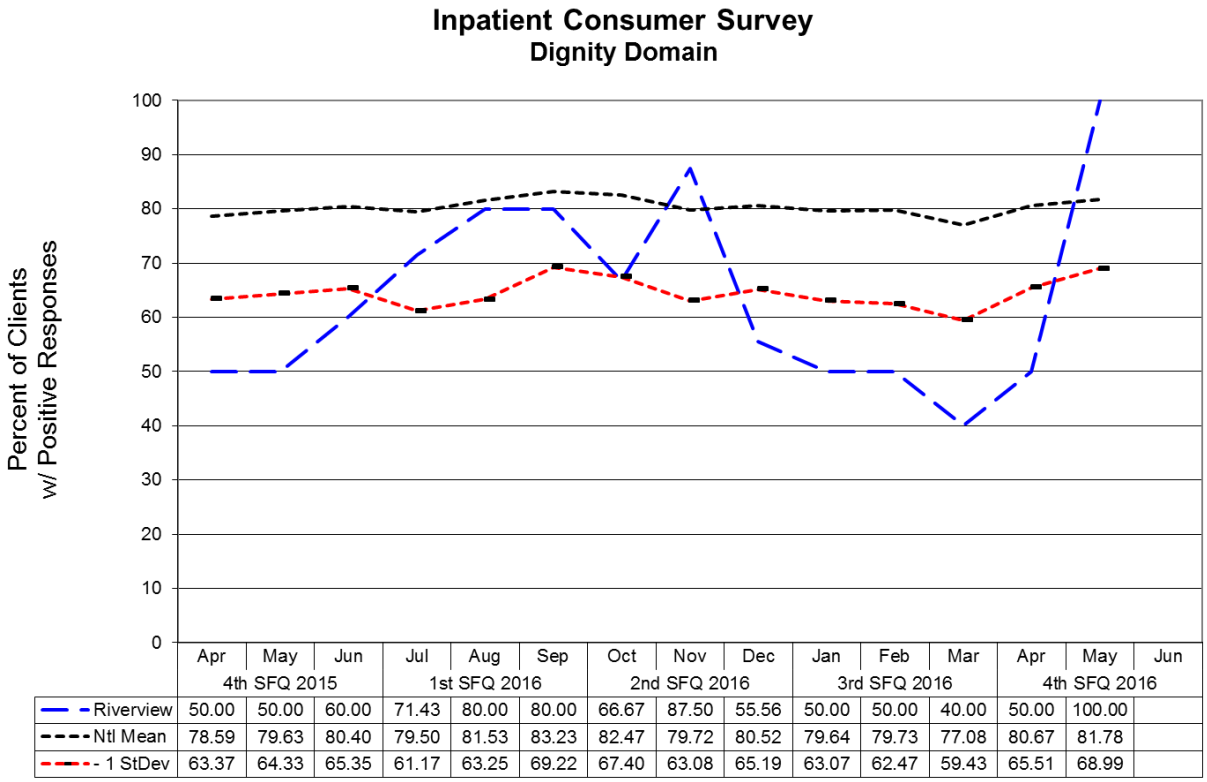


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	100.00	50.00	80.00	71.43	80.00	60.00	100.00	100.00	88.89	50.00	0.00	80.00	75.00	100.00	
Ntl Mean	75.15	75.96	77.87	75.43	76.56	76.60	78.06	75.57	78.59	73.98	74.43	75.54	78.57	80.76	
- 1 StDev	60.52	58.65	63.46	57.02	58.45	60.13	61.39	59.10	60.92	57.55	53.81	60.18	64.45	63.91	

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.

STRATEGIC PERFORMANCE EXCELLENCE

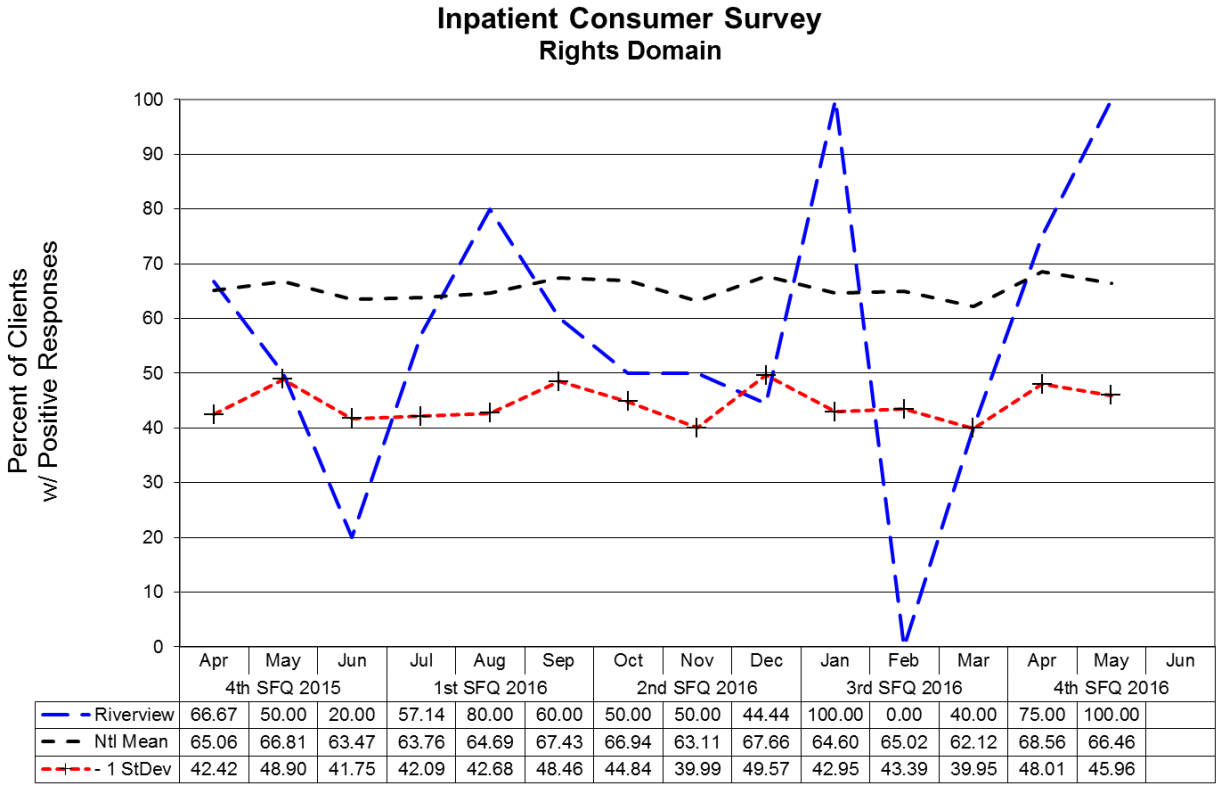


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	50.00	50.00	60.00	71.43	80.00	80.00	66.67	87.50	55.56	50.00	50.00	40.00	50.00	100.00	
Ntl Mean	78.59	79.63	80.40	79.50	81.53	83.23	82.47	79.72	80.52	79.64	79.73	77.08	80.67	81.78	
- 1 StDev	63.37	64.33	65.35	61.17	63.25	69.22	67.40	63.08	65.19	63.07	62.47	59.43	65.51	68.99	

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.

STRATEGIC PERFORMANCE EXCELLENCE

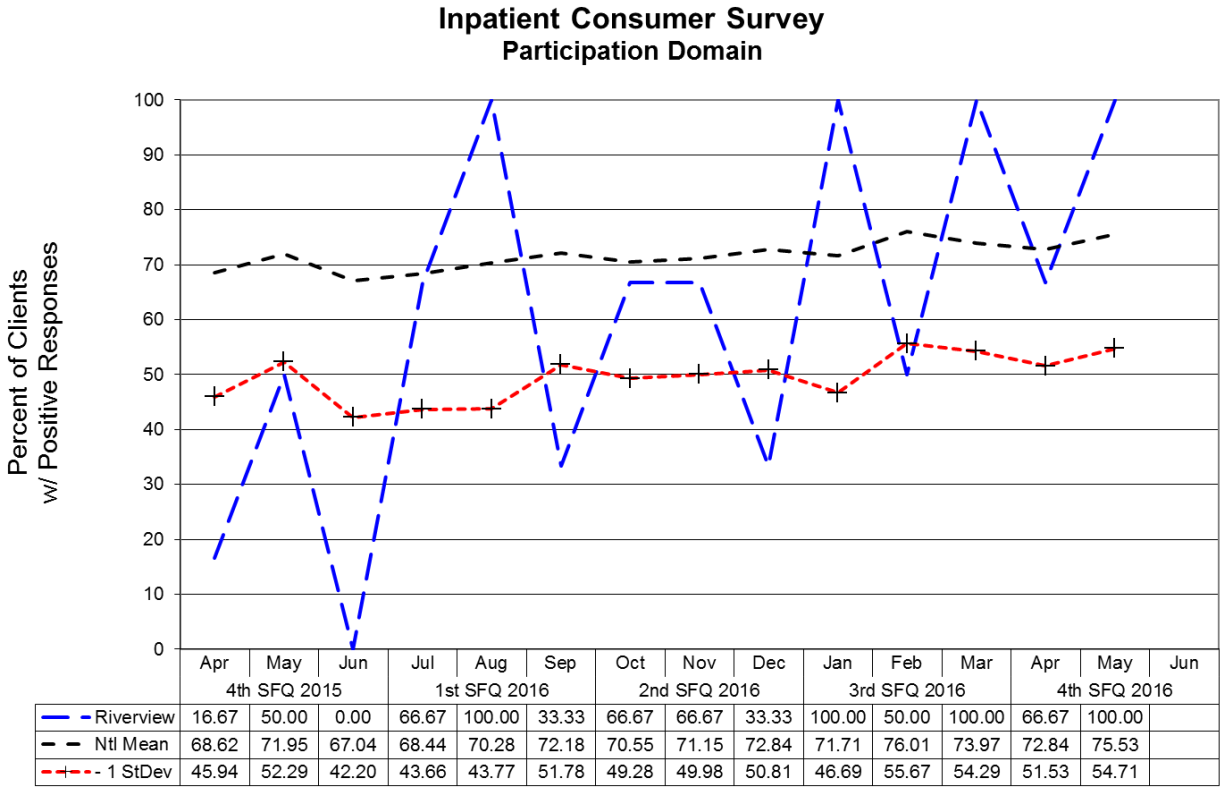


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	66.67	50.00	20.00	57.14	80.00	60.00	50.00	50.00	44.44	100.00	0.00	40.00	75.00	100.00	
Ntl Mean	65.06	66.81	63.47	63.76	64.69	67.43	66.94	63.11	67.66	64.60	65.02	62.12	68.56	66.46	
1 StDev	42.42	48.90	41.75	42.09	42.68	48.46	44.84	39.99	49.57	42.95	43.39	39.95	48.01	45.96	

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.

STRATEGIC PERFORMANCE EXCELLENCE

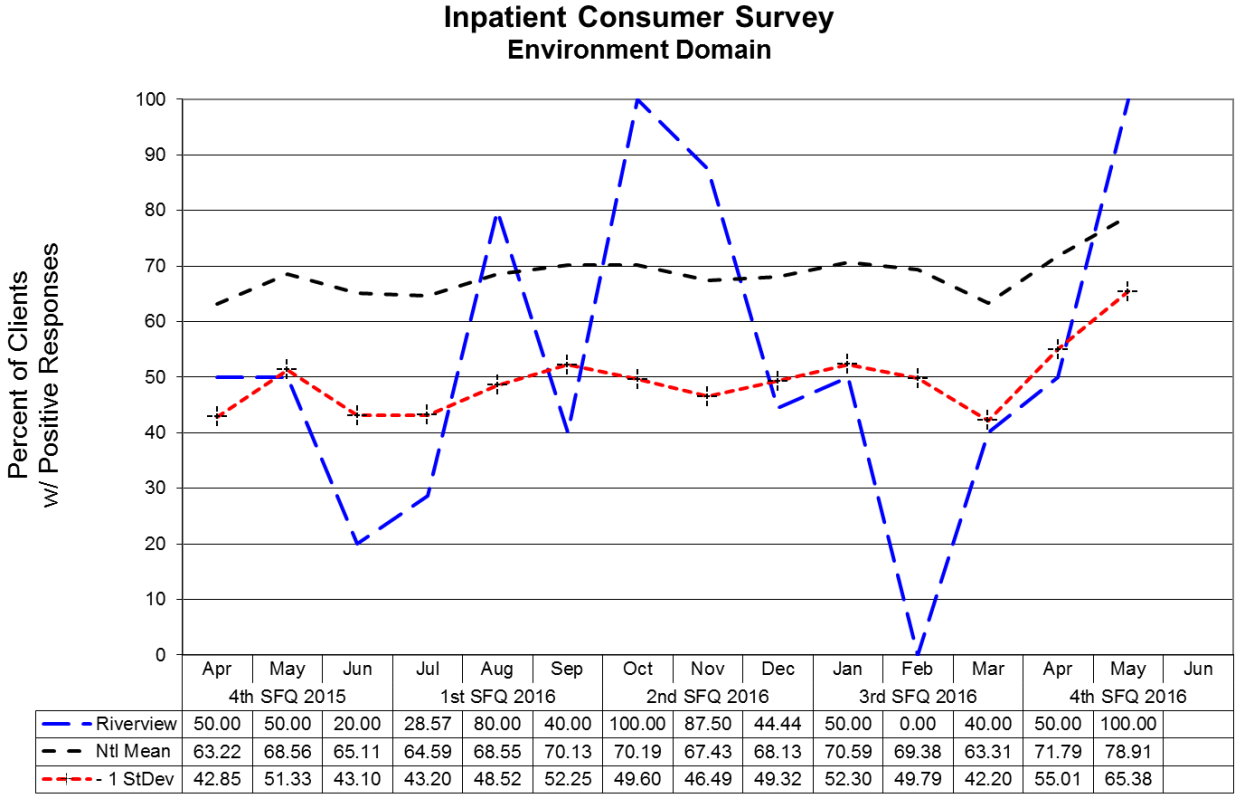


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	16.67	50.00	0.00	66.67	100.00	33.33	66.67	66.67	33.33	100.00	50.00	100.00	66.67	100.00	
Ntl Mean	68.62	71.95	67.04	68.44	70.28	72.18	70.55	71.15	72.84	71.71	76.01	73.97	72.84	75.53	
- 1 StDev	45.94	52.29	42.20	43.66	43.77	51.78	49.28	49.98	50.81	46.69	55.67	54.29	51.53	54.71	

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.

STRATEGIC PERFORMANCE EXCELLENCE

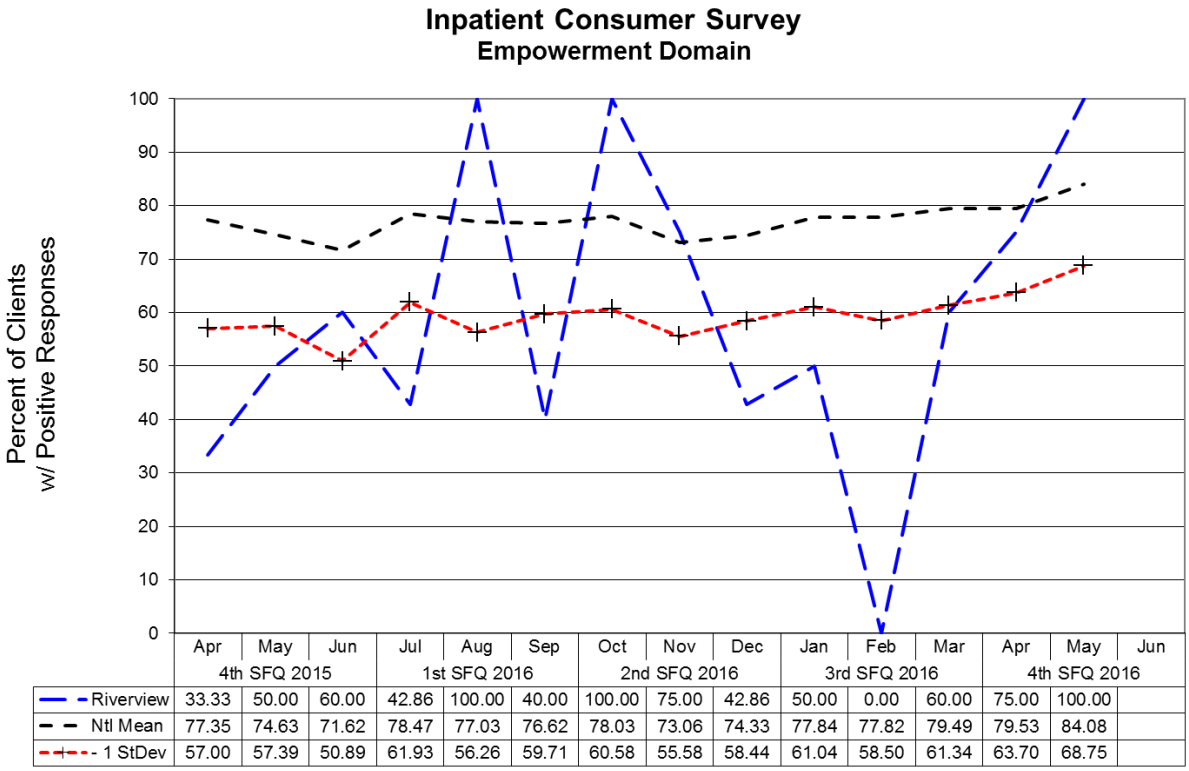


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	50.00	50.00	20.00	28.57	80.00	40.00	100.00	87.50	44.44	50.00	0.00	40.00	50.00	100.00	
Ntl Mean	63.22	68.56	65.11	64.59	68.55	70.13	70.19	67.43	68.13	70.59	69.38	63.31	71.79	78.91	
- 1 StDev	42.85	51.33	43.10	43.20	48.52	52.25	49.60	46.49	49.32	52.30	49.79	42.20	55.01	65.38	

Environment Domain Questions:

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

STRATEGIC PERFORMANCE EXCELLENCE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016			3rd SFQ 2016			4th SFQ 2016		
Riverview	33.33	50.00	60.00	42.86	100.00	40.00	100.00	75.00	42.86	50.00	0.00	60.00	75.00	100.00	
Ntl Mean	77.35	74.63	71.62	78.47	77.03	76.62	78.03	73.06	74.33	77.84	77.82	79.49	79.53	84.08	
1 StDev	57.00	57.39	50.89	61.93	56.26	59.71	60.58	55.58	58.44	61.04	58.50	61.34	63.70	68.75	

Empowerment Domain Questions:

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

STRATEGIC PERFORMANCE EXCELLENCE

Fall Reduction Strategies

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

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

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

Type of Fall by Patient and Month

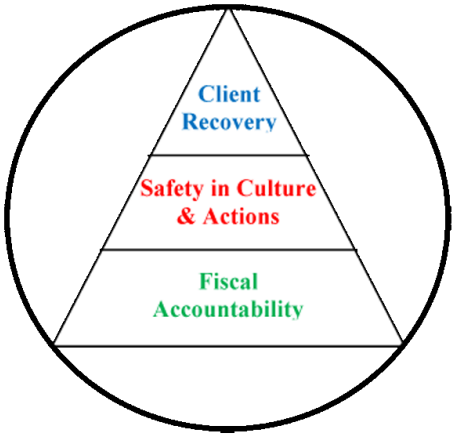
Fall Type	Patient	April	May	June	4Q2016
Un-Witnessed	MR91	2	1		**3**
	MR113*		1		**1**
	MR4296*		1		**1**
	MR5297		1		**1**
	MR7852	1			**1**
	MR7893	1			**1**
	MR7901	1			**1**
	MR7916			1	**1**
	Totals	**5**	**4**	**1**	**10**
Fall Type	**Patient**	**April**	**May**	**June**	**4Q2016**
Witnessed	MR4296*		2		**2**
	MR60			1	**1**
	MR113*	1			**1**
	MR657			1	**1**
	MR4916	1			**1**
	MR4940		1		**1**
	MR7576			1	**1**
	MR7736	1			**1**
	MR7830	1			**1**
	MR7873	1			**1**
	MR7878	1			**1**
	MR7892	1			**1**
	Totals	**7**	**3**	**3**	**13**

STRATEGIC PERFORMANCE EXCELLENCE

Process Improvement Plans

Priority Focus Areas for Strategic Performance Excellence

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



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

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

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

Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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

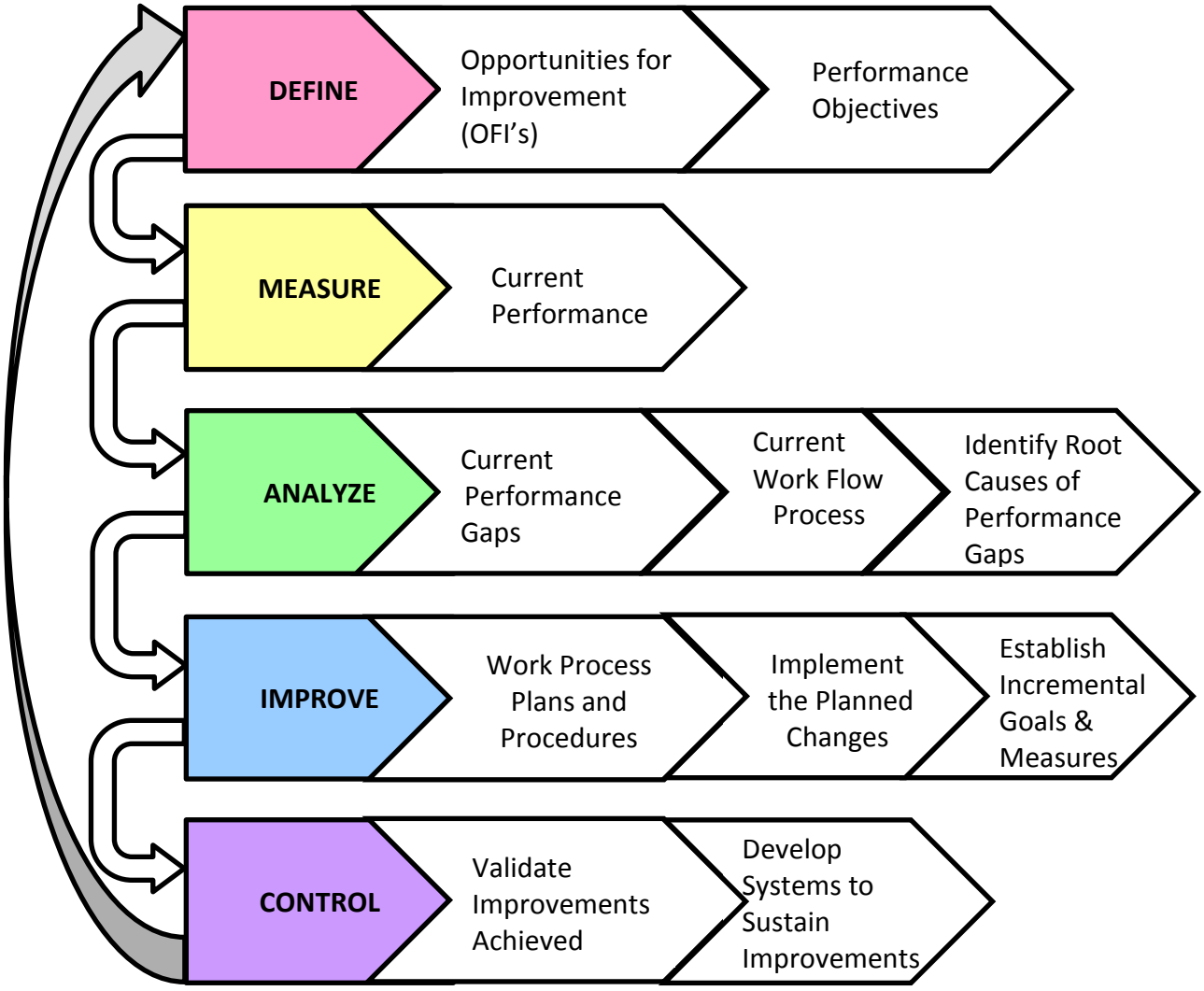
Promote a Safety Culture by…
Improving Communication
Improving Staffing Capacity and Capability
Evaluating and Mitigating Errors and Risk Factors
Promoting Critical Thinking
Supporting the Engagement and Empowerment of Staff Members

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

STRATEGIC PERFORMANCE EXCELLENCE

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

The Quarterly Report Consists of the Following:



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

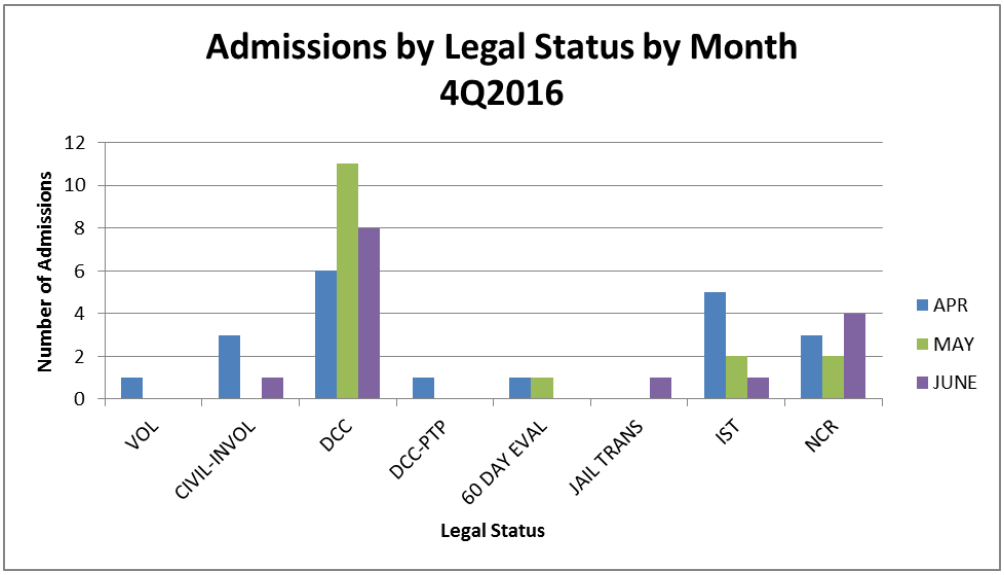
STRATEGIC PERFORMANCE EXCELLENCE

Admissions

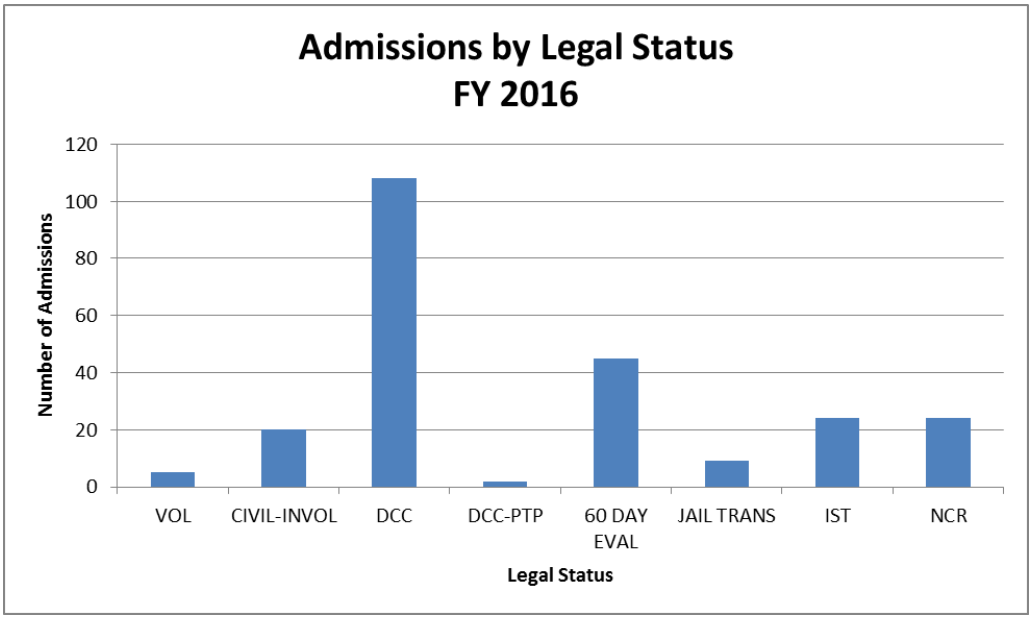
Responsible Party: Samantha Newman, RN, Admissions Nurse

Number of Admissions:

ADMISSIONS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**7**	**13**	**10**	**15**	**14**	**8**	**9**	**12**	**16**	**11**	**11**	**9**	**135**
VOL	0	1	1	0	1	0	1	0	0	1	0	0	**5**
CIVIL-INVOL	0	2	2	1	4	0	1	3	3	3	0	1	**20**
DCC	7	9	7	14	9	8	7	9	13	6	11	8	**108**
DCC-PTP	0	1	0	0	0	0	0	0	0	1	0	0	**2**
FORENSIC:	**10**	**16**	**8**	**8**	**5**	**8**	**10**	**10**	**7**	**9**	**5**	**6**	**102**
60 DAY EVAL	8	8	3	2	2	7	5	5	3	1	1	0	**45**
JAIL TRANS	0	0	2	1	0	0	2	2	1	0	0	1	**9**
IST	0	4	2	3	3	1	1	1	1	5	2	1	**24**
NCR	2	4	1	2	0	0	2	2	2	3	2	4	**24**
TOTAL	**17**	**29**	**18**	**23**	**19**	**16**	**19**	**22**	**23**	**20**	**16**	**15**	**237**



STRATEGIC PERFORMANCE EXCELLENCE

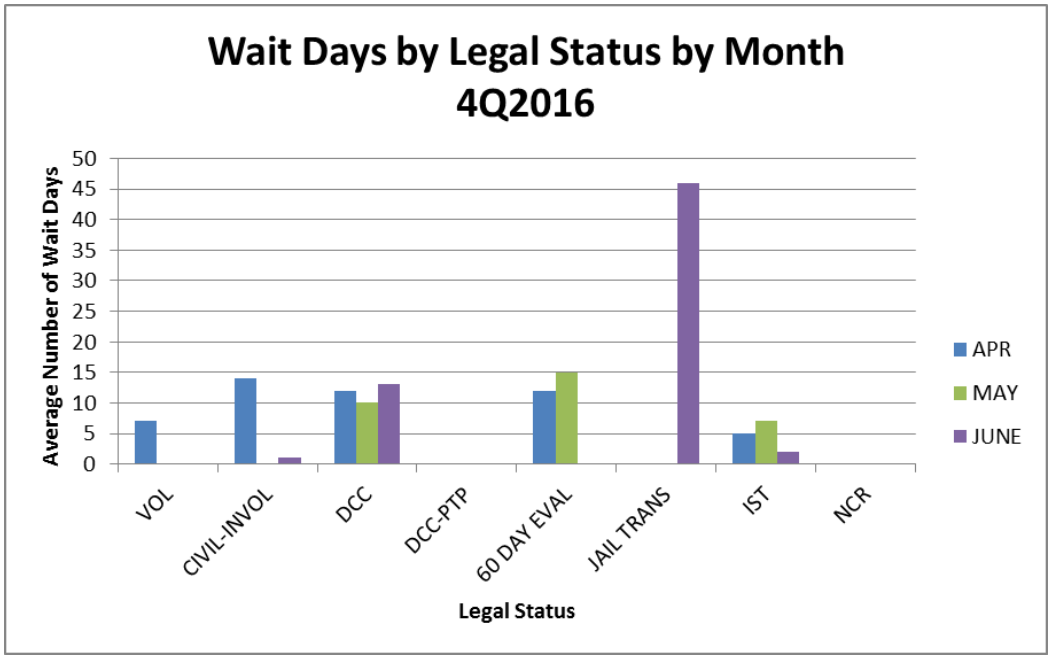


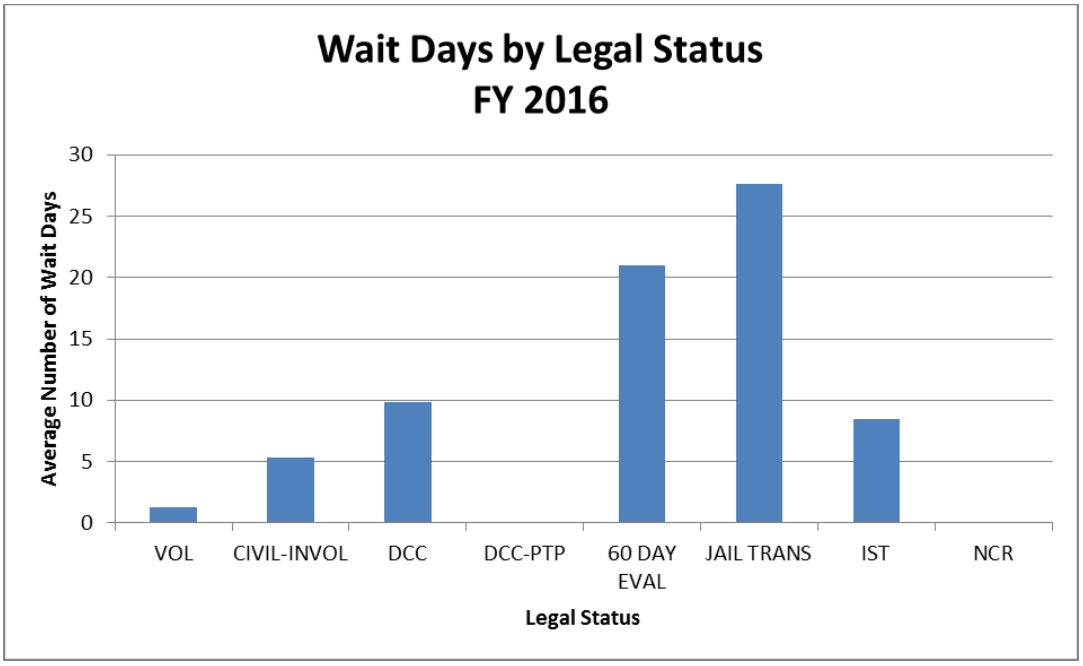
Average Number of Wait Days:

WAIT DAYS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**15**	**13**	**8**	**7**	**4**	**11**	**8**	**5**	**8**	**11**	**10**	**11**	**9**
VOL		1	1		0		3			7			**1**
CIVIL-INVOL		5	3	0	2		2	6	11	14		1	**5**
DCC	15	7	10	7	5	11	9	11	8	12	10	13	**10**
DCC-PTP		0								0			**0**
FORENSIC:	**53**	**18**	**19**	**15**	**14**	**22**	**17**	**10**	**7**	**4**	**6**	**8**	**16**
60 DAY EVAL	66	25	9	24	17	24	18	9	12	12	15		**21**
JAIL TRANS			46	12			38	28	14			46	**28**
IST		20	15	19	12	6	4	2	1	5	7	2	**8**
NCR	0	0	1	0			0	0	0	0	0	0	**0**
AVERAGE	**37**	**12**	**13**	**10**	**6**	**16**	**13**	**10**	**8**	**8**	**8**	**10**	**13**

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

STRATEGIC PERFORMANCE EXCELLENCE



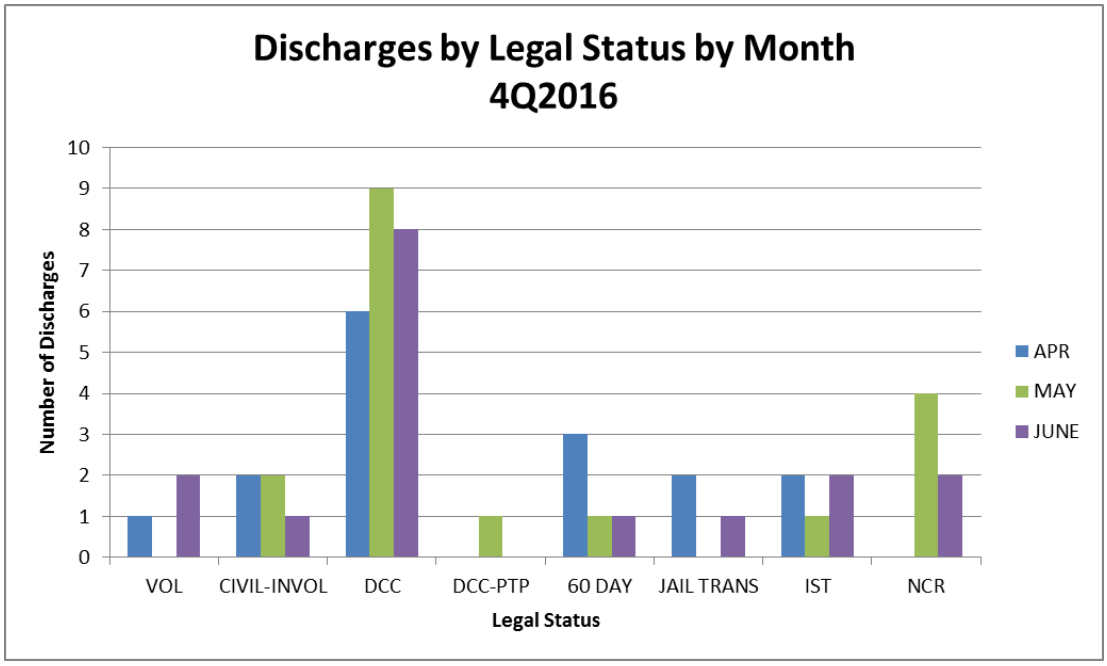


(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

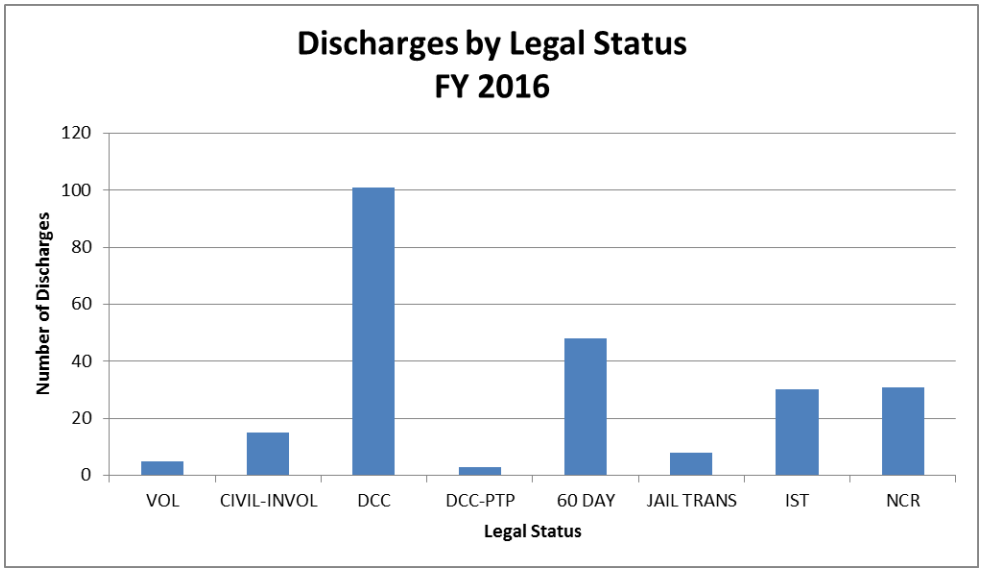
STRATEGIC PERFORMANCE EXCELLENCE

Number of Discharges:

DISCHARGES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**8**	**8**	**11**	**11**	**6**	**12**	**10**	**10**	**16**	**9**	**12**	**11**	**124**
VOL	0	0	0	0	0	1	1	0	0	1	0	2	**5**
CIVIL-INVOL	1	0	0	1	0	0	3	2	3	2	2	1	**15**
DCC	6	8	11	9	6	11	6	8	13	6	9	8	**101**
DCC-PTP	1	0	0	1	0	0	0	0	0	0	1	0	**3**
FORENSIC:	**10**	**16**	**10**	**6**	**6**	**9**	**9**	**13**	**7**	**7**	**6**	**6**	**105**
60 DAY	3	10	5	3	3	4	4	7	4	3	1	1	**48**
JAIL TRANS	0	0	1	0	0	1	1	2	0	2	0	1	**8**
IST	5	5	4	1	2	2	2	2	2	2	1	2	**30**
NCR	2	1	0	2	13	2	2	2	1	0	4	2	**31**
TOTAL	**18**	**24**	**21**	**17**	**12**	**21**	**19**	**23**	**23**	**16**	**18**	**17**	**229**



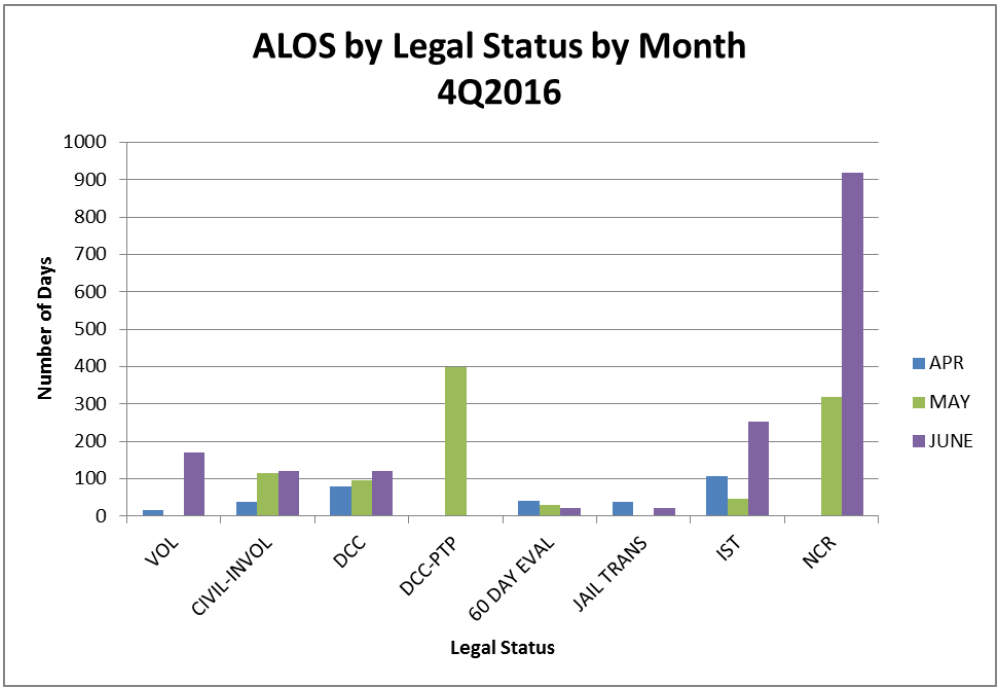
STRATEGIC PERFORMANCE EXCELLENCE

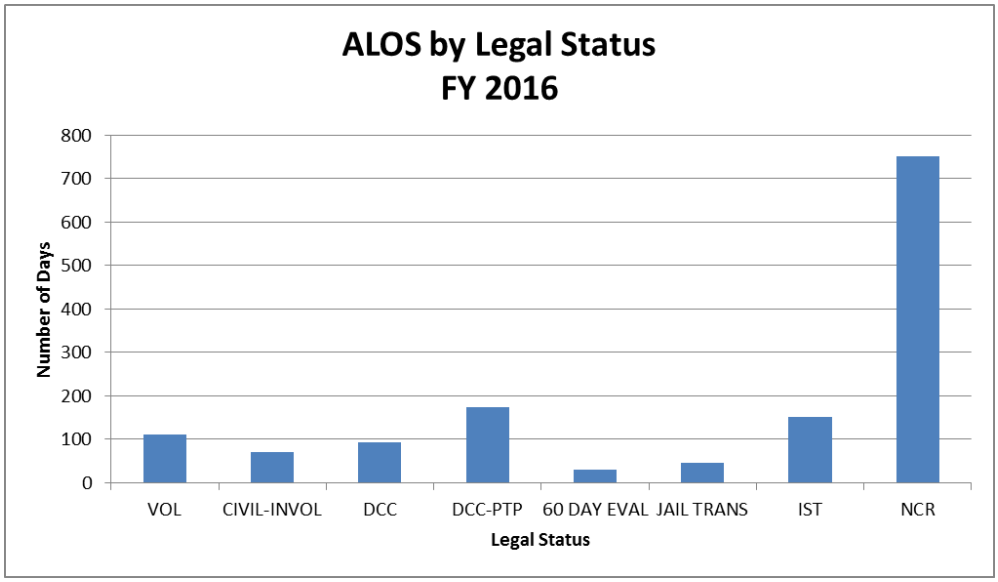


Average Length of Stay (Days):

ALOS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**64**	**70**	**83**	**65**	**74**	**122**	**129**	**98**	**87**	**139**	**124**	**131**	**99**
VOL						135	120			17		171	**111**
CIVIL-INVOL	23			64			88	97	21	38	115	122	**71**
DCC	71	70	83	67	74	121	147	98	102	79	95	122	**94**
DCC-PTP	61			60							400		**174**
FORENSIC:	**118**	**98**	**73**	**41**	**74**	**152**	**716**	**144**	**330**	**73**	**226**	**398**	**204**
60 DAY EVAL	24	27	28	26	50	30	29	28	25	40	31	22	**30**
JAIL TRANS			12			51	125	25		39		23	**46**
IST	74	252	146	50	108	161	90	295	227	107	47	253	**151**
NCR	371	31		59	80	438	3010	524	1757		320	915	**751**
AVERAGE	**94**	**88**	**78**	**57**	**74**	**135**	**407**	**124**	**161**	**75**	**158**	**225**	**140**

STRATEGIC PERFORMANCE EXCELLENCE





STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: NCR Admissions

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

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	NCR referrals admitted within 24 hours	N/A	100%	100%	100%	100%	**100%**
Actual			86% 6/7	100% 2/2	100% 6/6	100% 9/9	**96% 22/23**

Data Analysis: There were 9 NCR admissions this quarter. All were admitted the day of referral.

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

	April 2016	**May 2016**	**June 2016**	**4Q2016**
# of NCR Admissions	3	2	4	**9**
Average Wait Days	0	0	0	**0**

II. Measure Name: Jail Transfer Bed

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

Type of Measure: Performance Improvement

	April 2016	**May 2016**	**June 2016**	**4Q2016**
# of Jail Transfer Admissions	0	0	1	**1**
# of Jail Transfer Discharges	2	0	1	**3**

Data Analysis: One Jail Transfer admitted in June waited 46 days for admission. Charges were dropped, patient was moved to the civil side of the hospital, and Length of stay was 23 days.

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

STRATEGIC PERFORMANCE EXCELLENCE

III. Measure Name: Off Shift PA Admission Paperwork

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

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Documentation complete and accurate for admissions on off shifts	N/A	100%	100%	100%	100%	**100%**
Actual			100% 3/3	50% 1/2	N/A	100% 1/1	**83%** **5/6**

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Dental Clinic

Responsible Party: Dr. Ingrid Prikryl, DMD

I. Measure Name: Yearly Periodontal Charting

Measure Description: Complete a full mouth periodontal charting.

Type of Measure: Performance Improvement

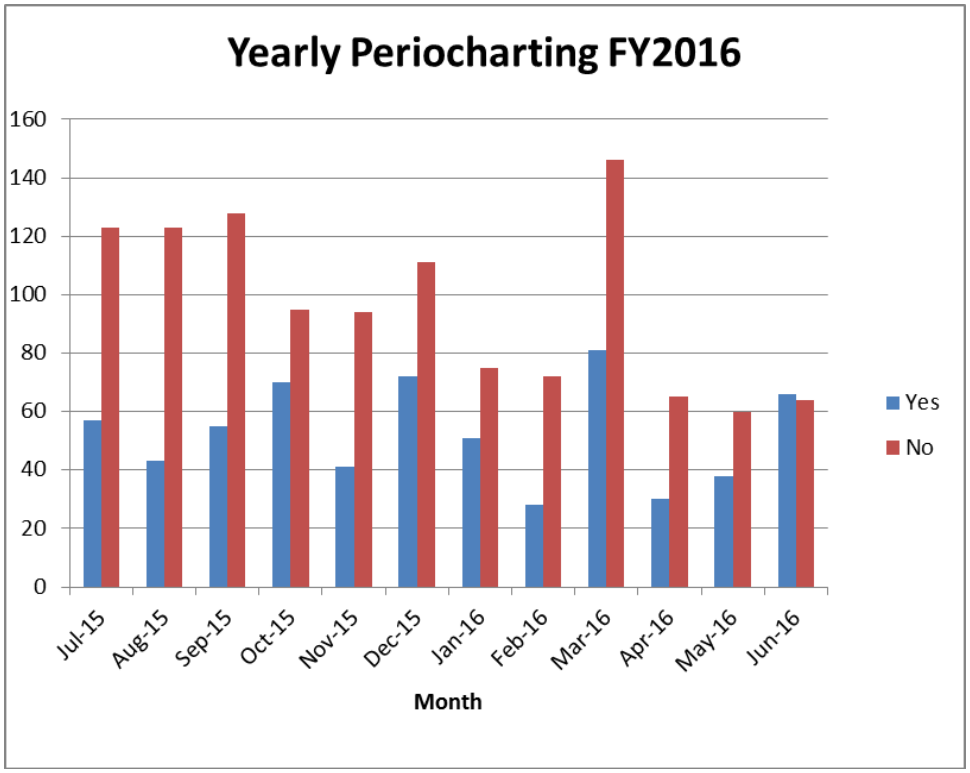
	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	% of recall appointments where full mouth periodontal charting was completed	FY 2015 42%	50%	55%	60%	65%	**75%**
Actual			30%	37%	35%	40%	**51%**

Data Analysis: To better report this measure, we will only measure periodontal charting on existing patients during their prophylactic recall appointments.

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

Comments: Our periodontal charting has improved each month, but we will continue to monitor in FY2017.

STRATEGIC PERFORMANCE EXCELLENCE



II. Measure Name: Improving Oral Hygiene

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

Type of Measure: Performance Improvement

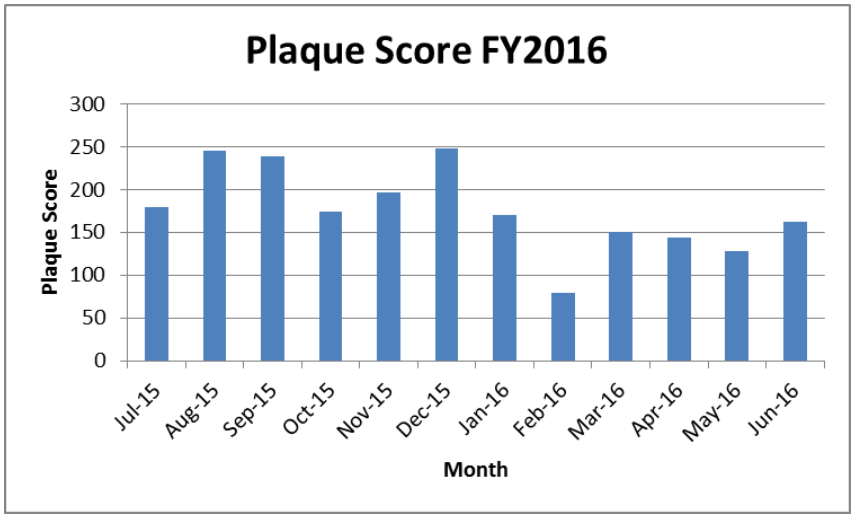
	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Plaque Score Monthly	Fair (220-160)	Poor	Poor	Fair	Fair	**Fair**
Actual			221	248	150	144	**158**

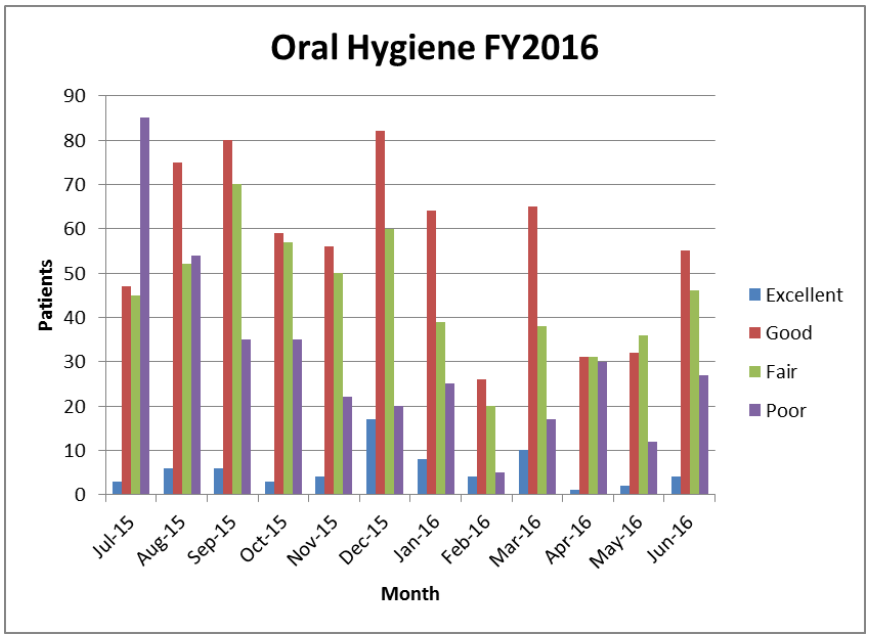
Data Analysis: Smaller numbers demonstrate less plaque on our patients' teeth, therefore improved oral hygiene. Q3 forward has decreased as we are only measuring prophy recall appointments.

STRATEGIC PERFORMANCE EXCELLENCE

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

Comments: Trying to educate our patients on brushing daily and its importance for proper oral care and retention of teeth. Data collected from daily collected plaque scores as of Q42016 is only on hygiene recall appointments.





STRATEGIC PERFORMANCE EXCELLENCE

III. Measure Name: Next Visit

Measure Description: Writing Next Visit in progress note.

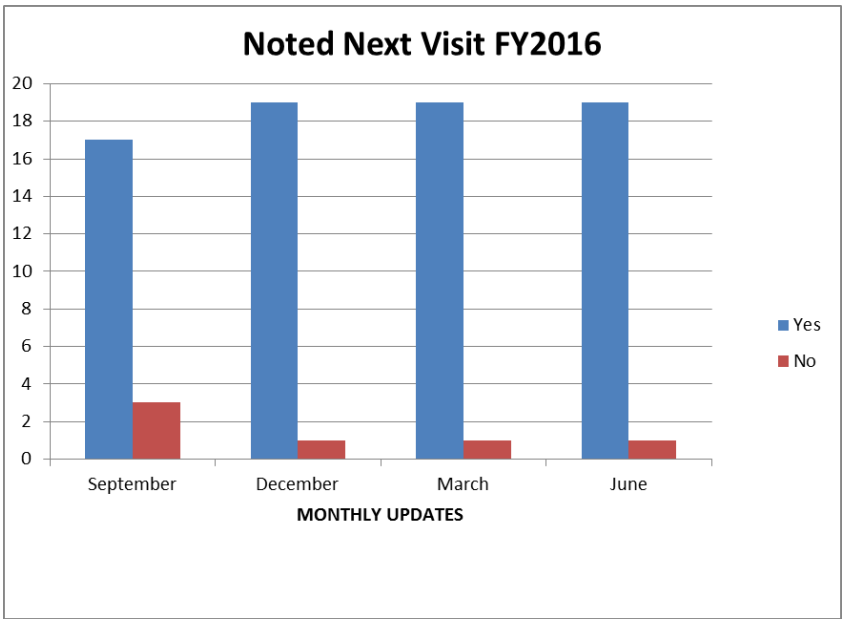
Type of Measure: Performance Improvement

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

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

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

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



STRATEGIC PERFORMANCE EXCELLENCE

IV. Measure Name: RMH and MEDS

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

Type of Measure: Quality Assurance

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

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

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

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

STRATEGIC PERFORMANCE EXCELLENCE

V. Measure Name: Blood Pressure

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

Type of Measure: Quality Assurance

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

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

Action Plan: Take blood pressure and pulse at the start of all dental appointments. To withstand dental care, blood pressure should be less than 160/90.

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

STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Medication Management Clinic

Responsible Party: Margaret Todd-Brown, RN

I. Measure Name: Reconciliation of Outpatient Medication List

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

Measure Type: Performance Improvement

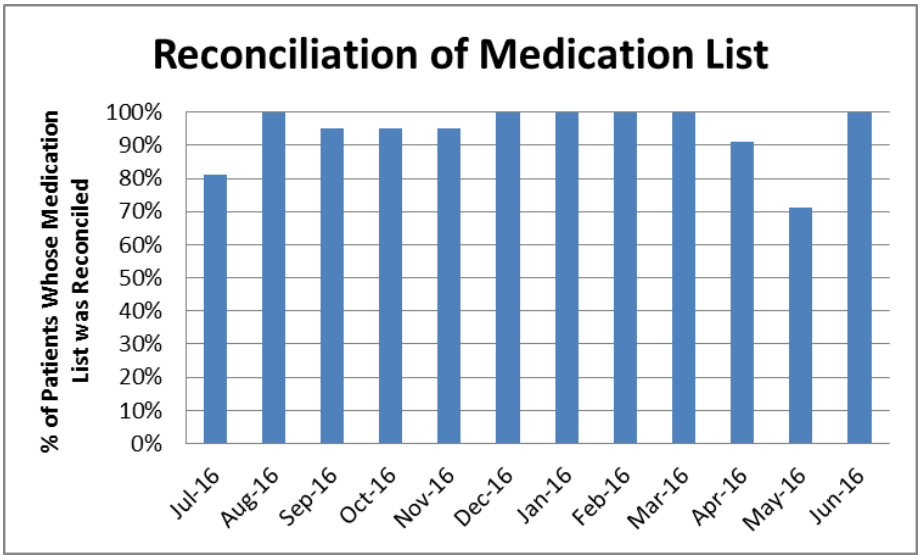
Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**FYTD**
Target	Reconciliation completed per visit.	2Q2015 73%	100%	100%	100%	100%	**100%**
Actual			94% 59/63	97% 57/59	100% 46/46	90% 26/29	**95% 188/197**

Data Analysis: FY2016 demonstrated a 9% improvement over FY2015. During the last quarter of FY2016 three medication reconciliations were missed. Two of these reconciliations were on a long term clinic patient who is developmentally disabled and unable to assist in the reconciliation process - he is escorted to appointments by members of his group home. It is unclear why the third medication reconciliation was missed.

Action Plan: The clinic will continue to track this PI measure with the goal of reaching 100%. Prior to future appointments with the gentleman who did not have documented medication reconciliations, the clinic RN will contact the group home and ask them to fax a medication list.

Comments: The last quarter of FY2016 was a period of transition for the clinic as a new RN and Medical Assistant have started.

STRATEGIC PERFORMANCE EXCELLENCE



II. Measure Name: Vital Signs

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

Measure Type: Quality Improvement

	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**FYTD**
Target	Reconciliation completed per visit.	FY2015 77%	100%	100%	100%	100%	**100%**
Actual			92% 58/63	95% 56/59	93% 43/46	90% 26/29	**93% 183/197**

Data Analysis: FY2016 had a 15% improvement from FY2015. During Q4 the vitals that were missed corresponded to the medication reconciliations that were also missed. Two of the vitals that were missed were not documented; historically the patient refuses vitals but nursing documentation did not reflect that they were refused. It is unclear why the third set of vitals was missed.

Action Plan: The clinic will continue to track this PI measure with the goal of reaching 100%. If a patient declines to have vitals taken, staff will document the refusal on the vitals flow sheet.

STRATEGIC PERFORMANCE EXCELLENCE

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela, Dietetic Services Manager

I. Measure Name: Nutrition Screen Completion

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

Type of Measure: Quality Assurance

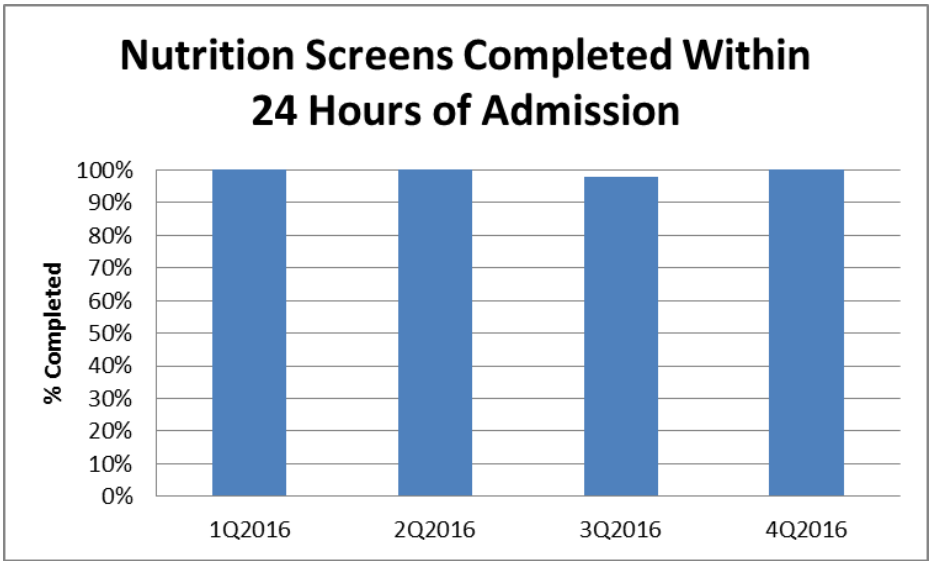
Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Nutrition screens completed on time	FY 2015 95%	95% 57/60	95% 58/61	95% 60/63	96% 48/50	**95% 223/234**
Actual			100% 60/60	100% 61/61	98% 62/63	100% 50/50	**100% 233/234**

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

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

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

STRATEGIC PERFORMANCE EXCELLENCE



II. Measure Name: Nutrition Screen Accuracy

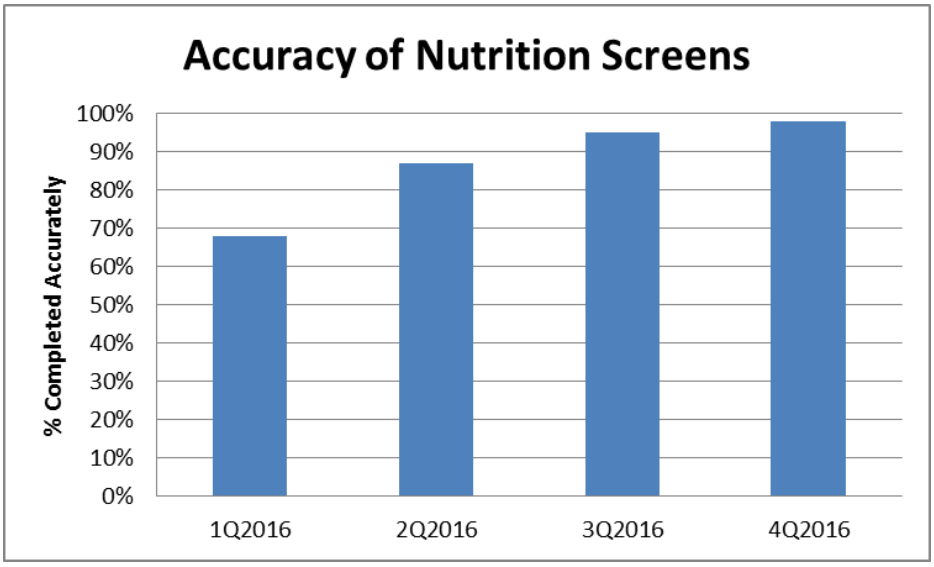
Measure Description: The Registered Dietitian will review every patient's Nursing Admission Data upon admission to assess ongoing compliance with the accuracy of the Nutrition Screen tool. This screen is utilized to attain nutrition indicators that necessitate dietary intervention.

Type of Measure: Performance Improvement

	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Nutrition screens completed accurately	FY 2016 Q1 68% 41/60	Baseline Established	95% 58/61	95% 59/62	95% 48/50	**95% 165/173**
Actual			68% 41/60	87% 53/61	95% 59/62	98% 49/50	**93% 161/173**

Data Analysis: These results indicate there has been a 3% improvement in the accuracy of the information gathered on the nutrition screen this quarter. The nutrition screen is completed by the nurse responsible for the admission. The nurse responsible for completing the nutrition screen that contained the inaccuracy is not regularly assigned to this task. The diagnosis on the nutrition screen that was not identified on one occasion was a "BMI>29. A summary of this measure since its implementation shows a positive and steady improvement from 68% 1st quarter baseline to 93% by end of Fy2016.

Action Plan: Met with the admitting nurse responsible for this data collection and provided guidance surrounding the proper method of completing the nutrition screen.



III. Measure Name: Hand Hygiene Compliance

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

Type of Measure: Performance Improvement

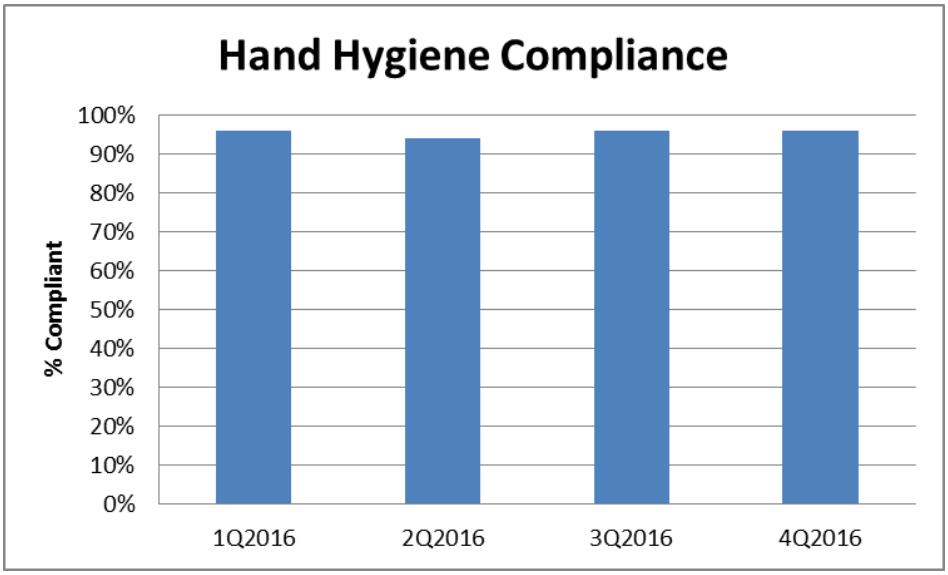
	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Dietary employees washing hands after break	FY 2015 98% 338/346	95% 339/356	95% 218/229	95% 274/288	95% 360/377	**95% 1191/1250**
Actual			96% 343/356	94% 215/229	96% 276/288	96% 363/377	**96% 1197/1250**

Data Analysis: The results of this quarter remain above 95%. There was a 0.4% increase in compliance. Total observations increased by 89. Eight employees accounted for the 14 times that handwashing wasn't observed.

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan:

- Continue this monitor as a QUALITY ASSURANCE MEASURE for the next reporting year.
- Provide a review of the proper hand washing times and techniques as quarterly training.
- Encourage front line supervisors to promote hand hygiene with their staff throughout the day.
- Provide this Performance Improvement Measure to staff to highlight the continued success.



Emergency Management

Responsible Party: Robert Patnaude, Emergency Management Coordinator

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

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

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

Type of Measure: Performance Improvement

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

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of timely and appropriate responses	FY2016 90% 144/159	90%	90%	90%	90%	**90%**
Actual			92% 147/159	96% 153/159	93% 148/159	96% 153/159	**94% 601/636**

Data Analysis: With a significant amount of hands-on demonstrations, radio tests, and an increase in the use of radios, data showed that staff has become very familiar with operating the radio once the radios have been deployed. While the actual percentage of compliance is above the set threshold, what continues to be a critical issue is the fact that staff are not receiving the notification to employ the radios. The notification is going out, but either the pager is not on, the battery is dead, or the pager is not being monitored well. We continue to investigate the most appropriate equipment such as non-battery dependent alert devices which are not so dependent on staff oversight and monitor the manner and number of pagers employed at any given time. We recently integrated our two-way radios into our duress system giving us the capability to mass notify staff via a computerized system.

Action Plan:

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

Comments: Over the course of this past year, 94% of assigned radio equipment is placed into service in a timely manner. We attribute this success from our Action Plan and from units such as our Operations Center which constantly monitors the use of the radios and provides immediate remedial instructions to our staff when deficiencies are discovered.
Although this response adequately assures that the majority of occupants will receive timely and critical information, it still leaves a small population of staff who could be at harm's way if they do not receive critical information through mass notification. At times, some units did not respond to the initial notification. We were still able to employ a back-up procedure to get that notification to them in a timely manner.

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

STRATEGIC PERFORMANCE EXCELLENCE

Areas/Groups Monitored N=Numerator D=Denominator	JUL 2015	AUG 2015	SEPT 2015	OCT 2015	NOV 2015	DEC 2015	JAN 2016	FEB 2016	MAR 2016	APR 2016	MAY 2016	JUNE 2016
Patient Care Areas/ # of radios												
Job Coach/1	1/1	1/1	1/1	1/1	1/1*	**0/1****	1/1*	1/1*	1/1*	1/1	1/1*	1/1
OPS/2	2/2	2/2	**1/2**	2/2	2/2*	2/2	2/2*	2/2	2/2*	2/2*	2/2*	2/2
Tx Mall, Clinic, Dietary, Med Rec/5	5/5*	5/5	**3/5**	5/5	5/5*	**4/5**5**	5/5*	5/5	**4/5**5**	**4/5**10**	5/5	5/5
US, UK, LS, LSSCU, LK, LKSCU/10	**9/10**	10/10	**8/10**	10/10	**7/10**3**	**9/10**	**9/10**3**	10/10	**7/10**3**	**7/10**12**11**	10/10	**8/10**11**
Support Services/ # of radios												
Administration/3	3/3*	3/3	3/3	3/3	3/3*	3/3	3/3*	3/3	3/3*	3/3*	3/3*	3/3
Housekeeping/ 10	**9/10**	10/10	**9/10**	**9/10*1**	10/10*	10/10	10/10	**9/10*9**	**5/10**8**	10/10	10/10	10/10
Maintenance/14	14/14	14/14	**12/14**	14/14	14/14*	14/14	14/14	14/14	14/14*	14/14*	14/14	14/14*
NOD/1	1/1	1/1	1/1	1/1	**0/1**4**	1/1*	1/1*	1/1*	1/1*	1/1*	1/1	1/1*
Nursing Services/1	1/1	1/1	**0/1**	**0/1**2**	1/1*	**0/1**6**	1/1	1/1	1/1*	1/1*	1/1	1/1
Operations/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1*	1/1	1/1	1/1
Security/4	4/4	4/4	4/4	4/4	4/4	4/4	4/4	4/4	4/4*	4/4*	4/4*	4/4
State Forensic Services/1	1/1	1/1	**0/1**	1/1	1/1*	**0/1**7**	1/1	1/1	1/1*	1/1*	1/1*	1/1
Patient Care Areas	**17/18**	**18/18**	**13/18**	**18/18**	**15/18**	**18/18**	**17/18**	**18/18**	**14/18**	**14/18**	**18/18**	**16/18**
Support Services	**34/35**	**32/35**	**30/35**	**33/35**	**34/35**	**32/35**	**35/35**	**34/35**	**30/35**	**35/35**	**35/35**	**35/35**
Total	**51/53**	**53/53**	**43/53**	**51/53**	**49/53**	**53/53**	**52/53**	**52/53**	**44/53**	**49/53**	**53/53**	**51/53**

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

STRATEGIC PERFORMANCE EXCELLENCE

Key:

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

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

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

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

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

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

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

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

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

**10 Operations called Dietary unit since staff did not respond to the "Code Triage". EMC and unit supervisor provided remedial training.

**11 Operations called LK unit since staff did not respond to the "Code Triage".

**12 US had the same person respond to the test. EMC requested that a different person test the 2nd radio which they complied.

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Responsible Party: Marcy Pepin, RN

I. Measure: Harbor Mall Hand-Off Communication

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

Type of Measure: Performance Improvement

Objectives	1Q 2016	2Q 2016	3Q 2016	4Q 2016	Total FY2016
Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	79% 44/56	93% 39/42	88% 37/42	80% 33/41	**85% 153/181**
SBAR information completed from the units to the Harbor Mall.	79% 44/56	93% 39/42	86% 36/42	98% 41/42	**88% 160/182**

Data Analysis: Overall compliance has improved from 87% last quarter to 89% this quarter. Indicator one decreased from 88% last quarter to 80% this quarter. Indicator two increased from 86% last quarter to 98% this quarter. Overall compliance for FY2016 is 86%.

Action Plan: Review the results of this audit with RN IVs and RN Vs from each unit. Maintain highlighted statement at the bottom of the HOC reminding unit staff to turn the sheets in by 10 minutes after the hour to ensure Harbor Mall are made aware of any issues with patients.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Responsible Party: Samantha Brockway, Medical Records Administrator

Documentation and Timeliness:

Indicators	4Q2016 Findings	4Q2016 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements, and Medical Staff bylaws timeframes.	51 charts for patients released during the quarter were sampled. 49 of the charts were completed within the required timeframe.	96%	80%
Discharge summaries will be completed within 15 days of discharge.	51 out of 51 discharge summaries were completed within 15 days of discharge.	100%	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	7 revised forms, 2 new forms, and 2 removed forms in 4Q2016 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 1661 dictated reports, 1661 were completed within 24 hours.	100%	90%

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

Actions: Continue to monitor.

STRATEGIC PERFORMANCE EXCELLENCE

Confidentiality:

Indicators	3Q2016 Findings	3Q2016 Compliance	Threshold Percentile
All patient information released from the Health Information Department will meet all Joint Commission, State, Federal & HIPAA standards.	2,752 requests for information (143 requests for patient information and 2,609 police checks) were released.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	All new employees/contract staff attended confidentiality/ HIPAA training.	100%	100%
Patient confidentiality/privacy issues tracked through incident reports.	0 privacy-related incident reports.		

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

No problems were found in 4Q2016 related to release of information from the Health Information Department and training of new employees/contract staff; however, compliance with current law and HIPAA regulations needs to be strictly adhered to requiring training, education, and policy development at all levels.

Actions: The above indicators will continue to be monitored.

STRATEGIC PERFORMANCE EXCELLENCE

Regulatory and Compliance Standards in Documentation

Ensuring Fiscal Responsibility in Documentation and Billing Practices

Indicator and Rationale for Selection	1Q2016	2Q2016	3Q2016	4Q2016
Identification Data	N/A	N/A	100% 65/65	100% 51/51
Medical History, including chief complaint; HPI; past, social & family hx.; ROS, and physical exam w/in 24 hr. conclusion and plan	N/A	N/A	100% 65/65	100% 51/51
Summary of patient's psychosocial needs as appropriate to the patients *	N/A	N/A	88% 57/65	61% 31/51
Psychiatric Evaluation in patient's record w/in 24 hr of admission	N/A	N/A	99% 64/65	100% 51/51
Physician (TO/VO w/in 72 hr.)	N/A	N/A	96% 230/240	92% 23/25
Evidence of appropriate informed consent	N/A	N/A	100% 65/65 13 Refused	100% 51/51 14 Refused
Clinical observations including the results of therapy.	N/A	N/A	100% 65/65	100% 51/51
Nursing discharge Progress Note with time of discharge departure	N/A	N/A	92% 60/65	90% 46/51
Consultation reports, when applicable	N/A	N/A	100% 52/52	81% 26/32
Results of autopsy, when performed	N/A	N/A	N/A	N/A
Advance Directive Status on admission and SW follow up after	N/A	N/A	99% 64/65	88% 28/32
Notice of Privacy	N/A	N/A	94% 61/65	91% 29/32
Chart Completion w/in 30 days of discharge date/discharge summary completed within 30 days	N/A	N/A	100% 65/65	94% 30/32
Discharge Packet sent to follow up provider within 5 days of discharge.	N/A	N/A	100% 65/65	100% 51/51

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

*N/A: Information not available, data tracking began in 3Q2016

STRATEGIC PERFORMANCE EXCELLENCE

Release of Information for Concealed Carry Permits:

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

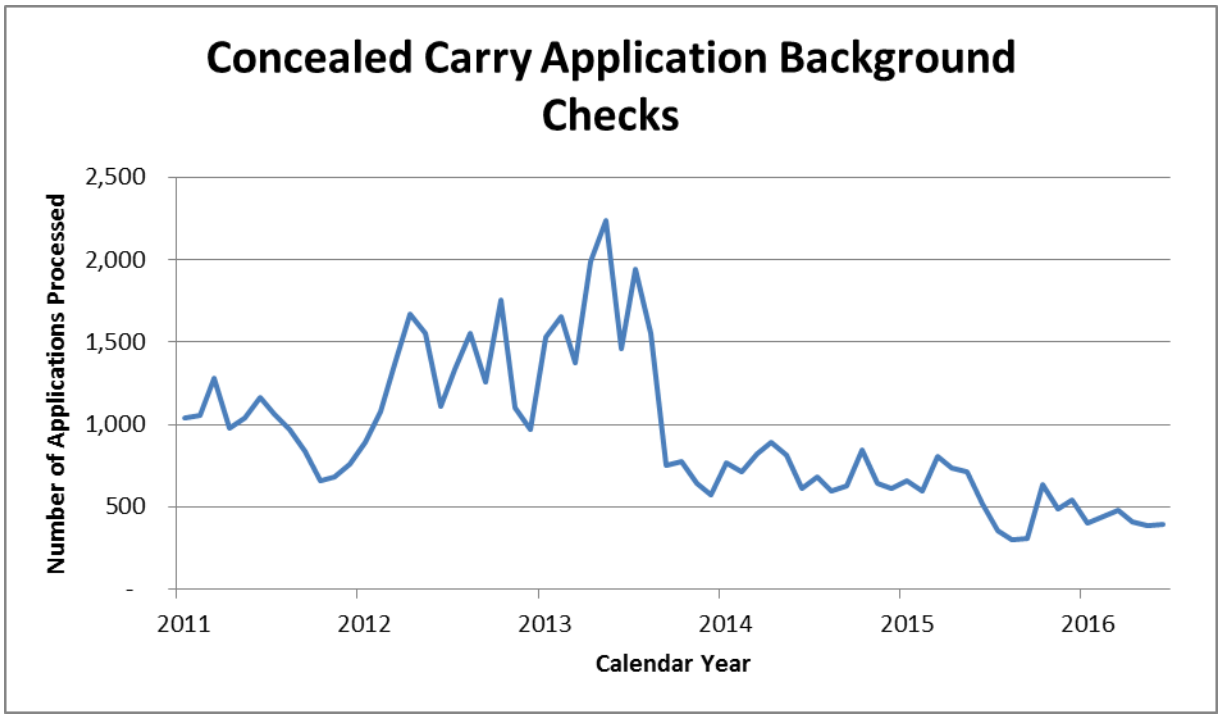
Analyze:
Data collected for the 4Q2016 showed that we received 1184 applications. This is a decrease from last quarter, 3Q2016, when we received 1316 applications.

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

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

Year	**FY2016**												**Total**
Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	
# Applications Received	353	302	304	634	489	542	401	439	476	411	384	389	5124

STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

Housekeeping

Responsible Party: Debora Proctor, Housekeeping Supervisor

I. Measure Name: Patient Living Area

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

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

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

Results:

Unit	Target	1Q2016	2Q2016	3Q2016	4Q2016	YTD
Lower Saco	85%	89%	94%	92%	93%	**92%**
Upper Saco	85%	87%	88%	88%	90%	**88%**
Lower Kennebec	85%	89%	90%	87%	89%	**89%**
Upper Kennebec	85%	87%	89%	90%	91%	**89%**
Overall Average	**85%**	**88%**	**90%**	**89%**	**91%**	**90%**

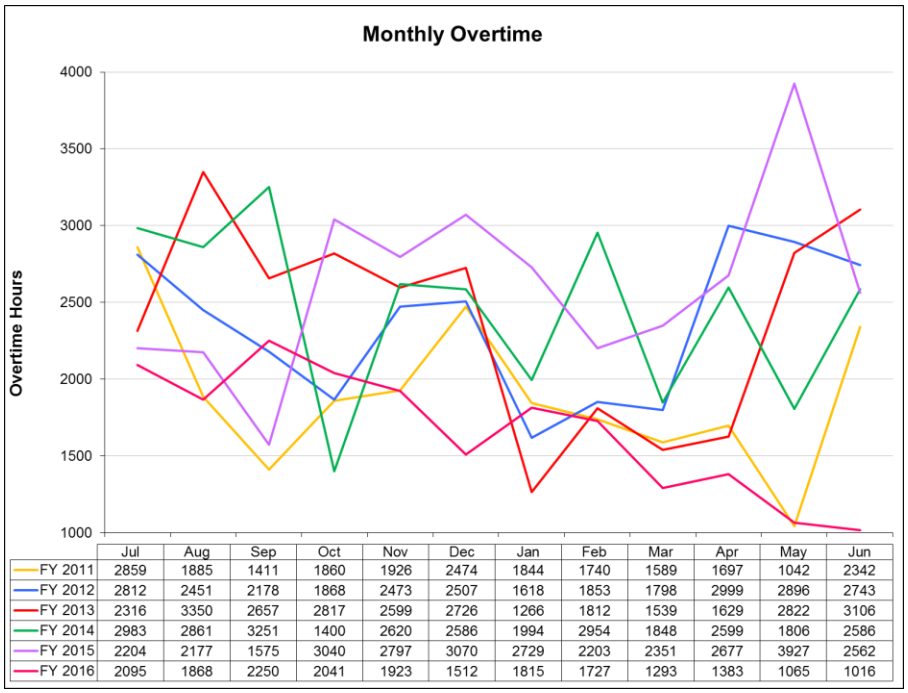
Data Analysis: The Housekeeping Supervisor inspected units monthly and found that window cleaning, dusting, and some floor care in the nurse's station were consistent problem areas.

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

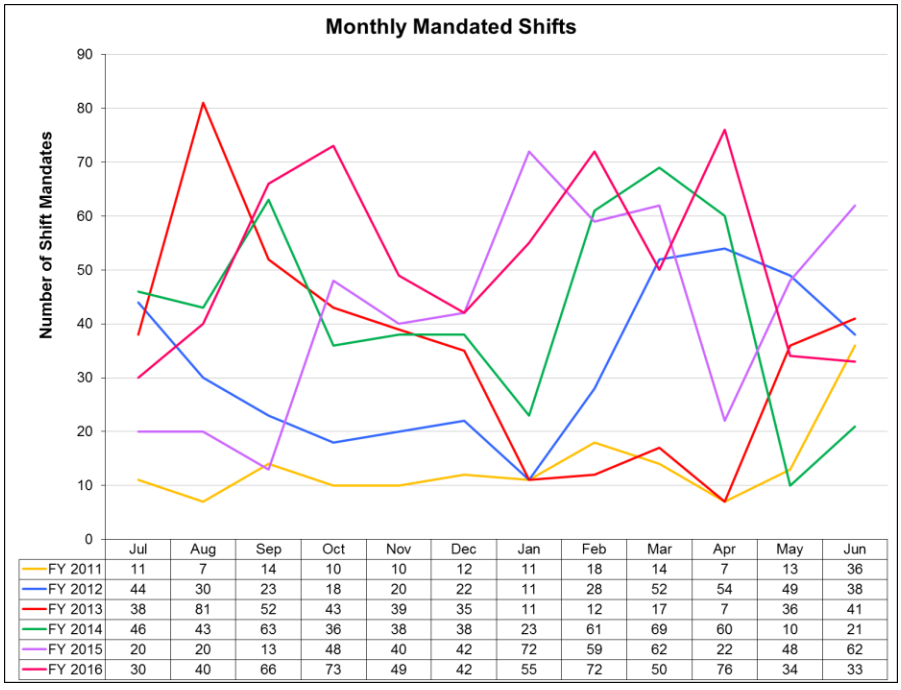
STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Person Responsible: Aimee Rice, Human Resources Manager



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



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

STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: License Reviews

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

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percentage Licenses Reviewed	FY 2014 98%	100%	100%	100%	100%	**100%**
Actual			100% 19/19	100% 6/6	100% 28/28	100% 40/40	**100% 93/93**

Data Analysis: During 4Q2016, there were 45 new hires. Of those, 40 were licensed, or potentially licensed. License and CNA Registry checks were performed prior to hire on all 40.

Action Plan: No action is needed at this time.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff

Responsible Party: Dr. William Nelson, Acting Clinical Director

Quality Improvement Plan
2015-2016

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

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

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

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

1. **Peer Review Activities**:

   a. Regularly scheduled internal peer review by full time medical staff occurs on a monthly basis at the Peer Review and Quality Assurance Committee. The group of assembled clinicians will review case histories and treatment plans, and offer recommendations for possible changes in treatment plans, for any patient judged by the attending physician or psychologist, or others (including nursing, administration, the risk manager, or the Clinical Director), and upon request, to not be exhibiting a satisfactory response to their medical, psychological, or psychiatric regimens. Our goal is to discuss a case monthly. Detailed minutes of these reviews will be maintained, and the effectiveness of the reviews will be determined by recording feedback from the reviewed clinician as to the helpfulness of the recommendations, and by subsequent reports of any clinical improvements or changes noted in the patients discussed over time. Such intensive case reviews can also serve as the generator of new clinical monitors if frequent or systematic problem areas are uncovered. In addition all medical staff members (full and part-time) will have a minimum of one chart every other month peer reviewed and rated for clinical pertinence of diagnosis and treatment as well as for documentation. These may include admission histories and physicals, discharge summaries, and progress notes. The results of these chart audits are available to the reviewed practitioners and trends will be monitored by the Clinical Director as part of performance review and credentialing decisions.

   b. Special internal peer review or focused review. At the direction of the Clinical Director a peer chart review is ordered for any significant adverse clinical event or significant unexpected variance. Examples would be a death, seclusion or restraint of one patient for eight or more continuous hours, patient elopement, the prescribing of three or more atypical antipsychotics for the same patient at the same time, or significant patient injury attributable to a medical intervention or error.

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

2. **MEC Subcommittee and IPEC Indicator Monitoring Activities**:
   The subcommittees of the MEC and the Integrated Performance Excellence Committee are the primary methods by which the medical staff monitor and analyze for trends all hospital-wide quality performance data as well as trends more specific to medical staff performance. The subcommittees, in turn, report their findings on a monthly basis to the Medical Executive Committee and to the Clinical Director for any needed action. The respective committees monitor the following indicators:
   a. Integrated Performance Excellence Committee (this is not a subcommittee of the Medical Staff but the Clinical Director serves as a member and is the primary liaison to the Medical Executive Committee).
      - Psychiatric Emergencies
      - Seclusion and Restraint Events
      - Staff or Patient Injuries
      - Priority I Incident Reports
      - Other clinical/administrative department monitoring activity
   b. Pharmacy and Therapeutics Committee:
      - Medication Errors Including Unapproved abbreviations
      - Adverse Drug Reactions
      - Pharmacy Interventions
      - Antibiotic Monitoring
      - Medication Use Evaluations
      - Psychiatric Emergency process
   c. Medical Records Committee:
      - Chart Completion Rate/Delinquencies
      - Clinical Pertinence of Documentation of Closed Records
   d. Infection Control Committee:
      - Infection Rates (hospital acquired and community acquired)
      - Staff Vaccination Rates/Titers
   e. Utilization Management Committee:
      - Admission Denials
      - Timeliness of Discharges After Denials
   f. Peer Review and Quality Assurance Committee:
      - Hospital-wide Core Measures and NASMHPD Data
      - Patient Satisfaction Surveys
      - Administrative concerns about quality
      - Special quality improvement monitors for the current year (see also the Appendix and number 6 below).
      - Reports from the Human Rights Committee regarding patient rights and safety issues
      - Specific case reviews

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

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

5. **Reports of Practitioner-specific Data to Individual Practitioners**:
The office of the Clinical Director will provide confidential outcomes of practitioner-specific data to each medical staff member within 30 days of the end of the fiscal year. This information will be available without the necessity of the practitioner requesting it. It will be placed in the confidential section of the practitioner's medical staff file and freely accessible during normal business hours. The office of the Clinical Director will notify all medical staff members when the data is available for review. Each medical staff member may discuss the data with the Clinical Director at any time.

6. **Process to amend the quality improvement plan, including adding or deleting any monitors or processes:**
Upon the recommendation of the Clinical Director, upon recommendation of the MEC as a whole after a request from any member of the medical staff, from a recommendation of the Integrated Performance Excellence Committee, or upon recommendation of the Advisory Board, this plan may be amended with appropriate approvals at any time. Examples of when amendments might be necessary are the detection of new clinical problems requiring monitoring or when it is discovered that current monitors are consistently at or near target thresholds for six consecutive months. Should the number of active clinical monitors fall below four at any time, replacement monitors will be activated within two months of termination of the

previous monitor (s). The Clinical Director, the Medical Staff President, and the MEC are jointly responsible for maintaining an active monitoring system at all times and to insure that all relevant clinical service areas or services are involved in monitoring. The Director of Integrated Quality will also assist in assuring the ongoing presence of appropriate monitors.

Quality Improvement Reporting Schedule to Medical Executive Committee

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

STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: Polyantipsychotic Therapy

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

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Justified Polyantipsychotic Therapy	85% (2015)	90%	90%	90%	90%	**90%**
Actual			77%	69%	78%	72%	**76%**

Data Analysis: All medication profiles in the hospital are reviewed in each month of the quarter for antipsychotic medication orders. Attending psychiatrists are required to complete a Polyantipsychotic Therapy Justification Form when a patient is prescribed more than one antipsychotic. The percentage of justified polyantipsychotic therapy amongst those patients prescribed two or more antipsychotics is reported here. This quarter we maintained the number of patients on justifiable polyantipsychotic therapy. An analysis of the patients on polyantipsychotic therapy yielded the following results: An average 13% of inpatients were prescribed two scheduled antipsychotics, which has decreased from 27% last quarter. The percentage of scheduled polyantipsychotic therapy versus the use of more than one antipsychotic on an as needed basis only, has evened out with values of 44% and 47% of all patients with polyantipsychotic therapy respectively. We have seen a small decrease in number of patients with triple antipsychotic therapy from 10 patients (4%) to 7 patients (3%). Out of all 78 patients using polyantipsychotic therapy, 10% were using more than two agents, and another 4% of those 78 patients were on more than two standing antipsychotic agents. Of note, 24 of the 78 patients (31%) were using another antipsychotic as adjunct to clozapine therapy. All patients either had regimens which were deemed pharmacologically rational or were documented as being in the cross-taper process.

STRATEGIC PERFORMANCE EXCELLENCE

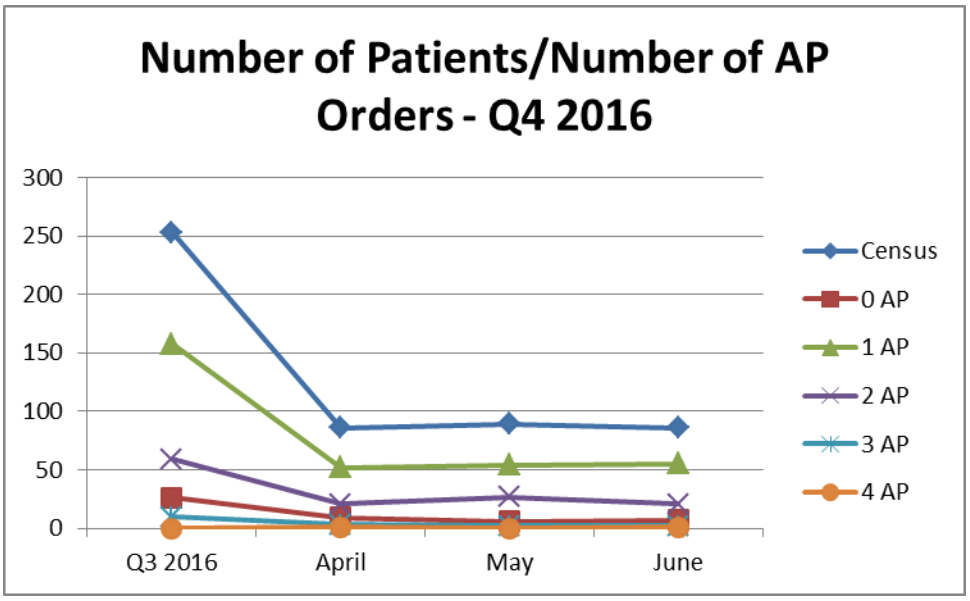
Action Plan: It was decided to continue to monitor polyantipsychotic therapy as a performance improvement as our use has increased over the year. Although our providers have provided justification of polyantipsychotic therapy in a higher percentage of cases, the facility also has increased in number of patients using triple and quadruple therapy. Pharmacy continues alerting providers to provide justifications for polyantipsychotic therapy. It may be beneficial to look more closely at those patients with three and four antipsychotic regimens in the future to lower this number.

Comments: This quarter the number of patients on polyantipsychotic therapy remains steady with appropriate documentation of justification. Of note, a large number of patients are receiving polyantipsychotic therapy as adjunct to clozapine or after failure of clozapine therapy, which is appropriate and may speak to the severity of the current census. Additionally, another large portion of polyantipsychotic therapy is due to the addition of another agent only on an as needed basis, and these agents are not typically carried over to discharge.

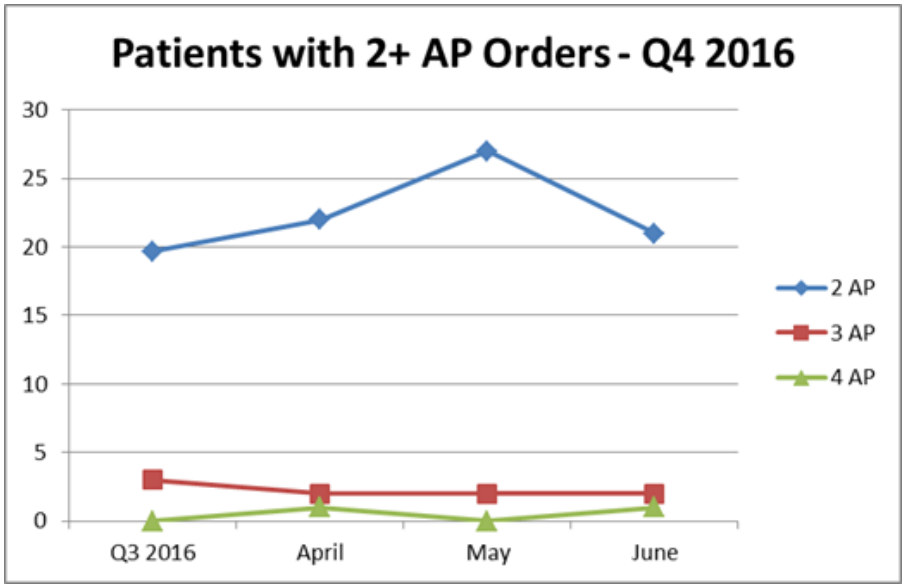
Q4 2016 Report	Q3 2016		April		May		June	
Census	254		86		89		86	
Antipsychotic Orders for Clients	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
No Antipsychotics	26	10	9	10	6	7	7	8
Mono-antipsychotic therapy	158	62	52	60	54	61	55	64
Two Antipsychotics	59	23	21	24	27	30	21	24
Three Antipsychotics	10	4	3	3	2	2	2	2
Four Antipsychotics	0	0	1	1	0	0	1	1
At least 1 antipsychotic	222	87	77	90	83	93	79	92
Total on Poly-antipsychotic therapy	69	27	25	29	29	33	24	28
Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics		31% (69/222)		32% (25/77)		35 % (29/83)		30% (24/79)
More than 2 antipsychotics	10	5%	3	4%	2	2%	3	4%
Poly-Antipsychotic therapy breakdown	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
SGA + FGA	29	42	7	28	11	38	13	54
2 SGAs ("Pine" + "Done")	9	13	3	12	6	21	2	8
Other (2 antipsychotic regimens)	24	35	11	44	9	31	9	38
Other 2 Antipsychotic Regimen Details	1) Clozapine + Olanzapine X7 2) Haloperidol + Chlorpromazine 3) Aripiprazole + Paliperidone X3 4) Clozapine + Quetiapine X2 5) Aripiprazole + Olanzapine X4		1) Clozapine/ Olanzapine X 4 2) Aripiprazole/ Ziprasidone 3) Aripiprazole/ Olanzapine X 2 4) Aripiprazole/ Quetiapine X 2 5) Paliperidone/ Aripiprazole		1) Aripiprazole/ Quetiapine (x2) 2) Risperidone/ Aripiprazole 2) Aripiprazole/ Olanzapine (x2) 3) Clozapine/ Olanzapine 4) Paliperidone/ Risperidone		1) Aripiprazole/ Quetiapine 2) Haloperidol/ Loxapine 3) Clozapine/ Olanzapine X 3 4) Aripiprazole/ Olanzapine	
3+ Antipsychotic Regimens	10	4.50%	3	4%	2	2%	3	4%
	1) Clozapine/ Haloperidol/ Olanzapine X3 2) Clozapine/ Ziprasidone/ Haloperidol 3)Clozapine/ Quetiapine/ Olanzapine X3 4) Clozapine/ Quetiapine/ Chlorpromazine 5) Chlorpromazine/ Perphenazine/ Quetiapine 6) Aripiprazole/ Haloperidol/		1) Paliperidone/ Risperidone/ Chlorpromazine 2) Paliperidone/ Risperidone/ Quetiapine 3) Clozapine/ Quetiapine/ Chlorpromazine 4) Aripiprazole/ Clozapine/ Olanzapine/ Quetiapine		1) Haloperidol/ Loxapine/ Olanzapine 2) Clozapine/ Quetiapine/ Chlorpromazine		1) Clozapine/ Chlorpromazine/ Olanzapine 2) Clozapine/ Haloperidol/ Ziprasidone 3) Clozapine/ Aripiprazole/ Quetiapine/ Olanzapine	
Justifiable Poly-Antipsychotic Therapy	78% (54/69)		60% (15/25)		76% (22/29)		79% (19/24)	

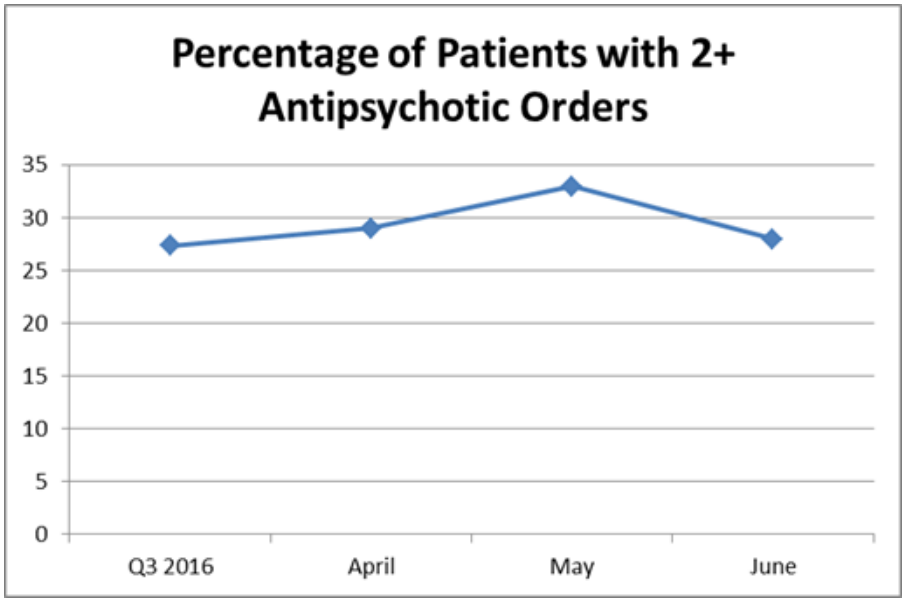
STRATEGIC PERFORMANCE EXCELLENCE

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



Number of Patients with 2+ Antipsychotic orders per Month:





II. Measure Name: Metabolic Monitoring

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

Type of Measure: Performance Improvement

	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Complete/Up-to-date Metabolic Parameters	73%	75%	75%	75%	75%	**75%**
Actual			73%	63%	57%	81%	**69%**

Data Analysis: The pharmacy completed data collection of metabolic monitoring parameters for all patients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all patients included BMI (Body Mass Index) and BP (blood pressure) plus lab results including HDL cholesterol, triglycerides, fasting blood sugar, and hemoglobin A1C. In this last quarter the facility has been able to meet the predetermined goal

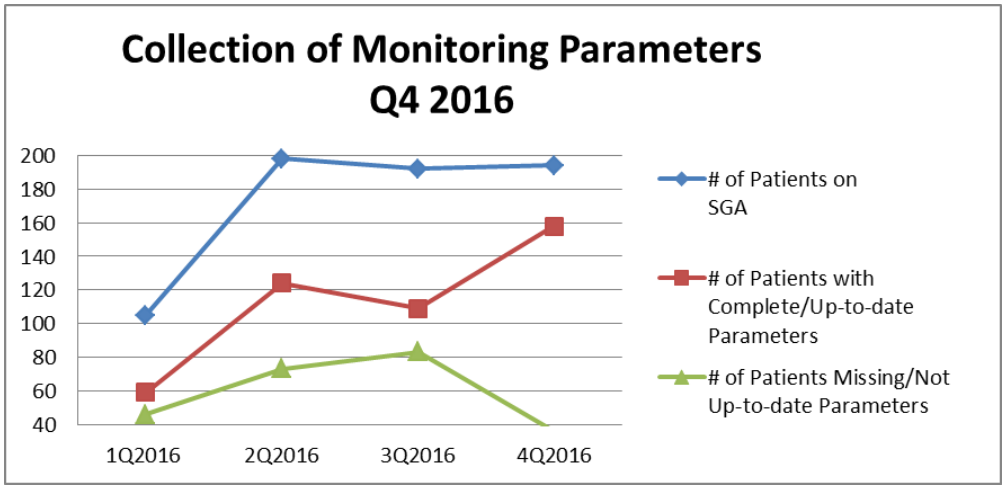
with 81% of patients on atypical antipsychotic therapy having complete and up-to-date laboratory results. Of the 18% of patients who were not up-to-date, 9% had refused blood draws multiple times throughout the quarter.

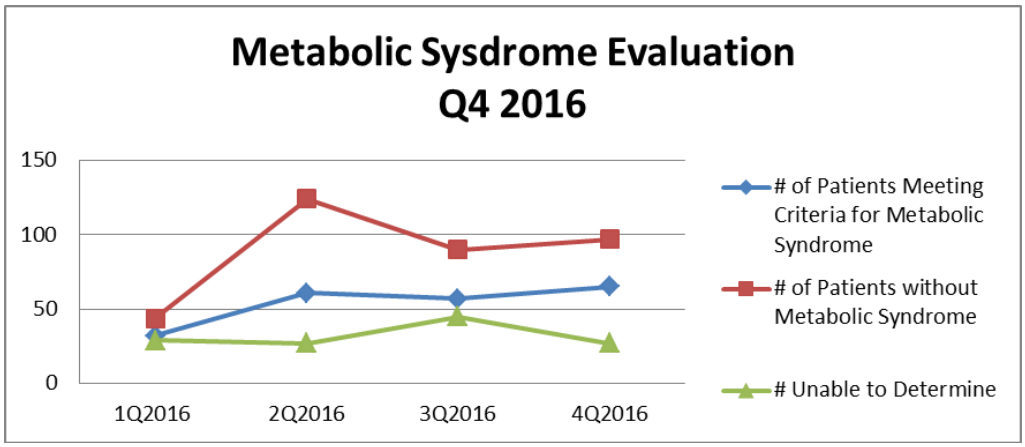
Action Plan: We will continue to monitor for Metabolic Syndrome in patients using SGA therapy. The patient's right to refuse assessment (weight, blood pressure and lab work) has been identified as a contributing factor to not being able to fully assess their metabolic status. Thus the goal of achieving 95% completed metabolic parameters is unrealistic and has been adjusted to a more reasonable goal of 75%. During this last quarter, a renewed effort between pharmacy and the medical service resulted in a significant increase in the number of patients who have complete monitoring parameters. To aid providers with this task, the pharmacy has been updating a flow sheet monthly for the medical service to identify which patients are due for lab work.

Comments: We saw a significant improvement this quarter from 57% to 81%, exceeding our goal of 75%. Of the patients that did not have complete/up-to-date parameters collected, 9% had documented refusals in contrast to 1% from last quarter. For the remaining patients, it is likely that they were recently initiated on the second generation antipsychotic agent at time of assessment and/or were recently admitted to the facility.

	1Q2016	2Q2016	3Q2016	4Q2016
# of Patients on SGA	105	198	192	194
# of Patients with Complete/Up-to-date Parameters	59 (56%)	124 (63%)	109 (57%)	158 (81%)
# of Patients Missing/Not Up-to-date Parameters	46 (44%)	74 (37%)	83 (43%)	36 (19%)
# of Patients Meeting Criteria for Metabolic Syndrome	32 (30%)	61 (31%)	57 (30%)	65 (34%)
# of Patients without Metabolic Syndrome	44 (42%)	124 (63%)	90 (47%)	97 (.5%)
# Unable to Determine	29 (28%)	27 (14%)	45 (23%)	27 (14%)
Documented Refusals	0	27 (14%)	1 (.01%)	17 (.9%)

STRATEGIC PERFORMANCE EXCELLENCE





III. Measure Name: Polytherapy

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

Type of Measure: Quality Assurance

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

Action Plan: Our plan is to continue to review patients with numerous medication orders at the monthly Peer Review Committee Meeting. An effort will be made to obtain more information on medication adherence and PRN usage for the patients reviewed. This monitor will be reported and discussed with the Medical Staff at the Peer Review and Pharmacy & Therapeutics (P&T) Committees, but it will no longer be reported on a quarterly basis.

Comments: Results this quarter continue to remain similar to previous quarters. The average number of agents has likely increased due to patient specific factors including an increased number of medically fragile patients. The number of medications per patient seems to reflect our current population.

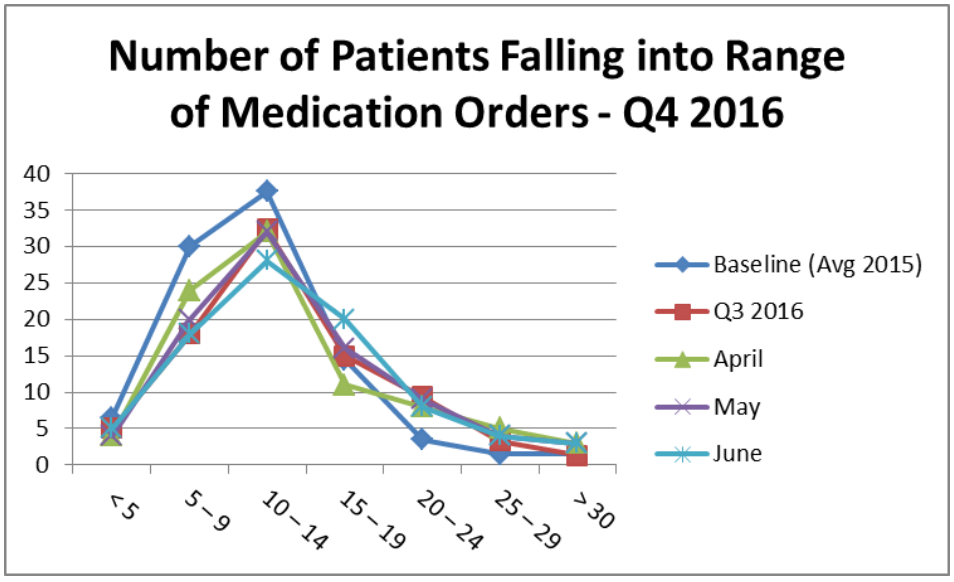
(Glossary of Terms, Acronyms & Abbreviations) (Back to Table of Contents)

STRATEGIC PERFORMANCE EXCELLENCE

	Baseline Average	Baseline Range	Q32016 Average	Q32016 Range	April Average	April Range	May Average	May Range	June Average	June Range
Total Orders	12.1	0-31	11	1-37	13	1-37	14	2-37	13.8	2-37
Scheduled	4.9	0-17	7	0-21	6	1-20	7	1-20	6.7	0-21
PRNs	5.9	0-19	10	0-21	7	0-21	8	1-21	7.6	1-21

Medication Number Range	Average Number of Patients (Baseline)	3Q2016 Average	April	May	June	4Q2016 Average
< 5	7	5	4	4	5	4
5 – 9	30	18	24	20	18	21
10 – 14	38	32	32	32	28	31
15 – 19	15	15	11	16	20	16
20 – 24	4	9	8	9	8	8
25 – 29	2	3	5	4	4	4
> 30	2	1	3	3	3	3

Number of Patients Falling into Range of Medication Orders



STRATEGIC PERFORMANCE EXCELLENCE

Nursing

Responsible Party: Renee Pfingst, RN, Acting Director of Nursing

I. Measure Name: Mandate Occurrences

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

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

Methods of monitoring: Monitoring would be performed by:

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

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

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

Unit: Mandate shift occurrences

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

STRATEGIC PERFORMANCE EXCELLENCE

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

	Baseline Sept 2013	1Q2016			2Q2016			3Q2016			4Q2016			Goal
		July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	April 2016	May 2016	June 2016	
Nursing Mandates	14	2	1	8	11	8	10	3	1	5	8	3	1	0
Mental Health Worker (MHW) Mandates	49	28	39	58	62	41	32	52	71	45	68	31	32	0

Nursing mandates increased from 9 last quarter to 12 this quarter.
MHW mandates decreased from 168 last quarter to 131 this quarter.

Analysis: On June 26, 2016, our Mental Health Workers and Acuity Specialists started their new twelve hour shift schedule. This change was initiated due to the number of staff who were mandated to cover vacant shifts and also the facility's charge to decrease the financial implications of overtime paid out.

Objective: Through collaboration with the MSEA and AFSME unions, staff and administration came to desired conclusion of twelve hours shifts which alternate two days on and two days off. RPC now has a flattened schedule where there are no more vacancies on the weekends than during the week. Most days, there is an overage of MHW to cover sick calls and attend required training for maintenance of credentials.

Goal: To essentially eliminate mandates and dramatically decrease the burden of overtime on our current fiscal goals. Staff retention and recruitment is part of this initiative. From April to June our mandates for MHW dropped by 50% and professional nurse mandates have also dropped 50%. Professional nursing staff schedules are presently being assessed to determine if we can offer the same type of schedule. At this time, due to vacancies, it is not feasible until we can hire more state line nursing staff.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

4Q2016 - Lower Saco

Indicators	Findings	Compliance
1. RN Assessment completed within 24 hours	15/15	100%
2. All sheets requiring signature authenticated by assessing RN	15/15	100%
3. Interim plan of care initiated within 8 hours and completed within 24 hours	7/15	47%
4. Medical Care Plan if medical problems are identified initiated within24 hours	6/15 1 N/A	47%
5. Suicide potential assessed upon admission (TASR)	15/15	100%
6. Informed Consent sheet signed	10/15	67%
7. Potential for violence assessed upon admission	15/15	100%
8. Fall Risk assessed upon admission	15/15	100%
9. Score of 6 or above incorporated into problem need list	10 N/A	67%
10. Dangerous Risk Tool done upon admission	15/15	100%
11. Score of 11 or above incorporated into Safety Problem	3/15 6 N/A	60%
12. Evidence of informed of their rights documentation	15/15	100%
13. Medication Reconciliation @ time of admission includes all medications (medical & psychiatric)	15/15	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

4Q2016 - Upper Saco

Indicators	Findings	Compliance
1. RN Assessment completed within 24 hours	4/4	100%
2. All sheets requiring signature authenticated by assessing RN	4/4	100%
3. Interim plan of care initiated within 8 hours and completed within 24 hours	2/4	50%
4. Medical Care Plan if medical problems are identified initiated within24 hours	2/4	50%
5. Suicide potential assessed upon admission (TASR)	4/4	100%
6. Informed Consent sheet signed	2/4	50%
7. Potential for violence assessed upon admission	4/4	100%
8. Fall Risk assessed upon admission	4/4	100%
9. Score of 6 or above incorporated into problem need list	1 N/A	25%
10. Dangerous Risk Tool done upon admission	4/4	100%
11. Score of 11 or above incorporated into Safety Problem	1/4 2 N/A	75%
12. Evidence of informed of their rights documentation	3/4	75%
13. Medication Reconciliation @ time of admission includes all medications (medical & psychiatric)	4/4	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

4Q2016 - Lower Kennebec

Indicators	Findings	Compliance
1. RN Assessment completed within 24 hours	26/27	96%
2. All sheets requiring signature authenticated by assessing RN	26/27	96%
3. Interim plan of care initiated within 8 hours and completed within 24 hours	23/27	85%
4. Medical Care Plan if medical problems are identified initiated within24 hours	12/27 6 N/A	67%
5. Suicide potential assessed upon admission (TASR)	27/27	100%
6. Informed Consent sheet signed	23/27 1 Refused	89%
7. Potential for violence assessed upon admission	27/27	100%
8. Fall Risk assessed upon admission	27/27	100%
9. Score of 6 or above incorporated into problem need list	1/27 9 N/A	37%
10. Dangerous Risk Tool done upon admission	27/27	100%
11. Score of 11 or above incorporated into Safety Problem	7/27 4 N/A	41%
12. Evidence of informed of their rights documentation	25/27 1 Refused	96%
13. Medication Reconciliation @ time of admission includes all medications (medical & psychiatric)	27/27	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

4Q2016 - Upper Kennebec

Indicators	Findings	Compliance
1. RN Assessment completed within 24 hours	4/4	100%
2. All sheets requiring signature authenticated by assessing RN	4/4	100%
3. Interim plan of care initiated within 8 hours and completed within 24 hours	4/4	100%
4. Medical Care Plan if medical problems are identified initiated within24 hours	2/4	50%
5. Suicide potential assessed upon admission (TASR)	4/4	100%
6. Informed Consent sheet signed	4/4	100%
7. Potential for violence assessed upon admission	4/4	100%
8. Fall Risk assessed upon admission	4/4	100%
9. Score of 6 or above incorporated into problem need list	1 N/A	25%
10. Dangerous Risk Tool done upon admission	4/4	100%
11. Score of 11 or above incorporated into Safety Problem	1/4 1 N/A	50%
12. Evidence of informed of their rights documentation	4/4	100%
13. Medication Reconciliation @ time of admission includes all medications (medical & psychiatric)	4/4	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Chart Review Effectiveness

4Q2016 Total – All Units

Indicators	Findings	Compliance
1. RN Assessment completed within 24 hours	49/50	98%
2. All sheets requiring signature authenticated by assessing RN	49/50	98%
3. Interim plan of care initiated within 8 hours and completed within 24 hours	36/50	72%
4. Medical Care Plan if medical problems are identified initiated within24 hours	22/50 7 N/A	58%
5. Suicide potential assessed upon admission (TASR)	50/50	100%
6. Informed Consent sheet signed	39/50 1 Refused	80%
7. Potential for violence assessed upon admission	50/50	100%
8. Fall Risk assessed upon admission	50/50	100%
9. Score of 6 or above incorporated into problem need list	1/50 21 N/A	44%
10. Dangerous Risk Tool done upon admission	50/50	100%
11. Score of 11 or above incorporated into Safety Problem	12/50 13 N/A	50%
12. Evidence of informed of their rights documentation	47/50 1 Refused	96%
13. Medication Reconciliation @ time of admission includes all medications (medical & psychiatric)	49/50	98%

STRATEGIC PERFORMANCE EXCELLENCE

Outpatient Services (OPS)

Responsible Party: Lisa Manwaring, Director

I. Measure Name: Admission Assessments

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

Measure Type: Performance Improvement

	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of assessments completed on time	FY 2015 0% 0/4	75%	75%	75%	75%	**75%**
Actual			0% 0/3	0% 0/5	0% 0/4	25% 1/4	**.06% 1/16**

Data Analysis: We had three charts with two assessments completed this quarter.

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Responsible Party: Julia Duncan, Peer Support Coordinator

Indicator: Inpatient Consumer Survey Return Rate

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

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

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

Methods of Monitoring:

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

Methods of Reporting:

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

Unit: All patient care/residential units

Baseline: Determined from previous year's data.

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

STRATEGIC PERFORMANCE EXCELLENCE

Survey Return Rate	Unit	Baseline	Target	1Q2016	2Q2016	3Q2016	4Q2016	YTD
The inpatient consumer survey is the primary tool for collecting data on how patients feel about the services they are provided at the hospital.	**LK**	15%	50%	44% 7/16	23% 3/13	64% 7/11	9% 1/11	**35%** **18/51**
	LS	5%	50%	0% 0/21	54% 7/13	13% 2/16	0% 0/10	**15%** **9/60**
	UK	45%	50%	18% 3/17	25% 4/16	19% 5/26	13% 3/22	**18%** **15/81**
	US	30%	50%	88% 7/8	100% 7/7	0% 0/5	12% 1/8	**53%** **15/28**
	Overall			**27%** **17/62**	**43%** **21/49**	**24%** **14/58**	**10%** **5/51**	**25%** **57/220**

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

Inpatient Consumer Survey Results:

#	Indicators	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD Average
1	I am better able to deal with crisis.	69%	82%	53%	70%	**69%**
2	My symptoms are not bothering me as much.	79%	77%	64%	65%	**71%**
3	The medications I am taking help me control symptoms that used to bother me.	75%	70%	42%	65%	**63%**
4	I do better in social situations.	71%	64%	56%	70%	**65%**
5	I deal more effectively with daily problems.	73%	83%	64%	64%	**71%**
6	I was treated with dignity and respect.	71%	65%	56%	65%	**64%**
7	Staff here believed that I could grow, change and recover.	69%	62%	56%	70%	**64%**
8	I felt comfortable asking questions about my treatment and medications.	68%	68%	72%	70%	**70%**
9	I was encouraged to use self-help/support groups.	72%	75%	58%	70%	**69%**
10	I was given information about how to manage my medication side effects.	68%	53%	64%	70%	**64%**
11	My other medical conditions were treated.	65%	69%	64%	55%	**63%**
12	I felt this hospital stay was necessary.	65%	48%	58%	40%	**53%**

STRATEGIC PERFORMANCE EXCELLENCE

#	Indicators	1Q 2016	2Q 2016	3Q 2016	4Q 2016	YTD Average
13	I felt free to complain without fear of retaliation.	69%	60%	44%	70%	**61%**
14	I felt safe to refuse medication or treatment during my hospital stay.	62%	46%	47%	60%	**54%**
15	My complaints and grievances were addressed.	63%	55%	47%	88%	**63%**
16	I participated in planning my discharge.	75%	43%	72%	88%	**69%**
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	63%	30%	53%	75%	**55%**
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	63%	32%	56%	60%	**53%**
19	The surroundings and atmosphere at the hospital helped me get better.	68%	63%	50%	65%	**62%**
20	I felt I had enough privacy in the hospital.	64%	61%	58%	60%	**61%**
21	I felt safe while I was in the hospital.	62%	62%	61%	65%	**63%**
22	The hospital environment was clean and comfortable.	66%	63%	56%	65%	**63%**
23	Staff were sensitive to my cultural background.	61%	52%	44%	69%	**56%**
24	My family and/or friends were able to visit me.	69%	64%	58%	75%	**67%**
25	I had a choice of treatment options.	64%	56%	44%	75%	**60%**
26	My contact with my doctor was helpful.	66%	58%	58%	70%	**63%**
27	My contact with nurses and therapists was helpful.	66%	64%	67%	75%	**68%**
28	If I had a choice of hospitals, I would still choose this one.	55%	45%	53%	45%	**50%**
29	Did anyone tell you about your rights?	71%	51%	50%	88%	**65%**
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	63%	54%	44%	69%	**57%**
31	Do you know someone who can help you get what you want or stand up for your rights?	74%	77%	50%	81%	**71%**
32	My pain was managed.	62%	75%	50%	**69%**	**64%**
	Overall Score	**67%**	**63%**	**55%**	**68%**	**63%**

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Responsible Party: Michael Migliore, Director of Pharmacy

I. **Measure Name: Controlled Substance Loss Data**

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

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2015**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Pharmacy	0.19%	0%	0%	0%	0%	0%
Actual			0%	0%	0%	0%	0%

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

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

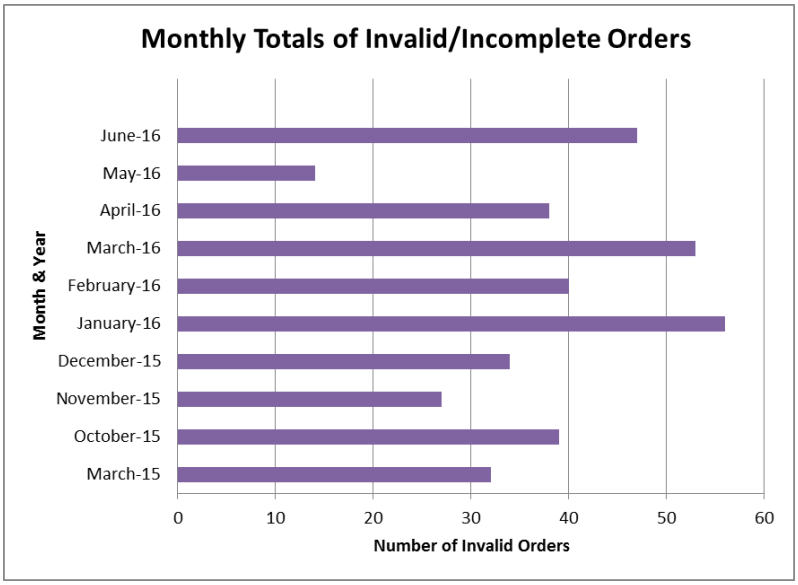
Comments: The action plan is providing the desired results.

STRATEGIC PERFORMANCE EXCELLENCE

II. **Measure Name: Invalid Orders**

Measure Description: Incomplete/Invalid Orders.

Type of Measure: Performance Improvement



*Data not available for April-September 2015

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

Data Analysis: For the 4Q2016 the number of invalid orders has decreased from last quarter partly due to staffing issues in the month of May and June. June reported 42 invalid/incomplete orders with 14 in May and 38 in April. Again, missing indications recorded high on the list. Although the numbers are lower this quarter, the Pharmacy Department continues to bring heightened awareness to this ongoing issue to all persons involved.

Action Plan: The Pharmacy Department is looking forward to the implementation of the CoCentrix CPOE (computerized physician order entry) system later this year. CPOE will eliminate incomplete orders by not permitting providers to initiate an order that is not complete. Once the conversion has occurred, the need to track incomplete will become obsolete.

STRATEGIC PERFORMANCE EXCELLENCE

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

Measure Description: Comprehensive Unit Compliance Audits

Type of Measure: Quality Assurance

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

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

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

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

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

STRATEGIC PERFORMANCE EXCELLENCE

IV. **Measure Name: Fiscal Accountability**

Measure Description: Monthly Tracking of Dispensed Discharge Prescriptions

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2015**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Actual	All	$15,764 for 861 Rx's	$5,281 for 368 Rx's	$3,720 for 312 Rx's	$7,679 for 461 Rx's	$5,237 for 304 Rx's	**$21,917 for 1445 Rx's**

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

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

	Baseline 2015	**1Q206**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**	**Change from 2015**	**Average FY2016**
$ spent	$15,764	$5,281	$3,720	$7,679	$5,237	$21,917	$6,153	$5,479
# RX's	861	368	312	461	304	1445	584	361
$ per Rx	$18.31	$14.35	$11.92	$16.66	$17.23	$15.17	($3.14)	$15.04

Comments: The fourth quarter reported lower overall prescription costs than the 3rd quarter and also reported a lower than average number of Rx's. The cost of a 4th quarter prescription was $17.23, a slight increase from the previous quarter. Comparing YTD vs. Baseline 2015, there was an increase of $6152.60 for 584 additional orders filled compared to the previous year. Although the figures are higher, the cost of an Rx has decreased by $3.14 due to the vigilant selection of medications and purchasing in accordance with the hospital's buying group. The Pharmacy Department is currently at 95% compliance for contract purchasing and is striving to improve that number. Overall, discharge prescriptions have increased in total numbers from the prior year as well as cost from the prior year. The Pharmacy Department is pleased to report an overall decrease in the average cost of each prescription compared to 2015 as represented in the YTD figures.

STRATEGIC PERFORMANCE EXCELLENCE

Psychology

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

I. Measure Name: Outpatient Readiness Scale (ORS)

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

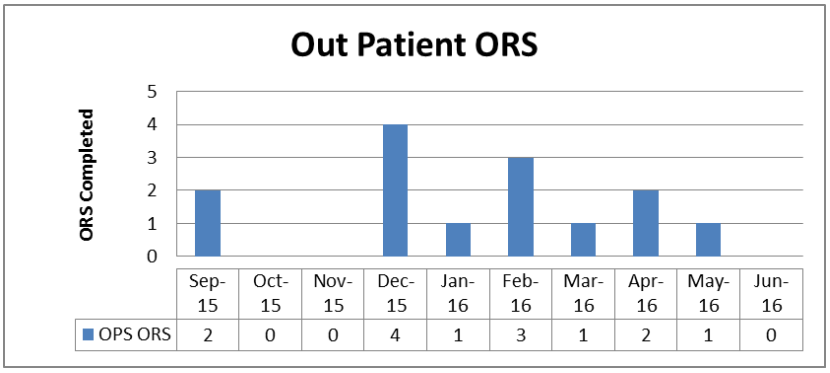
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of OPS recipients evaluated with ORS	2Q2016 New initiative 2%	75%	75%	75%	75%	**75%**
Actual			4% 2/47	9% 4/47	11% 5/47	6% 3/49	**29% 14/49**

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

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

Comments: While outcomes did not reach projected hopes, we will continue to assess patients on a more frequent basis as staff become more familiar with the assessment instrument. Our goal is double the number evaluated by the middle of next fiscal year.



STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Treatment Plan Improvement Initiative

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

Type of Measure: Performance improvement

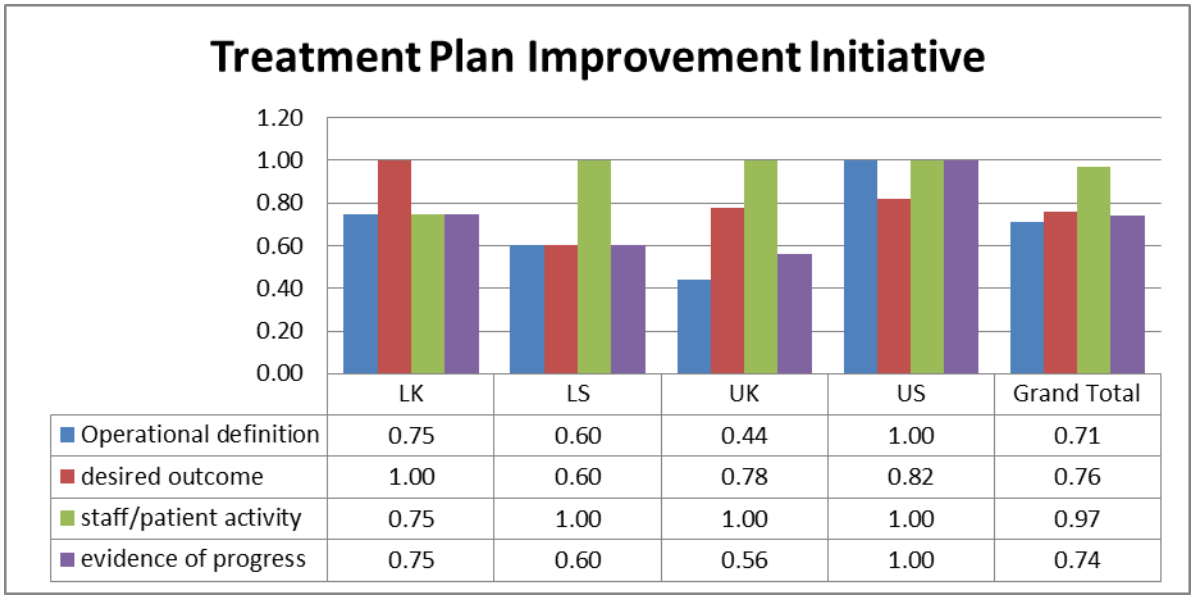
Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of treatment plans which meet new standard	3Q2016 New Initiative 2%	75%	75%	75%	75%	**75%**
Actual				20% 2/10	25% 3/12	79% 108/136	**72% 113/158**

Data Analysis: This initiative focused on the clarity of psychological treatment goals developed by departmental staff that would meet the desired level of thoroughness and conformity with desired standards. Baseline was measured from September 2015 to February 2016. The start of this initiative was February 15, 2016. At the close of the 4 quarter, 34 patients were identified as recipients of individualized psychological interventions. All of their treatment plans were evaluated for evidence of alignment with desired treatment plan qualities.

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

Comments: Each treatment plan was rated for the presence of defined characteristics: operational definition, desired outcome, staff/patient activity toward goal, and evidence of progress. The results are presented in the following graph, which allows for separate unit assessment as well.

STRATEGIC PERFORMANCE EXCELLENCE



	LK	LS	UK	US	Grand Total
Operational definition	0.75	0.60	0.44	1.00	0.71
desired outcome	1.00	0.60	0.78	0.82	0.76
staff/patient activity	0.75	1.00	1.00	1.00	0.97
evidence of progress	0.75	0.60	0.56	1.00	0.74

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

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

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

I. Measure Name: Occupational Therapy Service Orders

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

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

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

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

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient receiving OT services has an MD order	FY 2015 97%	100%	100%	100%	100%	**100%**
Actual			100% 25/25	100% 29/29	100% 25/25	100% 36/36	**100% 115/115**

Data Analysis: In review of Occupational Therapy Services Log all patients referred for services from April 1, 2015, to March 31, 2016, had both the referral sheet completed as well at the doctor's order attached to it.

Action Plan: Review the results of the audit with Occupational Therapy staff. This measure will be discontinued starting FY2017.

STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Vocational Services Documentation

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

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

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

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

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient working in the Voc. Rehab. Program has the required documentation	60%	100%	100%	100%	100%	**100%**
Actual			50% 6/12	91% 29/32	97% 29/30	90% 27/30	**886%** **91/104**

Data Analysis: Charts were audited using the Rehab. Services –Vocational Services tool. There were only 3 charts in which a weekly note was not done on time.

Action Plan: This will become a Quality Assurance measure beginning July 2016.

STRATEGIC PERFORMANCE EXCELLENCE

Safety & Security

Responsible Party: Philip Tricarico, Safety Officer

I. Measure Name: Grounds Safety & Security Incidents

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

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**Total**
Target	# of Incidents	*Baseline of 10	2	4	2	2	**10**
Actual			4	2	1	1	**8**

4Q2016: The 4Q2016 Target was (2). Our actual number was (1). We exceeded our goal! We have not had any issues this quarter with state owned pickup trucks and the contraband they frequently contained. We have been working with Capitol Police, Fleet Management and the Department of Conservation (agency the trucks are assigned to). There has been significant improvement in how often we are finding contraband items in these trucks. We will continue to work with all parties as we seek to resolve this issue. Although we had no issues this quarter a new system was implemented, by maintenance, for checking cars in and out. We will monitor and remain vigilant as we all get used to the new system. We are pleased that in all of the events, our Security staff or clinical staff had discovered/processed the event before there was a negative impact to the patients. The reporting, which follows below, continues to provide a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our aggressive rounds by Securitas continue to prove its worth with regard to Security's presence and patrol techniques. The stability and longevity of our Security staff

along with its cohesiveness with the Clinical component of the hospital has proven to be most effective in our management of practices.

Safety & Security Incidents:

Event	Date	Time	Location	Disposition	Comments
1. Safety Concern (Trash dumpster lock and chain broken)	4/12/16	0541	Parking Lot in rear of building	Maintenance immediately repaired the chain and lock.	While doing rounds, security found the dumpster unlocked. The potential for patients to get into the dumpster was very high. This would expose them to numerous items of contraband and would be a huge safety and security issue. NOD notified.

Quarterly Report 60a for Members on MaineCare Waitlist for CI

Report Dates: 01/01/2016 To 03/31/2016 **Report Run Date: 7/14/2016**

Report Source: Authorization data from KEPRO 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 KEPRO CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in KEPRO 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** - KEPRO completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare funds.

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

Number of people who were authorized for CI from the MaineCare wait list during the quarter 474

For those who received the service:

Average number of days waiting: 13 days

Percent waiting 30 days or less: 87.6%

Percent waiting 90 days or less: 99.8%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
AMHI Class N	444	439	5	385	58	1	13
AMHI Class Y	30	30	0	30	0	0	7
Totals	**474**	**469**	**5**	**415**	**58**	**1**	**13**

District	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
District 1	39	39	0	28	11	0	20
District 2	110	109	1	84	26	0	18
District 3	93	92	1	87	5	1	9
District 4	35	35	0	29	6	0	13
District 5	129	126	3	121	8	0	10
District 6	47	47	0	46	1	0	5
District 7	13	13	0	12	1	0	14
District 8	6	6	0	6	0	0	16
Unknown	2	2	0	2	0	0	16
Totals	**474**	**469**	**5**	**415**	**58**	**1**	**13**

Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
Alternative Wellness Services	1	1	0	1	0	0	6
Assistance Plus	40	40	0	40	0	0	4
Catholic Charities Maine	90	88	2	82	8	0	14
Charlotte White Center	9	9	0	9	0	0	6
Common Ties	73	72	1	72	1	0	7
Community Care	29	29	0	29	0	0	3
Community Counseling Center	1	1	0	1	0	0	8
Community Health & Counseling Services	14	14	0	12	2	0	20
Facing Change	1	1	0	1	0	0	0
Higher Ground Services	1	1	0	1	0	0	4
Kennebec Behavioral Health	78	76	2	70	8	0	11
Life by Design	4	4	0	4	0	0	14
MAS Home Care of Maine	1	1	0	1	0	0	15
Medical Care Development	1	1	0	0	1	0	53
Mid Coast Mental Health	14	14	0	10	4	0	17
OHI	1	1	0	1	0	0	11
Providence	3	3	0	1	2	0	23
Smart Child & Family Services	5	5	0	1	3	1	64
Sweetser	57	57	0	48	9	0	14
The Opportunity Alliance	46	46	0	28	18	0	22
Tri-County Mental Health	5	5	0	3	2	0	23
Totals	**474**	**469**	**5**	**415**	**58**	**1**	**13**

KEPRO INTELLIGENT VALUE

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: 01/01/2016 To 03/31/2016 **Report Run Date: 7/14/2016**

Report Source: Authorization data from KEPRO 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 KEPRO CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in KEPRO 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** - KEPRO completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare funds.

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

Number of people who were authorized for CI from the state-funded wait list during the quarter: 298

For those who received the service:

Average number of days waiting: 15 days

Percent waiting 30 days or less: 81.5%

Percent waiting 90 days or less: 97.3%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
AMHI Class N	288	21	267	233	47	8	15
AMHI Class Y	10	1	9	10	0	0	3
Totals	**298**	**22**	**276**	**243**	**47**	**8**	**15**

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	37	4	33	25	12	0	23
District 2	61	2	59	42	18	1	21
District 3	59	4	55	54	5	0	9
District 4	42	2	40	36	5	1	13
District 5	53	8	45	49	4	0	9
District 6	29	1	28	21	2	6	27
District 7	9	0	9	9	0	0	0
District 8	1	1	0	1	0	0	0
Unknown	7	0	7	6	1	0	10
Totals	**298**	**22**	**276**	**243**	**47**	**8**	**15**

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
Ascentria Care Alliance	1	1	0	0	1	0	64
Assistance Plus	23	3	20	21	2	0	5
Catholic Charities Maine	32	2	30	32	0	0	9
Charlotte White Center	4	0	4	4	0	0	2
Common Ties	44	2	42	44	0	0	6
Community Care	31	0	31	24	1	6	23
Community Counseling Center	9	0	9	3	6	0	38
Counseling Services Inc.	26	1	25	17	9	0	23
Kennebec Behavioral Health	27	5	22	25	2	0	11
Life by Design	1	1	0	1	0	0	0
Mid Coast Mental Health	29	2	27	29	0	0	3
OHI	1	1	0	0	1	0	30
Smart Child & Family Services	1	0	1	1	0	0	17
Sweetser	33	2	31	25	8	0	18
The Opportunity Alliance	23	1	22	9	13	1	32
Tri-County Mental Health	13	1	12	8	4	1	22
Totals	**298**	**22**	**276**	**243**	**47**	**8**	**15**

Report 67

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

Report Dates: 01/01/2016 To 03/31/2016 **Run Date: 07/14/2016**

Report Source: Authorization data from KEPRO CareConnection®

Definitions:

- **Non-hospitalized member -** MaineCare member who is not in an inpatient psychiatric facility at the time of application for services. This is indicated by the member not having an open authorization for inpatient psychiatric services on the day a CFSN is completed or on the day the member is referred for CI services.
- **Community support services:** Community support services is a group of mental health services providing support in the community to persons with serious mental illness. It includes CI, CRS, ACT and Adult Behavioral Health Homes
- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Adult Assertive Community Treatment (ACT)** provides individualized intensive integrated community-based services that are delivered by a multi-disciplinary team of practitioners who are available twenty-four(24) hours a day.
- **Behavioral Health Home (BHH)** is a service designed to integrate the systems of care of behavioral health and physical health.
- **Community Rehabilitation Services (CRS)** are delivered by a team, with primary case management for each member assigned to one team member.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in KEPRO CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in KEPRO 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 -** KEPRO completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.

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

Total number of non-hospitalized members admitted to any community support service: 3,519

Total assigned within 3 working days: 2,352	% assigned within 3 working days: 67%
Total assigned in 4 - 7 working days: 345	% assigned in 4 -7 working days: 10%
Total assigned within 7 working days: 2,697	% assigned within 7 working days: 77%
Total assigned after 8 or more working days: 822	% assigned after 8 or more working days: 23%

Service	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
H0040 - Adult Assertive Community Treatment - ACT	15	7	19	41
H2015 - Community Integration (CI)	1,295	219	384	1,898
H2018 - Community Rehabilitation Services (CRS)	9	2	6	17
T2022HB - Behavioral Health Homes - Adult	1,033	117	413	1,563
Total	**2,352**	**345**	**822**	**3,519**

Gender	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Female	1,503	214	520	2,237
Male	849	131	302	1,282
Total	**2,352**	**345**	**822**	**3,519**

Adult Age Groups	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
18-20	115	17	34	166
21-24	140	25	60	225
25-64	1,978	276	674	2,928
65-74	98	25	45	168
Over 75 Years Old	21	2	9	32
Total	**2,352**	**345**	**822**	**3,519**

AMHI Class	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	2,191	323	780	3,294
AMHI Class Y	161	22	42	225
Total	**2,352**	**345**	**822**	**3,519**

District	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	176	41	130	347
District 2/ Cumberland County	376	58	190	624
District 3/ Androscoggin, Franklin, and Oxford Counties	494	119	218	831
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	266	36	66	368
District 5/ Somerset and Kennebec Counties	506	54	118	678
District 6/ Piscataquis and Penobscot Counties	393	25	50	468
District 7/ Washington and Hancock Counties	58	3	21	82
District 8/ Aroostook County	56	8	19	83
Unknown	27	1	10	38
Total	**2,352**	**345**	**822**	**3,519**

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	63	8	10	81
Allies	18	0	0	18
Alternative Services	15	0	0	15
Alternative Wellness Services	22	5	22	49
AngleZ Behavioral Health Services-17 ACM	29	5	1	35
Aroostook Mental Health Services	25	1	3	29
Ascentria Care Alliance	20	0	4	24
Assistance Plus	164	12	44	220
Break of Day, Inc	14	6	0	20
Bright Future Healthier You	16	1	0	17
Broadreach Family & Community Services	23	0	1	24
Catholic Charities Maine	27	23	67	117
Central Maine Family Counseling	21	3	1	25
Charlotte White Center	5	3	4	12
Choices	6	0	0	6
Common Ties	27	24	19	70
Community Care	28	3	3	34
Community Counseling Center	70	5	34	109
Community Health & Counseling Services	72	10	26	108
Cornerstone Behavioral Healthcare	17	0	1	18
Counseling Services Inc.	100	12	82	194
Direct Community Care	13	0	2	15
Dirigo Counseling Clinic	37	0	3	40
Employment Specialist of Maine	0	0	5	5
Evergreen Behavioral Services	32	3	2	37
Facing Change	44	1	3	48
Fellowship Health Resources	4	0	0	4
Fullcircle Supports Inc	23	4	3	30
Gateway Community Services LLC	30	4	8	42
Goodwill Industries of Northern New England	1	0	0	1
Graham Behavioral Services	17	5	2	24
Healing Hearts LLC	5	1	3	9
Health Affiliates Maine	125	0	0	125
HealthReach network	2	0	1	3
Healthy Healing Counseling Inc	19	2	1	22
Higher Ground Services	25	1	0	26
Kennebec Behavioral Health	106	21	51	178
Learning Works	9	1	12	22
Life by Design	23	5	10	38
Maine Behavioral Health Organization	103	1	6	110
Maine Immigrant and Refugee Services	7	7	4	18
Maine Vocational & Rehabilitation Assoc.	10	2	5	17
Manna Inc	4	1	0	5
MAS Home Care of Maine	51	5	8	64
Medical Care Development	0	0	1	1
Merrymeeting	3	3	8	14
Mid Coast Mental Health	98	2	20	120
Motivational Services	13	7	1	21
Northeast Occupational Exchange	105	3	17	125

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Northern Lighthouse	4	0	0	4
Northern Maine General	0	1	2	3
Ocean Way Mental Health Agency	10	0	0	10
OHI	11	0	0	11
Oxford County Mental Health Services	26	5	6	37
Paramount Behavioral Services,Inc	20	1	3	24
Partnerships for Nonprofits, dba Reach	5	0	0	5
Penobscot Community Health Center	27	0	0	27
Pine Tree Community Services	67	2	2	71
Protea Integrated Health & Wellness	26	0	0	26
Providence	8	1	9	18
Riverview	2	1	0	3
Rumford Group Homes	13	1	0	14
Sequel Care of Maine	8	1	5	14
Shalom House	10	0	3	13
Smart Child & Family Services	1	0	4	5
Spurwink	1	1	0	2
St. Andre Homes	2	0	0	2
Sunrise Opportunities	7	0	0	7
Sweetser	89	54	58	201
Sweetser 26 - BHH Adult	27	0	0	27
The Opportunity Alliance	71	14	37	122
Tri-County Mental Health	216	61	194	471
Volunteers of America	0	2	1	3
York County Shelter Program	10	0	0	10
Total	**2,352**	**345**	**822**	**3,519**

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

Report 69

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

Report Dates: 01/01/2016 To 03/31/2016 **Run Date: 07/14/2016**

Report Source: Authorization data from KEPRO 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.
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- **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 -** KEPRO completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.

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

Total number of non-hospitalized members admitted to any community support service: 92

Total assigned within 2 working days: 59	% assigned within 2 working days: 64%
Total assigned in 3 - 7 working days: 15	% assigned in 3 -7 working days:16 %
Total assigned within 7 working days: 74	% assigned within 7 working days: 80%
Total assigned after 8 or more working days: 18	% assigned after 8 or more working days: 20%

Service	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
H0040 - Adult Assertive Community Treatment - ACT	11	4	5	20
H2015 - Community Integration (CI)	27	8	7	42
H2018 - Community Rehabilitation Services (CRS)	2	1	1	4
T2022HB - Behavioral Health Homes - Adult	19	2	5	26
Total	**59**	**15**	**18**	**92**

Gender	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Female	30	6	6	42
Male	29	9	12	50
Total	**59**	**15**	**18**	**92**

AMHI Class	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	38	10	14	62
AMHI Class Y	21	5	4	30
Total	**59**	**15**	**18**	**92**

District	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	4	0	6	10
District 2/ Cumberland County	7	5	4	16
District 3/ Androscoggin, Franklin, and Oxford Counties	4	4	3	11
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	7	1	0	8
District 5/ Somerset and Kennebec Counties	13	1	3	17
District 6/ Piscataquis and Penobscot Counties	18	3	0	21
District 7/ Washington and Hancock Counties	2	0	0	2
District 8/ Aroostook County	3	0	2	5
Unknown	1	1	0	2
Total	**59**	**15**	**18**	**92**

Providers	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	11	1	1	13
AngleZ Behavioral Health Services-17 ACM	1	0	0	1
Aroostook Mental Health Services	1	0	0	1
Assistance Plus	3	0	0	3
Catholic Charities Maine	3	0	3	6
Common Ties	1	0	2	3
Community Counseling Center	0	1	2	3
Community Health & Counseling Services	6	1	0	7
Counseling Services Inc.	3	0	3	6
Dirigo Counseling Clinic	1	0	0	1
Fullcircle Supports Inc	1	0	0	1
Health Affiliates Maine	2	1	0	3
HealthReach network	3	0	0	3
Kennebec Behavioral Health	3	1	1	5
Life by Design	2	0	1	3
Maine Vocational & Rehabilitation Assoc.	0	1	0	1
MAS Home Care of Maine	1	0	0	1
Mid Coast Mental Health	6	0	0	6
Motivational Services	2	0	1	3
Northeast Occupational Exchange	1	0	0	1
Northern Maine General	1	0	0	1
Oxford County Mental Health Services	0	1	0	1
Sequel Care of Maine	0	1	0	1
Shalom House	3	0	0	3
Sweetser	1	4	0	5
Tri-County Mental Health	3	2	2	7
Volunteers of America	0	1	2	3
Total	**59**	**15**	**18**	**92**