Department of Health and Human Service
Office of Adult Mental Health Services
Second Quarter State Fiscal Year 2011 (October, November, December 2011)
Report on Compliance Plan Standards: Community
February 1, 2011

	Compliance Standard	Report/Update
I.1	Implementation of all the system development steps in October 2006 Plan	As of March 2010, all 119 original components of the system development portion of the Consent Decree Plan of October 2006 have been accomplished or deleted per amendment.
I.2	Certify that a system is in place for identifying unmet needs	See attached *Cover: Unmet Needs January 2011* and *Unmet Needs by CSN for FY'11 Q1 (July, August, September 2010)*
I.3	Certify that a system is in place for Community Service Networks (CSNs) and related mechanisms to improve continuity of care	The Department's certification of August 19, 2009 was approved on October 7, 2009.
I.4	Certify that a system is in place for Consumer councils	The Department's certification of December 2, 2009 was approved on December 22, 2009.
I.5	Certify that a system is in place for new vocational services	All vocational components of the October 2006 Plan were completed in March 2010 and the Department will be seeking certification.
I.6	Certify that a system is in place for realignment of housing and support services	All components of the Consent Decree Plan of October 2006 related to the Realignment of Housing and Support Services were completed as of July 2009. Certification was submitted March 10, 2010. The Certification Request was withdrawn May 14, 2010.
I.7	Certify that a system is in place for a Quality Management system that includes specific components as listed on pages 5 and 6 of the plan	Department of Health and Human Services Office of Adult Mental Health Services Quality Management Plan/Community Based Services (April 2008) has been implemented: a copy of plan was submitted with the May 1, 2008 Quarterly Report.
II.1	Provide documentation that unmet needs data and information (data source list page 4 of compliance plan) is used in planning for resource development and preparing budget requests	Unmet needs reports are posted on the OAMHS CSN website on a quarterly basis in order to inform discussions and recommendations to the Department for meeting unmet needs. Budget submissions to the Governor and the Legislature are in part built on data regarding unmet needs. This is reflected in the financial documents submitted to DAFS.
II.2	Demonstrate reliability of unmet needs data based on evaluation	

II.3	Submission of budget proposals for adult mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs *(Amended language 9/29/09)*	Information regarding curtailments enacted 10/1/10 was shared with the Court Master. The supplemental budget for FY2011 contains no additional requests from OAMHS. The DHHS submission of the budget for FY2012/2013 includes the requested funding suggested by the Court Master, a total of an additional $4.6 million for services and $1 million for BRAP. This has been discussed with the Court Master.
II.4	Submission of the written presentation given to the legislative committees with jurisdiction over DHHS … which must include the budget requests that were made by the Department to satisfy its obligations under the Consent Decree Plan and that were not included in the Governor's proposed budget, an explanation of support and importance of the requests and expression of support … *(Amended language 9/29/09)*	DHHS has not yet been called upon by the legislature regarding the FY 2012/2013 budget.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	*CD Expenditures Report for FY09* emailed to Court Master and Plaintiff's Counsel on 2/25/10 and attached to the May 1, 2010 Quarterly Report.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs by CSN January 2011* for examples of the Department Utilizing the QM system.
III.1a	Document through quarterly or annual reports the data collected and activities to assure reliability (including ability of EIS to produce accurate data)	This quarterly report documents significant data collection and review activities of the OAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Based on contract reviews done in the 3rd and 4th quarters of FY'10, 100% of the agencies reviewed in Regions 1, 2 and 3 have protocols/procedures in place for client notification of rights, with documentation in provider files maintained within the regional offices. Based in licensing surveys, 100% of licensed mental health agencies have protocols/policies in place for client notification of the *Rights of Recipients.*
IV.2	If results fall below levels established for Performance and Quality Improvement Standard #4 – 1, 1a, 1b and 2 certain steps are taken • 1 = 90% informed about rights in a way they could understand • 1a = 95% with CIW report informed	Measurement for this standard relies on information gathered in the Class Member Survey. No Class Member Survey has been administered in 2010. In February 2010, the Department submitted a consent decree plan amendment request to the Court Master seeking to allow the use of the DIG survey instead of both the DIG Survey and the class member survey to

	about their rights • 1b = 90% with MaineCare report informed about their rights 2 = 90% of consumers report they were given information about their rights	measure performance of the state mental health system and compliance with the Consent Decree Plan. That amendment request, which would delete 4.1, 4.1a and 4.1b, was approved January 19, 2011. This compliance standard will reflect the approved changes in the next quarterly report, May 1, 2011. The percentage for standard 4.2 from the 2010 DIG Survey was 88.6%, slightly below the standard of 90%. While the data for the *Adult 2010 Mental Health & Well-being Survey* is available, the report currently in draft form for internal review and will be attached to the 5/1/11 Quarterly Report.
IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension	Standard met Calendar Years 2006, 2007, 2008 and 2009, and the 1st and 3rd quarters of calendar year (CY) 2010. In the 4th quarter CY 2010, there were 2 level II grievances and one was not responded to within the prescribed time frame. Data not available for the 2nd quarter CY10. See attached *Performance and Quality Improvement Standards: January 2011*, Standard 2
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if hearing is to be held or if parties concur.	Reporting began in the 1st quarter of calendar year 2008. The standard has been met, when there was a level III grievance, at 100% through the 4th quarter of calendar year (CY) 2010, though data was not available for the 2nd quarter CY10.
IV.5	90% hospitalized class members assigned worker within 2 days of request - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: January 2011*, Standard 5-2.
IV.6	90% non-hospitalized class members assigned worker within 3 days of request - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: January 2011*, Standard 5-3.
IV.7	95% of class members in hospital or community not assigned within 2 or 3 days, assigned within an additional 7 days - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: January 2011*, Standard 5-4.
IV.8	90% of class members enrolled in CSS with initial ISP completed within 30 days of enrollment - *must be met for 3 out of 4 quarters*	The standard was met for the 3rd and 4th quarters FY'08, all 4 quarters of FY'09 and FY'10, and the 1st quarter of FY'11. See attached *Performance and Quality Improvement Standards: January 2011*, Standard 5-5
IV.9	90% of class members had their 90 day ISP review(s) completed within that time period - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: January 2011*, Standard 5-6.

IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring and reporting of overdue ISPs to provider agencies continues on a quarterly basis.
IV.11	Data collected once a year shows that no > 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	Once-a-year report (completed January 2011) showed that 1.8% of class members enrolled in CS did not have their ISP reviewed before the next annual review. Those not completed appear to be data errors between APS Healthcare and EIS.
IV.12	Certify in quarterly reports that DHHS is meeting its obligation re: quarterly mailings	On May 14, 2010, the court approved a Stipulated Order that requires mailings to be done only semi-annually in 2010, moving to annually in 2011 and thereafter, as long as the number of unverified addresses remains at or below 15%. The most recent class member mailing occurred in December 2010. The current percentage of unverified addresses remains below 15% at 10.8%.
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - *must be met for 3 out of 4 quarters*	Standard met for all quarters of FY'10 and the 1st and 2nd quarters of FY'11. See attached *Class Member Treatment Planning Review*, Question 2A
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be met for 3 out of 4 quarters*	Standard has been met continuously since the first quarter of FY'08. See attached *Performance and Quality Improvement Standards: January 2011*, Standard 7-1a and *Class Member Treatment Planning Review,* Question 2B
IV.15	90% of ISPs reviewed have a crisis plan or documentation as to why one wasn't developed - *must be met for 3 out of 4 quarters*	Standard met for all quarters of FY'09 and FY'10, and the 1st and 2nd quarters of FY'11. See attached *Performance and Quality Improvement Standards: January 2011*, Standard 7-1c (does the consumer have a crisis plan) and *Class Member Treatment Planning Review*, Question 2F
IV.16	QM system documents that OAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	See attached *Class Member Treatment Planning Review*, Question 6.a.1 that addresses plans of correction.
IV.17	In 90% of ISPs reviewed, interim plans developed when resource needs not available within expected response times - *must be met for 3 out of 4 quarters*	Standard met for the 4th quarter, FY'10. See attached *Performance and Quality Improvement Standards: January 2011*, Standard 8-2 and *Class Member Treatment Plan Review,* Question 3F.
IV.18	90% of ISPs review included service agreement/treatment plan - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: January 2011*, Standard 9-1 and *Class Member Treatment Plan Review,* Questions 4B & C.

IV.19	90% of ACT/ICI/CI providers statewide meet prescribed case load ratios - *must be met for 3 out of 4 quarters* Note: As of 7/1/08, ICI is no longer a service provided by DHHS.	Community Integration -- standard met since the 2nd quarter FY'08. ACT – standard met for the 2nd, 3rd and 4th quarters FY'10 and the 1st and 2nd quarters FY'11. See attached *Performance and Quality Improvement Standards: January 2011*, Standard 10.1 and 10-2
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - *must be met for 3 out of 4 quarters*	ICMs -- standard met since the 2nd quarter FY'08. See attached *Performance and Quality Improvement Standards: January 2011*, Standard 10-4
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads (pg 10) *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: January 2011*, Standard 10-5
IV.21	Independent review of the ISP process finds that ISPs met a reasonable level of compliance as defined in Attachment B of the Compliance Plan	
IV.22	5% or fewer class members have ISP-identified unmet residential support - *must be met for 3 out of 4 quarters* **and**	Standard met for the 4th quarter FY'08; the 1st, 3rd and 4th quarters of FY'09; all quarters of FY'10; and the 1st quarter of FY'11. See attached *Performance and Quality Improvement Standards: January 2011*, Standard 12-1
IV.23	**EITHER** quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status **and**	Results reported in August 1, 2010 Quarterly Report. Next report will be in the August 1, 2011 report (FY'10 Q4 and FY'11 Qs 1, 2 and 3)
IV.24	Meet RPC discharge standards (below); **or** if not met document reasons and demonstrate that failure not due to lack of residential support services • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	Standard met for 4 quarters of FY'08, FY'09 and FY'10; and 1st and 2nd quarters FY'11 See attached *Performance and Quality Improvement Standards: January 2011*, Standards 12-2, 12-3 and 12-4
IV.25	10% or fewer class members have ISP-identified unmet needs for housing resources - *must be met for 3 out of 4 quarters* **and**	Standard met for quarters 3 and 4 FY'09 and 1st, 2nd and 3rd quarters of FY'10. Percentage for the 4th quarter FY'10 was 10.8% and for the 1st quarter FY'11, 10.5%. See attached *Performance and Quality Improvement*

		Standards: January 2011, Standard 14-1
IV.26	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of housing resources. • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	Standard 14-4 met for all quarters of FY'09; the 1st, 2nd and 4th quarters of FY'10; and the 1st and 2nd quarters of FY'11 Standard 14-5 met for the 2nd, 3rd and 4th quarters FY'09; the 2nd and 4th quarters of FY'10; and the 1st and 2nd quarters of FY'11 Standard 14-6 met for the 2nd and 4th quarters FY'09; the 2nd and 4th quarters FY'10; and the 1st and 2nd quarters of FY'11 See attached *Performance and Quality Improvement Standards: January 2011*, Standard 14-4, 14-5 & 14-6
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Standard met 2007, 2008, 2009 and 2010 (annual review). Results reported in *Performance and Quality Improvement Standards: January 2010 Report*, Standard 15-1
IV.28	90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in attachment C to the Compliance Plan	Standard met for 4 quarters of FY'09 and the 4th quarter of FY'10. In FY'10: 1st quarter 88.2% (15 of 17); 2nd quarter 81.8% (9 of 11); and 3rd quarter 82.4% (14 of 17). In FY'11, 88% (22 of 25) See attached *Performance and Quality Improvement Standards: January 2011*, Standard 16-1 and *Community Hospital Utilization Review – Class Members 1st Quarter of Fiscal Year 2011*.
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	Contracts with community hospitals contain the required compliance language. Sample of contract attached to the May 1, 2008 Quarterly Report.
IV.30	Evaluates compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	Hospital Contract reviews were completed in the 3rd an 4th quarters of FY10. Hospitals reviewed are in compliance with legal requirements for involuntary clients. However, the rate of obtaining ISPs and involving CSWs remains low.
IV.31	UR Nurses review all involuntary admissions funded by DHHS, take corrective action when they identify deficiencies and send notices of any violations to the licensing division and to the hospital	OAMHS reviews emergency involuntary admissions at the following hospitals: MaineGeneral (Augusta and Waterville), Spring Harbor, St. Mary's, Mid-Coast Hospital, Southern Maine Medical Center, PenBay Medical Center, Maine Medical Center/P6 and Acadia. See Standard IV.33 below regarding corrective actions.

IV.32	Licensing reviews of hospitals include an evaluation of compliance with patient rights and require a plan of correction to address any deficiencies.	1st Quarter FY'11: no Rights of Recipients violations
IV.33	• 90% of the time corrective action was taken when blue papers were not completed in accordance with terms • 90% of the time corrective action was taken when 24 hour certifications were not completed in accordance with terms • 90% of the time corrective action was taken when patient rights were not maintained	Standard met for FY'08, FY'09, and FY'10; and 1st quarter FY'11. See attached *Performance and Quality Improvement Standards: January 2011*, Standards 17-2a, 17-3a and 17-4a and *Community Hospital Utilization Review – Class Members 1st Quarter of Fiscal Year 2011*.
IV.34	QM system documents that if hospitals have fallen below the performance standard for any of the following, OAMHS made the information public through CSNs, addressed in contract reviews with hospitals and CSS providers, and took appropriate corrective action to enforce responsibilities • obtaining ISPs (90%) • creating treatment and discharge plan consistent with ISPs (90%) • involving CIWs in treatment and discharge planning (90%)	See attached *Performance and Quality Improvement Standards: January 2011*, Standards 18-1, 18-2 and 18-3 for data by hospital. While rates for obtaining ISPs are low, the participation of CIWs in treatment planning is generally high at 93.8%. For the past 4 quarters, participation was at 100% except for 1 hospital in FY'10 Q3 (85.7% - 6 of 7 patients); 1 hospital in FY'10 Q4 (83.3% - 5 of 6 patients); and 1 hospital FY'11 Q1 (50%, 1 of 2 patients). The report displaying data by hospital for community hospitals accepting emergency involuntary clients is shared quarterly by posting reports on the CSN section of the Office's website. See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members 1st Quarter of Fiscal Year 2011*.
IV.35	No more than 20-25% of face-to-face crisis contacts result in hospitalization – *must be met for 3 out of 4 quarters*	Standard met for the 1st Quarter of FY'11. In FY'10, standard met for the 1st quarter: slightly above at 25.7% for the 3rd quarter and 26% for the 4th quarter. Beginning with the 1st quarter of FY'09, the hospitalization rate has generally run between 1 to 3 percentage points higher than the standard. See attached *Performance and Quality Improvement Standards: January 2011*, Standard 19-1 and *Adult Mental Health Quarterly Crisis Report First Quarter, State Fiscal Year 2011 Summary Report*.
IV.36	90% of crisis phone calls requiring face-to-face assessments are responded to within an average of 30 minutes from the end of the phone call – *must be met for 3 out of 4 quarters*	Starting with July 2008 reporting from providers, OAMHS collects data on the total number of minutes for the response time (calculated from the determination of need for face to face contact or when the individual is ready and able to be seen to when the individual is actually seen) and figures an average.

		Average statewide for the first quarter of FY'11 was 33.3 minutes. See attached *Adult Mental Health Quarterly Crisis Report First Quarter, State Fiscal Year 2011 Summary Report.*
IV.37	90% of all face-to-face assessments result in resolution for the consumer within 8 hours of initiation of the face-to-face assessment – *must be met for 3 out of 4 quarters*	Standard has been met since the 2nd quarter of FY'08. See attached *Adult Mental Health Quarterly Crisis Report First Quarter, State Fiscal Year 2011 Summary Report.*
IV.38	90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – *must be met for 3 out of 4 quarters*	Standard has been met since the 1st quarter of FY'08. See attached *Performance and Quality Improvement Standards: January 2011*, Standard 19-4 and *Adult Mental Health Quarterly Crisis Report First Quarter, State Fiscal Year 2011 Summary Report.*
IV.39	QM system documents further review and appropriate corrective action if results fall below performance and quality improvement standard level #20-1 (90%; class members know how to get help in a crisis when they need it)	Measurement for this standard relies on information gathered in the Class Member Survey. No Class Member Survey has been administered in 2010. In February 2010, the Department submitted a consent decree plan amendment request to the Court Master seeking to allow the use of the DIG survey instead of both the DIG Survey and the class member survey to measure performance of the state mental health system and compliance with the Consent Decree Plan. That amendment request, which would delete this standard, was approved January 19, 2011. This compliance standard will reflect the approved change in the next quarterly report, May 1, 2011.
IV.40	Department has implemented the components of the CD plan related to vocational services	As of quarter 3 FY'10, the Department has implemented all components of the CD Plan related to Vocational Services.
IV.41	QM system documents that OAMHS conducts further review and takes appropriate corrective action if quarterly performance measure data shows that the numbers of class members < 62 years old and employed falls below 13% or the baselines established for Standards 26-2 and 26-3.	Measurement for this standard relies on information gathered in the Class Member Survey. No Class Member Survey has been administered in 2010. In February 2010, the Department submitted a consent decree plan amendment request to the Court Master seeking to allow the use of the DIG survey instead of both the DIG Survey and the class member survey to measure performance of the state mental health system and compliance with the Consent Decree Plan. That amendment request, which would revise this standard, was approved January 19, 2011. This compliance standard will reflect the approved changes in the next quarterly report, May 1, 2011.

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: January 2011*, Standard 21-1
IV.43	**EITHER** quarterly unmet mental health treatment needs for one year for qualified non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Results reported in August 1, 2010 Quarterly Report. Next report will be in the August 1, 2011 report (FY'10 Q4 and FY'11 Qs 1, 2 and 3)
IV.44	QM documentation shows that OAMHS conducts further review, takes appropriate corrective action if results of annual consumer survey fall below the levels identified in Standard # 22-1 (85% - whether class members can get the treatment services/supports needed) **and**	Measurement for this standard relies on information gathered in the Class Member Survey. No Class Member Survey has been administered in 2010. In February 2010, the Department submitted a consent decree plan amendment request to the Court Master seeking to allow the use of the DIG survey instead of both the DIG Survey and the class member survey to measure performance of the state mental health system and compliance with the Consent Decree Plan. That amendment request, which would revise this standard, was approved January 19, 2011. This compliance standard will reflect the approved changes for the next quarterly report, May 1, 2011.
IV.45	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of mental health treatment services in the community • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	Standard met for 4 quarters of FY'08, FY'09, FY'10 and the 1st and 2nd quarters of FY'11. See attached *Performance and Quality Improvement Standards: January 2011*, Standards 21-2, 21-3 and 21-4
IV.46	OAMHS lists in quarterly reports the programs sponsored that are designed to improve quality of life and community inclusion, including support of peer centers, social clubs, community connections training, wellness programs and leadership and advocacy training programs – list must cover prescribed topics and audiences that fit parameters of ¶105.	See attached *Performance and Quality Improvement Standards: January 2011*, Standard 30
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – *must be met for 3 out of 4 quarters*	Standard met for all quarters of FY'08, FY'09 and FY'10; and the 1st and 2nd quarters of FY'11. See attached *Performance and Quality Improvement Standards: January 2011*, Standard 28
IV.48	Provide documentation in quarterly reports of funding, developing, recruiting, and	See attached *Performance and Quality Improvement Standards: January 2011*, Standard 23-1 and 23-2

	supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	
IV.49	Certify that all contracts with providers include a requirement to refer family members to family support services, and produce documentation that contract reviews include evaluation of compliance with this requirement	100% of contracts contain this requirement. Annual contract reviews completed in the 3rd and 4th quarters of FY'10 in all 3 regions addressed this standard with documentation contained in contract files maintained by the regional office. See attached *Performance and Quality Improvement Standards:* Standard 25-1
IV.50	Lists in quarterly reports the number and types of mental health informational workshops, forums and presentations geared to general public that are designed to reduce myths/stigma and foster community integration (cover prescribed list and fit audience parameters)	See attached *Performance and Quality Improvement Standards: January 2011*, Standard 34 and attached *Public Education Report July/September 2010.*