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
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February 1, 2013

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

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

Dear Dan:

Enclosed, pursuant to paragraph 280 of the Settlement Agreement, please find the Substance Abuse and Adult Mental Health Services Quarterly Report for the quarter ending December 31, 2012.

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

Sincerely,

Guy R. Cousins

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

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

Department of Health & Human Services, Office of Adult Mental Health Services
Bates v. DHHS Consent Decree
October, November, December 2012 : 2st Quarter, SFY 2013
CONSENT DECREE REPORT

SUMMARY

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 second quarter of state fiscal year 2013, covering the period from October through December 2012. Each document title is linked to the PDF version of the document on the AMHS website. Links to the Word (or Excel) versions are also listed.

	DOCUMENT	DESCRIPTION
1	**Cover Letter, Quarterly Report** Section 1 & 1A *February 1, 2013* Microsoft Word or Adobe PDF	Letter to Dan Wathen, Court Master, submitting the Quarterly Report pursuant to paragraph 280 of the Settlement Agreement for the quarter ending December 31, 2012
2	**Second Quarter Fiscal Year 2013 Report on Compliance Plan Standards: Community** Section 2 Microsoft Word or Adobe PDF	Lists and updates the information pertaining to standards approved in October 2007 for evaluating and measuring DHHS compliance with the terms and principles of the Settlement Agreement.
3	**Performance and Quality Improvement Standards** *Section 3* Adobe PDF	Details the status of the Department's compliance with 34 specific performance and quality improvement standards (many are multi-part) required by the Consent Decree October 2006 Plan for this reporting quarter. Reporting includes the baseline, current level, performance standard, and compliance standard for each, including graphs.
4	**Public Education – Standard 34.1** *Section 4* Excel Version or Adobe PDF	Amplifies Standard 34.1 of the Performance and Quality Improvement Standards above, detailing the mental health workshops, forums, and presentations made, including levels of participation
5	**Performance Quality and Improvement Standards, Appendix: Adult Mental Health Data Sources** Section 5 Microsoft Word or Adobe PDF	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** Section 6 Microsoft Word or Adobe PDF	Provides a brief introduction to the unmet needs report as well as some definitions of the data, initial findings and next steps. Also includes needs data from other sources such as the APS Healthcare Contact for Service Notification Process.

	DOCUMENT	DESCRIPTION
7	**Unmet Needs by CSN for FY13 Q1** Section 7A Adobe PDF Section 7B Adobe PDF	Quarterly report drawn from the Enterprise Information System (EIS) by CSN (based on client zip code), from resource need data entered by community support case managers (CI, ACT, CRS and ICM) concerning consumers (class members and non-class members) who indicate a need for a resource that is not immediately available. Providers are required to enter the information electronically upon enrollment of a client in Community Support Services and update the information from their clients' Individual Service Plans (ISPs) every 90 days via an RDS (Resource Data Summary) entered as a component of prior authorization and continuing stay requests made to APS Healthcare via their online system, CareConnections.
8	**BRAP Waitlist Monitoring Report,** Section 8 Microsoft Word or Adobe PDF	Describes status of the DHHS Bridging Rental Assistance Program's (BRAP) waitlist, focusing on the numbers served over time by priority status.
9	**Class Member Treatment Planning Review for the 2nd Quarter of Fiscal Year 2013** Section 9 Adobe PDF	Aggregate report of document reviews completed on a random sample of class member ISPs by Consent Decree Coordinators following a standardized protocol.
10	**Community Hospital Utilization Review for the 2nd Quarter of Fiscal Year 2013: Class Members** Section 10A Microsoft Word or Adobe PDF Section 10B Adobe PDF	Aggregate report of Utilization Review (UR) of all persons with MaineCare or without insurance coverage admitted into emergency involuntary, community hospital based beds. UR data is reported one quarter behind to allow sufficient time for reviews and data entry to be completed.
11	**Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members for the 2nd Quarter Fiscal Year 2013** Section 11A Adobe PDF Section 11B Adobe PDF	Report drawn from UR data that details, by hospital, the percentage of ISPs obtained, ISPs consistent with the hospital treatment and discharge plan, and case manager involvement in hospital treatment and discharge planning. UR data is reported one quarter behind to allow sufficient time for reviews and data entry to be completed.
12	**DHHS Integrated Child/Adult Quarterly Crisis Report: 2nd Quarter, Fiscal Year 2013** Section 12 Adobe PDF	Aggregate quarterly report of crisis data submitted by crisis providers to the Office of Quality Improvement on a monthly basis.
13	**Riverview Psychiatric Center**	Reports on Riverview's compliance with specific indicators re:

	DOCUMENT	DESCRIPTION
	Performance Improvement Report Section 13 Microsoft Word or Adobe PDF	performance and quality; recording findings, problem, status, and actions for the specified quarter.
14	**APS Healthcare Reports** **A. Members on MaineCare Waitlist for Community Integration** (Adobe PDF) **B. Members on General Funds Waitlist for Community Integration** (Adobe PDF)	A & B: 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 ago so nearly everyone who was entered on the waitlist will have started the service.
15	**Location Effort Report Quarters 3 and 4 Fiscal Year 2012, Quarter 1 and 2, Fiscal Year 2013 (January 2012 – January 2013)** Section 15 Microsoft Word or Adobe PDF	Yearly report that documents efforts to maintain current, accurate addresses. Address information is entered into and traced through the DHHS EIS) Enterprise Information System – electronic database).

Department of Health and Human Service
Office of Adult Mental Health Services
Second Quarter State Fiscal Year 2013 (October, November, December 2013)
Report on Compliance Plan Standards: Community
February 1, 2013

	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 February 2013* and *Unmet Needs by CSN for FY13 Q1 (September, October, November 2012)*
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.
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 website on a quarterly basis in order to inform discussions and recommendations to the Department for meeting unmet needs. Budget submissions to the Governor and the Legislature are in part built on data regarding unmet needs. This is reflected in the financial documents submitted to DAFS.
II.2	Demonstrate reliability of unmet needs data based on evaluation	See *Cover: Unmet Needs February 2013* and the *Performance and Quality Improvement Standards: FY13 Quarter 2* for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data.

II.3	Submission of budget proposals for adult mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs *(Amended language 9/29/09)*	The Director of SAMHS provides the Court Master with an updated projection of needs and associated costs as part of his ongoing updates regarding Consent Decree Obligations.
II.4	Submission of the written presentation given to the legislative committees with jurisdiction over DHHS … which must include the budget requests that were made by the Department to satisfy its obligations under the Consent Decree Plan and that were not included in the Governor's proposed budget, an explanation of support and importance of the requests and expression of support … *(Amended language 9/29/09)*	See above.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	MaineCare and Grant Expenditure Report for FY11 was completed and submitted as part of the May 2012 report. Anticipate next report in May 2013.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs February 2013* and the *Performance and Quality Improvement Standards: February 2013* 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	See compliance standards II.3 and II.4 above for examples of how quality management data was used to support budget requests for systems improvement.
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Contract and licensing reviews are being conducted December 2012-February 2013. The results of these reviews will be reported in the next report.
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 2012 DIG Survey was 89.9% (up from 88.6%in 2010), slightly below the standard of 90%. This data will be shared with the CCSM as soon as SAMHS receives permission from the DHHS Office of Quality Improvement to release the data.
IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension	Standard met Calendar Years 2006, 2007, 2008 and 2009; the 1st and 3rd quarters of calendar year (CY) 2010 (data not available for the 2nd quarter); and the 2nd, 3rd

		and 4th quarters of CY11 (no Level II grievances reported in the 1st quarter of CY 2011). During the first quarter of FY13, there were 4 Level II grievances filed; 3 were responded to within the 5 day period for a 75% rate. During the second quarter there was 1 Level II grievance filed; it was responded to within the 5 day period (100% compliance).
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if hearing is to be held or if parties concur.	Reporting began in the 1st quarter of calendar year 2008. Standard met, when there was a level III grievance, at 100% through the 3rd quarter of calendar year (CY) 2011 (data not available for the 2nd quarter CY10). Standard not met in the 4th quarter CY11 (1 level 3 grievance). There were no Level III grievances filed in FY13.
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: February 2013*, Standard 5-2. There was a marked improvement from the prior quarter (47.1% to 66.7%) but still below the standard.
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: February 2013*, Standard 5-3. SAMHS has not met this standard for the prior 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: February 2013*, Standard 5-4. SAMHS has not met this standard for the prior 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: February 2013*, Standard 5-5. The standard met since the 3rd quarters of FY08
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: February 2013*, Standard 5-6. SAMHS has not met this standard for the past 4 quarters.
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. As the data has been consistent over time and the feedback and interaction with providers had lessened greatly, reports are now created quarterly and available to providers upon request. Providers were notified of this change on May 18, 2011. Providers are notified when reports are run. Some do

		request copies. Feedback has been minimal.
IV.11	Data collected once a year shows that no > 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	Data being collected in January 2013 and will be reported out next quarter.
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 mailing was sent in early December 2012. Percentage of unverified addresses remains below 15%.
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. SAHMS has met this standard in 3 of the past 4 quarters. The current percentage is 98.2%.
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2013,* Standard 7-1a and *Class Member Treatment Planning Review,* Question 2B Standard has been met continuously since the first quarter of FY08.
IV.15	90% of ISPs reviewed have a crisis plan or documentation as to why one wasn't developed - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2013,* Standard 7-1c (does the consumer have a crisis plan) and *Class Member Treatment Planning Review,* Question 2F Standard met since the beginning of FY09
IV.16	QM system documents that OAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	See Section 9 *Class Member Treatment Planning Review,* Question 6.a.1 that addresses plans of correction.
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: February 2013,* Standard 8-2 and *Class Member Treatment Plan Review,* Question 3F. SAMHS has met this standard in 3 out of the 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: February 2013,* Standard 9-1 and *Class Member Treatment Plan Review,* Questions 4B & C. SAMHS hast not met this standard in 3 of the past 4 quarters.
IV.19	90% of ACT/ICI/CI providers statewide meet prescribed case load ratios - *must be*	See attached *Performance and Quality Improvement Standards: February 2013,* Standard 10.1 and 10-2

	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 FY08. ACT – standard met for the 2nd, 3rd and 4th quarters FY10; the 1st, 2nd and 4th quarters FY11; all 4 quarters of FY12, and Quarters 1 and 2 of FY13.
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - *must be met for 3 out of 4 quarters*	ICMs' work is focused on community forensic and outreach services. Individual ICMs no longer carry caseloads. Should this change in the future, OAMHS will resume reporting on caseload ratios.
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2013*, Standard 10-5. This standard has not been met in the last 4 quarters.
IV.21	Independent review of the ISP process finds that ISPs met a reasonable level of compliance as defined in Attachment B of the Compliance Plan	
IV.22	5% or fewer class members have ISP-identified unmet residential support - *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: February 2013*, Standard 12-1 Standard met for the 4th quarter FY08; the 1st, 3rd and 4th quarters of FY09; all quarters of FY10 and FY11; all 4 quarters of FY12 and quarters 1 and 2 in FY13.
IV.23	**EITHER** quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status **and**	Unmet residential supports do not exceed 15 percentage points of Class Members. Data are normally reported in July. This report was produced in October this year but, in order to ensure data continuity, it uses only data that would have been reported in July. Reporting for this standard will be done again in July 2013. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.24	Meet RPC discharge standards (below); **or** if not met document reasons and demonstrate that failure not due to lack of residential support services • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: February 2013*, Standards 12-2, 12-3 and 12-4 Standard met since the beginning of FY08
IV.25	10% or fewer class members have ISP-identified unmet needs for housing	See attached *Performance and Quality Improvement Standards: February 2013*, Standard 14-1

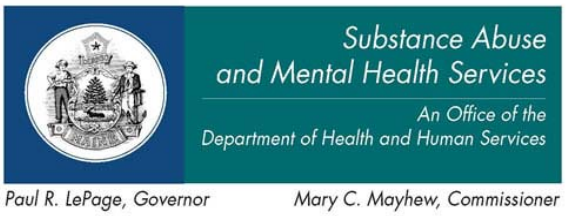
	resources - *must be met for 3 out of 4 quarters* **and**	Standard met for quarters 3 and 4 FY09 and 1st, 2nd and 3rd quarters of FY10. Percentage for the 4th quarter FY10 was 10.8%, just above the standard. Standard met for all quarters FY11, all 4 quarters of FY12 and the first two quarters in FY13
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: February 2013*, Standard 14-4, 14-5 & 14-6 Standard 14-4 met since the beginning of FY09, except for Q3 FY10. Standard 14-5 met for the 2nd, 3rd and 4th quarters FY09; the 2nd and 4th quarters of FY10; all quarters of FY11; and all 4 quarters of FY12; and first 2 quarters of FY13. Standard 14-6 met for the 2nd and 4th quarters FY09; the 2nd and 4th quarters FY10; all of FY11; and 4 quarters of FY12, and first 2 quarters of FY13.
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Results reported in *Performance and Quality Improvement Standards: July 2010 Report*, Standard 15-1 Standard met 2007, 2008, 2009 and 2010 (annual review). OAMHS submitted an amendment request to the court master to modify this requirement on November 23, 2011. The court master approved OAMHS' request to hold the 2011 annual review in abeyance pending a decision on the amendment request.
IV.28	90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in attachment C to the Compliance Plan	See attached *Performance and Quality Improvement Standards: February 2013*, Standard 16-1 and *Community Hospital Utilization Review – Class Members 4th Quarter of Fiscal Year 2012*. In FY10: 1st quarter 88.2% (15 of 17); 2nd quarter 81.8% (9 of 11); 3rd quarter 82.4% (14 of 17); and 4th quarter 90.9% (20 of 22). In FY11: 88% (22 of 25) in the 1st quarter; 75% (9 of 12) in the 2nd quarter; 78.9% (15 of 19) in the 3rd quarter and 80% (12 of 15) in the 4th quarter. In FY12: 76.2% (16 of 21) in the 1st quarter 63.6% (14 of 22) in the 2nd quarter 77.8% (7 of 9) in the 3rd quarter 73.7% (14 of 19) in the 4th quarter

		IN FY13: 100% (19 of 19) in the 1st quarter
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	See IV.30 below
IV.30	Evaluates compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	All involuntary hospital contracts are in place.
IV.31	UR Nurses review all involuntary admissions funded by DHHS, take corrective action when they identify deficiencies and send notices of any violations to the licensing division and to the hospital	SAMHS reviews emergency involuntary admissions at the following hospitals: MaineGeneral Medical Center, Spring Harbor, St. Mary's, Mid-Coast Hospital, Southern Maine Medical Center, PenBay Medical Center, Maine Medical Center/P6 and Acadia. See Standard IV.33 below regarding corrective actions.
IV.32	Licensing reviews of hospitals include an evaluation of compliance with patient rights and require a plan of correction to address any deficiencies.	9 Complaints Received 6 Complaints investigated 0 substantiated 0 Plan of correction sought 0 Rights of Recipients Violations
IV.33	• 90% of the time corrective action was taken when blue papers were not completed in accordance with terms • 90% of the time corrective action was taken when 24 hour certifications were not completed in accordance with terms • 90% of the time corrective action was taken when patient rights were not maintained	See attached *Performance and Quality Improvement Standards: February 2013*, Standards 17-2a, 17-3a and 17-4a and *Community Hospital Utilization Review – Class Members 1st Quarter of Fiscal Year 2013*. Standards met for FY08, FY09, FY10 and FY11; Standards met for all 4 quarters of FY12 Standards met for the first 2 quarters of FY13
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 report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members 1st Quarter of Fiscal Year 2013.* 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 18.2 met FY12 3rd and 4th quarter. Standard met for obtaining ISPs and creating treatment and discharge plans consistent with ISP; involving CWs in treatment and discharge planning was at 70%

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: February 2013*, Standard 19-1 and *Adult Mental Health Quarterly Crisis Report Second Quarter, State Fiscal Year 2013 Summary Report.* In FY10, standard met for the 1st quarter: slightly above for the 2nd (25.7%), 3rd (25.7%) and 4th (26.1%) quarters. In FY11, standard met for the 1st quarter, with the 2nd (25.6%), 3rd (26.2%) and 4th (26.4%) quarters' results being slightly above the standard. In FY12, standard met for the all 4 quarters. In FY 13, standard met first 2 quarters.
IV.36	90% of crisis phone calls requiring face-to-face assessments are responded to within an average of 30 minutes from the end of the phone call – *must be met for 3 out of 4 quarters*	See attached *Adult Mental Health Quarterly Crisis Report Second Quarter, State Fiscal Year 2013 Summary Report*. 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 calls requiring face to face assessments are responded to within an average of 30 minutes from the end of the phone call was met for all 4 Quarters in FY12 and first 2 quarters in FY13
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 Second Quarter, State Fiscal Year 2013 Summary Report*. Standard has been met since the 2nd quarter of FY08.
IV.38	90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2013*, Standard 19-4 and *Adult Mental Health Quarterly Crisis Report Second Quarter, State Fiscal Year 2013 Summary Report.* Standard has been met since the 1st quarter of FY08.
IV.39	Compliance Standard deleted 1/19/2011.	

IV.40	Department has implemented the components of the CD plan related to vocational services	As of quarter 3 FY10, the Department has implemented all components of the CD Plan related to Vocational Services.
IV.41	QM system shows that the Department conducts further review and takes appropriate corrective action if PS 26.3 data shows that the number of consumers under age 62 and employed in supportive or competitive employment falls below 10%. *(Amended language 1/19/11)*	2011 Adult Health and Well-Being Survey: 13.8% of consumers in supported and competitive employment (full or part time). The Director of the Office of Quality Improvement and staff from Office of Adult Mental Health quality management presented results from the 2011 Health and Wellness Survey to the Consumer Counsel of Maine August 17, 2012. The Department has requested feedback on recommendations from the Consumer Counsel on how they would like to see the data utilized.
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: February 2013*, Standard 21-1 SAMHS has not met this standard for the prior 4 quarters.
IV.43	**EITHER** quarterly unmet mental health treatment needs for one year for qualified non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet mental health treatment needs do not exceed 15 percentage points of Class Members. Data are normally reported in July. This report was produced in October this year but, in order to ensure data continuity, it uses only data that would have been reported in July. Reporting for this standard will be done again in July 2013. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.44	QM documentation shows that the Department conducts further review and takes appropriate corrective action if results from the DIG survey fall below the levels identified in Standard # 22-1 (the domain average of positive responses to the statements in the Perception of Access Domain is at or above 85%) *(Amended language 1/19/11)* **and**	2011 Adult Health and Well-Being Survey: 77% domain average of positive responses. The Director of the Office of Quality Improvement and staff from Office of Substance Abuse and Mental Health Services quality management presented results from the 2011 Health and Wellness Survey to the Consumer Counsel of Maine August 17, 2012. The Department has requested feedback on recommendations from the Consumer Counsel on how they would like to see the data utilized. SAMHS has received the draft 2*012 Adult Health and Well-being Survey*. SAMHS staff are waiting for permission from the Office of Quality Improvement to release the data.
IV.45	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of mental health treatment	See attached *Performance and Quality Improvement Standards: February 2013*, Standards 21-2, 21-3 and 21-4

	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 since the beginning of FY08
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: February 2013*, Standard 30
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2013*, Standard 28 Standard met for all quarters of FY08, FY09, FY10 and FY11. Standard met all 4 quarters for FY12 and the first quarter of FY13.
IV.48	Provide documentation in quarterly reports of funding, developing, recruiting, and supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	See attached *Performance and Quality Improvement Standards: February 2013*, Standard 23-1 and 23-2
IV.49	Certify that all contracts with providers include a requirement to refer family members to family support services, and produce documentation that contract reviews include evaluation of compliance with this requirement.	100% of contracts include this requirement. Documentation is maintained by the regional offices.
IV.50	Lists in quarterly reports the number and types of mental health informational workshops, forums and presentations geared to general public that are designed to reduce myths/stigma and foster community integration (cover prescribed list and fit audience parameters)	See attached *Performance and Quality Improvement Standards: February 2013*, Standard 34.1 and attached *Public Education Report October – December 2012.*



Consent Decree Performance and Quality Improvement Standards: February 2013

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

Starting fiscal year 2012, quarter 3, standard 5.2, 5.3 and 5.4 will now be calculated by APS Healthcare. Standard 5.1 will be calculated by APS Healthcare and reported on the next quarterly report, FY 12 Q4.

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

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

Definitions:

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

Calendar and Fiscal Year Definitions:

CY: Calendar Year - January 1 - December 31.

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

Compliance and Performance Standards: Summary Sheet
October - December 2012

Standard 1. Rights Dignity and Respect

Average of positive responses in the DIG Survey Quality and Appropriateness domain

Standard 2. Rights Dignity and Respect

Response to Level II Grievances within 5 days

Standard 3. Rights Dignity and Respect

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

Standard 4. Rights Dignity and Respect

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

Standard 5. Timeliness of ISP and CI/CSS Assignment

1. Class members requesting a worker who were assigned one.
2. Hospitalized class members assigned a worker in 2 days
3. Non-hospitalized class members assigned a worker in 3 days.
4. Class members not assigned on time, but within 1-7 extra days.
5. ISP completed within 30 days of service request.
6. 90 day ISP review completed within specified time frame
7. Initial ISPs not developed w/in 30 days, but within 60 days.
8. ISPs not reviewed within 90 days, but within 120 days.

Standard 7. CI/CSS/ Individualized Support Planning

1a. ISPs reflect the strengths of the consumer?
1b. ISPs consider need for crisis intervention and resolution services?
1c. Does the consumer have a crisis plan?
1d. Has the crisis plan been reviewed every 3 months?

Standard 8. CI/CSS Individualized Support Planning

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

Standard 9. ISP Service Agreements

ISPs that require Service Agreements that have current Service Agreements

Compliance and Performance Standards: Summary Sheet
October - December 2012

Standard 10. Case Load Ratios

1. ACT Statewide Case Load Ratio
2. Community Integration Statewide Case Load Ratio
3. Intensive Community Integration Statewide Case Load Ratio - deleted: ICI is no longer a service offered by MaineCare.
4. Intensive Case Management Statewide Case Load Ratio
5. OES Public Ward Case Management Case Load Ratio

Standard 11. CI/CSS Individualized Support Planning

Paragraph 74. Needs of Class Members not in Service

Standard 12. Housing & Residential Support Services

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

Standard 13. Housing & Residential Support Services

1. Average of positive responses in the DIG Survey Perception of Outcomes domain
2. Deleted: Amendment request to delete approved 01/19/2011

Standard 14. Housing & Residential Support Services

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

Standard 15. Housing & Residential Services

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

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

Inpatient admissions reasonably near community residence.

Compliance and Performance Standards: Summary Sheet
October - December 2012

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

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

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

3. Admissions in which 24 hour certification completed.

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

4. Admission in which patients' rights were maintained

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

5. Admissions for which medical necessity has been established.

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

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

Standard 19. Crisis intervention Services

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

Standard 20. Crisis Intervention Services

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

Standard 21. Treatment Services

1. Class Members with unmet mental health treatment needs.
2. Lack of MH Tx impedes Riverview discharge within 7 days of determination of readiness for discharge
3. Lack of MH Tx impedes Riverview discharge within 30 days of determination.
4. Lack of MH Tx impedes Riverview discharge within 45 days of determination

5.Class Members use an array of Mental Health Services

Standard 22. Treatment Services

1. Average of positive responses in the DIG Survey Perception of Access domain
2. Average of positive responses in the DIG survey General Satisfaction domain

Standard 23. Family Support Services

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

Compliance and Performance Standards: Summary Sheet
October - December 2012

Standard 24. Family Support Services

1. Counseling group participants reporting satisfaction with services
2. Program participants reporting satisfaction with education programs
3. Deleted: Family participants reporting satisfaction with respite services in the community - NAMI closed its respite programs as of January 2010

Standard 25. Family Support Services

1. Agency contracts with referral mechanism to family support
2. Families reporting satisfaction with referral process.

Standard 26. Vocational Employment Services

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

Standard 27. Vocational Employment Services

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

Standard 28. Transportation

Class Members with ISPs - Unmet transportation needs.

Standard 29. Transportation

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

Standard 30. Rec/Soc/Avocational/Spiritual Opportunities

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

Standard 31. Rec/Soc/Avoc/Spirtual

1. ISP identified class member unmet needs in recreational/social/avocational/spiritual areas
2. Average of positive responses in the DIG Survey Social Connectedness domain
3. Deleted: Amendment request to delete approved 01/19/2011

Standard 32. Individual Outcomes

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

Compliance and Performance Standards: Summary Sheet
October - December 2012

Standard 33. Recovery

1. Consumers reporting staff helped them to take charge of managing illness.
2. Consumers reporting staff believed they could grow, change, recover
3. Consumers reporting staff supported their recovery efforts
4. Deleted: Consumers reporting that providers offered learning opportunities: questions eliminated with 2007 DIG Survey
5. Consumers reporting providers stressed natural supports/friendships
6. Consumers reporting providers offered peer recovery groups.

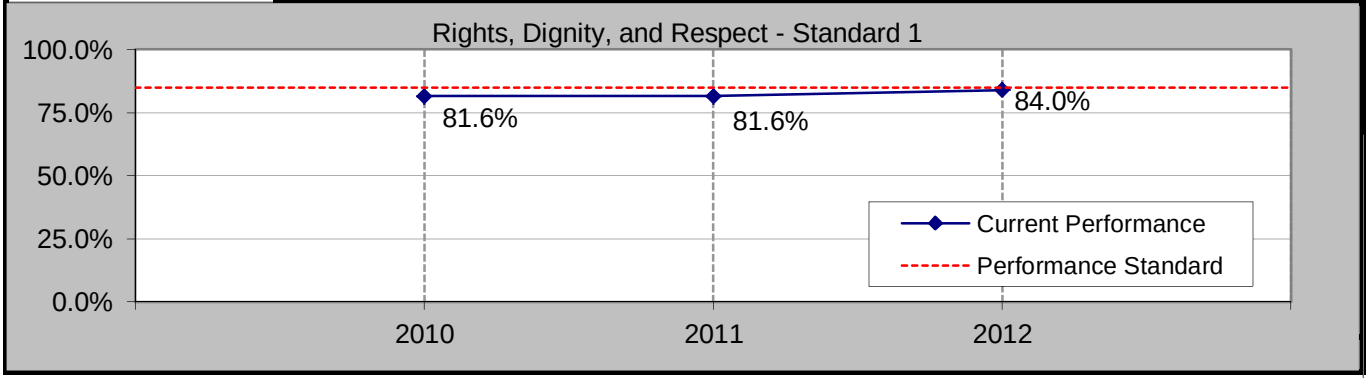
Standard 34. Public Education

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

Rights, Dignity, and Respect

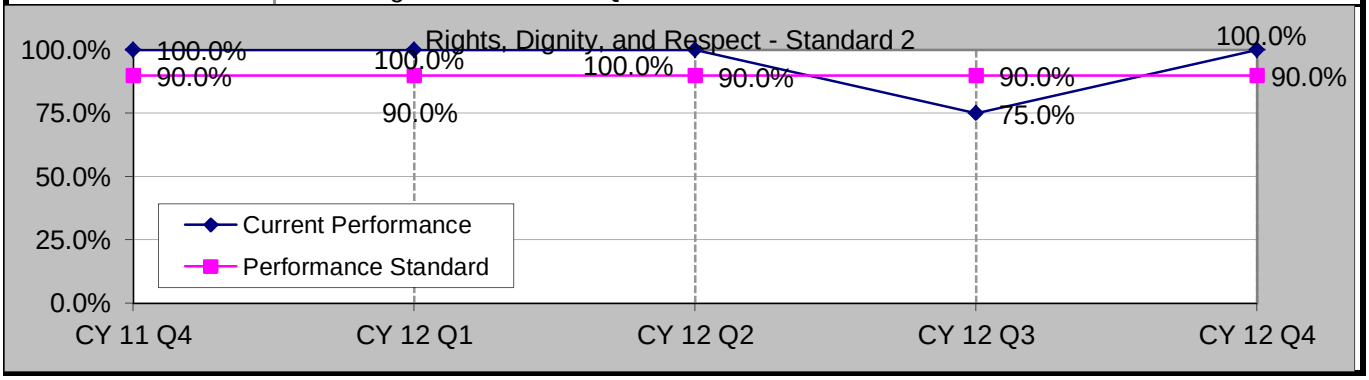
Standard 1 - Treated with respect for their individuality

Standard 1	
Measurement	Domain average of positive responses to the statements in the quality and appropriateness domain
Standard	Performance: at or above 85%
Data Source	DIG Survey
Current Level	84.0% (N=1337)



Standard 2 - Grievances are addressed in a timely manner

Standard 2	
Measurement	Response to Level II Grievances within 5 days or agreed upon extension
Standard	Performance: 90% Within 5 days or during extension
Data Source	DHHS Grievance Tracking System
Current Level	1 level II grievances CY12 Q4



Discussion:

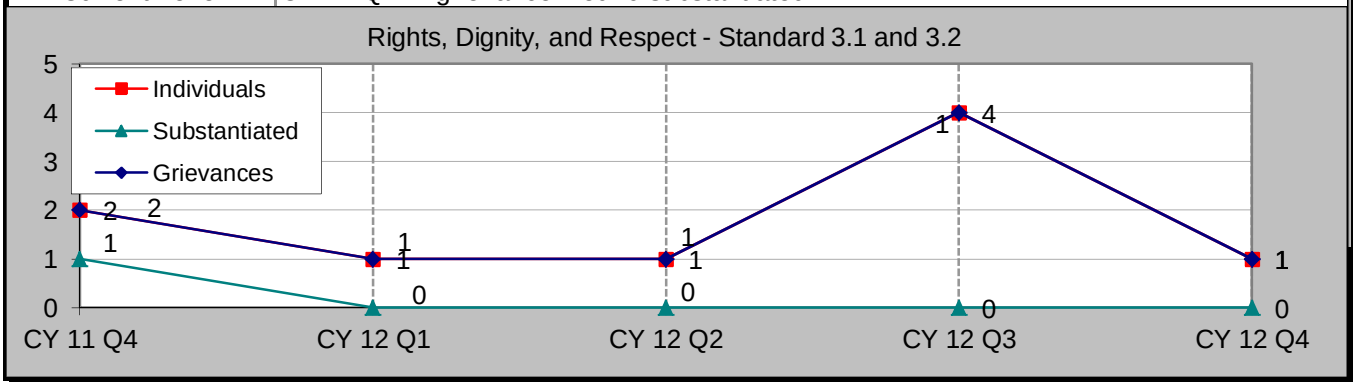
Standard 1: SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

Standard 2: Met from calendar year 2006 thru the 2nd quarter of calendar year 2012, except for Q4 CY 10 - in that quarter, one of two grievances was not responded to within the prescribed timeframe.

Rights, Dignity, and Respect

Standard 3 - Demonstrate rights are respected and maintained

Standard 3.1	
Measurement	Number of Level II grievances filed and number unduplicated people
Standard	No numerical standards necessary, ongoing monitoring of grievance trends.
Data Source	DHHS Grievance Tracking System
Current Level	CY 12 Q4 1 grievance filed. 1 individuals
Standard 3.2	
Measurement	Number of Level II grievances filed where violation is substantiated
Standard	No numerical standards necessary, ongoing monitoring of grievance trends.
Data Source	DHHS Grievance Tracking System
Current Level	CY 12 Q4 1 grievance filed. 0 substantiated



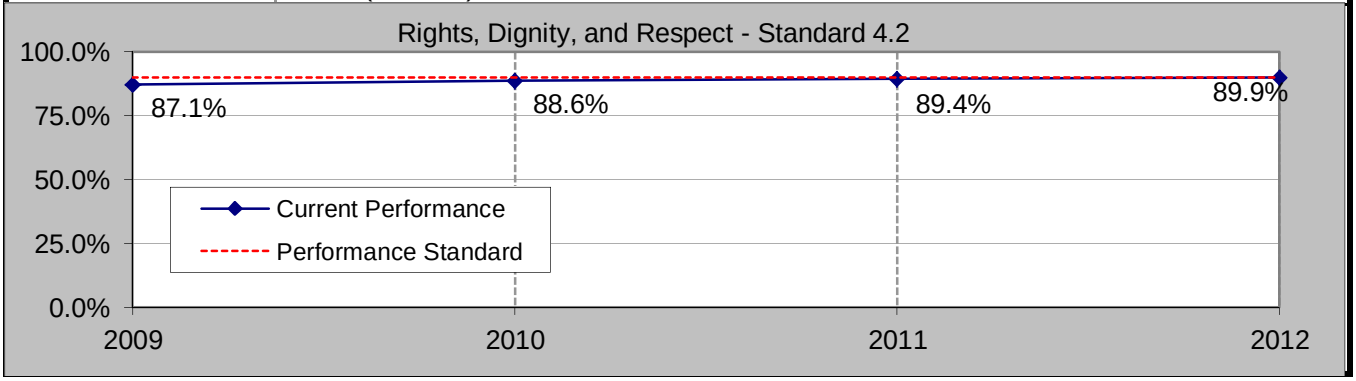
Comment:

Standard 3.1 and 3.2: SAMHS continues to monitor. The number of greivances are not statistically significant.

Rights, Dignity, and Respect

Standard 4 - Class Members are informed of their rights

Standard 4.2	
Measurement	Percent of consumers reporting they were given information about their rights.
Standard	Performance: 90%
	Compliance: See explanation below.
Data Source	Data Infrastructure Grant Survey, Q22
Current Level	89.9% (N=1309)



* Compliance standard for 4.2

If results fall below the performance standard level, the Department:

- •Consults with the Consumer Council of Maine (CCSM)
- •Takes corrective action if deemed necessary by the CCSM and
- •Develops that corrective action in collaboration with the CCSM

Discussion:

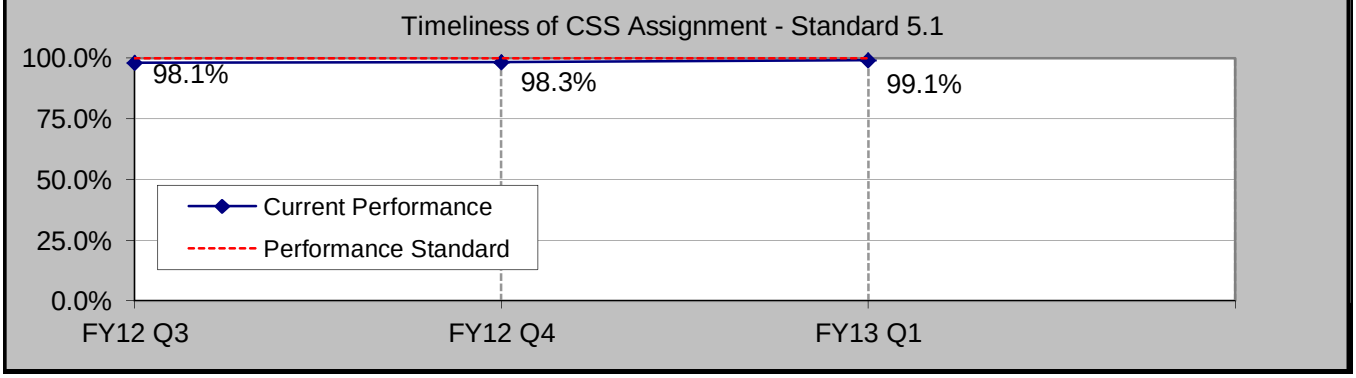
Percentage has increased from 87.9% to 89.4% over the past 4 calendar years. Data from the 2011 DIG survey were shared with the CCSM in November 2011.

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

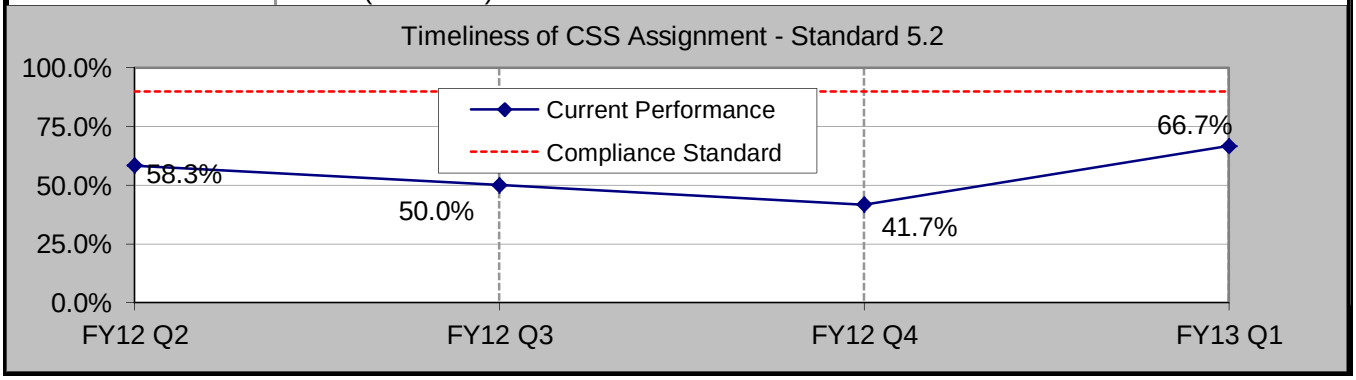
Community Integration / Community Support Services / Individualized Support Planning

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

Standard 5.1	
Measurement	Percentage of class members requesting a worker who were assigned one.
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	99.1% (115 out of 116)



Standard 5.2	
Measurement	Percentage of hospitalized class members who were a assigned a worker within 2 working days.
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	66.7% (4 out of 6)

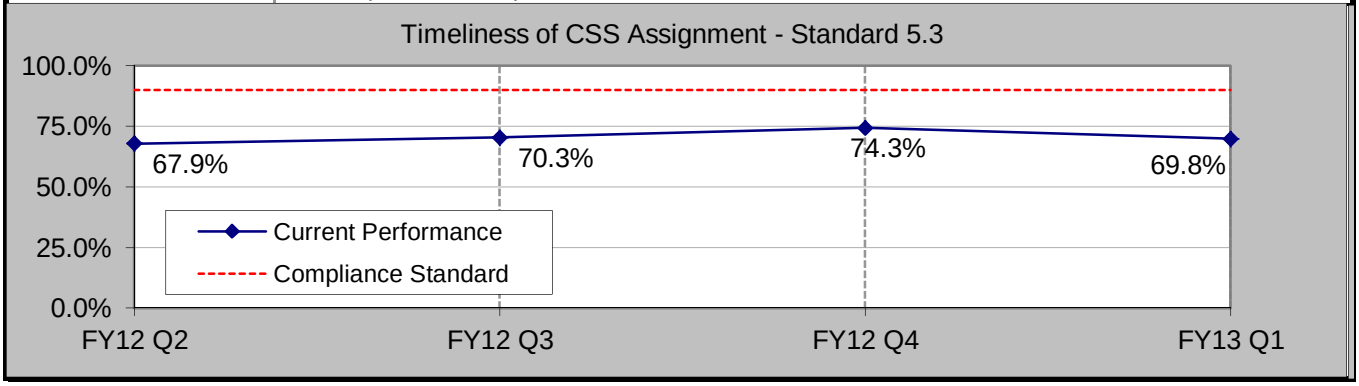


Discussion:

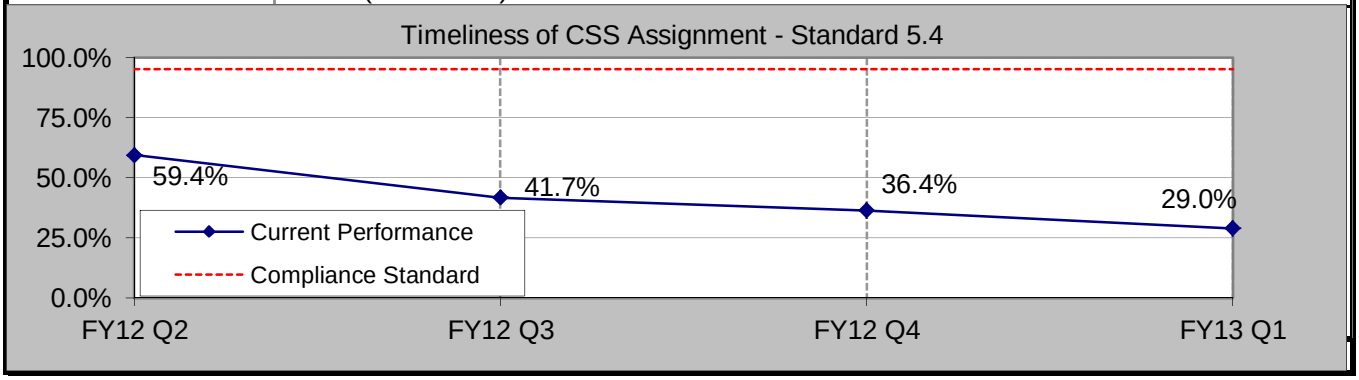
Standard 5.1 and 5.2: The department has begun to improve its process for monitoring agencies' performance and to increase assistance to agencies. This will not impact until the 3rd quarter FY 13 report.

Community Integration / Community Support Services / Individualized Support Planning

Standard 5.3	
Measurement	Percent of non-hospitalized class members assigned a worker within 3 working days.
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	69.8% (7 out of 101)



Standard 5.4	
Measurement	Percent of class members in hospital or community not assigned on time but were assigned within an additional 7 working days.
Standard	Performance: 100% Compliance: 95%
Data Source	ISP RDS Data
Current Level	29.0% (9 out of 31)

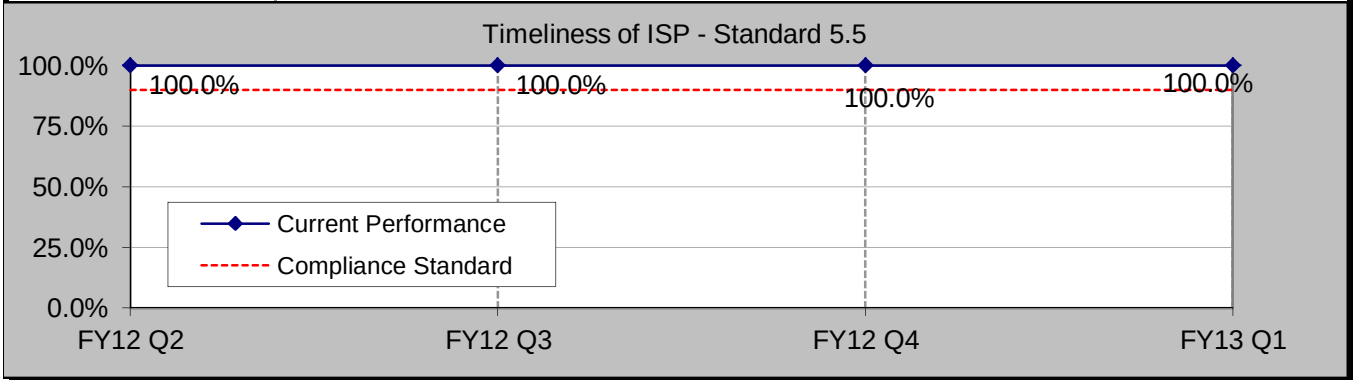


Discussion:

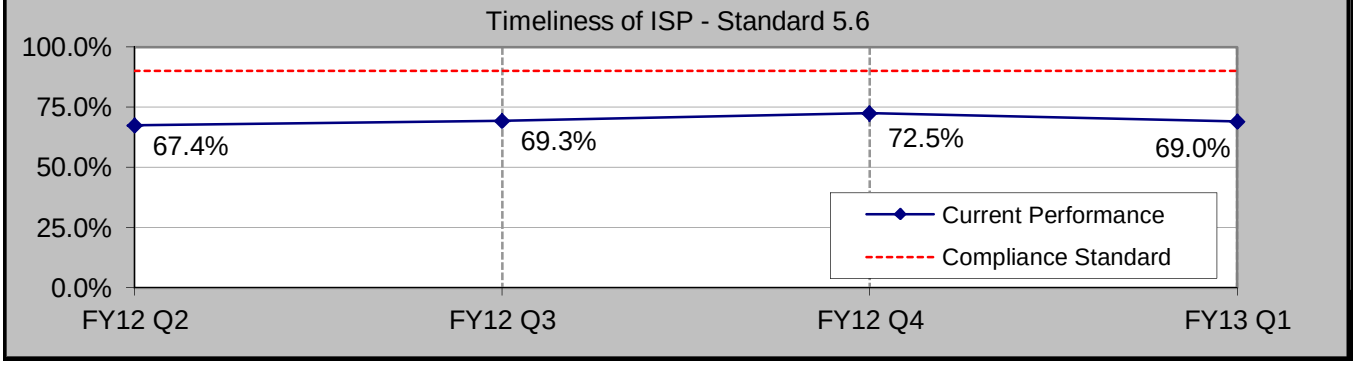
Standard 5.3 and 5.4: See discussion for standard 5.1 and 5.2

Community Integration / Community Support Services / Individualized Support Planning

Standard 5.5	
Measurement	Class member ISPs completed within 30 days of service request
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	100.0% (73 out of 73)



Standard 5.6	
Measurement	90 day class member ISP reviews completed within specified timeframe.
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	69.0% (725 out of 1050)



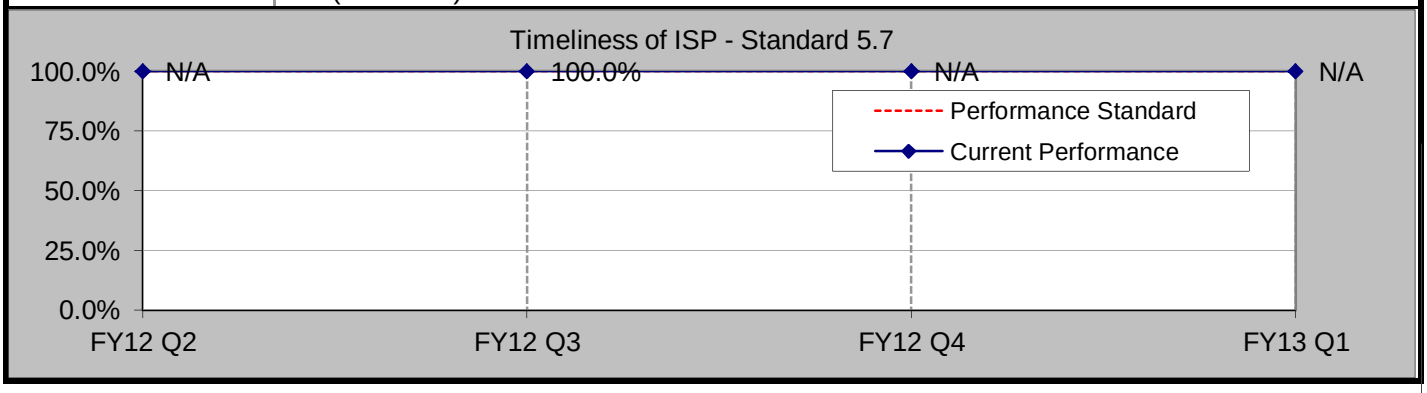
Comment:

Standard 5.5: this is a standard that is constently met.

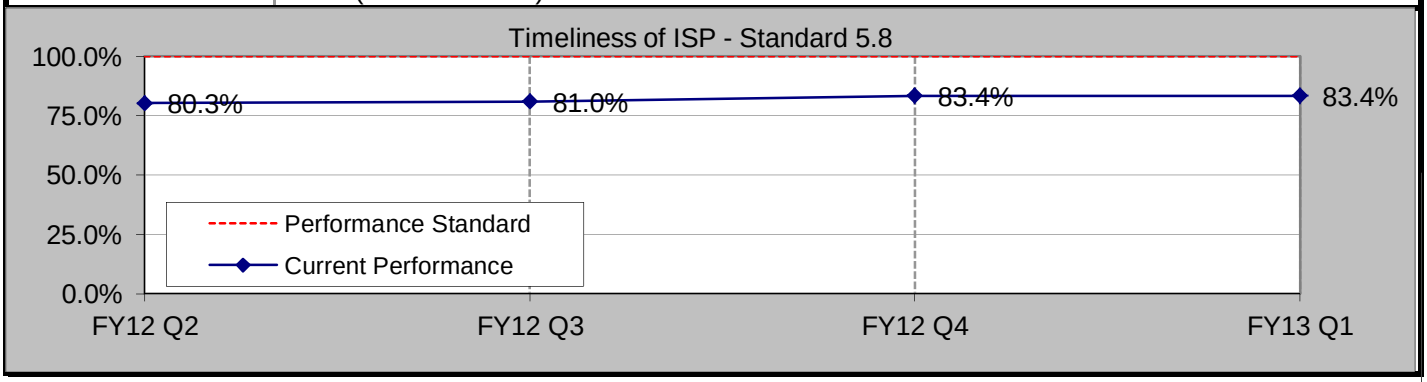
Standard 5.6: Field Quality Managers continue to train agency staff.

Community Integration / Community Support Services / Individualized Support Planning

Standard 5.7	
Measurement	Initial class member ISPs not developed within 30 days, but were developed within 60 working
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	N/A (0 out of 0)



Standard 5.8	
Measurement	Class member ISPs that were not reviewed within 90 days but were reviewed within 120
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	84.3%(274 out of 325)



Comment:

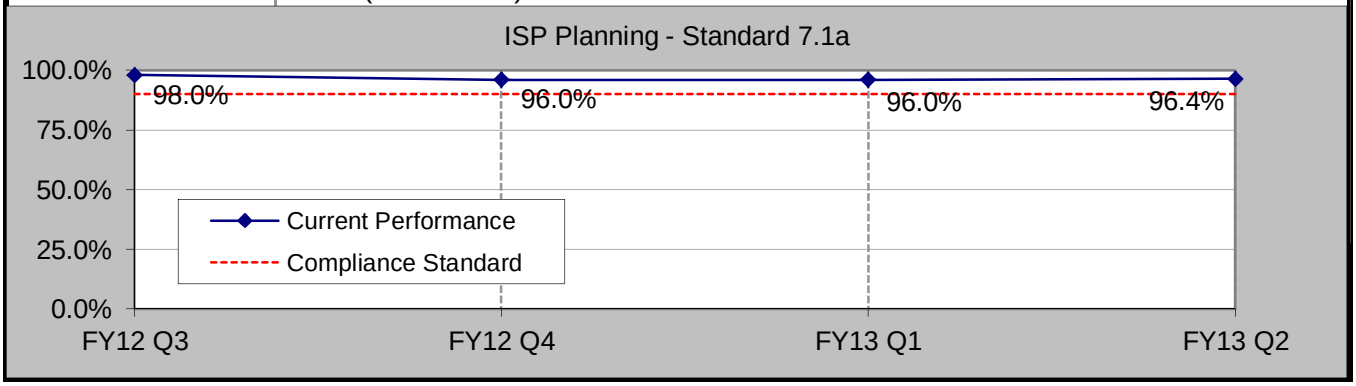
Standard 5.7: N/A

Standard 5.8: This area is being addressed by Quality Management Specialists ongoing training to agencies.

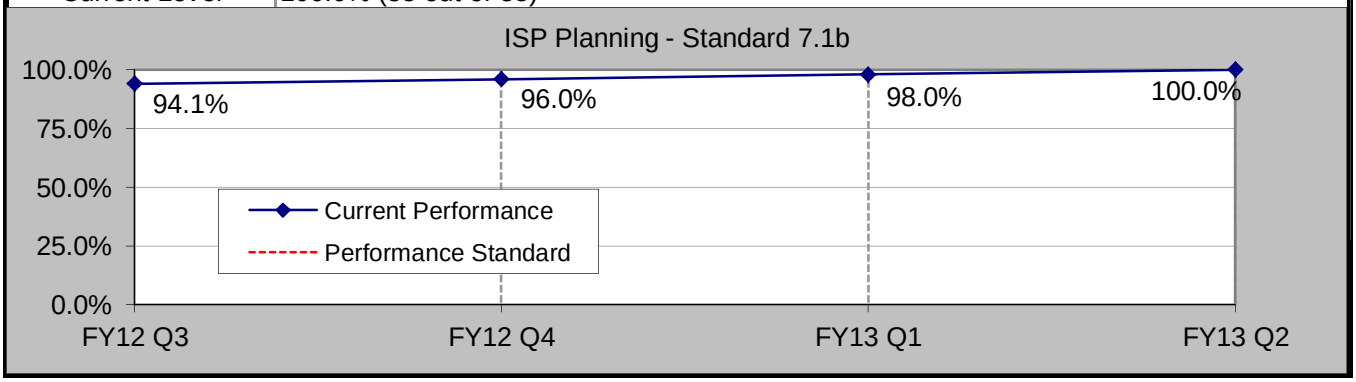
Community Integration / Community Support Services / Individualized Support Planning

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

Standard 7.1a	
Measurement	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?
Standard	Performance: 95%
	Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	96.4% (53 out of 55)



Standard 7.1b	
Measurement	Does record document the individual's potential need for crisis intervention and resolution services was considered during treatment planning?
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	100.0% (55 out of 55)



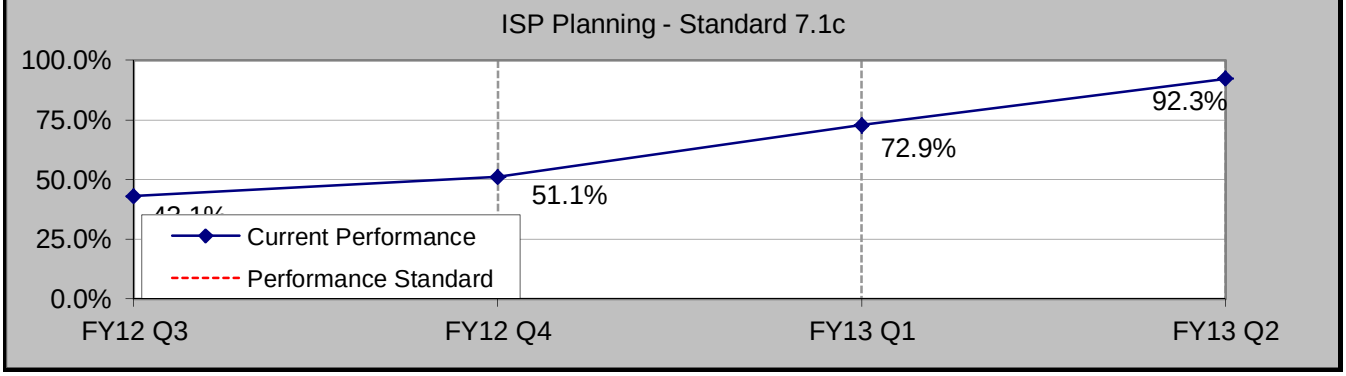
Discussion:

Standard 7.1a: Met continuously since the first quarter of FY 08.

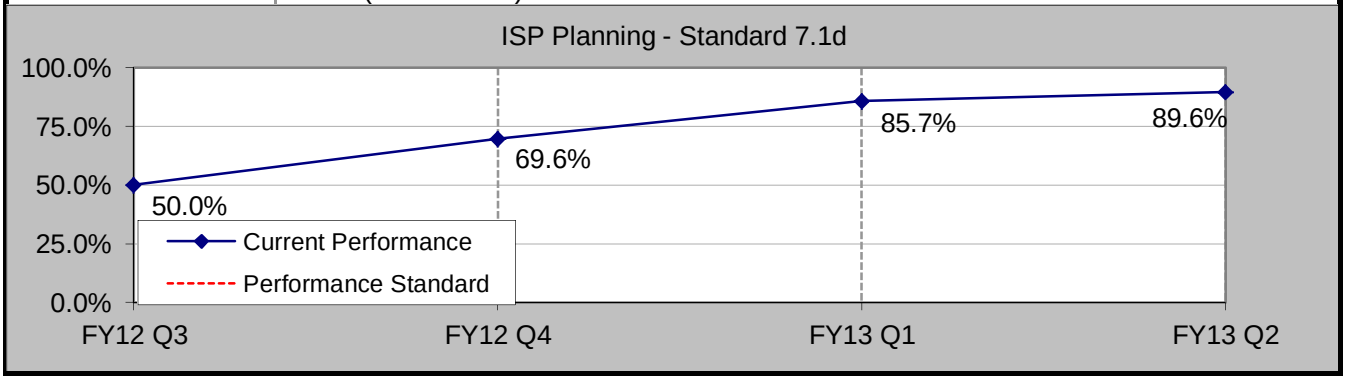
Standard 7.1b: Treatment plans document that crisis planning discussions are consistently occurring.

Community Integration / Community Support Services / Individualized Support Planning

Standard 7.1c	
Measurement	Does the record document that the consumer has a crisis plan?
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	92.3% (48 out of 52)



Standard 7.1d	
Measurement	If the consumer has a crisis plan, "has the crisis plan been reviewed as required, every 3 months?"
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	89.6% (43 out of 48)



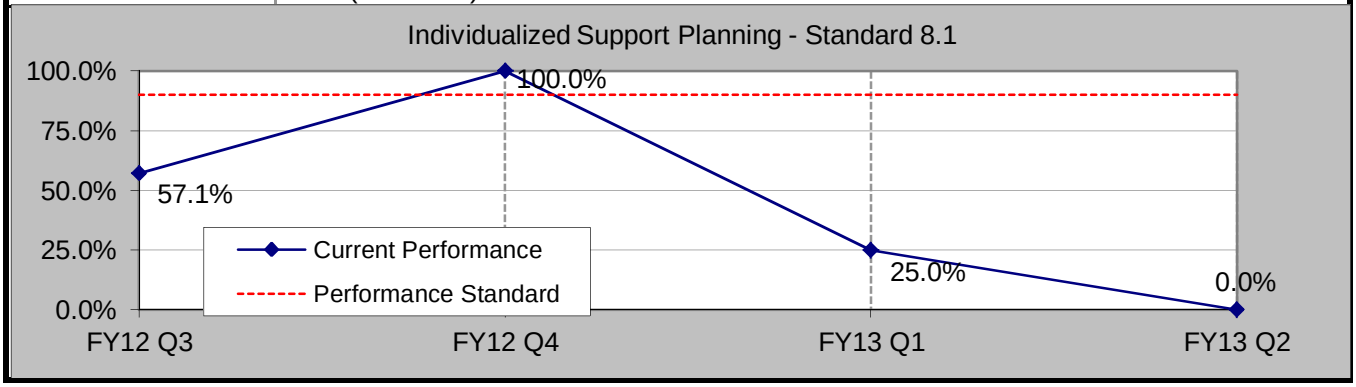
Comment:

Section 7.1c , and 7.1d: Field Service Specialists continue to train agency staff

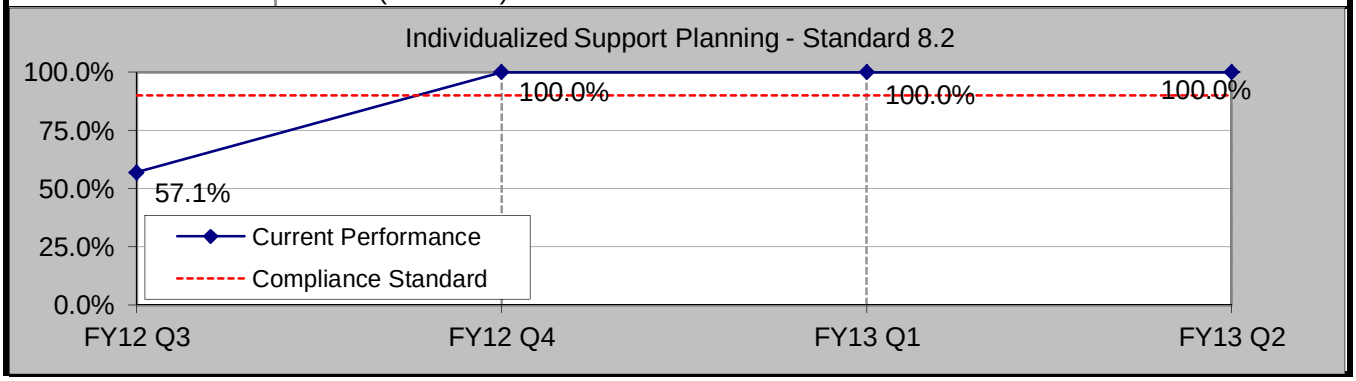
Community Integration / Community Support Services / Individualized Support Planning

Standard 8 - Services based on needs of class member rather than only available services

Standard 8.1	
Measurement	ISPs reviewed in which there is evidence that the ISP team reconvened after an unmet need was identified.
Standard	Performance: 90%
Data Source	Class Member Treatment Planning Review
Current Level	0.0% (0 out of 8)



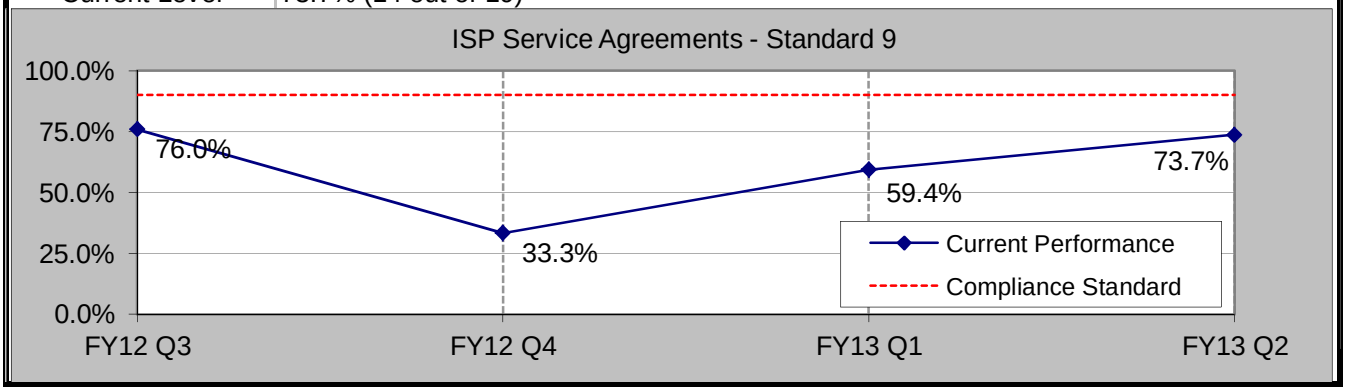
Standard 8.2	
Measurement	ISPs reviewed with identified unmet needs in which interim plans are established.
Standard	Performance: 95% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	100.0% (8 out of 8)



Community Integration / Community Support Services / Individualized Support Planning

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

Standard 9	
Measurement	ISPs with services identified and with a treatment plan signed by each provider.**
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	73.7% (14 out of 19)



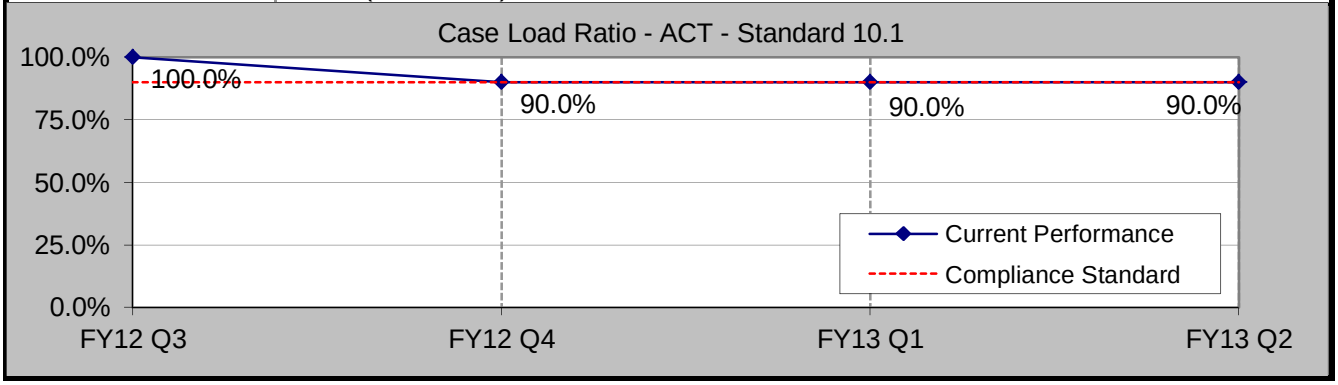
Comment:

Standard 9: Field Service Managers continue to train. Plans of corrections are required.

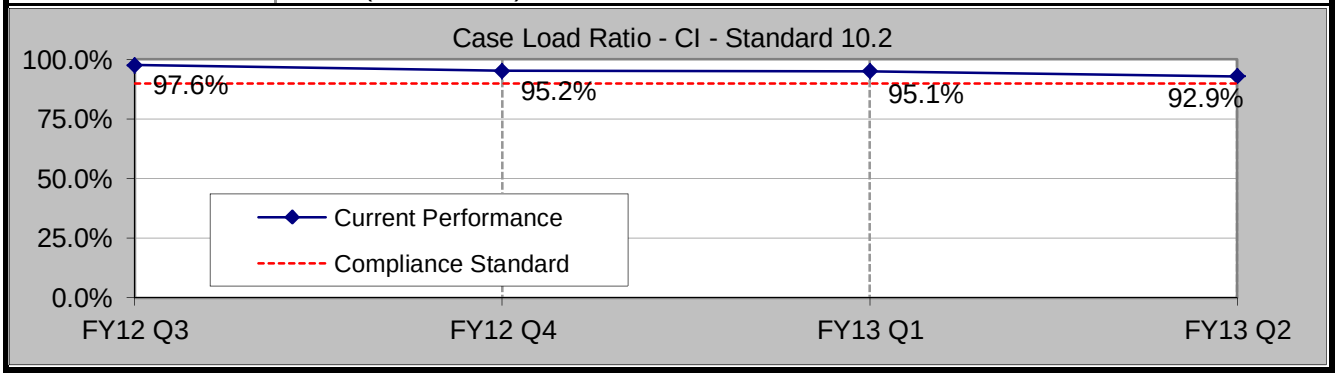
Community Integration / Community Support Services / Individualized Support Planning

Standard 10 - Case Load Ratio

Standard 10.1 - ACT	
Measurement	ACT Providers with average caseloads of 10 or fewer.
Standard	Compliance: 90% of all ACT Teams
Data Source	Agency Community Support Census/Staffing Ratio Database
Current Level	90.0% (9 out of 10)



Standard 10.2 - CI	
Measurement	Community Integration Providers with average caseloads of 40 or fewer.
Standard	Compliance: 90% of all CIW Providers
Data Source	Agency Community Support Census/Staffing Ratio Database
Current Level	92.9% (39 out of 42)



Discussion:

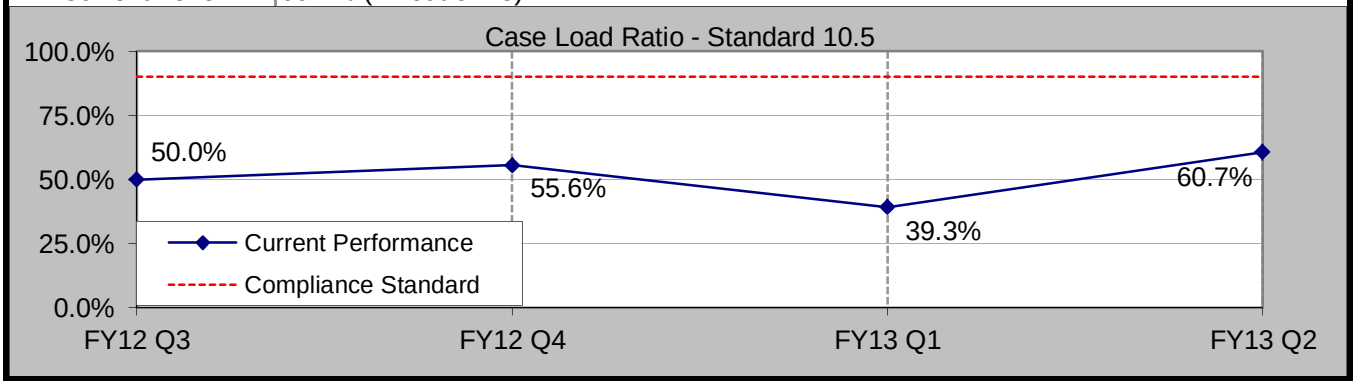
Standard 10.1: The 10/01/2009 revision of MaineCare Section 17 clearly specified staff to be included in calculating staffing ratios; ratio has been met since the 2nd quarter FY 10, except Q3 FY 11

Standard 10.2: Community Integration caseload ratios have been met since the 2nd quarter FY 08

Community Integration / Community Support Services / Individualized Support Planning

Standard 10.4 - ICM	
Measurement	Intensive Case Managers with average caseloads of 16 or fewer.
Standard	Compliance: 90% of all ICM Workers with Class Member caseloads
	ICMs focus on outreach with individuals in forensic facilities. ICMs no longer carry traditional caseloads. In the future, if ICMs carry caseloads, OAMHS will resume reporting caseload ratios.

Standard 10.5 - OADS	
Measurement	Office of Aging and Disability Services Case Managers with average caseload of 25 or fewer.
Standard	Compliance: 90% of all OADS Case Managers with Class Member Public Wards
Data Source	MAPSIS Case Counts for Workers with Class Members Public Wards
Current Level	60.7% (17 out of 28)



Discussion:

Standard 10.5: OADS continues not to meet staff/client ratios.

This will be a topic for discussion with the court master at a monthly meeting.

Community Integration / Community Support Services / Individualized Support Planning

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

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

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

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

Number of Callers with resource needs Jul 1 - Sept 30, 2012				
	Region 1	Region 2	Region 3	Total
Unique Individuals:	0	0	0	0
Unmet Needs:	0	0	0	0

Unmet Needs by Domain Jul 1 ~ Sept 30, 2012	
ISP Domain Areas	**State**
Mental Health Services	0
MH Crisis Planning Resources	0
Peer, Recovery & Support Resources	0
Substance Abuse Services	0
Housing Resources	0
Health Care Resources	0
Legal Resources	0
Financial Security Resources	0
Education Resources	0
Vocation Employment Resources	0
Living Skills Resources	0
Transportation Resources	0
Personal Growth/Community Participation Resources	0
Total	0

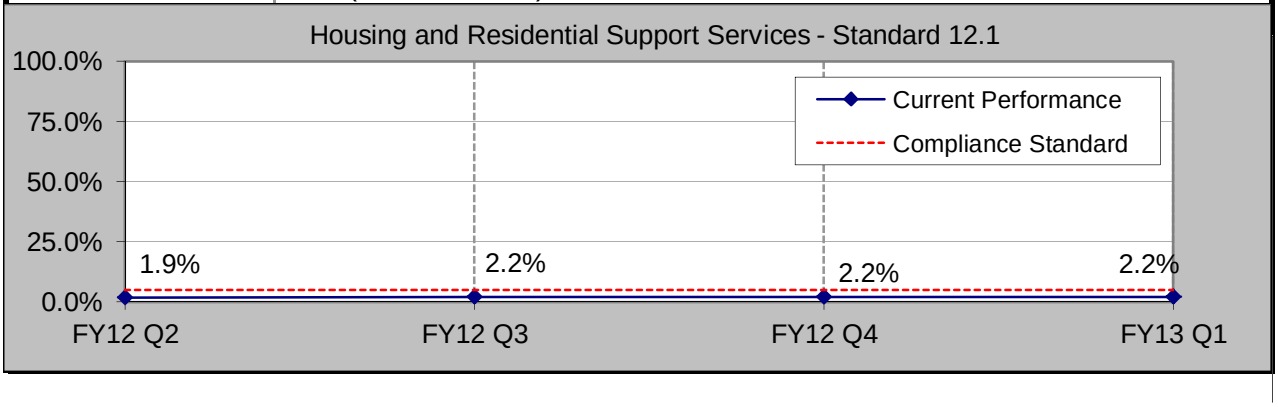
Comment:

Standard 11.1 and 11.2: Low number of documented consumer calls has been reviewed with supervisors.

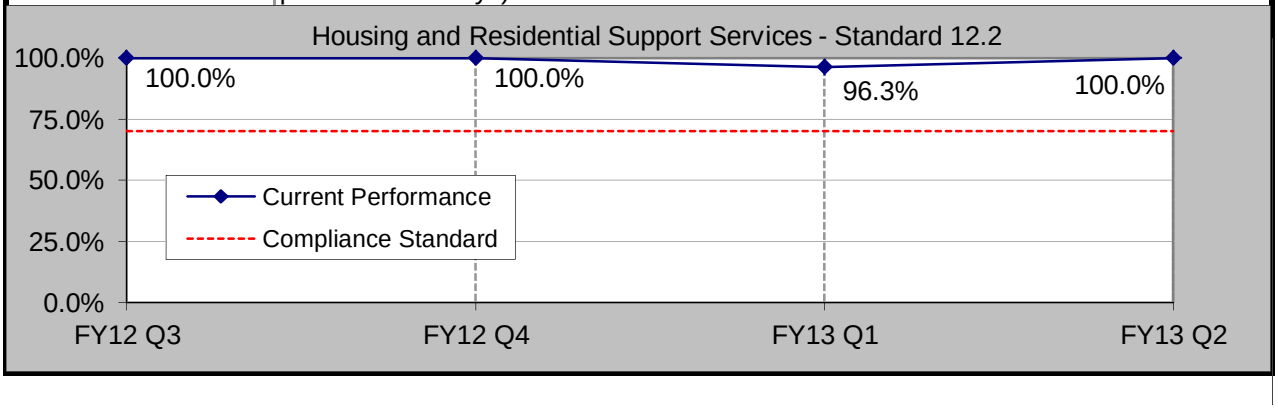
Community Resources and Treatment Services
Housing and Residential

Standard 12 - Residential Support services adequate to meet ISP needs of those ready for discharge

Standard 12.1	
Measurement	Class members in community with ISPs with unmet residential support needs.
Standard	Compliance: 5% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	2.2% (26 out of 1182)

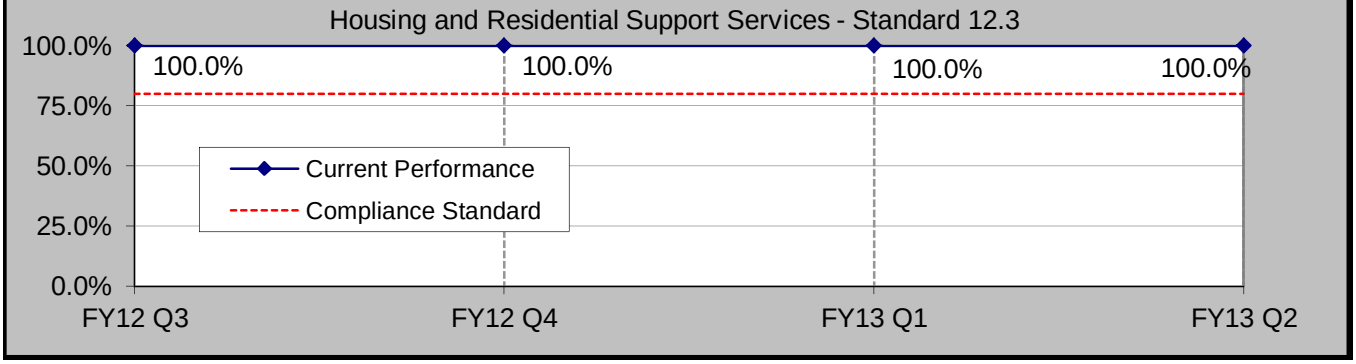


Standard 12.2	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY13 Q2 (Lack of residential supports did not impede discharge for any patient with 7 days)

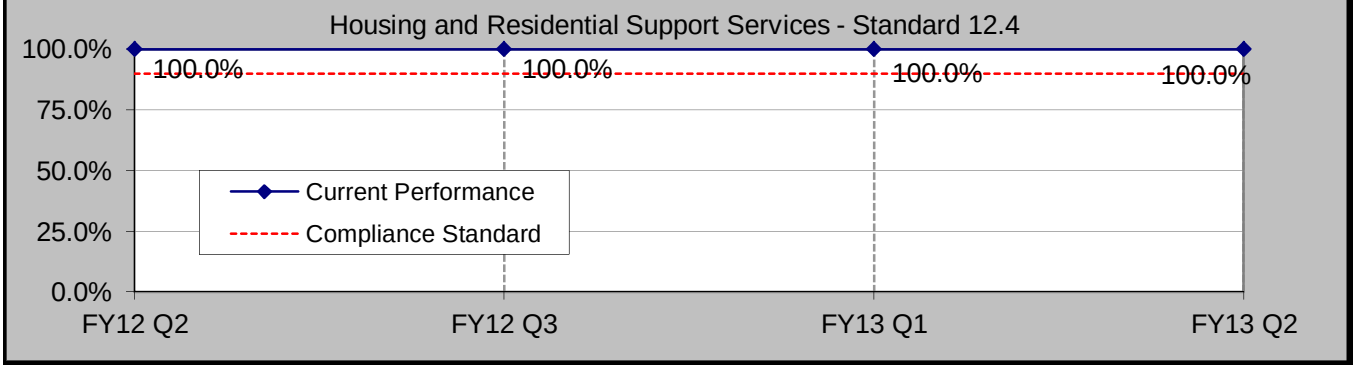


Community Resources and Treatment Services
Housing and Residential

Standard 12.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY13 Q2 (Lack of residential supports did not impede discharge for any patients within 30 days)



Standard 12.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Perfomance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY13 Q2 (Lack of residential supports did not impede discharge for any patients within 45 days)



Discussion:

Standard 12.1: Met since the 4th quarter FY 08 except for 1 quarter (Q2 FY 09)

Standards 12.2, 12.3, 12.4: Met since the 1st quarter of FY 09

Riverview Psychiatric Center Discharge Detail to amplify data presented in Standards 12.2, 12.3, 12.4

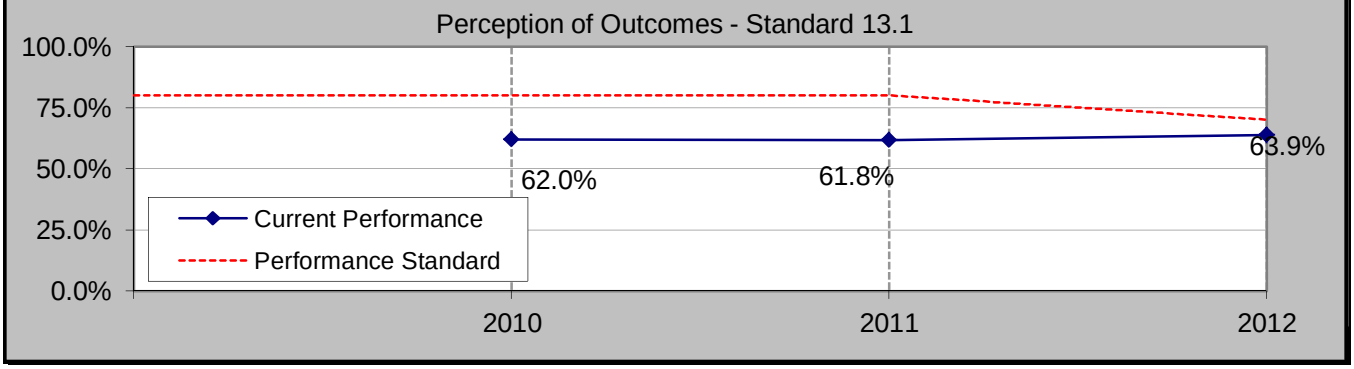
24 Civil Patients discharged in quarter

- 13 discharged at 7 days (54.2%)
- 4 discharged 8-30 days (16.7%)
- 4 discharged 31-45 days (16.7%)
- 3 discharged post 45 days (12.5%)

Residential Support Services did not impede discharge for any patient post clinical readiness for discharge.

Community Resources and Treatment Services
Housing and Residential

Standard 13.1	
Measurement	Domain average of positive responses to the questions in the Perception of Outcomes domain
Standard	Performance: at or above 70%
Data Source	DIG Survey
Current Level	63.9% (N=1338)



Discussion:

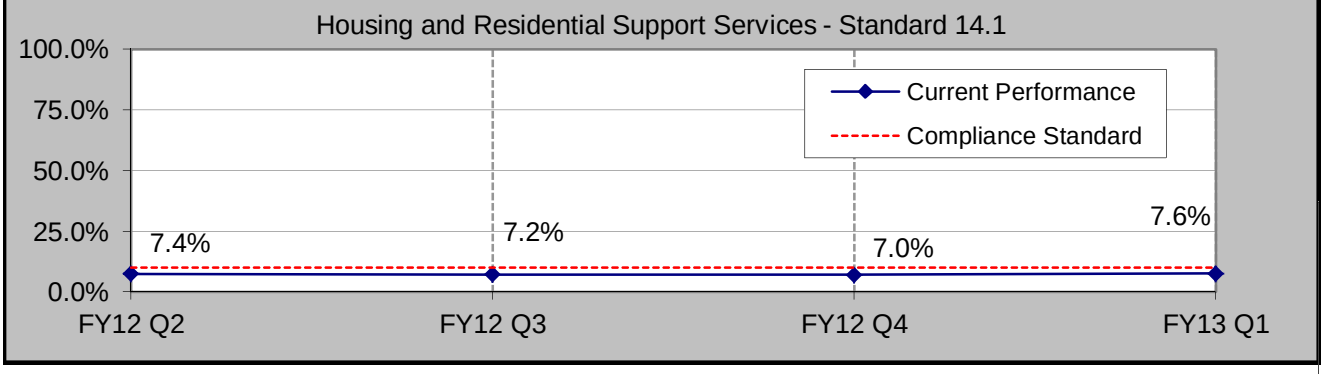
Standard 13.1: SAMHS has reached out to the Consumer Counsel of Maine for feedback and discussion on ways we can work with providers to improve.

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

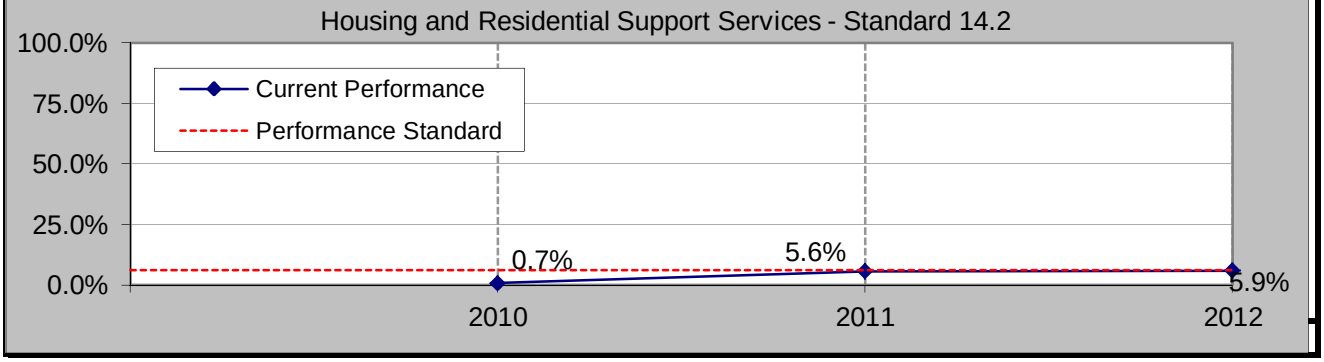
Community Resources and Treatment Services
Housing and Residential

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

Standard 14.1	
Measurement	Class members with ISPs with unmet housing needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	7.6% (90 out of 1182)



Standard 14.2	
Measurement	Percentage of respondents who experienced homelessness over 12-month period.
Standard	Performance: 6% or fewer
Data Source	DIG Survey, living situation data
Current Level	5.9% (N=1275)



Discussion:

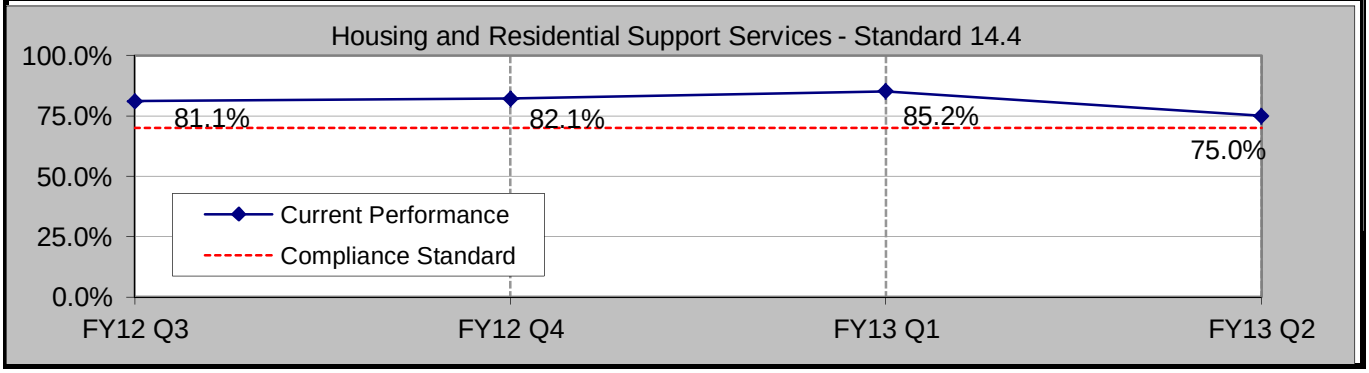
Standard 14.1: Met from quarter 3 FY 09 except for Q4 FY 10 (10.8%).

Standard 14.2: Starting in 2010, % of 'currently homeless' was reported instead of 'experienced homelessness over 12 month period'.

Standard 14.3: Request to delete approved 01/19/2011

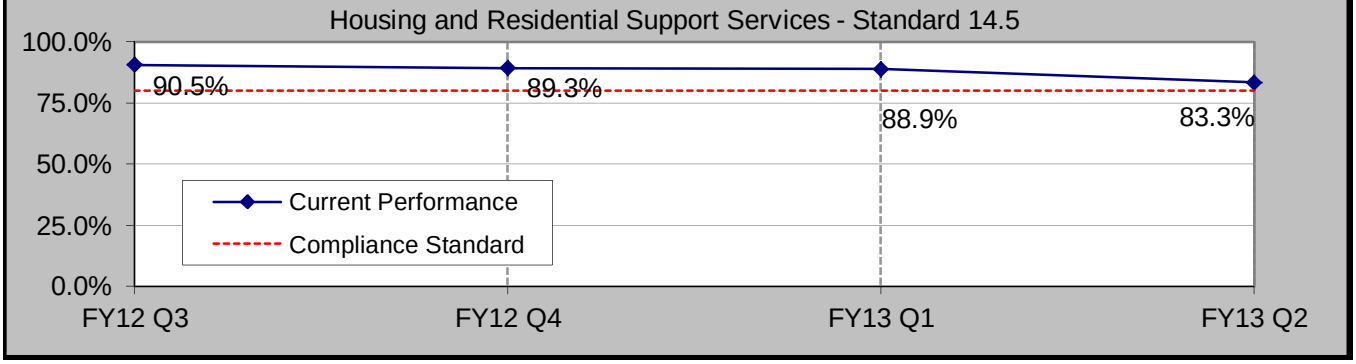
Community Resources and Treatment Services
Housing and Residential

Standard 14.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	75.0% FY13 Q2 (Lack of housing alternatives did not impede discharge for 18 out of 24 patients within 7 days)

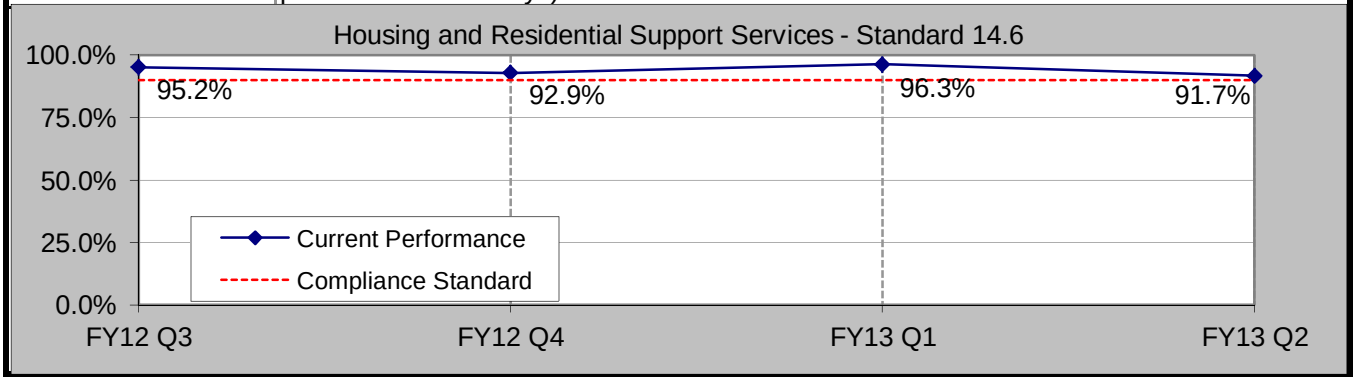


Community Resources and Treatment Services
Housing and Residential

Standard 14.5	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 96% (within 30 days of that determination) Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	83.3% FY13 Q2 (Lack of housing alternatives did not impede discharge for 20 out of 24 patients within 30 days)



Standard 14.6	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	91.7% FY13 Q2 (Lack of housing alternatives did not impede discharge for 22 out of 24 patients within 45 days)



Community Resources and Treatment Services
Housing and Residential

Discussion:

Standard 14.4: Met for all quarters FY 09; the 1st, 2nd, and 4th quarters of FY 10; all quarters FY11; all quarters of FY 12 and 1st and 2nd quarters of FY 13

Standard 14.5: Met the 3rd and 4th quarters FY 09; the 2nd and 4th quarters FY 10; all quarters FY 11; all quarters of FY 12 and 1st and 2nd quarters of FY 13

Standard 14.6: Met 2nd and 4th quarters FY 09; 2nd and 4th quarters FY 10; all quarters FY 11; all quarters of FY 12 and 1st and 2nd quarters of FY 13

Riverview Psychiatric Center Discharge Detail to amplify data presented in Standards 14.4, 14.5, 14.6:

24 Civil Patients discharged in quarter

13 discharged at 7 days (54.2%)
4 discharged 8-30 days (16.7%)
4 discharged 31-45 days (16.7%)
3 discharged post 45 days (12.5%)

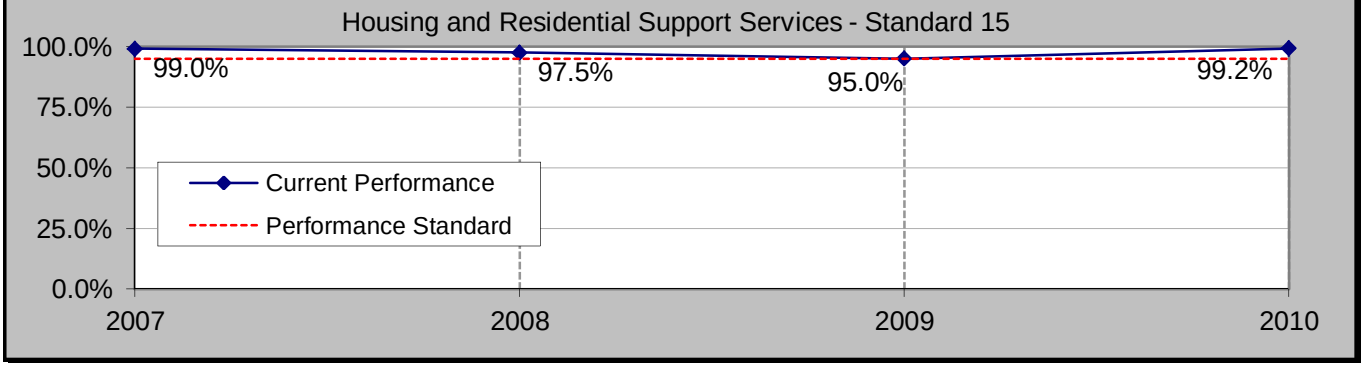
Housing Alternatives impeded discharge for 7 patients (29.2%)

3 patient discharged 8-30 days post clinical readiness for discharge
2 patients discharged 31-45 days post clinical readiness for discharge
2 patients discharged greater than 45 days post clinical readiness for discharge

Community Resources and Treatment Services
Housing and Residential

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

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



Discussion:

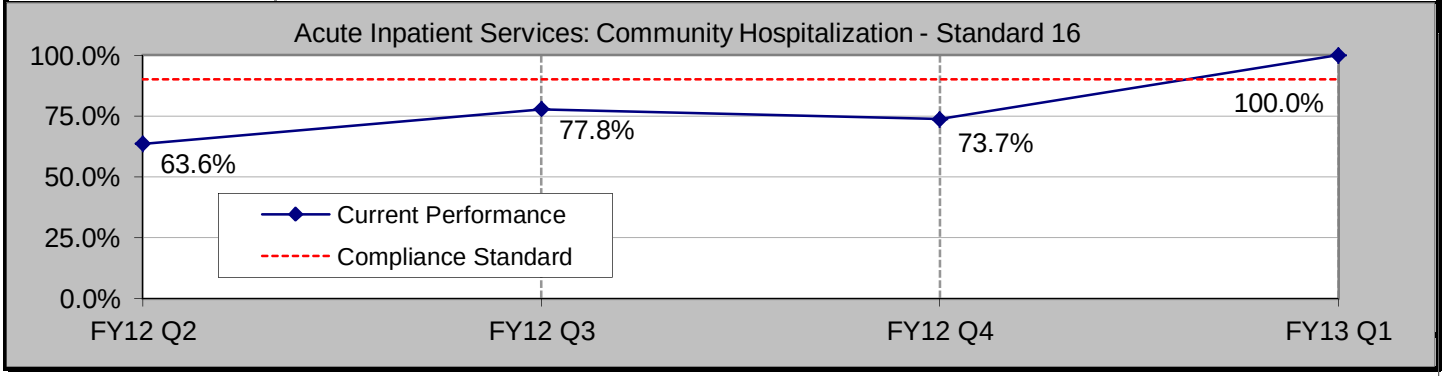
Standard met since 2007.

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

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

Standard 16 - Psychiatric Hospitalization reasonably near an individual's local community

Standard 16	
Measurement	Class Member admissions determined to be reasonably near an individual's local community of residence.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	UR Database/EIS
Current Level	100.0% (19 out of 19)



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

Discussion:

Standard not met since Q4 FY 10 except FY 13 Q1. The number of class member reviews is small making it difficult to draw conclusions systemically.

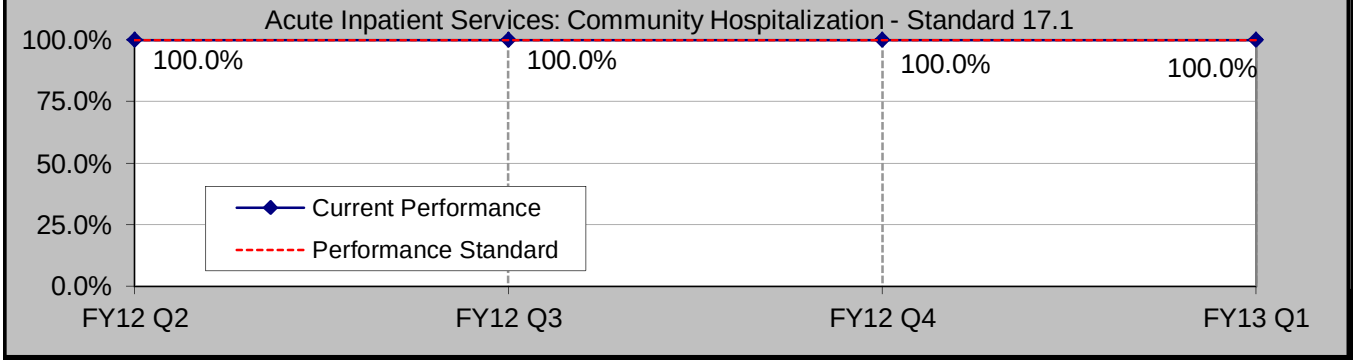
Recommendations:

Continue to monitor.

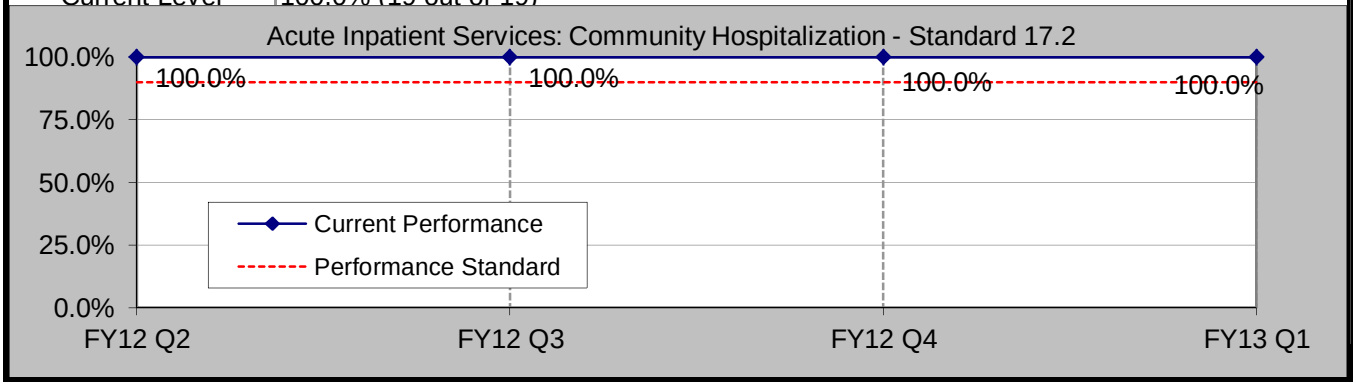
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

Standard 17.1	
Measurement	Class member involuntary admissions to community inpatient units have blue paper on file.
Standard	Performance: 100%
Data Source	UR Database/EIS
Current Level	100.0% (19 out of 19)

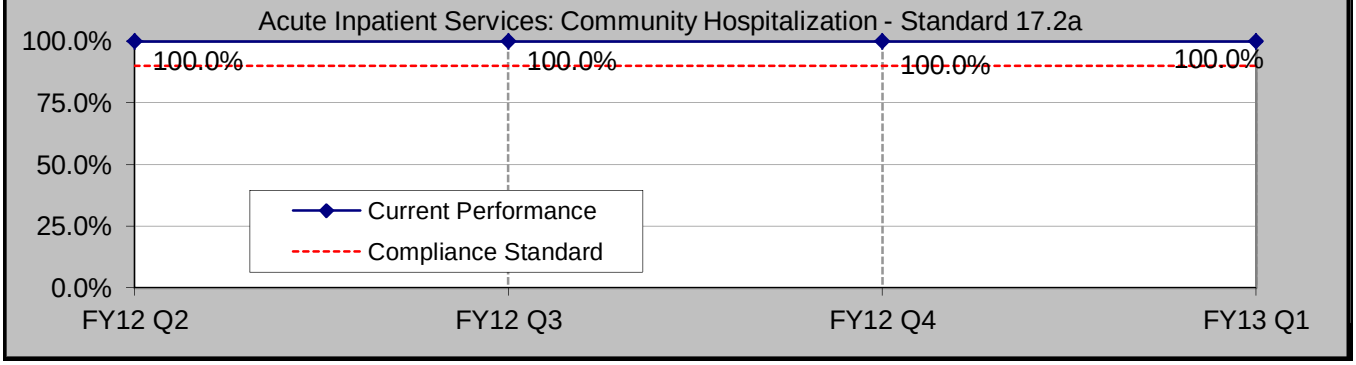


Standard 17.2	
Measurement	Blue paper was completed and in accordance with terms.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (19 out of 19)

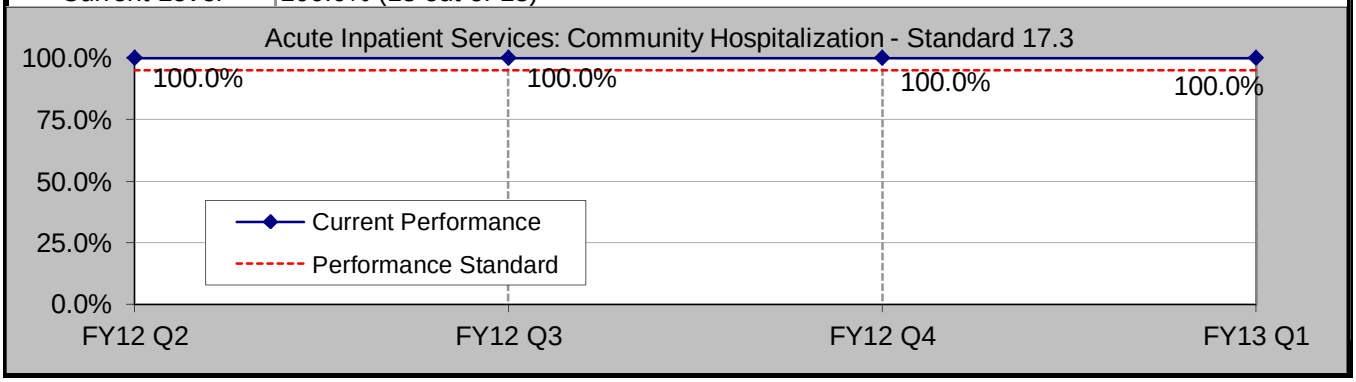


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

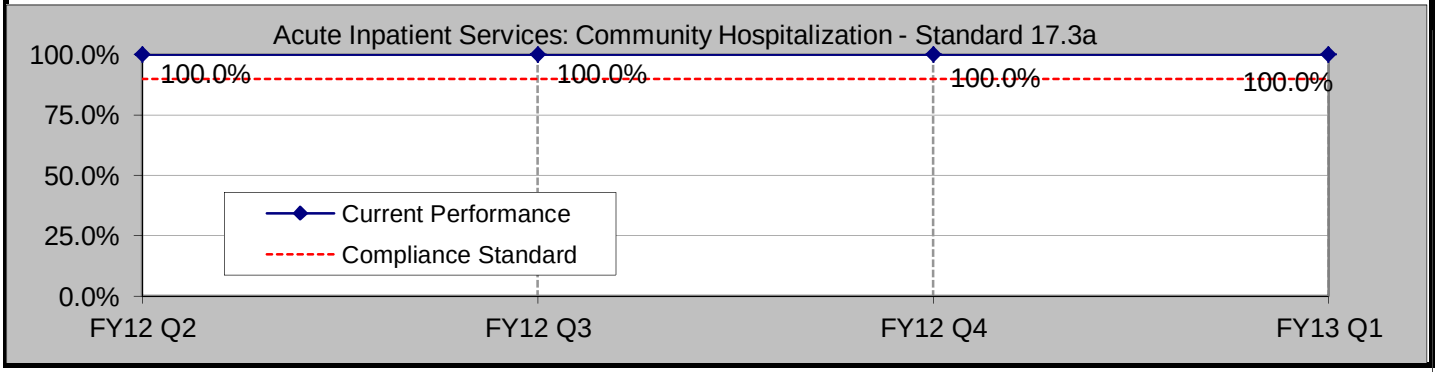


Standard 17.3	
Measurement	Class member involuntary admissions to community inpatient units in which 24 hour certification was completed.
Standard	Performance: 95%
Data Source	UR Database/EIS
Current Level	100.0% (18 out of 18)

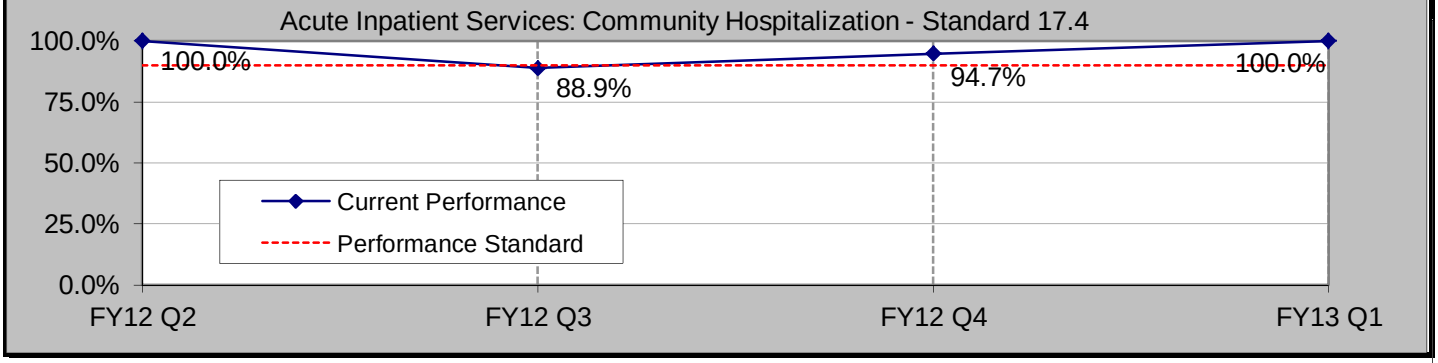


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

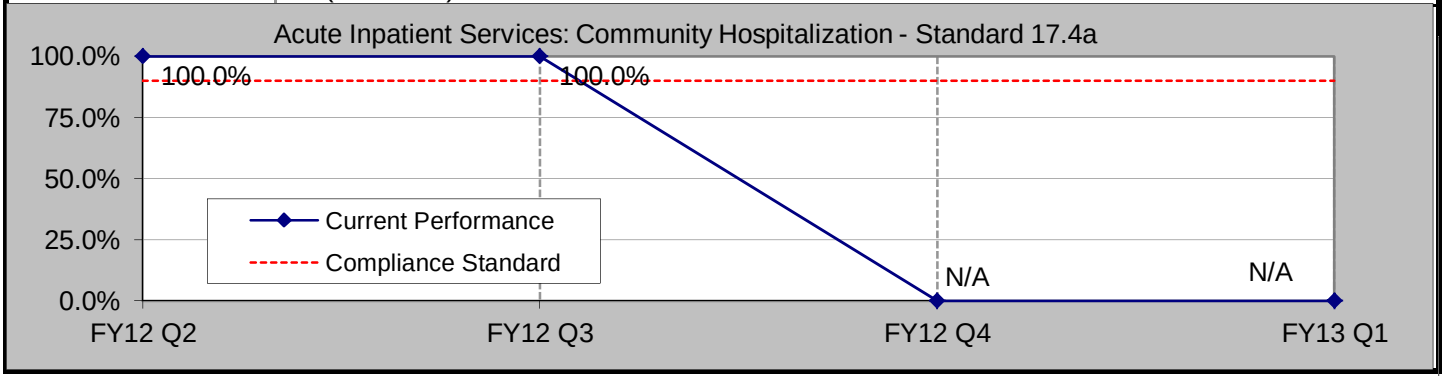


Standard 17.4	
Measurement	Class member involuntary admissions to community inpatient units in which patients' rights were maintained.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (19 out of 19)

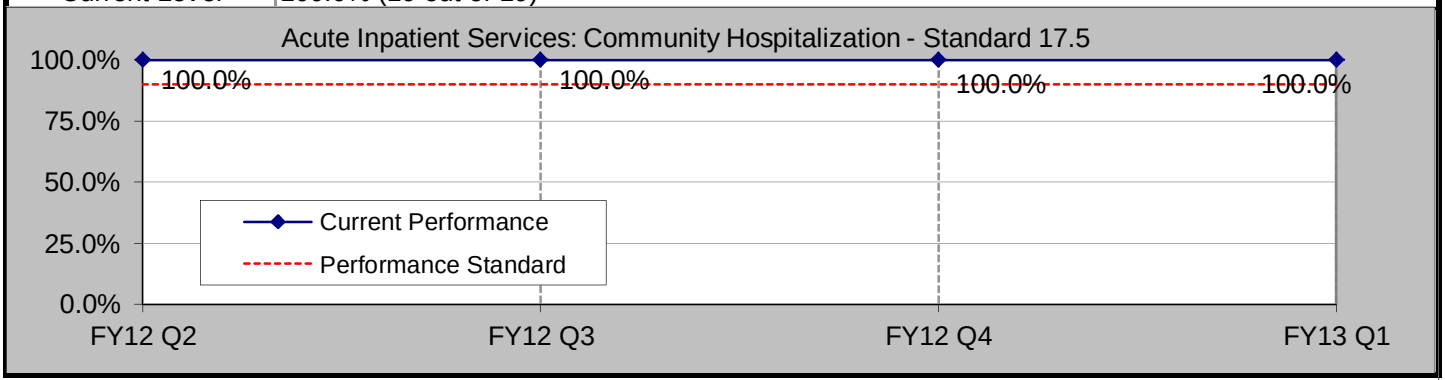


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

Standard 17.4a	
Measurement	Corrective action taken by UR nurse where documentation showed patients' rights not maintained.
Standard	Performance: 90% Compliance: 90%
Data Source	UR Database/EIS
Current Level	NA (0 out of 0)



Standard 17.5	
Measurement	Class member involuntary admissions for which medical necessity has been established.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (19 out of 19)



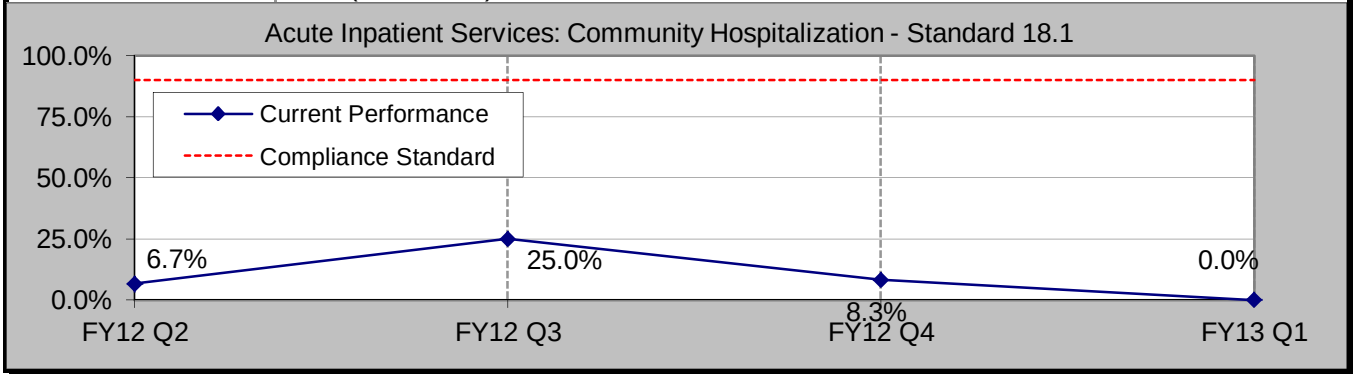
Discussion:

Standards 17.1, 17.2, 17.3, 17.4, 17.4a, and 17.5: Consistently met since the 1st quarter of FY 08

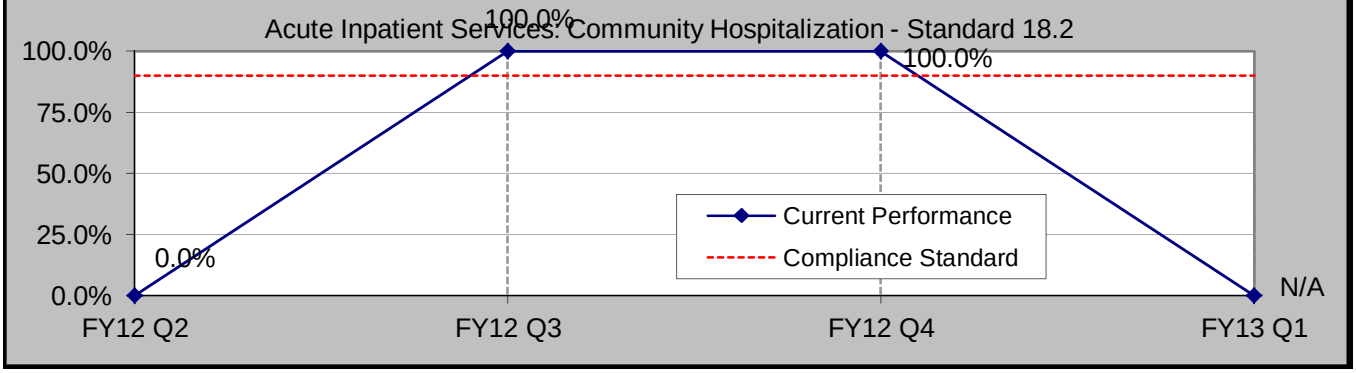
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

Standard 18.1	
Measurement	Class members admitted with ISPs for whom hospital obtained ISP.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	0.0% (0 out of 10)

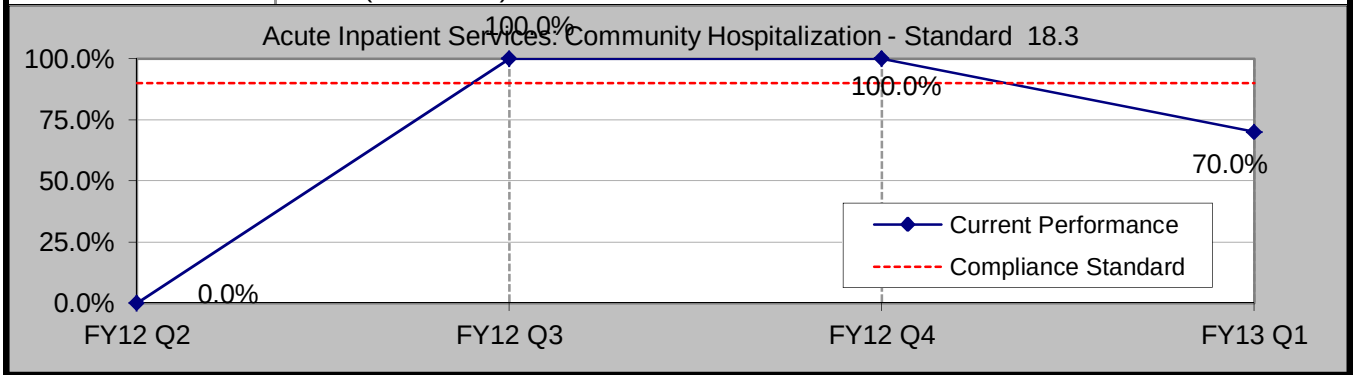


Standard 18.2	
Measurement	Treatment and discharge plan were determined to be consistent with ISP goals and objectives.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	N/A (0 out of 0)



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

Standard 18.3	
Measurement	CI/ICI/ICM/ACT worker participated in hospital treatment and discharge planning.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	70.0% (7 out of 10)



Discussion

OAMHS staff have met with Quality Improvement Director Jay Yoe.

standards 17.1, 17.2, 17.2a, 17.3, 17.3a, 17.4, 17.4a, 17.5, 19.1, 18.2, and 18.3 do not have statistically significant data

Standards 18.1, 18.2, and 18.3: Each quarter, hospital specific data regarding these standards is posted online and CSNs notified of their availability. Numbers for each standard are very small making it difficult to draw definitive conclusions. Worker participation has been higher than the hospital actually receiving the ISP.

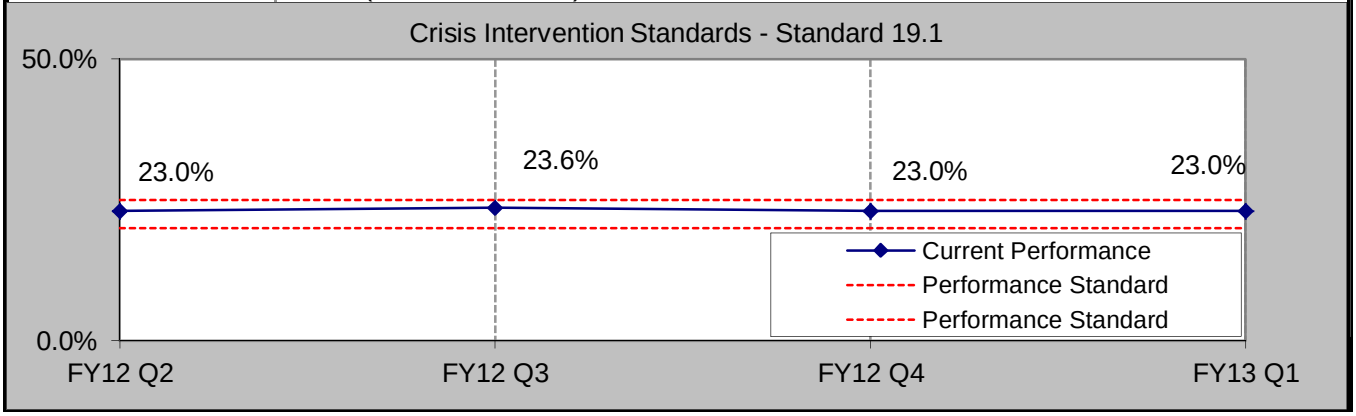
Recommendations:

Continue to monitor and post data on the SAMHS website

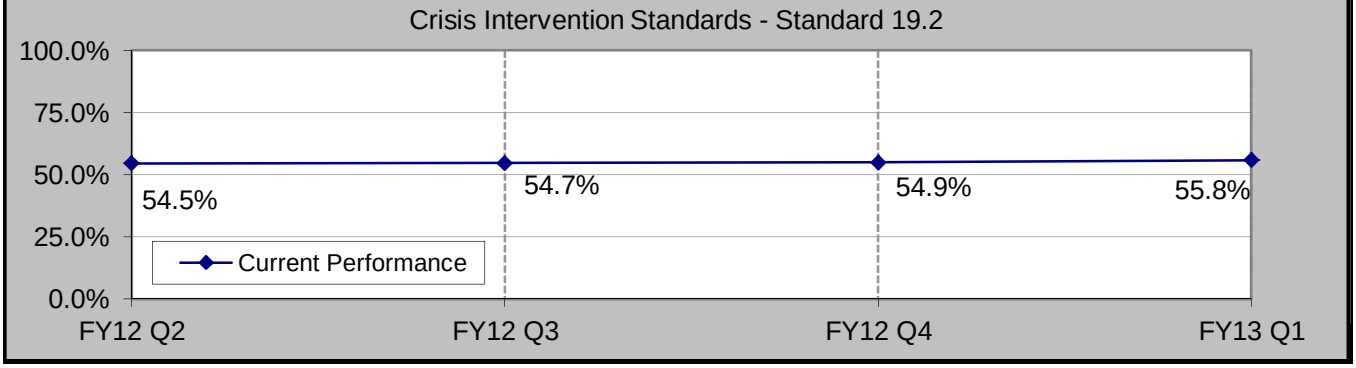
Community Resources and Treatment Services
Crisis Intervention Services

Standard 19 - Crisis services are effective and meet Settlement Agreement Standards

Standard 19.1	
Measurement	Face to face crisis contacts that result in hospitalizations.
Standard	Performance: No more than 20 - 25% are hospitalized as result of crisis intervention.
Data Source	Quarterly Contract Performance Data
Current Level	23.0% (1080 out of 4689)



Standard 19.2	
Measurement	Face to face crisis contacts that result in follow-up and/or referral to community based services.
Standard	To Be Established
Data Source	Quarterly Contract Performance Data
Current Level	55.8% (2615 out of 4689)



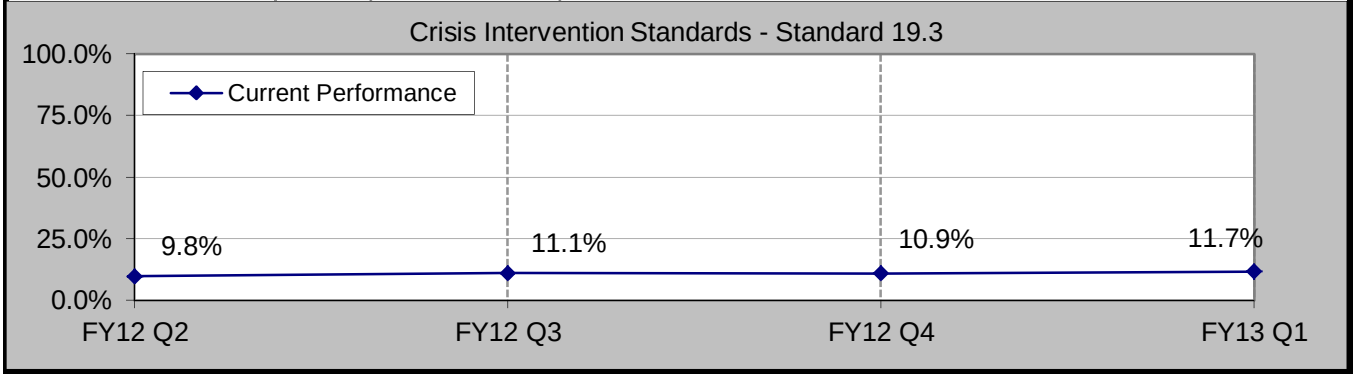
Comment:

Standard 19.1: This is a performance measure in the FY 13 contracts

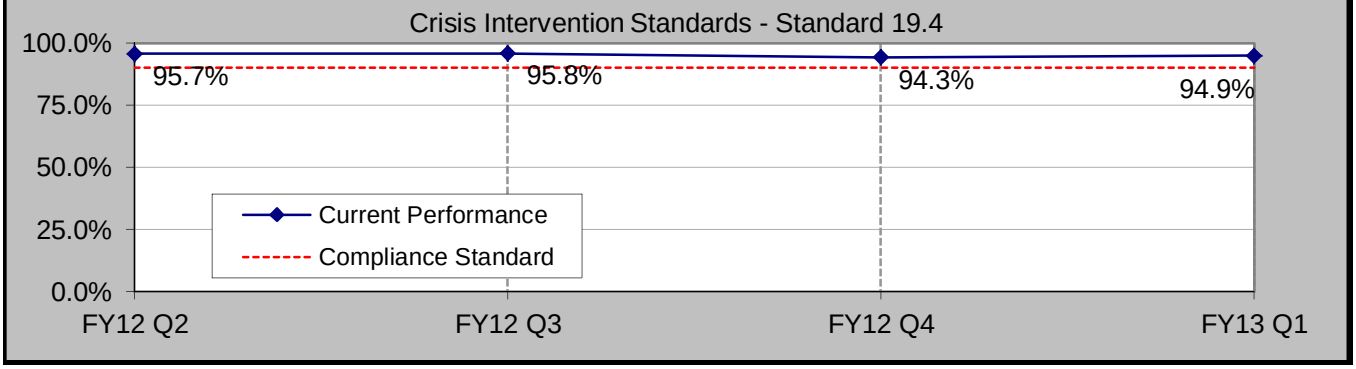
Standard 19.2: Continue to monitor.

Community Resources and Treatment Services
Crisis Intervention Services

Standard 19.3	
Measurement	Face to face crisis contacts in which a previously developed crisis plan was available and used.
Standard	To Be Established
Data Source	Quarterly Contract Performance Data
Current Level	11.7% (550 out of 4689)



Standard 19.4	
Measurement	Face to face crisis contacts in which client has a CI worker and worker was notified about the crisis.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	Quarterly Contract Performance Data
Current Level	94.9% (1167 out of 1230)



Discussion:

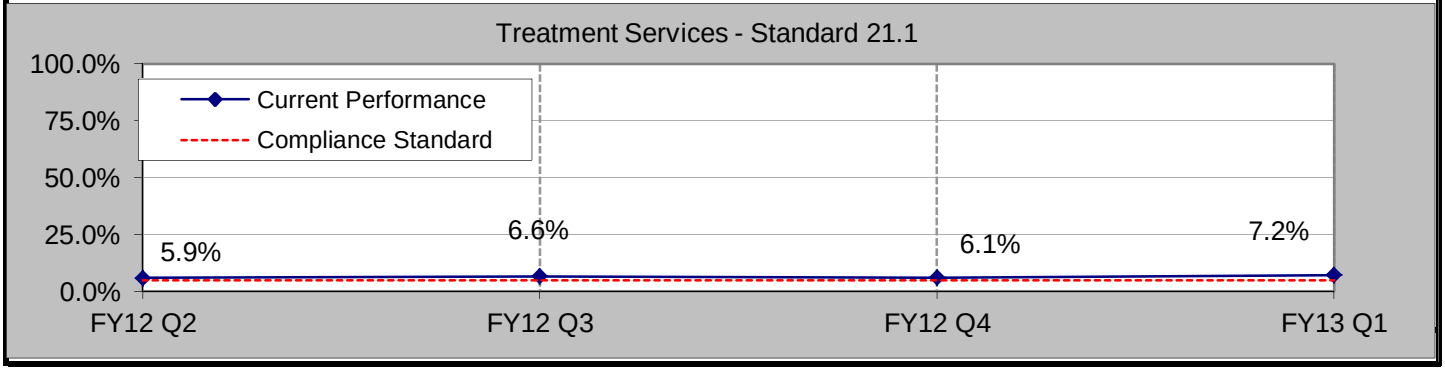
Standard 19.3: Continue to monitor.

Standard 19.4: Met since for FY' 09.

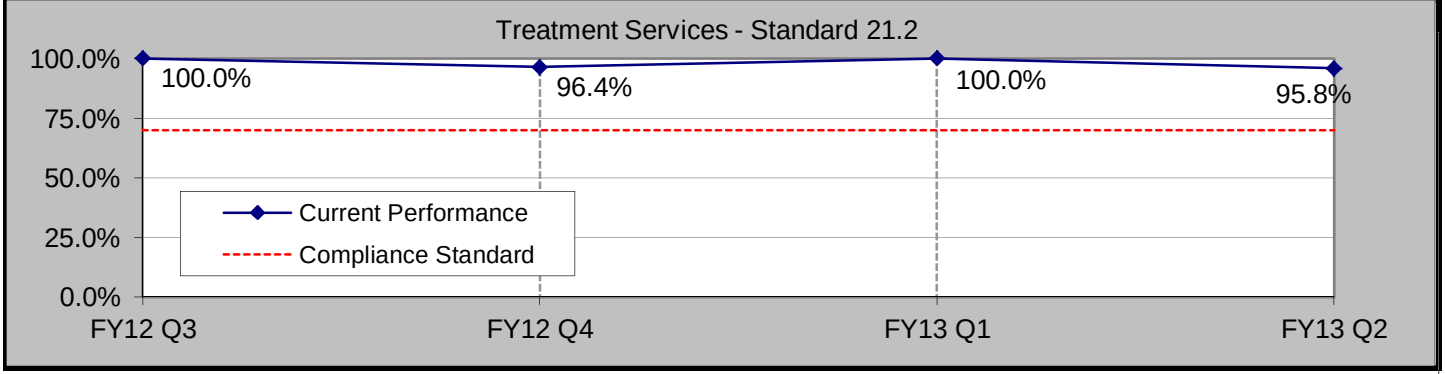
Community Resources and Treatment Services
Treatment Services

Standard 21 - An array of mental health treatment services are available and sufficient to meet ISP needs of class members and the needs of hospitalized class members ready for discharge.

Standard 21.1	
Measurement	Class members with ISPs with unmet mental health treatment needs
Standard	Compliance: 5% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	7.2% (85 out of 1182)

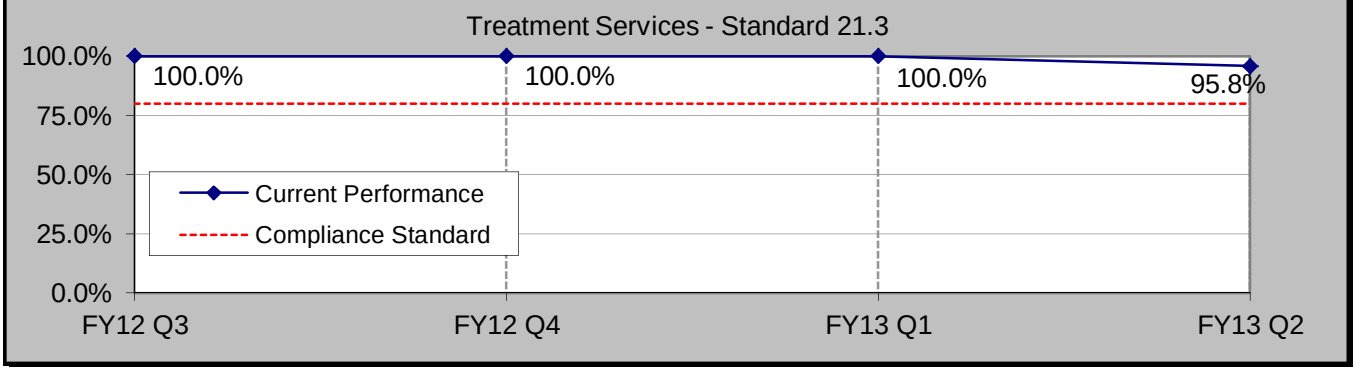


Standard 21.2	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination
Standard	Performance: 75% (within 7 days of that determination) Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	95.8% FY13 Q2 (Lack of mental health treatment did not impede discharge for 23 out of 24 patients within 7 days)

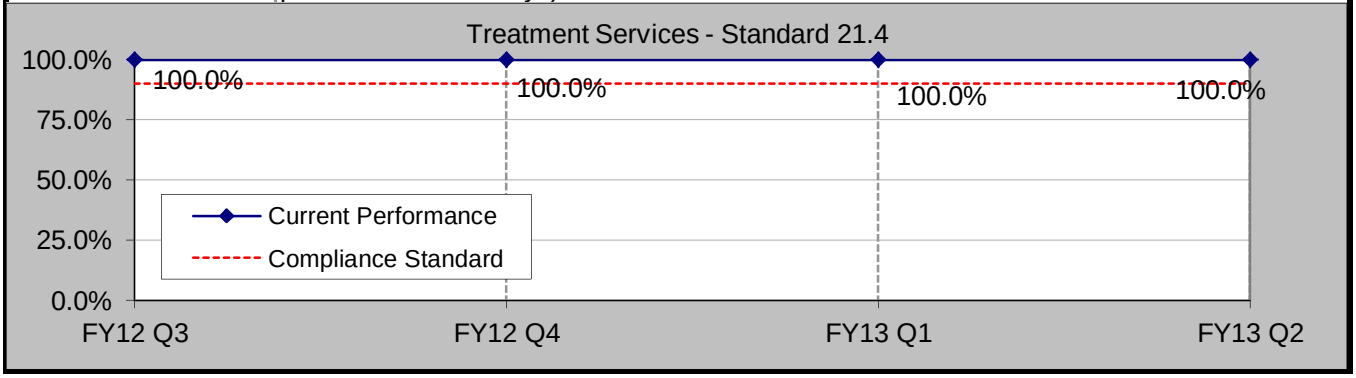


Community Resources and Treatment Services
Treatment Services

Standard 21.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	95.8% FY13 Q2 (Lack of mental health treatment did not impede discharge for 23 out of 24 patients within 30 days)



Standard 21.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination
Standard	Performance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY13 Q2 (Lack of mental health treatment did not impede discharge for any patients within 45 days)



Discussion:

Standard 21.1: Standard is consistently close to being met. Continue to monitor.

Standards 21.2, 21.3, 21.4: Met since the 1st quarter FY 08

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

24 Civil Patients discharged in quarter

13 discharged at 7 days (54.2%)
4 discharged 8-30 days (16.7%)
4 discharged 31-45 days (16.7%)
3 discharged post 45 days (12.5%)

Treatment services impeded discharge for 1 patient post clinical readiness for discharge (1%)

1 patients discharged 31-45 days post clinical readiness for discharge

Community Resources and Treatment Services
Treatment Services

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

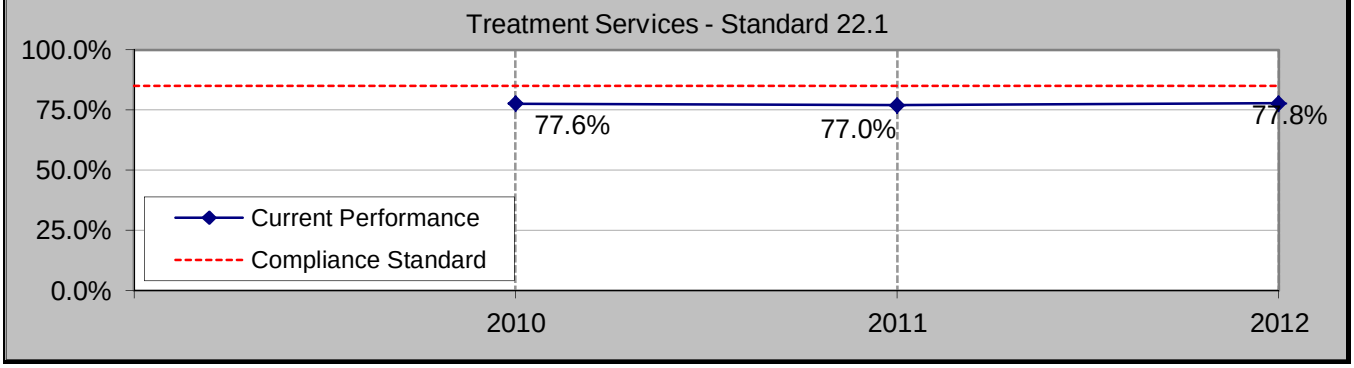
MaineCare Data FY 2012			
Mental Health Treatment Services Received	**Total Number**	**Total Number of Class Members**	**Percent of Class Members**
Assertive Community Treatment	891	306	34.3%
Community Integration	13,647	1,219	8.9%
Communty Rehabilitation	164	64	39.0%
Crisis Services	5,612	567	10.1%
Crisis Residential (CSU)	1,425	194	13.6%
Day Support/Day Treatment	957	117	12.2%
Medication Management	13,337	622	4.7%
Outpatient (Comp Assess&Therapy)	25,067	575	2.3%
Residential	821	366	44.6%
Skills Development	350	39	11.1%
Daily Living Supports	1,596	207	13.0%
***Total Unduplicated Count**	**37,933**	**1,826**	**4.8%**

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

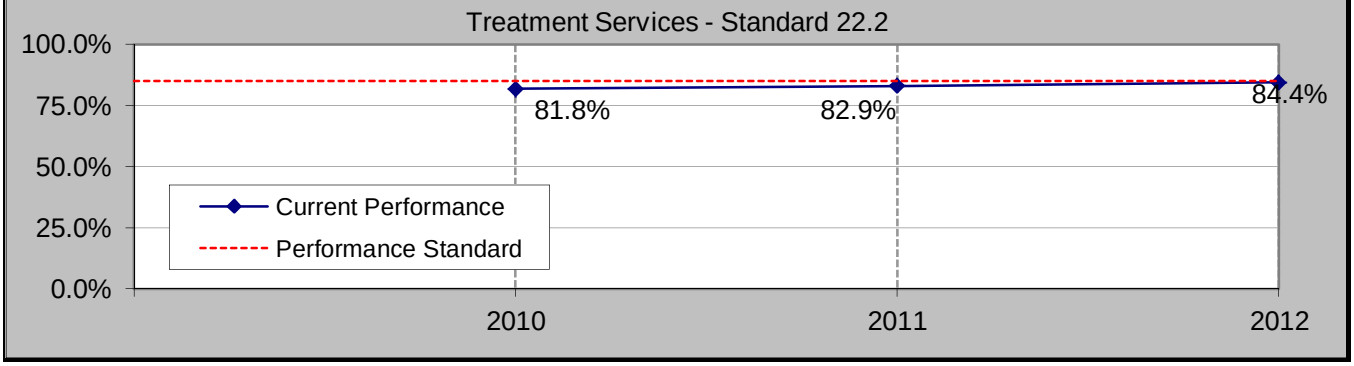
Community Resources and Treatment Services
Treatment Services

Standard 22 - Class members satisfied with access and quality of MH treatment services received.

Standard 22.1	
Measurement	Domain average of positive responses in the Perception of access domain
Standard	Performance: At or above 85% Compliance: OAMHS conducts review, takes action if results fall below defined levels.
Data Source	DIG Survey
Current Level	77.8% (N=1320)



Standard 22.2	
Measurement	Domain average of positive responses in the General Satisfaction domain
Standard	Performance: at or above 85%
Data Source	DIG Survey
Current Level	84.4% (N=1344)



Comment:

Standard 22.1 and 22.2: OAMHS has reached out to the Consumer Counsel of Maine for feedback and discussion on ways we can work with providers to improve.

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

Community Resources and Treatment Services
Family Support Services

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

Standard 23.1	
Measurement	Number of education programs developed and delivered meeting Settlement Agreement requirements
Standard	No standard necessary
Data Source	NAMI
Current Level	3 family to family class: Q1 FY 13

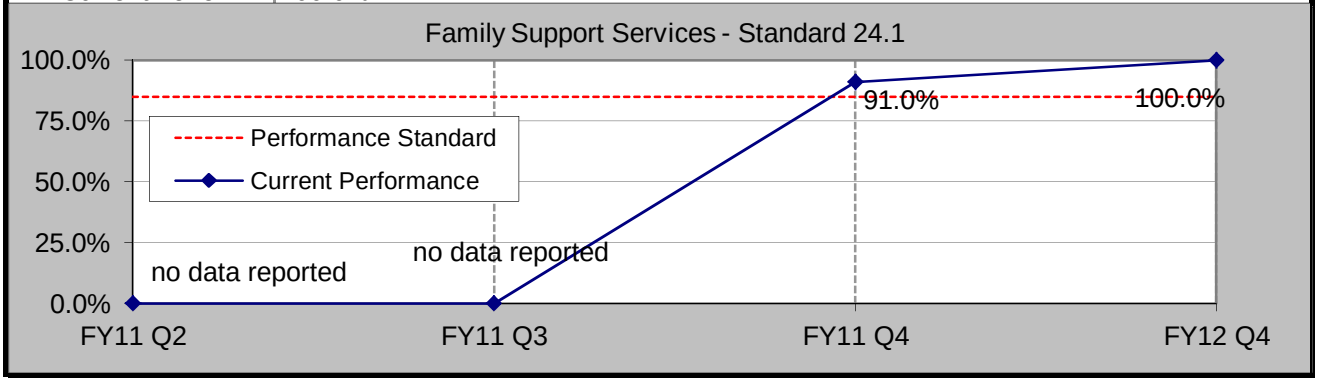
Standard 23.2	
Measurement	Number and distribution of family support services provided
Standard	No standard necessary
Data Source	NAMI
Current Level	16 family support groups, 16 sites: Q1 FY 13

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

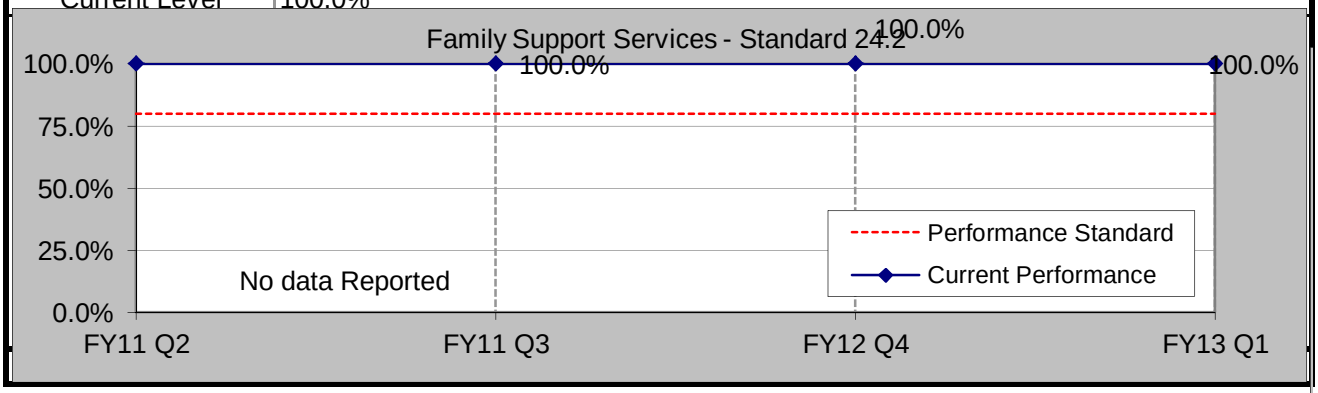
Community Resources and Treatment Services
Family Support Services

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

Standard 24.1	
Measurement	Percentage of support group and group counseling participants reporting satisfaction with services.
Standard	Performance: 85%
Data Source	NAMI
Current Level	100.0%



Standard 24.2	
Measurement	Percentage of program participants reporting satisfaction with education programs.
Standard	Performance: 80%
Data Source	NAMI
Current Level	100.0%



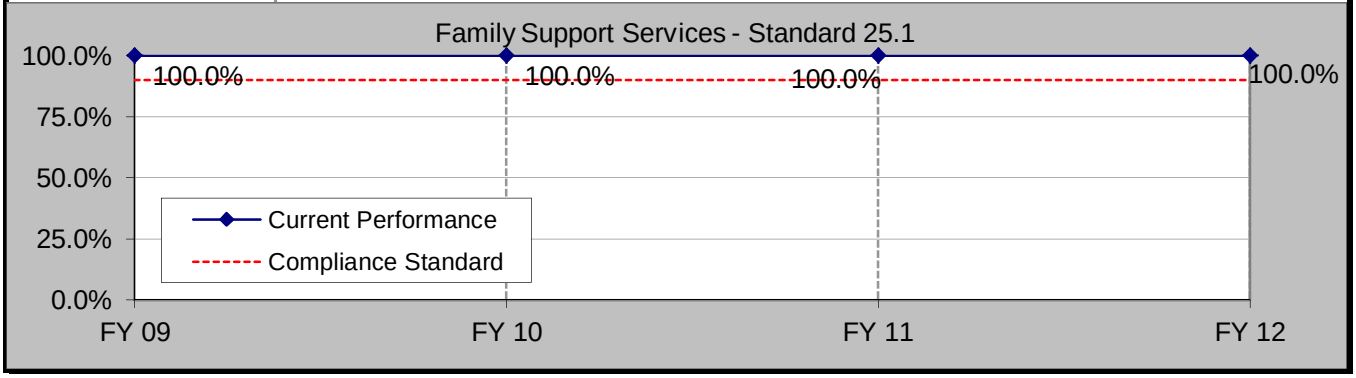
Discussion:

Standards 24.1 and 24.2: Data is now collected annually.

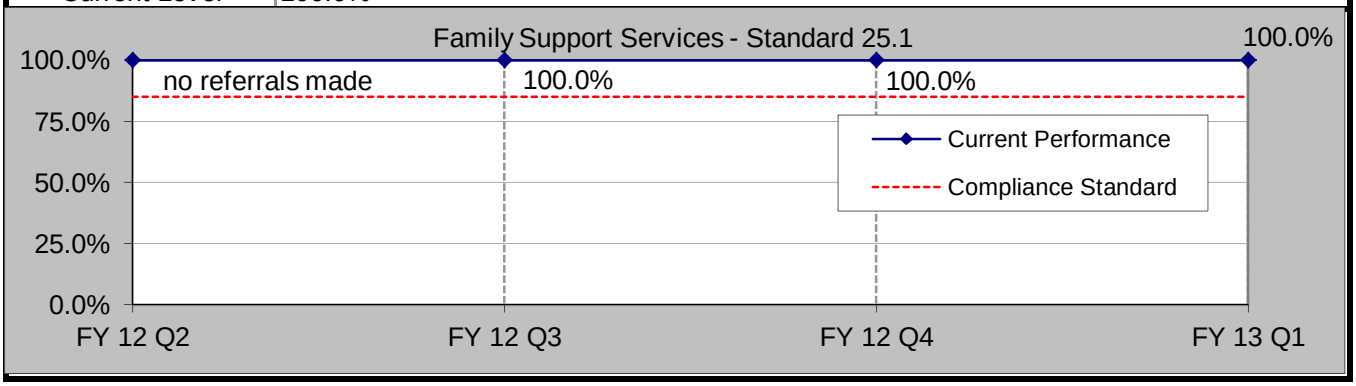
Community Resources and Treatment Services
Family Support Services

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

Standard 25.1	
Measurement	Agency contracts reviewed with documented evidence of referral mechanism to family support services.
Standard	Compliance: 90%
Data Source	Contract Reviews
Current Level	100.0%



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



Comment:

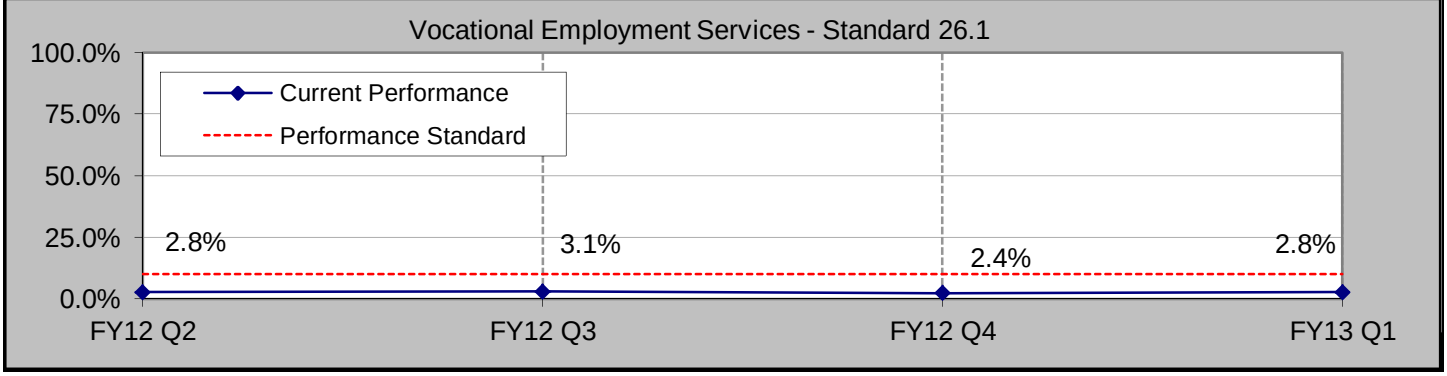
Standard 25.1: Consistently met

Standard 5.2: Consistently met when referrals have been made.

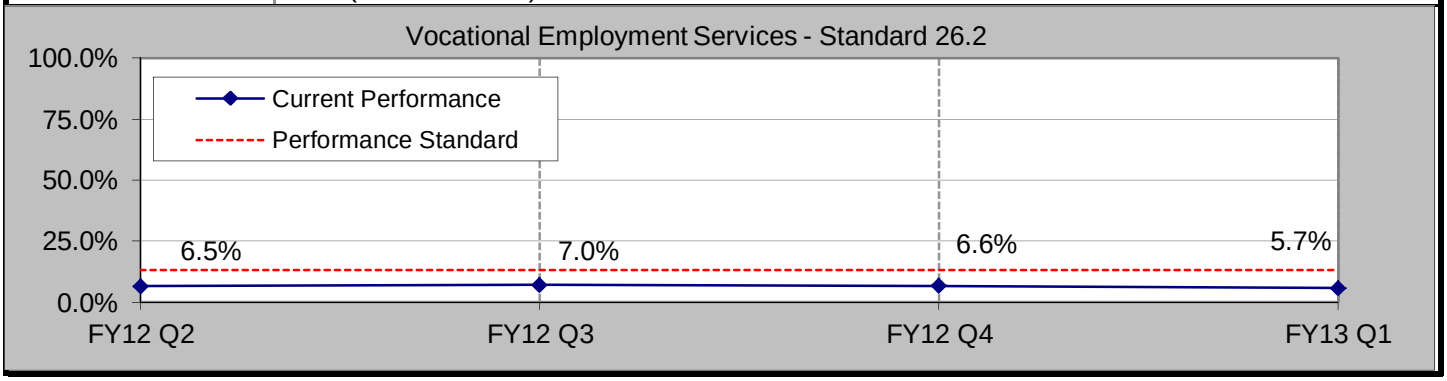
Community Resources and Treatment Services
Vocational Employment Services

Standard 26 - Reasonable efforts to provide array of vocational opportunities to meet ISP needs.

Standard 26.1	
Measurement	Class members with ISP identified unmet vocational/employment support needs.
Standard	Performance: 10% or fewer
Data Source	ISP RDS Data
Current Level	2.8% (33 out of 1182)



Standard 26.2	
Measurement	Class members younger than age 62 in competitive employment in the community.
Standard	Performance: 15% of class members employed in competitive employment. Compliance: 13% or Baseline (10.8%).
Data Source	ISP RDS Data
Current Level	5.7% (58 out of 1017)

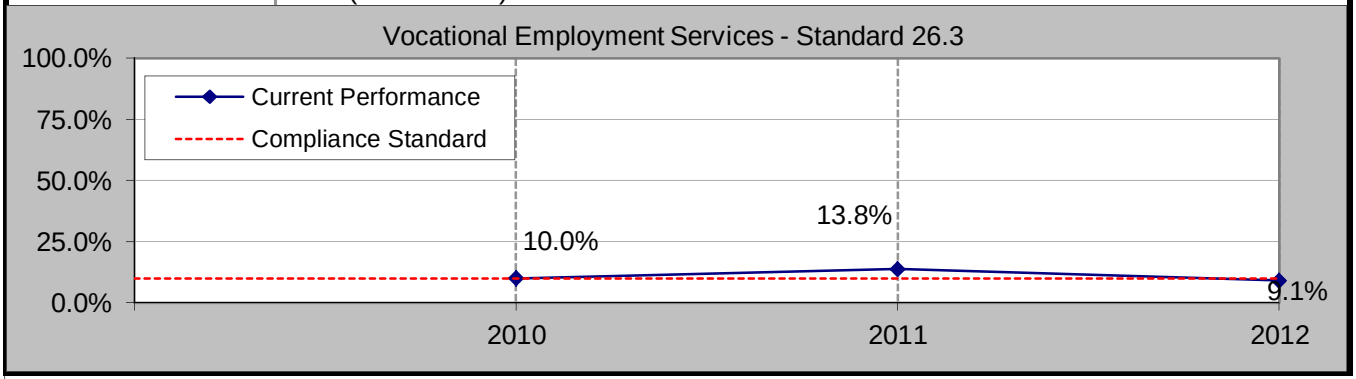


Discussion:

Standard 26.1: Standard continues to be met.

Community Resources and Treatment Services
Vocational Employment Services

Standard 26.3	
Measurement	Consumers under age 62 in supported and competitive employment (part or full time)
Standard	Performance: 15% in either competitive or supported employment Compliance: If number falls below 10%, Department conducts further review and takes appropriate action.
Data Source	DIG Survey
Current Level	9.1% (110 of 1205)



Discussion:

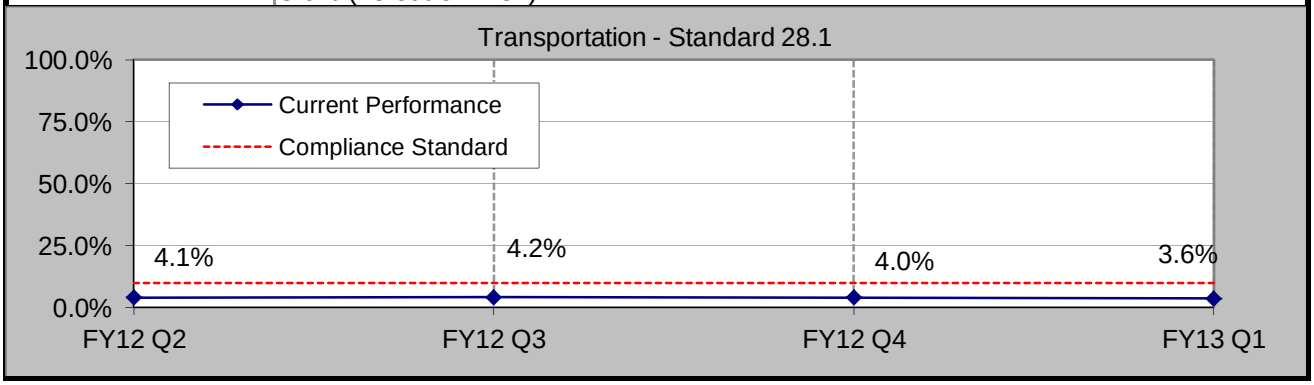
This standard factored out those persons responding to the DIG employment questions who are 62 and older, indicated they were retired or indicated they were not looking for work

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

Community Resources and Treatment Services
Transportation

Standard 28 - Reasonable efforts to identify and resolve transportation problems that may limit access to services

Standard 28.1	
Measurement	Percentage of class members with ISP identified unmet transportation needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	3.6% (43 out of 1182)



Discussion:

Standard continues to be met.

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

Standard 30.1	
Measurement	Number of social clubs/peer centers and participants by region.
Standard	Qualitative evaluation; no numerical standard required.
Data Source	Division of Community Partnerships Data
Current Level	32,786 total visits, 1306 unduplicated clients (11 of 13 social clubs/peer centers reporting for FY 13 Q1.)

Standard 30.2	
Measurement	Number of other peer support programs and participation.
Standard	Qualitative evaluation; no numerical standard required.
Data Source	Division of Community Partnerships Data
Current Level	29 Peer Support programs statewide during FY 2013 Q1. (includes social clubs/peer centers): Participation data is not collected for the Statewide Initiatives noted below.

Peer Support Groups funded by DHHS 2013 Q1:

Peer Centers and Social Clubs: Amistad -- Portland, Beacon House -- Rumford
Center for Life Enrichment -- Kittery, Common Connections -- Saco,
Friends Together -- Jay, Harmony Support Center -- Sanford, Harvest Social Club -- Caribou,
LINC -- Augusta, 100 Pine Street -- Lewiston, Sweetser Peer Center -- Brunswick
Together Place -- Bangor, Valley Social Club -- Madawaska, Waterville Social Club -- Waterville

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

Statewide:

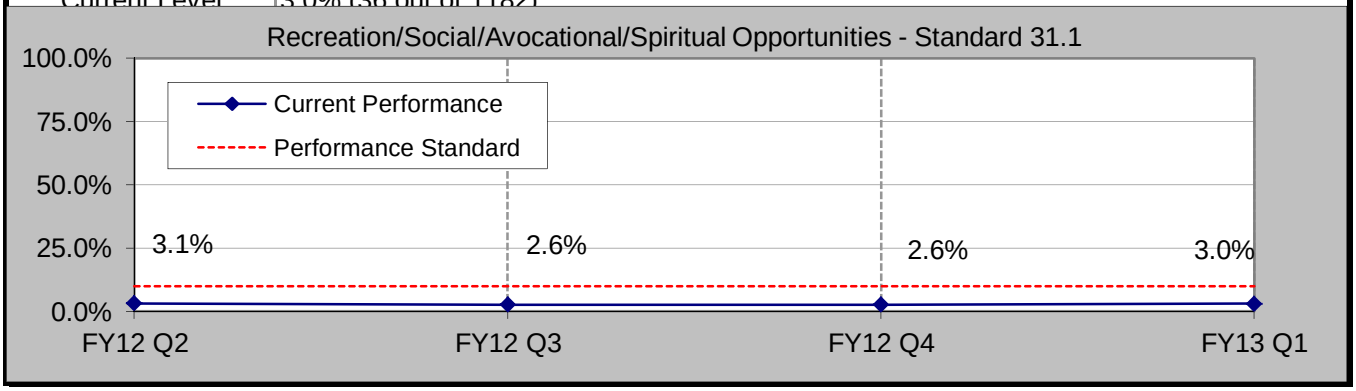
Community Connections: Community based recreational opportunities and leisure planning
MAPSRC (Maine Association of Psychosocial Rehabilitation Centers)

NAMI Support Groups primarily attended by consumers:

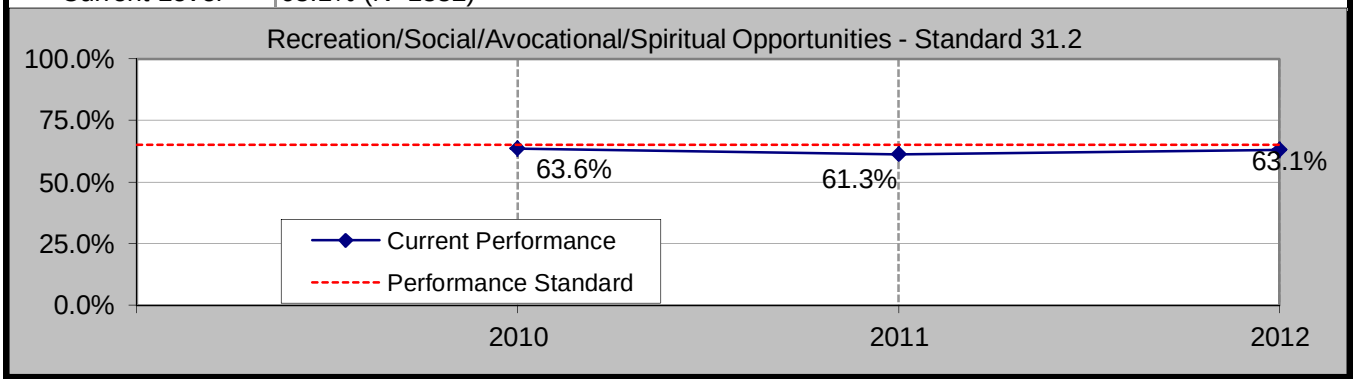
Augusta, Bangor, Biddeford, Brunswick, Damariscotta, Lewiston, Farmington, Rockland, Sanford, Waterville.

Standard 31 - Class member involvement in personal growth activities and community life.

Standard 31.1	
Measurement	ISP identified class member unmet needs in recreational, social, avocational and spiritual areas.
Standard	Performance: 10% or fewer
Data Source	ISP RDS Data
Current Level	3.0% (36 out of 1182)



Standard 31.2	
Measurement	Domain average of positive responses in the Social Connectedness domain
Standard	Performance: At or above 65%
Data Source	DIG Survey
Current Level	63.1% (N=1332)



Comments:

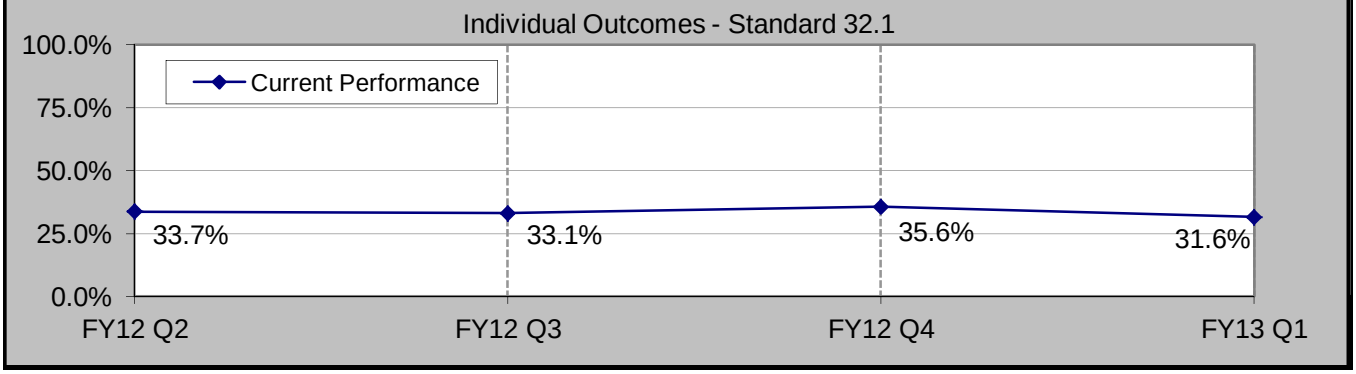
Standard 31.1: Continues to be met.

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

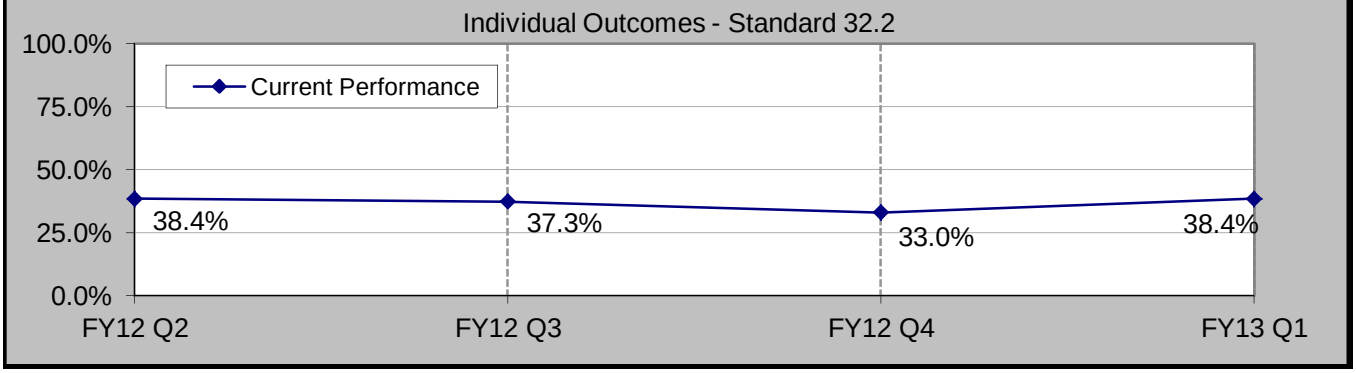
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

Standard 32 - Functional improvements in the lives of class members receiving services

Standard 32.1	
Measurement	Class Members demonstrating functional improvement on LOCUS between baseline and 12 month re-certification
Standard	Standard to be established.
Data Source	Enrollment data (Based on overall composite score.)
Current Level	31.6% (183 out of 580)



Standard 32.2	
Measurement	Class Members who have maintained level of functioning between baseline and 12 month re-certification.
Standard	Standard to be established.
Data Source	Enrollment data (Based on overall composite score.)
Current Level	38.4% (223 out of 580)

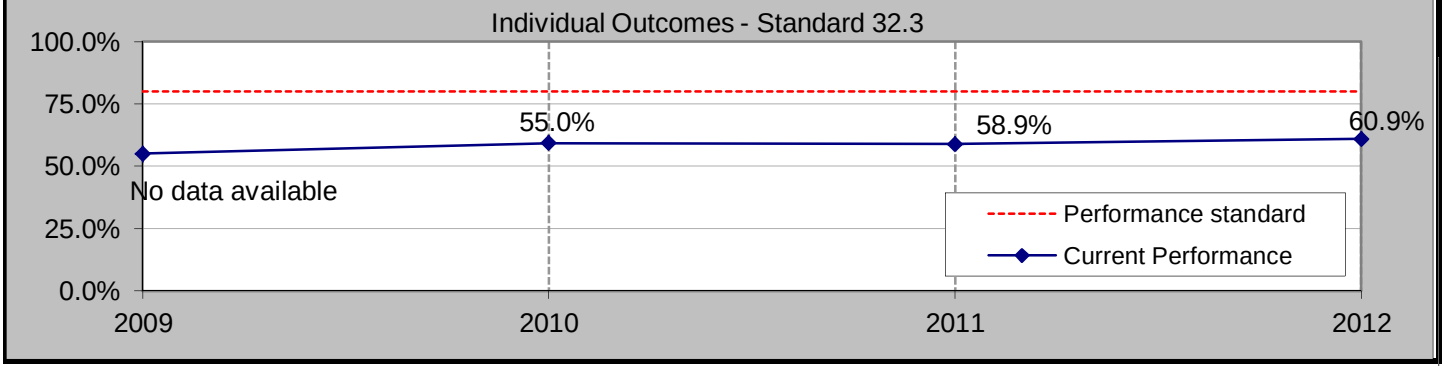


Comment

Standard 32.2: continue to monitor until standard is established.

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

Standard 32.3	
Measurement	Consumers reporting positively on functional outcomes on Data Infrastructure Survey outcome items.
Standard	Performance: 80%
Data Source	Data Infrastructure Grant Survey
Current Level	60.9% (N=1349)



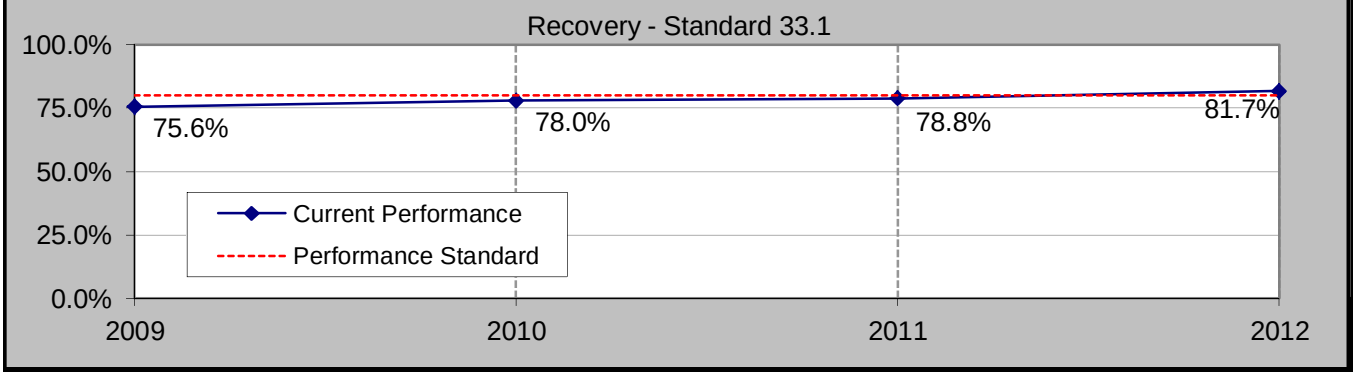
Discussion:

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

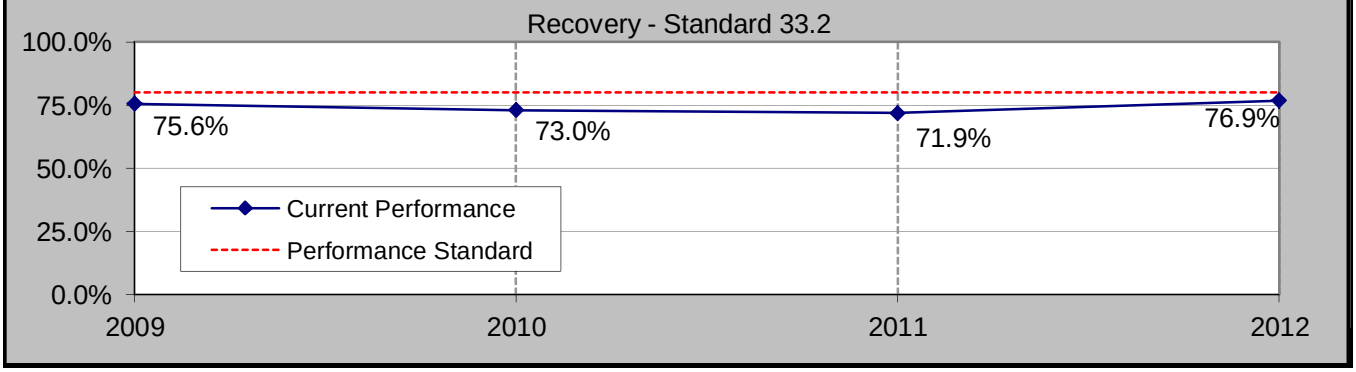
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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

Standard 33.1	
Measurement	Consumer reporting that agency staff helped them obtain information needed to take charge of managing illness.
Standard	Performance: 80%
Data Source	Data Infrastructure Grant Survey, Q20
Current Level	81.7% (N=1180)



Standard 33.2	
Measurement	Consumers reporting that agency staff believe that they can grow, change and recover
Standard	Performance: 80%
Data Source	Data Infrastructure Grant Survey, Q13
Current Level	76.9% (N=1271)

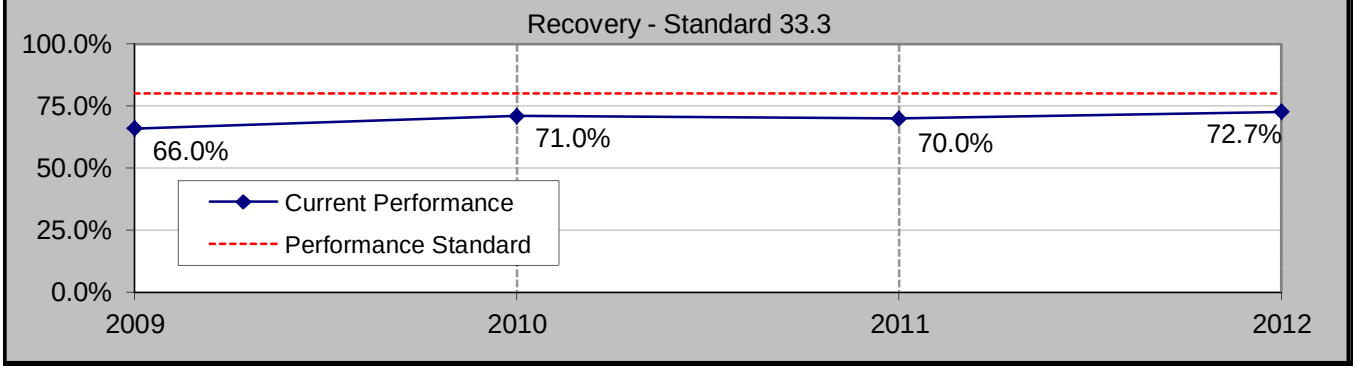


Comment:

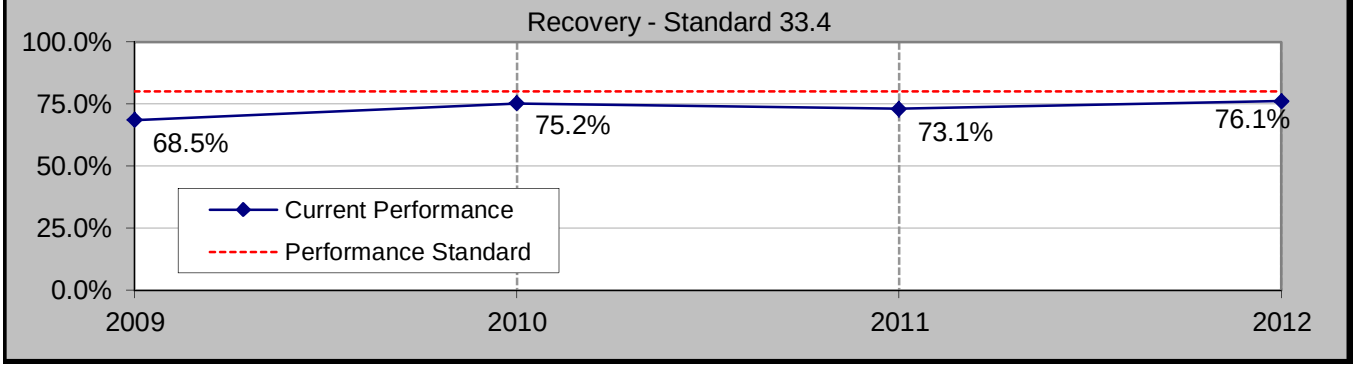
SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

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

Standard 33.3	
Measurement	Consumers reporting that agency services and staff supported their recovery and wellness efforts and beliefs.
Standard	Performance: 80%
Data Source	Data Infrastructure Grant Survey, Q15
Current Level	72.7% (N=1307)



Standard 33.4	
Measurement	Consumers reporting that providers offered opportunities to learn skills to strengthen and maintain wellness.
Standard	Performance: 80%
Data Source	Data Infrastructure Grant Survey, Q16
Current Level	76.1% (N=1292)

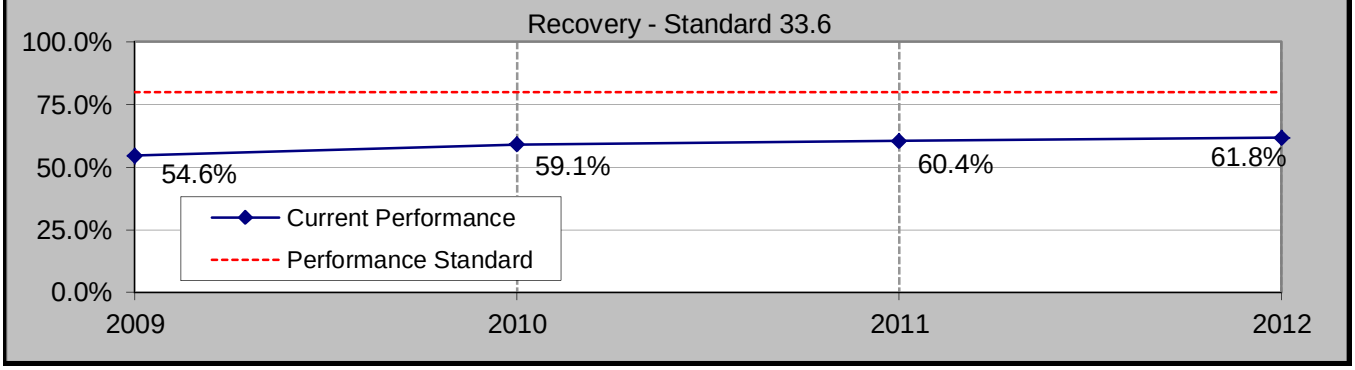


Comment:

Standard 33.3 and 33.4: SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

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

Standard 33.6	
Measurement	Consumers reporting that service providers offered mutual support or recovery-oriented groups run by peers.
Standard	Performance: 80%
Source	Data Infrastructure Grant Survey, Q17
Current Level	61.8% (N=1134)



Comments:

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

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

Standard 34 - Variety of public education programs on mental health and illness topics.

Standard 34.1	
Measurement	# of mental health workshops, forums, and presentations geared toward general public and level of participation.
Standard	Qualitative evaluation required, no numerical standard necessary.
Data Source	
Current Level	23 FY 13 Q1

Standard 34.2	
Measurement	Number and type of info packets, publications, press releases, etc. distributed to public audiences.
Standard	Qualitative evaluation required, no numerical standard necessary.
Data Source	
Current Level	1978 FY 13 Q1

Public Education- Standard 34

Oct - Dec 2012 (See Note Below)

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

As a result, NAMI Maine is submitting performance indicator data for July - Sept 2012

**Psychiatric & Forensic Grand Rounds, and Lunch and Learn, are open to the public and advertised by use of stakeholder email distribution lists.

Measure Method One:

Date & Location of Public Education Program	Audience: Public Service Agency	Audience: RPC and/or DDPC staff	Audience: Community Members	Audience: Other (Please Specify)	Total # of Participants	Topic: Addressing Myths & Stigma	Topic: Promoting Community Integration	Topic: Rights of MH Consumers and/or their Families	Topic: Other (Please Specify)	Total # Presentations/ # Participants This Quarter
10/2/12-RPC Augusta		11	1		12				PGR: Families on the Edge: Life in theAftermath of Homelessness	**23/467**
10/23/12 - RPC Augusta		9	1		10				PGR: Early Life Stress	
11/27/12 - RPC Augusta		10	1		11				Interdisciplinary, Proactive Psychiatric Consultation in a Medical Setting	
12/4/12- RPC Augusta		9	1		10				PGR: Evidence-Based Care for PTSD	
12/18/12-RPC Augusta		7	0		7				PGR: Using technology to Improve PTSD Treatment	
12/11/12 - RPC Augusta		10	1		11				PGR: Novel Approaches to Treatment of Psychiatric Cases	

10/19/12-Acadia Bangor	x	x	x		44	x	x	x	Vicarious Trauma Impact on the Child Welfare & Forensic Interviewing Workforce	
10/26/12-Acadia Bangor	x		x		28	x	x	x	Biochemestry of Trauma	
11/09/12-Acadia Bangor	x		x		25	x	x	x	Mindfulness	
12/14/12-Acadia Bangor	x		x		28	x	x	x	Crisis Centers	
NAMI 101; Bangor 7/12/12			x	family members	13	x	x	x		
NAMI 101; Augusta 8/10/12			x	family members	11	x	x	x		
Suicide Awareness; U Maine Farmington 8/29/12			x		65	x	x			
Suicide Awareness; Colby College Waterville 8/31/12			x		48	x	x			
Mental Illness and Adolesence 9/19/12			x		50	x	x	x		
Adolescent Mental Health Calais 10/9/12			x		22	x	x			
Crisis Intervention Training (CIT) Penobscot County	x			law enforcement	9				40 hr CIT training	
Crisis Intervention Training (CIT) Augusta	x			law enforcement	9				8 hour Child CIT	
10/11 Augusta			x	Consumers	10		x	x	Self-Care	
10/17,24,31 & 11/7 Bangor				Consumers	7	x	x	x	Healthy Connections	

10/25, 11/1,8,13,15,29, 12/6,13,20 Augusta	x			Consumers	13	x	x	x	CIPSS Training Program	
11/30 Augusta			x	Consumers	8		x		Building Connection	
12/12 Augusta			x	Consumers	16	x	x	x	Diversity	

Public Education- Standard 34
Oct - Dec 2012 (See note below)
Measure Method Two:

Note: Contracted agencies are allowed 1 month after the quarter to submit performance indicator data. As a result, NAMI Maine is submitting performance indicator data for July - Sept 2012

TOPIC of Info Packet,etc. Distributed to Public Audiences	TYPE of Info Packet, Publication, Press Release, etc. (Please Specify) Distributed to Public Audiences	TOTAL # Info Packets, Publications,etc Distributed This Quarter
Peer Support	Brochures, Articles	1,978
PGR: Families on the Edge: Life in theAftermath of Homelessness	Attendance & Eval form	
PGR: Early Life Stress	Attendance & Eval form	
Interdisciplinary, Proactive Psychiatric Consultation in a Medical Setting	Attendance & Eval form	
PGR: Strategies to Improve Evidence-Based Care for PTSD	Attendance & Eval form	
PGR: Using technology to Improve PTSD Treatment	Attendance & Eval form	
PGR: Novel Approaches to Treatment of Psychiatric Cases	Attendance & Eval form	
Vicarious Trauma & Its Impacts on the Child Welfare & Forensic Interviewing Workforce	Attendance & Eval form	
Biochemestry of Trauma	Attendance & Eval form	
Mindfulness	Attendance & Eval form	
Crisis Centers	Attendance & Eval form	
Consent Decree	Information Packet (47)	
National Institute for Mental Health	Brochures (1,464)	
Self-Care	Brochures, Articles	
Healthy Connections	Brochures, Articles	
CIPSS Training Program	Brochures, Articles	
Building Connection	Brochures, Articles	
Diversity	Brochures, Articles	

Family Support Services- Standard 23-25
Oct-Dec 2012 (see note below)

Note: Contracted agencies are allowed one month after the quarter to submit performance indicator data**.**
As a result, NAMI Maine is submitting performance indicator data for July - Sept 2012

Total # Presentations/ #Participants This Quarter	% Families Referred to FSS from MH Agencies Reporting Satisfaction w/Referral Process This Quarter	Educ on terms of Settlement Agreement	Educ on services, MI from varying perspectives	Educ on tx, meds, dx, prog, care	Family Group Meeting Facilitator	Group Counseling	Psycho-educational Programs	Respite Services (# of days)	Other (Please Specify)
Three Family to Family classes with 39 participants. Sixteen Family and Combined Support Groups with 826 people attending: Augusta, Bangor, Dover-Foxcroft, Ellsworth, Machias, Norway, Old Orchard Beach, Portland, Raymond, Rockport, Rumford, Sanford, South Paris, Skowhegan, Waterville, York	100	x	x	x	x	x	x	542 hours to 21 families	

Performance Indicators and Quality Improvement Standards

APPENDIX: ADULT MENTAL HEALTH DATA SOURCES

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

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

The Maine DHHS/OAMHS consumer survey is an adapted version of the National Mental Health Statistics Improvement (MHSIP) Consumer Survey that was specifically designed for use by adult recipients of mental health services. The survey is administered by mail in the summer. It is currently used by all State Mental Health Authorities across the country and will allow for state-to-state comparisons of satisfaction trends. The survey was designed to assess consumer experiences and satisfaction with their services and support in four primary domains, including: 1) Access to Services; 2) Quality and Appropriateness; 3) General Satisfaction; and 4) Outcomes.

Community Hospital Utilization Review Summary:

Data Type/Method: Service Review/Document Review
Target Population: Individuals admitted to community inpatient psychiatric hospitals on an emergency involuntary basis.
Approximate Sample Size: 150 per quarter.

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

Community Support Enrollment Data:

Data Type/Method: Demographic, clinical and diagnostic data for all consumers in Adult Mental Health Community Support Services (community integration, ACT, Community Rehabilitation Services and Intensive Case Management) maintained and reported from the Department's EIS (Enterprise Information System). Data is collected by APS Healthcare as part of its prior authorization process and fed into EIS twice a month.
Target Population: Adult Mental Health Consumers receiving Community Support.
Approximate Sample Size: 1500 class members of the total consumers enrolled in Community Support.

Community Support Services Census/Staffing Data:

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

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

Grievance Tracking Data:

Data Type/Method: Information pertaining to Level II and Level III Grievances.
Target Population: Consumers receiving any community based mental health service licensed, contracted or funded by DHHS and consumers who are patients at Riverview Psychiatric Center or Dorothea Dix Psychiatric Center.

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

Class Member Treatment Planning Review:

Data Type/Method: Service Review/Document Review
Target Population: Class Members receiving Community Support Services (ACT, CI)
Approximate Sample Size: As of the 3rd quarter FY11, sample size has been decreased to 50 per quarter, utilizing the random sampling methodology as previously developed. This allows the new OAMHS Division of Quality Management the time to assess and develop a new system of document reviews, not solely focused on treatment planning, that can be implemented across program areas and provide data for a wider group of individuals utilizing mental health services.

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

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

Data Type/Method: ISP RDS submitted by Community Support providers and collected by APS Healthcare as a component of their authorization process. Data is then fed into EIS twice a month.
Target Population: Adult Mental Health Consumers who receive Community Support Services (ACT, CI, and CRS).

The data is maintained and reported on through the DHHS Enterprise Information System (EIS). The ISP RDS captures ISP completion dates and consumer demographic data. The ISP RDS also captures data on the current housing/living situation of the person receiving services as well as the current vocational and employment statuses. Needed resources are tracked and include the following categories; Mental Health Services, Peer, Recovery and Support Services, Substance Abuse Services, Housing Resources, Health Care Resources, Legal Resources, Financial Resources, Educational Resources, Vocational Resources, Living Skills Resources, Transportation Resources, Personal Growth Resources and Other. The ISP RDS calculates unmet needs data by comparing current 90 day reviews to previous 90 days reviews.

Quarterly Contract Performance Indicator Data:

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

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

Department of Health and Human Services (DHHS)
Office of Substance Abuse and Mental Health Services (SAMHS)
Unmet Resource Needs Cover Document
February 2013

Attached Report:

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Quarter 1 (July, August, September 2013)

Population Covered:

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

Data Sources:

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

Unmet Resource Need Definition

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

Quality Improvement Measures

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

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

NIATx Quality Improvement Initiative. Managers in SAMHS were trained in the NIATx model of quality improvement during the prior quarter. NIATx is being deployed to address wait list and time to assignment issues in provider agencies. The model involves targeted changes using a rapid improvement methodology. SAMHS has contracted with a NIATx trainer who will provide on-site training and technical assistance for up to six contract provider sites in the state. In addition, a

SAMHS central office NIATx team has been formed and will be trained in using the model with employees. The Data/Quality Management Office is addressing the data needs for providers and central office staff to ensure they have the necessary data/quality management tools to measure their successes.
Identified Need: A,B

Wait List Graphs. On a weekly basis, the Data/Management staff update graphs of number of people on wait lists for CI, ACT and DLSS. Also, graphs for time to assignment are produced that correlate provide further information on these three services. This report is sent to management and field service staff to monitor trends in services over the past six months.
Identified Need: A

Contract Review Initiative. The Data/Quality Management staff are working with field service teams to ensure they have up-to-date, accurate service encounter data when they review progress toward meeting contract goals and establishing benchmarks for new contracts. A set of encounter data variables have been identified and are being tested in early 2013. After a review of that process, a final set of data variables will be produced and used for all contract reviews and negotiations.
Identified Need: A, B, D,E, I, J

Mental Health Rehabilitation/Crisis Service Provider Review. The Mental Health Rehabilitation/ Crisis Service Provider (MHRT/CSP) certification was developed by the crisis providers (Maine Crisis Network) over the past several years in collaboration with DHHS—adult mental health and children's behavioral health and the Muskie School. The MHRT/CSP is now ready to be implemented with providers. A review team consisting of two representatives from the Maine Crisis Network, two representatives from Children's Behavioral Health and two representatives from SAMHS will work together to conduct reviews at contracted agencies. Muskie is overseeing and organizing the review process and will collect our data to generate a summary report. We will be reviewing a total random sample of 238 MHRT/CSP records at 10 different crisis providers across the state. These reviews will occur during the first six months of 2013.
Identified Need: B

Contract Performance Measures. SAMHS has instituted contract performance measures for five services areas for FY13 contracts. Where appropriate, the measures are in alignment with standards under the consent decree. In a meeting with the DHHS Office of Quality Management, we agreed on a three year schedule for full implementation of measures; year one will be to validate the measures, year two to establish baselines, year 3 to test full implementation. At that point the measure will be put into Maine Care rule as well as being standardized for all SAMHS provider contracts.
Identified Need: A, B, C, D

Agency Score Card. Within 30 days after the submission of the quarterly report to the Court Master, the Data/Quality Manager will meet with the prevention, intervention, treatment and recovery managers to review standards deficiencies noted in the report. The managers will review systemic issues to determine if there are measures that are beyond the control of SAMHS staff to address. Once the managers meet, an agency score card listing all measures will be sent to field service teams to develop corrective action steps for meeting the standards. The agency score card and corrective actions steps will be sent to SAMHS management, field service teams and will be posted in the Data/Quality Management area of the SAMHS office.

Identified Need: A, B, C, D, E, F, G, H, I, J, K, L, M

Community Rehabilitation Services Survey. A face to face survey of clients who receive CRS services is being conducted in February 2013. The data collection instrument was shared with the court master in December 2012. The purpose of the survey is to determine whether residents understand the service delivery parameters of the CRS services as related to linkages to housing services. A report of the findings will be available in late February or early March 2013.
Identified Need: E, H, K

Substance Abuse and Mental Health Services
41 Anthony Ave, Augusta, ME 04333
Tel: (207)-287-4243 or (207)-287-4250
http://www.maine.gov/dhhs/mh/index.shtml

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Quarter 1

(July, Aug, Sept 2012)

Purpose of Report:

This report examines:

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

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

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

Data collection and reporting:

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

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

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

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

Report Run: Jan 16, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q1

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

CSN	Counties	Distinct People
CSN 1	Aroostook	336
CSN 2	Hancock, Penobscot, Piscataquis &	1,743
CSN 3	Kennebec & Somerset	1,938
CSN 4	Knox, Lincoln, Sagadahoc & Waldo	812
CSN 5	Androscoggin, Franklin & Oxford	1,868
CSN 6	Cumberland	1,937
CSN 7	York	450
Not Assigned	No legal address	343
Statewide		9,427

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

	2012 Q2			2012 Q3			2012 Q4			2013 Q1		
	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
CSN 1	103	368	28.0%	106	348	30.5%	94	331	28.4%	102	336	30.4%
CSN 2	455	1,756	25.9%	486	1,767	27.5%	500	1,799	27.8%	491	1,743	28.2%
CSN 3	316	1,822	17.3%	337	1,872	18.0%	320	1,950	16.4%	325	1,938	16.8%
CSN 4	206	725	28.4%	243	768	31.6%	240	779	30.8%	253	812	31.2%
CSN 5	539	1,704	31.6%	547	1,769	30.9%	620	1,831	33.9%	652	1,868	34.9%
CSN 6	577	1,826	31.6%	590	1,885	31.3%	590	1,919	30.7%	584	1,937	30.1%
CSN 7	164	540	30.4%	193	484	39.9%	193	467	41.3%	176	450	39.1%
N/A	95	354	26.8%	105	363	28.9%	101	355	28.5%	94	343	27.4%
Total	2,455	9,095	27.0%	2,607	9,256	28.2%	2,658	9,431	28.2%	2,677	9,427	28.4%

Report Run: Jan 16, 2013

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

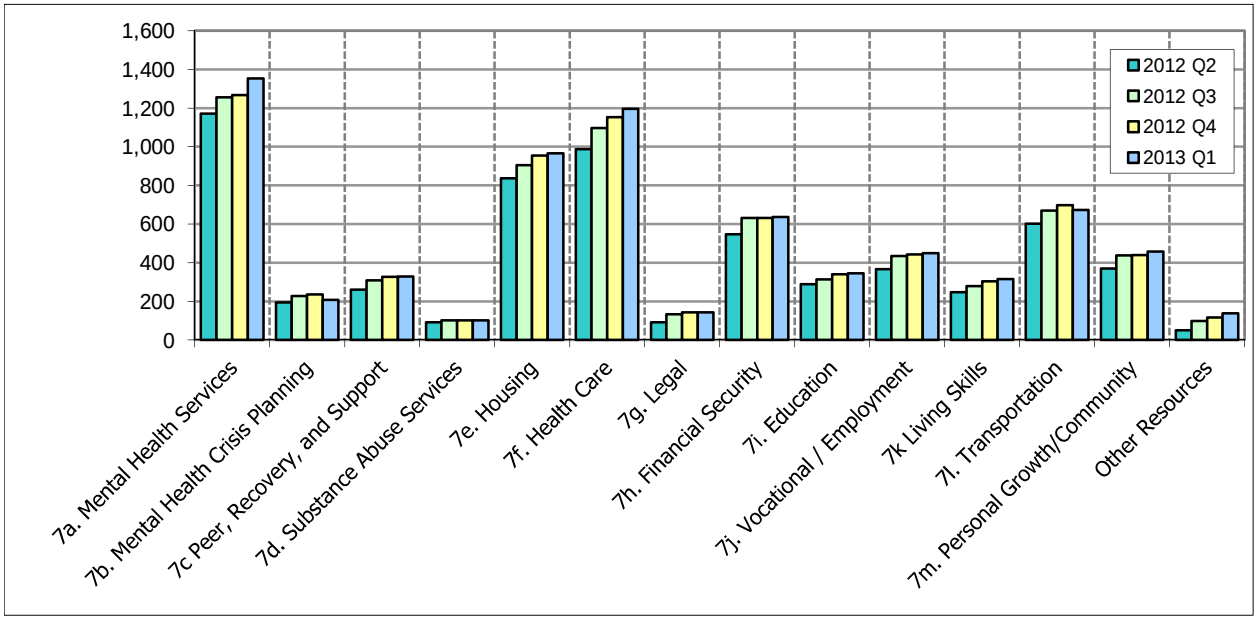


Table 3: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q2	2012 Q3	2012 Q4	2013 Q1
7a. Mental Health Services	1,171	1,255	1,267	1,353
7b. Mental Health Crisis Planning	195	228	235	207
7c Peer, Recovery, and Support	261	309	326	329
7d. Substance Abuse Services	91	101	102	102
7e. Housing	837	904	954	966
7f. Health Care	987	1,097	1,153	1,196
7g. Legal	92	133	143	143
7h. Financial Security	547	631	631	636
7i. Education	288	313	340	345
7j. Vocational / Employment	367	435	442	449
7k Living Skills	247	278	303	315
7l. Transportation	601	669	697	672
7m. Personal Growth/Community	370	437	439	458
Other Resources	50	99	116	138
Total Statewide Unmet Needs	6,104	6,889	7,148	7,309

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	9,095	9,256	9,431	9,427
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	34	29	25	35
7a-ii Community Integration Services	268	267	279	285
7a-iii Dialectical Behavioral Therapy	41	32	33	33
7a-iv Family Psycho-Educational Treatment	14	14	14	8
7a-v Group Counseling	24	36	37	36
7a-vi Individual Counseling	352	387	395	451
7a-vii Inpatient Psychiatric Facility	1	3	2	5
7a-viii Intensive Case Management	9	10	11	19
7a-x Psychiatric Medication Management	428	477	471	481
Total Unmet Resource Needs	1,171	1,255	1,267	1,353
Distinct Clients with Unmet Resource Needs	861	940	951	992
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	145	167	174	156
7b-ii Mental Health Advance Directives	50	61	61	51
Total Unmet Resource Needs	195	228	235	207
Distinct Clients with Unmet Resource Needs	177	201	214	189
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	28	35	46	51
7c-ii Recovery Workbook Group	2	3	2	1
7c-iii Social Club	97	120	115	113
7c-iv Peer-Run Trauma Recovery Group	24	36	39	35
7c-v Wellness Recovery and Action Planning	18	17	16	18
7c-vi Family Support	92	98	108	111
Total Unmet Resource Needs	261	309	326	329
Distinct Clients with Unmet Resource Needs	220	261	278	275
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	74	83	85	85
7d-ii Residential Treatment Substance Abuse Services	17	18	17	17
Total Unmet Resource Needs	91	101	102	102
Distinct Clients with Unmet Resource Needs	86	95	97	96

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	9,095	9,256	9,431	9,427
7e. Housing				
7e-i Supported Apartment	83	98	100	117
7e-ii Community Residential Facility	34	35	40	36
7e-iii Residential Treatment Facility (group home)	17	16	16	17
7e-iv Assisted Living Facility	31	33	42	39
7e-v Nursing Home	5	3	6	4
7e-vi Residential Crisis Unit	0	2	2	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	667	717	748	752
Total Unmet Resource Needs	837	904	954	966
Distinct Clients with Unmet Resource Needs	783	840	884	892
7f. Health Care				
7f-i Dental Services	531	581	603	616
7f-ii Eye Care Services	197	230	244	250
7f-iii Hearing Services	53	59	63	64
7f-iv Physical Therapy	33	29	31	35
7f-v Physician/Medical Services	173	198	212	231
Total Unmet Resource Needs	987	1,097	1,153	1,196
Distinct Clients with Unmet Resource Needs	755	820	855	869
7g. Legal				
7g-i Advocate	59	82	85	82
7g-ii Guardian (private)	27	41	45	47
7g-iii Guardian (public)	6	10	13	14
Total Unmet Resource Needs	92	133	143	143
Distinct Clients with Unmet Resource Needs	88	122	133	131
7h. Financial Security				
7h-i Assistance with Managing Money	300	367	372	379
7h-ii Assistance with Securing Public Benefits	206	223	226	219
7h-iii Representative Payee	41	41	33	38
Total Unmet Resource Needs	547	631	631	636
Distinct Clients with Unmet Resource Needs	489	557	554	568

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	9,095	9,256	9,431	9,427
7i. Education				
7i-i Adult Education (other than GED)	72	79	76	64
7i-ii GED	76	70	79	82
7i-iii Literacy Assistance	25	25	28	30
7i-iv Post High School Education	94	116	134	141
7i-v Tuition Reimbursement	21	23	23	28
Total Unmet Resource Needs	288	313	340	345
Distinct Clients with Unmet Resource Needs	266	287	313	318
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	35	34	32	49
7j-ii Club House and/or Peer Vocational Support	11	16	21	27
7j-iii Competitive Employment (no supports)	50	65	70	65
7j-iv Supported Employment	42	38	42	42
7j-v Vocational Rehabilitation	229	282	277	266
Total Unmet Resource Needs	367	435	442	449
Distinct Clients with Unmet Resource Needs	328	392	391	398
7k. Living Skills				
7k-i Daily Living Support Services	154	177	206	205
7k-ii Day Support Services	22	19	21	30
7k-iii Occupational Therapy	9	8	11	10
7k-iv Skills Development Services	62	74	65	70
Total Unmet Resource Needs	247	278	303	315
Distinct Clients with Unmet Resource Needs	223	253	281	288
7l. Transportation				
7l-i Transportation to ISP-Identified Services	293	350	336	334
7-ii Transportation to Other ISP Activities	165	164	187	180
7-iii After Hours Transportation	143	155	174	158
Total Unmet Resource Needs	601	669	697	672
Distinct Clients with Unmet Resource Needs	432	499	502	487
7m. Personal Growth/Community				
7m-i Avocational Activities	22	19	23	25

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	9,095	9,256	9,431	9,427
7m. Personal Growth/Community				
7m-ii Recreation Activities	101	115	128	127
7m-iii Social Activities	215	261	247	253
7m-iv Spiritual Activities	32	42	41	53
Total Unmet Resource Needs	370	437	439	458
Distinct Clients with Unmet Resource Needs	281	332	326	340
Other Resources				
Other Resources	50	99	116	138
Total Unmet Resource Needs	50	99	116	138
Distinct Clients with Unmet Resource Needs	50	99	116	138
Statewide Totals				
Total Unmet Resource Needs	6,104	6,889	7,148	7,309
Distinct Clients With any Unmet Resource Need	2,455	2,607	2,658	2,677
Distinct Clients with a RDS	9,095	9,256	9,431	9,427

Report Run: Jan 16, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q1

CSN 1 - Aroostook

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

2012 Q2			2012 Q3			2012 Q4			2013 Q1		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
103	368	28.0%	106	348	30.5%	94	331	28.4%	102	336	30.4%

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

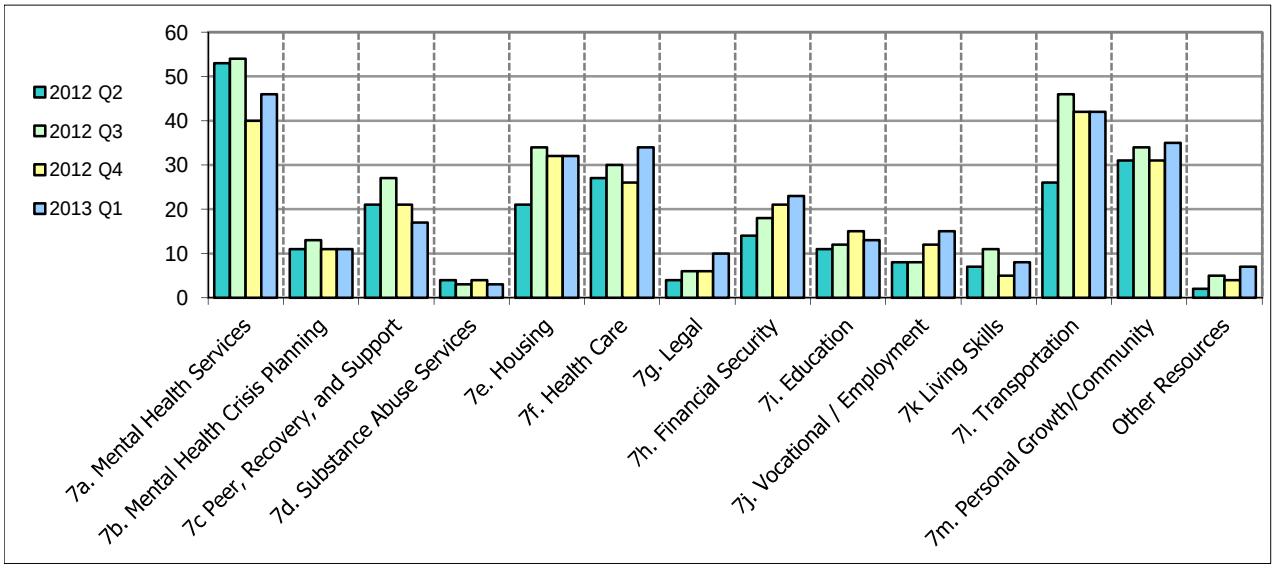


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q2	2012 Q3	2012 Q4	2013 Q1
7a. Mental Health Services	53	54	40	46
7b. Mental Health Crisis Planning	11	13	11	11
7c Peer, Recovery, and Support	21	27	21	17
7d. Substance Abuse Services	4	3	4	3
7e. Housing	21	34	32	32
7f. Health Care	27	30	26	34
7g. Legal	4	6	6	10
7h. Financial Security	14	18	21	23
7i. Education	11	12	15	13
7j. Vocational / Employment	8	8	12	15
7k Living Skills	7	11	5	8
7l. Transportation	26	46	42	42
7m. Personal Growth/Community	31	34	31	35
Other Resources	2	5	4	7
Total CSN 1 Unmet Needs	240	301	270	296

Report Run: Jan 16, 2013

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	368	348	331	336
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	0	1	0	0
7a-ii Community Integration Services	18	17	14	16
7a-iii Dialectical Behavioral Therapy	6	4	3	3
7a-iv Family Psycho-Educational Treatment	0	1	1	0
7a-v Group Counseling	1	0	2	0
7a-vi Individual Counseling	11	12	8	10
7a-vii Inpatient Psychiatric Facility	0	2	0	1
7a-viii Intensive Case Management	0	0	0	0
7a-x Psychiatric Medication Management	17	17	12	16
Total Unmet Resource Needs	53	54	40	46
Distinct Clients with Unmet Resource Needs	42	37	31	34
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	7	9	8	7
7b-ii Mental Health Advance Directives	4	4	3	4
Total Unmet Resource Needs	11	13	11	11
Distinct Clients with Unmet Resource Needs	10	11	10	9
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	1	1	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	14	20	17	11
7c-iv Peer-Run Trauma Recovery Group	0	1	0	0
7c-v Wellness Recovery and Action Planning	2	2	1	2
7c-vi Family Support	4	3	2	4
Total Unmet Resource Needs	21	27	21	17
Distinct Clients with Unmet Resource Needs	19	23	20	16
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	4	3	3	2
7d-ii Residential Treatment Substance Abuse Services	0	0	1	1
Total Unmet Resource Needs	4	3	4	3
Distinct Clients with Unmet Resource Needs	4	3	4	3

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	368	348	331	336
7e. Housing				
7e-i Supported Apartment	2	8	7	7
7e-ii Community Residential Facility	0	0	1	0
7e-iii Residential Treatment Facility (group home)	2	3	2	4
7e-iv Assisted Living Facility	2	3	1	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)	15	20	21	19
Total Unmet Resource Needs	21	34	32	32
Distinct Clients with Unmet Resource Needs	19	27	26	27
7f. Health Care				
7f-i Dental Services	15	14	12	9
7f-ii Eye Care Services	2	3	1	5
7f-iii Hearing Services	1	1	0	3
7f-iv Physical Therapy	1	1	2	3
7f-v Physician/Medical Services	8	11	11	14
Total Unmet Resource Needs	27	30	26	34
Distinct Clients with Unmet Resource Needs	25	27	23	27
7g. Legal				
7g-i Advocate	4	5	6	8
7g-ii Guardian (private)	0	1	0	1
7g-iii Guardian (public)	0	0	0	1
Total Unmet Resource Needs	4	6	6	10
Distinct Clients with Unmet Resource Needs	4	6	6	10
7h. Financial Security				
7h-i Assistance with Managing Money	6	9	10	14
7h-ii Assistance with Securing Public Benefits	8	9	11	9
7h-iii Representative Payee	0	0	0	0
Total Unmet Resource Needs	14	18	21	23
Distinct Clients with Unmet Resource Needs	13	17	18	20

Report Run: Jan 16, 2013

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	368	348	331	336
7i. Education				
7i-i Adult Education (other than GED)	5	5	5	2
7i-ii GED	3	4	4	5
7i-iii Literacy Assistance	1	0	1	2
7i-iv Post High School Education	1	2	4	3
7i-v Tuition Reimbursement	1	1	1	1
Total Unmet Resource Needs	11	12	15	13
Distinct Clients with Unmet Resource Needs	11	12	14	13
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	0	0	0	3
7j-ii Club House and/or Peer Vocational Support	0	0	0	0
7j-iii Competitive Employment (no supports)	1	1	1	0
7j-iv Supported Employment	2	2	4	4
7j-v Vocational Rehabilitation	5	5	7	8
Total Unmet Resource Needs	8	8	12	15
Distinct Clients with Unmet Resource Needs	7	8	11	13
7k. Living Skills				
7k-i Daily Living Support Services	3	4	1	4
7k-ii Day Support Services	2	0	1	3
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	2	7	3	1
Total Unmet Resource Needs	7	11	5	8
Distinct Clients with Unmet Resource Needs	6	8	4	7
7l. Transportation				
7l-i Transportation to ISP-Identified Services	16	25	20	21
7-ii Transportation to Other ISP Activities	5	7	7	7
7-iii After Hours Transportation	5	14	15	14
Total Unmet Resource Needs	26	46	42	42
Distinct Clients with Unmet Resource Needs	22	37	31	33
7m. Personal Growth/Community				
7m-i Avocational Activities	2	0	1	2

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	368	348	331	336
7m. Personal Growth/Community				
7m-ii Recreation Activities	9	6	10	9
7m-iii Social Activities	18	26	19	21
7m-iv Spiritual Activities	2	2	1	3
Total Unmet Resource Needs	31	34	31	35
Distinct Clients with Unmet Resource Needs	23	28	24	27
Other Resources				
Other Resources	2	5	4	7
Total Unmet Resource Needs	2	5	4	7
Distinct Clients with Unmet Resource Needs	2	5	4	7
CSN 1 Totals				
Total Unmet Resource Needs	240	301	270	296
Distinct Clients With any Unmet Resource Need	103	106	94	102
Distinct Clients with a RDS	368	348	331	336

Report Run: Jan 16, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q1

CSN 2 - Hancock, Washington, Penobscot, Piscataquis

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

2012 Q2			2012 Q3			2012 Q4			2013 Q1		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
455	1,756	25.9%	486	1,767	27.5%	500	1,799	27.8%	491	1,743	28.2%

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

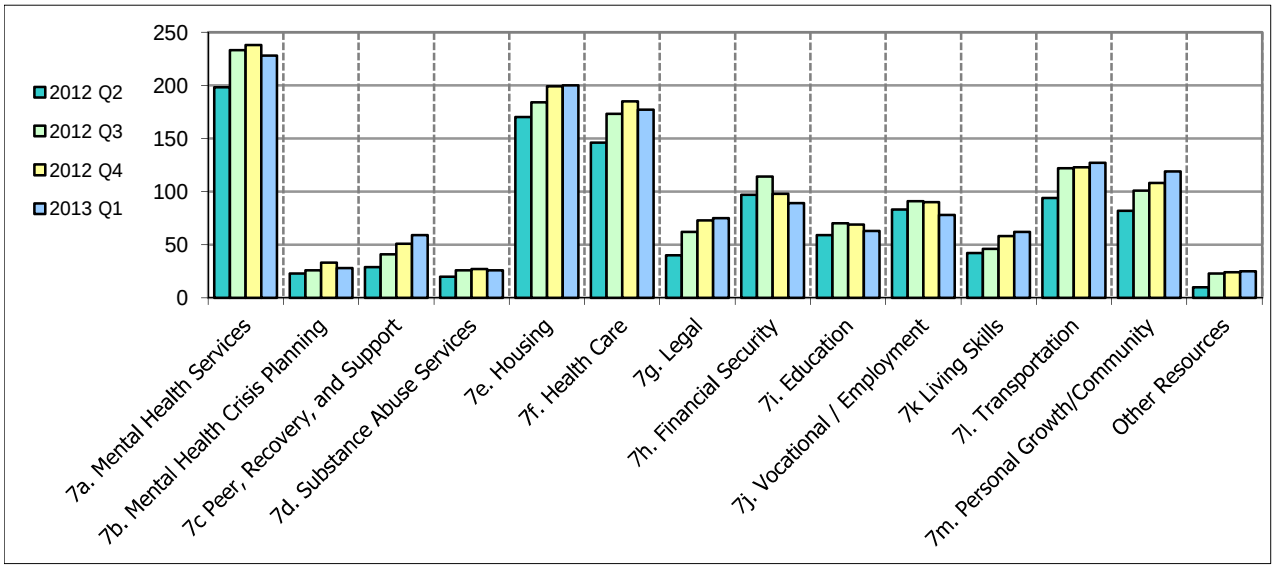


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q2	2012 Q3	2012 Q4	2013 Q1
7a. Mental Health Services	198	233	238	228
7b. Mental Health Crisis Planning	23	26	33	28
7c Peer, Recovery, and Support	29	41	51	59
7d. Substance Abuse Services	20	26	27	26
7e. Housing	170	184	199	200
7f. Health Care	146	173	185	177
7g. Legal	40	62	73	75
7h. Financial Security	97	114	98	89
7i. Education	59	70	69	63
7j. Vocational / Employment	83	91	90	78
7k Living Skills	42	46	58	62
7l. Transportation	94	122	123	127
7m. Personal Growth/Community	82	101	108	119
Other Resources	10	23	24	25
Total CSN 2 Unmet Needs	1,093	1,312	1,376	1,356

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,756	1,767	1,799	1,743
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	1	2	2
7a-ii Community Integration Services	40	56	58	52
7a-iii Dialectical Behavioral Therapy	2	2	2	2
7a-iv Family Psycho-Educational Treatment	2	2	3	2
7a-v Group Counseling	5	7	7	9
7a-vi Individual Counseling	70	82	83	87
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	3	1	2	1
7a-x Psychiatric Medication Management	74	82	81	73
Total Unmet Resource Needs	198	233	238	228
Distinct Clients with Unmet Resource Needs	143	167	164	159
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	19	21	27	24
7b-ii Mental Health Advance Directives	4	5	6	4
Total Unmet Resource Needs	23	26	33	28
Distinct Clients with Unmet Resource Needs	23	25	30	27
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	2	4	9	6
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	13	15	17	23
7c-iv Peer-Run Trauma Recovery Group	4	6	9	8
7c-v Wellness Recovery and Action Planning	3	3	7	8
7c-vi Family Support	7	13	9	14
Total Unmet Resource Needs	29	41	51	59
Distinct Clients with Unmet Resource Needs	22	33	39	45
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	17	23	24	24
7d-ii Residential Treatment Substance Abuse Services	3	3	3	2
Total Unmet Resource Needs	20	26	27	26
Distinct Clients with Unmet Resource Needs	20	25	26	25

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,756	1,767	1,799	1,743
7e. Housing				
7e-i Supported Apartment	16	18	17	22
7e-ii Community Residential Facility	5	6	8	6
7e-iii Residential Treatment Facility (group home)	3	2	1	1
7e-iv Assisted Living Facility	5	5	5	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)	141	153	167	164
Total Unmet Resource Needs	170	184	199	200
Distinct Clients with Unmet Resource Needs	157	169	187	183
7f. Health Care				
7f-i Dental Services	63	75	79	77
7f-ii Eye Care Services	40	51	52	52
7f-iii Hearing Services	5	7	9	6
7f-iv Physical Therapy	9	5	5	6
7f-v Physician/Medical Services	29	35	40	36
Total Unmet Resource Needs	146	173	185	177
Distinct Clients with Unmet Resource Needs	106	128	138	124
7g. Legal				
7g-i Advocate	16	25	30	32
7g-ii Guardian (private)	23	33	38	39
7g-iii Guardian (public)	1	4	5	4
Total Unmet Resource Needs	40	62	73	75
Distinct Clients with Unmet Resource Needs	37	52	64	64
7h. Financial Security				
7h-i Assistance with Managing Money	45	66	57	55
7h-ii Assistance with Securing Public Benefits	46	45	38	31
7h-iii Representative Payee	6	3	3	3
Total Unmet Resource Needs	97	114	98	89
Distinct Clients with Unmet Resource Needs	87	98	86	84

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

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,756	1,767	1,799	1,743
7i. Education				
7i-i Adult Education (other than GED)	10	10	9	10
7i-ii GED	10	14	13	9
7i-iii Literacy Assistance	4	4	3	4
7i-iv Post High School Education	25	32	35	33
7i-v Tuition Reimbursement	10	10	9	7
Total Unmet Resource Needs	59	70	69	63
Distinct Clients with Unmet Resource Needs	53	64	60	59
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	10	11	10	11
7j-ii Club House and/or Peer Vocational Support	1	0	2	3
7j-iii Competitive Employment (no supports)	22	22	20	17
7j-iv Supported Employment	10	7	10	8
7j-v Vocational Rehabilitation	40	51	48	39
Total Unmet Resource Needs	83	91	90	78
Distinct Clients with Unmet Resource Needs	67	76	71	67
7k. Living Skills				
7k-i Daily Living Support Services	28	31	45	43
7k-ii Day Support Services	1	1	2	4
7k-iii Occupational Therapy	1	0	1	2
7k-iv Skills Development Services	12	14	10	13
Total Unmet Resource Needs	42	46	58	62
Distinct Clients with Unmet Resource Needs	38	43	52	53
7l. Transportation				
7l-i Transportation to ISP-Identified Services	47	60	58	66
7-ii Transportation to Other ISP Activities	21	25	23	22
7-iii After Hours Transportation	26	37	42	39
Total Unmet Resource Needs	94	122	123	127
Distinct Clients with Unmet Resource Needs	70	94	97	98
7m. Personal Growth/Community				
7m-i Avocational Activities	4	3	4	7

Report Run: Jan 16, 2013

Report of Unmet Resource Needs

CSN 2

ancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,756	1,767	1,799	1,743
7m. Personal Growth/Community				
7m-ii Recreation Activities	27	35	35	38
7m-iii Social Activities	45	58	63	67
7m-iv Spiritual Activities	6	5	6	7
Total Unmet Resource Needs	82	101	108	119
Distinct Clients with Unmet Resource Needs	61	75	77	83
Other Resources				
Other Resources	10	23	24	25
Total Unmet Resource Needs	10	23	24	25
Distinct Clients with Unmet Resource Needs	10	23	24	25
CSN 2 Totals				
Total Unmet Resource Needs	1,093	1,312	1,376	1,356
Distinct Clients With any Unmet Resource Need	455	486	500	491
Distinct Clients with a RDS	1,756	1,767	1,799	1,743

Report Run: Jan 16, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q1

CSN 3 - Kennebec and Somerset

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

2012 Q2			2012 Q3			2012 Q4			2013 Q1		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
316	1,822	17.3%	337	1,872	18.0%	320	1,950	16.4%	325	1,938	16.8%

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

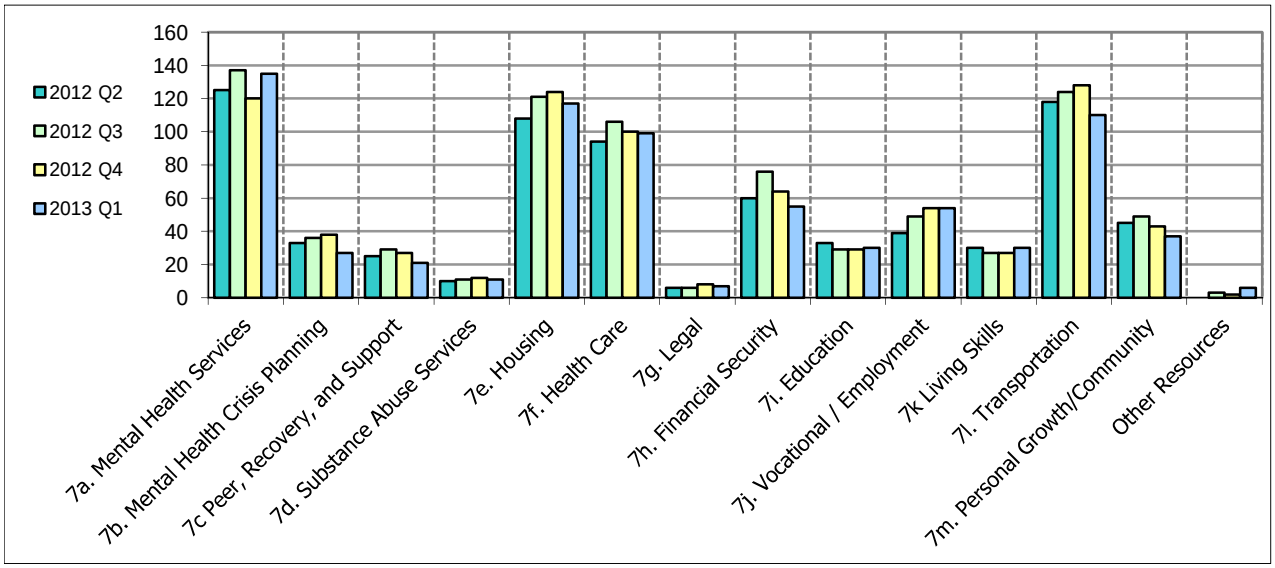

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q2	2012 Q3	2012 Q4	2013 Q1
7a. Mental Health Services	125	137	120	135
7b. Mental Health Crisis Planning	33	36	38	27
7c Peer, Recovery, and Support	25	29	27	21
7d. Substance Abuse Services	10	11	12	11
7e. Housing	108	121	124	117
7f. Health Care	94	106	100	99
7g. Legal	6	6	8	7
7h. Financial Security	60	76	64	55
7i. Education	33	29	29	30
7j. Vocational / Employment	39	49	54	54
7k Living Skills	30	27	27	30
7l. Transportation	118	124	128	110
7m. Personal Growth/Community	45	49	43	37
Other Resources	0	3	2	6
Total CSN 3 Unmet Needs	726	803	776	739

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

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,822	1,872	1,950	1,938
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	3	3	4	2
7a-ii Community Integration Services	36	33	28	41
7a-iii Dialectical Behavioral Therapy	1	2	0	0
7a-iv Family Psycho-Educational Treatment	2	1	2	2
7a-v Group Counseling	1	1	3	3
7a-vi Individual Counseling	34	40	39	39
7a-vii Inpatient Psychiatric Facility	0	0	0	1
7a-viii Intensive Case Management	0	2	1	1
7a-x Psychiatric Medication Management	48	55	43	46
Total Unmet Resource Needs	125	137	120	135
Distinct Clients with Unmet Resource Needs	93	103	87	92
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	25	25	26	21
7b-ii Mental Health Advance Directives	8	11	12	6
Total Unmet Resource Needs	33	36	38	27
Distinct Clients with Unmet Resource Needs	27	28	31	24
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	0	1	1	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	11	12	12	8
7c-iv Peer-Run Trauma Recovery Group	2	3	3	3
7c-v Wellness Recovery and Action Planning	0	0	0	0
7c-vi Family Support	12	13	11	10
Total Unmet Resource Needs	25	29	27	21
Distinct Clients with Unmet Resource Needs	23	27	26	20
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	6	8	8	7
7d-ii Residential Treatment Substance Abuse Services	4	3	4	4
Total Unmet Resource Needs	10	11	12	11
Distinct Clients with Unmet Resource Needs	10	11	12	11

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

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,822	1,872	1,950	1,938
7e. Housing				
7e-i Supported Apartment	3	3	3	5
7e-ii Community Residential Facility	7	6	7	5
7e-iii Residential Treatment Facility (group home)	2	1	0	0
7e-iv Assisted Living Facility	1	3	4	3
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	95	108	110	104
Total Unmet Resource Needs	108	121	124	117
Distinct Clients with Unmet Resource Needs	104	116	121	112
7f. Health Care				
7f-i Dental Services	45	49	49	51
7f-ii Eye Care Services	17	20	15	15
7f-iii Hearing Services	11	9	9	9
7f-iv Physical Therapy	4	2	2	1
7f-v Physician/Medical Services	17	26	25	23
Total Unmet Resource Needs	94	106	100	99
Distinct Clients with Unmet Resource Needs	74	80	80	83
7g. Legal				
7g-i Advocate	3	4	6	4
7g-ii Guardian (private)	0	0	0	1
7g-iii Guardian (public)	3	2	2	2
Total Unmet Resource Needs	6	6	8	7
Distinct Clients with Unmet Resource Needs	6	6	8	7
7h. Financial Security				
7h-i Assistance with Managing Money	33	43	35	31
7h-ii Assistance with Securing Public Benefits	22	28	24	19
7h-iii Representative Payee	5	5	5	5
Total Unmet Resource Needs	60	76	64	55
Distinct Clients with Unmet Resource Needs	54	67	55	50

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

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,822	1,872	1,950	1,938
7i. Education				
7i-i Adult Education (other than GED)	7	5	5	5
7i-ii GED	10	11	11	10
7i-iii Literacy Assistance	4	5	5	6
7i-iv Post High School Education	7	4	6	7
7i-v Tuition Reimbursement	5	4	2	2
Total Unmet Resource Needs	33	29	29	30
Distinct Clients with Unmet Resource Needs	31	27	27	28
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	3	3	4	5
7j-ii Club House and/or Peer Vocational Support	2	6	8	8
7j-iii Competitive Employment (no supports)	3	4	5	4
7j-iv Supported Employment	1	2	3	2
7j-v Vocational Rehabilitation	30	34	34	35
Total Unmet Resource Needs	39	49	54	54
Distinct Clients with Unmet Resource Needs	36	44	47	48
7k. Living Skills				
7k-i Daily Living Support Services	22	18	19	23
7k-ii Day Support Services	0	1	0	2
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	8	8	8	5
Total Unmet Resource Needs	30	27	27	30
Distinct Clients with Unmet Resource Needs	29	26	27	30
7l. Transportation				
7l-i Transportation to ISP-Identified Services	69	81	72	64
7-ii Transportation to Other ISP Activities	31	24	32	28
7-iii After Hours Transportation	18	19	24	18
Total Unmet Resource Needs	118	124	128	110
Distinct Clients with Unmet Resource Needs	92	101	93	80
7m. Personal Growth/Community				
7m-i Avocational Activities	1	1	0	0

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,822	1,872	1,950	1,938
7m. Personal Growth/Community				
7m-ii Recreation Activities	10	10	10	8
7m-iii Social Activities	32	35	30	26
7m-iv Spiritual Activities	2	3	3	3
Total Unmet Resource Needs	45	49	43	37
Distinct Clients with Unmet Resource Needs	35	40	34	29
Other Resources				
Other Resources	0	3	2	6
Total Unmet Resource Needs	0	3	2	6
Distinct Clients with Unmet Resource Needs	0	3	2	6
CSN 3 Totals				
Total Unmet Resource Needs	726	803	776	739
Distinct Clients With any Unmet Resource Need	316	337	320	325
Distinct Clients with a RDS	1,822	1,872	1,950	1,938

Report Run: Jan 16, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q1

CSN 4 - Knox, Lincoln, Sagadahoc, Waldo

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

2012 Q2			2012 Q3			2012 Q4			2013 Q1		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
206	725	28.4%	243	768	31.6%	240	779	30.8%	253	812	31.2%

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

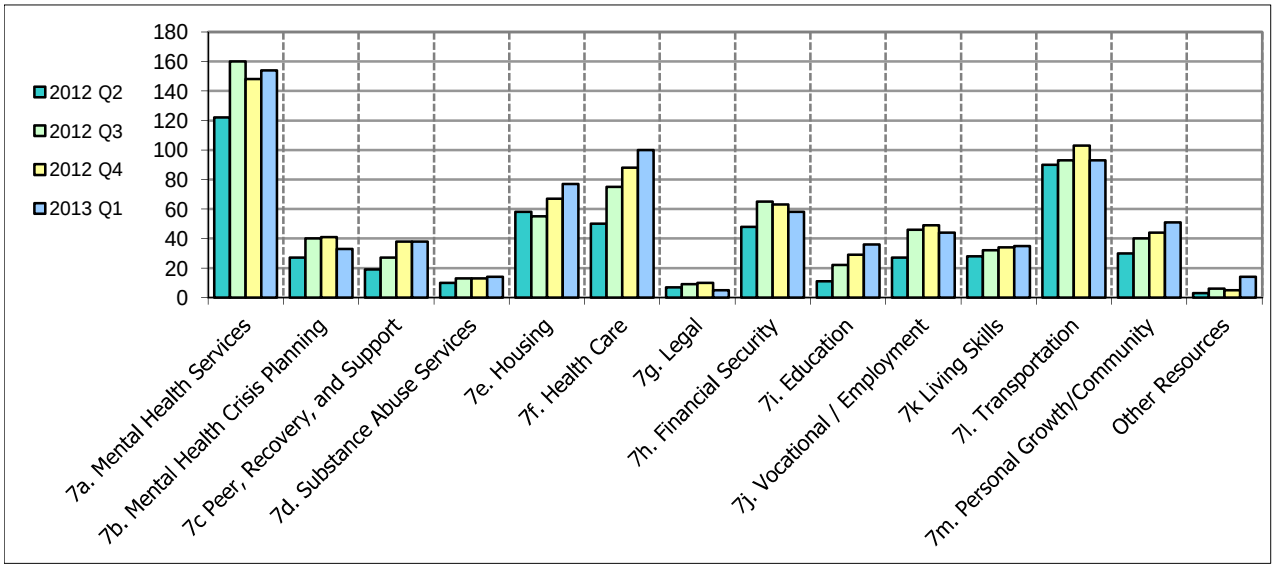

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q2	2012 Q3	2012 Q4	2013 Q1
7a. Mental Health Services	122	160	148	154
7b. Mental Health Crisis Planning	27	40	41	33
7c Peer, Recovery, and Support	19	27	38	38
7d. Substance Abuse Services	10	13	13	14
7e. Housing	58	55	67	77
7f. Health Care	50	75	88	100
7g. Legal	7	9	10	5
7h. Financial Security	48	65	63	58
7i. Education	11	22	29	36
7j. Vocational / Employment	27	46	49	44
7k Living Skills	28	32	34	35
7l. Transportation	90	93	103	93
7m. Personal Growth/Community	30	40	44	51
Other Resources	3	6	5	14
Total CSN 4 Unmet Needs	530	683	732	752

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	725	768	779	812
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	4	2	1	4
7a-ii Community Integration Services	40	48	45	51
7a-iii Dialectical Behavioral Therapy	1	1	2	1
7a-iv Family Psycho-Educational Treatment	1	1	1	0
7a-v Group Counseling	0	2	2	3
7a-vi Individual Counseling	32	46	43	47
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	2	1	0	1
7a-x Psychiatric Medication Management	42	59	54	47
Total Unmet Resource Needs	122	160	148	154
Distinct Clients with Unmet Resource Needs	86	112	112	113
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	21	33	34	26
7b-ii Mental Health Advance Directives	6	7	7	7
Total Unmet Resource Needs	27	40	41	33
Distinct Clients with Unmet Resource Needs	24	35	36	28
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	5	8	9	12
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	2	6	8	8
7c-iv Peer-Run Trauma Recovery Group	4	3	5	6
7c-v Wellness Recovery and Action Planning	0	0	0	0
7c-vi Family Support	8	10	16	12
Total Unmet Resource Needs	19	27	38	38
Distinct Clients with Unmet Resource Needs	17	26	33	33
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	9	11	11	12
7d-ii Residential Treatment Substance Abuse Services	1	2	2	2
Total Unmet Resource Needs	10	13	13	14
Distinct Clients with Unmet Resource Needs	9	12	12	13

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	725	768	779	812
7e. Housing				
7e-i Supported Apartment	5	7	10	13
7e-ii Community Residential Facility	1	1	1	1
7e-iii Residential Treatment Facility (group home)	2	1	3	3
7e-iv Assisted Living Facility	2	2	3	3
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	48	44	50	57
Total Unmet Resource Needs	58	55	67	77
Distinct Clients with Unmet Resource Needs	56	55	63	73
7f. Health Care				
7f-i Dental Services	29	38	50	59
7f-ii Eye Care Services	8	14	17	16
7f-iii Hearing Services	3	3	3	4
7f-iv Physical Therapy	1	4	3	4
7f-v Physician/Medical Services	9	16	15	17
Total Unmet Resource Needs	50	75	88	100
Distinct Clients with Unmet Resource Needs	43	60	71	81
7g. Legal				
7g-i Advocate	6	6	8	3
7g-ii Guardian (private)	1	3	2	2
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	7	9	10	5
Distinct Clients with Unmet Resource Needs	7	9	10	5
7h. Financial Security				
7h-i Assistance with Managing Money	30	41	41	35
7h-ii Assistance with Securing Public Benefits	15	20	18	16
7h-iii Representative Payee	3	4	4	7
Total Unmet Resource Needs	48	65	63	58
Distinct Clients with Unmet Resource Needs	42	58	55	52

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	725	768	779	812
7i. Education				
7i-i Adult Education (other than GED)	2	6	5	4
7i-ii GED	5	6	7	12
7i-iii Literacy Assistance	1	1	0	0
7i-iv Post High School Education	3	9	13	15
7i-v Tuition Reimbursement	0	0	4	5
Total Unmet Resource Needs	11	22	29	36
Distinct Clients with Unmet Resource Needs	11	21	28	35
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	3	4	3	3
7j-ii Club House and/or Peer Vocational Support	3	3	3	2
7j-iii Competitive Employment (no supports)	3	8	15	9
7j-iv Supported Employment	2	4	2	3
7j-v Vocational Rehabilitation	16	27	26	27
Total Unmet Resource Needs	27	46	49	44
Distinct Clients with Unmet Resource Needs	23	42	44	40
7k. Living Skills				
7k-i Daily Living Support Services	23	26	28	29
7k-ii Day Support Services	1	0	0	0
7k-iii Occupational Therapy	1	1	1	1
7k-iv Skills Development Services	3	5	5	5
Total Unmet Resource Needs	28	32	34	35
Distinct Clients with Unmet Resource Needs	28	31	34	33
7l. Transportation				
7l-i Transportation to ISP-Identified Services	46	52	50	51
7-ii Transportation to Other ISP Activities	32	31	40	32
7-iii After Hours Transportation	12	10	13	10
Total Unmet Resource Needs	90	93	103	93
Distinct Clients with Unmet Resource Needs	52	57	56	58
7m. Personal Growth/Community				
7m-i Avocational Activities	2	2	3	2

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	725	768	779	812
7m. Personal Growth/Community				
7m-ii Recreation Activities	4	9	12	14
7m-iii Social Activities	24	27	24	28
7m-iv Spiritual Activities	0	2	5	7
Total Unmet Resource Needs	30	40	44	51
Distinct Clients with Unmet Resource Needs	27	32	33	37
Other Resources				
Other Resources	3	6	5	14
Total Unmet Resource Needs	3	6	5	14
Distinct Clients with Unmet Resource Needs	3	6	5	14
CSN 4 Totals				
Total Unmet Resource Needs	530	683	732	752
Distinct Clients With any Unmet Resource Need	206	243	240	253
Distinct Clients with a RDS	725	768	779	812

Report Run: Jan 16, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q1

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

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

2012 Q2			2012 Q3			2012 Q4			2013 Q1		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
539	1,704	31.6%	547	1,769	30.9%	620	1,831	33.9%	652	1,868	34.9%

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

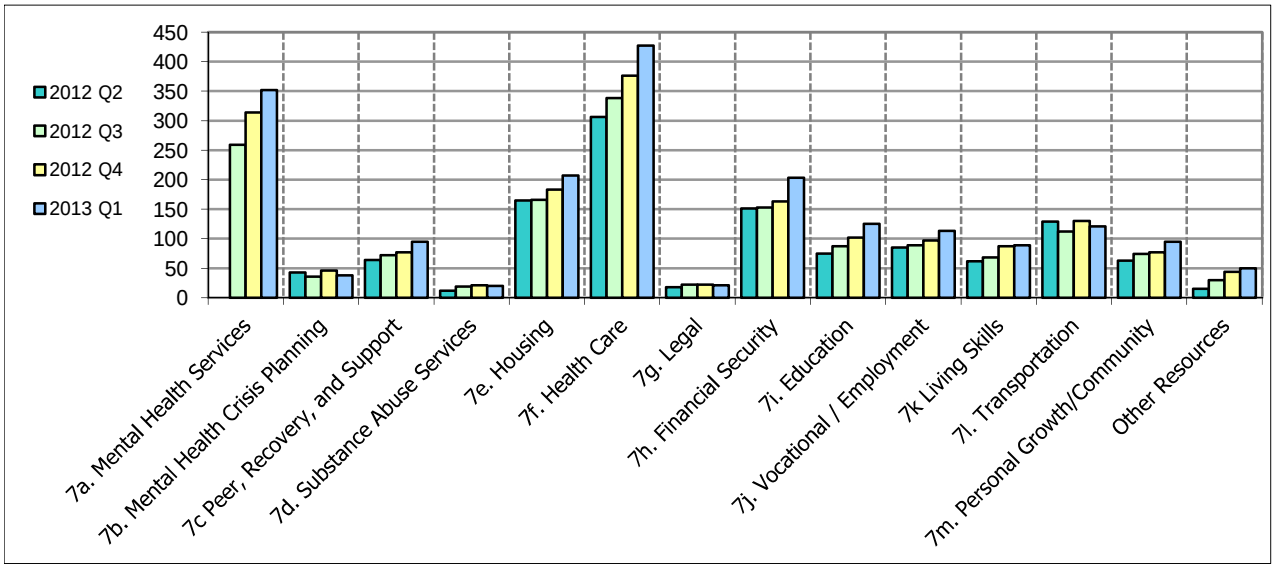

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q2	2012 Q3	2012 Q4	2013 Q1
7a. Mental Health Services	et Resource Need	259	314	352
7b. Mental Health Crisis Planning	43	36	46	38
7c Peer, Recovery, and Support	64	72	77	95
7d. Substance Abuse Services	12	19	21	20
7e. Housing	165	166	183	207
7f. Health Care	306	338	376	427
7g. Legal	18	22	22	21
7h. Financial Security	151	153	163	203
7i. Education	75	87	102	125
7j. Vocational / Employment	85	89	97	113
7k Living Skills	62	68	87	89
7l. Transportation	129	112	130	121
7m. Personal Growth/Community	63	74	77	95
Other Resources	15	30	44	50
Total CSN 5 Unmet Needs	1,445	1,525	1,739	1,956

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,704	1,769	1,831	1,868
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	11	8	8	10
7a-ii Community Integration Services	27	33	45	37
7a-iii Dialectical Behavioral Therapy	13	12	10	18
7a-iv Family Psycho-Educational Treatment	3	2	2	2
7a-v Group Counseling	5	10	11	9
7a-vi Individual Counseling	71	74	91	120
7a-vii Inpatient Psychiatric Facility	1	1	0	1
7a-viii Intensive Case Management	3	2	1	2
7a-x Psychiatric Medication Management	123	117	146	153
Total Unmet Resource Needs	257	259	314	352
Distinct Clients with Unmet Resource Needs	200	210	257	271
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	25	17	22	19
7b-ii Mental Health Advance Directives	18	19	24	19
Total Unmet Resource Needs	43	36	46	38
Distinct Clients with Unmet Resource Needs	40	32	43	35
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	5	4	6	13
7c-ii Recovery Workbook Group	1	2	1	0
7c-iii Social Club	14	21	16	19
7c-iv Peer-Run Trauma Recovery Group	8	13	16	14
7c-v Wellness Recovery and Action Planning	3	1	2	1
7c-vi Family Support	33	31	36	48
Total Unmet Resource Needs	64	72	77	95
Distinct Clients with Unmet Resource Needs	57	59	66	81
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	10	16	18	17
7d-ii Residential Treatment Substance Abuse Services	2	3	3	3
Total Unmet Resource Needs	12	19	21	20
Distinct Clients with Unmet Resource Needs	12	18	20	19

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,704	1,769	1,831	1,868
7e. Housing				
7e-i Supported Apartment	11	9	13	13
7e-ii Community Residential Facility	6	6	5	5
7e-iii Residential Treatment Facility (group home)	2	2	2	2
7e-iv Assisted Living Facility	6	3	6	5
7e-v Nursing Home	3	0	0	0
7e-vi Residential Crisis Unit	0	1	1	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	137	145	156	181
Total Unmet Resource Needs	165	166	183	207
Distinct Clients with Unmet Resource Needs	159	161	177	200
7f. Health Care				
7f-i Dental Services	178	198	202	231
7f-ii Eye Care Services	62	72	92	90
7f-iii Hearing Services	13	19	21	27
7f-iv Physical Therapy	7	9	8	10
7f-v Physician/Medical Services	46	40	53	69
Total Unmet Resource Needs	306	338	376	427
Distinct Clients with Unmet Resource Needs	231	243	254	286
7g. Legal				
7g-i Advocate	16	21	19	18
7g-ii Guardian (private)	1	0	2	1
7g-iii Guardian (public)	1	1	1	2
Total Unmet Resource Needs	18	22	22	21
Distinct Clients with Unmet Resource Needs	17	21	21	20
7h. Financial Security				
7h-i Assistance with Managing Money	92	90	94	118
7h-ii Assistance with Securing Public Benefits	52	56	62	77
7h-iii Representative Payee	7	7	7	8
Total Unmet Resource Needs	151	153	163	203
Distinct Clients with Unmet Resource Needs	138	138	146	181

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,704	1,769	1,831	1,868
7i. Education				
7i-i Adult Education (other than GED)	17	23	19	23
7i-ii GED	22	13	25	28
7i-iii Literacy Assistance	9	9	11	10
7i-iv Post High School Education	25	36	43	54
7i-v Tuition Reimbursement	2	6	4	10
Total Unmet Resource Needs	75	87	102	125
Distinct Clients with Unmet Resource Needs	71	78	96	111
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	7	5	3	9
7j-ii Club House and/or Peer Vocational Support	1	2	3	8
7j-iii Competitive Employment (no supports)	5	7	8	11
7j-iv Supported Employment	10	6	7	11
7j-v Vocational Rehabilitation	62	69	76	74
Total Unmet Resource Needs	85	89	97	113
Distinct Clients with Unmet Resource Needs	79	84	92	102
7k. Living Skills				
7k-i Daily Living Support Services	38	47	62	60
7k-ii Day Support Services	11	9	9	11
7k-iii Occupational Therapy	2	3	6	5
7k-iv Skills Development Services	11	9	10	13
Total Unmet Resource Needs	62	68	87	89
Distinct Clients with Unmet Resource Needs	54	62	79	81
7l. Transportation				
7l-i Transportation to ISP-Identified Services	42	43	51	48
7-ii Transportation to Other ISP Activities	42	34	37	36
7-iii After Hours Transportation	45	35	42	37
Total Unmet Resource Needs	129	112	130	121
Distinct Clients with Unmet Resource Needs	92	84	96	92
7m. Personal Growth/Community				
7m-i Avocational Activities	5	5	4	4

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,704	1,769	1,831	1,868
7m. Personal Growth/Community				
7m-ii Recreation Activities	15	21	27	26
7m-iii Social Activities	34	36	33	45
7m-iv Spiritual Activities	9	12	13	20
Total Unmet Resource Needs	63	74	77	95
Distinct Clients with Unmet Resource Needs	43	49	53	69
Other Resources				
Other Resources	15	30	44	50
Total Unmet Resource Needs	15	30	44	50
Distinct Clients with Unmet Resource Needs	15	30	44	50
CSN 5 Totals				
Total Unmet Resource Needs	1,445	1,525	1,739	1,956
Distinct Clients With any Unmet Resource Need	539	547	620	652
Distinct Clients with a RDS	1,704	1,769	1,831	1,868

Report Run: Jan 16, 2013

CSN 6 - Cumberland

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

2012 Q2			2012 Q3			2012 Q4			2013 Q1		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
577	1,826	31.6%	590	1,885	31.3%	590	1,919	30.7%	584	1,937	30.1%

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

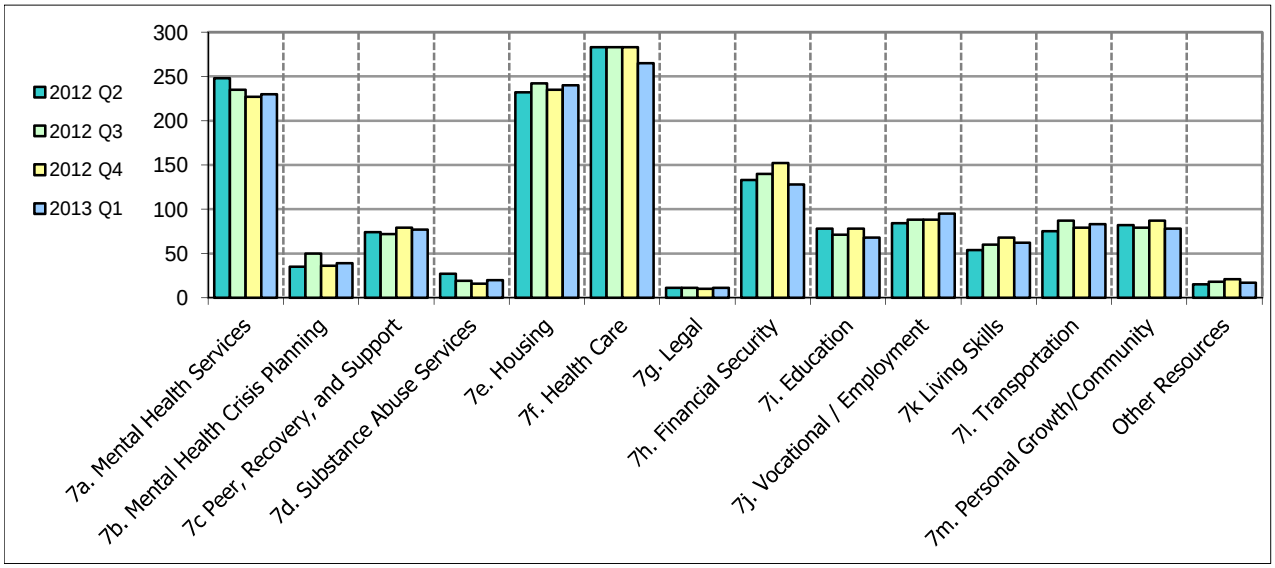

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q2	2012 Q3	2012 Q4	2013 Q1
7a. Mental Health Services	248	235	227	230
7b. Mental Health Crisis Planning	35	50	36	39
7c Peer, Recovery, and Support	74	72	79	77
7d. Substance Abuse Services	27	19	16	20
7e. Housing	232	242	235	240
7f. Health Care	283	283	283	265
7g. Legal	11	11	10	11
7h. Financial Security	133	140	152	128
7i. Education	78	71	78	68
7j. Vocational / Employment	84	88	88	95
7k Living Skills	54	60	68	62
7l. Transportation	75	87	79	83
7m. Personal Growth/Community	82	79	87	78
Other Resources	15	18	21	17
Total CSN 6 Unmet Needs	1,431	1,455	1,459	1,413

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

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,826	1,885	1,919	1,937
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	7	10	7	12
7a-ii Community Integration Services	44	31	35	36
7a-iii Dialectical Behavioral Therapy	10	5	9	5
7a-iv Family Psycho-Educational Treatment	6	6	4	0
7a-v Group Counseling	7	10	10	9
7a-vi Individual Counseling	92	85	83	75
7a-vii Inpatient Psychiatric Facility	0	0	2	2
7a-viii Intensive Case Management	1	3	7	13
7a-x Psychiatric Medication Management	81	85	70	78
Total Unmet Resource Needs	248	235	227	230
Distinct Clients with Unmet Resource Needs	169	172	165	167
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	29	40	31	32
7b-ii Mental Health Advance Directives	6	10	5	7
Total Unmet Resource Needs	35	50	36	39
Distinct Clients with Unmet Resource Needs	32	45	35	35
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	15	14	18	18
7c-ii Recovery Workbook Group	1	1	1	1
7c-iii Social Club	32	30	32	35
7c-iv Peer-Run Trauma Recovery Group	1	2	3	3
7c-v Wellness Recovery and Action Planning	7	6	5	7
7c-vi Family Support	18	19	20	13
Total Unmet Resource Needs	74	72	79	77
Distinct Clients with Unmet Resource Needs	58	56	66	60
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	22	14	13	16
7d-ii Residential Treatment Substance Abuse Services	5	5	3	4
Total Unmet Resource Needs	27	19	16	20
Distinct Clients with Unmet Resource Needs	25	17	15	18

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,826	1,885	1,919	1,937
7e. Housing				
7e-i Supported Apartment	39	39	39	45
7e-ii Community Residential Facility	11	12	13	14
7e-iii Residential Treatment Facility (group home)	6	6	8	6
7e-iv Assisted Living Facility	11	12	16	18
7e-v Nursing Home	2	2	4	2
7e-vi Residential Crisis Unit	0	1	1	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	163	170	154	155
Total Unmet Resource Needs	232	242	235	240
Distinct Clients with Unmet Resource Needs	210	218	205	212
7f. Health Care				
7f-i Dental Services	154	157	157	145
7f-ii Eye Care Services	50	51	49	52
7f-iii Hearing Services	17	19	16	11
7f-iv Physical Therapy	11	6	9	7
7f-v Physician/Medical Services	51	50	52	50
Total Unmet Resource Needs	283	283	283	265
Distinct Clients with Unmet Resource Needs	215	210	215	198
7g. Legal				
7g-i Advocate	8	9	6	7
7g-ii Guardian (private)	2	1	1	1
7g-iii Guardian (public)	1	1	3	3
Total Unmet Resource Needs	11	11	10	11
Distinct Clients with Unmet Resource Needs	11	11	10	11
7h. Financial Security				
7h-i Assistance with Managing Money	72	81	91	76
7h-ii Assistance with Securing Public Benefits	44	42	47	39
7h-iii Representative Payee	17	17	14	13
Total Unmet Resource Needs	133	140	152	128
Distinct Clients with Unmet Resource Needs	117	122	134	114

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,826	1,885	1,919	1,937
7i. Education				
7i-i Adult Education (other than GED)	24	25	27	19
7i-ii GED	23	16	15	14
7i-iii Literacy Assistance	5	3	7	7
7i-iv Post High School Education	24	26	26	25
7i-v Tuition Reimbursement	2	1	3	3
Total Unmet Resource Needs	78	71	78	68
Distinct Clients with Unmet Resource Needs	70	65	71	62
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	7	5	7	10
7j-ii Club House and/or Peer Vocational Support	2	2	3	4
7j-iii Competitive Employment (no supports)	13	14	15	19
7j-iv Supported Employment	9	8	11	9
7j-v Vocational Rehabilitation	53	59	52	53
Total Unmet Resource Needs	84	88	88	95
Distinct Clients with Unmet Resource Needs	79	82	78	85
7k. Living Skills				
7k-i Daily Living Support Services	26	33	39	33
7k-ii Day Support Services	5	5	6	7
7k-iii Occupational Therapy	4	2	2	2
7k-iv Skills Development Services	19	20	21	20
Total Unmet Resource Needs	54	60	68	62
Distinct Clients with Unmet Resource Needs	48	55	63	57
7l. Transportation				
7l-i Transportation to ISP-Identified Services	44	50	46	41
7-ii Transportation to Other ISP Activities	15	20	17	23
7-iii After Hours Transportation	16	17	16	19
Total Unmet Resource Needs	75	87	79	83
Distinct Clients with Unmet Resource Needs	59	68	66	63
7m. Personal Growth/Community				
7m-i Avocational Activities	8	4	5	4

Report Run: Jan 16, 2013

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

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	1,826	1,885	1,919	1,937
7m. Personal Growth/Community				
7m-ii Recreation Activities	23	20	22	21
7m-iii Social Activities	40	42	48	42
7m-iv Spiritual Activities	11	13	12	11
Total Unmet Resource Needs	82	79	87	78
Distinct Clients with Unmet Resource Needs	64	62	65	62
Other Resources				
Other Resources	15	18	21	17
Total Unmet Resource Needs	15	18	21	17
Distinct Clients with Unmet Resource Needs	15	18	21	17
CSN 6 Totals				
Total Unmet Resource Needs	1,431	1,455	1,459	1,413
Distinct Clients With any Unmet Resource Need	577	590	590	584
Distinct Clients with a RDS	1,826	1,885	1,919	1,937

Report Run: Jan 16, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q1

CSN 7 - York

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

2012 Q2			2012 Q3			2012 Q4			2013 Q1		
People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs	People with Unmet Needs	Distinct People	% With Unmet Needs
164	540	30.4%	193	484	39.9%	193	467	41.3%	176	450	39.1%

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

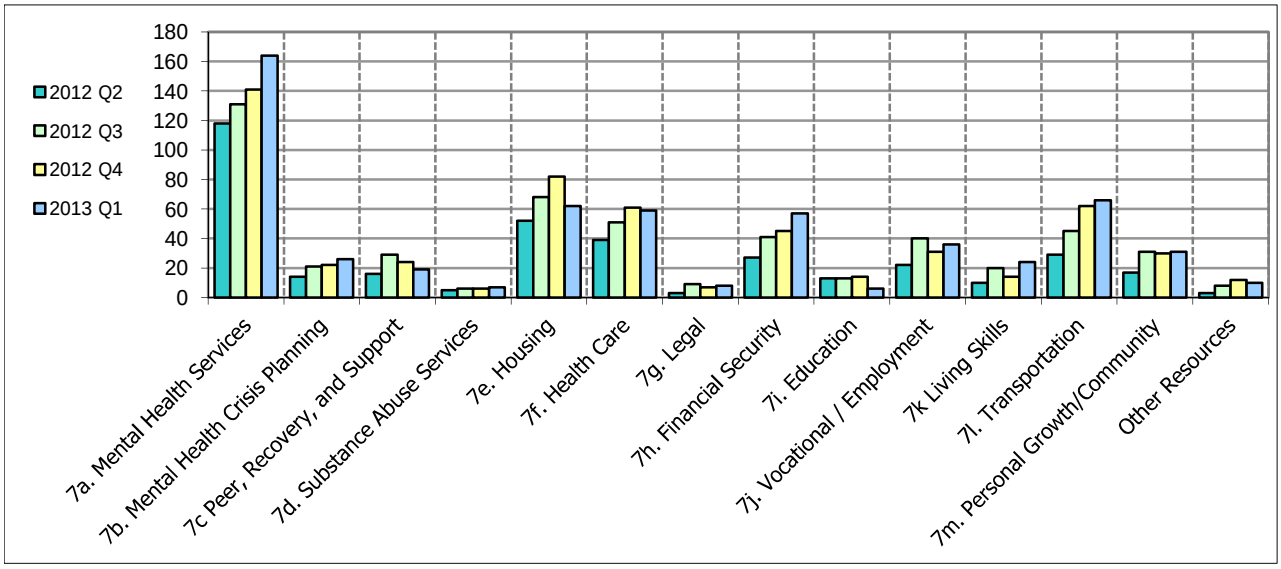

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q2	2012 Q3	2012 Q4	2013 Q1
7a. Mental Health Services	118	131	141	164
7b. Mental Health Crisis Planning	14	21	22	26
7c Peer, Recovery, and Support	16	29	24	19
7d. Substance Abuse Services	5	6	6	7
7e. Housing	52	68	82	62
7f. Health Care	39	51	61	59
7g. Legal	3	9	7	8
7h. Financial Security	27	41	45	57
7i. Education	13	13	14	6
7j. Vocational / Employment	22	40	31	36
7k Living Skills	10	20	14	24
7l. Transportation	29	45	62	66
7m. Personal Growth/Community	17	31	30	31
Other Resources	3	8	12	10
Total CSN 7 Unmet Needs	368	513	551	575

Report Run: Jan 16, 2013

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

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	540	484	467	450
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	7	4	3	4
7a-ii Community Integration Services	47	40	46	46
7a-iii Dialectical Behavioral Therapy	6	3	5	1
7a-iv Family Psycho-Educational Treatment	0	1	1	2
7a-v Group Counseling	4	3	1	1
7a-vi Individual Counseling	27	34	38	57
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	0	1	0	1
7a-x Psychiatric Medication Management	27	45	47	52
Total Unmet Resource Needs	118	131	141	164
Distinct Clients with Unmet Resource Needs	93	101	104	121
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	13	18	21	25
7b-ii Mental Health Advance Directives	1	3	1	1
Total Unmet Resource Needs	14	21	22	26
Distinct Clients with Unmet Resource Needs	13	19	21	26
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	0	3	2	2
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	5	9	9	8
7c-iv Peer-Run Trauma Recovery Group	4	6	1	0
7c-v Wellness Recovery and Action Planning	2	5	1	0
7c-vi Family Support	5	6	11	9
Total Unmet Resource Needs	16	29	24	19
Distinct Clients with Unmet Resource Needs	14	26	20	17
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	4	5	6	6
7d-ii Residential Treatment Substance Abuse Services	1	1	0	1
Total Unmet Resource Needs	5	6	6	7
Distinct Clients with Unmet Resource Needs	4	6	6	6

Report Run: Jan 16, 2013

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	540	484	467	450
7e. Housing				
7e-i Supported Apartment	4	10	10	9
7e-ii Community Residential Facility	2	1	3	4
7e-iii Residential Treatment Facility (group home)	0	0	0	0
7e-iv Assisted Living Facility	3	4	4	1
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)	43	52	65	48
Total Unmet Resource Needs	52	68	82	62
Distinct Clients with Unmet Resource Needs	48	63	73	56
7f. Health Care				
7f-i Dental Services	24	27	34	25
7f-ii Eye Care Services	9	10	12	13
7f-iii Hearing Services	1	0	3	2
7f-iv Physical Therapy	0	1	2	4
7f-v Physician/Medical Services	5	13	10	15
Total Unmet Resource Needs	39	51	61	59
Distinct Clients with Unmet Resource Needs	30	41	47	42
7g. Legal				
7g-i Advocate	3	7	7	7
7g-ii Guardian (private)	0	0	0	0
7g-iii Guardian (public)	0	2	0	1
Total Unmet Resource Needs	3	9	7	8
Distinct Clients with Unmet Resource Needs	3	9	7	8
7h. Financial Security				
7h-i Assistance with Managing Money	11	24	27	34
7h-ii Assistance with Securing Public Benefits	14	14	18	21
7h-iii Representative Payee	2	3	0	2
Total Unmet Resource Needs	27	41	45	57
Distinct Clients with Unmet Resource Needs	23	35	38	45

Report Run: Jan 16, 2013

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

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	540	484	467	450
7i. Education				
7i-i Adult Education (other than GED)	5	3	5	1
7i-ii GED	2	3	4	2
7i-iii Literacy Assistance	1	3	1	1
7i-iv Post High School Education	5	3	4	2
7i-v Tuition Reimbursement	0	1	0	0
Total Unmet Resource Needs	13	13	14	6
Distinct Clients with Unmet Resource Needs	12	11	13	6
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	2	5	4	6
7j-ii Club House and/or Peer Vocational Support	0	0	0	1
7j-iii Competitive Employment (no supports)	3	6	2	3
7j-iv Supported Employment	7	6	3	4
7j-v Vocational Rehabilitation	10	23	22	22
Total Unmet Resource Needs	22	40	31	36
Distinct Clients with Unmet Resource Needs	19	33	27	29
7k. Living Skills				
7k-i Daily Living Support Services	7	10	8	12
7k-ii Day Support Services	0	1	1	1
7k-iii Occupational Therapy	0	1	0	0
7k-iv Skills Development Services	3	8	5	11
Total Unmet Resource Needs	10	20	14	24
Distinct Clients with Unmet Resource Needs	9	16	14	22
7l. Transportation				
7l-i Transportation to ISP-Identified Services	12	22	26	30
7-ii Transportation to Other ISP Activities	8	10	21	23
7-iii After Hours Transportation	9	13	15	13
Total Unmet Resource Needs	29	45	62	66
Distinct Clients with Unmet Resource Needs	19	31	43	40
7m. Personal Growth/Community				
7m-i Avocational Activities	0	3	5	5

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Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	540	484	467	450
7m. Personal Growth/Community				
7m-ii Recreation Activities	7	6	7	8
7m-iii Social Activities	10	20	17	16
7m-iv Spiritual Activities	0	2	1	2
Total Unmet Resource Needs	17	31	30	31
Distinct Clients with Unmet Resource Needs	14	27	24	22
Other Resources				
Other Resources	3	8	12	10
Total Unmet Resource Needs	3	8	12	10
Distinct Clients with Unmet Resource Needs	3	8	12	10
CSN 7 Totals				
Total Unmet Resource Needs	368	513	551	575
Distinct Clients With any Unmet Resource Need	164	193	193	176
Distinct Clients with a RDS	540	484	467	450

Report Run: Jan 16, 2013

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

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	354	363	355	343
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	0	0	0	1
7a-ii Community Integration Services	16	9	8	6
7a-iii Dialectical Behavioral Therapy	2	3	2	3
7a-iv Family Psycho-Educational Treatment	0	0	0	0
7a-v Group Counseling	1	3	1	2
7a-vi Individual Counseling	15	14	10	16
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	0	0	0	0
7a-x Psychiatric Medication Management	16	17	18	16
Total Unmet Resource Needs	50	46	39	44
Distinct Clients with Unmet Resource Needs	35	38	31	35
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	6	4	5	2
7b-ii Mental Health Advance Directives	3	2	3	3
Total Unmet Resource Needs	9	6	8	5
Distinct Clients with Unmet Resource Needs	8	6	8	5
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	0	0	0	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	6	7	4	1
7c-iv Peer-Run Trauma Recovery Group	1	2	2	1
7c-v Wellness Recovery and Action Planning	1	0	0	0
7c-vi Family Support	5	3	3	1
Total Unmet Resource Needs	13	12	9	3
Distinct Clients with Unmet Resource Needs	10	11	8	3
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	2	3	2	1
7d-ii Residential Treatment Substance Abuse Services	1	1	1	0
Total Unmet Resource Needs	3	4	3	1
Distinct Clients with Unmet Resource Needs	2	3	2	1

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Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	354	363	355	343
7e. Housing				
7e-i Supported Apartment	3	4	1	3
7e-ii Community Residential Facility	2	3	2	1
7e-iii Residential Treatment Facility (group home)	0	1	0	1
7e-iv Assisted Living Facility	1	1	3	1
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)	25	25	25	24
Total Unmet Resource Needs	31	34	32	31
Distinct Clients with Unmet Resource Needs	30	31	32	29
7f. Health Care				
7f-i Dental Services	23	23	20	19
7f-ii Eye Care Services	9	9	6	7
7f-iii Hearing Services	2	1	2	2
7f-iv Physical Therapy	0	1	0	0
7f-v Physician/Medical Services	8	7	6	7
Total Unmet Resource Needs	42	41	34	35
Distinct Clients with Unmet Resource Needs	31	31	27	28
7g. Legal				
7g-i Advocate	3	5	3	3
7g-ii Guardian (private)	0	3	2	2
7g-iii Guardian (public)	0	0	2	1
Total Unmet Resource Needs	3	8	7	6
Distinct Clients with Unmet Resource Needs	3	8	7	6
7h. Financial Security				
7h-i Assistance with Managing Money	11	13	17	16
7h-ii Assistance with Securing Public Benefits	5	9	8	7
7h-iii Representative Payee	1	2	0	0
Total Unmet Resource Needs	17	24	25	23
Distinct Clients with Unmet Resource Needs	15	22	22	22

Report Run: Jan 16, 2013

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

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	354	363	355	343
7i. Education				
7i-i Adult Education (other than GED)	2	2	1	0
7i-ii GED	1	3	0	2
7i-iii Literacy Assistance	0	0	0	0
7i-iv Post High School Education	4	4	3	2
7i-v Tuition Reimbursement	1	0	0	0
Total Unmet Resource Needs	8	9	4	4
Distinct Clients with Unmet Resource Needs	7	9	4	4
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	3	1	1	2
7j-ii Club House and/or Peer Vocational Support	2	3	2	1
7j-iii Competitive Employment (no supports)	0	3	4	2
7j-iv Supported Employment	1	3	2	1
7j-v Vocational Rehabilitation	13	14	12	8
Total Unmet Resource Needs	19	24	21	14
Distinct Clients with Unmet Resource Needs	18	23	21	14
7k. Living Skills				
7k-i Daily Living Support Services	7	8	4	1
7k-ii Day Support Services	2	2	2	2
7k-iii Occupational Therapy	1	1	1	0
7k-iv Skills Development Services	4	3	3	2
Total Unmet Resource Needs	14	14	10	5
Distinct Clients with Unmet Resource Needs	11	12	8	5
7l. Transportation				
7l-i Transportation to ISP-Identified Services	17	17	13	13
7-ii Transportation to Other ISP Activities	11	13	10	9
7-iii After Hours Transportation	12	10	7	8
Total Unmet Resource Needs	40	40	30	30
Distinct Clients with Unmet Resource Needs	26	27	20	23
7m. Personal Growth/Community				
7m-i Avocational Activities	0	1	1	1

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

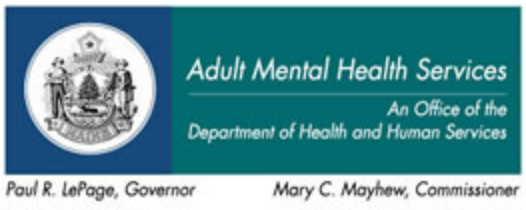
Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 1
(July, Aug, Sept 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Distinct Clients with a RDS	354	363	355	343
7m. Personal Growth/Community				
7m-ii Recreation Activities	6	8	5	3
7m-iii Social Activities	12	17	13	8
7m-iv Spiritual Activities	2	3	0	0
Total Unmet Resource Needs	20	29	19	12
Distinct Clients with Unmet Resource Needs	14	19	16	11
Other Resources				
Other Resources	2	6	4	9
Total Unmet Resource Needs	2	6	4	9
Distinct Clients with Unmet Resource Needs	2	6	4	9
CSN Not Assigned Totals				
Total Unmet Resource Needs	271	297	245	222
Distinct Clients With any Unmet Resource Need	95	105	101	94
Distinct Clients with a RDS	354	363	355	343

Report Run: Jan 16, 2013

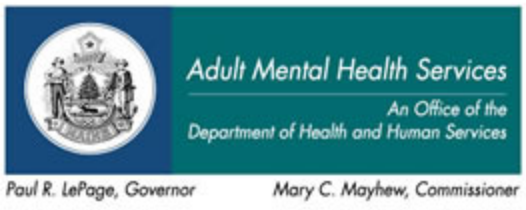


'Other' Unmet Resource Needs

Other Resources

For RDS Between Oct 1, 2012 and Dec 31, 2012

Peo_ID	RDS Date	Description	Date IDed	Days Unmet
ALLIES INC				
247209	11/20/2012	HANDICAP ACCESSIBLE HOUSING	7/7/2012	136
200910	11/10/2012	FOOD PANTRY	2/29/2012	255
191254	10/11/2012	APPROPRIATE SIGN LANGUAGE CLASS	7/14/2011	455
ALTERNATIVE SERVICES NE INC				
166279	12/8/2012	TRANSPORTATION TO NON MAINE CARE APPOINTMENTS	4/10/2012	242
167539	11/2/2012	NATURAL SUPPORTS WITHIN CURRENT COMMUNITY/HOME	4/20/2012	196
171301	12/20/2012	HOME REPAIR/ CLEANING	7/15/2012	158
AROOSTOOK MENTAL HEALTH SERVICES, INC.				
329796	10/24/2012	HOME REPAIR	5/8/2012	162
198275	12/15/2012	NURSING CARE	10/4/2011	438
244094	12/18/2012	IN-HOME HELP	7/1/2011	536
219481	12/1/2012	LINKAGE TO COMMUNITY - SUPPORT WITH CONNECTING W/OTHERS	7/5/2012	149
ASSISTANCE PLUS				
225260	12/4/2012	MAINE CARE HEALTH INSURANCE	3/8/2012	271
131855	10/7/2012	AGENCY FOR THE BLIND	1/12/2012	269
166398	11/2/2012	MAKING A WILL	4/4/2012	212
BROADREACH FAMILY AND COMMUNITY SERVICES				
358125	11/8/2012	PSYCHOLOGICAL EVALUATION	6/28/2012	133
236579	12/5/2012	NEUROPSY EVALUATION	4/12/2012	237
CATHOLIC CHARITIES				
145766	11/8/2012	APARTEMENT THAT ACCEPTS BRAP	7/18/2012	113
355285	10/18/2012	PERSONAL CARE SERVICES	6/29/2012	111
341343	11/8/2012	CHILD CARE	1/13/2012	300
273888	11/13/2012	FURNITURE	8/27/2010	809
257417	10/23/2012	CHILD CARE FOR YOUNGEST CHLILD TO MAINTAIN MENTAL HEALTH APPOINTMENTS	10/27/2010	727
247861	10/15/2012	AQUIRED BRAIN INJURY SERVICES	10/21/2011	360
219410	11/26/2012	LEGAL	2/25/2011	640
214936	10/17/2012	SKILLS TO COPE W/ HEIGHTEND ANXIETY AND PANIC ON HER OWN OR WITH OTHER SUPPORTS BESIDES CASE MGMT.	10/14/2011	369
207313	12/11/2012	HOMEMAKER SERVICES	8/27/2012	106
200480	10/27/2012	LIVING SKILLS RES	10/12/2007	1,842



'Other' Unmet Resource Needs

Other Resources

For RDS Between Oct 1, 2012 and Dec 31, 2012

Peo_ID	RDS Date	Description	Date IDed	Days Unmet
158704	12/5/2012	FURNITURE, APPLIANCES	3/6/2012	274
151073	10/17/2012	SKILLS TO CONSISTENTLY SET APPROPRIATE BOUNDRIES W/ OTHERS.	10/14/2011	357
146409	12/19/2012	MOTORIZXED SCOOTER	6/1/2012	130

COMMON TIES MENTAL HEALTH COALITION

233712	11/12/2012	PRIMARY RESIDENCE OF SON, MOVING TO SOUTH PORTLAND	2/1/2012	285
337494	12/5/2012	COMMUNITY RESOURCES FOR NEW BABY	12/27/2011	344
253830	12/5/2012	FIND APARTMENT	12/27/2011	344
198721	10/9/2012	SUPPORTS FOR ELDERLY MOTHER BEYOND CLIENTS ABILITIES	11/13/2009	1,061
332119	12/15/2012	GET DRIVERS LICENSE	10/4/2011	372
167227	10/17/2012	DRIVING PERMIT	2/9/2012	251
229755	10/24/2012	RENTAL DEPOSIT RETURNED	5/8/2012	169
312617	10/22/2012	VOLUNTEER	2/7/2012	258
354718	11/28/2012	BUGETING FOOD STAMPS FOR HEALTHY FOOD PURCHASES AND MEAL PLANNING	6/12/2012	169
256135	10/31/2012	HOMEMAKING SERVICES	6/19/2009	1,230
336590	10/17/2012	VOLUNTEER OPPORTUNITIES	12/7/2011	315
124671	11/21/2012	DRIVERS LICENSE	10/18/2011	400

COMMUNITY CARE

202017	11/27/2012	LONG-TERM MAINECARE FOR ASSISTED LIVING FACILITY	4/2/2012	239

COMMUNITY COUNSELING CENTER

227837	10/26/2012	INDEPENDENT APARTMENT	7/27/2012	91
213354	12/3/2012	PROBATION	11/15/2010	749
205219	12/14/2012	INDEPENENT HOUSING	8/16/2012	120
202204	11/6/2012	HEAD INJURY TREATMENT AND RESIDENCE THAT ADRESSES HIS LEVEL ON NEED	8/27/2009	1,167
316411	11/21/2012	ACCESSING SERVICES FROM LOCAL GA	5/25/2011	546
326066	12/3/2012	MEALS ON WHEELS	8/2/2012	123
283338	10/17/2012	FOOD RESOURCES	5/5/2011	531
264504	10/9/2012	SSI BENEFITS	4/23/2010	900
262099	11/25/2012	FOOD PANTRY	11/17/2010	739

COMMUNITY HEALTH AND COUNSELING SERVICES

216410	11/30/2012	ASSISTANCE WITH SETTING UP TRAILER.	7/30/2012	123
246526	11/18/2012	OBTAIN A VEHICLE	5/22/2012	180
261687	12/15/2012	RENEWAL OF DRIVERS LICENSE	1/18/2012	332
231869	11/14/2012	ALTERNATE SUBSIDY NON RELIANT ON CIS	1/4/2010	1,045
248464	10/31/2012	ASSISTANCE WITH SECURITY DEPOSIT	4/9/2009	1,301

'Other' Unmet Resource Needs

Other Resources

For RDS Between Oct 1, 2012 and Dec 31, 2012

Peo_ID	RDS Date	Description	Date IDed	Days Unmet
231598	10/1/2012	DOMESTIC VIOLENCE SUPPORT	6/8/2012	115
218961	11/2/2012	DENTURES	4/3/2012	213
257355	11/26/2012	SAFE AND AFFORDABLE HOUSING	3/1/2011	636
160960	12/14/2012	DHHS CUSTODY ISSUES	8/16/2012	109
154943	11/2/2012	GETTING BIRTH CERTIFICATE, STATE ID	9/15/2011	414
354600	11/27/2012	CHILD CARE SERVICES	4/2/2012	213
358110	12/30/2012	OBTAIN A VEHICLE	7/3/2012	180
206268	12/16/2012	CLEANING SERVICE	10/3/2011	440

COUNSELING SERVICES, INC.

332167	10/16/2012	DENTURES/IMPLANTS	9/30/2011	397
332525	11/7/2012	CLIENT WANTS A DOG TO INCREASE STABILITY	8/7/2012	92
215054	10/8/2012	HOARDING SUPPORT GROUP	11/11/2011	332
169905	10/26/2012	ASSISTED LIVING FACILITY FOR INDIVIDUALS WITH MENTAL HEALTH ISSUES OTHER THAN ELDERLY	11/3/2011	358
170851	11/1/2012	NEEDS FURNITURE	7/23/2012	101
202199	10/5/2012	WOMANS SUPPORT GROUP	10/5/2011	366
314656	10/12/2012	FURNITURE FOR APARTMENT	10/31/2011	347

HEALTH AFFILIATES MAINE

129803	11/20/2012	WANTS DRIVERS LICENSE	8/8/2011	470
169168	10/30/2012	PORTABLE OXYGEN	7/31/2012	91
192777	10/18/2012	ASSISTANCE WITH DV CHARGE	8/4/2011	441
204761	12/2/2012	MANAGING ANXIETY IN THE COMMUNITY AND ADVOCACY SERVICES FOR CONFLICT IN THE HOUSING BUILDING.	8/31/2011	459
205553	10/27/2012	HOUSING	5/21/2012	159
228798	11/1/2012	VOLUNTEER IN COMPASSIONATE CARE ACTIVITY	10/20/2011	365
232934	10/30/2012	MOVING SUPPORT TO NEW TOWN; VEHICLE	10/19/2011	377
237820	10/27/2012	LEARNING DISABILITY TESTING;	7/16/2011	469
247127	10/13/2012	FIRST FLOOR APARTMENT	10/7/2011	372
247233	11/1/2012	LEGAL RESOURCES: CRIMINAL LAWYER TO ASSIST WITH IRS/HR BLOCK ISSUES	10/20/2011	378
250927	10/16/2012	IMMIGRATION	10/26/2011	366
260689	10/16/2012	GROUP FOR AMPUTEES, PROSTHETIC LEG	8/12/2011	431
260906	10/22/2012	LOOKING FOR HOUSE TO EITHER RENT OR BUY	2/7/2012	254
264474	12/2/2012	TCM FOR CHILDREN	3/1/2012	276
277400	10/18/2012	CHILDCARE	7/27/2011	449
298379	12/3/2012	HEAP	3/21/2012	257
305019	10/15/2012	MOVE TO ANOTHER APARTMENT IN SAME HOUSING COMPLEX	4/19/2012	179

'Other' Unmet Resource Needs

Other Resources

For RDS Between Oct 1, 2012 and Dec 31, 2012

Peo_ID	RDS Date	Description	Date IDed	Days Unmet
305453	10/15/2012	HEAP ASSISTANCE	4/20/2011	544
322120	11/20/2012	NEEDS A CAR, WOULD LIKE LEGAL CONSULT TO DETERMINE IF ENTITLED TO MONEY, POSSIBLE EMERGENCY SHELTER	8/8/2011	430
323547	12/3/2012	IMMIGRATION	12/3/2011	366
336505	12/1/2012	HOME OWNERSHIP; IMMIGRATION	12/30/2011	337
341388	11/2/2012	OTHER VOCATIONAL/EMPLOYMENT RESOURCES -EMDC	2/19/2012	257
344187	12/11/2012	REPAIRS FOR TRANSPORTATION/CAR	3/28/2012	258
345823	12/7/2012	LEGAL SUPPORT WITH HOUSING ISSUE	3/27/2012	255
348165	12/5/2012	IMMIGRATION RELATED TO NATURALIZATION OF CHILDREN	4/12/2012	204
354614	10/24/2012	TO OWN A HOME	5/1/2012	176
355281	12/4/2012	IMMIGRATION	7/2/2012	115
361697	10/28/2012	IMMIGRATION NEEDS	7/28/2012	92

KENNEBEC BEHAVIORAL HEALTH

169387	11/12/2012		5/14/2012	182

LIFE BY DESIGN

342929	12/13/2012	OBTAINING NEUROPSYCH	3/13/2012	275
203981	12/18/2012	HOUSE REPAIRED	3/23/2012	270
204815	12/3/2012	CIWC	3/21/2012	254
205497	12/20/2012	LEGAL REPRESENTATION	7/13/2012	160
152409	11/30/2012	VOLUNTEERING	7/17/2012	136

MAINE VOCATIONAL AND REHABILITATION ASSOCIATES, INC.

256147	11/16/2012	EATING DISORDER CENTER	6/27/2012	142
249570	12/19/2012	LEGAL SUPPORT AROUND CUSTODY ISSUES FOR CHILDREN	6/1/2012	201

OXFORD COUNTY MENTAL HEALTH SERVICES

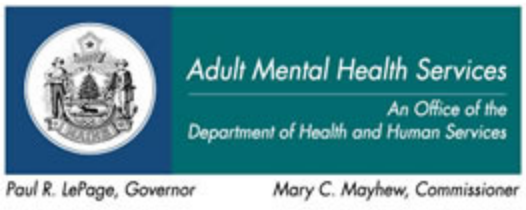
332003	10/15/2012	NEUROPSYCH EVALUATION	4/19/2012	169

SUNRISE OPPORTUNITIES

266899	10/10/2012	USE PORTABLE SECTION 8 VOUCHER FOR MOVE TO PENOBSCOT COUNTY	2/13/2012	240

SWEETSER

248504	10/4/2012	LEGAL ASSISTANCE	2/10/2012	237
226464	10/4/2012	OTHER HOUSING-LANDLORD IS NOT RENEWING LEASE	5/30/2012	152
224867	12/21/2012	MEDICAL SPECIALISTS RELATED TO ONGOING DEBILITATING CONDITION	6/20/2012	184
202791	11/5/2012	SENIOR COLLEGE CLASSES	2/15/2012	264
201544	11/18/2012	P.R.O.P. (LINK TO WEATHERIZATION, ELP, AND HOUSING SUPPORTS)	10/17/2011	398



'Other' Unmet Resource Needs

Other Resources

For RDS Between Oct 1, 2012 and Dec 31, 2012

Peo_ID	RDS Date	Description	Date IDed	Days Unmet
201090	11/9/2012	PRODUCTIVITY INCREASING ACTIVITIES	12/9/2009	1,066
171222	11/30/2012	HOMEMAKER SERVICES	4/1/2011	609
166412	12/5/2012	12-STEP	4/6/2012	243
359763	10/25/2012	GUARDIAN ASSESSMENT	6/25/2012	122
103858	10/12/2012	DRIVERS LICENSE	12/12/2011	305
146474	12/7/2012	CULTURAL ACTIVITIES	9/9/2011	455
355234	11/30/2012	PSYCH TESTING	7/30/2012	91
353094	12/4/2012	VISITING NURSES	7/2/2012	155
345840	12/3/2012	HOUSING	3/12/2012	224
314725	11/9/2012	PARENTING CLASSES	12/20/2011	325

THE OPPORTUNITY ALLIANCE

166640	12/12/2012	WANTS TO PURCHASE HOME THROUGH SEC 8 HOME BUY PROGRAM	4/24/2012	232
200464	11/12/2012	NEEDS A WALKER OR REPAIR FOR CURRENT WALKER	11/16/2011	362
251037	11/29/2012	CHILDCARE	2/17/2009	1,381

TRI COUNTY MENTAL HEALTH SERVICES

337488	10/24/2012	DRIVERS LICENSE	5/8/2012	156

YORK COUNTY SHELTERS INC

345776	12/3/2012	COMMUNITY REHABILITATION SERVICES	3/12/2012	266
Total Unmet Resource Needs				**128**

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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Substance Abuse and Mental Health Services
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Bridging Rental Assistance Program (BRAP)
Monitoring Report
Quarter 2 FY2013 (October, November, December 2012)

The Bridging Rental Assistance Program (BRAP) has been established in recognition that recovery can only begin in a safe, healthy, and decent environment, a place one can call home. The Office of Substance Abuse and Adult Mental Health Services recognizes the necessity for rental assistance for persons with mental illness, particularly those being discharged from hospitals, group homes, and homeless shelters. There is not a single housing market in the country where a person receiving Social Security as his or her sole income source can afford to rent even a modest one-bedroom apartment. According to a report issued by the Technical Assistance Collaborative, *Priced out in 2010*, in Maine, 98% of a person's SSI standard monthly payment is needed to pay for the average one-bedroom apartment statewide. In Cumberland County the amount is 104% and Sagadahoc 106%. In the City of Portland 126% of a person's SSI is necessary to pay for the average one-bedroom apartment and in the KEYS area (Kittery, Elliot, York and South Berwick) 125%.

BRAP is designed to assist individuals who have a psychiatric disability with housing costs for up to 24 months or until the individuals are awarded a Housing Choice Voucher (aka Section 8 Voucher), another federal subsidy, or until the individuals have an alternative housing placement. All units subsidized by BRAP funding must meet the U.S. Department of Housing and Urban Development's Housing Quality Standards and Fair Market Rents. Following a ***Housing First*** model, initial BRAP recipients are encouraged, but not required to accept the provision of services to go hand in hand with the voucher.

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

On July 13, 2007, because the number of persons with BRAP vouchers was 41 over the maximum, the BRAP Wait List Protocol was fully activated. The following report details the census activity over the most recent four quarters. Trending information from the previous reports is provided so ongoing activity can be readily measured against longitudinal trends.

The bullets below highlight some of the details regarding persons who are currently waiting for a BRAP voucher: The percentage terms reflect the percentage of relative change compared to the last report, the formula is ((Current Report Number – Previous Report Number) / Current Report Number).

- Priority #1 applicants (Discharge from a psychiatric hospital within the last 6 months). Riverview and Dorothea Dix consumers are typically not waiting more than 5 days from the date of a completed application. Priority 1 applicants waiting for a BRAP voucher have increased from 5 to 23 persons, up 360%.
- Priority #2 applicants (Homeless) have increased from 269 to 342 up 27%

- Priority #3 applicants (Substandard Housing) up from 2 to 3, up 50%.
- Priority #4 applicants (Community Residential Facility) have increased from 38 to 44 persons, up 16%.
- Persons on the waitlist greater than 90 days have increased from 184 to 242 persons, up 32%.

Since inception of the wait list, there has been a total of 2,038 BRAP vouchers awarded broken down as follows: Priority #1, 947; Priority #2, 843; Priority #3, 27; Priority #4, 209. Note that 12 vouchers have been awarded to persons with no priority. In the last quarter 35 vouchers were awarded and 127 people were added to the waitlist.

The current BRAP census as of December 31, 2012 is 756 vouchers. Given the fiscal climate, it is unlikely there will be any carry-over or no-lapse in funds clause this year. We anticipate using all FY13 plus all carry-over funds by the end of June 2013.

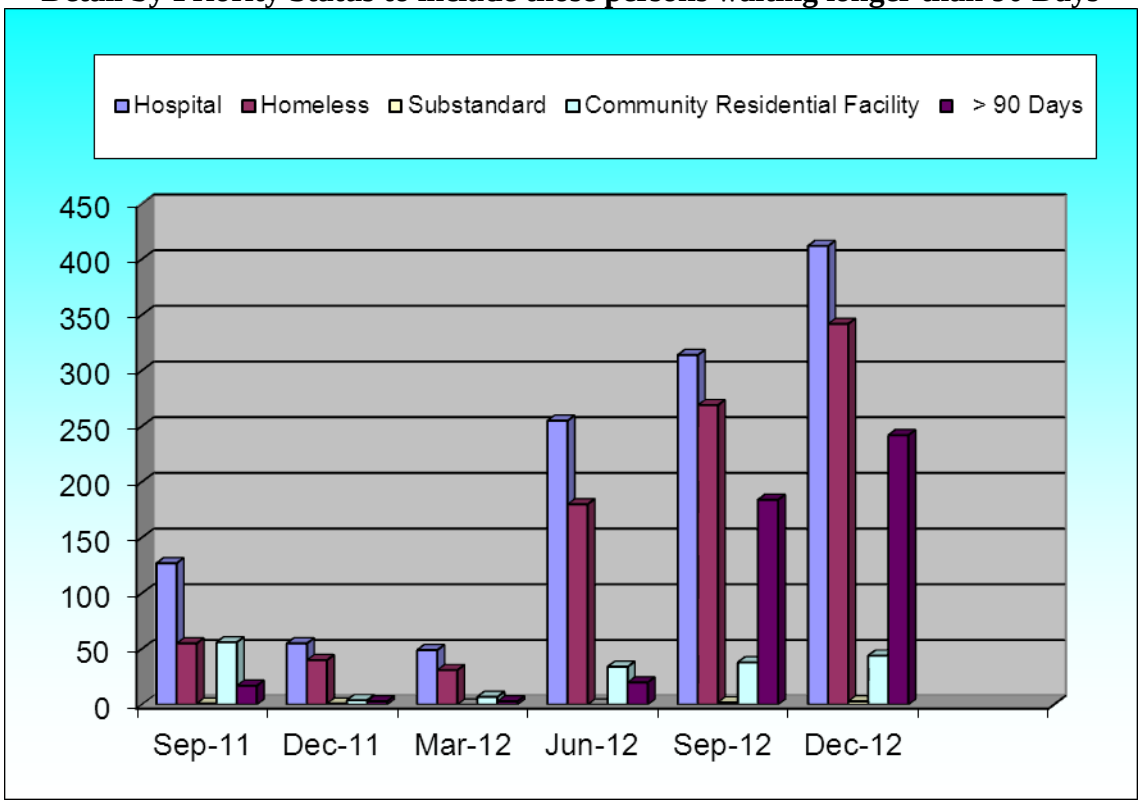
The number of persons on the program for greater than 24 months remains steady at 25% of the entire program. This is principally a result of decades of federal and state cuts to low-income and supportive housing programs. The lack of availability of these resources, particularly Section 8 at the federal level, has translated to increased pressures on state programs such as BRAP.

HUD has recently issued a second definition of homelessness which has a direct impact on the Shelter Plus Care program. We are awaiting further clarification from HUD on the new definitions before implementing them into the BRAP program—HUD is currently training its Regional Representatives in Washington on the new HEARTH Act. HUDs new homeless definition is broader than the existing one and includes 'at-risk' categories and it is likely we will have to narrow BRAP to the 'literally homeless' category in order to stay within limits of funding and manage waitlists.

Other potential impacts to the program surround General Assistance and TANF as BRAP currently has an income requirement, and is not desgined to support 100% of the rental assistance. Depending on legislative initiatives and outcomes this Legislative session (126th) we may need to modify BRAP program guidelines regarding income and longevity.

SAMHS administered a substantial number of Shelter Plus Care vouchers, 807 as of December 31, 2012. This program is funded by the U.S. Department of Housing and Urban Development and has seen significant growth over the last decade, the result of SAMHS having aggressively applyed for and received new grants each year. The FY2013 annual budget for Shelter Plus Care is $7.1 million. The total dollars for all SPC grants (one year renewals to 5 year new contracts) administered by SAMHS is $13,434,250. Shelter Plus Care (SPC) is designed to provide permanent rental subsidies (housing vouchers) and supportive services (provided by MaineCare) to literally homeless individuals with: severe and persistent mental illness (63%), chronic substance abuse and mental illness (30%), and chronic substance abuse and HIV/AIDS (7%).

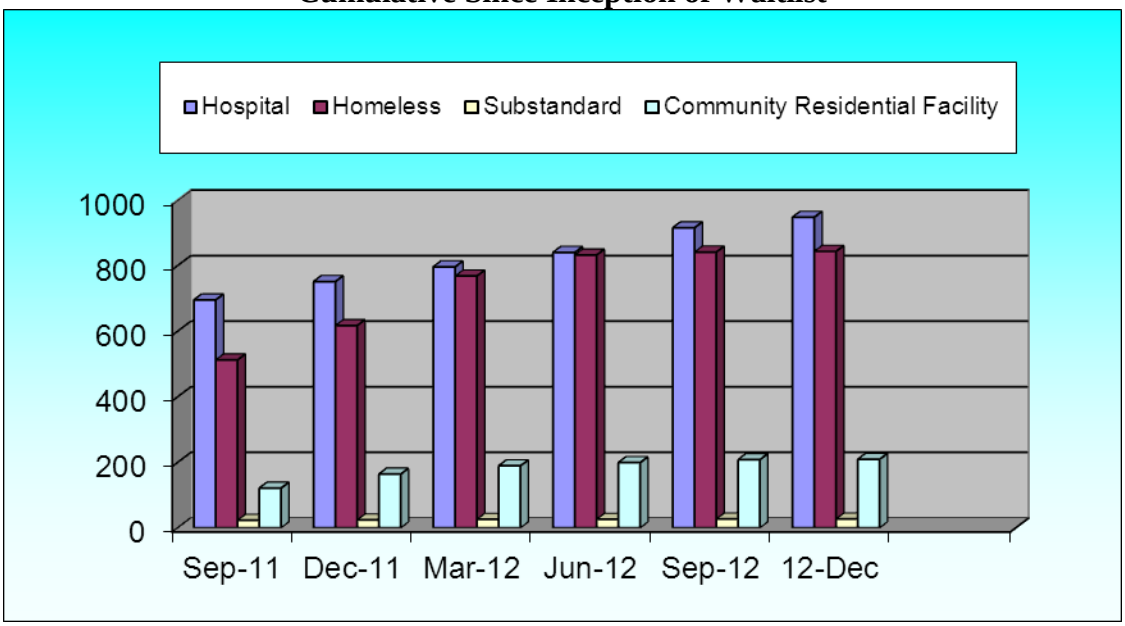
BRAP Waitlist Status--Graph:
Detail by Priority Status to include those persons waiting longer than 90 Days



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

Reporting Period	Sep-11	Dec-11	Mar-12	Jun-12	Sep-12	Dec-12	% Change relative to Last Report
Total number of persons waiting for BRAP	127	55	49	255	314	412	31%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	15	9	11	41	5	23	360%
Priority 2—Homeless (HUD Transitional Definition)	55	40	31	180	269	342	27%
Priority 3—Sub-standard Housing	1	1	0	0	2	3	50%
Priority 4—Leaving a Community Residential living facility	56	4	7	34	38	44	16%
Total number of persons on wait list more than 90 days awaiting voucher	17	3	3	20	184	242	32%

BRAP Awards—Graph
Cumulative Since Inception of Waitlist



BRAP Awards—Table
Cumulative Since Inception of Waitlist

Reporting Periods	Sep-11	Dec-11	Mar-12	Jun-12	Sep-12	12-Dec	% Change relative to Last Report
Cumulative number of persons awarded BRAP	1361	1566	1790	1908	2003	2038	2%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	695	751	796	840	915	947	3%
Priority 2—Homeless (HUD Transitional Definition)	512	617	768	832	841	843	0%
Priority 3—Sub-standard Housing	23	24	26	26	27	27	0%
Priority 4—Leaving a DHHS funded living facility	121	164	189	199	208	209	0%

Note: 12 persons awarded with no priority

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 2nd Quarter of Fiscal Year 2013

(October, November, December 2012)

		2012 Q3	2012 Q4	2013 Q1	2013 Q2
Total Plans Reviewed		51	50	50	55
I Releases					
1A	Does the record document that the agency has planned with and educated the consumer regarding releases of information at intake/initial treatment planning process?	100.0% 21 of 21	100.0% 17 of 17	100.0% 13 of 13	100.0% 18 of 18
1B	Does the record document that the agency has planned with and educated the consumer regarding releases of information during each treatment plan review?	80.4% 41 of 51	77.8% 35 of 45	77.6% 38 of 49	96.2% 51 of 53
1C	Does the record document that the consumer has a primary care physician (PCP)?	94.0% 47 of 50	94.0% 47 of 50	95.8% 46 of 48	88.7% 47 of 53
1D	If 1C. is yes, has there been an attempt to obtain releases signed by the consumer for the sharing of information with the PCP?	80.9% 38 of 47	85.1% 40 of 47	82.6% 38 of 46	85.1% 40 of 47
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?	88.2% 45 of 51	90.0% 45 of 50	95.8% 46 of 48	98.2% 54 of 55
2B	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?	98.0% 50 of 51	96.0% 48 of 50	96.0% 48 of 50	96.4% 53 of 55
2C	Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?	98.0% 50 of 51	95.7% 45 of 47	95.9% 47 of 49	98.2% 54 of 55
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?	94.1% 48 of 51	96.0% 48 of 50	98.0% 48 of 49	100.0% 55 of 55
2E	Does the record document that the consumer has a crisis plan?	43.1% 22 of 51	51.1% 23 of 45	72.9% 35 of 48	92.3% 48 of 52
2F	If 2E. is no, is the reason documented?	100.0% 29 of 29	100.0% 22 of 22	100.0% 13 of 13	100.0% 4 of 4
2G	If 2E. is yes, has the crisis plan been reviewed as required every three months?	50.0% 11 of 22	69.6% 16 of 23	85.7% 30 of 35	89.6% 43 of 48
2H	If 2E. is yes, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?	133.3% 4 of 3	N/A 4 of 0	54.5% 6 of 11	100.0% 4 of 4
2I	Does the record document that the consumer has a mental health advance directive?	2.0% 1 of 51	7.7% 3 of 39	12.2% 6 of 49	12.7% 7 of 55
2J	If 2I. is yes, has the advance directive been reviewed at least annually by the CSW and consumer?	0.0% 0 of 1	33.3% 1 of 3	50.0% 3 of 6	0.0% 0 of 7
2K	If 2I. is no, is the reason why documented?	100.0% 50 of 50	100.0% 36 of 36	100.0% 43 of 43	100.0% 48 of 48
III Needed Resources					
3A	Does the record document that natural supports (family/friends) are being accessed as a resource?	94.1% 48 of 51	92.0% 46 of 50	100.0% 11 of 11	N/A 0 of 0
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% 4 of 4	N/A 0 of 0	N/A 0 of 0
3C	Does the record document that generic resources (those resources that anyone can access) are being accessed?	96.1% 49 of 51	100.0% 50 of 50	91.7% 11 of 12	100.0% 2 of 2

3D	If 3C. is no, has the worker discussed with the consumer the consideration of generic resources as a resource?	0.0%	0 of 2	N/A	0 of 0	0.0%	0 of 1	N/A	0 of 0
3E	Does the record document a resource need that has not been provided according to/within the expected response time?	13.7%	7 of 51	15.4%	6 of 39	26.7%	4 of 15	80.0%	8 of 10
3F	Does the treatment plan reflect interim planning?	57.1%	4 of 7	100.0%	6 of 6	100.0%	4 of 4	100.0%	8 of 8
3G	Does the record document that the treatment team reconvened after the unmet need was identified?	57.1%	4 of 7	100.0%	6 of 6	25.0%	1 of 4	0.0%	0 of 8
IV Service Agreements									
4A	Does the record document that service agreements are required for this plan? (see paragraph 69 protocol for definitions)	49.0%	25 of 51	34.9%	15 of 43	65.3%	32 of 49	34.5%	19 of 55
4B	If 4A. is yes, have service agreements been acquired?	80.0%	20 of 25	40.0%	6 of 15	65.6%	21 of 32	73.7%	14 of 19
4C	If 4A. is yes, are the service agreements current?	76.0%	19 of 25	33.3%	5 of 15	59.4%	19 of 32	73.7%	14 of 19
V Vocational Services									
5A	Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?	87.5%	42 of 48	90.0%	45 of 50	100.0%	50 of 50	98.2%	54 of 55
5B	Does the record document that the vocational domain is being addressed with the consumer at each 90 day treatment plan review?	92.0%	46 of 50	85.4%	41 of 48	94.0%	47 of 50	98.2%	54 of 55
VI Comments									
6A	Plan of correction requested?	43.1%	22 of 51	42.0%	21 of 50	32.0%	16 of 50	27.3%	15 of 55
6A.1.	Plan of correction for section 2A. (required when not all domains assessed) included?	100.0%	6 of 6	100.0%	5 of 5	0.0%	0 of 2	0.0%	0 of 1
6C	Plan of correction received?	100.0%	22 of 22	95.2%	20 of 21	68.8%	11 of 16	66.7%	10 of 15
6D	Were corrections made to the satisfaction of the CDC?	100.0%	22 of 22	100.0%	20 of 20	100.0%	11 of 11	100.0%	10 of 10

Report Run by: Brandi.Giguere Report Run on: Jan 10, 2013 at 9:00:51 AM

Division of Licensing and Regulatory Services/Hospitals
Quarterly Consent Decree Reporting
Psychiatric Hospitals

This report covers:
2013 Fiscal Year __ First Quarter (July, August, September)
X Second Quarter (October, November, December)
__ Third Quarter (January, February, March)21
__ Fourth Quarter (April, May, June)

__0__ Number of Surveys Completed
0 Number of non-accredited hospitals (specify): _____
_____
0Number accredited hospitals (specify): _____
_____
0Number in which Office of Adult Mental Health Service UR Nurse participated
0Number of SODs (statements of deficiencies) forwarded to the Office of Adult Mental Health Services

9 Number of Complaints Received **6** Number of Complaints Investigated
0 Number substantiated
0Number of Rights of Recipients of Mental Health Services violations
0 Number of Plans of Correction sought

Summary of Rights violations by Hospital:

Other: _____
_____
_____
_____
_____

Completed by: **Bethany Laflin** Date: **01/14/2013**

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

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

Community Hospital Utilization Review for Involuntary Admissions

All Clients

For the 1st Quarter of Fiscal Year 2013

(July, August, September 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Total Admissions	117	115	128	98
Hospital				
Hospitalized in Local Area	78.6% (92 of 117)	83.5% (96 of 115)	84.4% (108 of 128)	83.7% (82 of 98)
Hospitalization Made Voluntary	78.6% (92 of 117)	85.2% (98 of 115)	81.2% (104 of 128)	86.7% (85 of 98)
Legal Status				
Blue Paper on File	99.1% (116 of 117)	100.0% (115 of 115)	95.3% (122 of 128)	100.0% (98 of 98)
Blue Paper Complete/Accurate	99.1% (115 of 116)	99.1% (114 of 115)	98.4% (120 of 122)	100.0% (98 of 98)
If not complete, Follow up per policy	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (2 of 2)	N/A (0 of 0)
24 Hr. Certification Required	83.8% (98 of 117)	89.6% (103 of 115)	90.6% (116 of 128)	87.8% (86 of 98)
24 Hr. Certification on file	96.9% (95 of 98)	99.0% (102 of 103)	99.1% (115 of 116)	98.8% (85 of 86)
24 Hr. Certification Complete/Accurate	97.9% (93 of 95)	99.0% (101 of 102)	100.0% (115 of 115)	100.0% (85 of 85)
If not, Follow up per policy	100.0% (2 of 2)	100.0% (1 of 1)	N/A (0 of 0)	N/A (0 of 0)
Quality Care				
Medical Necessity Established	100.0% (117 of 117)	100.0% (115 of 115)	100.0% (128 of 128)	100.0% (98 of 98)
Active Treatment Within Guidelines	100.0% (117 of 117)	100.0% (115 of 115)	99.2% (127 of 128)	100.0% (98 of 98)
Patient's Rights Maintained	95.7% (112 of 117)	96.5% (111 of 115)	95.3% (122 of 128)	99.0% (97 of 98)
If not maintained, follow up per policy	80.0% (4 of 5)	100.0% (3 of 3)	100.0% (4 of 4)	100.0% (1 of 1)
Inappropriate Use of Blue Paper	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Individual Service Plans				
Receiving Case Management Services	29.9% (35 of 117)	28.7% (33 of 115)	23.4% (30 of 128)	19.4% (19 of 98)
Case Manager Involved with Discharge Planning	88.6% (31 of 35)	90.9% (30 of 33)	86.7% (26 of 30)	78.9% (15 of 19)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (35 of 35)	97.0% (32 of 33)	90.0% (27 of 30)	84.2% (16 of 19)
Hospital Obtained ISP when authorized	2.9% (1 of 35)	3.1% (1 of 32)	11.1% (3 of 27)	0.0% (0 of 16)
Treatment and Discharge Plan Consistant with ISP	0.0% (0 of 1)	100.0% (1 of 1)	100.0% (3 of 3)	N/A (0 of 0)

Report Run: Jan 11, 2013

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

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

For the 1st Quarter of Fiscal Year 2013

(July, August, September, 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Number of Admissions	23	10	19	19
Involuntarily Admitted Clients who were Receiving CSS Services	15	5	13	10
Number of ISPs Hospitals were Authorized to Obtain	15	4	12	10
Number of ISPs Hospitals Obtained	1	1	1	0

FY QTR	Hospital	Admissions	Receiving Community Support Services	Hospital Obtained ISP when authorized	Treatment and Discharge Plan Consistant with ISP	Case Worker Involved with Treatment and Discharge Planning
2012 Q1	Acadia	5	60.0% (3 of 5)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Maine General - Waterville	3	66.7% (2 of 3)	50.0% (1 of 2)	0.0% (0 of 1)	100.0% (2 of 2)
	Mid-coast Hospital	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	PenBay Medical Center	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Spring Harbor	9	55.6% (5 of 9)	0.0% (0 of 5)	N/A (0 of 0)	80.0% (4 of 5)
	St. Mary's	4	100.0% (4 of 4)	0.0% (0 of 4)	N/A (0 of 0)	50.0% (2 of 4)
2012 Q2	Acadia	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Maine General - Waterville	1	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	PenBay Medical Center	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Spring Harbor	4	50.0% (2 of 4)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	St. Mary's	2	50.0% (1 of 2)	N/A (0 of 0)	N/A (0 of 0)	100.0% (1 of 1)
2012 Q4	Acadia	5	80.0% (4 of 5)	25.0% (1 of 4)	100.0% (1 of 1)	100.0% (4 of 4)
	Mid-coast Hospital	2	50.0% (1 of 2)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	5	60.0% (3 of 5)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Spring Harbor	6	66.7% (4 of 6)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (4 of 4)
	St. Mary's	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
2012 Q4	PenBay Medical Center	4	0.0% (0 of 4)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	4	75.0% (3 of 4)	0.0% (0 of 3)	N/A (0 of 0)	0.0% (0 of 3)
	Spring Harbor	9	77.8% (7 of 9)	0.0% (0 of 7)	N/A (0 of 0)	100.0% (7 of 7)
	St. Mary's	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)

Report Run: Jan 11, 2013

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

Class Members

For the 1st Quarter of Fiscal Year 2013

(July, August, September 2012)

	2012 Q2	2012 Q3	2012 Q4	2013 Q1
Total Admissions	22	9	19	19
Hospital				
Hospitalized in Local Area	63.6% (14 of 22)	77.8% (7 of 9)	73.7% (14 of 19)	100.0% (19 of 19)
Hospitalization Made Voluntary	68.2% (15 of 22)	77.8% (7 of 9)	57.9% (11 of 19)	78.9% (15 of 19)
Legal Status				
Blue Paper on File	100.0% (22 of 22)	100.0% (9 of 9)	100.0% (19 of 19)	100.0% (19 of 19)
Blue Paper Complete/Accurate	100.0% (22 of 22)	100.0% (9 of 9)	100.0% (19 of 19)	100.0% (19 of 19)
If not complete, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
24 Hr. Certification Required	86.4% (19 of 22)	88.9% (8 of 9)	94.7% (18 of 19)	94.7% (18 of 19)
24 Hr. Certification on file	100.0% (19 of 19)	100.0% (8 of 8)	100.0% (18 of 18)	100.0% (18 of 18)
24 Hr. Certification Complete/Accurate	100.0% (19 of 19)	100.0% (8 of 8)	100.0% (18 of 18)	100.0% (18 of 18)
If not, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Quality Care				
Medical Necessity Established	100.0% (22 of 22)	100.0% (9 of 9)	100.0% (19 of 19)	100.0% (19 of 19)
Active Treatment Within Guidelines	100.0% (22 of 22)	100.0% (9 of 9)	94.7% (18 of 19)	100.0% (19 of 19)
Patient's Rights Maintained	100.0% (22 of 22)	88.9% (8 of 9)	94.7% (18 of 19)	100.0% (19 of 19)
If not maintained, follow up per policy	N/A (0 of 0)	100.0% (1 of 1)	N/A (0 of 0)	N/A (0 of 0)
Inappropriate Use of Blue Paper	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Individual Service Plans				
Receiving Case Management Services	68.2% (15 of 22)	55.6% (5 of 9)	68.4% (13 of 19)	52.6% (10 of 19)
Case Manager Involved with Discharge Planning	80.0% (12 of 15)	100.0% (5 of 5)	100.0% (13 of 13)	70.0% (7 of 10)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (15 of 15)	80.0% (4 of 5)	92.3% (12 of 13)	100.0% (10 of 10)
Hospital Obtained ISP when authorized	6.7% (1 of 15)	25.0% (1 of 4)	8.3% (1 of 12)	0.0% (0 of 10)
Treatment and Discharge Plan Consistant with ISP	0.0% (0 of 1)	100.0% (1 of 1)	100.0% (1 of 1)	N/A (0 of 0)

Report Run: Jan 11, 2013

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

Maine Department of Health and Human Services

Integrated Quarterly Crisis Report

STATEWIDE with GRAPHS

Quarter 2 (October, November, December) SFY 2013

I. Consumer Demographics (Unduplicated Counts - Face to Face)

Gender	Children	Males	644	Females	639				
	Adults	Males	2096	Females	2049				
Age Range	Children	<5y.o.	11	5-9	156	10-14	576	15-17	540
	Adults	18-21	443	22-35	1320	36-60	1965	61 & Older	390
Payment Source	Children	MaineCare	909	Private Ins.	309	Uninsured	80	Medicare	3
	Adults	MaineCare	2249	Private Ins.	727	Uninsured	790	Medicare	466

II. Summary of All Crisis Contacts

	CHILDREN	ADULT
a. Total number of telephone contacts.	9353	43394
b. Total number of all ***INITIAL*** face to face contacts.	1324	4386
c. Number in II.b. who are children/youth with MENTAL RETARDATION/AUTISM/PERVASIVE DEVELOPMENTAL DISORDER	85	
d. Number of face to face contacts that are ongoing support for crisis resolution/stabilization.	280	1557

III. Initial Crisis Contact Information

	CHILDREN		ADULT	
a. Total number of **INITIAL** face to face contacts in which wellness plan, crisis plan, ISP or advanced directive plan previously developed with the individual was used.	173	13.1%	432	9.8%
b. Number of **INITIAL** face to face contacts who have a Community Support Worker (CI, CRS, ICM, ACT,TCM).	457	34.5%	1152	26.3%
c. Number of **INITIAL** face to face contacts who have a Community Support Worker and whose worker was notified of the crisis.	442	96.7%	1096	95.1%
d. **SUM TOTAL** 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.			109755	25.0
e. Number of **INITIAL** face to face contacts in Emergency Department with final disposition made within 8 hours of that contact.			2404	91.4%
f. Number of **INITIAL** face to face contacts ***NOT*** in Emergency Department with final disposition made within 8 hours of that contact.			1731	98.6%

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	731	1 to 2 hours	300	2 to 4 hours	206	More than 4 hours	66
	55%		23%		16%		5%

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

Less than 3 hours	930	3 to 6 hours	255	6 to 8 hours	25	8 to 14 hours	30	More than 14 hours	50
	70%		19%		2%		2%		4%

IV. Site of Initial Face to Face Contacts

Number of face to face contacts seen in :	CHILDREN		ADULT	
a. Primary Residence (Home)	251	19.0%	361	8.2%
b. Family/Relative/Other Residence	21	1.6%	24	0.5%
c. Other Community Setting (Work, School, Police Dept., Public Place)	137	10.3%	154	3.5%
d. SNF, Nursing Home, Boarding Home	0	0.0%	40	0.9%
e. Residential Program (Congregate Community Residence, Apartment Program)	4	0.3%	45	1.0%
f. Homeless Shelter	4	0.3%	31	0.7%
g. Provider Office	12	0.9%	96	2.2%
h. Crisis Office	218	16.5%	764	17.4%
i. Emergency Department	659	49.8%	2630	60.0%
j. Other Hospital Location	13	1.0%	143	3.3%
k. Incarcerated (Local Jail, State Prison, Juvenile Correction Facility)	5	0.4%	98	2.2%
NOTE: Sum of Crisis Resolutions must equal II.b.= Total no. of all INITIAL face-to-face contacts — **Sec. IV Total**	1324	100%	4386	100%

V. Initial Crisis Resolution (Mutually Exclusive & Exhaustive)

Number of face to face contacts that resulted in:	CHILDREN		ADULT	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	45	3.4%	247	5.6%
b. Crisis stabilization with *referral to new provider* for mental health/substance abuse follow-up	275	20.8%	800	18.2%
c. Crisis stabilization with *referral back to current provider* for mental health/substance abuse follow-up	517	39.0%	1630	37.2%
d. Admission to Crisis Stabilization Unit	224	16.9%	480	10.9%
e. Inpatient Hospitalization-Medical	12	0.9%	114	2.6%
f. Voluntary Psychiatric Hospitalization	247	18.7%	852	19.4%
g. Involuntary Psychiatric Hospitalization	4	0.3%	181	4.1%
h. Admission to Detox Unit	0	0.0%	82	1.9%
NOTE: Sum of Crisis Resolutions must equal II.b.= Total no. of all INITIAL face-to-face contacts — **Sec. V Total**	1324	100%	4386	100%

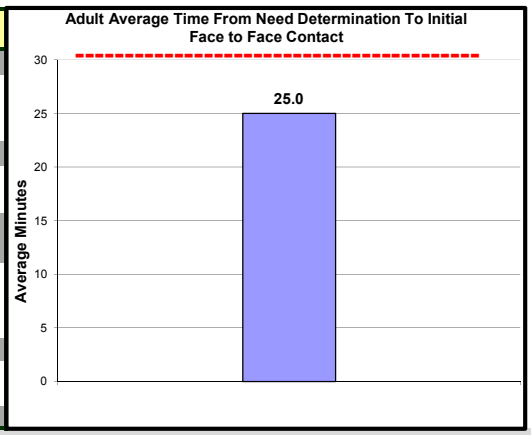
RJ Melville MSW MPA 1.25.2013

STATE OF MAINE
Quarterly Crisis Report
SFY 2013
QTR2

ADULTS ONLY

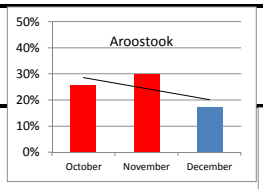
Adult AMHI CONSENT DECREE FEEDBACK REPORT

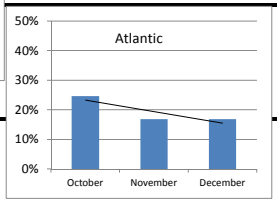
No.	Result	STANDARD
IV.35	23.6%	No more than 20-25% of face to face contacts result in Psychiatric Hospitalization.
IV.36	25.0 Average Minutes	90% of Crisis Phone Calls Requiring Face to Face Assessments are responded to within an average of 30 minutes from the end of the phone call.
IV. 37	94.3%	90% of all Face to Face Assessments Result in Resolution for the Consumer Within 8 Hours of Initiation of the Face to Face Assessment.
IV.38	95.1%	90% of all Face to Face Contacts in which the client has a Community Support Worker, the Worker is notified of the crisis.

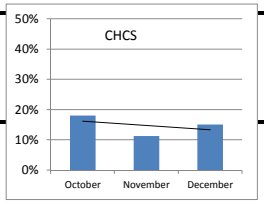


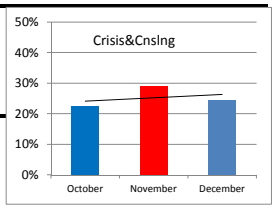
Adult AMHI Consent Decree Standard: No More Than 20-25% of face to face contacts result in Psychiatric hospitalization.
Actual Percent face to face contacts resulting in Psychiatric Hospitalization.

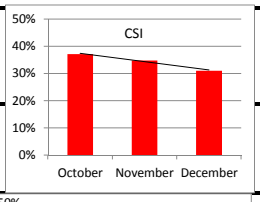
AGENCY	MONTH	October	November	December
AMHC Aroostook		26%	30%	17%
AMHC Atlantic		25%	17%	17%
CHCS		18%	11%	15%
Crisis & Counseling		22%	29%	25%
CSI		37%	35%	31%
EVERGREEN		8%	18%	9%
MCMH		41%	36%	34%
Opportunity Alliance		5%	10%	8%
OCMH		11%	17%	15%
Sweetser Region 2		34%	28%	27%
Tri County MH		39%	25%	21%

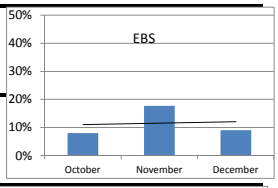


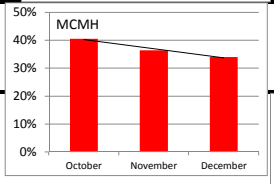


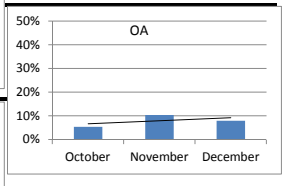


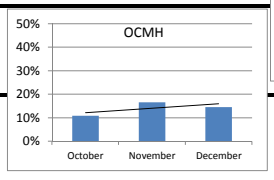


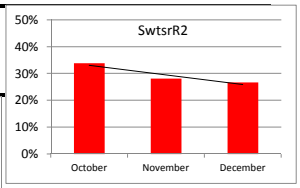


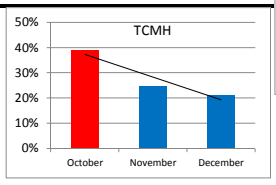






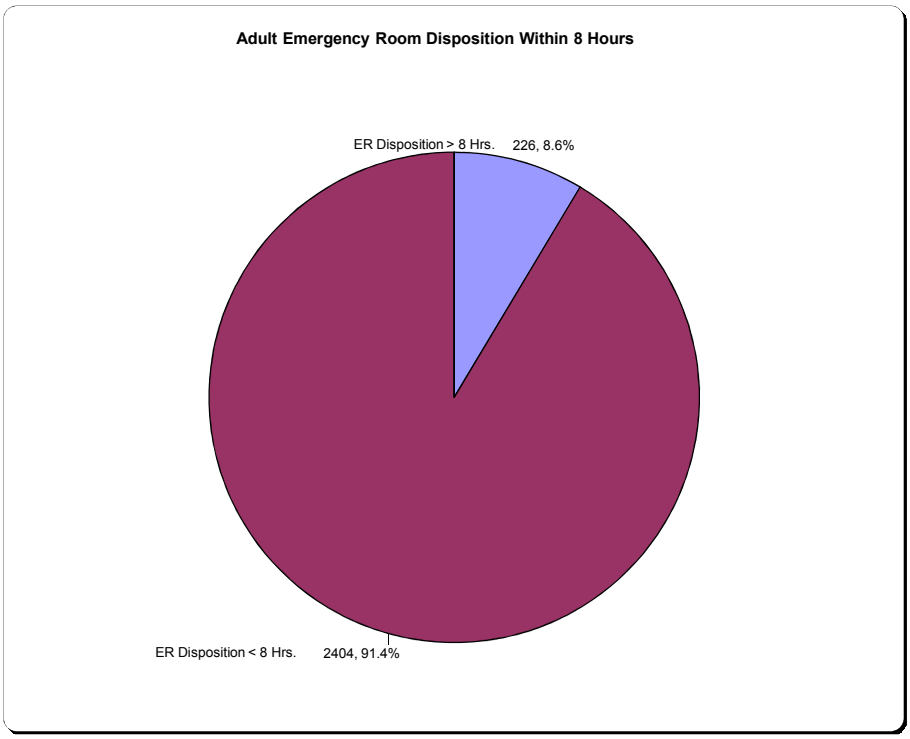


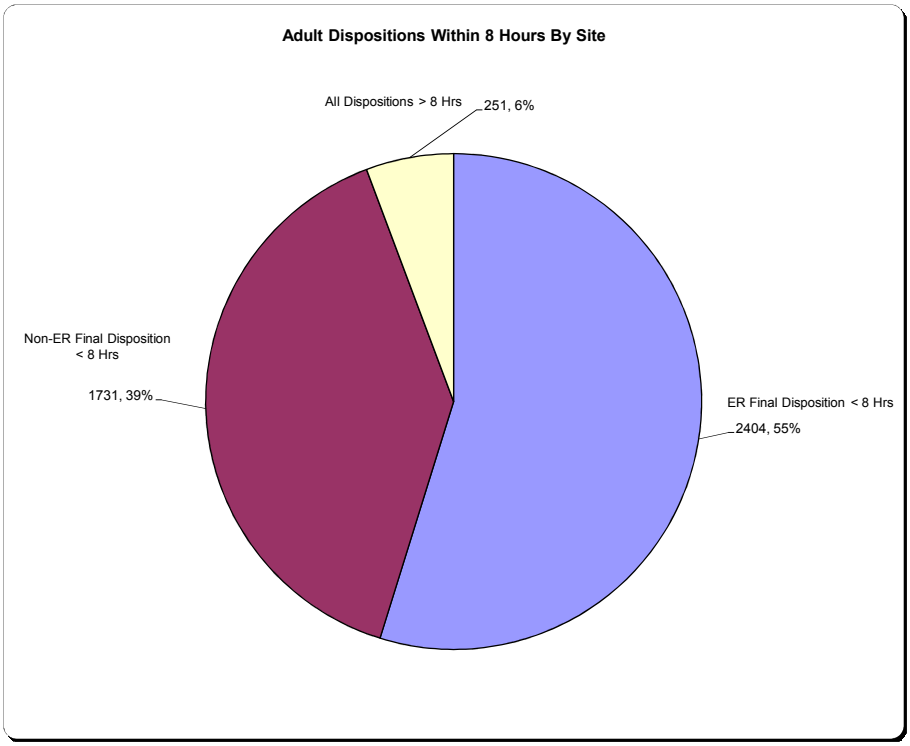




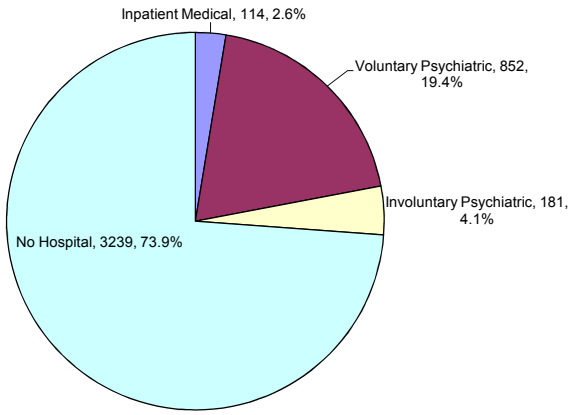
NOTES
1) Red Bars > 25%
2) Black lines are trend lines

ADULTS ONLY

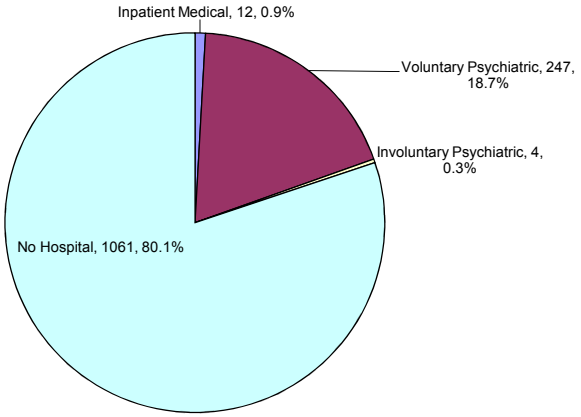

Adult Emergency Room Disposition Within 8 Hours
ER Disposition > 8 Hrs.
226, 8.6%
ER Disposition < 8 Hrs.
2404, 91.4%


Adult Dispositions Within 8 Hours By Site
All Dispositions > 8 Hrs
251, 6%
Non-ER Final Disposition
< 8 Hrs
1731, 39%
ER Final Disposition < 8 Hrs
2404, 55%

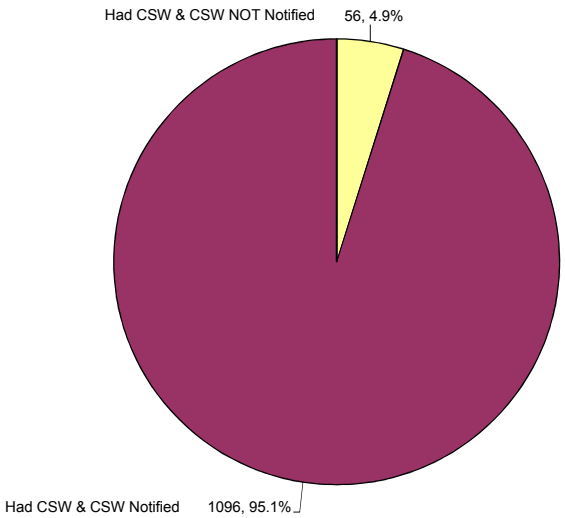
Adult Initial Contacts Hospitalized



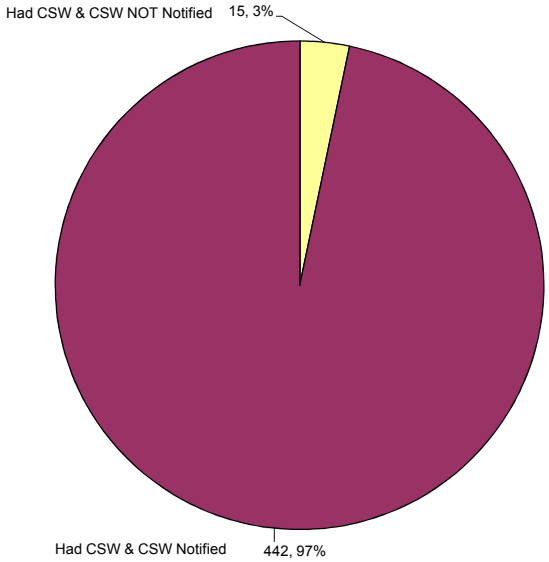
Children Initial Contacts Hospitalized

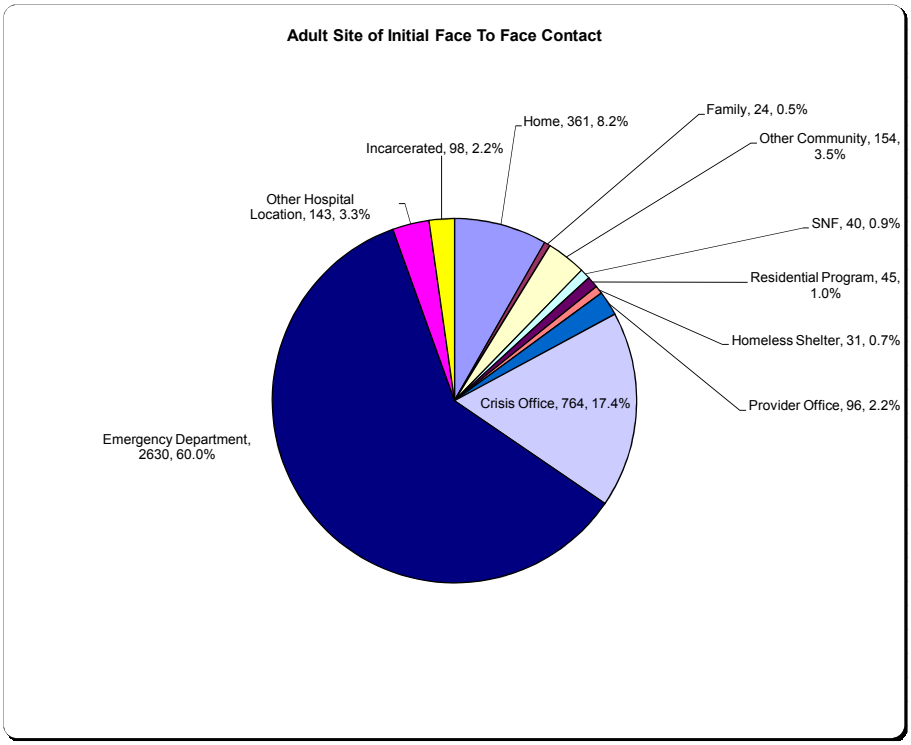


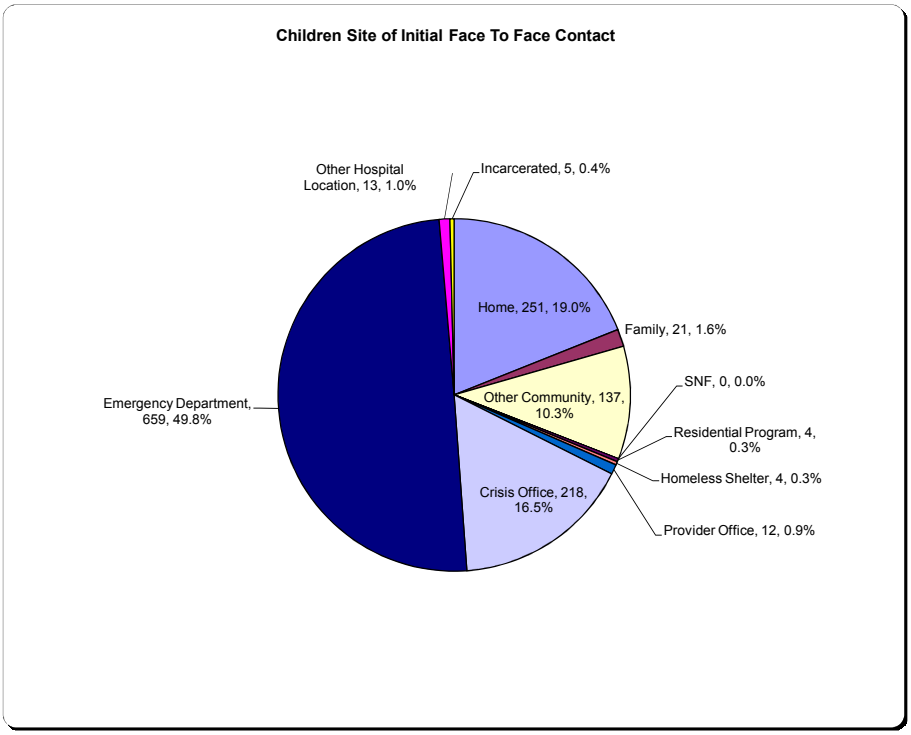
Adult Initial Face to Face Contacts in Which the Client has a CI Worker & The Worker is Notified of the Crisis



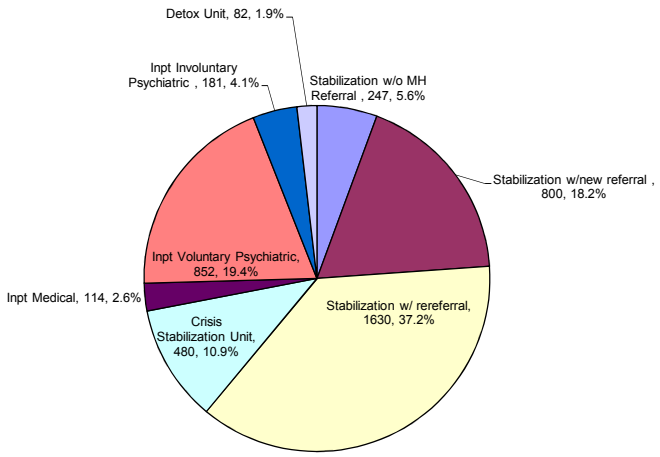
Children Initial Face to Face Contacts in Which the Client has a CI Worker & The Worker is Notified of the Crisis



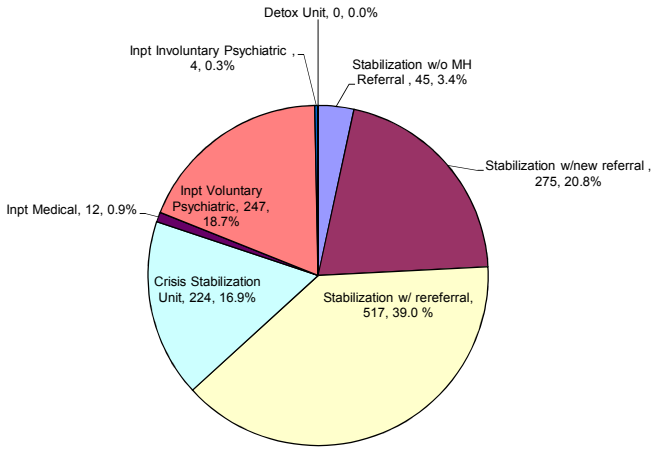

Adult Site of Initial Face To Face Contact
Home, 361, 8.2%
Family, 24, 0.5%
Other Community, 154, 3.5%
Incarcerated, 98, 2.2%
Other Hospital Location, 143, 3.3%
SNF, 40, 0.9%
Residential Program, 45, 1.0%
Homeless Shelter, 31, 0.7%
Provider Office, 96, 2.2%
Crisis Office, 764, 17.4%
Emergency Department, 2630, 60.0%


Children Site of Initial Face To Face Contact
Other Hospital Location, 13, 1.0%
Incarcerated, 5, 0.4%
Home, 251, 19.0%
Family, 21, 1.6%
SNF, 0, 0.0%
Other Community, 137, 10.3%
Residential Program, 4, 0.3%
Emergency Department, 659, 49.8%
Homeless Shelter, 4, 0.3%
Crisis Office, 218, 16.5%
Provider Office, 12, 0.9%

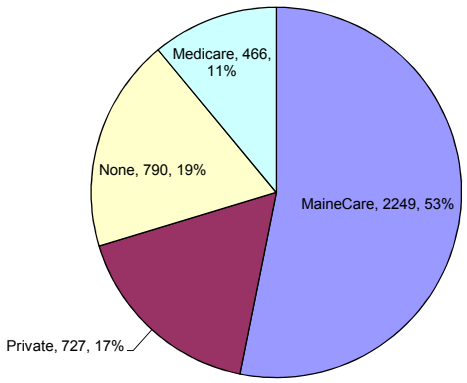
Adult Initial Crisis Resolution



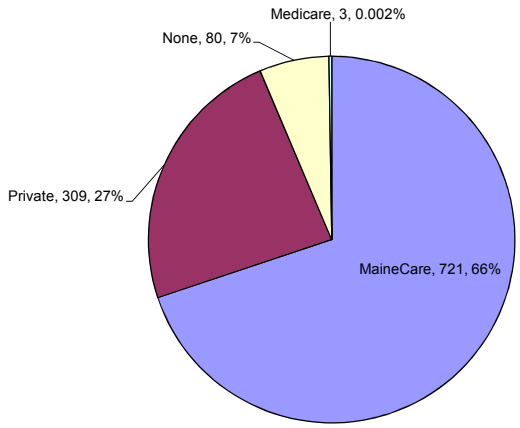
Children Initial Crisis Resolution

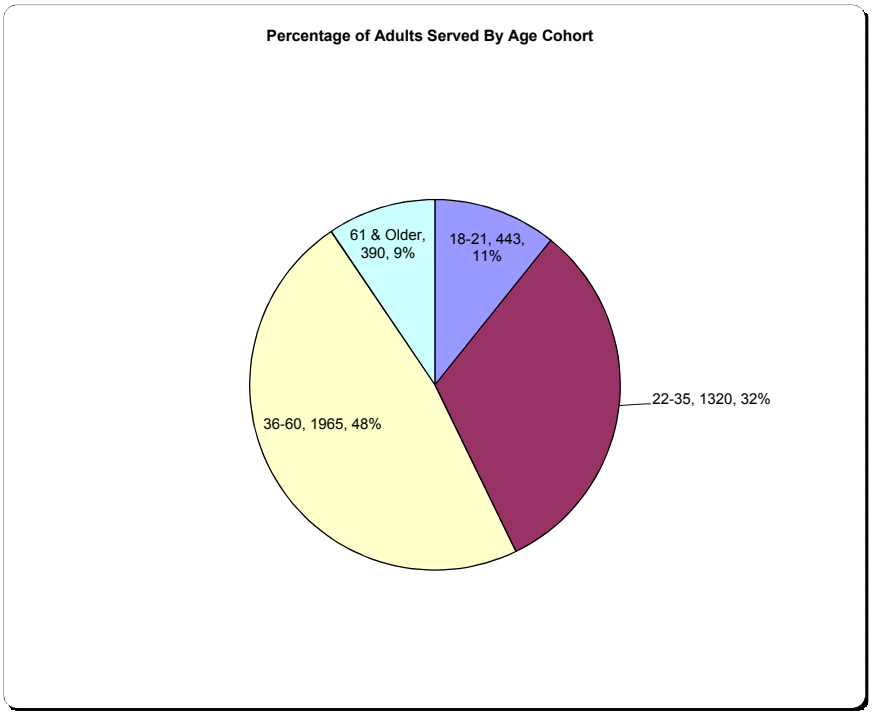


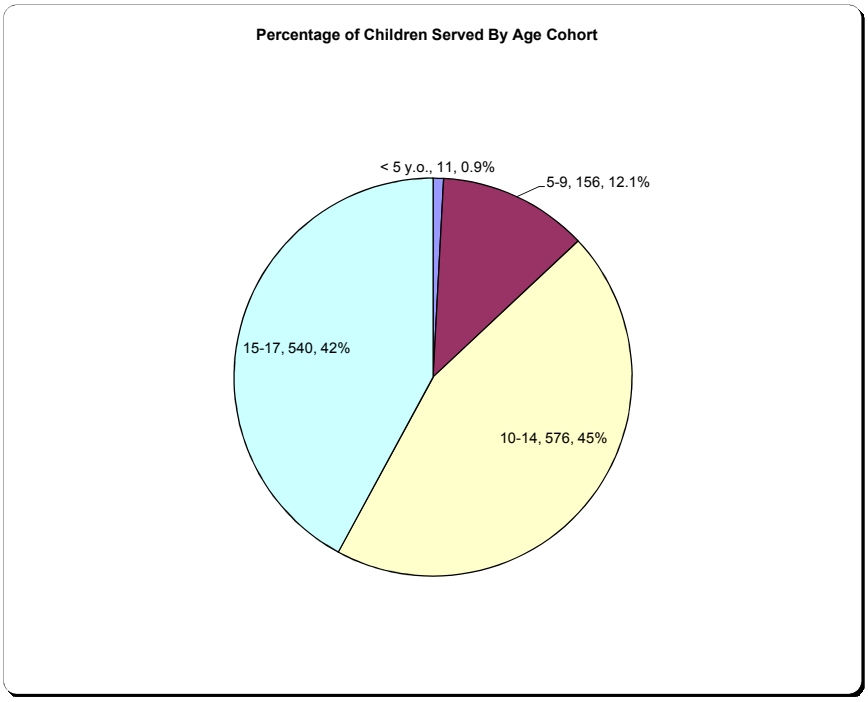
Percentage of Adults Served By Payment Source

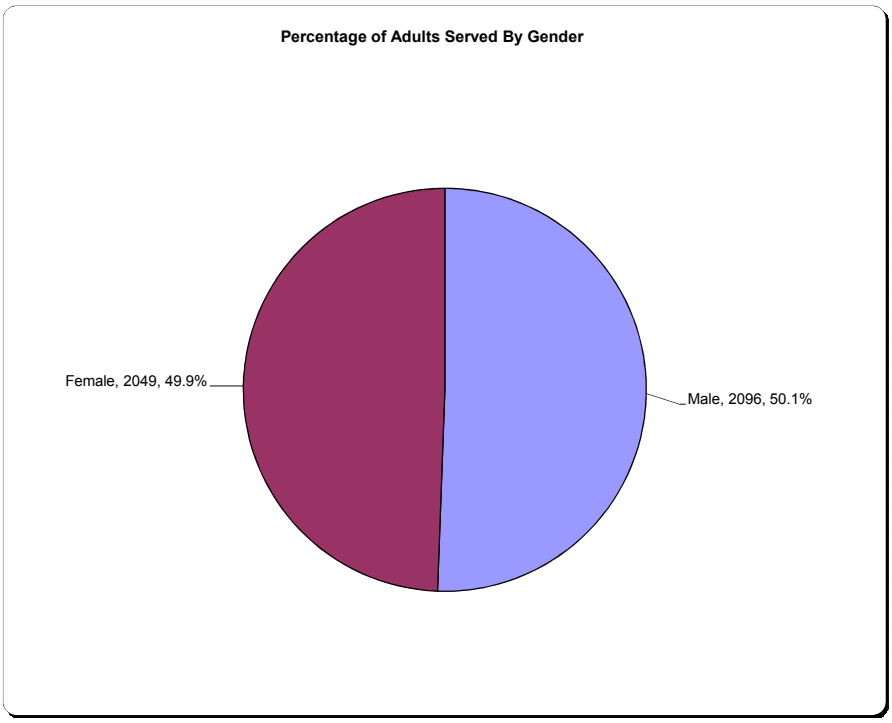


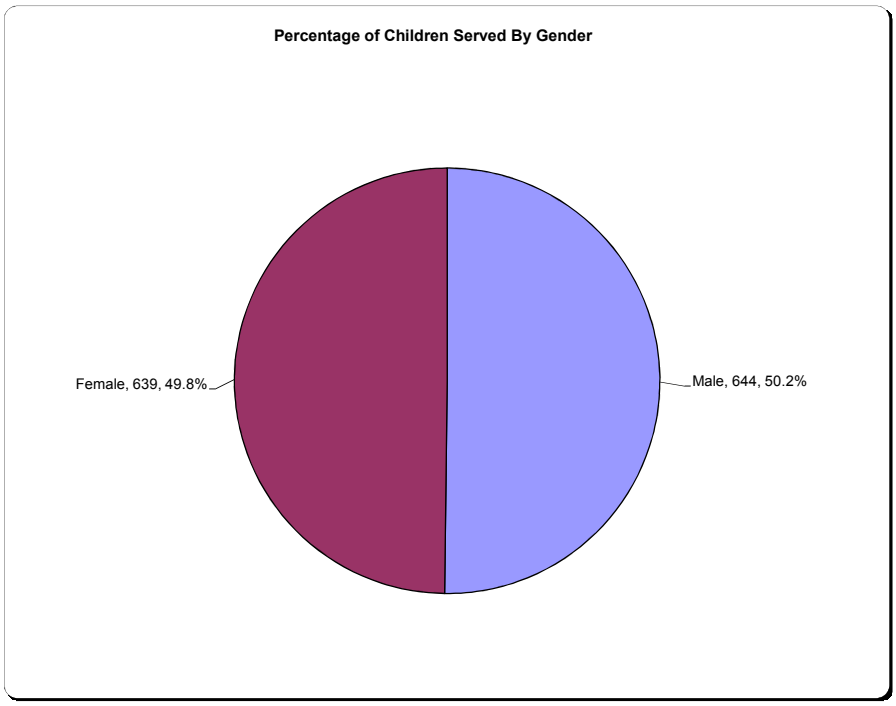
Percentage of Children Served By Payment Source

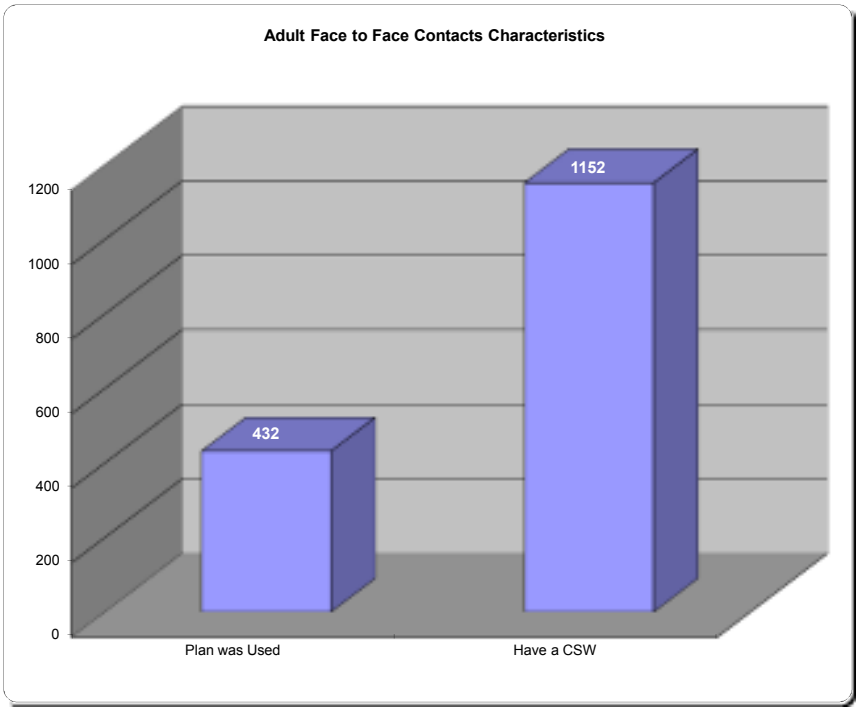


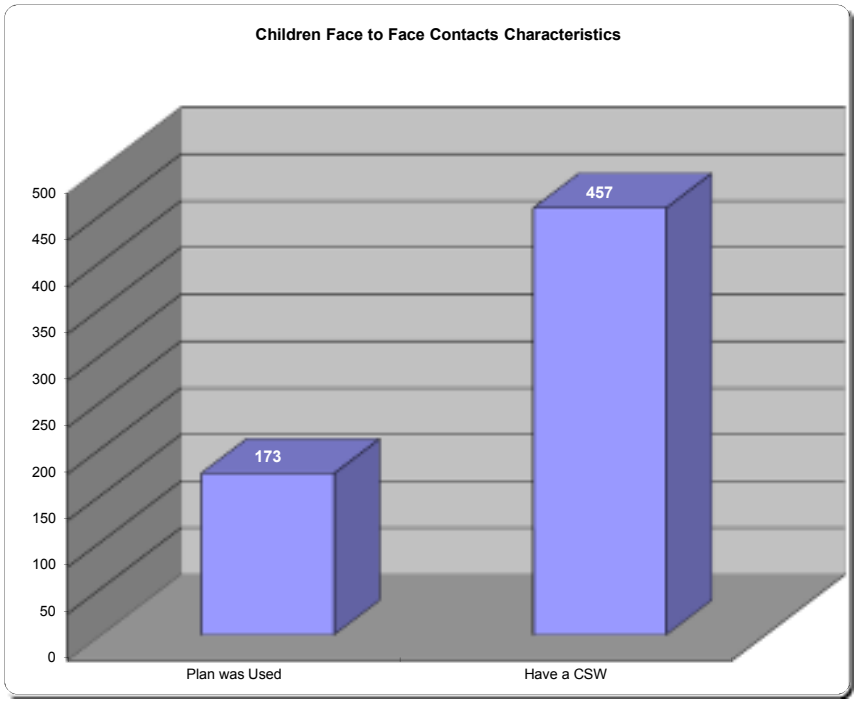

Percentage of Adults Served By Age Cohort
61 & Older, 390, 9%
18-21, 443, 11%
22-35, 1320, 32%
36-60, 1965, 48%


Percentage of Children Served By Age Cohort
< 5 y.o., 11, 0.9%
5-9, 156, 12.1%
15-17, 540, 42%
10-14, 576, 45%


Percentage of Adults Served By Gender
Female, 2049, 49.9%
Male, 2096, 50.1%


Percentage of Children Served By Gender
Female, 639, 49.8%
Male, 644, 50.2%


Adult Face to Face Contacts Characteristics
1200
1000
800
600
400
200
0
1152
432
Plan was Used
Have a CSW


Children Face to Face Contacts Characteristics
500
450
400
350
300
250
200
150
100
50
0
457
173
Plan was Used
Have a CSW

Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE

SECOND STATE FISCAL QUARTER 2013
October, November, December 2012

Mary Louise McEwen, RN, MBA
Superintendent

January 22, 2013

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Table of Contents

Table of Contents

Glossary of Terms, Acronyms & Abbreviations

ACT	Assertive Community Treatment
ADC	Automated Dispensing Cabinets (for medications)
ADON	Assistant Director of Nursing
AOC	Administrator on Call
CCM	Continuation of Care Management (Social Work Services)
CCP	Continuation of Care Plan
CMS	Centers for Medicare & Medicaid Services
CoP	Community of Practice or Conditions of Participation (CMS)
CPI	Continuous Process (or Performance) Improvement
CPR	Cardio-Pulmonary Resuscitation
CSP	Comprehensive Service Plan
GAP	Goal, Assessment, Plan Documentation
HOC	Hand off communications.
IMD	Institute for Mental Disease
ICDCC	Involuntary Civil District Court Commitment
ICDCC-M	Involuntary Civil District Court Commitment, Court Ordered Medications
ICDCC-PTP	Involuntary Civil District Court Commitment, Progressive Treatment Plan
IC-PTP+M	Involuntary Commitment, Progressive Treatment Plan, Court Ordered Medications
ICRDCC	Involuntary Criminal District Court Commitment
INVOL CRIM	Involuntary Criminal Commitment
INVOL-CIV	Involuntary Civil Commitment
ISP	Individualized Service Plan
IST	Incompetent to Stand Trial
LCSW	Licensed Clinical Social Worker
LPN	License Practical Nurse
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
MAR	Medication Administration Record
MRDO	Medication Resistant Disease Organism (MRSA, VRE, C-Dif)
NAPPI	Non Abusive Psychological and Physical Intervention
NASMHPD	National Association of State Mental Health Program Directors
NCR	Not Criminally Responsible
NOD	Nurse on Duty
NP	Nurse Practitioner
NPSG	National Patient Safety Goals (established by the Joint Commission)
NRI	NASMHPD Research Institute, Inc.
OT	Occupational Therapist
PA or PA-C	Physician's Assistant (Certified)
PCHDCC	Pending Court Hearing
PCHDCC+M	Pending Court Hearing for Court Ordered Medications

Glossary of Terms, Acronyms & Abbreviations

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
R.A.C.E.	Rescue/Alarm/Confine/Extinguish
RN	Registered Nurse
RT	Recreation Therapist
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SAMHS	Substance Abuse and Mental Health Services, Office of (Maine DHHS)
SBAR	Acronym for a model of concise communications first developed by the US Navy Submarine Command. S = Situation, B = Background, A = Assessment, R = Recommendation
SD	Standard Deviation – a measure of data variability.
Seclusion, Locked	Client is placed in a secured room with the door locked.
Seclusion, Open	Client is placed in a room and instructed not to leave the room.
SRC	Single Room Care (seclusion)
URI	Upper respiratory infection
UTI	Urinary tract infection
VOL	Voluntary – Self
VOL-OTHER	Voluntary – Others (Guardian)
MHW	Mental Health Worker

INTRODUCTION

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

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

There are three major sections that make up this report:

The first section reflects compliance factors related to the Consent Decree and includes those performance measure described in the Order Adopting Compliance Standards dated October 29, 2007.

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

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

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

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

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CONSENT DECREE

Consent Decree Plan

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

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

Client Rights

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

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. Clients are routinely informed of their rights upon admission	--	--	74% 37/50	91% 42/46

This measure has recently been established. The practice of informing clients of their rights is often delayed as a result of admission acuity. While this process is usually completed after the initial assessment and stabilization, documentation of the act may not be readily available for abstraction. Further refinement of the process is warranted.

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	3Q2012	4Q2012	1Q2013	2Q2013
1. Level II grievances responded to by RPC on time.	100% 3/3	100% 4/4	100% 1/1	100% 5/5
2. Level I grievances responded to by RPC on time.	87% 39/45	56% 63/112	73% 27/37	60% 64/106

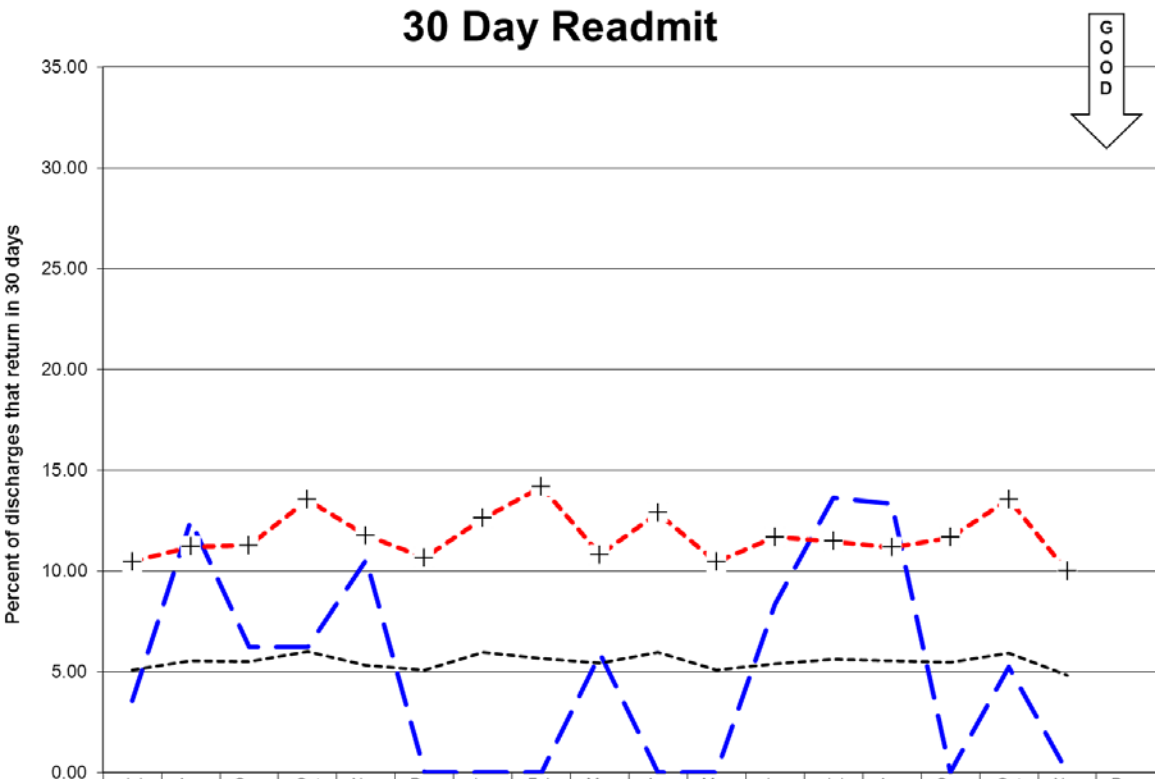
Admissions

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

Client Legal Status on Admission	3Q2012	4Q2012	1Q2013	2Q2013
ICDCC	29	19	17	9
ICDCC-M	1			
ICDCC-PTP				
IC-PTP+M				
ICRDCC			3	
INVOL CRIM	33	39	19	34
INVOL-CIV	3			
PCHDCC			1	
PCHDCC+M		1		1
VOL	2	4	6	
VOL-OTHER	1			

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;



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	3.57	12.50	6.25	6.25	10.53	0.00	0.00	0.00	5.88	0.00	0.00	8.33	13.64	13.33	0.00	5.26	0.00	
Ntl Mean	5.09	5.53	5.51	6.00	5.31	5.08	5.96	5.65	5.42	5.97	5.11	5.39	5.64	5.54	5.48	5.92	4.82	
+1 StDev	10.47	11.21	11.26	13.53	11.76	10.65	12.61	14.18	10.8	12.89	10.45	11.69	11.47	11.17	11.67	13.55	9.99	

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

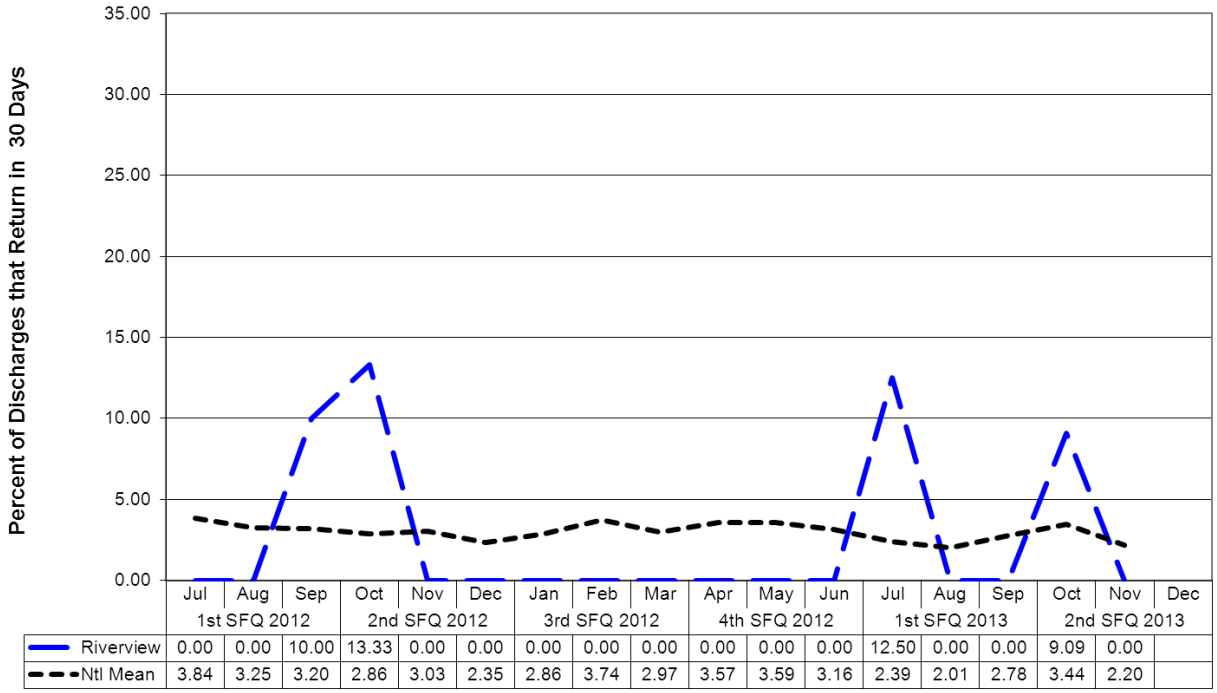
The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility stratified by forensic or civil classifications. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

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

CONSENT DECREE

30 Day Readmit

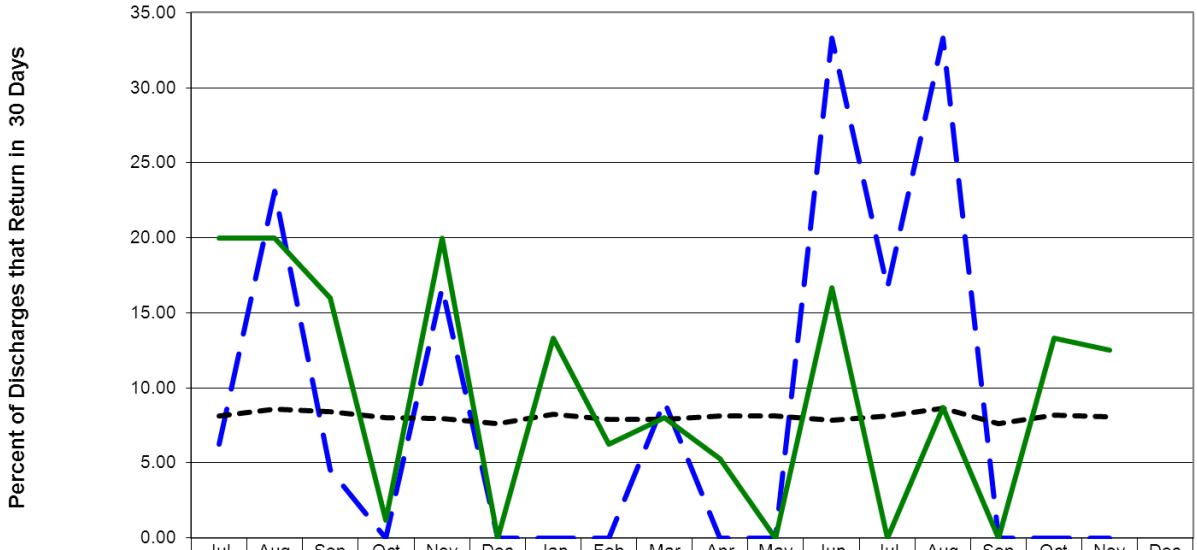
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	10.00	13.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	12.50	0.00	0.00	9.09	0.00	
Ntl Mean	3.84	3.25	3.20	2.86	3.03	2.35	2.86	3.74	2.97	3.57	3.59	3.16	2.39	2.01	2.78	3.44	2.20	

30 Day Readmit

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	6.25	23.08	4.55	0.00	16.67	0.00	0.00	0.00	9.09	0.00	0.00	33.33	16.67	33.33	0.00	0.00	0.00	
Ntl Mean	8.12	8.55	8.39	8.00	7.95	7.63	8.25	7.90	7.88	8.11	8.15	7.84	8.12	8.64	7.60	8.18	8.06	
Dorothea Dix	20.00	20.00	16.00	1.17	20.00	0.00	13.33	6.25	8.00	5.26	0.00	16.67	0.00	8.70	0.00	13.33	12.50	

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

REVIEW OF READMISSION OCCURRING WITHIN 60 DAYS

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	100% 1/1	100% 3/3	100% 3/3	n/a 0/0

REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (i.e.: group home, apartment, etc) c. Geographic location of residence d. Community support network e. Client demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with ACT Team	100% 4 NCR clients were re-admitted to RPC; 1 for violation of court order, 1 who was readmitted due to elopement and 2 for increased psychiatric symptoms.	100% 4 NCR clients were re-admitted to RPC; 1 for violation of court order, 1 who was readmitted due to elopement and 2 for increased psychiatric symptoms	100% 8 readmissions to RPC, 2 medical admissions to MMC	100% 3 clients were re-admitted to RPC;all were NCR, two due to increased psychiatric symptoms, one for using illicit substance in the forensic group home.
2. ACT Team will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%	100%	

Current Quarter Summary

1. All readmissions were male, under the care of the DHHS Commissioner (NCR) and living in group homes/assisted living within two miles of the office/hospital. Two clients are between 50 and 65, and the third in his mid thirties. Two were psychiatric readmissions; one who had been

generally stable in the community with few readmissions for several years, the other had not yet fully stabilized since initial discharge from RPC approximately one year ago. The latter has had acute and chronic medical issues that required medical hospitalization. The third used an illicit substance on the property of his group home where he had been living without incident for eight months. The first re-admission was discharged successfully back to his group home after two weeks, the second remains in Riverview and the third was discharged back to his group home after 10 weeks. In all cases, the direct care staff of the group homes, and the ACT Team were carefully monitoring behavior changes prior to re-admission.

2. The ACT Team and the inpatient unit of RPC (Lower Saco) worked collaboratively to minimize the time spent in Riverview while maximizing the opportunity for success upon their return to the community placements. For the remaining client on Lower Saco, there is a plan in place to secure housing through the Veterans Administration system. In addition, Peer Support Specialists from the inpatient units and the ACT Team collaborated effectively in order to assist clients with their transitions.

CONSENT DECREE

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

Client Admission Diagnoses	3Q12	4Q12	1Q13	2Q13	TOT
ADJUSTMENT DIS W MIXED DISTURBANCE OF EMOTIONS & CONDUCT	1		1		2
ADJUSTMENT DISORDER WITH DEPRESSED MOOD	1		1	1	3
ADJUSTMENT DISORDER WITH DISTURBANCE OF CONDUCT	1				1
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD	2	1		3	6
ADJUSTMENT REACTION NOS	2	1	2	1	6
ALCOHOL ABUSE-IN REMISS				1	1
ALCOH DEP NEC/NOS-REMISS		1			1
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH	1				1
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC			1		1
BIPOLAR DISORDER, UNSPECIFIED	6	5	6	5	22
DELUSIONAL DISORDER		3		1	4
DEPRESS DISORDER-UNSPEC	2	1			3
DEPRESSIVE DISORDER NEC				2	2
DRUG ABUSE NEC-IN REMISS		3		1	4
DRUG MENTAL DISORDER NOS	1				1
HEBEPHRENIA-CHRONIC	1				1
IMPULSE CONTROL DIS NOS	1		1	1	3
INTERMITT EXPLOSIVE DIS				1	1
MOOD DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE			1	1	2
OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER			1		1
OTH PERSISTENT MENTAL DIS DUE TO COND CLASSIFIED ELSEWHERE				1	1
PARANOID SCHIZO-CHRONIC	9	1	7	5	22
PARANOID SCHIZO-UNSPEC	1				1
PERSON FEIGNING ILLNESS		1		1	2
POSTTRAUMATIC STRESS DISORDER	3	4	2	3	12
PSYCHOSIS NOS	13	6	6	4	29
REC DEPR DISOR-PSYCHOTIC		1			1
RECUR DEPR DISOR-SEVERE		2			2
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	16	10	9	6	35
SCHIZOPHRENIA NOS-CHR	2	3	1		6
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED	1				1
UNSPEC PERSISTENT MENTAL DIS DUE TO COND CLASS ELSEWHERE		3			3
UNSPECIFIED EPISODIC MOOD DISORDER	4	9	7	6	26
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER		2			2
Total Admissions	69	57	46	44	216
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	1.4%	7.0%	0.0%	4.5%	3.2%

Peer Supports

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

V8) 80% of all clients have documented contact with a peer specialist during hospitalization;

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

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. Attendance at Comprehensive Treatment Team meetings. (v9)	91% 427/471	91% 387/427	90% 410/458	87% 342/395
2. Attendance at Service Integration meetings. (v8)	100% 65/65	93% 52/56	100% 42/42	100% 31/31
3. Contact during admission. (v8)	100% 69/69	100% 63/63	100% 46/46	100% 44/44

Treatment Planning

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

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

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. Preliminary Continuity of Care meeting completed by end of 3rd day	100% 30/30	96% 29/30	93% 28/30	100% 30/30
2. Service Integration form completed by the end of the 3rd day	100% 30/30	100% 30/30	93% 28/30	100% 30/30
3a. Client Participation in Preliminary Continuity of Care meeting.	96% 29/30	96% 29/30	93% 28/30	96% 29/30
3b. CCM Participation in Preliminary Continuity of Care meeting.	100% 30/30	100% 30/30	93% 28/30	100% 30/30
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	96% 29/30	93% 28/30	93% 28/30	100% 30/30
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	93% 28/30	96% 29/30	96% 29/30	93% 28/30
4b. Annual Psychosocial Assessment completed and current in chart	100% 30/30	100% 30/30	100% 30/30	100% 30/30

Medical Staff, Nursing, and Rehabilitation Services are all engaged in the initial review process. Evidence of fulfilling the standard can be found through a review of individual charts.

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

Indicators	3Q2012	4Q2012	1Q2013	2Q2013
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	93% 42/45	95% 43/45	95% 43/45	97% 44/45
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload	93% 14/15	100% 15/15	93% 14/15	93% 14/15
3. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	95% 57/60	96% 58/60	98% 59/60	96% 58/60

Medical Staff, Nursing, and Rehabilitation Services are all engaged in the treatment planning process. Evidence of fulfilling the standard can be found through a review of individual charts.

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

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

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

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 to validate this chart review.

Medications

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

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

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

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

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

CONSENT DECREE

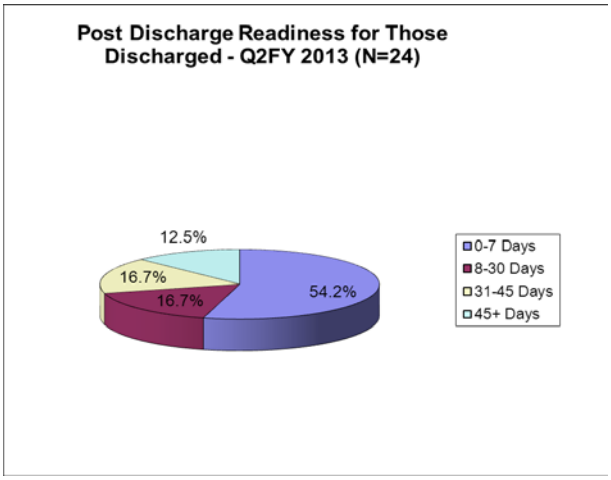
Discharges

Quarterly performance data shows that in 4 consecutive quarters:

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

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

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



Cumulative percentages & targets are as follows:

Within 7 days = (13) 54.2% (target 70%)
Within 30 days = (4) 70.9% (target 80%)
Within 45 days = (4) 87.6% (target 90%)
Post 45 days = (3) 12.5% (target 0%)

Barriers to Discharge Following Clinical Readiness

Residential Supports (0)

Treatment Services (1)

1 client discharged 44 days post clinical readiness

Housing (7)

1 client discharged 2 days post clinical readiness
1 client discharged 15 days post clinical readiness
1 client discharged 16days post clinical readiness
1 client discharged 33 days post clinical readiness
1 client discharged 44 days post clinical readiness
1 client discharged 72 days post clinical readiness
1 client discharged 208 days post clinical readiness

The previous four quarters are displayed in the table below

		Within 7 days	Within 30days	Within 45 days	45 +days
Target >>		70%	80%	90%	< 10%
1Q2013	N=27	66.7%	85.2%	96.3%	3.7%
4Q2012	N=28	53.6%	89.2%	92.9%	7.1%
3Q2012	N=42	69.0%	85.7%	92.9%	7.1%
2Q2012	N=42	69.0%	85.7%	92.9%	7.1%

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;

V21a) 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	3Q2012	4Q2012	1Q2013	2Q2013
1. The Client Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 12/12	100% 13/13	100% 13/13	100% 12/12
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 12/12	100% 13/13	100% 13/13	100% 12/12
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	100% 12/12	100% 13/13	100% 13/13	100% 12/12
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 12/12	100% 13/13	100% 13/13	100% 12/12

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	3Q2012	4Q2012	1Q2013	2Q2013
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	100% 3/3	100% 7/7	60% 3/5	100% 3/3
2. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	100% 3/3	100% 5/5	100% 9/9	100% 5/5
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually				

Staffing and Staff Training

V23) Riverview performance data shows that 95% of all new direct care staff have received 90% of their orientation training before having been assigned to duties requiring unsupervised direct care of patients;

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. New employees will complete new employee orientation within 60 days of hire.	100% 25/25	100% 21/21		
2. New employees will complete CPR training within 30 days of hire.	100% 25/25	100% 21/21		
3. New employees will complete NAPPI training within 60 days of hire.	100% 25/25	100% 21/21		
4. Riverview and Contract staff will attend CPR training bi-annually.	100% 50/51*	100% 29/31		
5. Riverview and Contract staff will attend NAPPI training annually.	100% 118/118	100% 112/134*		
6. Riverview and Contract staff will attend Annual training.	100% 27/27	100% 238/244*		

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications.

*****One Riverview employee is out of compliance due to being out of work on a medical leave one employee is out of compliance on light duty.

*Two Riverview employees on Leave of Absence Status, will complete this requirement upon return to regular duty.

*Seventeen Riverview employees scheduled to attend training on December 27 were prohibited due to a state inclement weather shutdown day. All scheduled to attend on January 24 or January 30, 2013. Five Riverview employees on leave of absence or light duty during this quarter will complete this mandatory training prior to returning to regular employ.

*Six employees on leave of absence during this quarter will not return to work until their Annual Training is complete.

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
3Q2012	14	Jan- March 2012	Winter Semester (see1Q13 Quarterly Report)
4Q2012	11	Apr – June 2012	Spring Semester (see1Q13 Quarterly Report)
1Q2013	3	Jul – Sep 2012	Summer Hiatus (see1Q13 Quarterly Report)
10/4/12	1	Adverse drug reactions and reporting	Miranda Cole, PharmD, BCPP
10/11/12	1	To Hope or To Elope	Teresa Mayo, PsyD
10/11/12	1	NAPPI Recertification	Jeff Freeman
10/18/12	1	Continuation of Presentation on Transvestic Fetishism	Randy Beal, PMHNP
10/25/12	1	Client Centered, Stage Matched Treatment Planning	Michael Morse, LCSW, CCS
11/8/12	1	Illicit Drugs of New England	Benjamin Nordstrom, MD, PhD
11/15/12	1	A Newly Minted NCR	Brendan Kirby, MD
11/29/12	1	Columbia Suicide Severity Rating Scale	Douglas Noordsy, MD
12/20/12	1	NPSG.03.05.01: Meeting the Anticoagulation Standard in the Psychiatric Setting	Miranda Cole, PharmD, BCPP Elizabeth Dragatsi, RPh

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

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

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

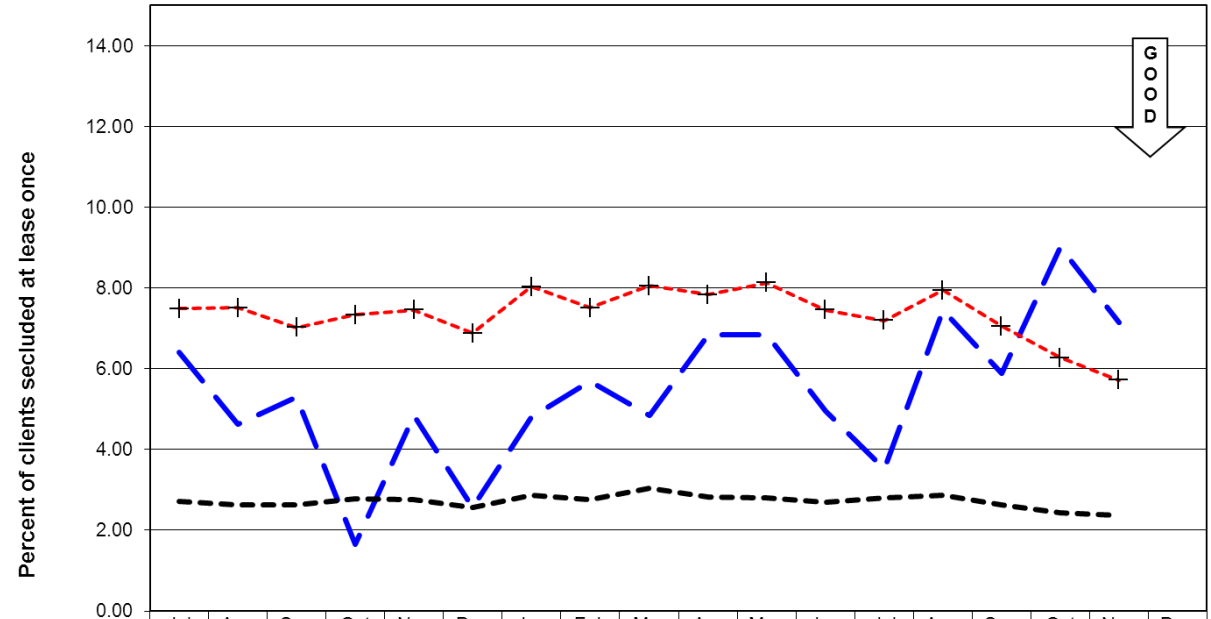
Treatment teams regularly monitor the needs of individual clients and make recommendations for ongoing treatment modalities. Staffing levels are carefully monitored to ensure that all treatment goals, exercise needs, and outdoor activities are achievable. Staffing does not present a barrier to the fulfillment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

CONSENT DECREE

Use of Seclusion and Restraints

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

Percent of Clients Secluded



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	6.40	4.62	5.30	1.65	4.84	2.56	4.80	5.69	4.84	6.84	6.84	4.96	3.51	7.44	5.88	9.01	7.14	
Ntl Mean	2.71	2.63	2.62	2.79	2.77	2.56	2.86	2.77	3.04	2.82	2.81	2.69	2.80	2.87	2.64	2.43	2.36	
+1 StDev	7.49	7.51	7.02	7.34	7.46	6.88	8.03	7.51	8.05	7.84	8.13	7.45	7.19	7.94	7.05	6.27	5.72	

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

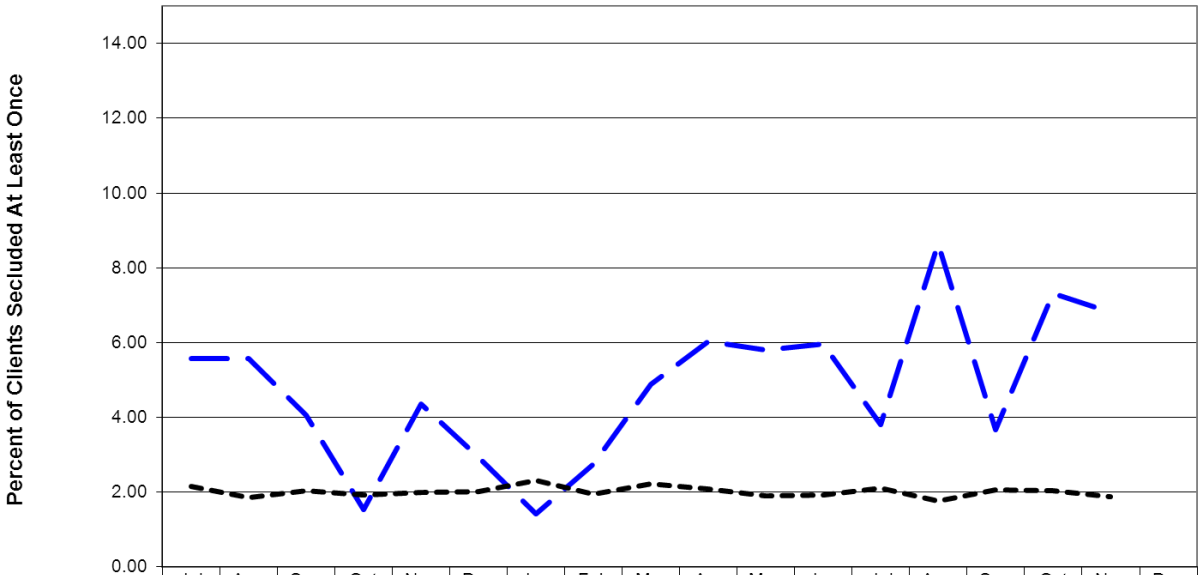
The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

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

CONSENT DECREE

Percent of Clients Secluded

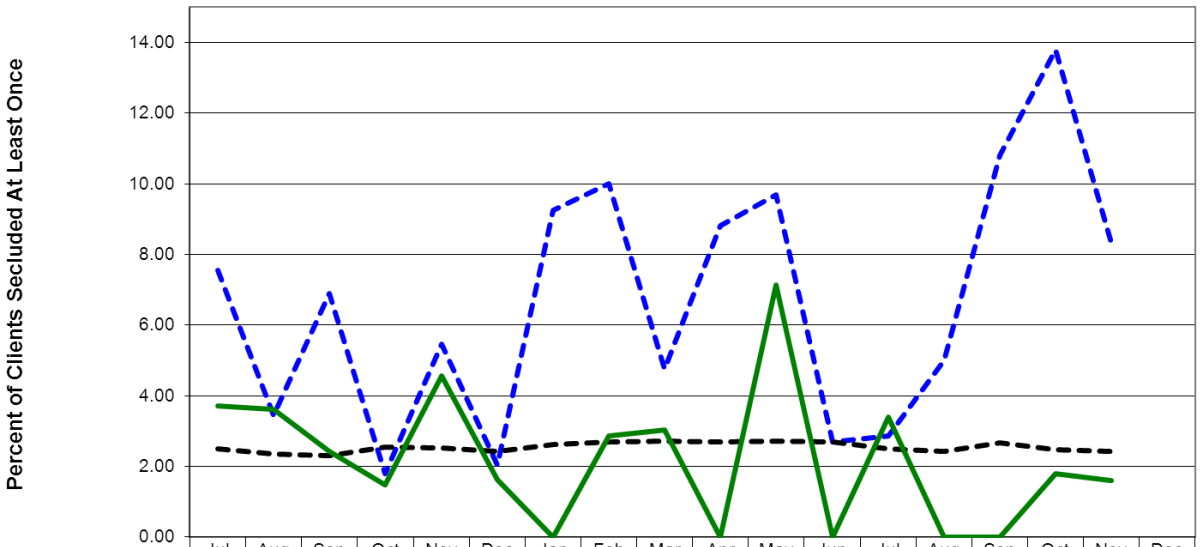
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	5.56	5.56	4.05	1.54	4.35	2.94	1.41	2.74	4.88	6.02	5.81	5.95	3.8	8.64	3.66	7.32	6.82	
Ntl Mean	2.14	1.85	2.03	1.92	1.99	2.02	2.32	1.95	2.21	2.08	1.9	1.92	2.1	1.75	2.06	2.04	1.88	

Percent of Clients Secluded

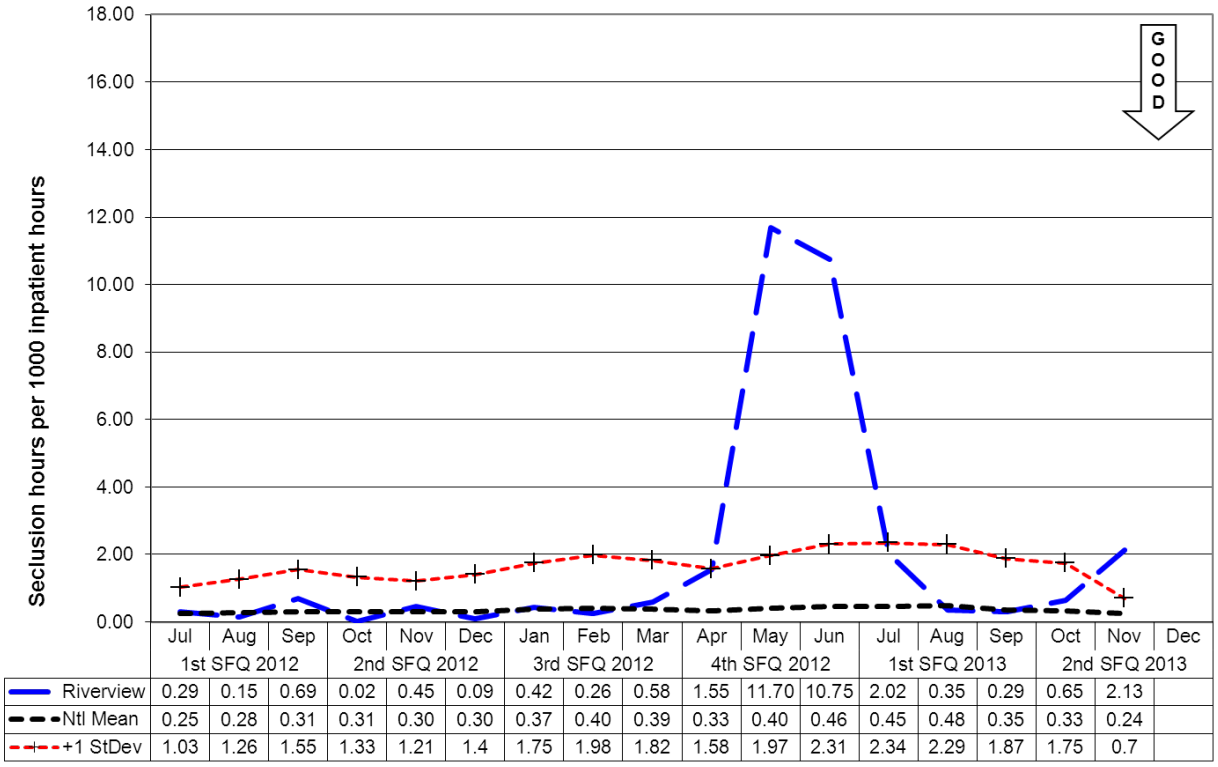
Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	7.55	3.45	6.9	1.79	5.45	2.04	9.26	10	4.76	8.82	9.68	2.7	2.86	5	10.81	13.79	8.33	
Ntl Mean	2.5	2.36	2.29	2.55	2.53	2.43	2.61	2.68	2.71	2.69	2.72	2.7	2.5	2.43	2.67	2.47	2.41	
Dorothea Dix	3.70	3.61	2.41	1.47	4.55	1.61	0.00	2.86	3.03	0.00	7.14	0.00	3.39	0.00	0.00	1.79	1.59	

CONSENT DECREE

Seclusion Hours



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.29	0.15	0.69	0.02	0.45	0.09	0.42	0.26	0.58	1.55	11.70	10.75	2.02	0.35	0.29	0.65	2.13	
Ntl Mean	0.25	0.28	0.31	0.31	0.30	0.30	0.37	0.40	0.39	0.33	0.40	0.46	0.45	0.48	0.35	0.33	0.24	
+1 StDev	1.03	1.26	1.55	1.33	1.21	1.4	1.75	1.98	1.82	1.58	1.97	2.31	2.34	2.29	1.87	1.75	0.7	

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

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

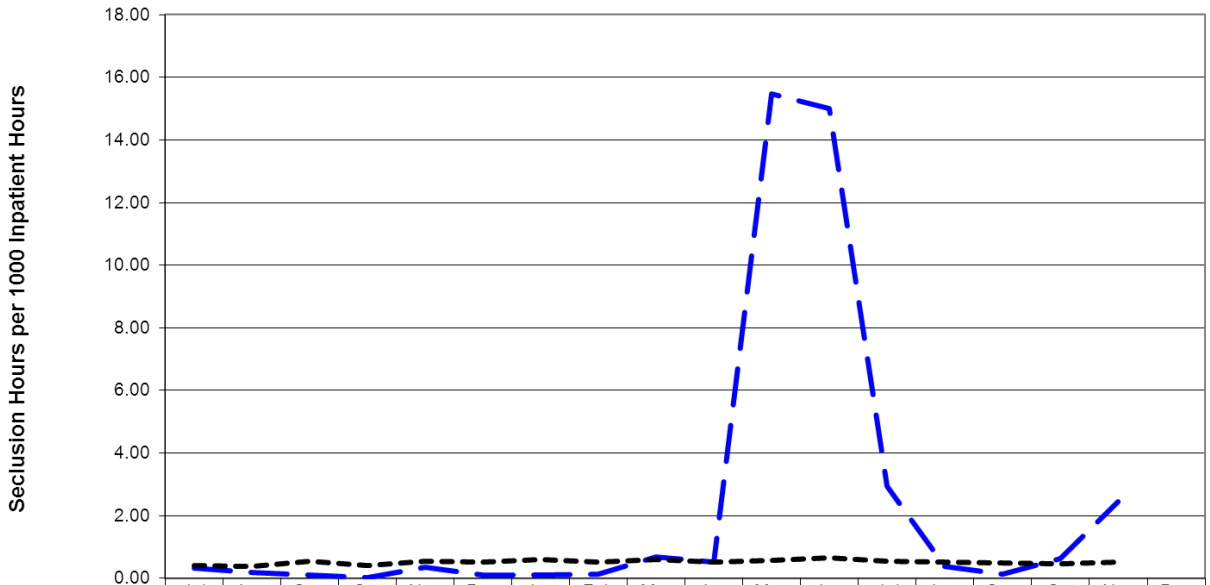
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

CONSENT DECREE

Seclusion Hours

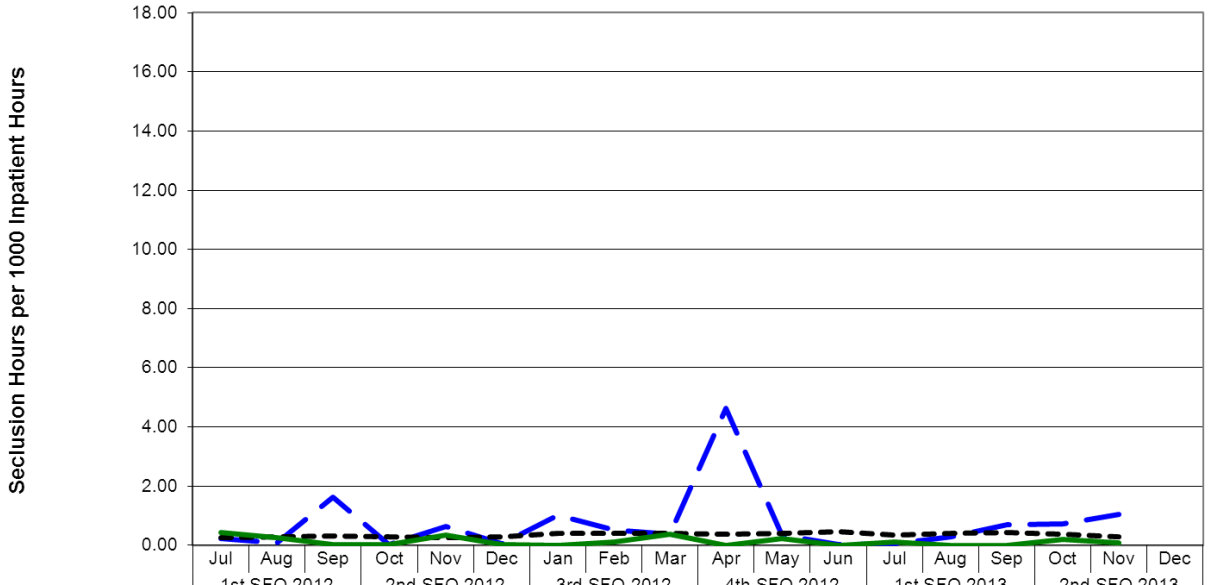
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.33	0.18	0.09	0.02	0.34	0.11	0.1	0.12	0.69	0.5	15.47	15.01	2.94	0.37	0.12	0.63	2.43	
Ntl Mean	0.4	0.38	0.53	0.41	0.55	0.51	0.59	0.52	0.59	0.52	0.57	0.64	0.55	0.5	0.49	0.448	0.5	

Seclusion Hours

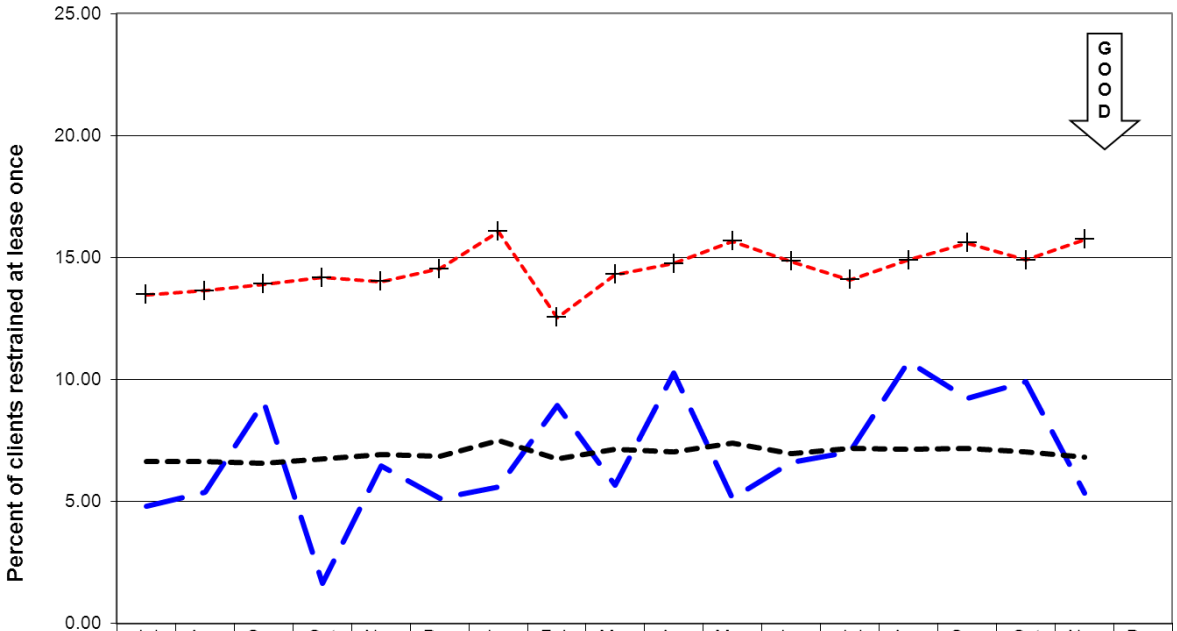
Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.23	0.09	1.61	0.02	0.62	0.06	1	0.51	0.37	4.64	0.35	0.03	0.04	0.29	0.68	0.71	1.04	
Ntl Mean	0.24	0.27	0.31	0.28	0.26	0.27	0.4	0.41	0.4	0.37	0.4	0.47	0.35	0.39	0.42	0.37	0.27	
Dorothea Dix	0.44	0.25	0.02	0.02	0.33	0.02	0.00	0.10	0.38	0.00	0.22	0.00	0.10	0.00	0.00	0.20	0.09	

CONSENT DECREE

Percent of Clients Restrained



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	4.80	5.38	9.09	1.65	6.45	5.13	5.60	8.94	5.65	10.26	5.13	6.61	7.02	10.74	9.24	9.91	5.36	
Ntl Mean	6.64	6.64	6.58	6.73	6.92	6.85	7.50	6.74	7.15	7.04	7.39	6.95	7.17	7.14	7.17	7.02	6.80	
+1 StDev	13.47	13.63	13.91	14.18	14.01	14.53	16.06	12.55	14.31	14.76	15.66	14.84	14.09	14.89	15.6	14.89	15.74	

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

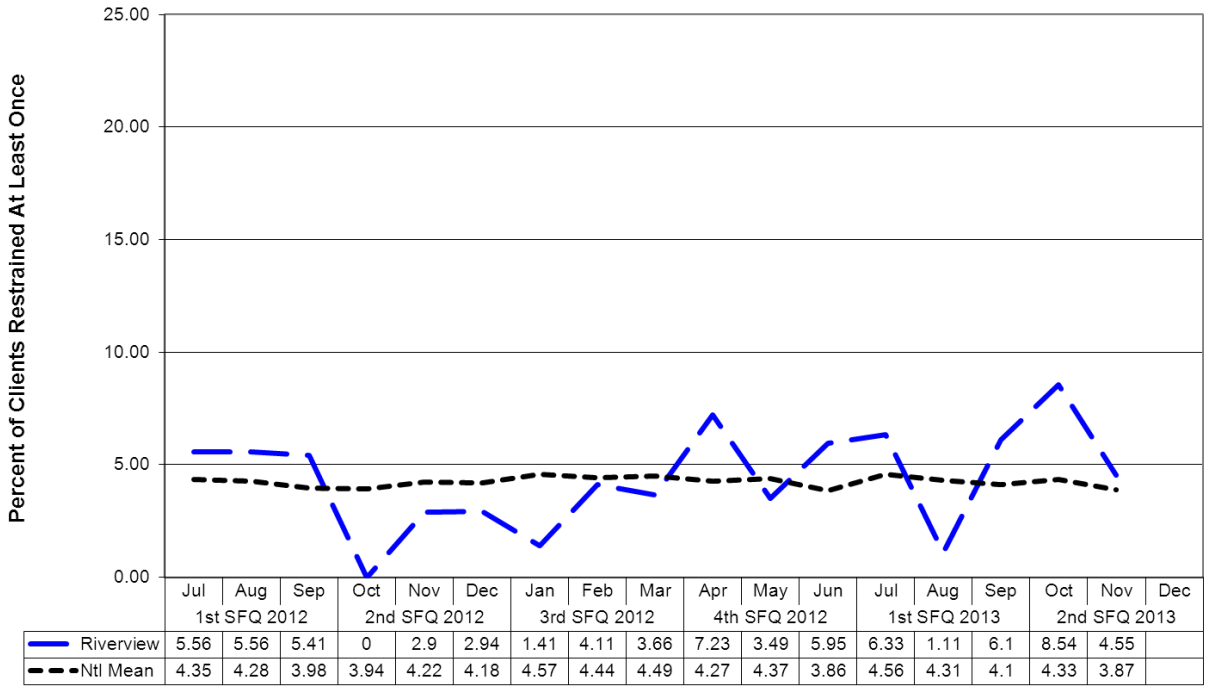
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

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

CONSENT DECREE

Percent of Clients Restrained

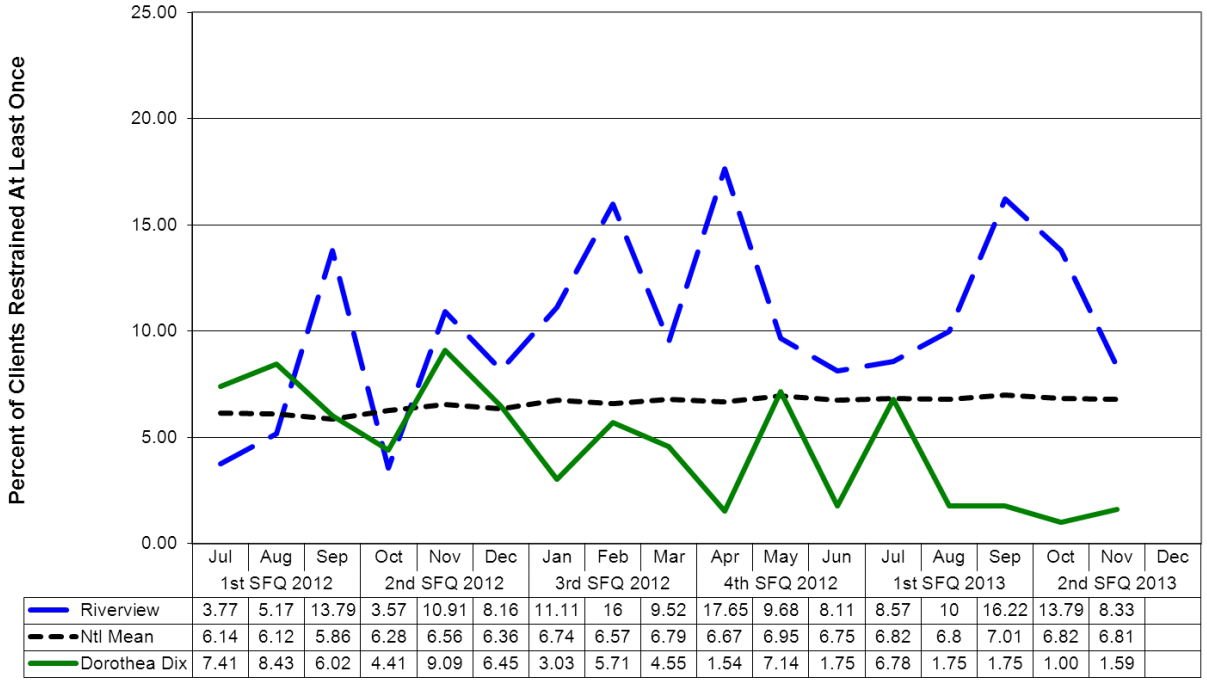
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	5.56	5.56	5.41	0	2.9	2.94	1.41	4.11	3.66	7.23	3.49	5.95	6.33	1.11	6.1	8.54	4.55	
Ntl Mean	4.35	4.28	3.98	3.94	4.22	4.18	4.57	4.44	4.49	4.27	4.37	3.86	4.56	4.31	4.1	4.33	3.87	

Percent of Clients Restrained

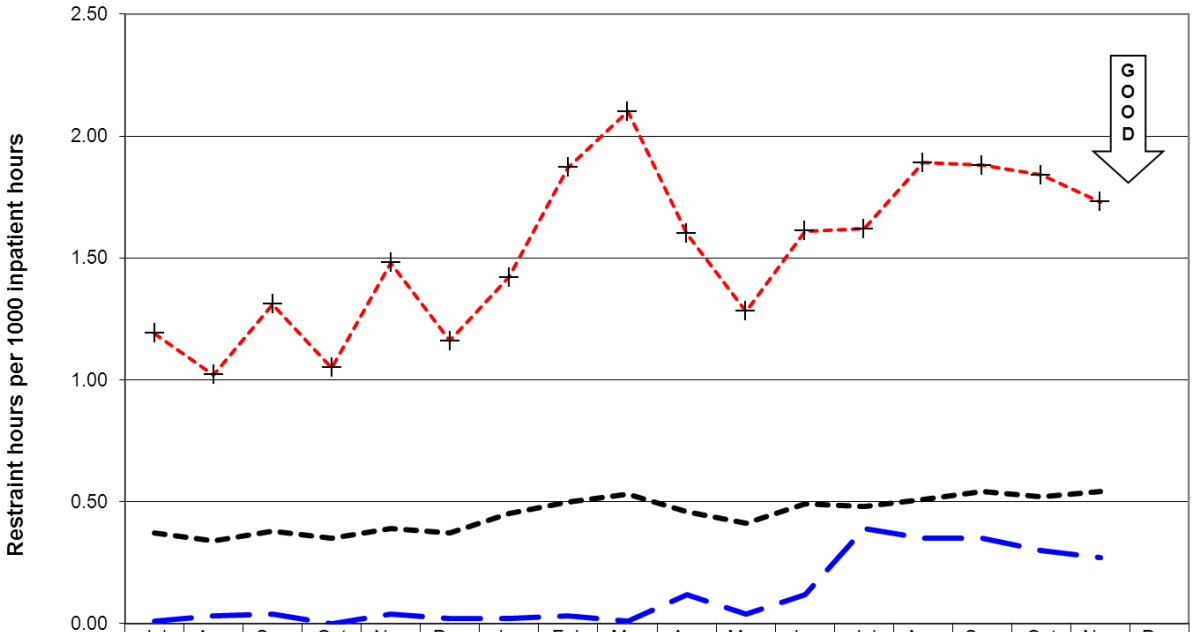
Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	3.77	5.17	13.79	3.57	10.91	8.16	11.11	16	9.52	17.65	9.68	8.11	8.57	10	16.22	13.79	8.33	
Ntl Mean	6.14	6.12	5.86	6.28	6.56	6.36	6.74	6.57	6.79	6.67	6.95	6.75	6.82	6.8	7.01	6.82	6.81	
Dorothea Dix	7.41	8.43	6.02	4.41	9.09	6.45	3.03	5.71	4.55	1.54	7.14	1.75	6.78	1.75	1.75	1.00	1.59	

CONSENT DECREE

Restraint Hours



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.01	0.03	0.04	0.00	0.04	0.02	0.02	0.03	0.01	0.12	0.04	0.12	0.39	0.35	0.35	0.30	0.27	
Ntl Mean	0.37	0.34	0.38	0.35	0.39	0.37	0.45	0.50	0.53	0.46	0.41	0.49	0.48	0.51	0.54	0.52	0.54	
+1 StDev	1.19	1.02	1.31	1.05	1.48	1.16	1.42	1.87	2.1	1.6	1.28	1.61	1.62	1.89	1.88	1.84	1.73	

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

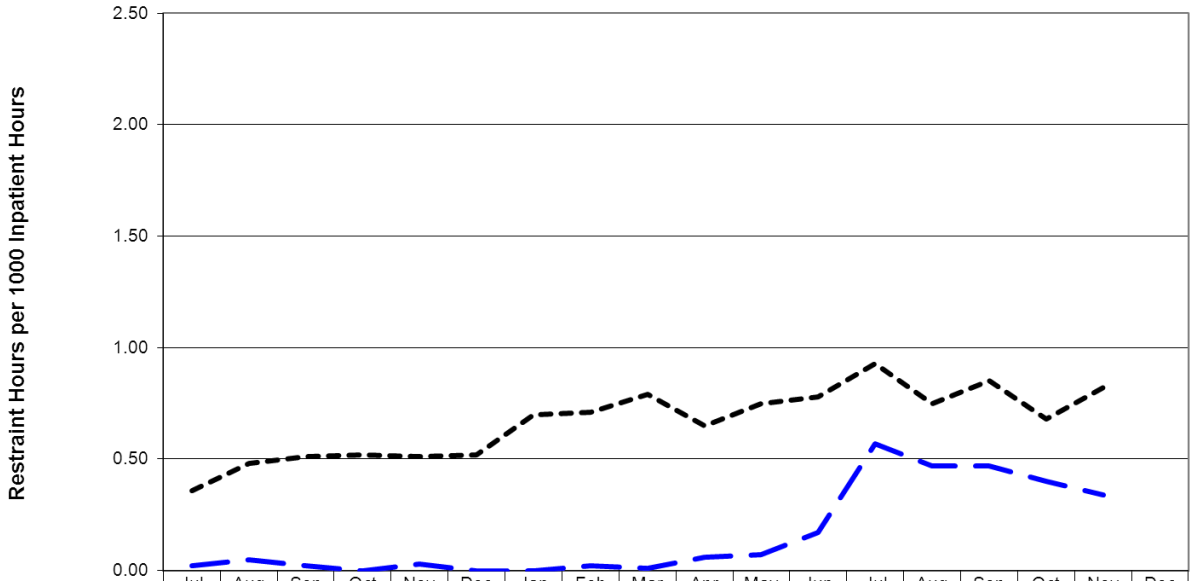
The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

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

CONSENT DECREE

Restraint Hours

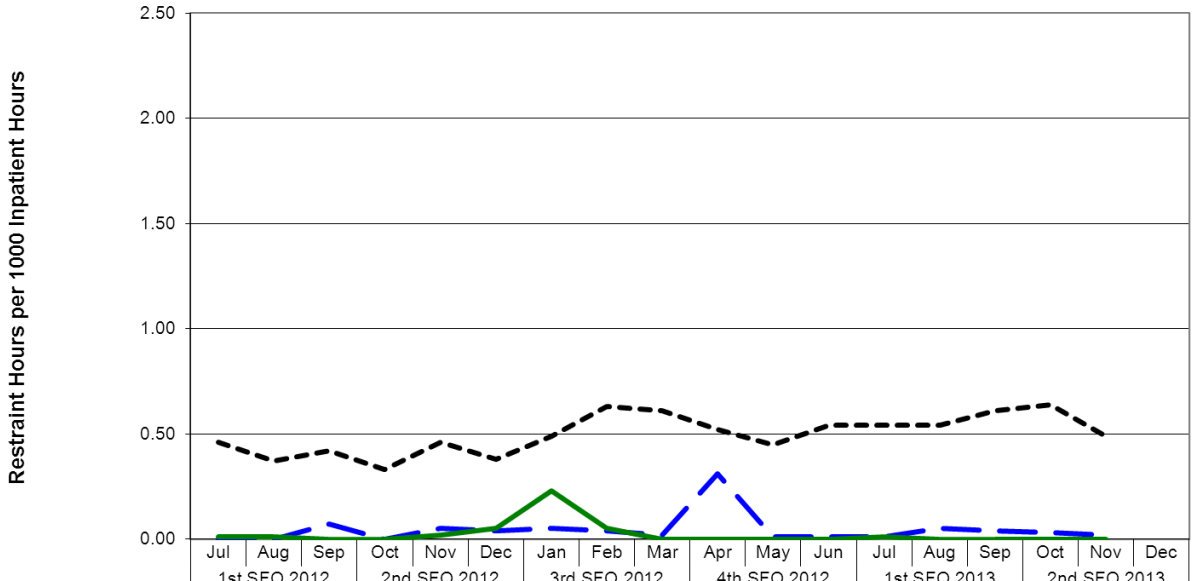
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.02	0.05	0.02	0.00	0.03	0.00	0.00	0.02	0.01	0.06	0.07	0.17	0.57	0.47	0.47	0.40	0.34	
Ntl Mean	0.36	0.48	0.51	0.52	0.51	0.52	0.70	0.71	0.79	0.65	0.75	0.78	0.93	0.75	0.85	0.68	0.82	

Restraint Hours

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	0.07	0.00	0.05	0.04	0.05	0.04	0.02	0.31	0.01	0.01	0.01	0.05	0.04	0.03	0.02	
Ntl Mean	0.46	0.37	0.42	0.33	0.46	0.38	0.49	0.63	0.61	0.52	0.45	0.54	0.54	0.54	0.61	0.64	0.49	
Dorothea Dix	0.01	0.01	0.00	0.00	0.02	0.05	0.23	0.05	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.00	

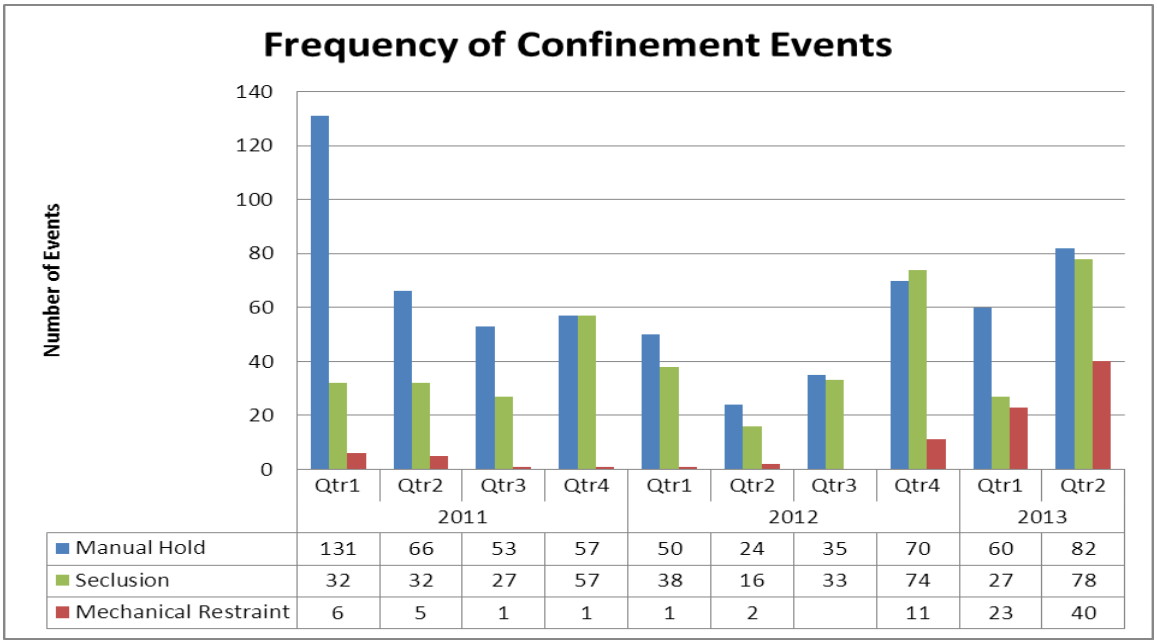
CONSENT DECREE

Confinement Event Detail

2nd Quarter 2013

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
FR0000312892	32	13	29	74	37%	37%
FR0000289611	11	23	7	41	21%	58%
FR0000366310	9		12	21	11%	68%
FR0000374611	4		7	11	6%	74%
FR0000386581	3		5	8	4%	78%
FR0000344234	3		3	6	3%	81%
FR0000363754	2	2	1	5	3%	83%
FR0000387175	3	1		4	2%	85%
FR0000390369	1		3	4	2%	87%
FR0000363713	3		1	4	2%	89%
FR0000307819	1		2	3	2%	91%
FR0000372664	3			3	2%	92%
FR0000368050	2		1	3	2%	94%
FR0000387951		1	1	2	1%	95%
FR0000328245	1		1	2	1%	96%
FR0000377945	1		1	2	1%	97%
FR0000385542			2	2	1%	98%
FR0000366096			1	1	1%	98%
FR0000387837	1			1	1%	99%
FR0000374801			1	1	1%	99%
FR0000372250	1			1	1%	100%
FR0000000232	1			1	1%	100%
Grand Total	82	40	78	200		

28% (22/78) of average hospital population experienced some form of confinement event during the 2nd fiscal quarter 2013. Eight of these clients (10% of the average hospital population) accounted for 85% of the containment events. The trend in frequency of confinement event, specifically the increase in the trend related to mechanical restraints is due to a few high acute clients requiring special management to ensure the safety of the milieu.



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

	2Q12	3Q12	4Q12	1Q13	2Q13
Danger to Others/Self	15	31	73	23	78
Danger to Others	1	2		4	
Danger to Self			1		
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	16	33	74	27	78

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

	2Q12	3Q12	4Q12	1Q13	2Q13
Danger to Others/Self	2		11	22	40
Danger to Others				1	
Danger to Self					
% Dangerous Precipitation	100%	--	100%	100%	100%
Total Events	2	0	11	23	40

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 26 & 27

CONSENT DECREE

Confinement Events Management

Seclusion Events (78) Events

Standard	Threshold	Compliance
The record reflects that seclusion was absolutely necessary to protect the patient from causing physical harm to self or others, or if the patient was examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption that significantly interferes with other patients' treatment.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%
The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	100%
The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%
The record reflects that, if the physician or physician extender was not immediately available to examine the patient, the patient was placed in seclusion following an examination by a nurse.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in seclusion, and if there is a delay, the reasons for the delay.	90%	100%
The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least 3 times per hour.)	90%	100%
Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.	75%	100%
The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
The medical order states the conditions under which the patient may be sooner released.	85%	100%
The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document reason for seclusion, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released, unless clinically contraindicated, at least every 2 hours or as necessary for eating, drinking, bathing, toileting or special medical orders.	85%	100%
Reports of seclusion events were forwarded to medical director and advocate.	90%	100%
The record reflects that, for persons with mental retardation, the regulations governing seclusion of clients with mental retardation were met.	85%	100%
The medical order for seclusion was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events (40) Events

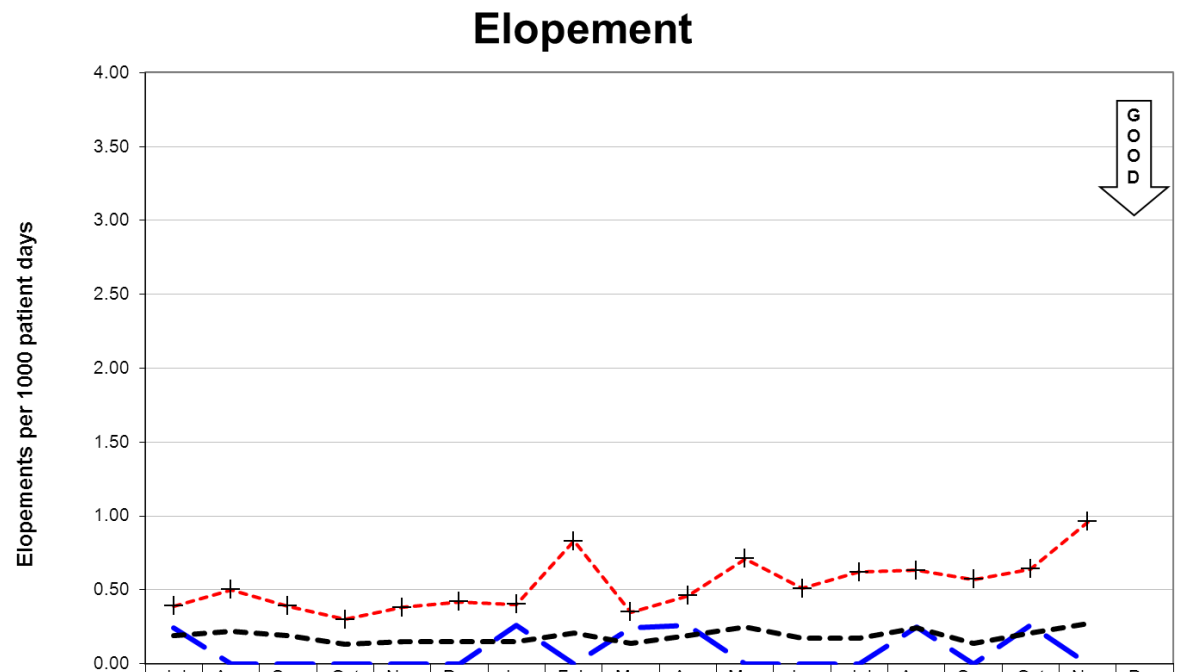
Standard	Threshold	Compliance
The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%
The record reflects that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

Standard	Threshold	Compliance
The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	100%
The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document the reason for the restraint, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	100%
The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	100%
Copies of events were forwarded to medical director and advocate.	90%	100%
For persons with mental retardation, the applicable regulations were met.	85%	100%
The record reflects that the order was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A
A restraint event that exceeds 24 hours will be reviewed against the following requirement: If total consecutive hours in restraint, with renewals, exceeded 24 hours, the record reflects that the patient was medically assessed and treated for any injuries; that the order extending restraint beyond 24 hours was entered by Medical Director (or if the Medical Director is out of the hospital, by the individual acting in the Medical Director's stead) following examination of the patient; and that the patient's guardian or representative has been notified.	90%	100%

CONSENT DECREE

Client Elopements

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.24	0.00	0.00	0.00	0.00	0.00	0.26	0.00	0.24	0.26	0.00	0.00	0.00	0.25	0.00	0.26	0.00	
Ntl Mean	0.19	0.22	0.19	0.13	0.15	0.15	0.15	0.21	0.14	0.19	0.25	0.17	0.17	0.24	0.14	0.21	0.27	
StDev	0.39	0.5	0.39	0.3	0.38	0.42	0.4	0.83	0.35	0.46	0.71	0.51	0.62	0.63	0.57	0.64	0.96	

This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

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

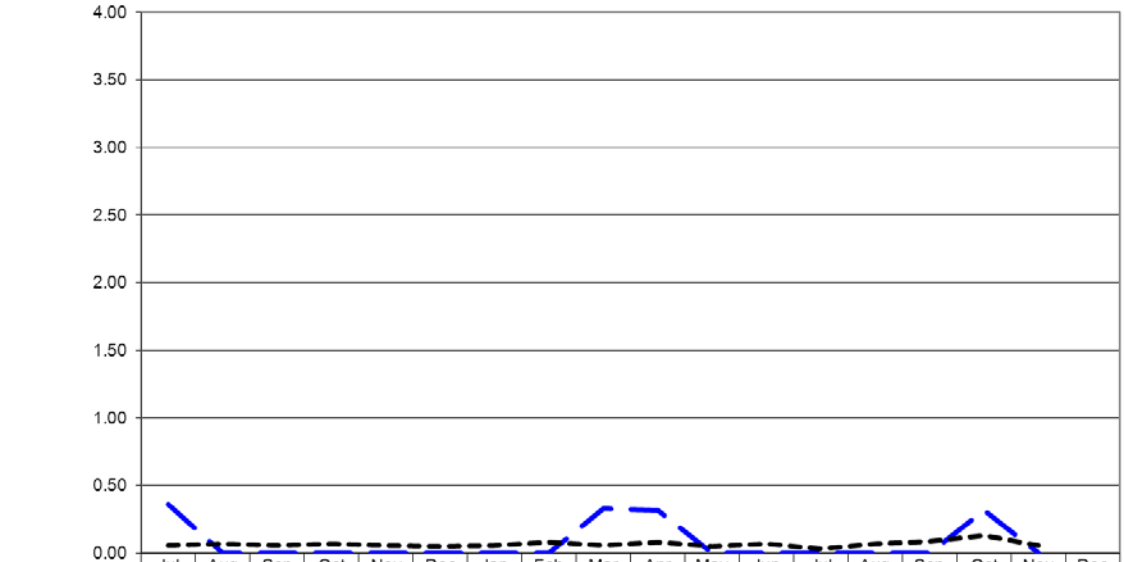
The following graphs depict the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

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

CONSENT DECREE

Elopement

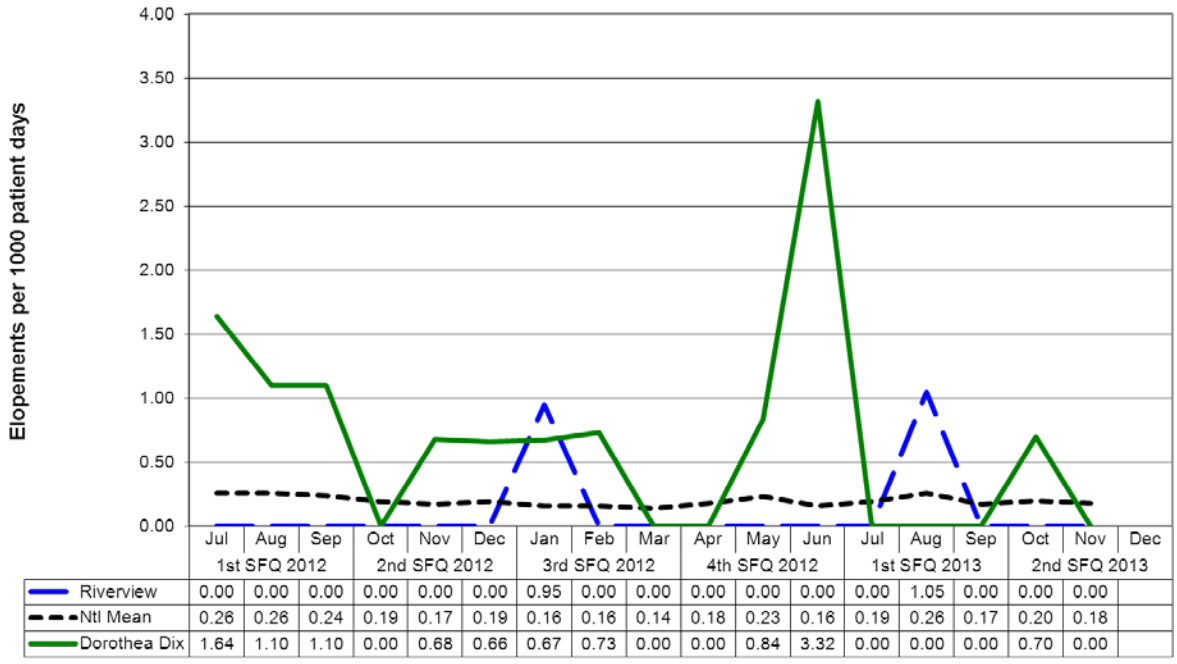
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.36	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.33	0.32	0.00	0.00	0.00	0.00	0.00	0.32	0.00	
Ntl Mean	0.06	0.07	0.06	0.07	0.06	0.05	0.06	0.08	0.06	0.08	0.05	0.07	0.03	0.07	0.09	0.13	0.06	

Elopement

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.95	0.00	0.00	0.00	0.00	0.00	0.00	1.05	0.00	0.00	0.00	
Ntl Mean	0.26	0.26	0.24	0.19	0.17	0.19	0.16	0.16	0.14	0.18	0.23	0.16	0.19	0.26	0.17	0.20	0.18	
Dorothea Dix	1.64	1.10	1.10	0.00	0.68	0.66	0.67	0.73	0.00	0.00	0.84	3.32	0.00	0.00	0.00	0.70	0.00	

Client Injuries

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

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

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

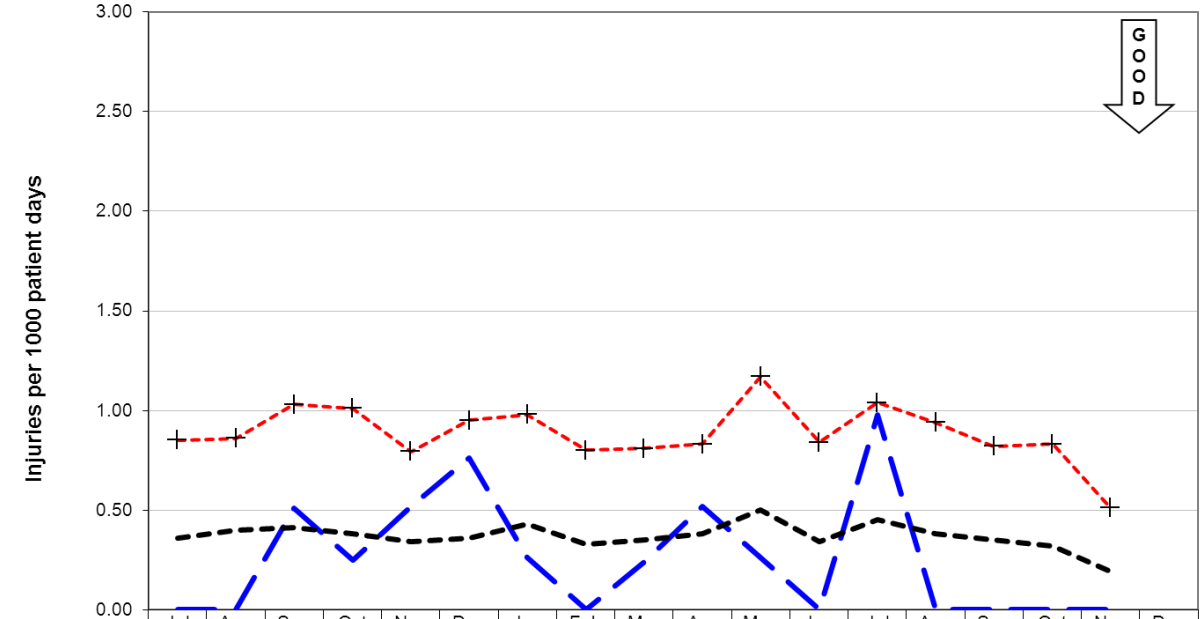
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

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

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

CONSENT DECREE

Client Injury Rate



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	0.51	0.25	0.52	0.76	0.26	0.00	0.24	0.52	0.26	0.00	0.98	0.00	0.00	0.00	0.00	
Ntl Mean	0.36	0.40	0.41	0.38	0.34	0.36	0.43	0.33	0.35	0.38	0.50	0.34	0.45	0.38	0.35	0.32	0.19	
+1 StDev	0.85	0.86	1.03	1.01	0.79	0.95	0.98	0.80	0.81	0.83	1.17	0.84	1.04	0.94	0.82	0.83	0.51	

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

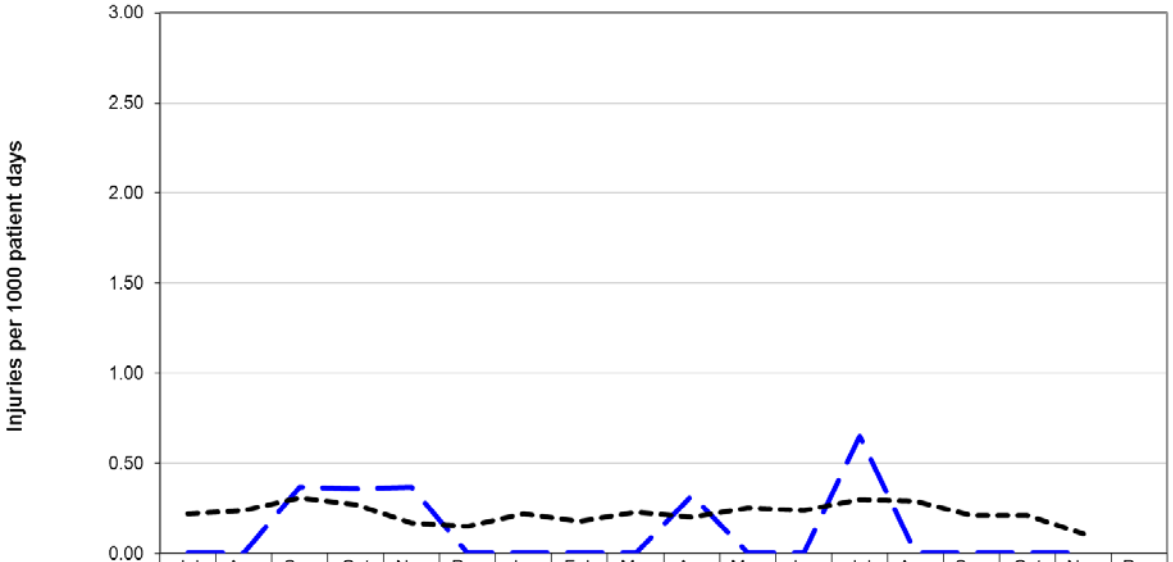
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

CONSENT DECREE

Client Injury Rate

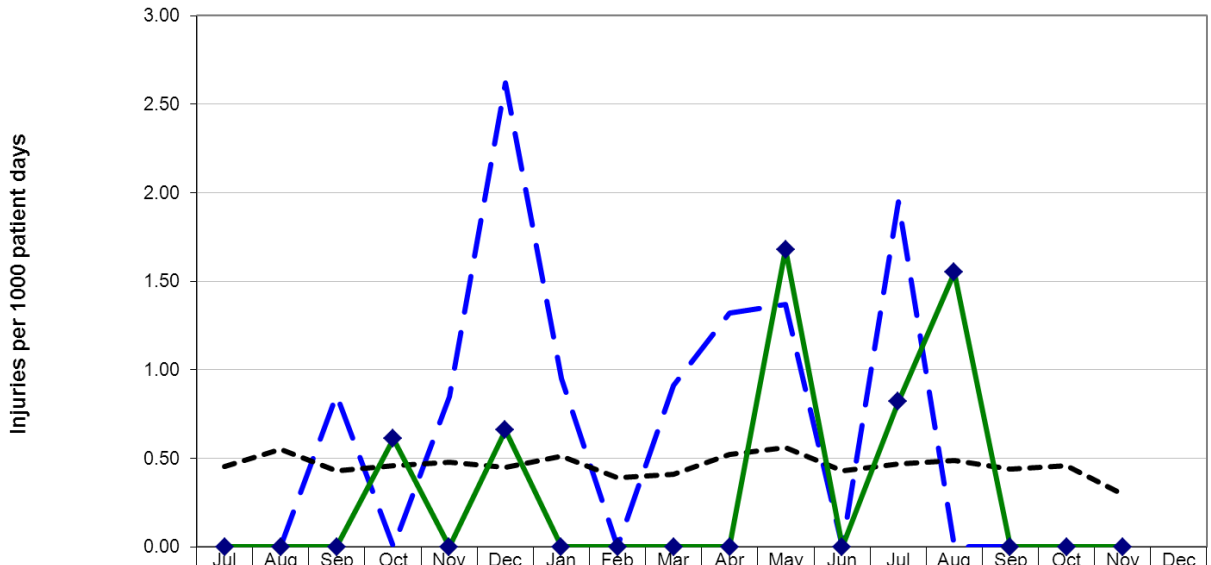
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	0.37	0.36	0.37	0.00	0.00	0.00	0.00	0.32	0.00	0.00	0.65	0.00	0.00	0.00	0.00	
Ntl Mean	0.22	0.24	0.31	0.27	0.17	0.15	0.22	0.18	0.23	0.20	0.25	0.24	0.30	0.29	0.21	0.21	0.11	

Client Injury Rate

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	0.00	0.00	0.86	0.00	0.85	2.62	0.95	0.00	0.91	1.32	1.37	0.00	1.95	0.00	0.00	0.00	0.00	
Ntl Mean	0.46	0.55	0.43	0.46	0.48	0.45	0.51	0.39	0.41	0.52	0.56	0.43	0.47	0.49	0.44	0.46	0.30	
Dorothea Dix	0.00	0.00	0.00	0.61	0.00	0.66	0.00	0.00	0.00	0.00	1.68	0.00	0.82	1.55	0.00	0.00	0.00	

Severity of injury by Month

Severity	OCT	NOV	DEC	2Q2013
No Treatment	15	10	13	38
Minor First Aid		1		1
Medical Intervention Required			1	1
Hospitalization Required				
Death Occurred				
Total	15	11	14	40

The event that required medical intervention involved a client to client assault.

Type and Cause of Injury by Month

Type - Cause	OCT	NOV	DEC	2Q2013
Accident – Fall Unwitnessed	8	4	7	19
Accident – Fall Witnessed	5	4	5	14
Accident – Other	1	3	2	6
Assault				0
Self-Injurious Behavior	1			1

Due to the potential for injury and since falls are the predominant cause of potentially injurious events, fall incidents remain a focus of the hospital. Three of the fall incidents that occurred during the last quarter required medical intervention by an in-house provider, four required minor first aid. The remainder required no treatment.

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	3Q2012	4Q2012	1Q2013	2Q2013
Abuse Physical	3	2	3	5
Abuse Sexual	3	10	6	2
Abuse Verbal				1
Coercion	1	2		
Neglect	1			

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

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

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with the Joint Commission on November 15-19, 2010.

The surveyors identified four areas of direct impact that required a review and revision of hospital processes within 45 days.

The surveyors identified nine areas of indirect impact that required a review and revision of hospital processes within 60 days.

Riverview received notification of full accreditation status on October 3, 2011 with an effective date of November 20, 2010.

V35) Riverview maintains its hospital license;

Riverview maintains licensing status as required through the Department of Health and Human Services Division of Licensing and Regulatory Services Centers for Medicare and Medicaid Services.

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

Centers for Medicare and Medicaid Services certification is ongoing and applicable for all units, including the Lower Saco SCU. Lower Saco SCU received CMS Certification in January 2011. This certification is required to ensure reimbursement under Medicare, Medicaid, and through the Disproportionate Share Process.

V37) Riverview conducts quarterly monitoring of performance indicators in key areas of hospital administration, in accordance with the Consent Decree Plan, 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 this document and a transition to an improvement orientated methodology that is support by the Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence.

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

In 1987, The Joint Commission announced its *Agenda for Change,* which outlined a series of major steps designed to modernize the accreditation process. A key component of the *Agenda for Change* was the eventual introduction of standardized core performance measures into the accreditation process. As the vision to integrate performance measurement into accreditation became more focused, the name ORYX® was chosen for the entire initiative. The ORYX 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 healthcare organizations using the same measures that were designed and collected based on standard specifications. The availability of over 8,000 disparate ORYX measures also limited the size of some comparison groups and hindered statistically valid data analyses. To address these challenges, standardized sets of valid, reliable, and evidence-based quality measures have been implemented by The Joint Commission for use within the ORYX initiative.

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

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

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

Assessment

Treatment Planning and Implementation

Hope and Empowerment

Patient Driven Care

Patient Safety

Continuity and Transition of Care

Outcomes

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

JOINT COMMISSION

Admissions Screening (HBIPS 1)

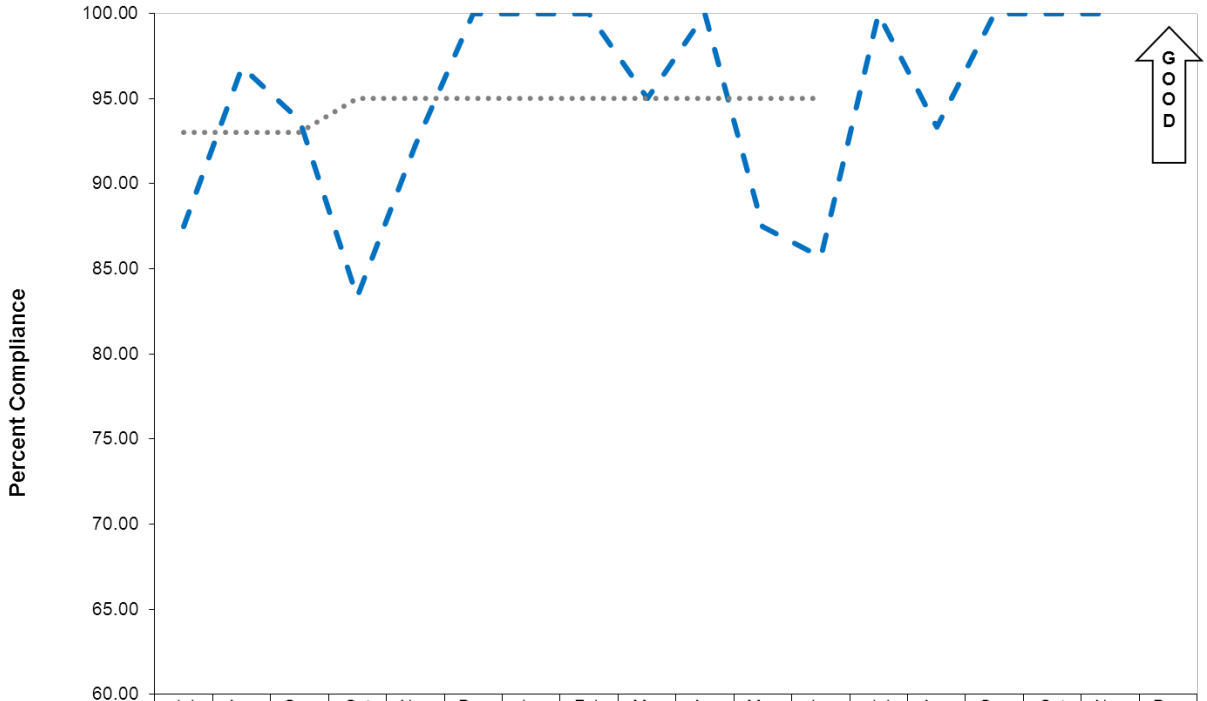
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

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

Rationale

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



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	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	87.50	96.88	93.75	83.33	92.31	100.00	100.00	100.00	95.00	100.00	87.50	85.71	100.00	93.33	100.00	100.00	100.00	
TJC Target	93.00	93.00	93.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

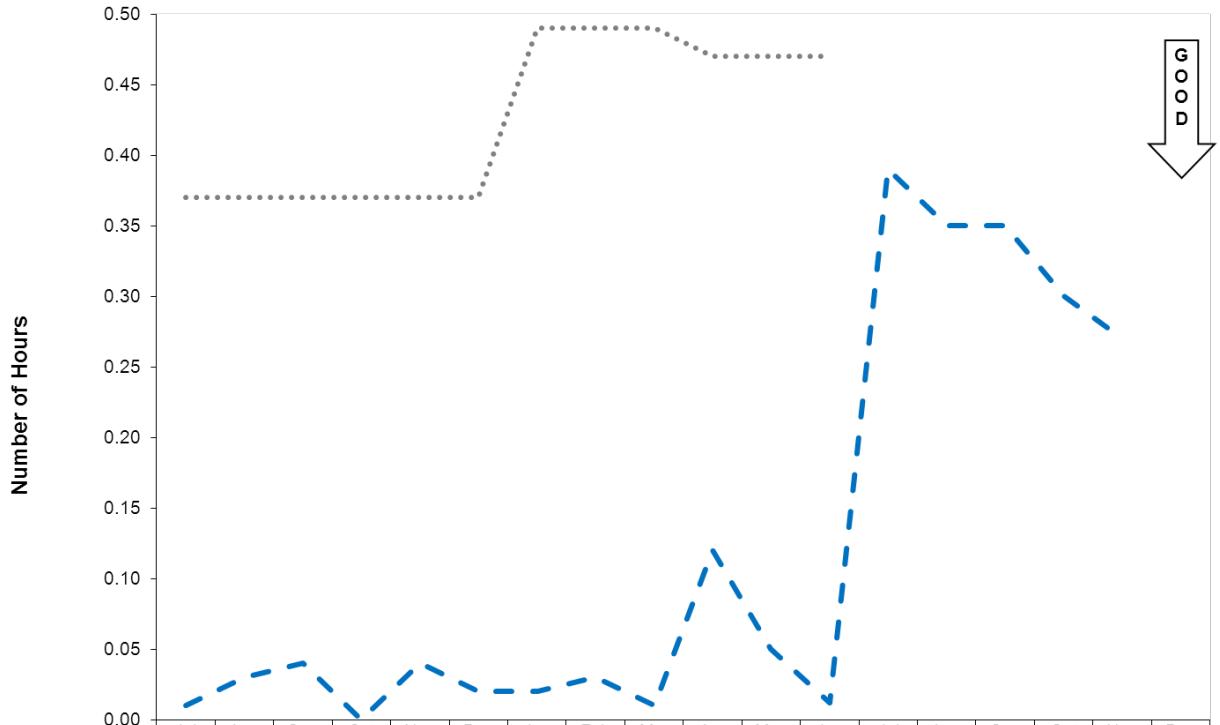
Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting 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).



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	0.01	0.03	0.04	0.00	0.04	0.02	0.02	0.03	0.01	0.12	0.05	0.01	0.39	0.35	0.35	0.30	0.27	
TJC Target	0.37	0.37	0.37	0.37	0.37	0.37	0.49	0.49	0.49	0.47	0.47	0.47						

JOINT COMMISSION

Seclusion (HBIPS 3)

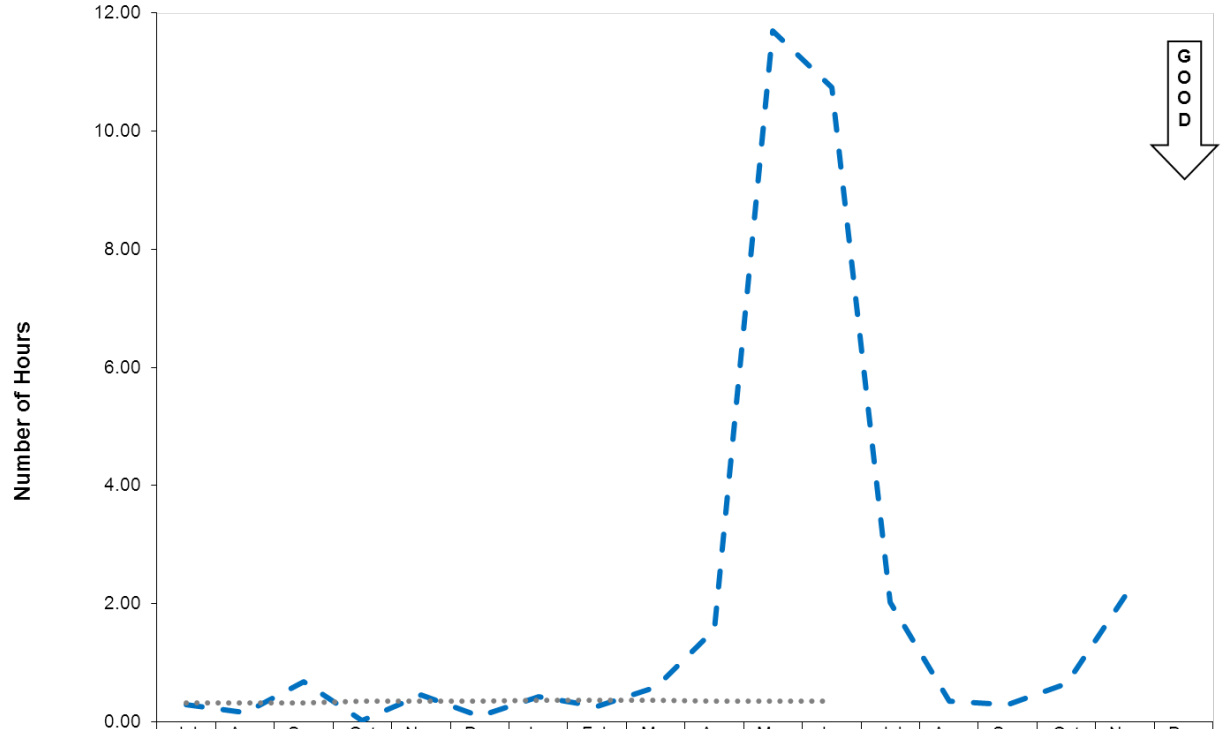
Hours of Use

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).



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	0.29	0.15	0.68	0.02	0.45	0.09	0.42	0.26	0.58	1.55	11.70	10.75	2.02	0.35	0.29	0.65	2.13	
TJC Target	0.31	0.31	0.31	0.34	0.34	0.34	0.36	0.36	0.36	0.35	0.35	0.35						

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

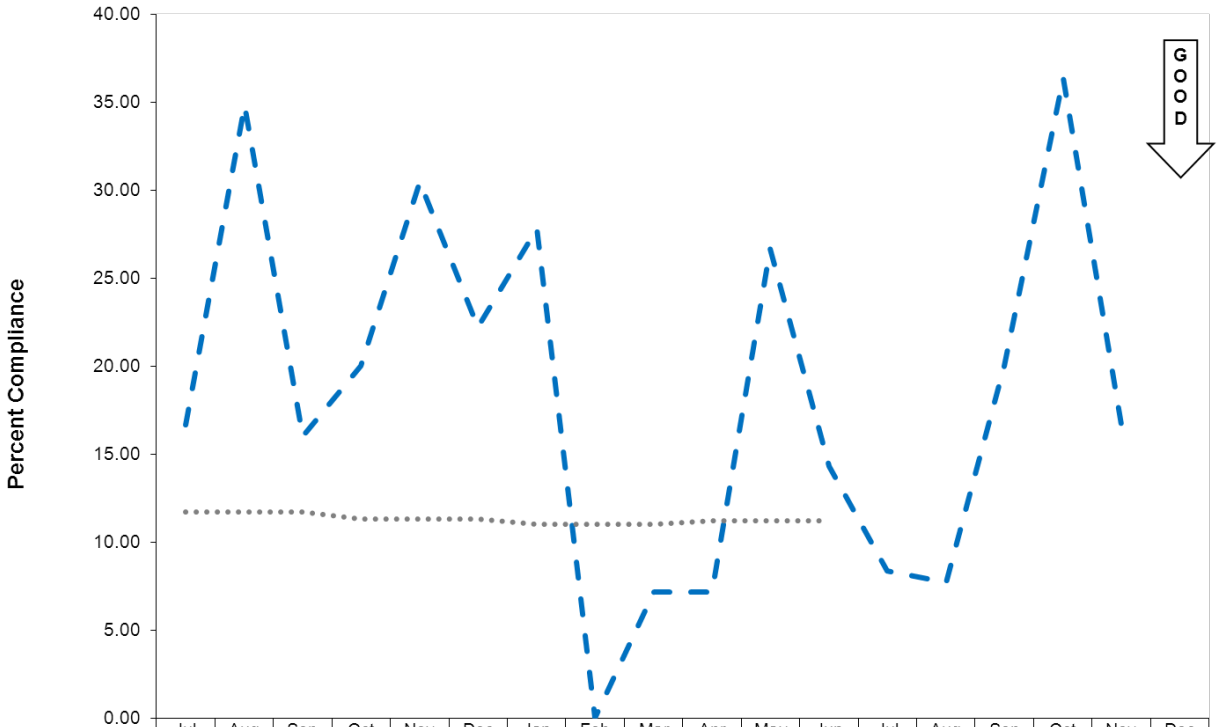
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

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)



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	16.67	34.78	16.00	20.00	30.43	22.22	27.78	0.00	7.14	7.14	26.67	14.29	8.33	7.69	20.00	36.36	16.67	
TJC Target	11.70	11.70	11.70	11.30	11.30	11.30	11.00	11.00	11.00	11.20	11.20	11.20						

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

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

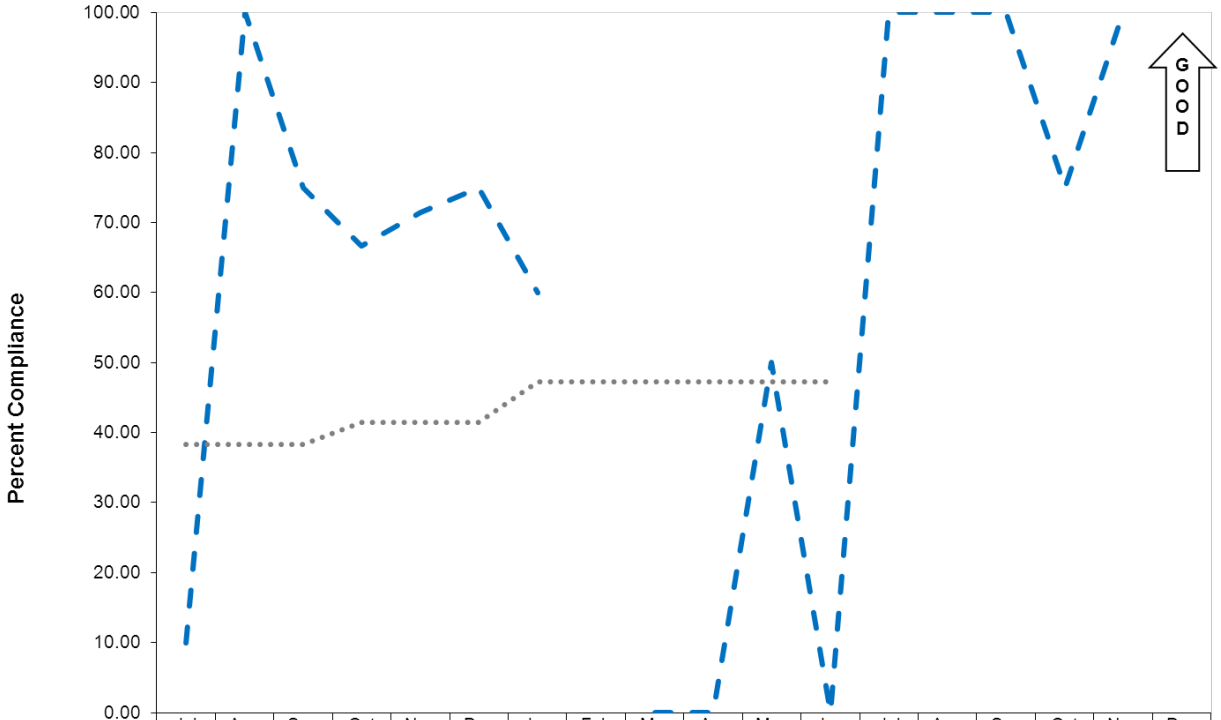
Rationale

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006).

Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in *treatment resistant* patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients *without* a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	10.00	100.00	75.00	66.67	71.43	75.00	60.00		0.00	0.00	50.00	0.00	100.00	100.00	100.00	75.00	100.00	
TJC Target	38.30	38.30	38.30	41.50	41.50	41.50	47.30	47.30	47.30	47.20	47.20	47.20						

JOINT COMMISSION

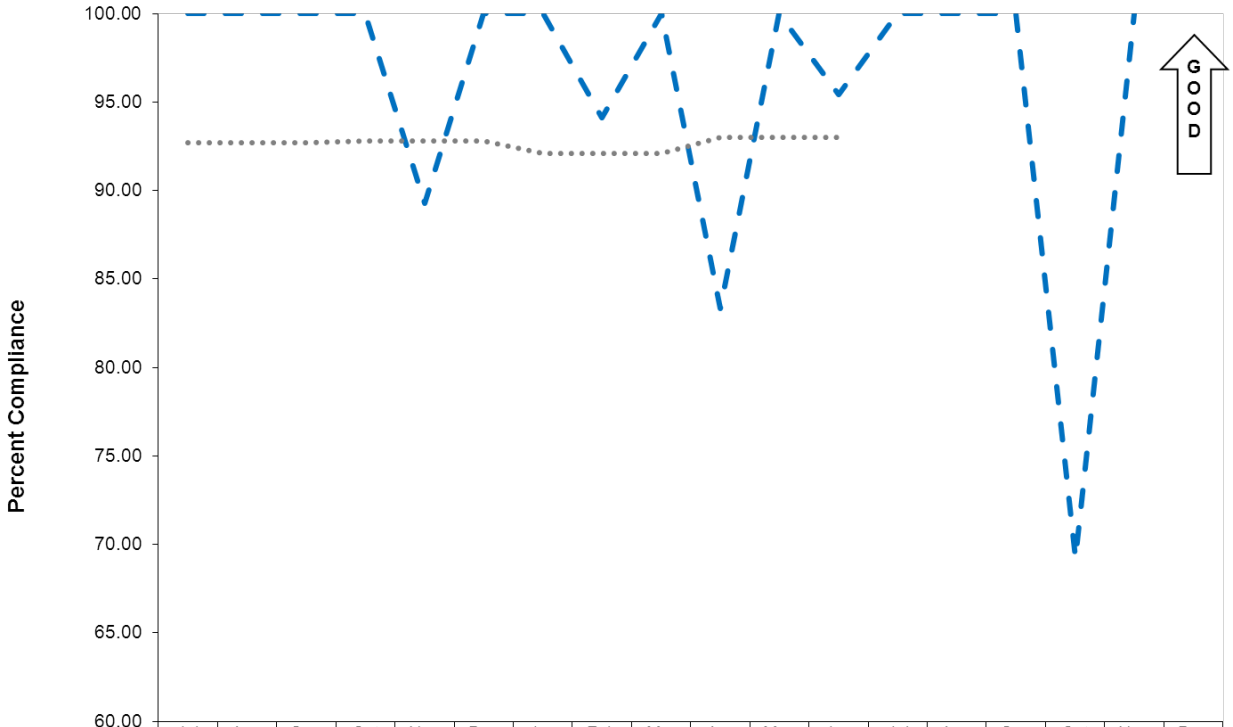
Post Discharge Continuing Care Plan (HBIPS 6)

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).



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	100.00	100.00	100.00	100.00	89.29	100.00	100.00	94.12	100.00	83.33	100.00	95.45	100.00	100.00	100.00	69.23	100.00	
TJC Target	92.70	92.70	92.70	92.80	92.80	92.80	92.10	92.10	92.10	93.00	93.00	93.00						

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

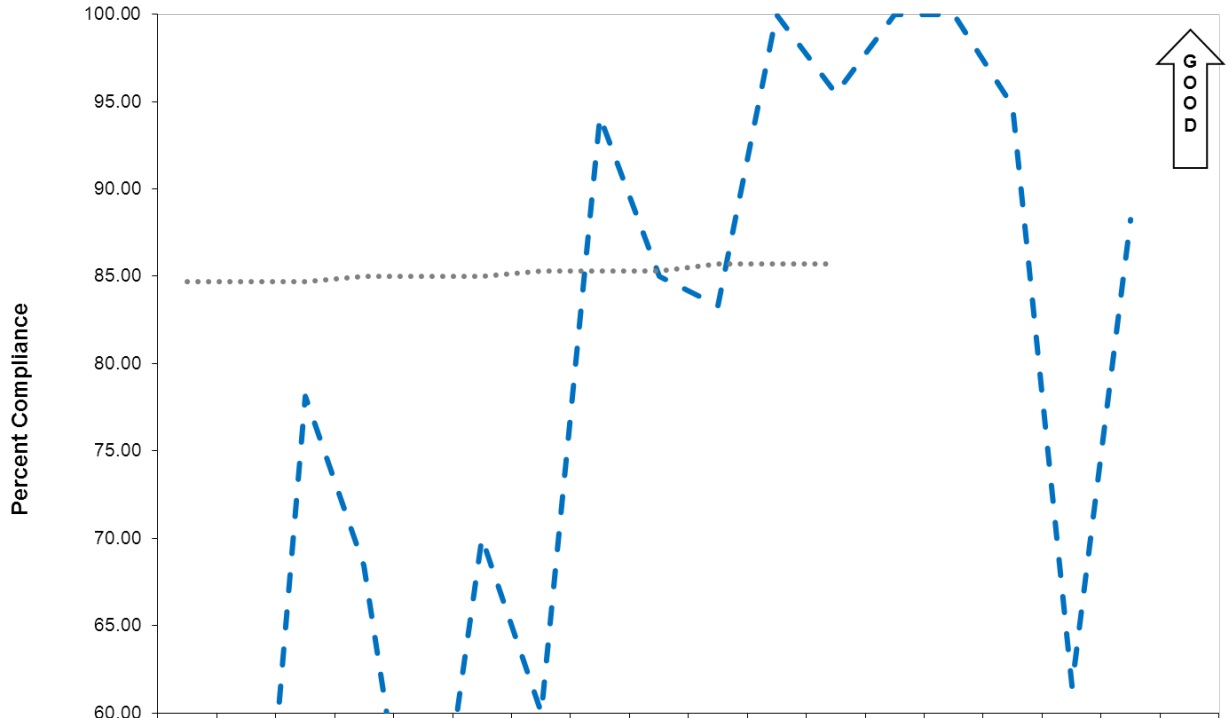
To Next Level of Care Provider on Discharge

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
RPC Rate	45.83	38.71	78.13	68.42	46.43	70.00	60.00	94.12	85.00	83.33	100.00	95.45	100.00	100.00	94.74	61.54	88.24	
TJC Target	84.70	84.70	84.70	85.00	85.00	85.00	85.30	85.30	85.30	85.70	85.70	85.70						

JOINT COMMISSION

Joint Commission Priority Focus Areas

Capital Community Clinic

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

Dental Clinic Timeout/Identification of Client

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
National Patent Safety Goals Goal 1: Improve the accuracy of Client Identification. Capital Community Dental Clinic assures accurate client identification by: asking the client to state his/her name and date of birth. A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the dental assistant.	**July** 100% 14/14 **August** 100% 4/4 **September** 100% 5/5 **Total** 100% 23/23	**October** 100% 5/5 **November** 100% 3/3 **December** 100% 4/4 **Total** 100% 12/12	**January** **February** **March** **Total**	**April** **May** **June** **Total**

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. All clients with tooth extractions, will be assessed and have teaching post procedure, on the following topics, as provided by the Dentist or Dental Assistant • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. 3. Post dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications	**July** 100% 14/14 **August** 100% 4/4 **September** 100% 5/5 **Total** 100% 23/23	**October** 100% 5/5 **November** 100% 3/3 **December** 100% 4/4 **Total** 100% 12/12	**January** **February** **March** **Total**	**April** **May** **June** **Total**

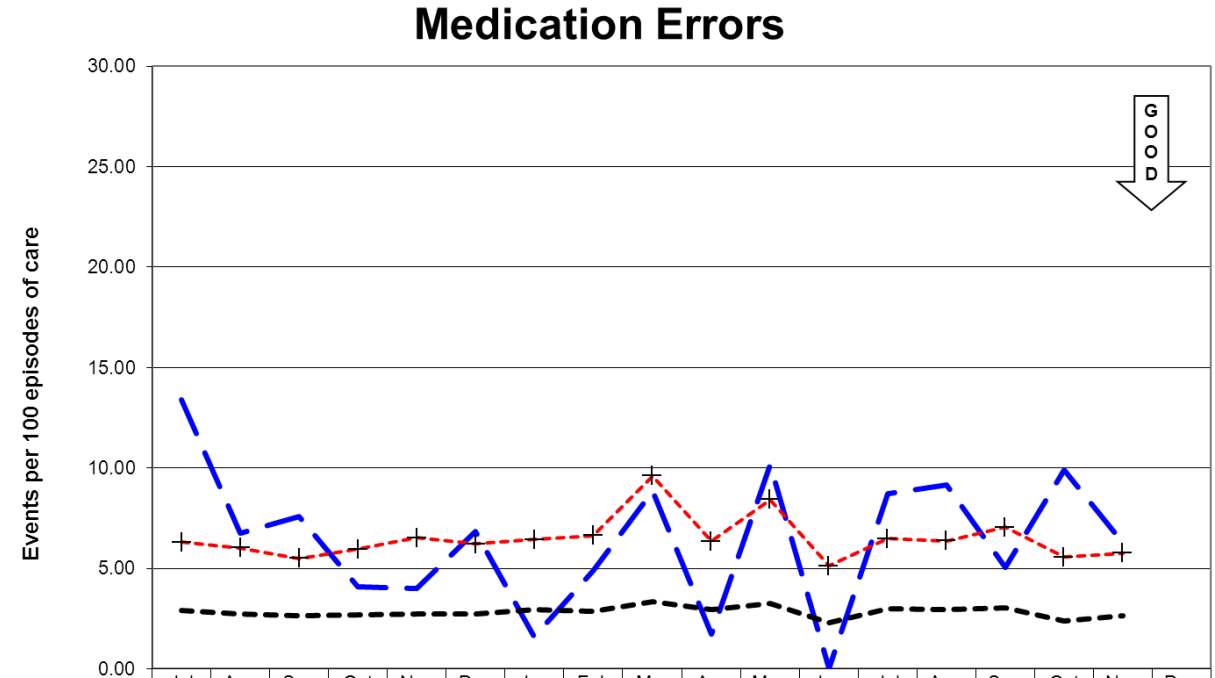
JOINT COMMISSION

Medication Management

Medication Errors and Adverse Reactions

TJC PI.01.01.01 EP14: The hospital collects data on the following: Significant medication errors. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)

TJC PI.01.01.01 EP15: The hospital collects data on the following: Significant adverse drug reactions. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	13.39	6.77	7.58	4.10	4.00	6.84	1.60	4.88	8.87	1.71	10.17	0.00	8.70	9.17	5.04	9.91	6.25	
Ntl Mean	2.89	2.73	2.65	2.68	2.71	2.71	2.95	2.85	3.36	2.93	3.26	2.30	2.97	2.96	3.05	2.36	2.62	
+1 StDev	6.31	6.03	5.49	5.95	6.52	6.22	6.43	6.63	9.6	6.34	8.43	5.13	6.47	6.36	7.05	5.55	5.75	

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

JOINT COMMISSION

MEDICATION ERRORS RELATED TO STAFFING EFFECTIVENESS

Date	Co-mission	Omit	Float	New	O/T	Unit Acuity	Staff Mix
7/9/12	7 meds omitted once	Y	N	Y	N	UK	1 RN, 1 LPN, 4 MHW
9/5/12	Benadryl given wrong time	N	Y	Y	N	LK	3 RN, 1 LPN, 7 MHW
9/12/12	Novolog insulin	Y	N	Y	N	UK	1 RN, 1 LPN, 3.5 MHW
9/12/12	2 meds, Melatonin and Benadryl omitted x4 doses	Y	N	N	N	LS	2 RN, 0 LPN, 8 MHW
9/28/12	IM Lasix not given	Y	Y	Y	Y	LK	4.5 RN, 0.5 LPN, 7 MHW
10/1/12	6 meds omitted x1	Y	Y	Y	N	US	2 RN, 4 MHW
10/4/12	Zyprexa IM back up given late	N	Y	Y	N	US	2 RN, 3 MHW
10/8/12	Diazapine given	N	N	Y	N	UK	2 RN, 5 MHW
10/8/12	Lithium x1 dose	Y	Y	N	Y	LS	2 RN, 1 LPN, 7 MHW
10/8/12	Lamotrigine without order in wrong pocket	N	Y	N	Y	LS	2 RN, 1 LPN, 7 MHW
10/8/12	Beano x 7 doses	Y	N	N	N	US	2 RN, 1 LPN, 4 MHW
10/10/12	Lasix 40 mg. IM	Y	Y	Y	N	LK	3 RN, 1 LPN, 7 MHW
10/16/12	Symbicort inhaler x 3 doses	Y	N	N	N	LS	3 RN, 1 LPN, 7 MHW
10/23/12	Budesomide 9 mg.	Y	N	Y	N	LS	3 RN, 1 LPN, 8 MHW
10/25/12	Wrong time x 29 variances	N	N	N	N	US	3 RN, 4 MHW
10/26/12	Tylenol omitted x 4 doses	Y	N	Y	Y	LKS	3 RN, 1 LPN, 7 MHW
10/31/12	Reglan 10 mg.	Y	Y	Y	N	LS	4 RN, 1 LPN, 7 MHW
11/6/12	Thorazine given, exceeding amount ordered	N	N	N	N	LS	1 RN, 1 LPN, 3 MHW
11/6/12	Novolog insulin	Y	N	Y	N	UK	3 RN, 5 MHW
11/13/12	Benadryl	Y	Y	Y	N	LS	4 RN, 1 LPN, 7 MHW
11/16/12	Proctofoam HC x 6 variances	Y	N	Y	N	LS	2 RN, 3 MHW
11/20/12	Trazadone given, order was Thorazine	N	N	Y	N	LS	3 RN, 7 MHW
11/22/12	Celexa 40 mg.	Y	N	N	N	LS	4 RN, 1 LPN, 8 MHW
12/4/12	Navane 5 mg.	Y	N	Y	N	LK	4 RN, 7 MHW
12/8/12	4 meds omitted x 1	Y	N	Y	N	US	2 RN, 3 MHW
11/13/12	Ativan wasted and marked as given	Y	Y	Y	N	LS	4RN, 1 LPN, 8 MHW
12/12/12	Haldol Dec missed	Y	Y	Y	N	LK	3 RN, 1 LPN, 7 MHW
Totals		20	21	19	4		
Percent		74%	78%	70%	15%		

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

JOINT COMMISSION

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

Prescribing

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

Dispensing

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

Administration

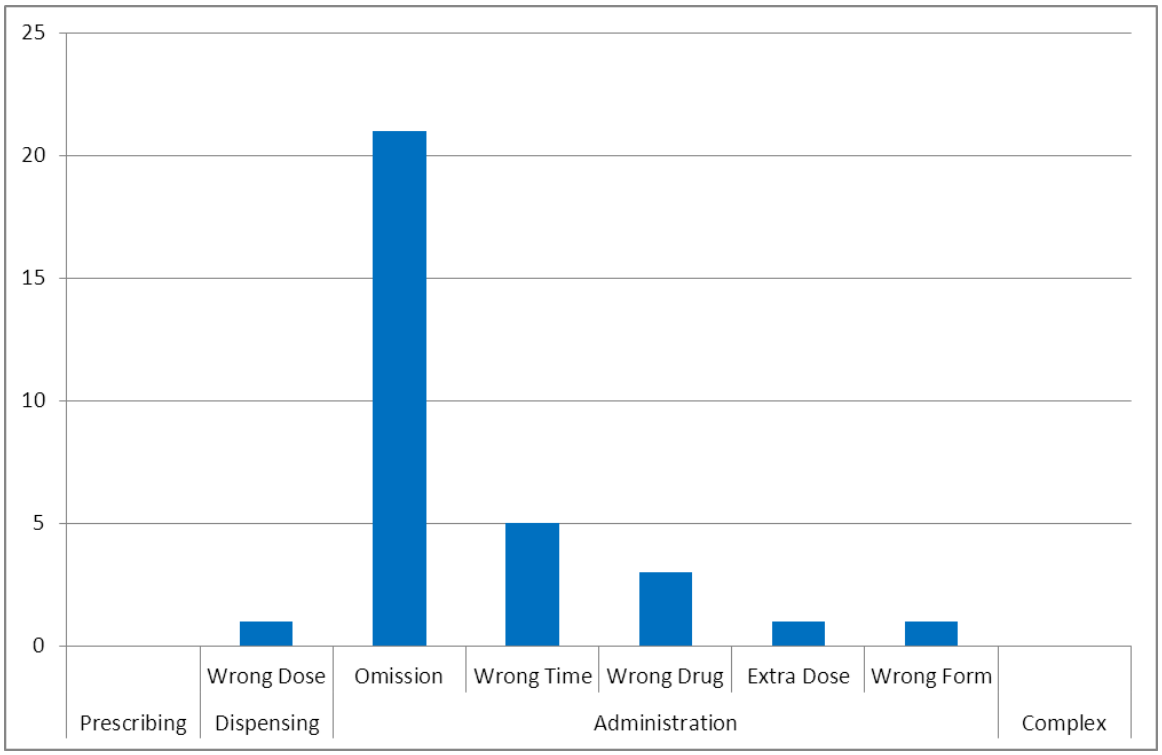
An error of administration occurs when there is an incorrect selection and administration of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber.

Complex

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

Causes of Medication Variances

2nd Quarter 2013



JOINT COMMISSION

Inpatient Consumer Survey

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

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

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

Rate of Response for the Inpatient Consumer Survey

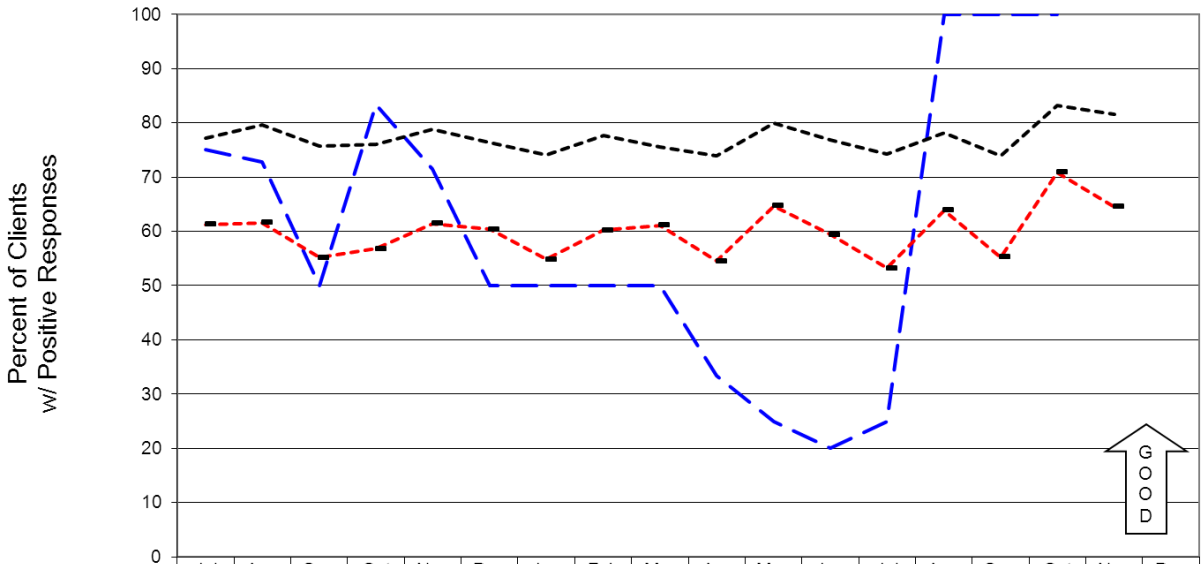
Indicators	3Q2012	4Q2012	1Q2013	2Q2013
Client satisfaction surveys completed.	48% 10/21	46% 12/26	80% 8/10	65% 15/23

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

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

JOINT COMMISSION

Inpatient Consumer Survey
Outcome Domain



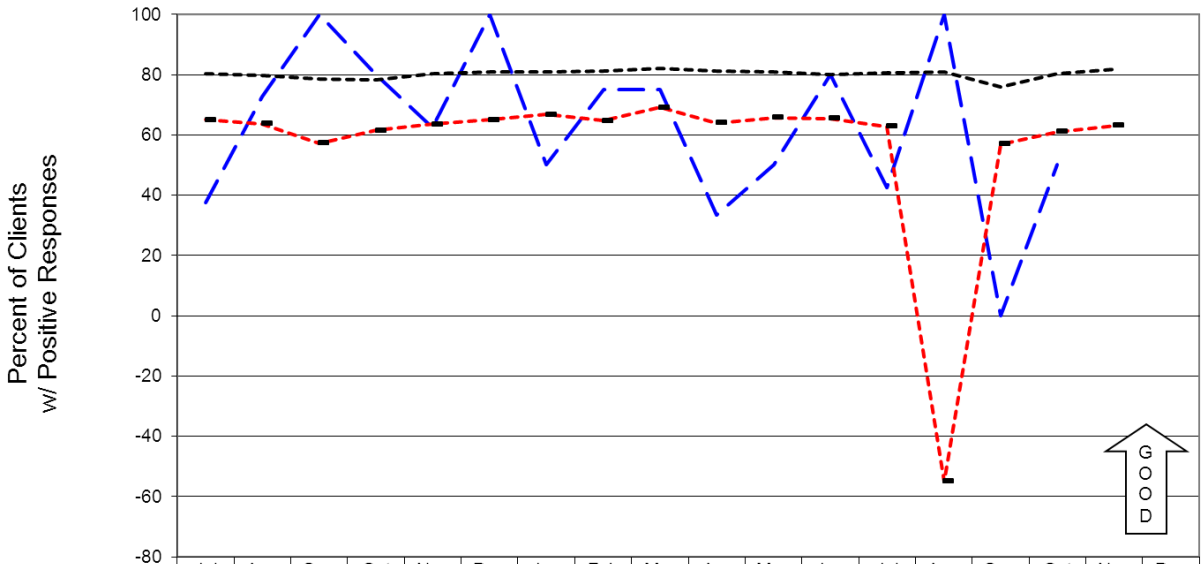
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	75.00	72.73	50.00	83.33	71.43	50.00	50.00	50.00	50.00	33.33	25.00	20.00	25.00	100.0	100.0	100.0		
Ntl Mean	77.16	79.65	75.78	76.06	78.76	76.42	74.02	77.68	75.51	73.94	80.01	76.92	74.26	78.21	73.88	83.27	81.62	
- 1 StDev	61.26	61.62	55.17	56.79	61.43	60.35	54.81	60.24	61.09	54.51	64.66	59.39	53.19	63.90	55.28	70.87	64.53	

Outcome Domain Questions

1. I am better able to deal with crisis.
2. My symptoms are not bothering me as much.
3. I do better in social situations.
4. I deal more effectively with daily problems.

JOINT COMMISSION

Inpatient Consumer Survey
Dignity Domain



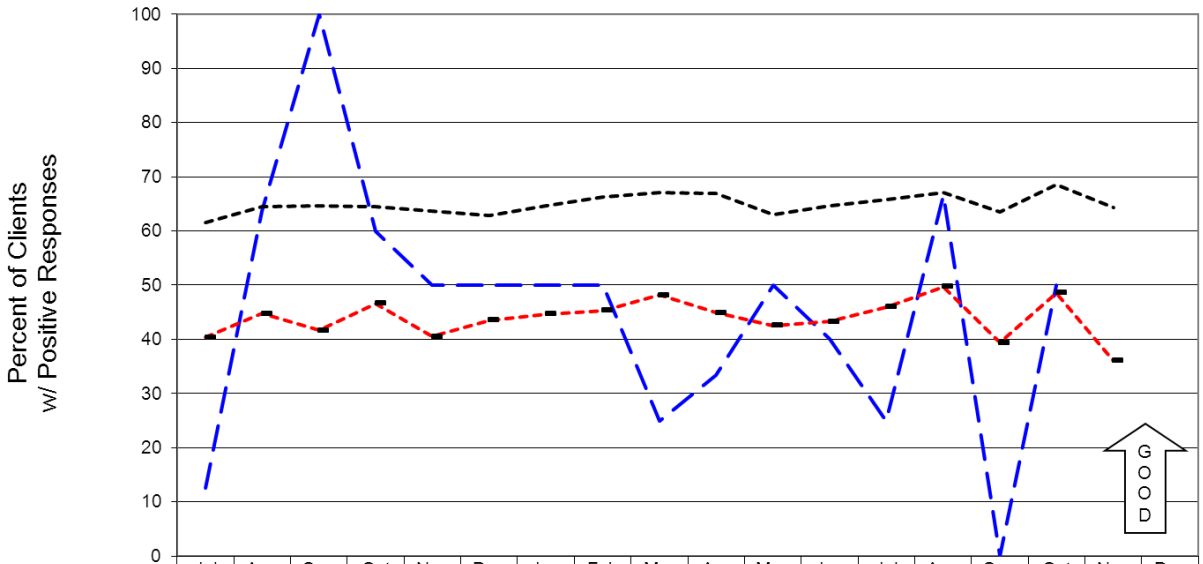
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	37.50	72.73	100.0	80.00	62.50	100.0	50.00	75.00	75.00	33.33	50.00	80.00	42.50	100.0	0.00	50.00		
Ntl Mean	80.36	79.72	78.51	78.16	80.42	80.87	80.98	81.24	82.20	81.29	80.96	79.96	80.49	81.02	76.06	80.21	81.66	
1 StDev	64.98	63.68	57.26	61.46	63.54	65.00	66.73	64.78	69.18	64.01	65.80	65.44	62.76	-55.0	56.93	61.05	63.09	

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.

JOINT COMMISSION

Inpatient Consumer Survey
Rights Domain



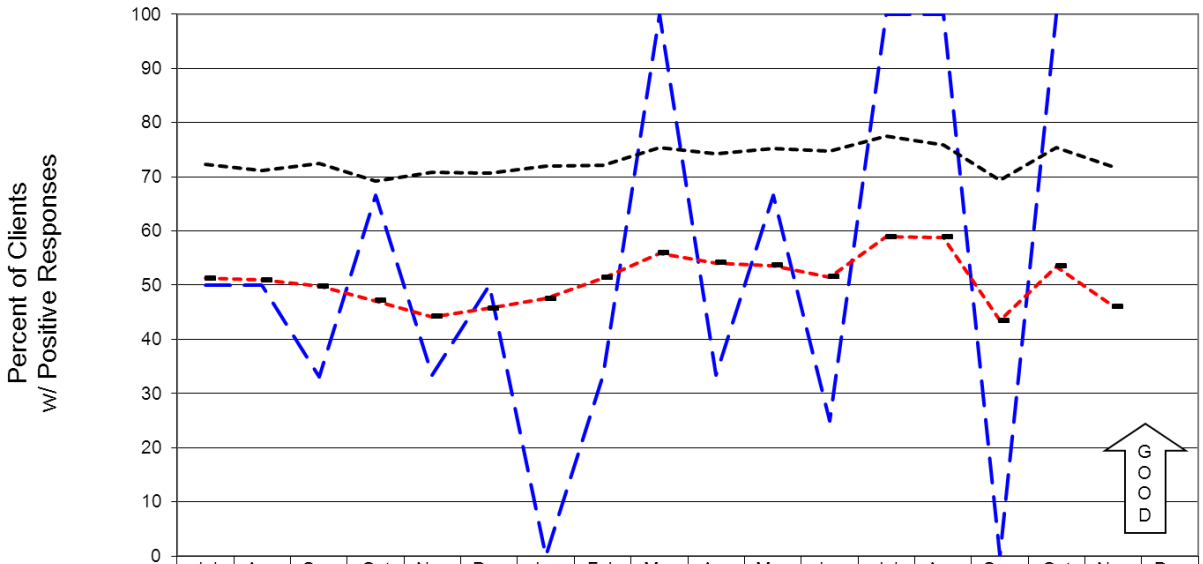
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	12.50	63.64	100.0	60.00	50.00	50.00	50.00	50.00	25.00	33.33	50.00	40.00	25.00	66.67	0.00	50.00		
Ntl Mean	61.57	64.46	64.61	64.42	63.65	62.80	64.70	66.20	67.12	66.94	63.08	64.62	65.81	67.06	63.55	68.59	64.29	
- 1 StDev	40.38	44.71	41.65	46.65	40.51	43.50	44.66	45.35	48.14	44.91	42.51	43.25	45.95	49.72	39.38	48.59	36.03	

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.

JOINT COMMISSION

Inpatient Consumer Survey
Participation Domain

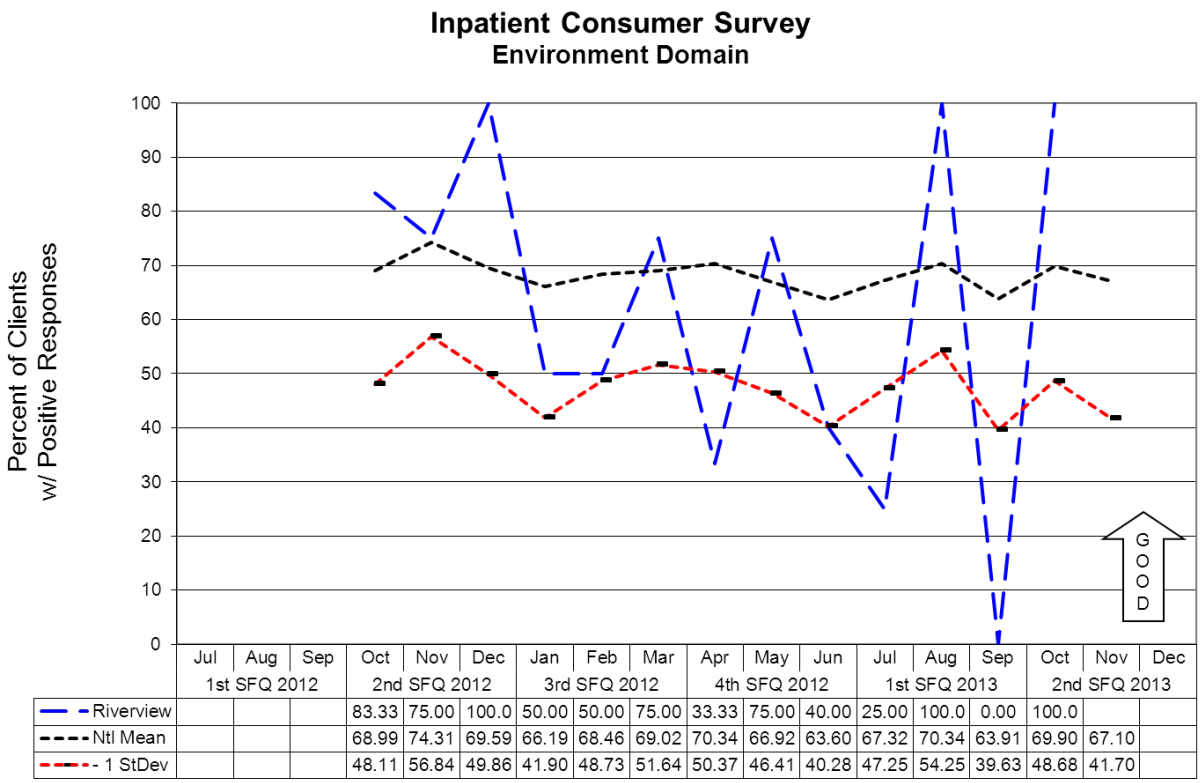


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview	50.00	50.00	33.00	66.67	33.33	50.00	0.00	33.33	100.0	33.33	66.67	25.00	100.0	100.0	0.00	100.0		
Ntl Mean	72.31	71.18	72.43	69.26	70.78	70.69	71.99	72.13	75.33	74.30	75.19	74.79	77.56	75.88	69.30	75.40	71.80	
- 1 StDev	51.23	50.96	49.76	47.11	44.15	45.72	47.50	51.32	55.86	54.07	53.58	51.54	58.92	58.84	43.45	53.43	46.05	

Participation Domain Questions

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

JOINT COMMISSION



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2012			2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013		
Riverview				83.33	75.00	100.0	50.00	50.00	75.00	33.33	75.00	40.00	25.00	100.0	0.00	100.0		
Ntl Mean				68.99	74.31	69.59	66.19	68.46	69.02	70.34	66.92	63.60	67.32	70.34	63.91	69.90	67.10	
1 StDev				48.11	56.84	49.86	41.90	48.73	51.64	50.37	46.41	40.28	47.25	54.25	39.63	48.68	41.70	

Environment Domain

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

Data aggregation on this domain began in October 2011. A trend analysis pattern related to this data is only now becoming apparent.

JOINT COMMISSION

Fall Reduction Strategies

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

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

Type of Fall by Client and Month

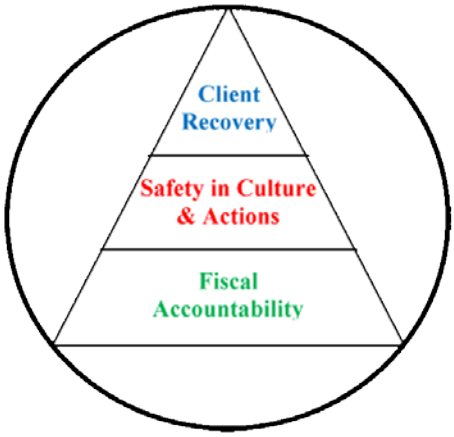
Fall Type	Client	Location	OCT	NOV	DEC	2Q2013
Un-witnessed	FR0000328245*	UK	3		1	4
	FR0000366310*	LKSCU	1	1	1	3
	FR0000390369	LKCIV			2	2
	FR0000370213	UK	1		1	2
	FR0000250266*	LKCIV	1	1		2
	FR0000329516	UK		1		1
	FR0000307819	UK	1			1
	FR0000379255	LSSCU		1		1
	FR0000312579	CCC			1	1
	FR0000368050	UK			1	1
	FR0000366682	UK	1			1
Witnessed	FR0000377945	UK		3		3
	FR0000328245*	UK	2	1		3
	FR0000250266*	LKCIV	2			2
	FR0000371724	LKCIV	1			1
	FR0000372250	UK			1	1
	FR0000356600	LKCIV			1	1
	FR0000379214	LKSCU			1	1
	FR0000359323	UK			1	1
	FR0000366310*	LKSCU			1	1

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

STRATEGIC PERFORMANCE EXCELLENCE

Priority Focus Areas
for Strategic Performance Excellence

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



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

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

STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

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

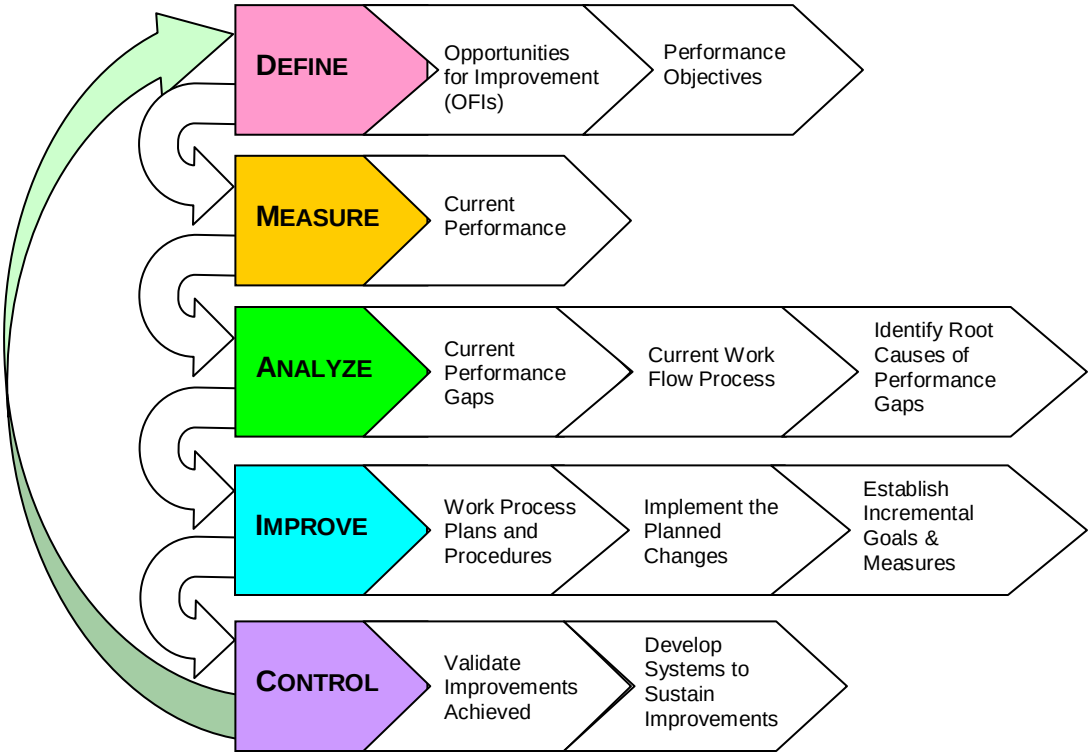
Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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

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

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

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



STRATEGIC PERFORMANCE EXCELLENCE

Admissions

DEFINE

OPPORTUNITIES FOR IMPROVEMENT (OFI'S)

- Streamline Pre-Admission Face Sheet (PAFS) and remove obsolete items.

PERFORMANCE OBJECTIVES

- Decrease paperwork redundancy due to repetitive information on current worksheet.
- Increase provider satisfaction with information gathered and accessibility of information.

MEASURE

Based on a survey:

- How happy are the employees with the new PASF forms?
- Does it contain the proper/needed information?
- Is it easy to find the information needed?
- Is it well organized?
- Is it legible?
- Is it easier/faster to complete than the previous forms?
- Overall improvement of the forms?

ANALYZE

CURRENT PERFORMANCE GAPS:

- Duplication of the same information required.
- Wasted space on the PSAF.
- Time consuming to complete multiple forms.
- Disorganized, hard to read and find information.
- Lacking important information needed.

CURRENT WORK FLOW PROCESS:

- Based on the amount of history faxed from the referral source, at times, 50-100 pages or more of information is sent per client. This may come in several packets over a period of time, which needs to be reviewed to determine if the client is appropriate for admission.
- The average wait period is 24 days for an admission (based on figures of Sept, 2012 Forensic Referral List) and many clients decompensate further and have to be medically cleared an additional time.

IDENTIFY ROOT CAUSES OF PERFORMANCE GAPS:

- Time and duplication of client information.
- Lacking important information needed.

STRATEGIC PERFORMANCE EXCELLENCE

IMPROVE:

WORK PROCESS PLANS AND PROCEDURES:

- Talk to the Nurse IV and other direct care staff to gather opinions on Admission form revision.
- Hand out survey's to be completed and get feedback regarding the new forms.

IMPLEMENT THE PLANNED PROCEDURES:

- Rearrange the needed information.
- Remove non-applicable items from the PAFS.
- Attend the scheduled meeting with Medical Records staff and obtain approval for 1st draft of changes.
- Add additional information needed by the units upon admission.

CONTROL:

VALIDATE IMPORVEMENTS ACHIEVED

- Based on interviews and surveys completed by staff: Is it working?

DEVELOP SYSTEMS TO SUSTAIN IMPORVEMENTS:

- A new form will be used to support the previous Admission forms.
- It will be reviewed each year to determine if it continues to support the admission process adequately.
- Any feedback from direct staff will be discussed and implemented as necessary for improvements.

Admissions Pilot PSFA Form

Please rate the new forms .
1. The new admission pilot forms contain the information needed upon admission. Strongly Disagree Disagree Agree Strongly Agree
2. It is easy to find the information needed on the new admission pilot forms. Strongly Disagree Disagree Agree Strongly Agree
3. The new admission pilot forms are well organized. Strongly Disagree Disagree Agree Strongly Agree
4. The information is legible on the new admission pilot forms. Strongly Disagree Disagree Agree Strongly Agree
5. For those of you who have to complete the new form: It now takes less time to complete the new PASF form than it did to complete the old PASF form. Strongly Disagree Disagree Agree Strongly Agree
6. I would not make any changes to the new admission pilot forms. Strongly Disagree Disagree Agree Strongly Agree
Comments Section: (Any suggestions are welcomed)

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions												
Hand Hygiene Compliance: In an effort to monitor, sustain and improve hand hygiene compliance, the Dietary department measures its results through observations of Dietary staff when returning from a scheduled break.												
1st Quarter			2nd Quarter			3rd Quarter			4th Quarter			Goal
Baseline Established	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 10%	Findings	Compliance	Target – Q3 + 10%	Findings	Compliance	
58%	22/43	N/A	70%	18/34	53%							80-90%

Data

18 compliant staff / 34 hand hygiene observations = 53% hand hygiene compliance rate

Summary

The data collection rate is too low to determine the actual hand hygiene compliance rate over time.

Action Plan

Discuss the percent data collection with Food Service Manager and Dietitian and encourage greater consistency.

Provide Hand Hygiene In-service to all Dietary staff. Assure attendance by all employees.

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

INDICATOR

GROUNDS SAFETY/SECURITY INCIDENTS

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

Monitoring would be performed by;

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

METHODS OF REPORTING

Reporting would occur by one or all of the following methods;

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

UNIT

Hospital grounds as defined above

BASELINE

To be determined after compilation of data during the months on August/12 to September/12.

Q2-Q4 TARGETS

Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

Department: Safety & Security Responsible Party: Rick Levesque
Environment of Care Committee

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Grounds Safety & Security Incidents Safety/Security incidents occurring on the grounds at Riverview, which include "*Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches*	# of Incidents	* Baseline of 10 was determined in the months of Aug. & Sept. of 2012	*	(10) -5%	(13) -5%			

SUMMARY OF EVENTS

Originally, the Q2 Target was (10)-5%. When reviewing the Q2 Quarter, we realized that since July was not part of the computation of the Baseline, and August and September were the only months used, we actually set a very high goal of the Q2 Target. Q2's Actual number was slightly lower at (13) when you consider that (13) actually covered an entire quarter. We feel that having tracked a full quarter, we are well positioned with regard to reporting this new indicator and that the Q3 Target is more realistic. We hope that the reporting, which follows below, provides 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. We have also placed signage throughout the property, added additional cameras, and improved exterior lighting by upgrading the type of bulbs used.

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
Vehicle driving erratically in area	10/12/12	2000	Roadway	Local PD Called	Alerted Security and Operations to monitor future
Possible Criminal Mischief (gas cap removed) from vehicle	10/14/12	1815	Staff Lot	Operator refused call to PD	1. Reviewed camera. Nothing found. 2. Alerted Security and Operations
Safety Threat (part of yard gate)	10/28/12	2045	Kennebec Yard	Item secured by Security	1. Security checked for other items 2. Maintenance notified 3. Repair completed

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Objectives	*Findings*	*Compliance*
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	*19 of 42*	*45%*
2. RN signature/Harbor Mall staff signatures present.	*28 of 28*	*100%*
3. SBAR information completed from the units to the Harbor Mall.	*28 of 42*	*67%*
4. SBAR information completed from the Harbor Mall to the receiving unit.	*28 of 28*	*100%*

DEFINE

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

MEASURE

Indicator number one was 55% for the first quarter and decreased to 45% for this quarter. Indicator number two was 100% for the first quarter and remains at 100% for this quarter. Indicator number three was 64% for the first quarter and increased to 67% for this quarter. Indicator number four was 95% for the first quarter and increased to 100% for this quarter.

ANALYZE

Due to high performance and consistency indicator data was not collected for indicators two and four for December. Continue to concentrate on indicators one and three to improve current performance gaps.

IMPROVE

On September 11, 2012 I attended the charge nurse meeting to present the hand of communication sheets results from April thru August 2012. We made a change on Lower Saco so they would have one sheet instead of two. One charge nurse is going to initiate an earlier time for the sheets to be completed so they will arrive at the mall on time. Some changes have not been implemented which may account for not achieving objective number one.

CONTROL

Treatment team coordinators on three units are nurses we are expecting our fourth in January. The Hand off Communication sheets is one of their responsibilities. The plan is to meet with all four treatment team coordinators to explain the Hand of Communication policy for the Harbor Mall.

Department: Harbor Mall Responsible Party: Lisa Manwaring, PSD

Strategic Objectives							
Hand of Communication	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
95% of HOC sheets were received at the Harbor Mall within the designated time frame.	55	60	70	80	90	95%	
95% of SBAR information completed from the units to the Harbor Mall	64	60	70	80	90	95%	

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Define

The opportunity for improvement selected for the Health Information Department is cross-auditing the coding of medical staff charges and discharges with Dorothea Dix Psychiatric Center.

Measure

Each month, ten medical staff charges and ten discharges will be randomly selected. Coding staff at Dorothea Dix Psychiatric Center (DDPC) will audit Riverview Psychiatric Center's (RPC) coding, and RPC will audit DDPC's charges.

Analyze

Comparing values with DDPC may point out areas of improvement in our coding processes.

Improve

At this point, there is no baseline as this is a new process. The baseline will be defined with data gathered for the quarter 2 report.

Control

To be defined after 3 months of data.

Department: Medical Records Responsible Party: Nicole Ginka

Strategic Objectives								
Fiscal Accountability	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Billing Compliance Audit Process A method of conducting an audit of the accuracy and validity of bills submitted for reimbursement to Medicare, Medicaid, and third part payers is an integral function of the CMS Compliance Program as recommended by the CMS Office of the Inspector General.	This is an integrate process that includes the participation of both the RPC and DDPC Medical Records Departments	* Baseline will be determined the 2nd quarter 2013	*	*				

Note

During the discovery process of the original plan for process improvement, A different area of needed improvement was found. As a result the original plan has been amended. Cross-auditing with DDPC will still continue with regard to coding compliance standards, but process improvement measures will be focused on improving documentation & charges at RPC.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

(Revised Performance Excellence Project)

Define

The opportunity for improvement in the Health Information Department is auditing the charges submitted, along with documentation of those charges.

Measure

25 providers submitted superbills to the Health Information department for quarter 2.

Analyze

One provider submitted 10 superbills in October with no documentation found. After discussions with the provider, the November audits improved-there were notes for all submitted superbills. In December, 10 superbills were submitted, with only 2 having notes documented. Another issue found was the amount of duplicate superbills being submitted. In October, there were 16 duplicates submitted. There were no duplicates in November. In December, there were 3. There are 2 providers involved in the duplicates issued.

Improve

Work with above provider on appropriate/consistent documentation. In regard to the duplicate issue, documentation seems to be sporadic. Instead of noting/completing superbills when visit occurs, it appears to be happening all at once with some providers. Speak with Medical Director for recommendations.

Control

Continue auditing 10 superbills & documentation per provider.

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Define

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

Measure

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

Analyze

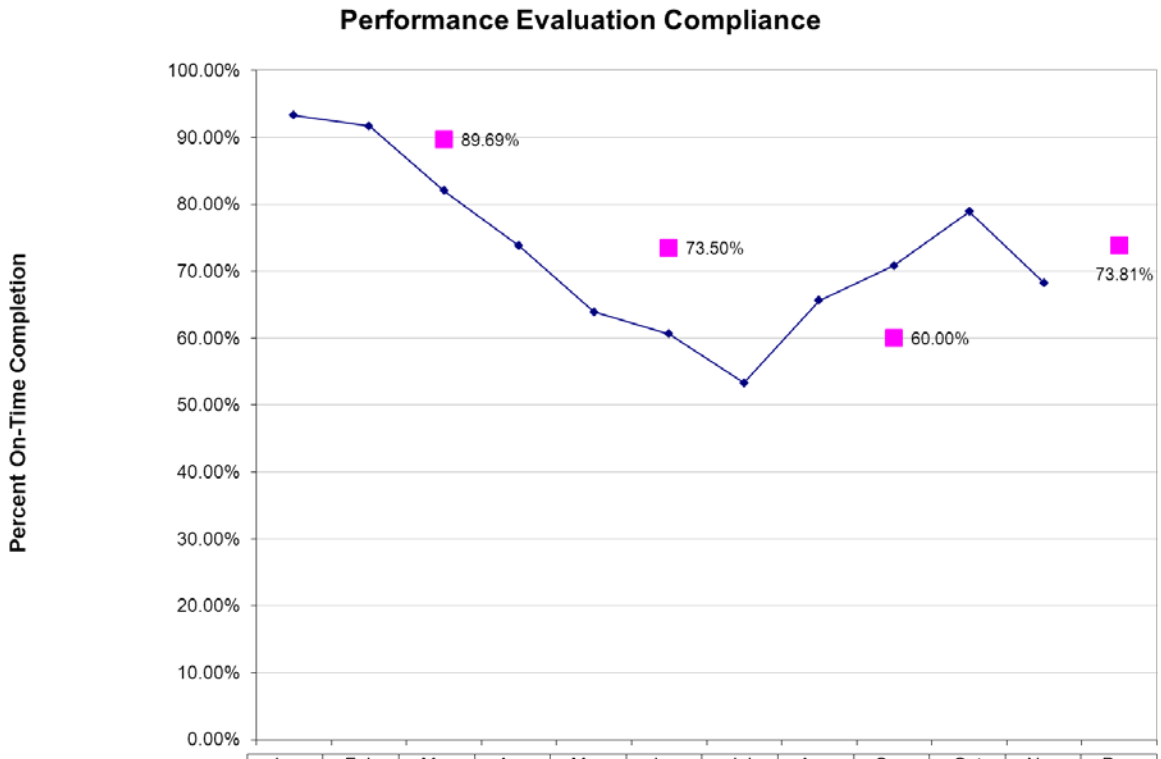
A thorough analysis of the root causes for lack of compliance with this performance standard is indicated. This analysis

Improve

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

Control

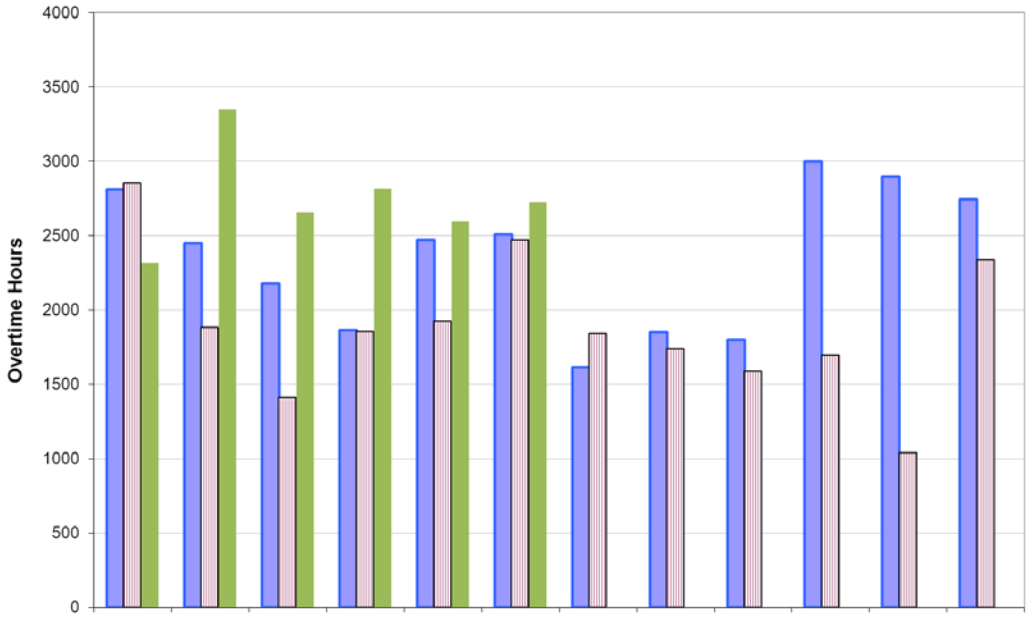
Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Monthly % Compliance	93.33%	91.67%	82.05%	73.81%	63.89%	60.61%	53.33%	65.63%	70.83%	78.95%	68.18%	
Quarterly % Compliance			89.69%			73.50%			60.00%			73.81%

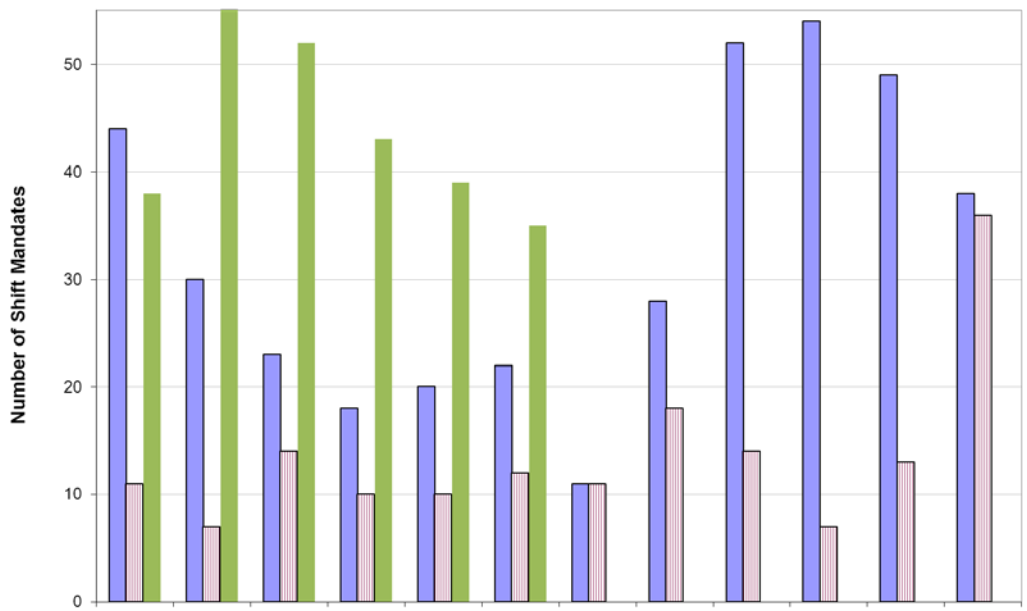
STRATEGIC PERFORMANCE EXCELLENCE

Monthly Overtime



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	2812	2451	2178	1868	2473	2507	1618	1853	1798	2999	2896	2743
FY 2011	2859	1885	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2013	2316	3350	2657	2817	2599	2726						

Monthly Mandated Shifts

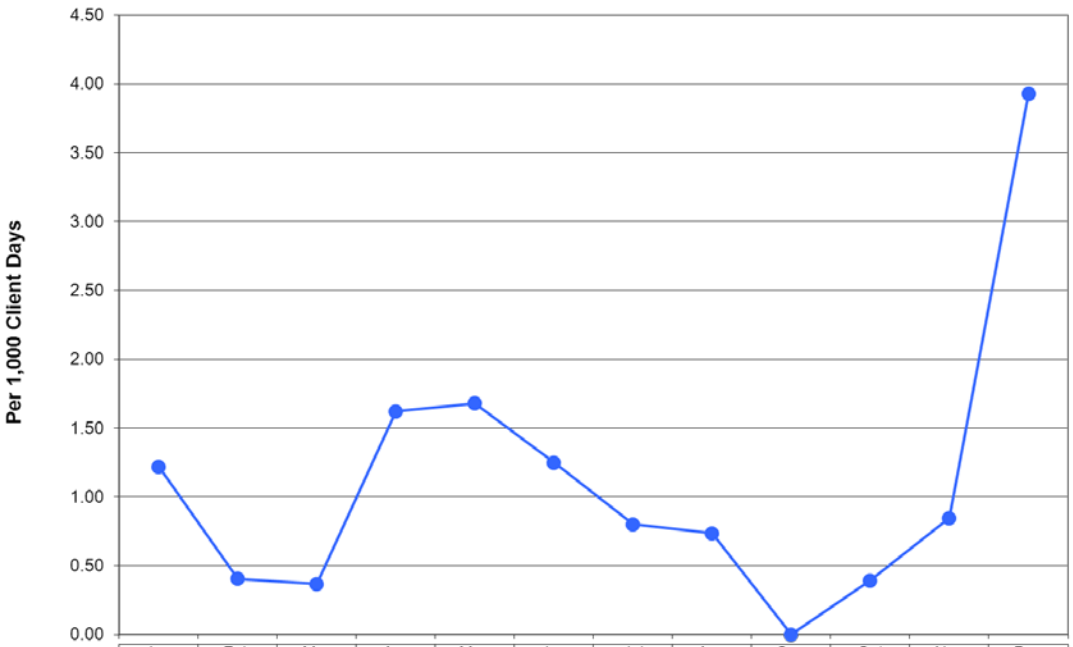


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2013	38	81	52	43	39	35						

The nursing department has implemented a staffing patterns study in an attempt to minimize the incidence of mandates. Further information on this study can be viewed on page 72 of this report.

STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Lost Time Ratio	1.22	0.40	0.37	1.62	1.68	1.25	0.80	0.74	0.00	0.39	0.85	3.93

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

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Lost Time Ratio	0.00	0.40	0.37	0.00	0.00	0.00	0.00	0.37	0.00	0.39	0.00	0.44

STRATEGIC PERFORMANCE EXCELLENCE

Infection Prevention and Control

Responsible Party: Kathleen Mitton RN

Strategic Objective: Safety in Culture and Actions

Hand Hygiene Measurement: To gain an accurate and consistent perspective on employee hand hygiene practice, an effective measurement process needs to be in place. Current experience has demonstrated that the collection of observations of employee hand hygiene practice is inconsistent and incomplete. The measure will strive to improve the process of data collection and measurement.

Unit	Baseline	Q1-Target	Compliance	Q2-Target	Compliance	Q3 - Target	Compliance	Q4 - Target	Compliance	Goal	Comment
Lower Kennebec	71%	B + 6%	**83%** ↑	Q1 +6%	**100%** ↑	Q2 +6%		Q3 +6%		95%	
Upper Kennebec	74%	B + 5%	**83%** ↑	Q1 +5%	**100%** ↑	Q2 +5%		Q3 +5%		95%	
Lower Saco	34%	B +15%	**33%** ↓	Q1 +15%	**75%** ↑	Q2 +15%		Q3 +16%		95%	
Upper Saco	59%	B +9%	**54%** ↓	Q1 +9%	**98%**↑	Q2 +9%		Q3 +9%		95%	

Mean hand hygiene compliance rate: 70%

Indicator

Each unit will do 80 hand hygiene observations per month.

Indicator

Increase hand hygiene compliance rate to 80%.

Summary

All units have improved significantly in data collection this quarter. A somewhat accurate hand hygiene compliance rate can be determined if data collection remains constant (95%+) over time

Medical Staff

1. Identification of Opportunities for Improvement:

   Some members of the medical staff have long complained about lack of timeliness and difficulty in obtaining certain psychological services. For example there is an nuclear process for requesting or ordering such services as individual psychotherapy, psychological testing, and related activities for individual clients. Furthermore there continued to be anecdotal complaints of the quality and responsiveness of some services. A review of the process did determine that there was a "Request Form for Psychological Services" in existence but it was not widely disseminated amongst all units and providers. There was also a "Psychological Services Satisfaction Survey" in existence, but again, it was neither widely known nor utilized. Initial work by the Medical Executive Committee was done to improve both forms and to mandate their use by all medical and nursing staff when requesting any psychological service.

2. The Measurement Process:

   The Medical Executive Committee is in the process of revising both the Referral Form and the Satisfaction Survey to better articulate the ordering clinician's specific need for a service, the clinical question to be addressed, and the time acuity of the need. It was agreed that the ordering clinicians would always utilize this form and no procedure would be conducted without one. It was further agreed that there would be a central point of contact in the Psychology Section Office for the review of the requests for service, a triage function, and the assignment of requested tasks (therapy or testing or consultation) to individual psychologists for completion. The Chief of Section, Dr. DiRocco, will oversee the process and track the time from assignment to completion (or in the case of psychotherapy until the first session has been completed). He will also make certain ordering medical staff complete a Satisfaction Questionnaire upon completion of the requested task, and he will track the outcome of this rating scale. We will therefore be tracking two data sets: one of timeliness of completion of requested service and one on the quality and usefulness of the completed work product.

3. Baseline Measures:

   Dr. DiRocco is in the process of obtaining additional baseline data on the averages and range of time to completion of a given service, and on the averages and range of ratings on the Satisfaction Survey. An initial accounting found that over the period of mid-June to mid-August the average time to completion of requested psychological testing was 9.6 working days, with a range of 2 to 31 working days. Additional baseline data, incorporating all requested services (not just testing), is necessary. Once these are obtained we will determine our goals of improvement for the next 4 quarters.

4. Goal of Improvement and Measures of Success:

   We will monitor on a monthly basis the average waiting time for completion of the requested service, and the ratings of satisfaction with the service. Our goal obviously is to improve both timeliness and quality of the reports and interventions. We will make further process improvements as needed based on the data obtained over the next 4 quarters.

Quarterly Update

2nd Quarter 2013	Due to a significant loss of Psychology providers during the past few months this study has been delayed until replacements can be recruited.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing

INDICATOR

Mandate Occurrences

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

Monitoring will be performed by members of the Staffing Improvement Task Force which includes representation of Nurses and Mental Health Workers on all units, Staffing Office and Nursing Leadership.

METHODS OF MONITORING

Monitoring would be performed by;

- Staffing Office Database Tracking System

METHODS OF REPORTING

Reporting would occur by one or all of the following methods;

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

UNIT

Mandate shift occurrences

BASELINE

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

MONTHLY TARGETS

Baseline –10% each month

STRATEGIC PERFORMANCE EXCELLENCE

Department: Nursing Responsible Party: Holly Harmon, DON Staffing Improvement Task Force

Strategic Objectives							
Safety in Culture and Actions	Baseline August 2012	Mth 1 Sep 2012	Mth 2 Oct 2012	Mth 3 Nov 2012	Mth 4 Dec 2012	Goal	Comments
Mandate Occurrences - Nurses When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	24	10	5	0	6	16 (10% reduction monthly x4 from baseline)	Goal exceeded.
Mandate Occurrences – Mental Health Workers When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	53	38	36	34	28	35 (10% reduction monthly x4 from baseline)	Goal exceeded

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

INDICATOR

Client Satisfaction Survey Return Rate

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

Peer Services Director and Peer Support Team Leader will be responsible for developing tracking tools to monitor survey due dates and surveys that are offered, refused, and completed. Full-time peer support staff will be responsible for offering surveys to clients and tracking them until the responsibility can be assigned to one person.

METHODS OF MONITORING

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

METHODS OF REPORTING

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

UNIT

All client care/residential units

BASELINE

Determined from previous year's data.

QUARTERLY TARGETS

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

STRATEGIC PERFORMANCE EXCELLENCE

Department: Peer Support Responsible Party: Holly Dixon

Strategic Objectives								
Client Recovery	Unit	Baseline	Q1	Q2 Result	Q3 Target	Q4 Target	Goal	Comments
CSS Return Rate								
The client satisfaction survey is the primary tool for collecting data on how clients feel about the services they are provided at the hospital. Data collection has been low on all units and the way in which the surveys are administered has challenges based on the unit operations and performance of the peer support worker.	LK	15%	ND	*9%*	25%	50%	50%	*Percentages are calculated based on number of people eligible to receive a survey vs. the number of people who completed the surveys.*
	LS	5%	ND	*0%*	25%	50%	50%	
	UK	45%	ND	*44%*	50%	50%	50%	
	US	30%	ND	*78%*	50%	50%	50%	

Summary

Compliance on LK dropped below baseline this quarter. This was primarily due to the shift in population from mostly civil to mostly forensic. Administering surveys with the forensic population is different and adjustments were not made quickly enough to capture more data. The return rate on LS continues to be very low, primarily due to a staffing issue. Closer monitoring will be put into place to ensure increased compliance. The return rate on UK remained near baseline and increased significantly on US. The increase on US was primarily due to a change in staffing on that unit. Targets for 3rd quarter have been established.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

Strategic Objectives							
Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Pyxis CII Safe Comparison *Daily and monthly comparison of Pyxis vs CII Safe transactions*	Sept-Oct 2	0	0	0	0	0	CII Safe implemented 8/28/12 with goal of zero inaccurate transactions occurring; 100% resolution of errors
Quarterly Results	1						
Medication Room Audits *Monthly comprehensive audits of 14 criteria*	Apr-June 100%	100%	100%	100%	100%	100%	
Quarterly Results		92%					Unit inspections completed for July and August only.
Pyxis Discrepancies *Monthly monitoring and trending of Pxyis discrepancies.*	Aug-Nov 107/mo	107	107	50	50	50/mo	Target goal is 50/month discrepancies after 6 months of Pyxis use
Quarterly Results		128					
Pyxis Overrides *Monthly monitoring and trending of Pyxis overrides for controlled drugs*	Aug-Nov 25/month	25	25	10	10	10/mo	Target goal is 10/month after 6 months of Pyxis use
Quarterly Results		32					
Fiscal Accountability	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions *Monitoring and Tracking of dispensed Discharge Prescriptions*							Data collection and analysis being implemented and will be reported retrospectively

STRATEGIC PERFORMANCE EXCELLENCE

Program Services

Define

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

Measure

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

Analyze

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

Improve

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

Control

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Program Services
Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 7-5-5 7-7-7	 85% 100%	**14 weekly**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	6-6-5		
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	7-7-7		
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	3/ 30 0-0-30%	10%	**100%**
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	**100%**
7. **The client is able to state who his primary staff is**	30/30	100%	**100%**

EVALUATION OF EFFECTIVENESS

Evenings groups have remained the same and attendance the same in spite of a lower census in December and November. Day groups have been less stable with facilitators not always the same and the groups sometimes changed at the last moment due to acuity on the unit. The clients attending seem to enjoy the groups.

ISSUES

This is the first month with any of the on unit groups being reflected in the treatment plans. 3 out of 10 charts have the on units groups reflected for a 30% monthly but only 10% for the quarter. LK still needs to come up with a group offering on the unit for the weekends.

ACTIONS

Have developed two templates that staff can use to document client attendance. One is already in Meditech while the other is formatted in Microsoft and must be copied and pasted into Meditech. Will continue to work on consistency and capturing active treatment on unit before attempting to increase the number of group offerings. Again, this indicator reflects only the on unit groups facilitated by nursing and MHWs. Four active treatment groups are offered Monday through Friday on the unit for those unable to attend the treatment mall. Will discuss with the PSD and RN IVs the need to provide active treatment 7 days a week for the clients unable to attend the treatment mall.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services
Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 5-5-0 5-5-5	 35% 71%	**14 weekly**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	3-3-0		
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	4-3-2		
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	0/ 0 0-0-0%	0%	**100%**
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	**100%**
7. **The client is able to state who his primary staff is**	30/30	100%	**100%**

EVALUATION OF EFFECTIVENESS

Upper Kennebec has struggled with on unit groups. In October, Focus Group was offered 5 days a week with a fair response. UK typically has more of a treatment mall attending milieu. Evenings groups were more of a leisure nature and again, showed fair response in October.

November and December, group facilitation was sporadic at best. Many of the clients on UK attend the mall during the day and afternoon. In the evening, they prefer the computer lab and gym rather than the unit groups.

ISSUES

Inconsistency of groups being provided especially on first shift. Minimal documentation in Meditech.

Second shift has been more consistent in providing groups, more leisure in nature but attendance is sparse. Some of the clients report that since they routinely attend the treatment mall during the day and afternoon that they prefer not to go to groups on the unit in the evening.

ACTIONS

Will have RN IV meet with staff to look at what offerings might be made to encourage especially clients who do not attend the treatment mall to engage in some type of therapeutic activity on the unit. Will recommend perhaps an off unit activity or group that clients with a level 3A might attend if the preference is to do something off unit. As long as it is an offering for those who cannot attend the mall, it would benefit the clients in need.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services
Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	Main/SCU 4 / 5 5 / 5	 64% 71%	 **7 / 7 = 14** **7 / 7 = 14**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	3 / 1.5		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	3.5/ 1		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	0	0%	**100%**
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	**100%**
7. **The client is able to state who his primary staff is**	27/30	90%	**100%**

EVALUATION OF EFFECTIVENESS

ISSUES

The Lower Saco unit has made a start at offering on-unit groups, although the documentation in the medi-tech is sporadic. There is no evidence that this treatment effort is being reflected in the treatment plans.

ACTIONS

I have discussed this issue with some of the staff. I will meet with the Nursing leadership and the Treatment Team Coordinator to make sure these groups get prescribed in the treatment plans and bring documentation shortfalls to the staff meeting agendas.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services
Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	6 10	86% 100%	**Days/ Even.** **7 / 7 = 14**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	2 Avg.		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	4 Avg.		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	0	0%	**100%**
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	**100%**
7. **The client is able to state who his primary staff is**	30/30	100%	**100%**

EVALUATION OF EFFECTIVENESS

ISSUES

The Upper Saco unit has made a good start at offering on-unit groups, although the documentation in the Medi-tech is sporadic. There is no evidence that this treatment effort is being reflected in the treatment plans.

ACTIONS

I have discussed this issue with some of the staff. I will meet with the Nursing leadership and the Treatment Team Coordinator to make sure these groups get prescribed in the treatment plans and bring documentation shortfalls to the staff meeting agendas.

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Vocational Incentive Program Treatment Plans *The objective of this improvement project is to ensure vocational treatment plans are initiated on all clients within 5 days of beginning work and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.*	55%	70%	85%	100%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	Treatment plans were completed in a timely fashion but the review and updates were not consistent. Documentation is not always done on a weekly basis. Goal for next quarter is to increase by 15%.
Quarterly Results		77%					

Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Client/Staff Injuries in the Gym (to start in the second quarter) *The objective of this improvement project is to reduce/eliminate staff/client injury in the gym by increasing education on the proper techniques for equipment use as well as proper techniques for other activities in done in the gym. This will also include education on performing environmental checks of the area to ensure there are no safety issues.*							
Quarterly Results		No injuries during the quarter					

APS Healthcare

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

Quarterly Report 60a for Members on MaineCare Waitlist for CI

Report Dates: 07/01/2012 To 09/30/2012 **Report Run Date: 1/15/2013**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **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 authorization start date of the service to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare 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 215

For those who received the service: Average number of days waiting: 17 days

Percent waiting 30 days or less: 79% Percent waiting 90 days or less: 99%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
AMHI Class N	201	195	6	158	41	2	18
AMHI Class Y	14	13	1	12	2	0	9
Totals	**215**	**208**	**7**	**170**	**43**	**2**	**17**

CSN	# 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
CSN 2 Hancock, Washington, Penobscot, and Piscataquis	19	19	0	13	6	0	20
CSN 3 Kennebec and Somerset	2	1	1	2	0	0	4
CSN 4 Knox, Lincoln, Sagadahoc, and Waldo	1	0	1	1	0	0	0
CSN 5 Androscoggin, Franklin, and Oxford	12	11	1	12	0	0	7
CSN 6 Cumberland	89	88	1	80	9	0	10
CSN 7 York	80	77	3	52	26	2	26
Unknown	12	12	0	10	2	0	18
Totals	**215**	**208**	**7**	**170**	**43**	**2**	**17**

APS Healthcare

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

Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
Acadia Healthcare	16	16	0	11	5	0	17
Charlotte White Center	1	1	0	1	0	0	21
Common Ties	1	0	1	1	0	0	18
Community Care	2	2	0	2	0	0	20
Counseling Services Inc.	107	104	3	71	34	2	25
Dirigo Counseling Clinic	1	1	0	1	0	0	5
Maine Behavioral Health Organization	1	1	0	1	0	0	0
Sweetser	8	7	1	6	2	0	19
The Opportunity Alliance	78	76	2	76	2	0	6
Totals	**215**	**208**	**7**	**170**	**43**	**2**	**17**

APS Healthcare

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

Quarterly Report 60b for People on State-funded Waitlist for CI

Report Dates: 07/01/2012 To 09/30/2012 **Report Run Date: 1/15/2013**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **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 authorization start date of the service to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare 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: 48

For those who received the service: Average number of days waiting: 34 days

Percent waiting 30 days or less: 52% Percent waiting 90 days or less: 96%

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	45	5	40	22	21	2	36
AMHI Class Y	3	0	3	3	0	0	5
Totals	**48**	**5**	**43**	**25**	**21**	**2**	**34**

CSN	# 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
CSN 1 Aroostook	2	1	1	2	0	0	5
CSN 2 Hancock, Washington, Penobscot, and Piscataquis	5	2	3	3	1	1	41
CSN 3 Kennebec and Somerset	1	0	1	1	0	0	0
CSN 4 Knox, Lincoln, Sagadahoc, and Waldo	6	1	5	5	1	0	15
CSN 5 Androscoggin, Franklin, and Oxford	6	1	5	3	3	0	21
CSN 6 Cumberland	15	0	15	10	4	1	25
CSN 7 York	13	0	13	1	12	0	64
Totals	**48**	**5**	**43**	**25**	**21**	**2**	**34**

APS Healthcare

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

Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
Aroostook Mental Health Services	1	0	1	1	0	0	9
Catholic Charities Maine	1	0	1	0	1	0	51
Common Ties	1	0	1	1	0	0	5
Community Care	4	2	2	2	1	1	51
Community Counseling Center	5	0	5	4	1	0	18
Counseling Services Inc.	14	0	14	1	12	1	66
Health Affiliates Maine	1	0	1	1	0	0	0
Life by Design	1	1	0	1	0	0	0
Sweetser	5	0	5	4	1	0	10
The Opportunity Alliance	10	2	8	7	3	0	22
Tri-County Mental Health	3	0	3	2	1	0	12
Umbrella Mental Health Services	2	0	2	1	1	0	31
Totals	**48**	**5**	**43**	**25**	**21**	**2**	**34**

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
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Location Effort Report
Quarters 3 and 4, Fiscal Year 2012, Quarters 1 and 2, Fiscal Year 2013
(January 2012 – January 2013)

The DHHS Office of Substance Abuse and Mental Health Services (SAMHS) continued its efforts to maintain current, accurate addresses for *Bates v. DHHS Consent Decree* class members. Address information is entered into and tracked through the DHHS EIS (Enterprise Information System – electronic database).

During the 3rd and 4th quarters of FY12, and the 1st and 2nd quarters of FY13, Data Specialists within the Office of Substance Abuse and Mental Health Services (SAMHS) have utilized the following sources for the purpose of locating class members for whom the SAMHS does not have a verified address:

- Department of Motor Vehicles
- APS Healthcare
- Riverview Psychiatric Center Admission and Discharge Data Sheets
- Census lists from participating Correctional Facilities
- Internet searches (White Pages, Google, Zaba Search, Infobel, etc)
- Newspaper obituaries
- Social Security Death Index

SAMHS received address information from the following sources that was used to update address information in EIS:

- US Postal Service (forwarding information)
- Demographic information and assessments in EIS

As SAMHS can not verify addresses directly through Social Security (SS), the Data Specialists send all returned letters to the SS office in clean envelopes that then are forwarded to clients for whom SS has an address. The SS office returns a list noting those that they forwarded and anyone who may be deceased. SAMHS keeps the returned letters with the annual Location Efforts Report. Unverified are only sent annually at the request of the SS Administration.

In December 2012, the Data Specialists sent an annual mailing to all class members who are not in service (including class members living out of state) to inform them of the services that may be available to them in Maine, along with contact information for Field Quality Management (QM) Specialists. 'Not in service' is defined as not receiving Community Support Services (Community Integration, Community Rehabilitation Services and Assertive Community Treatment). All letters include a self-addressed, postage paid post card to be mailed back with address changes. If a letter is returned, it is re-sent if updated address information can be obtained through the aforementioned process.

Address information is entered into EIS on a continuous basis. Data Specialists keep documentation as to who received the annual mailing both in state and out of state, the response (numbers of postcards returned, number of postcards requesting contact from a CDC, letters returned, etc.), as well as an annual list of all class

members, including those who are deceased. Any returned contact with client comments is forwarded to the Field QM Specialist in the area where the client resides or to the assigned Out of State coordinator.

On 10/16/09, the Department formally requested to amend the Stipulated Order of February 1997 to change quarterly mailings to class members to an annual mailing. Permission to move to a mailing twice a year for calendar 2010 was approved. If monitored unverified addresses remained at or below 15% during that year, mailings could occur annually. SAMHS is now doing a mailing on an annual basis. The percentage for this report is 9.5% (413 of 4330) class members.

See table below for current data regarding class member numbers and location efforts.

LOCATION EFFORT SUMMARY: Bates v. DHHS Consent Decree
(As of January 28, 2013)

FISCAL YEAR AND QUARTER	FY09 Q2 OCT-DEC	FY09 Q3 JAN-MAR	FY09 Q4 APR-JUN	FY10 Q1 JUL-SEPT	FY10 Q2 OCT-DEC	FY10 Q3,Q4 JAN-JUN	FY11 Q1,Q2 JUL-DEC	FY11 Q3,Q4 FY12 Q1, Q2 JAN-JAN	FY12 Q3,Q4 FY13 Q1, Q2 JAN-JAN
TOTAL CLASS MEMBERS (NOT DECEASED)	4168	4184	4193	4199	4204	4222	4244	4275	4330
LETTERS SENT (CLIENTS NOT IN SERVICE OR IN JAIL OR HOSPITALS OR NO CONTACT)	1867	1768	1830	1784	1792	1909	1931	1967	2040
LETTERS RETURNED	220	63	280	152	141	214	237	409	581
LETTERS RESENT	162	53	131	97	158	178	152	273	212
CDC CARDS RETURNED	138	116	24	106	93	101	99	23	12
LETTERS SENT FOR SS VERIFICATION	33	27	41	0	0	14	10	0	0
UNVERIFIED	455	458	424	472	467	451	459	450	413
RESIDING IN A TEMPORY RESIDENCE					289	297	334	340	353
VERIFIED IN STATE	3115	3099	3120	3052	2918	2931	2909	2940	2901
VERIFIED OUT OF STATE	346	333	331	371	321	325	326	326	428
NO CONTACT IN STATE	116	126	135	140	149	151	156	162	174
NO CONTACT OUT OF STATE	47	52	54	55	57	60	60	57	61
DECEASED	1129	1144	1160	1183	1211	1233	1250	1348	1417

TEMPORARY RESIDENCE REFERS TO ANY FEDERAL, STATE, OR COUNTY CORRECTIONAL FACILITY , HOMELESS SHELTER, OR PSYCHIATRIC CENTER