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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February 1, 2014

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

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

Dear Dan:

Enclosed, pursuant to paragraph 280 of the Settlement Agreement, please find the Substance Abuse and Adult Mental Health Services Quarterly Report for the quarter ending Dec 31, 2013.

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 2013: 2nd Quarter, SFY 2014
CONSENT DECREE REPORT

SUMMARY
(Section 1A)

The DHHS Office of Substance Abuse and Mental Health Services is required to report to the Court quarterly regarding compliance and progress toward meeting specific standards as delineated in the Bates v. DHHS Consent Decree Settlement Agreement, the Consent Decree Plan of October 2006, and the Compliance Standards approved October 29, 2007. The following documents are submitted as the Quarterly Progress Report for the second quarter of state fiscal year 2014, covering the period from October through December, 2013. A link to the PDF version of each document is provided on the SAMHS website.

	DOCUMENT	DESCRIPTION
1	**Cover Letter, Quarterly Report:** February, 2014 *Section 1* Microsoft Word or Adobe PDF	Letter to Dan Wathen, Court Master, submitting the Quarterly Report pursuant to paragraph 280 of the Settlement Agreement for the quarter ending December 31, 2013.
2	**Report on Compliance Plan Standards: Community** *Section 2* Microsoft Word or Adobe PDF	Lists and updates the information pertaining to standards approved in October 2007 for evaluating and measuring DHHS compliance with the terms and principles of the Settlement Agreement.
3	**Performance and Quality Improvement Standards** *Section 3* Adobe PDF	Details the status of the Department's compliance with 34 specific performance and quality improvement standards (many are multi-part) required by the Consent Decree October 2006 Plan for this reporting quarter. Reporting includes the baseline, current level, performance standard, and compliance standard for each, including graphs.
4	**Public Education – Standard 34.1** *Section 4* Excel Version or Adobe PDF	Amplifies Standard 34.1 of the Performance and Quality Improvement Standards above, detailing the mental health workshops, forums, and presentations made, including levels of participation
5	**Performance Quality and Improvement Standards, Appendix: Adult Mental Health Data Sources** *Section 5* Microsoft Word or Adobe PDF **Consent Decree Performance and Quality Improvement Standard 5.** *Section 5A* 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. Aggregate report of assignment time to service and completion time of Individual Support Plans (ISPs). Data gathered from Contact for Service Notifications, Prior Authorizations, and Continued Stay Requests via APS Care Connections.

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

	DOCUMENT	DESCRIPTION
	Microsoft Word or Adobe PDF	
14	**APS Healthcare Reports** *Section 14* Adobe PDF	For members on the Community Integration waitlist who were authorized for this service, how long they waited. These reports count the number of days from the date the CFSN was opened to the date the service was authorized. The reports are run 2 quarters behind, therefore, those who were entered on the waitlist will have started the service.
15	**Location Effort Report** *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 Substance Abuse and Mental Health Services
Second Quarter State Fiscal Year 2014
Report on Compliance Plan Standards: Community
February 1, 2014

	Compliance Standard	Report/Update
I.1	Implementation of all the system development steps in October 2006 Plan	As of March 2010, all 119 original components of the system development portion of the Consent Decree Plan of October 2006 have been accomplished or deleted per amendment.
I.2	Certify that a system is in place for identifying unmet needs	See attached *Cover: Unmet Needs February 2014* and *Unmet Needs by CSN for FY14 Q1. Found in Section 7.*
I.3	Certify that a system is in place for Community Service Networks (CSNs) and related mechanisms to improve continuity of care	The Department's certification of August 19, 2009 was approved on October 7, 2009.
I.4	Certify that a system is in place for Consumer councils	The Department's certification of December 2, 2009 was approved on December 22, 2009.
I.5	Certify that a system is in place for new vocational services	The Department certification of September 17, 2011 was approved November 21, 2011.
I.6	Certify that a system is in place for realignment of housing and support services	All components of the Consent Decree Plan of October 2006 related to the Realignment of Housing and Support Services were completed as of July 2009. Certification was submitted March 10, 2010. The Certification Request was withdrawn May 14, 2010.
I.7	Certify that a system is in place for a Quality Management system that includes specific components as listed on pages 5 and 6 of the plan	Department of Health and Human Services Office of Adult Mental Health Services Quality Management Plan/Community Based Services (April 2008) has been implemented; a copy of plan was submitted with the May 1, 2008 Quarterly Report. A new quality improvement plan for 2013-2018 is being developed.
II.1	Provide documentation that unmet needs data and information (data source list page 4 of compliance plan) is used in planning for resource development and preparing budget requests	Unmet needs reports are posted on the SAMHS website on a quarterly basis in order to inform discussions and recommendations to the Department for meeting unmet needs. Budget submissions to the Governor and the Legislature are in part built on data regarding unmet needs. This is reflected in the financial documents submitted to DAFS.
II.2	Demonstrate reliability of unmet needs data based on evaluation	See *Cover: Unmet Needs and Quality Improvement Initiatives February 2014* and the *Performance and Quality Improvement Standards: February 2014* for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data. SAMHS is reviewing the reliability of the unmet needs data. From this review, a plan will be developed to provider training and technical assistance on identifying, recording and implementing services for unmet needs.
II.3	Submission of budget proposals for adult	The Director of SAMHS provides the Court Master

	mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs *(Amended language 9/29/09)*	with an updated projection of needs and associated costs as part of his ongoing updates regarding Consent Decree Obligations.
II.4	Submission of the written presentation given to the legislative committees with jurisdiction over DHHS … which must include the budget requests that were made by the Department to satisfy its obligations under the Consent Decree Plan and that were not included in the Governor's proposed budget, an explanation of support and importance of the requests and expression of support … *(Amended language 9/29/09)*	See above.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	MaineCare and Grant Expenditure Report for FY11 and FY12 was provided in the May 2013 report. The next report will be provided in the May 2014 report.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs February 2014* and the *Performance and Quality Improvement Standards: February 2014* for examples of the Department Utilizing the QM system.
III.1a	Document through quarterly or annual reports the data collected and activities to assure reliability (including ability of EIS to produce accurate data)	This quarterly report documents significant data collection and review activities of the SAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	See compliance standards II.3 and II.4 above for examples of how quality management data was used to support budget requests for systems improvement.
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Contract and licensing reviews are conducted as licenses expire. A report from DLRS is included; during the last quarter 29 of 29 agencies had protocol/procedures in place for client notification of rights.
IV.2	If results from the DIG Survey fall below levels established for Performance and Quality Improvement Standard 4.2, 90% of consumers report they were given information about their rights, the Department: (i) consults with the Consumer Council System of Maine (CCSM); (ii) takes corrective action a determined necessary by CCSM; and (iii) develops that corrective action in consultation with CCSM. *(Amended language 1/19/11)*	The percentage for standard 4.2 from the 2012 DIG Survey was 89.9% (up from 88.6%in 2010). These data are posted on the SAMHS website and provided to the Consumer Council of Maine. SAMHS met to address the methodology used for the survey and to boost consumer participation in the survey to be distributed in the fall of 2013.
IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension.	Grievances have been responded to consistently over time. During the first quarter there was 1 Level II grievances filed; It was not responded to within the 5 day period.
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if hearing is to be held or if parties concur.	Reporting began in the 1st quarter of calendar year 2008. Standard has been consistently addressed. There have been no Level III grievances filed in FY14.
IV.5	90% hospitalized class members assigned	See attached *Performance and Quality Improvement*

	worker within 2 days of request - *must be met for 3 out of 4* quarters	*Standards: February 2014* Standard 5-2. This standard has not been met for the past 4 quarters.
IV.6	90% non-hospitalized class members assigned worker within 3 days of request - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 5-3. This standard has not been met for the past 4 quarters.
IV.7	95% of class members in hospital or community not assigned within 2 or 3 days, assigned within an additional 7 days - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 5-4. This standard has not been met for the past 4 quarters.
IV.8	90% of class members enrolled in CSS with initial ISP completed within 30 days of enrollment - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 5-5. This standard has not been met for the past 4 quarters.
IV.9	90% of class members had their 90 day ISP review(s) completed within that time period - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 5-6. This standard has not been met for the past 4 quarters.
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. As the data has been consistent over time and the feedback and interaction with providers had lessened greatly, reports are now created quarterly and available to providers upon request. Providers were notified of this change on May 18, 2011. Providers are notified when reports are run. Some do request copies. Feedback has been minimal.
IV.11	Data collected once a year shows that no > 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	The 2012 data analysis indicates that out of 1,398 records for review, that 84 (6%) did not have an ISP review within the prescribed time frame. 2013 Data being collected in January 2014 and will be reported 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%. Percentage of unverified addresses for the December 2012 mailing remained below 15%. Most recent mailing was completed December 2013 and the report will be provided in the February report.
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - *must be met for 3 out of 4 quarters*	See Section 9 *Class Member Treatment Planning Review*, Question 2A. This standard has been met in 4 out of the 4 quarters. The current percentage is 100.0%.
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be*	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 7-1a and *Class*

	met for 3 out of 4 quarters	*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 2014,* Standard 7-1c (does the consumer have a crisis plan) and *Class Member Treatment Planning Review*, Question 2F Standard met since the beginning of FY09
IV.16	QM system documents that SAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	See Section 9 *Class Member Treatment Planning Review*, Question 6.a.1 that addresses plans of correction. In 30.6% of cases, SAMHS required a correction action plan from providers.
IV.17	In 90% of ISPs reviewed, interim plans developed when resource needs not available within expected response times - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 8-2 and *Class Member Treatment Plan Review,* Question 3F. This standard has been met in 4 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 2014*, Standard 9-1 and *Class Member Treatment Plan Review,* Questions 4B & C. This standard has not been met in 3 of the past 4 quarters.
IV.19	90% of ACT/ICI/CI providers statewide meet prescribed case load ratios - *must be met for 3 out of 4 quarters* Note: As of 7/1/08, ICI is no longer a service provided by DHHS.	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 10.1 and 10-2 Community Integration -- standard met since the 2nd quarter FY08. ACT – standard met for the 2nd, 3rd and 4th quarters FY10; the 1st, 2nd and 4th quarters FY11; FY 12, FY13, and 1st and 2nd quarter FY14
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - *must be met for 3 out of 4 quarters*	ICMs' work is focused on community forensic and outreach services. Individual ICMs no longer carry caseloads. Should this change in the future, SAMHS will resume reporting on caseload ratios.
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 10-5. This standard has not been met in the last 4 quarters.
IV.21	Independent review of the ISP process finds that ISPs met a reasonable level of compliance as defined in Attachment B of the Compliance Plan	
IV.22	5% or fewer class members have ISP-identified unmet residential support - *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 12-1 Standard met for the 4th quarter FY08; the 1st, 3rd and 4th quarters of FY09; all quarters of FY10 and FY11; all 4

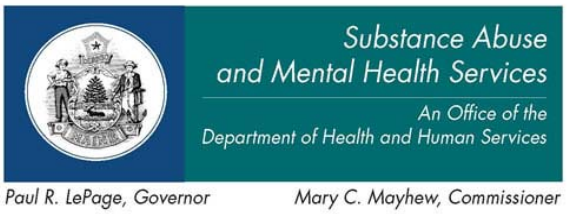
		quarters of FY12, FY13; and 1st quarter FY 14.
IV.23	**EITHER** quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status **and**	Unmet residential supports do not exceed 15 percentage points of Class Members. Reporting for this standard will be done again in July 2014. 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 2014*, Standards 12-2, 12-3 and 12-4 Standard met since the beginning of FY08.
IV.25	10% or fewer class members have ISP-identified unmet needs for housing resources - *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 14-1 Standard met in FY 2014 Q1 and 23 out of the last 27 quarters.
IV.26	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of housing resources. • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 14-4, 14-5 & 14-6 Standard 14-4 met since the beginning of FY09, except for Q3 FY10. Standard 14-5 met for the 2nd, 3rd and 4th quarters FY09; the 2nd and 4th quarters of FY10; FY11; FY12 FY13and 1st and 2nd quarter of FY 14. Standard 14-6 met for the 2nd and 4th quarters FY09; the 2nd and 4th quarters FY10; FY11; FY12, FY13, and 1st and 2nd quarters FY 14.
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Results reported in *Performance and Quality Improvement Standards: July 2010 Report*, Standard 15-1 This standard has been met since 2007. SAMHS submitted an amendment request to the court master to modify this requirement on November 23, 2011. The court master approved SAMHS' request to hold the 2011 annual review in abeyance pending a decision on the amendment request.
IV.28	90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in	See attached *Performance and Quality Improvement Standards: November2013*, Standard 16-1 and *Community Hospital Utilization Review – Class*

	attachment C to the Compliance Plan	*Members 4th Quarter of Fiscal Year 2013*. 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 92.9% (13 of 14) in the 2nd quarter 86.7% (13 of 15) in the 3rd quarter 90.0% (18 of 20) in the 4th quarter IN FY 14: 27.3 (3 of 11) in the 1st quarter
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	See IV.30 below
IV.30	Evaluates compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	All involuntary hospital contracts are in place.
IV.31	UR Nurses review all involuntary admissions funded by DHHS, take corrective action when they identify deficiencies and send notices of any violations to the licensing division and to the hospital	SAMHS reviews emergency involuntary admissions at the following hospitals: Maine General Medical Center, Spring Harbor, St. Mary's, Mid-Coast Hospital, Southern Maine Medical Center, PenBay Medical Center, Maine Medical Center/P6 and Acadia. See Standard IV.33 below regarding corrective actions.
IV.32	Licensing reviews of hospitals include an evaluation of compliance with patient rights and require a plan of correction to address any deficiencies.	6 Complaints Received 9 Complaints investigated 1 Substantiated 0 Plan of correction sought (plan already in place) 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 2014*, Standards 17-2a, 17-3a and 17-4a and *Community Hospital Utilization Review – Class Members 1st Quarter of Fiscal Year 2014*. Standards met for FY08, FY09, FY10, FY11, and FY12 Standards met for FY13, and 1st Quarter FY 14
IV.34	QM system documents that if hospitals have fallen below the performance standard for any of the following, SAMHS made the	See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members1st Quarter of Fiscal Year 2014*.

	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%)	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 for the past 4 quarters. Standard met for obtaining ISPs and creating treatment and discharge plans consistent with ISP; involving CWs in treatment and discharge planning was at 100% in 1st quarter FY 2014.
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 2014 Summary Report*. In FY11, standard met for the 1st quarter, with the 2nd (25.6%), 3rd (26.2%) and 4th (26.4%) quarters' results being slightly above the standard. In FY12, standard met all 4 quarters. In FY 13, standard met all 4 quarters. In FY 14, standard met 1st quarter, 2 quarter slightly above standard (26.3%)
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 S* *Second Quarter, State Fiscal Year 2014 Summary Report*. Starting with July 2008 reporting from providers, SAMHS collects data on the total number of minutes for the response time (calculated from the determination of need for face to face contact or when the individual is ready and able to be seen to when the individual is actually seen) and figures an average. Average statewide calls requiring face to face assessments are responded to within an average of 30 minutes from the end of the phone call was met for all 4 Quarters in FY12, 4 quarters in FY13 and 1st and 2nd quarter of FY14.
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 2014 Summary Report*. Standard has been met since the 2nd quarter of FY08.
IV.38	90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2013*, Standard 19-4 and *Adult Mental Health Quarterly Crisis Report Second Quarter, State Fiscal Year 2014 Summary Report*. Standard met 3 out of 4 quarters.
IV.39	Compliance Standard deleted 1/19/2011.	
IV.40	Department has implemented the components of the CD plan related to	As of quarter 3 FY10, the Department has implemented all components of the CD Plan related to Vocational

	vocational services	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)*	2012 Adult Health and Well-Being Survey: 9.1% 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 the findings at a Health Forum on July 18, 2013. The Department has requested feedback on recommendations from the Consumer Council on how they would like to see the data utilized. There has been no formal feedback as requested but SAMHS and the Consumer Counsel continue to meet on a monthly basis which provides a foundation for sharing information.
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 2014*, Standard 21-1 This standard has not been met for the prior 4 quarters.
IV.43	**EITHER** quarterly unmet mental health treatment needs for one year for qualified non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet mental health treatment needs do not exceed 15 percentage points of Class Members. Reporting for this standard will be done again in July 2014. 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**	2012 Adult Health and Well-Being Survey: 77.8% domain average of positive responses. The Director of the Office of Quality Improvement and staff from Office of Adult Mental Health quality management will present the results of the 2012 survey will be presented at an APS Forum in the fall of 2013. The Department has requested feedback on recommendations from the Consumer Counsel on how they would like to see the data utilized. There has been no formal feedback as requested but SAMHS and the Consumer Counsel continue to meet on a monthly basis which provides a foundation for sharing information.
IV.45	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of mental health treatment services in the community • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination	See attached *Performance and Quality Improvement Standards: February 2014*, Standards 21-2, 21-3 and 21-4 Standard met since the beginning of FY08

	• 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	
IV.46	SAMHS lists in quarterly reports the programs sponsored that are designed to improve quality of life and community inclusion, including support of peer centers, social clubs, community connections training, wellness programs and leadership and advocacy training programs – list must cover prescribed topics and audiences that fit parameters of ¶105.	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 30
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 28 This standard has been consistently met since FY08.
IV.48	Provide documentation in quarterly reports of funding, developing, recruiting, and supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	See attached *Performance and Quality Improvement Standards: February 2014*, Standard 23-1 and 23-2. NAMI Maine is the provider of the family support services.
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 2014*, Standard 34.1 and attached *Public Education Report for the past quarter*.



Consent Decree Performance and Quality Improvement Standards: February 2014

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

Starting fiscal year 2012, quarter 3, standard 5.2, 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 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.
Standard has been me	The most recent data available for the Standard.
Performance Standard:	Standard set as a component of the Department's approved Adult Mental Health Services Plan dated October 13, 2006.
Compliance Standard:	Standard set as a component of the Department's approved standards for defining substantial compliance approved October 29, 2007.

Calendar and Fiscal Year Definitions:

CY: Calendar Year - January 1 - December 31.

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

Compliance and Performance Standards: Summary Sheet
October - December 2013

Standard 1. Rights Dignity and Respect

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

Standard 2. Rights Dignity and Respect

Response to Level II Grievances within 5 days

Standard 3. Rights Dignity and Respect

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

Standard 4. Rights Dignity and Respect

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

Standard 5. Timeliness of ISP and CI/CSS Assignment

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

Standard 7. CI/CSS/ Individualized Support Planning

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

Standard 8. CI/CSS Individualized Support Planning

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

Standard 9. ISP Service Agreements

ISPs that require Service Agreements that have current Service Agreements

Compliance and Performance Standards: Summary Sheet
October - December 2013

Standard 10. Case Load Ratios

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

Standard 11. CI/CSS Individualized Support Planning

Paragraph 74. Needs of Class Members not in Service

Standard 12. Housing & Residential Support Services

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

Standard 13. Housing & Residential Support Services

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

Standard 14. Housing & Residential Support Services

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

Standard 15. Housing & Residential Services

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

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

Inpatient admissions reasonably near community residence.

Compliance and Performance Standards: Summary Sheet
October - December 2013

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

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

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

3. Admissions in which 24 hour certification completed.

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

4. Admission in which patients' rights were maintained

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

5. Admissions for which medical necessity has been established.

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

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

Standard 19. Crisis intervention Services

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

Standard 20. Crisis Intervention Services

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

Standard 21. Treatment Services

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

5.Class Members use an array of Mental Health Services

Standard 22. Treatment Services

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

Standard 23. Family Support Services

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

Compliance and Performance Standards: Summary Sheet
October - December 2013

Standard 24. Family Support Services

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

Standard 25. Family Support Services

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

Standard 26. Vocational Employment Services

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

Standard 27. Vocational Employment Services

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

Standard 28. Transportation

Class Members with ISPs - Unmet transportation needs.

Standard 29. Transportation

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

Standard 30. Rec/Soc/Avocational/Spiritual Opportunities

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

Standard 31. Rec/Soc/Avoc/Spirtual

1. ISP identified class member unmet needs in recreational/social/avocational/spiritual areas Social Connectedness domain

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

Standard 32. Individual Outcomes

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

Compliance and Performance Standards: Summary Sheet
October - December 2013

Standard 33. Recovery

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

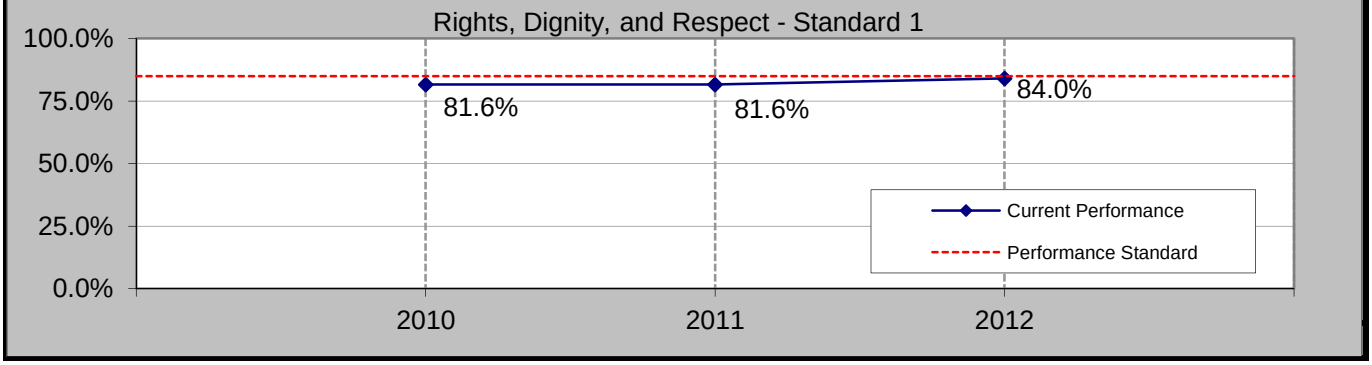
Standard 34. Public Education

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

Rights, Dignity, and Respect

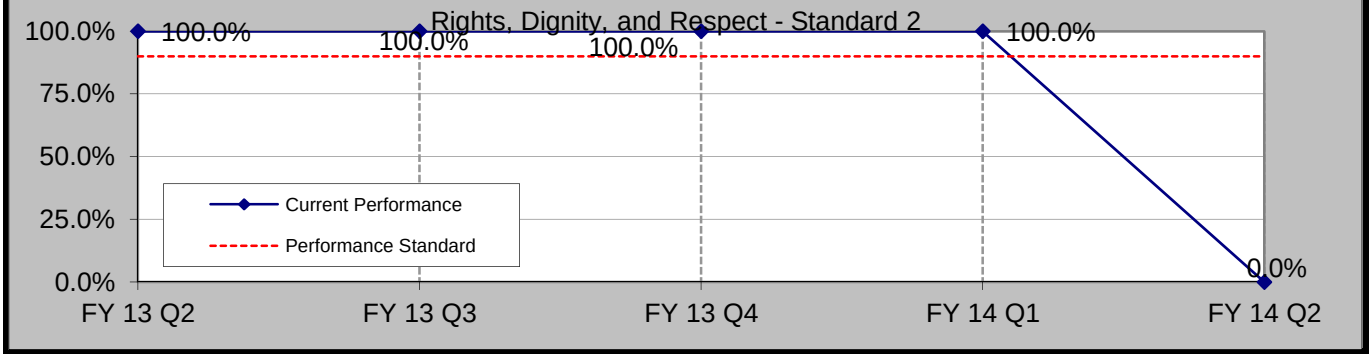
Standard 1 - Treated with respect for their individuality

Standard 1	
Measurement	Domain average of positive responses to the statements in the quality and appropriateness domain
Standard	Performance: at or above 85%
Data Source	Adult Mental Health and Well Being Survey
Current Level	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 FY14 Q1

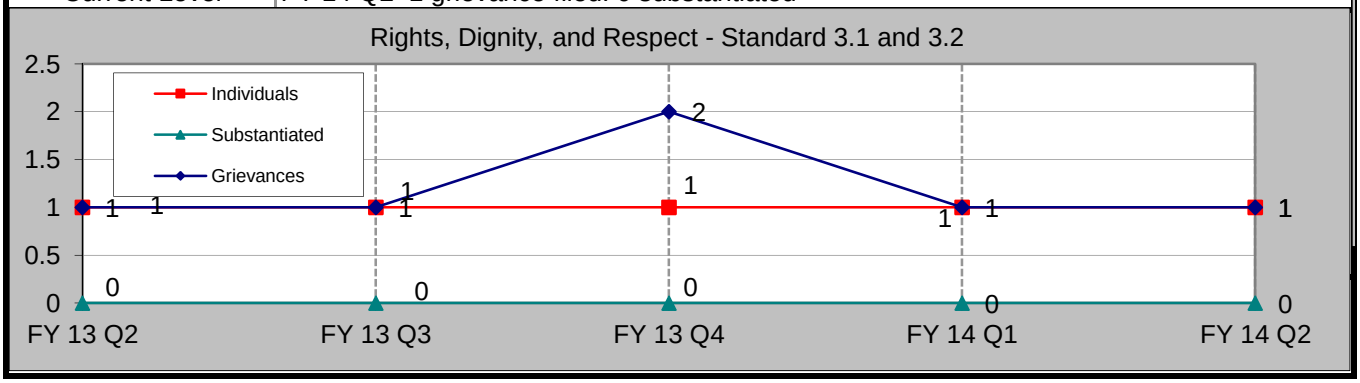


Rights, Dignity, and Respect

Standard 3 - Demonstrate rights are respected and maintained

Standard 3.1	
Measurement	Number of Level II grievances filed and number unduplicated people
Standard	No numerical standards necessary, ongoing monitoring of grievance trends.
Data Source	DHHS Grievance Tracking System
Current Level	FY 14 Q2 1 grievance filed. 1 individuals

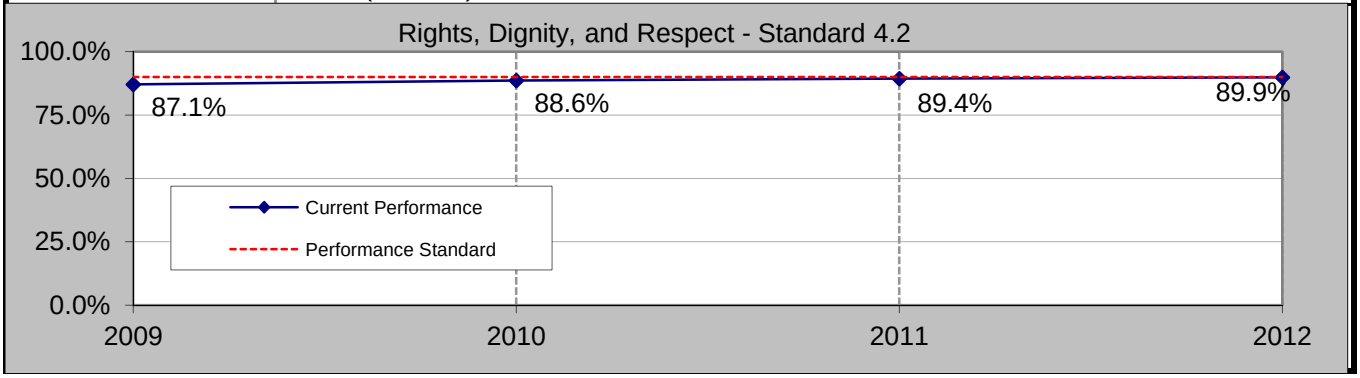
Standard 3.2	
Measurement	Number of Level II grievances filed where violation is substantiated
Standard	No numerical standards necessary, ongoing monitoring of grievance trends.
Data Source	DHHS Grievance Tracking System
Current Level	FY 14 Q2 1 grievance filed. 0 substantiated



Rights, Dignity, and Respect

Standard 4 - Class Members are informed of their rights

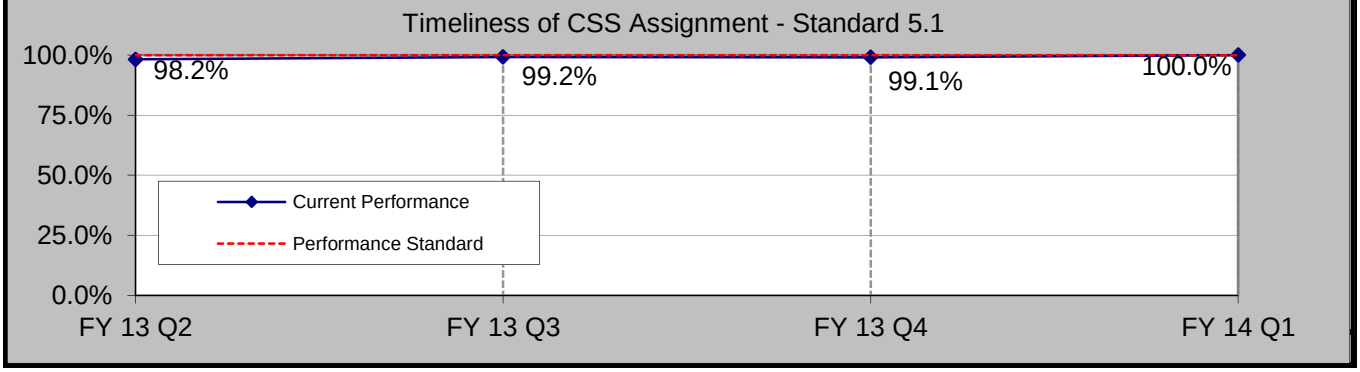
Standard 4.2	
Measurement	Percent of consumers reporting they were given information about their rights.
Standard	Performance: 90%
	Compliance: See explanation below.
Data Source	Adult Mental Health and Well Being Survey Q22
Current Level	89.9% (N=1309)



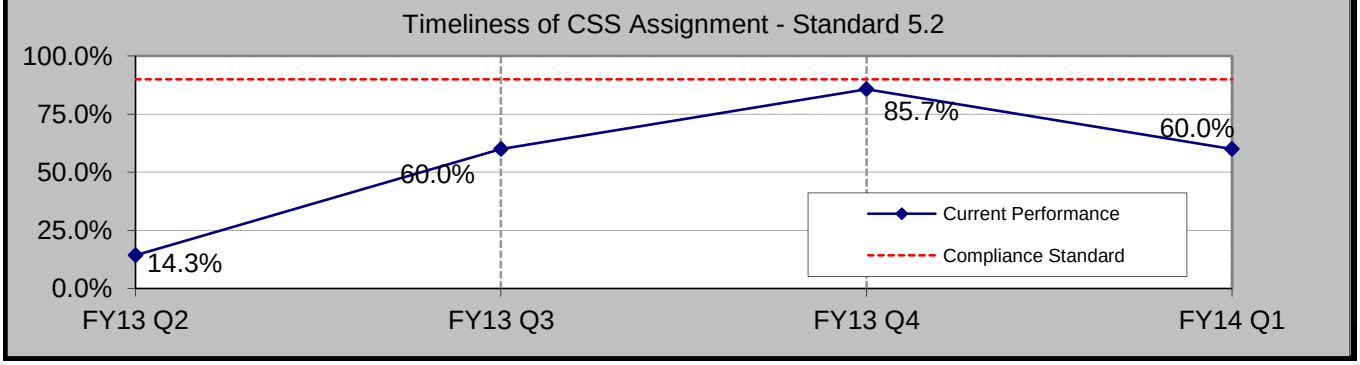
Community Integration / Community Support Services / Individualized Support Planning

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

Standard 5.1	
Measurement	Percentage of class members requesting a worker who were assigned one.
Standard	Performance: 100%
Data Source	APS Healthcare
Current Level	100.0% (120 out of 120)

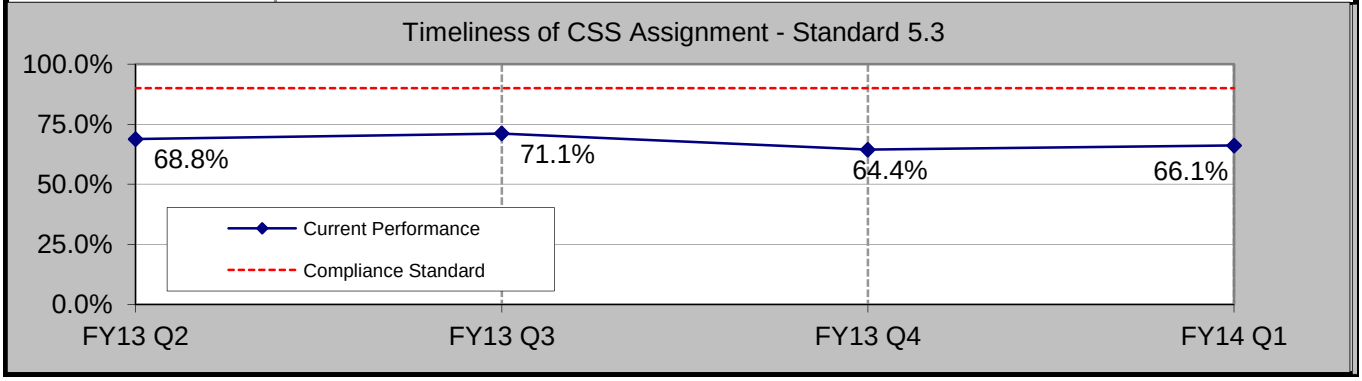


Standard 5.2	
Measurement	Percentage of hospitalized class members who were a assigned a worker within 2 working days.
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	APS Healthcare
Current Level	60.0% (3 out of 5)

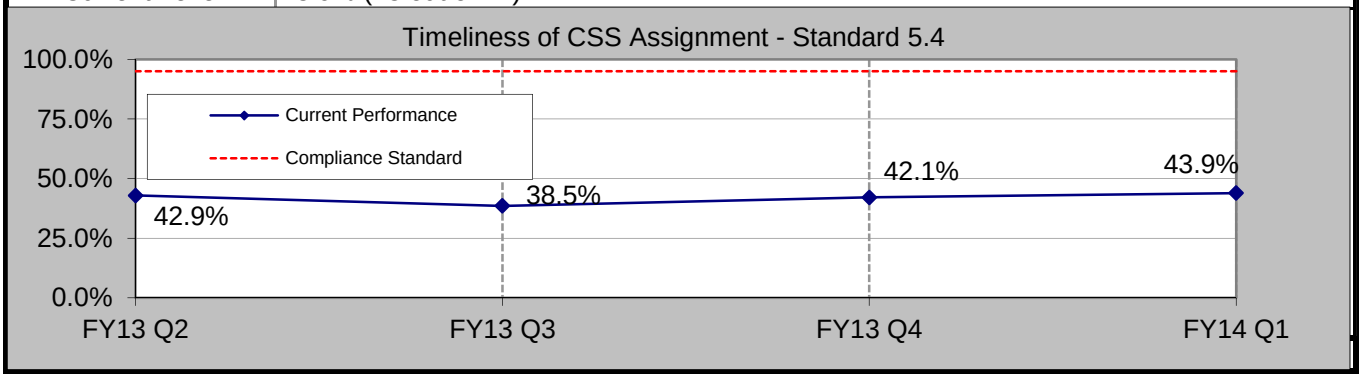


Community Integration / Community Support Services / Individualized Support Planning

Standard 5.3	
Measurement	Percent of non-hospitalized class members assigned a worker within 3 working days.
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	APS Healthcare
Current Level	66.1% (76 out of 115)

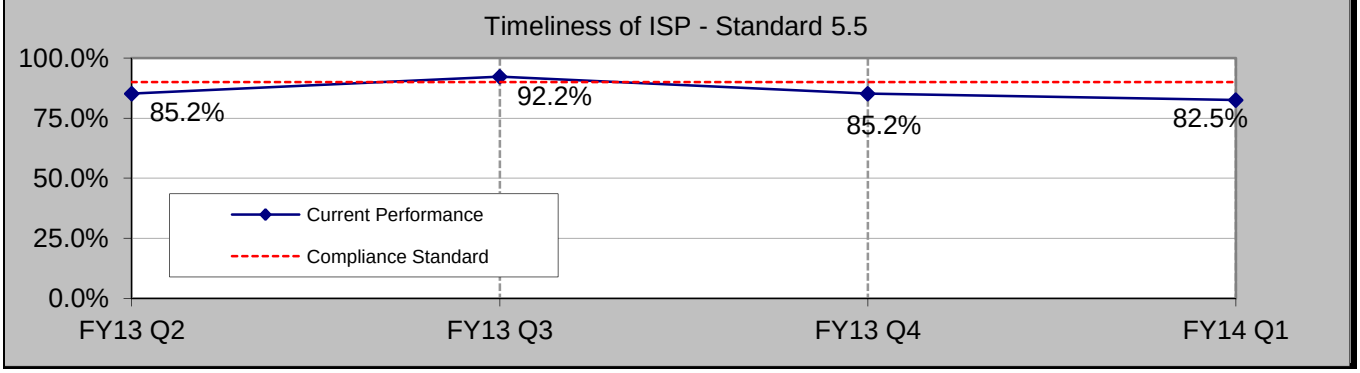


Standard 5.4	
Measurement	Percent of class members in hospital or community not assigned on time but were assigned within an additional 7 working days.
Standard	Performance: 100%
	Compliance: 95%
Data Source	APS Healthcare
Current Level	43.9% (18 out of 41)

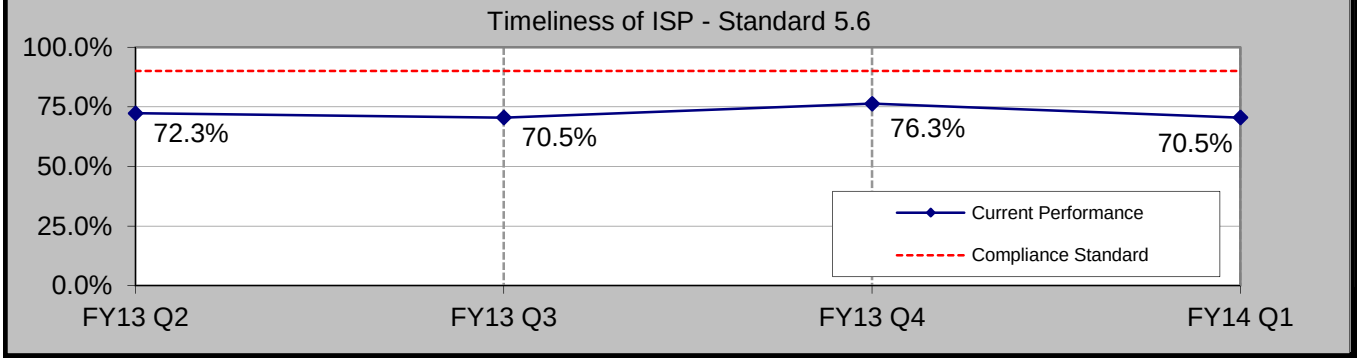


Community Integration / Community Support Services / Individualized Support Planning

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	82.5% (48 out of 56)

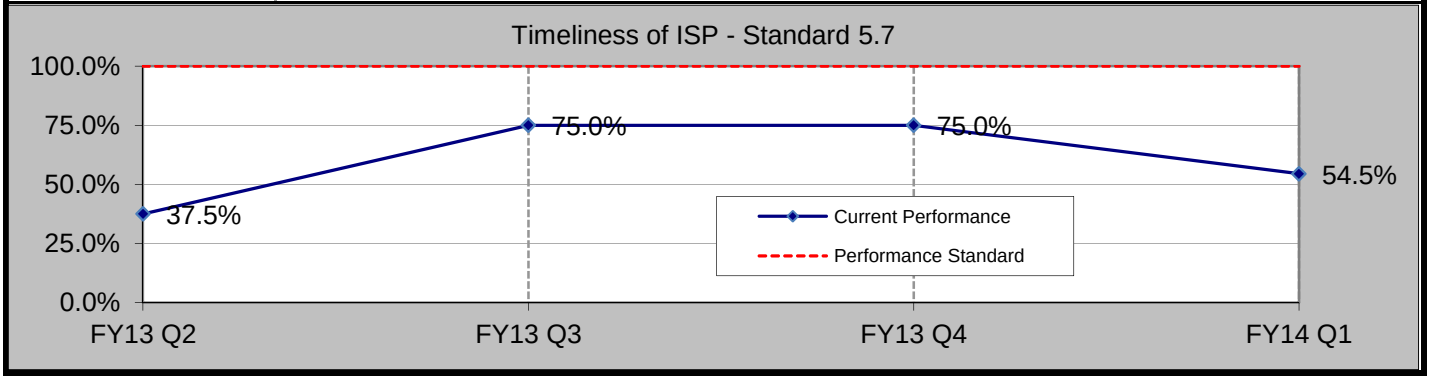


Standard 5.6	
Measurement	90 day class member ISP reviews completed within specified timeframe.
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	70.5% (732 out of 1039)

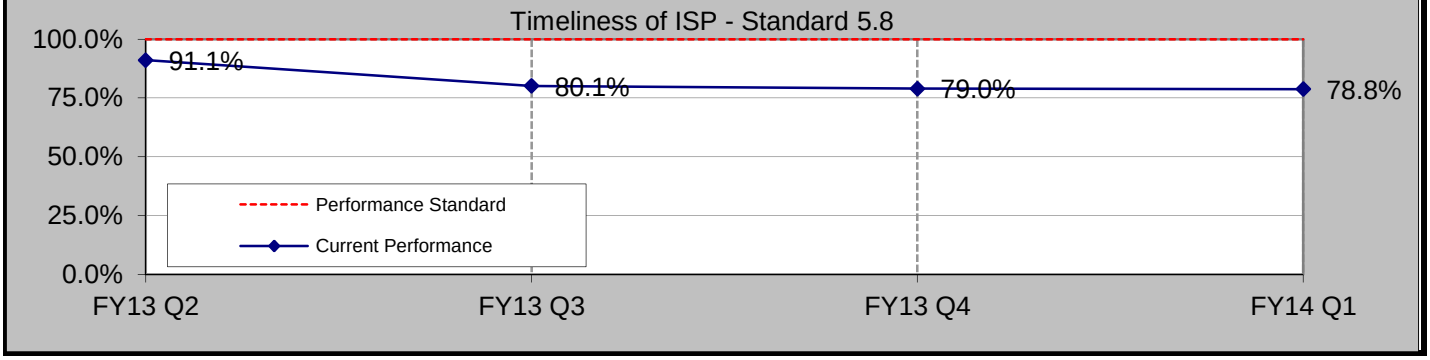


Community Integration / Community Support Services / Individualized Support Planning

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	54.5% (6 out of 11)



Standard 5.8	
Measurement	Class member ISPs that were not reviewed within 90 days but were reviewed within 120 working
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	78.8% (199 out of 252)



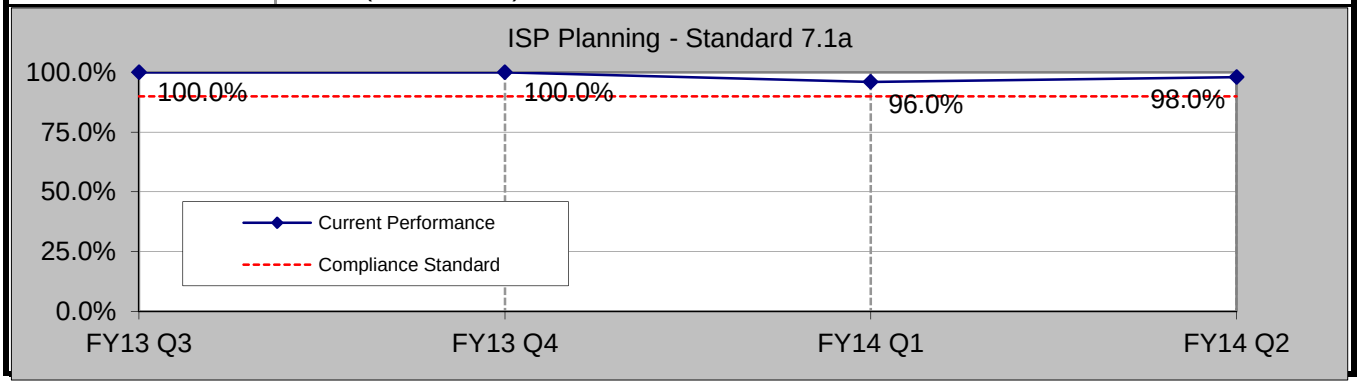
Discussion:

Standards 5.1 - 5.8: Field Quality Managers have completed additional agency trainings around assignment times. Assignment time performance measures are now included in Rider E of agency contracts. Data Quality Management Team will identify outliers for follow up by the treatment team and provider agencies driving these numbers.

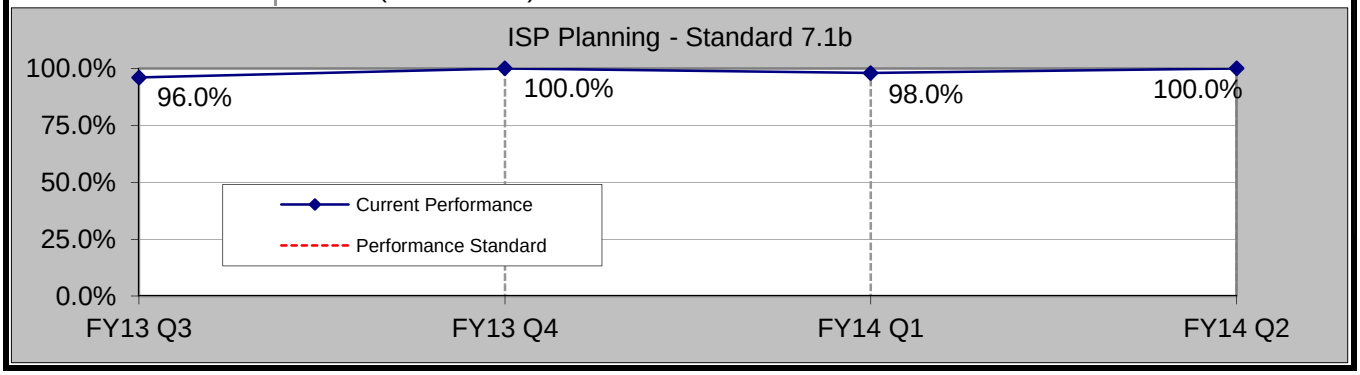
Community Integration / Community Support Services / Individualized Support Planning

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

Standard 7.1a	
Measurement	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?
Standard	Performance: 95% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	98.0% (48 out of 49)

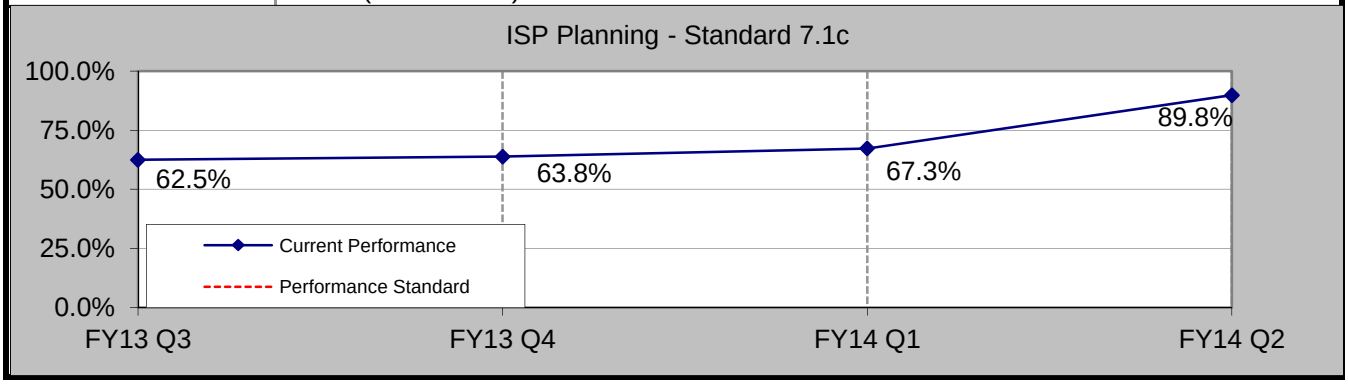


Standard 7.1b	
Measurement	Does record document the individual's potential need for crisis intervention and resolution services was considered during treatment planning?
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	100.0% (49 out of 49)

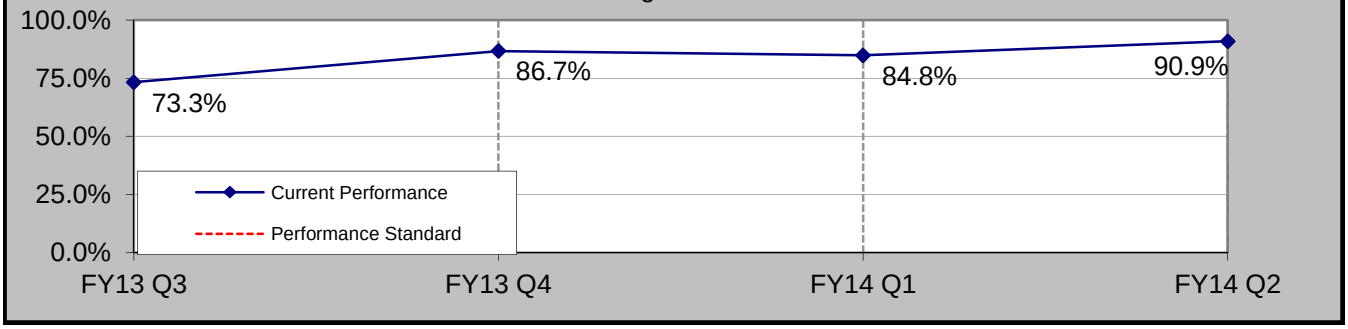


Community Integration / Community Support Services / Individualized Support Planning

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	89.8% (44 out of 49)



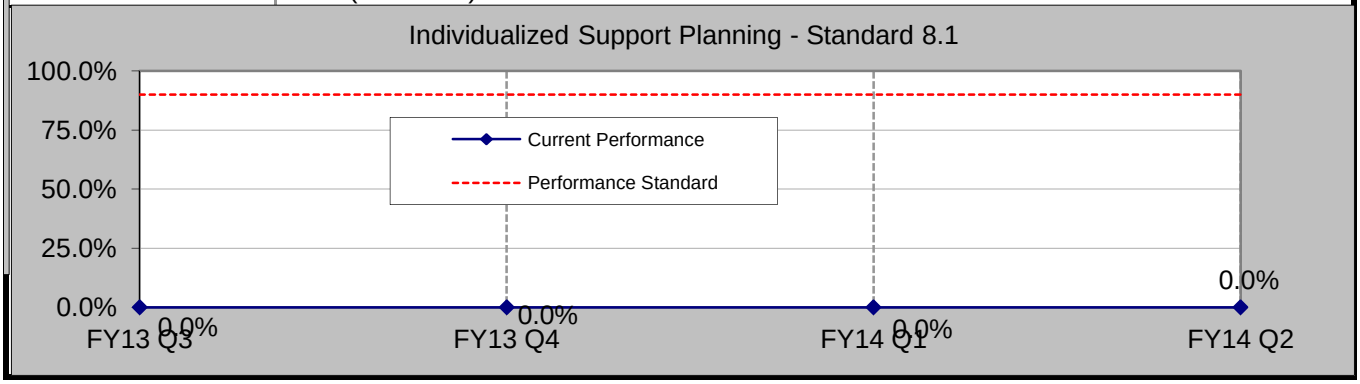
Standard 7.1d	
Measurement	If the consumer has a crisis plan, "has the crisis plan been reviewed as required, every 3 months?"
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	90.9% (40 out of 44)



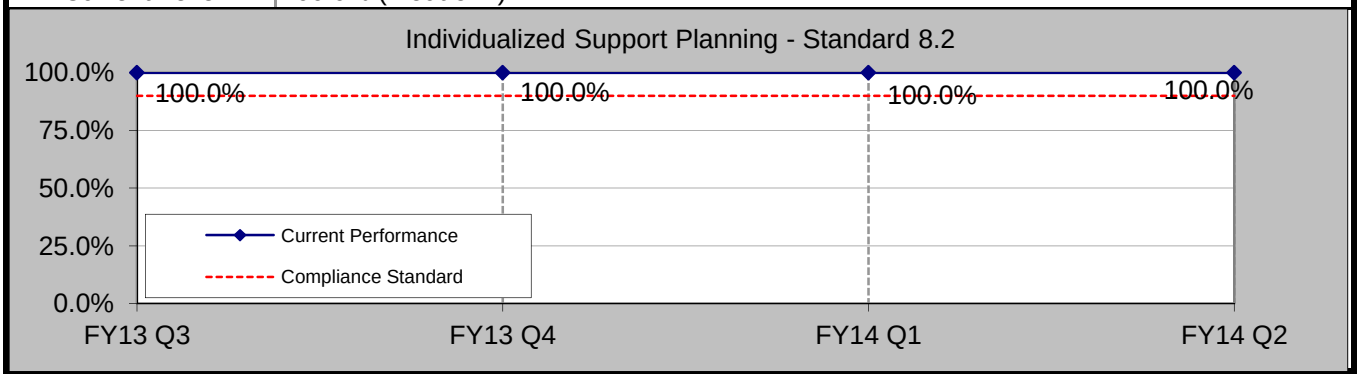
Community Integration / Community Support Services / Individualized Support Planning

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 1)



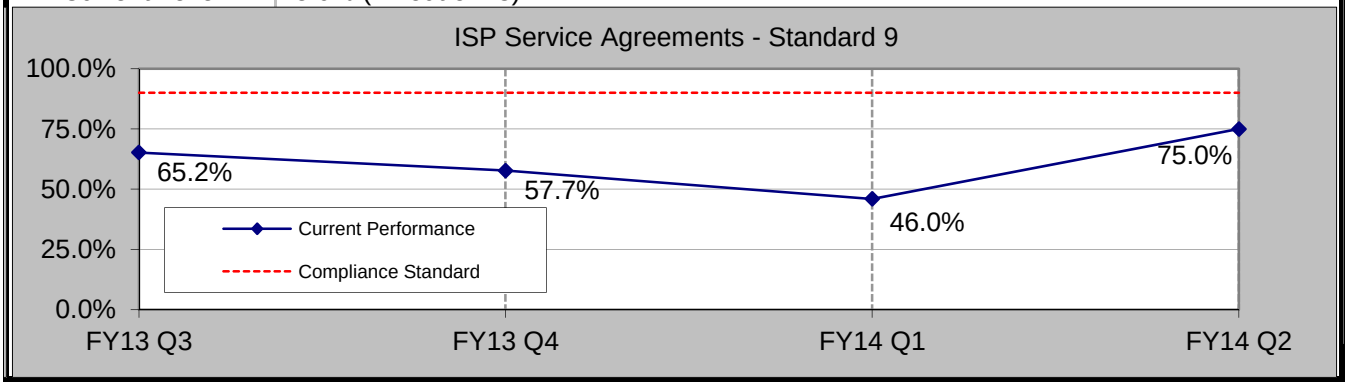
Standard 8.2	
Measurement	ISPs reviewed with identified unmet needs in which interim plans are established.
Standard	Performance: 95% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	100.0% (1 out of 1)



Community Integration / Community Support Services / Individualized Support Planning

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

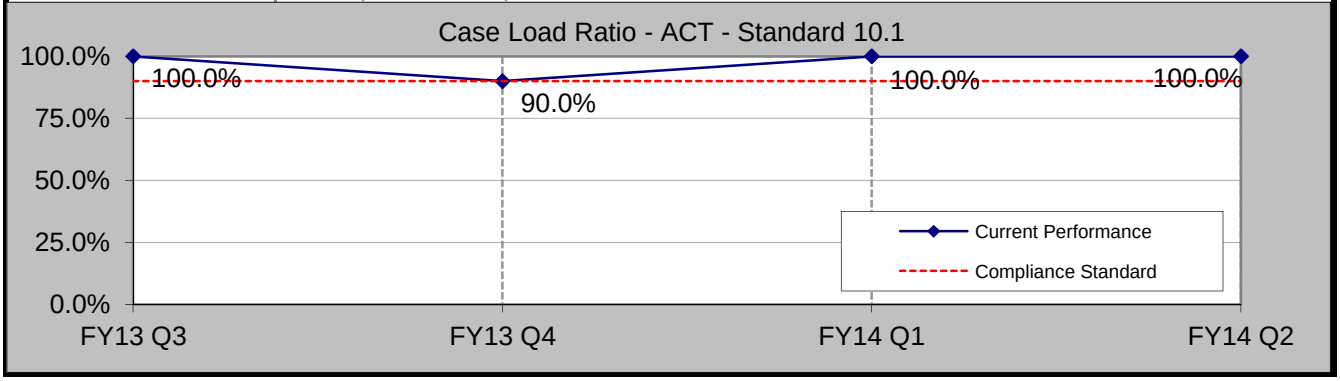
Standard 9	
Measurement	ISPs with services identified and with a treatment plan signed by each provider.**
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	75.0% (21 out of 28)



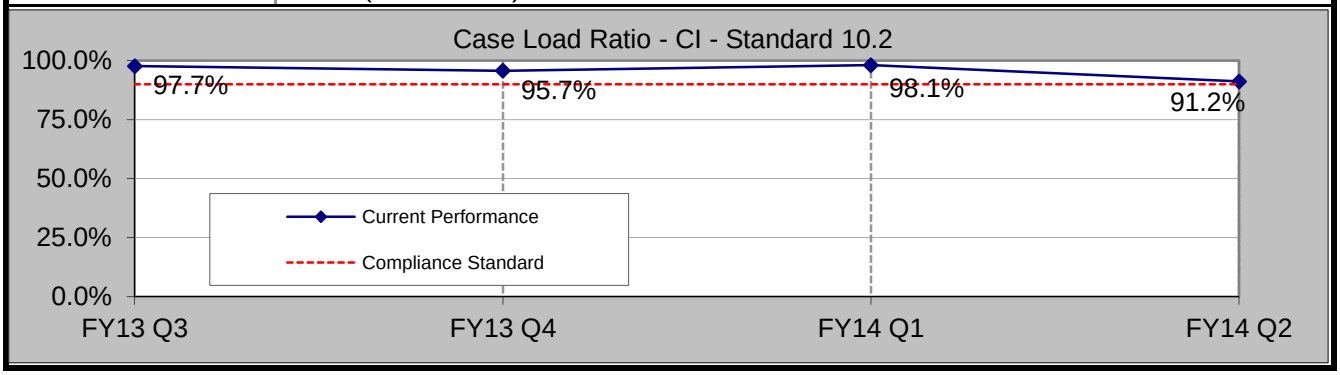
Community Integration / Community Support Services / Individualized Support Planning

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	100% (10 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	91.2% (52 out of 57)



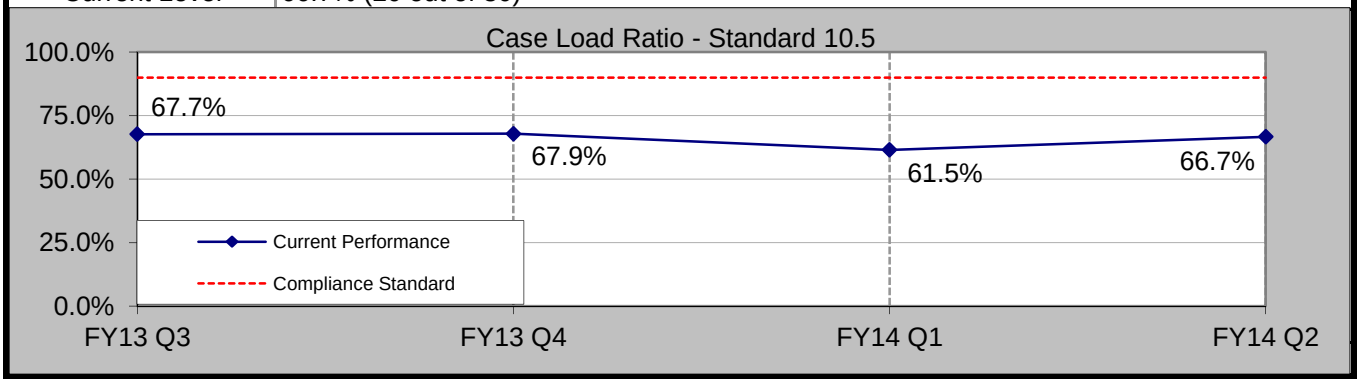
Discussion;

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

Community Integration / Community Support Services / Individualized Support Planning

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

Standard 10.5 - OADS	
Measurement	Office of Aging and Disability Services Case Managers with average caseload of 25 or fewer.
Standard	Compliance: 90% of all OADS Case Managers with Class Member Public Wards
Data Source	MAPSIS Case Counts for Workers with Class Members Public Wards
Current Level	66.7% (20 out of 30)



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.

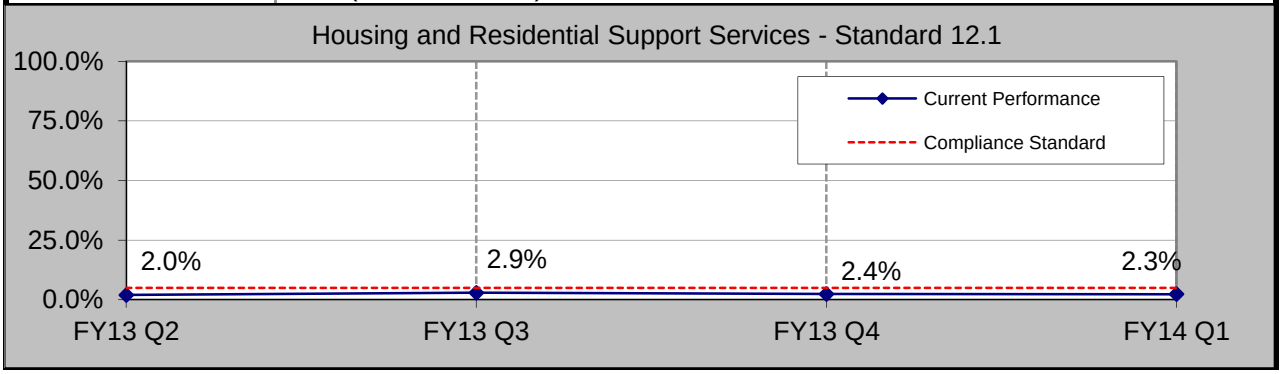
Number of Callers with resource needs Jul 1 - Sept 30, 2013				
	Region 1	Region 2	Region 3	Total
Unique Individuals:	2	0	0	2
Unmet Needs:	0	0	0	0

Unmet Needs by Domain Jul 1 ~ Sept 31, 2013	
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

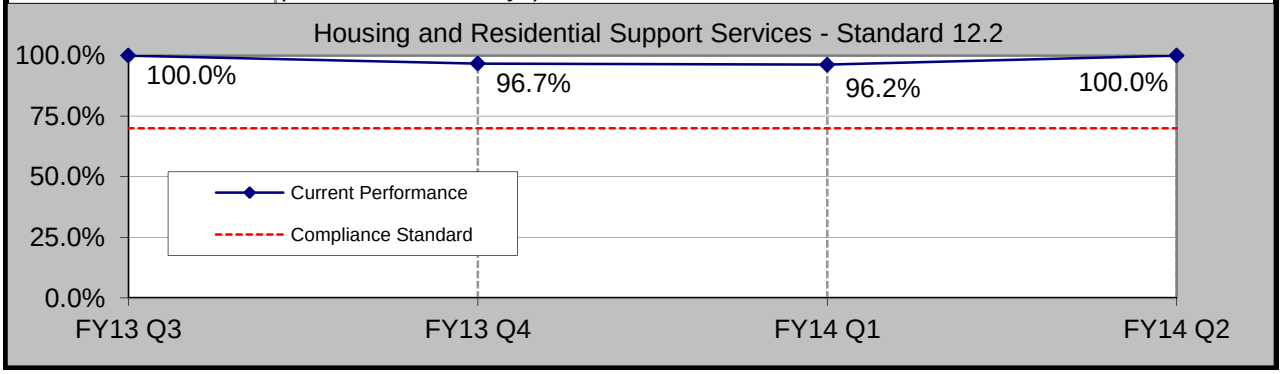
Community Resources and Treatment Services
Housing and Residential

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	2.3% (27 out of 1160)

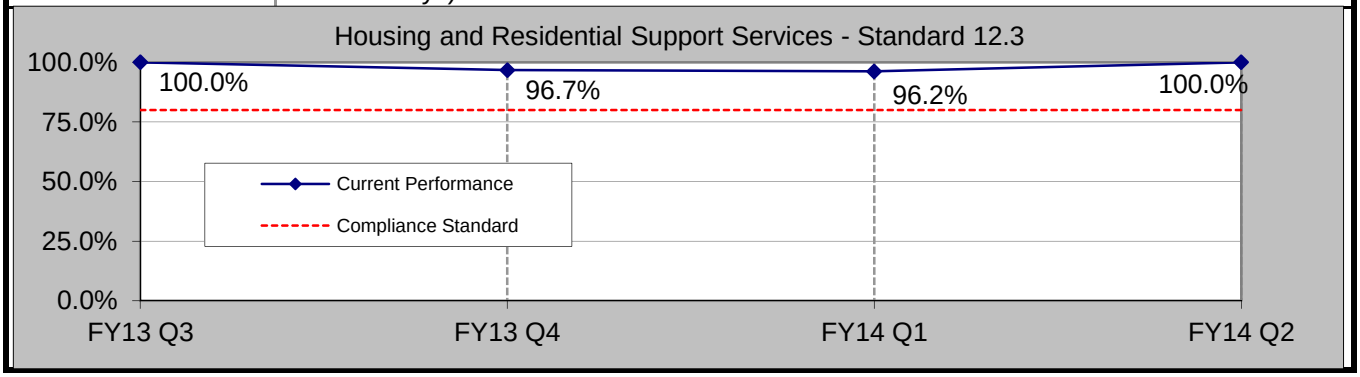


Standard 12.2	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 Q2 (Lack of residential supports did not impede discharge for any patients within 7 days)

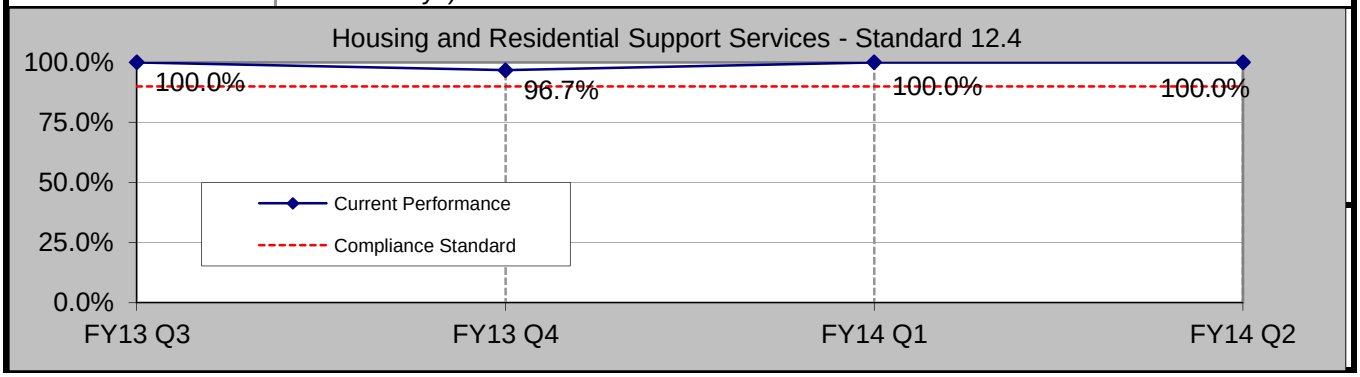


Community Resources and Treatment Services
Housing and Residential

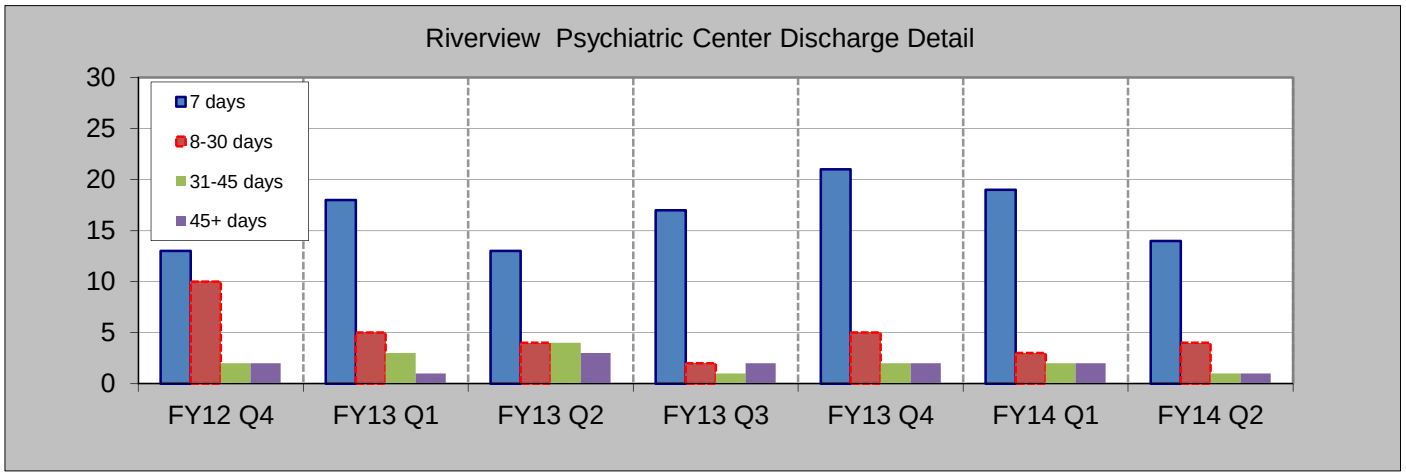
Standard 12.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 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% FY14 Q2 (Lack of residential supports did not impede discharge any patients within 45 days)



Community Resources and Treatment Services
Housing and Residential



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

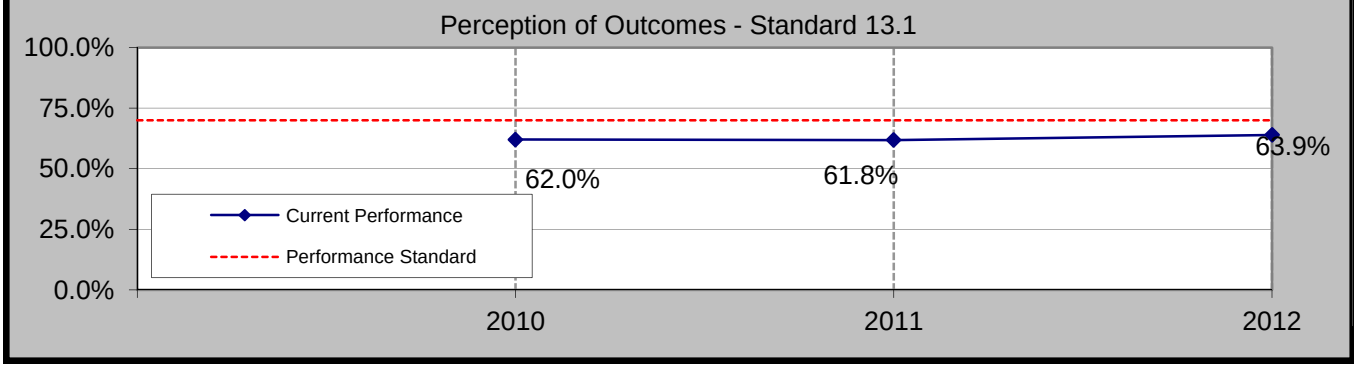
20 Civil Patients discharged in quarter

- 14 discharged at 7 days (70.0%)
- 4 discharged 8-30 days (20.0%)
- 1 discharged 31-45 days (5.0%)
- 1 discharged post 45 days (5.0%)

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

Community Resources and Treatment Services
Housing and Residential

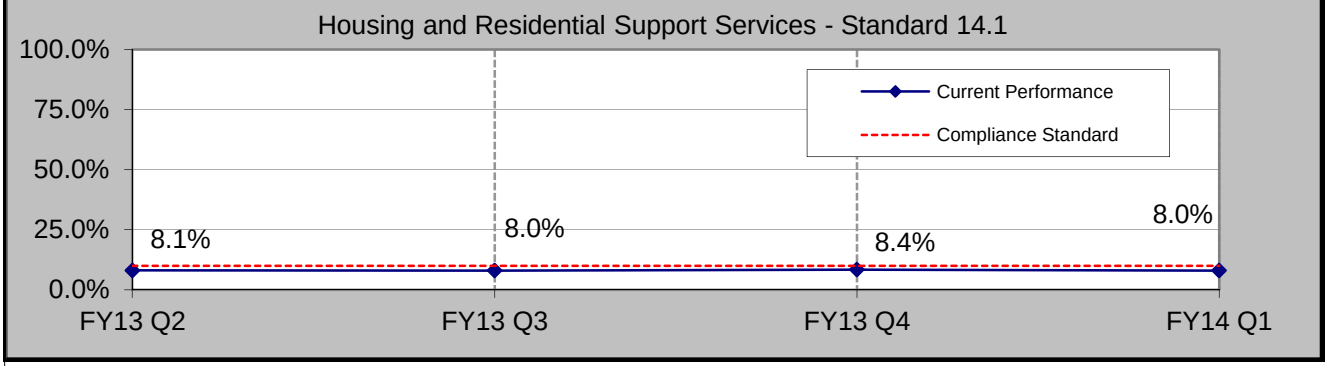
Standard 13.1	
Measurement	Domain average of positive responses to the questions in the Perception of Outcomes domain
Standard	Performance: at or above 70%
Data Source	Adult Mental Health and Well Being Survey
Current Level	63.9% (N=1338)



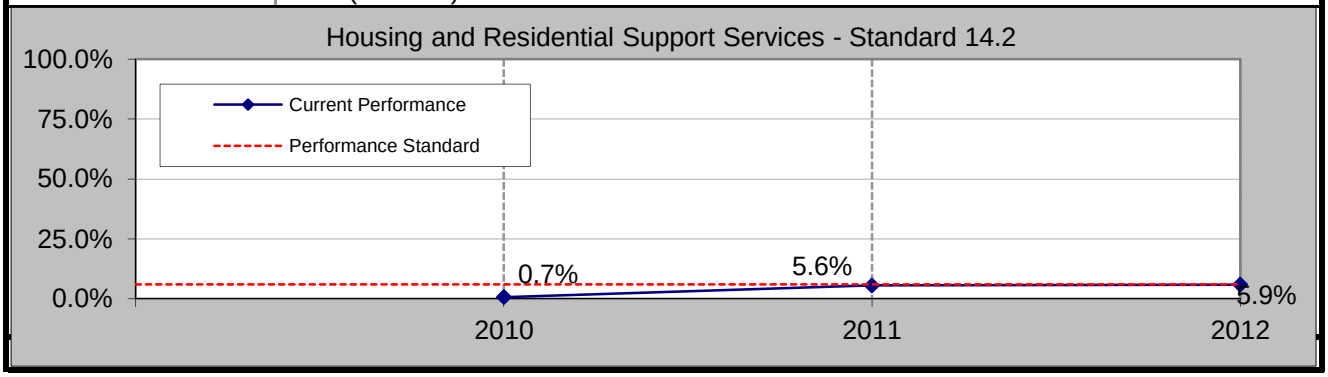
Community Resources and Treatment Services
Housing and Residential

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

Standard 14.1	
Measurement	Class members with ISPs with unmet housing needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	8.0% (93 out of 1160)

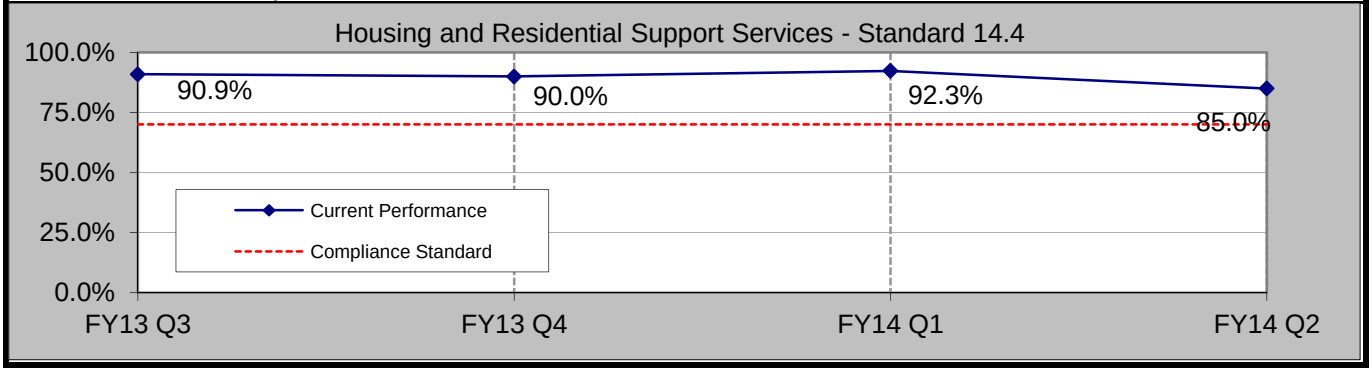


Standard 14.2	
Measurement	Percentage of respondents who experienced homelessness over 12-month period.
Standard	Performance: 6% or fewer
Data Source	Adult Mental Health and Well Being Survey, living situation data
Current Level	5.9% (N=1275)



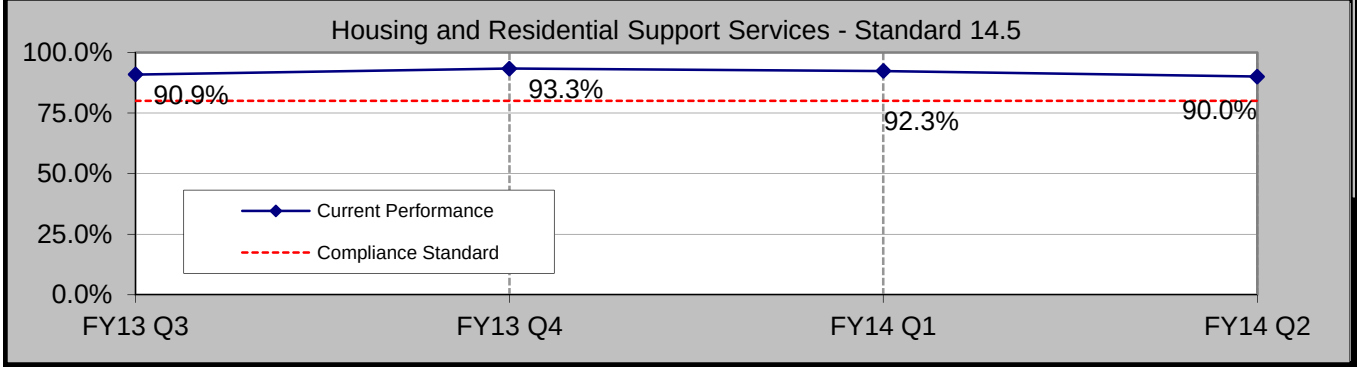
Community Resources and Treatment Services
Housing and Residential

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	85.0% FY14 Q2. (Lack of housing alternatives did not impede discharge for 17 out of 20 patients within 7 days)

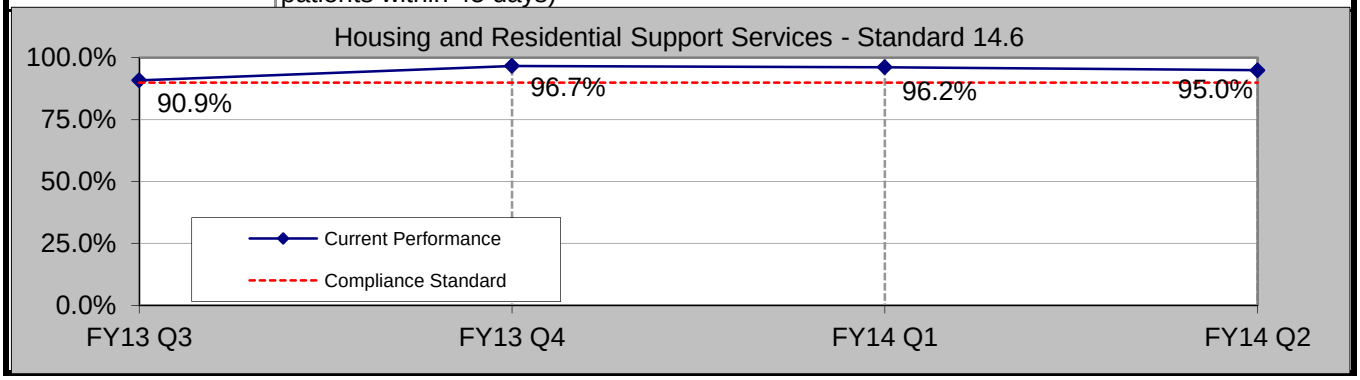


Community Resources and Treatment Services
Housing and Residential

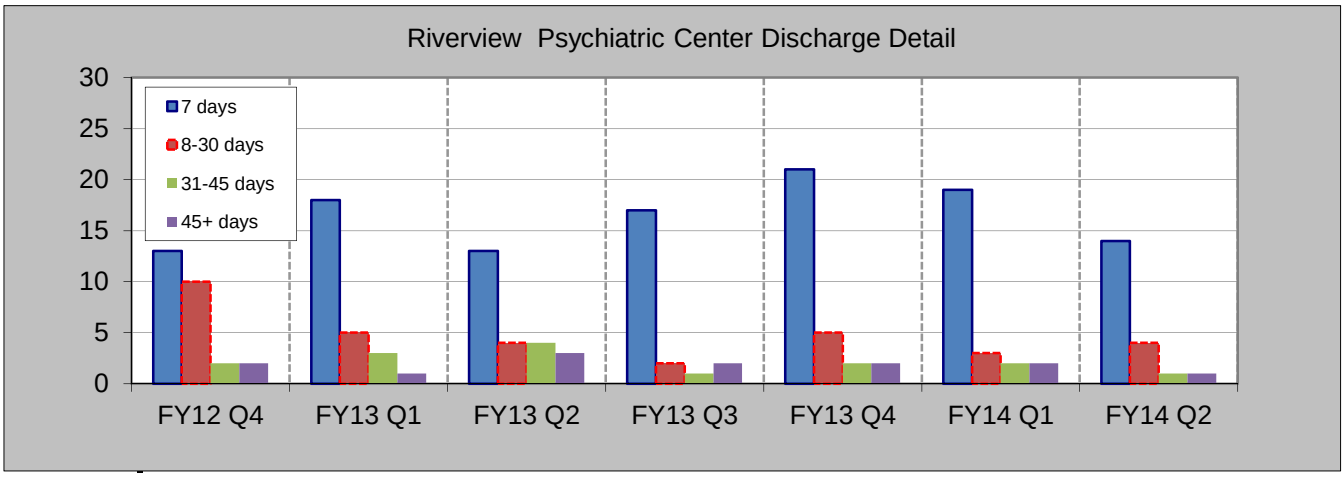
Standard 14.5	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	90.0% FY14 Q2 (Lack of housing alternatives did not impede discharge for 18 out of 20 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	95.0% FY14 Q2 (Lack of housing alternatives did not impede discharge for 25 out of 26 patients within 45 days)



Community Resources and Treatment Services
Housing and Residential



20 Civil Patients discharged in quarter

14 discharged at 7 days (70.0%)
4 discharged 8-30 days (20.0%)
1 discharged 31-45 days (5.0%)
1 discharged post 45 days (5.0%)

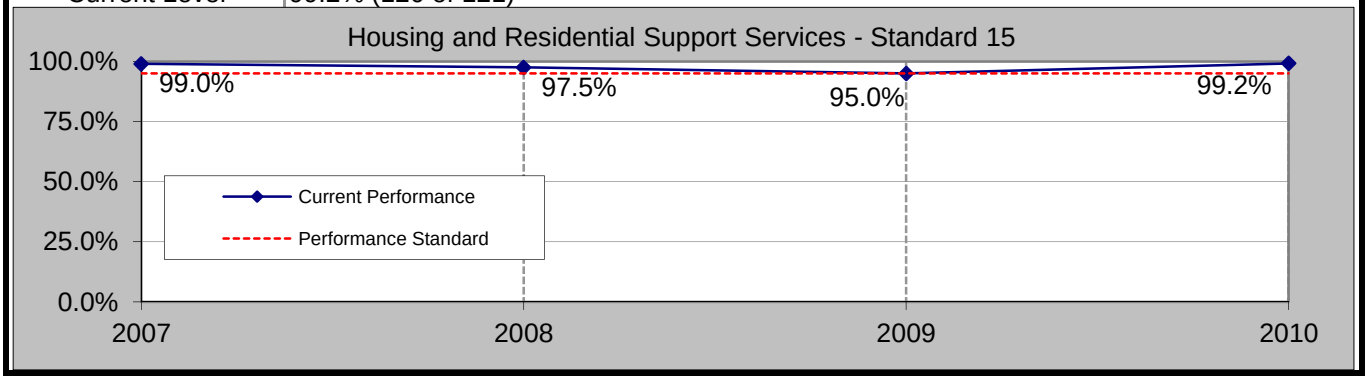
Housing Alternatives impeded discharge for 3 patients (15.0%)

1 patient discharged within 7-30 days post clinical readiness for discharge
1 patient discharged within 31-45 days post clinical readiness for discharge
1 patient discharged greater than 45 days post clinical readiness for discharge

Community Resources and Treatment Services
Housing and Residential

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

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

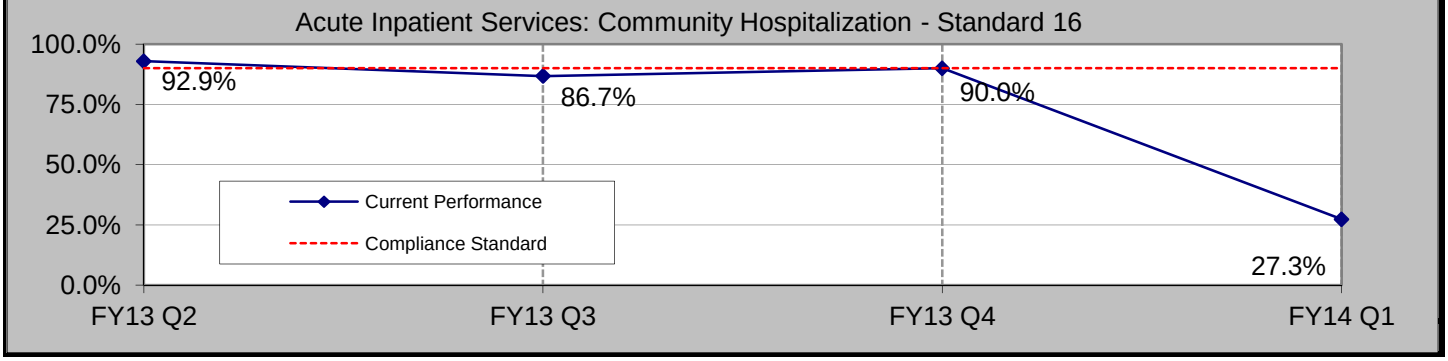


The protocol for obtaining the informed consent of Class Members to live in homes with greater than 8 beds (Settlement Agreement Paragraph 96) is followed annually to track data for this standard. SAMHS submitted an amendment request to modify this requirement on November 23, 2011. While the request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

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

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

Standard 16	
Measurement	Class Member admissions determined to be reasonably near an individual's local community of residence.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	UR Database/EIS
Current Level	27.3% (3 out of 11)



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

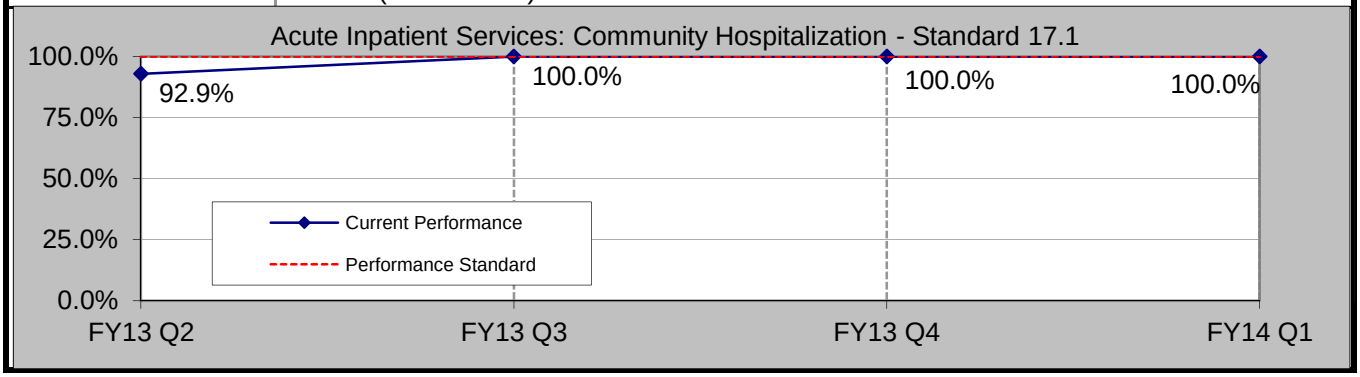
Discussion:

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

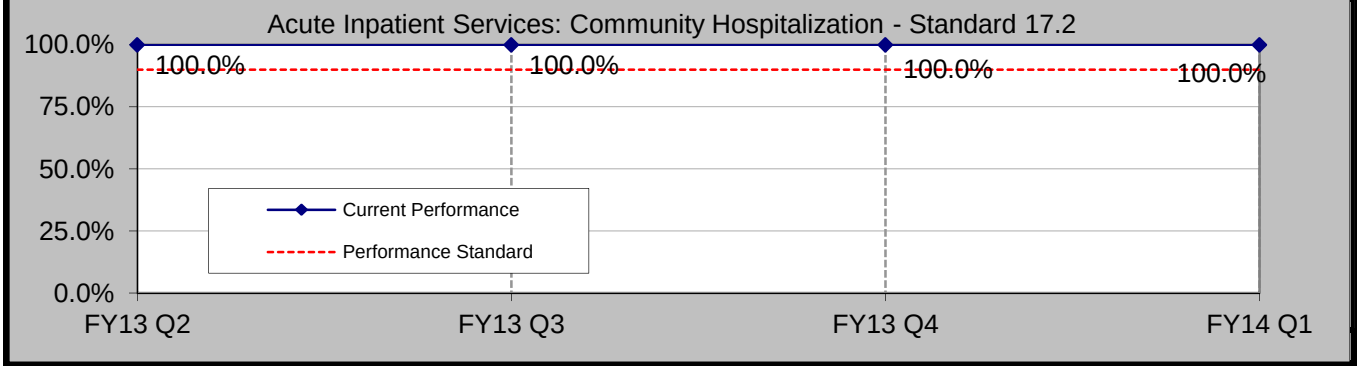
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

Standard 17.1	
Measurement	Class member involuntary admissions to community inpatient units have blue paper on file.
Standard	Performance: 100%
Data Source	UR Database/EIS
Current Level	100.0% (11 out of 11)

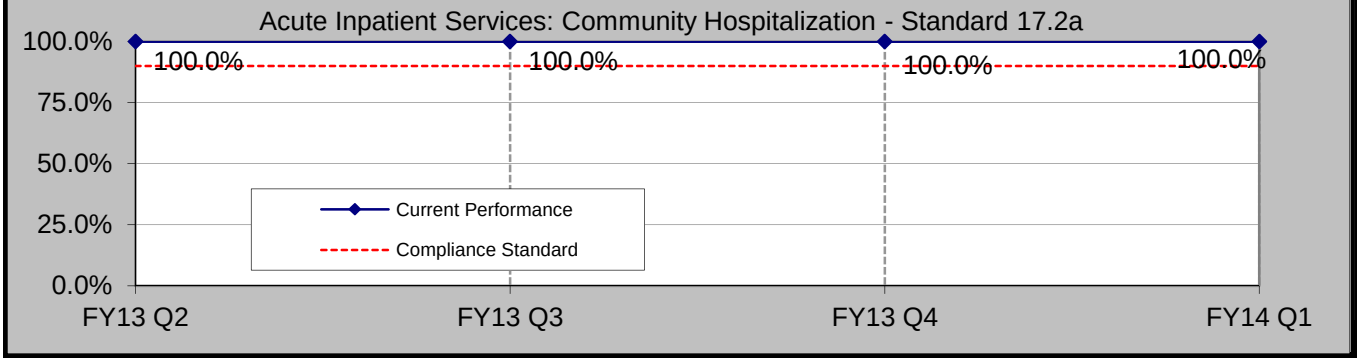


Standard 17.2	
Measurement	Blue paper was completed and in accordance with terms.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (11 out of 11)

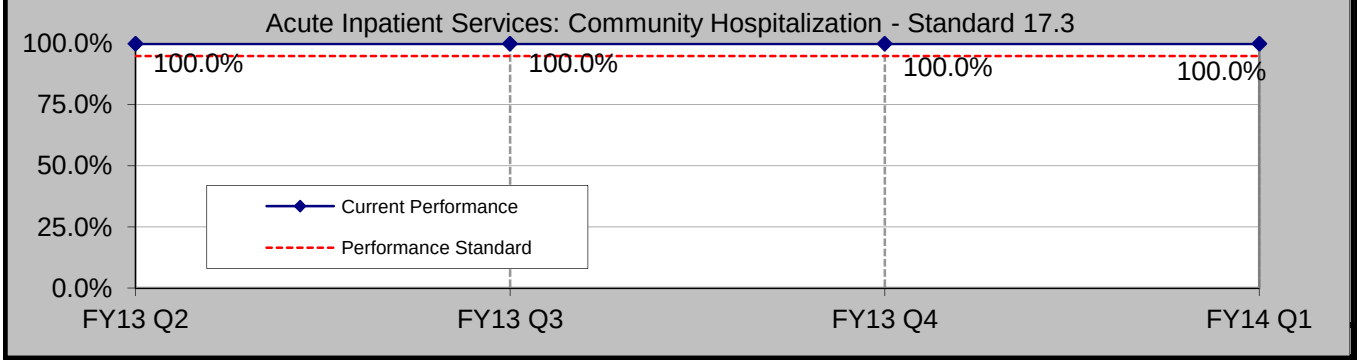


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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)

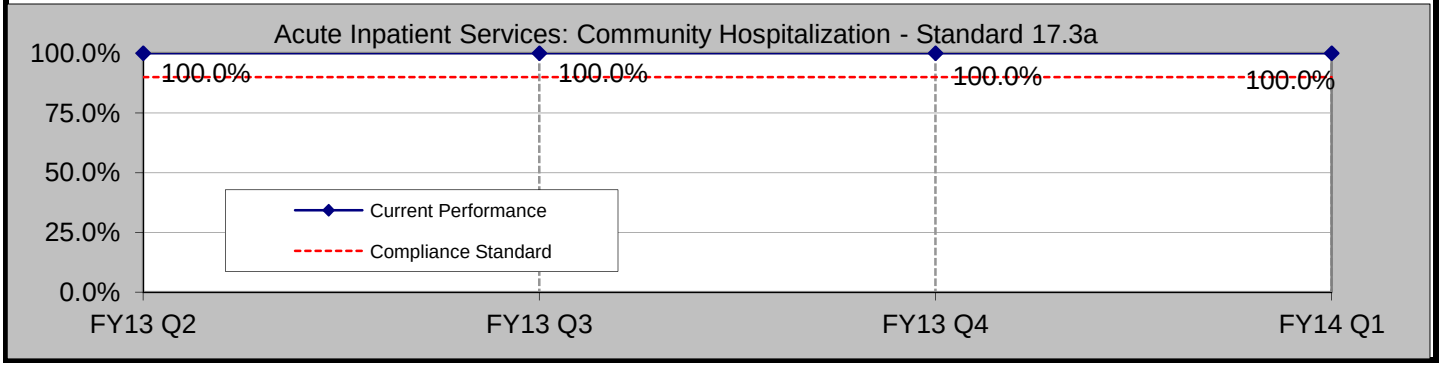


Standard 17.3	
Measurement	Class member involuntary admissions to community inpatient units in which 24 hour certification was completed.
Standard	Performance: 95%
Data Source	UR Database/EIS
Current Level	100.0% (11 out of 11)

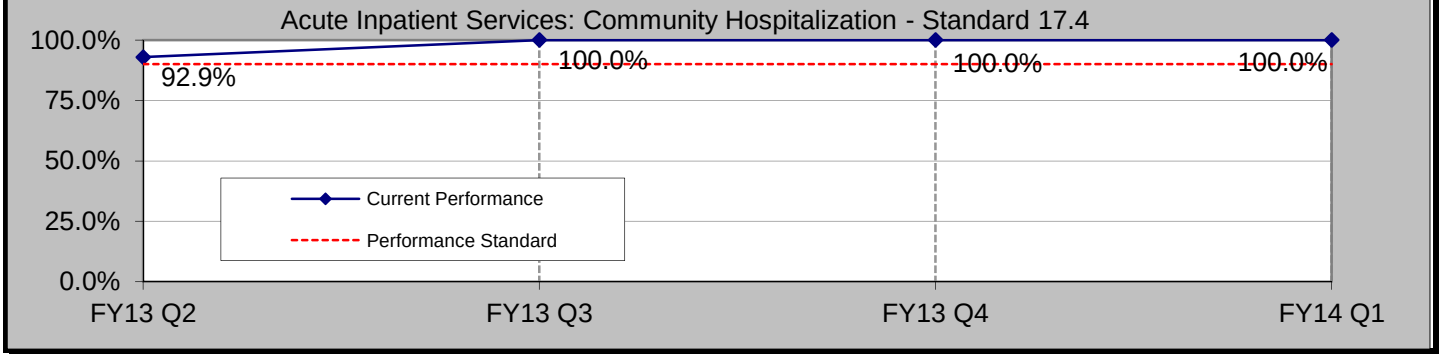


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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)

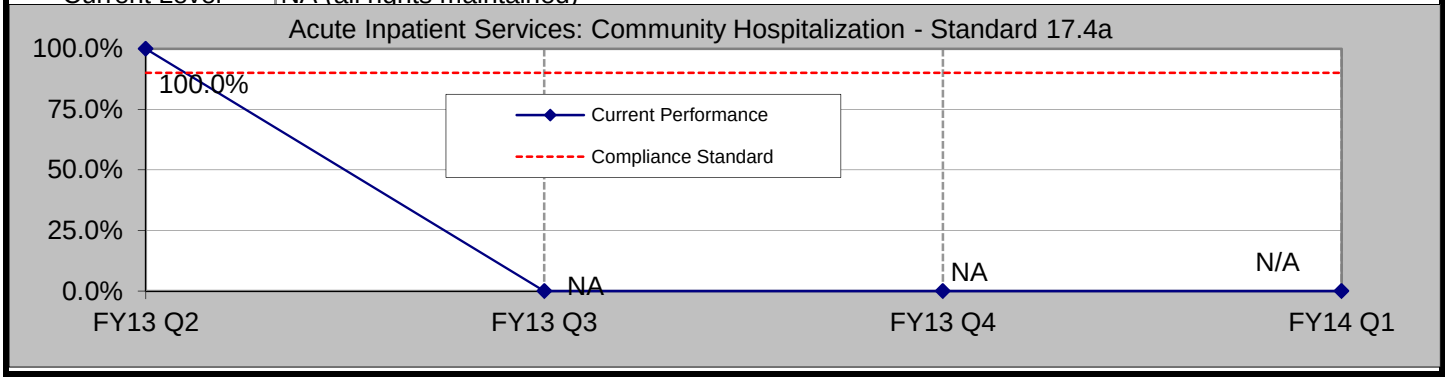


Standard 17.4	
Measurement	Class member involuntary admissions to community inpatient units in which patients' rights were maintained.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (11 out of 11)

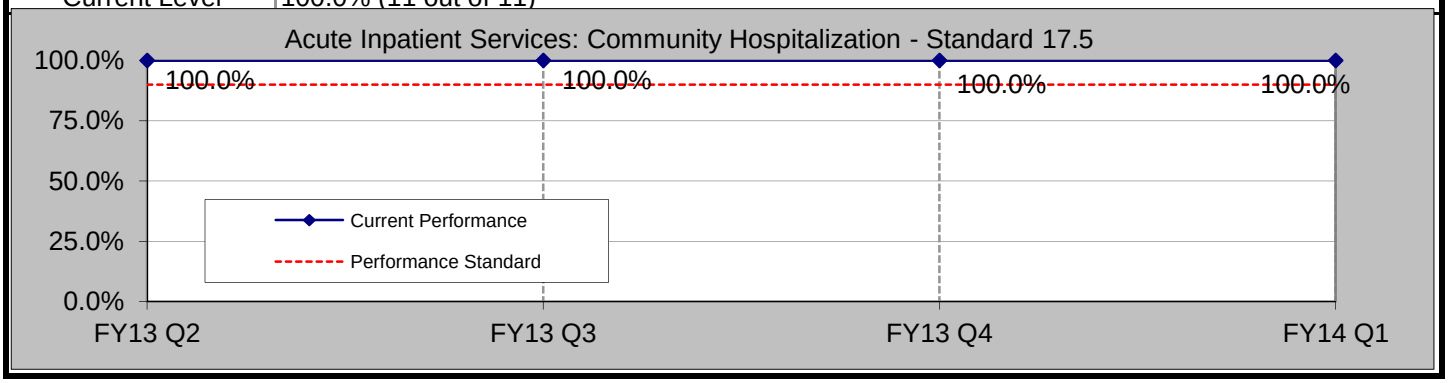


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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



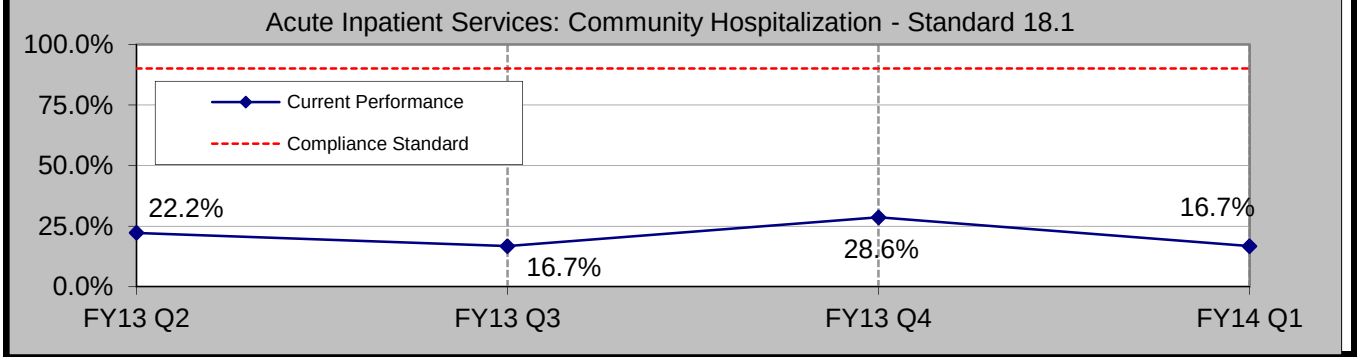
Standard 17.5	
Measurement	Class member involuntary admissions for which medical necessity has been established.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (11 out of 11)



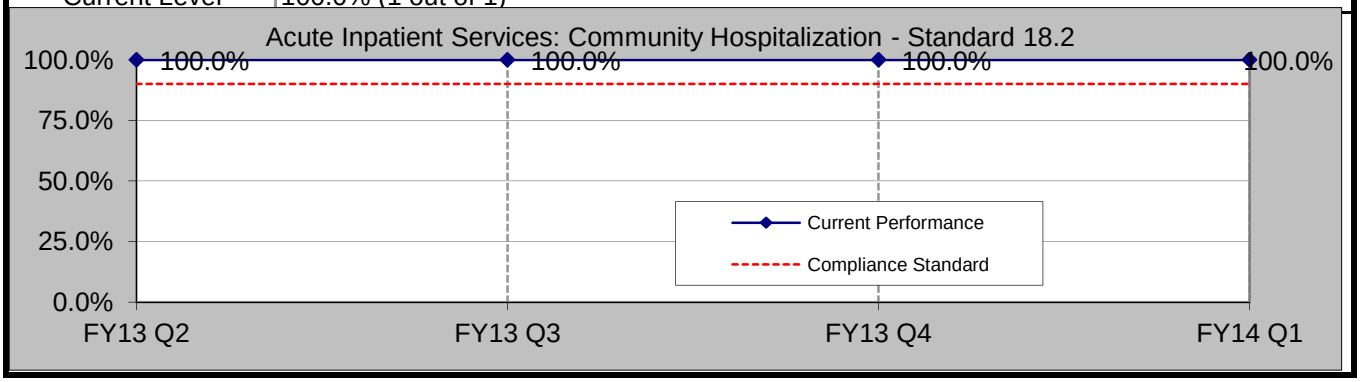
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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	16.7% (1 out of 6)

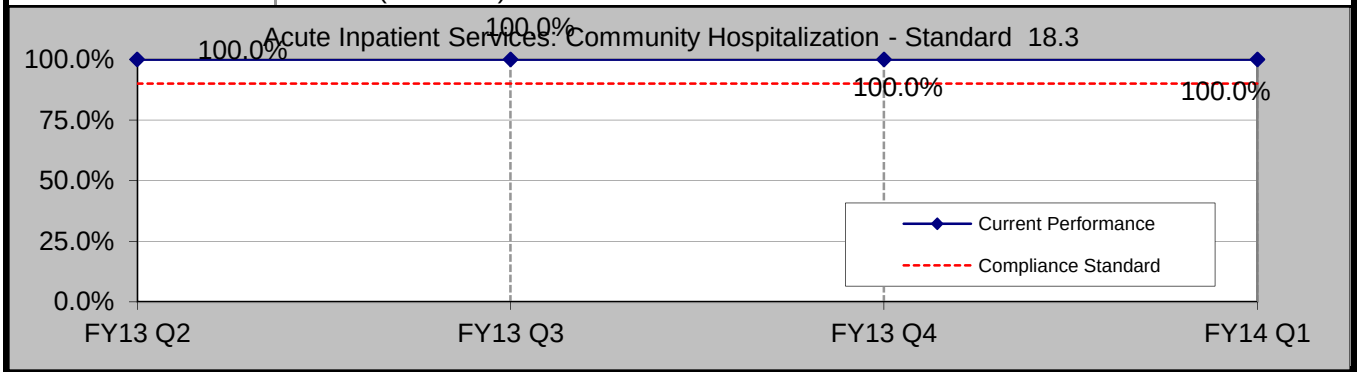


Standard 18.2	
Measurement	Treatment and discharge plan were determined to be consistent with ISP goals and objectives.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (1 out of 1)



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

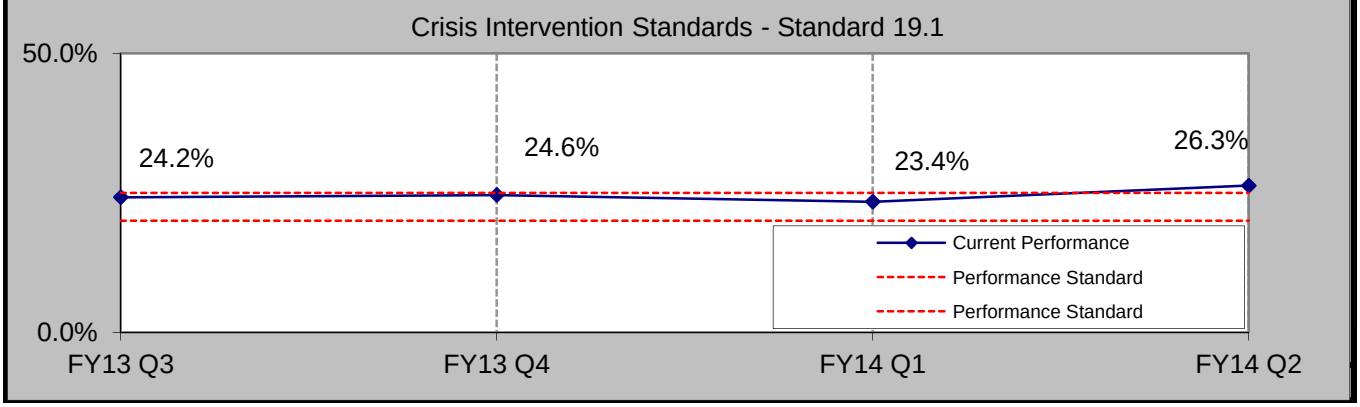
Standard 18.3	
Measurement	CI/ICI/ICM/ACT worker participated in hospital treatment and discharge planning.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (6 out of 6)



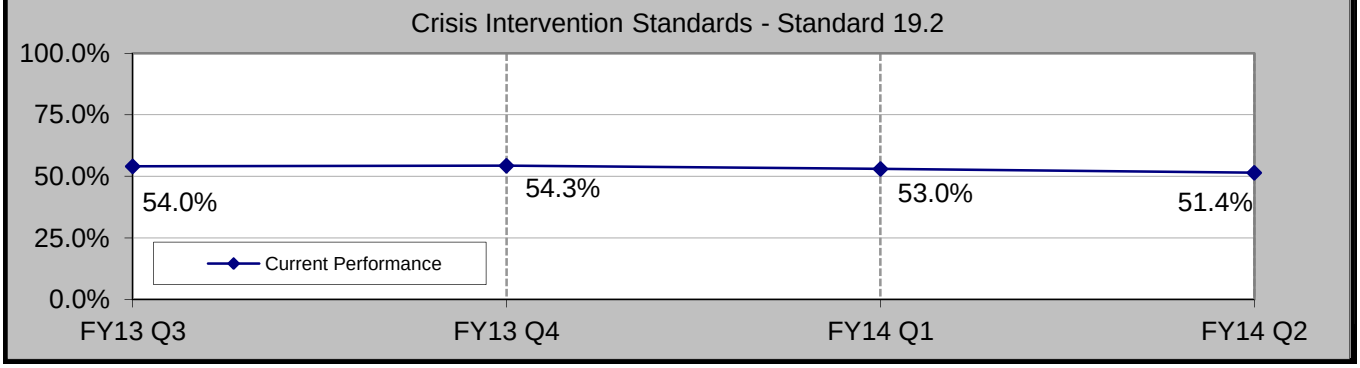
Community Resources and Treatment Services
Crisis Intervention Services

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

Standard 19.1	
Measurement	Face to face crisis contacts that result in hospitalizations.
Standard	Performance: No more than 20 - 25% are hospitalized as result of crisis intervention.
Data Source	Quarterly Crisis Contract Performance Data
Current Level	26.3% (1049 out of 3988)



Standard 19.2	
Measurement	Face to face crisis contacts that result in follow-up and/or referral to community based services.
Standard	To Be Established
Data Source	Quarterly Crisis Contract Performance Data
Current Level	51.4 % (2049 out of 3988)

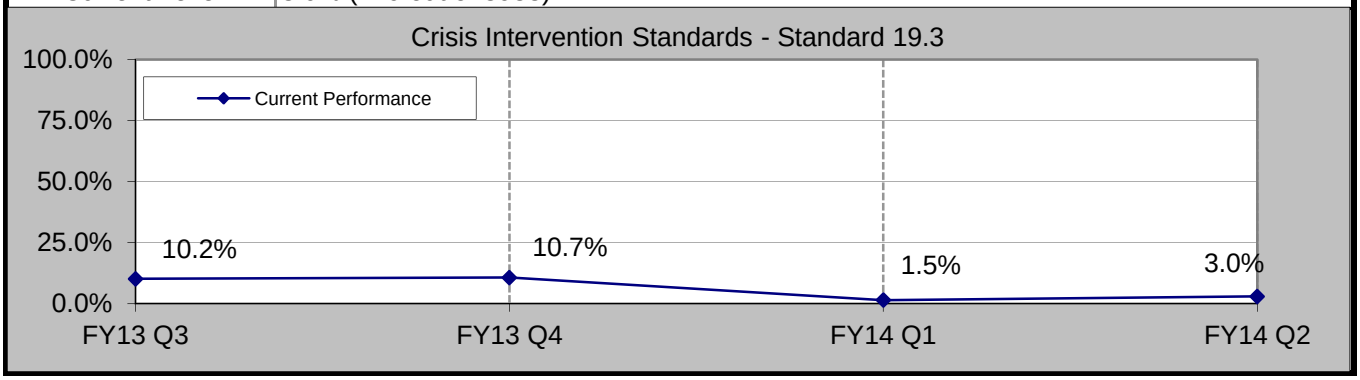


Discussion:

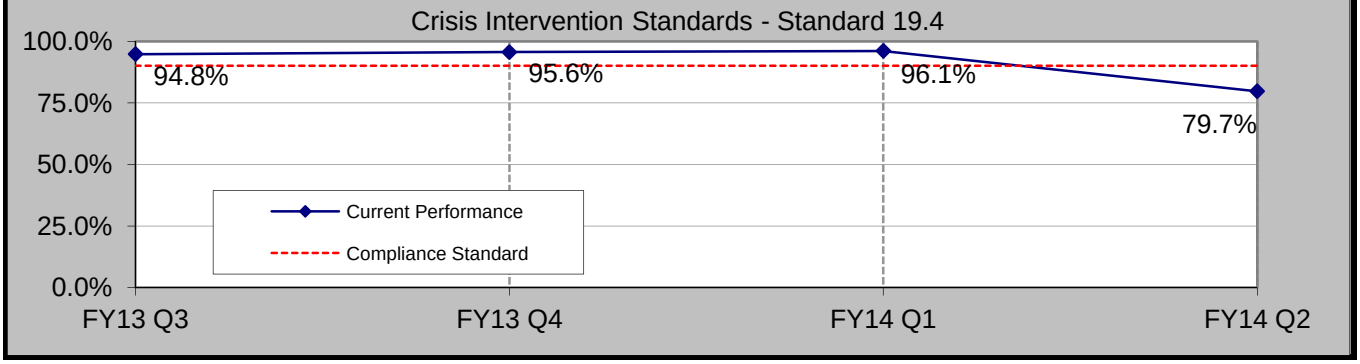
Standard 19.1: This quarter reports a 1.3 increase above the standard. This is not an uncommon occurence when examining the standard historically. Standard will continue to be monitored for compliance,

Community Resources and Treatment Services
Crisis Intervention Services

Standard 19.3	
Measurement	Face to face crisis contacts in which a previously developed crisis plan was available and used.
Standard	To Be Established
Data Source	Quarterly Crisis Contract Performance Data
Current Level	3.0% (119 out of 3988)



Standard 19.4	
Measurement	Face to face crisis contacts in which client has a CI worker and worker was notified about the crisis.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	Quarterly Crisis Contract Performance Data
Current Level	79.7% (1023 out of 1284)



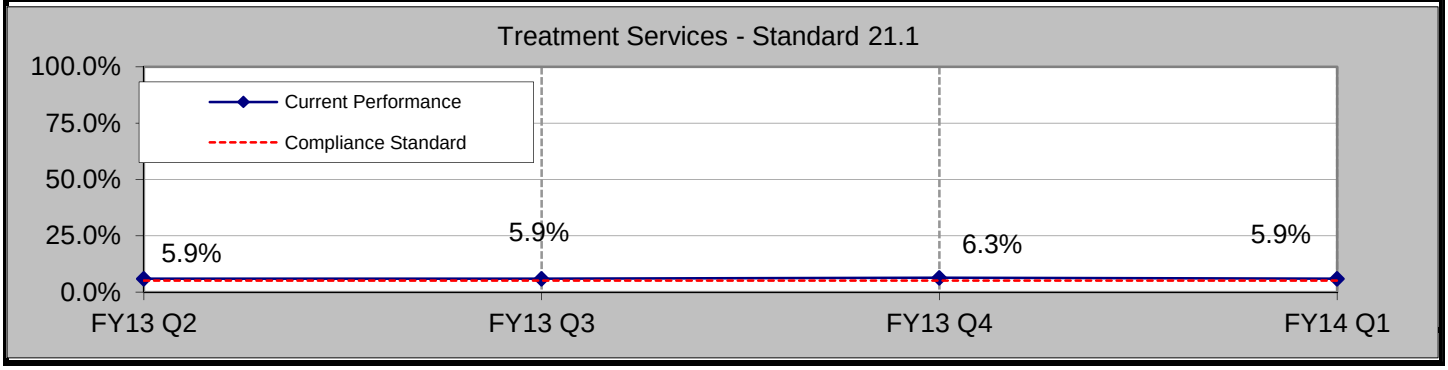
Discussion:

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

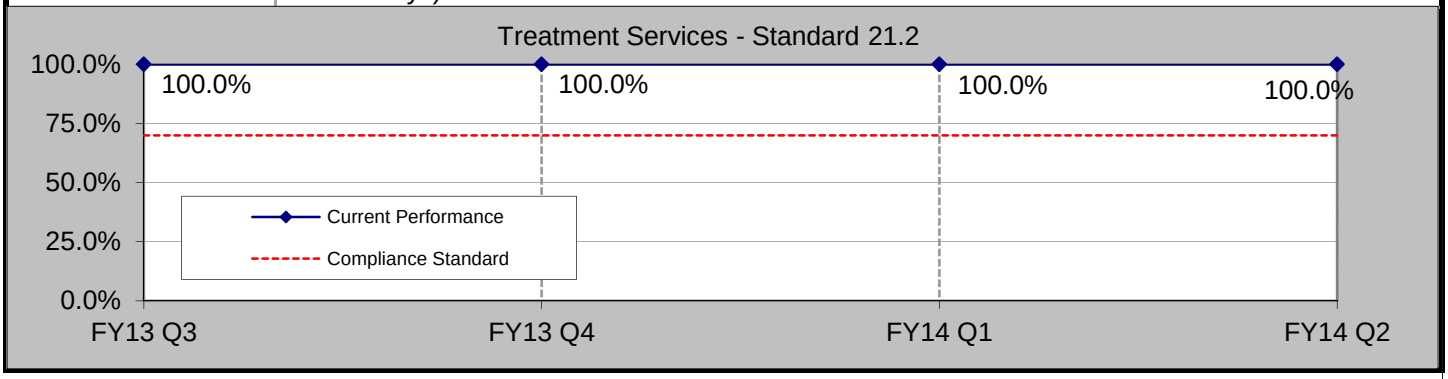
Community Resources and Treatment Services
Treatment Services

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

Standard 21.1	
Measurement	Class members with ISPs with unmet mental health treatment needs
Standard	Compliance: 5% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	5.9% (69 out of 1160)

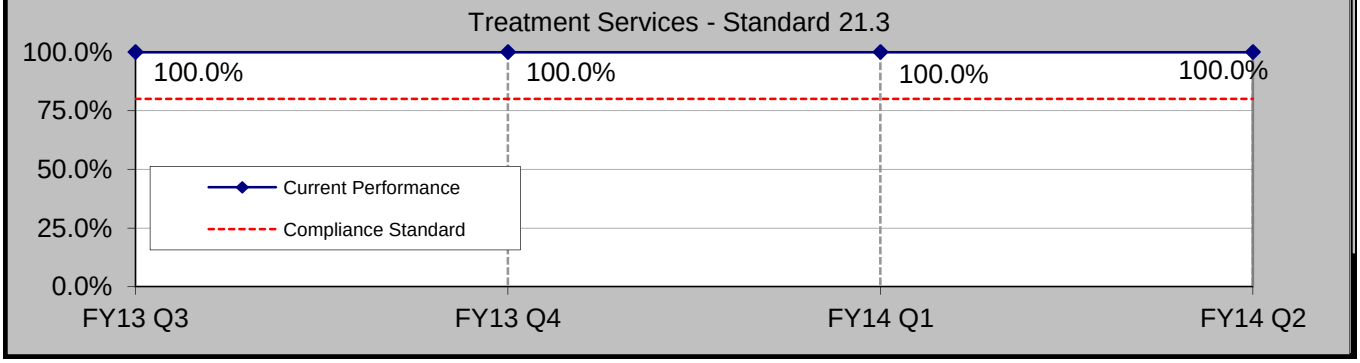


Standard 21.2	
measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 Q2 (Lack of mental health treatment did not impede discharge for any patients within 7 days)

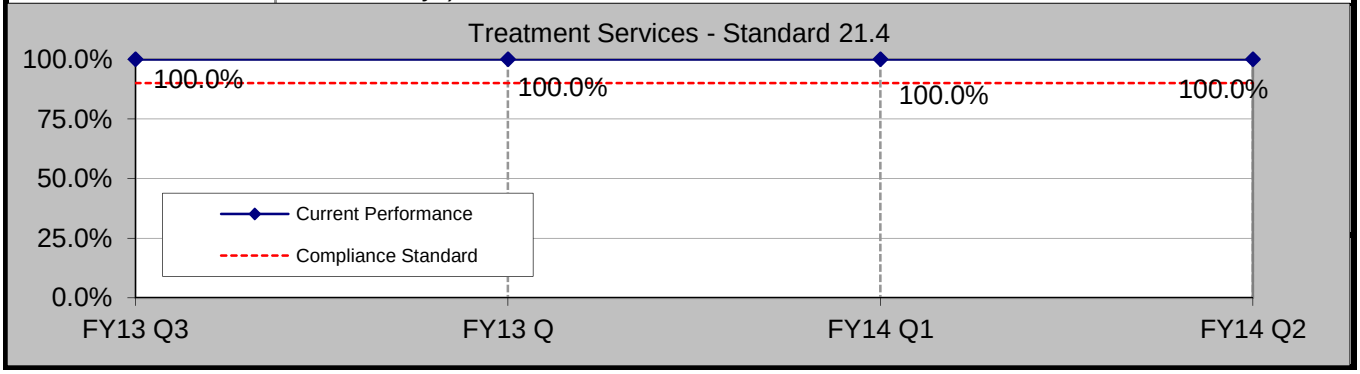


Community Resources and Treatment Services
Treatment Services

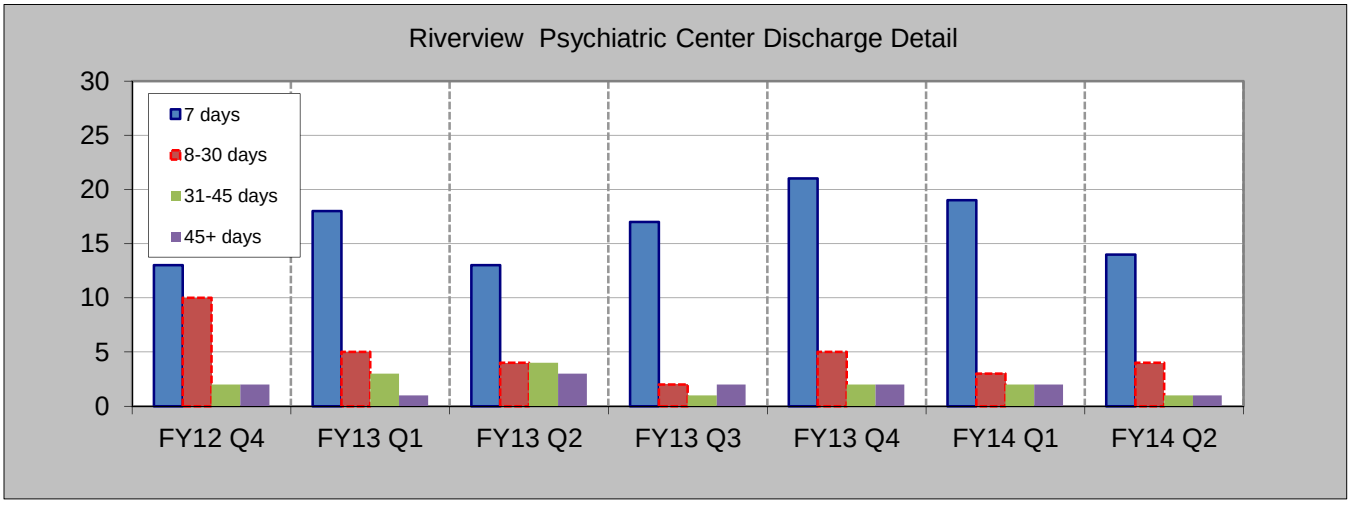
Standard 21.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination
Standard	Performance: 96% (within 30 days of that determination) Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 Q2 (Lack of mental health treatment did not impede discharge for any patients within 30 days)



Standard 21.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination
Standard	Performance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 2 (Lack of mental health treatment did not impede discharge for any patients within 45 days)



Community Resources and Treatment Services
Treatment Services



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

<u>20 Civil Patients discharged in quarter</u>

14 discharged at 7 days (70.0%)
4 discharged 8-30 days (20.0%)
1 discharged 31-45 days (5.0%)
1 discharged post 45 days (5.0%)

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

Community Resources and Treatment Services
Treatment Services

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

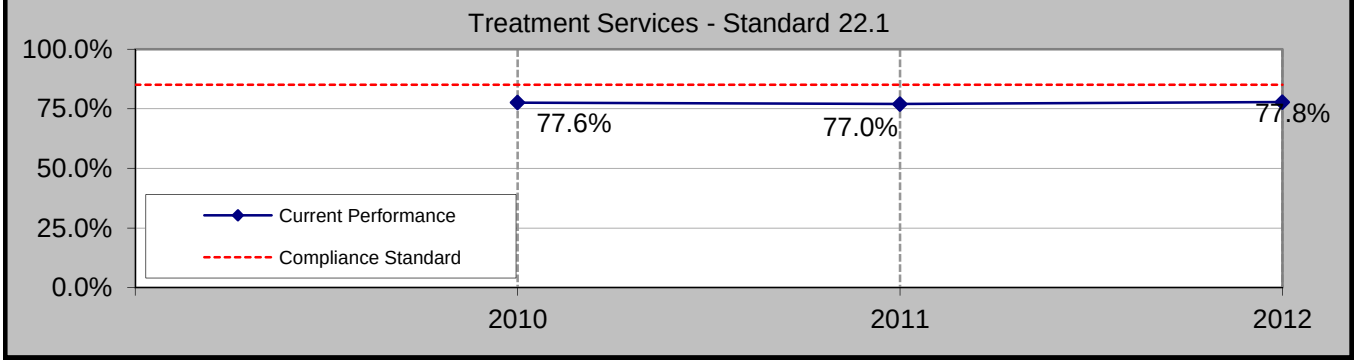
MaineCare Data FY 2013			
Mental Health Treatment Services Received	**Total Number**	**Total Number of Class Members**	**Percent of Class Members**
Assertive Community Treatment	863	285	33.0%
Community Integration	14,670	1,170	8.0%
Communty Rehabilitation	185	64	34.6%
Crisis Services	5,186	543	10.5%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

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

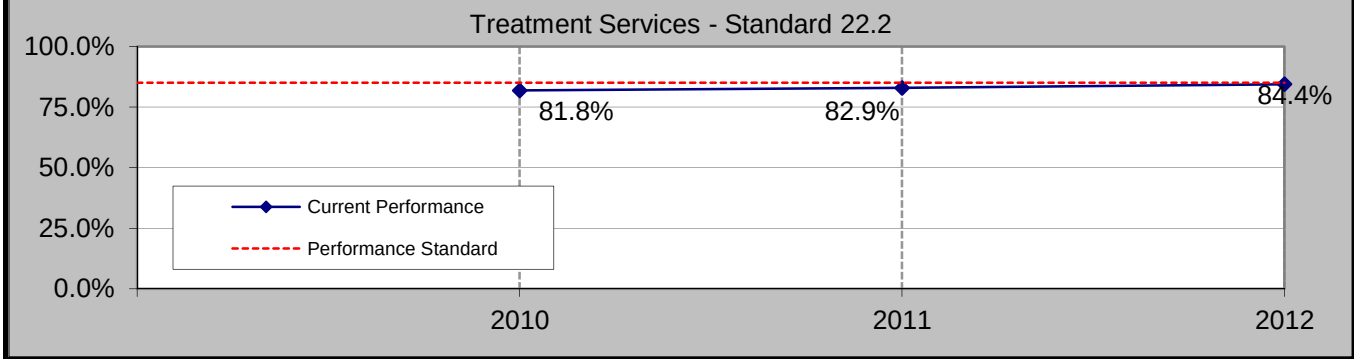
Community Resources and Treatment Services
Treatment Services

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

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



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



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	5 family to family classes: Q1 FY 14

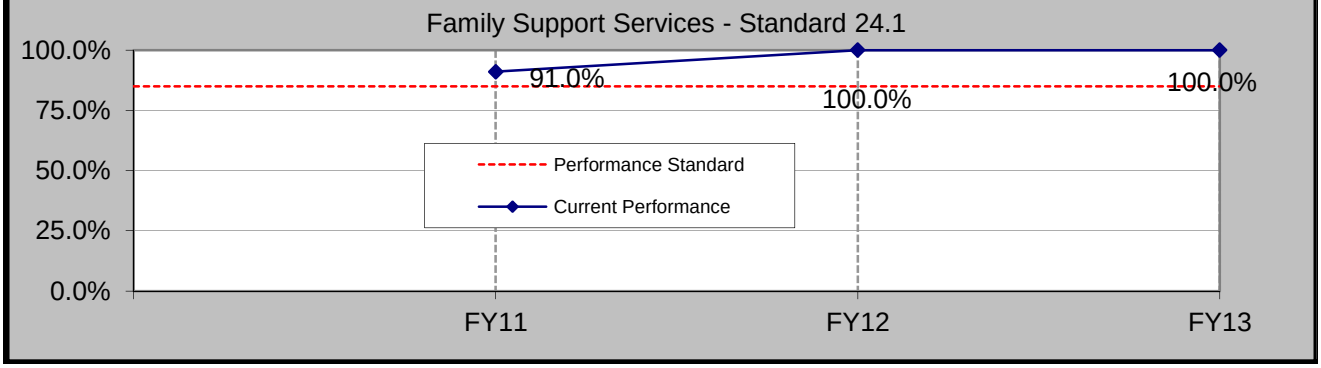
Standard 23.2	
Measurement	Number and distribution of family support services provided
Standard	No standard necessary
Data Source	NAMI
Current Level	34 family support groups, 17 sites: Q1 FY 14

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

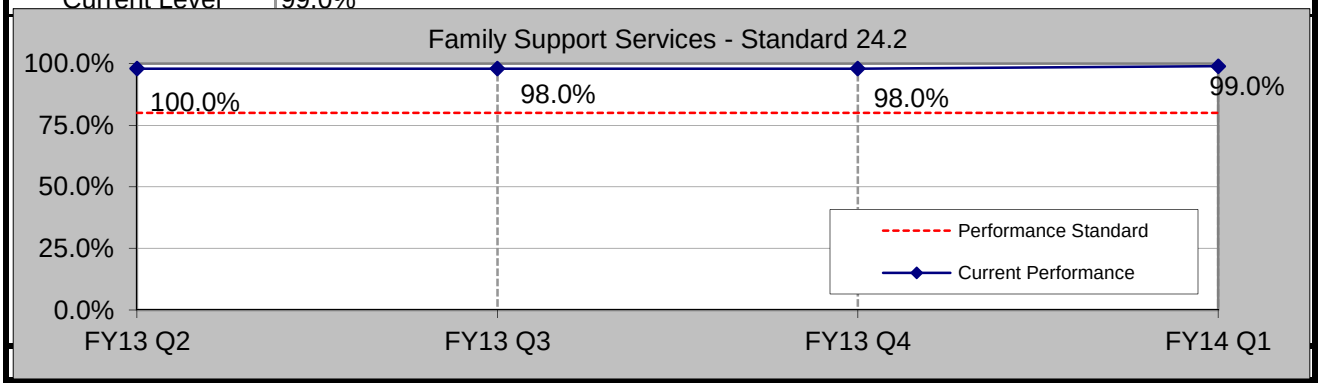
Community Resources and Treatment Services
Family Support Services

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

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



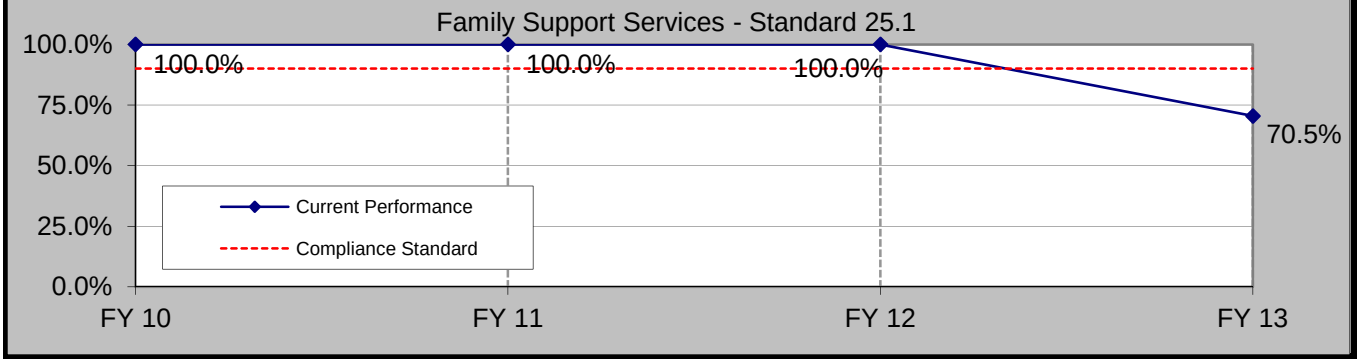
Standard 24.2	
Measurement	Percentage of program participants reporting satisfaction with education programs.
Standard	Performance: 80%
Data Source	NAMI
Current Level	99.0%



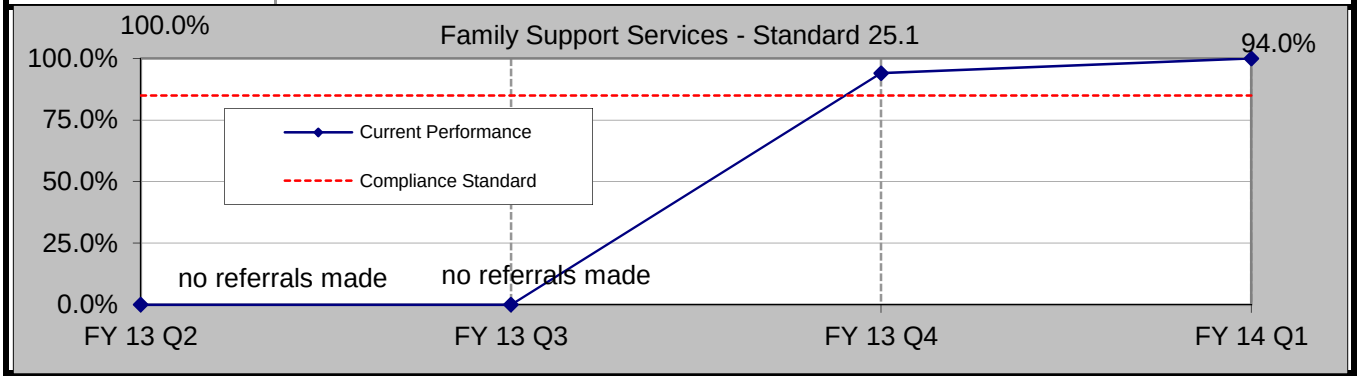
Community Resources and Treatment Services
Family Support Services

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	70.5 % (103 of 146)



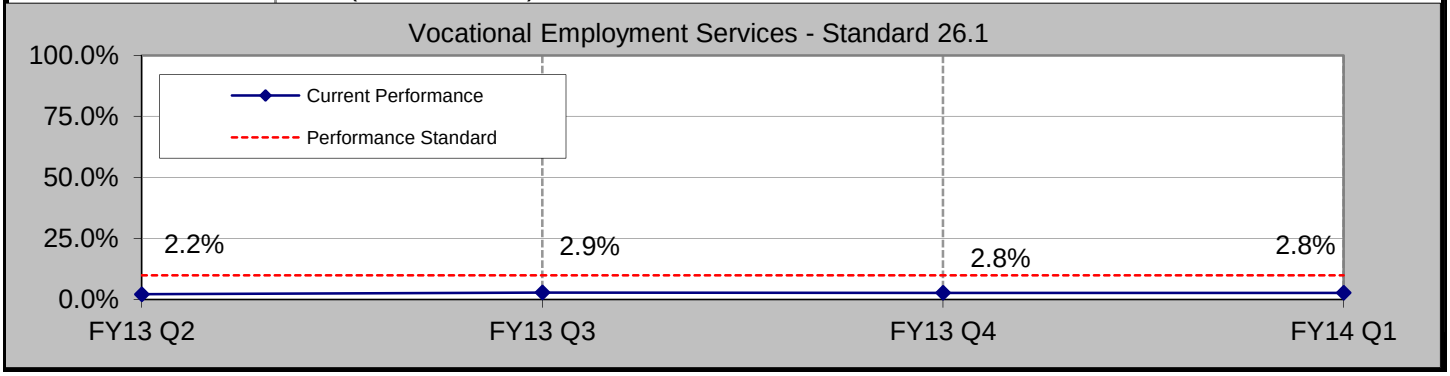
Standard 25.2	
Measurement	Families receiving referrals for family support services reporting satisfaction with referral process.
Standard	Performance: 85%
Data Source	NAMI
Current Level	100.0%



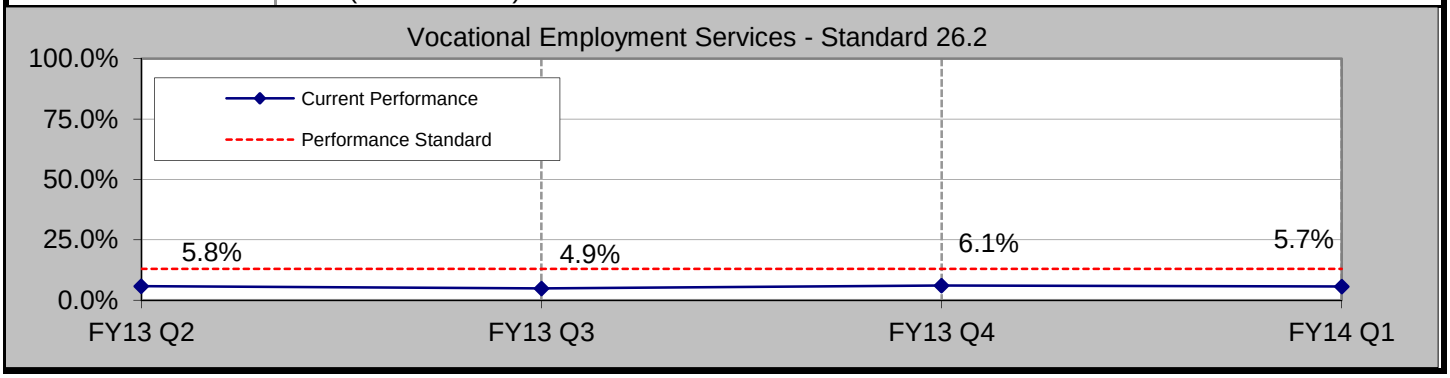
Community Resources and Treatment Services
Vocational Employment Services

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

Standard 26.1	
Measurement	Class members with ISP identified unmet vocational/employment support needs.
Standard	Performance: 10% or fewer
Data Source	ISP RDS Data
Current Level	2.8% (32 out of 1160)

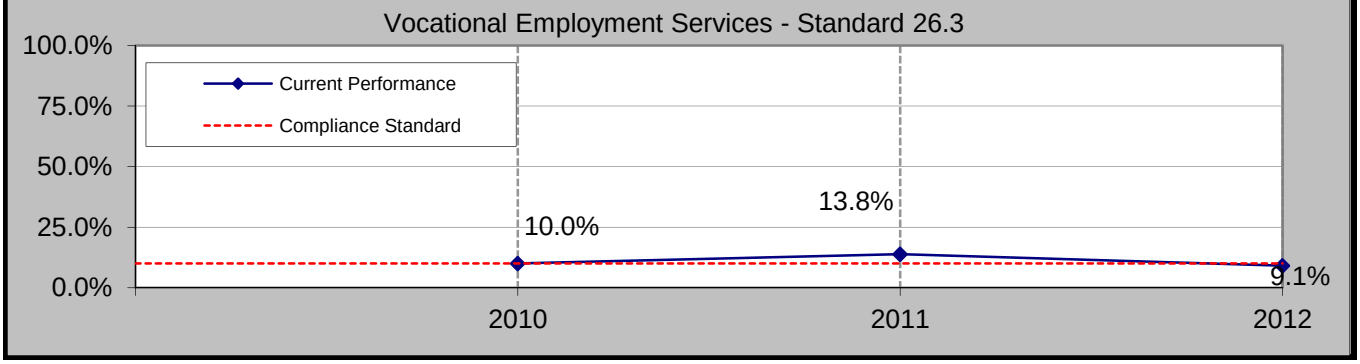


Standard 26.2	
Measurement	Class members younger than age 62 in competitive employment in the community.
Standard	Performance: 15% of class members employed in competitive employment. Compliance: 13% or Baseline (10.8%).
Data Source	ISP RDS Data
Current Level	5.7% (56 out of 980)



Community Resources and Treatment Services
Vocational Employment Services

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



Discussion:

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

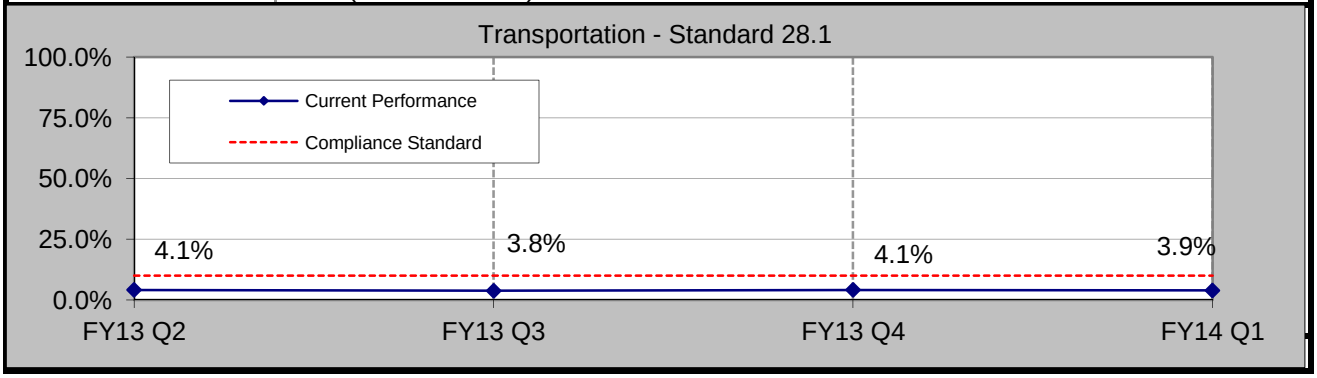
The response rate for the Adult Mental Health survey was very low in 2012 and the department is currently working on a plan to have a higher response rate.

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

Community Resources and Treatment Services
Transportation

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

Standard 28.1	
Measurement	Percentage of class members with ISP identified unmet transportation needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	3.9% (45 out of 1160)



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

Standard 30.1	
Measurement	Number of social clubs/peer centers and participants by region.
Standard	Qualitative evaluation; no numerical standard required.
Data Source	Treatment and Recovery
Current Level	21831 total visits,1490 unduplicated clients (10 of 13 social clubs/peer centers reporting for FY 14 Q1.)

Standard 30.2	
Measurement	Number of other peer support programs and participation.
Standard	Qualitative evaluation; no numerical standard required.
Data Source	Treatment and Recovery
Current Level	28 Peer Support programs statewide during FY 2014 Q1. (includes social clubs/peer centers): Participation data is not collected for the Statewide Initiatives noted below.

Peer Support Groups funded by DHHS FY2014 Q1:

Peer Centers and Social Clubs:

AMHC -- Caribou, Madawaska, 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:

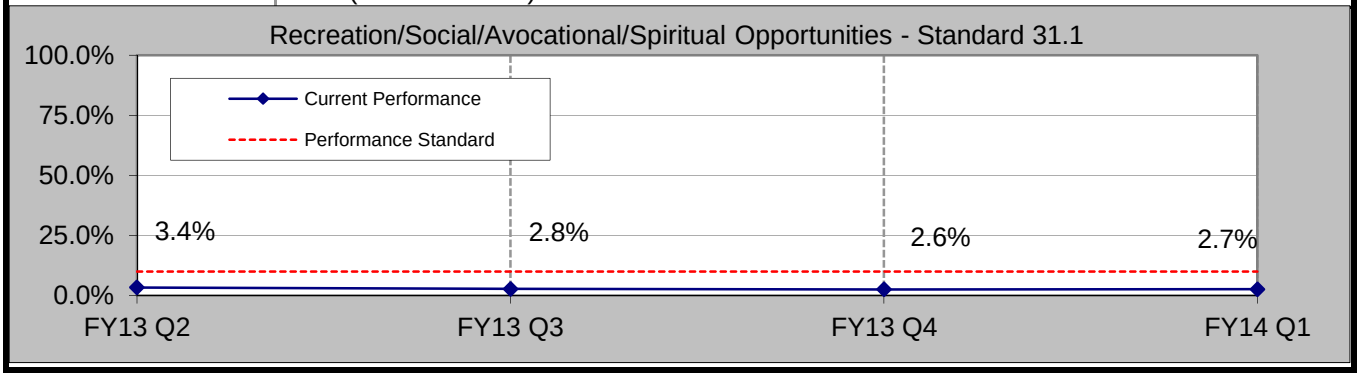
Community Connections: Community based recreational opportunities and leisure planning
MAPSRC (Maine Association of Psychosocial Rehabilitation Centers)

NAMI Support Groups primarily attended by consumers:

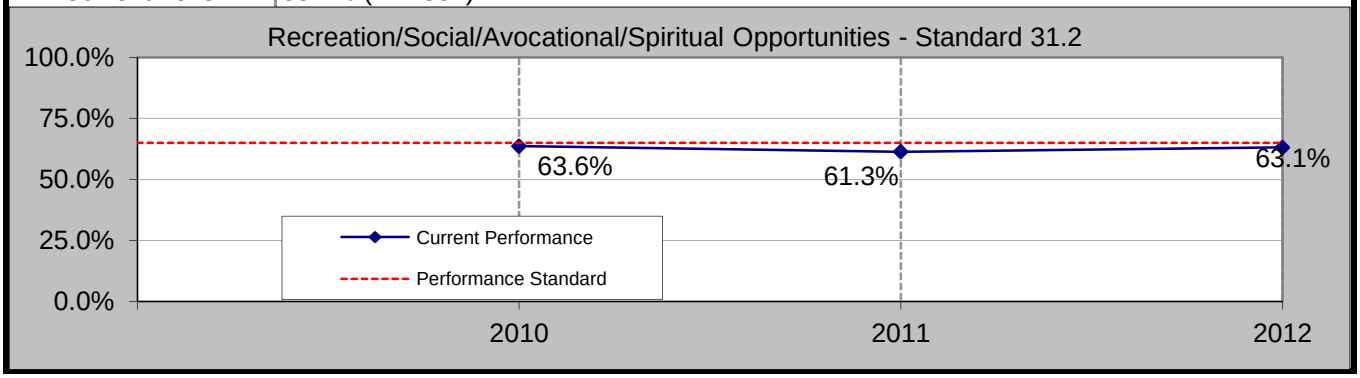
Augusta, Bangor, Biddeford, Brunswick, Damariscotta, Lewiston, Farmington, Rockland, Sanford, Waterville.

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	2.7% (31 out of 1160)



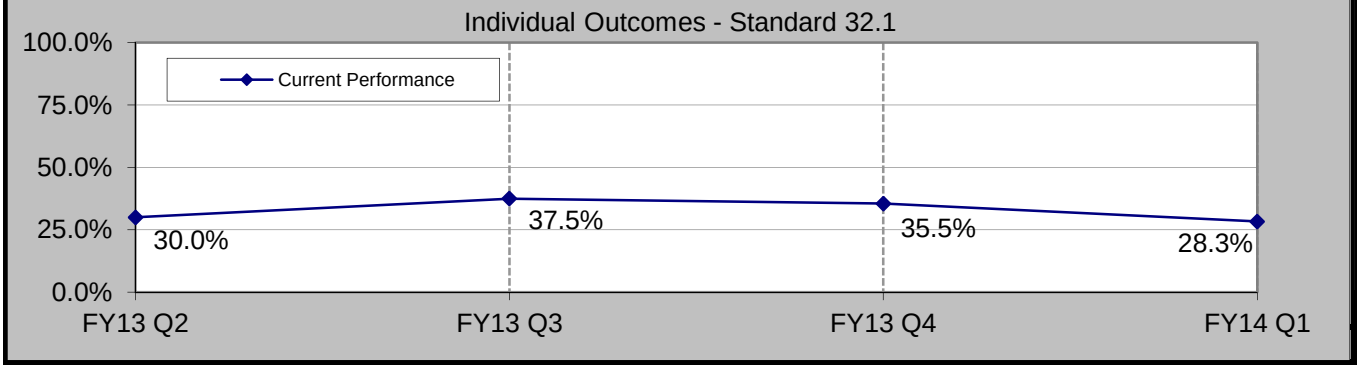
Standard 31.2	
Measurement	Domain average of positive responses in the Social Connectedness domain
Standard	Performance: At or above 65%
Data Source	Adult Mental Health and Well Being Survey
Current Level	63.1% (N=1332)



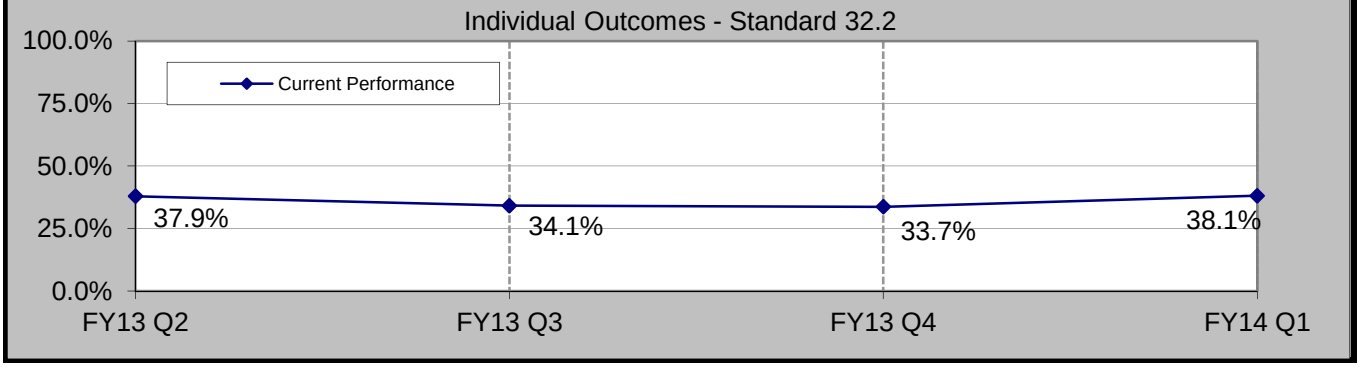
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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	28.3% (104 out of 367)

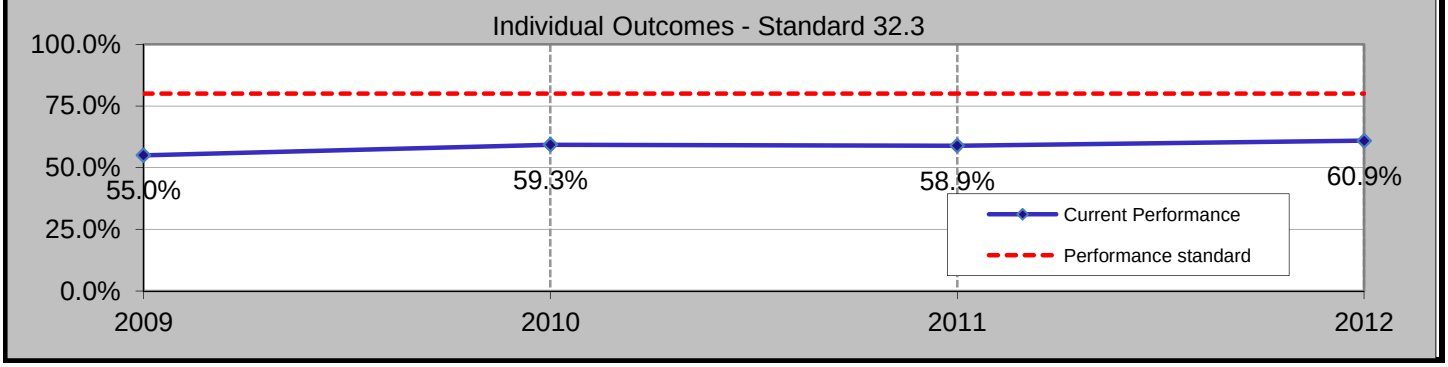


Standard 32.2	
Measurement	Class Members who have maintained level of functioning between baseline and 12 month re-certification.
Standard	Standard to be established.
Data Source	Enrollment data (Based on overall composite score.)
Current Level	38.1% (104 out of 367)



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

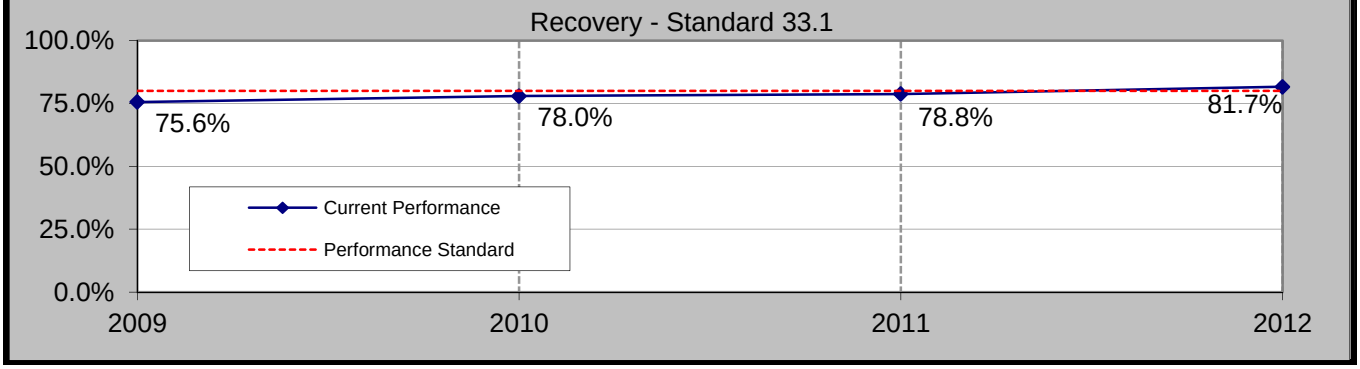
Standard 32.3	
Measurement	Consumers reporting positively on functional outcomes on Adult Mental Health and Well Being Survey outcome items.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	60.9% (N=1349)



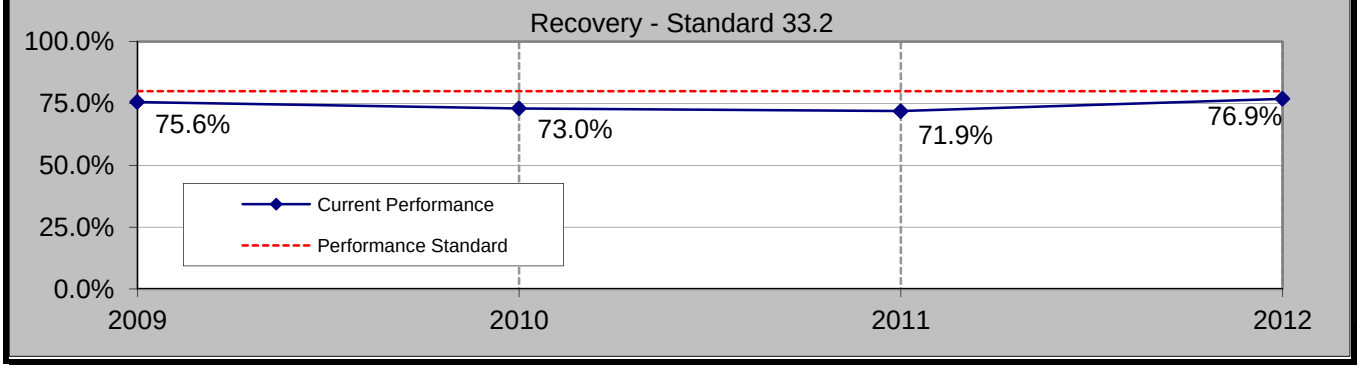
System Outcomes: Supporting the Recovery of Adults with Mental Illness
Recovery

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

Standard 33.1	
Measurement	Consumer reporting that agency staff helped them obtain information needed to take charge of managing illness.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	81.7% (N=1180)

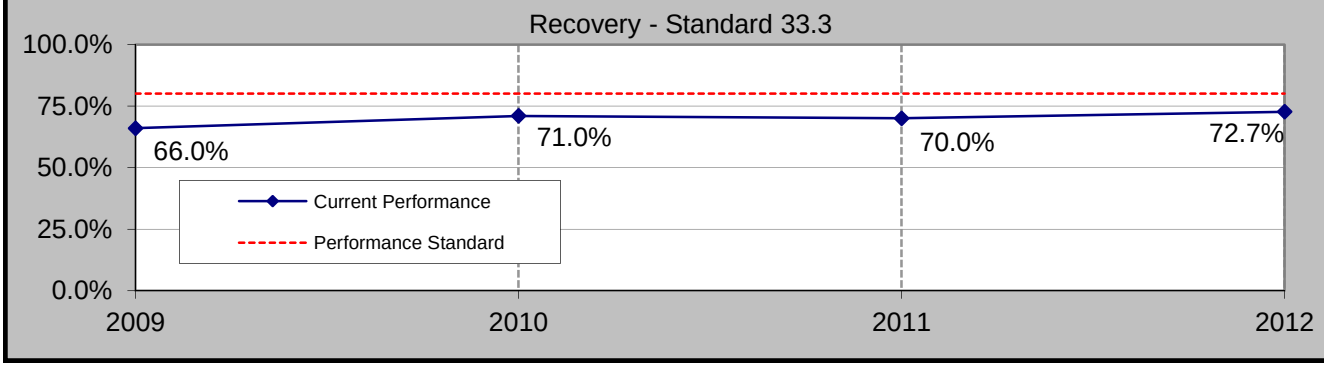


Standard 33.2	
Measurement	Consumers reporting that agency staff believe that they can grow, change and recover
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	76.9% (N=1271)

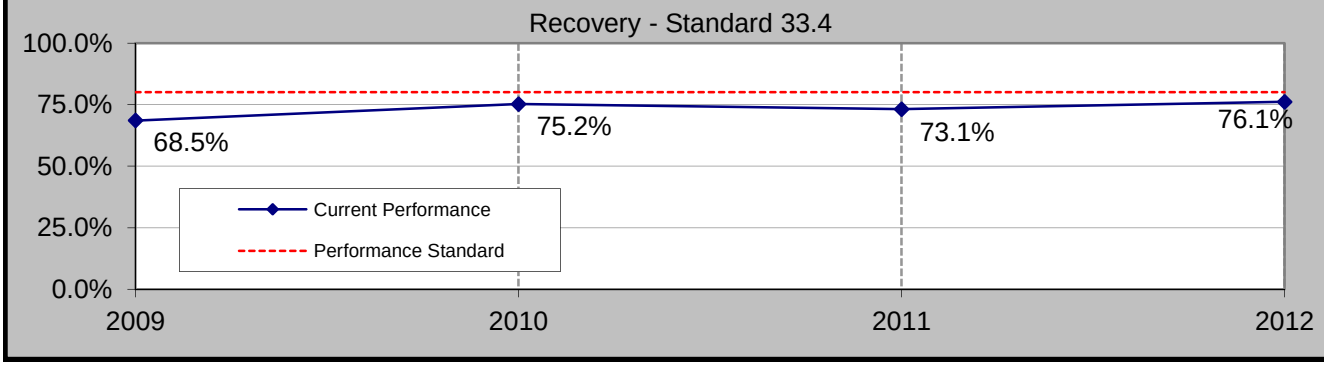


System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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

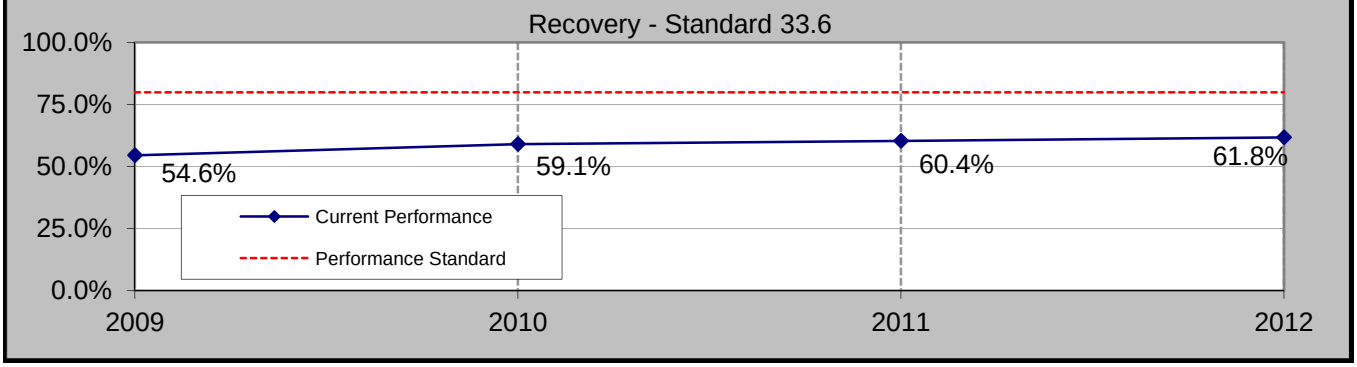


Standard 33.4	
Measurement	Consumers reporting that providers offered opportunities to learn skills to strengthen and maintain wellness.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey Q16
Current Level	76.1% (N=1292)



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

Standard 33.6	
Measurement	Consumers reporting that service providers offered mutual support or recovery-oriented groups run by peers.
Standard	Performance: 80%
Source	Adult Mental Health and Well Being Survey
Current Level	61.8% (N=1134)



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

Standard 34.1	
Measurement	# of mental health workshops, forums, and presentations geared toward general public and level of participation.
Standard	Qualitative evaluation required, no numerical standard necessary.
Data Source	NAMI
Current Level	57 FY14 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	NAMI
Current Level	3596 FY14 Q1

Public Education- Standard 34

Oct - Dec 2013 (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 2013

**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
October 3,10,17, 24, 31, November 7, 14, 21 December 5 (Biddeford)	x	x		Consumers	15	x	x	x	CIPSS Training	
October 7-11 (Augusta)	x			Consumers	10	x	x	x	Pathways to Recovery Facilitator Training	
October 8, 15, 29 (Portland)				Consumers	6	x	x	x	Healthy Connections	
November 8 (August)				Consumers	12	x	x	x	Crreating your Elevator Speech	
November 12th (Augusta)				Consumers	16		x	x	So You Think You Know Your Rights	
December 2 (Portland)	x		x	Consumers	15	x	x	x	Peer Support 101	
December 3 (Augusta)	x		x	Consumers	5	x	x	x	Peer Support 101	
December 9 (Lewiston)	x		x	Consumers	10	x	x	x	Peer Support 101	
December 12 (Augusta)				Consumers	12	x	x	x	Can I do That?	
2 Crisis Intervention Team trainings Penobscot (9/9-13/13) & York Counties (9/16-20/13)	Law Enforcement/ corrections, first responders			Law Enforcement	43	X	X	X	40 hour CIT	
2 Gatekeeper Trainings (Augusta (9/6/13), Bangor (9/24/13)	x		x	school, community, primary care	37	x	x		suicide prevention Gatekeeper 6.5 hours	
Suicide Assessment for Clinicians Waterville (9/9/13)	x				7	x	x	x	One 6 hour Suicide Assessment for Clinicians training	
Participation in VA Mental Health Summit (9/13/13)	x	x	x	VA staff	40		x	x		
Total of 11 in July: Bangor 7/1,10,11,15,19; Auburn 7/16; Augusta 7/17,27; South Portland 7/29. Total of 6 in August: Bangor 8/5,8,26; Augusta 8/19; South Portland 8/22/29; September Total of 6: Augusta 9/25; Norway 9/24; South Portland 9/17, 13, 19; Waterville 9/21.	x	x	x	new respite providers	24	x	x	x	2 hour orientation for Family Respite Providers	
Organized and staffed phone bank for WCSH TV (9/20/13)	x		x	Consumers and Family	64 calls received	x	x		Resources and navigating the MH system	
Suicide Awareness Session Augusta 9/10 and Farmington 9/21. Two veterans event presentations. Other schools, colleges and private companies widely distributed across Maine)	x		x	School & college staff, private companies, veterans	228	x			6 Suicide Prevention Awareness Sessions (inc. Schools, College, and Private Companies) widely distributed across Maine	
Family to Family Bangor 4/11 ,Brunswick 5/20 , Dover-Foxcroft 5/21 , Augusta 9/16, Westbrook 9/30	x		x	Family Members	82	x	x	x	Five 12-week trainings started or ended during this quarter	
Leadership Training, Lewiston, 8/17-8/18/13			x	Consumers	6	x	x	x	Two-day support group facilitation training	
Family to Family Teacher training			x	Family members	N/A	x	x	x	offered annually in spring	

10/1/13-RPC		13	1		14				PGR: Research Advances in the Treatment of Adolescents with Co-Occurring Psychiatric and Substance Abuse Disorders	
10/8/13- RPC		8	0		9				PGR: Tobacco Addiction: Motivation Based Treatments & Organizational Change	
10/15/13 - RPC		6	0		6				PGR: Prescribing Psychotropics in the Absence of Psychiatric Diagnosis: What's Happening in the Elderly and Should We Be Concerned?	
10/22/13- RPC		11	0		11				PGR: Where is the Missing Heritability for Neuropsychiatric Diseases? Presented by: Jason H. Moore, PhD	
10/29/13 - RPC		10	1		11				PGR: Advances in Brain Stimulation for Depression	
11/5/13 - RPC		11	0		11				PGR: Update in Diabetes Care and Implications for Metabolic Perturbations Caused by Medications used in Psychiatry	
11/19/13- RPC		14	1		15				PGR:Rethinking Depression and Its Treatment	
12/3/13- RPC		10	1		11				PGR: Personality Trait or Psychiatric Symptom? Thinking Dimensionally in a Binary World	
12/10/13- RPC		13	0		13				PGR:How We Can Increase the Life Expectancy of People with Mental Illness by 10 Years in 10 Years	
12/13/13-RPC		8	0		8				PGR:Establishing a Standard of Care-Using a Learning Collaborative Approach to Improve Office Based Opioid Treatment	
10/11/13-Acadia Bangor	x	x	x		44	x	x	x	The Art & Science of Somatic Coaching: Tools for Self-Management for Practitioners & Clients	

Performance Indicators and Quality Improvement Standards

APPENDIX: ADULT MENTAL HEALTH DATA SOURCES

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

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

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

Community Hospital Utilization Review Summary:

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

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

Community Support Enrollment Data:

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

Community Support Services Census/Staffing Data:

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

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

Grievance Tracking Data:

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

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

Class Member Treatment Planning Review:

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

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

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

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

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

Quarterly Contract Performance Indicator Data:

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

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

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

Attached Report:

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 1

Population Covered:

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

Data Sources:

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

Unmet Resource Need Definition

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

Quality Improvement Measures

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

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

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

Ongoing Quality Improvement Initiatives

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

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

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

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

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

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

SAMHS's ability to meet the compliance standards. The workgroup has reviewed data from FY2006 to the present to determine patterns of compliance with the standards. The data have been analyzed and recommendations have been made to the Commissioner, Court Master, and Plaintiffs Attorneys.
Identified Need: A,B,C,D,E,F,G,H,I,J,K,L,M

Contract Performance Measures. SAMHS has instituted contract performance measures for five services areas for FY13 contracts and fourteen services areas for FY14 contracts. Where appropriate, the measures are in alignment with standards under the Consent Decree Plan. In a meeting with the DHHS Office of Quality Management, we agreed on a three year schedule for full implementation of measures; year one will be to validate the measures, year two to establish baselines, year 3 to test full implementation. At that point the measures will be put into Maine Care rule as well as being standardized for all SAMHS provider contracts.
Identified Need: A, B, C, D

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

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

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

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

Maine Crisis Network, two representatives from Children's Behavioral Health and two representatives from SAMHS will work together to conduct reviews at contracted agencies. Muskie staff are overseeing and organizing the review process and will collect the data to generate a summary report. This review has been pushed back to FY14.
Identified Need: B

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

SAMHS Quality Management Plan 2013-2018. A team in the Data and Quality Management division is undertaking the development of a new SAMHS comprehensive quality management plan for 2013-2018. The team members are engaging with division leaders in the four pillars of SAMHS services (prevention, intervention, treatment and recovery) to develop profiles of programs, specific initiatives, evidence based or promising practice services being offered and standardized performance measures. The team is meeting weekly to review information, receive feedback from team members and refine the work with staff within each of the four pillars of SAMHS services. The scope of the final plan will be inclusive of all SAMHS services and the required Consent Decree services will be imbedded within the larger document. Anticipated completion date for the draft has been pushed back and will be contingent on filling a vacated position, the Data Quality Manager.
Identified Need: A,B,C,D,E,F,G,H,I,J,K,L,M

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

Substance Abuse and Mental Health Services
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Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 1

(July, Aug, Sept 2013)

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 9, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q1

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

CSN	Counties	Distinct People
CSN 1	Aroostook	402
CSN 2	Hancock, Penobscot, Piscataquis & Washington	1,846
CSN 3	Kennebec & Somerset	2,047
CSN 4	Knox, Lincoln, Sagadahoc & Waldo	792
CSN 5	Androscoggin, Franklin & Oxford	2,002
CSN 6	Cumberland	2,114
CSN 7	York	484
Not Assigned	No legal address	367
Statewide		10,054

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

	2013 Q2			2013 Q3			2013 Q4			2014 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	114	382	29.8%	136	393	34.6%	133	387	34.4%	137	402	34.1%
CSN 2	459	1,705	26.9%	431	1,760	24.5%	429	1,870	22.9%	467	1,846	25.3%
CSN 3	352	1,967	17.9%	349	1,991	17.5%	373	2,085	17.9%	370	2,047	18.1%
CSN 4	240	805	29.8%	238	830	28.7%	219	834	26.3%	216	792	27.3%
CSN 5	626	1,928	32.5%	615	1,926	31.9%	634	2,057	30.8%	634	2,002	31.7%
CSN 6	591	1,946	30.4%	606	2,013	30.1%	648	2,125	30.5%	662	2,114	31.3%
CSN 7	181	545	33.2%	158	547	28.9%	186	558	33.3%	147	484	30.4%
N/A	106	388	27.3%	116	397	29.2%	107	368	29.1%	109	367	29.7%
Total	2,669	9,666	27.6%	2,649	9,857	26.9%	2,729	10,284	26.5%	2,742	10,054	27.3%

Report Run: Jan 9, 2014

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

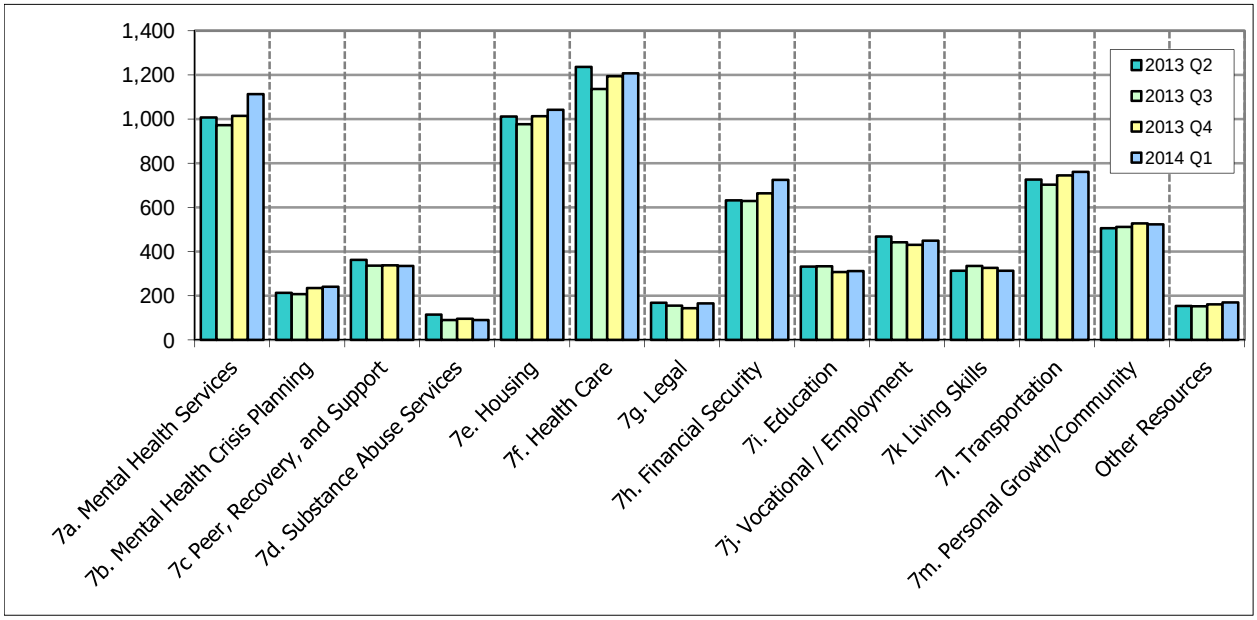

Table 3: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q2	2013 Q3	2013 Q4	2014 Q1
7a. Mental Health Services	1,008	972	1,015	1,113
7b. Mental Health Crisis Planning	214	207	235	241
7c Peer, Recovery, and Support	363	337	338	335
7d. Substance Abuse Services	115	91	96	91
7e. Housing	1,012	977	1,013	1,042
7f. Health Care	1,236	1,136	1,194	1,208
7g. Legal	168	155	144	165
7h. Financial Security	632	629	664	725
7i. Education	332	334	307	312
7j. Vocational / Employment	468	442	431	449
7k Living Skills	313	335	327	313
7l. Transportation	727	703	745	761
7m. Personal Growth/Community	506	512	528	524
Other Resources	154	153	162	170
Total Statewide Unmet Needs	7,248	6,983	7,199	7,449

Report Run: Jan 9, 2014

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

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

Report of Unmet Resource Needs

Statewide

(All CSNs)

Fiscal Year 2014 Quarter 1

(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	9,666	9,857	10,284	10,054
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	36	51	62	61
7a-iii Dialectical Behavioral Therapy	32	31	40	40
7a-iv Family Psycho-Educational Treatment	8	11	16	18
7a-v Group Counseling	32	41	34	42
7a-vi Individual Counseling	430	397	413	484
7a-vii Inpatient Psychiatric Facility	2	5	6	6
7a-viii Intensive Case Management	22	26	24	31
7a-x Psychiatric Medication Management	482	461	482	492
Total Unmet Resource Needs	1,008	972	1,015	1,113
Distinct Clients with Unmet Resource Needs	802	791	858	894
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	160	149	179	185
7b-ii Mental Health Advance Directives	54	58	56	56
Total Unmet Resource Needs	214	207	235	241
Distinct Clients with Unmet Resource Needs	192	186	220	221
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	45	42	40	41
7c-ii Recovery Workbook Group	3	4	4	7
7c-iii Social Club	127	112	109	111
7c-iv Peer-Run Trauma Recovery Group	39	36	34	29
7c-v Wellness Recovery and Action Planning	22	25	24	32
7c-vi Family Support	127	118	127	115
Total Unmet Resource Needs	363	337	338	335
Distinct Clients with Unmet Resource Needs	301	271	278	270
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	97	71	78	74
7d-ii Residential Treatment Substance Abuse Services	18	20	18	17
Total Unmet Resource Needs	115	91	96	91
Distinct Clients with Unmet Resource Needs	111	86	94	88

7e. Housing

Report Run: Jan 9, 2014

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

Report of Unmet Resource Needs

Statewide

(All CSNs)

Fiscal Year 2014 Quarter 1

(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	9,666	9,857	10,284	10,054
7e. Housing				
7e-ii Community Residential Facility	31	35	35	41
7e-iii Residential Treatment Facility (group home)	15	13	13	13
7e-iv Assisted Living Facility	47	43	42	49
7e-v Nursing Home	5	4	4	6
7e-vi Residential Crisis Unit	2	2	2	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	800	762	802	818
Total Unmet Resource Needs	1,012	977	1,013	1,042
Distinct Clients with Unmet Resource Needs	938	896	935	951
7f. Health Care				
7f-i Dental Services	638	598	616	622
7f-ii Eye Care Services	254	227	232	232
7f-iii Hearing Services	58	57	62	52
7f-iv Physical Therapy	39	38	38	39
7f-v Physician/Medical Services	247	216	246	263
Total Unmet Resource Needs	1,236	1,136	1,194	1,208
Distinct Clients with Unmet Resource Needs	914	874	921	915
7g. Legal				
7g-i Advocate	100	95	93	109
7g-ii Guardian (private)	52	43	40	41
7g-iii Guardian (public)	16	17	11	15
Total Unmet Resource Needs	168	155	144	165
Distinct Clients with Unmet Resource Needs	155	147	136	155
7h. Financial Security				
7h-i Assistance with Managing Money	368	358	367	407
7h-ii Assistance with Securing Public Benefits	223	230	255	267
7h-iii Representative Payee	41	41	42	51
Total Unmet Resource Needs	632	629	664	725
Distinct Clients with Unmet Resource Needs	572	561	592	641

Report Run: Jan 9, 2014

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

Report of Unmet Resource Needs

Statewide

(All CSNs)

Fiscal Year 2014 Quarter 1

(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	9,666	9,857	10,284	10,054
7i. Education				
7i-ii GED	87	95	86	88
7i-iii Literacy Assistance	34	29	29	27
7i-iv Post High School Education	110	105	102	115
7i-v Tuition Reimbursement	26	25	24	17
Total Unmet Resource Needs	332	334	307	312
Distinct Clients with Unmet Resource Needs	306	310	284	295
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	45	42	43	37
7j-ii Club House and/or Peer Vocational Support	26	22	26	38
7j-iii Competitive Employment (no supports)	70	67	66	67
7j-iv Supported Employment	42	46	42	48
7j-v Vocational Rehabilitation	285	265	254	259
Total Unmet Resource Needs	468	442	431	449
Distinct Clients with Unmet Resource Needs	414	395	380	391
7k. Living Skills				
7k-i Daily Living Support Services	217	227	222	214
7k-ii Day Support Services	27	29	32	24
7k-iii Occupational Therapy	13	8	9	13
7k-iv Skills Development Services	56	71	64	62
Total Unmet Resource Needs	313	335	327	313
Distinct Clients with Unmet Resource Needs	290	309	305	291
7l. Transportation				
7l-i Transportation to ISP-Identified Services	366	357	362	377
7-ii Transportation to Other ISP Activities	196	192	197	202
7-iii After Hours Transportation	165	154	186	182
Total Unmet Resource Needs	727	703	745	761
Distinct Clients with Unmet Resource Needs	512	510	529	524
7m. Personal Growth/Community				
7m-i Avocational Activities	20	23	24	27

Report Run: Jan 9, 2014

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

Report of Unmet Resource Needs

Statewide

(All CSNs)

Fiscal Year 2014 Quarter 1

(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	9,666	9,857	10,284	10,054
7m. Personal Growth/Community				
7m-iii Social Activities	289	297	315	301
7m-iv Spiritual Activities	60	54	48	61
Total Unmet Resource Needs	506	512	528	524
Distinct Clients with Unmet Resource Needs	367	372	395	379
Other Resources				
Other Resources	154	153	162	170
Total Unmet Resource Needs	154	153	162	170
Distinct Clients with Unmet Resource Needs	154	153	162	170
Statewide Totals				
Total Unmet Resource Needs	7,248	6,983	7,199	7,449
Distinct Clients With any Unmet Resource Need	2,669	2,649	2,729	2,742
Distinct Clients with a RDS	9,666	9,857	10,284	10,054

Report Run: Jan 9, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q1

CSN 1 - Aroostook

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

2013 Q2			2013 Q3			2013 Q4			2014 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
114	382	29.8%	136	393	34.6%	133	387	34.4%	137	402	34.1%

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

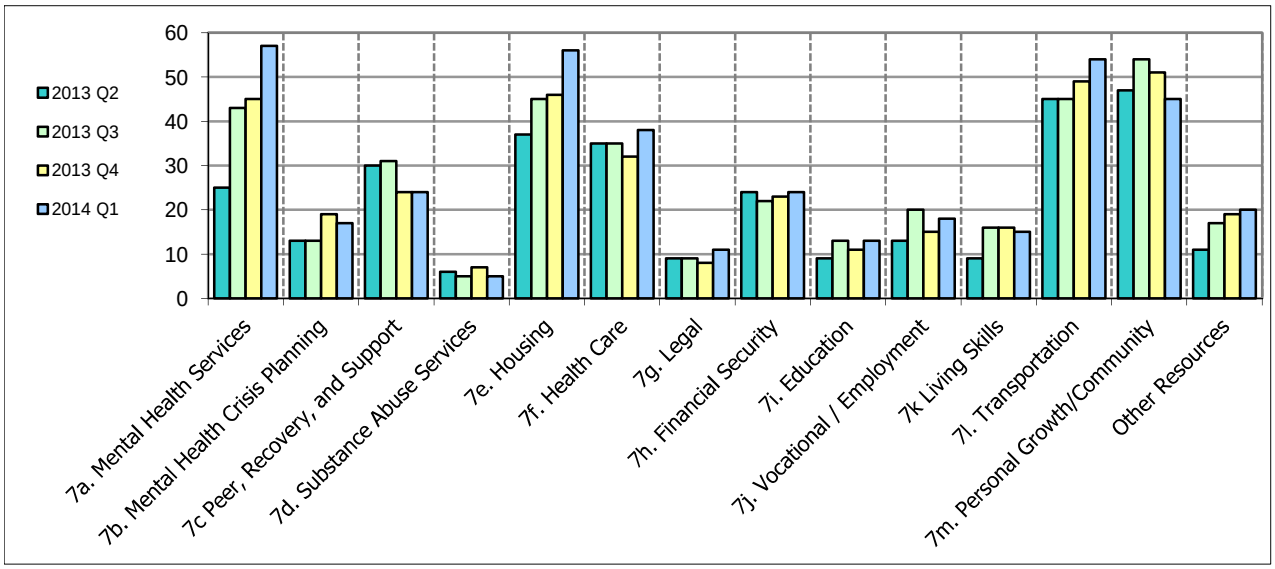

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q2	2013 Q3	2013 Q4	2014 Q1
7a. Mental Health Services	25	43	45	57
7b. Mental Health Crisis Planning	13	13	19	17
7c Peer, Recovery, and Support	30	31	24	24
7d. Substance Abuse Services	6	5	7	5
7e. Housing	37	45	46	56
7f. Health Care	35	35	32	38
7g. Legal	9	9	8	11
7h. Financial Security	24	22	23	24
7i. Education	9	13	11	13
7j. Vocational / Employment	13	20	15	18
7k Living Skills	9	16	16	15
7l. Transportation	45	45	49	54
7m. Personal Growth/Community	47	54	51	45
Other Resources	11	17	19	20
Total CSN 1 Unmet Needs	313	368	365	397

Report Run: Jan 9, 2014

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	382	393	387	402
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	0	0	0	0
7a-iii Dialectical Behavioral Therapy	4	6	7	5
7a-iv Family Psycho-Educational Treatment	0	1	2	1
7a-v Group Counseling	0	5	3	7
7a-vi Individual Counseling	4	7	8	14
7a-vii Inpatient Psychiatric Facility	1	1	0	1
7a-viii Intensive Case Management	0	1	0	0
7a-x Psychiatric Medication Management	16	22	25	29
Total Unmet Resource Needs	25	43	45	57
Distinct Clients with Unmet Resource Needs	21	36	38	46
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	10	8	15	12
7b-ii Mental Health Advance Directives	3	5	4	5
Total Unmet Resource Needs	13	13	19	17
Distinct Clients with Unmet Resource Needs	12	11	18	14
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	2	0	1
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	19	20	14	17
7c-iv Peer-Run Trauma Recovery Group	3	2	2	1
7c-v Wellness Recovery and Action Planning	1	1	2	2
7c-vi Family Support	6	6	6	3
Total Unmet Resource Needs	30	31	24	24
Distinct Clients with Unmet Resource Needs	25	26	21	22
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	5	5	7	5
7d-ii Residential Treatment Substance Abuse Services	1	0	0	0
Total Unmet Resource Needs	6	5	7	5
Distinct Clients with Unmet Resource Needs	6	5	7	5

Report Run: Jan 9, 2014

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 20114 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	382	393	387	402
7e. Housing				
7e-i Supported Apartment	7	11	10	11
7e-ii Community Residential Facility	0	0	2	2
7e-iii Residential Treatment Facility (group home)	3	2	2	3
7e-iv Assisted Living Facility	2	1	2	4
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	25	31	30	36
Total Unmet Resource Needs	37	45	46	56
Distinct Clients with Unmet Resource Needs	34	39	38	45
7f. Health Care				
7f-i Dental Services	9	13	13	16
7f-ii Eye Care Services	7	3	3	7
7f-iii Hearing Services	2	1	1	1
7f-iv Physical Therapy	1	2	2	1
7f-v Physician/Medical Services	16	16	13	13
Total Unmet Resource Needs	35	35	32	38
Distinct Clients with Unmet Resource Needs	31	32	29	30
7g. Legal				
7g-i Advocate	8	7	6	6
7g-ii Guardian (private)	0	2	2	4
7g-iii Guardian (public)	1	0	0	1
Total Unmet Resource Needs	9	9	8	11
Distinct Clients with Unmet Resource Needs	8	9	7	10
7h. Financial Security				
7h-i Assistance with Managing Money	13	12	13	13
7h-ii Assistance with Securing Public Benefits	11	10	10	11
7h-iii Representative Payee	0	0	0	0
Total Unmet Resource Needs	24	22	23	24
Distinct Clients with Unmet Resource Needs	23	22	22	24

Report Run: Jan 9, 2014

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	382	393	387	402
7i. Education				
7i-i Adult Education (other than GED)	1	4	2	1
7i-ii GED	5	4	4	6
7i-iii Literacy Assistance	2	1	1	1
7i-iv Post High School Education	1	3	3	4
7i-v Tuition Reimbursement	0	1	1	1
Total Unmet Resource Needs	9	13	11	13
Distinct Clients with Unmet Resource Needs	9	13	11	13
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	2	1	4
7j-ii Club House and/or Peer Vocational Support	1	1	1	1
7j-iii Competitive Employment (no supports)	1	2	1	0
7j-iv Supported Employment	2	6	2	3
7j-v Vocational Rehabilitation	8	9	10	10
Total Unmet Resource Needs	13	20	15	18
Distinct Clients with Unmet Resource Needs	11	16	14	16
7k. Living Skills				
7k-i Daily Living Support Services	5	6	5	7
7k-ii Day Support Services	1	2	3	0
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	3	8	8	8
Total Unmet Resource Needs	9	16	16	15
Distinct Clients with Unmet Resource Needs	8	15	15	13
7l. Transportation				
7l-i Transportation to ISP-Identified Services	21	25	25	28
7-ii Transportation to Other ISP Activities	8	8	11	11
7-iii After Hours Transportation	16	12	13	15
Total Unmet Resource Needs	45	45	49	54
Distinct Clients with Unmet Resource Needs	32	36	36	38
7m. Personal Growth/Community				
7m-i Avocational Activities	0	1	0	2

Report Run: Jan 9, 2014

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

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	382	393	387	402
7m. Personal Growth/Community				
7m-ii Recreation Activities	14	15	16	9
7m-iii Social Activities	29	35	33	30
7m-iv Spiritual Activities	4	3	2	4
Total Unmet Resource Needs	47	54	51	45
Distinct Clients with Unmet Resource Needs	35	42	40	34
Other Resources				
Other Resources	11	17	19	20
Total Unmet Resource Needs	11	17	19	20
Distinct Clients with Unmet Resource Needs	11	17	19	20
CSN 1 Totals				
Total Unmet Resource Needs	313	368	365	397
Distinct Clients With any Unmet Resource Need	114	136	133	137
Distinct Clients with a RDS	382	393	387	402

Report Run: Jan 9, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q1

CSN 2 - Hancock, Washington, Penobscot, Piscataquis

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

2013 Q2			2013 Q3			2013 Q4			2014 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
459	1,705	26.9%	431	1,760	24.5%	429	1,870	22.9%	467	1,846	25.3%

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

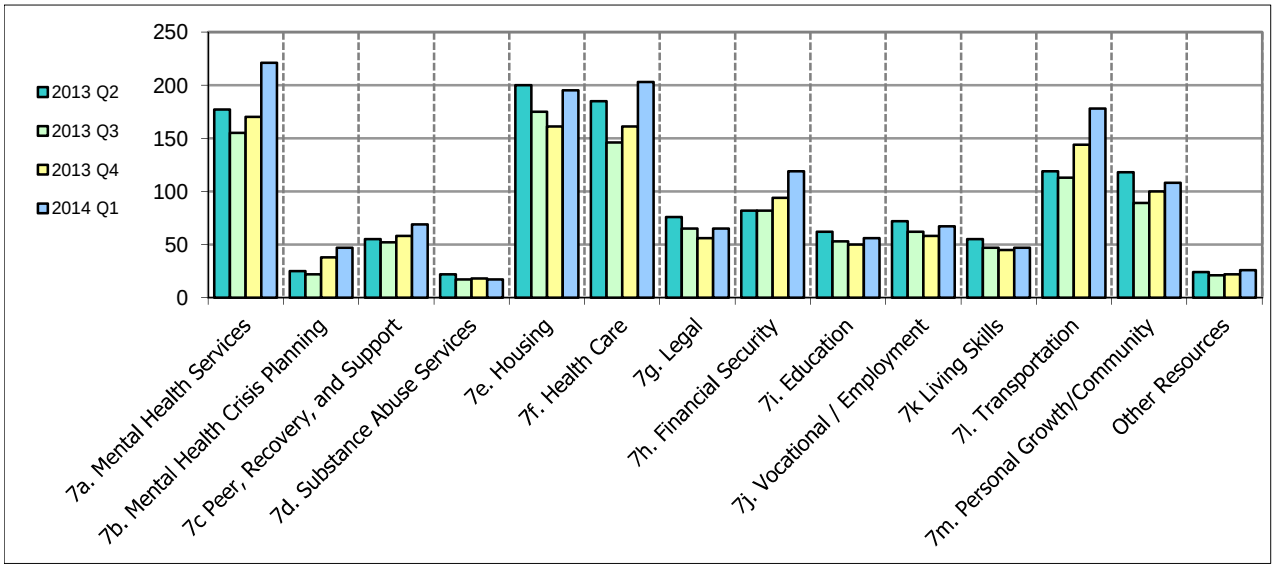

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q2	2013 Q3	2013 Q4	2014 Q1
7a. Mental Health Services	177	155	170	221
7b. Mental Health Crisis Planning	25	22	38	47
7c Peer, Recovery, and Support	55	52	58	69
7d. Substance Abuse Services	22	17	18	17
7e. Housing	200	175	161	195
7f. Health Care	185	146	161	203
7g. Legal	76	65	56	65
7h. Financial Security	82	82	94	119
7i. Education	62	53	50	56
7j. Vocational / Employment	72	62	58	67
7k Living Skills	55	47	45	47
7l. Transportation	119	113	144	178
7m. Personal Growth/Community	118	89	100	108
Other Resources	24	21	22	26
Total CSN 2 Unmet Needs	1,272	1,099	1,175	1,418

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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 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,705	1,760	1,870	1,846
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	2	3	3
7a-iii Dialectical Behavioral Therapy	2	1	2	2
7a-iv Family Psycho-Educational Treatment	4	4	5	5
7a-v Group Counseling	9	9	6	7
7a-vi Individual Counseling	86	71	73	106
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	1	1	1	5
7a-x Psychiatric Medication Management	73	67	80	93
Total Unmet Resource Needs	177	155	170	221
Distinct Clients with Unmet Resource Needs	134	121	131	155
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	23	19	34	40
7b-ii Mental Health Advance Directives	2	3	4	7
Total Unmet Resource Needs	25	22	38	47
Distinct Clients with Unmet Resource Needs	24	20	36	44
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	6	6	6	6
7c-ii Recovery Workbook Group	1	1	1	1
7c-iii Social Club	14	15	12	15
7c-iv Peer-Run Trauma Recovery Group	11	11	12	10
7c-v Wellness Recovery and Action Planning	8	6	7	10
7c-vi Family Support	15	13	20	27
Total Unmet Resource Needs	55	52	58	69
Distinct Clients with Unmet Resource Needs	38	35	40	48
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	19	13	15	16
7d-ii Residential Treatment Substance Abuse Services	3	4	3	1
Total Unmet Resource Needs	22	17	18	17
Distinct Clients with Unmet Resource Needs	20	15	16	17

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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 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,705	1,760	1,870	1,846
7e. Housing				
7e-i Supported Apartment	23	13	16	26
7e-ii Community Residential Facility	4	6	4	6
7e-iii Residential Treatment Facility (group home)	1	0	0	0
7e-iv Assisted Living Facility	9	9	7	10
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)	163	147	134	153
Total Unmet Resource Needs	200	175	161	195
Distinct Clients with Unmet Resource Needs	186	165	152	183
7f. Health Care				
7f-i Dental Services	88	62	67	83
7f-ii Eye Care Services	44	38	34	46
7f-iii Hearing Services	5	7	5	8
7f-iv Physical Therapy	7	7	7	9
7f-v Physician/Medical Services	41	32	48	57
Total Unmet Resource Needs	185	146	161	203
Distinct Clients with Unmet Resource Needs	132	117	123	143
7g. Legal				
7g-i Advocate	29	30	24	29
7g-ii Guardian (private)	43	32	30	32
7g-iii Guardian (public)	4	3	2	4
Total Unmet Resource Needs	76	65	56	65
Distinct Clients with Unmet Resource Needs	67	60	52	59
7h. Financial Security				
7h-i Assistance with Managing Money	46	42	47	70
7h-ii Assistance with Securing Public Benefits	35	39	42	41
7h-iii Representative Payee	1	1	5	8
Total Unmet Resource Needs	82	82	94	119
Distinct Clients with Unmet Resource Needs	76	72	82	102

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Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,705	1,760	1,870	##
7i. Education				
7i-ii GED	8	6	4	5
7i-iii Literacy Assistance	5	5	3	4
7i-iv Post High School Education	30	25	26	28
7i-v Tuition Reimbursement	12	8	9	10
Total Unmet Resource Needs	62	53	50	56
Distinct Clients with Unmet Resource Needs	54	49	46	52
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	8	7	8	6
7j-ii Club House and/or Peer Vocational Support	2	2	2	2
7j-iii Competitive Employment (no supports)	18	18	19	22
7j-iv Supported Employment	7	7	8	7
7j-v Vocational Rehabilitation	37	28	21	30
Total Unmet Resource Needs	72	62	58	67
Distinct Clients with Unmet Resource Needs	62	53	49	54
7k. Living Skills				
7k-i Daily Living Support Services	36	35	31	32
7k-ii Day Support Services	3	3	4	3
7k-iii Occupational Therapy	2	1	1	3
7k-iv Skills Development Services	14	8	9	9
Total Unmet Resource Needs	55	47	45	47
Distinct Clients with Unmet Resource Needs	47	40	39	41
7l. Transportation				
7l-i Transportation to ISP-Identified Services	57	51	64	83
7-ii Transportation to Other ISP Activities	22	25	35	45
7-iii After Hours Transportation	40	37	45	50
Total Unmet Resource Needs	119	113	144	178
Distinct Clients with Unmet Resource Needs	91	84	94	108
7m. Personal Growth/Community				
7m-i Avocational Activities	6	6	8	10

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Report of Unmet Resource Needs

CSN 2

ancock, Washington, Penobscot, Piscataquis)

Fiscal Year 20131 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,705	1,760	1,870	1,846
7m. Personal Growth/Community				
7m-iii Social Activities	65	49	55	55
7m-iv Spiritual Activities	7	4	5	12
Total Unmet Resource Needs	118	89	100	108
Distinct Clients with Unmet Resource Needs	79	61	69	70
Other Resources				
Other Resources	24	21	22	26
Total Unmet Resource Needs	24	21	22	26
Distinct Clients with Unmet Resource Needs	24	21	22	26
CSN 2 Totals				
Total Unmet Resource Needs	1,272	1,099	1,175	1,418
Distinct Clients With any Unmet Resource Need	459	431	429	467
Distinct Clients with a RDS	1,705	1,760	1,870	1,846

Report Run: Jan 9, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

CSN 3 - Kennebec and Somerset

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

2013 Q2			2013 Q3			2013 Q4			2014 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
352	1,967	17.9%	349	1,991	17.5%	373	2,085	17.9%	370	2,047	18.1%

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

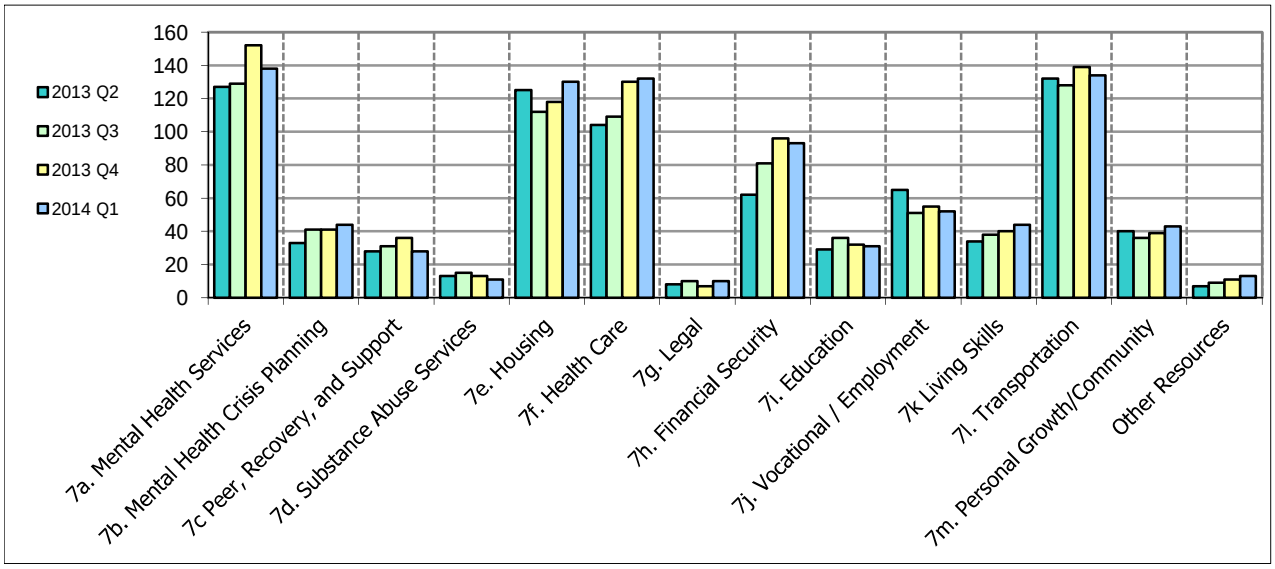

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q2	2013 Q3	2013 Q4	2014 Q1
7a. Mental Health Services	127	129	152	138
7b. Mental Health Crisis Planning	33	41	41	44
7c Peer, Recovery, and Support	28	31	36	28
7d. Substance Abuse Services	13	15	13	11
7e. Housing	125	112	118	130
7f. Health Care	104	109	130	132
7g. Legal	8	10	7	10
7h. Financial Security	62	81	96	93
7i. Education	29	36	32	31
7j. Vocational / Employment	65	51	55	52
7k Living Skills	34	38	40	44
7l. Transportation	132	128	139	134
7m. Personal Growth/Community	40	36	39	43
Other Resources	7	9	11	13
Total CSN 3 Unmet Needs	807	826	909	903

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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 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,967	1,991	2,085	2,047
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	5	4	3	4
7a-iii Dialectical Behavioral Therapy	0	0	3	2
7a-iv Family Psycho-Educational Treatment	1	1	1	1
7a-v Group Counseling	3	4	5	3
7a-vi Individual Counseling	54	54	66	60
7a-vii Inpatient Psychiatric Facility	1	1	1	1
7a-viii Intensive Case Management	1	2	2	2
7a-x Psychiatric Medication Management	62	63	71	65
Total Unmet Resource Needs	127	129	152	138
Distinct Clients with Unmet Resource Needs	95	100	113	103
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	23	28	31	31
7b-ii Mental Health Advance Directives	10	13	10	13
Total Unmet Resource Needs	33	41	41	44
Distinct Clients with Unmet Resource Needs	26	33	36	38
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	3	4	4	3
7c-ii Recovery Workbook Group	1	1	1	2
7c-iii Social Club	11	8	10	6
7c-iv Peer-Run Trauma Recovery Group	0	1	1	1
7c-v Wellness Recovery and Action Planning	1	2	1	1
7c-vi Family Support	12	15	19	15
Total Unmet Resource Needs	28	31	36	28
Distinct Clients with Unmet Resource Needs	26	28	33	25
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	9	9	9	7
7d-ii Residential Treatment Substance Abuse Services	4	6	4	4
Total Unmet Resource Needs	13	15	13	11
Distinct Clients with Unmet Resource Needs	13	14	13	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 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,967	1,991	2,085	2,047
7e. Housing				
7e-ii Community Residential Facility	4	4	3	7
7e-iii Residential Treatment Facility (group home)	2	2	1	2
7e-iv Assisted Living Facility	2	2	1	1
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)	107	96	107	113
Total Unmet Resource Needs	125	112	118	130
Distinct Clients with Unmet Resource Needs	117	105	114	124
7f. Health Care				
7f-i Dental Services	52	56	62	64
7f-ii Eye Care Services	18	20	23	25
7f-iii Hearing Services	7	8	12	10
7f-iv Physical Therapy	1	1	3	2
7f-v Physician/Medical Services	26	24	30	31
Total Unmet Resource Needs	104	109	130	132
Distinct Clients with Unmet Resource Needs	87	91	108	110
7g. Legal				
7g-i Advocate	4	5	4	5
7g-ii Guardian (private)	1	1	1	1
7g-iii Guardian (public)	3	4	2	4
Total Unmet Resource Needs	8	10	7	10
Distinct Clients with Unmet Resource Needs	6	8	5	8
7h. Financial Security				
7h-i Assistance with Managing Money	34	33	37	39
7h-ii Assistance with Securing Public Benefits	25	41	51	45
7h-iii Representative Payee	3	7	8	9
Total Unmet Resource Needs	62	81	96	93
Distinct Clients with Unmet Resource Needs	57	69	86	88

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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 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,967	1,991	2,085	2,047
7i. Education				
7i-ii GED	10	15	10	9
7i-iii Literacy Assistance	6	5	7	7
7i-iv Post High School Education	7	9	8	9
7i-v Tuition Reimbursement	2	2	2	2
Total Unmet Resource Needs	29	36	32	31
Distinct Clients with Unmet Resource Needs	26	34	29	28
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	7	3	3	2
7j-ii Club House and/or Peer Vocational Support	8	6	12	11
7j-iii Competitive Employment (no supports)	4	3	2	3
7j-iv Supported Employment	4	2	3	3
7j-v Vocational Rehabilitation	42	37	35	33
Total Unmet Resource Needs	65	51	55	52
Distinct Clients with Unmet Resource Needs	54	46	49	46
7k. Living Skills				
7k-i Daily Living Support Services	28	36	37	35
7k-ii Day Support Services	0	0	1	1
7k-iii Occupational Therapy	0	0	0	1
7k-iv Skills Development Services	6	2	2	7
Total Unmet Resource Needs	34	38	40	44
Distinct Clients with Unmet Resource Needs	34	38	40	43
7l. Transportation				
7l-i Transportation to ISP-Identified Services	87	84	85	83
7-ii Transportation to Other ISP Activities	28	25	31	30
7-iii After Hours Transportation	17	19	23	21
Total Unmet Resource Needs	132	128	139	134
Distinct Clients with Unmet Resource Needs	100	100	103	99
7m. Personal Growth/Community				
7m-i Avocational Activities	1	1	0	0

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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 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,967	1,991	2,085	2,047
7m. Personal Growth/Community				
7m-iii Social Activities	30	28	35	36
7m-iv Spiritual Activities	2	1	0	0
Total Unmet Resource Needs	40	36	39	43
Distinct Clients with Unmet Resource Needs	34	31	36	37
Other Resources				
Other Resources	7	9	11	13
Total Unmet Resource Needs	7	9	11	13
Distinct Clients with Unmet Resource Needs	7	9	11	13
CSN 3 Totals				
Total Unmet Resource Needs	807	826	909	903
Distinct Clients With any Unmet Resource Need	352	349	373	370
Distinct Clients with a RDS	1,967	1,991	2,085	2,047

Report Run: Jan 9, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q1

CSN 4 - Knox, Lincoln, Sagadahoc, Waldo

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

2013 Q2			2013 Q3			2013 Q4			2014 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
240	805	29.8%	238	830	28.7%	219	834	26.3%	216	792	27.3%

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

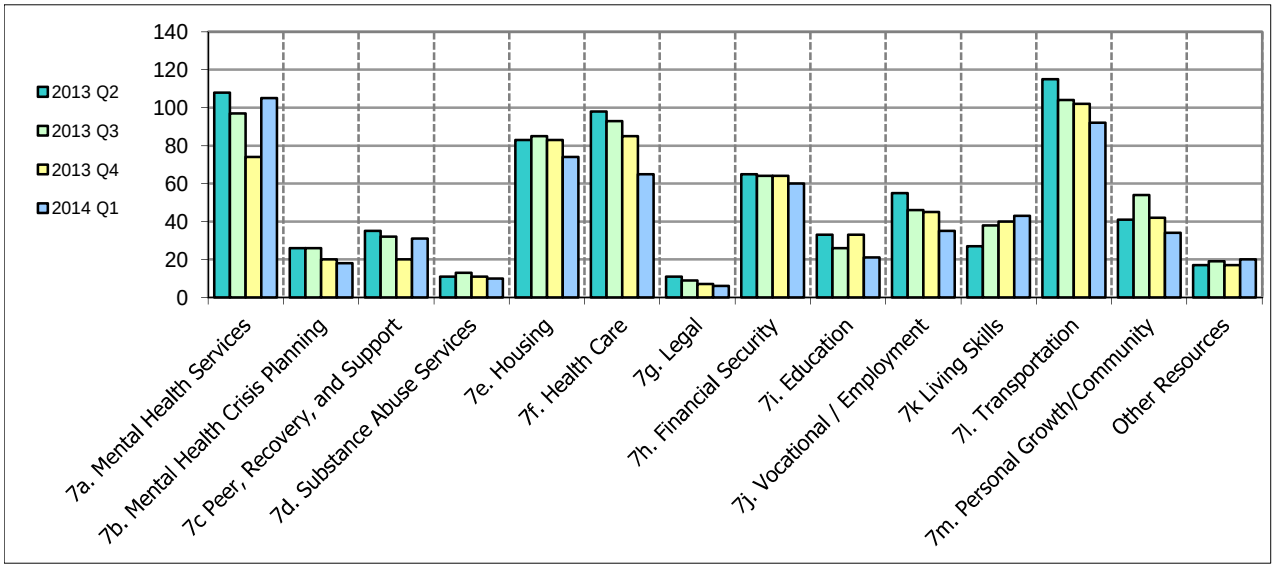

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q2	2013 Q3	2013 Q4	2014 Q1
7a. Mental Health Services	108	97	74	105
7b. Mental Health Crisis Planning	26	26	20	18
7c Peer, Recovery, and Support	35	32	20	31
7d. Substance Abuse Services	11	13	11	10
7e. Housing	83	85	83	74
7f. Health Care	98	93	85	65
7g. Legal	11	9	7	6
7h. Financial Security	65	64	64	60
7i. Education	33	26	33	21
7j. Vocational / Employment	55	46	45	35
7k Living Skills	27	38	40	43
7l. Transportation	115	104	102	92
7m. Personal Growth/Community	41	54	42	34
Other Resources	17	19	17	20
Total CSN 4 Unmet Needs	725	706	643	614

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Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	805	830	834	792
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	6	3	3	2
7a-iii Dialectical Behavioral Therapy	1	1	0	3
7a-iv Family Psycho-Educational Treatment	0	0	0	1
7a-v Group Counseling	2	1	1	3
7a-vi Individual Counseling	48	47	41	46
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	0	1	2	2
7a-x Psychiatric Medication Management	51	44	27	48
Total Unmet Resource Needs	108	97	74	105
Distinct Clients with Unmet Resource Needs	81	72	61	85
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	21	21	14	14
7b-ii Mental Health Advance Directives	5	5	6	4
Total Unmet Resource Needs	26	26	20	18
Distinct Clients with Unmet Resource Needs	24	24	19	17
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	6	3	2	8
7c-ii Recovery Workbook Group	0	0	0	1
7c-iii Social Club	7	9	4	5
7c-iv Peer-Run Trauma Recovery Group	4	5	3	2
7c-v Wellness Recovery and Action Planning	0	0	0	2
7c-vi Family Support	18	15	11	13
Total Unmet Resource Needs	35	32	20	31
Distinct Clients with Unmet Resource Needs	32	27	19	26
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	9	10	10	9
7d-ii Residential Treatment Substance Abuse Services	2	3	1	1
Total Unmet Resource Needs	11	13	11	10
Distinct Clients with Unmet Resource Needs	10	11	11	10

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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 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	805	830	834	792
7e. Housing				
7e-i Supported Apartment	8	13	9	9
7e-ii Community Residential Facility	2	2	3	3
7e-iii Residential Treatment Facility (group home)	2	2	3	4
7e-iv Assisted Living Facility	5	6	6	4
7e-v Nursing Home	0	2	2	2
7e-vi Residential Crisis Unit	0	1	1	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	66	59	59	51
Total Unmet Resource Needs	83	85	83	74
Distinct Clients with Unmet Resource Needs	80	74	73	63
7f. Health Care				
7f-i Dental Services	52	53	45	37
7f-ii Eye Care Services	16	23	17	11
7f-iii Hearing Services	7	4	6	3
7f-iv Physical Therapy	4	1	1	1
7f-v Physician/Medical Services	19	12	16	13
Total Unmet Resource Needs	98	93	85	65
Distinct Clients with Unmet Resource Needs	75	72	68	51
7g. Legal				
7g-i Advocate	9	6	5	3
7g-ii Guardian (private)	2	3	2	3
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	11	9	7	6
Distinct Clients with Unmet Resource Needs	11	9	7	6
7h. Financial Security				
7h-i Assistance with Managing Money	41	43	36	32
7h-ii Assistance with Securing Public Benefits	17	15	21	20
7h-iii Representative Payee	7	6	7	8
Total Unmet Resource Needs	65	64	64	60
Distinct Clients with Unmet Resource Needs	58	57	56	46

Report Run: Jan 9, 2014

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

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	805	830	834	792
7i. Education				
7i-ii GED	9	8	12	8
7i-iii Literacy Assistance	0	0	1	0
7i-iv Post High School Education	11	10	13	11
7i-v Tuition Reimbursement	6	3	2	0
Total Unmet Resource Needs	33	26	33	21
Distinct Clients with Unmet Resource Needs	31	24	32	21
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	5	4	4	4
7j-ii Club House and/or Peer Vocational Support	0	0	0	2
7j-iii Competitive Employment (no supports)	9	10	9	2
7j-iv Supported Employment	6	4	5	6
7j-v Vocational Rehabilitation	35	28	27	21
Total Unmet Resource Needs	55	46	45	35
Distinct Clients with Unmet Resource Needs	50	43	38	28
7k. Living Skills				
7k-i Daily Living Support Services	21	32	30	30
7k-ii Day Support Services	3	1	3	1
7k-iii Occupational Therapy	0	1	1	1
7k-iv Skills Development Services	3	4	6	11
Total Unmet Resource Needs	27	38	40	43
Distinct Clients with Unmet Resource Needs	27	36	36	38
7l. Transportation				
7l-i Transportation to ISP-Identified Services	60	52	54	49
7-ii Transportation to Other ISP Activities	41	38	34	28
7-iii After Hours Transportation	14	14	14	15
Total Unmet Resource Needs	115	104	102	92
Distinct Clients with Unmet Resource Needs	68	60	64	57
7m. Personal Growth/Community				
7m-i Avocational Activities	2	2	4	3

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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 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	805	830	834	792
7m. Personal Growth/Community				
7m-iii Social Activities	26	37	27	20
7m-iv Spiritual Activities	5	5	1	2
Total Unmet Resource Needs	41	54	42	34
Distinct Clients with Unmet Resource Needs	33	42	34	26
Other Resources				
Other Resources	17	19	17	20
Total Unmet Resource Needs	17	19	17	20
Distinct Clients with Unmet Resource Needs	17	19	17	20
CSN 4 Totals				
Total Unmet Resource Needs	725	706	643	614
Distinct Clients With any Unmet Resource Need	240	238	219	216
Distinct Clients with a RDS	805	830	834	792

Report Run: Jan 9, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

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

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

2013 Q2			2013 Q3			2013 Q4			2014 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
626	1,928	32.5%	615	1,926	31.9%	634	2,057	30.8%	634	2,002	31.7%

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

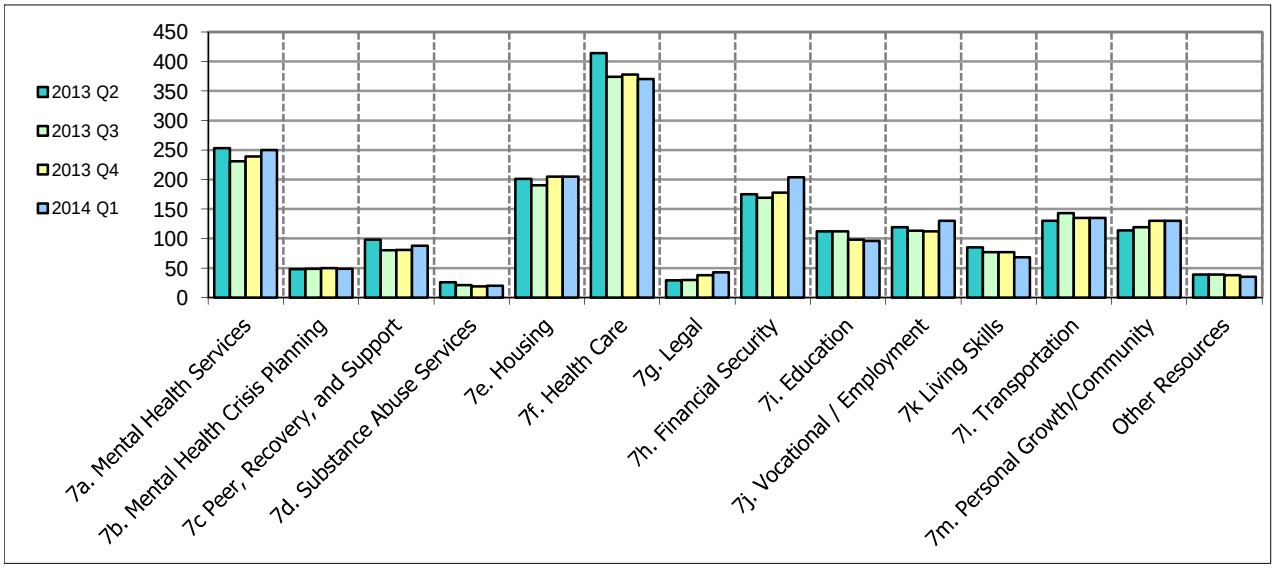

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q2	2013 Q3	2013 Q4	2014 Q1
7a. Mental Health Services	253	231	239	250
7b. Mental Health Crisis Planning	48	49	50	49
7c Peer, Recovery, and Support	98	80	81	88
7d. Substance Abuse Services	26	21	19	20
7e. Housing	201	190	205	205
7f. Health Care	414	374	378	370
7g. Legal	29	30	38	43
7h. Financial Security	175	169	178	204
7i. Education	112	112	98	96
7j. Vocational / Employment	119	113	112	130
7k Living Skills	85	77	77	68
7l. Transportation	130	143	135	135
7m. Personal Growth/Community	114	119	130	130
Other Resources	39	39	38	35
Total CSN 5 Unmet Needs	1,843	1,747	1,778	1,823

Report Run: Jan 9, 2014

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

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,928	1,926	2,057	2,002
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	3	5	7	4
7a-iii Dialectical Behavioral Therapy	11	11	15	21
7a-iv Family Psycho-Educational Treatment	1	2	4	5
7a-v Group Counseling	2	7	5	8
7a-vi Individual Counseling	106	90	82	102
7a-vii Inpatient Psychiatric Facility	0	2	2	2
7a-viii Intensive Case Management	0	0	3	5
7a-x Psychiatric Medication Management	130	114	121	103
Total Unmet Resource Needs	253	231	239	250
Distinct Clients with Unmet Resource Needs	208	192	208	210
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	26	23	26	32
7b-ii Mental Health Advance Directives	22	26	24	17
Total Unmet Resource Needs	48	49	50	49
Distinct Clients with Unmet Resource Needs	43	46	48	47
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	10	10	10	11
7c-ii Recovery Workbook Group	0	1	1	2
7c-iii Social Club	27	18	22	30
7c-iv Peer-Run Trauma Recovery Group	8	5	3	7
7c-v Wellness Recovery and Action Planning	2	4	6	6
7c-vi Family Support	51	42	39	32
Total Unmet Resource Needs	98	80	81	88
Distinct Clients with Unmet Resource Needs	88	69	73	76
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	25	19	17	17
7d-ii Residential Treatment Substance Abuse Services	1	2	2	3
Total Unmet Resource Needs	26	21	19	20
Distinct Clients with Unmet Resource Needs	26	21	19	20

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Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,928	1,926	2,057	2,002
7e. Housing				
7e-ii Community Residential Facility	5	4	4	4
7e-iii Residential Treatment Facility (group home)	1	1	2	1
7e-iv Assisted Living Facility	7	4	5	3
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	1	1	1	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	175	166	178	184
Total Unmet Resource Needs	201	190	205	205
Distinct Clients with Unmet Resource Needs	191	179	194	194
7f. Health Care				
7f-i Dental Services	227	202	199	191
7f-ii Eye Care Services	84	75	83	79
7f-iii Hearing Services	24	22	22	18
7f-iv Physical Therapy	12	16	13	13
7f-v Physician/Medical Services	67	59	61	69
Total Unmet Resource Needs	414	374	378	370
Distinct Clients with Unmet Resource Needs	289	268	275	270
7g. Legal				
7g-i Advocate	27	25	33	40
7g-ii Guardian (private)	1	1	1	0
7g-iii Guardian (public)	1	4	4	3
Total Unmet Resource Needs	29	30	38	43
Distinct Clients with Unmet Resource Needs	29	30	38	43
7h. Financial Security				
7h-i Assistance with Managing Money	111	110	111	132
7h-ii Assistance with Securing Public Benefits	55	50	59	65
7h-iii Representative Payee	9	9	8	7
Total Unmet Resource Needs	175	169	178	204
Distinct Clients with Unmet Resource Needs	162	158	162	186

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Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,928	1,926	2,057	2,002
7i. Education				
7i-ii GED	32	40	33	37
7i-iii Literacy Assistance	11	11	8	7
7i-iv Post High School Education	38	27	26	27
7i-v Tuition Reimbursement	5	8	8	3
Total Unmet Resource Needs	112	112	98	96
Distinct Clients with Unmet Resource Needs	105	103	89	91
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	6	9	8	7
7j-ii Club House and/or Peer Vocational Support	10	9	8	10
7j-iii Competitive Employment (no supports)	12	10	10	11
7j-iv Supported Employment	12	13	11	13
7j-v Vocational Rehabilitation	79	72	75	89
Total Unmet Resource Needs	119	113	112	130
Distinct Clients with Unmet Resource Needs	109	102	103	119
7k. Living Skills				
7k-i Daily Living Support Services	62	53	58	49
7k-ii Day Support Services	9	9	8	9
7k-iii Occupational Therapy	8	3	3	3
7k-iv Skills Development Services	6	12	8	7
Total Unmet Resource Needs	85	77	77	68
Distinct Clients with Unmet Resource Needs	78	73	74	66
7l. Transportation				
7l-i Transportation to ISP-Identified Services	48	55	45	49
7-ii Transportation to Other ISP Activities	43	48	46	43
7-iii After Hours Transportation	39	40	44	43
Total Unmet Resource Needs	130	143	135	135
Distinct Clients with Unmet Resource Needs	89	103	95	96
7m. Personal Growth/Community				
7m-i Avocational Activities	3	3	3	4

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Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,928	1,926	2,057	2,002
7m. Personal Growth/Community				
7m-iii Social Activities	58	60	70	65
7m-iv Spiritual Activities	25	20	23	26
Total Unmet Resource Needs	114	119	130	130
Distinct Clients with Unmet Resource Needs	74	77	91	87
Other Resources				
Other Resources	39	39	38	35
Total Unmet Resource Needs	39	39	38	35
Distinct Clients with Unmet Resource Needs	39	39	38	35
CSN 5 Totals				
Total Unmet Resource Needs	1,843	1,747	1,778	1,823
Distinct Clients With any Unmet Resource Need	626	615	634	634
Distinct Clients with a RDS	1,928	1,926	2,057	2,002

Report Run: Jan 9, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

CSN 6 - Cumberland

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

2013 Q2			2013 Q3			2013 Q4			2014 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
591	1,946	30.4%	606	2,013	30.1%	648	2,125	30.5%	662	2,114	31.3%

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

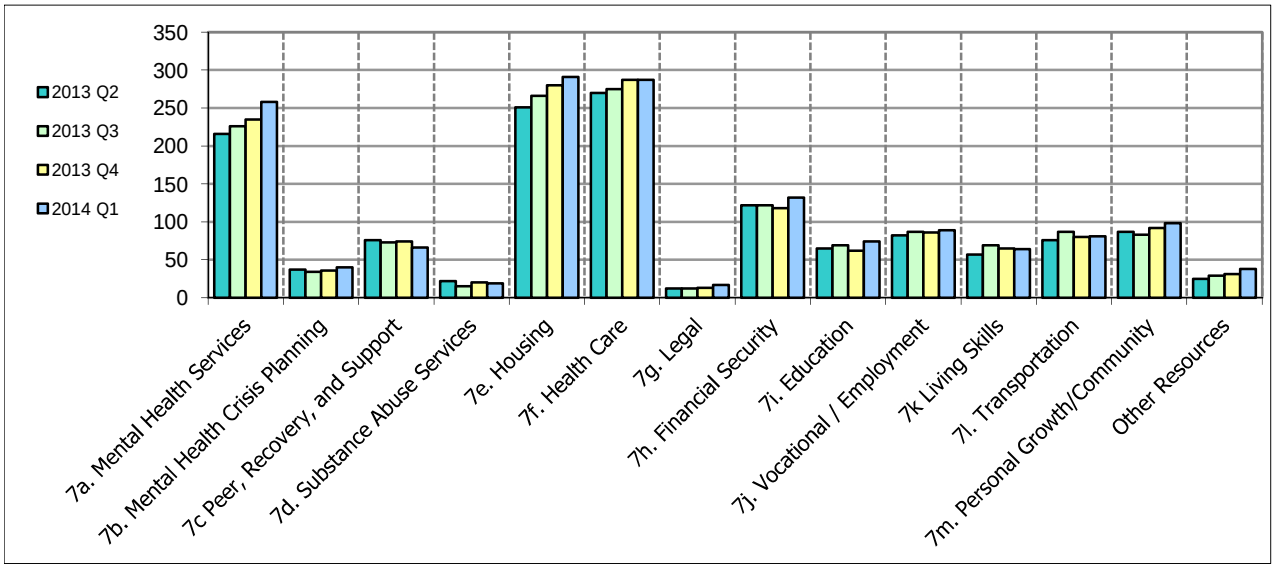

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q2	2013 Q3	2013 Q4	2014 Q1
7a. Mental Health Services	216	226	235	258
7b. Mental Health Crisis Planning	37	34	36	40
7c Peer, Recovery, and Support	76	73	74	66
7d. Substance Abuse Services	22	15	20	19
7e. Housing	251	266	280	291
7f. Health Care	270	275	287	287
7g. Legal	12	12	13	17
7h. Financial Security	122	122	118	132
7i. Education	65	69	62	74
7j. Vocational / Employment	82	87	86	89
7k Living Skills	57	69	65	64
7l. Transportation	76	87	80	81
7m. Personal Growth/Community	87	83	92	98
Other Resources	25	29	31	38
Total CSN 6 Unmet Needs	1,398	1,447	1,479	1,554

Report Run: Jan 9, 2014

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

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,946	2,013	2,125	2,114
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	13	28	36	38
7a-iii Dialectical Behavioral Therapy	8	6	3	4
7a-iv Family Psycho-Educational Treatment	1	2	2	2
7a-v Group Counseling	11	10	10	10
7a-vi Individual Counseling	78	72	78	97
7a-vii Inpatient Psychiatric Facility	0	0	1	1
7a-viii Intensive Case Management	15	19	14	15
7a-x Psychiatric Medication Management	90	89	91	91
Total Unmet Resource Needs	216	226	235	258
Distinct Clients with Unmet Resource Needs	162	165	190	193
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	31	31	31	33
7b-ii Mental Health Advance Directives	6	3	5	7
Total Unmet Resource Needs	37	34	36	40
Distinct Clients with Unmet Resource Needs	34	32	34	36
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	15	13	16	9
7c-ii Recovery Workbook Group	1	1	0	0
7c-iii Social Club	32	28	29	26
7c-iv Peer-Run Trauma Recovery Group	5	5	6	6
7c-v Wellness Recovery and Action Planning	8	9	7	9
7c-vi Family Support	15	17	16	16
Total Unmet Resource Needs	76	73	74	66
Distinct Clients with Unmet Resource Needs	58	54	56	47
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	17	11	14	13
7d-ii Residential Treatment Substance Abuse Services	5	4	6	6
Total Unmet Resource Needs	22	15	20	19
Distinct Clients with Unmet Resource Needs	22	15	20	17

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Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,946	2,013	2,125	2,114
7e. Housing				
7e-ii Community Residential Facility	11	13	15	14
7e-iii Residential Treatment Facility (group home)	4	4	4	3
7e-iv Assisted Living Facility	16	16	18	23
7e-v Nursing Home	2	1	1	3
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	172	180	195	209
Total Unmet Resource Needs	251	266	280	291
Distinct Clients with Unmet Resource Needs	223	235	250	256
7f. Health Care				
7f-i Dental Services	146	153	170	180
7f-ii Eye Care Services	56	50	49	43
7f-iii Hearing Services	10	11	12	10
7f-iv Physical Therapy	6	7	5	7
7f-v Physician/Medical Services	52	54	51	47
Total Unmet Resource Needs	270	275	287	287
Distinct Clients with Unmet Resource Needs	204	212	228	233
7g. Legal				
7g-i Advocate	7	8	11	16
7g-ii Guardian (private)	2	1	1	0
7g-iii Guardian (public)	3	3	1	1
Total Unmet Resource Needs	12	12	13	17
Distinct Clients with Unmet Resource Needs	12	12	13	17
7h. Financial Security				
7h-i Assistance with Managing Money	71	65	64	67
7h-ii Assistance with Securing Public Benefits	39	44	43	49
7h-iii Representative Payee	12	13	11	16
Total Unmet Resource Needs	122	122	118	132
Distinct Clients with Unmet Resource Needs	113	110	109	118

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Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,946	2,013	2,125	2,114
7i. Education				
7i-ii GED	14	14	13	19
7i-iii Literacy Assistance	6	6	7	5
7i-iv Post High School Education	21	24	23	28
7i-v Tuition Reimbursement	1	1	1	1
Total Unmet Resource Needs	65	69	62	74
Distinct Clients with Unmet Resource Needs	60	63	58	71
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	9	9	9	6
7j-ii Club House and/or Peer Vocational Support	2	3	2	3
7j-iii Competitive Employment (no supports)	16	17	17	21
7j-iv Supported Employment	5	6	7	11
7j-v Vocational Rehabilitation	50	52	51	48
Total Unmet Resource Needs	82	87	86	89
Distinct Clients with Unmet Resource Needs	76	81	76	78
7k. Living Skills				
7k-i Daily Living Support Services	33	37	36	40
7k-ii Day Support Services	5	8	8	6
7k-iii Occupational Therapy	3	1	2	4
7k-iv Skills Development Services	16	23	19	14
Total Unmet Resource Needs	57	69	65	64
Distinct Clients with Unmet Resource Needs	54	63	59	59
7l. Transportation				
7l-i Transportation to ISP-Identified Services	39	48	46	44
7-ii Transportation to Other ISP Activities	20	24	17	21
7-iii After Hours Transportation	17	15	17	16
Total Unmet Resource Needs	76	87	80	81
Distinct Clients with Unmet Resource Needs	62	68	67	68
7m. Personal Growth/Community				
7m-i Avocational Activities	3	3	3	3

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Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	1,946	2,013	2,125	2,114
7m. Personal Growth/Community				
7m-iii Social Activities	46	42	52	53
7m-iv Spiritual Activities	15	14	11	11
Total Unmet Resource Needs	87	83	92	98
Distinct Clients with Unmet Resource Needs	67	64	72	73
Other Resources				
Other Resources	25	29	31	38
Total Unmet Resource Needs	25	29	31	38
Distinct Clients with Unmet Resource Needs	25	29	31	38
CSN 6 Totals				
Total Unmet Resource Needs	1,398	1,447	1,479	1,554
Distinct Clients With any Unmet Resource Need	591	606	648	662
Distinct Clients with a RDS	1,946	2,013	2,125	2,114

Report Run: Jan 9, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

CSN 7 - York

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

2013 Q2			2013 Q3			2013 Q4			2014 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
181	545	33.2%	158	547	28.9%	186	558	33.3%	147	484	30.4%

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

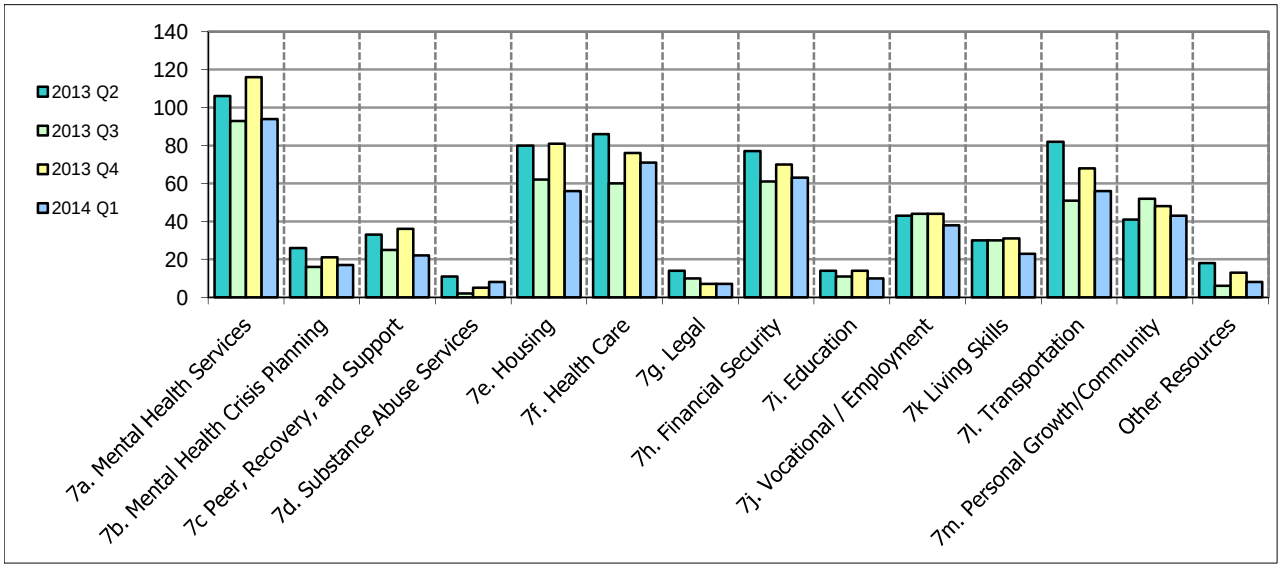

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q2	2013 Q3	2013 Q4	2014 Q1
7a. Mental Health Services	106	93	116	94
7b. Mental Health Crisis Planning	26	16	21	17
7c Peer, Recovery, and Support	33	25	36	22
7d. Substance Abuse Services	11	2	5	8
7e. Housing	80	62	81	56
7f. Health Care	86	60	76	71
7g. Legal	14	10	7	7
7h. Financial Security	77	61	70	63
7i. Education	14	11	14	10
7j. Vocational / Employment	43	44	44	38
7k Living Skills	30	30	31	23
7l. Transportation	82	51	68	56
7m. Personal Growth/Community	41	52	48	43
Other Resources	18	6	13	8
Total CSN 7 Unmet Needs	661	523	630	516

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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 7
(York)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	545	547	558	484
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	7	4	8	8
7a-iii Dialectical Behavioral Therapy	4	4	8	3
7a-iv Family Psycho-Educational Treatment	1	1	1	2
7a-v Group Counseling	4	4	3	2
7a-vi Individual Counseling	43	38	45	37
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	2	1	1	1
7a-x Psychiatric Medication Management	45	41	50	41
Total Unmet Resource Needs	106	93	116	94
Distinct Clients with Unmet Resource Needs	75	67	84	65
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	23	14	20	16
7b-ii Mental Health Advance Directives	3	2	1	1
Total Unmet Resource Needs	26	16	21	17
Distinct Clients with Unmet Resource Needs	24	15	20	17
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	2	4	2	3
7c-ii Recovery Workbook Group	0	0	1	1
7c-iii Social Club	13	6	12	9
7c-iv Peer-Run Trauma Recovery Group	7	6	6	2
7c-v Wellness Recovery and Action Planning	2	2	1	1
7c-vi Family Support	9	7	14	6
Total Unmet Resource Needs	33	25	36	22
Distinct Clients with Unmet Resource Needs	26	21	29	20
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	9	2	5	7
7d-ii Residential Treatment Substance Abuse Services	2	0	0	1
Total Unmet Resource Needs	11	2	5	8
Distinct Clients with Unmet Resource Needs	10	2	5	7

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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 7
(York)

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	545	547	558	484
7e. Housing				
7e-ii Community Residential Facility	4	4	3	3
7e-iii Residential Treatment Facility (group home)	2	2	1	0
7e-iv Assisted Living Facility	5	3	2	2
7e-v Nursing Home	2	0	0	0
7e-vi Residential Crisis Unit	1	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	61	48	66	46
Total Unmet Resource Needs	80	62	81	56
Distinct Clients with Unmet Resource Needs	72	58	76	52
7f. Health Care				
7f-i Dental Services	38	31	34	27
7f-ii Eye Care Services	18	11	13	14
7f-iii Hearing Services	2	2	4	2
7f-iv Physical Therapy	7	3	6	5
7f-v Physician/Medical Services	21	13	19	23
Total Unmet Resource Needs	86	60	76	71
Distinct Clients with Unmet Resource Needs	61	45	56	48
7g. Legal				
7g-i Advocate	12	9	7	7
7g-ii Guardian (private)	0	0	0	0
7g-iii Guardian (public)	2	1	0	0
Total Unmet Resource Needs	14	10	7	7
Distinct Clients with Unmet Resource Needs	14	10	7	7
7h. Financial Security				
7h-i Assistance with Managing Money	38	39	46	36
7h-ii Assistance with Securing Public Benefits	32	20	22	24
7h-iii Representative Payee	7	2	2	3
Total Unmet Resource Needs	77	61	70	63
Distinct Clients with Unmet Resource Needs	59	47	55	50

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	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	545	547	558	484
7i. Education				
7i-ii GED	5	2	6	1
7i-iii Literacy Assistance	4	1	2	2
7i-iv Post High School Education	1	4	2	5
7i-v Tuition Reimbursement	0	1	1	0
Total Unmet Resource Needs	14	11	14	10
Distinct Clients with Unmet Resource Needs	13	11	12	9
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	8	7	9	6
7j-ii Club House and/or Peer Vocational Support	2	0	1	8
7j-iii Competitive Employment (no supports)	8	4	6	5
7j-iv Supported Employment	2	5	4	3
7j-v Vocational Rehabilitation	23	28	24	16
Total Unmet Resource Needs	43	44	44	38
Distinct Clients with Unmet Resource Needs	34	35	35	31
7k. Living Skills				
7k-i Daily Living Support Services	23	19	19	15
7k-ii Day Support Services	2	0	1	2
7k-iii Occupational Therapy	0	2	1	1
7k-iv Skills Development Services	5	9	10	5
Total Unmet Resource Needs	30	30	31	23
Distinct Clients with Unmet Resource Needs	28	29	30	22
7l. Transportation				
7l-i Transportation to ISP-Identified Services	40	27	30	28
7-ii Transportation to Other ISP Activities	26	14	16	13
7-iii After Hours Transportation	16	10	22	15
Total Unmet Resource Needs	82	51	68	56
Distinct Clients with Unmet Resource Needs	51	37	50	38
7m. Personal Growth/Community				
7m-i Avocational Activities	3	4	2	2

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	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	545	547	558	484
7m. Personal Growth/Community				
7m-iii Social Activities	23	31	31	28
7m-iv Spiritual Activities	2	5	5	4
Total Unmet Resource Needs	41	52	48	43
Distinct Clients with Unmet Resource Needs	31	38	36	34
Other Resources				
Other Resources	18	6	13	8
Total Unmet Resource Needs	18	6	13	8
Distinct Clients with Unmet Resource Needs	18	6	13	8
CSN 7 Totals				
Total Unmet Resource Needs	661	523	630	516
Distinct Clients With any Unmet Resource Need	181	158	186	147
Distinct Clients with a RDS	545	547	558	484

Report Run: Jan 9, 2014

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

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	388	397	368	367
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	0	5	2	2
7a-iii Dialectical Behavioral Therapy	2	2	2	0
7a-iv Family Psycho-Educational Treatment	0	0	1	1
7a-v Group Counseling	1	1	1	2
7a-vi Individual Counseling	11	18	20	22
7a-vii Inpatient Psychiatric Facility	0	1	2	1
7a-viii Intensive Case Management	3	1	1	1
7a-x Psychiatric Medication Management	15	21	17	22
Total Unmet Resource Needs	32	49	46	51
Distinct Clients with Unmet Resource Needs	26	38	33	37
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	3	5	8	7
7b-ii Mental Health Advance Directives	3	1	2	2
Total Unmet Resource Needs	6	6	10	9
Distinct Clients with Unmet Resource Needs	5	5	9	8
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	2	0	0	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	4	8	6	3
7c-iv Peer-Run Trauma Recovery Group	1	1	1	0
7c-v Wellness Recovery and Action Planning	0	1	0	1
7c-vi Family Support	1	3	2	3
Total Unmet Resource Needs	8	13	9	7
Distinct Clients with Unmet Resource Needs	8	11	7	6
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	4	2	1	0
7d-ii Residential Treatment Substance Abuse Services	0	1	2	1
Total Unmet Resource Needs	4	3	3	1
Distinct Clients with Unmet Resource Needs	4	3	3	1
7e. Housing				

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(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	388	397	368	367
7e-i Supported Apartment	1	2	3	4
7e-ii Community Residential Facility	1	2	1	2
7e-iii Residential Treatment Facility (group home)	0	0	0	0
7e-iv Assisted Living Facility	1	2	1	2
7e-v Nursing Home	1	1	1	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	31	35	33	26
Total Unmet Resource Needs	35	42	39	35
Distinct Clients with Unmet Resource Needs	35	41	38	34
7f. Health Care				
7f-i Dental Services	26	28	26	24
7f-ii Eye Care Services	11	7	10	7
7f-iii Hearing Services	1	2	0	0
7f-iv Physical Therapy	1	1	1	1
7f-v Physician/Medical Services	5	6	8	10
Total Unmet Resource Needs	44	44	45	42
Distinct Clients with Unmet Resource Needs	35	37	34	30
7g. Legal				
7g-i Advocate	4	5	3	3
7g-ii Guardian (private)	3	3	3	1
7g-iii Guardian (public)	2	2	2	2
Total Unmet Resource Needs	9	10	8	6
Distinct Clients with Unmet Resource Needs	8	9	7	5
7h. Financial Security				
7h-i Assistance with Managing Money	14	14	13	18
7h-ii Assistance with Securing Public Benefits	9	11	7	12
7h-iii Representative Payee	2	3	1	0
Total Unmet Resource Needs	25	28	21	30
Distinct Clients with Unmet Resource Needs	24	26	20	27
7i. Education				

Report Run: Jan 9, 2014

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Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	388	397	368	367
7i-i Adult Education (other than GED)	3	4	2	4
7i-ii GED	4	6	4	3
7i-iii Literacy Assistance	0	0	0	1
7i-iv Post High School Education	1	3	1	3
7i-v Tuition Reimbursement	0	1	0	0
Total Unmet Resource Needs	8	14	7	11
Distinct Clients with Unmet Resource Needs	8	13	7	10
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	1	1	2
7j-ii Club House and/or Peer Vocational Support	1	1	0	1
7j-iii Competitive Employment (no supports)	2	3	2	3
7j-iv Supported Employment	4	3	2	2
7j-v Vocational Rehabilitation	11	11	11	12
Total Unmet Resource Needs	19	19	16	20
Distinct Clients with Unmet Resource Needs	18	19	16	19
7k. Living Skills				
7k-i Daily Living Support Services	9	9	6	6
7k-ii Day Support Services	4	6	4	2
7k-iii Occupational Therapy	0	0	1	0
7k-iv Skills Development Services	3	5	2	1
Total Unmet Resource Needs	16	20	13	9
Distinct Clients with Unmet Resource Needs	14	15	12	9
7l. Transportation				
7l-i Transportation to ISP-Identified Services	14	15	13	13
7-ii Transportation to Other ISP Activities	8	10	7	11
7-iii After Hours Transportation	6	7	8	7
Total Unmet Resource Needs	28	32	28	31
Distinct Clients with Unmet Resource Needs	19	22	20	20
7m. Personal Growth/Community				
7m-i Avocational Activities	2	3	4	3
7m. Personal Growth/Community				

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Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 1
(July, Aug, Sept 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Distinct Clients with a RDS	388	397	368	367
7m-ii Recreation Activities	4	5	9	4
7m-iii Social Activities	12	15	12	14
7m-iv Spiritual Activities	0	2	1	2
Total Unmet Resource Needs	18	25	26	23
Distinct Clients with Unmet Resource Needs	14	17	17	18
Other Resources				
Other Resources	13	13	11	10
Total Unmet Resource Needs	13	13	11	10
Distinct Clients with Unmet Resource Needs	13	13	11	10
CSN Not Assigned Totals				
Total Unmet Resource Needs	265	318	282	285
Distinct Clients With any Unmet Resource Need	106	116	107	109
Distinct Clients with a RDS	388	397	368	367

Report Run: Jan 9, 2014

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

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Bridging Rental Assistance Program (BRAP)
Monitoring Report
Quarter 2 FY2014 (October, November, December 2013)

The Bridging Rental Assistance Program (BRAP) has been established in recognition that recovery can only begin in a safe, healthy, and decent environment, a place one can call home. The Office of Substance Abuse and Adult Mental Health Services recognizes the necessity for rental assistance for persons with mental illness, particularly those being discharged from hospitals, group homes, homeless shelters,and places considered substandard for human habitation. There is not a single housing market in the country where a person receiving Social Security as his or her sole income source can afford to rent even a modest one-bedroom apartment. According to a report issued by the Technical Assistance Collaborative, *Priced out in 2012* in Maine, 95% of a person's SSI standard monthly payment is needed to pay for the average one-bedroom apartment statewide. In Cumberland County the amount is 94% and Sagadahoc 98%. In the City of Portland 115% of a person's SSI is necessary to pay for the average one-bedroom apartment and in the KEYS area (Kittery, Elliot, York and South Berwick) 110%.

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

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

The bullets below highlight some of the details regarding persons who are currently waiting for a BRAP voucher: The percentage terms reflect the percentage of relative change compared to the last report. As is reflected by the bullets below (see table and graph on last page), the BRAP program has made very efficient utilization of the influx of funds in this fiscal year in the last 6 months.

- 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 1 to 2 persons, up 100%--both of these persons have vouchers reserved for them upon discharge.
- Priority #2 applicants (Homeless) have decreased from 92 to83 persons down 10%
- Priority #3 applicants (Substandard Housing) remains at 3 persons.
- Priority #4 applicants (Community Residential Facility) have also increased from 9 to 10 persons, up 10%.

- Persons on the waitlist greater than 90 days have remained the same at16—we are following up on all of these individuals to confirm their status.

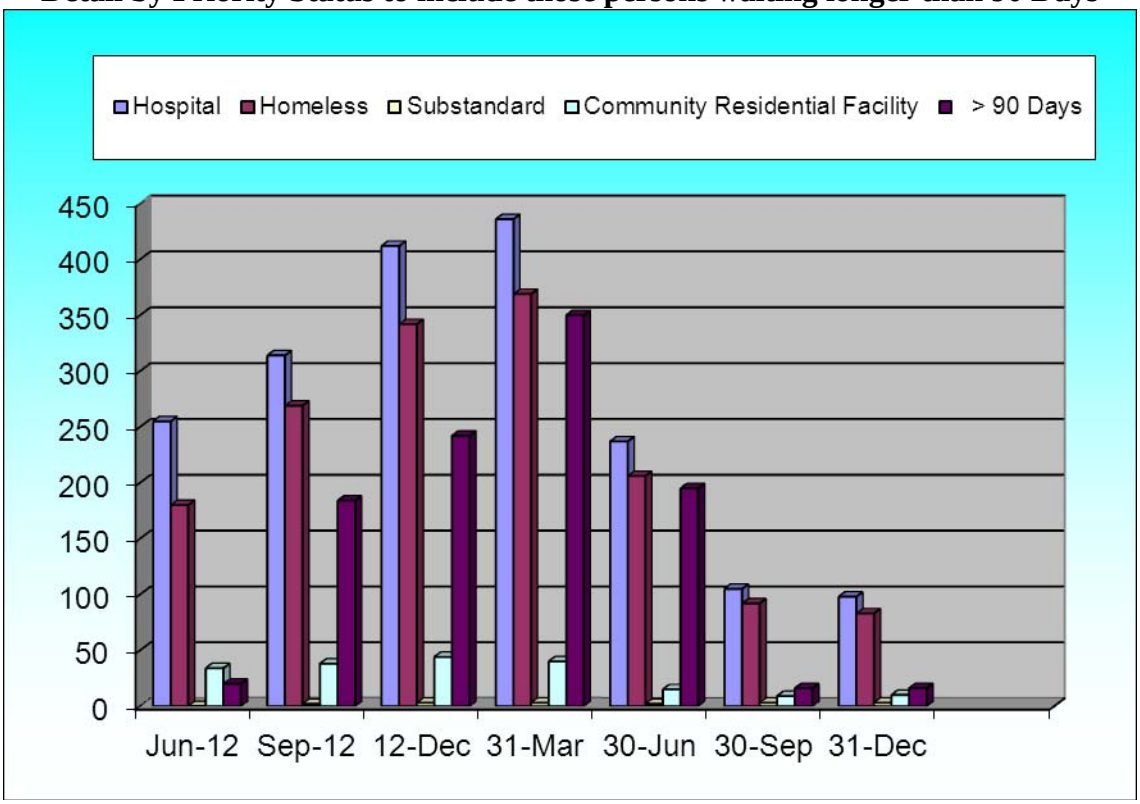
Since inception of the wait list, there has been a total of 2,668 BRAP vouchers awarded broken down as follows: Priority #1, 1,210; Priority #2, 1,171; Priority #3, 36; Priority #4, 236. Note that 15 vouchers have been awarded to persons with no priority. In the last quarter 218 vouchers were awarded.

The current BRAP census as of December 31, 2013 is 1,142 vouchers issued well above our targeted goal of 930 vouchers. Due to management of voucher funding we have been able to house well above that amount—resulting in a decreasing waitlist. However despite the steady increase in vouchers issued, our waitlist is projected to climb over the next two quarters as the census levels out. The overall budget for FY 14 increased to $5,018,508 which is allowing us to better meet the waitlist needs and push for expansion into more rural areas where vouchers have not been traditionally utilized due to housing stock as well as community education and partnership. This is being done through our established administrative agents as well as the developing relationships with the PATH program, Continuums of Care, and Homeless Councils. We now have several persons housed in Washington county and continue to address the more rural parts of the State through partnering with the previously mentioned groups as well as using our existing, contracted LAA's for reaching out to those communities. Our office has met with these agencies with specific goals of increasing utilization where the clients are, rather than where the vouchers can be used by quickly finding new resources and increasing community education and partnerships.

The number of persons on the program for greater than 24 months remains 50% of the entire program. This is principally a result of decades of federal and state cuts to low-income and supportive housing programs, including persons who will not qualify for Section 8 due criminal activity. The lack of availability of these resources, particularly Section 8 at the federal level, has translated to increased pressures on state programs such as BRAP.

SAMHS administers a substantial number of Shelter Plus Care vouchers, more than any other state on a per-capita basis. The census was 889 as of December 31, 2013. This program is funded by the U.S. Department of Housing and Urban Development and has seen significant growth over the last decade, the result of SAMHS aggressively applying for and receiving new grants each year. It should be noted that HUD has eliminated new project funding through an overall reduction of over 5% in this latest funding round. Shelter Plus Care has retained it's existing funding however no new SPC applications have been submitted. The FY2014 annual budget for Shelter Plus Care is $7.9 million. The total dollars for all SPC grants (one year renewals to 5 year new contracts) administered by SAMHS is $14,101,781. Shelter Plus Care (SPC) provides 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

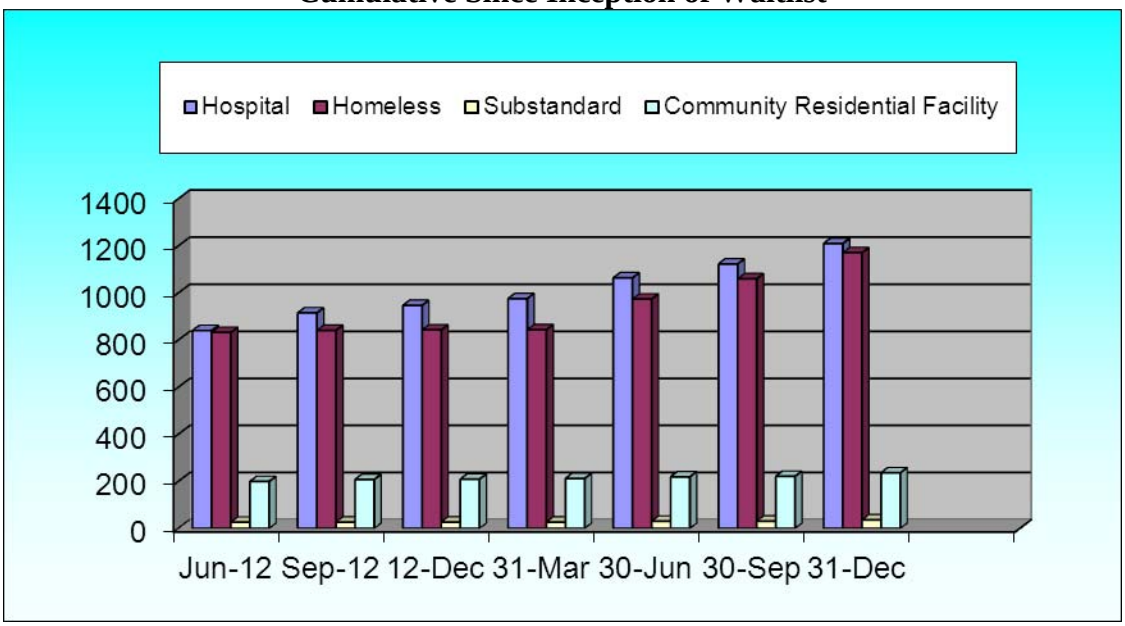


BRAP Waitlist Status—Table:
Detail by Priority Status to include those persons waiting longer than 90 Days

Reporting Period	Jun-12	Sep-12	12-Dec	31-Mar	30-Jun	30-Sep	31-Dec	% Change relative to Last Report
Total number of persons waiting for BRAP	255	314	412	436	237	105	98	-7%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	41	5	23	22	12	1	2	100%
Priority 2—Homeless (HUD Transitional Definition)	180	269	342	369	206	92	83	-10%
Priority 3—Sub-standard Housing	0	2	3	3	2	3	3	0%
Priority 4—Leaving a Community Residential living facility	34	38	44	40	15	9	10	10%
Total number of persons on wait list more than 90 days awaiting voucher	20	184	242	350	195	16	16	0%

*****Note: Both Priority #1 persons are in mental health facilities awaiting discharge—vouchers are dedicated to these persons when ready

BRAP Awards—Graph
Cumulative Since Inception of Waitlist



BRAP Awards—Table
Cumulative Since Inception of Waitlist

Reporting Periods	Jun-12	Sep-12	12-Dec	31-Mar	30-Jun	30-Sep	31-Dec	% Change relative to Last Report
Cumulative number of persons awarded BRAP	1908	2003	2038	2071	2300	2450	2668	8%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	840	915	947	976	1064	1123	1210	7%
Priority 2—Homeless (HUD Transitional Definition)	832	841	843	844	974	1060	1171	9%
Priority 3—Sub-standard Housing	26	27	27	27	30	31	36	14%
Priority 4—Leaving a DHHS funded living facility	199	208	209	212	219	221	236	6%

*Note: 15 persons awarded with no priority

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Class Member Treatment Planning Review

For the 2nd Quarter of Fiscal Year 2014

(October, November, December, 2013)

		2013 Q3		2013 Q4		2014 Q1		2014 Q2	
Total Plans Reviewed		50		49		50		49	
I Releases									
1A	Does the record document that the agency has planned with and educated the consumer regarding releases of information at intake/initial treatment planning process?	100.0%	18 of 18	90.0%	9 of 10	100.0%	16 of 16	93.8%	15 of 16
1B	Does the record document that the agency has planned with and educated the consumer regarding releases of information during each treatment plan review?	83.3%	40 of 48	85.7%	42 of 49	80.4%	37 of 46	72.9%	35 of 48
1C	Does the record document that the consumer has a primary care physician (PCP)?	92.0%	46 of 50	91.8%	45 of 49	90.0%	45 of 50	98.0%	48 of 49
1D	If 1C. is yes, has there been an attempt to obtain releases signed by the consumer for the sharing of information with the PCP?	91.3%	42 of 46	80.0%	36 of 45	80.0%	36 of 45	77.1%	37 of 48
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?	98.0%	49 of 50	95.9%	47 of 49	92.0%	46 of 50	100.0%	49 of 49
2B	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?	100.0%	50 of 50	100.0%	49 of 49	96.0%	48 of 50	98.0%	48 of 49
2C	Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?	98.0%	49 of 50	95.9%	47 of 49	94.0%	47 of 50	98.0%	48 of 49
2D	Does the record document that the individual's potential need for crisis intervention and resolution services was considered with the consumer during treatment planning?	96.0%	48 of 50	100.0%	49 of 49	98.0%	49 of 50	100.0%	49 of 49
2E	Does the record document that the consumer has a crisis plan?	62.5%	30 of 48	63.8%	30 of 47	67.3%	33 of 49	89.8%	44 of 49
2F	If 2E. is no, is the reason documented?	100.0%	18 of 18	100.0%	17 of 17	100.0%	16 of 16	100.0%	5 of 5
2G	If 2E. is yes, has the crisis plan been reviewed as required every three months?	73.3%	22 of 30	86.7%	26 of 30	84.8%	28 of 33	90.9%	40 of 44
2H	If 2E. is yes, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?	50.0%	3 of 6	77.8%	7 of 9	100.0%	7 of 7	87.5%	7 of 8
2I	Does the record document that the consumer has a mental health advance directive?	4.1%	2 of 49	8.3%	4 of 48	4.1%	2 of 49	4.1%	2 of 49
2J	If 2I. is yes, has the advance directive been reviewed at least annually by the CSW and consumer?	0.0%	0 of 2	0.0%	0 of 4	0.0%	0 of 2	100.0%	2 of 2
2K	If 2I. is no, is the reason why documented?	100.0%	47 of 47	100.0%	44 of 44	100.0%	47 of 47	100.0%	47 of 47
III Needed Resources									

3A	Does the record document that natural supports (family/friends) are being accessed as a resource?	N/A	0 of 0	N/A	0 of 0	N/A	0 of 0	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?	N/A	0 of 0	N/A	0 of 0	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?	75.0%	3 of 4	50.0%	1 of 2	75.0%	3 of 4	N/A	0 of 0
3D	If 3C. is no, has the worker discussed with the consumer the consideration of generic resources as a resource?	0.0%	0 of 1	0.0%	0 of 1	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?	60.0%	3 of 5	60.0%	3 of 5	54.5%	6 of 11	100.0%	1 of 1
3F	Does the treatment plan reflect interim planning?	100.0%	3 of 3	100.0%	3 of 3	100.0%	6 of 6	100.0%	1 of 1
3G	Does the record document that the treatment team reconvened after the unmet need was identified?	0.0%	0 of 3	0.0%	0 of 3	0.0%	0 of 6	0.0%	0 of 1
IV Service Agreements									
4A	Does the record document that service agreements are required for this plan? (see paragraph 69 protocol for definitions)	47.9%	23 of 48	53.1%	26 of 49	46.0%	23 of 50	57.1%	28 of 49
4B	If 4A. is yes, have service agreements been acquired?	73.9%	17 of 23	73.1%	19 of 26	56.5%	13 of 23	78.6%	22 of 28
4C	If 4A. is yes, are the service agreements current?	65.2%	15 of 23	57.7%	15 of 26	47.8%	11 of 23	75.0%	21 of 28
V Vocational Services									
5A	Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?	98.0%	49 of 50	100.0%	48 of 48	95.8%	46 of 48	100.0%	47 of 47
5B	Does the record document that the vocational domain is being addressed with the consumer at each 90 day treatment plan review?	93.8%	45 of 48	85.4%	41 of 48	89.6%	43 of 48	81.6%	40 of 49
VI Comments									
6A	Plan of correction requested?	30.0%	15 of 50	53.1%	26 of 49	52.0%	26 of 50	30.6%	15 of 49
6A.1.	Plan of correction for section 2A. (required when not all domains assessed) included?	0.0%	0 of 1	0.0%	0 of 2	0.0%	0 of 4	N/A	0 of 0
6C	Plan of correction received?	93.3%	14 of 15	61.5%	16 of 26	65.4%	17 of 26	66.7%	10 of 15
6D	Were corrections made to the satisfaction of the CDC?	100.0%	14 of 14	100.0%	16 of 16	100.0%	17 of 17	90.0%	9 of 10

Report Run by: Brandi.Giguere Report Run on: Jan 7, 2014 at 11:15:15 AM

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

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

Community Hospital Utilization Review for Involuntary Admissions

All Clients

For the 1st Quarter of Fiscal Year 2014

(July, August, September, 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Total Admissions	133	137	123	119
Hospital				
Hospitalized in Local Area	87.2% (116 of 133)	86.1% (118 of 137)	84.6% (104 of 123)	84.0% (100 of 119)
Hospitalization Made Voluntary	75.2% (100 of 133)	75.9% (104 of 137)	71.5% (88 of 123)	81.5% (97 of 119)
Legal Status				
Blue Paper on File	99.2% (132 of 133)	100.0% (137 of 137)	99.2% (122 of 123)	100.0% (119 of 119)
Blue Paper Complete/Accurate	100.0% (132 of 132)	100.0% (137 of 137)	100.0% (122 of 122)	99.2% (118 of 119)
If not complete, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	100.0% (1 of 1)
24 Hr. Certification Required	91.0% (121 of 133)	82.5% (113 of 137)	87.8% (108 of 123)	89.9% (107 of 119)
24 Hr. Certification on file	99.2% (120 of 121)	100.0% (113 of 113)	100.0% (108 of 108)	100.0% (107 of 107)
24 Hr. Certification Complete/Accurate	100.0% (120 of 120)	100.0% (113 of 113)	100.0% (108 of 108)	100.0% (107 of 107)
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% (133 of 133)	100.0% (137 of 137)	100.0% (123 of 123)	99.2% (118 of 119)
Active Treatment Within Guidelines	100.0% (133 of 133)	100.0% (137 of 137)	100.0% (123 of 123)	100.0% (119 of 119)
Patient's Rights Maintained	97.7% (130 of 133)	100.0% (137 of 137)	98.4% (121 of 123)	97.5% (116 of 119)
If not maintained, follow up per policy	100.0% (2 of 2)	N/A (0 of 0)	0.0% (0 of 1)	100.0% (3 of 3)
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	29.3% (39 of 133)	23.4% (32 of 137)	17.9% (22 of 123)	18.5% (22 of 119)
Case Manager Involved with Discharge Planning	94.9% (37 of 39)	93.8% (30 of 32)	100.0% (22 of 22)	95.5% (21 of 22)
Total Clients who Authorized Hospital to Obtain ISP	97.4% (38 of 39)	100.0% (32 of 32)	100.0% (22 of 22)	100.0% (22 of 22)
Hospital Obtained ISP when authorized	7.9% (3 of 38)	6.2% (2 of 32)	18.2% (4 of 22)	18.2% (4 of 22)
Treatment and Discharge Plan Consistent with ISP	100.0% (3 of 3)	100.0% (2 of 2)	100.0% (4 of 4)	75.0% (3 of 4)

Report Run: Jan 13, 2014

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

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

Community Hospital Utilization Review for Involuntary Admissions

Class Members

For the 1st Quarter of Fiscal Year 2014
(July, August, September, 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Total Admissions	15	16	20	11
Hospital				
Hospitalized in Local Area	93.3% (14 of 15)	87.5% (14 of 16)	90.0% (18 of 20)	27.3% (3 of 11)
Hospitalization Made Voluntary	46.7% (7 of 15)	56.2% (9 of 16)	65.0% (13 of 20)	54.5% (6 of 11)
Legal Status				
Blue Paper on File	93.3% (14 of 15)	100.0% (16 of 16)	100.0% (20 of 20)	100.0% (11 of 11)
Blue Paper Complete/Accurate	100.0% (14 of 14)	100.0% (16 of 16)	100.0% (20 of 20)	100.0% (11 of 11)
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	100.0% (15 of 15)	87.5% (14 of 16)	95.0% (19 of 20)	90.9% (10 of 11)
24 Hr. Certification on file	93.3% (14 of 15)	100.0% (14 of 14)	100.0% (19 of 19)	100.0% (10 of 10)
24 Hr. Certification Complete/Accurate	100.0% (14 of 14)	100.0% (14 of 14)	100.0% (19 of 19)	100.0% (10 of 10)
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% (15 of 15)	100.0% (16 of 16)	100.0% (20 of 20)	100.0% (11 of 11)
Active Treatment Within Guidelines	100.0% (15 of 15)	100.0% (16 of 16)	100.0% (20 of 20)	100.0% (11 of 11)
Patient's Rights Maintained	93.3% (14 of 15)	100.0% (16 of 16)	100.0% (20 of 20)	100.0% (11 of 11)
If not maintained, follow up per policy	100.0% (1 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Inappropriate Use of Blue Paper	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Individual Service Plans				
Receiving Case Management Services	60.0% (9 of 15)	43.8% (7 of 16)	35.0% (7 of 20)	54.5% (6 of 11)
Case Manager Involved with Discharge Planning	100.0% (9 of 9)	100.0% (7 of 7)	100.0% (7 of 7)	100.0% (6 of 6)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (9 of 9)	100.0% (7 of 7)	100.0% (7 of 7)	100.0% (6 of 6)
Hospital Obtained ISP when authorized	22.2% (2 of 9)	14.3% (1 of 7)	28.6% (2 of 7)	16.7% (1 of 6)
Treatment and Discharge Plan Consistent with ISP	100.0% (2 of 2)	100.0% (1 of 1)	100.0% (2 of 2)	100.0% (1 of 1)

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Community Hospital Utilization Review for Involuntary Admissions

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

For the 1st Quarter of Fiscal Year 2014

(July, August, September, 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Number of Admissions	133	137	123	119
Involuntarily Admitted Clients who were Receiving CSS Services	39	32	22	22
Number of ISPs Hospitals were Authorized to Obtain	38	32	22	22
Number of ISPs Hospitals Obtained	3	2	4	4

FY QTR	Hospital	Admissions	Receiving Community Support Services	Hospital Obtained ISP when authorized	Treatment and Discharge Plan Consistant with ISP	Case Worker Involved with Treatment and Discharge Planning
2013 Q2	Acadia	23	21.7% (5 of 23)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	Maine General - Waterville	7	42.9% (3 of 7)	66.7% (2 of 3)	100.0% (2 of 2)	100.0% (3 of 3)
	Maine Medical Center	3	33.3% (1 of 3)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	11	18.2% (2 of 11)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	PenBay Medical Center	16	50.0% (8 of 16)	0.0% (0 of 8)	N/A (0 of 0)	100.0% (8 of 8)
	Select	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	20	20.0% (4 of 20)	0.0% (0 of 4)	N/A (0 of 0)	75.0% (3 of 4)
	Spring Harbor	39	38.5% (15 of 39)	7.1% (1 of 14)	100.0% (1 of 1)	93.3% (14 of 15)
	St. Mary's	13	7.7% (1 of 13)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
2013 Q3	Acadia	25	32.0% (8 of 25)	12.5% (1 of 8)	100.0% (1 of 1)	100.0% (8 of 8)
	Maine General - Waterville	9	11.1% (1 of 9)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Maine Medical Center	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	10	50.0% (5 of 10)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	PenBay Medical Center	8	25.0% (2 of 8)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Select	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	28	7.1% (2 of 28)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Spring Harbor	46	21.7% (10 of 46)	0.0% (0 of 10)	N/A (0 of 0)	80.0% (8 of 10)
	St. Mary's	9	33.3% (3 of 9)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
2013 Q4	Acadia	17	17.6% (3 of 17)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Maine General - Waterville	14	28.6% (4 of 14)	100.0% (4 of 4)	100.0% (4 of 4)	100.0% (4 of 4)
	Mid-coast Hospital	4	25.0% (1 of 4)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	7	14.3% (1 of 7)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Select	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	11	18.2% (2 of 11)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Spring Harbor	54	14.8% (8 of 54)	0.0% (0 of 8)	N/A (0 of 0)	100.0% (8 of 8)
	St. Mary's	15	20.0% (3 of 15)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
2014 Q1	Acadia	22	13.6% (3 of 22)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Maine General - Waterville	8	37.5% (3 of 8)	100.0% (3 of 3)	100.0% (3 of 3)	100.0% (3 of 3)
	Mid-coast Hospital	12	8.3% (1 of 12)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	5	20.0% (1 of 5)	100.0% (1 of 1)	0.0% (0 of 1)	100.0% (1 of 1)
	Southern Maine Medical Center	21	14.3% (3 of 21)	0.0% (0 of 3)	N/A (0 of 0)	66.7% (2 of 3)
	Spring Harbor	41	24.4% (10 of 41)	0.0% (0 of 10)	N/A (0 of 0)	100.0% (10 of 10)
	St. Mary's	10	10.0% (1 of 10)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)

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Community Hospital Utilization Review for Involuntary Admissions

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

For the 1st Quarter of Fiscal Year 2014

(July, August, September, 2013)

	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Number of Admissions	15	16	20	11
Involuntarily Admitted Clients who were Receiving CSS Services	9	7	7	6
Number of ISPs Hospitals were Authorized to Obtain	9	7	7	6
Number of ISPs Hospitals Obtained	2	1	2	1

FY QTR	Hospital	Admissions	Receiving Community Support Services	Hospital Obtained ISP when authorized	Treatment and Discharge Plan Consistant with ISP	Case Worker Involved with Treatment and Discharge Planning
2013 Q2	**Acadia**	2	100.0% (2 of 2)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Waterville	2	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	PenBay Medical Center	5	60.0% (3 of 5)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Southern Maine Medical Center	3	33.3% (1 of 3)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Spring Harbor	2	50.0% (1 of 2)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	St. Mary's	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
2013 Q3	**Acadia**	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Maine General - Waterville	3	33.3% (1 of 3)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Mid-coast Hospital	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	PenBay Medical Center	2	100.0% (2 of 2)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Southern Maine Medical Center	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	8	50.0% (4 of 8)	0.0% (0 of 4)	N/A (0 of 0)	100.0% (4 of 4)
2013 Q4	**Acadia**	2	50.0% (1 of 2)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Maine General - Waterville	3	66.7% (2 of 3)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	PenBay Medical Center	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	12	33.3% (4 of 12)	0.0% (0 of 4)	N/A (0 of 0)	100.0% (4 of 4)
	St. Mary's	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
2014 Q1	**Acadia**	3	66.7% (2 of 3)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Waterville	1	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Mid-coast Hospital	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	PenBay Medical Center	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	4	75.0% (3 of 4)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)

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

Maine Department of Health and Human Services

Integrated Crisis Report

Crisis Report for Quarter 2 FY14

October, November and December 2013 - Statewide

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

Gender	Children	Males	608	Females	839	1447				
	Adults	Males	2,514	Females	2,743	5257				
Age Range	Children	< 5	26	5 - 9	159	10 - 14	598	15-17	664	1447
	Adults	18 - 21	576	22 - 35	1,682	36 - 60	2,450	>60	549	5257
Payment Source	Children	MaineCare	975	Private Ins.	395	Uninsured	75	Medicare	2	1447
	Adults	MaineCare	2,597	Private Ins.	1,150	Uninsured	1,049	Medicare	461	5257

II. Summery Of All Crisis Contacts

	Children	Adults
a. Total number of telephone contacts	7,576	36,199
b. Total number of all Initial face-to-face contacts	1,230	3,988
c. Number in II.b. who are children/youth with Mental Retardation/Autism/Pervasive Dev. Disorder	103	
d. Number of face-to-face contacts that are ongoing support for crisis resolution/stabilization	225	1,285

III. Initial Crisis Contact Infomation

	Children		Adults	
a. Total number of Initial face-to-face contacts in which a wellness plan, crisis plan, ISP or advanced directive plan previously developed with the individual was used	133	10.8%	119	3.0%
b. Number of Initial face-to-face contacts who have a Community Support Worker (CI,CRS,ICM, ACT,TCM)	480	39.0%	1,284	32.2%
c. Number of Initial face-to-face contacts who have a Comm. Support Worker that was notified of crisis	393	32.0%	1,023	79.7%
d. SUM time in minutes for all Initial face-to-face contacts in II.b. from determination of need for face-to-face contact or when individual was ready and able to be seen to Initial face-to-face contact			123,873	31.1%
e. Number of Initial face-to-face contacts in Emergency Department with final disp. within 8 hours			2,149	53.9%
f. Number of Initial face-to-face contacts not in Emergency Department with final disp. within 8 hours			1,495	37.5%

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.	1067	1 to 2 Hours	138	2 to 4 Hours	20	More Than 4 Hours	5	
Percent	86.7%	Percent	11.2%	Percent	1.6%	Percent	0.4%	

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

Less Than 3 Hours	561	3 to 6 Hours	534	6 to 8 Hours	46	8 to 14 Hours	37	> 14	52
Percent	45.6%	Percent	43.4%	Percent	3.7%	Percent	3.0%	Percent	4.2%

IV. Site Of Initial Face-to-Face Contacts

	Children		Adults	
a. Primary Care Residence (Home)	166	13.5%	350	8.8%
b. Family/Relative/Other Residence	39	3.2%	27	0.7%
c. Other Community Setting (Work, School, Police Dept, Public Place)	122	9.9%	107	2.7%
d. SNF, Nursing Home, Boarding Home	0	0.0%	12	0.3%
e. Residential Program (Congregate Community Residence, Apartment Program)	4	0.3%	55	1.4%
f. Homeless Shelter	1	0.1%	37	0.9%
g. Provider Office	30	2.4%	124	3.1%
h. Crisis Office	194	15.8%	637	16.0%
i. Emergency Department	654	53.2%	2,438	61.1%
j. Other Hospital Location	13	1.1%	125	3.1%
k. Incarcerated (Local Jail, State Prison, Juvenile Correction Facility)	7	0.6%	76	1.9%
Totals:	1,230	100%	3,988	100%

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

	Children		Adults	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	38	3.1%	213	5.3%
b. Crisis stabilization with referral to new provider for mental health/substance abuse follow up	272	22.1%	818	20.5%
c. Crisis stabilization with referral back to current provider for mental health/substane abuse follow up	454	36.9%	1,231	30.9%
d. Admission to Crisis Stabilization Unit	183	14.9%	498	12.5%
e. Inpatient Hospitalization Medical	8	0.7%	96	2.4%
f. Voluntary Psychiatric Hospitalization	271	22.0%	871	21.8%
g. Involuntary Psychiatric Hospitalization	4	0.3%	178	4.5%
h. Admission to Detox Unit	0	0.0%	83	2.1%
Totals:	1,230	100%	3,988	100%

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

Department of Health and Human Services
Substance Abuse and Mental Health Services
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
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February 1, 2014

Integrated Quarterly Crisis Report

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

Two agencies providing crisis services have failed to receive their incentive payments due to lack of compliance with new procedure for collecting data.

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

Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE

SECOND STATE FISCAL QUARTER 2014
October, November, December 2013

Mary Louise McEwen, RN, MBA
Superintendent

January 17, 2014

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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. Comparison data is not always available for the last month in the quarter and is included in the next report.

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

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

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

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

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CONSENT DECREE

Consent Decree Plan

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

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

Client Rights

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

Indicators	3Q2013	4Q2013	1Q2014	2Q2014
1. Clients are routinely informed of their rights upon admission	91% 42/46	100% 19/20 1 refusal	98% 52/55 2 refused	100% 45/45 (15/15 for decertified unit)

This measure has shown improvement in the past two quarters. 98% this quarter and 100% last quarter. Clients are informed of their rights and asked to sign that information has been provided to them. If they refuse, the staff documents the refusal and sign, date & time the refusal.

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

Indicators	3Q2013	4Q2013	1Q2014	2Q2014
1. Level II grievances responded to by RPC on time.	100% 1/1	0/0	50% 3/6	100% 1/1
2. Level I grievances responded to by RPC on time.	95% 96/101	98% 58/59	98% 59/60	100% 61/61

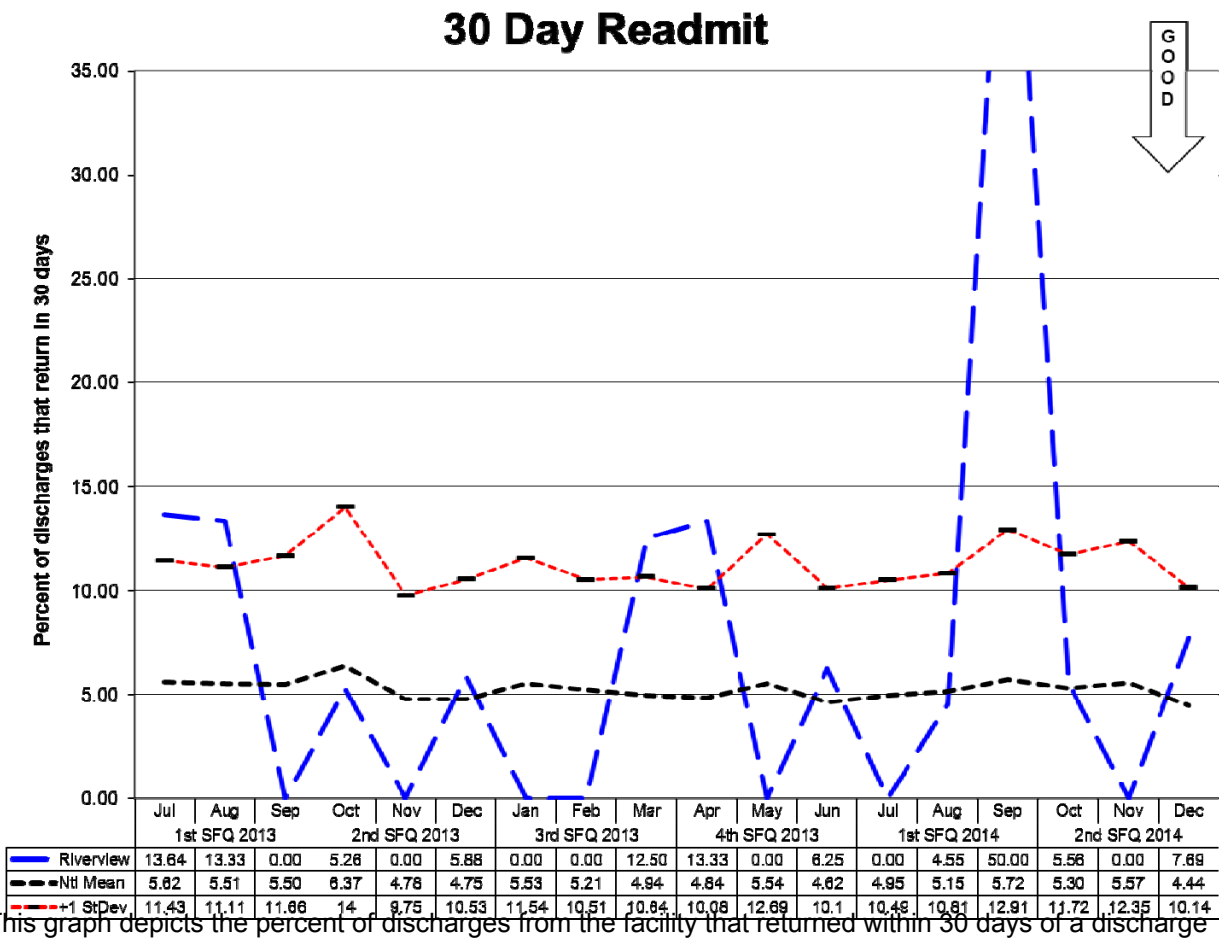
Admissions

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

Legal Status on Admission	3Q2013	4Q2013	1Q2014	2Q2014
ICDCC	20	17	30	15
ICRDCC				
INVOL CRIM	21			
INVOL CRIM – Forensic Evaluation		16	24	18
INVOL CRIM – IST		3	5	12
INVOL CRIM – NCR			3	8
INVOL CRIM – Jail Transfer				
INVOL-CIV	1		1	3
PCHDCC		3		
PCHDCC+M	1			
PCHDSS-PTP-R		1		
VOL	7	3		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 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	13.64	13.33	0.00	5.26	0.00	5.88	0.00	0.00	12.50	13.33	0.00	6.25	0.00	4.55	50.00	5.56	0.00	7.69
Ntl Mean	5.62	5.51	5.50	6.37	4.76	4.75	5.53	5.21	4.94	4.84	5.54	4.62	4.95	5.15	5.72	5.30	5.57	4.44
+1 StDev	11.43	11.11	11.66	14	9.75	10.53	11.54	10.51	10.64	10.08	12.69	10.1	10.48	10.81	12.91	11.72	12.35	10.14

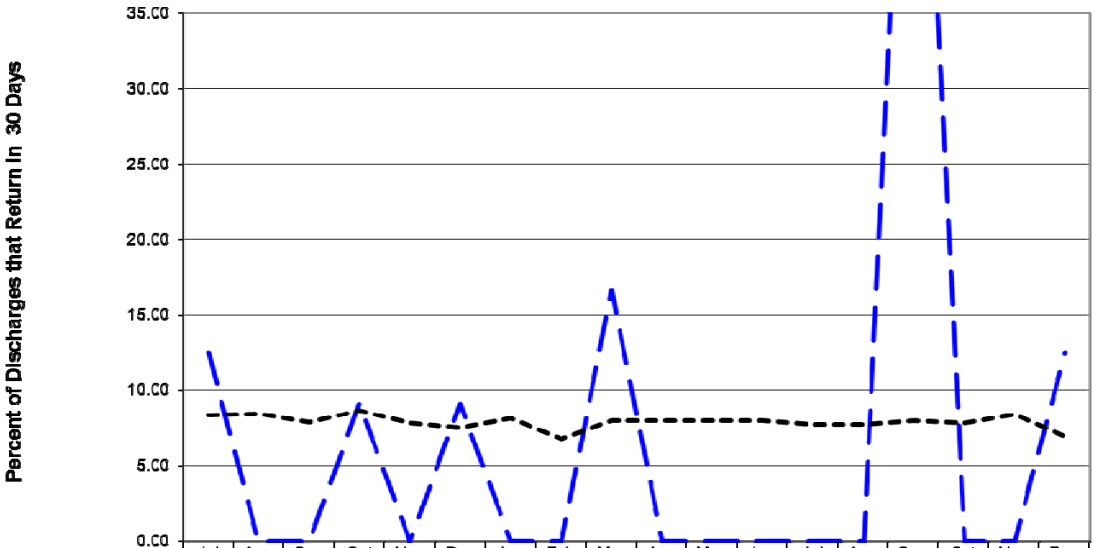
This graph depicts the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

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

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

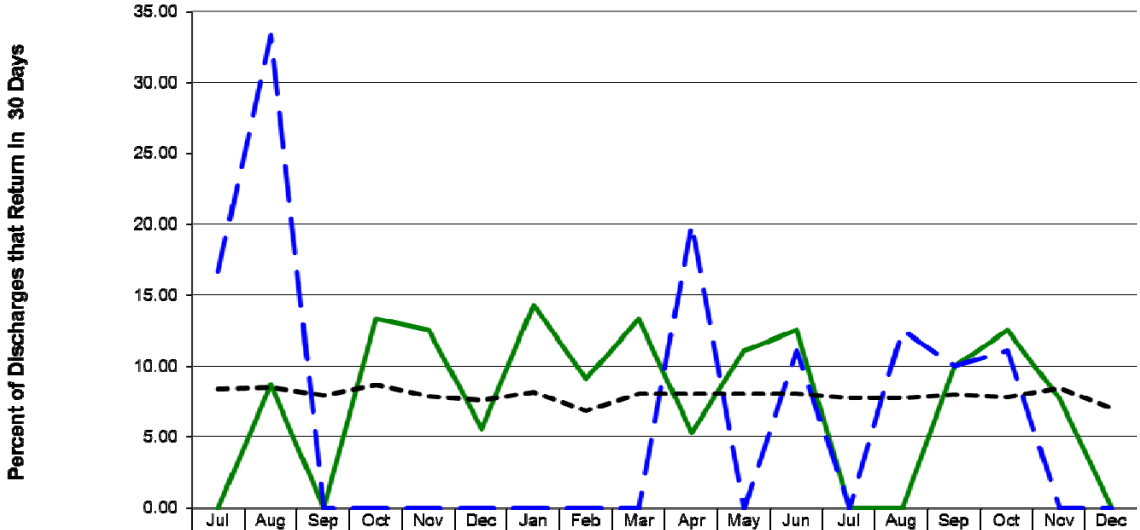
CONSENT DECREE

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 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	12.50	0.00	0.00	9.09	0.00	9.09	0.00	0.00	16.67	0.00	0.00	0.00	0.00	0.00	66.67	0.00	0.00	12.50
National Mean	8.34	8.45	7.88	8.65	7.83	7.54	8.11	6.79	7.98	7.99	7.99	8	7.72	7.70	7.97	7.80	8.38	6.97

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 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Dorothea Dix	0.00	8.70	0.00	13.33	12.50	5.56	14.29	9.09	13.33	5.26	11.11	12.50	0.00	0.00	10.00	12.50	7.69	0.00
Riverview	16.67	33.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	11.11	0.00	12.50	10.00	11.11	0.00	0.00
National Mean	8.34	8.45	7.88	8.65	7.83	7.54	8.11	6.79	7.98	7.99	7.99	8	7.72	7.70	7.97	7.80	8.38	6.97

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	3Q2013	4Q2013	1Q2014	2Q2014
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	100% 2/2	100% 3/3	100% 2/2	100% 1/1

In this aspect area one of the clients that returned is on the Progressive Treatment program with the Riverview ACT team and as part of his court ordered treatment plan was returned to the hospital after displaying increased symptoms in his current group home. Client will remain on PTP and return to placement once stable. The second client is under Progressive Treatment with a provider in Portland he eloped from his group home placement and was re-admitted to Riverview as part of his court ordered treatment plan for increased symptomology. Client will also return to his placement under the PTP. The third client was discharged at his request to the Oxford St Shelter after refusing all placement offerings from his team. Client was assigned to a case manager and psychiatric providers. Client left the shelter and was re-admitted to Riverview after he was found wandering in the community exhibiting aggressive behaviors and psychotic symptoms. Team will work with client to identify needs and wants and set up a discharge plan if client will accept that provides him with a more stable living environment that can provide a compliment of mental health services.

CONSENT DECREE

REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	3Q2013	4Q2013	1Q2014	2Q2014
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% 3 clients were returned to RPC; two for substance use and 1 for psychiatric decompensating.	100% 5 clients were returned to RPC; 4 for psychiatric symptoms, one for relapse while in supervised apartment.	100% 2 clients were returned to RPC for psychiatric instability,	100% 1 client was returned to RPC for psychiatric instability due to substance abuse relapse
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. Readmission was male, age 25; client readmitted is socioeconomically disadvantaged, had been living in his group home for one year, has family support and uses resources that are available such as transportation, educational opportunities, leisure activities. Client was medication adherent, was experiencing medical issues related to lower GI, and had been attending appointments as scheduled with the ACT Team.
2. The ACT Team and the inpatient unit of RPC (Upper Saco) worked collaboratively to minimize the time spent in Riverview while maximizing the opportunity for success upon return to community placements.

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	2Q13	3Q13	1Q14	2Q14	TOT
ADJUSTMENT DISORDER WITH DEPRESSED MOOD	1				**1**
ADJUSTMENT DISORDER WITH ANXIETY		1			**1**
ADJUST DISORDER WITH MIXED ANXIETY & DEPRESSED MOOD	3	1	2	1	**7**
ADJUSTMENT REACTION NOS	1	1	1		**3**
ALCOHOL ABUSE-IN REMISS	1				**1**
ANXIETY STATE NOS		1			**1**
ATTN DEFICIT W HYPERACT		1	1	2	**4**
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPEC				3	**3**
BIPOLAR DISORDER, UNSPECIFIED	5	5	9	4	**23**
DELUSIONAL DISORDER	1	2			**3**
DEPRESS DISORDER-UNSPEC				3	**3**
DEPRESSIVE DISORDER NEC	2	2	6		**10**
DRUG ABUSE NEC-IN REMISS	1				**1**
FACTITIOUS DIS W PREDOMINANTLY PSYCHOLOGICAL SIGNS & SYMPTOM				1	**1**
FACTITIOUS ILL NEC/NOS				1	**1**
HEBEPHRENIA-UNSPEC				1	**1**
IMPULSE CONTROL DIS NOS	1	2		1	**4**
INTERMITT EXPLOSIVE DIS	1	1	2		**4**
MOOD DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE	1				**1**
OTH PERSISTENT MENTAL DIS DUE TO COND CLASS ELSEWHERE	1				**1**
PARANOID SCHIZO-CHRONIC	5	8	10	3	**26**
PARANOID SCHIZO-UNSPEC		1	2	1	**4**
PERSON FEIGNING ILLNESS	1		1	1	**3**
POSTTRAUMATIC STRESS DISORDER	3	3	4		**10**
PSYCHOSIS NOS	4	4	5	10	**23**
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	6	9	12	13	**40**
SCHIZOPHRENIA NOS-CHR		1		1	**2**
SCHIZOPHRENIA NOS-UNSPEC		2			**2**
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED		1		1	**2**
UNSPECIFIED EPISODIC MOOD DISORDER	6	4	8	6	**24**
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER				3	**3**
Total Admissions	**44**	**50**	**63**	**56**	**213**
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	4.55%	0.00%	0.00%	0.00%	1%

Peer Supports

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

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

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

Indicators	3Q2013	4Q2013	1Q2014	2Q2014
1. Attendance at Comprehensive Treatment Team meetings. (v9)	87% 354/406	87% 362/418	84% 408/488	86% 352/411
2. Attendance at Service Integration meetings. (v8)	98% 48/49	79% 26/33	95% 53/56	100% 41/41
3. Contact during admission. (v8)	100% 50/50	100% 46/46	100% 56/56	100% 57/57

Treatment Planning

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

Indicators	3Q2013	4Q2013	1Q2014	2Q2014
1. Preliminary Continuity of Care meeting completed by end of 3rd day	100% 30/30	100% 30/30	100% 30/30	100% 30/30
2. Service Integration form completed by the end of the 3rd day	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3a. Client Participation in Preliminary Continuity of Care meeting.	96% 29/30	100% 30/30	100% 30/30	100% 30/30
3b. CCM Participation in Preliminary Continuity of Care meeting.	100% 30/30	100% 30/30	100% 30/30	100% 30/30
3c. Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) Participation in Preliminary Continuity of Care meeting.	100% 30/30	100% 30/30	93% 28/30	90% 27/30
4a.Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	93% 28/30	90% 27/30	96% 29/30	93% 28/30
4b. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and social worker role	100% 30/30	100% 30/30	96% 29/30	100% 30/30
4c. Annual Psychosocial Assessment completed and current in chart	N/A	N/A	100% 15/15	100% 15/15

Summary: For area 4A we had two psych-social assignments that were started but not completed within the 7 day timeframe required. Both staff were addressed in individual supervision.

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

Indicators	3Q2013	4Q2013	1Q2014	2Q2014
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	93% 43/45	96% 44/45	96% 29/30	93% 28/30
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	95% 14/15	100% 15/15	N/A	N/A
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.	96% 58/60	91% 55/60	100% 30/30	100% 30/30

Data is no longer being collected for #2 as all information is not lumped together into #1.

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

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

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

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

V13) The treatment plans reflect

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

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

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

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

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

Medications

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

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

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

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

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

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

CONSENT DECREE

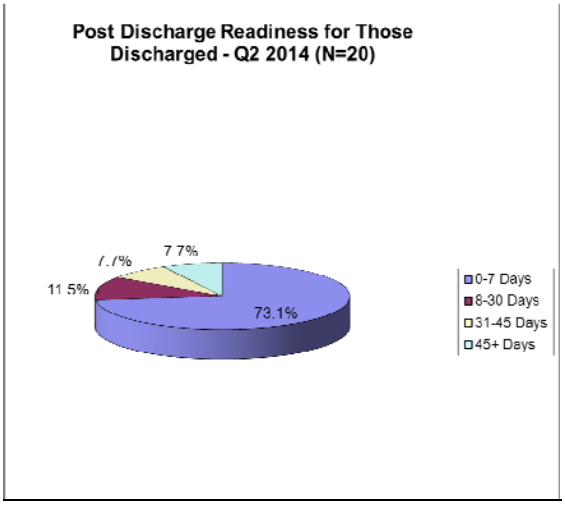
Discharges

Quarterly performance data shows that in 3 consecutive quarters:

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

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

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



Cumulative percentages & targets are as follows:

Within 7 days = (15) 73.1% (target 70%)
Within 30 days = (17) 84.6% (target 80%)
Within 45 days = (18) 92.3% (target 90%)
Post 45 days = (2) 7.7% (target 0%)

Barriers to Discharge Following Clinical Readiness

Residential Supports (1%)

1 client discharged 41 days post clinical readiness

Housing (10%)

1 client discharged 34 days post clinical readiness
1 client discharged 111 days post clinical readiness

Treatment Services (0)

No barriers in this area

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%
1Q2014	N=26	73.1%	84.6%	92.3%	7.7%
4Q2013	N=30	70%	86.7%	93.3%	6.7%
3Q2013	N=22	77.3%	86.4%	90.0%	9.1%
2Q2013	N-24	54.2%	70.9%	87.6%	12.5%

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	3Q2013	4Q2013	1Q2014	2Q2014
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% 12/12	100% 11/11
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% 12/12	100% 11/11
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	100% 12/12	100% 13/13	91% 11/12	100% 11/11
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	91% 11/12	100% 11/11

Meeting was cancelled once for the Christmas holiday but a report encompassing two weeks was distributed.

CONSENT DECREE

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

Indicators	3Q2013	4Q2013	1Q2014	2Q2014
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	87% 7/8	80% 8/10	12% 1/8	0% 0/4
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$ 9/9	100% 4/4	100% 2/2	100% 4/4
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually				100% 92/92

Summary: Area 1, to address this area of continued challenge Social Work Director and Program Service Director will investigate why this area continues to not meet compliance, identify the barriers in the system, and create a system of tracking to ensure that this indicator comes into compliance going forward.

Staffing and Staff Training

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014	2014 Total
1. Riverview and Contract staff will attend CPR training bi-annually.	*40/46	*64/67			93%
2. Riverview and Contract staff will attend NAPPI training annually.	*101/120	*137/157			85%
3. Riverview and Contract staff will attend Annual training.	*11/25	*78/81			83%

1Q 2014

1. *Of the six employees who are not in compliance, two staff are on Workers Compensation status, two staff are on Family Medical Leave, one transferred and missed training due to family emergency. All are scheduled for next available training. One staff is out of the country,

2. *Of the nineteen employees who are not in compliance two are on Workers Compensation leave, one is on LOA. Those remaining are scheduled for the next available training.

3. *Of the eleven staff who are not in compliance; two staff are on Workers Compensation, one is out of the country, one has transferred to another department. Supervisors of remaining staff have been informed they are in non-compliance and corrective actions have been taken.

2Q 2014

1. Three employees who are out of compliance are on leave status.

2. Eight of the employees are on leave status. The remaining twelve will be attending the next offered behavior management /physical intervention training.

3. The three the individuals who are not in compliance are on leave status.

Goal: SD will provide opportunities for employees to gain, develop and renew skills knowledge and aptitudes.
Objective: 100% of employees will be provided with an opportunity both formal and informal training and/or learning experiences that contribute to individual growth and improved performance in current position.
SD will survey staff annually and develop trainings to address training needs as identified by staff.
Current Status: **1Q SFY 13-14**
Employee Education needs survey distributed to employees in March of 2013.
As a result of identified needs, the training entitled ***Personality Disorder Characteristics and Effective* Interventions** was developed and presented in August 2013.
August 19 & 26 2013, Susan C. Righthand, Ph.D, a nationally recognized speaker and consultant in the field of psychological assessment and treatment of sex offenders, conducted a *two part* training entitled: ***Working Effectively with Adult Sexual Offenders:*** *Characteristics, Assessment, and Interventions* available to all Riverview Psychiatric Center Employees.
August 20, 2013 Dr. Kenneth Beattie provided an in-service entitled: ***The Psychology of Working with Emotionally Challenging and Emotionally Challenged Clients.*** This training was developed in response to the Employee Education needs survey distributed to employees in March of 2013 and made available to all Riverview Psychiatric Center employees.
August 5, 2013, ***Single Wrist Restraint Application*** training was held to provide an opportunity to practice skills taught in the Initial NAPPI course provided to New Employees and NAPPI Recertification Class provided on a monthly basis through-out the year to Riverview Psychiatric Center employees. Over sixty unit staff attended.

CONSENT DECREE

2Q SFY 13-14

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

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

On January 18th, James Claiborn, Ph. D, provided training entitled ***Understanding Behavior and Treatment Planning*** in which participants learned :

How to identify, define and describe behavior.
How to develop interventions that reinforce behavior we want to increase and extinguish behavior we want to decrease.

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

Goal: SD will develop and implement a comprehensive mentoring program to assist new employees in gaining the skills necessary to do their job.
Objective: 100% of new Mental Health Workers will be paired with a mentor and will satisfactorily complete 12 competency areas on the unit orientation prior to being assigned regular duties requiring direct care of patients.
Current Status: **1Q SFY 13-14**
100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

2Q SFY 13-14
100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

CONSENT DECREE

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

DATE	HRS	TITLE	PRESENTER
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)
2Q2013	9	Oct – Dec 2012	Fall Semester (see2Q13 Quarterly Report)
3Q2013	11	Jan – Mar 2013	Winter Semester (see 3Q13 Quarterly Report)
4Q2013	12	Apr – June 2013	Spring Semester (see 4Q13 Quarterly Report)
1Q2014	5.5	July - September 2013	Summer Semester (see 1Q14 Quarterly Report)
10/15/13	1	Peer Review Committee: Case Review	William Nelson, MD
10/17/13	1	Epigenetics – The Future of Medicine: A Primer and References to Major Mental Illness	George Davis, MD
10/24/13	1	Overview of Changes in DSM-5 Psychotic Disorders	Douglas Noordsy, MD
10/31/13	1	Differences Between ODT and SL Tablet Formulations	Miranda Cole, PharmD Patrick Cote, RN Renee Dufresne, Pharmacy Student
11/7/13	1	Recovery, Treatment Resistance, and Recidivism: Three Case Reviews	David Dettmann, DO
11/2013	1	Peer Review Committee: Case Review	William Nelson, MD
11/21/13	1	Mass Shootings: Is Prevention Possible/ A Forum For Discussion	Mitch Manin, MD

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

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

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

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

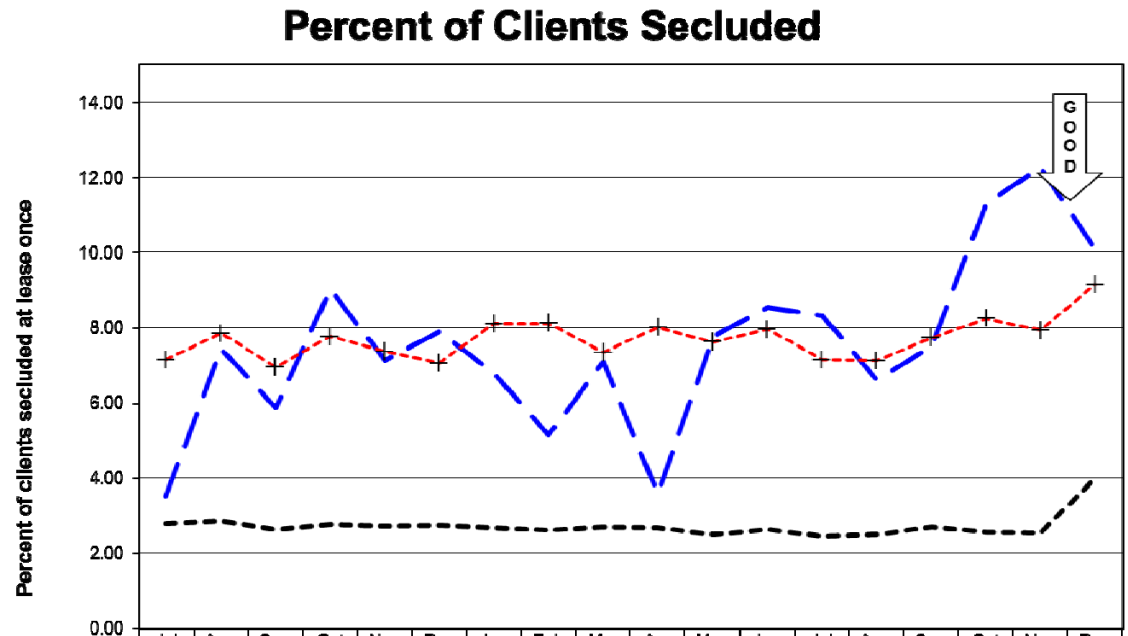
V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	3.51	7.44	5.88	9.01	7.14	7.89	6.78	5.13	7.08	3.57	7.76	8.55	8.33	6.61	7.50	11.30	12.28	10.08
Ntl Mean	2.78	2.84	2.62	2.76	2.70	2.74	2.66	2.61	2.68	2.66	2.50	2.62	2.45	2.50	2.68	2.56	2.53	3.98
+1 StDev	7.15	7.84	6.95	7.76	7.37	7.06	8.1	8.11	7.34	8.01	7.62	7.95	7.15	7.13	7.72	8.24	7.93	9.14

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.

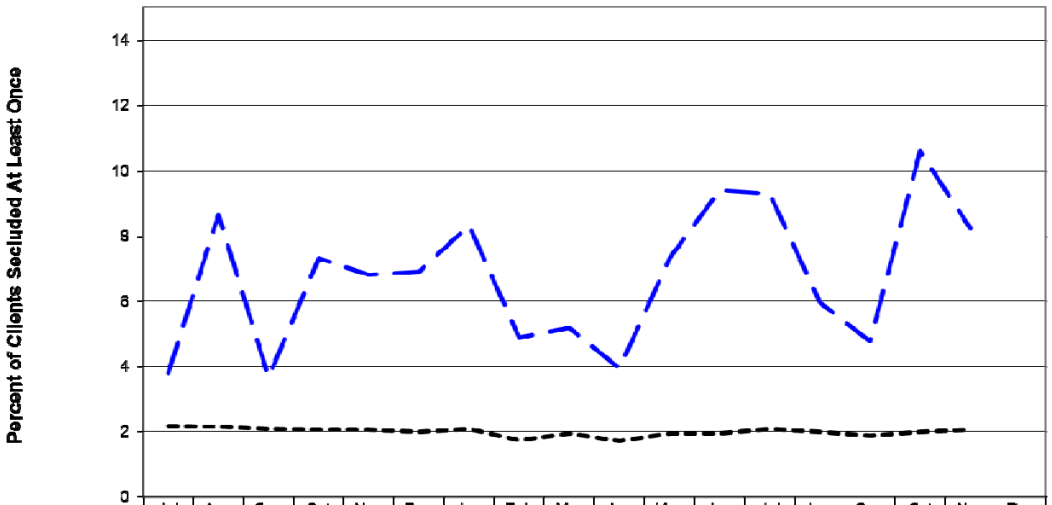
The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

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

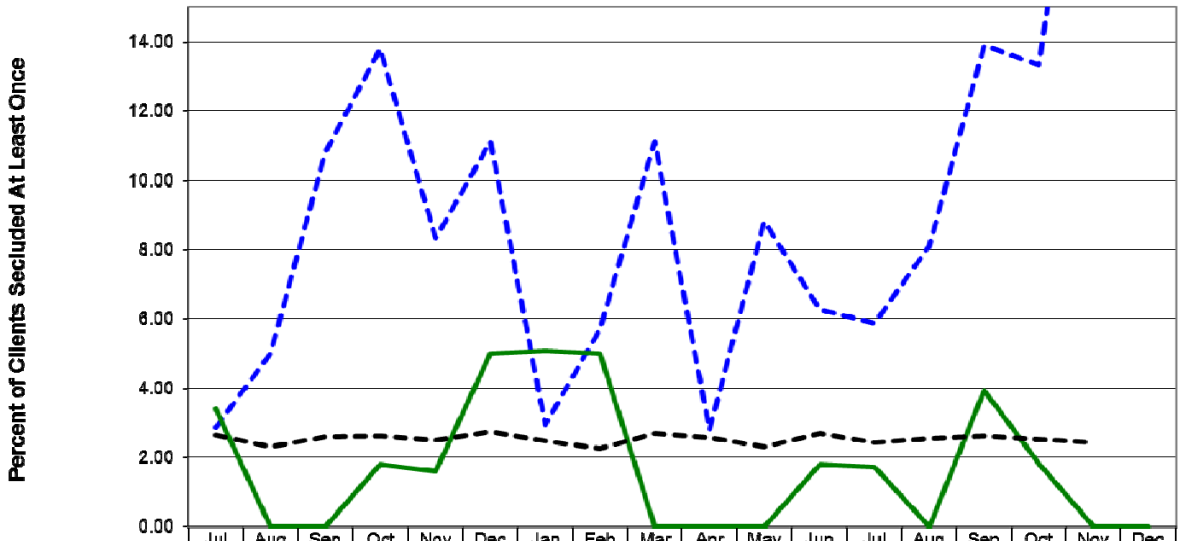
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	3.6	6.64	3.66	7.32	6.82	6.9	8.33	4.88	5.19	3.95	7.32	9.41	9.3	5.95	4.76	10.59	6.24	
Ntl Mean	2.18	2.18	2.08	2.05	2.05	1.99	2.08	1.73	1.95	1.72	1.94	1.95	2.08	2	1.88	2	2.06	

Percent of Clients Secluded

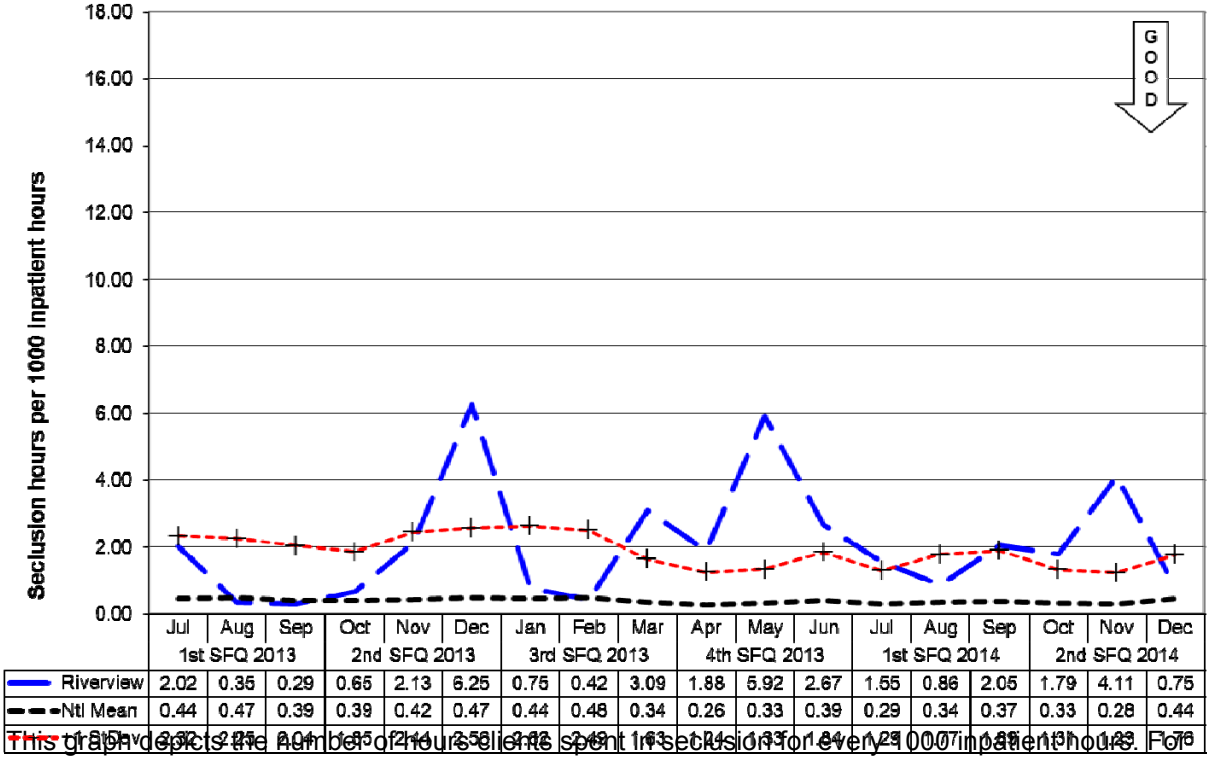
Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	2.86	5	10.81	13.79	8.33	11.11	2.94	5.71	11.11	2.78	8.82	6.25	5.88	8.11	13.89	13.33	24.14	
Dorothea Dix	3.39	0.00	0.00	1.79	1.59	5.00	5.08	5.00	0.00	0.00	0.00	1.79	1.72	0.00	3.92	1.82	0.00	0.00
Ntl Mean	2.63	2.29	2.58	2.62	2.5	2.74	2.46	2.26	2.69	2.56	2.31	2.68	2.41	2.54	2.62	2.51	2.43	

CONSENT DECREE

Seclusion Hours



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	2.02	0.35	0.29	0.65	2.13	6.25	0.75	0.42	3.09	1.88	5.92	2.67	1.55	0.86	2.05	1.79	4.11	0.75
Ntl Mean	0.44	0.47	0.39	0.39	0.42	0.47	0.44	0.48	0.34	0.26	0.33	0.39	0.29	0.34	0.37	0.33	0.28	0.44
Ntl Stay	2.32	2.25	2.04	1.85	2.11	2.58	2.02	2.49	1.63	1.24	1.33	1.84	1.29	1.07	1.86	1.31	1.23	1.76

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.

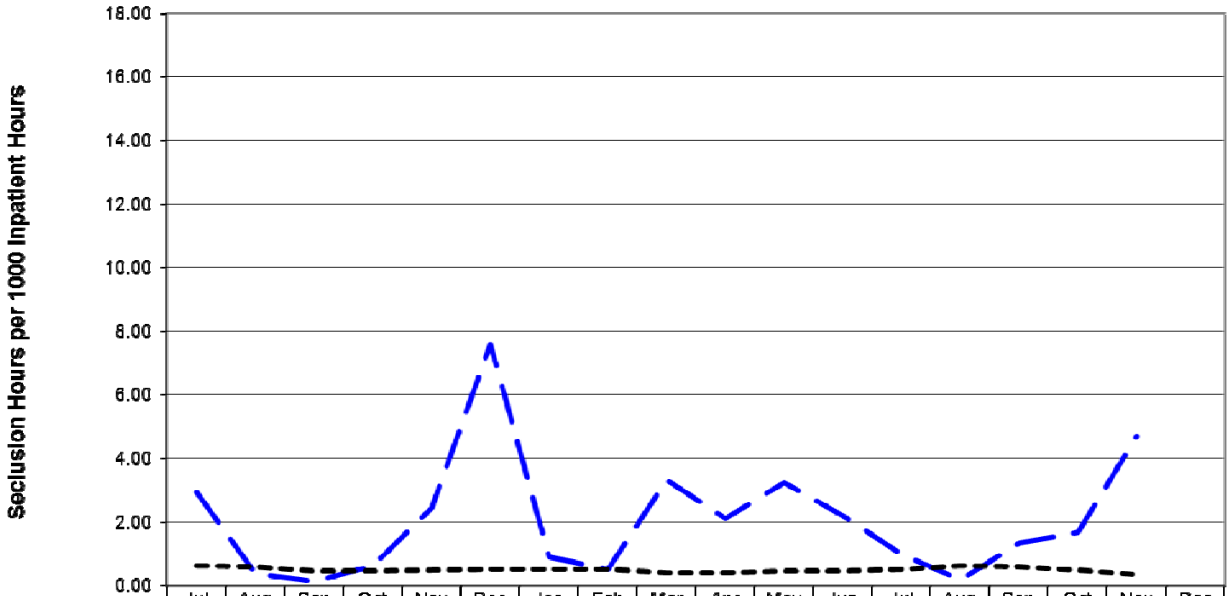
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

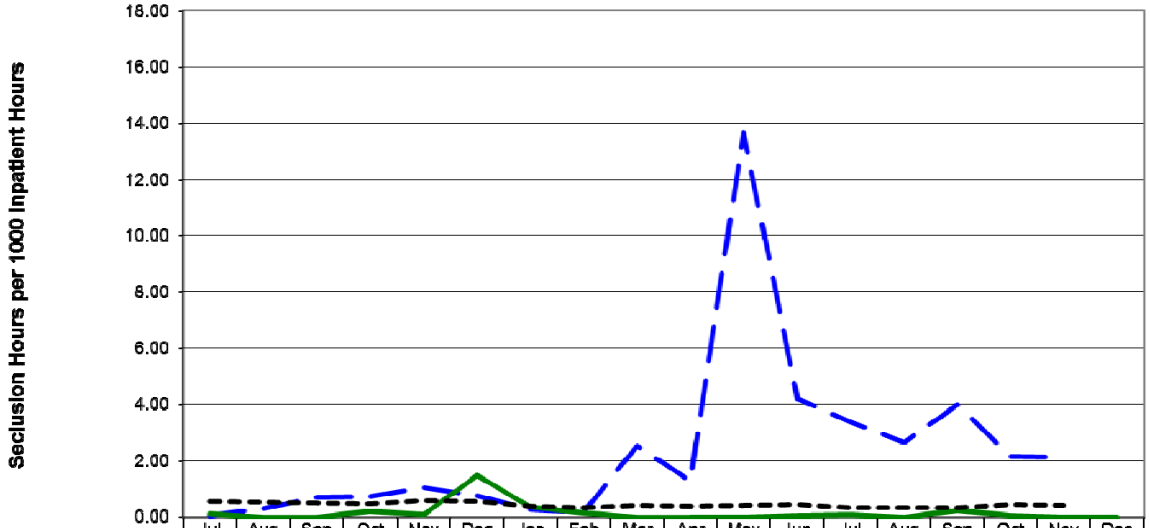
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	2.94	0.37	0.12	0.63	2.43	7.6	0.9	0.52	3.32	2.11	3.23	2.2	0.97	0.19	1.34	1.67	4.71	
Ntl Mean	0.62	0.59	0.46	0.46	0.57	0.54	0.36	0.3	0.39	0.4	0.46	0.45	0.5	0.61	0.6	0.48	0.36	

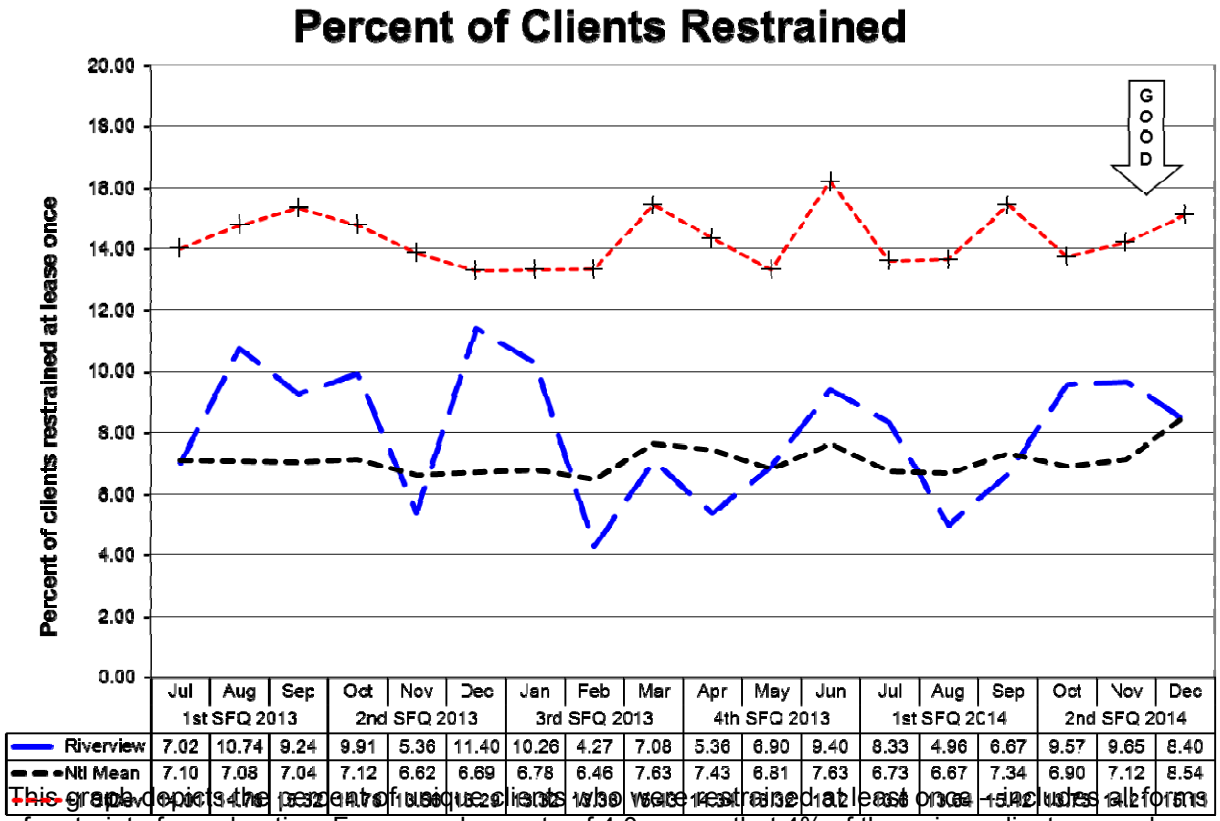
Seclusion Hours

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	0.04	0.29	0.68	0.71	1.04	0.74	0.26	0.16	2.53	1.26	13.65	4.18	3.37	2.63	3.98	2.14	2.12	
Dorothea Dix	0.10	0.00	0.00	0.20	0.09	1.47	0.35	0.13	0.00	0.00	0.00	0.06	0.09	0.00	0.22	0.05	0.00	0.00
Ntl Mean	0.54	0.51	0.49	0.46	0.57	0.54	0.36	0.3	0.4	0.36	0.4	0.42	0.3	0.31	0.32	0.43	0.41	

CONSENT DECREE



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.

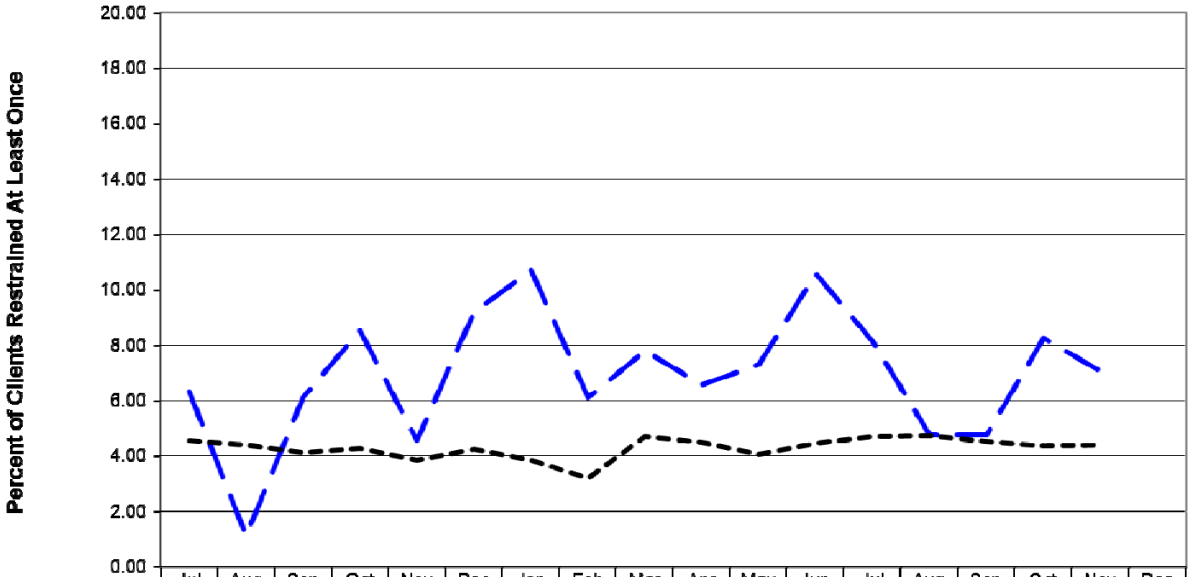
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

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

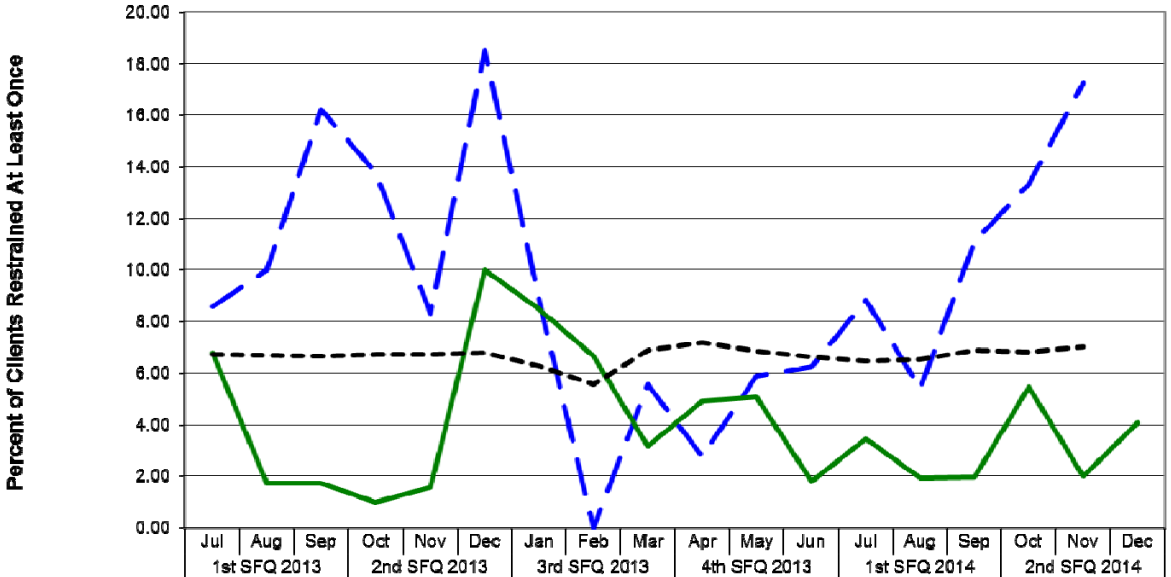
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	6.33	1.11	6.1	8.54	4.55	9.2	10.71	6.1	7.79	6.58	7.32	10.59	6.14	4.76	4.76	8.24	7.06	
Ntl Mean	4.56	4.41	4.11	4.27	3.86	4.23	3.85	3.19	4.7	4.48	4.07	4.46	4.7	4.72	4.52	4.36	4.39	

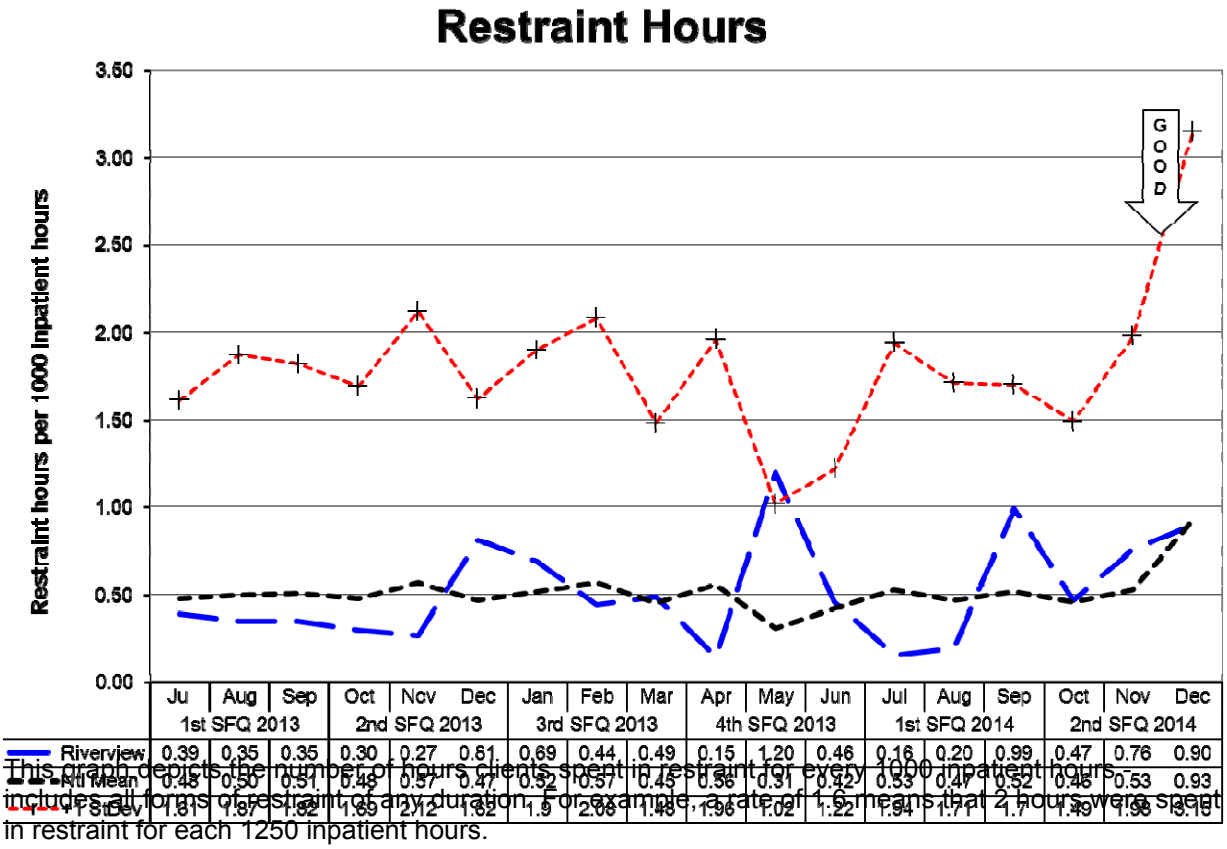
Percent of Clients Restrained

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	8.57	10	16.22	13.79	8.33	18.52	8.82	0	5.56	2.78	5.88	6.25	8.82	5.41	11.11	13.33	17.24	
Dorothea Dix	6.78	1.75	1.75	1.00	1.59	10.00	8.47	6.67	3.17	4.92	5.08	1.79	3.45	1.92	1.96	5.45	2.00	4.08
Ntl Mean	6.72	6.7	6.66	6.72	6.72	6.78	6.27	5.55	6.9	7.18	6.87	6.62	6.48	6.53	6.88	6.82	7.03	

CONSENT DECREE



This graph depicts the number of hours clients spent in restraint for every 1000 inpatient hours. It 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.

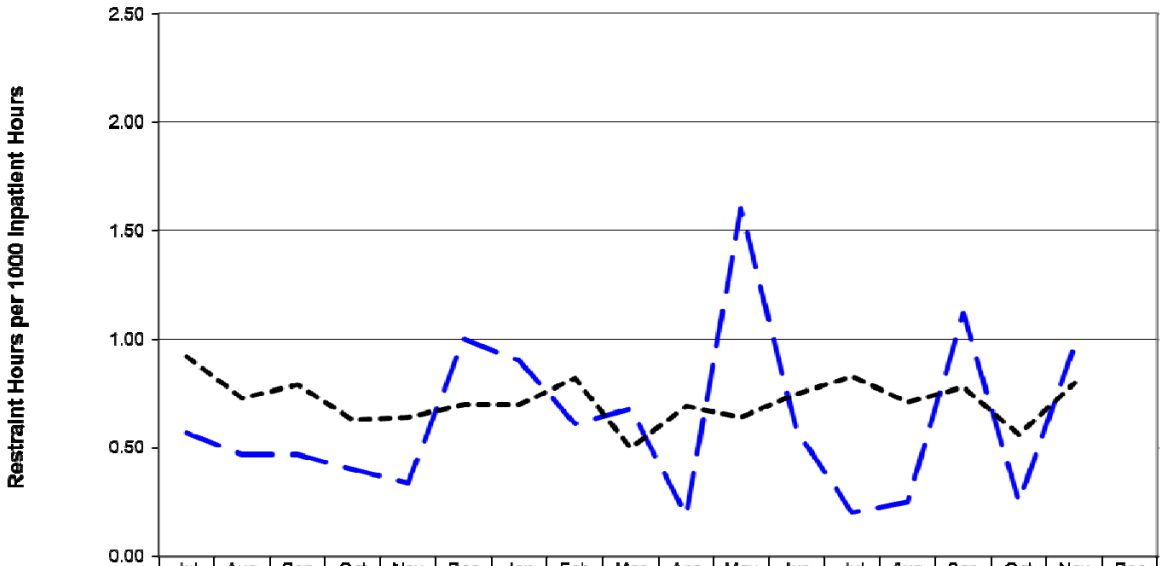
The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

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

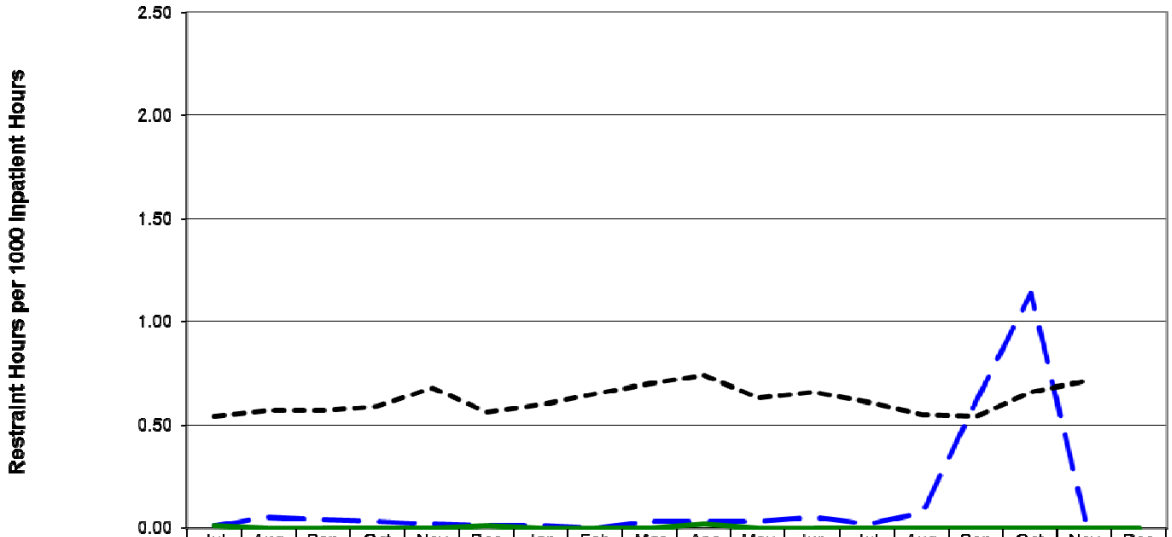
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	0.57	0.47	0.47	0.40	0.34	1.00	0.90	0.61	0.68	0.19	1.60	0.58	0.2	0.25	1.12	0.25	0.97	
Ntl Mean	0.92	0.73	0.79	0.63	0.64	0.70	0.70	0.82	0.50	0.69	0.64	0.75	0.83	0.71	0.78	0.56	0.80	

Restraint Hours

Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	0.01	0.05	0.04	0.03	0.02	0.01	0.01	0	0.03	0.03	0.03	0.05	0.02	0.07	0.62	1.14	0.04	
Dorothea Dix	0.01	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Ntl Mean	0.54	0.57	0.57	0.59	0.68	0.56	0.60	0.65	0.70	0.74	0.63	0.66	0.61	0.55	0.54	0.66	0.71	

CONSENT DECREE

Confinement Event Detail

2nd Quarter 2014

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR00000657	26	36	11	73	31.6%	31.6%
MR00007411	31	11	3	45	19.5%	51.1%
MR00006963	6		13	19	8.2%	59.3%
MR00003374	5		7	12	5.2%	64.5%
MR00006330	2		9	11	4.8%	69.3%
MR00000814		2	6	8	3.5%	72.7%
MR00007419	3		4	7	3.0%	75.8%
MR00004814	2		3	5	2.2%	77.9%
MR00007431			4	4	1.7%	79.7%
MR00006955			4	4	1.7%	81.4%
MR00003726	1		2	3	1.3%	82.7%
MR00004271		1	2	3	1.3%	84.0%
MR00004637	1		2	3	1.3%	85.3%
MR00005267	1		2	3	1.3%	86.6%
MR00000029	1	1	1	3	1.3%	87.9%
MR00007394	1		2	3	1.3%	89.2%
MR00007340	1		2	3	1.3%	90.5%
MR00006799	1		2	3	1.3%	91.8%
MR00007359	2			2	0.9%	92.6%
MR00007127	1		1	2	0.9%	93.5%
MR00007189	1		1	2	0.9%	94.4%
MR00007291	1		1	2	0.9%	95.2%
MR00007455	1		1	2	0.9%	96.1%
MR00006314			2	2	0.9%	97.0%
MR00007458	1		1	2	0.9%	97.8%
MR00000091	1		1	2	0.9%	98.7%
MR00007314	1			1	0.4%	99.1%
MR00002313	1			1	0.4%	99.6%
MR00007457			1	1	0.4%	100.0%
	92	**51**	**88**	**231**		

39% (29/74) of average hospital population experienced some form of confinement event during the 2nd fiscal quarter 2014. Five of these clients (7% of the average hospital population) accounted for 69% 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.

CONSENT DECREE

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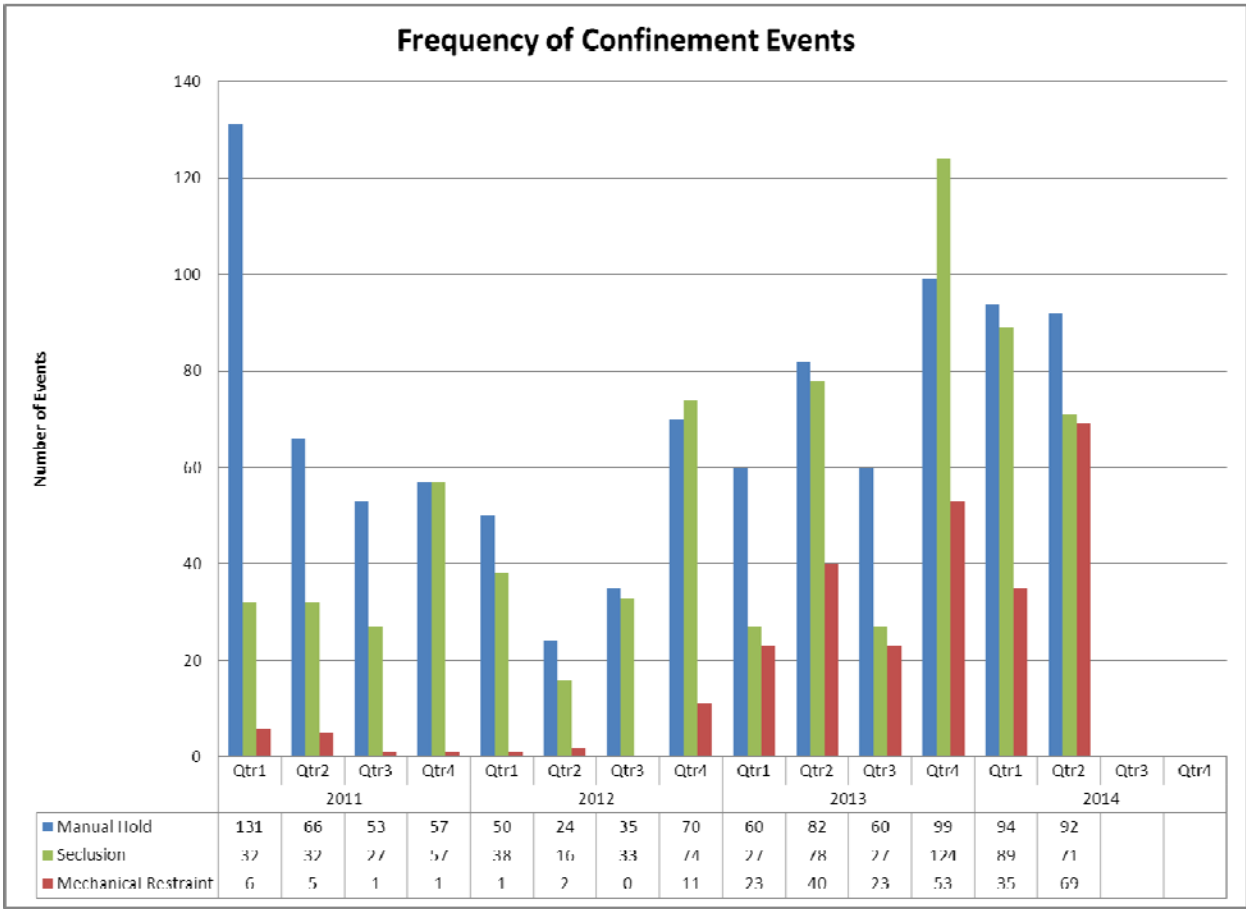

Since December 2012, Riverview has been admitting an increasing number of forensic clients that are extremely violent and difficult to manage. This increase in high acutiy clients has required the use of specialized management techniques that ensure the safety of these clients, other clients, and staff while attempting to maintain a therapeutic mileau.

Best practices from other forensic facilities and recommendations from experts in forensic client management from other State of Maine departments have been considered in the management of these clients.

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

	2Q13	3Q13	4Q13	1Q14	2Q14
Danger to Others/Self	78	50	124	71	88
Danger to Others					
Danger to Self		1			
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	78	51	124	71	88

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

	2Q13	3Q13	4Q13	1Q14	2Q14
Danger to Others/Self	40	40	53	29	51
Danger to Others					
Danger to Self					1
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	40	40	53	29	52

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

See Pages 29 & 30

CONSENT DECREE

Confinement Events Management

Seclusion Events (88) 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 (52) Events

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

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

Client Elopements

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

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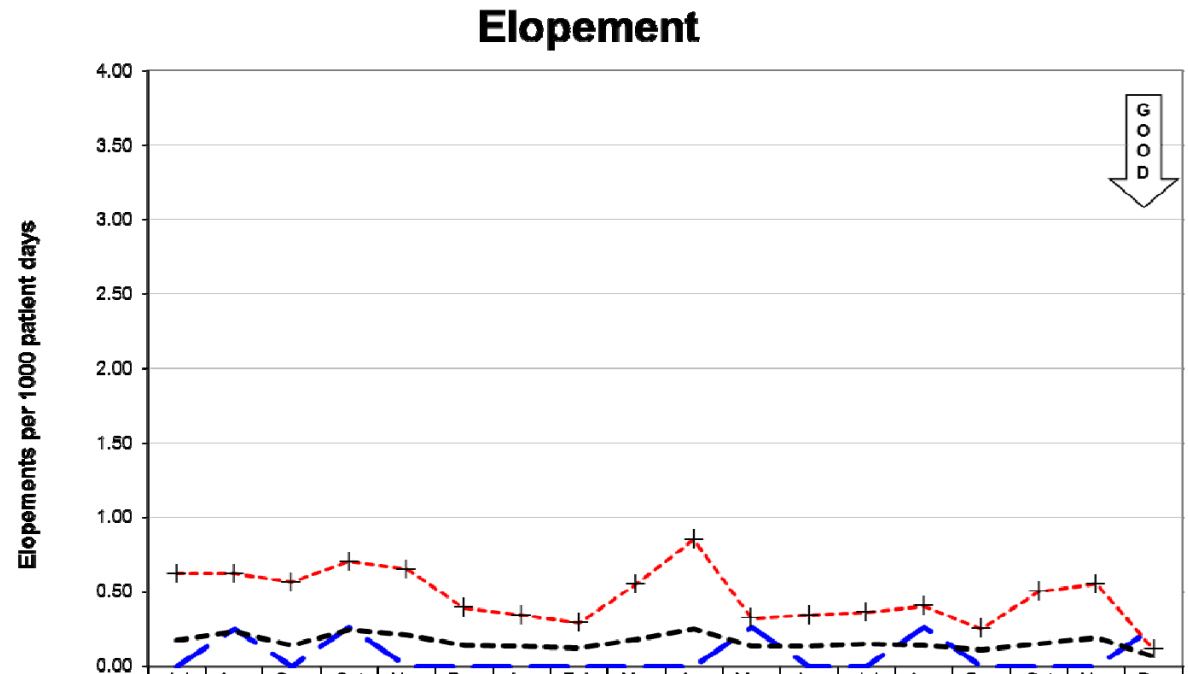


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	0.00	0.25	0.00	0.26	0.00	0.00	0.00	0.00	0.00	0.00	0.26	0.00	0.00	0.26	0.00	0.00	0.00	0.26
Ntl Mean	0.17	0.23	0.14	0.24	0.21	0.14	0.13	0.12	0.16	0.25	0.13	0.13	0.15	0.14	0.11	0.15	0.19	0.06
StDev	0.62	0.62	0.56	0.7	0.65	0.39	0.34	0.29	0.55	0.85	0.32	0.34	0.38	0.4	0.25	0.5	0.55	0.11

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.

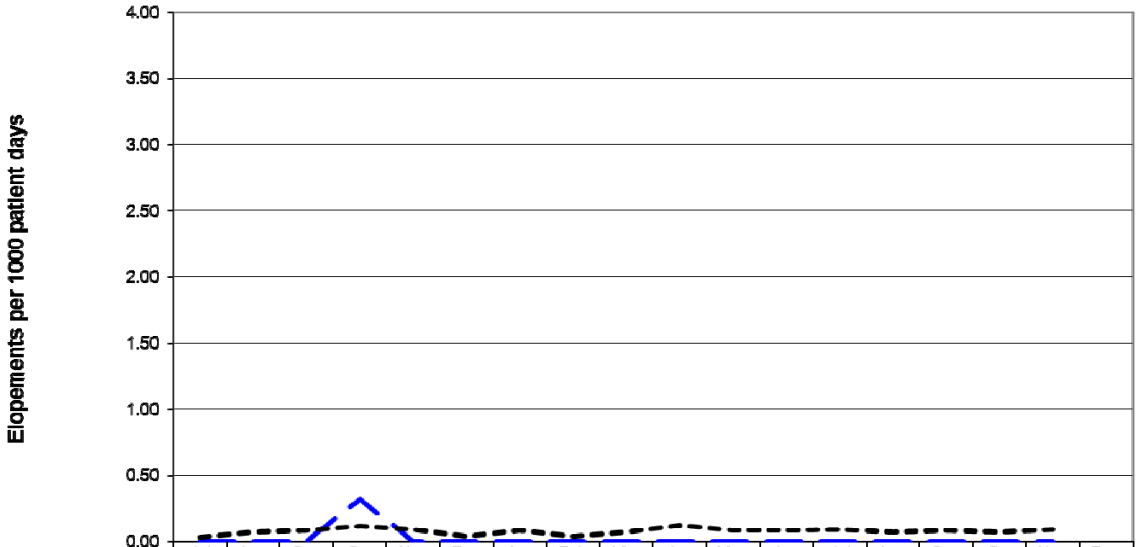
An elopement is defined as any time a client is “absent from a location defined by the client’s privilege status regardless of the client’s leave or legal status.”

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.

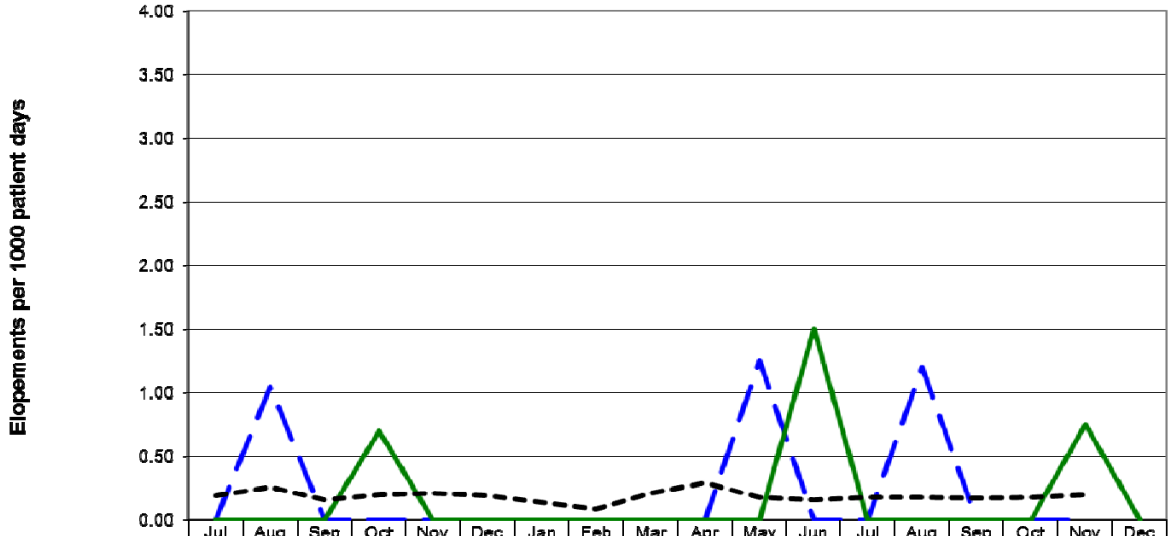
CONSENT DECREE

Elopement
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	0.00	0.00	0.00	0.32	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.03	0.07	0.08	0.11	0.09	0.04	0.08	0.04	0.07	0.12	0.08	0.08	0.09	0.07	0.08	0.07	0.09	

Elopement
Civil Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	0.00	1.05	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.25	0.00	0.00	1.20	0.00	0.00	0.00	
Dorothea Dix	0.00	0.00	0.00	0.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.50	0.00	0.00	0.00	0.00	0.75	0.00
Ntl Mean	0.19	0.26	0.16	0.20	0.21	0.19	0.14	0.09	0.21	0.29	0.16	0.16	0.18	0.18	0.17	0.18	0.20	

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.

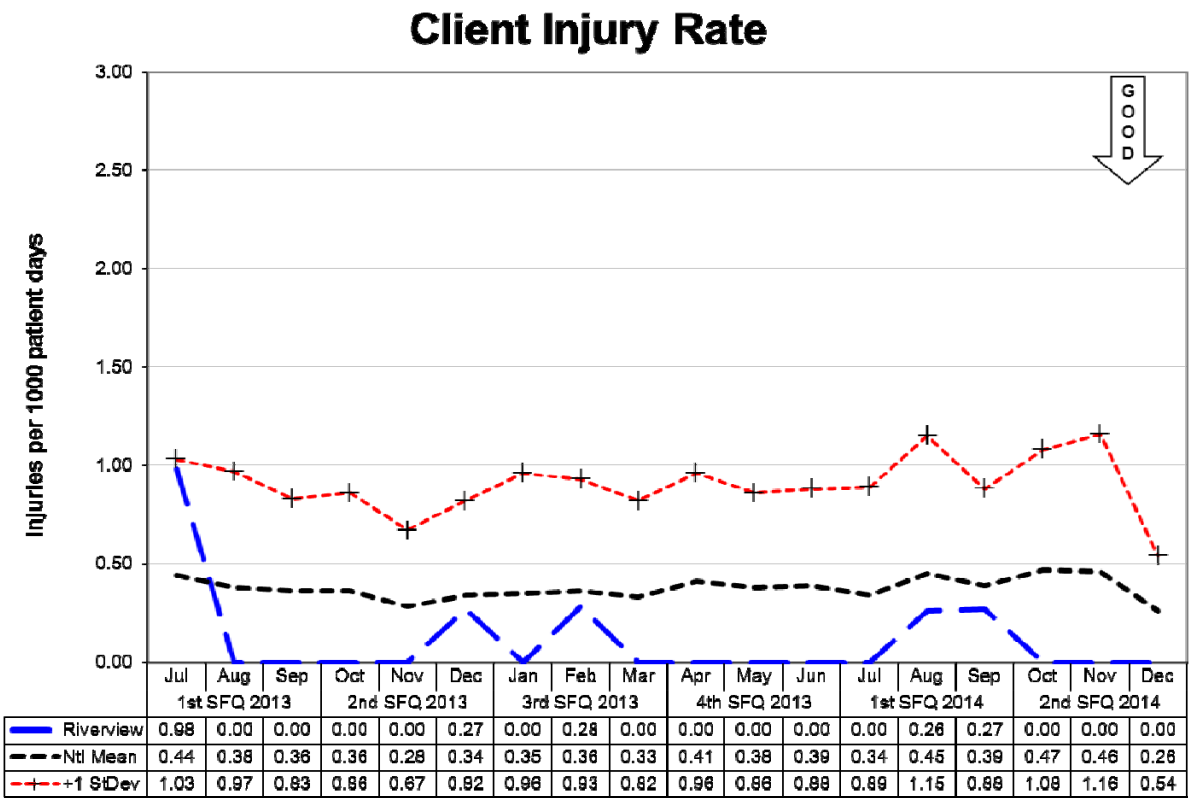
“Non-reportable” injuries include those that require: 1) No Treatment, or 2) Minor First Aid

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	0.98	0.00	0.00	0.00	0.00	0.27	0.00	0.28	0.00	0.00	0.00	0.00	0.00	0.26	0.27	0.00	0.00	0.00
Ntl Mean	0.44	0.38	0.36	0.36	0.28	0.34	0.35	0.36	0.33	0.41	0.38	0.39	0.34	0.45	0.39	0.47	0.46	0.26
+1 StDev	1.03	0.97	0.83	0.86	0.67	0.92	0.96	0.93	0.82	0.96	0.86	0.89	0.89	1.15	0.88	1.08	1.16	0.54

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.

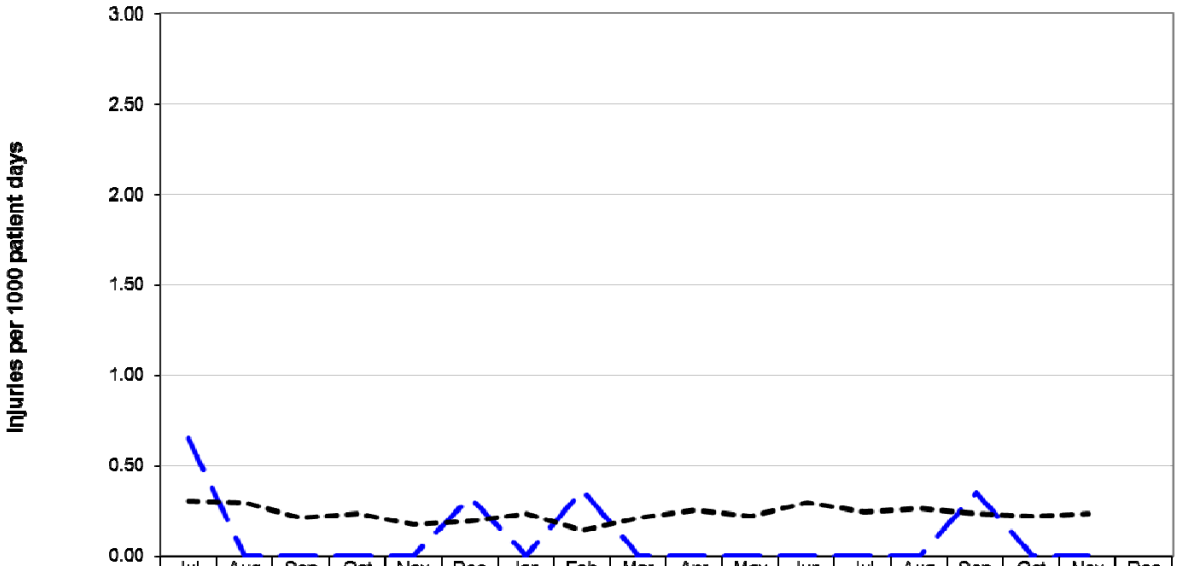
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

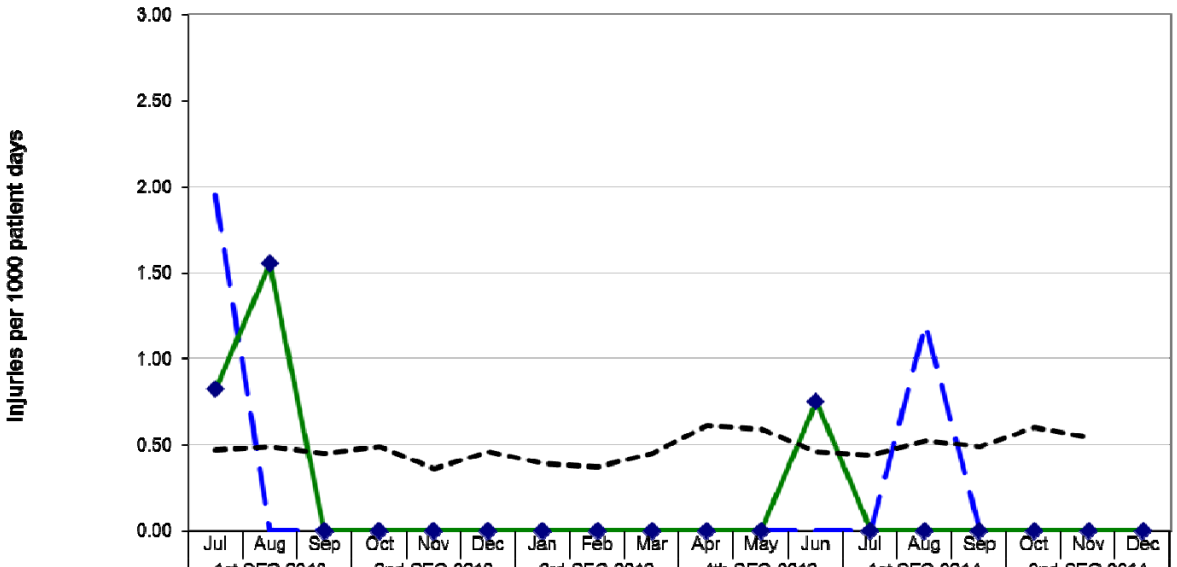
Forensic Stratification



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	0.65	0.00	0.00	0.00	0.00	0.32	0.00	0.36	0.00	0.00	0.00	0.00	0.00	0.00	0.35	0.00	0.00	
Ntl Mean	0.30	0.29	0.21	0.23	0.17	0.19	0.23	0.14	0.21	0.25	0.22	0.29	0.24	0.26	0.23	0.22	0.23	

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 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			
Riverview	1.95	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.20	0.00	0.00	0.00		
Dorothea Dix	0.82	1.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.75	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.47	0.49	0.45	0.49	0.36	0.46	0.39	0.37	0.45	0.61	0.59	0.46	0.44	0.52	0.49	0.60	0.54		

CONSENT DECREE

Severity of injury by Month

Severity	OCT	NOV	DEC	2Q2014
No Treatment	58	31	27	**116**
Minor First Aid				
Medical Intervention Required				
Hospitalization Required				
Death Occurred				
Total	**58**	**31**	**27**	**116**

Type and Cause of Injury by Month

Type - Cause	OCT	NOV	DEC	2Q2014
Accident – Fall Unwitnessed	4	1	2	7
Accident – Fall Witnessed	9	2	7	18
Accident – Other		1	1	2
Assault – Client to Client	21	16	3	40
Self-Injurious Behavior	24	11	14	49
Total	**58**	**31**	**27**	**116**

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

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

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

Patient Abuse, Neglect, Exploitation, Injury or Death

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

Type of Allegation	3Q2013	4Q2013	1Q2014	2Q2014
Abuse Physical	2	3	3	4
Abuse Sexual	2	5	4	2
Abuse Verbal			1	1
Coercion/Exploitation		1		
Neglect				

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

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

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with The Joint Commission on November 11-13, 2013. A triennial accreditation survey is expected to occur in November 2016 or earlier.

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

The surveyors identified four BHC and sixteen HAP areas of indirect impact that required a review and revision of hospital processes within 60 days. Three of the HAP areas were clarified within the ten days and were accepted.

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;

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance by August 27, 2013. A revisit by CMS occurred on September 16th and 17th, 2013. The Medicare Provider Agreement will not be accepted unless CMS finds that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and that the hospital has fulfilled, or has made satisfactory arrangements to fulfill, all of its statutory and regulatory responsibilities of its previous agreement. See Section 1866(c) of the Social Security Act and 42 C.F.R.§489.57. Riverview is currently in the process of applying for recertification.

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

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

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

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

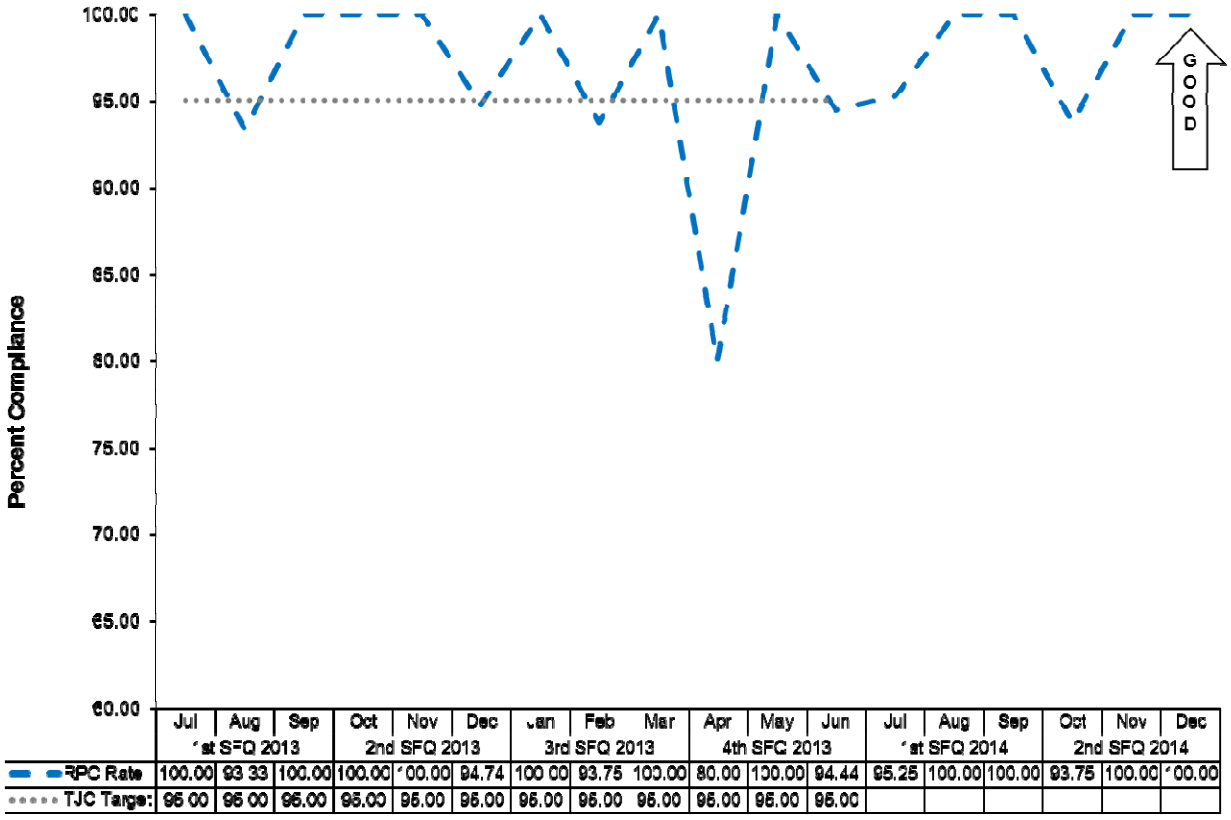
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

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.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
RPC Rate	100.00	93.33	100.00	100.00	100.00	94.74	100.00	93.75	100.00	80.00	100.00	94.44	95.25	100.00	100.00	93.75	100.00	100.00
TJC Target:	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

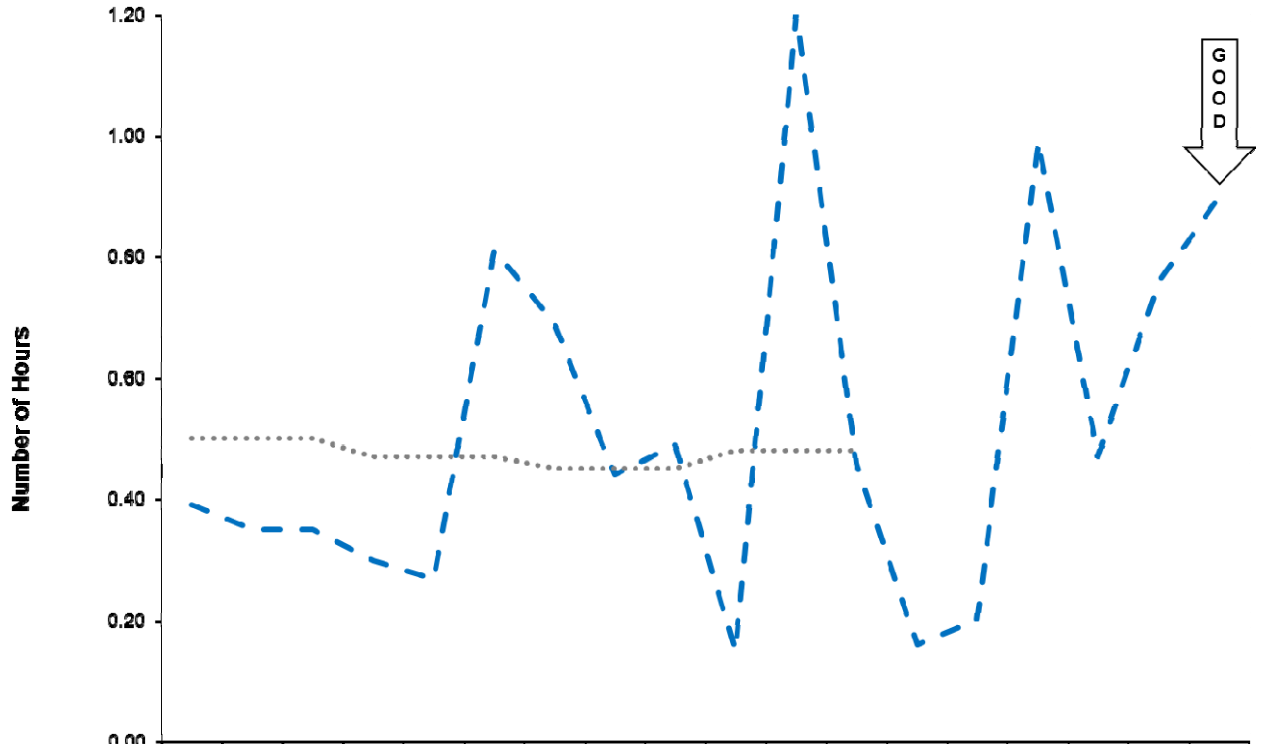
Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting 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 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
RPC Rate	0.39	0.35	0.35	0.30	0.27	0.81	0.69	0.44	0 49	0.15	1.20	0.46	0.16	0.20	0.99	0.47	0.76	0.90
TJC Target	0.50	0.50	0.50	0.47	0.47	0.47	0.45	0.45	0 45	0.48	0.48	0.48						

JOINT COMMISSION

Seclusion (HBIPS 3)

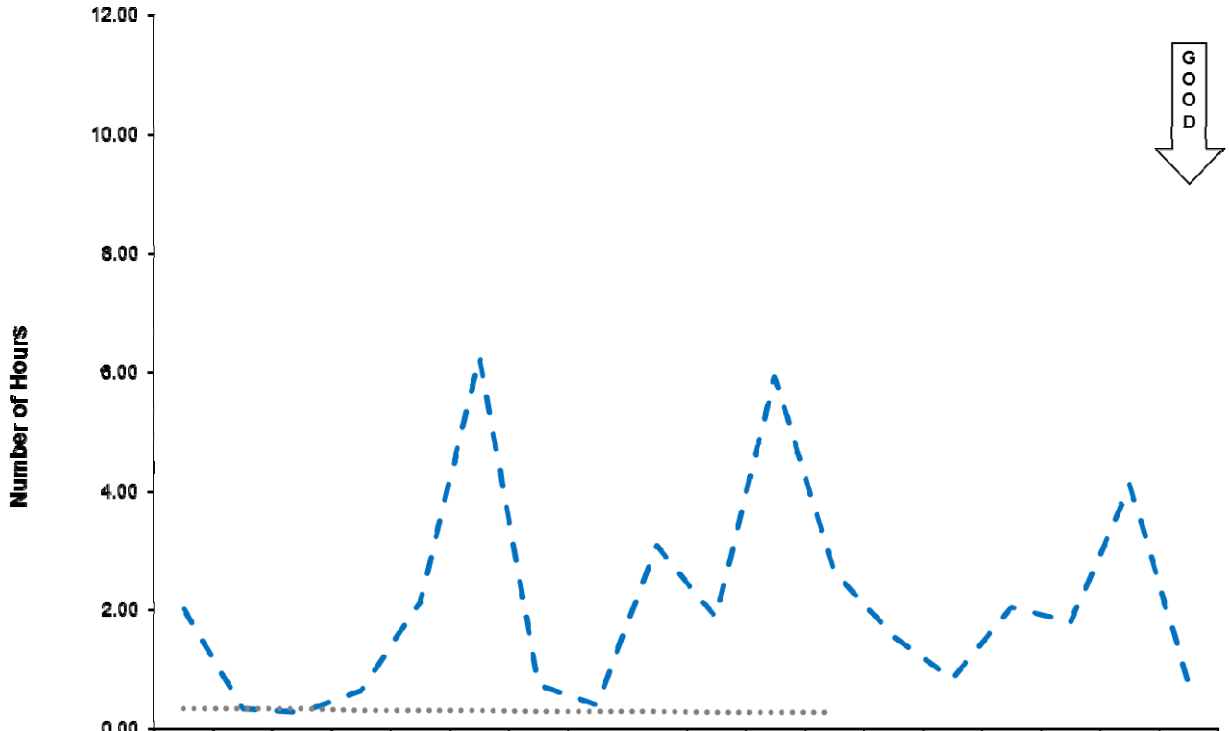
Hours of Use

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 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
RPC Rate	2.02	0.35	0.29	0.65	2.13	6.25	0.75	0.42	3.09	1.88	5.92	2.67	1.55	0.85	2.05	1.79	4.17	0.75
TJC Target:	0.36	0.36	0.36	0.32	0.32	0.32	0.31	0.31	0.31	0.30	0.30	0.30						

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

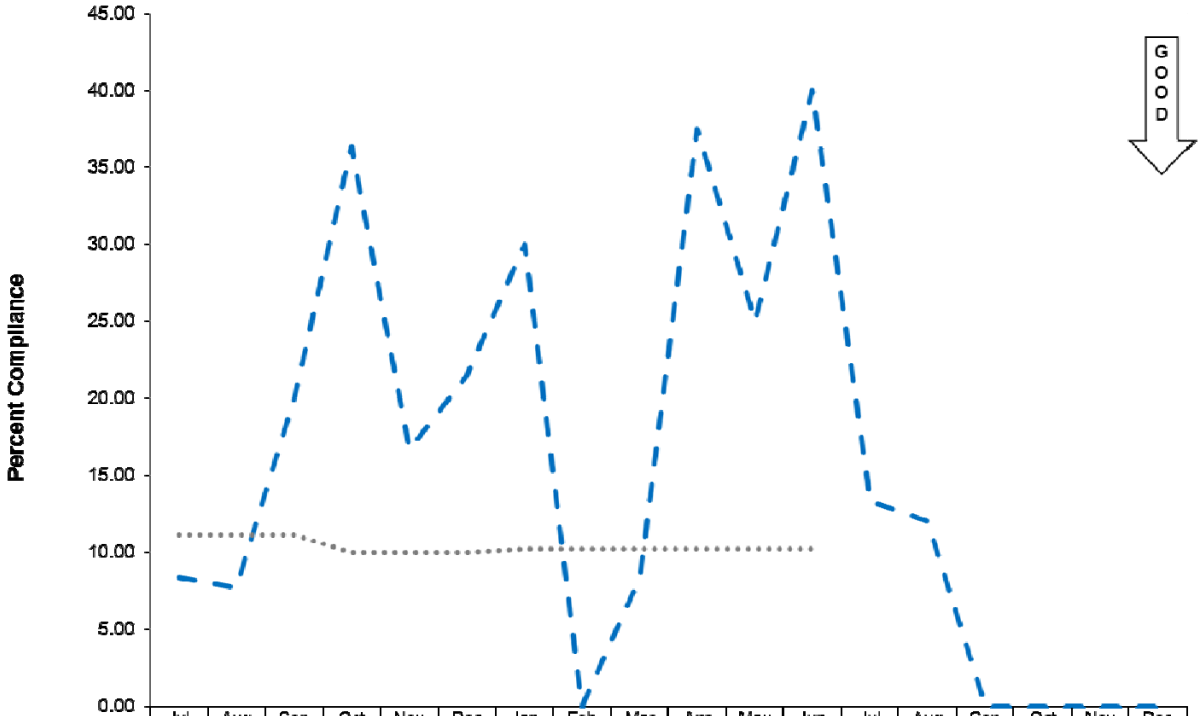
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

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 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
RPC Rate	8.33	7.69	20.00	36.36	16.67	21.43	30.00	0.00	8.33	37.50	25.00	40.00	13.33	12.00	0.00	0.00	0.00	0.00
TJC Data	11.10	11.10	11.10	10.00	10.00	10.00	10.20	10.20	10.20	10.20	10.20	10.20						

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

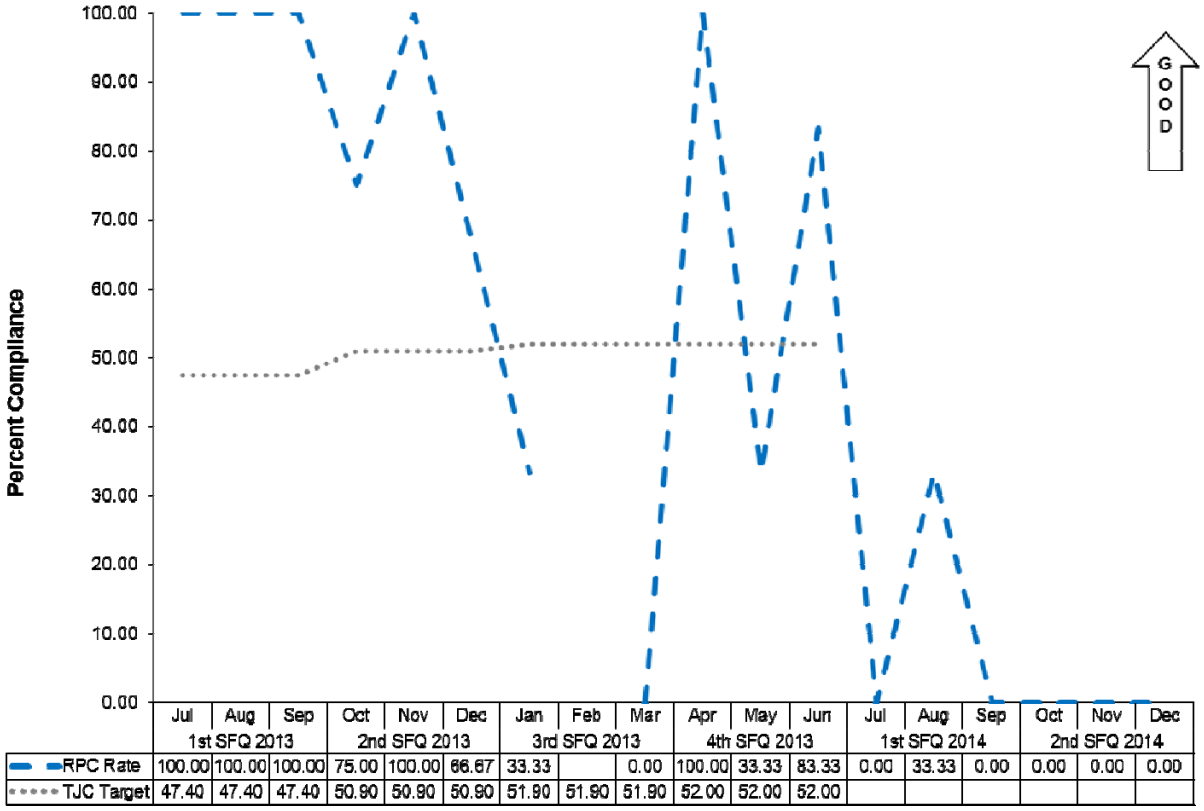
Rationale

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 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
RPC Rate	100.00	100.00	100.00	75.00	100.00	66.67	33.33		0.00	100.00	33.33	83.33	0.00	33.33	0.00	0.00	0.00	0.00
TJC Target	47.40	47.40	47.40	50.90	50.90	50.90	51.90	51.90	51.90	52.00	52.00	52.00						

JOINT COMMISSION

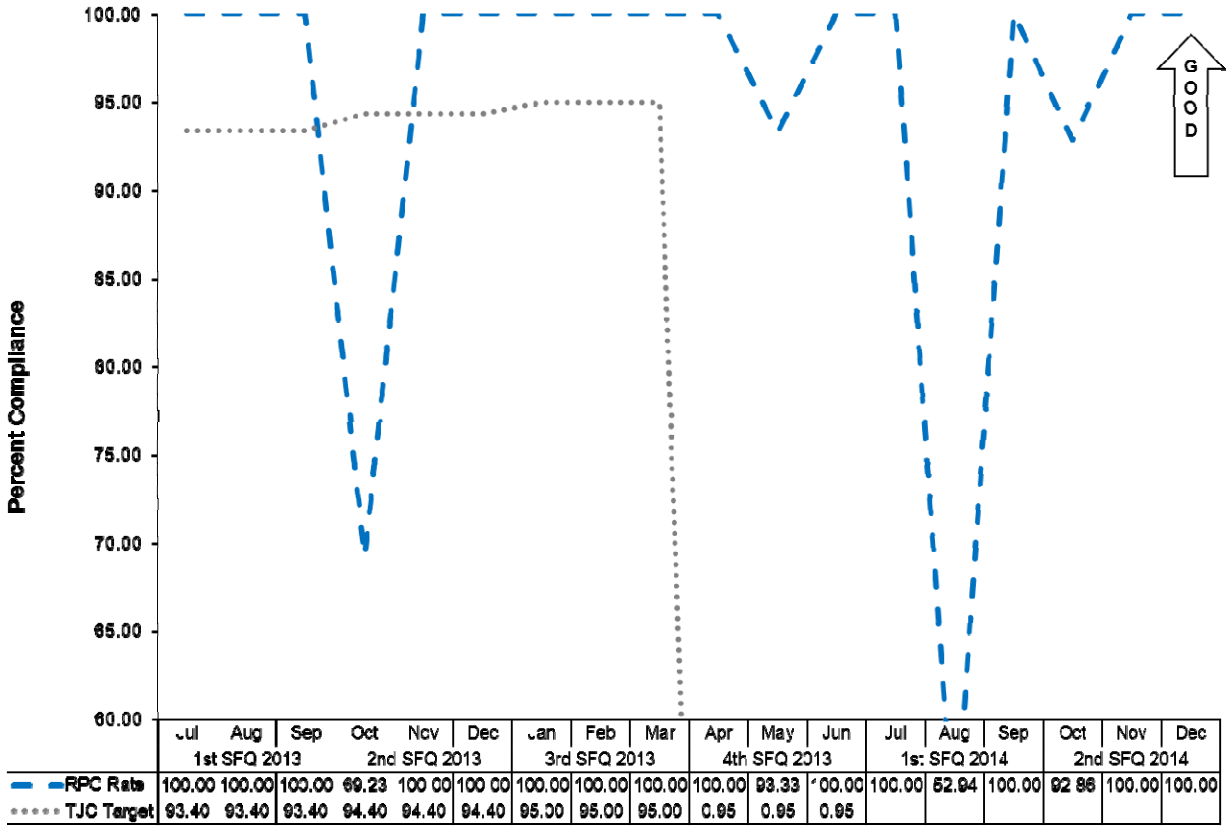
Post Discharge Continuing Care Plan (HBIPS 6)

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
RPC Rate	100.00	100.00	100.00	69.23	100.00	100.00	100.00	100.00	100.00	100.00	93.33	100.00	100.00	52.94	100.00	92.86	100.00	100.00
TJC Target	93.40	93.40	93.40	94.40	94.40	94.40	95.00	95.00	95.00	0.95	0.95	0.95						

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

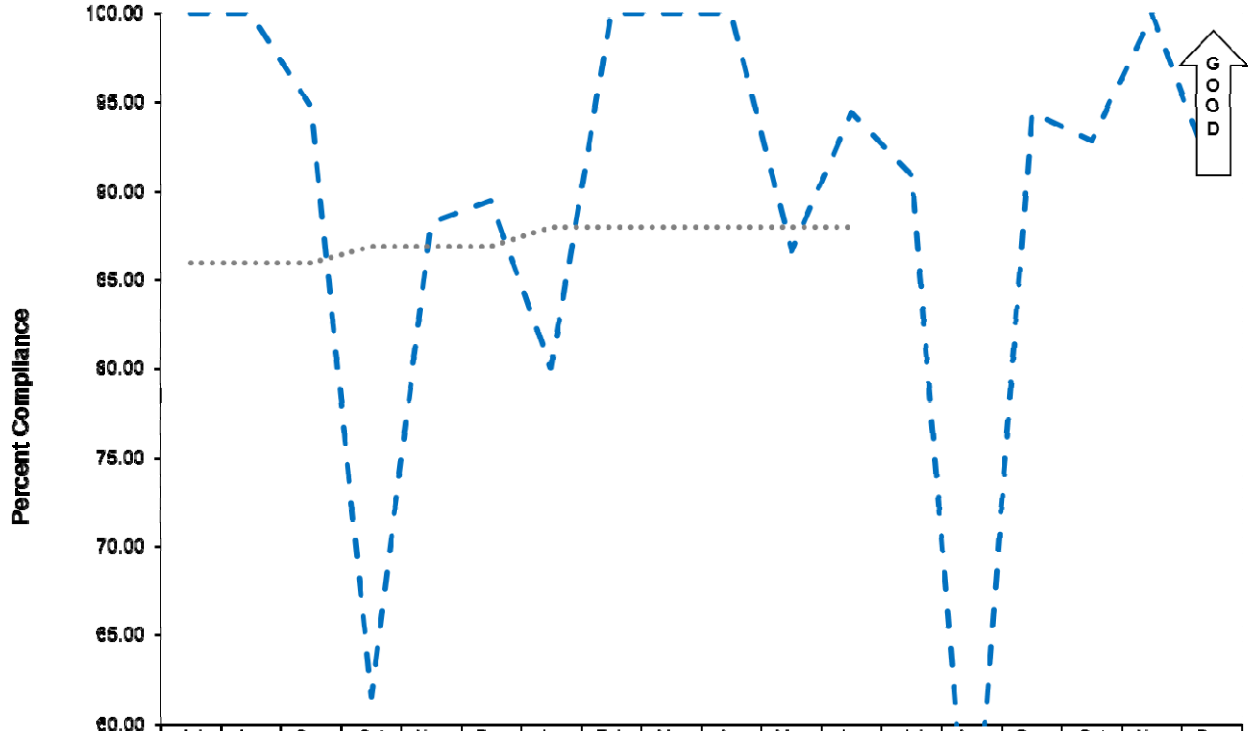
To Next Level of Care Provider on Discharge

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 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
RFC Rate	100.00	100.00	94.74	61.54	88.24	89.47	80.00	100.00	100.00	100.00	86.67	94.44	90.91	50.00	94.44	92.86	100.00	90.91
TJC Target	86.00	86.00	86.00	86.90	86.90	86.90	88.00	88.00	88.00	88.00	88.00	88.00						

JOINT COMMISSION

Capital Community Clinic

Adverse Reactions to Sedation or Anesthesia

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

Dental Clinic Timeout/Identification of Client

Indicators	3Q2013	4Q2013	1Q2014	2Q2014
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.	**January** 100% 7/7 **February** 100% 3/3 **March** 100% 9/9 **Total** 100% 19/19	**April** 100% 2/2 **May** 100% 7/7 **June** 100% 7/7 **Total** 100% 16/16	**July** 100% 6/6 **August** 100% 2/2 **September** 100% 4/4 **Total** 100% 12/12	**October** 100% 3/3 **November** 100% 1/1 **December** 100% 2/2 **Total** 100% 6/6

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	3Q2013	4Q2013	1Q2014	2Q2014
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	**January** 100% 7/7 **February** 100% 3/3 **March** 100% 9/9 **Total** 100% 19/19I	**April** 100% 2/2 **May** 100% 7/7 **June** 100% 7/7 **Total** 100% 16/16	**July** 100% 6/6 **August** 100% 2/2 **September** 100% 4/4 **Total** 100% 12/12	**October** 100% 3/3 **November** 100% 1/1 **December** 100% 2/2 **Total** 100% 6/6

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management

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

72 Bed Hospital

Indicators	2Q14 Findings	2Q14 Compliance	Threshold Percentile
Total number of infections for the first quarter of the fiscal year, per 1000 patient days	12/2.3	100%	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	4/2.2	100%	1 SD within the mean

Data:
Pneumonitis
Cellulitis Right Leg
Conjunctivitis-HAI
Compound Infection (bacterial & fungal) of second right digit-HAI
Pneumonia-HAI
Right Thumb Paronychia
Empriical Treatment/probable early impetigo
Dental
Prophylactic measure-blister left foot > could progress to cellulitis
Chronic sinusitis following URI-HAI
Prophylactic treatment ingrown toeanil
Hemorrhoidal fissure
Hospital Associated Infections (HAI): 4
Community Acquired Infections (CAI): 7
Ideosyncratic Infections: 1

Summary: Distribution of infections is scattered throughout the hospital. No trending. There was one incident of pneumonia in a young worman with chronic underlying medical problems. She was hospitalized at MaineGeneral Medical Center (MGMC).

Plan: Continue total house surveillance.

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management

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

Lower Saco Decertified Unit

Indicators	2Q14 Findings	2Q14 Compliance	Threshold Percentile
Total number of infections for the first quarter of the fiscal year, per 1000 patient days	10/7.7	100%	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	2/1.3	100%	1 SD within the mean

Data:
Candida Intertrigo left breast
Impetiginous rosaecea with pustiles & exudate
Cellulitis right ear secondery to rosaesea & folliculitis
2 Dental Abscess
Tinea pedis – HAI
URI-HAI
UTI
Laceration of forearm.-prophylactic treatment
Prophylactic treatment of urinary incontinence

Hospital Associated Infections (HAI): 2
Community Acquired Infections (CAI): 7
Idiosyncatic Infections: 1
Total Infections: 10

Summary: No trending. No unusual infections.One isolated case of Tinea Pedis.
Plan: Continue total house surveillance.

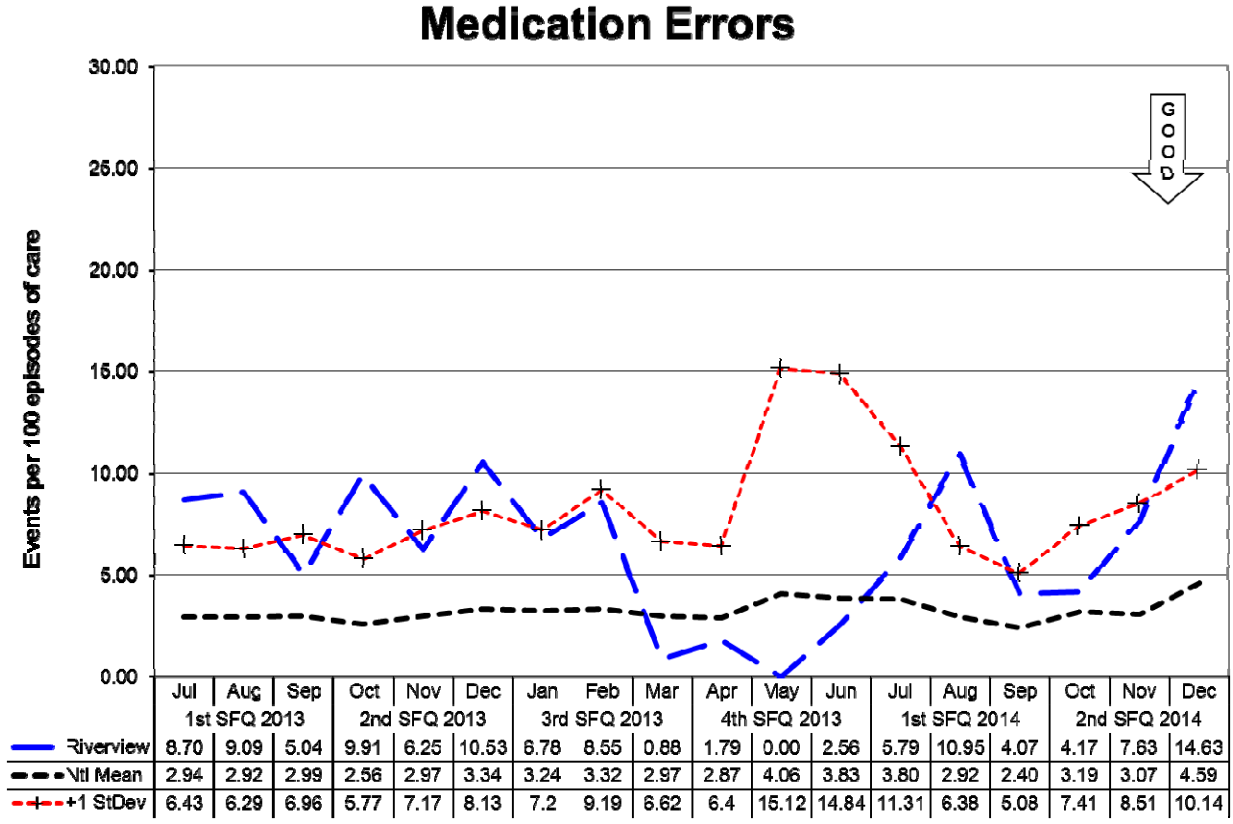
JOINT COMMISSION

Medication Management

Medication Errors and Adverse Reactions

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

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	8.70	9.09	5.04	9.91	6.25	10.53	6.78	8.55	0.88	1.79	0.00	2.56	5.79	10.95	4.07	4.17	7.63	14.63
Ntl Mean	2.94	2.92	2.99	2.56	2.97	3.34	3.24	3.32	2.97	2.87	4.06	3.83	3.80	2.92	2.40	3.19	3.07	4.59
+1 StDev	6.43	6.29	6.96	5.77	7.17	8.13	7.2	9.19	6.62	6.4	15.12	14.84	11.31	6.38	5.08	7.41	8.51	10.14

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

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

Prescribing

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

Dispensing

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

Administration

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

Complex

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

Review, Reporting and Follow-up Process

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

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

JOINT COMMISSION

Medication Management - Administration Process

Medication Errors Related to Staffing Effectiveness

Date	OMIT	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
9/2/2013	N	Wrong time Motrin	N	N	N	US	1 RN 1 LPN 4 MHW
9/22/2013	Y	Itraconazole x2 doses	N	N	N	US	2 RN, 0 LPN, 4 MHW
10/15/2013	Y	Insulin	N	N	N	LK	3 RN, 1 LPN, 7 MHW
10/16/2013	N	Wrong time	N	N	N	LS	4 RN, 0 LPN, 7 MHW
10/16/2013	N	Wrong dose Loxapine	N	N	N	LK	3 RN, 1 LPN, 7 MHW
10/16/2013	N	No valid order	N	N	N	LK	3 RN, 1 LPN 7 MHW
10/18/2013	N	Wrong dose	N	Y	N	US	3 RN, 0 LPN, 4 MHW
10/19/2013	N	No valid order x5	N	N	N	LS	3 RN, 7 MHW
10/20/2013	Y	Magnesium	Y	N	N	LS	3 RN 1 LPN, 8 MHW
10/22/2013	Y	Omission x1	N	N	N	LS	3 RN, 0 LPN, 7 MHW
11/3/2013	N	No valid order	N	N	Y	US	2 RN, 0 LPN, 4 MHW
11/4/2013	N	Wrong time	N	N	N	UK	2 RN, 0 LPN, 4 MHW
11/14/2013	N	Wrong time	N	N	N	LS	4 RN, 0 LPN, 7 MHW
11/16/2013	Y	Haldol	N	N	N	LK	3 RN, 0 LPN, 7 MHW
11/17/2013	N	Wrong dose	N	N	Y	LS	3 RN, 1 LPN, 8 MHW
11/18/2013	N	Expired drug - insulin	N	N	N	LK	3 RN,1 LPN 5 MHW
11/19/2013	N	Wrong dose	N	N	N	UK	2 RN, 2 LPN, 4 MHW
11/21/2013	Y	Without valid order	N	Y	N	US	3 RN, 5 MHW
11/26/2013	Y	Insulin	N	N	N	LS	4 RN, 0 LPN, 7 MHW
11/27/2013	Y	Omission x 3	N	Y	N	UK	1 RN, 0 LPN, 3 MHW
12/3/2013	N	Wrong dose x2	N	Y	N	LS	3 RN, 0 LPN, 7 MHW
12/4/2013	N	Wrong time	N	Y	N	UK	3 RN, 4 MHW
12/4/2013	N	Wrong dose	N	Y	N	US	3 RN, 0 LPN, 4 MHW
12/4/2013	Y	Levothyroxine x2	N	N	N	LS	3 RN, 1 LPN, 8 MHW
12/8/2013	N	Med without valid order	Y	N	N	LS	3 RN, 0 LPN, 8 MHW
12/13/2013	N	Wrong time	N	Y	N	LK	4 RN, 0 LPN, 7 MHW
12/16/2013	Y	Synthroid x 4	N	Y	N	UK	1RN, 0 LPN, 3 MHW
12/21/2013	Y	Omission x5	Y	N	N	LS	4 RN 0 LPN 7 MHW
12/22/2013	Y	Omission x1 **	Y	Y	N	US	2 RN, 0 LPN, 4 MHW
12/22/2013	Y	Omission x1 **	Y	Y	N	US	2 RN, 0 LPN, 4 MHW
12/22/2013	Y	Omission x1 **	Y	Y	N	US	2 RN 0 LPN 4 MHW
12/22/2013	Y	Omission x1 **	Y	Y	N	US	2 RN 0 LPN 4 MHW
Totals	**19**		**11**	**8**	**2**	LS: 11	US: 14 LK: 6 UK: 5
Percent	**53%**		**31%**	**22%**	**6%**	**31%**	**39% 17% 14%**

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

JOINT COMMISSION

Summary

There were a total of 44 medication errors this quarter (38 last quarter and 28 the quarter before). 18 of the medication errors were omissions. Of the 18 omissions, 9 came from a single event in which the medication station (Pyxis draw failure) failed to open during an off shift and the night cabinet did not have the needed medications. 9 medication errors were dose related. 7 medication errors were related to wrong time. 9 medication errors were medications given without a valid order. One error involved an expired medication being given. (insulin) The insulin was labelled incorrectly by staff when opened. (labelled for 30 days rather than 28) Eleven of the medication errors were committed by staff floating to another unit or by staff who have been designated as “floats.” This is misleading in a way however as it was a float who experienced the draw failure that resulted in 9 omissions, through no fault of her own, and she did an excellent job with notifying the right people and completing all the related paperwork. 17 of the 44 errors were by new staff here at RPC. Again, although 17 may appear high for new staff committing medications errors, 9 of those are because it was a new nurse, who was hired as a float experience the draw failure that resulted in 9 omissions, and as stated previously, she did an excellent job notifying, completing paperwork and administering medications to the clients who did not have medications affected by the draw failure.

Actions

All nursing related medication errors were noted to have appropriate staffing levels. One of the actions to consider may be to return to a designated medication nurse for each unit. Nurse Pharmacy Committee meets monthly and is working towards identifying issues with medication management and identifying solutions to issues identified. Medication errors are reviewed weekly by Pharmacist, Medical Director, Risk Manager and Executive Nurse after the RN IV on the unit reviews the error with the staff person responsible for individual teaching and issue / process identification. Pharmacy is looking into different programs that can be added to Pyxis to help reduce the possibility of medications errors.

JOINT COMMISSION

Medication Management - Dispensing Process

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

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

CMS Plan of Correction Tag #A-494 and Tag #A-506 – Lower Saco								
Medication Management	Unit	Baseline Oct 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Controlled Substance Loss Data Monthly CII Safe Transactions Report Generated and Reviewed	Lower Saco	100%	100%	100%			100%	Goal of 100% compliance in tracking CII safe transactions
Quarterly Results			**100% (Oct)**	**100% (Nov & Dec)**				
Monthly CII Safe Transactions Report Separately Maintained	Rx	100%	100%	100%				Transaction Reports separately maintained for Lower Saco
Quarterly Results			**100% (Oct)**	**100% (Nov & Dec)**				
After-Hours Drug Access Monitoring Monitor daily after-hours drug distribution reports	Rx	100%	100%	100%				Monitor daily after hours drug distribution reports to ensure compliance with policy
Quarterly Results			**100% (Oct)**	**100% (Nov & Dec)**				No after-hours drugs needed for Lower Saco during October

The key indicators in Medication Management are focused on preventing Controlled Substances loss and monitoring/trending of adverse drug reactions and clinical interventions. *Controlled Substances Loss* reviews two key reports generated by the Pyxis CII Safe which compare controlled drug transactions between the pharmacy's CII Safe and the various Pyxis Medstations; and, the purchasing data from our drug wholesaler and the corresponding CII Safe transactions. In both instances, we are looking for zero variation. *Medication Management Monitoring* is comprised of the reporting, review and monitoring of adverse drug reactions (ADR's) and Clinical Interventions as documented in the Resource Documentation tool to generate historical and graphical analysis which is reported to the P&T Committee regularly. TJC requires ongoing reporting and surveillance of adverse drug reactions, medication errors and medication related issues to the hospital wide performance improvement program with the goal of strategies to minimize their occurrence.

JOINT COMMISSION

Inpatient Consumer Survey

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

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

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

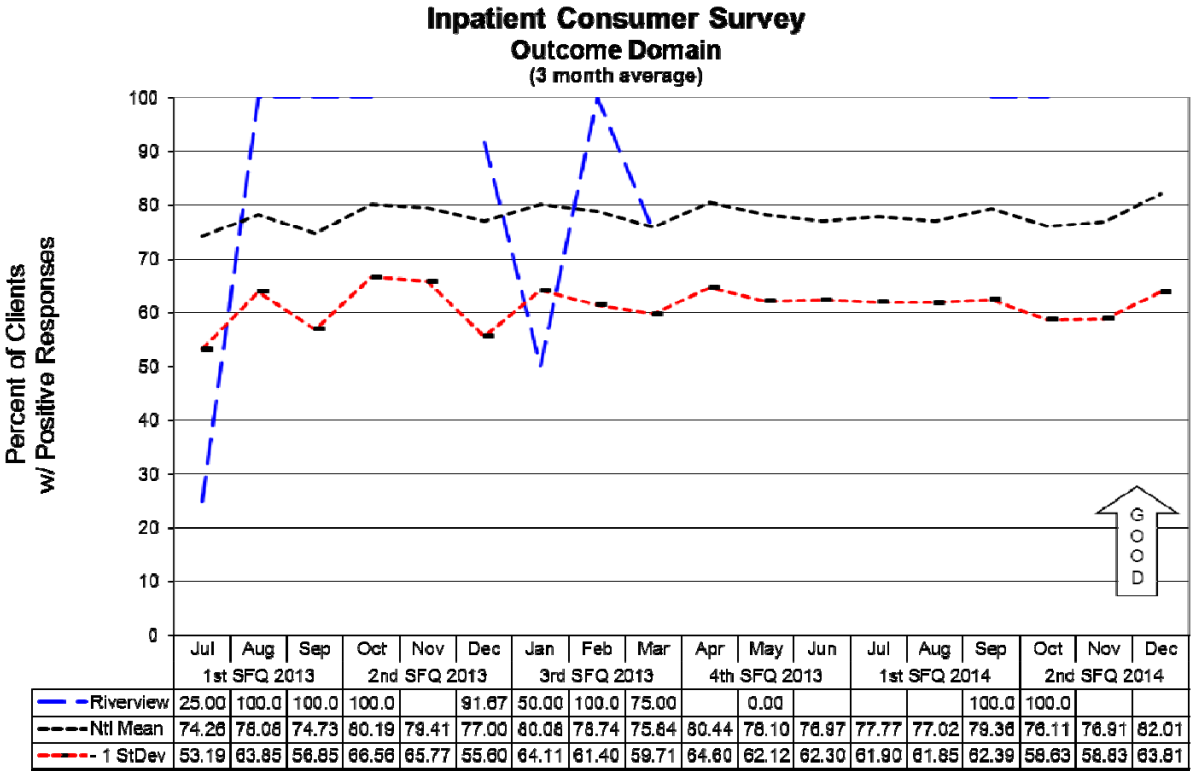
Rate of Response for the Inpatient Consumer Survey

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

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

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

JOINT COMMISSION

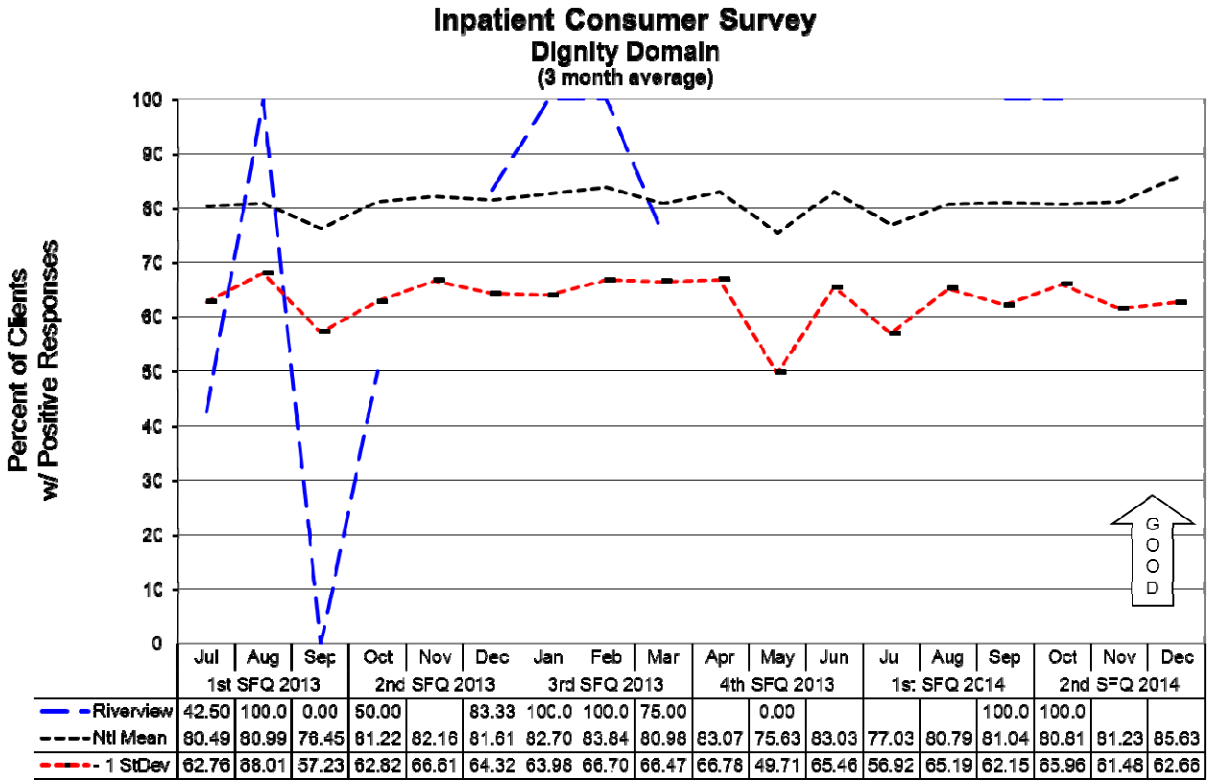


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	25.00	100.0	100.0	100.0		91.67	50.00	100.0	75.00		0.00				100.0	100.0		
Ntl Mean	74.26	76.08	74.73	80.19	79.41	77.00	80.08	78.74	75.64	80.44	78.10	76.97	77.77	77.02	79.36	76.11	76.91	82.01
- 1 StDev	53.19	63.85	56.85	66.56	65.77	55.60	64.11	61.40	59.71	64.60	62.12	62.30	61.90	61.85	62.39	58.63	58.83	63.81

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



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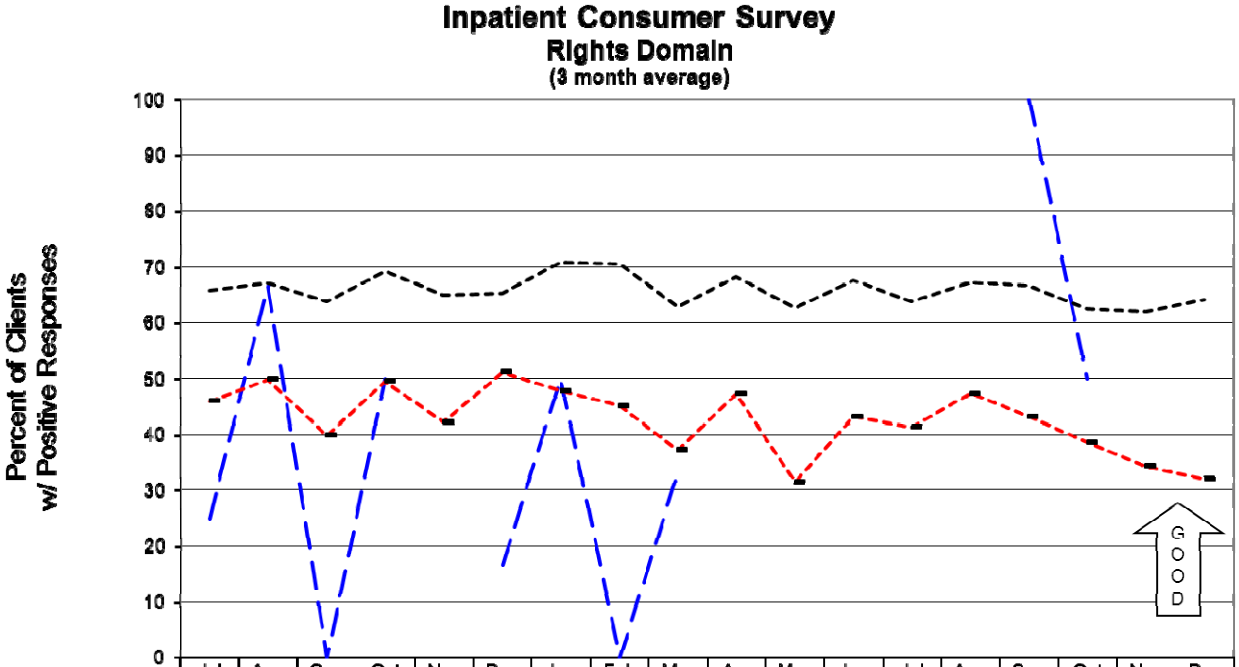
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	42.50	100.0	0.00	50.00		83.33	100.0	100.0	75.00		0.00				100.0	100.0		
Ntl Mean	80.49	80.99	76.45	81.22	82.16	81.61	82.70	83.84	80.98	83.07	75.63	83.03	77.03	80.79	81.04	80.81	81.23	85.63
1 StDev	62.76	66.01	57.23	62.82	66.61	64.32	63.98	66.70	66.47	66.78	49.71	65.46	56.92	65.19	62.15	65.96	61.48	62.66

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

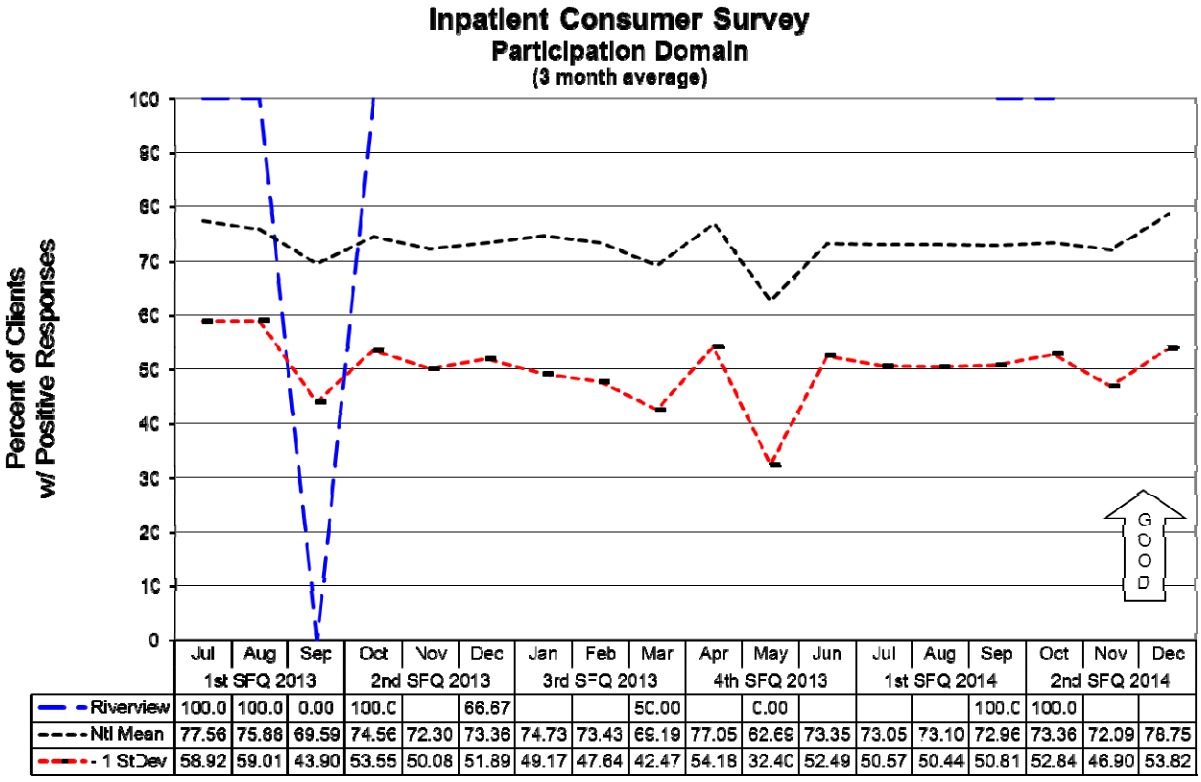


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	25.00	66.67	0.00	50.00		16.67	50.00	0.00	33.33		0.00				100.0	50.00		
Ntl Mean	65.81	67.05	63.77	69.19	64.95	65.36	70.76	70.45	62.90	68.21	62.82	67.58	63.81	67.19	66.61	62.54	62.07	64.21
- 1 StDev	45.95	49.85	39.74	49.54	42.12	51.20	47.82	45.04	37.16	47.30	31.37	43.08	41.27	47.34	43.12	38.57	34.28	31.98

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

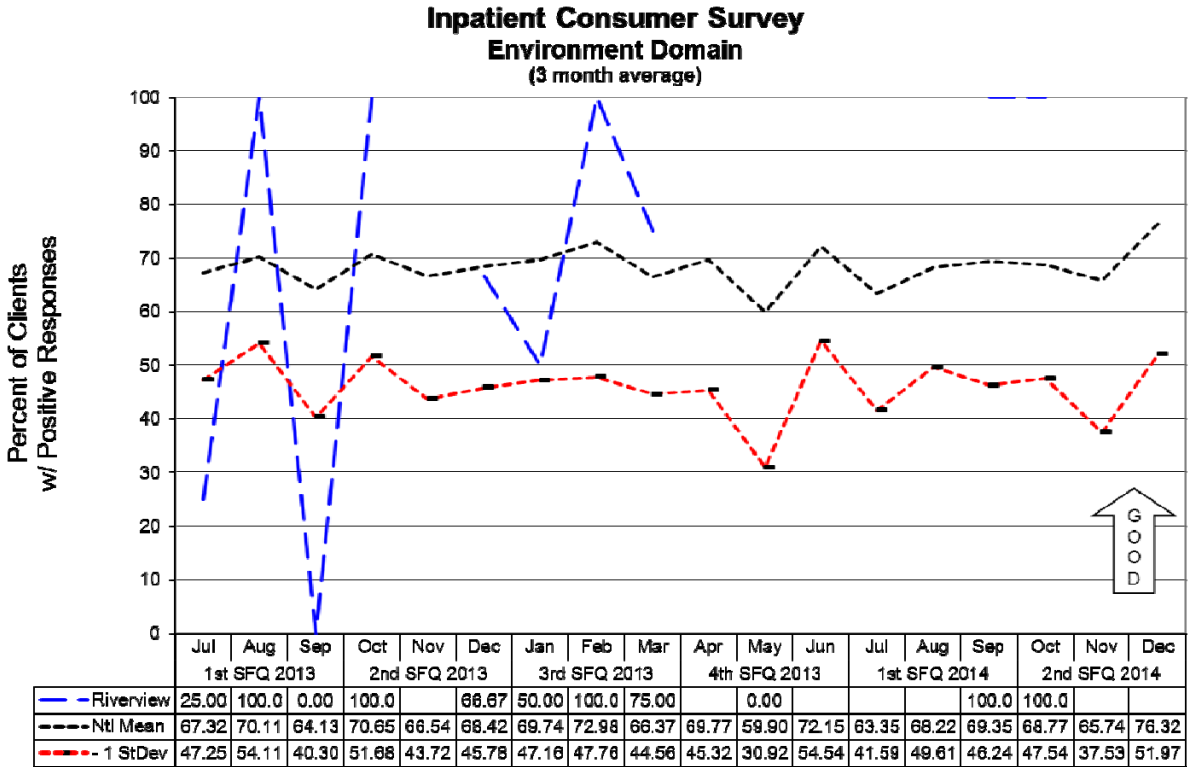


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	100.0	100.0	0.00	100.0		66.67			50.00		0.00				100.0	100.0		
Ntl Mean	77.56	75.66	69.59	74.56	72.30	73.36	74.73	73.43	69.19	77.05	62.69	73.35	73.05	73.10	72.96	73.36	72.09	76.75
1 StDev	58.92	59.01	43.90	53.55	50.08	51.89	49.17	47.64	42.47	54.18	32.40	52.49	50.57	50.44	50.81	52.84	46.90	53.82

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



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	1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014		
Riverview	25.00	100.0	0.00	100.0		66.67	50.00	100.0	75.00		0.00				100.0	100.0		
Ntl Mean	67.32	70.11	64.13	70.65	66.54	68.42	69.74	72.98	66.37	69.77	59.90	72.15	63.35	68.22	69.35	68.77	65.74	76.32
- 1 StDev	47.25	54.11	40.30	51.68	43.72	45.78	47.16	47.76	44.56	45.32	30.92	54.54	41.59	49.61	46.24	47.54	37.53	51.97

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

Pain Management

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

Indicator	3Q2013	4Q2013	1Q2014	2Q2014
Pre-administration	91%	68%	70%	74% 2774 of 3749
Post-administration	81%	59%	60%	63% 2362 of 3749

SUMMARY

Both “Pre” and “Post” assessments continue to be up slightly from previous quarter but still lower than previous quarters. The number of pain medications given this quarter continues to be higher than the previous quarter (3749 PRN meds for pain this quarter compared to 2516 PRN pain meds last quarter) There were only 1011 pain meds given in second quarter of FY 2013.

ACTIONS

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

JOINT COMMISSION

Fall Reduction Strategies

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

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

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

Type of Fall by Client and Month

Fall Type	Client	OCT	NOV	DEC	2Q2014
Un-witnessed	MR00006963*	4			4
	MR00000091*		1		1
	MR00000016*			1	1
	MR00004891			1	1
Witnessed	MR00000016*	2			2
	MR00000091*	1			1
	MR00006309	1			1
	MR00006145	1			1
	MR00006963*	4	2	4	10
	MR00004814			1	1
	MR00006695			2	2

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

Review, Reporting and Follow-up Process

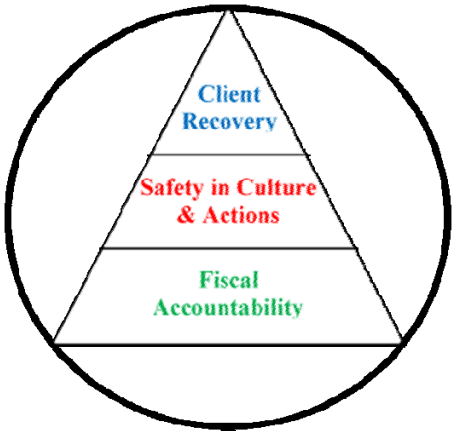
The Falls Assessment and Prevention Process Review Team (PRT) meets monthly to evaluate the causation factors related to the falls reported on the units and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices.

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

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

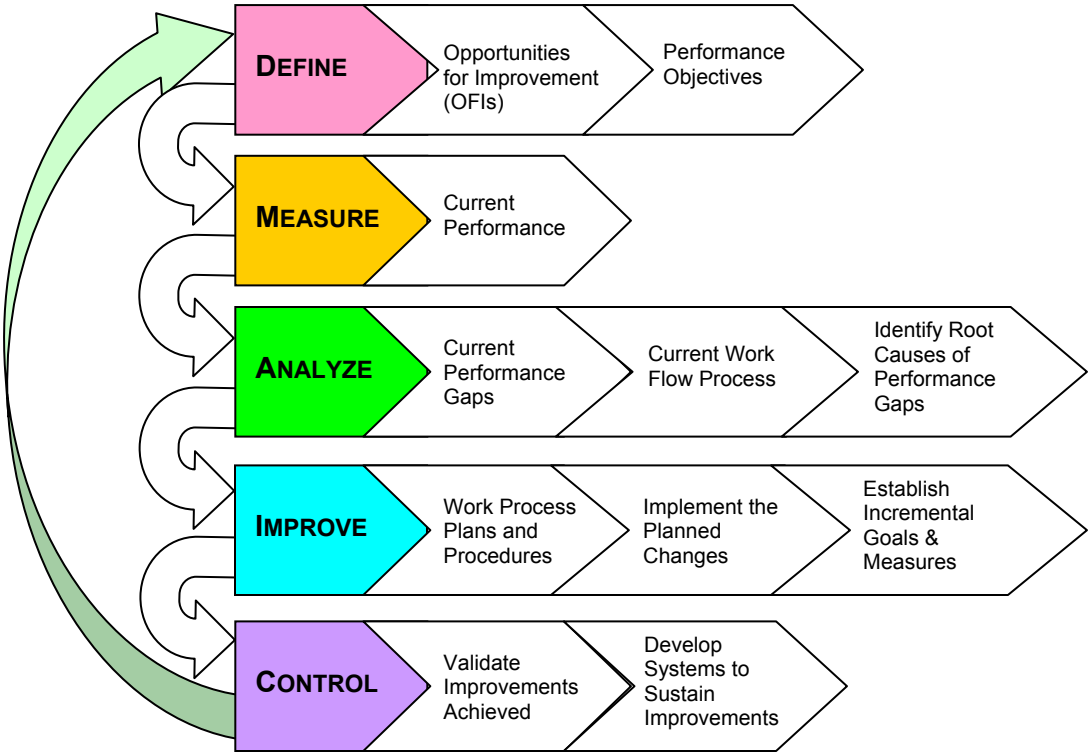
Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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 Process Improvement Activities
2Q2014

- The Office of Admissions has improved data collection and reporting; monthly data is no longer delineated by receiving unit rather by client legal status. This allows for more meaningful data analysis.

- Several county jails reported difficulty utilizing our discharge paperwork; we are no longer using the SBAR as the only means of discharge communication.

- The Office of Admissions continues to work with Maine State Prison and LD1515 to develop and coordinate RPC's role as gatekeeper for the new mental health unit. We have toured the new mental health wing and are excited about this project.

- The Office of Admissions continues to provide nursing education to new hires and existing employees who would like to review the admissions process.

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions													
Hand Hygiene Compliance: In an effort to monitor, sustain and improve hand hygiene compliance, the Dietary department measures its results through observations of Dietary staff when returning from a scheduled break.													
	1st Quarter 2014			2nd Quarter 2014			3rd Quarter 2014			4th Quarter 2014			Goal
Baseline	Target – Baseline	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 12%	Findings	Compliance	Target – Q3 + 12%	Findings	Compliance	
85%	85%	16/30	53%	65%	33/57	58%	70%						80-90%

Data

33 compliant observations / 57 hand hygiene observations = 58% hand hygiene compliance rate

Summary

- Hand hygiene compliance has increased by 5%.
- Hand hygiene observations have increased; 30 observations last quarter to 57 observations this first quarter.
- Reformatting the Hand Hygiene Tool simplified the observation process and aided with the increase of observations for this quarter.

Action Plan

- Continue use of the improved Hand Hygiene Tool.
- Encourage employees to adhere to hand hygiene via verbal interaction/reminders.
- The Food Service Manager will provide employee education every quarter to include, Interactive Hand Hygiene education.
- The Food Service Manager will present this quarterly report at the departmental staff meeting.
- Update hand hygiene signage and place in different locations.

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

72 Bed Psychiatric Hospital

Strategic Objective: Safety in Culture and Actions

Nutrition Screen Completion: In an effort to monitor, improve and sustain timely completion of the nutrition screen for all admissions to RPC; a 72 bed Psychiatric Hospital, the Registered Dietitian will review each Nutrition Screen within the Initial Nursing Admission Data. This screen will be completed by Nursing within 24 hours of admission.

	1st Quarter 2014			2nd Quarter 2014			3rd Quarter 2014			4th Quarter 2014			
Baseline	Target – Baseline	Findings	Compliance	Target – Q1 + 1%	Findings	Compliance	Target – Q2 + 1%	Findings	Compliance	Target – Q3 + 0%	Findings	Compliance	Goal
93.5%	93.5%	29/31	93.5%	94%	30/31	97%	98%						90-95%

Data:

30 Nutrition screens completed w/in 24 hours of admission

31 Total Admissions

= 97% of nutrition screens completed within 24 hours of admission

Summary:

- The Registered Dietitian reviewed the nutrition screens of the 31 client admissions for this quarter.
- Upon review, the RD discovered 3 nutrition screens incomplete.
- RD spoke with the admitting nurse and requested completion of the screen resulting in two of the three being complete within 24 hours of admission.
-

Action Plan:

- RD will continue correspondence with nursing staff regarding the discovery of an incomplete nutrition screen.
- Present quarterly report at departmental staff meeting and IPEC meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Lower Saco Decertified Unit

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

Data:

26 Nutrition screens completed w/in 24 hours of admission

26 Total Admissions

= 100% of nutrition screens completed within 24 hours of admission

Summary:

- The Registered Dietitian reviewed the nutrition screens of the 26 client admissions for this quarter.
- Upon review, the RD discovered 1 nutrition screen incomplete.
- RD spoke with the admitting nurse and requested completion of the screen resulting in 100% completion within 24 hours of admission.

Action Plan:

- RD will continue correspondence with nursing staff regarding the discovery of an incomplete nutrition screen.
- Present quarterly report at departmental staff meeting and IPEC meeting.

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 from July 2013 to June 2014.

2014 Q1-Q4 TARGETS

Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

Department: Safety & Security

Responsible Party: Bob Patnaude, Safety Officer

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q1 Target Actual	Q2 Target Actual	Q3 Target Actual	Q4 Target Actual	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	(16) -5% (24)	(24) -5% (7)	(7) -5%		Baseline -5%	

SUMMARY OF EVENTS

The Q2 Target was (24)-5%. Our actual number was (7); a significant decrease this quarter. We are pleased that in all the cases, our Security staff or clinical staff have discovered items before those items get into the hands of anyone who would have an ill intent with the items. We feel that the reporting, which follows below, continues to provide a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our aggressive rounds by Security continues to prove its' worth with regard to Security's presence and patrol techniques.

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
1. Safety Threat (Small pen attachment found outside)	10/2/13	1730	Kennebec Yard	Given to Charge Nurse	1. MHW found on picnic table. 2. RN and NOD immediately notified 3. Safety notified 4. IR # 6097 completed
2. Safety Concern (Tobacco product on and outside staff vehicle)	10/13/13	1640	Staff Parking Lot	Owner called to vehicle to secure	1. Security found during checks 2. Owner contacted and secured 3. NOD notified 4. IR # 562 SEC completed/Safety notified
3. Safety Concern (Construction debris left by contracted construction crew)	10/27/13	0700	Outside Front Lobby	Safety and Maintenance Dir. Asked Security to keep there and maintain vigilance	1. Security found during checks 2. Safety, NOD, and Maintenance notified 3. Security to patrol and monitor 4. IR # 566 SEC completed, removed next day
4. Safety Concern (Construction debris left by contracted construction crew)	10/27/13	0940	Outside by Sebago Room exit door	Security properly disposed of item (2 ft. piece of wire)	1. Security found during checks 2. NOD notified 3. Security disposed of item 4. IR # 567 SEC completed/Safety notified

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
5. Security Threat (Metal can top in open bed of pick-up)	11/12/13	1040	Staff Parking Lot	Owner called and secured. Security reminded owner of threat.	1. Security discovered during rounds 2. Operations sent out email to identify owner 3. Owner responded and secured 4. NOD notified 5. IR # 573 SEC completed/Safety notified
6. Safety & Security Threat (Vehicle operator displaying road rage after following State vehicle into lot)	11/12/13	2015	State Vehicle Parking Area	Security responded outside. Capitol Police and APD called. PD investigated.	1. Security responded outside to assist staff 2. Security called Capitol and Augusta PD 3. Police investigated 4. IR # 162- US completed/Safety notified and assisted Security and both police departments.
7. Safety Concern (Metal object found on ground; may have come off roof)	11/24/13	2010	Saco Yard	Secured by Security	1. Security found during rounds 2. NOD notified 3. IR # 521 completed/Safety notified

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Objectives	*3Q2013*	*4Q2013*	*1Q2014*	*2Q2014*
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	*67% 28 of 42*	*60% 25/42*	*71% 30/41*	*69% 29/42*
2. SBAR information completed from the units to the Harbor Mall.	*76% 32 of 42*	*88% 37/42*	*86% 36/42*	*88% 37/42*

DEFINE

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

MEASURE

Indicator number one has decreased from 71% last quarter to 69% for this quarter. Indicator number two has increased from 86% last quarter to 88% this quarter.

ANALYZE

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

IMPROVE

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

CONTROL

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

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Documentation and Timeliness

Indicators	2Q14 Findings	2Q14 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 52 discharges in quarter 2 2014. Of those, 51 were completed by 30 days.	98 %	80%
Discharge summaries will be completed within 15 days of discharge.	52 out of 52 discharge summaries were completed within 15 days of discharge during quarter 2 2014.	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	12 forms were approved/ revised in quarter 2 2014 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 714 dictated reports, 714 were completed within 24 hours.	100%	90%

Summary: The indicators are based on the review of all discharged records. There was 98% compliance with record completion. Weekly “charts needing attention” lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 100% compliance with timely & accurate medical transcription services.

Actions: Continue to monitor.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Confidentiality

Indicators	2Q14 Findings	2Q14 Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	5467 requests for information (139 requests for client information and 5328 police checks) were released for quarter 2 2014.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	29 new employees/contract staff in quarter 2 2014.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident report during quarter 2 2014.	100%	100%

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

No problems were found in quarter 2 related to release of information from the Health Information department and training of new employees/contract staff, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Actions: The above indicators will continue to be monitored.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Release of Information for Concealed Carry Permits

Define

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

Analyze

Data collected for the 2nd quarter 2014 showed that we received 5328 applications. This is a decrease from last quarter (1st quarter 2014) when we received 6189 applications.

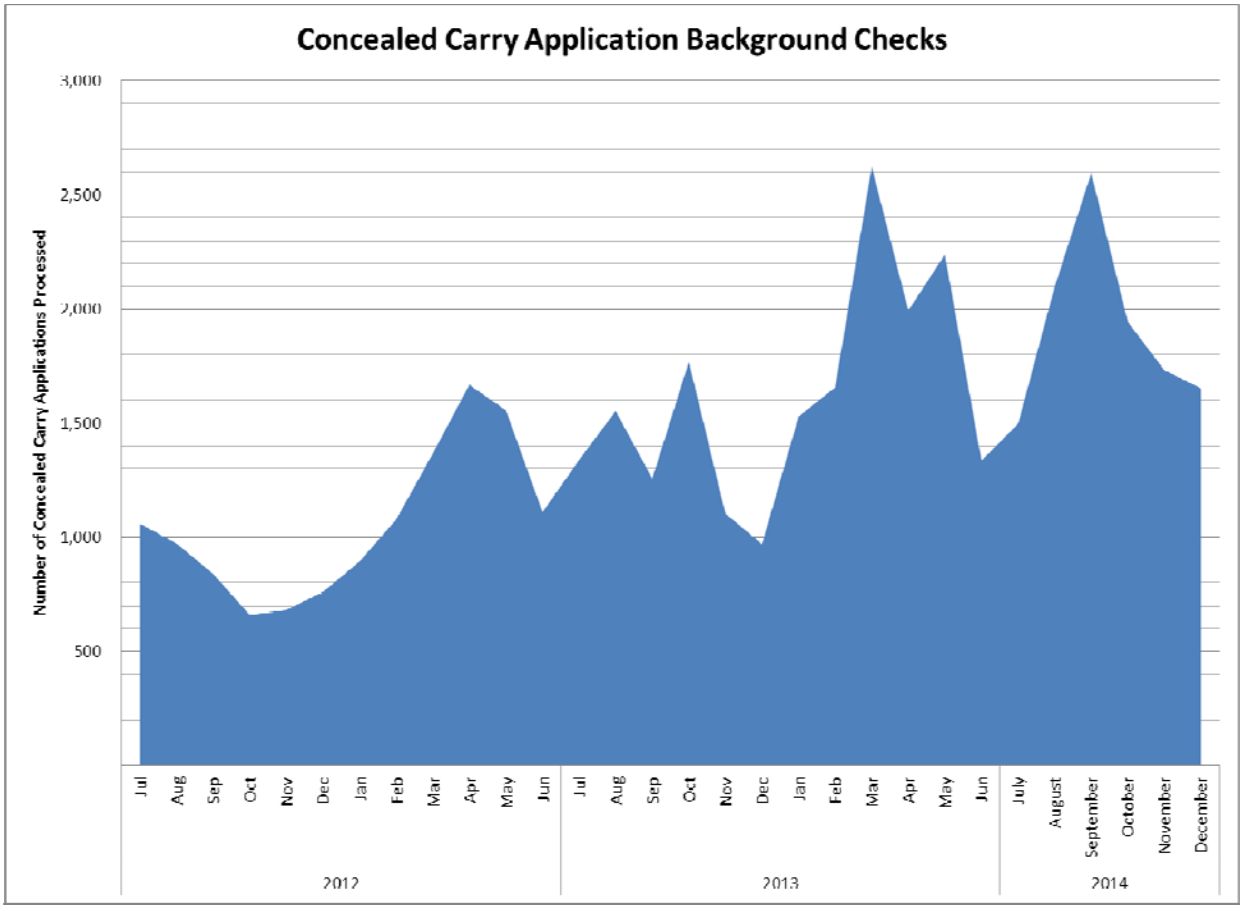
Improve

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

NOTE: At the end of the reporting period, there were 0 police checks outstanding for Riverview Psychiatric Center.

FY 2013/2014	Jan`	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
# Applications Received	1529	1657	2623	1993	2239	1336	1497	2096	2596	1944	1732	1652
Avg Receipt Delay	--	--	35	26	42	66	82	76	30	-	-	-
Max Receipt Delay	--	--	381	451	504	1694	1568	258	508	-	-	-
Avg Processing Time	--	--	11	8	13	15	13	11	3	-	-	-
Max Processing Time	--	--	13	11	20	19	45	15	7	-	-	-

STRATEGIC PERFORMANCE EXCELLENCE



Over the past two years the number of applications for concealed carry permits has increased significantly. While there is a seasonal drop in applications during the winter months the overall trend has been upward with March 2013 showing the highest volume of applications to date.

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Define

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

Measure

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

Analyze

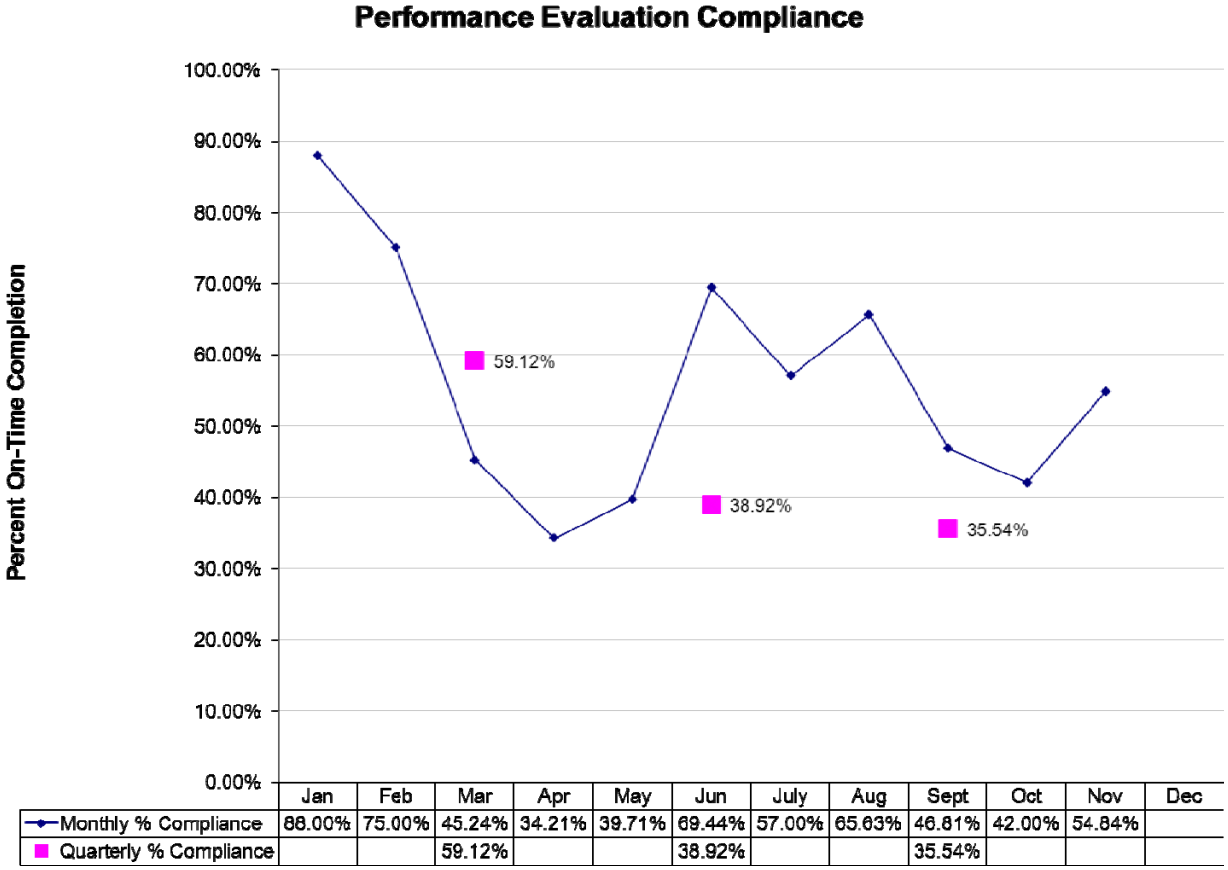
A thorough analysis of the root causes for lack of compliance with this performance standard is indicated.

Improve

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

Control

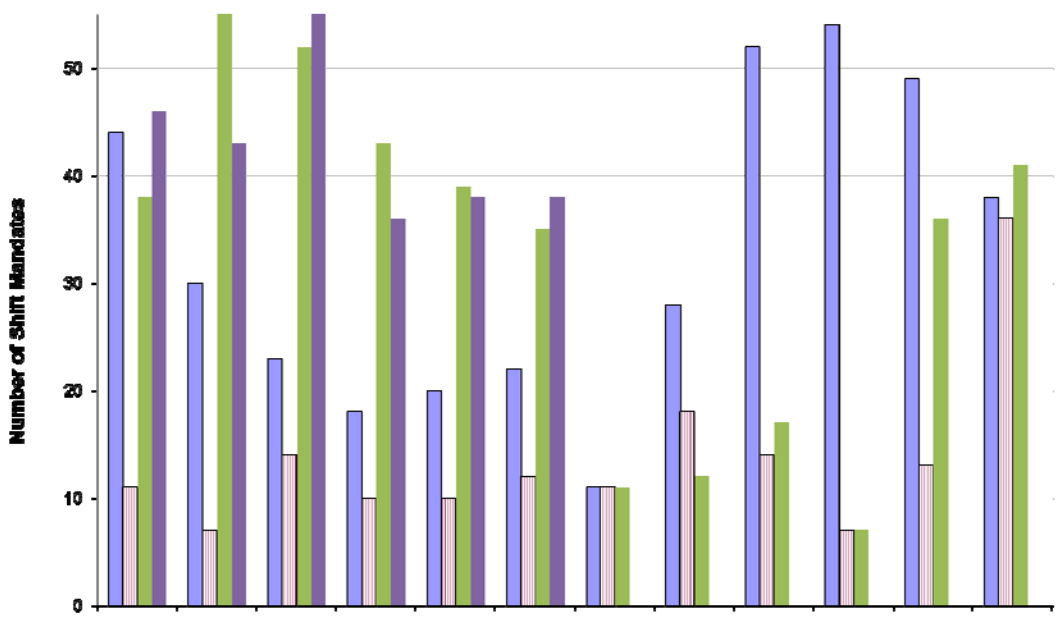
Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.



	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
Monthly % Compliance	88.00%	75.00%	45.24%	34.21%	39.71%	69.44%	57.00%	65.63%	46.81%	42.00%	54.84%	
Quarterly % Compliance			59.12%			38.92%			35.54%			

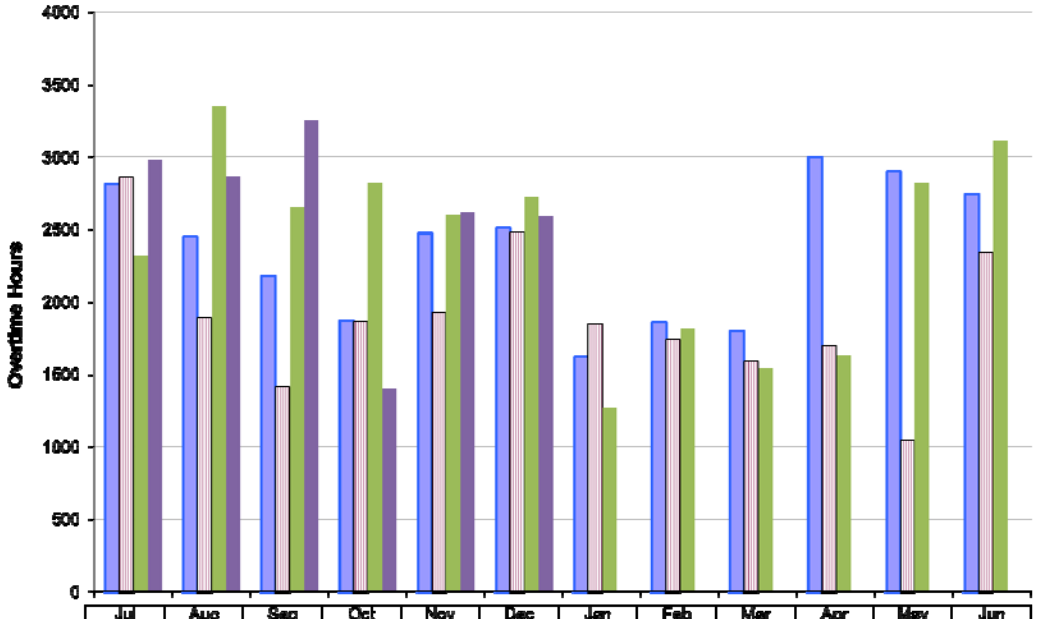
STRATEGIC PERFORMANCE EXCELLENCE

Monthly Mandated Shifts



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY 2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2013	38	81	52	43	39	35	11	12	17	7	36	41
FY 2014	46	43	63	36	38	38						

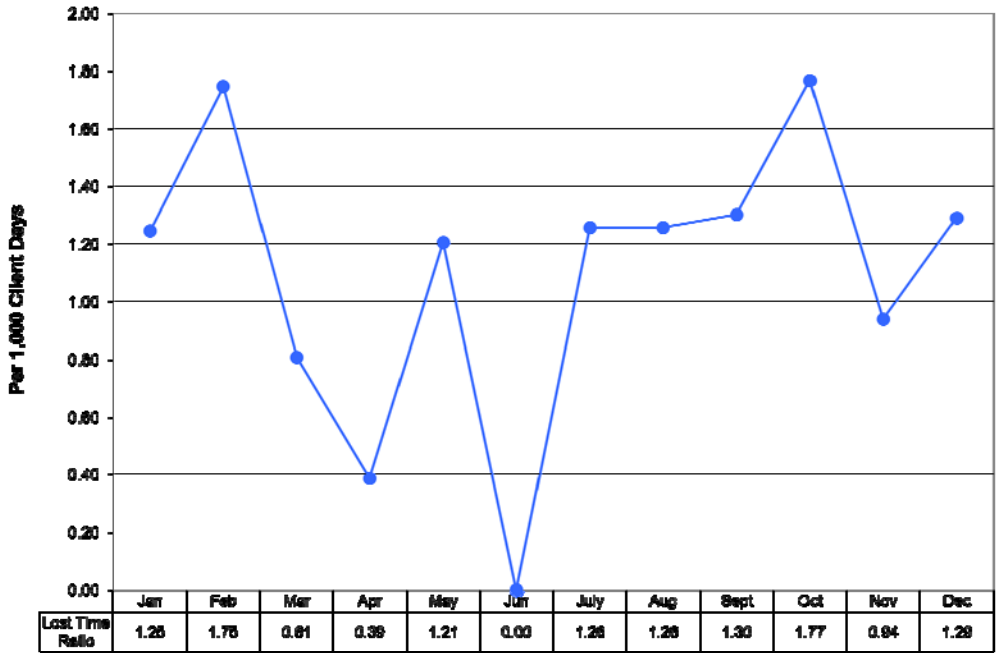
Monthly Overtime



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	2812	2461	2178	1866	2473	2507	1618	1853	1798	2999	2889	2743
FY 2011	2859	1895	1411	1860	1928	2474	1844	1740	1589	1697	1042	2342
FY 2013	2316	3350	2657	2817	2599	2726	1266	1812	1539	1629	2822	3108
FY 2014	2683	2881	3251	1400.25	2920.25	2589						

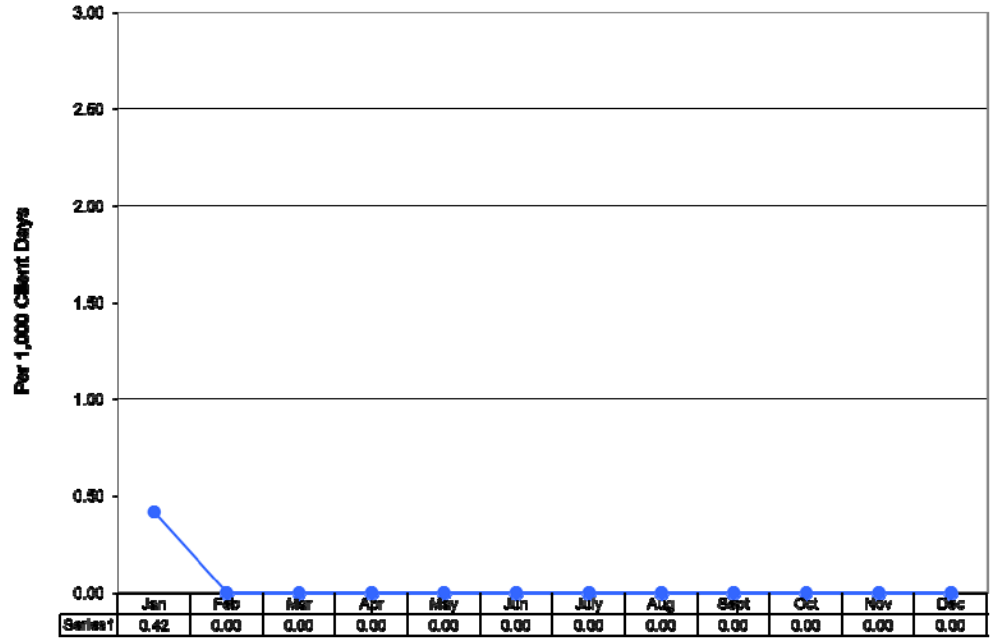
STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
Lost Time Ratio	1.25	1.75	0.81	0.39	1.21	0.00	1.26	1.26	1.30	1.77	0.94	1.29

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



	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
Series1	0.42	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Timeliness of Psychological Testing

Data Collection: All requests for psychological testing or evaluation were reviewed during the time period of October, November and December 2013. The date of the request, the medical staff member requesting the information, the date of initiation of testing and date of completion of testing were determined for comparison to target norms.

Findings: During the period in question, there were a total of three requests for psychological testing, two for general psychological assessment and one for neuropsychological testing. The requests for psychological assessment were completed in 10 and 3 days respectively, well within the hoped for time frame. A single request, however, for neuropsychological testing was completed in a total of 51 days, which is outside the hoped for target of 30 days.

Analysis: It is noted that during the previous quarter requests for psychological testing had markedly decreased. This remained the case through this quarter and it is felt that it also relates to a temporary reduction in the number of psychologists available within the hospital. Overall, the timeliness of testing was below the threshold of 90%, on this occasion 66.7%; however, the marked difference between the request for neuropsychological testing and standard psychological testing is noted.

Plan: A Director of the psychology department has now been appointed and has commenced work. It is expected that reorganization of the psychology department will result not only in the department being able to reach its threshold of 90% but that, in addition, there will be an increase in availability of psychological testing and thereafter an increase in utilization of psychological testing within the hospital once again.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Polyantipsychotic Medication Monitoring

	October	November	December
Census	70	71	72
Antipsychotic Orders for Clients			
No Antipsychotics	12 (17%)	13 (18%)	14 (19%)
Mono-antipsychotic therapy	38 (54%)	35 (49%)	36 (50%)
Two Antipsychotics	15 (21%)	17 (24%)	18 (25%)
Three Antipsychotics	5 (7%)	6 (8%)	3 (4%)
Four Antipsychotics	0 (0%)	0 (0%)	1 (2%)
At least 1 antipsychotic	58 (83%)	58 (82%)	58 (81%)
Total on Poly-antipsychotic therapy	20 (29%)	23 (32%)	22 (31%)
Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics	34%	40%	38%
More than 2 antipsychotics	5 (7%)	6 (8%)	4 (6%)
Poly-Antipsychotic therapy breakdown			
SGA + FGA	7 (47%)	10 (59%)	12 (67%)
2 SGAs ("Pine" + "Done")	3 (20%)	5 (29%)	3 (16.5%)
Other (2 antipsychotic regimens)	5 (33%)	2 (12%)	3 (16.5%)
Other 2 Antipsychotic Regimen Details	1) loxapine scheduled & prn + chlorpromazine injection prn 2) clozapine scheduled + olanzapine ODT scheduled 3) paliperidone palmitate (long acting injection) + aripiprazole scheduled & prn 4) chlorpromazine scheduled + fluphenazine scheduled 5) aripiprazole scheduled + quetiapine prn	1) loxapine prn + chlorpromazine prn 2) clozapine scheduled + quetiapine prn	2 SGA combinations: 1) aripiprazole scheduled + olanzapine prn 2) clozapine scheduled + quetiapine prn 3) paliperidone palmitate (long acting injection) + risperidone scheduled
3+ Antipsychotic Regimens	1) haloperidol scheduled & prn, olanzapine scheduled, quetiapine scheduled & prn 2) haloperidol scheduled & prn, olanzapine ODT prn, ziprasidone injection prn 3) olanzapine ODT	1) haloperidol scheduled & prn, olanzapine scheduled, quetiapine scheduled & prn 2) haloperidol scheduled & prn, olanzapine ODT prn, ziprasidone injection prn 3) paliperidone palmitate	1) olanzapine scheduled & prn, risperidone scheduled & prn, chlorpromazine prn 2) aripiprazole scheduled, haloperidol scheduled, ziprasidone scheduled 3) haloperidol scheduled

	scheduled & prn, paliperidone palmitate (long acting injection), risperidone prn 4) clozapine scheduled, haloperidol prn, quetiapine prn 5) aripiprazole scheduled, haloperidol scheduled, ziprasidone scheduled	(long acting injection), risperidone solution scheduled, aripiprazole prn 4) paliperidone palmitate (long acting injection), quetiapine scheduled, risperidone prn 5) aripiprazole scheduled, haloperidol scheduled, ziprasidone scheduled 6) aripiprazole scheduled, olanzapine prn, quetiapine prn	& prn, olanzapine scheduled, quetiapine scheduled & prn 4) clozapine scheduled, haloperidol scheduled, olanzapine ODT prn, ziprasidone Injection prn)
***Justifiable Poly-Antipsychotic Therapy**	16/20 (80%) [below goal of 90%]	19/23 (83%) [below goal of 90%]	20/22 (91%) [above goal of 90%]

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

*This portion was added based on an evaluation of the poly pharmacy regimens. One flaw with this is that we cannot tell if there is the intent to cross taper and discontinue a particular antipsychotic

Data Collection

All medication profiles in the hospital were reviewed on three occasions this quarter in October, November and December. We were particularly interested in the proportion of clients who were receiving more than one antipsychotic medication, since practice guidelines by the American Psychiatric Association clearly discourage this practice. When a case of poly-pharmacy was encountered we further required the prescriber to justify the practice based on pre-agreed upon clinical elements required to make the justification.

Findings

Over the quarter we found that about 82% of clients were receiving at least one antipsychotic medication. Of these clients, about 37% were receiving more than one such agent, and by definition was a case of poly-pharmacy. Within this overall percentage we noted that in October the percentage was 34, in November it was 40, and in December it was 38. This is an increase in poly-antipsychotic therapy from the previous quarter (32.2% total, 37.3% July, 33.3% August, and 26.6% September).

Analysis

We were below our target of 90% justified for the quarter at 84.6%. The trend line showed improvement over the quarter and was above threshold in December at 91%. The overall percentage of clients receiving poly-antipsychotic therapy increased from last quarter but remained relatively constant within quarter. There were no clients receiving ultrahigh numbers of medications (greater than 3 antipsychotics) in October or November and only one client with four antipsychotic orders in December.

Plan

We will continue this monitor for another quarter since appropriate antipsychotic prescribing is both a common task in the hospital as well as one fraught with many potential negative sequellae. We will continue to give feedback to medical staff and to look closely at all cases where it has been difficult to wean the client off high doses of multiple drugs. A full review of all cases of antipsychotic treatment will be undertaken in January.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Antibiotic Use Monitoring

Data Collection

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

Findings

During the monitoring period there were 26 orders for antibiotics. In two instances the antibiotic order form was not utilized, both in the month of December. This a 92% adherence rate for the quarter. The orders for October were presented at the November P&T Committee meeting where 100% adherence rate of form utilization was reported. Review of the indications by pharmacy showed that all antibiotic orders were for appropriate indications. November and December adherence rates to the utilization of the antibiotic order form 100% and 67%, respectively. The indications are due to be reviewed by a peer review team prior to the January P&T Committee meeting.

Analysis

Though concerning that the 100% scores through October/November dropped off in December, the low number of cases involved suggests a readily rectifiable situation, as noted below in the plan. This material will be presented and discussed at the January peer review meeting of medical staff. Based on first quarter analysis of this monitor, it is expected to be able to integrate use of the antibiotic prescribing sheet into hospital culture quite successfully, and it is hoped that termination of this monitor may even occur during the course of 2014.

Plan

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

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Metabolic Monitoring of Atypical Antipsychotics

Data Collection

The pharmacy completed data collection of metabolic monitoring parameters for all clients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all clients included BMI (Body Mass Index) and BP (blood pressure) plus lab results including HDL cholesterol, triglycerides, fasting blood sugar, and hemoglobin A1c. Also collected were the dates of the last tests and the names of the atypical drugs each client was receiving. This information is posted on the physician's shared drive and presented monthly at the Pharmacy and Therapeutics (P&T) Committee Meeting

Findings

During the monitoring period there were 67 clients receiving at least one atypical antipsychotic agent. Data was completely recorded for all desired data elements for 47 of 67 (or 70%) clients. We found that about 23.9% of clients taking an atypical antipsychotic met the criteria for Metabolic Syndrome. Twenty-two percent of clients were missing enough data elements that their metabolic status was unable to be determined. Missing data elements were primarily related to lab studies, mostly due to refusal of clients to obtain blood work. About 47% of clients with values for each data element did not have these obtained within the last quarter, suggesting the need to evaluate each client's metabolic monitoring frequency.

Analysis

At 70% we were below our target of 95% of clients on atypical antipsychotics having a complete metabolic profile available to the pharmacist and to the medical staff. This was primarily due to missing laboratory values in the data base due to refusals. However, by the end of the quarter metabolic syndrome status could not be determined for only 7 (16.3%) clients. Thus data was complete for 83.7% of clients on second generation antipsychotics, indicating some improvement on this indicator.

Plan

Going forward, our plan will be to review the recommended metabolic monitoring frequency for each client to optimize the monitoring and prevent unnecessary lab work. We will continue to monitor the data elements of metabolic monitoring for each client prescribed a second generation antipsychotic. We will also continue to refine and improve our data entry. We will explore the concept of a metabolic clinic to better assess, identify, monitor, educate and treat clients at risk for metabolic syndrome.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing

INDICATOR

Mandate Occurrences

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

Monitoring will be performed by members of the Staffing Improvement Task Force which includes representation of Nurses and Mental Health Workers on all units, Staffing Office and Nursing Leadership.

METHODS OF MONITORING

Monitoring would be performed by;

- Staffing Office Database Tracking System

METHODS OF REPORTING

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

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

UNIT

Mandate shift occurrences

BASELINE

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

MONTHLY TARGETS

Baseline –10% each month

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Mandates

Staffing Improvement Task Force

Safety in Culture and Actions	Unit	7/2013	8/2013	9/2013	10/2013	11/2013	12/2013	Goal
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.	# of shifts	5	3 plus	20	4	8	9	16 (10% reduction monthly x4 from baseline)
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.	# of shifts	51	30 plus	98	32	30	29	35 (10% reduction monthly from baseline)

Comments

Nursing mandates were down this quarter from 28 in the previous quarter to 21
MHW mandates down this quarter from 179 to 91

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

INDICATOR

Client Satisfaction Survey Return Rate

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

Peer Services Director and Peer Support Team Leader will be responsible for developing tracking tools to monitor survey due dates and surveys that are offered, refused, and completed. Full-time peer support staff will be responsible for offering surveys to clients and tracking them until the responsibility can be assigned to one person.

METHODS OF MONITORING

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

METHODS OF REPORTING

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

UNIT

All client care/residential units

BASELINE

Determined from previous year's data.

QUARTERLY TARGETS

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

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Inpatient Client Survey – Improving the Rate of Return

Department: Peer Support Responsible Party: Chris Monahan

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

STRATEGIC PERFORMANCE EXCELLENCE

Summary of Inpatient Client Survey Results

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

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

Safety in Culture and Actions

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

Fiscal Accountability

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

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

Strategic Objectives								
Safety in Culture & Actions	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Pyxis CII Safe Comparison *Daily and monthly comparison of Pyxis vs CII Safe transactions*	Rx		0%	0%	0%	0%		Goal of no discrepancies between Pyxis and CII safe transactions.
Quarterly Results			**0.3%**	**0%**				
Veriform Medication Room Audits *Monthly comprehensive audits of criteria*	All	97%	100%	100%	100%	100%	90%	Overall compliance is 98% for Q1 and Q2
Quarterly Results			**98%**	**98%**				
Pyxis Discrepancies *Monthly monitoring and trending of Pxyis discrepancies.*	All	63/mo	50	50	50	50	50/mo	Trending of monthly data was significantly increased for Q2 vs Q1
Quarterly Results			**226 (75/mo)**	**403 (134/mo)**				
Pyxis Overrides – Controlled Drugs *Monthly monitoring and trending of Pyxis overrides for Controlled Drugs*	All	15/mo	10	10	10	10	10	Target goal is 10/month
Quarterly Results			**65**	**53**				
Fiscal Accountability	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions *Monitoring and Tracking of dispensed Discharge Prescriptions*	Rx	$8440 334 Drugs	$5262 418 Drugs	$4184 252 Drugs				Significant costs are incurred in providing discharge drugs

STRATEGIC PERFORMANCE EXCELLENCE

Program Services

Define

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

Measure

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

Analyze

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

Improve

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

Control

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	7 7	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**)**	2.5	50%	5/group
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**)**	2.5	50%	5/group
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	10/10	50%	100%
5. **The client can identify distress tolerance tools on the unit**	5/10	50%	100%
6. **The client is able to state who his primary staff is**	9/10	90%	100%

EVALUATION OF EFFECTIVENESS

There continues to be unit groups seven days a week on Lower Kennebec, one on the day shift and one on the evening shift. The groups are posted to the left of the nursing station. The treatment plans now include groups.

ISSUES

Attendance in unit groups has decreased on both the day and evening shift from 57% to 50%. The decrease in attendance cannot be attributed to a single factor and is most likely influenced by client movement due to admissions and transfers.

ACTIONS

Nurses will conduct unit groups on the day and evening shift Monday through Friday. MHWs will conduct the groups on weekends. Participation will be monitored and trends will be explored and identified. The acting PSD has been reassigned to the Upper Kennebec unit. The former PSD has been reassigned to the Lower Kennebec unit.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	7/7	100%	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)	2	10%	5/group
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)	4/7	57%	5/group
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	10	100%	100%
5. **The client can identify distress tolerance tools on the unit (re named coping tools)**	8/10	80%	100%
6. **The client is able to state who his primary staff is**	8/10	100%	100%

EVALUATION OF EFFECTIVENESS

On unit groups are posted and occur daily on the day and evening shifts. Participation is low between 1 and 3. Staff has identified 5 clients that do not attend groups at the mall or groups on the unit. This issue has been incorporated in the treatment plans of those clients. Isolation is an issue with two of those clients. On unit groups have been incorporated in all of the treatment plans. Distress tolerance tools have been renamed coping tools to be more consistent with recovery-based language. Primary staff names and assignments are listed each shift on a dry erase board by the day room.

ISSUES

Since on unit groups are part of the care plans, deviation from the posted groups and structure needs to be avoided. The staff needs to understand the importance of maintaining the structure and maintain compliance with the groups as posted. Unofficial substitutions of groups cannot occur.

ACTIONS

Encourage ideas from clients and staff for topics for on unit groups. Collaborate with other units for what groups have a high interest and attendance rate. Explore low attendance rates and consider time changes for the groups. Educate staff and state a clear expectation on the importance of initial introductions to their primary clients. Identify clients that do not attend on unit groups or treatment mall groups. Review interventions for these specific clients and this specific issue for effectiveness and review and revise the treatment plans.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week	Main/SCU		
Day shift →	36 / 12	100%	7 / 7 = 14
Evenings →	27 / 10	100%	7 / 7 = 14
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)	4.5 / 1.5		N/A
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)	3.5/ 1		N/A
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	10	100%	100%
5. The client can identify distress tolerance tools on the unit	27/30	90%	100%
6. The client is able to state who his primary staff is	30/30	100%	100%
INDICATOR	FINDINGS	%	THRESHOLD

EVALUATION OF EFFECTIVENESS

ISSUES

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

ACTIONS

RT staff members are very important in providing diversion and therapy groups to Lower Saco clients, which needs to be maintained. The unit is offering many more groups weekly than the threshold; we need to be working to improve quality and variety with the groups provided. We are adding some new staff acuity specialist positions, which once in place should help address acuity situations and further improve overall quality of groups.

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STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 19 12	 100% 100%	**Days/ Even.** **7 / 7 = 14**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	2.5avg./19grps		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	4avg./12grps		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	3	30%	**100%**
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	**100%**
6. **The client is able to state who his primary staff is**	30/30	100%	**100%**

EVALUATION OF EFFECTIVENESS

ISSUES

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

ACTIONS

Nearly all clients' length of stays on Upper Saco are for longer stays than most clients on other units, and as such they quickly become familiar with distress tolerance tools (MP3 players ,cards ,exercise machines, etc.) and how to access them. They also know their assigned primary staff. The team coordinator has been incorporating off- unit groups in client treatment plans, but additional efforts need to be made to get all on-unit offered groups in individual treatment plans. Continued efforts are being made to offer groups to those clients that have less activity at the hospital treatment mall. The unit RN 4 is addressing with nursing staff the need to further improve this area.

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Vocational Incentive Program Treatment Plans *The objective of this improvement project is to ensure vocational treatment plans are initiated on all clients within 5 days of beginning work and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.*	55%	92%	95%	98%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	All charts reviewed had current plans but 2 of the charts reviewed did not have weekly progress notes. They had been done biweekly on this client working in the community with minimal vocational supervision.
Quarterly Results		95%	88%				

Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Recreational Therapy Assessments & Treatment Plans *The objective of this improvement project is to ensure that Recreational Therapy assessments are completed within 7 days of admission and that a treatment plan is initiated after the assessment and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.*	75%	85%	90%	95%	100%	The treatment plans will be reviewed more regularly and updated at each client treatment team meeting or if there is any change in client status	All assessments reviewed were done within allotted time frame and all treatment plans reviewed were current but in 3 of the 36 charts reviewed had missing progress note documentation for 2 weeks.
Quarterly Results		85%	91%				

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery & Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Occupational Therapy referrals and doctors orders. *The objective of this improvement project is to ensure each client receiving Occupational Therapy Services from RPC OT staff has a doctor's order as well as a referral form completed prior to the initiation of services.*	33%	50% 39 of 43	75% 13 of 16	100%	100%	To increase the percentage of referrals and doctor's orders by 25 % each quarter until we attain 100% compliance .	There were 3 clients who had services initiated prior to receiving the MD order. The order had been written but there was confusion on who to send the hard copy of the order to. Nursing staff educated in the OT referral process.
Quarterly Results		91%	81%				

APS Healthcare

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

Report Number: 27 and 28

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

(Includes MaineCare members and Courtesy Reviews done by APS)

Report Dates: 07/01/2013 To 09/30/2013

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Non-hospitalized member -** MaineCare member who is not in an inpatient psychiatric facility at the time of application for services. This is indicated by the member not having an open authorization for inpatient psychiatric services on the day a CFSN is completed or on the day the member is referred for CI services.
- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a waiting list for service. When there is a CFSN, it is used in conjunction with the start date of the service to determine the number of days the member waited.
- **Referral Date** is a field in CareConnection that the Provider may fill in when a member applies for a service. If the member is not put on a waiting list, (i.e. no CFSN) the referral date is used with the 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 tme of admission, but is expected to be served using either MaineCare and/or state funds.
- **SMI - Serious Mental Illness.** A proxy for serious mental illness (SMI) is the use of specific services. All active adult members who used Section 17 (Community Support) or resided in a PNMI setting within 12 months of the date of this report. Section 17 services include: Community Integration (CI), Intensive Case Management (ICM), Assertive Community Treatment (ACT), Community Rehabilitation Services (CRS) as well as Daily Living Support Services, Day Supports-Day Treatment, Skills Development-Group Therapy, Skills Development-Ongoing Support to Maintain Employment, and the Specialized Group Services of WRAP, Recovery Wkbk, TREM, or DBT.

What This Report Measures: The number of non-hospitalized members authorized for Community Integration (CI) and whether they a. were assigned to a case manager in the CI service within 3 working days, b.) Waited 4 - 7 working days to be assigned to a CI worker or c.)

Total number of non-hospitalized members applying for CI: 2,128
Total assigned within 3 working days: 1,327
Total assigned in 4 - 7 working days: 289
Total assigned within 7 working days: 1,616
Total assigned after 8 or more working days: 512

% assigned within 3 working days: 62%
% assigned in 4 -7 working days: 14%
% assigned within 7 working days: 76%
% assigned after 8 or more working days: 24%

Gender	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Female	851	193	321	1,365
Male	476	96	191	763
Total	**1,327**	**289**	**512**	**2,128**

Adult Age Groups	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
18-20	103	23	42	168
21-24	105	24	42	171
25-64	1,065	228	408	1,701
65-74	43	14	15	72
Over 75 Years Old	11	0	5	16
Total	**1,327**	**289**	**512**	**2,128**

SMI	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
SMI	1,327	289	512	2,128
Total	**1,327**	**289**	**512**	**2,128**

AMHI Class	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	1,251	272	490	2,013
AMHI Class Y	76	17	22	115
Total	**1,327**	**289**	**512**	**2,128**

District	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	91	34	76	201
District 2/ Cumberland County	209	80	118	407
District 3/ Androscoggin, Franklin, and Oxford Counties	266	71	109	446
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	157	24	55	236
District 5/ Somerset and Kennebec Counties	250	32	50	332
District 6/ Piscataquis and Penobscot Counties	241	28	66	335
District 7/ Washington and Hancock Counties	54	10	24	88
District 8/ Aroostook County	51	8	9	68
Unknown	8	2	5	15
Total	**1,327**	**289**	**512**	**2,128**

APS Healthcare

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

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	8	1	0	9
Allies	14	4	15	33
Alternative Services	20	1	1	22
AngleZ Behavorial Health Services - ACM	52	8	8	68
AngleZ Behavorial Health Services - DLS	0	0	3	3
Aroostook Mental Health Services	20	3	2	25
Assistance Plus	17	4	19	40
Behavior Health Solutions for Me	2	1	0	3
Break of Day, Inc	11	6	4	21
Broadreach Family & Community Services	29	1	1	31
Catholic Charities Maine	57	36	31	124
Charlotte White Center	5	6	13	24
Choices	20	0	0	20
Common Ties	77	15	10	102
Community Care	12	5	4	21
Community Counseling Center	47	20	40	107
Community Health & Counseling Services	134	12	20	166
Connections for Kids	0	0	1	1
Cornerstone Behavioral Healthcare - CM	33	4	2	39
Counseling Services Inc.	39	33	74	146
Direct Community Care	20	0	0	20
Dirigo Counseling Clinic	17	0	0	17
Employment Specialist of Maine	2	3	7	12
Evergreen Behavioral Services	4	0	0	4
Fullcircle Supports Inc	40	0	1	41
Goodwill Industries of Northern New England	1	0	0	1
Graham Behavioral Services	17	5	1	23
Harbor Family Services	12	0	2	14
Healing Hearts LLC	15	1	1	17
Health Affiliates Maine	76	16	15	107
Higher Ground Services	15	3	1	19
Kennebec Behavioral Health	79	0	5	84
Life by Design	18	2	1	21
Lutheran Social Services	16	0	0	16
Maine Behavioral Health Organization	59	1	3	63
Maine Vocational & Rehabilitation Assoc.	10	0	3	13
Manna Inc	10	0	3	13
Merrymeeting Behavioral Health Associates-Adult Case Mgmt	0	1	0	1
Mid Coast Mental Health	21	7	25	53
Motivational Services	8	0	0	8
Northeast Occupational Exchange	9	9	38	56
Ocean Way Mental Health Agency	2	1	0	3
OHI	6	0	1	7
Oxford County Mental Health Services	1	11	7	19
Port Resources-Sec 17	5	0	0	5
Rumford Group Homes	12	0	0	12
Shalom House	23	1	3	27
Smart Child & Family Services	10	2	5	17
St. Andre Homes	11	3	2	16

Stepping Stones	8	0	1	9
Sunrise Opportunities	3	1	4	8
Sweetser	112	11	13	136
The Opportunity Alliance	38	31	21	90
Tri-County Mental Health	41	20	78	139
Umbrella Mental Health Services	9	0	23	32
Total	**1,327**	**289**	**512**	**2,128**

APS Healthcare

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

Report Number: 29 and 30

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

(Includes MaineCare members and Courtesy Reviews done by APS)

Report Dates: 07/01/2013 To 09/30/2013

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Hospitalized member -** MaineCare member who is in an inpatient psychiatric facility at the time of application for services. This is indicated by the member having an open authorization for inpatient psychiatric services at the time a CFSN authorization is entered into CareConection or on the day that the member is referred for CI services.
- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a waiting list for service. When there is a CFSN, it is used in conjunction with the start date of the service to determine the number of days the member waited.
- **Referral Date** is a field in CareConnection that the Provider may fill in when a member applies for a service. If the member is not put on a waiting list, (i.e. no CFSN) the referral date is used with the 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 tme of admission, but is expected to be served using either MaineCare and/or state funds.
- **SMI - Serious Mental Illness.** A proxy for serious mental illness (SMI) is the use of specific services. All active adult members who used Section 17 (Community Support) or resided in a PNMI setting within 12 months of the date of this report. Section 17 services include: Community Integration (CI), Intensive Case Management (ICM), Assertive Community Treatment (ACT), Community Rehabilitation Services (CRS) as well as Daily Living Support Services, Day Supports-Day Treatment, Skills Development-Group Therapy, Skills Development-Ongoing Support to Maintain Employment, and the Specialized Group Services of WRAP, Recovery Wkbk, TREM, or DBT.

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

Total number of hospitalized members applying for CI: 39

Total assigned within 2 working days: 25	% assigned within 2 working days: 64%
Total assigned in 3 - 7 working days: 6	% assigned in 3 -7 working days:15 %
Total assigned within 7 working days: 31	% assigned within 7 working days: 79%
Total assigned after 8 or more working days: 8	% assigned after 8 or more working days: 21%

Gender	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Female	14	2	6	22
Male	11	4	2	17
Total	**25**	**6**	**8**	**39**

SMI	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
SMI	25	6	8	39
Total	**25**	**6**	**8**	**39**

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AMHI Class	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	22	5	7	34
AMHI Class Y	3	1	1	5
Total	**25**	**6**	**8**	**39**

District	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
District 2/ Cumberland County	7	1	1	9
District 3/ Androscoggin, Franklin, and Oxford Counties	2	1	3	6
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	1	0	2	3
District 5/ Somerset and Kennebec Counties	8	2	1	11
District 6/ Piscataquis and Penobscot Counties	6	2	1	9
District 8/ Aroostook County	1	0	0	1
Total	**25**	**6**	**8**	**39**

Providers	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	3	0	0	3
Alternative Services	1	0	0	1
AngleZ Behavorial Health Services - ACM	2	0	0	2
Aroostook Mental Health Services	1	0	0	1
Assistance Plus	0	1	1	2
Broadreach Family & Community Services	1	0	0	1
Catholic Charities Maine	5	1	0	6
Common Ties	1	0	0	1
Community Care	0	1	0	1
Community Health & Counseling Services	5	0	1	6
Cornerstone Behavioral Healthcare - CM	0	1	0	1
Employment Specialist of Maine	0	1	0	1
Graham Behavioral Services	2	0	0	2
Health Affiliates Maine	0	0	3	3
Kennebec Behavioral Health	2	0	0	2
Maine Behavioral Health Organization	1	0	0	1
Mid Coast Mental Health	0	0	2	2
Tri-County Mental Health	1	1	1	3
Total	**25**	**6**	**8**	**39**

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: 07/01/2013 To 09/30/2013 **Report Run Date: 1/15/2014**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **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 777

For those who received the service: Average number of days waiting: 13 days

Percent waiting 30 days or less: 89% 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	# auth in > 91	Average # days waiting
AMHI Class N	718	707	11	638	77	3	13
AMHI Class Y	59	59	0	56	2	1	9
Totals	**777**	**766**	**11**	**694**	**79**	**4**	**13**

District	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
District 1	101	99	2	81	19	1	20
District 2	231	229	2	209	22	0	12
District 3	224	221	3	201	23	0	13
District 4	44	44	0	39	3	2	14
District 5	107	107	0	100	6	1	11
District 6	36	33	3	33	3	0	10
District 7	8	7	1	6	2	0	23
District 8	16	16	0	15	1	0	6
Unknown	10	10	0	10	0	0	11
Totals	**777**	**766**	**11**	**694**	**79**	**4**	**13**

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	# auth in > 91	Average # days waiting
Alternative Services	1	1	0	1	0	0	3
AngleZ Behavorial Health Services - ACM	35	35	0	34	1	0	8
AngleZ Behavorial Health Services - DLS	1	1	0	1	0	0	0
Assistance Plus	43	43	0	40	3	0	10
Break of Day, Inc	4	4	0	4	0	0	3
Catholic Charities Maine	99	99	0	98	1	0	8
Common Ties	50	49	1	49	1	0	9
Community Care	20	16	4	17	3	0	12
Community Counseling Center	44	44	0	41	3	0	12
Community Health & Counseling Services	5	5	0	5	0	0	9
Counseling Services Inc.	111	110	1	92	19	0	18
Direct Community Care	5	5	0	5	0	0	0
Health Affiliates Maine	57	57	0	54	3	0	10
Higher Ground Services	8	8	0	8	0	0	4
Life by Design	12	12	0	11	1	0	4
Maine Behavioral Health Organization	1	1	0	1	0	0	3
Mid Coast Mental Health	11	11	0	7	3	1	28
Motivational Services	1	1	0	1	0	0	0
Shalom House	6	6	0	6	0	0	6
Sunrise Opportunities	5	5	0	3	2	0	33
Sweetser	21	19	2	10	8	3	44
The Opportunity Alliance	99	98	1	95	4	0	8
Tri-County Mental Health	114	112	2	89	25	0	19
UCP VI	1	1	0	1	0	0	15
Umbrella Mental Health Services	23	23	0	21	2	0	9
Totals	**777**	**766**	**11**	**694**	**79**	**4**	**13**

APS Healthcare

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

Quarterly Report 60a2 Reasons Members Are Removed from MaineCare Waitlist for CI Without Being Authorized for CI
Report Dates: 07/01/2013 To 09/30/2013

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 CareConnecton 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.

What This Report Measures: This report shows the reasons members were removed from the MaineCare CI waitlist without being authorized for either MaineCare CI or state-funded CI. The report is run 2 quarters ago to give time for providers to contact the potential clients. Providers enter the reasons for removal from the waitlist by filling in the discharge plan when they discharge a CFSN in APS CareConnection.

Number of people who were removed from the MaineCare CI wait list waitlist by providers without being authorized for the service: 367
Number of people with information about the reason for removal from the waitlist entered: 197

Reasons for removal from the waitlist	# of members
Client is not eligible for this service	7
Client relocated out of area	1
Deceased	1
Error	6
Transfer	36
Unable to contact	97
Withdrawal of request by client	2
Withdrawal request by client	22
Other: already receiving CI	2
Other: client incarcerated	1
Other: No Dx received	1
Other: Provider discharged member with plan to provide CI service. Actual service started more than 14 days later	11
Other: Provider referred to CI but no CI authorization in place.	8
Other: resides outsides catchment area	2
Total	**197**

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: 07/01/2013 To 09/30/2013 **Report Run Date: 1/15/2014**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **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: 181

For those who received the service: Average number of days waiting: 24 days

Percent waiting 30 days or less: 75% Percent waiting 90 days or less: 97%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
AMHI Class N	174	25	149	130	39	5	24
AMHI Class Y	7	3	4	5	1	1	32
Totals	**181**	**28**	**153**	**135**	**40**	**6**	**24**

District	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
District 1	22	3	19	8	11	3	47
District 2	62	9	53	49	12	1	21
District 3	43	4	39	36	7	0	19
District 4	22	5	17	14	6	2	36
District 5	18	3	15	14	4	0	16
District 6	6	1	5	6	0	0	14
District 7	3	2	1	3	0	0	11
District 8	4	1	3	4	0	0	7
Unknown	1	0	1	1	0	0	28
Totals	**181**	**28**	**153**	**135**	**40**	**6**	**24**

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Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
Alternative Services	1	1	0	1	0	0	4
Assistance Plus	14	1	13	12	2	0	17
Break of Day, Inc	10	4	6	5	3	2	45
Catholic Charities Maine	8	2	6	8	0	0	6
Common Ties	8	1	7	8	0	0	6
Community Care	5	3	2	5	0	0	12
Community Counseling Center	11	0	11	10	1	0	17
Community Health & Counseling Services	2	0	2	2	0	0	7
Counseling Services Inc.	20	1	19	3	15	2	58
Kennebec Behavioral Health	1	0	1	1	0	0	0
Life by Design	2	1	1	2	0	0	8
Lutheran Social Services	1	1	0	1	0	0	0
Maine Vocational & Rehabilitation Assoc.	1	0	1	0	1	0	50
Mid Coast Mental Health	11	2	9	8	3	0	29
Oxford County Mental Health Services	1	0	1	1	0	0	26
Shalom House	1	0	1	1	0	0	24
Smart Child & Family Services	3	2	1	2	1	0	29
Sweetser	10	2	8	6	2	2	38
The Opportunity Alliance	34	4	30	32	2	0	11
Tri-County Mental Health	37	3	34	27	10	0	25
Totals	**181**	**28**	**153**	**135**	**40**	**6**	**24**

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Quarterly Report 60b2 Reasons Members Are Removed from State-Funded Waitlist for CI Without Being Authorized for CI

Report Dates: 07/01/2013 To 09/30/2013

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 CareConnecton 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.

What This Report Measures: This report shows the reasons members were removed from the state-funded CI waitlist without being authorized for either MaineCare CI or state-funded CI. The report is run 2 quarters ago to give time for providers to contact the potential clients. Providers enter the reasons for removal from the waitlist by filling in the discharge plan when they discharge a CFSN in APS CareConnection.

Number of people who were removed from the state-funded CI wait list waitlist by providers without being authorized for the service: 151
Number of people with information about the reason for removal from the waitlist entered: 91

Reasons for removal from the waitlist	# of members
Client is not eligible for this service	3
Client relocated out of area	1
Error	1
Transfer	22
Unable to contact	34
Withdrawal request by client	8
Other: incarcerated	2
Other: No MaineCare	1
Other: Provider discharged member with plan to provide CI service. Actual service started more than 14 days later	8
Other: Provider referred to CI but no CI authorization in place.	11
Total	**91**

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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Location Effort Report
Quarters 3 and 4, Fiscal Year 2013, Quarters 1 and 2, Fiscal Year 2014
(January 2013 – January 2014)

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 FY13, and the 1st and 2nd quarters of FY14, 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 2013, 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 10.0% (441 of 4405) 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 23, 2014)

FISCAL YEAR AND QUARTER	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	FY13 Q3,Q4 FY14 Q1, Q2 JAN-JAN
TOTAL CLASS MEMBERS (NOT DECEASED)	4184	4193	4199	4204	4222	4244	4275	4330	4405
LETTERS SENT (CLIENTS NOT IN SERVICE OR IN JAIL OR HOSPITALS OR NO CONTACT)	1768	1830	1784	1792	1909	1931	1967	2040	2022
LETTERS RETURNED	63	280	152	141	214	237	409	581	373
LETTERS RESENT	53	131	97	158	178	152	273	212	149
CDC CARDS RETURNED	116	24	106	93	101	99	23	12	28
LETTERS SENT FOR SS VERIFICATION	27	41	0	0	14	10	0	0	0
UNVERIFIED	458	424	472	467	451	459	450	413	441
RESIDING IN A TEMPORY RESIDENCE				289	297	334	340	353	394
VERIFIED IN STATE	3099	3120	3052	2918	2931	2909	2940	2901	2905
VERIFIED OUT OF STATE	333	331	371	321	325	326	326	428	421
NO CONTACT IN STATE	126	135	140	149	151	156	162	174	178
NO CONTACT OUT OF STATE	52	54	55	57	60	60	57	61	66
DECEASED	1144	1160	1183	1211	1233	1250	1348	1417	1462

TEMPORARY RESIDENCE REFERS TO ANY FEDERAL, STATE, OR COUNTY CORRECTIONAL FACILITY , HOMELESS SHELTER, OR PSYCHIATRIC CENTER