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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Feb 1, 2016

Daniel E. Wathen, Esq.
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Augusta, ME 04330

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

Dear Justice Walthen:

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

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

Sincerely,

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

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

Department of Health & Human Services, Office of Adult Mental Health Services
Bates v. DHHS Consent Decree
Oct, Nov, Dec 2015 2nd Quarter, SFY 2016
CONSENT DECREE REPORT

SUMMARY
(Section 1A)

The DHHS Office of Substance Abuse and Mental Health Services is required to report to the Court quarterly regarding compliance and progress toward meeting specific standards as delineated in the Bates v. DHHS Consent Decree Settlement Agreement, the Consent Decree Plan of October 2006, and the Compliance Standards approved October 29, 2007. The following documents are submitted as the Quarterly Progress Report for the 2nd quarter of state fiscal year 2016, covering the period October, November, and December 2015. A link to the PDF version of each document is provided on the SAMHS website.

		DESCRIPTION
1	**Cover Letter, Quarterly Report:** Feb, 2016 *Section 1*	Letter to Dan Wathen, Court Master, submitting the Quarterly Report pursuant to paragraph 280 of the Settlement Agreement for the quarter ending Dec 31, 2015.
2	**Report on Compliance Plan Standards: Community** *Section 2*	Lists and updates the information pertaining to standards approved in October 2007 for evaluating and measuring DHHS compliance with the terms and principles of the Settlement Agreement.
3	**Performance and Quality Improvement Standards** *Section 3*	Details the status of the Department's compliance with 19 specific performance and quality improvement standards (many are multi-part) required by the Consent Decree October 2006 Plan for this reporting quarter. Reporting includes the baseline, current level, performance standard, and compliance standard for each, including graphs.
4	**Consent Decree Performance and Quality Improvement Standard 5.** *Section 4*	Aggregate report of assignment time to service and completion time of Individual Support Plans (ISPs). Data gathered from Contact for Service Notifications, Prior Authorizations, and Continued Stay Requests via APS Care Connections.
5	**Performance Quality and Improvement Standards, Appendix: Adult Mental Health Data Sources** *Section 5*	Lists and describes all of the data sources used for measuring and reporting the Department's compliance on the Performance and Quality Improvement Standards.
6	**Cover: Unmet Needs and Quality Improvement Initiative** *Section 6*	Provides a brief introduction to the unmet needs report as well as some definitions of the data, initial findings and next steps. Also includes information on the quality improvement initiatives undertaken by SAMHS.
7	**Unmet Needs by CSN** *Section 7*	Quarterly report drawn from the Enterprise Information System (EIS) by CSN (based on client zip code), from resource need data entered by community support case managers (CI, ACT, CRS, and BHH)

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

Summary of new Initiatives at SAMHS

The Office of Substance Abuse and Mental Health Services (SAMHS) has hired a staff member to, among other duties, analyze and manage the Waitlist system. The Waitlist has improved dramatically from January 2015 to January 2016 as represented by a 40% overall reduction in persons waiting for services; however, the data still shows that a significant number of consumers are remaining on the wait list well beyond the assignment times for community integration services specified in the Settlement Agreement. SAMHS will continue to analyze and improve the Waitlist system over the coming months with the goal of achieving substantial compliance. This process includes an analysis of the existing system, as well the relationships and business processes between: APS HealthCare, the Provider Community, SAMHS, and the consumers themselves.

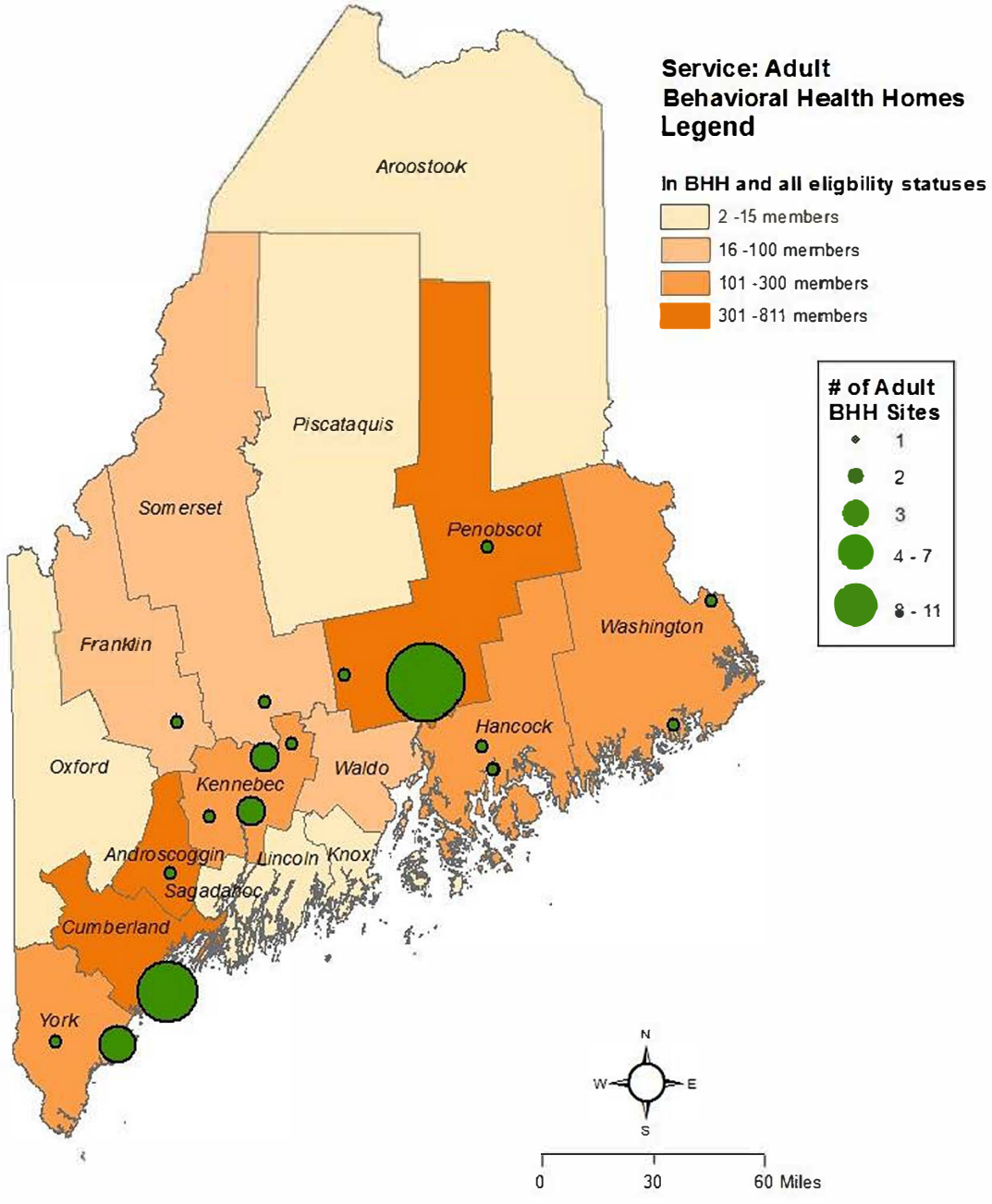
The Behavioral Health Home (BHH) initiative has blossomed and there are currently sixteen (16) agencies with thirty six (36) sites serving 2,198 adults (see map at the end of this summary). The Office of MaineCare Services has received applications from seven (*7)* new agencies and expansion requests from four (4) existing agencies that will create thirty-four (34) new sites in the coming months. All totaled, there will be seventy (70) BHH sites as these additional sites come online.

Three staff units from SAMHS have been moved to other offices within DHHS. In each instance, these units will be able to leverage additional resources and expertise of offices to which they are being moved. The Data Team will be moving to the Office of Continuous Quality Improvement where the expertise of the staff will assist those moving to produce better and more accurate reports. The Prevention Team will be moving to the Maine Center for Disease Control to work with others on current and new prevention initiatives. This move will bring both the public attention and resources to bear, from a command and control footing of Maine's CDC, to the heroin and opiate epidemic currently gripping the state. Several members of the Gatekeeping group will be joining the Office of MaineCare Services to combine with existing staff from multiple offices in the creation of a multi-disciplinary Complex Case Management team to effectively coordinate persons moving from psychiatric hospitals and local emergency rooms to community levels of care. SAMHS will retain contracting functions within the portfolio of Residential Treatment facilities (PNMIs) and remain a part of current discharge planning groups at the state psychiatric hospitals.

In the coming months, SAMHS and the Office of the Attorney General will be working on a proposal to reconcile the days to assignment (2 days for class members who are hospitalized, 3 days for class members in the community and 7 days for non-class

members) with upcoming changes in Section 17 of the MaineCare Benefits Manual, which will require a 7-day referral to service. With these rule changes, we intend to negotiate an amendment to the Settlement Agreement to align the required assignment times to the proposed change to Section 17.

Adult Behavioral Health Homes
Numbers in Service By County
Most recent CI or BHH Authorization of FY 2015



APS Healthcare

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

	Compliance Standard	Report/Update
I.1	Implementation of all the system development steps in October 2006 Plan	As of March 2010, all 119 original components of the system development portion of the Consent Decree Plan of October 2006 have been accomplished or deleted per amendment.
I.2	Certify that a system is in place for identifying unmet needs	See attached *Cover: Unmet Needs February 2016* And *Unmet Needs by CSN for FY16 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 Draft Quality Improvement plan for 2015-2020 has been developed and has been distributed to the DRME, the Court Master, SAMHS staff and the Commissioner's Office. It is currently undergoing some revisions before it is released to the public.
II.1	Provide documentation that unmet needs data and information (data source list page 4 of compliance plan) is used in planning for resource development and preparing budget requests	Department submitted funding requests to meet all identified needs under the Consent Decree, both through the supplemental budget and the next biennial budget, with support of the Governor ; and the Legislature enacted a budget including all requests. These funds are now part of the base budget instead of having to be submitted as budget requests for additional grant funds.
II.2	Demonstrate reliability of unmet needs data based on evaluation	See *Cover: Unmet Needs and Quality Improvement Initiatives February 2016* and the *Performance and Quality Improvement Standards: February 2016* for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data. SAMHS continues to review the reliability of the unmet

		needs data to ensure proper identifying, recording and implementation of services for unmet needs. See Section 6.
II.3	Submission of budget proposals for adult mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs *(Amended language 9/29/09)*	The Director of SAMHS provides the Court Master with an updated projection of needs and associated costs as part of his ongoing updates regarding Consent Decree obligations.
II.4	Submission of the written presentation given to the legislative committees with jurisdiction over DHHS … which must include the budget requests that were made by the Department to satisfy its obligations under the Consent Decree Plan and that were not included in the Governor's proposed budget, an explanation of support and importance of the requests and expression of support … *(Amended language 9/29/09)*	See above.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	MaineCare and Grant Expenditure Report for FY 14 provided in the May 2015 report, section 15.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs February 2016* and the *Performance and Quality Improvement Standards: February 2016* 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 standard II.4 above for examples of how quality management data was used to support budget requests for systems improvement. Unmet need reports have been used to identify where additional funds are needed for delivery of services.
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Contract and licensing reviews are conducted as licenses expire. A report from DLRS is available; during the last quarter 27 of 27 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 2014 DIG Survey was 88.1%. These data are posted on the SAMHS website and provided to the Consumer Council of Maine. SAMHS distributed the survey in September 2015 and the recipients have until October 31, 2015 to return the survey. The survey is based on the model Perception of Care developed by the New York Office of Alcoholism and Substance Abuse. See longer explanation in Section 5.
IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.

IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if hearing is to be held or if parties concur.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.5	90% hospitalized class members assigned worker within 2 days of request - *must be met for 3 out of 4* quarters	See attached *Performance and Quality Improvement Standards: February 2016,* Standard 5-2. This standard has not been met for the past 4 quarters.
IV.6	90% non-hospitalized class members assigned worker within 3 days of request - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2016,* Standard 5-3. This standard has not been met for the past 4 quarters.
IV.7	95% of class members in hospital or community not assigned within 2 or 3 days, assigned within an additional 7 days - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2016,* Standard 5-4. This standard has not been met for the past 4 quarters.
IV.8	90% of class members enrolled in CSS with initial ISP completed within 30 days of enrollment - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2016,* Standard 5-5. This standard has not been met for the past 3 quarters but has been met this quarter.
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 2016,* Standard 5-6. This standard has not been met for the past 4 quarters
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. The data has been consistent over time and since May 2011, reports are created quarterly and available to providers upon request.
IV.11	Data collected once a year shows that no more than 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	The 2015 data analysis indicates that out of 1,441 records for review, 173 (12.0%) did not have an ISP review within the prescribed time frame.
IV.12	Certify in quarterly reports that DHHS is meeting its obligation re: quarterly mailings	On December 10, 2014, the court approved an amendment to a Stipulated Order that requires monitoring of class member addresses. If the percentage of unverified addresses exceeds 15%, the court master will review the efforts and make necessary recommendations. A list of class member's addresses is available to the court master, plaintiff's counsel and the court upon request.
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - *must be met for 3 out of 4 quarters*	See Section 9 *Class Member Treatment Planning Review,* Question 2A. This standard has been met in all 4 of the last quarters. The percentage for this quarter is 100.0%.
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be met for 3 out of 4 quarters*	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.15	90% of ISPs reviewed have a crisis plan or documentation as to why one wasn't	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.

	developed - *must be met for 3 out of 4 quarters*	
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. Corrective action taken when all domains were not assessed.
IV.17	In 90% of ISPs reviewed, interim plans developed when resource needs not available within expected response times - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2016,* Standard 8-2 and *Class Member Treatment Plan Review,* Question 3F. This standard has not been met in the last 4 quarters.
IV.18	90% of ISPs review included service agreement/treatment plan - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2016,* Standard 9-1 and *Class Member Treatment Plan Review,* Questions 4B & C. This standard has not been met in the last 4 quarters.
IV.19	90% of ACT/ICI/CI providers statewide meet prescribed case load ratios - *must be met for 3 out of 4 quarters* Note: As of 7/1/08, ICI is no longer a service provided by DHHS.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - *must be met for 3 out of 4 quarters*	ICMs' work is focused on community forensic and outreach services. Individual ICMs no longer carry caseloads. Should this change in the future, SAMHS will resume reporting on caseload ratios.
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2016,* Standard 10-5. This standard has been met in FY 15 Q2, Q3, Q4 and FY 16 Q1, and Q2
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 2016,* Standard 12-1 Standard met for the FY08 Q4; FY09 Q1,Q3, and Q4; FY10; FY11; FY12, FY13;FY 14, and FY 15, and FY16 Q1
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 needs for non-class members do not exceed 15 percentage points of the same for Class Members. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.24	Meet RPC discharge standards (below); **or**	See attached *Performance and Quality Improvement*

	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)	*Standards: February 2016,* 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 2016,* Standard 14-1 Standard met in FY 14 Q3 and 31 out of the last 35 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 2016,* Standard 14-4, 14-5 & 14-6 Standard 14-4 met since the beginning of FY09, except for FY10 Q3, FY15 Q4 and FY 16 Q1 and Q2. Standard 14-5 met FY09 Q2; Q3; and Q4; FY10 Q2 and Q4; FY11;FY12, FY13, FY 14, FY 15, and FY 16 Q1 and Q2 Standard 14-6 met FY09 Q2 and Q4; FY10 Q2; and Q4; FY11, FY12, FY13, and FY 14, FY 15 Q1 and Q4; and FY 16 Q1 and Q2
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Standard no longer reported per amendment dated May 8, 2014.
IV.28	90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in attachment C to the Compliance Plan	See attached *Performance and Quality Improvement Standards: February 2016,* Standard 16-1 and *Community Hospital Utilization Review – Class Members 1st Quarter of Fiscal Year 2016.* IN FY13 Q1: 100% (19 of 19) Q2: 92.9% (13 of 14) Q3: 86.7% (13 of 15) Q4: 90.0% (18 of 20) IN FY14 Q1: 27.3%(3 of 11) Q2: 76.5% (13 of 17) Q3: 84.6 % (11 of 13) Q4: 100.0 % (12 of 12) IN FY15 Q1: 100.0%%(12 of 12) Q2: 77.8 (14 of 18) Q3: 95.5% (21 of 22) Q4: 86.7% (13 of 15) IN FY16 Q1: 79.2 (19 of 24) Q2: 94.4 (17 of 18)
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs	See IV.30 below

	and involve CSWs in treatment and discharge planning	
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.	51 Complaints Received 23 Complaints investigated 2 Substantiated 1 Plan of correction sought 0 Rights of Recipients Violations found
IV.33	• 90% of the time corrective action was taken when blue papers were not completed in accordance with terms • 90% of the time corrective action was taken when 24 hour certifications were not completed in accordance with terms • 90% of the time corrective action was taken when patient rights were not maintained	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.34	QM system documents that if hospitals have fallen below the performance standard for any of the following, SAMHS made the information public through CSNs, addressed in contract reviews with hospitals and CSS providers, and took appropriate corrective action to enforce responsibilities • obtaining ISPs (90%) • creating treatment and discharge plan consistent with ISPs (90%) • involving CIWs in treatment and discharge planning (90%)	See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members 1st Quarter of Fiscal Year 2016.* The report displaying data by hospital for community hospitals accepting emergency involuntary clients is shared quarterly by posting reports on the CSN section of the Office's website. Standard 18.1 has been met once in the past 4 quarters. Standard 18.2 has been met for the past 4 quarters. Standard 18.3 has been met for the past 4 quarters.
IV.35	No more than 20-25% of face-to-face crisis contacts result in hospitalization – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2016*, Standard 19-1 and *Adult Mental Health Quarterly Crisis Report 2nd Quarter, State Fiscal Year 2016 Summary Report*. Standard met In FY12,FY13, FY14 Q1, Q3, Q2 slightly above standard (26.3%), Q4 slightly above standard (26.1%), FY 15 Q1, Q3 and Q4, and slightly above standard in Q2 (25.6%); standard met in FY 16 Q1 and Q2
IV.36	90% of crisis phone calls requiring face-to-	See attached *Adult Mental Health Quarterly Crisis*

	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* Per amendment dated May 8,2014 the standard now reads as follows: 90% of crisis calls requiring face-to-face assessments are responded to within an average of 60 minutes from the end of the phone call	*Report 2nd Quarter, State Fiscal Year 2016 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 – this standard was met FY12, FY13, FY14 Q1, Q2, Q4. FY 15 Q2, Q3, Q4 and FY 16 Q1 and Q2
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 2nd Quarter, State Fiscal Year 2016 Summary Report.* Standard has been met since FY08 Q2 until FY 15 Q1 (87.2%), Q2 (87.7%), Q3 (86.8%), Q4 (86.7%) and in FY 16 Q1 (88.6%). Standard met FY 16 Q2 (90.2%)
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 2016*, Standard 19-4 and *Adult Mental Health Quarterly Crisis Report 2nd Quarter, State Fiscal Year 2016 Summary Report.* Standard met all 4 quarters.
IV.39	Compliance Standard deleted 1/19/2011.	
IV.40	Department has implemented the components of the CD plan related to vocational services	As of FY10, Q3, the Department has implemented all components of the CD Plan related to Vocational Services.
IV.41	QM system shows that the Department conducts further review and takes appropriate corrective action if PS 26.3 data shows that the number of consumers under age 62 and employed in supportive or competitive employment falls below 10%. *(Amended language 1/19/11)*	2014 Adult Health and Well-Being Survey: 10.2 % of consumers in supported and competitive employment (full or part time).
IV.42	5% or fewer class members have unmet needs for mental health treatment services – *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: February 2016*, Standard 21-1 This standard has not been met for the last 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 for non-class members do not exceed 15 percentage points of the same for Class Members. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.44	QM documentation shows that the	2014 Adult Health and Well-Being Survey: 83.3%

	Department conducts further review and takes appropriate corrective action if results from the DIG survey fall below the levels identified in Standard # 22-1 (the domain average of positive responses to the statements in the Perception of Access Domain is at or above 85%) *(Amended language 1/19/11)* **and**	domain average of positive responses.
IV.45	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of mental health treatment services in the community • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: February 2016*, Standards 21-2, 21-3 and 21-4 Standard met since the beginning of FY08
IV.46	The department documents the programs it has sponsored that are designed to improve quality of life and community inclusion for class members, including support of peer centers, social clubs, community connections training, wellness programs, and leadership and advocacy training programs. Standard amended per amendment dated May 8, 2014	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: February 2016*, Standard 28 This standard has been consistently met since FY08.
IV.48	Provide documentation in quarterly reports of funding, developing, recruiting, and supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.49	Certify that all contracts with providers include a requirement to refer family members to family support services, and produce documentation that contract reviews include evaluation of compliance with this requirement.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.
IV.50	The department documents the number and types of mental health informational workshops, forums, and presentations geared toward the general public that are designed to reduce myths and stigma of mental illness and to foster community integration or persons with mental illness.	Standard no longer reported per amendment dated May 8, 2014. Report available upon request.

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

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

Consent Decree Performance and Quality Improvement Standards: February 2016

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

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

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

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

Calendar and Fiscal Year Definitions:
CY: Calendar Year - January 1 - December 31.
FY: Fiscal Year - State Fiscal Year July 1 - June 30.

Compliance and Performance Standards: Summary Sheet
October - December 2015

Standard 1. Rights Dignity and Respect

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

Standard 2. Rights Dignity and Respect

Consent Decree Performance and Quality Improvement Standards: November 2015

Standard 3. Rights Dignity and Respect

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

Standard 4. Rights Dignity and Respect

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

Standard 5. Timeliness of ISP and CI/CSS Assignment

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

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

Standard 7. CI/CSS/ Individualized Support Planning

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

Standard 8. CI/CSS Individualized Support Planning

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

Standard 9. ISP Service Agreements

ISPs that require Service Agreements that have current Service Agreements

Compliance and Performance Standards: Summary Sheet
October - December 2015

Standard 10. Case Load Ratios

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

Standard 11. CI/CSS Individualized Support Planning

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

Standard 12. Housing & Residential Support Services

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

Standard 13. Housing & Residential Support Services

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

Standard 14. Housing & Residential Support Services

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

Standard 15. Housing & Residential Services

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

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

Inpatient admissions reasonably near community residence.

Compliance and Performance Standards: Summary Sheet
October - December 2015

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

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

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

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

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

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

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

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

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

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

Standard 19. Crisis intervention Services

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

Standard 20. Crisis Intervention Services

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

Standard 21. Treatment Services

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

Standard 22. Treatment Services

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

Standard 23. Family Support Services

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

Compliance and Performance Standards: Summary Sheet
October - December 2015

Standard 24. Family Support Services

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

Standard 25. Family Support Services

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

Standard 26. Vocational Employment Services

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

Standard 27. Vocational Employment Services

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

Standard 28. Transportation

Class Members with ISPs - Unmet transportation needs.

Standard 29. Transportation

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

Standard 30. Rec/Soc/Avocational/Spiritual Opportunities

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

Standard 31. Rec/Soc/Avoc/Spirtual

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

Standard 32. Individual Outcomes

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

Compliance and Performance Standards: Summary Sheet
October - December 2015

Standard 33. Recovery

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

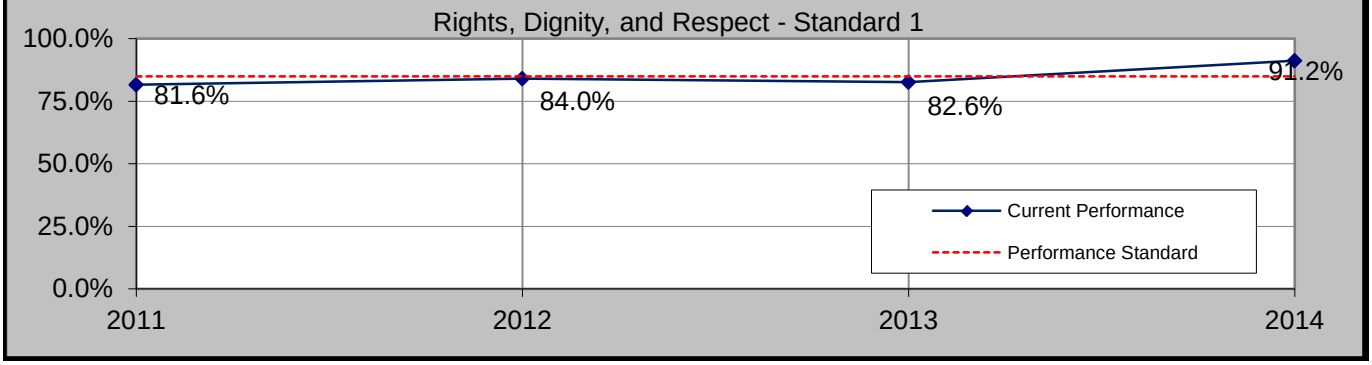
Standard 34. Public Education

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

Rights, Dignity, and Respect

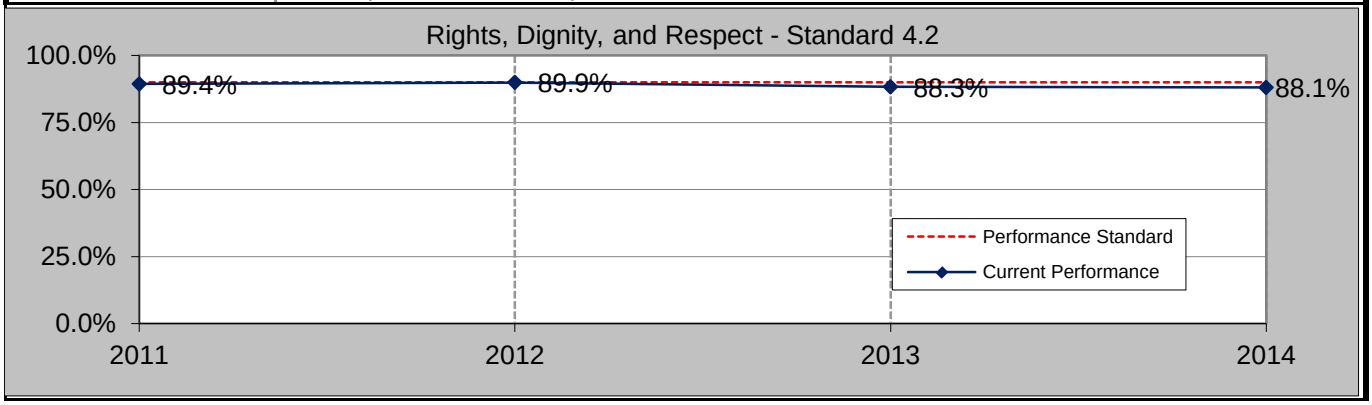
Standard 1 - Treated with respect for their individuality

Standard 1	
Measurement	Domain average of positive responses to the statements in the quality and appropriateness domain
Standard	Performance: at or above 85%
and Quality Improveme	Adult Mental Health and Well Being Survey
Current Level	91.2% (1051 out of 1153)



Standard 4 - Class Members are informed of their rights

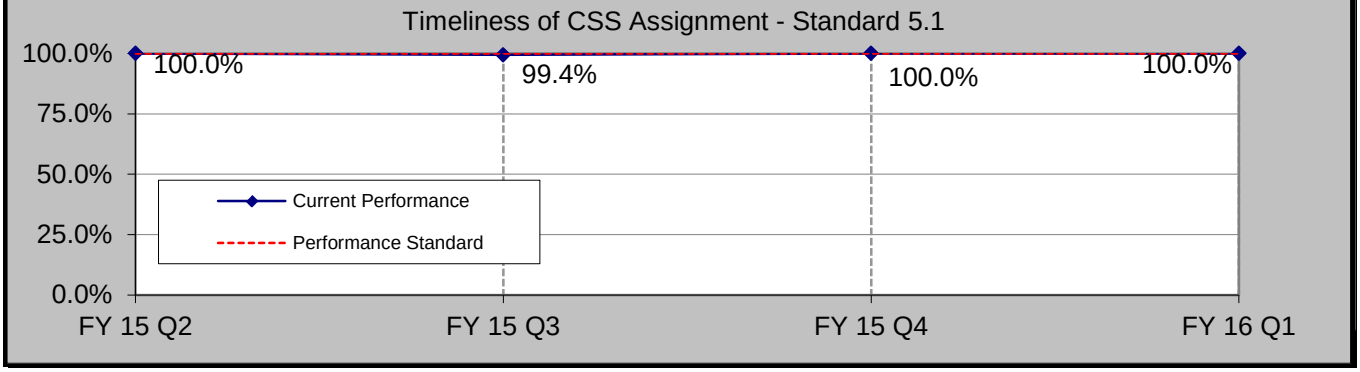
Standard 4.2	
Measurement	Percent of consumers reporting they were given information about their rights.
	Performance: 90%
Data Source	Adult Mental Health and Well Being Survey Q22
Current Level	88.1% (1016 out of 1163)



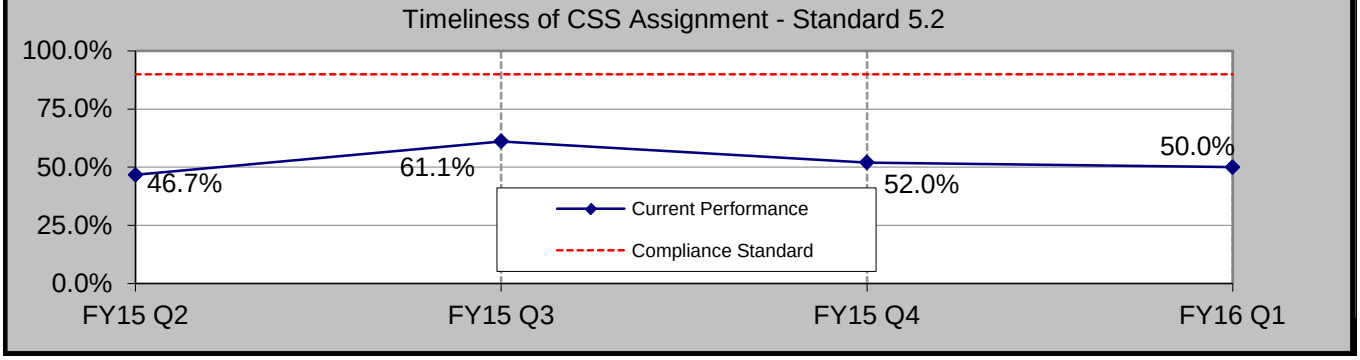
Community Integration / Community Support Services / Individualized Support Planning

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
and Quality Improveme	100.0% (159 out of 159)

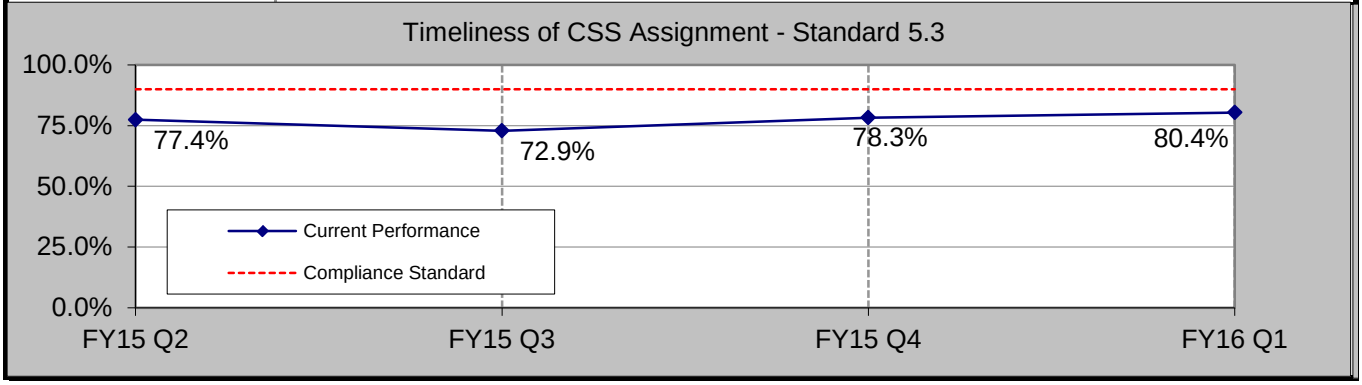


Standard 5.2	
Measurement	Percentage of hospitalized class members who were a assigned a worker within 2 working days.
Standard	Performance: 90%
	APS Healthcare
Current Level	50.0% (8 out of 16)

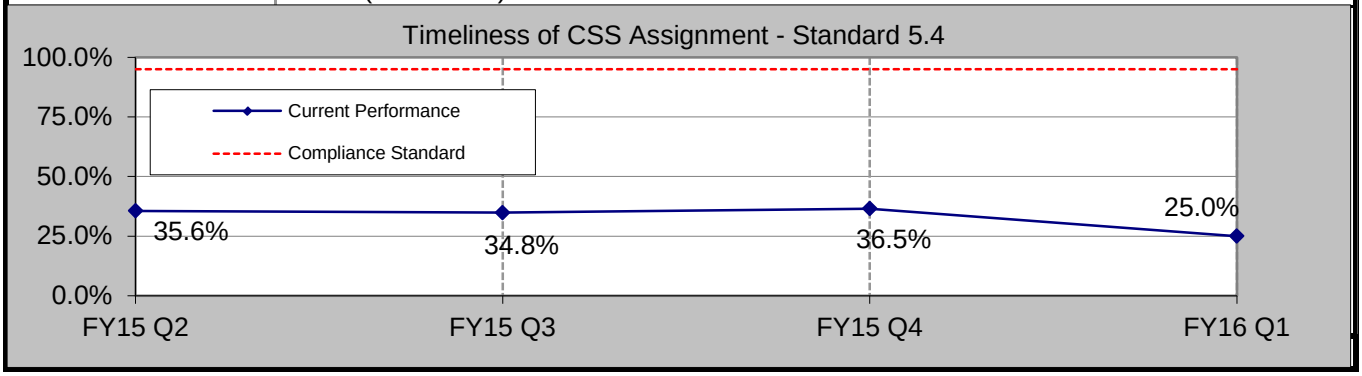


Community Integration / Community Support Services / Individualized Support Planning

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	80.4% (115 out of 143)



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	25.0% (9 out of 36)

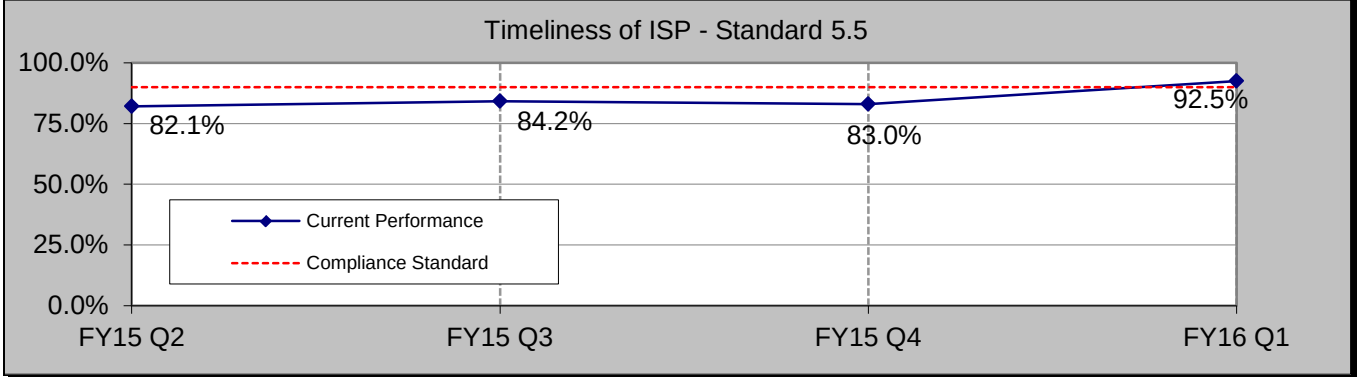


Standards 5.1 -5.4 – Calculations are now based on days from Contact for Service Notification to date of assignment.

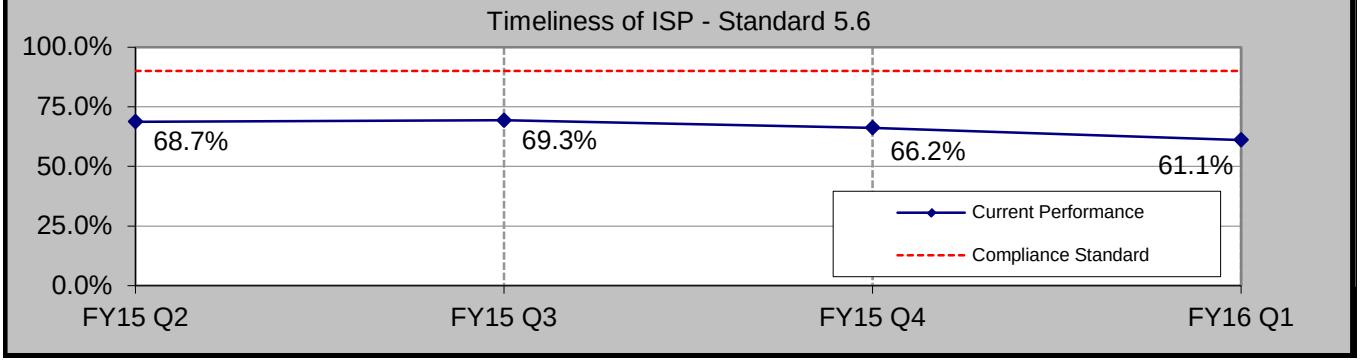
Starting with Fiscal Year 2015 Quarter 1, Standard 5.1 – 5.4 will now be calculated using CI, ACT, CRS and BHH data. Prior to this quarter, only CI was used in calculations for these standards.

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	92.5% (49 out of 53)

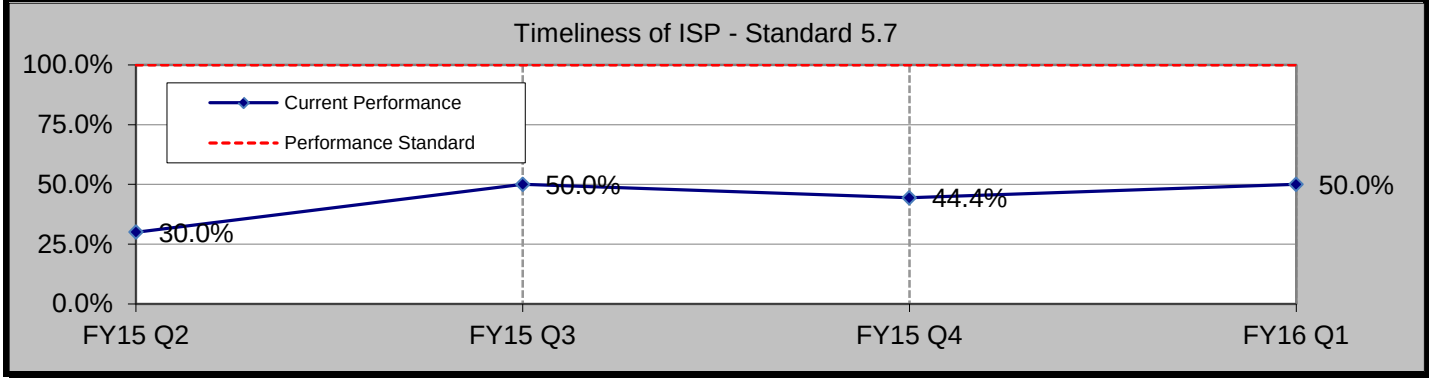


Standard 5.6	
Measurement	90 day class member ISP reviews completed within specified timeframe.
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	61.1% (596 out of 976)

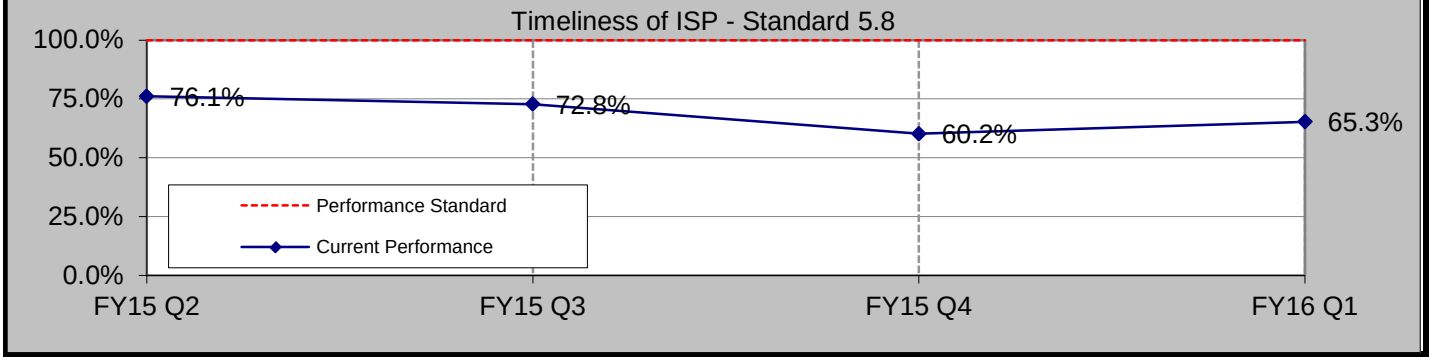


Community Integration / Community Support Services / Individualized Support Planning

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	50.0% (2 out of 4)



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	65.3% (248 out of 380)



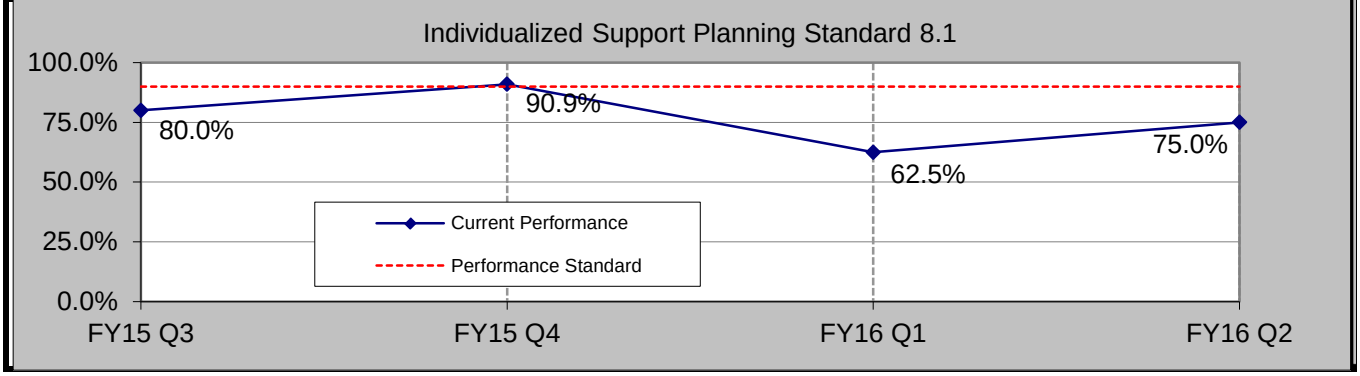
Discussion:

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. Consent Decree Process Improvement has also been deployed within seven agencies to collaberate around resolution to these issues.

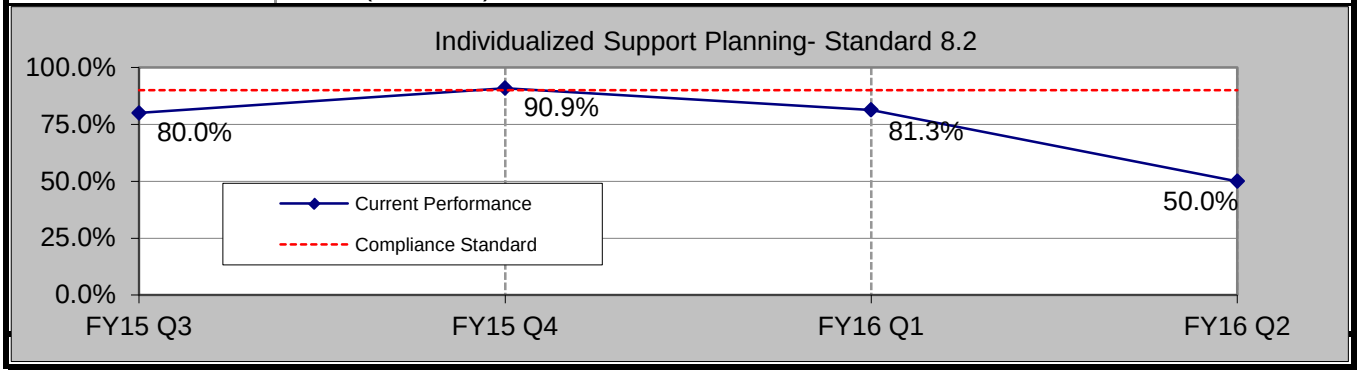
Community Integration / Community Support Services / Individualized Support Planning

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

Standard 8.1	
Measurement	ISPs reviewed in which there is evidence that the ISP team reconvened after an unmet need was identified.
Standard	Performance: 90%
Data Source	Class Member Treatment Planning Review
Current Level	75.0% (6 out of 8)



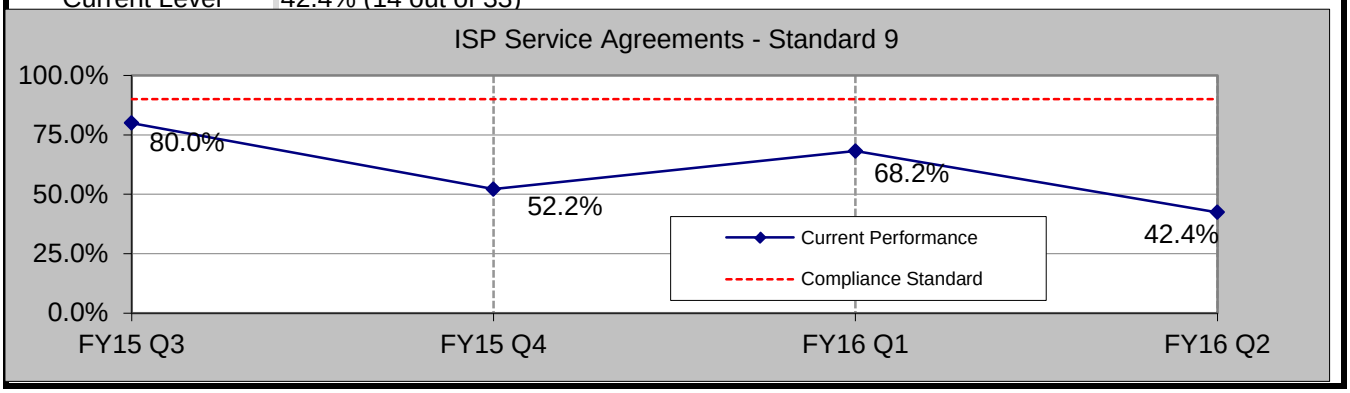
Standard 8.2	
Measurement	ISPs reviewed with identified unmet needs in which interim plans are established.
Standard	Performance: 95% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	50.0% (4 out of 8)



Community Integration / Community Support Services / Individualized Support Planning

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

Standard 9	
Measurement	ISPs with services identified and with a treatment plan signed by each provider.**
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	42.4% (14 out of 33)



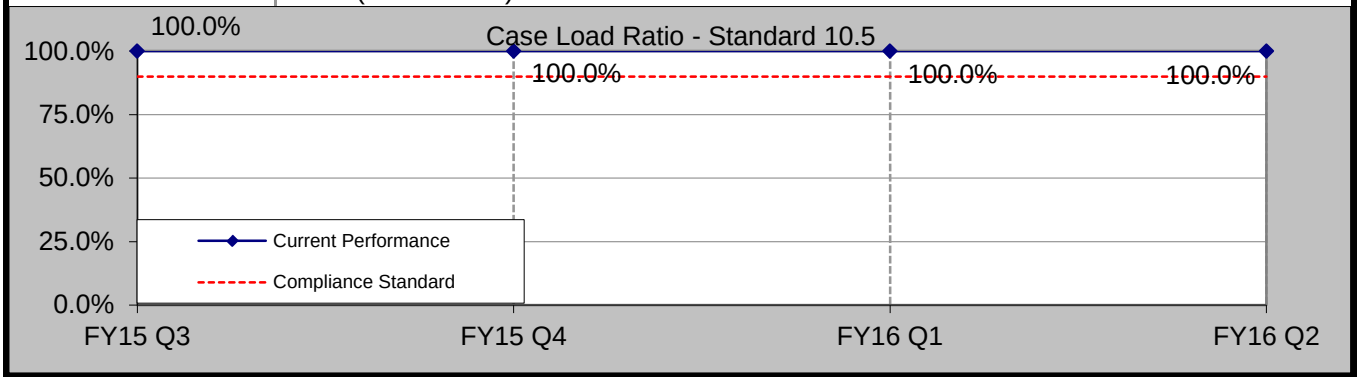
Discussion:

Standards 8.1, 8.2 and 9 - Field Quality Managers continue to perform document reviews and work with the agencies around unmet needs and service agreements.

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 40 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	100% (26 out of 26)



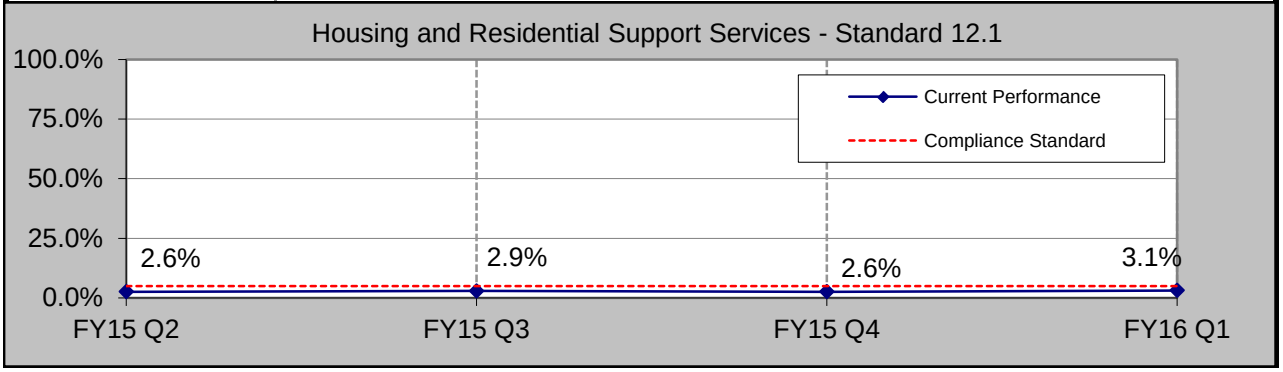
Discussion:

Standard 10.5 - Per amendment dated December 10, 2014 average case load was changed from 25 to 40.

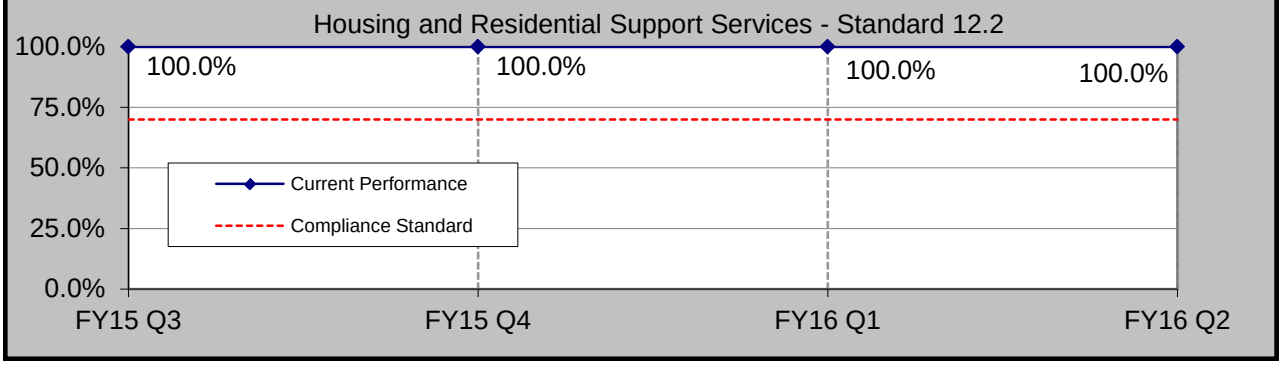
Community Resources and Treatment Services
Housing and Residential

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)
and Quality Improveme	ISP RDS Data
Current Level	3.1% (34 out of 1091)

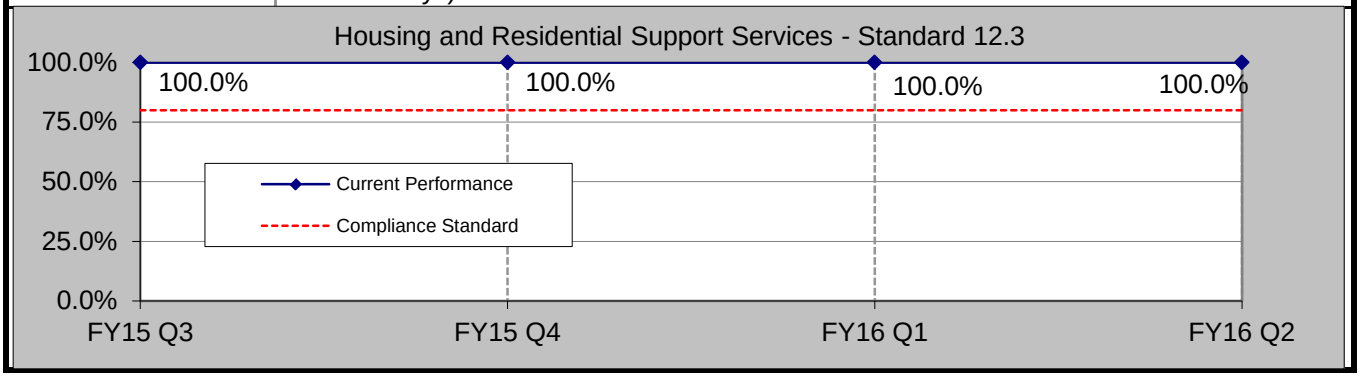


Standard 12.2	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge is not impeded due to lack of residential support services)
	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY16 Q2 (Lack of residential supports did not impede discharge for 28 out of 28 patients within 7 days)

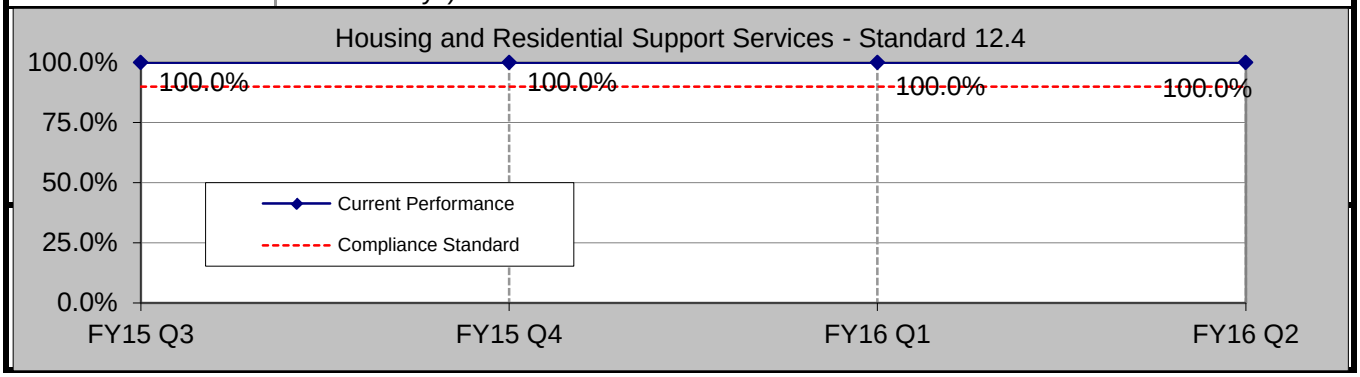


Community Resources and Treatment Services
Housing and Residential

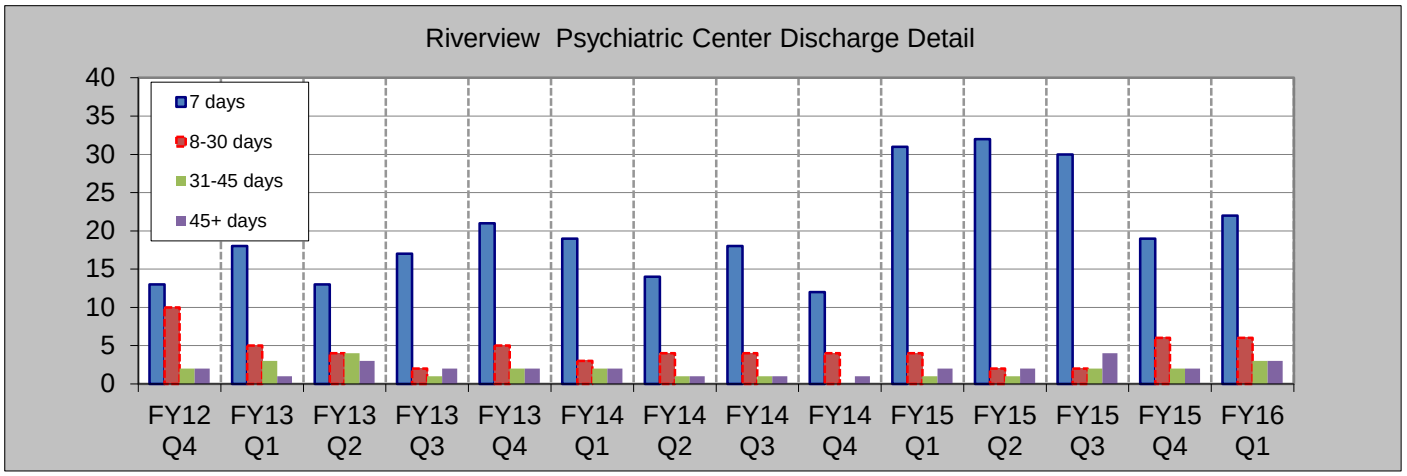
Standard 12.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY16 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% FY16 Q2 (Lack of residential supports did not impede discharge any patients within 45 days)



Community Resources and Treatment Services
Housing and Residential



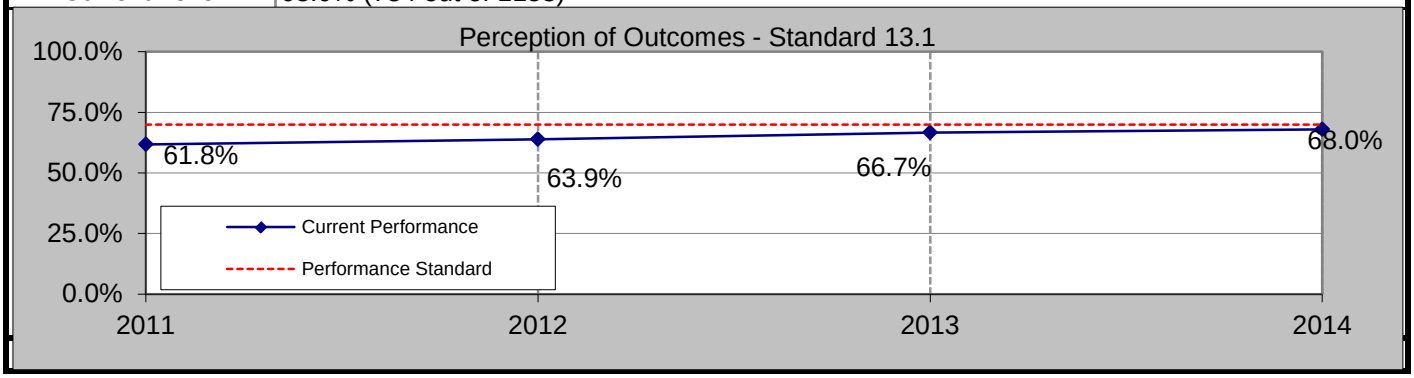
Riverview Psychiatric Center Discharge Detail to amplify data presented in Standards 12.2, 12.3, 12.4:

28 Civil Patients discharged in quarter

19 discharged at 7 days (67.9%)
5 discharged 8-30 days (17.9%)
1 discharged 31-45 days (3.6%)
3 discharged post 45 days (10.7%)

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

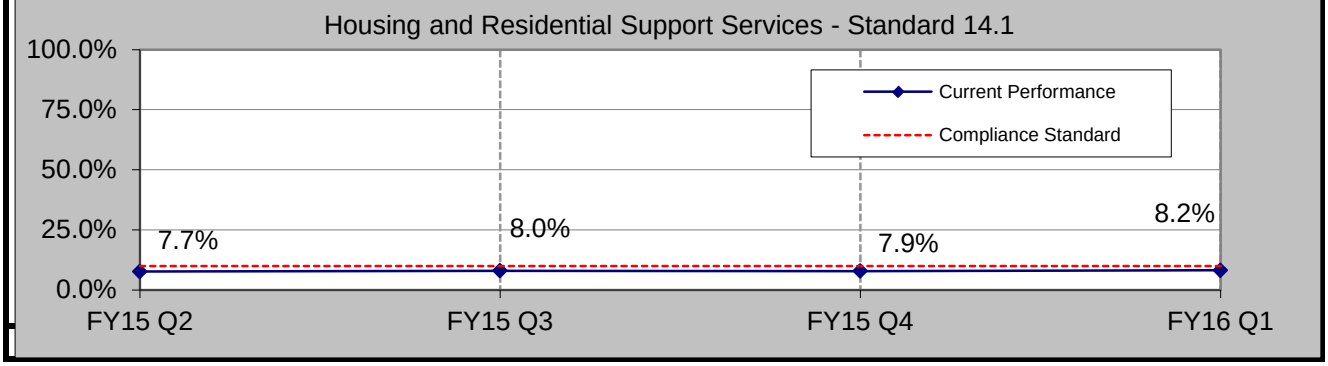
Standard 13.1	
Measurement	Domain average of positive responses to the questions in the Perception of Outcomes domain
Standard	Performance: at or above 70%
Data Source	Adult Mental Health and Well Being Survey
Current Level	68.0% (784 out of 1153)



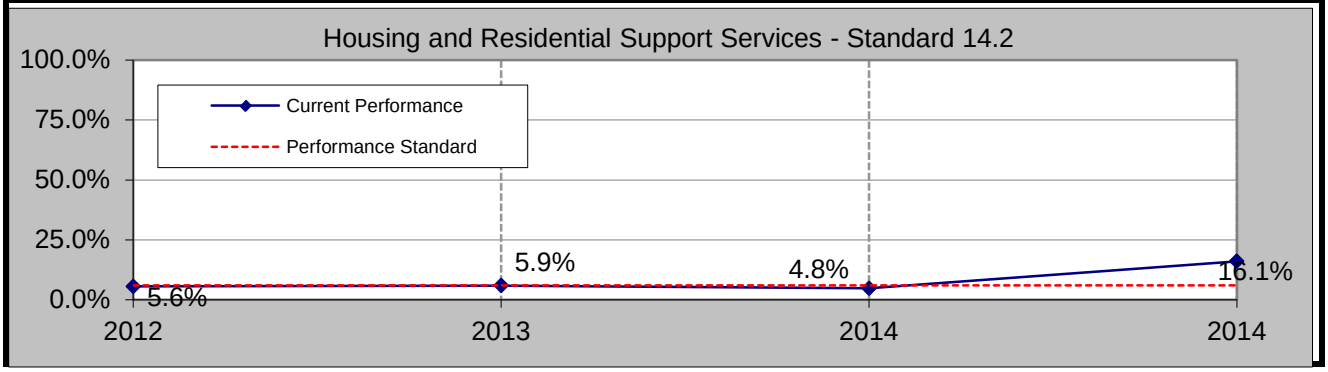
Community Resources and Treatment Services
Housing and Residential

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	8.2% (90 out of 1091)

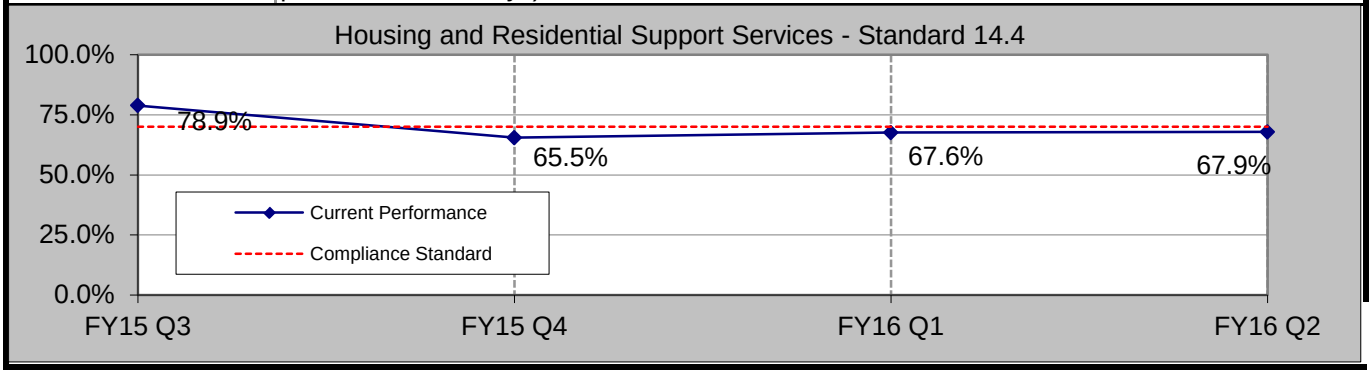


Standard 14.2	
Measurement	Percentage of respondents who experienced homelessness over 12-month period.
Standard	Performance: 6% or fewer
Data Source	Adult Mental Health and Well Being Survey, living situation data
Current Level	16.1% (186 out of 1153)

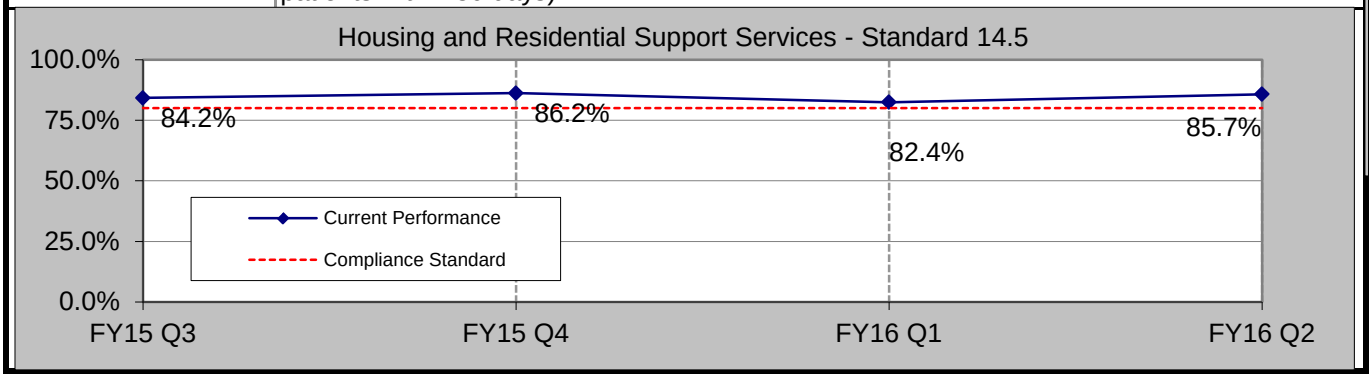


Community Resources and Treatment Services
Housing and Residential

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	67.9% FY16 Q2 (Lack of housing alternatives did not impede discharge for 19 out of 28 patients within 7 days)

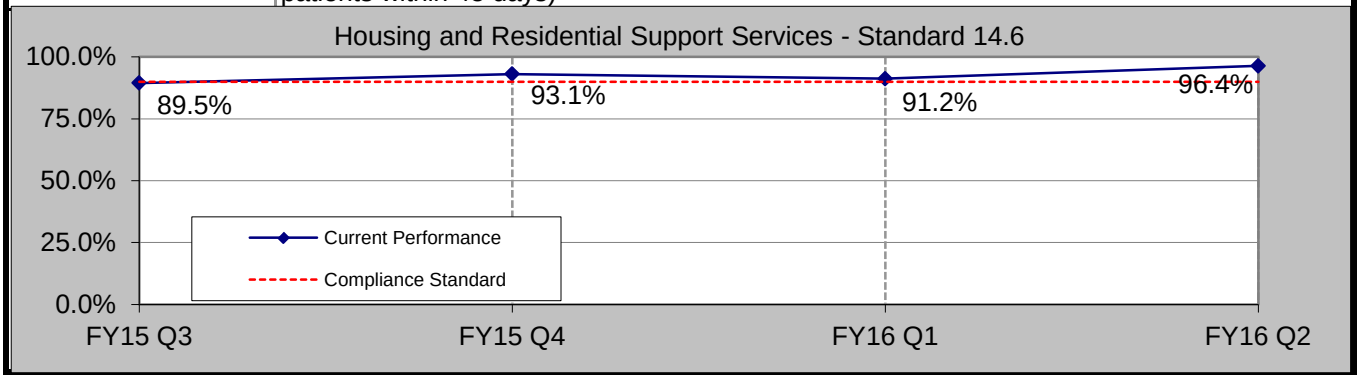


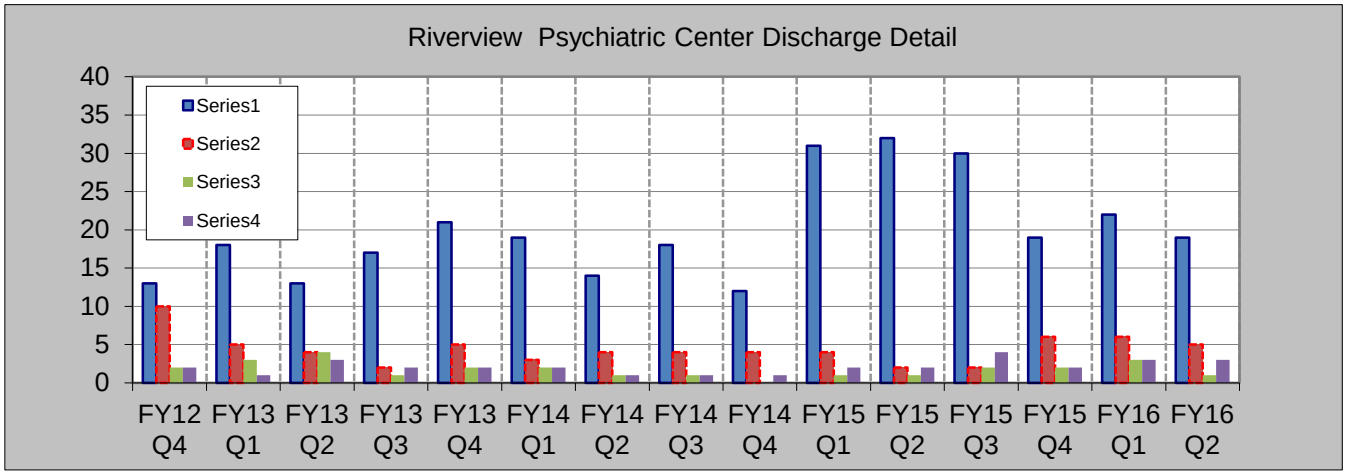
Standard 14.5	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	85.7% FY16 Q2(Lack of housing alternatives did not impede discharge for 24 out of 287 patients within 30 days)



Community Resources and Treatment Services
Housing and Residential

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	96.4% FY16 Q2 (Lack of housing alternatives did not impede discharge for 27 out of 28 patients within 45 days)





28 Civil Patients discharged in quarter

19 discharged at 7 days (67.9%)
5 discharged 8-30 days (17.9%)
1 discharged 31-45 days (3.6%)
3 discharged post 45 days (10.7%)

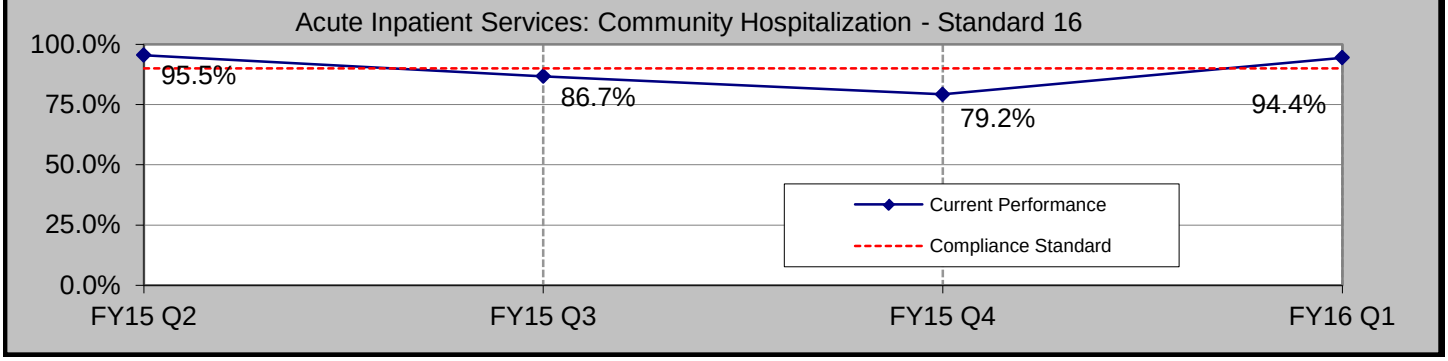
Housing Alternatives impeded discharge for 9 patients (32.1%)

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

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

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

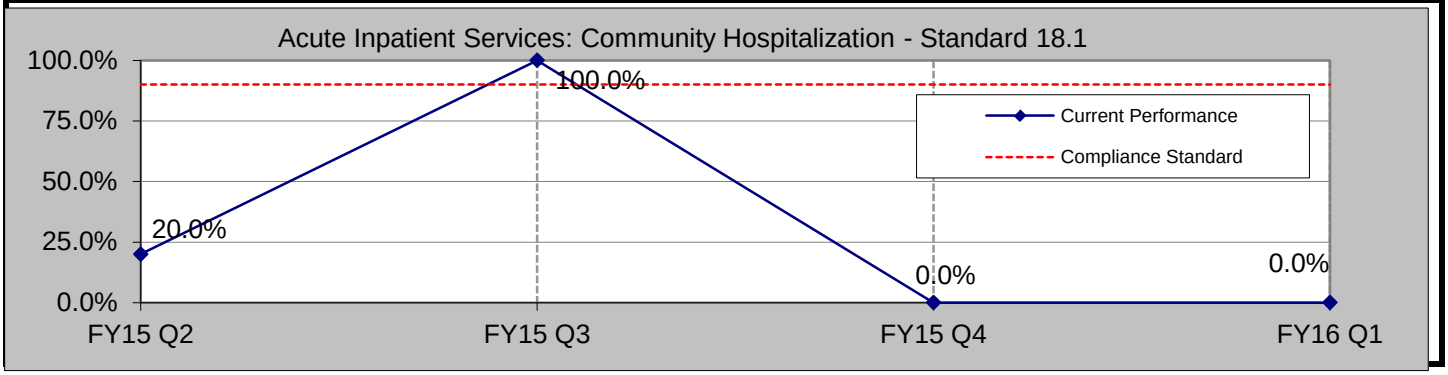
Standard 16	
Measurement	Class Member admissions determined to be reasonably near an individual's local community of residence.
Standard	Compliance: 90% (3 out of 4 quarters)
and Quality Improveme	UR Database/EIS
Current Level	94.4% (17 out of 18)



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

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

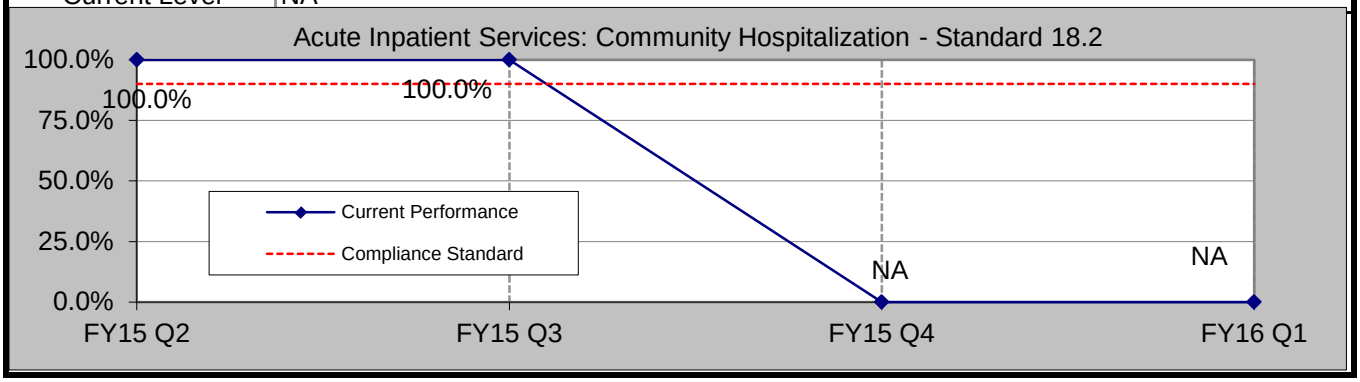
Standard 18.1	
Measurement	Class members admitted with ISPs for whom hospital obtained ISP.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	0.0% (0 out of 6)



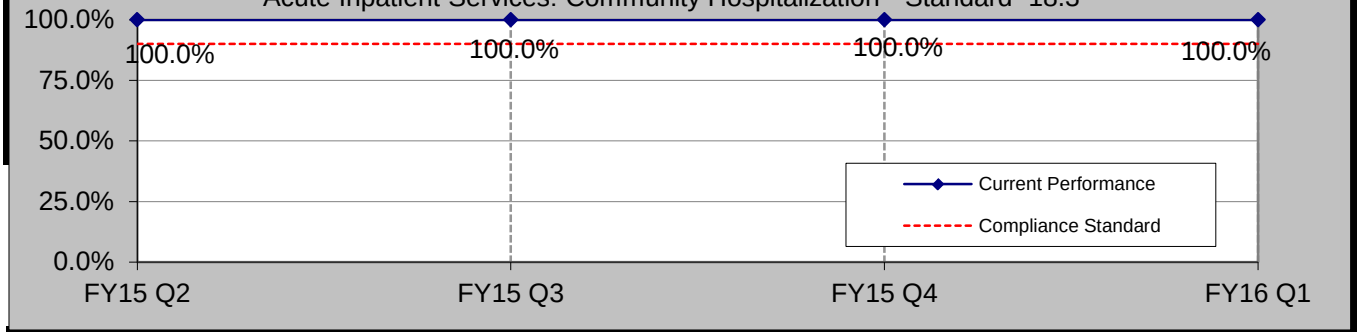
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

Standard 18.2	
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	NA



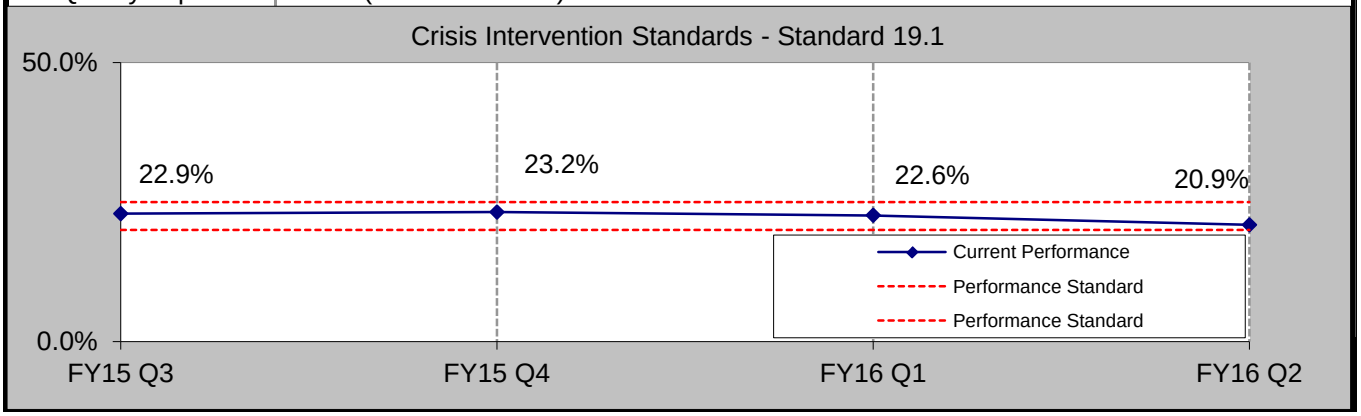
Standard 18.3	
Measurement	CI/ICI/ICM/ACT worker participated in hospital treatment and discharge planning.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (6 out of 6)



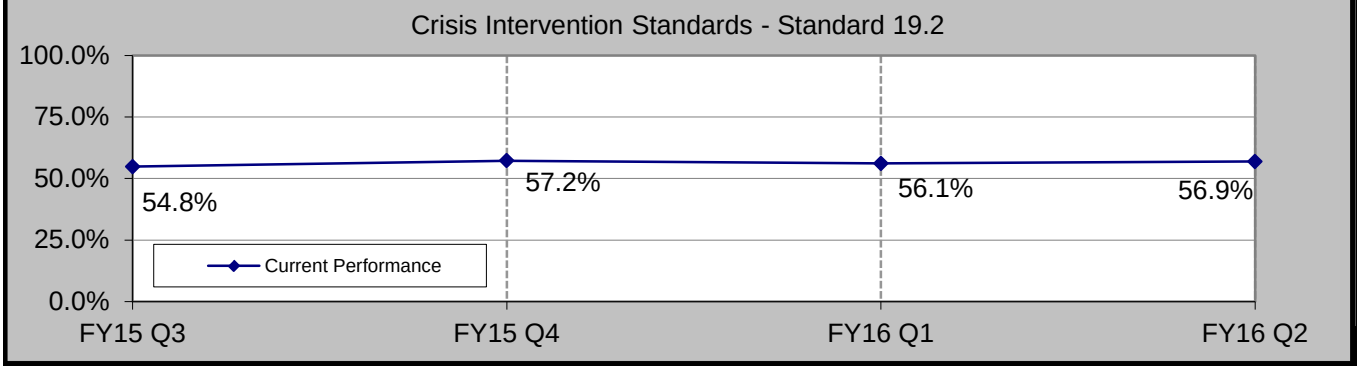
Community Resources and Treatment Services
Crisis Intervention Services

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
and Quality Improveme	20.9% (784 out of 3750)

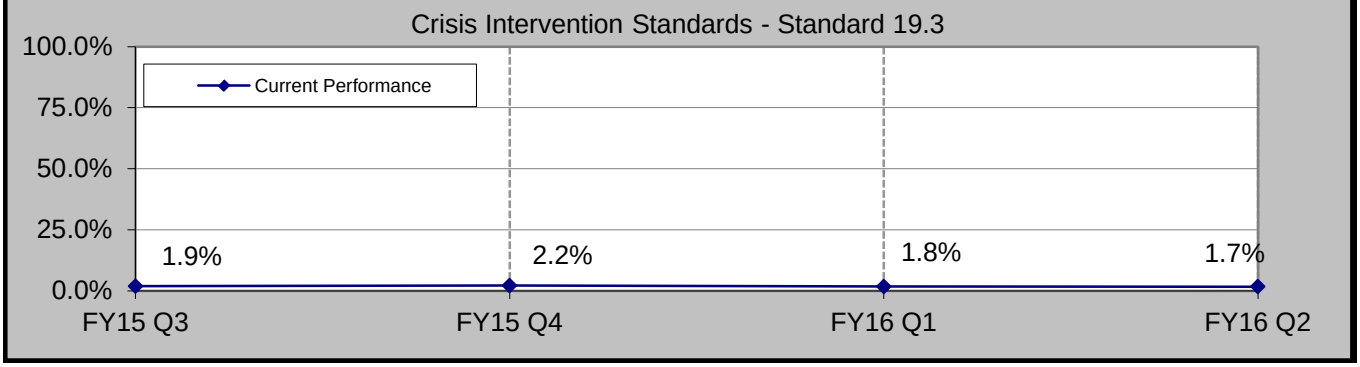


Standard 19.2	
Measurement	Face to face crisis contacts that result in follow-up and/or referral to community based services.
Standard	To Be Established
Data Source	Quarterly Crisis Contract Performance Data
	56.9 % (2135 out of 3750)

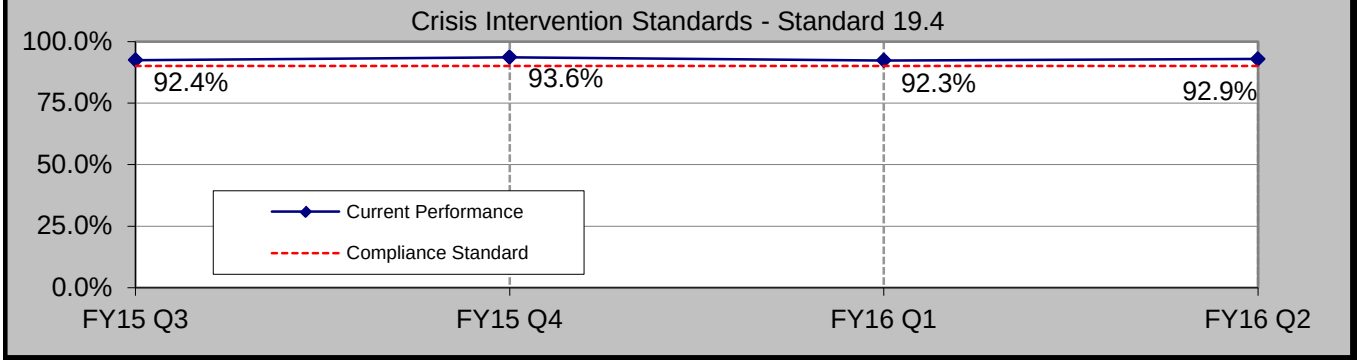


Community Resources and Treatment Services
Crisis Intervention Services

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	1.7% (63 out of 3750)



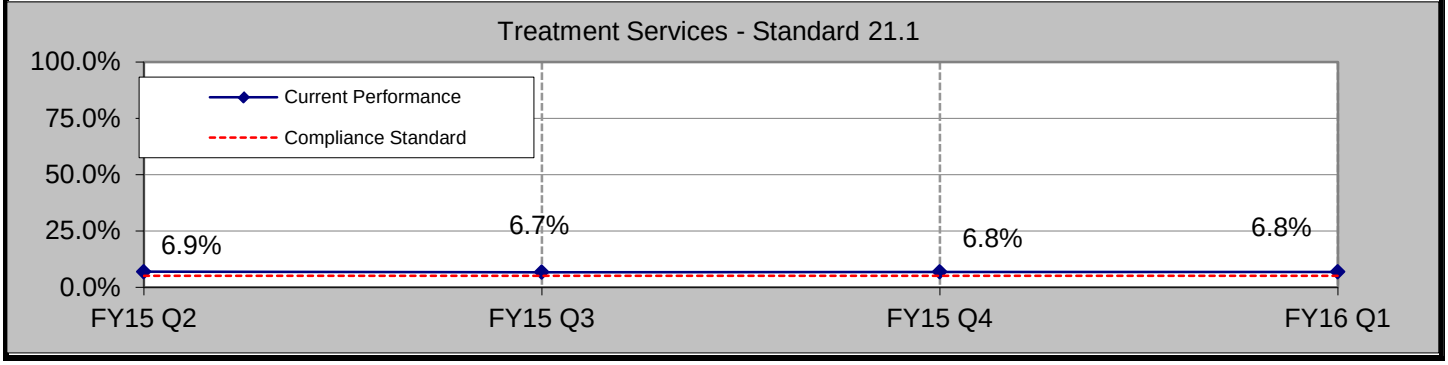
Standard 19.4	
Measurement	Face to face crisis contacts in which client has a CI worker and worker was notified about the crisis.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	Quarterly Crisis Contract Performance Data
Current Level	92.9% (887 out of 955)



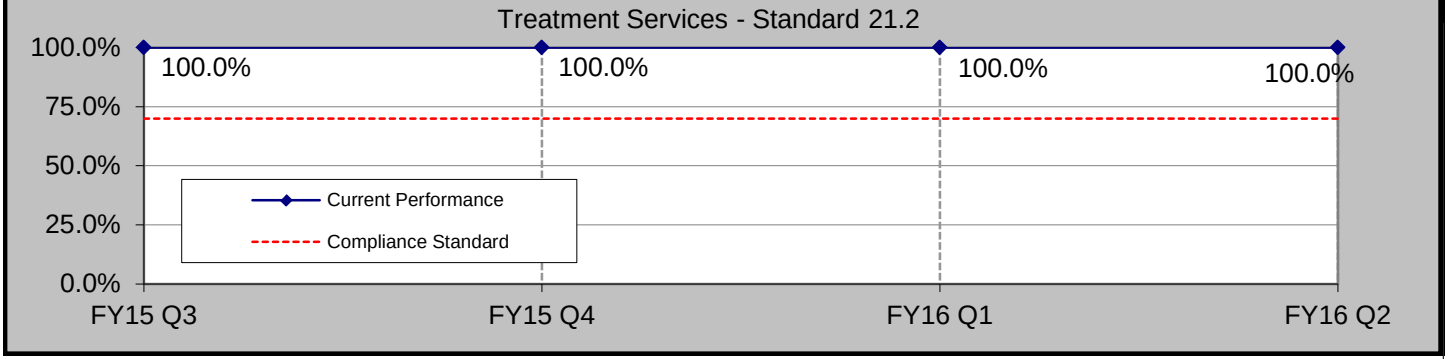
Community Resources and Treatment Services
Treatment Services

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)
and Quality Improveme	ISP RDS Data
Current Level	6.8% (74 out of 1091)

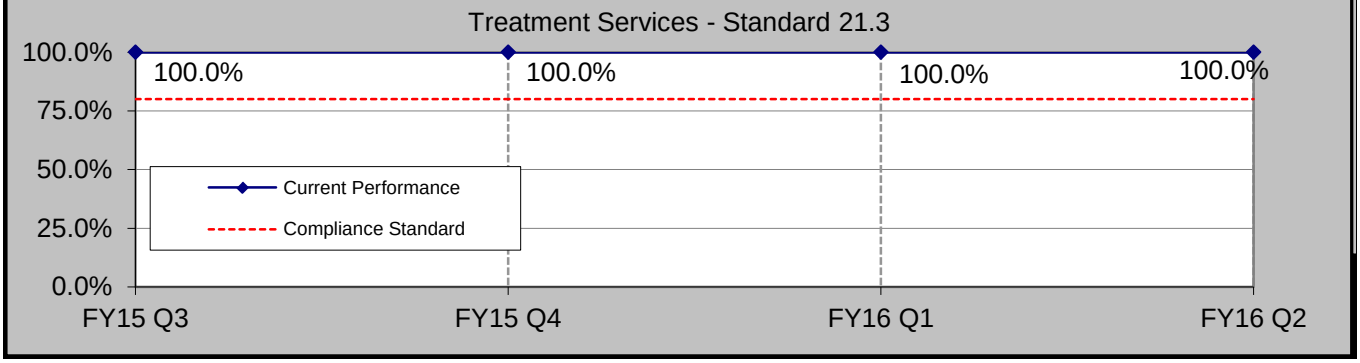


Standard 21.2	
measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination
Standard	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY16 Q2 (Lack of mental health treatment did not impede discharge for any patients within 7 days)

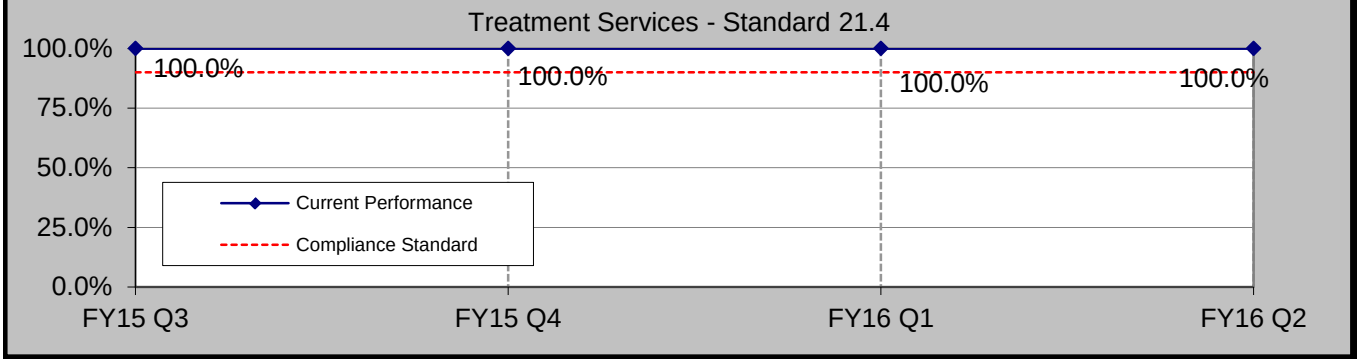


Community Resources and Treatment Services
Treatment Services

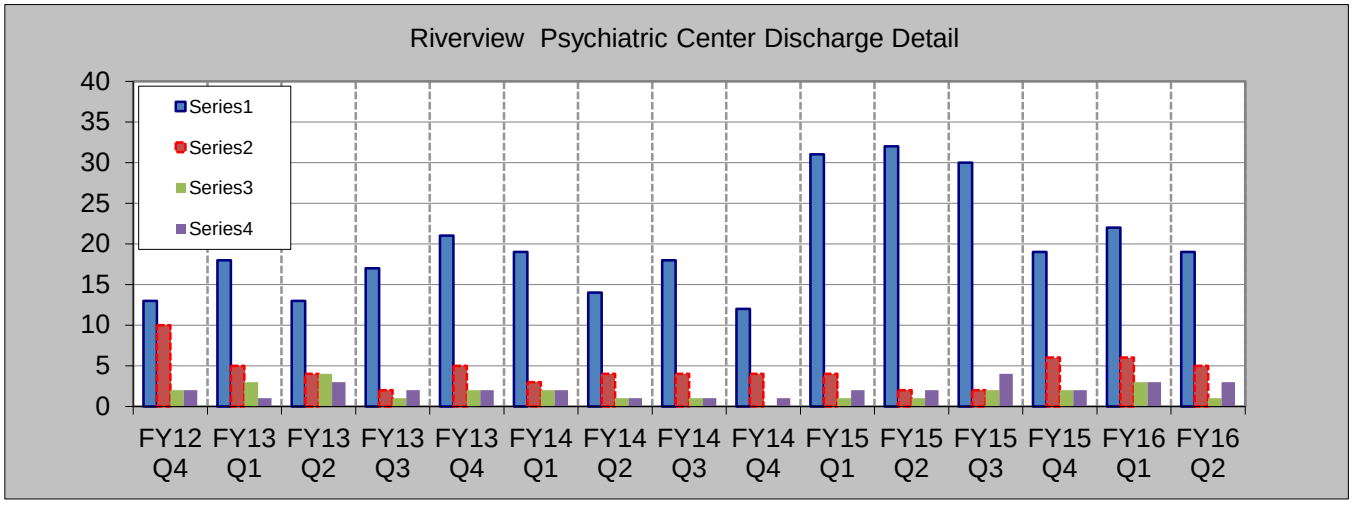
Standard 21.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination
Standard	Performance: 96% (within 30 days of that determination) Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY16 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% FY16 Q2 (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

28 Civil Patients discharged in quarter

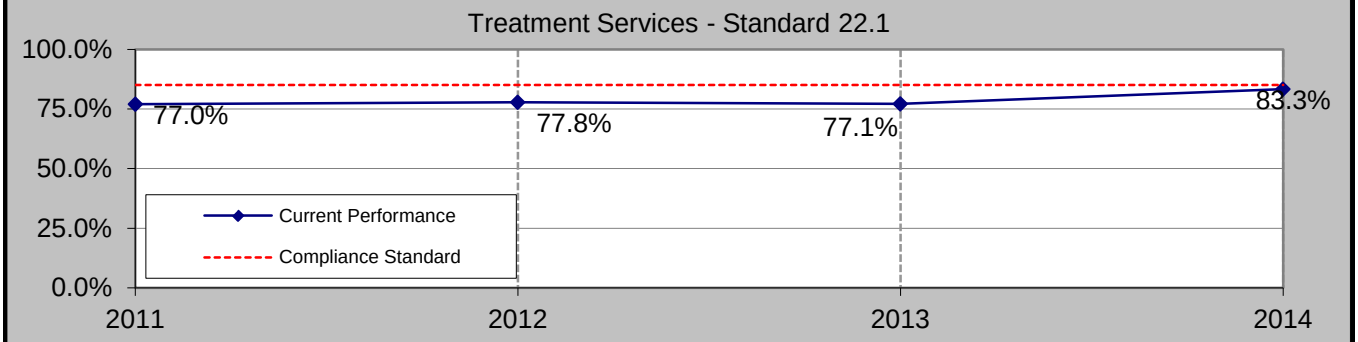
19 discharged at 7 days (67.9%)
5 discharged 8-30 days (17.9%)
1 discharged 31-45 days (3.6%)
3 discharged post 45 days (10.7%)

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

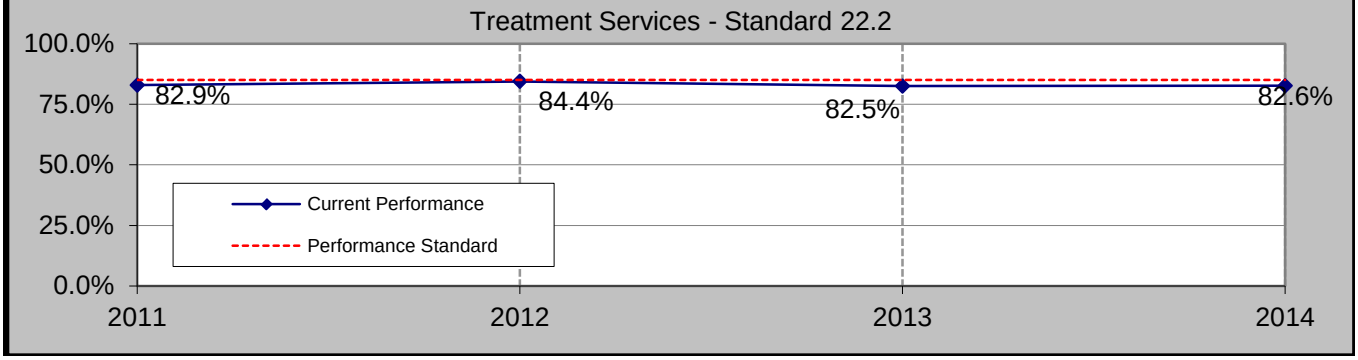
Community Resources and Treatment Services
Treatment Services

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	83.3%



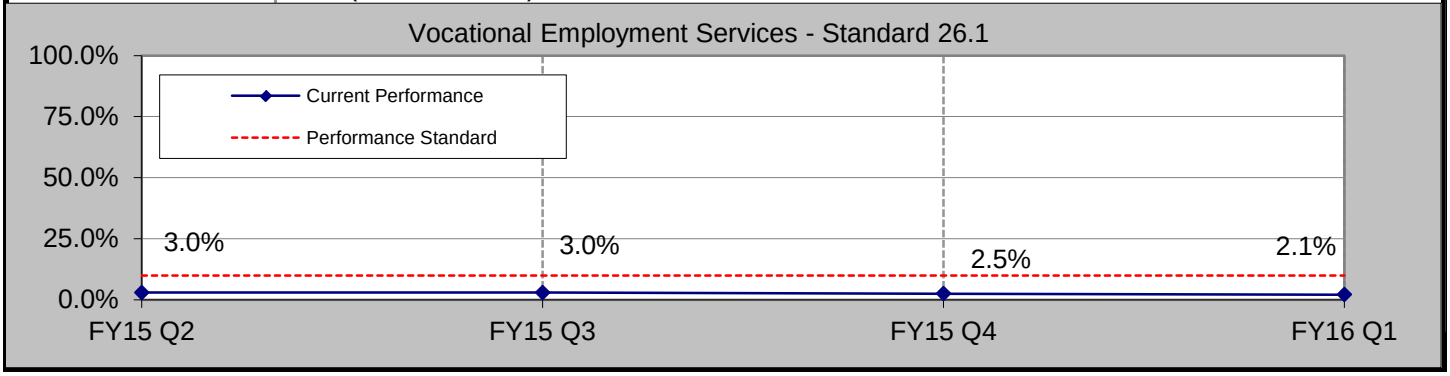
Standard 22.2	
Measurement	Domain average of positive responses in the General Satisfaction domain
Standard	Performance: at or above 85%
Data Source	Adult Mental Health and Well Being Survey
Current Level	82.6%



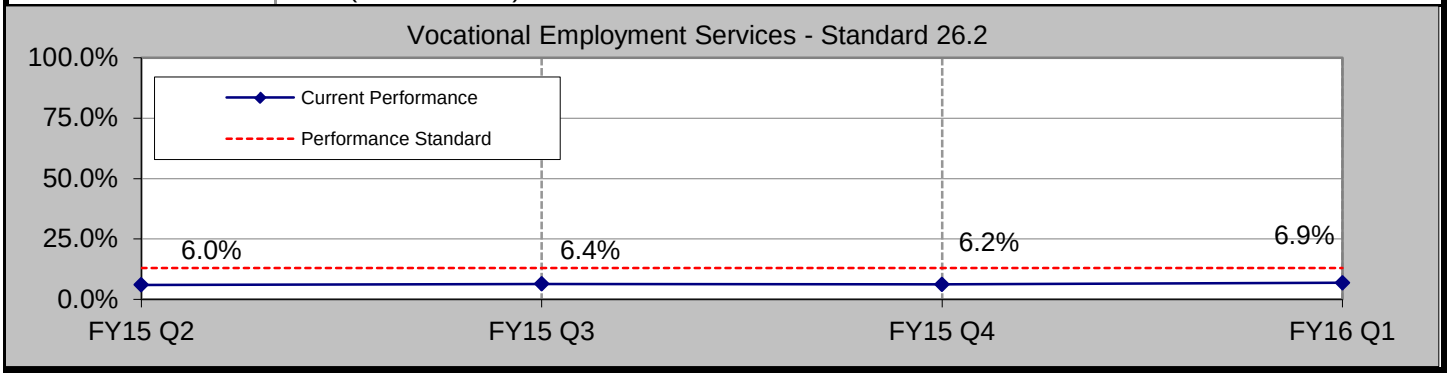
Community Resources and Treatment Services
Vocational Employment Services

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
and Quality Improveme	ISP RDS Data
Current Level	2.1% (21 out of 1091)

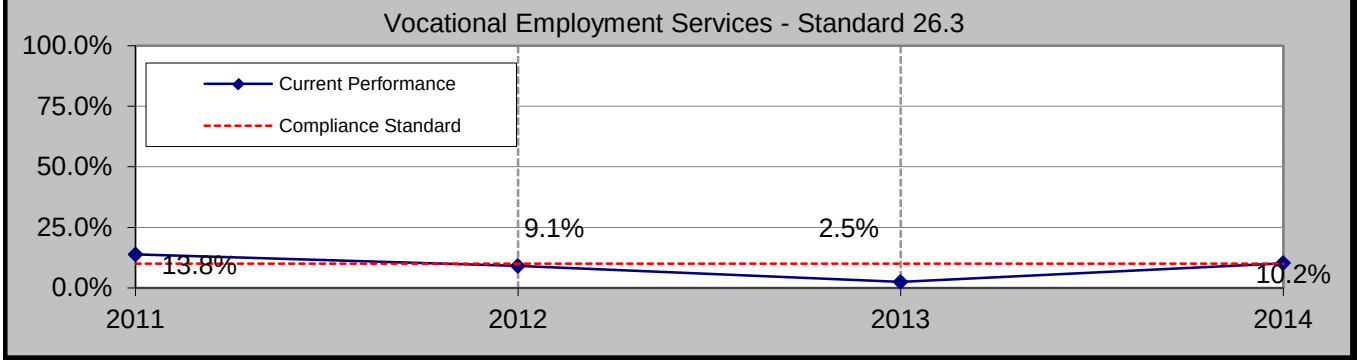


Standard 26.2	
Measurement	
Standard	Performance: 15% of class members employed in competitive employment.
	ISP RDS Data
Current Level	6.9% (62 out of 902)



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	10.2% (110 out of 1080)



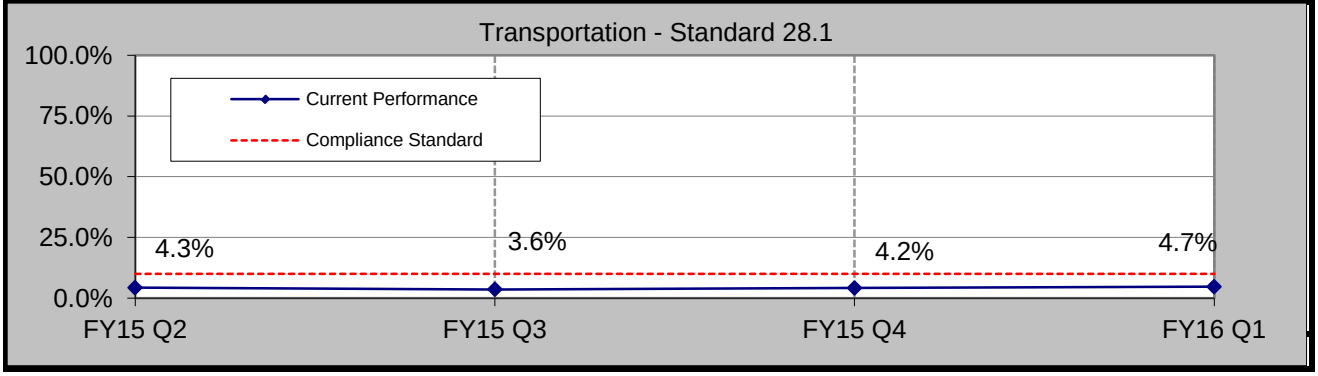
Discussion:

This standard factored out those persons responding to the Adult Mental Health and Well Being Survey employment questions who are 62 and older.

Community Resources and Treatment Services
Transportation

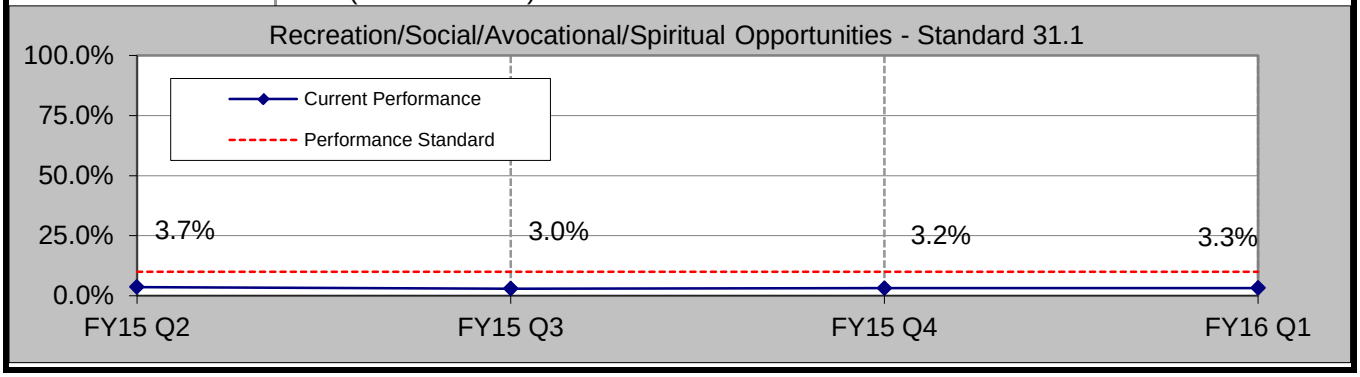
Standard 28 - Reasonable efforts to identify and resolve transportation problems that may limit access to services

Standard 28.1	
Measurement	Percentage of class members with ISP identified unmet transportation needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
and Quality Improveme	ISP RDS Data
Current Level	4.7% (51 out of 1091)

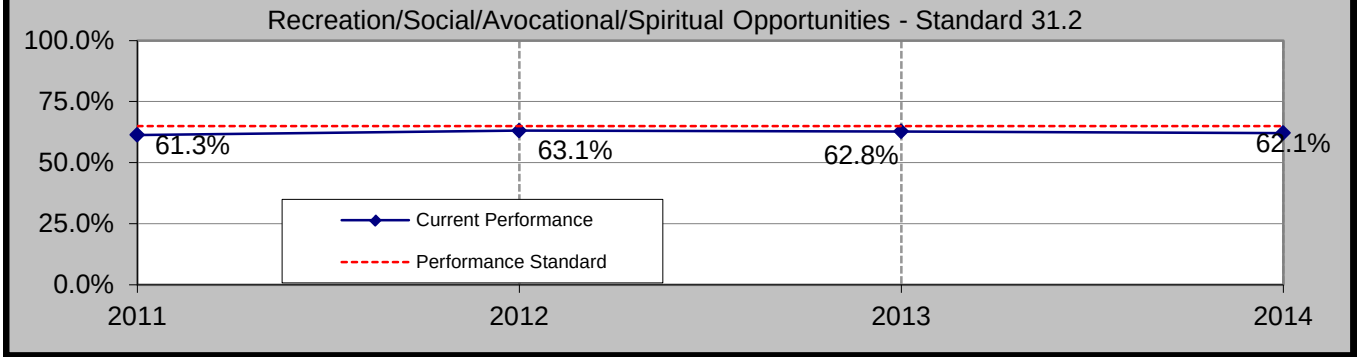


Standard 31 - Class member involvement in personal growth activities and community life.

Standard 31.1	
Measurement	ISP identified class member unmet needs in recreational, social, avocational and spiritual areas.
Standard	Performance: 10% or fewer
Data Source	ISP RDS Data
Current Level	3.3% (36 out of 1091)



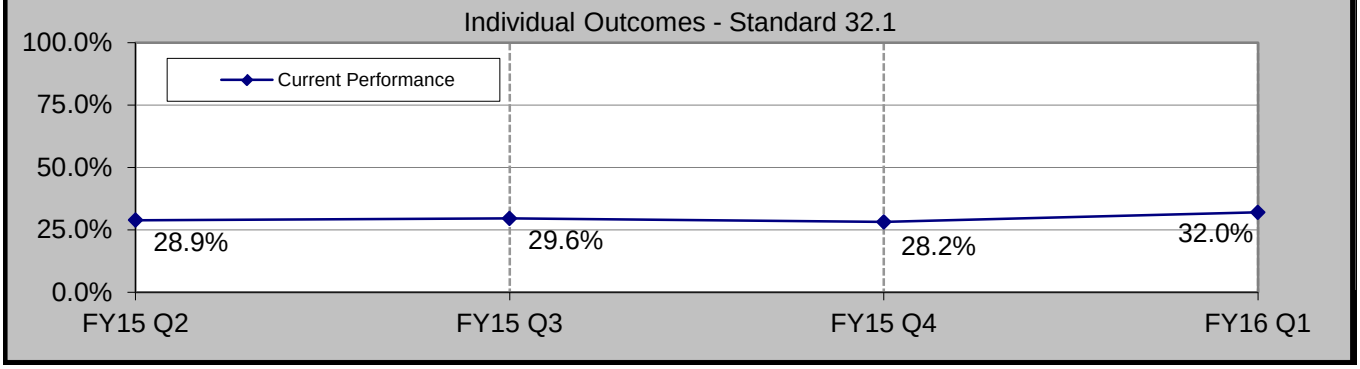
Standard 31.2	
Measurement	Domain average of positive responses in the Social Connectedness domain
Standard	Performance: At or above 65%
Data Source	
Current Level	62.1% (716 out of 1153)



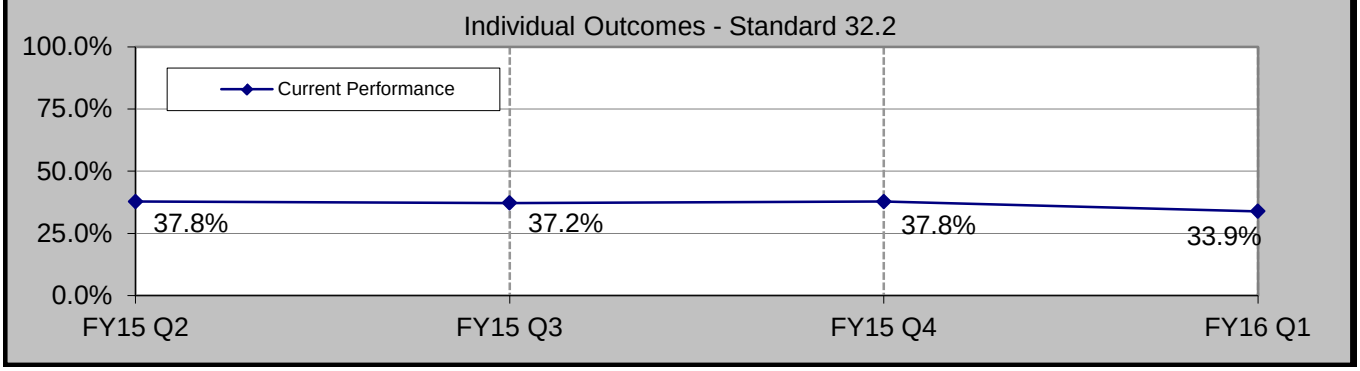
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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.
and Quality Improveme	Enrollment data (Based on overall composite score.)
Current Level	32.0% (456 out of 1426)

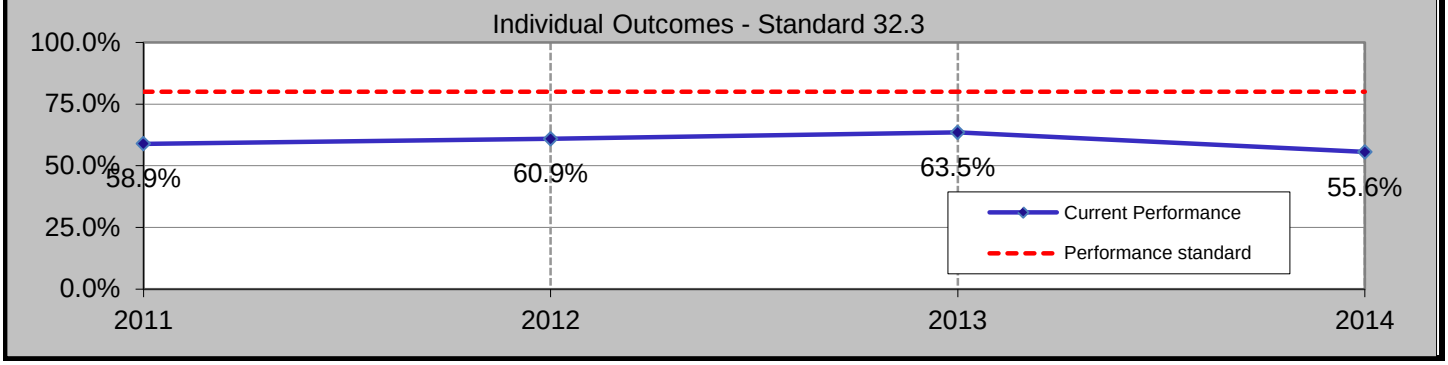


Standard 32.2	
Measurement	How the standard is being measured .
Standard	
	Enrollment data (Based on overall composite score.)
Current Level	33.9% (483 out of 1426)



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

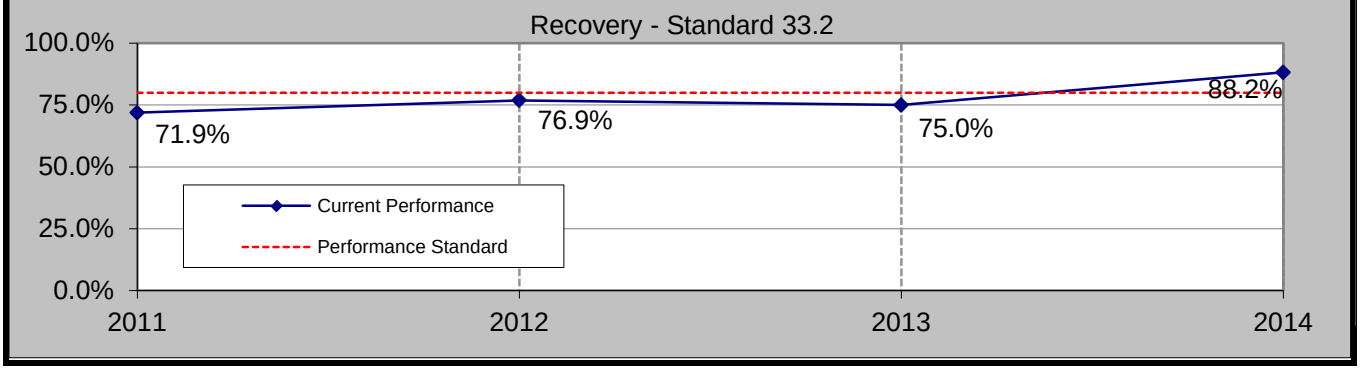
Standard 32.3	
Measurement	Consumers reporting positively on functional outcomes on Adult Mental Health and Well Being Survey outcome items.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	55.6%



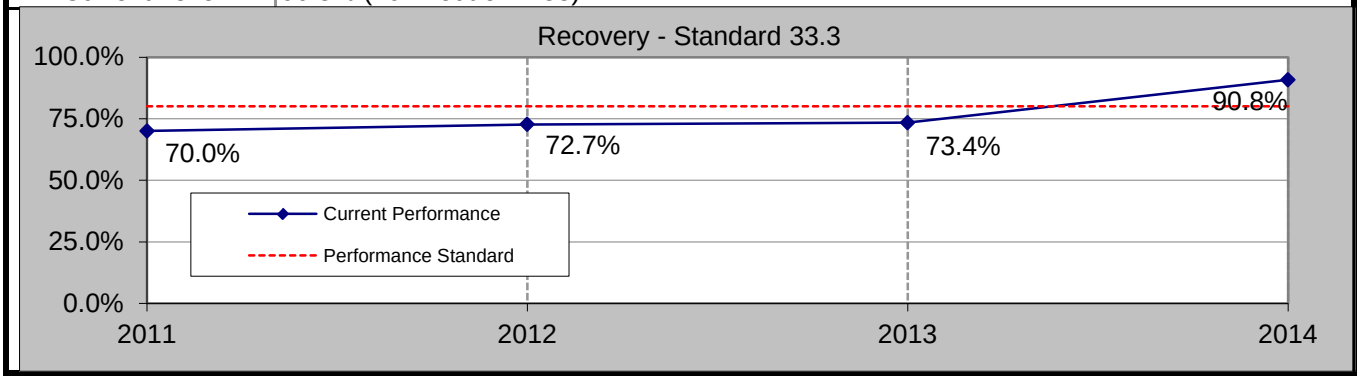
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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

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



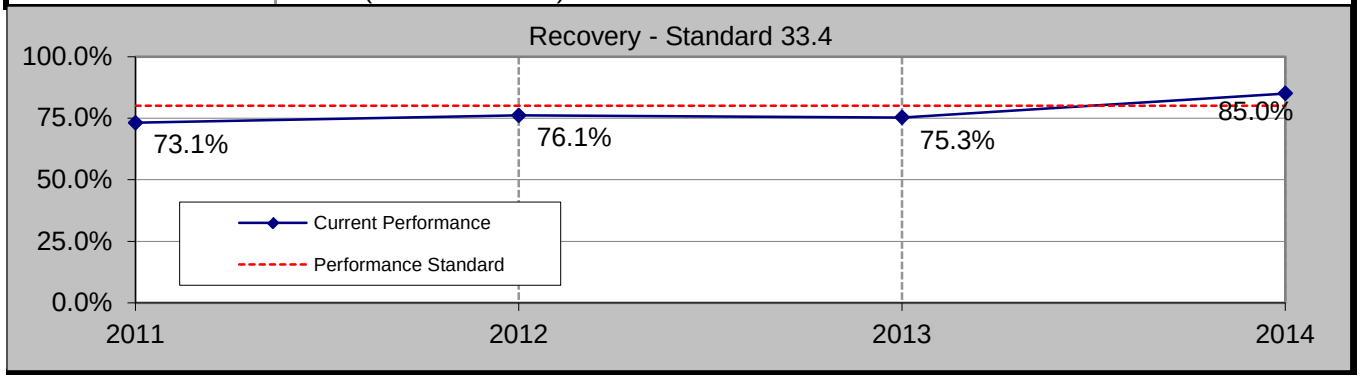
Standard 33.3	
Measurement	Consumers reporting that agency services and staff supported their recovery and wellness efforts and beliefs.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey Q15
Current Level	90.8% (1047 out of 1153)



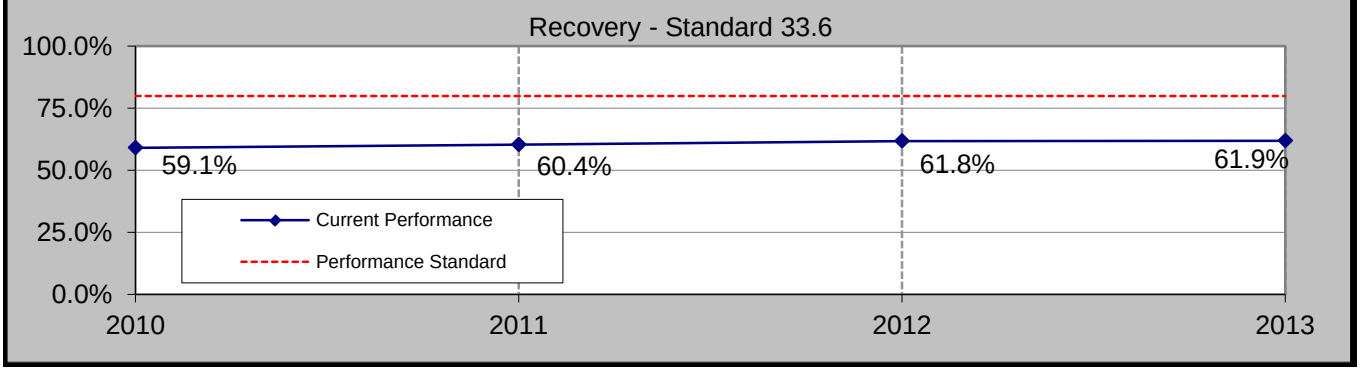
System Outcomes: Supporting the Recovery of Adults with Mental Illness

Recovery

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	85.0% (980 out of 1153)



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	50.7% (584 out of 1153)



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

Consent Decree Performance and Quality Improvement Standard 5

Report for: 2016 Q1
(July, August, September 2015)
(Class Members)

Measurement			
Method 1	Percent of class members requesting a worker who were assigned one.		
	2015 Q2	100.0%	(158 of 158)
	2015 Q3	100.0%	(189 of 189)
	2015 Q4	100.0%	(209 of 209)
	2016 Q1	100.0%	(159 of 159)
Method 2	Percent of hospitalized class members who were assigned a worker within 2 days.		
	2015 Q2	64.0%	(16 of 25)
	2015 Q3	62.5%	(15 of 24)
	2015 Q4	52.0%	(13 of 25)
	2016 Q1	50.0%	(8 of 16)
Method 3	Percent of non-hospitalized class members assigned a worker within 3 days.		
	2015 Q2	81.4%	(105 of 129)
	2015 Q3	78.9%	(105 of 133)
	2015 Q4	80.0%	(132 of 165)
	2016 Q1	80.4%	(115 of 143)
Method 4	Percent of class members in hospital or community not assigned on time but were assigned within 1-7 additional days.		
	2015 Q2	43.3%	(13 of 30)
	2015 Q3	48.6%	(18 of 37)
	2015 Q4	45.2%	(19 of 42)
	2016 Q1	25.0%	(9 of 36)
Method 5	ISP completed within 30 days of service request.		
	2015 Q2	81.8%	(45 of 55)
	2015 Q3	83.7%	(41 of 49)
	2015 Q4	81.5%	(44 of 54)
	2016 Q1	92.5%	(49 of 53)
Method 6	90 Day ISP review completed within specified timeframe.		
	2015 Q2	62.4%	(663 of 1,062)
	2015 Q3	62.7%	(671 of 1,070)
	2015 Q4	67.5%	(692 of 1,025)
	2016 Q1	61.1%	(596 of 976)

Method 7	Initial ISPs not developed within 30 days, but were developed within 60 days.		
	2015 Q2	30.0%	(3 of 10)
	2015 Q3	37.5%	(3 of 8)
	2015 Q4	30.0%	(3 of 10)
	2016 Q1	50.0%	(2 of 4)

Method 8	ISPs that were not reviewed within 90 days, but were reviewed within 120 days.		
	2015 Q2	65.4%	(261 of 399)
	2015 Q3	70.4%	(281 of 399)
	2015 Q4	88.0%	(293 of 333)
	2016 Q1	65.3%	(248 of 380)

As of: Jan 11, 2016 Run By:
Brandi.Giguere
Starting with Fiscal Year 2009, Quarter 1 (July, August, September 2008) all calculations are based on 'working days' to time of assignment. The first three quarters were re-calculated using this new formula.

Performance Indicators and Quality Improvement Standards

APPENDIX: ADULT MENTAL HEALTH DATA SOURCES

Adult Health and Well- Survey:

Data Type/Method: Handout Survey
Target Population: All people who receive a Community Integration or Behavioral Health Home Service, ACT and Community Rehabilitation Services.
Approximate Sample Size Responses: 1400

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

The survey was administered in late August. 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. Additional questions were added regarding employment.

Community Hospital Utilization Review Summary:

Data Type/Method: Service Review/Document Review
Target Population: Individuals admitted to community inpatient psychiatric hospitals on an emergency involuntary basis.
Approximate Sample Size: 105 per quarter.

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 Behavioral Health Homes) maintained and reported from the Department's EIS (Enterprise Information System). Data is collected by APS Healthcare as part of its prior authorization process and fed into EIS twice a month.
Target Population: Adult Mental Health Consumers receiving Community Support approximately 18,900 with approximately 1200 are class members..

Community Support Services Census/Staffing Data:

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

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

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

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

Grievance Tracking Data:

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

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

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

Class Member Treatment Planning Review:

Data Type/Method: Service Review/Document Review

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

Approximate Sample Size: 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.

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

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

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

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

The data is collected in APS Healthcare, sent to SAMHS and reported through the DHHS Enterprise Information System (EIS). The ISP RDS captures ISP completion dates. The ISP RDS also captures data on the current housing/living situation of the person receiving services as well as the current vocational/employment statuses. Needed resources are tracked and include the following categories; Mental Health Services, Peer, Recovery and Support Services, Substance Abuse Services, Housing

Resources, Health Care Resources, Legal Resources, Financial Resources, Educational Resources, Vocational Resources, Living Skills Resources, Transportation Resources, Personal Growth Resources and Other. The ISP RDS calculates unmet needs data by comparing current 90 day reviews to previous 90 days reviews. See Section 6 for other changes to the RDS.

Quarterly Contract Performance Measures Data:

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

Performance measures are in 27 mental health direct services contracts. There are also some performance measures in the indirect services contracts.

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

Attached Report:

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

Population Covered:

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

Data Sources:

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

Unmet Resource Need Definition

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

Quality Improvement Measures

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

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

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

Ongoing Quality Improvement Initiatives

SAMHS Website – Redesign. 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. The redesign will assist the public in accessing information regarding unmet needs. All aspects of the new site should be rolled-out in December 2016.
Identified Need: A, B, C, D, E, F, G, H, I, J, K, L,M

Contract Performance Measures. SAMHS has instituted contract performance measures for twenty seven direct services which include but are not limited to Community Integration, ACT, Community Rehabilitation Services, Behavioral Health Homes, Daily Living Support Services, Skills Development, Medication Management, Residential Treatment and Gero-Psych Nursing Homes. Where appropriate, the measures are in alignment with standards under the Consent Decree Plan. All direct services contracts have measure in FY16. SAMHS will be reviewing all measures before implementing FY17 contracts.
Identified Need: A, B, C, D, E, J, K, L.

Contract Review Initiative. The Data/Quality Management staff worked 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. SAMHS has built an easy query tool to help office staff identify service utilization patterns across three sources of funding. Also, a tool was built to assist providers in sending their data to SAMHS. This entire project has been completed, but Data/Quality Management staff will continue to monitor to assure providers' data is being sent successfully.
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 worked together to conduct reviews at contracted agencies. Muskie staff collected the data, produced a summary report and made recommendations with plans to implement those recommendations. Discussions continue regarding the recommendations.
Identified Need: B

Mental Health Rehabilitation Technician- SAMHS, Muskie School, providers and consumers have formed a group to redesign the certification of the Mental Health Rehabilitation Technician/Community. The group has worked over the last several months to come up with ways to redesign the certification. The new requirements will be gradually implemented in order for the schools to change their curriculum. This initiative continues to move forward but hasn't been formalized.
Identified Need: A, B, C, D, E, F, G, H, I, J, K, L, M

Consent Decree Process Improvement Quality Improvement Initiative
A manager has been hired to oversee the Consent Decree to perform an analysis on the Waitlist system.
Currently agencies are getting their Waitlists directly from APS Healthcare. The agencies are to respond to the Field Service Managers and Field Service Specialist regarding each consumer and their status regarding wait time, continuing on the waitlist, in service, discharged, rescheduling appointments or other explanation. The Waitlist has decreased by % f
Identified Need: A, B

SAMHS Quality Management Plan 2015-2020- The **DRAFT** Quality Management Plan has been completed. The Plan has been given to Disability Rights Maine, the Attorney General's office and the Court Master for review. The Plan has been disseminated to all of SAMHS staff for updates and corrections. The Plan is now under review and will have significant changes in the near future due to reassignment of staff to other DHHS offices.
Identified Need: A,B,C,D,E,F,G,H,I,J,K,L,M

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

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

Resource Data Summary- A combined project with SAMHS, APS Healthcare and providers to assess what would be helpful for providers in entering and discharging unmet needs in APS Healthcare. SAMHS and APS have worked out a system to delete the reporting of an unmet need of those who have received the service but were not closed by the agency. This will provide SAMHS with a true picture of unmet needs for those that receive services that are entered into APS Healthcare. Other initiatives are planned to ensure accuracy of the RDS.
A, B, C, D, E, F, G, H, I, J, K, L, M

Section 17- There are currently proposed changes to Section 17. There has been an opportunity for the public to comment to the proposed rules. At this time the changes are not final. This is Phase I of proposed changes. There will be Phase II and possibly Phase III changes to Section 17.
A, C

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

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http://www.maine.gov/dhhs/mh/index.shtml

Statewide Report of Unmet Resource Needs for Fiscal Year 2016 Quarter 1

July, August, September, 2015

Purpose of Report:

This report examines:

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

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

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

Data collection and reporting:

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

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

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

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

Statewide Report of Unmet Resource Needs for Fiscal Year 2016 Quarter 1

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

CSN		Distinct People
CSN 1	Aroostook	420
CSN 2	Hancock, Penobscot, Piscataquis & Washington	1,928
CSN 3	Kennebec & Somerset	2,318
CSN 4	Knox, Lincoln, Sagadahoc & Waldo	949
CSN 5	Androscoggin, Franklin & Oxford	2,113
CSN 6	Cumberland	2,010
CSN 7	York	696
Not Assigned	No legal address	384
Statewide		10,818

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

	2015 Q2			2015 Q3			2015 Q4			2016 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	151	429	35.2%	151	413	36.6%	145	396	36.6%	143	420	34.0%
CSN 2	458	1,930	23.7%	497	1,912	26.0%	449	1,801	24.9%	497	1,928	25.8%
CSN 3	408	2,291	17.8%	414	2,193	18.9%	401	2,136	18.8%	440	2,318	19.0%
CSN 4	273	948	28.8%	245	904	27.1%	252	962	26.2%	281	949	29.6%
CSN 5	648	2,119	30.6%	610	1,987	30.7%	602	2,013	29.9%	596	2,113	28.2%
CSN 6	612	2,251	27.2%	595	2,102	28.3%	580	2,021	28.7%	586	2,010	29.2%
CSN 7	329	840	39.2%	296	809	36.6%	9	802	1.1%	242	696	34.8%
N/A	137	485	28.2%	123	432	28.5%	119	421	28.3%	108	384	28.1%
Total	3,016	11,293	26.7%	2,931	10,752	27.3%	2,831	10,552	26.8%	2,893	10,818	26.7%

Report Run: Jan 5, 2016

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

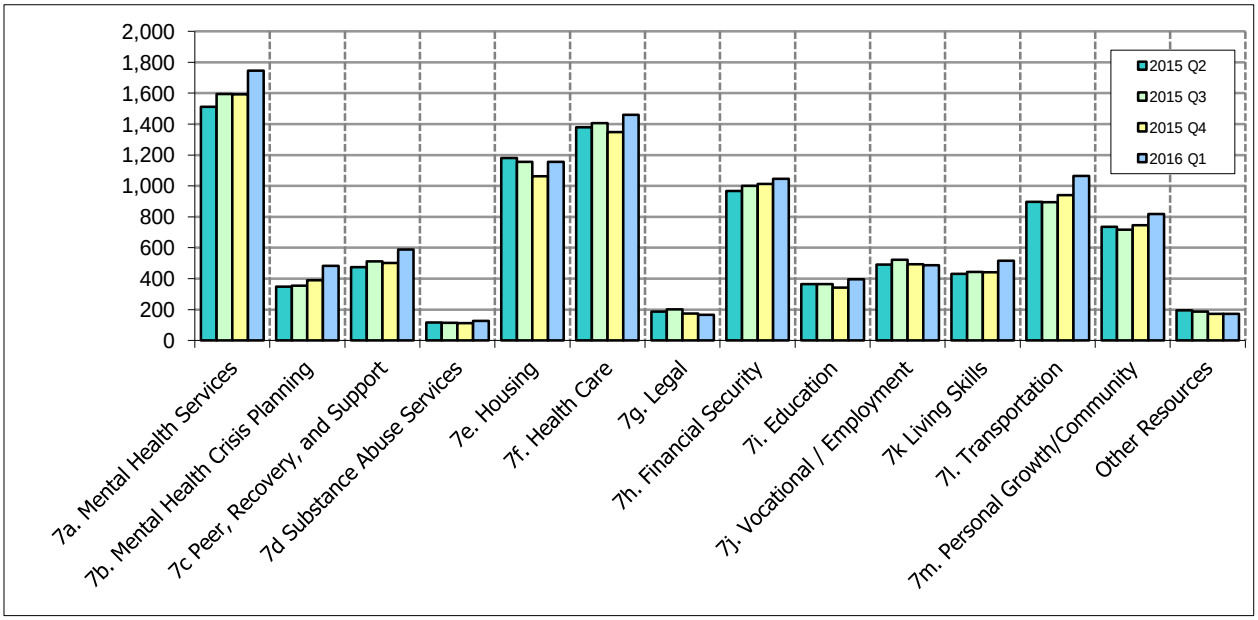

Table 3: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2015 Q2	2015 Q3	2015 Q4	2016 Q1
7a. Mental Health Services	1,511	1,594	1,592	1,746
7b. Mental Health Crisis Planning	349	355	389	483
7c Peer, Recovery, and Support	475	512	502	589
7d Substance Abuse Services	116	115	113	126
7e. Housing	1,180	1,155	1,063	1,155
7f. Health Care	1,380	1,405	1,349	1,460
7g. Legal	187	202	174	167
7h. Financial Security	968	1,001	1,013	1,046
7i. Education	365	364	343	396
7j. Vocational / Employment	492	523	493	487
7k Living Skills	431	443	441	517
7l. Transportation	896	894	940	1,065
7m. Personal Growth/Community	735	717	746	818
Other Resources	195	186	173	173
Total Statewide Unmet Needs	9,280	9,466	9,331	10,228

Report Run: Jan 5, 2016

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

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

Report of Unmet Resource Needs

Statewide
(Class Members and Non-Class Member)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	11,293	10,752	10,552	10,818
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	50	30	48	48
7a-iii Dialectical Behavioral Therapy	79	80	89	82
7a-iv Family Psycho-Educational Treatment	15	20	23	31
7a-v Group Counseling	64	77	71	76
7a-vi Individual Counseling	628	679	659	770
7a-vii Inpatient Psychiatric Facility	5	5	7	8
7a-viii Intensive Case Management	62	66	88	98
7a-x Psychiatric Medication Management	608	637	607	633
Total Unmet Resource Needs	1,511	1,594	1,592	1,746
Distinct Clients with Unmet Resource Needs	1,163	1,181	1,165	1,272
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	276	272	311	403
7b-ii Mental Health Advance Directives	73	83	78	80
Total Unmet Resource Needs	349	355	389	483
Distinct Clients with Unmet Resource Needs	317	315	358	451
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	58	57	63	65
7c-ii Recovery Workbook Group	5	7	5	6
7c-iii Social Club	184	193	183	191
7c-iv Peer-Run Trauma Recovery Group	34	41	47	55
7c-v Wellness Recovery and Action Planning	38	51	46	55
7c-vi Family Support	156	163	158	217
Total Unmet Resource Needs	475	512	502	589
Distinct Clients with Unmet Resource Needs	375	404	388	446
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	103	96	95	107
7d-ii Residential Treatment Substance Abuse Services	13	19	18	19
Total Unmet Resource Needs	116	115	113	126
Distinct Clients with Unmet Resource Needs	114	110	108	120

Report Run: Jan 5, 2016

Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

Statewide
(Class Members and Non-Class Member)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	11,293	10,752	10,552	10,818
7e. Housing				
7e-i Supported Apartment	142	131	114	120
7e-ii Community Residential Facility	43	42	34	39
7e-iii Residential Treatment Facility (group home)	31	22	19	23
7e-iv Assisted Living Facility	60	48	47	49
7e-v Nursing Home	4	3	4	3
7e-vi Residential Crisis Unit	4	2	0	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	896	907	845	920
Total Unmet Resource Needs	1,180	1,155	1,063	1,155
Distinct Clients with Unmet Resource Needs	1,076	1,059	992	1,061
7f. Health Care				
7f-i Dental Services	685	688	646	648
7f-ii Eye Care Services	256	280	245	278
7f-iii Hearing Services	42	36	47	65
7f-iv Physical Therapy	48	52	54	63
7f-v Physician/Medical Services	349	349	357	406
Total Unmet Resource Needs	1,380	1,405	1,349	1,460
Distinct Clients with Unmet Resource Needs	1,036	1,022	980	1,015
7g. Legal				
7g-i Advocate	128	146	135	135
7g-ii Guardian (private)	43	37	25	22
7g-iii Guardian (public)	16	19	14	10
Total Unmet Resource Needs	187	202	174	167
Distinct Clients with Unmet Resource Needs	172	189	165	161
7h. Financial Security				
7h-i Assistance with Managing Money	581	591	616	628
7h-ii Assistance with Securing Public Benefits	344	356	345	362
7h-iii Representative Payee	43	54	52	56
Total Unmet Resource Needs	968	1,001	1,013	1,046
Distinct Clients with Unmet Resource Needs	846	857	848	873

Report Run: Jan 5, 2016

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

Report of Unmet Resource Needs

Statewide
(Class Members and Non-Class Member)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	11,293	10,752	10,552	10,818
7i. Education				
7i-i Adult Education (other than GED)	96	99	103	134
7i-ii GED	92	83	77	89
7i-iii Literacy Assistance	36	40	37	47
7i-iv Post High School Education	121	124	111	107
7i-v Tuition Reimbursement	20	18	15	19
Total Unmet Resource Needs	365	364	343	396
Distinct Clients with Unmet Resource Needs	327	317	295	336
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	34	46	42	51
7j-ii Club House and/or Peer Vocational Support	42	38	36	37
7j-iii Competitive Employment (no supports)	91	97	79	74
7j-iv Supported Employment	53	66	63	65
7j-v Vocational Rehabilitation	272	276	273	260
Total Unmet Resource Needs	492	523	493	487
Distinct Clients with Unmet Resource Needs	423	449	427	410
7k. Living Skills				
7k-i Daily Living Support Services	297	300	300	339
7k-ii Day Support Services	30	32	37	46
7k-iii Occupational Therapy	12	17	15	19
7k-iv Skills Development Services	92	94	89	113
Total Unmet Resource Needs	431	443	441	517
Distinct Clients with Unmet Resource Needs	389	390	389	447
7l. Transportation				
7l-i Transportation to ISP-Identified Services	465	457	491	545
7-ii Transportation to Other ISP Activities	249	251	261	306
7-iii After Hours Transportation	182	186	188	214
Total Unmet Resource Needs	896	894	940	1,065
Distinct Clients with Unmet Resource Needs	610	606	626	678

Report Run: Jan 5, 2016

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Report of Unmet Resource Needs

Statewide
(Class Members and Non-Class Member)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	11,293	10,752	10,552	10,818
7m. Personal Growth/Community				
7m-i Avocational Activities	32	31	28	33
7m-ii Recreation Activities	195	196	200	214
7m-iii Social Activities	424	418	433	469
7m-iv Spiritual Activities	84	72	85	102
Total Unmet Resource Needs	735	717	746	818
Distinct Clients with Unmet Resource Needs	508	499	518	561
Other Resources				
Other Resources	195	186	173	173
Total Unmet Resource Needs	195	186	173	173
Distinct Clients with Unmet Resource Needs	195	186	173	173
Statewide Totals				
Total Unmet Resource Needs	9,280	9,466	9,331	10,228
Distinct Clients With any Unmet Resource Need	3,016	2,931	2,831	2,893
Distinct Clients with a RDS	11,293	10,752	10,552	10,818

Report Run: Jan 5, 2016

Statewide Report of Unmet Resource Needs for Fiscal Year 2016 Quarter 1

CSN 1 - Aroostook

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

2015 Q2			2015 Q3			2015 Q4			2016 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
151	429	35.2%	151	413	36.6%	145	396	36.6%	143	420	34.0%

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

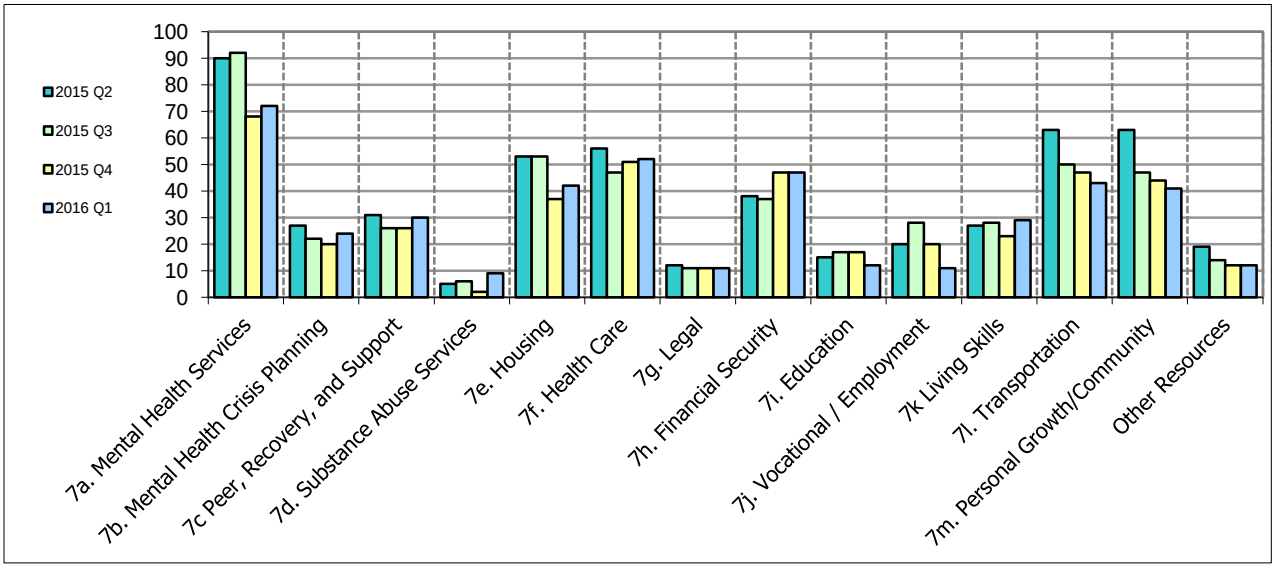

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2015 Q2	2015 Q3	2015 Q4	2016 Q1
7a. Mental Health Services	90	92	68	72
7b. Mental Health Crisis Planning	27	22	20	24
7c Peer, Recovery, and Support	31	26	26	30
7d. Substance Abuse Services	5	6	2	9
7e. Housing	53	53	37	42
7f. Health Care	56	47	51	52
7g. Legal	12	11	11	11
7h. Financial Security	38	37	47	47
7i. Education	15	17	17	12
7j. Vocational / Employment	20	28	20	11
7k Living Skills	27	28	23	29
7l. Transportation	63	50	47	43
7m. Personal Growth/Community	63	47	44	41
Other Resources	19	14	12	12
Total CSN 1 Unmet Needs	519	478	425	435

Report Run: Jan 6, 2016

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

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	429	413	396	420
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	1	3	3	2
7a-iii Dialectical Behavioral Therapy	5	5	4	6
7a-iv Family Psycho-Educational Treatment	2	2	1	2
7a-v Group Counseling	8	6	5	8
7a-vi Individual Counseling	42	36	26	29
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	4	4	3	2
7a-x Psychiatric Medication Management	28	36	26	23
Total Unmet Resource Needs	90	92	68	72
Distinct Clients with Unmet Resource Needs	68	71	57	53
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	25	21	19	23
7b-ii Mental Health Advance Directives	2	1	1	1
Total Unmet Resource Needs	27	22	20	24
Distinct Clients with Unmet Resource Needs	26	21	19	23
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	0	0	1	1
7c-ii Recovery Workbook Group	0	0	0	1
7c-iii Social Club	19	17	16	15
7c-iv Peer-Run Trauma Recovery Group	2	1	0	1
7c-v Wellness Recovery and Action Planning	2	2	1	2
7c-vi Family Support	8	6	8	10
Total Unmet Resource Needs	31	26	26	30
Distinct Clients with Unmet Resource Needs	27	24	23	25
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	5	6	2	6
7d-ii Residential Treatment Substance Abuse Services	0	0	0	3
Total Unmet Resource Needs	5	6	2	9
Distinct Clients with Unmet Resource Needs	5	6	2	6

Report Run: Jan 6, 2016

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Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	429	413	396	420
7e. Housing				
7e-i Supported Apartment	12	14	9	9
7e-ii Community Residential Facility	1	2	1	2
7e-iii Residential Treatment Facility (group home)	5	2	1	1
7e-iv Assisted Living Facility	4	3	2	4
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	1	1	0	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	30	31	24	25
Total Unmet Resource Needs	53	53	37	42
Distinct Clients with Unmet Resource Needs	44	42	33	35
7f. Health Care				
7f-i Dental Services	26	24	23	21
7f-ii Eye Care Services	13	9	9	10
7f-iii Hearing Services	0	0	1	2
7f-iv Physical Therapy	2	2	4	3
7f-v Physician/Medical Services	15	12	14	16
Total Unmet Resource Needs	56	47	51	52
Distinct Clients with Unmet Resource Needs	41	36	35	37
7g. Legal				
7g-i Advocate	10	9	10	10
7g-ii Guardian (private)	2	2	1	1
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	12	11	11	11
Distinct Clients with Unmet Resource Needs	12	11	11	11
7h. Financial Security				
7h-i Assistance with Managing Money	19	18	26	24
7h-ii Assistance with Securing Public Benefits	19	19	21	23
7h-iii Representative Payee	0	0	0	0
Total Unmet Resource Needs	38	37	47	47
Distinct Clients with Unmet Resource Needs	33	32	42	40

Report Run: Jan 6, 2016

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

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	429	413	396	420
7i. Education				
7i-i Adult Education (other than GED)	2	2	3	1
7i-ii GED	2	3	3	4
7i-iii Literacy Assistance	3	4	2	2
7i-iv Post High School Education	7	7	7	5
7i-v Tuition Reimbursement	1	1	2	0
Total Unmet Resource Needs	15	17	17	12
Distinct Clients with Unmet Resource Needs	15	15	13	12
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	3	2	2
7j-ii Club House and/or Peer Vocational Support	1	1	1	1
7j-iii Competitive Employment (no supports)	0	3	2	1
7j-iv Supported Employment	5	7	3	2
7j-v Vocational Rehabilitation	13	14	12	5
Total Unmet Resource Needs	20	28	20	11
Distinct Clients with Unmet Resource Needs	15	21	18	11
7k. Living Skills				
7k-i Daily Living Support Services	12	12	10	11
7k-ii Day Support Services	2	5	4	6
7k-iii Occupational Therapy	0	0	0	2
7k-iv Skills Development Services	13	11	9	10
Total Unmet Resource Needs	27	28	23	29
Distinct Clients with Unmet Resource Needs	24	24	21	25
7l. Transportation				
7l-i Transportation to ISP-Identified Services	29	24	24	24
7-ii Transportation to Other ISP Activities	16	11	6	6
7-iii After Hours Transportation	18	15	17	13
Total Unmet Resource Needs	63	50	47	43
Distinct Clients with Unmet Resource Needs	43	39	36	32

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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 1
(Aroostook)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	429	413	396	420
7m. Personal Growth/Community				
7m-i Avocational Activities	2	0	1	0
7m-ii Recreation Activities	15	12	9	10
7m-iii Social Activities	43	32	30	26
7m-iv Spiritual Activities	3	3	4	5
Total Unmet Resource Needs	63	47	44	41
Distinct Clients with Unmet Resource Needs	48	37	36	29
Other Resources				
Other Resources	19	14	12	12
Total Unmet Resource Needs	19	14	12	12
Distinct Clients with Unmet Resource Needs	19	14	12	12
CSN 1 Totals				
Total Unmet Resource Needs	519	478	425	435
Distinct Clients With any Unmet Resource Need	151	151	145	143
Distinct Clients with a RDS	429	413	396	420

Report Run: Jan 6, 2016

Statewide Report of Unmet Resource Needs for Fiscal Year 2016 Quarter 1

CSN 2 - Hancock, Washington, Penobscot, Piscataquis

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

2015 Q2			2015 Q3			2015 Q4			2016 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
458	1,930	23.7%	497	1,912	26.0%	449	1,801	24.9%	497	1,928	25.8%

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

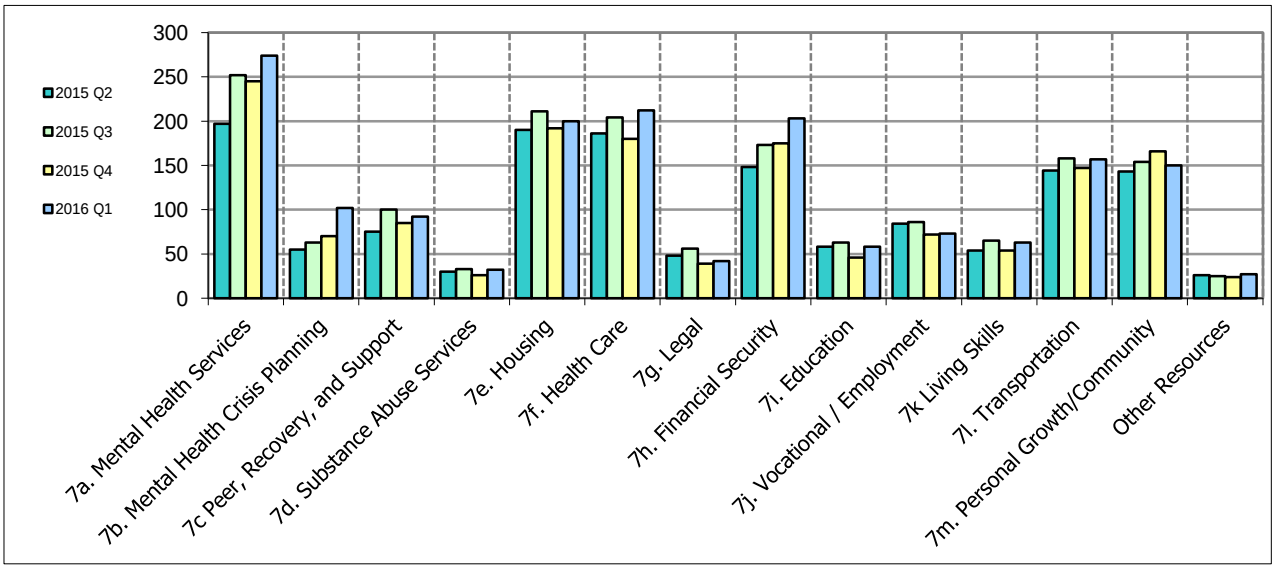

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2015 Q2	2015 Q3	2015 Q4	2016 Q1
7a. Mental Health Services	197	252	245	274
7b. Mental Health Crisis Planning	55	63	70	102
7c Peer, Recovery, and Support	75	100	85	92
7d. Substance Abuse Services	30	33	26	32
7e. Housing	190	211	192	200
7f. Health Care	186	204	180	212
7g. Legal	48	56	39	42
7h. Financial Security	148	173	175	203
7i. Education	58	63	46	58
7j. Vocational / Employment	84	86	72	73
7k Living Skills	54	65	54	63
7l. Transportation	144	158	147	157
7m. Personal Growth/Community	143	154	166	150
Other Resources	26	25	24	27
Total CSN 2 Unmet Needs	1,438	1,643	1,521	1,685

Report Run: Jan 6, 2016

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

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	1,930	1,912	1,801	1,928
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	3	2	3
7a-iii Dialectical Behavioral Therapy	1	4	5	5
7a-iv Family Psycho-Educational Treatment	1	3	2	2
7a-v Group Counseling	5	17	18	16
7a-vi Individual Counseling	96	112	117	133
7a-vii Inpatient Psychiatric Facility	2	2	2	2
7a-viii Intensive Case Management	4	7	12	19
7a-x Psychiatric Medication Management	86	104	87	94
Total Unmet Resource Needs	197	252	245	274
Distinct Clients with Unmet Resource Needs	152	186	182	206
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	42	42	55	85
7b-ii Mental Health Advance Directives	13	21	15	17
Total Unmet Resource Needs	55	63	70	102
Distinct Clients with Unmet Resource Needs	48	53	63	92
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	3	3	6	6
7c-ii Recovery Workbook Group	0	2	1	1
7c-iii Social Club	30	30	32	36
7c-iv Peer-Run Trauma Recovery Group	4	9	5	5
7c-v Wellness Recovery and Action Planning	6	20	16	15
7c-vi Family Support	32	36	25	29
Total Unmet Resource Needs	75	100	85	92
Distinct Clients with Unmet Resource Needs	59	79	69	73
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	27	26	21	28
7d-ii Residential Treatment Substance Abuse Services	3	7	5	4
Total Unmet Resource Needs	30	33	26	32
Distinct Clients with Unmet Resource Needs	29	31	23	30

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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 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	1,930	1,912	1,801	1,928
7e. Housing				
7e-i Supported Apartment	16	20	19	17
7e-ii Community Residential Facility	4	4	5	6
7e-iii Residential Treatment Facility (group home)	1	2	3	3
7e-iv Assisted Living Facility	15	14	13	11
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	1	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	153	171	152	163
Total Unmet Resource Needs	190	211	192	200
Distinct Clients with Unmet Resource Needs	179	195	178	184
7f. Health Care				
7f-i Dental Services	81	86	75	91
7f-ii Eye Care Services	44	40	36	46
7f-iii Hearing Services	4	5	5	9
7f-iv Physical Therapy	8	12	10	10
7f-v Physician/Medical Services	49	61	54	56
Total Unmet Resource Needs	186	204	180	212
Distinct Clients with Unmet Resource Needs	139	148	127	151
7g. Legal				
7g-i Advocate	16	27	22	27
7g-ii Guardian (private)	28	24	14	14
7g-iii Guardian (public)	4	5	3	1
Total Unmet Resource Needs	48	56	39	42
Distinct Clients with Unmet Resource Needs	43	51	37	40
7h. Financial Security				
7h-i Assistance with Managing Money	87	98	105	119
7h-ii Assistance with Securing Public Benefits	56	66	61	73
7h-iii Representative Payee	5	9	9	11
Total Unmet Resource Needs	148	173	175	203
Distinct Clients with Unmet Resource Needs	121	137	143	166

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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 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	1,930	1,912	1,801	1,928
7i. Education				
7i-i Adult Education (other than GED)	11	12	12	15
7i-ii GED	9	11	7	11
7i-iii Literacy Assistance	3	4	4	6
7i-iv Post High School Education	28	31	20	21
7i-v Tuition Reimbursement	7	5	3	5
Total Unmet Resource Needs	58	63	46	58
Distinct Clients with Unmet Resource Needs	50	56	41	51
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	8	8	10	10
7j-ii Club House and/or Peer Vocational Support	6	4	6	10
7j-iii Competitive Employment (no supports)	26	20	11	13
7j-iv Supported Employment	12	17	12	14
7j-v Vocational Rehabilitation	32	37	33	26
Total Unmet Resource Needs	84	86	72	73
Distinct Clients with Unmet Resource Needs	66	71	57	61
7k. Living Skills				
7k-i Daily Living Support Services	37	43	34	43
7k-ii Day Support Services	2	3	2	2
7k-iii Occupational Therapy	1	2	1	1
7k-iv Skills Development Services	14	17	17	17
Total Unmet Resource Needs	54	65	54	63
Distinct Clients with Unmet Resource Needs	50	58	47	57
7l. Transportation				
7l-i Transportation to ISP-Identified Services	77	79	76	77
7-ii Transportation to Other ISP Activities	36	42	39	39
7-iii After Hours Transportation	31	37	32	41
Total Unmet Resource Needs	144	158	147	157
Distinct Clients with Unmet Resource Needs	97	109	96	110

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Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	1,930	1,912	1,801	1,928
7m. Personal Growth/Community				
7m-i Avocational Activities	12	11	11	7
7m-ii Recreation Activities	45	45	52	44
7m-iii Social Activities	72	83	86	84
7m-iv Spiritual Activities	14	15	17	15
Total Unmet Resource Needs	143	154	166	150
Distinct Clients with Unmet Resource Needs	93	104	107	107
Other Resources				
Other Resources	26	25	24	27
Total Unmet Resource Needs	26	25	24	27
Distinct Clients with Unmet Resource Needs	26	25	24	27
CSN 2 Totals				
Total Unmet Resource Needs	1,438	1,643	1,521	1,685
Distinct Clients With any Unmet Resource Need	458	497	449	497
Distinct Clients with a RDS	1,930	1,912	1,801	1,928

Report Run: Jan 6, 2016

Statewide Report of Unmet Resource Needs for Fiscal Year 2016 Quarter 1

CSN 3 - Kennebec and Somerset

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

2015 Q2			2015 Q3			2015 Q4			2016 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
408	2,291	17.8%	414	2,193	18.9%	401	2,136	18.8%	440	2,318	19.0%

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

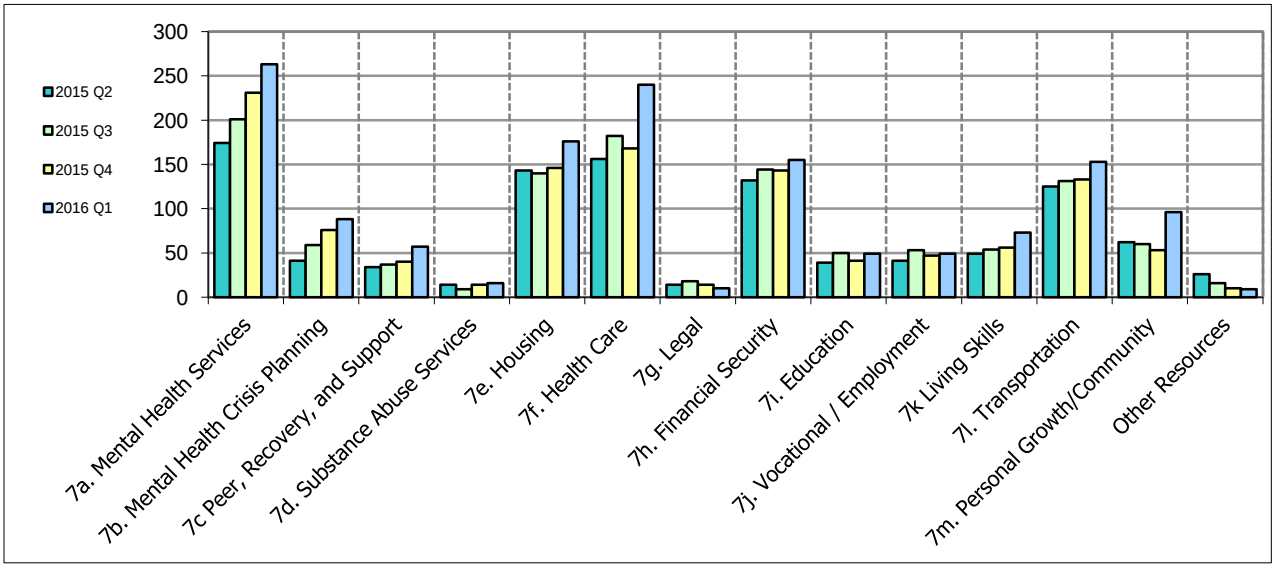

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2015 Q2	2015 Q3	2015 Q4	2016 Q1
7a. Mental Health Services	174	201	231	263
7b. Mental Health Crisis Planning	41	59	76	88
7c Peer, Recovery, and Support	34	37	40	57
7d. Substance Abuse Services	14	9	14	16
7e. Housing	143	140	146	176
7f. Health Care	156	182	168	240
7g. Legal	14	18	14	10
7h. Financial Security	132	144	143	155
7i. Education	39	50	41	49
7j. Vocational / Employment	41	53	47	49
7k Living Skills	49	54	56	73
7l. Transportation	125	131	133	153
7m. Personal Growth/Community	62	60	53	96
Other Resources	26	16	10	9
Total CSN 3 Unmet Needs	1,050	1,154	1,172	1,434

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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 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,291	2,193	2,136	2,318
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	2	4	1
7a-iii Dialectical Behavioral Therapy	2	4	3	7
7a-iv Family Psycho-Educational Treatment	1	1	2	1
7a-v Group Counseling	6	9	8	6
7a-vi Individual Counseling	68	78	89	114
7a-vii Inpatient Psychiatric Facility	1	1	3	4
7a-viii Intensive Case Management	3	3	9	12
7a-x Psychiatric Medication Management	91	103	113	118
Total Unmet Resource Needs	174	201	231	263
Distinct Clients with Unmet Resource Needs	141	158	172	187
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	32	46	57	64
7b-ii Mental Health Advance Directives	9	13	19	24
Total Unmet Resource Needs	41	59	76	88
Distinct Clients with Unmet Resource Needs	36	52	67	79
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	2	3	4	7
7c-ii Recovery Workbook Group	0	0	1	0
7c-iii Social Club	13	19	16	27
7c-iv Peer-Run Trauma Recovery Group	4	4	5	6
7c-v Wellness Recovery and Action Planning	1	0	1	0
7c-vi Family Support	14	11	13	17
Total Unmet Resource Needs	34	37	40	57
Distinct Clients with Unmet Resource Needs	29	31	32	48
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	11	6	11	15
7d-ii Residential Treatment Substance Abuse Services	3	3	3	1
Total Unmet Resource Needs	14	9	14	16
Distinct Clients with Unmet Resource Needs	13	8	13	16

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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 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,291	2,193	2,136	2,318
7e. Housing				
7e-i Supported Apartment	9	8	8	8
7e-ii Community Residential Facility	6	3	3	4
7e-iii Residential Treatment Facility (group home)	4	2	2	4
7e-iv Assisted Living Facility	5	7	8	9
7e-v Nursing Home	1	1	0	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	118	119	125	150
Total Unmet Resource Needs	143	140	146	176
Distinct Clients with Unmet Resource Needs	136	133	139	168
7f. Health Care				
7f-i Dental Services	70	83	75	98
7f-ii Eye Care Services	23	31	29	42
7f-iii Hearing Services	7	8	7	9
7f-iv Physical Therapy	1	3	4	10
7f-v Physician/Medical Services	55	57	53	81
Total Unmet Resource Needs	156	182	168	240
Distinct Clients with Unmet Resource Needs	130	143	124	169
7g. Legal				
7g-i Advocate	9	11	9	7
7g-ii Guardian (private)	2	2	2	0
7g-iii Guardian (public)	3	5	3	3
Total Unmet Resource Needs	14	18	14	10
Distinct Clients with Unmet Resource Needs	13	18	14	10
7h. Financial Security				
7h-i Assistance with Managing Money	73	84	91	92
7h-ii Assistance with Securing Public Benefits	49	47	41	47
7h-iii Representative Payee	10	13	11	16
Total Unmet Resource Needs	132	144	143	155
Distinct Clients with Unmet Resource Needs	114	126	123	132

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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 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,291	2,193	2,136	2,318
7i. Education				
7i-i Adult Education (other than GED)	11	12	10	15
7i-ii GED	5	5	6	8
7i-iii Literacy Assistance	7	9	5	9
7i-iv Post High School Education	13	19	17	15
7i-v Tuition Reimbursement	3	5	3	2
Total Unmet Resource Needs	39	50	41	49
Distinct Clients with Unmet Resource Needs	34	42	33	40
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	2	0	1
7j-ii Club House and/or Peer Vocational Support	7	10	10	9
7j-iii Competitive Employment (no supports)	2	5	7	2
7j-iv Supported Employment	4	6	3	4
7j-v Vocational Rehabilitation	27	30	27	33
Total Unmet Resource Needs	41	53	47	49
Distinct Clients with Unmet Resource Needs	38	45	44	42
7k. Living Skills				
7k-i Daily Living Support Services	37	45	48	59
7k-ii Day Support Services	1	2	1	3
7k-iii Occupational Therapy	0	0	0	1
7k-iv Skills Development Services	11	7	7	10
Total Unmet Resource Needs	49	54	56	73
Distinct Clients with Unmet Resource Needs	49	52	54	67
7l. Transportation				
7l-i Transportation to ISP-Identified Services	76	69	72	87
7-ii Transportation to Other ISP Activities	33	41	43	50
7-iii After Hours Transportation	16	21	18	16
Total Unmet Resource Needs	125	131	133	153
Distinct Clients with Unmet Resource Needs	91	89	91	104

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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 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,291	2,193	2,136	2,318
7m. Personal Growth/Community				
7m-i Avocational Activities	3	4	4	4
7m-ii Recreation Activities	12	15	14	29
7m-iii Social Activities	44	40	33	58
7m-iv Spiritual Activities	3	1	2	5
Total Unmet Resource Needs	62	60	53	96
Distinct Clients with Unmet Resource Needs	49	43	39	65
Other Resources				
Other Resources	26	16	10	9
Total Unmet Resource Needs	26	16	10	9
Distinct Clients with Unmet Resource Needs	26	16	10	9
CSN 3 Totals				
Total Unmet Resource Needs	1,050	1,154	1,172	1,434
Distinct Clients With any Unmet Resource Need	408	414	401	440
Distinct Clients with a RDS	2,291	2,193	2,136	2,318

Report Run: Jan 6, 2016

Statewide Report of Unmet Resource Needs for Fiscal Year 2016 Quarter 1

CSN 4 - Knox, Lincoln, Sagadahoc, Waldo

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

2015 Q2			2015 Q3			2015 Q4			2016 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
273	948	28.8%	245	904	27.1%	252	962	26.2%	281	949	29.6%

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

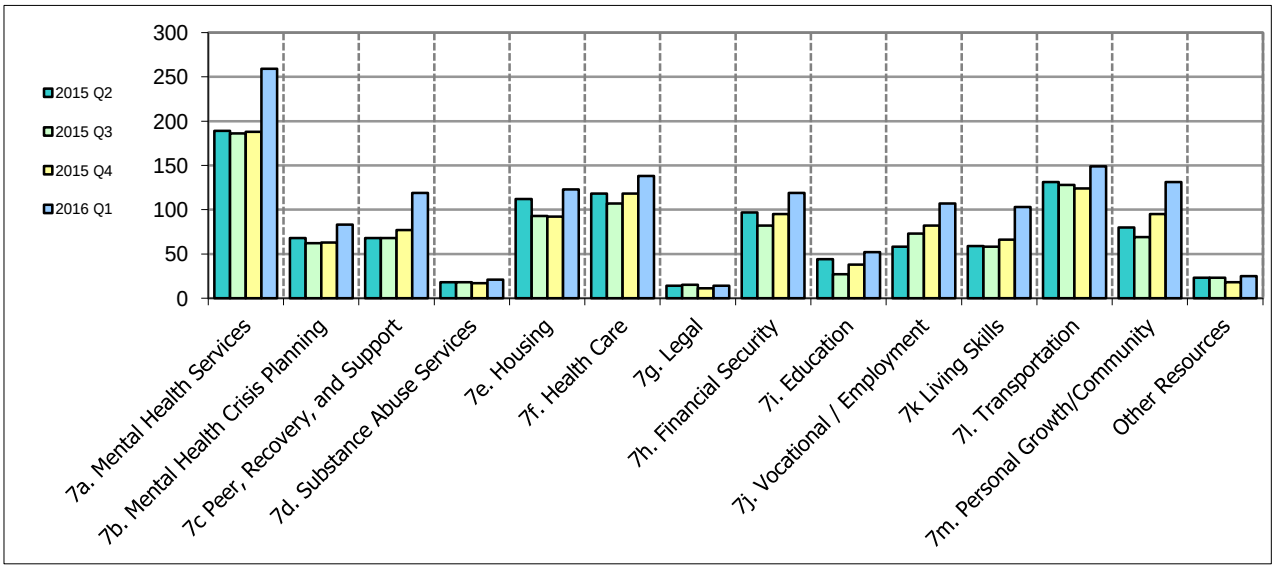

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2015 Q2	2015 Q3	2015 Q4	2016 Q1
7a. Mental Health Services	189	186	188	259
7b. Mental Health Crisis Planning	68	62	63	83
7c Peer, Recovery, and Support	68	68	77	119
7d. Substance Abuse Services	18	18	17	21
7e. Housing	112	93	92	123
7f. Health Care	118	107	118	138
7g. Legal	14	15	11	14
7h. Financial Security	97	82	95	119
7i. Education	44	27	38	52
7j. Vocational / Employment	58	73	82	107
7k Living Skills	59	58	66	103
7l. Transportation	131	128	124	149
7m. Personal Growth/Community	80	69	95	131
Other Resources	23	23	18	25
Total CSN 4 Unmet Needs	1,079	1,009	1,084	1,443

Report Run: Jan 6, 2016

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

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	948	904	962	949
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	13	11	18	22
7a-iii Dialectical Behavioral Therapy	4	6	6	9
7a-iv Family Psycho-Educational Treatment	6	8	7	10
7a-v Group Counseling	9	10	7	7
7a-vi Individual Counseling	74	75	71	95
7a-vii Inpatient Psychiatric Facility	0	0	0	1
7a-viii Intensive Case Management	9	9	13	17
7a-x Psychiatric Medication Management	74	67	66	98
Total Unmet Resource Needs	189	186	188	259
Distinct Clients with Unmet Resource Needs	127	118	119	156
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	54	45	46	68
7b-ii Mental Health Advance Directives	14	17	17	15
Total Unmet Resource Needs	68	62	63	83
Distinct Clients with Unmet Resource Needs	59	54	60	80
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	7	11	10	11
7c-ii Recovery Workbook Group	1	2	1	1
7c-iii Social Club	27	19	23	27
7c-iv Peer-Run Trauma Recovery Group	3	4	8	10
7c-v Wellness Recovery and Action Planning	3	4	8	15
7c-vi Family Support	27	28	27	55
Total Unmet Resource Needs	68	68	77	119
Distinct Clients with Unmet Resource Needs	56	53	52	78
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	18	17	15	20
7d-ii Residential Treatment Substance Abuse Services	0	1	2	1
Total Unmet Resource Needs	18	18	17	21
Distinct Clients with Unmet Resource Needs	18	17	17	21

Report Run: Jan 6, 2016

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

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	948	904	962	949
7e. Housing				
7e-i Supported Apartment	18	9	13	15
7e-ii Community Residential Facility	2	2	2	4
7e-iii Residential Treatment Facility (group home)	8	6	5	7
7e-iv Assisted Living Facility	4	3	2	5
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	80	73	70	92
Total Unmet Resource Needs	112	93	92	123
Distinct Clients with Unmet Resource Needs	96	86	84	105
7f. Health Care				
7f-i Dental Services	62	57	58	65
7f-ii Eye Care Services	19	17	18	24
7f-iii Hearing Services	2	2	3	6
7f-iv Physical Therapy	1	2	4	5
7f-v Physician/Medical Services	34	29	35	38
Total Unmet Resource Needs	118	107	118	138
Distinct Clients with Unmet Resource Needs	89	78	87	98
7g. Legal				
7g-i Advocate	12	13	11	14
7g-ii Guardian (private)	1	0	0	0
7g-iii Guardian (public)	1	2	0	0
Total Unmet Resource Needs	14	15	11	14
Distinct Clients with Unmet Resource Needs	13	14	11	14
7h. Financial Security				
7h-i Assistance with Managing Money	59	47	53	73
7h-ii Assistance with Securing Public Benefits	35	32	38	42
7h-iii Representative Payee	3	3	4	4
Total Unmet Resource Needs	97	82	95	119
Distinct Clients with Unmet Resource Needs	82	71	69	90

Report Run: Jan 6, 2016

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

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	948	904	962	949
7i. Education				
7i-i Adult Education (other than GED)	8	2	8	13
7i-ii GED	13	8	9	10
7i-iii Literacy Assistance	4	3	2	2
7i-iv Post High School Education	17	14	16	19
7i-v Tuition Reimbursement	2	0	3	8
Total Unmet Resource Needs	44	27	38	52
Distinct Clients with Unmet Resource Needs	40	26	31	41
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	4	10	11	18
7j-ii Club House and/or Peer Vocational Support	1	1	2	2
7j-iii Competitive Employment (no supports)	8	7	9	11
7j-iv Supported Employment	3	8	8	14
7j-v Vocational Rehabilitation	42	47	52	62
Total Unmet Resource Needs	58	73	82	107
Distinct Clients with Unmet Resource Needs	51	60	62	73
7k. Living Skills				
7k-i Daily Living Support Services	49	42	45	69
7k-ii Day Support Services	1	2	5	10
7k-iii Occupational Therapy	0	4	4	6
7k-iv Skills Development Services	9	10	12	18
Total Unmet Resource Needs	59	58	66	103
Distinct Clients with Unmet Resource Needs	56	53	57	84
7l. Transportation				
7l-i Transportation to ISP-Identified Services	75	73	66	74
7-ii Transportation to Other ISP Activities	41	38	40	51
7-iii After Hours Transportation	15	17	18	24
Total Unmet Resource Needs	131	128	124	149
Distinct Clients with Unmet Resource Needs	82	79	73	82

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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 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	948	904	962	949
7m. Personal Growth/Community				
7m-i Avocational Activities	0	0	2	7
7m-ii Recreation Activities	22	24	30	42
7m-iii Social Activities	44	38	49	68
7m-iv Spiritual Activities	14	7	14	14
Total Unmet Resource Needs	80	69	95	131
Distinct Clients with Unmet Resource Needs	48	44	56	77
Other Resources				
Other Resources	23	23	18	25
Total Unmet Resource Needs	23	23	18	25
Distinct Clients with Unmet Resource Needs	23	23	18	25
CSN 4 Totals				
Total Unmet Resource Needs	1,079	1,009	1,084	1,443
Distinct Clients With any Unmet Resource Need	273	245	252	281
Distinct Clients with a RDS	948	904	962	949

Report Run: Jan 6, 2016

Statewide Report of Unmet Resource Needs for Fiscal Year 2016 Quarter 1

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

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

2015 Q2			2015 Q3			2015 Q4			2016 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
648	2,119	30.6%	610	1,987	30.7%	602	2,013	29.9%	596	2,113	28.2%

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

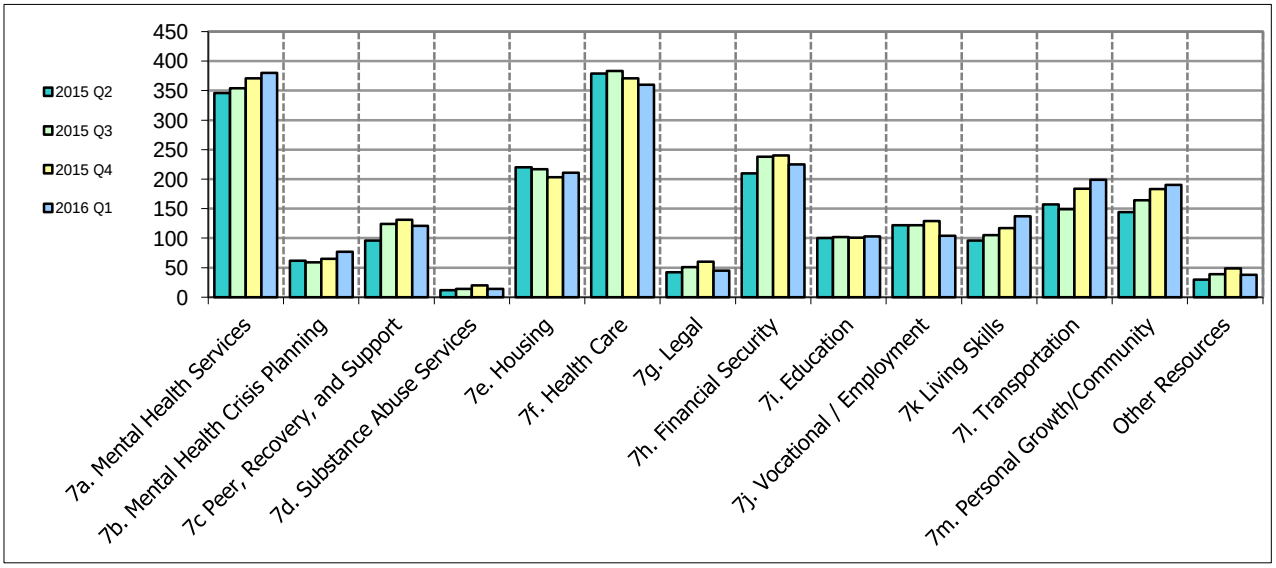

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2015 Q2	2015 Q3	2015 Q4	2016 Q1
7a. Mental Health Services	346	354	371	380
7b. Mental Health Crisis Planning	62	59	65	77
7c Peer, Recovery, and Support	96	124	131	121
7d. Substance Abuse Services	12	14	20	14
7e. Housing	220	217	203	211
7f. Health Care	379	383	371	360
7g. Legal	42	51	60	45
7h. Financial Security	210	238	240	225
7i. Education	100	102	101	103
7j. Vocational / Employment	122	122	129	104
7k Living Skills	96	105	117	137
7l. Transportation	157	149	184	199
7m. Personal Growth/Community	144	164	183	190
Other Resources	30	39	49	38
Total CSN 5 Unmet Needs	2,016	2,121	2,224	2,204

Report Run: Jan 6, 2016

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

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,119	1,987	2,013	2,113
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	5	7	7	10
7a-iii Dialectical Behavioral Therapy	28	26	38	27
7a-iv Family Psycho-Educational Treatment	2	4	2	4
7a-v Group Counseling	13	16	19	21
7a-vi Individual Counseling	140	158	156	176
7a-vii Inpatient Psychiatric Facility	1	1	0	0
7a-viii Intensive Case Management	11	7	12	15
7a-x Psychiatric Medication Management	146	135	137	127
Total Unmet Resource Needs	346	354	371	380
Distinct Clients with Unmet Resource Needs	279	263	282	300
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	42	43	53	64
7b-ii Mental Health Advance Directives	20	16	12	13
Total Unmet Resource Needs	62	59	65	77
Distinct Clients with Unmet Resource Needs	59	52	62	75
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	15	14	14	15
7c-ii Recovery Workbook Group	3	2	1	1
7c-iii Social Club	34	46	47	43
7c-iv Peer-Run Trauma Recovery Group	6	10	11	17
7c-v Wellness Recovery and Action Planning	7	7	8	6
7c-vi Family Support	31	45	50	39
Total Unmet Resource Needs	96	124	131	121
Distinct Clients with Unmet Resource Needs	82	99	101	90
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	10	13	19	12
7d-ii Residential Treatment Substance Abuse Services	2	1	1	2
Total Unmet Resource Needs	12	14	20	14
Distinct Clients with Unmet Resource Needs	12	14	20	13

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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 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,119	1,987	2,013	2,113
7e. Housing				
7e-i Supported Apartment	20	19	19	19
7e-ii Community Residential Facility	4	4	4	5
7e-iii Residential Treatment Facility (group home)	2	1	2	1
7e-iv Assisted Living Facility	3	2	1	2
7e-v Nursing Home	0	0	1	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	191	191	176	184
Total Unmet Resource Needs	220	217	203	211
Distinct Clients with Unmet Resource Needs	211	207	190	198
7f. Health Care				
7f-i Dental Services	180	178	167	154
7f-ii Eye Care Services	80	92	76	74
7f-iii Hearing Services	18	12	18	25
7f-iv Physical Therapy	12	19	22	20
7f-v Physician/Medical Services	89	82	88	87
Total Unmet Resource Needs	379	383	371	360
Distinct Clients with Unmet Resource Needs	267	260	259	240
7g. Legal				
7g-i Advocate	40	49	55	42
7g-ii Guardian (private)	1	1	3	2
7g-iii Guardian (public)	1	1	2	1
Total Unmet Resource Needs	42	51	60	45
Distinct Clients with Unmet Resource Needs	41	51	58	44
7h. Financial Security				
7h-i Assistance with Managing Money	124	139	137	128
7h-ii Assistance with Securing Public Benefits	82	92	92	90
7h-iii Representative Payee	4	7	11	7
Total Unmet Resource Needs	210	238	240	225
Distinct Clients with Unmet Resource Needs	191	205	192	186

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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 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,119	1,987	2,013	2,113
7i. Education				
7i-i Adult Education (other than GED)	28	29	34	39
7i-ii GED	35	33	27	31
7i-iii Literacy Assistance	6	10	13	11
7i-iv Post High School Education	29	27	25	19
7i-v Tuition Reimbursement	2	3	2	3
Total Unmet Resource Needs	100	102	101	103
Distinct Clients with Unmet Resource Needs	93	87	88	86
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	6	10	9	9
7j-ii Club House and/or Peer Vocational Support	13	11	8	9
7j-iii Competitive Employment (no supports)	21	22	23	16
7j-iv Supported Employment	10	12	19	13
7j-v Vocational Rehabilitation	72	67	70	57
Total Unmet Resource Needs	122	122	129	104
Distinct Clients with Unmet Resource Needs	112	110	116	92
7k. Living Skills				
7k-i Daily Living Support Services	68	77	81	88
7k-ii Day Support Services	9	7	11	12
7k-iii Occupational Therapy	3	4	5	5
7k-iv Skills Development Services	16	17	20	32
Total Unmet Resource Needs	96	105	117	137
Distinct Clients with Unmet Resource Needs	89	90	105	120
7l. Transportation				
7l-i Transportation to ISP-Identified Services	75	72	96	100
7-ii Transportation to Other ISP Activities	45	41	52	56
7-iii After Hours Transportation	37	36	36	43
Total Unmet Resource Needs	157	149	184	199
Distinct Clients with Unmet Resource Needs	105	102	120	124

Report Run: Jan 6, 2016

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

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,119	1,987	2,013	2,113
7m. Personal Growth/Community				
7m-i Avocational Activities	4	3	3	5
7m-ii Recreation Activities	36	44	47	44
7m-iii Social Activities	83	94	105	109
7m-iv Spiritual Activities	21	23	28	32
Total Unmet Resource Needs	144	164	183	190
Distinct Clients with Unmet Resource Needs	103	115	128	129
Other Resources				
Other Resources	30	39	49	38
Total Unmet Resource Needs	30	39	49	38
Distinct Clients with Unmet Resource Needs	30	39	49	38
CSN 5 Totals				
Total Unmet Resource Needs	2,016	2,121	2,224	2,204
Distinct Clients With any Unmet Resource Need	648	610	602	596
Distinct Clients with a RDS	2,119	1,987	2,013	2,113

Report Run: Jan 6, 2016

Statewide Report of Unmet Resource Needs for Fiscal Year 2016 Quarter 1

CSN 6 - Cumberland

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

2015 Q2			2015 Q3			2015 Q4			2016 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
612	2,251	27.2%	595	2,102	28.3%	580	2,021	28.7%	586	2,010	29.2%

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

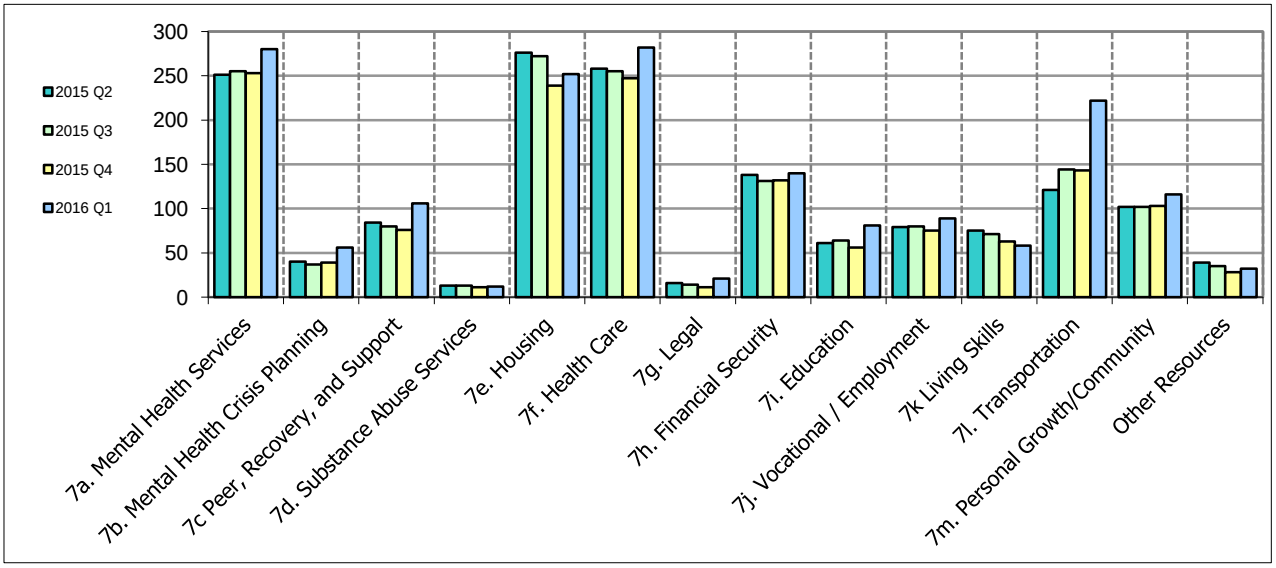

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2015 Q2	2015 Q3	2015 Q4	2016 Q1
7a. Mental Health Services	251	255	253	280
7b. Mental Health Crisis Planning	40	37	39	56
7c Peer, Recovery, and Support	84	80	76	106
7d. Substance Abuse Services	13	13	11	12
7e. Housing	276	272	239	252
7f. Health Care	258	255	247	282
7g. Legal	16	14	11	21
7h. Financial Security	138	131	132	140
7i. Education	61	64	56	81
7j. Vocational / Employment	79	80	75	89
7k Living Skills	75	71	63	58
7l. Transportation	121	144	143	222
7m. Personal Growth/Community	102	102	103	116
Other Resources	39	35	28	32
Total CSN 6 Unmet Needs	1,553	1,553	1,476	1,747

Report Run: Jan 6, 2016

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

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,251	2,102	2,021	2,010
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	23	2	7	7
7a-iii Dialectical Behavioral Therapy	9	11	12	15
7a-iv Family Psycho-Educational Treatment	1	1	6	7
7a-v Group Counseling	16	13	10	15
7a-vi Individual Counseling	103	121	110	121
7a-vii Inpatient Psychiatric Facility	0	0	0	1
7a-viii Intensive Case Management	21	26	26	21
7a-x Psychiatric Medication Management	78	81	82	93
Total Unmet Resource Needs	251	255	253	280
Distinct Clients with Unmet Resource Needs	194	196	188	216
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	35	30	32	51
7b-ii Mental Health Advance Directives	5	7	7	5
Total Unmet Resource Needs	40	37	39	56
Distinct Clients with Unmet Resource Needs	37	33	34	53
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	19	16	16	14
7c-ii Recovery Workbook Group	0	1	1	2
7c-iii Social Club	34	32	28	27
7c-iv Peer-Run Trauma Recovery Group	4	5	7	10
7c-v Wellness Recovery and Action Planning	5	5	4	7
7c-vi Family Support	22	21	20	46
Total Unmet Resource Needs	84	80	76	106
Distinct Clients with Unmet Resource Needs	59	61	61	87
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	10	9	8	6
7d-ii Residential Treatment Substance Abuse Services	3	4	3	6
Total Unmet Resource Needs	13	13	11	12
Distinct Clients with Unmet Resource Needs	13	13	11	12

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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 6
(Cumberland)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,251	2,102	2,021	2,010
7e. Housing				
7e-i Supported Apartment	46	39	27	33
7e-ii Community Residential Facility	16	19	10	13
7e-iii Residential Treatment Facility (group home)	9	6	2	4
7e-iv Assisted Living Facility	17	10	13	11
7e-v Nursing Home	2	1	2	2
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	186	197	185	189
Total Unmet Resource Needs	276	272	239	252
Distinct Clients with Unmet Resource Needs	246	243	230	233
7f. Health Care				
7f-i Dental Services	157	151	147	149
7f-ii Eye Care Services	40	39	37	51
7f-iii Hearing Services	3	4	6	7
7f-iv Physical Therapy	11	6	6	9
7f-v Physician/Medical Services	47	55	51	66
Total Unmet Resource Needs	258	255	247	282
Distinct Clients with Unmet Resource Needs	204	198	191	196
7g. Legal				
7g-i Advocate	12	11	9	17
7g-ii Guardian (private)	2	2	1	2
7g-iii Guardian (public)	2	1	1	2
Total Unmet Resource Needs	16	14	11	21
Distinct Clients with Unmet Resource Needs	16	14	11	21
7h. Financial Security				
7h-i Assistance with Managing Money	79	74	86	89
7h-ii Assistance with Securing Public Benefits	46	44	40	41
7h-iii Representative Payee	13	13	6	10
Total Unmet Resource Needs	138	131	132	140
Distinct Clients with Unmet Resource Needs	127	120	121	124

Report Run: Jan 6, 2016

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

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,251	2,102	2,021	2,010
7i. Education				
7i-i Adult Education (other than GED)	22	29	22	36
7i-ii GED	17	15	14	20
7i-iii Literacy Assistance	5	6	7	10
7i-iv Post High School Education	14	12	12	14
7i-v Tuition Reimbursement	3	2	1	1
Total Unmet Resource Needs	61	64	56	81
Distinct Clients with Unmet Resource Needs	57	57	51	72
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	6	7	6	7
7j-ii Club House and/or Peer Vocational Support	2	2	2	2
7j-iii Competitive Employment (no supports)	16	19	16	16
7j-iv Supported Employment	8	8	12	15
7j-v Vocational Rehabilitation	47	44	39	49
Total Unmet Resource Needs	79	80	75	89
Distinct Clients with Unmet Resource Needs	68	73	68	82
7k. Living Skills				
7k-i Daily Living Support Services	47	42	38	33
7k-ii Day Support Services	11	11	11	10
7k-iii Occupational Therapy	2	2	1	1
7k-iv Skills Development Services	15	16	13	14
Total Unmet Resource Needs	75	71	63	58
Distinct Clients with Unmet Resource Needs	65	60	54	49
7l. Transportation				
7l-i Transportation to ISP-Identified Services	58	71	75	109
7-ii Transportation to Other ISP Activities	38	46	44	72
7-iii After Hours Transportation	25	27	24	41
Total Unmet Resource Needs	121	144	143	222
Distinct Clients with Unmet Resource Needs	84	95	97	131

Report Run: Jan 6, 2016

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	2,251	2,102	2,021	2,010
7m. Personal Growth/Community				
7m-i Avocational Activities	3	4	2	3
7m-ii Recreation Activities	24	22	24	19
7m-iii Social Activities	65	67	65	72
7m-iv Spiritual Activities	10	9	12	22
Total Unmet Resource Needs	102	102	103	116
Distinct Clients with Unmet Resource Needs	77	74	77	87
Other Resources				
Other Resources	39	35	28	32
Total Unmet Resource Needs	39	35	28	32
Distinct Clients with Unmet Resource Needs	39	35	28	32
CSN 6 Totals				
Total Unmet Resource Needs	1,553	1,553	1,476	1,747
Distinct Clients With any Unmet Resource Need	612	595	580	586
Distinct Clients with a RDS	2,251	2,102	2,021	2,010

Report Run: Jan 6, 2016

Statewide Report of Unmet Resource Needs for Fiscal Year 2016 Quarter 1

CSN 7 - York

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

2015 Q2			2015 Q3			2015 Q4			2016 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
329	809	40.7%	296	802	36.9%	283	802	35.3%	242	696	34.8%

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

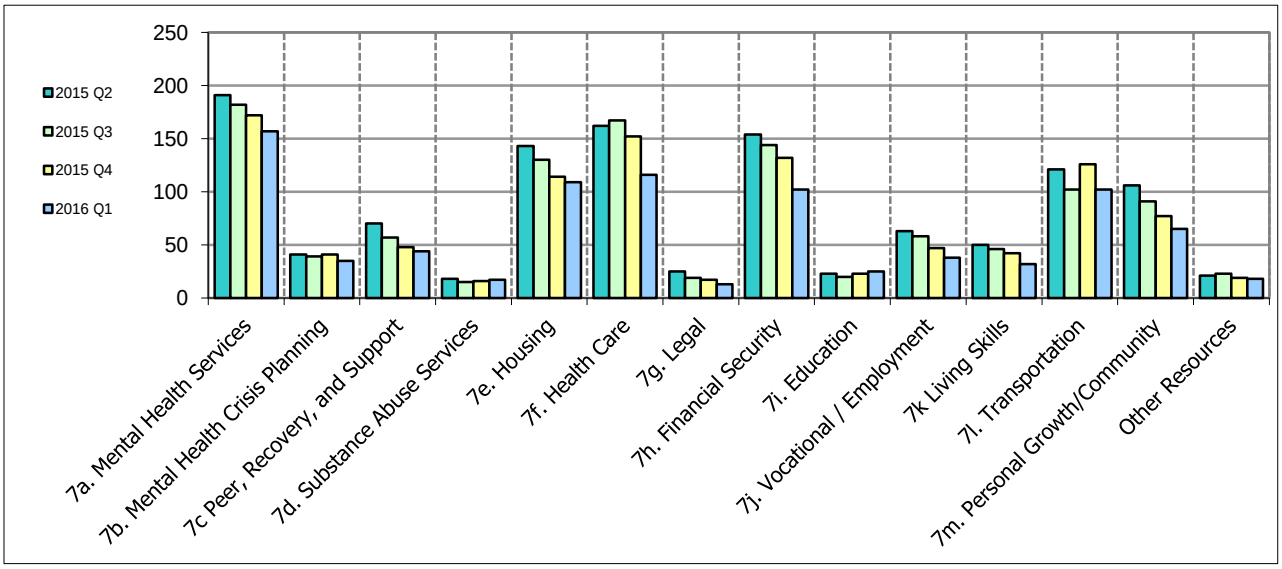

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2015 Q2	2015 Q3	2015 Q4	2016 Q1
7a. Mental Health Services	191	182	172	157
7b. Mental Health Crisis Planning	41	39	41	35
7c Peer, Recovery, and Support	70	57	48	44
7d. Substance Abuse Services	18	15	16	17
7e. Housing	143	130	114	109
7f. Health Care	162	167	152	116
7g. Legal	25	19	17	13
7h. Financial Security	154	144	132	102
7i. Education	23	20	23	25
7j. Vocational / Employment	63	58	47	38
7k Living Skills	50	46	42	32
7l. Transportation	121	102	126	102
7m. Personal Growth/Community	106	91	77	65
Other Resources	21	23	19	18
Total CSN 7 Unmet Needs	1,188	1,093	1,026	873

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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 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	840	809	802	696
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	4	1	5	2
7a-iii Dialectical Behavioral Therapy	29	22	18	10
7a-iv Family Psycho-Educational Treatment	2	1	3	5
7a-v Group Counseling	4	4	3	0
7a-vi Individual Counseling	75	75	65	71
7a-vii Inpatient Psychiatric Facility	1	1	2	0
7a-viii Intensive Case Management	6	6	9	9
7a-x Psychiatric Medication Management	70	72	67	60
Total Unmet Resource Needs	191	182	172	157
Distinct Clients with Unmet Resource Needs	145	133	114	109
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	36	35	37	32
7b-ii Mental Health Advance Directives	5	4	4	3
Total Unmet Resource Needs	41	39	41	35
Distinct Clients with Unmet Resource Needs	37	36	38	32
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	11	10	9	8
7c-ii Recovery Workbook Group	1	0	0	0
7c-iii Social Club	21	21	13	11
7c-iv Peer-Run Trauma Recovery Group	11	7	9	5
7c-v Wellness Recovery and Action Planning	9	8	6	6
7c-vi Family Support	17	11	11	14
Total Unmet Resource Needs	70	57	48	44
Distinct Clients with Unmet Resource Needs	52	42	36	34
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	17	14	13	16
7d-ii Residential Treatment Substance Abuse Services	1	1	3	1
Total Unmet Resource Needs	18	15	16	17
Distinct Clients with Unmet Resource Needs	18	15	15	17

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Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	840	809	802	696
7e. Housing				
7e-i Supported Apartment	17	19	16	15
7e-ii Community Residential Facility	7	5	5	1
7e-iii Residential Treatment Facility (group home)	2	2	3	2
7e-iv Assisted Living Facility	9	6	6	4
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	2	1	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	106	97	84	87
Total Unmet Resource Needs	143	130	114	109
Distinct Clients with Unmet Resource Needs	124	117	101	102
7f. Health Care				
7f-i Dental Services	80	82	75	47
7f-ii Eye Care Services	22	39	26	20
7f-iii Hearing Services	6	4	4	3
7f-iv Physical Therapy	9	6	3	4
7f-v Physician/Medical Services	45	36	44	42
Total Unmet Resource Needs	162	167	152	116
Distinct Clients with Unmet Resource Needs	120	115	111	83
7g. Legal				
7g-i Advocate	18	14	11	10
7g-ii Guardian (private)	2	1	1	0
7g-iii Guardian (public)	5	4	5	3
Total Unmet Resource Needs	25	19	17	13
Distinct Clients with Unmet Resource Needs	21	17	15	13
7h. Financial Security				
7h-i Assistance with Managing Money	108	101	85	67
7h-ii Assistance with Securing Public Benefits	39	36	37	29
7h-iii Representative Payee	7	7	10	6
Total Unmet Resource Needs	154	144	132	102
Distinct Clients with Unmet Resource Needs	133	123	114	86

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Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	840	809	802	696
7i. Education				
7i-i Adult Education (other than GED)	6	5	6	8
7i-ii GED	5	3	7	4
7i-iii Literacy Assistance	6	3	3	5
7i-iv Post High School Education	6	8	6	8
7i-v Tuition Reimbursement	0	1	1	0
Total Unmet Resource Needs	23	20	23	25
Distinct Clients with Unmet Resource Needs	19	17	20	21
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	5	4	4	4
7j-ii Club House and/or Peer Vocational Support	10	8	4	3
7j-iii Competitive Employment (no supports)	13	16	9	12
7j-iv Supported Employment	8	6	3	1
7j-v Vocational Rehabilitation	27	24	27	18
Total Unmet Resource Needs	63	58	47	38
Distinct Clients with Unmet Resource Needs	50	48	41	35
7k. Living Skills				
7k-i Daily Living Support Services	32	28	29	22
7k-ii Day Support Services	4	2	1	0
7k-iii Occupational Therapy	5	4	3	3
7k-iv Skills Development Services	9	12	9	7
Total Unmet Resource Needs	50	46	42	32
Distinct Clients with Unmet Resource Needs	38	38	34	28
7l. Transportation				
7l-i Transportation to ISP-Identified Services	54	50	61	51
7-ii Transportation to Other ISP Activities	32	26	30	22
7-iii After Hours Transportation	35	26	35	29
Total Unmet Resource Needs	121	102	126	102
Distinct Clients with Unmet Resource Needs	83	69	85	70

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Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	840	809	802	696
7m. Personal Growth/Community				
7m-i Avocational Activities	6	7	5	6
7m-ii Recreation Activities	31	27	19	20
7m-iii Social Activities	53	45	46	33
7m-iv Spiritual Activities	16	12	7	6
Total Unmet Resource Needs	106	91	77	65
Distinct Clients with Unmet Resource Needs	69	60	55	44
Other Resources				
Other Resources	21	23	19	18
Total Unmet Resource Needs	21	23	19	18
Distinct Clients with Unmet Resource Needs	21	23	19	18
CSN 7 Totals				
Total Unmet Resource Needs	1,188	1,093	1,026	873
Distinct Clients With any Unmet Resource Need	329	296	283	242
Distinct Clients with a RDS	840	809	802	696

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Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	485	432	421	384
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	0	1	2	1
7a-iii Dialectical Behavioral Therapy	1	2	3	3
7a-iv Family Psycho-Educational Treatment	0	0	0	0
7a-v Group Counseling	3	2	1	3
7a-vi Individual Counseling	30	24	25	31
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	4	4	4	3
7a-x Psychiatric Medication Management	35	39	29	20
Total Unmet Resource Needs	73	72	64	61
Distinct Clients with Unmet Resource Needs	57	56	51	45
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	10	10	12	16
7b-ii Mental Health Advance Directives	5	4	3	2
Total Unmet Resource Needs	15	14	15	18
Distinct Clients with Unmet Resource Needs	15	14	15	17
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	0	3	3
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	6	9	8	5
7c-iv Peer-Run Trauma Recovery Group	0	1	2	1
7c-v Wellness Recovery and Action Planning	5	5	2	4
7c-vi Family Support	5	5	4	7
Total Unmet Resource Needs	17	20	19	20
Distinct Clients with Unmet Resource Needs	11	15	14	11
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	5	5	6	4
7d-ii Residential Treatment Substance Abuse Services	1	2	1	1
Total Unmet Resource Needs	6	7	7	5
Distinct Clients with Unmet Resource Needs	6	6	7	5

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Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	485	432	421	384
7e. Housing				
7e-i Supported Apartment	4	3	3	4
7e-ii Community Residential Facility	3	3	4	4
7e-iii Residential Treatment Facility (group home)	0	1	1	1
7e-iv Assisted Living Facility	3	3	2	3
7e-v Nursing Home	1	1	1	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	32	28	29	30
Total Unmet Resource Needs	43	39	40	42
Distinct Clients with Unmet Resource Needs	40	36	37	36
7f. Health Care				
7f-i Dental Services	29	27	26	23
7f-ii Eye Care Services	15	13	14	11
7f-iii Hearing Services	2	1	3	4
7f-iv Physical Therapy	4	2	1	2
7f-v Physician/Medical Services	15	17	18	20
Total Unmet Resource Needs	65	60	62	60
Distinct Clients with Unmet Resource Needs	46	44	46	41
7g. Legal				
7g-i Advocate	11	12	8	8
7g-ii Guardian (private)	5	5	3	3
7g-iii Guardian (public)	0	1	0	0
Total Unmet Resource Needs	16	18	11	11
Distinct Clients with Unmet Resource Needs	13	13	8	8
7h. Financial Security				
7h-i Assistance with Managing Money	32	30	33	36
7h-ii Assistance with Securing Public Benefits	18	20	15	17
7h-iii Representative Payee	1	2	1	2
Total Unmet Resource Needs	51	52	49	55
Distinct Clients with Unmet Resource Needs	45	43	44	49

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Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	485	432	421	384
7i. Education				
7i-i Adult Education (other than GED)	8	8	8	7
7i-ii GED	6	5	4	1
7i-iii Literacy Assistance	2	1	1	2
7i-iv Post High School Education	7	6	8	6
7i-v Tuition Reimbursement	2	1	0	0
Total Unmet Resource Needs	25	21	21	16
Distinct Clients with Unmet Resource Needs	19	17	18	13
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	3	2	0	0
7j-ii Club House and/or Peer Vocational Support	2	1	3	1
7j-iii Competitive Employment (no supports)	5	5	2	3
7j-iv Supported Employment	3	2	3	2
7j-v Vocational Rehabilitation	12	13	13	10
Total Unmet Resource Needs	25	23	21	16
Distinct Clients with Unmet Resource Needs	23	21	21	14
7k. Living Skills				
7k-i Daily Living Support Services	15	11	15	14
7k-ii Day Support Services	0	0	2	3
7k-iii Occupational Therapy	1	1	1	0
7k-iv Skills Development Services	5	4	2	5
Total Unmet Resource Needs	21	16	20	22
Distinct Clients with Unmet Resource Needs	18	15	17	17
7l. Transportation				
7l-i Transportation to ISP-Identified Services	21	19	21	23
7-ii Transportation to Other ISP Activities	8	6	7	10
7-iii After Hours Transportation	5	7	8	7
Total Unmet Resource Needs	34	32	36	40
Distinct Clients with Unmet Resource Needs	25	24	28	25

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Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2016 Quarter 1
(July, Aug, Sept 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Distinct Clients with a RDS	485	432	421	384
7m. Personal Growth/Community				
7m-i Avocational Activities	2	2	0	1
7m-ii Recreation Activities	10	7	5	6
7m-iii Social Activities	20	19	19	19
7m-iv Spiritual Activities	3	2	1	3
Total Unmet Resource Needs	35	30	25	29
Distinct Clients with Unmet Resource Needs	21	22	20	23
Other Resources				
Other Resources	11	11	13	12
Total Unmet Resource Needs	11	11	13	12
Distinct Clients with Unmet Resource Needs	11	11	13	12
CSN Not Assigned Totals				
Total Unmet Resource Needs	437	415	403	407
Distinct Clients With any Unmet Resource Need	137	123	119	108
Distinct Clients with a RDS	485	432	421	384

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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

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Bridging Recovery Assistance Program (BRAP)
Monitoring Report
Quarter 1 FY2016 (July, August, September 2015)

The Bridging Recovery Assistance Program (BRAP) has been established in recognition that recovery can only begin in a safe, healthy, and decent environment; a place one can call home. The Office of Substance Abuse and Adult Mental Health Services also recognizes that recovery is achieved on an individual basis which is not predicated by length of time but rather individual progress, successes and the necessity for rental assistance for persons with mental illness where length of assistance and amount of services are measured in need rather than in months. 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,[1] in Maine, 95 percent 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 percent and Sagadahoc 98 percent. In the City of Portland 115 percent 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 percent.

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

The BRAP program has recently gone through the RFP process and is in the process of signing the contract with the chosen BRAP program provider recipient.

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

BRAP Waitlist

The bullets below highlight some of the details regarding the 287 persons who are currently waiting for a BRAP voucher: The percentage terms reflect the percentage of relative change compared to the last report.

- Priority 1: 51 BRAP applicants who were discharded from a psychiatric hospital within the last 6 months are waiting for BRAP services. Typically, Riverview and Dorothea Dix consumers are not waiting more than 3 business days from the date of a completed application to receiving a BRAP voucher.
- Priority #2: 213 BRAP applicants who meet HUD's definition of Transitional Homelessnes are waiting for BRAP services.

[1] Cooper, E., O'Hara, A, Siner, N., and Zovistoski, A. Priced Out In 2012: The Housing Crisis for People with Disabilities. Technical Assistance Collaborative Inc. Consortium for Citizens with Disabilities, Housing Task Force. 2013.

- Priority #3: 7 BRAP applicants identified as living in sub-standard housing (Substandard Housing). Statewide priority 3 waiting for BRAP services is 8 persons.
- Priority #4: 14 BRAP applicants identified as having left a DHHS funded community residential facility within the past six months are waiting for BRAP services.
- Currently, 197 individuals have been on the waitlist for BRAP services for more than 90 day, this reflects the maximum use of funds available.

BRAP Vouchers Awarded

Since BRAP's inception, there has been a total of 3,262 BRAP vouchers awarded, which are broken down as follows:

- Priority #1: 1507 individuals discharged from psychiatric hospitals have been awarded BRAP vouchers
- Priority #2: 1434 individuals who meet HUD's transitional homeless definition have been awarded BRAP vouchers
- Priority #3: 47 individuals identified as living in sub-standard housing have been awarded BRAP vouchers
- Priority #4: 287 individuals who were leaving a DHHS funded living facility have been awarded BRAP vouchers.

Note that, since BRAP's inception, 23 vouchers have been awarded to persons with no priority assigned to them. In the second quarter of fiscal year 2016, a total of 35 BRAP vouchers were awarded.

The BRAP census as of December 30,2015 was 1597 vouchers, of which 43 of these voucher holders are awarded and currently seeking housing.

Additional funding of $1,233,947 was added to the BRAP budget of $5,372,414, which brings the total FY16 BRAP budget to $6,606,361, which will allow for an additional 150-200 additional vouchers in FY16. SAMHS is working closely with community providers and councils in order to direct these vouchers to those most in need as well as those leaving State funded Hospitals and Residential Facilities.

The number of individuals on the BRAP program for 24 months or more remains steady at 50% of the entire BRAP program. This is seen as a direct result of decades of federal and state cuts to low-income and supportive housing programs, including persons who will not qualify for Section 8 due to a criminal history. The lack of availability of these resources, particularly Section 8 at the federal level, has translated to an increased amount of pressure on state programs such as BRAP, to pick up where these programs have left off.

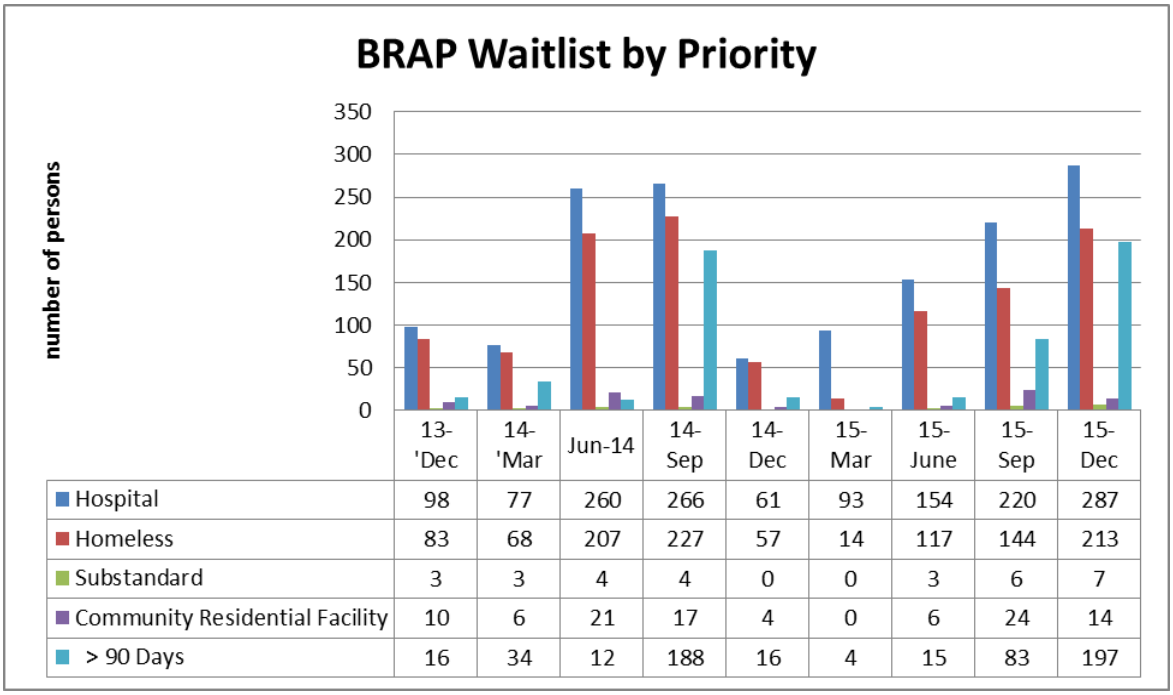
Other Housing Programs

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

Lastly, SAMHS administers a substantial number of Shelter Plus Care vouchers, funded by the U.S. Department of Housing and Urban Development, more than any other state on a per-capita basis. The census as of December 30, 2015 is 1,919 vouchers, of which 43 of these voucher holders are awarded and currently seeking housing. This program has seen significant growth over the last decade, which is the direct result of SAMHS

aggressively applying for, and receiving, new grants annually.However, there has been no increase in HUD funding over the past two years, causing a zero increase in grants funded through HUD. SAMHS is focusing vouchers, when they become available through turnover, on the Chronic and Long Term homeless populations who generally qualify for this program.

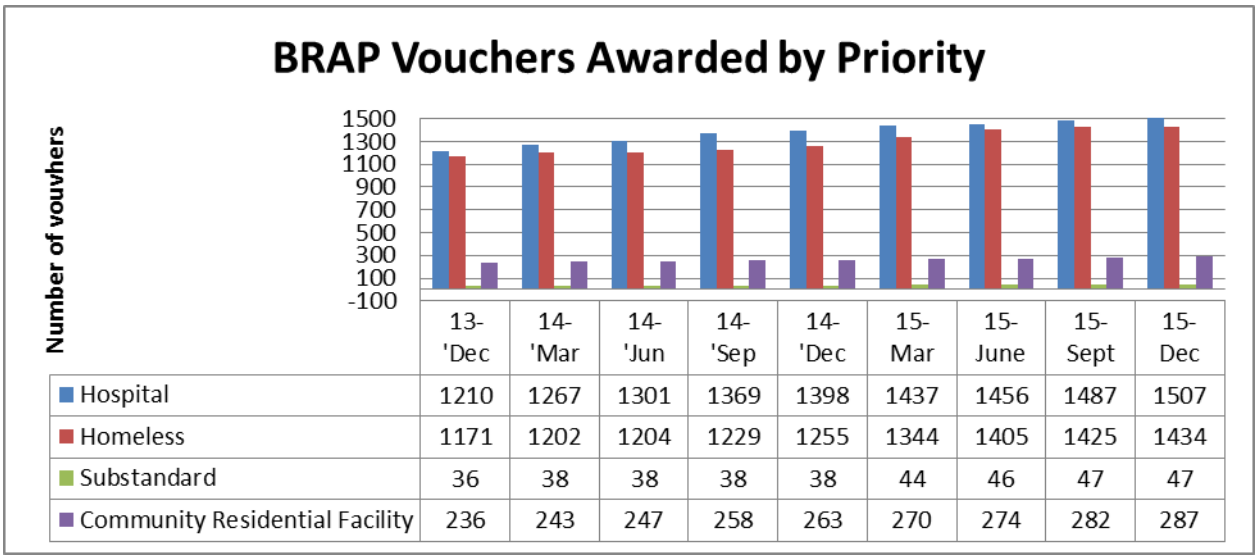
BRAP Waitlist Status--Graph:
Detail by Priority Status to include those persons waiting longer than 90 Days



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

Reporting Period	13-'Dec	14-'Mar	Jun-14	14-Sep	14-Dec	15-Mar	15-June	15-Sep	15-Dec	% Change relative to Last Report
Total number of persons waiting for BRAP	98	77	260	266	61	93	154	220	287	30%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	2	0	26	17	0	0	27	46	51	11%
Priority 2—Homeless (HUD Transitional Definition)	83	68	207	227	57	14	117	144	213	48%
Priority 3—Sub-standard Housing	3	3	4	4	0	0	3	6	7	17%
Priority 4—Leaving a Community Residential living facility	10	6	21	17	4	0	6	24	14	-42%
Total number of persons on wait list more than 90 days awaiting voucher	16	34	12	188	16	4	15	83	197	137%

BRAP Awards—Graph and Table
Cumulative Since Inception of Waitlist



	13-'Dec	14-'Mar	14-'Jun	14-'Sep	14-'Dec	15-Mar	15-June	15-Sept	15-Dec
Hospital	1210	1267	1301	1369	1398	1437	1456	1487	1507
Homeless	1171	1202	1204	1229	1255	1344	1405	1425	1434
Substandard	36	38	38	38	38	44	46	47	47
Community Residential Facility	236	243	247	258	263	270	274	282	287

BRAP Awards—Table
Cumulative Percent Change Since Inception of Waitlist

Reporting Periods	13-'Dec	14-'Mar	14-'Jun	14-'Sep	14-'Dec	15-Mar	15-June	15-Sept	15-Dec	% Change relative to Last Report
Cumulative number of persons awarded BRAP	2668	2767	2808	2914	2974	3116	3203	3262	3297	1.07%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	1210	1267	1301	1369	1398	1437	1456	1487	1507	1.34%
Priority 2—Homeless (HUD Transitional Definition)	1171	1202	1204	1229	1255	1344	1405	1425	1434	0.63%
Priority 3—Sub-standard Housing	36	38	38	38	38	44	46	47	47	0.00%
Priority 4—Leaving a DHHS funded living facility	236	243	247	258	263	270	274	282	287	1.77%

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Class Member Treatment Planning Review

For the 2nd Quarter of Fiscal Year 2016

(October, November, December, 2015)

		2015 Q3	2015 Q4	2016 Q1	2016 Q2
Total Plans Reviewed		45	49	50	50
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% 5 of 5	83.3% 15 of 18	100.0% 9 of 9	92.6% 25 of 27
1B	Does the record document that the agency has planned with and educated the consumer regarding releases of information during each treatment plan review?	100.0% 45 of 45	87.8% 43 of 49	100.0% 48 of 48	93.5% 43 of 46
1C	Does the record document that the consumer has a primary care physician (PCP)?	93.3% 42 of 45	93.8% 45 of 48	90.0% 45 of 50	90.0% 45 of 50
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?	97.6% 41 of 42	77.8% 35 of 45	88.9% 40 of 45	86.7% 39 of 45
II Treatment Plan					

2A	Does the record document that the domains of housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional/psychological, and psychiatric were assessed with the consumer in treatment planning?	100.0% 45 of 45	78.7% 37 of 47	100.0% 49 of 49	100.0% 50 of 50
2C	Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?	97.7% 43 of 44	100.0% 47 of 47	91.8% 45 of 49	100.0% 50 of 50
2I	Does the record document that the consumer has a mental health advance directive?	17.8% 8 of 45	6.3% 3 of 48	4.0% 2 of 50	8.0% 4 of 50
2J	If 2I. is yes, has the advance directive been reviewed at least annually by the CSW and consumer?	62.5% 5 of 8	100.0% 3 of 3	50.0% 1 of 2	50.0% 2 of 4
2K	If 2I. is no, is the reason why documented?	100.0% 37 of 37	100.0% 45 of 45	100.0% 48 of 48	100.0% 46 of 46
III Needed Resources					
3A	Does the record document that natural supports (family/friends) are being accessed as a resource?	91.1% 41 of 45	93.8% 45 of 48	90.0% 45 of 50	86.0% 43 of 50
3B	If 3A. is no, has the worker discussed with the consumer the consideration of natural supports as a resource?	100.0% 4 of 4	100.0% 3 of 3	100.0% 5 of 5	100.0% 7 of 7
3C	Does the record document that generic resources (those resources that anyone can access) are being accessed?	95.6% 43 of 45	89.6% 43 of 48	94.0% 47 of 50	94.0% 47 of 50
3D	If 3C. is no, has the worker discussed with the consumer the consideration of generic resources as a resource?	0.0% 0 of 2	0.0% 0 of 5	0.0% 0 of 3	0.0% 0 of 3
3E	Does the record document a resource need that has not been provided according to/within the expected response time?	11.1% 5 of 45	24.4% 11 of 45	32.0% 16 of 50	16.0% 8 of 50
3F	Does the treatment plan reflect interim planning?	80.0% 4 of 5	90.9% 10 of 11	81.3% 13 of 16	50.0% 4 of 8

3G	Does the record document that the treatment team reconvened after the unmet need was identified?	80.0%	4 of 5	90.9%	10 of 11	62.5%	10 of 16	75.0%	6 of 8
IV Service Agreements									
4A	Does the record document that service agreements are required for this plan? (see paragraph 69 protocol for definitions)	55.6%	25 of 45	46.9%	23 of 49	44.0%	22 of 50	66.0%	33 of 50
4B	If 4A. is yes, have service agreements been acquired?	80.0%	20 of 25	52.2%	12 of 23	68.2%	15 of 22	42.4%	14 of 33
4C	If 4A. is yes, are the service agreements current?	80.0%	20 of 25	52.2%	12 of 23	68.2%	15 of 22	42.4%	14 of 33
V Vocational Services									
5A	Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?	100.0%	45 of 45	81.3%	39 of 48	100.0%	50 of 50	98.0%	49 of 50
5B	Does the record document that the vocational domain is being addressed with the consumer at each 90 day treatment plan review?	86.7%	39 of 45	79.6%	39 of 49	91.8%	45 of 49	94.0%	47 of 50
VI Comments									
6A	Plan of correction requested?	17.8%	8 of 45	51.0%	25 of 49	26.0%	13 of 50	44.0%	22 of 50
6A.1.	Plan of correction for section 2A. (required when not all domains assessed) included?	N/A	0 of 0	100.0%	10 of 10	N/A	0 of 0	N/A	0 of 0
6C	Plan of correction received?	87.5%	7 of 8	96.0%	24 of 25	76.9%	10 of 13	22.7%	5 of 22
6D	Were corrections made to the satisfaction of the CDC?	100.0%	7 of 7	100.0%	24 of 24	100.0%	10 of 10	100.0%	5 of 5

Report Run by: Brandi.Giguere Report Run on: Jan 4, 2016 at 10:44:14 AM

Adult Mental Health Services
An Office of the
Department of Health and Human Services

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

Community Hospital Utilization Review for Involuntary

Class Member and Non Class Member

For the 1st Quarter of Fiscal Year 2016

(July, August, September, 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Total Admissions	116	99	113	95
Hospital				
Hospitalized in Local Area	89.7% (104 of 116)	93.9% (93 of 99)	88.5% (100 of 113)	91.6% (87 of 95)
Hospitalization Made Voluntary	73.3% (85 of 116)	71.7% (71 of 99)	77.9% (88 of 113)	63.2% (60 of 95)
Quality Care				
Active Treatment Within Guidelines	99.1% (115 of 116)	100.0% (99 of 99)	100.0% (113 of 113)	100.0% (95 of 95)
Individual Service Plans				
Receiving Case Management Services	20.7% (24 of 116)	18.2% (18 of 99)	23.0% (26 of 113)	20.0% (19 of 95)
Case Manager Involved with Discharge Planning	100.0% (24 of 24)	100.0% (18 of 18)	96.2% (25 of 26)	94.7% (18 of 19)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (24 of 24)	100.0% (18 of 18)	100.0% (26 of 26)	100.0% (19 of 19)
Hospital Obtained ISP when authorized	16.7% (4 of 24)	11.1% (2 of 18)	0.0% (0 of 26)	0.0% (0 of 19)
Treatment and Discharge Plan Consistant with ISP	100.0% (4 of 4)	100.0% (2 of 2)	N/A (0 of 0)	N/A (0 of 0)

Report Run: Jan 22, 2016

For questions, contact the Data Specialist Team at the Office of Adult Mental Health Services

Community Hospital Utilization Review for Involuntary

Class Members

For the 1st Quarter of Fiscal Year 2016

(July, August, September, 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Total Admissions	22	16	24	18
Hospital				
Hospitalized in Local Area	95.5% (21 of 22)	87.5% (14 of 16)	79.2% (19 of 24)	94.4% (17 of 18)
Hospitalization Made Voluntary	27.3% (6 of 22)	31.2% (5 of 16)	58.3% (14 of 24)	27.8% (5 of 18)
Quality Care				
Active Treatment Within Guidelines	100.0% (22 of 22)	100.0% (16 of 16)	100.0% (24 of 24)	100.0% (18 of 18)
Individual Service Plans				
Receiving Case Management Services	22.7% (5 of 22)	6.2% (1 of 16)	37.5% (9 of 24)	33.3% (6 of 18)
Case Manager Involved with Discharge Planning	100.0% (5 of 5)	100.0% (1 of 1)	100.0% (9 of 9)	100.0% (6 of 6)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (5 of 5)	100.0% (1 of 1)	100.0% (9 of 9)	100.0% (6 of 6)
Hospital Obtained ISP when authorized	20.0% (1 of 5)	100.0% (1 of 1)	0.0% (0 of 9)	0.0% (0 of 6)
Treatment and Discharge Plan Consistant with ISP	100.0% (1 of 1)	100.0% (1 of 1)	N/A (0 of 0)	N/A (0 of 0)

Report Run: Jan 22, 2016

For questions, contact the Data Specialist Team at the Office of Adult Mental Health Services

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

Community Hospital Utilization Review for Involuntary Admissions

Performance Standard 18-1,2,3 by Hospital: Class Member and Non-Class Member

For the 1st Quarter of Fiscal Year 2016

(July, August, September, 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Number of Admissions	116	99	113	95
Involuntarily Admitted Clients who were Receiving CSS Services	24	18	26	19
Number of ISPs Hospitals were Authorized to Obtain	24	18	26	19
Number of ISPs Hospitals Obtained	4	2	0	0

FY QTR	Hospital	Admissions	Receiving Community Support Services	Hospital Obtained ISP when authorized	Treatment and Discharge Plan Consistant with ISP	Case Worker Involved with Treatment and Discharge Planning
2015 Q2	**Acadia**	21	28.6% (6 of 21)	0.0% (0 of 6)	N/A (0 of 0)	100.0% (6 of 6)
	Maine General - Augusta	9	44.4% (4 of 9)	100.0% (4 of 4)	100.0% (4 of 4)	100.0% (4 of 4)
	Mid-coast Hospital	7	14.3% (1 of 7)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	5	20.0% (1 of 5)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	14	14.3% (2 of 14)	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	6	33.3% (2 of 6)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
2015 Q3	**Acadia**	19	26.3% (5 of 19)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	Maine General - Augusta	6	33.3% (2 of 6)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	Mid-coast Hospital	6	33.3% (2 of 6)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	PenBay Medical Center	4	0.0% (0 of 4)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	18	16.7% (3 of 18)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Spring Harbor	33	15.2% (5 of 33)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	St. Mary's	13	7.7% (1 of 13)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
2015 Q4	**Acadia**	16	31.2% (5 of 16)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	Maine General - Augusta	3	33.3% (1 of 3)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	6	16.7% (1 of 6)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	9	22.2% (2 of 9)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Spring Harbor	63	22.2% (14 of 63)	0.0% (0 of 14)	N/A (0 of 0)	92.9% (13 of 14)
	St. Mary's	14	21.4% (3 of 14)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
2016 Q1	**Acadia**	9	22.2% (2 of 9)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Augusta	8	12.5% (1 of 8)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Maine Medical Center	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	3	33.3% (1 of 3)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	5	20.0% (1 of 5)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	17	41.2% (7 of 17)	0.0% (0 of 7)	N/A (0 of 0)	85.7% (6 of 7)
	Spring Harbor	38	13.2% (5 of 38)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	St. Mary's	14	7.1% (1 of 14)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)

Report Run: Jan 22, 2016

For questions, contact the Data Specialist Team at the Office of Adult Mental Health Services

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

Community Hospital Utilization Review for Involuntary Admissions

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

For the 1st Quarter of Fiscal Year 2016

(July, August, September, 2015)

	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Number of Admissions	13	10	19	11
Involuntarily Admitted Clients who were Receiving CSS Services	4	1	8	5
Number of ISPs Hospitals were Authorized to Obtain	4	1	8	5
Number of ISPs Hospitals Obtained	1	1	0	0

FY QTR	Hospital	Admissions	Receiving Community Support Services	Hospital Obtained ISP when authorized	Treatment and Discharge Plan Consistant with ISP	Case Worker Involved with Treatment and Discharge Planning
2015 Q2	**Acadia**	2	50.0% (1 of 2)	100.0% (1 of 1)	NA (0 of 0)	100.0% (1 of 1)
	Maine General - Augusta	2	50.0% (1 of 2)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Southern Maine Medical Center	1	0.0% (0 of 1)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
	Spring Harbor	8	25.0% (2 of 8)	100.0% (2 of 2)	NA (0 of 0)	100.0% (2 of 2)
2015 Q3	**Acadia**	1	0.0% (0 of 1)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
	Maine General - Augusta	1	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Southern Maine Medical Center	1	0.0% (0 of 1)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
	Spring Harbor	7	0.0% (0 of 7)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
2015 Q4	**Acadia**	2	0.0% (0 of 2)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)
	Maine General - Augusta	1	100.0% (1 of 1)	100.0% (1 of 1)	NA (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	1	100.0% (1 of 1)	100.0% (1 of 1)	NA (0 of 0)	100.0% (1 of 1)
	Spring Harbor	15	40.0% (6 of 15)	100.0% (6 of 6)	NA (0 of 0)	100.0% (6 of 6)
2016 Q1	**Acadia**	2	50.0% (1 of 2)	100.0% (1 of 1)	NA (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	1	100.0% (1 of 1)	100.0% (1 of 1)	NA (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	1	100.0% (1 of 1)	100.0% (1 of 1)	NA (0 of 0)	100.0% (1 of 1)
	Spring Harbor	6	33.3% (2 of 6)	100.0% (2 of 2)	NA (0 of 0)	100.0% (2 of 2)
	St. Mary's	1	0.0% (0 of 1)	NA (0 of 0)	NA (0 of 0)	NA (0 of 0)

Report Run: Jan 22, 2016

For questions, contact the Data Specialist Team at the Office of Adult Mental Health Services

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

Maine Department of Health and Human Services

Integrated Quarterly Crisis Report

STATEWIDE with GRAPHS

QTR2 (October, November and December) SYF16

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

Gender	Children	Males	666	Females	680				
	Adults	Males	2,405	Females	2,260				
Age Range	Children	< 5	3	5 - 9	149	10 - 14	587	15-17	607
	Adults	18 - 21	473	22 - 35	1,425	36 - 60	2,237	>60	530
Payment Source	Children	MaineCare	933	Private Ins.	305	Uninsured	107	Medicare	1
	Adults	MaineCare	2,258	Private Ins.	821	Uninsured	1,299	Medicare	287

II. Summary Of All Crisis Contacts

	Children	Adults
a. Total number of telephone contacts	6,848	27,450
b. Total number of all Initial face-to-face contacts	1,149	3,750
c. Number in II.b. who are children/youth with Mental Retardation/Autism/Pervasive Dev. Disorder	124	
d. Number of face-to-face contacts that are ongoing support for crisis resolution/stabilization	206	1,221

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	71	6.2%	63	1.7%
b. Number of Initial face-to-face contacts who have a Community Support Worker (CI,CRS,ICM, ACT,TCM)	385	33.5%	955	25.5%
c. Number of Initial face-to-face contacts who have a Comm. Support Worker that was notified of crisis	372	96.6%	887	92.9%
d. SUM time in minutes for all Initial face-to-face contacts in II.b. from determination of need for face-to-face contact or when individual was ready and able to be seen to Initial face-to-face contact			101,160	27
e. Number of Initial face-to-face contacts in Emergency Department with final disp. within 8 hours			1,977	52.7%
f. Number of Initial face-to-face contacts not in Emergency Department with final disp. within 8 hours			1,404	37.4%

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.	963	1 to 2 Hours	156	2 to 4 Hours	23	More Than 4 Hours	7	
Percent	83.8%	Percent	13.6%	Percent	2.0%	Percent	0.6%	

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

Less Than 3 Hours	531	3 to 6 Hours	482	6 to 8 Hours	38	8 to 14 Hours	40	> 14	58
Percent	46.2%	Percent	41.9%	Percent	3.3%	Percent	3.5%	Percen	5.0%

IV. Site Of Initial Face-To-Face Contacts

	Children		Adults	
a. Primary Care Residence (Home)	130	11.3%	333	8.9%
b. Family/Relative/Other Residence	38	3.3%	30	0.8%
c. Other Community Setting (Work, School, Police Dept, Public Place)	138	12.0%	106	2.8%
d. SNF, Nursing Home, Boarding Home	0	0.0%	11	0.3%
e. Residential Program (Congregate Community Residence, Apartment Program)	15	1.3%	64	1.7%
f. Homeless Shelter	1	0.1%	33	0.9%
g. Provider Office	31	2.7%	147	3.9%
h. Crisis Office	158	13.8%	572	15.3%
i. Emergency Department	634	55.2%	2,277	60.7%
j. Other Hospital Location	4	0.3%	99	2.6%
k. Incarcerated (Local Jail, State Prison, Juvenile Correction Facility)	0	0.0%	78	2.1%
Totals:	1,149	100%	3,750	100%

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

	Children		Adults	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	34	3.0%	179	4.8%
b. Crisis stabilization with referral to new provider for mental health/substance abuse follow up	232	20.2%	800	21.3%
c. Crisis stabilization with referral back to current provider for mental health/substane abuse follow up	455	39.6%	1,335	35.6%
d. Admission to Crisis Stabilization Unit	143	12.4%	450	12.0%
e. Inpatient Hospitalization Medical	14	1.2%	114	3.0%
f. Voluntary Psychiatric Hospitalization	264	23.0%	646	17.2%
g. Involuntary Psychiatric Hospitalization	6	0.5%	138	3.7%
h. Admission to Detox Unit	1	0.1%	88	2.3%
Totals:	1,149	100%	3,750	100%

Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON ORGANIZATIONAL PERFORMANCE EXCELLENCE

SECOND STATE FISCAL QUARTER 2016

October, November, December 2015

Robert J. Harper
Superintendent
January 22, 2016

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Table of Contents

STRATEGIC PERFORMANCE EXCELLENCE

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Glossary of Terms, Acronyms & Abbreviations

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

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

Introduction

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

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

There are three major sections that make up this report:

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

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

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

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

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

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CONSENT DECREE

Consent Decree Plan

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

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

Patient Rights

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

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. Patients are routinely informed of their rights upon admission.	95% 57/60	100% 45/45	100% 79/79	80% 16/20

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

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	3Q2015	4Q2015	1Q2016	2Q2016
1. Level II grievances responded to by RPC on time.	N/A	100% 1/1	100% 1/1	N/A
2. Level I grievances responded to by RPC on time.	98% 96/98	52% 45/86	78% 129/165	51%* 49/97

*48 grievances were not responded to on time or cannot be accounted for.

CONSENT DECREE

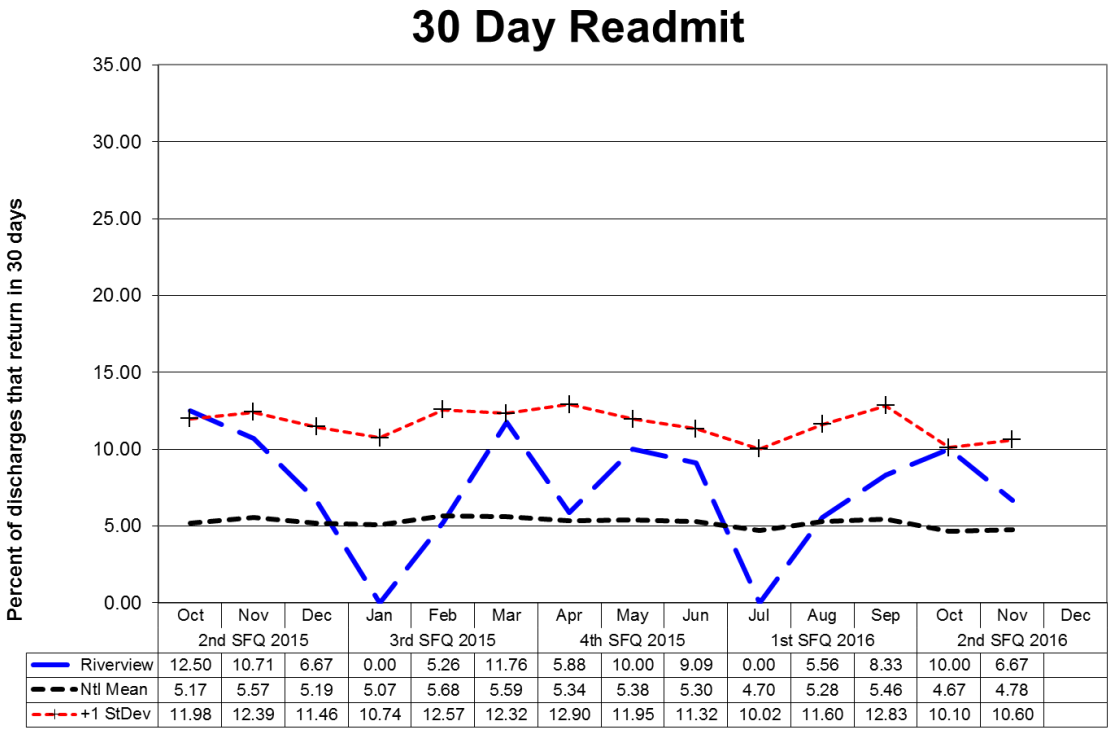
Admissions

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

ADMISSIONS	3Q2015	4Q2015	1Q2016	2Q2016	Total
CIVIL:	**26**	**25**	**30**	**37**	**118**
VOL	0	1	2	1	**4**
CIVIL-INVOL	3	2	4	5	**14**
DCC	22	20	23	31	**96**
DCC-PTP	1	2	1	0	**4**
FORENSIC:	**17**	**20**	**34**	**21**	**92**
60 DAY EVAL	3	6	19	11	**39**
JAIL TRANS	0	0	2	1	**3**
IST	5	13	6	7	**31**
NCR	9	1	7	2	**19**
TOTAL	**43**	**45**	**64**	**58**	**210**

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	12.50	10.71	6.67	0.00	5.26	11.76	5.88	10.00	9.09	0.00	5.56	8.33	10.00	6.67	
Ntl Mean	5.17	5.57	5.19	5.07	5.68	5.59	5.34	5.38	5.30	4.70	5.28	5.46	4.67	4.78	
+1 StDev	11.98	12.39	11.46	10.74	12.57	12.32	12.90	11.95	11.32	10.02	11.60	12.83	10.10	10.60	

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

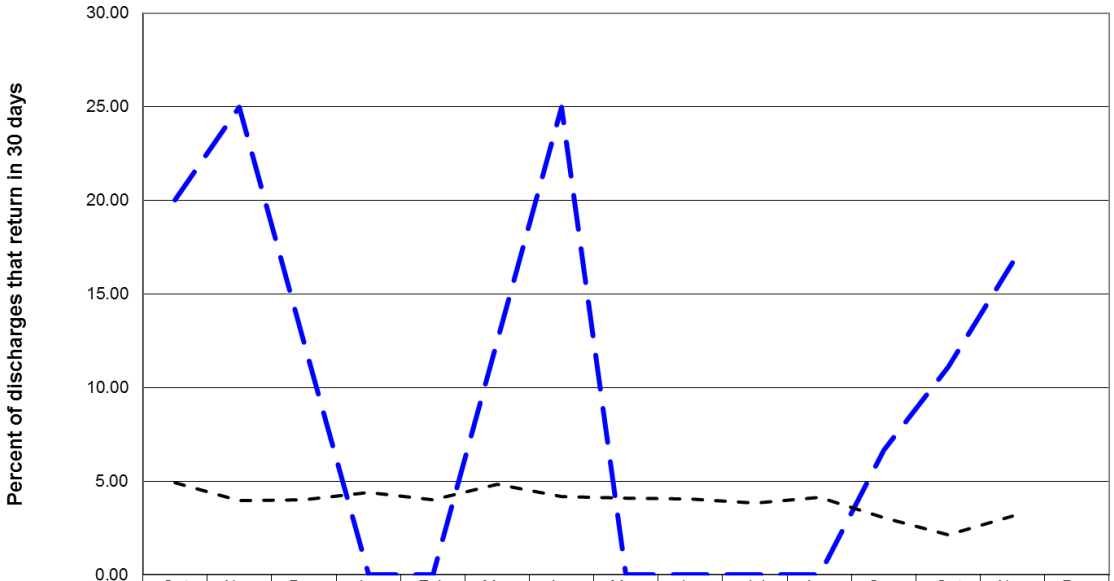
Reasons for patient readmission are varied and may include decompensating or lack of compliance with a PTP. Specific causes for readmission are reviewed with each patient upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient granularity to determine trends for causes of readmission. Between August 2013 and November 2014, the Lower Saco Unit was decertified; patients had to be discharged and readmitted in our Meditech Electronic Medical Record system whenever they transferred units within the hospital (either from or to Lower Saco), which caused them to show up as a 30 Day Readmission, even though they never left the hospital.

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

CONSENT DECREE

30 Day Readmit

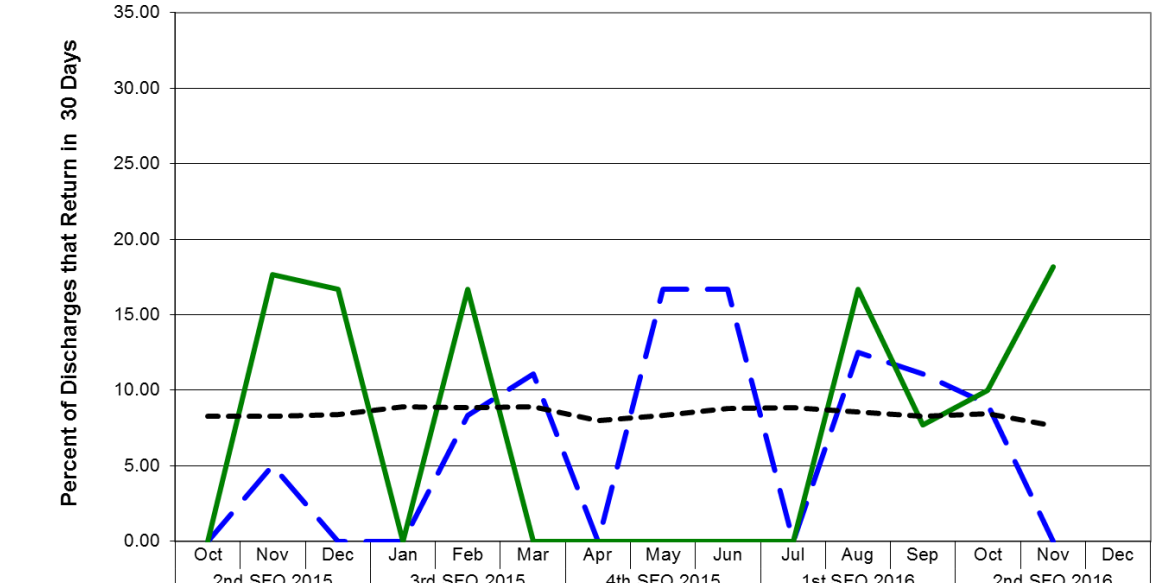
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	20.00	25.00	12.50	0.00	0.00	12.50	25.00	0.00	0.00	0.00	0.00	6.67	11.11	16.67	
Ntl Mean	4.93	3.98	4.02	4.41	3.99	4.84	4.19	4.11	4.04	3.84	4.14	3.06	2.12	3.15	

30 Day Readmit

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.00	5.00	0.00	0.00	8.33	11.11	0.00	16.67	16.67	0.00	12.50	11.11	9.09	0.00	
Dorothea Dix	0.00	17.65	16.67	0.00	16.67	0.00	0.00	0.00	0.00	0.00	16.67	7.69	10.00	18.18	
Ntl Mean	8.27	8.29	8.37	8.91	8.83	8.89	8.01	8.31	8.80	8.85	8.54	8.27	8.44	7.67	

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

REVIEW OF READMISSION OCCURRING WITHIN 60 DAYS

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge, and for each patient who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources; and, where such a need or change was indicated, that corrective action was taken.	100% 5/5	100% 2/2	100% 5/5	100% 4/4

2Q2016:

Four patients were readmitted in 2Q2016. Of the four readmitted, two spent less than 30 days in the community. Patient 1 spent 2 days in the community post discharge; he was readmitted after eloping while in the community. Patient 2 was discharged to Maine General for an emerging medical crisis for 4 days then was readmitted. Patient 3 was a forensic discharge from an IST evaluation and was readmitted on an NCR order 5 days after discharge. Patient 4 was a forensic discharge from a 60 day evaluation and returned within 23 days on an IST order.

CONSENT DECREE

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

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. The Program Service Director of the Outpatient Services Program will review all patient cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (group home, apartment, etc.) c. Geographic location of residence d. Community support network e. Patient demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with Outpatient Treatment	100% 6/6	100% 1/1	100% 6/6	100% 2/2
2. Outpatient Services will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%	100%	100%

2Q2016:

1. Two patients returned to RPC: One patient due to an increase in delusional thought process who was experiencing difficulty with his vision causing a safety issue, and another patient for being intrusive, disruptive and oppositional.
2. 100% attendance at RPC treatment team meetings that OPS was scheduled to attend.

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.

PATIENT ADMISSION DIAGNOSIS	3Q15	4Q15	1Q16	2Q16	TOTAL
ADJUSTMENT DISORDER WITH DEPRESSED MOOD				1	**1**
ADJUSTMENT DISORDER W/ MIXED DISTURBANCE OF EMOTIONS & CONDUCT		1	1		**2**
ADJUSTMENT REACTION NOS	1				**1**
ANTISOCIAL PERSONALITY			1		**1**
ATTENTION DEFICIT W/ HYPERACTIVITY			1		**1**
AUTISTIC DISORDER				1	**1**
BIPOLAR DISORD, CRNT EPISODE MANIC W/O PSYCH FEATURES, MILD				1	**1**
BIPOLAR DISORD, CRNT EPSD DEPRESS, SEVERE, W PSYCH FEATURES				1	**1**
BIPOLAR DISORDER, UNSPECIFIED	1		10	6	**17**
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE, SPEC W/ PSYCHOTIC BEHAV		1	1		**2**
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE, W/O PSYCHOTIC FEATURES		1	1		**2**
BIPOLAR I, MOST REC EPIS (OR CURRENT) MIXED, UNSPEC	1				**1**
BIPOLAR I, REC EPIS OR CURRENT MANIC, IN PARTIAL OR UNSPEC REMISSION		1	1		**2**
BIPOLAR I, REC EPIS OR CURRENT MANIC, SEVERE, W/ PSYCHOTIC BEHAV			2		**2**
DELUSIONAL DISORDERS		1	1	1	**3**
DEMENTIA IN OTH DISEASES CLASSD ELSWHR W/O BEHAVRL DISTURB				1	**1**
DEPRESSIVE DISORDER NEC			3		**3**
DEPRESSIVE DISORDER-SEVERE	1	2			**3**
DEPRESSIVE DISORDER-UNSPEC			1		**1**
HEBEPHRENIA-UNSPEC	2				**2**
IMPULSE CONTROL DISORDER NOS		1			**1**
MAJOR DEPRESSV DISORDER, RECURRENT SEVERE W/O PSYCH FEATURES				1	**1**
OTH PSYCH DISORDER NOT DUE TO A SUB OR KNOWN PHYSIOL COND				1	**1**
OTHER SCHIZOPHRENIA				2	**2**

CONSENT DECREE

PATIENT ADMISSION DIAGNOSIS	3Q15	4Q15	1Q16	2Q16	TOTAL
OTHER SPEC PERVASIVE DEVELOPMENT DIS, CURRENT OR ACTIVE STATE	1	2			**3**
PARANOID SCHIZOPHRENIA				1	**1**
PARANOID SCHIZOPHRENIA-CHRONIC W/EXACERBATION	3				**3**
PARANOID SCHIZOPHRENIA-UNSPEC	1	1	1		**3**
POSTTRAUMATIC STRESS DISORDER	8	8	5	2	**23**
PSYCHOSIS NOS			4		**4**
RECURRENT DEPRESSIVE DISORDER-PSYCHOTIC		1	1		**2**
SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE				14	**14**
SCHIZOAFFECTIVE DISORDER, CHRONIC W/EXACER	17	17			**34**
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED			14	6	**20**
SCHIZOPHRENIA NOS-CHRONIC	1	5			**6**
SCHIZOPHRENIA, UNSPECIFIED		1	14	9	**24**
UNSPECIFIED ALCOHOL-INDUCED MENTAL DISORDERS	6	2			**8**
UNSPECIFIED EPISODIC MOOD DISORDER			2		**2**
UNSP PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSICAL COND				11	**11**
Total Admissions	43	45	64	59	**211**
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0%	0%	0%	2%	**< 1%**

CONSENT DECREE

Peer Supports

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

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

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

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. Attendance at Comprehensive Treatment Team meetings. (v9)	96% 383/414	91% 383/414	89% 331/404 25 declined	86% 446/515
2. Attendance at Service Integration meetings. (v8)	93% 26/28	61% 19/31	97% 61/63	96% 47/49
3. Contact during admission. (v8)	100% 43/43	100% 45/45	100% 64/64	100% 49/49
4. Community Integration/Bridging Inpatient & OPS. Inpatient trips OPS	100% 71 163	100% 25 142	100% 58 27	100% 91 131
5. Peer Support will make an attempt to assist all patients in recognizing their personal medicine and filling out form.	100% 43/43	100% 45/45	0% 0/64	82% 40/49
6. Peer Support will make a documented attempt to have patients fill out a survey before discharge or annually to evaluate the effectiveness of the peer support relationship during hospitalization.	82% 46/56	62% 28/45	22% 14/63	41% 20/49
7. Grievances responded to on time by Peer Support, within 1 day of receipt.	100% 98/98	100% 86/86	100% 161/161	100% 97/97
8. Peer Specialist will meet with resident's within 48 hours of admission and complete progress note to document meeting.	New Indicator Added FY 2016		100% 64/64	100% 49/49
9. Each resident has documented contact with a peer supporter during their hospitalization (target is 100%).	New Indicator Added FY 2016		100% 64/64	100% 49/49

CONSENT DECREE

2Q2016:

1. Out of the 515 treatment team meetings, Peer Support attended 404. For 45 meetings, the patient refused to have Peer Support at the meeting or Peer Support was not notified of the change in time of the meeting.

4. During this quarter, the Peer Support Coordinator will be implementing a new method to find candidates for the bridging program, which will be reported next quarter.

6. Due to staff turnover on one unit and orienting new staff surveys for one unit is lower than usual for the unit with the most discharges. This should be resolved in the next quarterly report. The Peer Support Coordinator will be going around monthly to each unit surveying the patients as to their view of the Peer Support Program and what stands in the way of giving data of completing surveys.

Treatment Planning

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

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. Service Integration Meeting and form completed by the end of the 3rd day.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
2. Patient participation in Service Integration Meeting.	93% 42/45	95% 43/45	93% 42/45	95% 43/45
3. Social Worker participation in Service Integration Meeting.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
4. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	95% 43/45	95% 43/45	97% 44/45	95% 43/45
5. Initial Comprehensive Assessment contains summary narrative with conclusion and recommendations for discharge and Social Worker role.	100% 45/45	100% 45/45	100% 45/45	100% 45/45
6. Annual Psychosocial Assessment completed and current in chart.	100% 10/10	100% 10/10	100% 10/10	100% 10/10

2Q2016:

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

4. Two Comprehensive Psychosocial Assessments were not completed within the 7 day timeframe.

CONSENT DECREE

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

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all patients on assigned **CCM** caseload.	97% 44/45	100% 45/45	91% 41/45	95% 43/45
2. Treatment plans will have measurable goals and interventions listing patient strengths and areas of need related to transition to the community or transition back to a correctional facility.	100% 45/45	100% 45/45	100% 45/45	100% 45/45

2Q2016:

1. Two charts had a late progress note for the prior week which was found during chart audits. The meeting was held with patient but the note was a late entry. This issue was discussed with the individual team members and support was given in supervision.

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

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

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

CONSENT DECREE

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

V13) The treatment plans reflect:

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

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

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

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

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

Medications

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

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

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

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

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

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

CONSENT DECREE

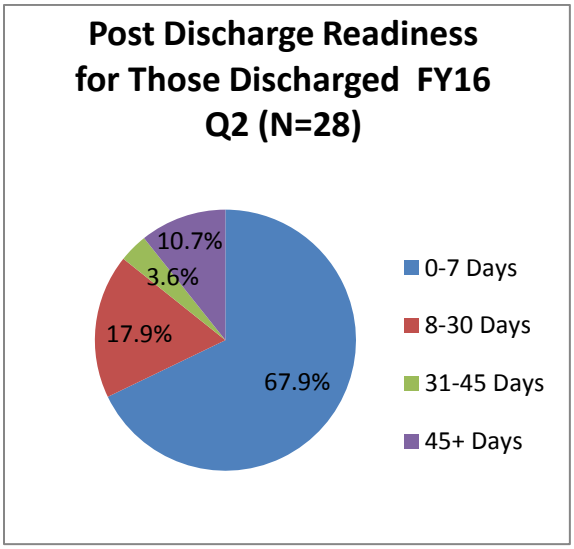
Discharges

Quarterly performance data shows that in 3 consecutive quarters:

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

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

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



Cumulative percentages & targets are as follows:

Within 7 days = (19) 67.9% (target 70%)

Within 30 days = (5) 85.7% (target 80%)

Within 45 days = (1) 89.3% (target 90%)

Post 45 days = (3) 10.7% (target 0%)

Barriers to Discharge Following Clinical Readiness:

Residential Supports (0) No barriers in this area	Housing (9) • 5 patients discharged 8-30 days post clinical readiness (9, 10(2), 15, and 20 days) • 1 patient discharged 31-45 days post clinical readiness (33 days) • 3 patients discharged 45+ days post clinical readiness (49, 63 and 79 days)
Treatment Services (0) No barriers in this area	
Other (0) No barriers in this area	

CONSENT DECREE

The previous four quarters are displayed in the table below

		Within 7 days	Within 30 days	Within 45 days	45+ days
Target >>		**70%**	**80%**	**90%**	**< 10%**
1Q2016	N=34	64.7%	82.3%	91.1%	8.9%
4Q2015	N=29	65.6%	86.2%	93.1%	6.9%
3Q2015	N=38	78.9%	86.8%	89.4%	10.6%
2Q2015	N=39	82.1%	87.2%	89.7%	10.3%

CONSENT DECREE

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

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

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

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

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

Indicators	3Q2015	4Q2015	1Q2016	2Q2016
1. The Patient Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 10/10	100% 12/12	100% 12/12	100% 12/12
2. The Patient Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 10/10	100% 12/12	100% 12/12	100% 12/12
3. The Patient Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	90% 9/10	92% 11/12	83% 10/12	92% 11/12
4. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 10/10	100% 12/12	100% 12/12	92% 11/12

2Q2016:

3. On one occasion the report was not sent out electronically during the week, it was presented at the Wednesday Housing Meeting as a two week snapshot, due to the Director's vacation.

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	3Q2015	4Q2015	1Q2016	2Q2016
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	0% 0/8	66% 2/3	66% 2/3	0% 0/6
2. The assigned **CCM** will review the new court order with the patient and document the meeting in a progress note or treatment team note.	100% 2/2	100% 3/3	100% 3/3	100% 3/3
3. Annual Reports (due in December) to the Commissioner for all inpatient NCR patients are submitted annually	N/A	N/A	N/A	0% 0/25

2Q2016:

1. Six Institutional Reports were completed, but none of the reports were completed in the 10 business day timeframe. We continue to monitor the process to track the reports in the quarter to get improved results for completion.
2. None of the NCR annual reports were completed in December. They remain in process and will be completed and reported on in 3Q2016.

Staffing and Staff Training

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

Indicators	3Q2015	4Q2015	1Q2016	2Q2016	YTD Findings
1. Riverview and Contract staff will attend CPR training bi-annually.	100% 26/26	98% 55/56	100% 55/55	100% 47/47	**99% 183/184**
2. Riverview and Contract staff will attend Annual training.	74% 34/46	89% 25/28	86% 89/104	97% 56/58	**86% 204/236**
3. Riverview and contract staff will attend MOAB training bi-annually	99% 389/391	94% 421/446	100% 28/28	100% 11/11	**97% 849/876**

2Q2016:

2. Two employees are out of compliance for the month of December. Employees and their supervisors have been notified and corrective action is being taken. All staff out of compliance in 1Q2016 are now in compliance.

3. MOAB was initiated in January 2014. This quarter a total of 11 employees received MOAB training. Since the initiation date 351 current employees have completed MOAB training. Recertification trainings will begin January 2016. Data will be collected to reflect new employees who have been trained in MOAB as well as those who have been recertified. Beginning 3Q2016, RPC staff (including contractors) will attend MOAB annually. This is a leadership initiative to improve staff competence and confidence when working with physically aggressive patients to safely and effectively manage behavior through the use of verbal de-escalation and physical intervention strategies.

CONSENT DECREE

Responsible Party: Susan Bundy, Director of Staff Development

I. Measure Name: Ongoing Education and Training

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

Type of Measure: Performance Improvement

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

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

Comments: Neither Non-Violent Communication or Motivational Interviewing was offered in 1Q2016 or 2Q2016 due to staff shortages and budgetary constraints. RPC remains committed to this goal. Motivational Interviewing is scheduled for January 2016.

II. Measure Name: Seclusion and Restraint Reduction

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

Type of Measure: Performance Improvement

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

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

***Average # of events per month in FY 2015: 62.3**

CONSENT DECREE

FY 2016	Manual Holds	Mechanical Restraints	Locked Seclusion	Total Events Per Quarter
Quarter 1	95	6	75	**176**
Quarter 2	61	0	43	**104**
Quarter 3				
Quarter 4				
Total # of events	**156**	**6**	**118**	**280**

***Average # of events per month in FY 2016 to date: 47**

Action Plan:

Staff will receive initial and ongoing education training in MOAB, Non Violent Communication and Motivational Interviewing to assist in establishing therapeutic relationships so that, when a crisis begins, staff will be more influential and effective in preventing the use of seclusion and restraint. Staff Development will provide ongoing education to reinforce the organization's commitment to ensuring a caring, respectful, therapeutic environment. Data gathered through hospital performance measures will be analyzed to determine progress.

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
3Q2015	13	January – March 2015	
4Q2015	17	April – June 2015	
1Q2016	4	July – September 2015	
10/1/2015	1	Shared Decision-Making in the Care of Adults with Severe Mental Illnesses	Will Torrey, MD
10/5/2015	6	Assessment of Risk for Violence in Juveniles	Debra Baeder, PhD, ABPP
10/8/2015	1	A Selection of Medical Co-morbidities in Patients Admitted Over the Past Year	George Davis, MD
10/15/2015	1	Under the Surface: Exploring attachment patterns, family roles and personality traits	Brooke Hoffmann
10/22/2015	1	Pharmacologic Treatment for Alcohol & Opiate Use Disorders: A review of current evidence	Sarah Perry, PharmD
10/29/2015	2	Diagnosis Over a Time Period: A Patient Review with Dartmouth	Miriam Davidson, PMHNP Dan Filene, MD Art Dirocco, PhD Lorraine Zamudio, PsyD
11/12/2015	1	Practical Guide for the Treatment of Nightmares	Randall Beal, PMNP
11/17/2015	1	Med Staff PI & QA Committee	Brendan Kirby, MD
11/19/2015	1	Back when the Barn was New: Part II	Susan Newkirk-Sanborn, PhD
12/3/2015	1	Management of Insomnia	Sarah Perry, PharmD Alexii West, PharmD Student
12/10/2015	1	Facing the End of Life in a Psychiatric Hospital	Regana Sisson, MD
12/16/2015	1	Public Guardianship Training	David White/Jeff Shapiro, OADS
12/17/2015	1	Dancing with the Devil: A Review of Old and New Street Drugs	David Dettmann, DO

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

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

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

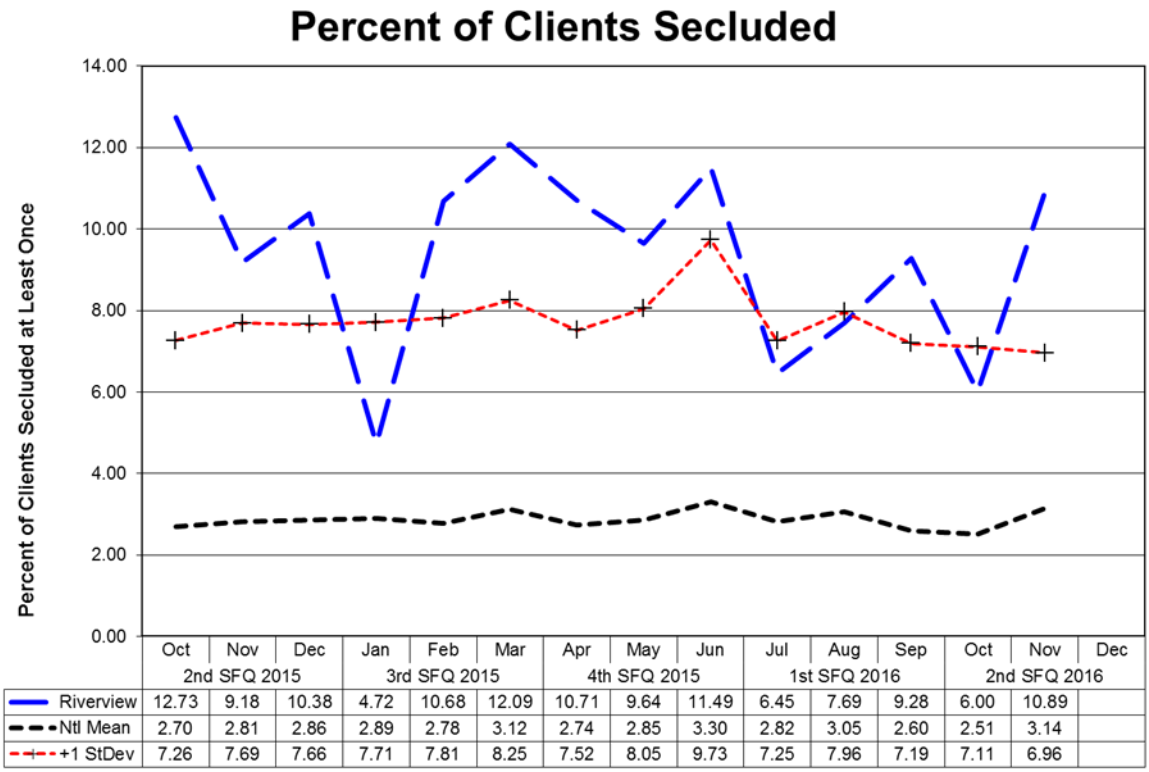
Staffing levels are most often determined by an analysis of unit acuity, individual monitoring needs of the patients who reside on specific units, and unit census.

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

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

Use of Seclusion and Restraints

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	12.73	9.18	10.38	4.72	10.68	12.09	10.71	9.64	11.49	6.45	7.69	9.28	6.00	10.89	
Ntl Mean	2.70	2.81	2.86	2.89	2.78	3.12	2.74	2.85	3.30	2.82	3.05	2.60	2.51	3.14	
+1 StDev	7.26	7.69	7.66	7.71	7.81	8.25	7.52	8.05	9.73	7.25	7.96	7.19	7.11	6.96	

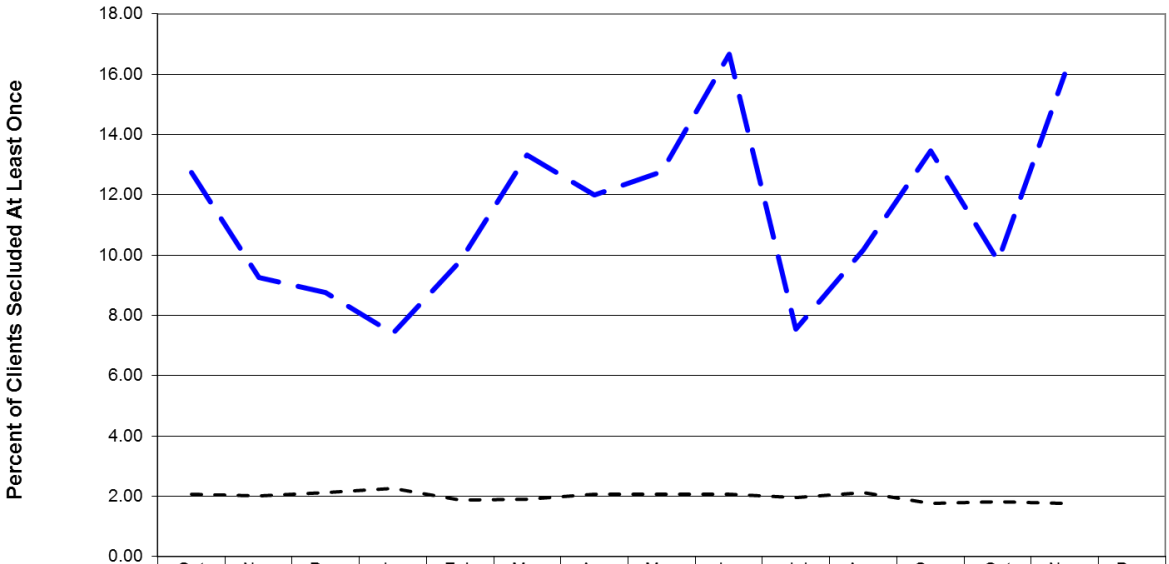
This graph depicts the percent of unique patients who were secluded at least once. For example, rates of 3.0 means that 3% of the unique patients served were secluded at least once.

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

CONSENT DECREE

Percent of Clients Secluded

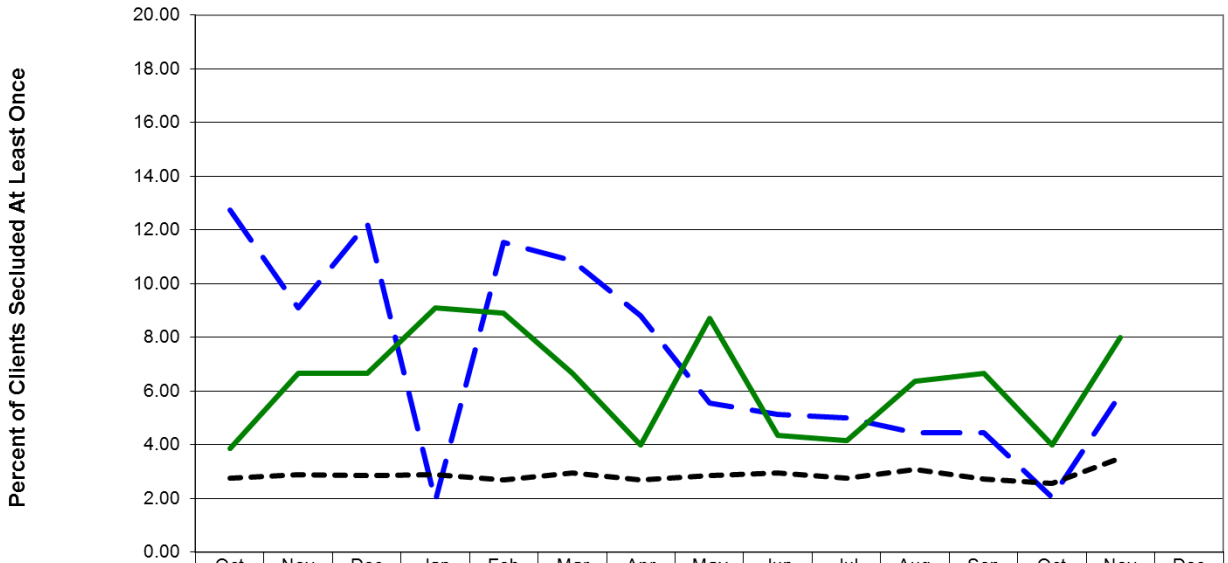
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	12.73	9.26	8.77	7.41	9.80	13.33	12.00	12.77	16.67	7.55	10.17	13.46	9.80	16.00	
Ntl Mean	2.08	2.02	2.11	2.25	1.86	1.89	2.08	2.08	2.08	1.95	2.11	1.76	1.83	1.75	

Percent of Clients Secluded

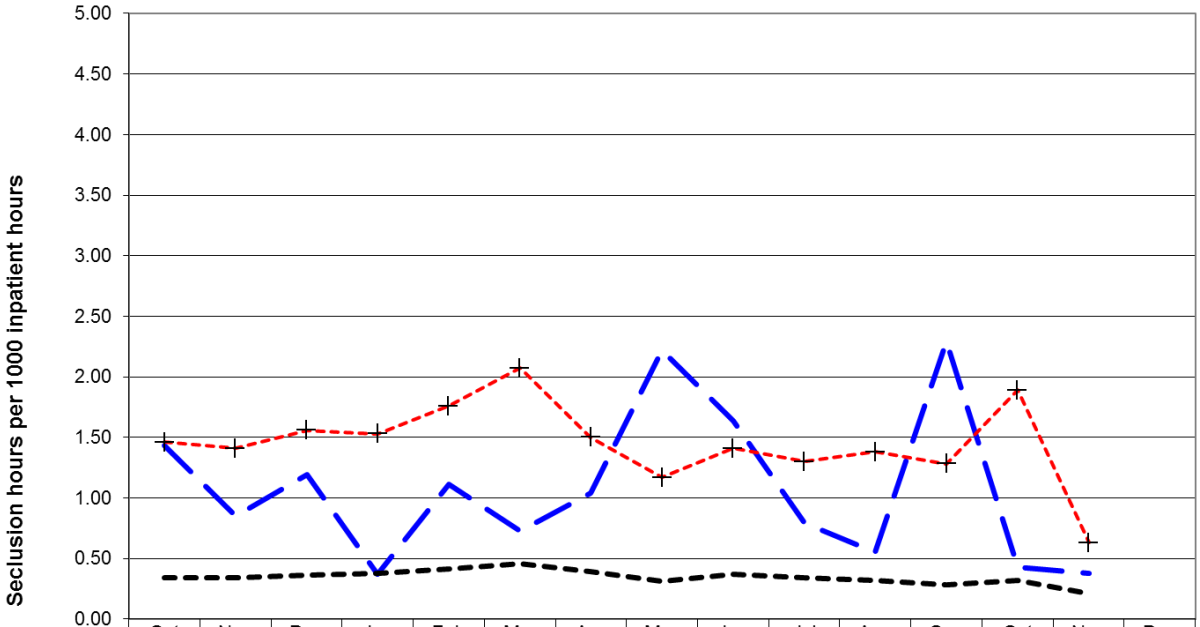
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	12.73	9.09	12.24	1.92	11.54	10.87	8.82	5.56	5.13	5.00	4.44	4.44	2.04	5.88	
Dorothea Dix	3.85	6.67	6.67	9.09	8.89	6.67	4.00	8.70	4.35	4.17	6.38	6.67	4.00	8.00	
Ntl Mean	2.75	2.90	2.85	2.89	2.71	2.95	2.69	2.86	2.97	2.77	3.08	2.73	2.58	3.51	

CONSENT DECREE

Seclusion Hours



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	1.43	0.85	1.19	0.37	1.11	0.73	1.04	2.22	1.64	0.79	0.55	2.29	0.43	0.38	
Ntl Mean	0.34	0.34	0.36	0.38	0.41	0.46	0.39	0.31	0.37	0.34	0.32	0.28	0.32	0.21	
+1 StDev	1.46	1.41	1.56	1.53	1.76	2.07	1.50	1.17	1.41	1.30	1.38	1.28	1.89	0.63	

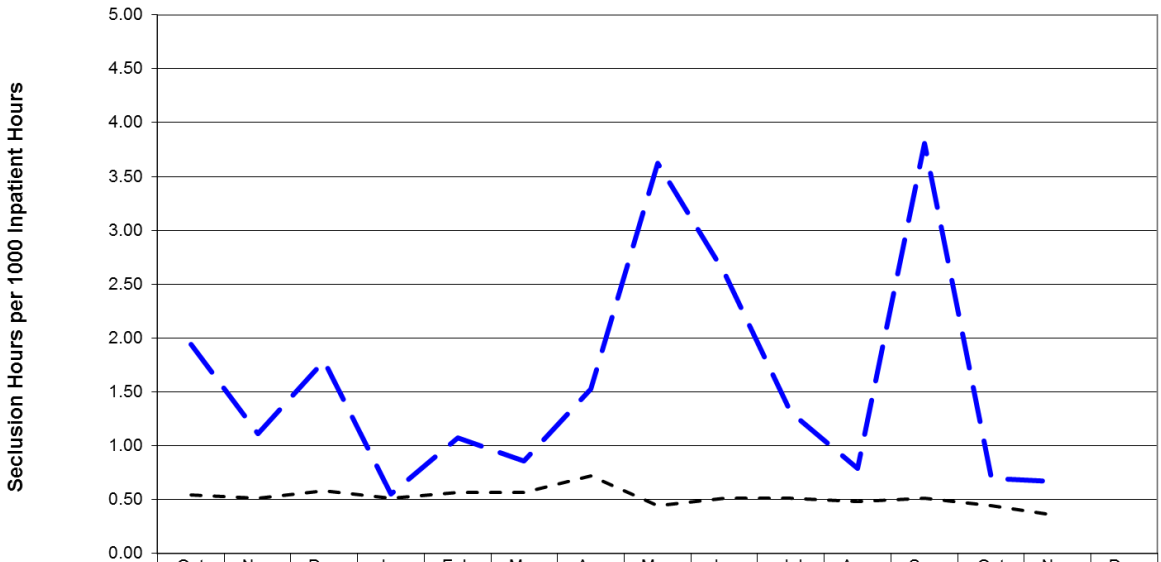
This graph depicts the number of hours patients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

CONSENT DECREE

Seclusion Hours

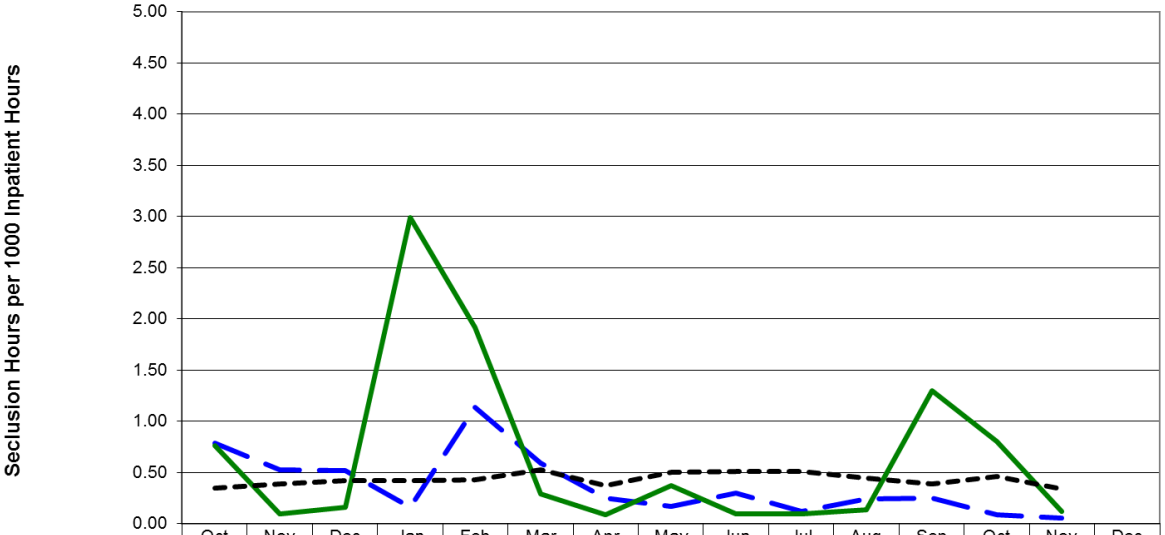
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	1.94	1.11	1.79	0.55	1.07	0.86	1.53	3.62	2.60	1.31	0.79	3.81	0.70	0.67	
Ntl Mean	0.54	0.51	0.58	0.51	0.57	0.57	0.72	0.44	0.51	0.51	0.48	0.51	0.44	0.35	

Seclusion Hours

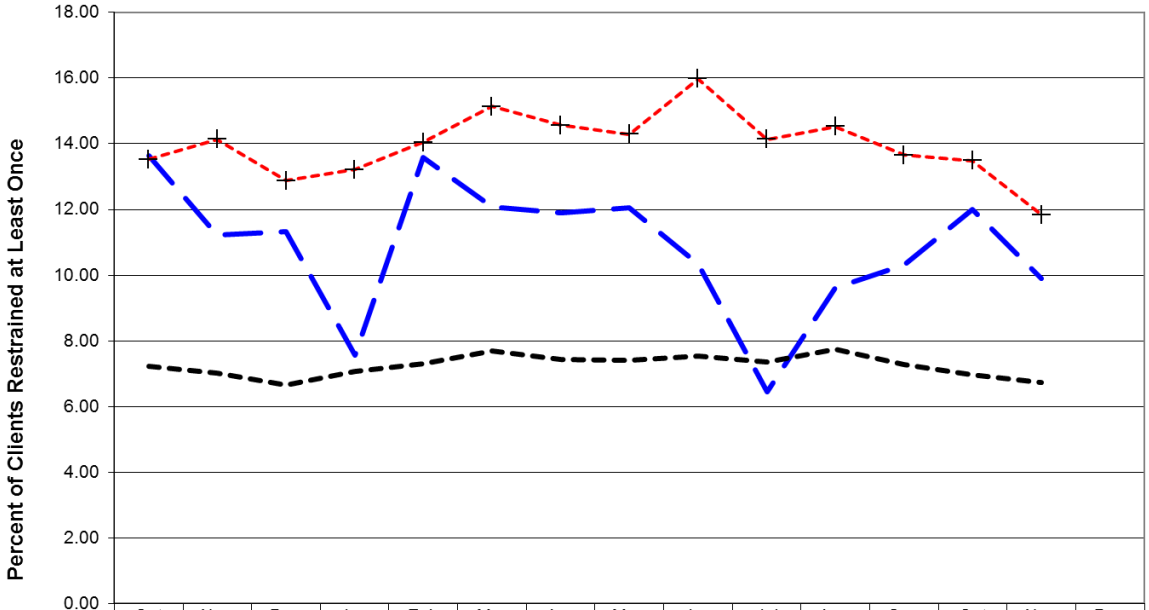
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.79	0.53	0.52	0.16	1.14	0.59	0.25	0.17	0.30	0.12	0.24	0.25	0.09	0.06	
Dorothea Dix	0.76	0.10	0.16	2.99	1.92	0.29	0.09	0.37	0.10	0.10	0.14	1.30	0.80	0.12	
Ntl Mean	0.35	0.39	0.42	0.42	0.43	0.53	0.37	0.50	0.51	0.51	0.45	0.39	0.46	0.34	

CONSENT DECREE

Percent of Clients Restrained



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	13.64	11.22	11.32	7.55	13.59	12.09	11.90	12.05	10.34	6.45	9.62	10.31	12.00	9.90	
Ntl Mean	7.23	7.01	6.66	7.07	7.29	7.69	7.42	7.41	7.54	7.35	7.74	7.28	6.96	6.73	
+1 StDev	13.52	14.13	12.88	13.22	14.05	15.14	14.57	14.29	15.98	14.14	14.53	13.66	13.49	11.84	

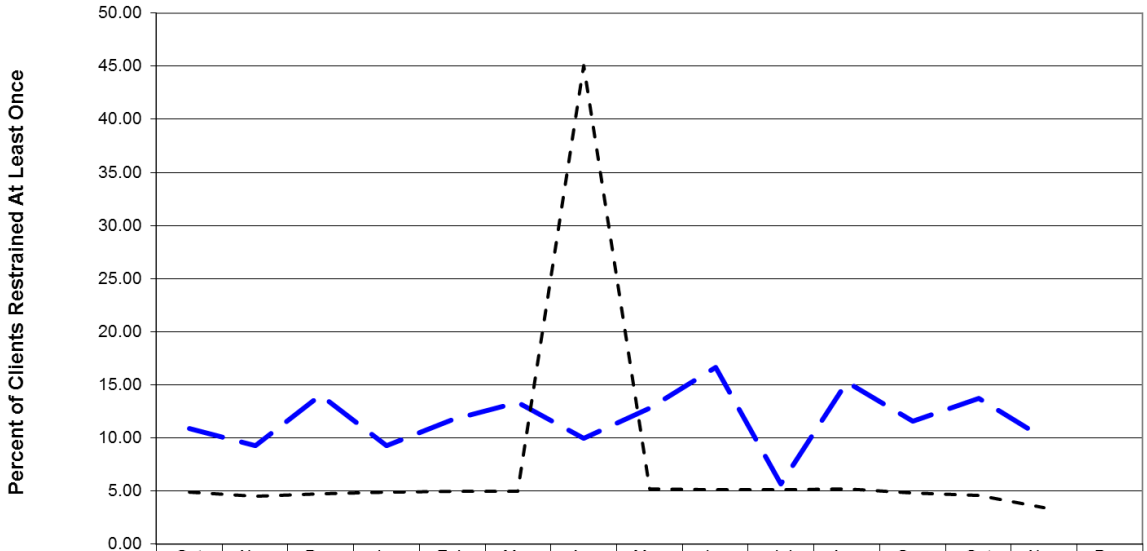
This graph depicts the percent of unique patients who were restrained at least once and includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique patients served were restrained at least once.

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

CONSENT DECREE

Percent of Clients Restrained

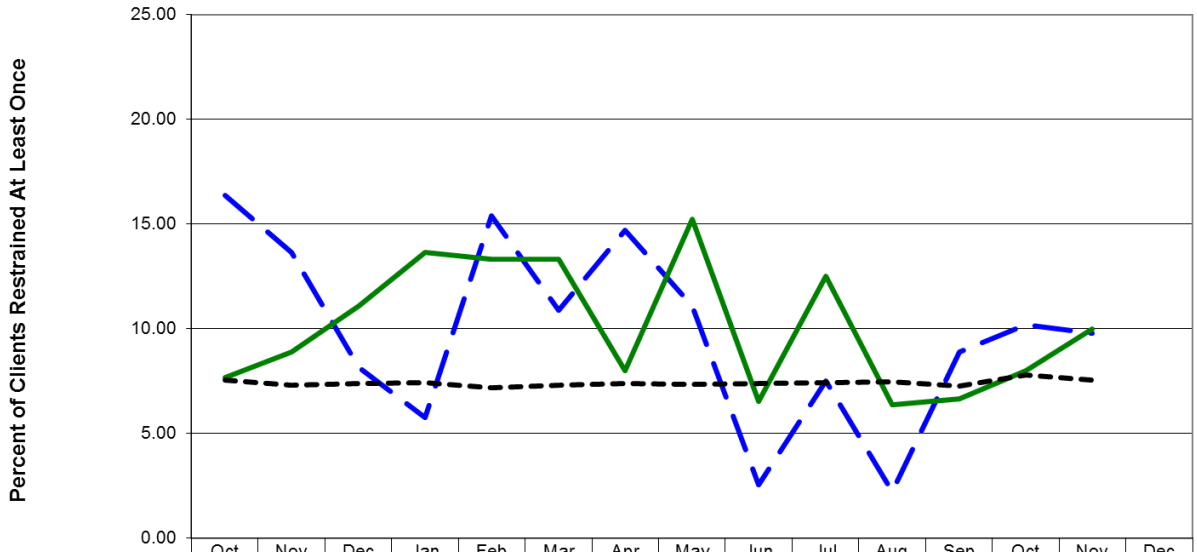
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	10.91	9.26	14.04	9.26	11.76	13.33	10.00	12.77	16.67	5.66	15.25	11.54	13.73	10.00	
Ntl Mean	4.89	4.52	4.71	4.87	4.95	4.96	45.07	5.19	5.14	5.15	5.20	4.78	4.56	3.44	

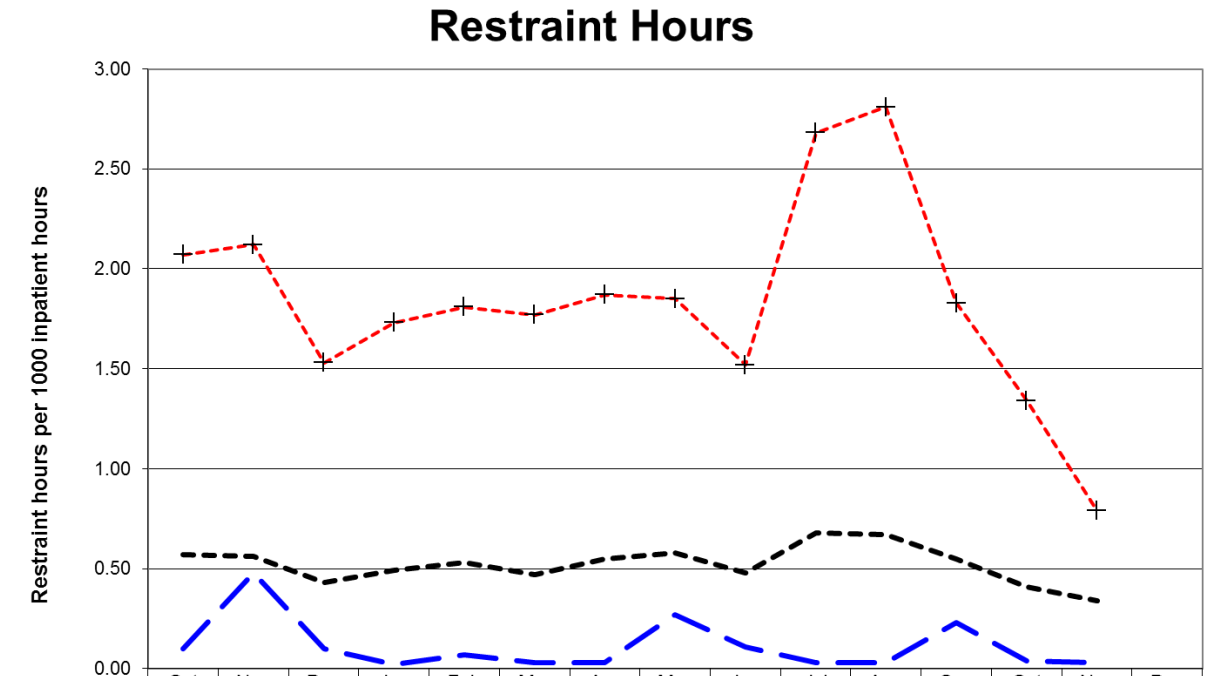
Percent of Clients Restrained

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	16.36	13.64	8.16	5.77	15.38	10.87	14.71	11.11	2.56	7.50	2.22	8.89	10.20	9.80	
Dorothea Dix	7.69	8.89	11.11	13.64	13.33	13.33	8.00	15.22	6.52	12.50	6.38	6.67	8.00	10.00	
Ntl Mean	7.56	7.31	7.38	7.43	7.20	7.33	7.40	7.35	7.41	7.44	7.47	7.28	7.80	7.55	

CONSENT DECREE



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.10	0.48	0.10	0.02	0.07	0.03	0.03	0.27	0.11	0.03	0.03	0.23	0.04	0.03	
Ntl Mean	0.57	0.56	0.43	0.49	0.53	0.47	0.55	0.58	0.48	0.68	0.67	0.55	0.41	0.34	
+1 StDev	2.07	2.12	1.53	1.73	1.81	1.77	1.87	1.85	1.52	2.68	2.81	1.83	1.34	0.79	

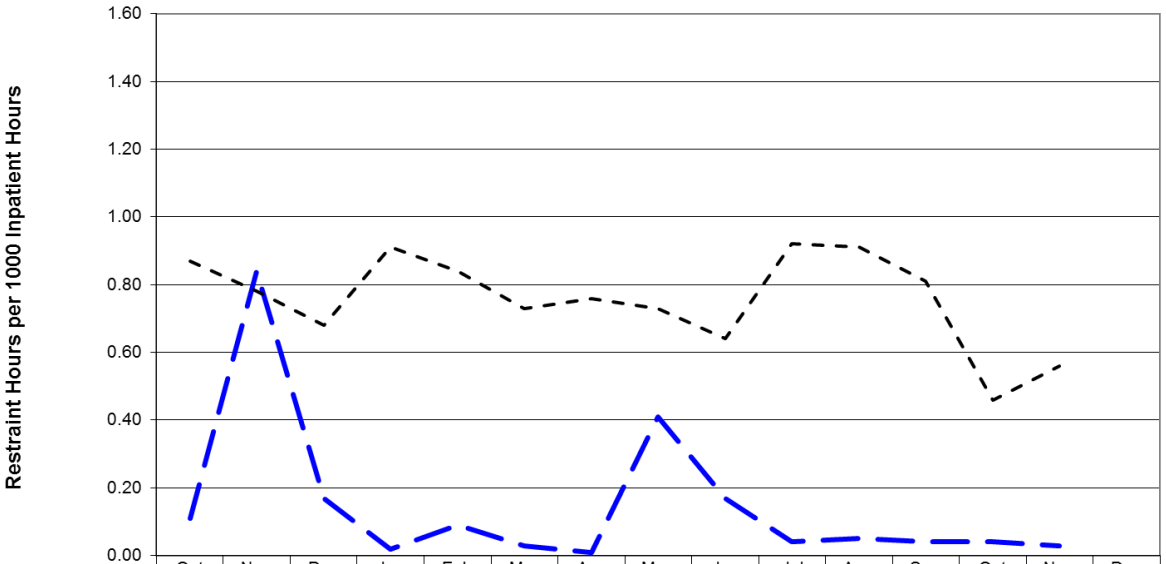
This graph depicts the number of hours patients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.

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

CONSENT DECREE

Restraint Hours

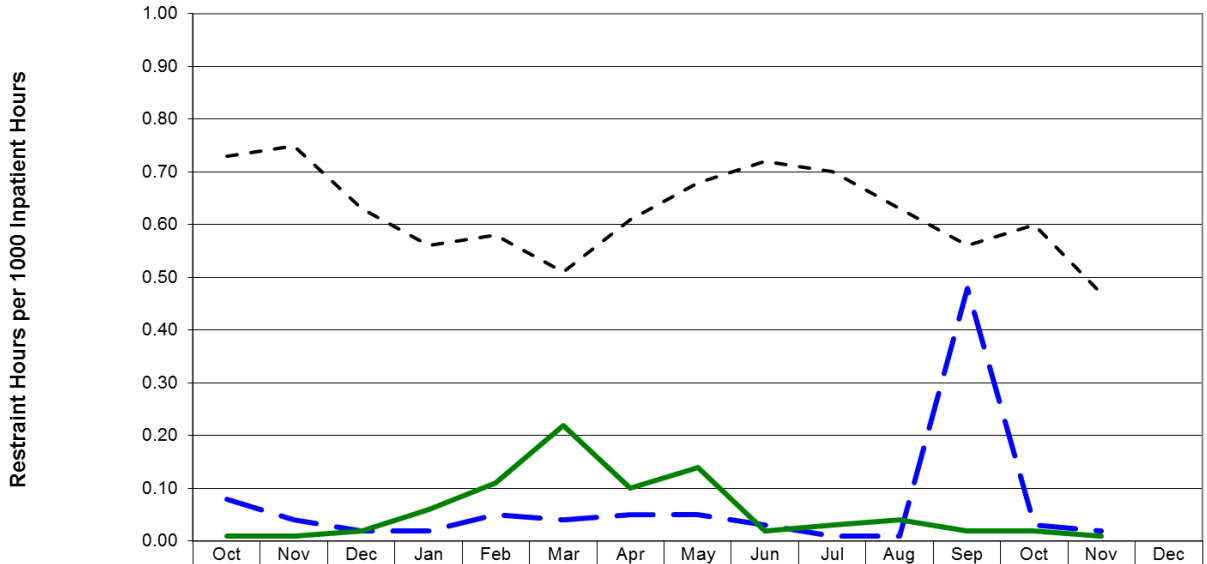
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.11	0.84	0.17	0.02	0.09	0.03	0.01	0.41	0.17	0.04	0.05	0.04	0.04	0.03	
Ntl Mean	0.87	0.78	0.68	0.91	0.84	0.73	0.76	0.73	0.64	0.92	0.91	0.81	0.46	0.56	

Restraint Hours

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.08	0.04	0.02	0.02	0.05	0.04	0.05	0.05	0.03	0.01	0.01	0.48	0.03	0.02	
Dorothea Dix	0.01	0.01	0.02	0.06	0.11	0.22	0.10	0.14	0.02	0.03	0.04	0.02	0.02	0.01	
Ntl Mean	0.73	0.75	0.63	0.56	0.58	0.51	0.61	0.68	0.72	0.70	0.63	0.56	0.60	0.47	

CONSENT DECREE

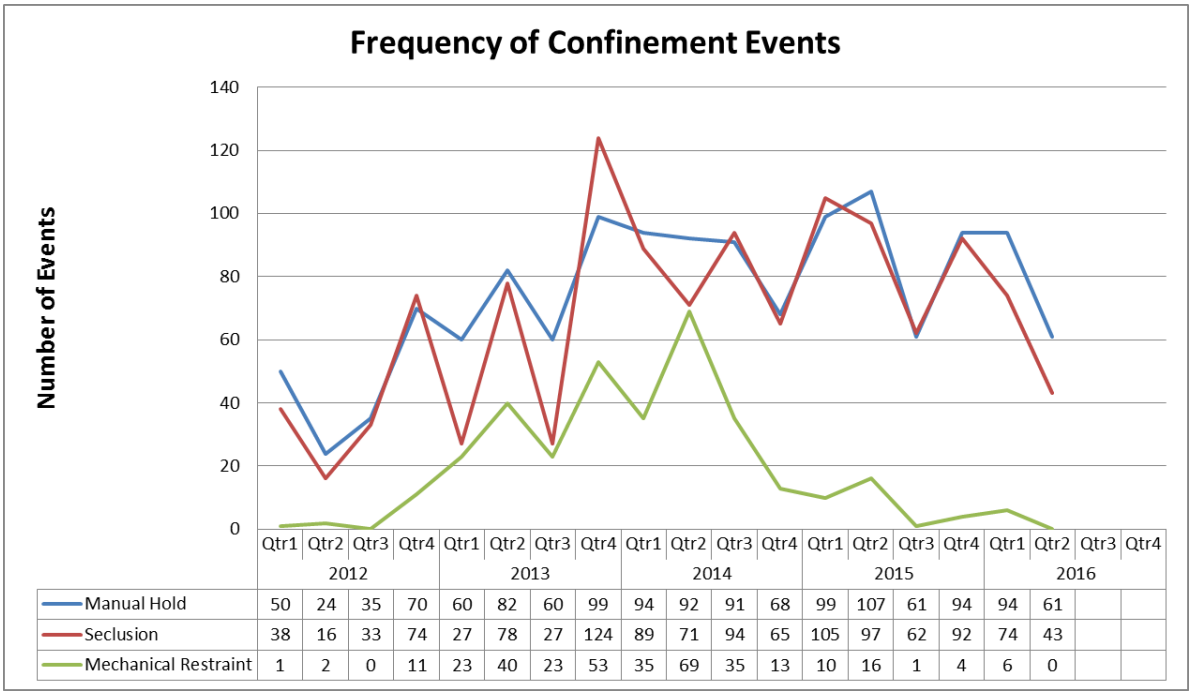
Confinement Event Detail

2Q2016

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR3374	16		11	27	25.96%	25.96%
MR193	7		6	13	12.50%	38.46%
MR7833	6		4	10	9.62%	48.08%
MR104	3		3	6	5.77%	53.85%
MR7127	3		2	5	4.81%	58.65%
MR7809	1		4	5	4.81%	63.46%
MR7032	1		3	4	3.85%	67.31%
MR7607	2		2	4	3.85%	71.15%
MR107	1		2	3	2.88%	74.04%
MR763	3			3	2.88%	76.92%
MR4841	1		1	2	1.92%	78.85%
MR5267	1		1	2	1.92%	80.77%
MR7118	2			2	1.92%	82.69%
MR7495	2			2	1.92%	84.62%
MR7575	1		1	2	1.92%	86.54%
MR7820	1		1	2	1.92%	88.46%
MR7823	2			2	1.92%	90.38%
MR7846	1		1	2	1.92%	92.31%
MR4	1			1	0.96%	93.27%
MR7189	1			1	0.96%	94.23%
MR7509	1			1	0.96%	95.19%
MR7739	1			1	0.96%	96.15%
MR7828	1			1	0.96%	97.12%
MR7830	1			1	0.96%	98.08%
MR7837	1			1	0.96%	99.04%
MR1187			1	1	0.96%	100.00%
	61	**0**	**43**	**104**		

31% (26/85) of the average hospital population experienced some form of confinement event during 2Q2016. Five of these patients (6% of the average hospital population) accounted for 58.65% of the containment events.

CONSENT DECREE



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

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

	3Q2015	4Q2015	1Q2016	2Q2016	Total
Danger to Others/Self	7	88	74	43	**212**
Danger to Others	55	1			**56**
Danger to Self		3			**3**
% Dangerous Precipitation	100%	100%	100%	100%	**100%**
Total Events	**62**	**92**	**74**	**43**	**271**

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

	3Q2015	4Q2015	1Q2016	2Q2016	Total
Danger to Others/Self		4	6		**10**
Danger to Others	1				**1**
Danger to Self					**0**
% Dangerous Precipitation	100%	100%	100%		**100%**
Total Events	**1**	**4**	**6**	**0**	**11**

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 30 & 31

CONSENT DECREE

Confinement Events Management

Seclusion Events (43) 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%

CONSENT DECREE

Confinement Events Management

Seclusion Events, Continued (43) Events

Standard	Threshold	Compliance
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 Clinical Director and Patient Advocate.	90%	100%
The record reflects that, for persons with mental retardation, the regulations governing seclusion of patients 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 (0) 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%	N/A
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	N/A
The record reflects that the decision to place the patient in restraint was made by a physician or physician extender	90%	N/A
The decision to place the patient in restraint was entered in the patient's records as a medical order.	90%	N/A
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%	N/A
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%	N/A
The record reflects that the patient was kept under constant observation during restraint.	95%	N/A
Individuals implementing restraint have been trained in techniques and alternatives.	90%	N/A
The record reflects that reasonable efforts taken to notify guardian or designated representative as soon as possible that patient was placed in restraint.	75%	N/A
The medical order states time of entry of order and that number of hours shall not exceed four.	90%	N/A
The medical order shall state the conditions under which the patient may be sooner released.	85%	N/A

CONSENT DECREE

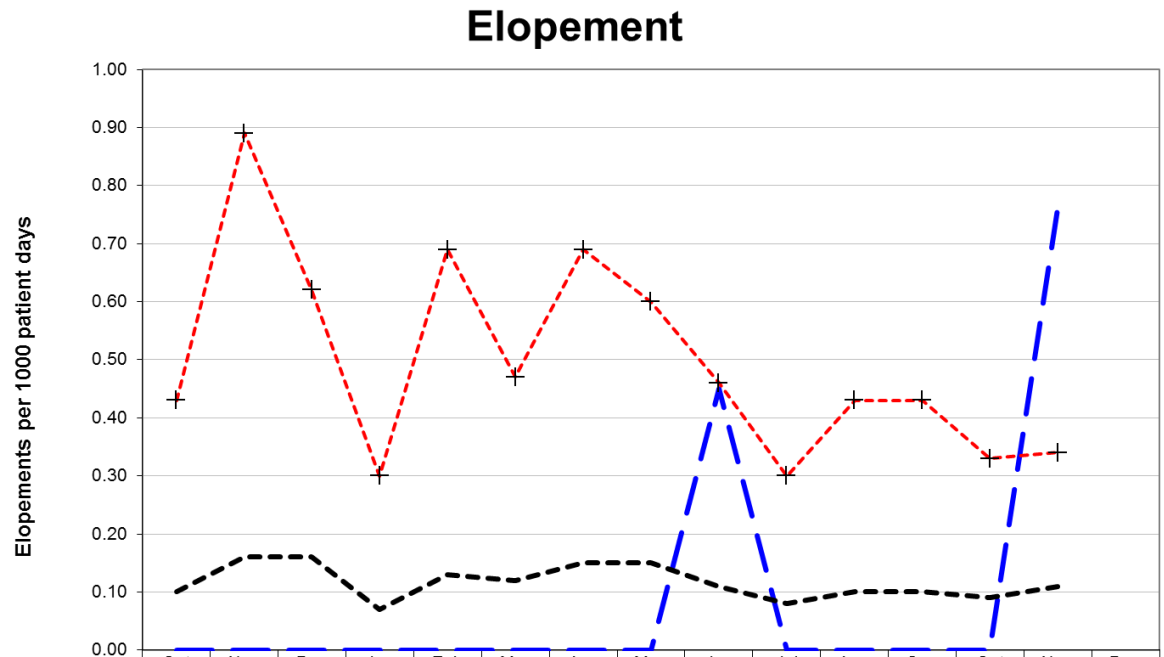
Confinement Events Management

Mechanical Restraint Events, Continued (0) Events

Standard	Threshold	Compliance
The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.	90%	N/A
The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.	70%	N/A
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%	N/A
The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.	90%	N/A
The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.	90%	N/A
Copies of events were forwarded to Clinical Director and Patient Advocate.	90%	N/A
For persons with mental retardation, the applicable regulations were met.	85%	N/A
The record reflects that the order was not entered as a PRN order.	90%	N/A
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 Clinical Director (or if the Clinical Director is out of the hospital, by the individual acting in the Clinical Director's stead) following examination of the patient; and that the patient's guardian or representative has been notified.	90%	N/A

Patient Elopements

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



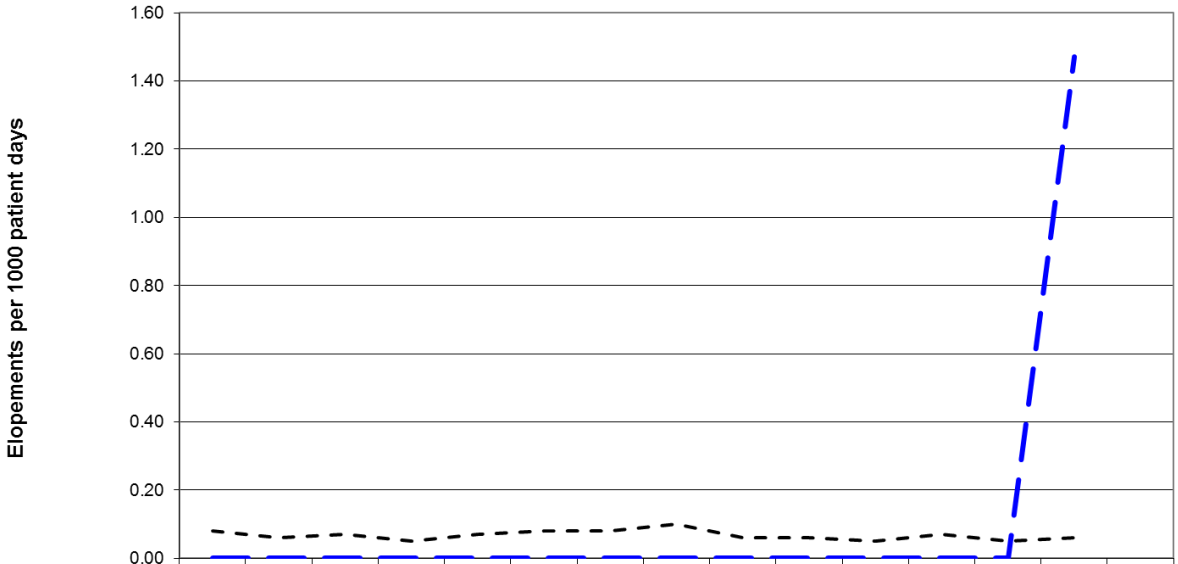
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.45	0.00	0.00	0.00	0.00	0.76	
Ntl Mean	0.10	0.16	0.16	0.07	0.13	0.12	0.15	0.15	0.11	0.08	0.10	0.10	0.09	0.11	
+1 StDev	0.43	0.89	0.62	0.30	0.69	0.47	0.69	0.60	0.46	0.30	0.43	0.43	0.33	0.34	

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

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

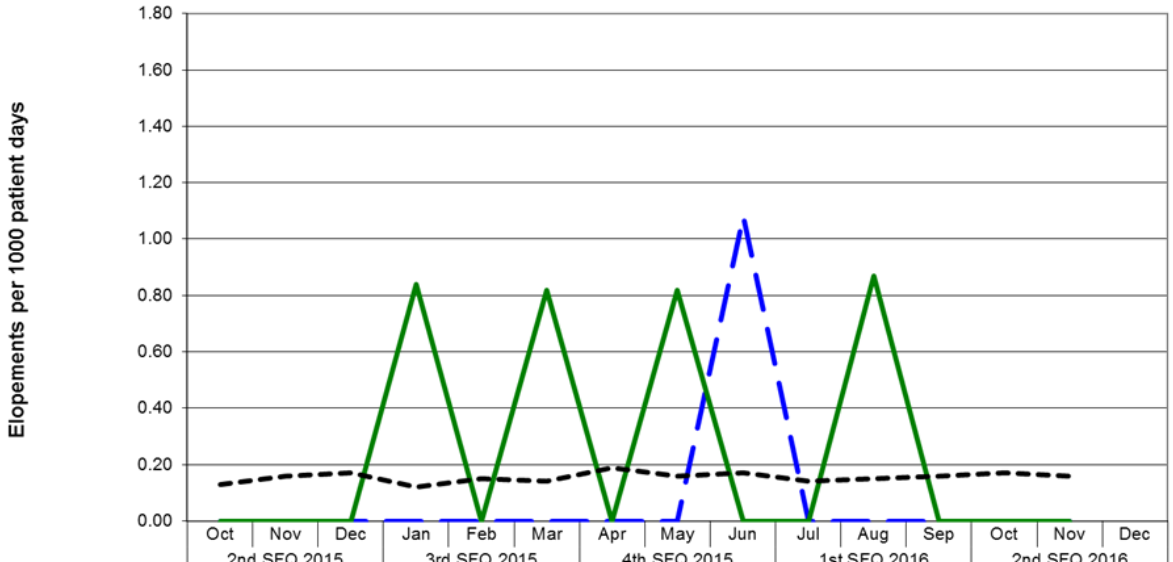
CONSENT DECREE

Elopement
Forensic Stratification



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

Elopement
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.08	0.00	0.00	0.00	0.00	0.00	
Dorothea Dix	0.00	0.00	0.00	0.84	0.00	0.82	0.00	0.82	0.00	0.00	0.87	0.00	0.00	0.00	
Ntl Mean	0.13	0.16	0.17	0.12	0.15	0.14	0.19	0.16	0.17	0.14	0.15	0.16	0.17	0.16	

Patient Injuries

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

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

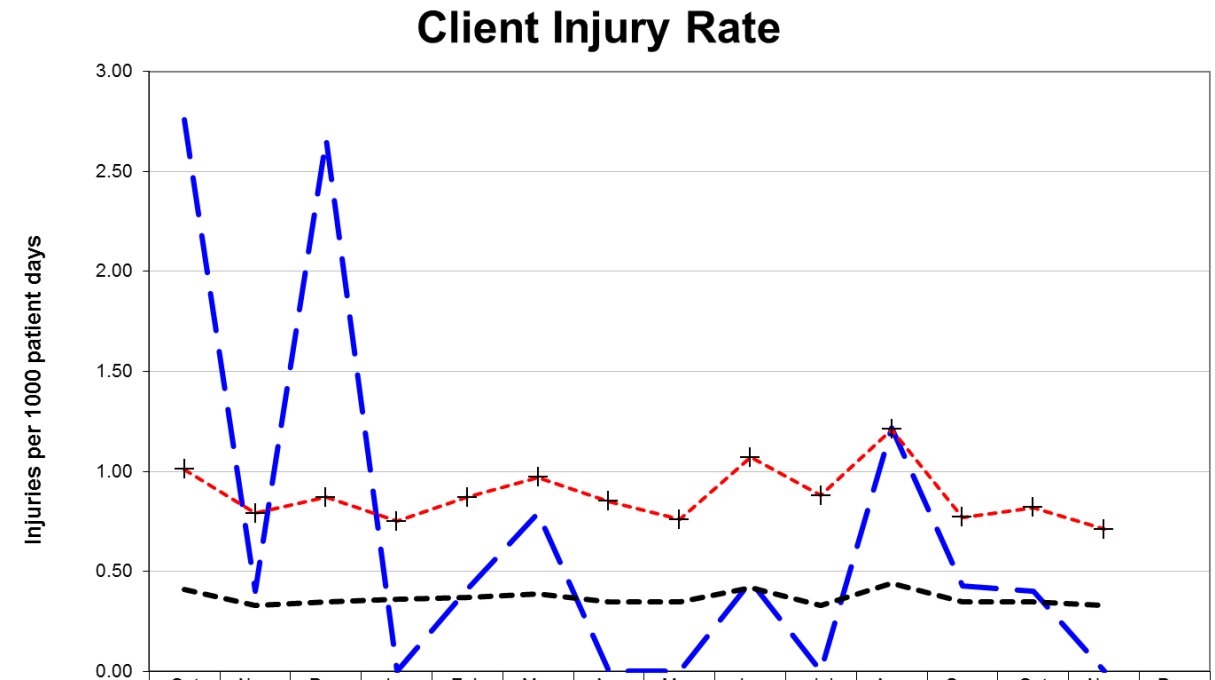
"Non-reportable" injuries include those that require: 1) No Treatment, or 2) Minor First Aid

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

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

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

CONSENT DECREE



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	2.76	0.40	2.66	0.00	0.41	0.79	0.00	0.00	0.45	0.00	1.22	0.43	0.40	0.00	
Ntl Mean	0.41	0.33	0.35	0.36	0.37	0.39	0.35	0.35	0.42	0.33	0.44	0.35	0.35	0.33	
+1 StDev	1.01	0.79	0.87	0.75	0.87	0.97	0.85	0.76	1.07	0.88	1.21	0.77	0.82	0.71	

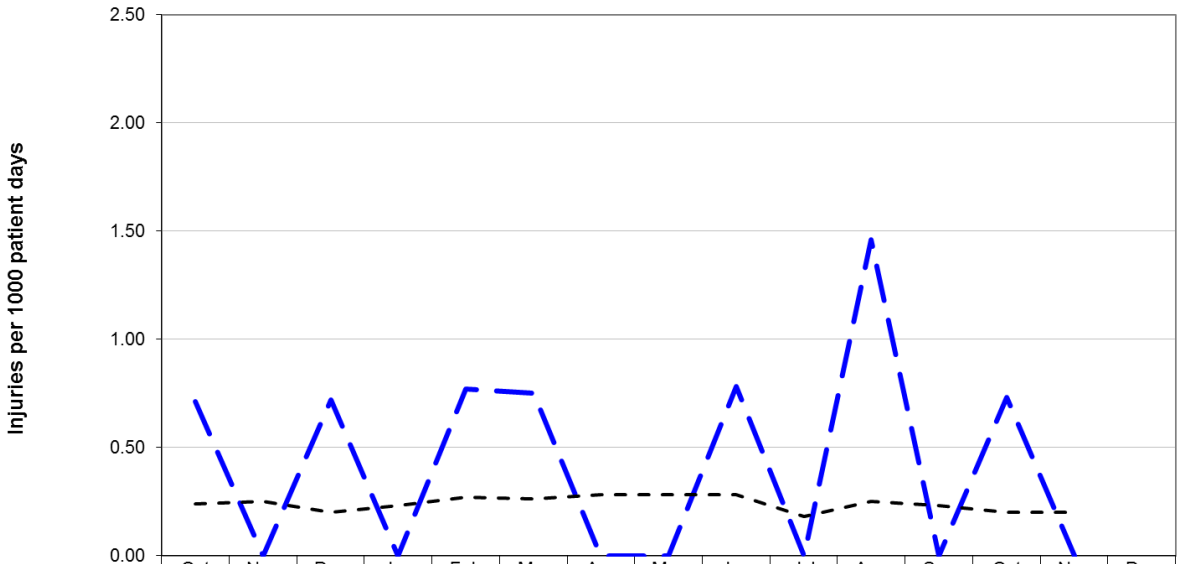
This graph depicts the number of patient injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

CONSENT DECREE

Client Injury Rate

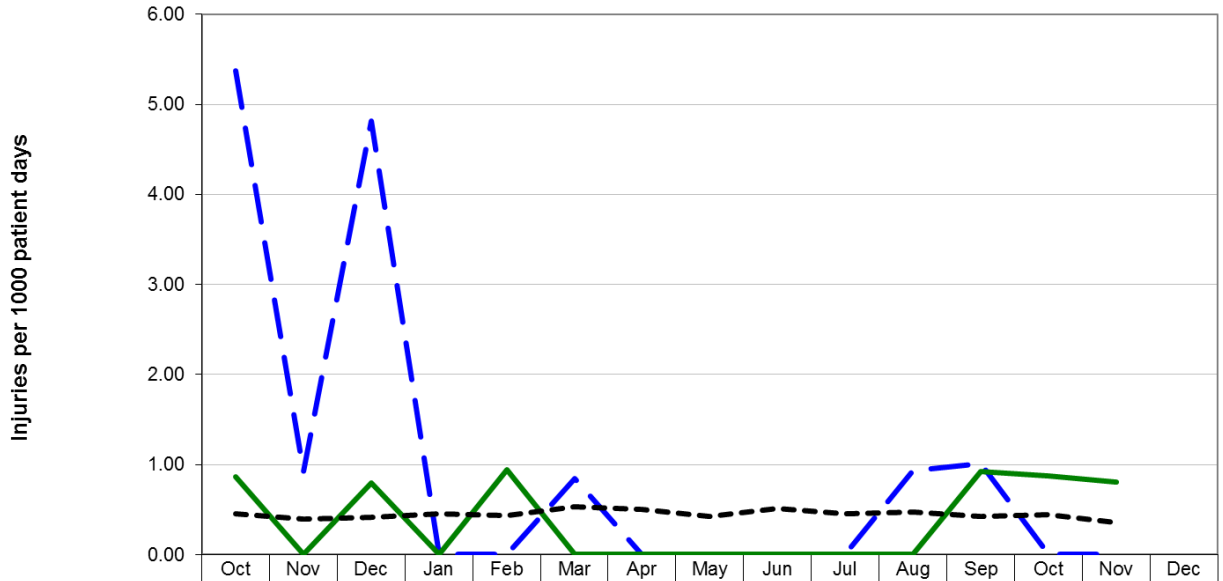
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	0.71	0.00	0.72	0.00	0.77	0.75	0.00	0.00	0.78	0.00	1.46	0.00	0.73	0.00	
Ntl Mean	0.24	0.25	0.20	0.23	0.27	0.26	0.28	0.28	0.28	0.18	0.25	0.23	0.20	0.20	

Client Injury Rate

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	5.37	0.92	4.81	0.00	0.00	0.84	0.00	0.00	0.00	0.00	0.93	1.01	0.00	0.00	
Dorothea Dix	0.86	0.00	0.80	0.00	0.94	0.00	0.00	0.00	0.00	0.00	0.00	0.92	0.87	0.81	
Ntl Mean	0.45	0.39	0.41	0.45	0.43	0.53	0.50	0.42	0.51	0.45	0.47	0.42	0.44	0.36	

CONSENT DECREE

Type and Cause of Injury by Month

Type - Cause	OCT	NOV	DEC	2Q2016
Accident – Fall	3	4	2	**9**
Accident – Other	1	1	1	**3**
Assault – Patient to Patient	2	0	1	**3**
Injury – Other	2	0	0	**2**
Self-Injurious Behavior	3	2	8	**13**
Total	**11**	**7**	**12**	**30**

Severity of Injury by Month

Severity	OCT	NOV	DEC	2Q2016
No Treatment	3	1	3	**7**
Minor First Aid	6	4	8	**18**
Medical Intervention Required	2	2	1	**5**
Hospitalization Required	0	0	0	**0**
Death Occurred	0	0	0	**0**
Total	**11**	**7**	**12**	**30**

Note: Previous quarterly report numbers may have been higher as they included data on incidents as well as injuries. This report has been modified to only include injuries. Per NASMHPD, injuries occur when harm or damage is done.

Due to changes in reporting standards related to "criminal" events as defined by the "State of Maine Rules for Reporting Sentinel Events", effective February 1, 2013, as defined the by "National Quality Forum 2011 List of Serious Reportable Events," the number of reportable "assaults" that occur as the result of patient interactions increased significantly. This change is due primarily as a result of the methods and rules related to data collection and abstraction. Further information on Fall Reduction Strategies can be found under The Joint Commission Priority Focus Areas section of this report.

Patient Abuse, Neglect, Exploitation, Injury or Death

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

Type of Allegation	3Q2015	4Q2015	1Q2016	2Q2016	Total
Abuse Verbal	3	5	8	11	**27**
Abuse Physical	14	9	14	11	**48**
Abuse Sexual	10	6	27	9	**52**
Neglect	1	0	3	2	**6**
Coercion/Exploitation	0	3	2	4	**9**
Total	**28**	**23**	**54**	**37**	**142**

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

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

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

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

V35) Riverview maintains its hospital license;

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

V36) The hospital seeks CMS certification;

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance in eight areas by August 27, 2013. Plans are being developed to apply for certification in 2016.

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

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

CONSENT DECREE

Quality Improvement Measures from "Response to the Recommendations from the Report by Elizabeth Jones, Consultant"

Approved by the Maine Superior Court on February 27, 2015

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
Prior to his/her treatment team meeting, the class members should be provided the opportunity to meet with a peer specialist in order to prepare for the discussion and to clearly outline any preferences for treatment or discharge planning. Recovery-oriented approaches to treatment, including employment, should be consistently explored with and offered to class member, despite disinterest or refusal at the time of admission.	Treatment Team Coordinators will document all patient engagement in preparation for Treatment Team meetings. The daily chart audit form used by Treatment Team Coordinators/Auditors will be updated by Medical Records to reflect which patients received pre-treatment team meeting engagement.	Patients are engaged prior to their treatment team meeting by a staff member who is very familiar with them. Using a written guide they help the patient focus on how best to use their upcoming treatment meeting time. The hospital is developing further staff training on how to engage patients who are initially resistant to this approach. Treatment Team members do have discussions prior to the patient being involved in the meeting to focus on what maybe the next appropriate step in the class members care. When the patient joins the meeting the focus is engaging them in the discussion to see in what direction the treatment plan will head in. If the goals for the patient are good & appropriate it is ok for them to repeat as long as the interventions change to assist in continue progress towards achieving or maintaining the identified goal. Vocational employment continues to a primary focus for all patients who have court permission to work in the community as well as for patients who have the required level for various jobs at RPC.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		There has been a decrease in number of patients choosing to participate in this opportunity at RPC.
Riverview's leadership should take immediate steps to ensure that the principles of the Recovery model are clearly defined, articulated, and supported throughout each of the four units.	100% of patient records will include documentation of the patient's input into their individualized treatment plan and that the input was used during the Treatment Team meeting.	Implementation of recovery oriented practice has led to a significant reduction in Hands on Holds, Restraints and Seclusions at the hospital. In September 2015, RPC had 8 minutes of restraints for every 1,000 hours of inpatient care. One newly admitted patient, who was very ill, accounted for all of these restraints. She has had no restraints in the past 2 weeks. In September 2015, RPC had 2.24 hours of seclusion per 1,000 hours of inpatient care. One patient accounted for more than half of these hours of seclusion. Riverview has initiated 12 new courses in recovery focused patient care for staff. 4 Clinical Case Conferences have focused on the Recovery Model and care. The hospital has a Recovery Training Specialist to provide training and services to staff. Riverview is a “trauma informed” hospital that works with patients who have experienced many types of trauma in their lives. At intake, all patients complete a questionnaire regarding trauma and history. During New Hire

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		Orientation, all staff are trained in competencies regarding Trauma and Recovery in order to provide the most appropriate level of care.
Riverview's clinical leadership should work with nursing and Mental Health Worker staff to design and implement case conferences or Grand Rounds so that there is greater knowledge, skills, and support in working with class members with challenging behaviors.	The list of case conferences and Grand Rounds will be maintained. The roster of staff participation will be maintained by the Staff and Organizational Development Office. These data will be reported in the Quarterly Report.	The hospital holds a clinical education conference every Thursday at noon. Staff from across all disciplines at the hospital are welcome to participate. 6 patient specific Clinical Case Conferences have been held since January. 4 Recovery Model specific Clinical Conferences have been held since January. 4 Allied Health Clinical Case Conferences on Spirituality, Cultural Differences, Encountering the Other and Compassion Fatigue have been held since January. The conferences include staff from all disciplines at Riverview and when appropriate participation from faculty at Geisel Medical School at Dartmouth College.
Efforts should be initiated to intensify the opportunities offered to class members on the Forensic Units in order to increase their social skills and their knowledge and performance competencies about subjects of interest to them.	Patient Individualized Treatment Plans will contain documentation of participation in all treatment activities. Treatment Team Coordinators will conduct daily chart audits to ensure documentation.	Treatment mall groups change every thirteen weeks. Prior to the new schedule being developed group ideas are requested from patients at the community meetings held on the units. Although specifically not identified with a Trauma label, Psychology and Social Work offer groups that focus on a variety of trauma issues. The

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		titles of the groups are kept discreet to protect the patients in these groups from being stigmatized.
Efforts should be initiated to intensify the opportunities offered to class members on the Forensic Units in order to increase their social skills and their knowledge and performance competencies about subjects of interest to them.	Patient Individualized Treatment Plans will contain documentation of participation in all treatment activities. Treatment Team Coordinators will conduct daily chart audits to ensure documentation.	Treatment mall groups change every thirteen weeks. Prior to the new schedule being developed group ideas are requested from patients at the community meetings held on the units. Although specifically not identified with a Trauma label, Psychology and Social Work offer groups that focus on a variety of trauma issues. The titles of the groups are kept discreet to protect the patients in these groups from being stigmatized.
Riverview should be managed as a single Hospital and the exclusion of Lower Saco from the federal Medicaid program should be reconsidered as an urgent priority.	Completed in November 2014.	In 2013, the hospital was bifurcated in an effort to meet CMS requirements for certification. A decision was made in November 2014 that this separation interfered with the delivery of high quality services at the hospital. Instead of operating two hospitals in one building (Lower Kennebec, Upper Kennebec, and Upper Saco were treated as one hospital with their own distinct staffing and policies and Lower Saco operated as a separate hospital within the same facility). Operating the hospital as it was originally conceived helps ensure that all patients

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		have access to all services.
In order to ensure that any limitations are not in violation of the Consent Decree, restrictive practices, including access to outdoor areas, should be reviewed with involvement by class members and mental health workers.	Unit activity logs will be reviewed on a monthly basis to determine whether any limitations in a patient's access to treatment or services occurred. Unit community meetings will include a standing agenda item to review whether any restrictive practices were in place.	All units in which patients can get levels to walk on grounds offer at minimum 4 walking groups per week as part of programming. This does not include times when impromptu walks are offered when there is extra staff on the unit. Lower Saco offers their SCU fitness groups on the unit outside weather permitting. Treatment groups provide Equine Therapy, Pet Therapy, Trail Walking and Sports in the Community as part of the Mall schedule. The hospital has developed an "Open Hospital" model which allows patients (with allowable privileges) to go outside on hospital grounds 3 times per day.
The use of seclusion and restraint requires continued independent review to ensure that there are adequate alternatives designed and implemented for any class member potentially subject to such restrictive measures. Specifically, class members with a history of unacceptable behavior, such as aggression towards peers and/or staff, need to be reviewed again by the treatment team, and, if necessary, by an independent clinical consultant, to	The Risk Manager reviews 100% of cases of seclusion and restraint events including the content and timeliness of events. The hospital sends weekly reports of seclusion and restraint events to the Court Master. The Staff and Organizational Development Office will conduct its first annual review of the MOAB program and present results to Executive Leadership in January 2015.	In January 2014 RPC switched to the *Management of Aggressive Behavior* (MOAB) model. The program was evaluated in the summer and fall of 2015 to measure knowledge, ability and belief about the efficacy and fidelity of the training and implementation. A mixed methodology approach was used in the evaluation. *The first* part of the evaluation consisted of testing the competency of staff in demonstrating knowledge and a

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
determine whether sufficiently individualized interventions are being designed and consistently implemented to replace unacceptable behavior with appropriate alternative behaviors.		ability of MOAB techniques. The staff consistently were unable to demonstrate MOAB techniques. However they quite easily demonstrated NAPPI techniques. It is important to note: The fact that staff reverted back to skills they had learned over many years of practice (NAPPI) is not unusual in this case. Through repetition and practice, motor skills become automatic. The brain in essence "hardwires" the skills into long-term memory. The key is to replace those "muscle memories" with new memories (skills) through the repetition and practice of new skills and/or techniques. Riverview is providing consistent on-going instruction by providing annual MOAB recertification training and skills drills to improve staff competency through opportunities to develop new muscle memories to replace those acquired through NAPPI training. *The second* part of the evaluation consisted on reviewing six videos of patient related events on the Lower Saco unit of the hospital. The reviewers determined that the staff consistently and correctly used MOAB approved

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		techniques in all six incidents viewed. MOAB is used at a higher rate on the Lower Saco unit than any other area of the hospital. *The third* part of the evaluation consisted of a survey of employees. Fifty-four employees were interviewed using a seven question survey. Employees indicated a high degree of belief in the level of training they had received and that MOAB was an effective behavior management tool in managing patient behaviors in the hospital.
The reporting requirements by Paragraphs 188 and 189 of the Consent Decree should be completed as mandated.	On an annual basis (starting in January 2015), the Staff and Organizational Development Office will present a report to Executive Leadership at the hospital on the Behavioral Management system being used. The report will include (but is not limited to) information on: Documentation on certification and external reviews of behavioral management system Number of staff trained Number of staff retrained Results of inter-rater reliability tests for trainers	The hospital reviews all seclusion and restraint events. The hospital has been recognized by The Joint Commission for its very low use of restraints over the past two years. There is a review of practices and devices every time there is a seclusion and restraint event at Riverview. The hospital used an outside consultant this year to review the MOAB program to ensure fidelity; the hospital also conducted an assessment of MOAB. The hospital did identify problems and a corrective action plan is being developed. The hospital did introduce a safety transport chair in the hospital this year which allows us to safely move patients between floors; safety transport chairs were reviewed by staff to determine which one best met

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
	Number of staff injuries Number of patient injuries Number of incident reports showing that staff varied from techniques Review of fact-findings or investigations where behavioral management system failed to achieve goals Findings from external reviews of the MOAB program The Risk Manager reviews 100% of all incident reports for seclusion and restraint daily to determine whether further actions are required. A summary report of 100% of all seclusion and restraint events are sent to the Court Master weekly.	the needs of patients and staff at the hospital. Industry standards were used to assure the safety of the chair and all care staff have been trained on its use. The hospital enhanced its already extensive reporting to satisfy the Court Master and Plaintiffs' Counsel needs on Paragraph 189.
In light of the current demographics of admissions to Riverview, the adequacy of staffing requires further independent review. It is highly recommended that staffing ratios be determined by acuity rather than by census on the units.	The hospital will continue to monitor the staffing ratio as defined in the Consent Decree. In addition, the Integrated Quality team will work with Clinical Leadership to establish measurements to test the reliability and validity of data used with acuity based models to ensure that, in addition to meeting the Consent Decree's minimum staffing ratios, staffing is sufficient to carry out Consent Decree requirements.	The challenge of appropriately staffing state-run psychiatric hospitals continues across the country. RPC is competing with the Veteran's Administration and two other hospitals with psychiatric units to recruit and retain the best staff. The hospital is working with the state hospitals in New Hampshire and Vermont on Patient Acuity Scales which will help inform staffing needs. This is a long term project and the hospital is not expecting immediate results of this study.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		Work continues in recruiting for all positions. New positions were funded in the last legislative session and are being filled. The hospital continues to be challenged by trained employees who leave for other state positions which are of less intensity. A recent change in the staffing model has been implemented and is an enormous step in moving toward unit based staffing. An overall of the staffing plan was completed in an effort to "even out" staff scheduling. The hospital hired a new Director of Nursing during the past quarter who is addressing nursing staffing needs.
The use of "float" staff, especially those recently hired at Riverview, requires review in order to reduce the likelihood of risk due to unfamiliarity with and knowledge of the individuals with challenging behaviors or the need for specialized interventions. This review is especially critical for any assignment to the Forensic Units.	100% of new staff on acute units will have received and passed competency based skills training before being assigned.	The Director of Nursing is currently reviewing staffing models to be used in the hospital. In 2015, the hospital will move to a unit-based staffing model to enhance the continuity of care for all patients. To make the staffing model effective the hospital has initiated: Restructured orientation for unit staff – The new plan is to have nurse educator work with the Staff Development office to have all staff receive full orientation before they work on any unit, in order to improve safety for patients and staff alike. Mentoring of new staff by experienced personnel – The Nurse Educator and Nurse Managers will implement a preceptorship program.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		We are seeking assistance from a sister hospital. Regular monitoring of new staff by the nursing education staff – Preceptorship program will be implemented based on an effective preceptor model, and employees who are preceptors will receive additional training and receive a differential in pay. Development of a skills based competency model before staff are assigned to acute units – Nursing will work with Staff Development and RN Managers to develop competencies relative to their hired positions. Riverview Psychiatric Center will be contracting with Applied Management Systems, Donna Watson-Dillon, to review staffing model vs census driven staffing model. As per Elizabeth Jones' recommendation of January 2015, we should be utilizing the training budget of $60,000 to improve staff competencies, which includes preceptorship of all staff.
There should be consideration of supplemental pay for staff assigned to the Lower Saco unit.	The Human Resource office reviews its payroll records to ensure that staff who are eligible for the supplemental pay are receiving it according to Human Resource guidance.	Any adjustment to salary for a group of employees requires bargaining with the appropriate union. The increase for staff working on the lower, more acute units was negotiated with the bargaining unit as part of their current contract. The new contract did not take effect until 9/1/2015.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
Discussions should be held with Mental Health Workers and nursing staff to determine what additional measures are required to reduce the pressures experienced by staff and the resulting effects on the class members hospitalized for treatment.	Action steps will be developed based on the results of the DHHS Human Resources survey. The results of the survey and subsequent action steps will be reported to the Quality Improvement Committee and distributed to staff and included in the Quarterly Report.	It was identified that staff, specifically front line staff, face working in stressful and challenging environments due to the acuity of the patients at the hospital. In June, 2015 an Employee Assistance Program training was piloted for Lower Saco Mental Health Workers. Several Mental Health Workers were able to attend reported mixed thoughts on the usefulness of the information. RPC recognized that there are times when a violent event can result in employee physical and/or emotional trauma. In March 2015, RPC developed its own Employee Crisis Support Team to provide support to staff in need. The ECS Team respond to STAT calls and provide support via: restoring the functioning of the organizational structure; clarify the circumstances of the event; assess staff needs, demonstrate care and support, and plan for the immediate future.

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
Qualification for Mental Health Workers should not be reduced.	100% of Mental Health workers meet and maintain the competencies required for their positions.	The hospital is bound by the minimum requirements of the Bureau of Human Resources for state positions. Currently a Mental Health Worker position requires that the applicant have a high school diploma or equivalency as well as Certified Nursing Assistant or other approved training. The hospital is committed to move from a custodial care focused model to one that is focused on current evidence based practices of bio-psychosocial rehabilitation and recovery. This will necessitate a long term culture change at the hospital, one that is focused on specific skills which center around psychiatric treatment versus custodial care. The hospital believes this expansion into best practice care will require a continued focused on staff education and training. The hospital provides employees the ability to gain, develop and renew skills through: New Employee Orientation, Supplemental Training; Unit/Department Orientation and Training; Annual Mandatory Training; and In Services Training and Education. The Department worked with University of Maine, Augusta to submit a bill

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
		provide training to employees. The bill is being considered in the 2016 session.
Continuing effort is required to ensure that all staff understand the mandate for reporting any suspected abuse, neglect, or exploitation of class members.	100% of incidents of abuse, neglect or exploitation are reported to Adult Protective Services. This will be monitored by a monthly review of incident reports. On a bi-monthly basis, the hospital's survey team (comprised of quality improvement staff from both Riverview and Dorothea Dix) will conduct an audit of the patient records for seclusion/restraint events to ensure that all events have been reported.	The Risk Manager continues to verify that all allegations of abuse, neglect or exploitation are reported to Adult Protective Services. All incidents are reviewed. A monthly report is sent to hospital's Human Rights Committee for review. On a monthly review of Incident Reports, the hospital's survey team (comprised of quality improvement staff from both RPC and DDPC) conduct an audit of the patient records for seclusion/restraint events to ensure that all events have been reported.
With consultation from class members and staff on the units, there should an examination of the weaknesses and vulnerabilities that could lead to abuse, neglect and exploitation at Riverview.	A content analysis will be conducted on all debriefing forms to determine themes and patterns. The results from this analysis will be shared with leadership and included in the Quarterly Report. Results of staff surveys will be included in the Quarterly Report. The results of the patient discharge survey will continue to be included in the Quarterly Report.	The hospital's Human Rights Committee has reviewed a patient survey instrument. Members of the Peer Support Office will conduct the survey across the hospital. After completion of the survey, staff will meet with patients and staff on the units about weaknesses and vulnerabilities about abuse, neglect and exploitation. Patient discharge survey data are included in the Quarterly Report.
The Consent Decree language should be modified to specify that timely reporting of abuse and neglect cases should be made to Adult Protective Services (APS), Licensing, the Court Master and Plaintiffs' Counsel.	100% of alleged cases of abuse, neglect, or exploitation are reviewed and reported as required by statute, rule, and Consent Decree. The Court Master and Patient Advocate will receive copies of the validation form received after	The Risk Manager continues to verify that all cases of abuse, neglect, or exploitation are reviewed and reported as required by statute, rule, and Consent Decree. The Court Master and Patient Advocates receive copies of the validation form received after submitting

CONSENT DECREE

Recommendation	Quality Improvement Measure	Actions Taken During the Quarter
	submitting reports to Adult Protective Services. A monthly summary report of all allegations of abuse, neglect, and exploration is prepared for the hospital's Human Rights Committee. Substantiated claims of abuse, neglect, or exploitation are noted in the hospital's Quarterly Report.	Report to APS. A monthly summary is prepared for the hospital's HRC. Substantiated claims of abuse, neglect, or exploitation are noted in the hospital's Quarterly Report.

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

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

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

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

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

JOINT COMMISSION

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

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

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

JOINT COMMISSION

Admissions Screening (HBIPS 1)

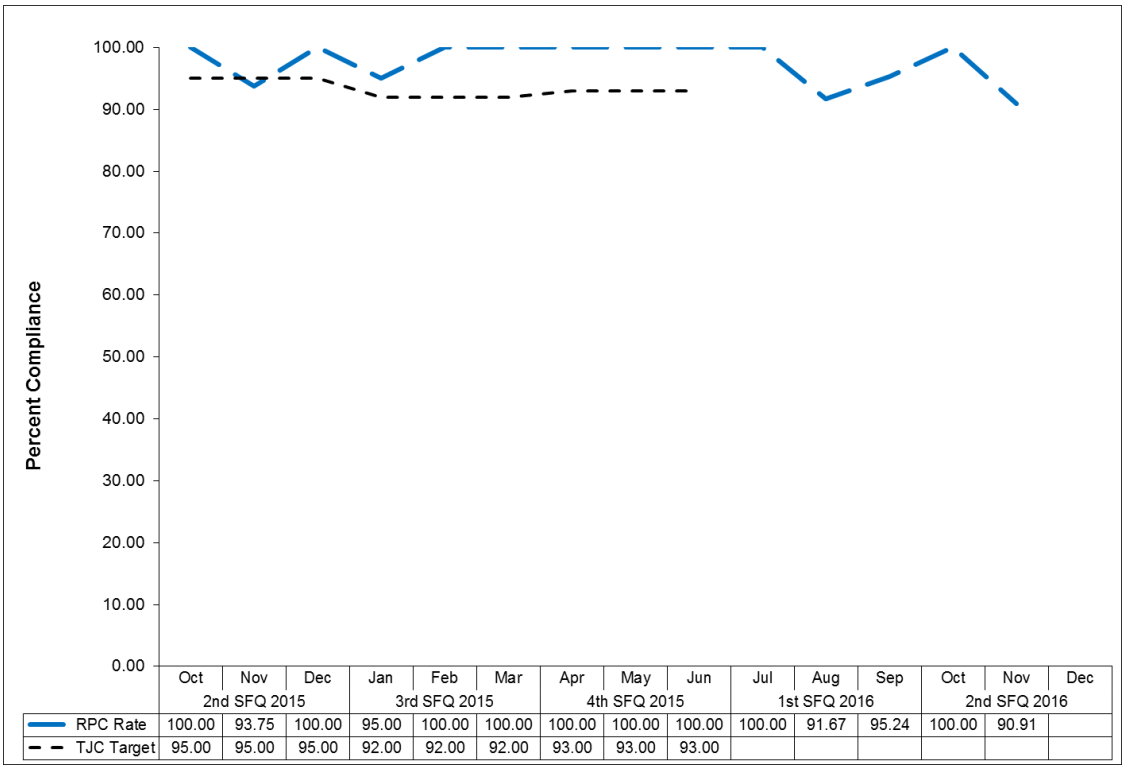
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

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

Rationale

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



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RPC Rate	100.00	93.75	100.00	95.00	100.00	100.00	100.00	100.00	100.00	100.00	91.67	95.24	100.00	90.91	
TJC Target	95.00	95.00	95.00	92.00	92.00	92.00	93.00	93.00	93.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

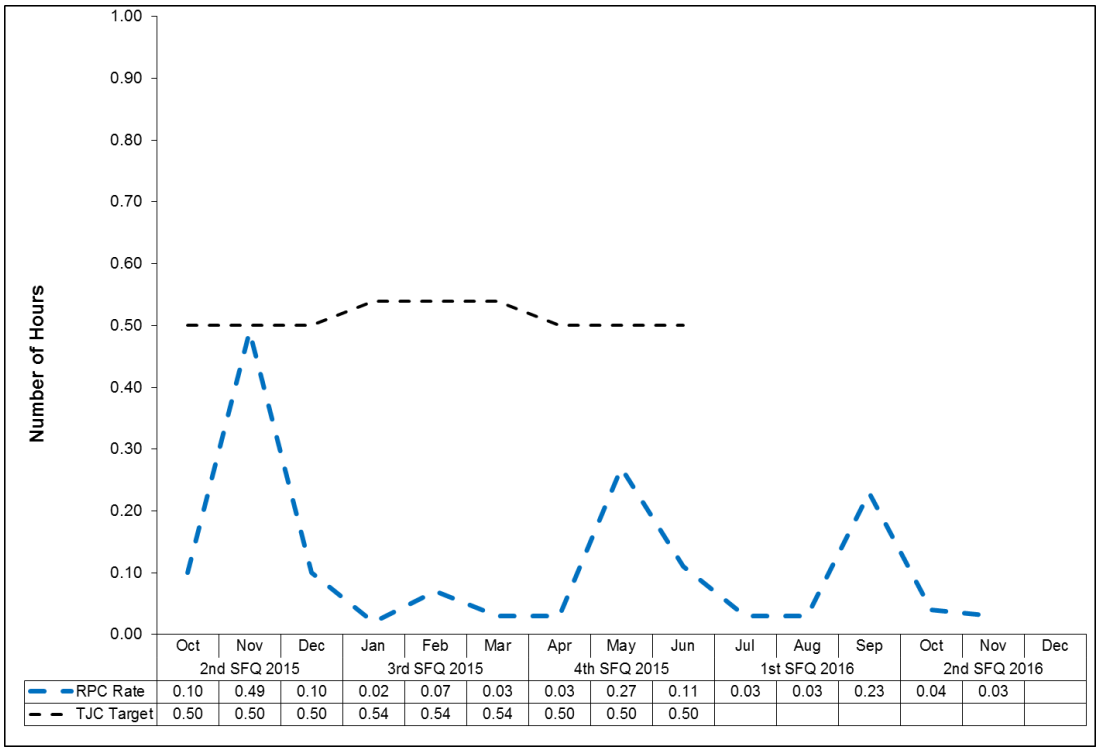
Hours of Use

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).



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	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
RPC Rate	0.10	0.49	0.10	0.02	0.07	0.03	0.03	0.27	0.11	0.03	0.03	0.23	0.04	0.03	
TJC Target	0.50	0.50	0.50	0.54	0.54	0.54	0.50	0.50	0.50						

JOINT COMMISSION

Seclusion (HBIPS 3)

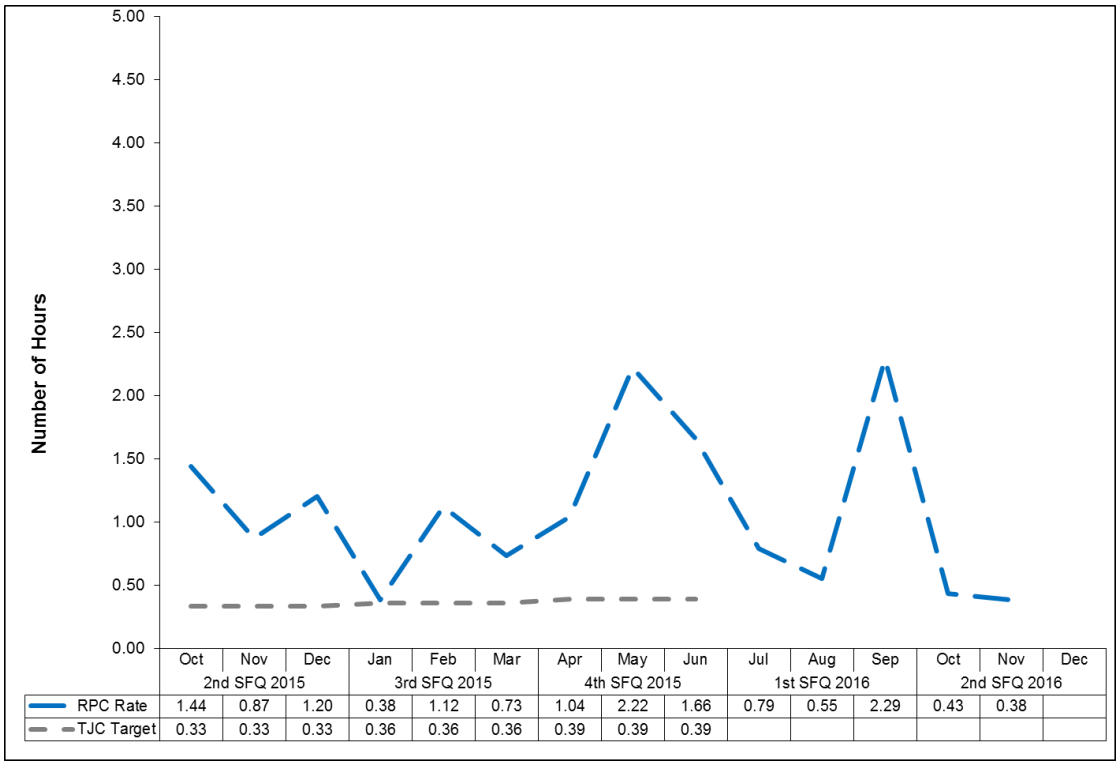
Hours of Use

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).



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	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
RPC Rate	1.44	0.87	1.20	0.38	1.12	0.73	1.04	2.22	1.66	0.79	0.55	2.29	0.43	0.38	
TJC Target	0.33	0.33	0.33	0.36	0.36	0.36	0.39	0.39	0.39						

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

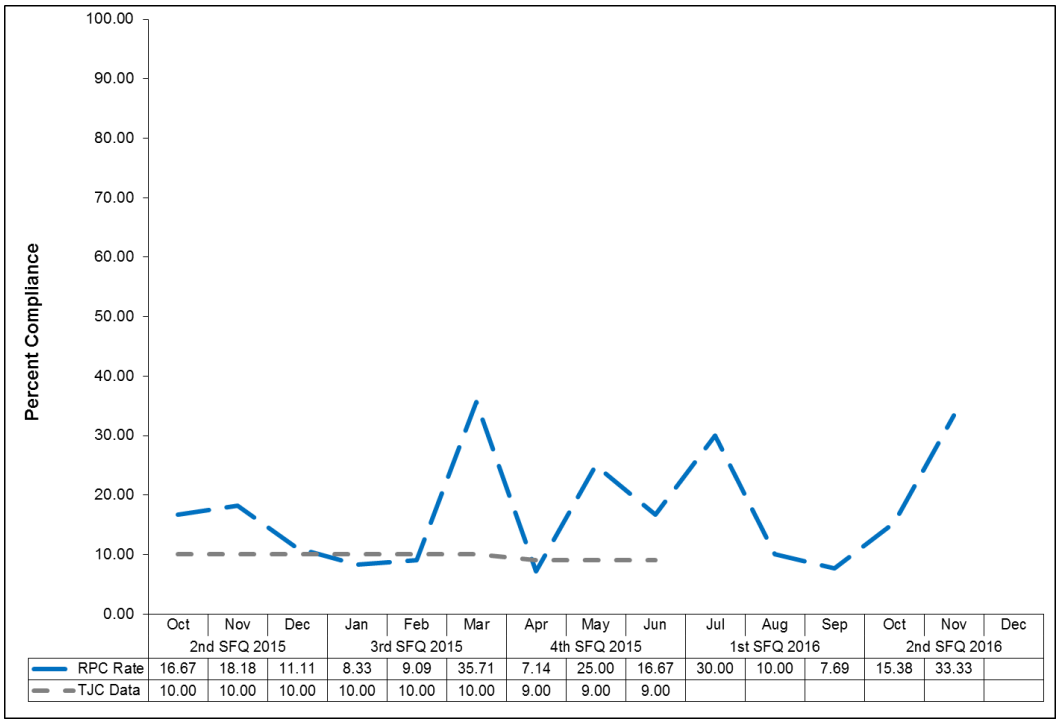
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications.

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)



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	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
RPC Rate	16.67	18.18	11.11	8.33	9.09	35.71	7.14	25.00	16.67	30.00	10.00	7.69	15.38	33.33	
TJC Data	10.00	10.00	10.00	10.00	10.00	10.00	9.00	9.00	9.00						

JOINT COMMISSION

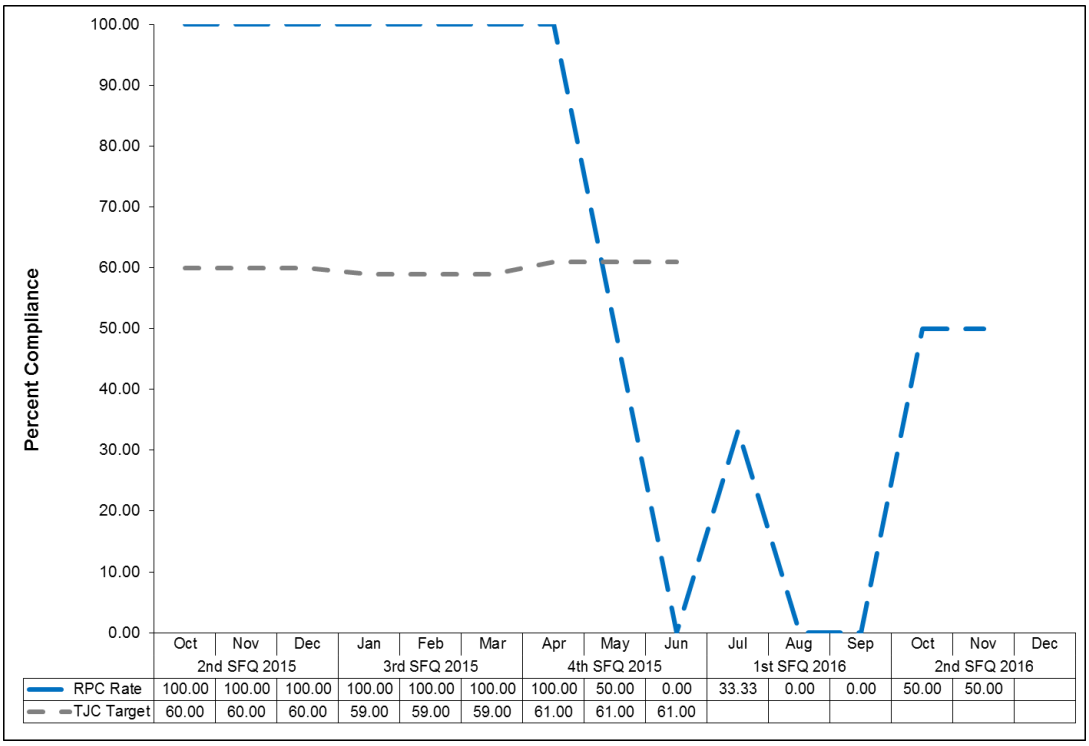
Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

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

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

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



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	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
RPC Rate	100.00	100.00	100.00	100.00	100.00	100.00	100.00	50.00	0.00	33.33	0.00	0.00	50.00	50.00	
TJC Target	60.00	60.00	60.00	59.00	59.00	59.00	61.00	61.00	61.00						

JOINT COMMISSION

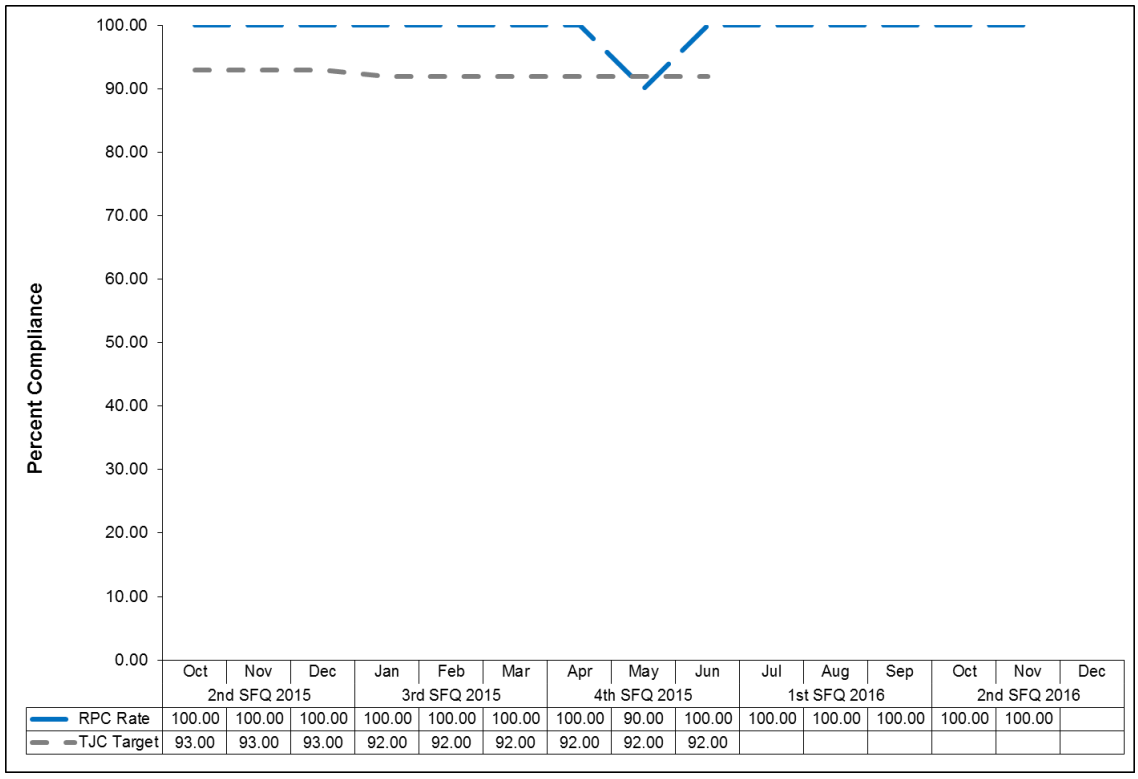
Post Discharge Continuing Care Plan (HBIPS 6)

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).



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	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
RPC Rate	100.00	100.00	100.00	100.00	100.00	100.00	100.00	90.00	100.00	100.00	100.00	100.00	100.00	100.00	
TJC Target	93.00	93.00	93.00	92.00	92.00	92.00	92.00	92.00	92.00						

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

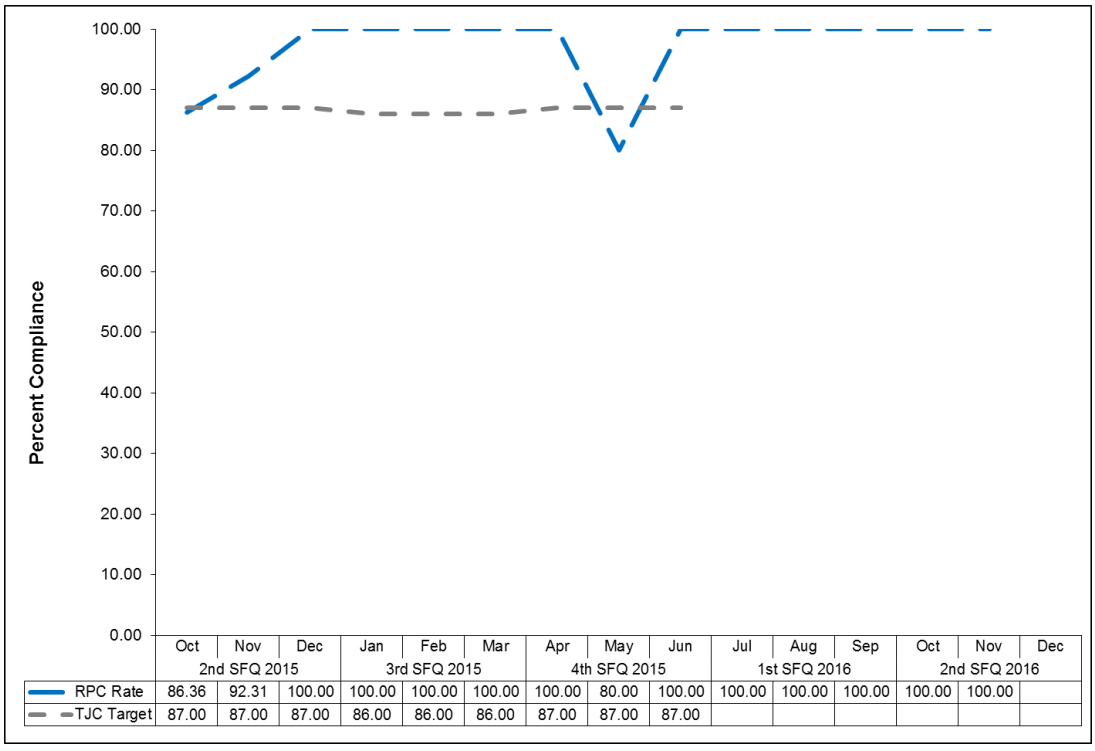
To Next Level of Care Provider on Discharge

Description

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

Rationale

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



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	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
RPC Rate	86.36	92.31	100.00	100.00	100.00	100.00	100.00	80.00	100.00	100.00	100.00	100.00	100.00	100.00	
TJC Target	87.00	87.00	87.00	86.00	86.00	86.00	87.00	87.00	87.00						

JOINT COMMISSION

Contract Performance Indicators

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

2Q2016 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Robert J. Harper Superintendent	All indicators met standards.
Community Dental, Region II	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Comprehensive Pharmacy Services	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Comtec Security	Richard Levesque Director of Support Services	All indicators met or exceeded standards.
Cummins Northeast	Richard Levesque Director of Support Services	All indicators met standards.
Dartmouth Medical School	Robert J. Harper Superintendent	All indicators exceeded standards.
Disability Rights Center	Robert J. Harper Superintendent	All indicators met standards.
G & E Roofing	Richard Levesque Director of Support Services	All indicators met standards.
Goodspeed & O'Donnell	Dr. Brendan Kirby Clinical Director	No services were provided during this timeframe.
Liberty Healthcare – After Hours Coverage	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Liberty Healthcare – Physician Staffing	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Main Security Surveillance	Richard Levesque Director of Support Services	All indicators met standards.
Maine General Community Care/HealthReach	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Maine General Medical Center – Laboratory Services	Dr. Brendan Kirby Clinical Director	All indicators met standards.

JOINT COMMISSION

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

JOINT COMMISSION

Adverse Reactions to Sedation or Anesthesia

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

Capital Community Clinic - Dental Clinic

Dental Clinic Timeout/Identification of Patient

Indicators	3Q2015	4Q2015	1Q2016	2Q2016	Total
National Patent Safety Goals Goal 1: Improve the accuracy of Patient Identification. Capital Community Dental Clinic assures accurate patient identification by: asking the patient to state his/her name and date of birth. A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the Dental Assistant.	**Jan** 100% 4/4 **Feb** 100% 6/6 **Mar** 100% 4/4 **Total** 100% 14/14	**April** 100% 3/3 **May** N/A 0/0 **June** 100% 1/1 **Total** 100% 4/4	**July** 100% 3/3 **Aug** N/A 0/0 **Sept** N/A 0/0 **Total** 100% 3/3	**Oct** 100% 2/2 **Nov** 100% 1/1 **Dec** 100% 1/1 **Total** 100% 4/4	**100%** **25/25**

JOINT COMMISSION

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	3Q2015	4Q2015	1Q2016	2Q2016	Total
1. All patients with tooth extractions will be assessed and have teaching post procedure on the following topics, as provided by the Dentist or Dental Assistant: • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The patient, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. 3. Post dental extraction patients will receive a follow-up phone call from the clinic within 24 hours of procedure to assess for post procedure complications	**Jan** 100% 4/4 **Feb** 100% 6/6 **Mar** 100% 4/4 **Total** 100% 14/14	**April** 100% 3/3 **May** N/A 0/0 **June** 100% 1/1 **Total** 100% 4/4	**July** 100% 3/3 **Aug** N/A 0/0 **Sept** N/A 0/0 **Total** 100% 3/3	**Oct** 100% 2/2 **Nov** 100% 1/1 **Dec** 100% 1/1 **Total** 100% 4/4	**100%** **25/25**

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management

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

Infection Control

Responsible Party: Larry Plant, Director of Nursing

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

Measure Description: Monitor and Measure of Hospital Associated Infections

Measure Type: Quality Assurance

Results							
Target	**Unit**	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**YTD**
Within 1 STDV of the Mean	Hospital Associated Infection Rate	FY 2014 1 STDV within the mean	7 HAI/IC Rate 1.1	4 HAI/IC Rate 0.83	12 HAI/IC Rate 1.7	6 HAI/ 1 CAI	
Actual Outcome			1 STDV within the mean	1 STDV within the mean			

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

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

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

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Infections:

Lower Kennebec:
Urinary Tract Infection

Lower Saco:
Pneumonia (CAI)

Lower Saco SCU:
Nickel size wound on left leg

Upper Saco:
Bladder Infection
Folliculitis of Chest

Upper Kennebec:
Left great toe infection x2
H Pylori
Frequent Metastatic Breast Cancer lesions

Data Analysis:
Total Infections: 8
HAI: 7
CAI: 1
Idiosyncratic Infections: 0
Patient Days: 7854

Plan: Ongoing surveillance

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II. Measure Name: Employee Hand Hygiene Rate

Measure Description:

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

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Employee Hand Hygiene Compliance	80% FY 2015	>90%	>90%	>90%	>90%	**>90%**
Actual			95%	98%* (December 2015 only)			**97**

Data:

Upper Saco Meds – no data
Upper Saco Milieu 7-3 – no data
Upper Saco Milieu 3-11 – no data

Upper Kennebec Meds –100%
Upper Kennebec Milieu 7-3 – 100%
Upper Kennebec Milieu 3-11 – 100%

Lower Kennebec Meds – 100%
Lower Kennebec Milieu 7-3 – 98%
Lower Kennebec Milieu 3-11 – 85%

Lower Saco Meds – 100%
Lower Saco Milieu 7-3 – 100%
Lower Saco Milieu 3-11 – 100%

Infection Control Nurse – position vacant

***Note:** The Infection Control Nurse position was vacated in November 2015. Hand Hygiene data was only available for December 2015 for 3 of the 4 patient units. Data will be provided in the next quarterly report.

Plan: Continue to monitor and measure.

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III. Measure Name: Assisting Patients with Daily Hygiene

Measure Description: Staff offer hand gel to patients prior to breakfast, lunch, and dinner, thirty (30) days per month.

Measure Type: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Employee Hand Hygiene Compliance	98% FY 2015	>90%	>90%	>90%	>90%	**>90%**
Actual			95%	Not enough data available to quantify			**95%**

Data:
December 2015 data (October and November data is not available):
Lower Saco Main: 100%
Lower Saco SCU: data not available
Upper Saco: Data not available
Lower Kennebec Main: 96%
Lower Kennebec SCU: 85%
Upper Kennebec: 100%

Note: The Infection Control Nurse position was vacated in November 2015. Daily Hygiene data was only available for some of the units. Data will be provided in the next quarterly report.

Plan: Continue to monitor and measure.

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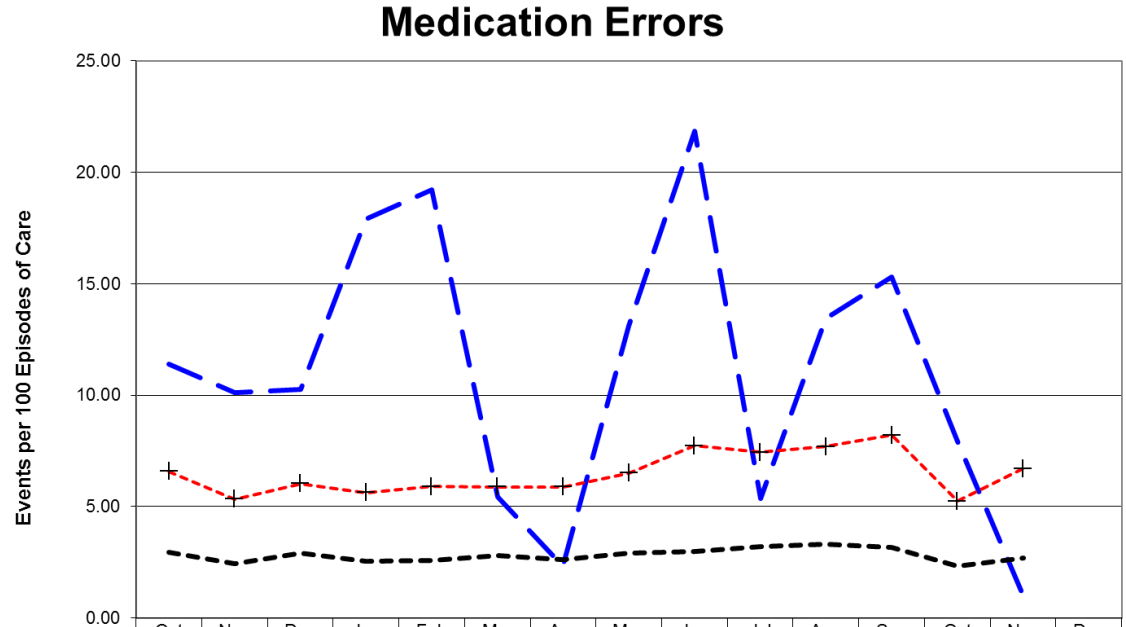
Medication Errors and Adverse Reactions

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)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	11.40	10.10	10.28	17.92	19.23	5.43	2.33	13.10	21.84	5.38	13.46	15.31	7.92	0.97	
Ntl Mean	2.96	2.45	2.92	2.54	2.60	2.80	2.61	2.92	2.98	3.22	3.32	3.18	2.33	2.69	
+1 StDev	6.58	5.34	6.03	5.63	5.91	5.88	5.89	6.50	7.73	7.44	7.69	8.21	5.25	6.70	

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

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

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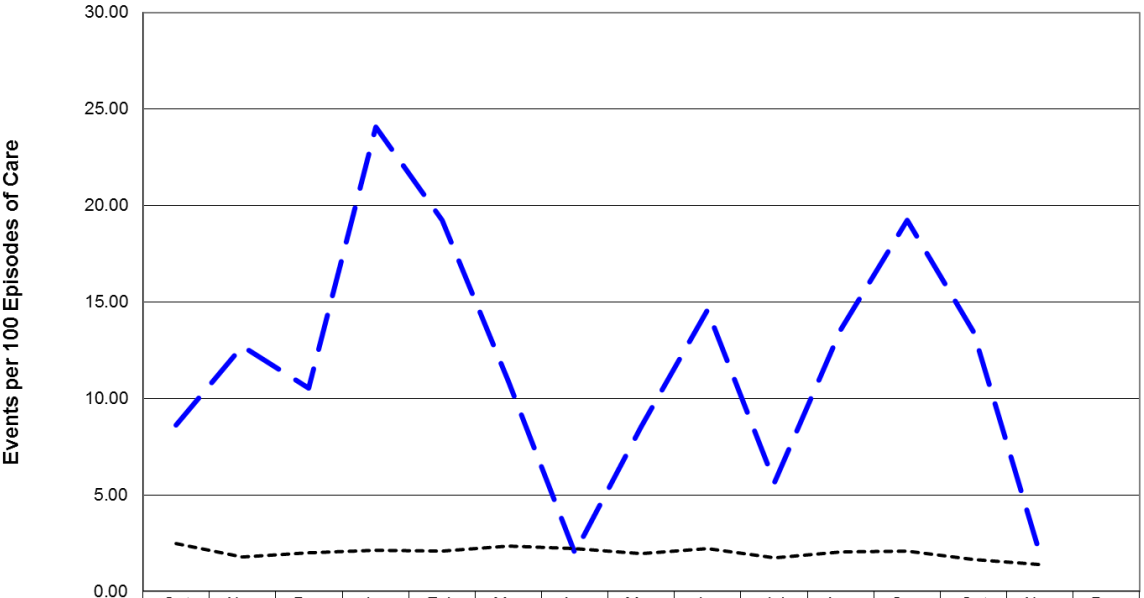
Medication Errors

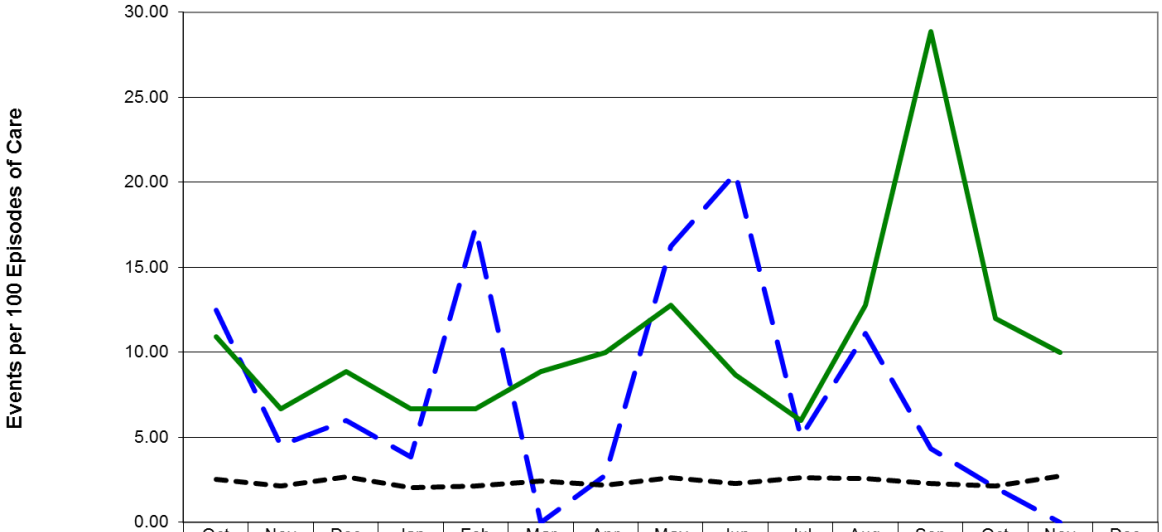
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	8.62	12.73	10.53	24.07	19.23	10.87	2.00	8.51	14.58	5.66	13.56	19.23	13.46	1.96	
Ntl Mean	2.47	1.80	2.00	2.13	2.09	2.33	2.23	1.97	2.24	1.72	2.05	2.07	1.64	1.41	

Medication Errors

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview	12.50	4.55	6.00	3.85	17.31	0.00	2.78	16.22	20.51	5.00	11.11	4.35	2.04	0.00	
Dorothea Dix	10.91	6.67	8.89	6.67	6.67	8.89	10.00	12.77	8.70	6.00	12.77	28.89	12.00	10.00	
Ntl Mean	2.54	2.12	2.68	2.03	2.14	2.42	2.21	2.64	2.30	2.62	2.57	2.28	2.12	2.75	

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Medication Variances

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

Prescribing

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

Dispensing

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

Administration

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

Complex

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

Review, Reporting and Follow-up Process:

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

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

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Administration Process

Medication Errors Related to Staffing Effectiveness

Date	Omit	Type of Error	Float	New	O/T	Unit	Staff Mix		
							RN	LPN	MHW
12/15/2014	N	WRONG FORM X7	N	N	N	LKM	3	0	6
4/5/2015	N	WRONG DRUG X3	Y	N	N	US	4	0	4
5/18/2015	N	WRONG FORM	Y	N	N	LKM	2	0	6
5/19/2015	N	WRONG DOSE X3	N	N	N	LKM	3	1	6
6/19/2015	Y	OMISSION	N	N	N	US	2	0	3
6/20/2015	N	EXTRA DOSE	N	N	N	US	2	1	3
6/27/2015	Y	OMISSION	N	N	N	LSS	2	0	8
7/31/2015	Y	OMISSION	Y	N	N	LSM	3	1	9
8/3/2015	N	WRONG DOSE	Y	N	N	LSM	3	1	7
8/8/2015	N	WRONG TIME	Y	N	N	LSM	2	1	7
8/10/2015	N	EXTRA DOSE	N	N	N	US	2	1	3
8/26/2015	N	WRONG TIME	N	N	N	US	2	0	3
8/28/2015	Y	OMISSION	N	Y	N	LKS	3	1	7
8/29/2015	Y	OMISSION	Y	N	N	LKM	2	0	6
8/29/2015	Y	OMISSION	Y	N	N	LKM	2	0	6
8/30/2015	Y	OMISSION X2	N	Y	N	US	2	1	3
9/4/2015	N	WRONG DOSE	N	N	N	LKM	3	1	7
9/4/2015	Y	OMISSION X2	N	Y	N	LSS	3	1	7
9/4/2015	N	EXTRA DOSE	N	N	N	LSS	2	0	6
9/7/2015	N	WRONG ROUTE	N	N	N	LSS	3	1	7
9/9/2015	N	WRONG DOSE	N	N	N	UK	3	1	3
9/10/2015	N	WRONG DOSE X2	Y	N	N	LKM	2	1	7
9/10/2015	Y	OMISSION	N	N	N	LSM	2	1	8
9/11/2015	N	WRONG DOSE X2	Y	N	N	LKM	3	1	7
9/14/2015	N	EXTRA DOSE	N	Y	N	LSM	2	1	7
9/15/2015	N	WRONG TIME	N	Y	N	LSM	3	1	7
9/16/2015	N	WRONG FORM	N	N	N	UK	2	1	3
9/16/2015	N	WRONG FORM	N	N	N	UK	2	1	3
9/17/2015	N	WRONG TIME	N	N	N	LSM	3	1	7
9/18/2015	Y	OMISSION	N	Y	N	US	3	1	4
9/21/2015	N	EXTRA DOSE X2	Y	N	N	LSM	3	1	8
9/25/2015	Y	OMISSION	N	N	Y	LKM	2	1	5
9/25/2015	Y	OMISSION X3	N	N	N	LSM	3	1	7
9/25/2015	Y	OMISSION X3	N	N	N	LSM	3	1	8

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10/3/2015	N	WRONG TIME	N	Y	N	US	1	1	3
10/4/2015	Y	OMISSION	Y	N	N	LSM	2	1	7
10/5/2015	Y	OMISSION				LKM			
10/5/2015	Y	OMISSION X2	Y	N	N	US	2	0	3
10/6/2015	Y	OMISSION X10	N	N	N	US	2	1	3
10/7/2015	N	EXTRA DOSE X4				LKM			
10/12/2015	N	WRONG DOSE	Y	N	N	LKM	2	0	6
10/15/2015	N	WRONG FORM	N	N	N	LKM	4	0	8
10/15/2015	N	WRONG TIME	N	N	N	LKM	3	1	7
10/15/2015	Y	OMISSION	N	N	N	LSM	3	1	7
10/19/2015	Y	OMISSION	N	N	N	LKS	3	1	7
10/25/2015	N	WRONG DRUG	N	N	N	LKM	2	1	7
10/25/2015	Y	OMISSION	N	N	N	UK	2	0	3
10/25/2015	Y	OMISSION	N	N	N	UK	2	0	3
10/26/2015	Y	OMISSION	N	N	N	LKM	3	1	7
11/7/2015	N	EXTRA DOSE	N	N	N	LKS	2	0	3
11/8/2015	Y	OMISSION	N	N	N	LKM	2	1	6
11/13/2015	N	EXTRA DOSE X2	Y	N	N	LKS	2	1	6
11/13/2015	Y	OMISSION	N	N	N	US	2	1	3
12/4/2015	N	EXTRA DOSE	N	N	N	US	1	0	4
12/29/2015	N	EXTRA DOSE	Y	N	N	LSS	1	0	3
Totals:	**40**		**22**	**9**	**1**	**LS: 23**	**US: 25**	**LK: 35**	**UK: 5**
Percent	**45%**	**88 Total Errors**	**25%**	**10%**	**1%**	**26%**	**28%**	**40%**	**6%**

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

Type of Error	# of Errors
Extra Dose	15
Omission	40
Wrong Dose	11
Wrong Drug	4
Wrong Form	11
Wrong Time	6
Wrong Route	1

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Dispensing Process

Measure	Unit	Baseline 2014	Goal	3Q 2015	4Q 2015	1Q 2016	2Q 2016
1. Controlled Substance Loss Data: Daily Pyxis-CII Safe Compare Report.	All	0.875%	0% Target: Actual:	 0% 0%	 0% 0%	 0% 0%	 0% 0%
2. Controlled Substance Loss Data: Monthly CII Safe Vendor Receipt Report.	Rx	0	0 Target: Actual:	 0 0	 0 0	 0 0	 0 0
3. Controlled Substance Loss Data: Monthly Pyxis Controlled Drug discrepancies.	All	0/mo	0 Target: Actual:	 0 0 (0/ mo)	 0 0 (0/ mo)	 0 0 (0/ mo)	 0 0 (0/ mo)
4. Medication Management Monitoring: Measures of drug reactions, adverse drug events and other management data.	Rx	8/year	0 Target: Actual:	 0 2	 0 3	 0 0	 0 0
5. Medication Management Monitoring: Resource Documentation Reports of Clinical Interventions.	Rx	99/ quarter	100% Target: Actual:	 100% 73	 100% 56	 100% 31	 100% 144
6. Psychiatric Emergency Process: Monthly audit of all psych emergencies measures against 9 criteria.	All	100%	100% Target: Actual:	 100% 93%	 100% 94%	 100% 78%	 100% 98%
7. Operational Audit: Monthly audit of 3 operational indicators from CPS contract.	Rx	100%	100% Target: Actual:	 100% 100%	 100% 100%	 100% 100%	 100% 100%

Note: Previous figures for Criteria #3 were reported on the number of discrepancies discovered in Pyxis. This number is not reflective of the number of controlled substances lost, but rather the number of times a simple mistake, such as a miscount, occurred. To ensure accuracy pharmacy staff reviewed past logs of controlled substances and found no substances unaccounted for.

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 patient satisfaction in six areas or domains of focus. These domains include Outcomes, Dignity, Rights, Participation, Environment, and Empowerment.

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

Rate of Response for the Inpatient Consumer Survey:

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

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

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

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

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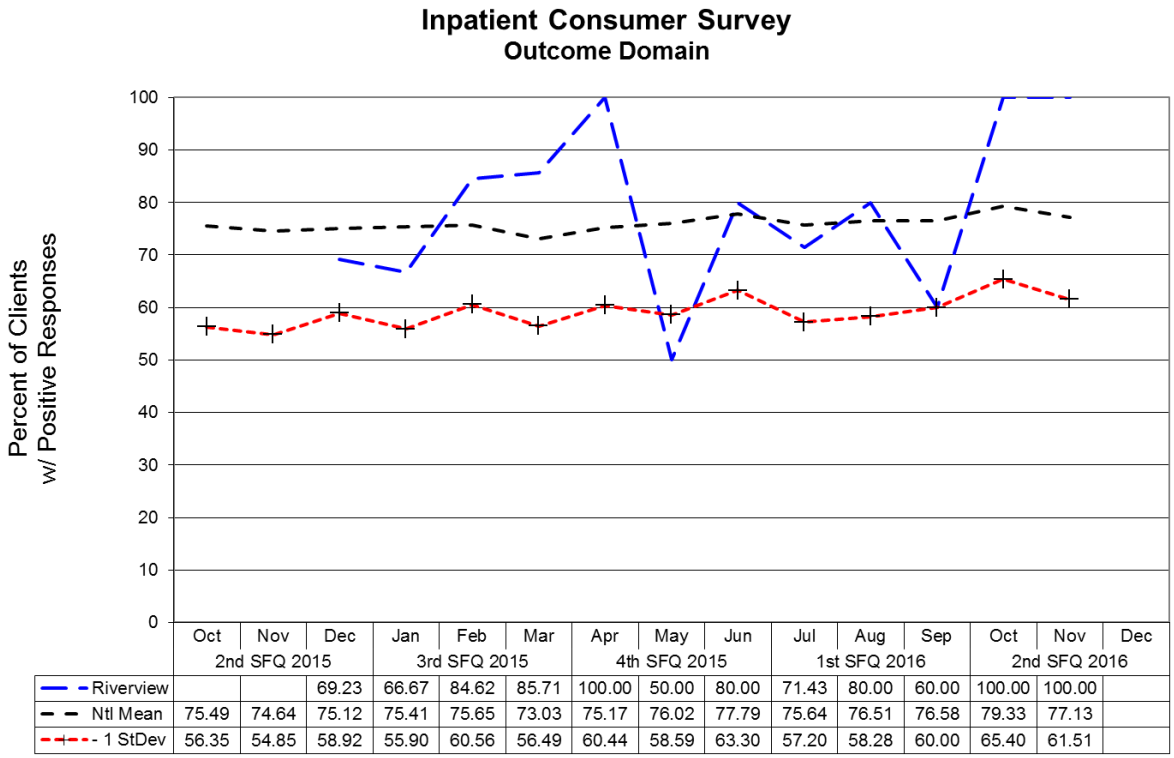

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			69.23	66.67	84.62	85.71	100.00	50.00	80.00	71.43	80.00	60.00	100.00	100.00	
Ntl Mean	75.49	74.64	75.12	75.41	75.65	73.03	75.17	76.02	77.79	75.64	76.51	76.58	79.33	77.13	
1 StDev	56.35	54.85	58.92	55.90	60.56	56.49	60.44	58.59	63.30	57.20	58.28	60.00	65.40	61.51	

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.

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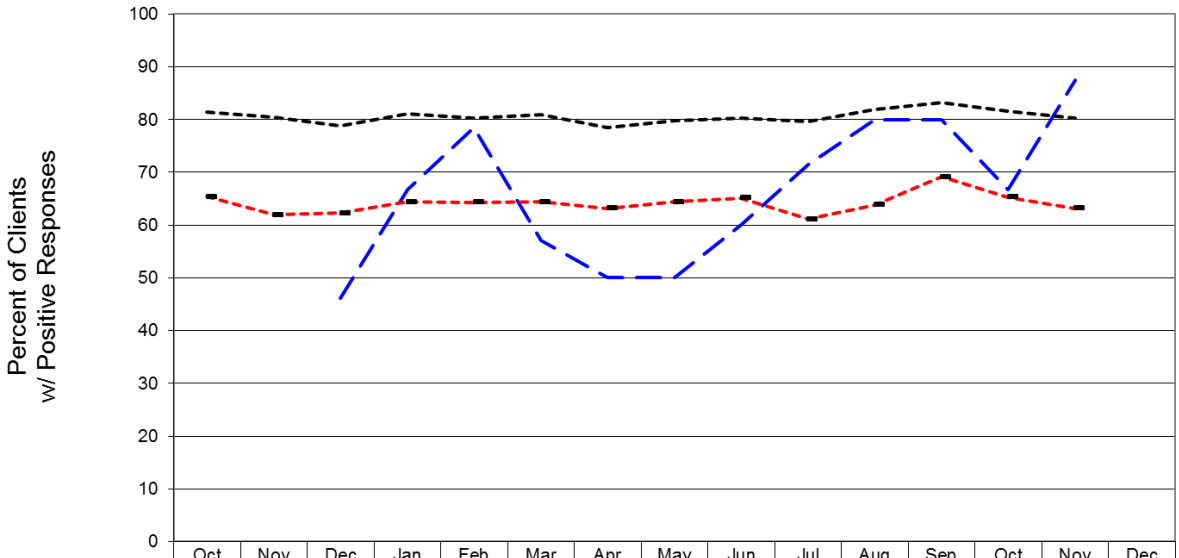
Inpatient Consumer Survey
Dignity Domain



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			46.15	66.67	78.57	57.14	50.00	50.00	60.00	71.43	80.00	80.00	66.67	87.50	
Ntl Mean	81.44	80.38	78.90	81.15	80.24	80.93	78.48	79.75	80.28	79.58	81.92	83.22	81.66	80.30	
1 StDev	65.36	61.96	62.32	64.41	64.30	64.43	63.18	64.37	65.16	61.14	63.82	69.11	65.34	63.19	

Dignity Domain Questions:

1. I was treated with dignity and respect.
2. Staff here believed that I could grow, change and recover.
3. I felt comfortable asking questions about my treatment and medications.
4. I was encouraged to use self-help/support groups.

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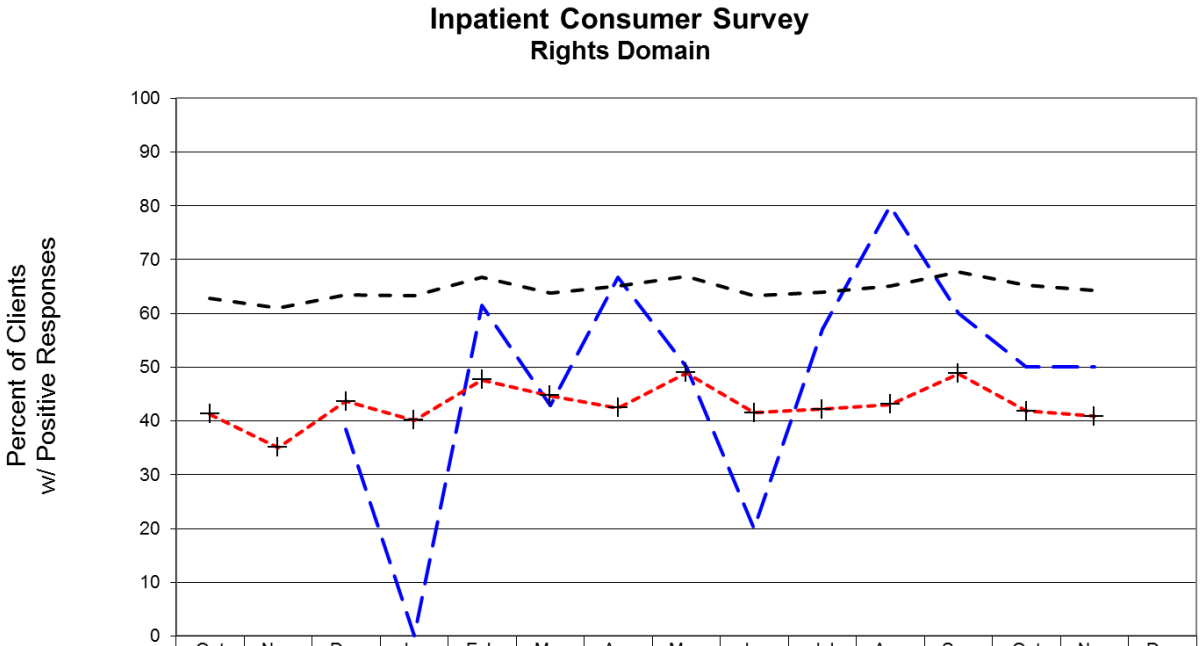

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			38.46	0.00	61.54	42.86	66.67	50.00	20.00	57.14	80.00	60.00	50.00	50.00	
Ntl Mean	62.73	61.01	63.46	63.23	66.69	63.76	65.17	66.95	63.35	63.94	65.03	67.71	65.25	64.32	
1 StDev	41.29	35.04	43.63	40.14	47.65	44.68	42.40	48.95	41.50	42.18	43.06	48.76	41.89	40.85	

Rights Domain Questions:

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

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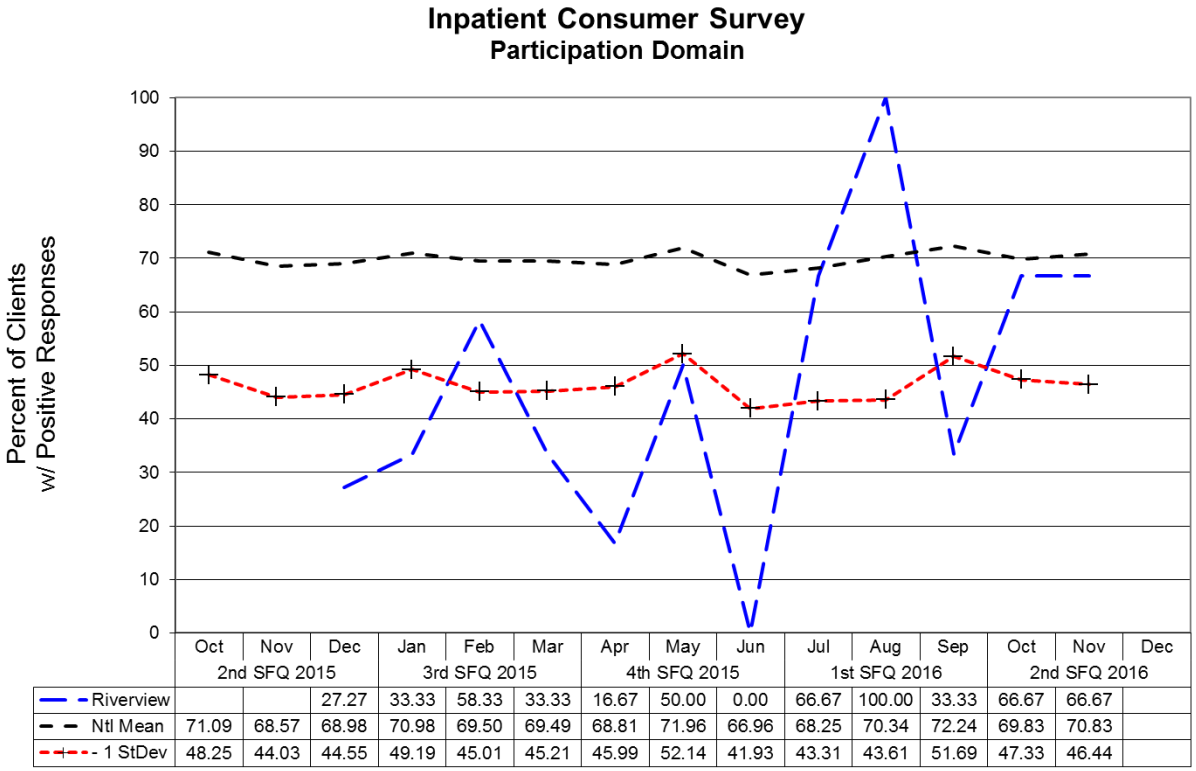

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			27.27	33.33	58.33	33.33	16.67	50.00	0.00	66.67	100.00	33.33	66.67	66.67	
Ntl Mean	71.09	68.57	68.98	70.98	69.50	69.49	68.81	71.96	66.96	68.25	70.34	72.24	69.83	70.83	
1 StDev	48.25	44.03	44.55	49.19	45.01	45.21	45.99	52.14	41.93	43.31	43.61	51.69	47.33	46.44	

Participation Domain Questions:

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

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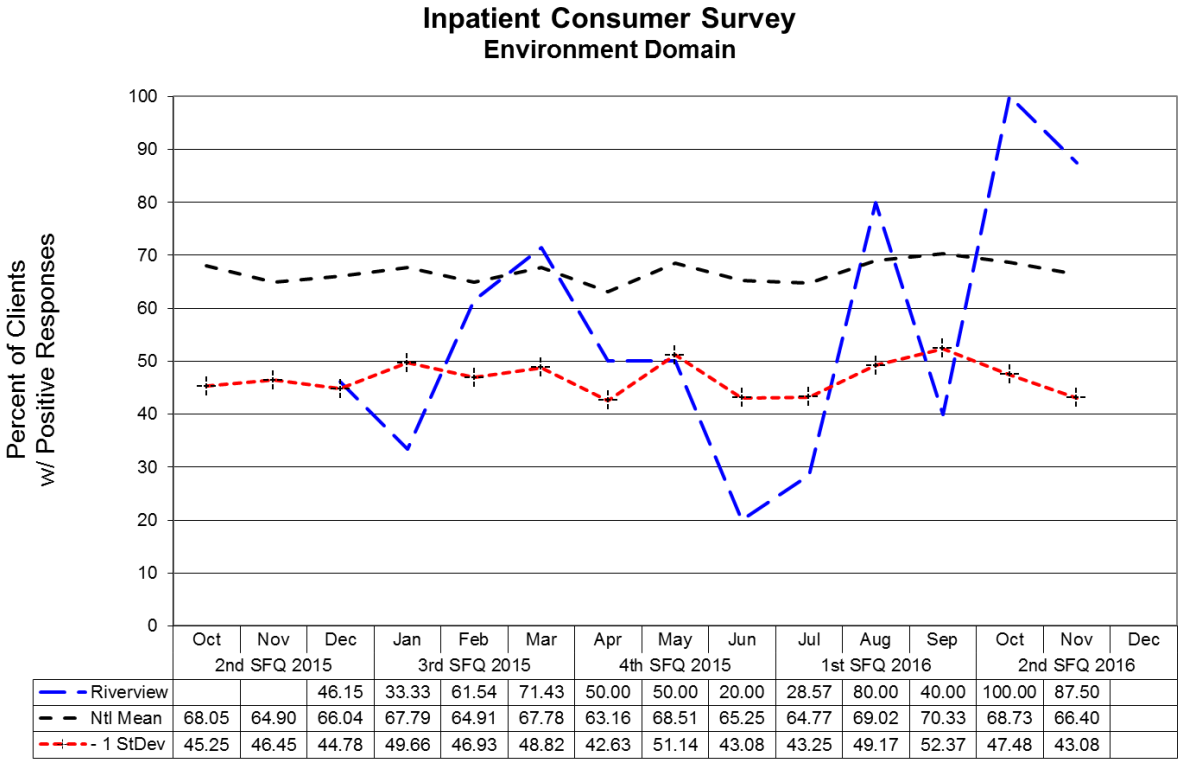

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	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			46.15	33.33	61.54	71.43	50.00	50.00	20.00	28.57	80.00	40.00	100.00	87.50	
Ntl Mean	68.05	64.90	66.04	67.79	64.91	67.78	63.16	68.51	65.25	64.77	69.02	70.33	68.73	66.40	
1 StDev	45.25	46.45	44.78	49.66	46.93	48.82	42.63	51.14	43.08	43.25	49.17	52.37	47.48	43.08	

Environment Domain Questions:

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

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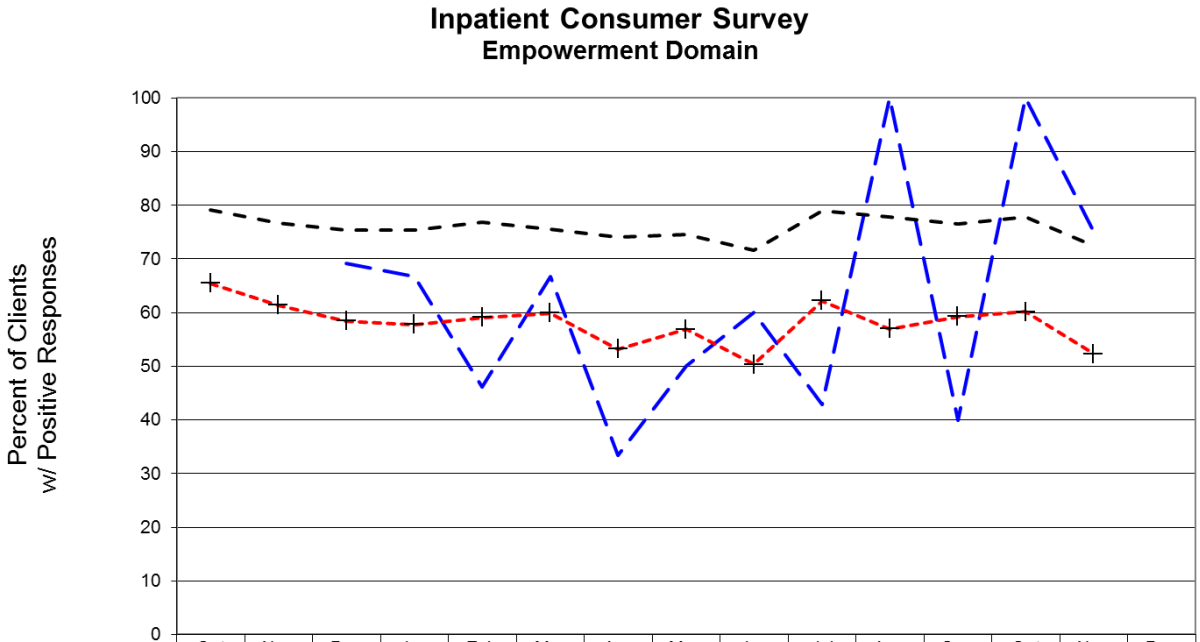


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2nd SFQ 2015			3rd SFQ 2015			4th SFQ 2015			1st SFQ 2016			2nd SFQ 2016		
Riverview			69.23	66.67	46.15	66.67	33.33	50.00	60.00	42.86	100.00	40.00	100.00	75.00	
Ntl Mean	79.07	76.62	75.44	75.31	76.90	75.61	74.07	74.60	71.59	78.92	77.81	76.55	77.89	72.37	
1 StDev	65.47	61.42	58.47	57.81	59.08	59.87	53.25	56.91	50.35	62.23	56.98	59.23	60.14	52.32	

Empowerment Domain Questions:

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

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.

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

Type of Fall by Patient and Month:

Fall Type	Patient	OCT	NOV	DEC	2Q2016
Un-witnessed	MR175		2		**2**
	MR5053		1	1	**2**
	MR5901			1	**1**
	MR6354			1	**1**
	MR6714	1			**1**
	MR7832*	2			**2**
	Totals	**3**	**3**	**3**	**9**
Fall Type	**Patient**	**OCT**	**NOV**	**DEC**	**2Q2016**
Witnessed	MR156			1	**1**
	MR3374			1	**1**
	MR7665	1	2		**3**
	MR7832*		1		**1**
	MR7837		1		**1**
	Totals	**1**	**4**	**2**	**7**

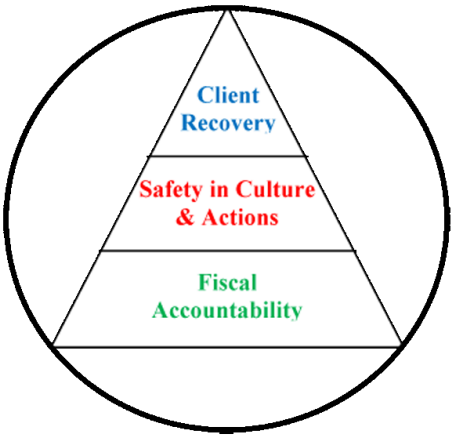
*Patients have experienced witnessed and un-witnessed falls during the reporting quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Process Improvement Plans

Priority Focus Areas for Strategic Performance Excellence

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



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

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

STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

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

Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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

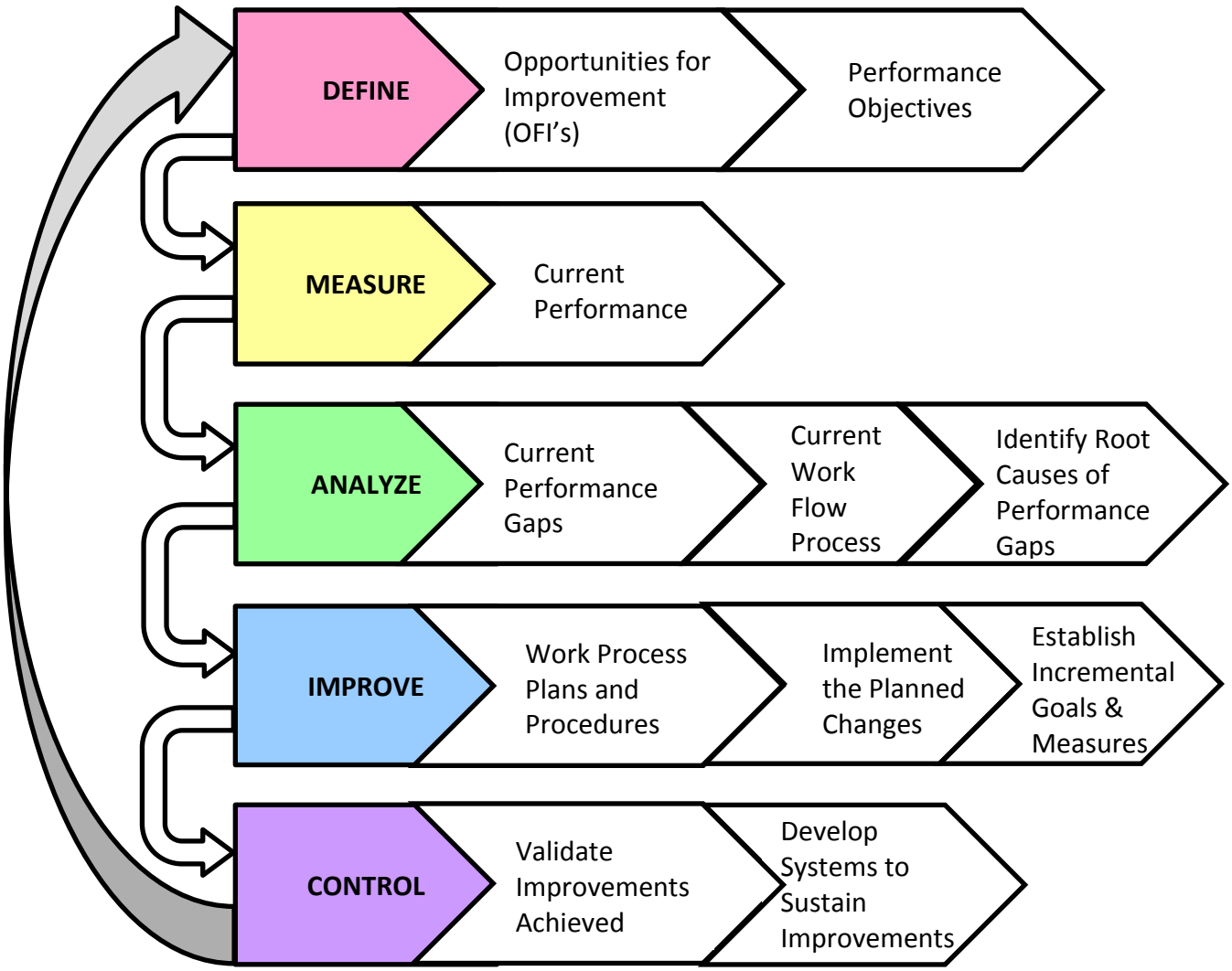
Promote a Safety Culture by…
Improving Communication
Improving Staffing Capacity and Capability
Evaluating and Mitigating Errors and Risk Factors
Promoting Critical Thinking
Supporting the Engagement and Empowerment of Staff Members

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

STRATEGIC PERFORMANCE EXCELLENCE

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

The Quarterly Report Consists of the Following:



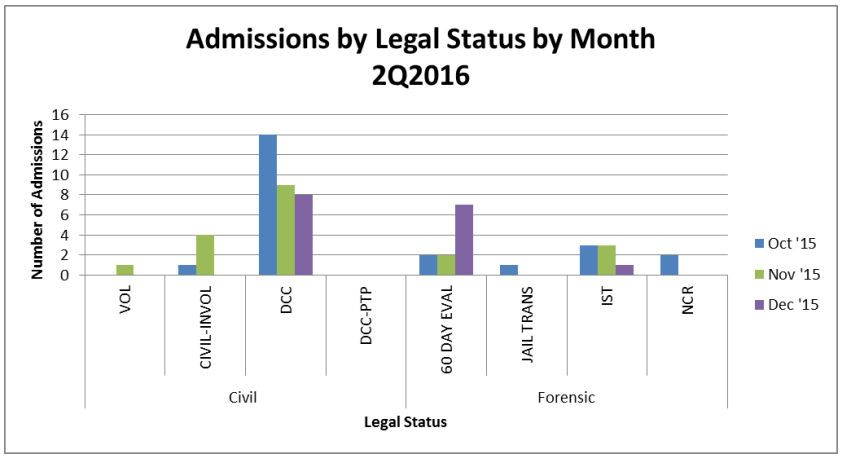
STRATEGIC PERFORMANCE EXCELLENCE

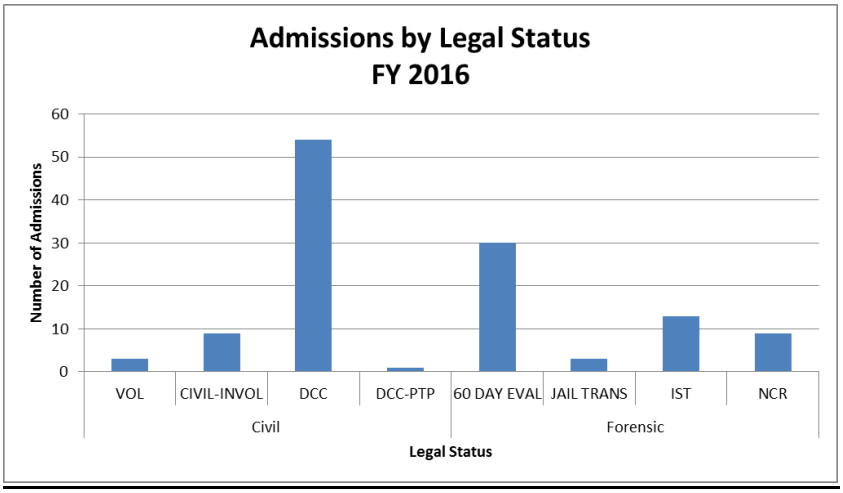
Admissions

Responsible Party: Jamie Meader, RN, Admissions Nurse

Number of Admissions:

ADMISSIONS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**7**	**13**	**10**	**15**	**14**	**8**							**67**
VOL	0	1	1	0	1	0							**3**
CIVIL-INVOL	0	2	2	1	4	0							**9**
DCC	7	9	7	14	9	8							**54**
DCC-PTP	0	1	0	0	0	0							**1**
FORENSIC:	**10**	**16**	**8**	**8**	**5**	**8**							**55**
60 DAY EVAL	8	8	3	2	2	7							**30**
JAIL TRANS	0	0	2	1	0	0							**3**
IST	0	4	2	3	3	1							**13**
NCR	2	4	1	2	0	0							**9**
TOTAL	**17**	**29**	**18**	**23**	**19**	**16**							**122**



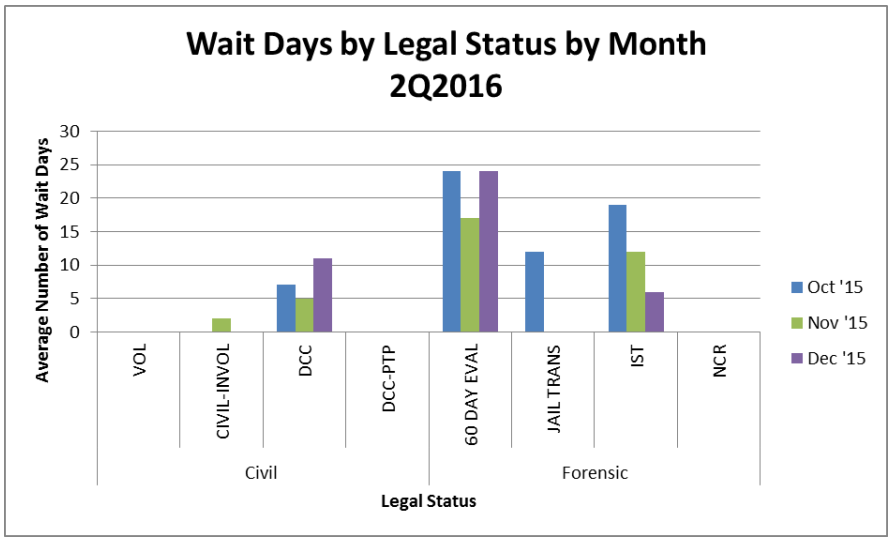


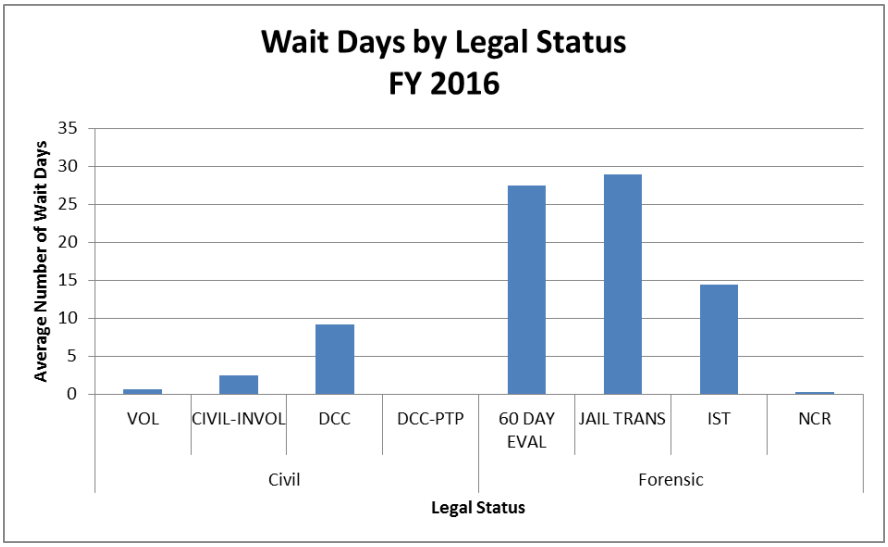
STRATEGIC PERFORMANCE EXCELLENCE

Average Number of Wait Days:

WAIT DAYS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**15**	**6**	**8**	**7**	**4**	**11**							**9**
VOL		1	1		0								**1**
CIVIL-INVOL		5	3	0	2								**3**
DCC	15	7	10	7	5	11							**9**
DCC-PTP		0											**0**
FORENSIC:	**53**	**18**	**19**	**15**	**14**	**22**							**24**
60 DAY EVAL	66	25	9	24	17	24							**28**
JAIL TRANS			46	12									**29**
IST		20	15	19	12	6							**14**
NCR	0	0	1	0									**0**
AVERAGE	**37**	**12**	**13**	**10**	**6**	**16**							**16**

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

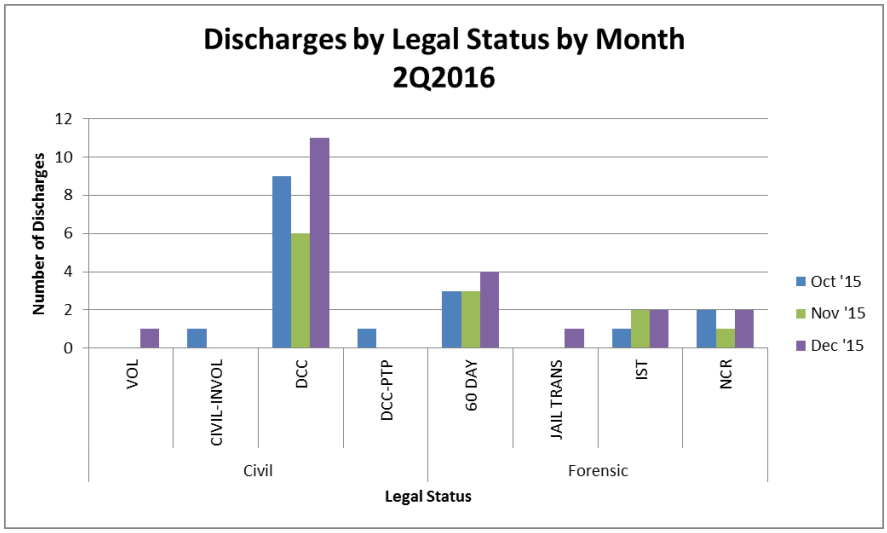


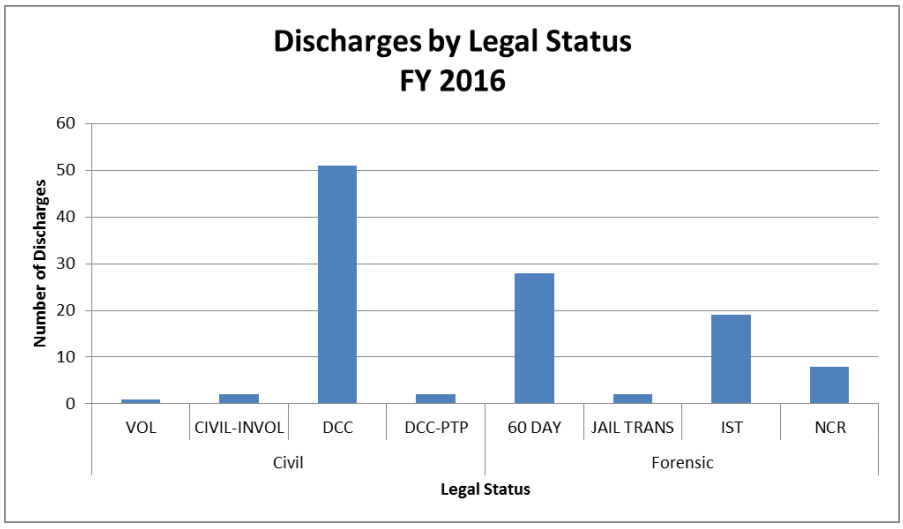


STRATEGIC PERFORMANCE EXCELLENCE

Number of Discharges:

DISCHARGES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL:	**8**	**8**	**11**	**11**	**6**	**12**							**56**
VOL	0	0	0	0	0	1							**1**
CIVIL-INVOL	1	0	0	1	0	0							**2**
DCC	6	8	11	9	6	11							**51**
DCC-PTP	1	0	0	1	0								**2**
FORENSIC:	**10**	**16**	**10**	**6**	**6**	**9**							**57**
60 DAY	3	10	5	3	3	4							**28**
JAIL TRANS	0	0	1	0	0	1							**2**
IST	5	5	4	1	2	2							**19**
NCR	2	1	0	2	1	2							**8**
TOTAL	**18**	**24**	**21**	**17**	**12**	**21**							**113**

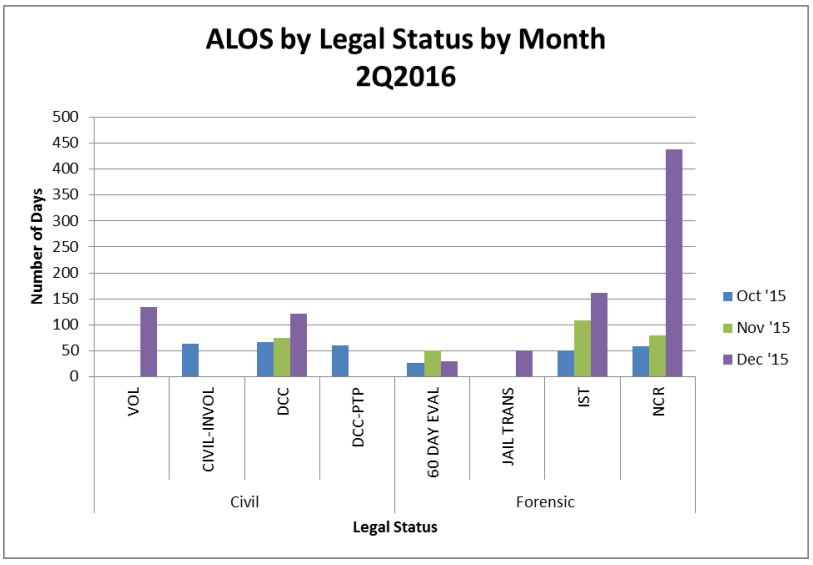


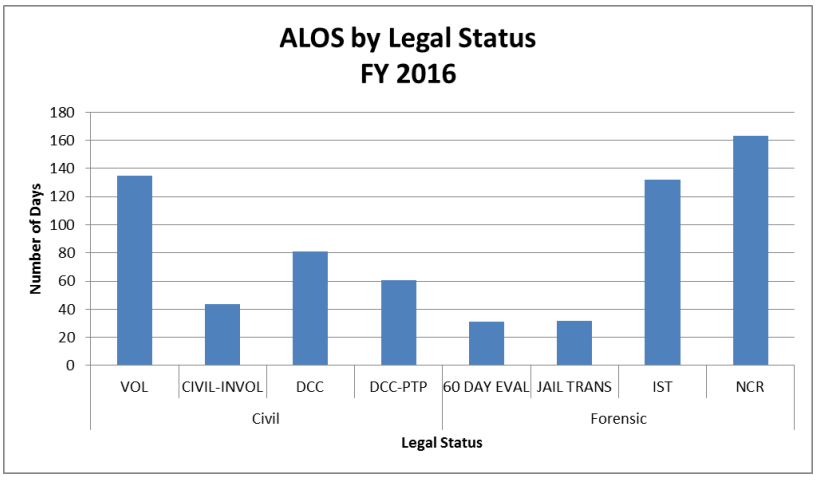


STRATEGIC PERFORMANCE EXCELLENCE

Average Length of Stay (Days):

ALOS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	AVG
CIVIL:	**64**	**70**	**83**	**65**	**74**	**122**							**80**
VOL						135							**135**
CIVIL-INVOL	23			64									**44**
DCC	71	70	83	67	74	121							**81**
DCC-PTP	61			60									**61**
FORENSIC:	**118**	**98**	**73**	**41**	**74**	**152**							**93**
60 DAY EVAL	24	27	28	26	50	30							**31**
JAIL TRANS			12			51							**32**
IST	74	252	146	50	108	161							**132**
NCR	371	31	0	59	80	438							**163**
AVERAGE	**94**	**88**	**78**	**57**	**74**	**135**							**88**





STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: NCR Admissions

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

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	NCR referrals admitted within 24 hours	N/A	100%	100%	100%	100%	**100%**
Actual			86% 6/7	100% 2/2			**89% 8/9**

Data Analysis: Two NCR admissions occurred this quarter and both were admitted on the day of referral.

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

Graph/Chart:

	October 2015	**November 2015**	**December 2015**	**2Q2016**
# of NCR Admissions	2	0	0	**2 (Total)**
Wait Days	0	0	0	**0 (Average)**

II. Measure Name: Jail Transfer Bed

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

Type of Measure: Performance Improvement

Data Analysis: One Jail Transfer was admitted this quarter. JTF was admitted in October and waited 12 days for admission. There was a LOS of 51 days (patient was returned to jail and bailed out). JTF admitted from last quarter had charges dismissed and was transferred to the civil side.

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

Graph/Chart:

	October 2015	November 2015	December 2015	2Q2016 Total
# of Jail Transfer (JTF) Admissions	1	0	0	**1**
# of Jail Transfer (JTF) Discharges	0	0	1	**1**

III. Measure Name: Off Shift PA Admission Paperwork

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

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Documentation complete and accurate for admissions on off shifts	N/A	100%	100%	100%	100%	**100%**
Actual			100% 3/3	50% 1/2			**80% 4/5**

Data Analysis: Two off shift admissions occurred this quarter. One admission was completed as policy dictates; the other admission was missing multiple documents. The PA was notified of the missing documentation for follow up.

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

STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Dental Clinic

Responsible Party: Dr. Ingrid Prikryl, Dentist

I. Measure Name: Yearly Periodontal Charting

Measure Description: Complete a full mouth periodontal charting.

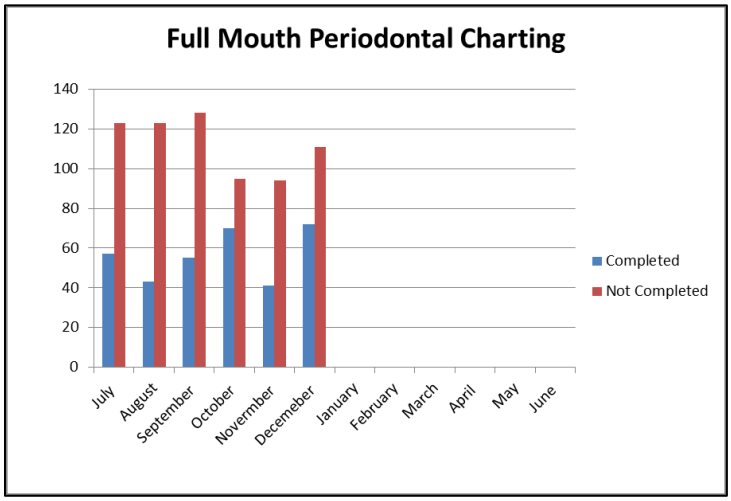
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	% of appointments where full mouth periodontal charting was completed	FY 2015 42%	50%	55%	60%	65%	**75%**
Actual			41%	61%			**50%**

Data Analysis: 2Q2016 periodontal charting increased by 20%.

Action Plan: Charting to be completed by the hygienist during prophy appointments and/or with dentist during exam appointment.

Comments: Target is to be at 60% by the next six month recall cycle and then at 75% after 12 month recall. This is a challenge because not all patients are able and/or willing to sit for periodontal charting.



STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Improving Oral Hygiene

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

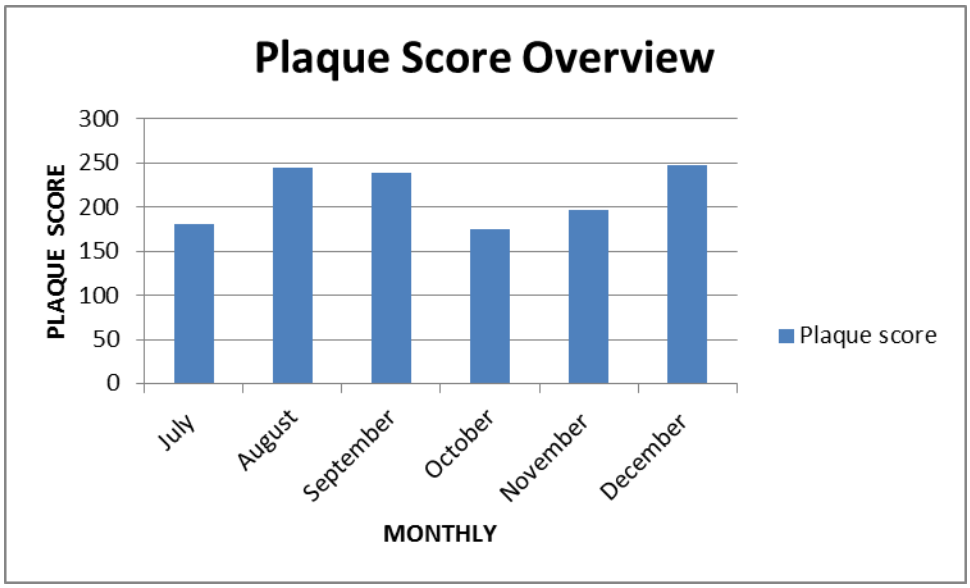
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Plaque Score Monthly	Fair 213.25	Fair (220-16)	Fair (220-16)			
Actual			Poor 221	Fair 207			**Fair 214**

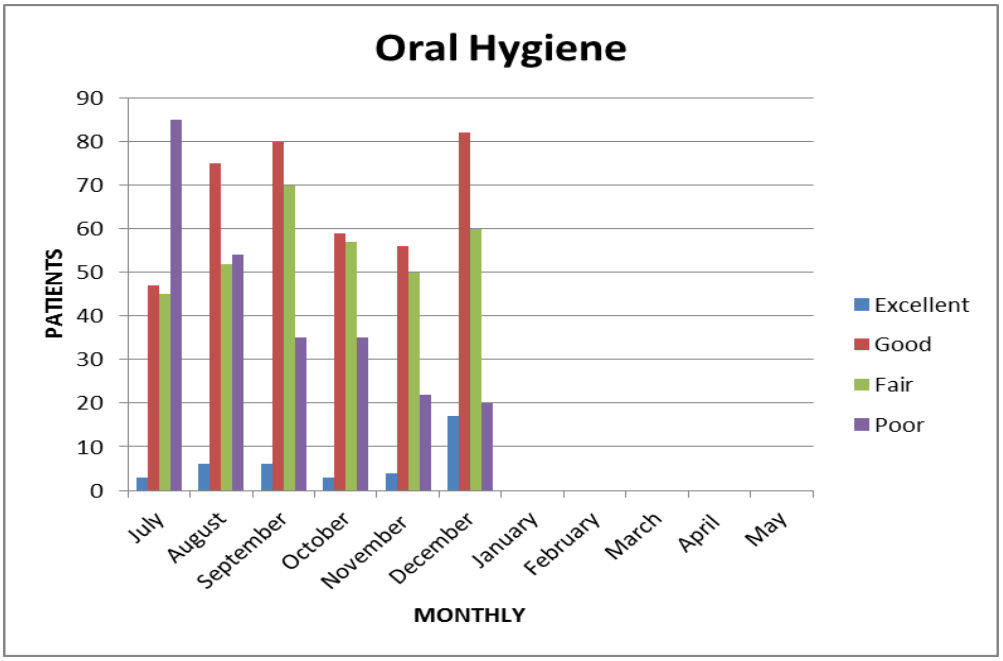
Data Analysis: Smaller numbers demonstrate less plaque on our patients' teeth, therefore improved oral hygiene.

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

Comments: We are working to educate our patients on brushing daily and its importance for proper oral care and retention of teeth.



STRATEGIC PERFORMANCE EXCELLENCE



III. Measure Name: Next Visit

Measure Description: Writing Next Visit in progress note.

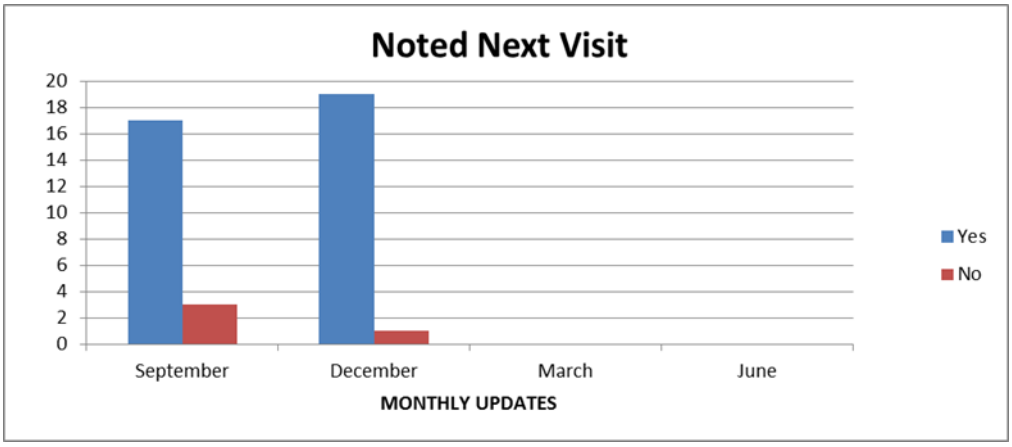
Type of Measure: Performance Improvement

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

Data Analysis: FY2015 YTD was 66%; therefore, it has become a performance improvement measure. we would like this measure to be at 90 – 100%. We had a 35% increase from 1Q2016 to 2Q2016.

Action Plan: Write at the end of every progress note what the next visit is going to be even if it is a 3 MRC or denture adjustment as needed. Random weekly checks on most recent progress note will be measured on daily tally sheet.

STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Medication Management Clinic

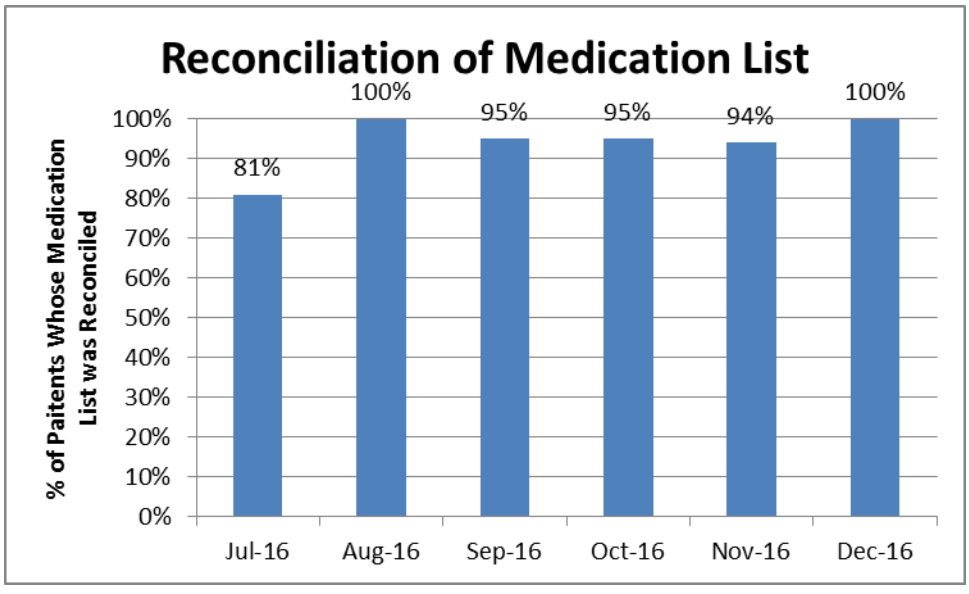
Responsible Party: Robin Weeks, Medical Assistant

I. Measure Name: Reconciliation of Outpatient Medication List

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

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**YTD**
Target	Reconciliation completed per visit.	FY15 Q2 73%	100%	100%	100%	100%	**100%**
Actual			85% 46/54	100% 59/59	94% 59/63	97% 57/59	**94% 221/235**



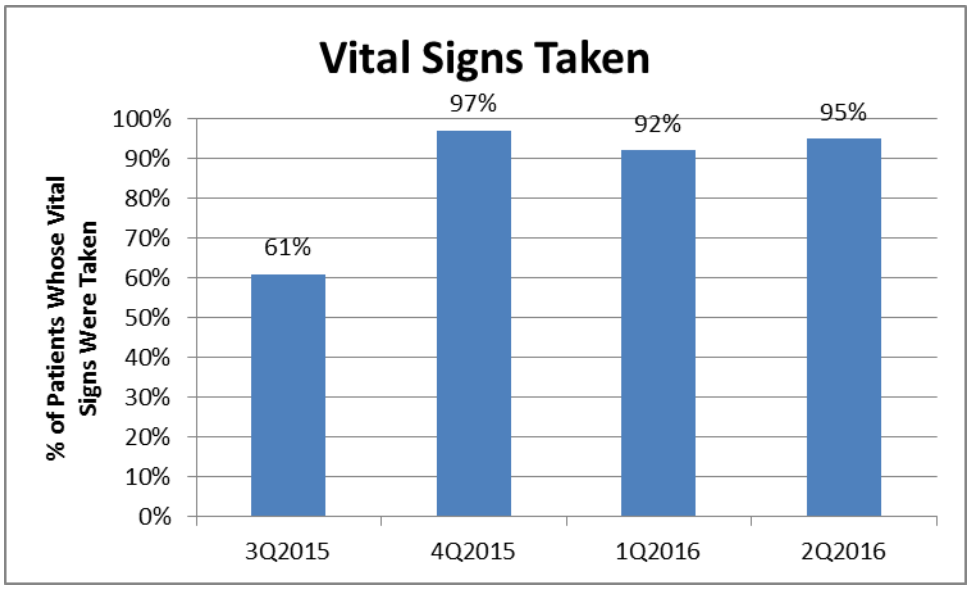
STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Vital Signs

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

Measure Type: Quality Improvement

Results							
	Unit	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**YTD**
Target	Reconciliation completed per visit.	FY15 Q1 73%	100%	100%	100%	100%	**100%**
Actual			61% 28/46	97% 57/59	92% 58/63	95% 56/59	**82% 199/227**



STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela, Dietetic Services Manager

I. Measure Name: Nutrition Screen Completion

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

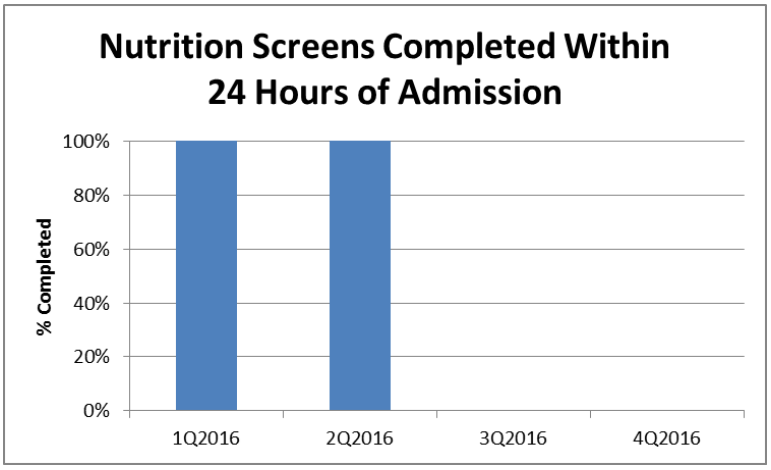
Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Nutrition screens completed on time	FY 2015 95%	95%	95%	95%	95%	**95%**
Actual			100% 60/60	100% 61/61			**100% 121/121**

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

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

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



STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Nutrition Screen Accuracy

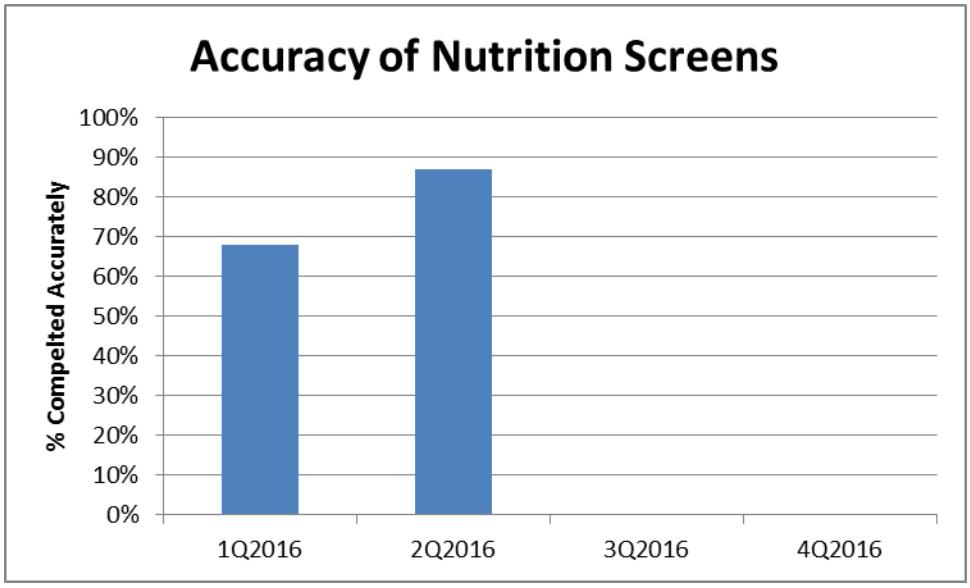
Measure Description: The Registered Dietitian will review every patient's Nursing Admission Data, upon admission, to assess ongoing compliance with the accuracy of the Nutrition Screen tool. This screen is utilized to attain nutrition indicators that necessitate dietary intervention.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Nutrition screens completed accurately	FY 2016 Q1 68% 41/60	Baseline established	95%			**95%**
Actual			68% 41/60	87% 53/61			**78% 94/121**

Data Analysis: These results indicate there has been an 18.7% improvement in the accuracy of the information gathered on the nutrition screen. The nutrition screen is completed by the nurse responsible for the admission. The diagnosis on the nutrition screen that is commonly not identified is the "BMI>29"; 7 of the 8 errors. Additionally, seven of the eight errors were documented by the same admitting nurse.

Action Plan: Meet with the admitting nurse responsible for this data collection to determine if there is a barrier or misinterpretation of the requirements for completing the screening.



STRATEGIC PERFORMANCE EXCELLENCE

III. Measure Name: Hand Hygiene Compliance

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

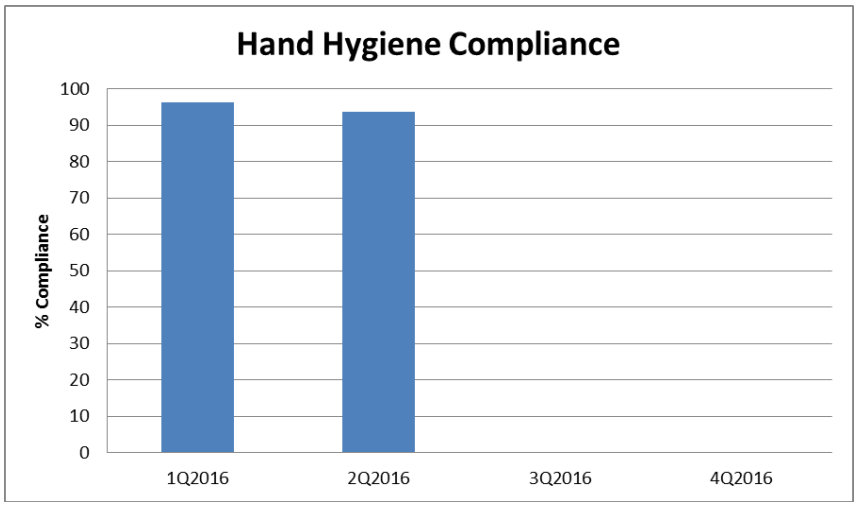
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of Dietary employees washing hands after break	FY 2015 98% 338/346	90%	95%			**93%**
Actual			96% 343/356	94% 215/229			**93% 558/585**

Data Analysis: The results of this quarter remain above 90%. There was a 2.5% decrease in compliance. Total observations decreased by 127. Two employees accounted for eight of the fourteen times that handwashing wasn't observed. Seven additional employees weren't observed washing their hands once within this rating period.

Action Plan:

- Continue to have front line supervisors monitor handwashing compliance after breaks.
- Provide hand hygiene training annually and review techniques with staff not in compliance.
- Encourage front line supervisors to promote hand hygiene with their staff throughout the day.



STRATEGIC PERFORMANCE EXCELLENCE

Emergency Management

Responsible Party: Robert Patnaude, Emergency Management Coordinator

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

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

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

Type of Measure: Performance Improvement

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

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of timely and appropriate responses	FY2016 90% 144/159	90%	90%			**90%**
Actual			92% 147/159	96% 153/159			**94% 300/318**

Data Analysis: With a significant amount of hands-on demonstrations, radio tests, and an increase in the use of radios, data showed that staff has become very familiar with operating the radio. Although the actual percentage of timely and appropriate responses has increased, the critical components such as having alert notification equipment in ready order needs improvement. We continue to investigate the most appropriate equipment that is not so dependent on staff oversight.

Action Plan:

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

Comments: 96% of assigned radio equipment is placed into service in a timely manner. Although this response adequately assures that the majority of occupants will receive timely and critical information, it still leaves a small population of staff who could be in harm's way if they do not receive critical information through mass notification.

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

STRATEGIC PERFORMANCE EXCELLENCE

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

STRATEGIC PERFORMANCE EXCELLENCE

Key:

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

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

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

*3 Operations had to call (2) units. Staff did not respond to the Code Triage.

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

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

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

*7 Operations had to call unit. Department Director was the only person in office. EMC to provide remedial training as requested.

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Responsible Party: Rebecca Eastman, RN

I. Measure: Harbor Mall Hand-Off Communication

Objectives	3Q 2015	4Q 2015	1Q 2016	2Q 2016	Total FY2016
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	86% 36/42	76% 32/42	79% 44/56	93% 39/42	**83% 151/182**
2. SBAR information completed from the units to the Harbor Mall.	86% 36/42	74% 31/42	79% 44/56	93% 39/42	**83% 150/182**

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

Measure: 71% for July, 86% for August, 93% for September, 79% for October, 100% for November, and 100% for December. Measure increased from 79% in 1Q2016 to 93% in 2Q2016.

Analyze: For October there was one sheet that was not turned in. For November the specific time frame for being late was five minutes. For December the specific time frame for being late was four minutes. We will continue to concentrate on both indicators to maintain current performance.

Improve: We will review the results of this report with the RN IV's from each unit. We will also review the data for HOC sheets that did not arrive at the mall within the designated time frame from the units. We added a statement at the bottom of the sheet reminding them to be turned in by ten minutes after the hour so the leaders know if there are any issues with the patients and it is highlighted in yellow.

Control: To continue to monitor the data and follow up with any unit(s) that may be having difficulties in developing or maintaining a process to meet the objectives above.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Responsible Party: Michelle Welch, RHIT

Documentation and Timeliness:

Indicators	2Q2016 Findings	2Q2016 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	49 charts for patients released during the quarter were samples. 100% of the charts were completed within the required timeframe.	100%	80%
Discharge summaries will be completed within 15 days of discharge.	47 of the 49 discharge summaries were completed within 15 days of discharge.	96%	100%
Medical transcription will be timely and accurate.	Out of requested dictated reports, all were completed within 24 hours.	100%	90%

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

Actions: Continue to monitor.

STRATEGIC PERFORMANCE EXCELLENCE

Confidentiality:

Indicators	2Q2016 Findings	2Q2016 Compliance	Threshold Percentile
All patient information released from the Health Information Department will meet all Joint Commission, State, Federal & HIPAA standards.	1822 requests for information (157 requests for patient information and 1665 police checks) were released.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	All new employees/contract staff attended confidentiality/HIPAA training.	100%	100%
Confidentiality/privacy issues tracked through incident reports.	0 privacy-related incident reports.		

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

No problems were found in 2Q2016 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

Release of Information for Concealed Carry Permits:

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

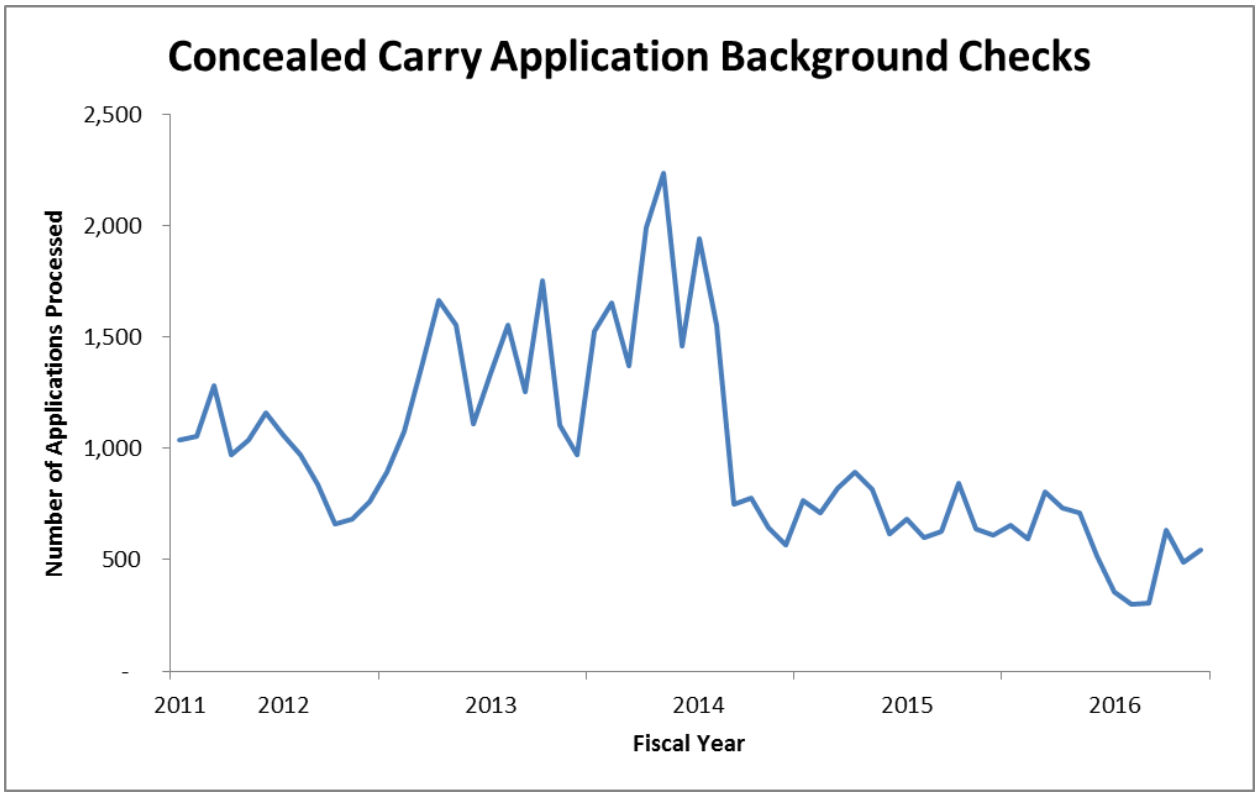
Analyze:
Data collected for the 2Q2016 showed that we received 1665 applications. This is an increase from last quarter 1Q2016 when we received 959 applications.

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

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

Year	FY 2015						FY2016						Total
Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
# Applications Received	655	594	806	732	713	516	353	302	304	634	489	542	6640

STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

Housekeeping

Responsible Party: Debora Proctor, Housekeeping Supervisor

I. Measure Name: Patient Living Area

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

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

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

Results:

Unit	Target	4Q2015	1Q2016	2Q2016	3Q2016	YTD
Lower Saco	85%	91%	89%	94%		**90%**
Upper Saco	85%	88%	87%	88%		**87%**
Lower Kennebec	85%	85%	89%	90%		**87%**
Upper Kennebec	85%	90%	87%	89%		**88%**
Overall Average	**85%**	**89%**	**88%**	**90%**		**88%**

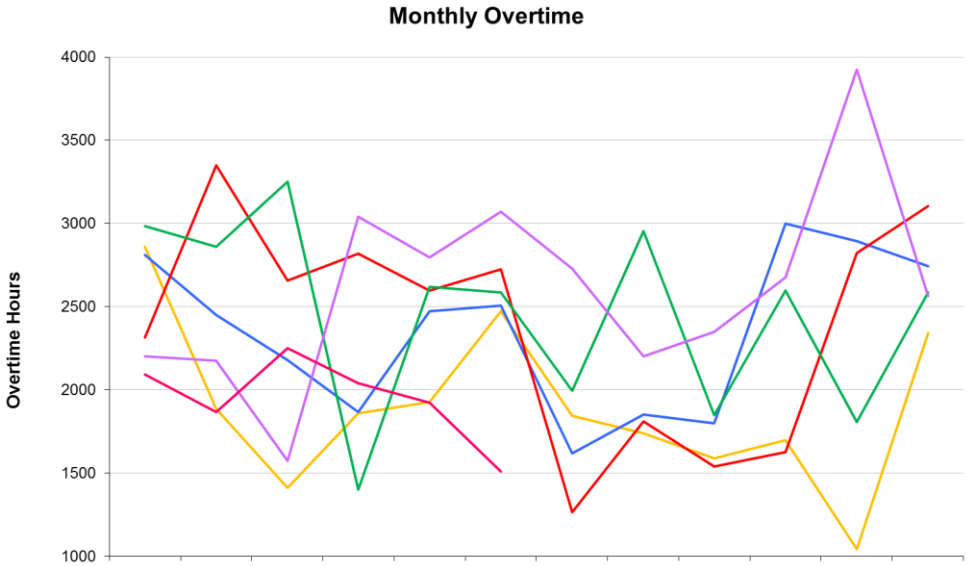
Data Analysis: The Housekeeping Supervisor inspected units monthly and found that window cleaning, water cooler cleaning and floor care in the nurses station were consistent problem areas.

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

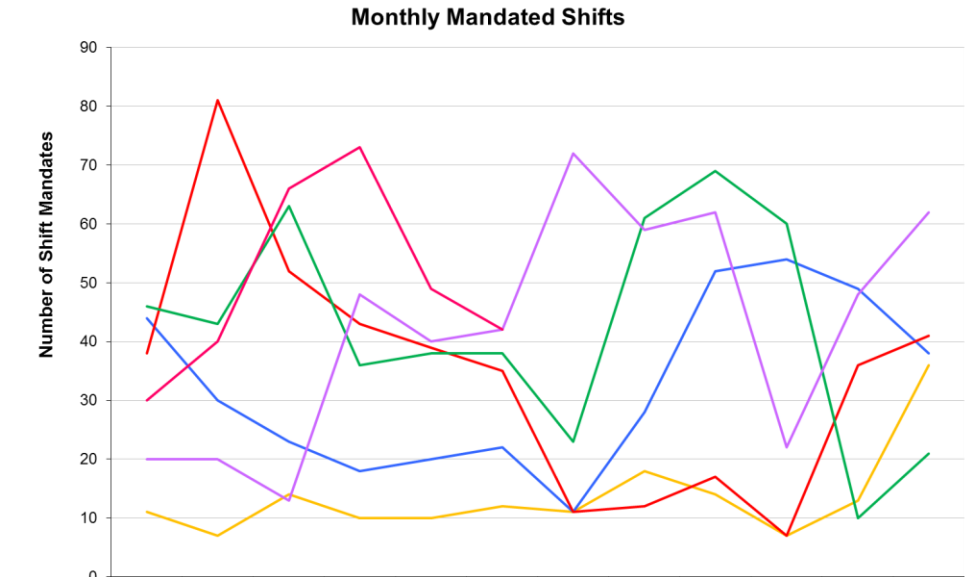
STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Person Responsible: Aimee Rice, Human Resources Manager



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



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

STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: License Reviews

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

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percentage Licenses Reviewed	FY 2014 98%	100%	100%	100%	100%	**100%**
Actual			100% 19/19	100% 6/6			**100% 25/25**

Data Analysis: During 2Q2016, there were 8 new hires. Of those, 6 were licensed, or potentially licensed. License and CNA Registry checks were performed prior to hire on all 6.

Action Plan: No action is needed at this time.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff

Responsible Party: Dr. Brendan Kirby, Clinical Director

Quality Improvement Plan
2015-2016

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

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

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

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

STRATEGIC PERFORMANCE EXCELLENCE

1. **Peer Review Activities**:

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

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

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

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

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

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

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

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

insure that all relevant clinical service areas or services are involved in monitoring. The Director of Integrated Quality will also assist in assuring the ongoing presence of appropriate monitors.

Quality Improvement Reporting Schedule to Medical Executive Committee

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

STRATEGIC PERFORMANCE EXCELLENCE

I. Measure Name: Polyantipsychotic Therapy

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

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**YTD**
Target	Justified Polyantipsychotic Therapy	85% (2015)	90%	90%	90%	90%	**90%**
Actual			93%	63%	77%	69%	**76%**

Data Analysis: All medication profiles in the hospital are reviewed in each month of the quarter for antipsychotic medication orders. Attending psychiatrists are required to complete a Polyantipsychotic Therapy Justification Form when a patient is prescribed more than one antipsychotic. The percentage of justified polyantipsychotic therapy amongst those patients prescribed two or more antipsychotics is reported here. This quarter we regained round in the number of patients on justifiable polyantipsychotic therapy. An analysis of the patients on polyantipsychotic therapy yielded the following results: One patient was discharged on two antipsychotics without justification for the polyantipsychotic therapy, although the combination was pharmacologically rational. During the past quarter, 22 inpatients were prescribed two scheduled antipsychotics which is lower than last quarter. Ten of the 22 patients do not have justification for the polyantipsychotic therapy, though 7 of those regimens are pharmacologically rational. There are 30 inpatients currently prescribed 2 antipsychotics; one scheduled and one PRN (as needed); all of these regimens are deemed pharmacologically rational.

STRATEGIC PERFORMANCE EXCELLENCE

Action Plan: This monitor was moved to Quality Assurance at the end of the second quarter. We will continue to monitor for appropriate justification of polyantipsychotic therapy. With the reorganization of the polyantipsychotic documentation process, numbers have improved from last quarter. Pharmacy has resumed alerting providers to provide justifications implementing some which may be partially responsible for this improvement as well.

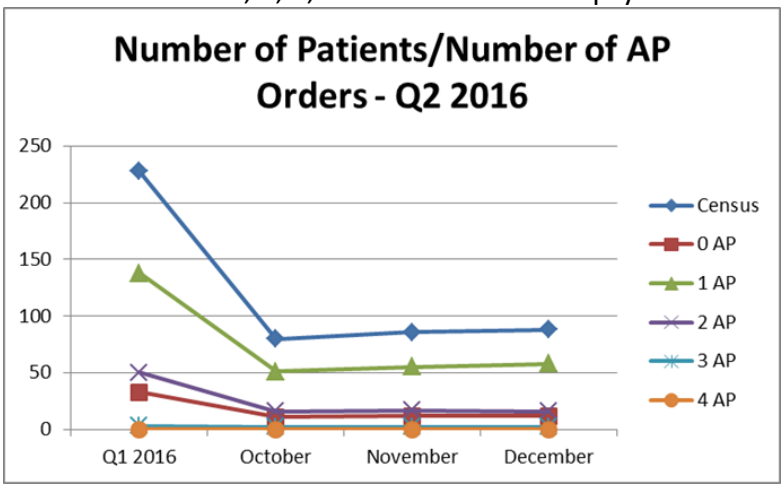
Comments: This quarter saw an improvement in the number of patients on polyantipsychotic therapy but not an increase in documentation of justification for polyantipsychotic therapy. With the new staff becoming more familiar with the process as well as a transition from paper documentation sheets to an excel database, continued improvement is expected.

Graph/Chart:

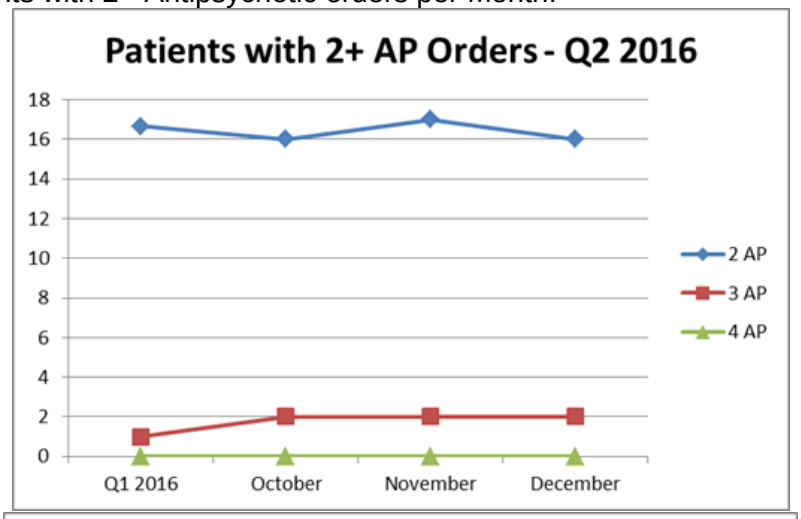
Q2 2016 Report	Q1 2016		October		November		December	
Census	225		80		86		88	
Antipsychotic Orders for Clients	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
No Antipsychotics	34	15	11	14	12	14	12	14
Mono-antipsychotic therapy	143	64	51	64	55	64	58	66
Two Antipsychotics	48	21	16	20	17	20	16	18
Three Antipsychotics	3	1	2	3	2	2	2	2
Four Antipsychotics	0	0	0	0	0	0	0	0
At least 1 antipsychotic	188	84	69	86	74	86	74	84
Total on Poly-antipsychotic therapy	51	23	18	23	19	22	18	20
Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics		27% (51/188)		26% (18/69)		26% (19/74)		20.45% (18/88)
More than 2 antipsychotics	3	1.60%	2	0	2	3%		2.27%
Poly-Antipsychotic therapy breakdown	*N*	*%*	*N*	*%*	*N*	*%*		*%*
SGA + FGA	22	43	8	44	7	37	5	28
2 SGAs ("Pine" + "Done")	7	14	0	0	2	11	1	6
Other (2 antipsychotic regimens)	20	39	10	56	7	37	5	28
Details	1) Clozapine + Olanzapine (x3)		1) Clozapine + Olanzapine		1) Aripiprazole + Quetiapine		1) Aripiprazole + Olanzapine	
	2) Olanzapine + Quetiapine		2) Quetiapine + Aripiprazole (x2)		2) Aripiprazole + Olanzapine		2) Quetiapine + Olanzapine (x2)	
	3) Asenapine + Olanzapine		3) Risperidone + Aripiprazole		3) Paliperidone + Aripiprazole		3) Clozapine + Olanzapine (x5)	
	4) Aripiprazole + Paliperidone		4) Aripiprazole + Olanzapine		4) Clozapine + Olanzapine (x4)		4) Aripiprazole + Quetiapine	
	5) Aripiprazole + Quetiapine		5) Aripiprazole + Paliperidone		5) Clozapine + Quetiapine		5) Aripiprazole + Paliperidone	
	6) Clozapine + Quetiapine							
	7) Paliperidone + Ziprasidone							
	8) Aripiprazole + Olanzapine							
3+ Antipsychotic Regimens	3	1.60%	2	11%	2	3%	2	11
	1) Clozapine + Olanzapine +		1) Clospaine + Aripiprazole +		1) Haloperidol + Clozapine +		1) Paliperidone + Fluphenazine +	
	2) Clozapine + Haloperidol		2) Olanzapine + Paliperidone +		2) Aripiprazole + Olanzapine +		2) Haloperidol + Ziprasidone +	
Justifiable Poly-Antipsychotic Therapy	77% (40/53)		61% (11/18)		79% (15/19)		66% (12/18)	

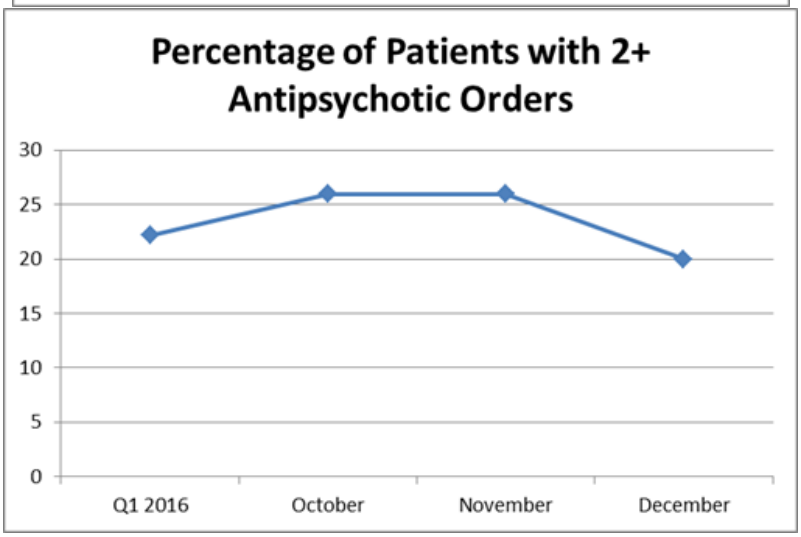
STRATEGIC PERFORMANCE EXCELLENCE

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



Number of Patients with 2+ Antipsychotic orders per Month:





STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Metabolic Monitoring

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

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**YTD**
Target	Complete/Up-to-date Metabolic Parameters	73%%	75%	75%	75%	75%	**75%**
Actual			71%	79%	73%	63%	**72%**

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

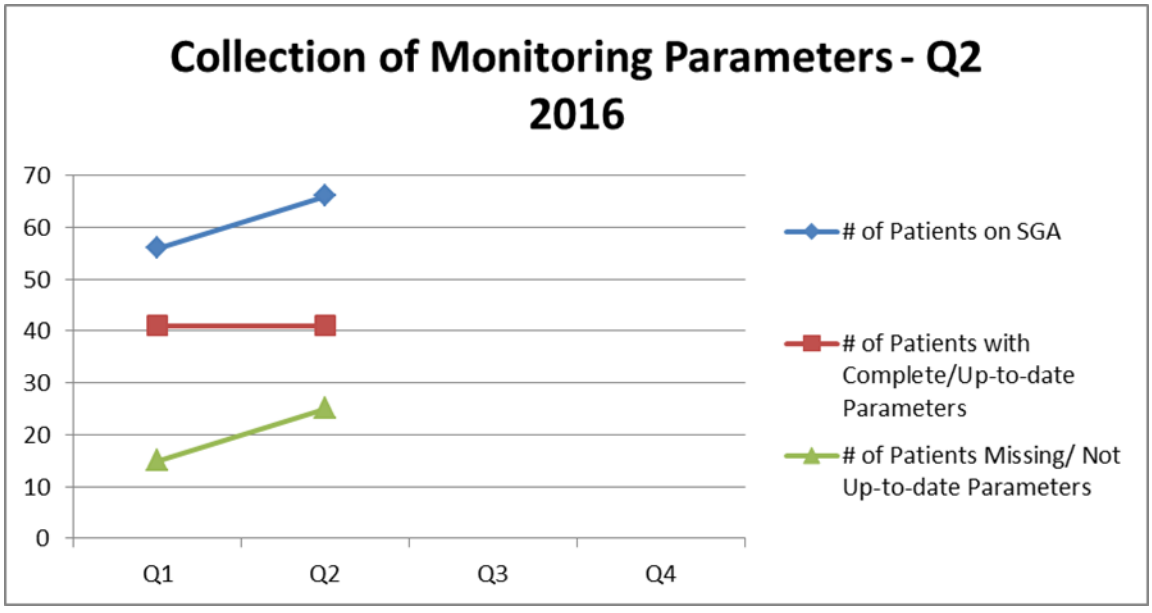
Action Plan: We will continue to monitor SGA therapy by monitoring for Metabolic Syndrome. The patient's right to refuse assessment (weight, blood pressure and lab work) has been identified as a contributing factor to not being able to fully assess their metabolic status. Thus the goal of achieving 95% completed metabolic parameters is unrealistic and has been adjusted to a more reasonable goal of 75%. We have also started incorporating documentation of patient's refusals. This indicates that the provider is making the attempt to monitor the medication. In an attempt to streamline lab work, the Medical Staff has decided to incorporate lab work with the annual physical. This may impact this monitor going forward as data has been collected based on the most recent lab work and addition or changes in SGA therapy.

Comments: We saw a further decrease this last quarter to 63%, remaining below our goal of 75%. Of the patients that did not have complete/up-to-date parameters collected, 14% had documented refusals. For the remainder of the patients, it is likely that their annual physical is not due and thus annual labs have not been ordered.

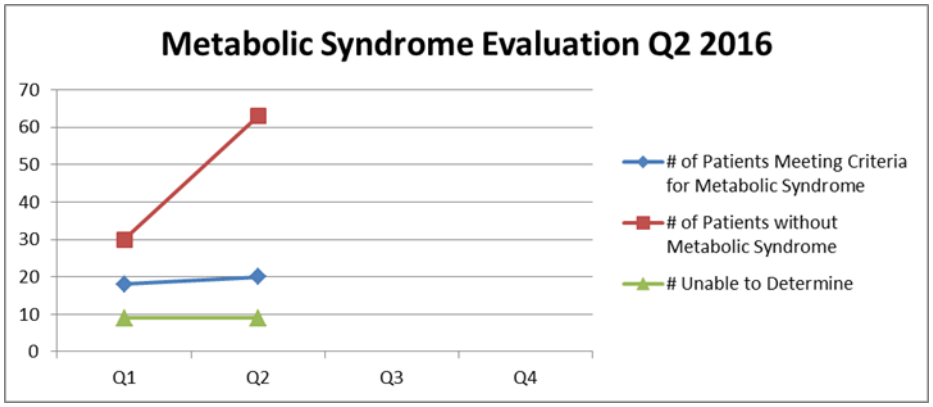
STRATEGIC PERFORMANCE EXCELLENCE

Graph/Chart:

	3Q2015	4Q2015	1Q2016	2Q2016
# of Patients on SGA	100	105	56	198
# of Patients with Complete/Up-to-date Parameters	86 (86%)	59 (56%)	41 (73%)	124 (63%)
# of Patients Missing/Not Up-to-date Parameters	14 (14%)	46 (44%)	15 (27%)	74 (37%)
# of Patients Meeting Criteria for Metabolic Syndrome	29 (29%)	32 (30%)	18 (32%)	61 (31%)
# of Patients without Metabolic Syndrome	64 (64%)	44 (42%)	30 (54%)	124 (63%)
# Unable to Determine	7 (7%)	29 (28%)	8 (14%)	27 (14%)
Documented Refusals	6 (43%)	N/A	9 (16%)	27 (14%)



STRATEGIC PERFORMANCE EXCELLENCE



III. Measure Name: Polytherapy

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

Type of Measure: Performance Improvement

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

Action Plan: Our plan is to continue to review patients with numerous medication orders at the monthly Peer Review Committee Meeting. An effort will be made to

obtain more information on medication adherence and PRN usage for the patients reviewed. This monitor will be reported and discussed with the Medical Staff at the Peer Review and Pharmacy & Therapeutics (P&T) Committees.

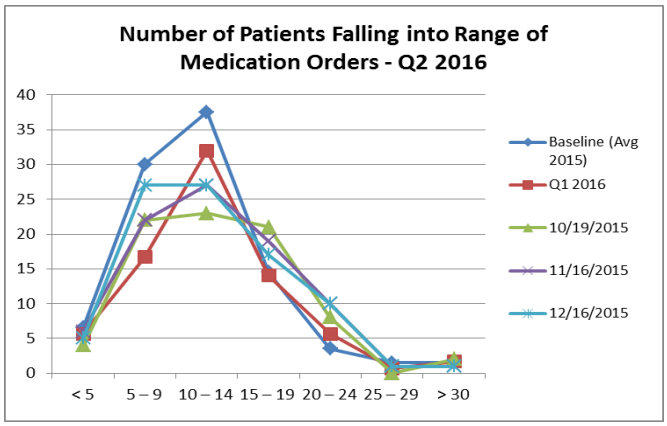
Comments: Results this quarter remain similar to last quarter. The average number of agents has likely increased due to patient specific factors including an increased number of medically fragile patients. As the number of medications per patient seems to reflect our current population, it is reasonable to transition this measure from performance improvement towards quality assurance.

Graph/Chart:

	Baseline Average	Baseline Range	Q1 2016 Average	Q1 2016 Range	10/19/15 Average	10/19/15 Range	11/16/15 Average	11/16/15 Range	12/16/15 Average	12/16/15 Range
Total Orders	12.1	0-31	12.43	0-42	13.26	1-42	12.72	1-32	13	0-31
Scheduled	4.9	0-17	6.17	0-21	6.51	0-21	6.13	1-19	6	0-20
PRNs	5.9	0-19	6.83	0-23	7.35	0-22	7.02	0-18	7	0-19

Medication Number Range	Number of Patients (Baseline)	1Q2065	10/19/15	11/16/15	12/16/15	2Q2016
< 5	7	17	4	6	5	6
5 – 9	30	50	22	22	27	17
10 – 14	38	96	23	27	27	32
15 – 19	15	42	21	19	17	14
20 – 24	4	17	8	10	10	6
25 – 29	2	2	0	1	1	1
> 30	2	5	2	1	1	2

Number of Patients Falling in to Range of Medication Orders:



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
- Human Resources Department Payroll System

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

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

Unit: Mandate shift occurrences

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

Monthly Targets: 10% reduction monthly x4 from baseline

STRATEGIC PERFORMANCE EXCELLENCE

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

	New Baseline Sept 2013	3Q2015			4Q2015			3Q2015			1Q2016			Goal
		Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	
Nursing Mandates	14	6	20	11	2	4	6	2	1	8	11	8	10	10% reduction monthly x4 from baseline)
Mental Health Worker (MHW) Mandates	49	66	39	51	20	44	56	28	39	58	62	41	32	10% reduction monthly x4 from baseline)

Nursing mandates increased from 11 last quarter to 29 this quarter.
MHW mandates increased from 125 last quarter to 135 this quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

2Q2016 - Lower Saco

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	12 of 15	80%
2. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
3. Weekly Summary note completed.	4 of 15	27%
4. Diabetes education Teaching checklist shows documentation of patient teaching (diabetic patients)	15 n/a	100%
5. Multidisciplinary Teaching checklist active being completed.	14 of 15	93%
6. Dental education Teaching checklist	11 of 15	73%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	15 of 15	100%
8. Annual Assessment completed.	6 of 15 3 n/a	60%
9. Patient's rights signed.	11 of 15 1 ref.	80%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	11 of 15 1 n/a	80%
11. Informed Consent signed and dated	7 of 15 1 ref.	53%
12. STG Interventions are clear, simple behavioral actions for nurses	11 of 15 4 n/a	100%
13. STG for patient is behavioral and measurable	10 of 15 4 n/a	93%
14. SRC monitor sheets completed	1 of 15 14 n/a	100%
15. Patient debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	15 n/a	100%
16. Safety meeting held 72 hours after coercive event	15 n/a	100%
17. Treatment plan updated after every coercive event	15 n/a	100%
18. Staff debriefing completed within 24 hrs of coercive event	15 n/a	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

2Q2016 - Upper Saco

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	15 of 15	100%
2. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
3. Weekly Summary note completed.	12 of 15	80%
4. Diabetes education Teaching checklist shows documentation of patient teaching (diabetic patients)	1 of 15 13 n/a	93%
5. Multidisciplinary Teaching checklist active being completed.	14 of 15	93%
6. Dental education Teaching checklist	14 of 15	93%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	14 of 15	93%
8. Annual Assessment completed.	9 of 15	60%
9. Patient's rights signed.	14 of 15 1 ref.	100%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	15 of 15	100%
11. Informed Consent signed and dated	14 of 15 1 ref.	100%
12. STG Interventions are clear, simple behavioral actions for nurses	15 of 15	100%
13. STG for patient is behavioral and measurable	11 of 15	73%
14. SRC monitor sheets completed	15 n/a	100%
15. Patient debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	15 n/a	100%
16. Safety meeting held 72 hours after coercive event	15 n/a	100%
17. Treatment plan updated after every coercive event	15 n/a	100%
18. Staff debriefing completed within 24 hrs of coercive event	15 n/a	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

2Q2016 - Lower Kennebec

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	13 of 15	87%
2. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
3. Weekly Summary note completed.	2 of 15	13%
4. Diabetes education Teaching checklist shows documentation of patient teaching (diabetic patients)	1 of 15 10 n/a	73%
5. Multidisciplinary Teaching checklist active being completed.	15 of 15	100%
6. Dental education Teaching checklist	14 of 15 1 ref.	100%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	14 of 15 1 loc.	100%
8. Annual Assessment completed.	15 of 15	100%
9. Patient's rights signed.	6 of 15 3 loc.	60%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	14 of 15	93%
11. Informed Consent signed and dated	4 of 15 3 loc.	47%
12. STG Interventions are clear, simple behavioral actions for nurses	15 of 15	100%
13. STG for patient is behavioral and measurable	14 of 15	93%
14. SRC monitor sheets completed	14 n/a	93%
15. Patient debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	1 of 15 13 n/a	93%
16. Safety meeting held 72 hours after coercive event	1 of 15 13 n/a	93%
17. Treatment plan updated after every coercive event	13 n/a	87%
18. Staff debriefing completed within 24 hrs of coercive event	2 of 15 13 n/a	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

2Q2016 - Upper Kennebec

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	11 of 15	73%
2. STGs/ Interventions relate directly to content of GAP note.	13 of 15	87%
3. Weekly Summary note completed.	9 of 15	60%
4. Diabetes education Teaching checklist shows documentation of patient teaching (diabetic patients)	1 of 15 14 n/a	100%
5. Multidisciplinary Teaching checklist active being completed.	14 of 15 1 n/a	100%
6. Dental education Teaching checklist	13 of 15 1 n/a	93%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	15 of 15	100%
8. Annual Assessment completed.	10 of 15 2 n/a	80%
9. Patient's rights signed.	10 of 15 1 ref., 1 loc.	80%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	10 of 15 3 n/a	87%
11. Informed Consent signed and dated	10 of 15 1 loc.	73%
12. STG Interventions are clear, simple behavioral actions for nurses	10 of 15 5 n/a	100%
13. STG for patient is behavioral and measurable	9 of 15 5 n/a	93%
14. SRC monitor sheets completed	15 n/a	100%
15. Patient debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	15 n/a	100%
16. Safety meeting held 72 hours after coercive event	15 n/a	100%
17. Treatment plan updated after every coercive event	15 n/a	100%
18. Staff debriefing completed within 24 hrs of coercive event	15 n/a	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

2Q2015

Total – All Units

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	51 of 60	85%
2. STGs/ Interventions relate directly to content of GAP note.	58 of 60	97%
3. Weekly Summary note completed.	27 of 60	45%
4. Diabetes education Teaching checklist shows documentation of patient teaching (diabetic patients)	3 of 60 52 n/a	92%
5. Multidisciplinary Teaching checklist active being completed.	57 of 60 1 n/a	97%
6. Dental education Teaching checklist	52 of 60 1 ref., 1 n/a	90%
7. Nursing Assessment of Suicide risk being completed with Treatment Plan review	58 of 60 1 loc	98%
8. Annual Assessment completed.	40 of 60 5 n/a	75%
9. Patient's rights signed.	41 of 60 4 loc., 3 ref.	80%
10. Treatment Plan Reviewed/Modified Every 2 Weeks	50 of 60 4 n/a	90%
11. Informed Consent signed and dated	35 of 60 4 loc., 2 ref.	68%
12. STG Interventions are clear, simple behavioral actions for nurses	51 of 60 9 n/a	100%
13. STG for patient is behavioral and measurable	44 of 60 9 n/a	88%
14. SRC monitor sheets completed	1 of 60 58 n/a	98%
15. Patient debriefings completed w/in 24 hours after episodes of HOH/SRC/Restraints	1 of 60 58 n/a	98%
16. Safety meeting held 72 hours after coercive event	1 of 60 58 n/a	98%
17. Treatment plan updated after every coercive event	58 n/a	97%
18. Staff debriefing completed within 24 hrs of coercive event	2 of 60 58 n/a	100%

STRATEGIC PERFORMANCE EXCELLENCE

Outpatient Services (OPS)

Responsible Party: Lisa Manwaring, Director

I. Measure Name: Admission Assessments

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

Measure Type: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Percent of assessments completed on time	FY 2015 0% 0/4	85%	85%	85%	85%	**85%**
Actual			0% 0/3	0% 0/5			**0% 0/8**

Data Analysis: We had one chart with all three assessments this quarter but one was late. This quarter we had five admissions. Three charts had two out of three assessments.

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Responsible Party: Samantha St. Pierre, Peer Support Coordinator

Indicator: Inpatient Consumer Survey Return Rate

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

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

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

Methods of Monitoring:

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

Methods of Reporting:

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

Unit: All patient care/residential units

Baseline: Determined from previous year's data.

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

STRATEGIC PERFORMANCE EXCELLENCE

Survey Return Rate	Unit	Baseline	Target	3Q2015	4Q2015	1Q2016	2Q2016	YTD
The inpatient consumer survey is the primary tool for collecting data on how patients feel about the services they are provided at the hospital.	**LK**	15%	50%	37%	20%	41% 7/17	23% 3/13	**30%**
	LS	5%	50%	62%	0%	0% 0/21	54% 7/13	**29%**
	UK	45%	50%	26%	27%	18% 3/17	25% 4/16	**24%**
	US	30%	50%	100%	100%	88% 7/8	100% 7/7	**97%**
	Overall						**43%**	**45%**

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

Inpatient Consumer Survey Results:

#	Indicators	3Q 2015	4Q 2015	1Q 2016	2Q 2016	Average
1	I am better able to deal with crisis.	75%	69%	69%	82%	**74%**
2	My symptoms are not bothering me as much.	73%	69%	79%	77%	**73%**
3	The medications I am taking help me control symptoms that used to bother me.	71%	77%	75%	70%	**73%**
4	I do better in social situations.	73%	63%	71%	64%	**68%**
5	I deal more effectively with daily problems.	75%	71%	73%	83%	**76%**
6	I was treated with dignity and respect.	69%	73%	71%	65%	**70%**
7	Staff here believed that I could grow, change and recover.	74%	63%	69%	62%	**67%**
8	I felt comfortable asking questions about my treatment and medications.	71%	54%	68%	68%	**65%**
9	I was encouraged to use self-help/support groups.	77%	56%	72%	75%	**70%**
10	I was given information about how to manage my medication side effects.	60%	63%	68%	53%	**61%**
11	My other medical conditions were treated.	69%	65%	65%	69%	**67%**
12	I felt this hospital stay was necessary.	50%	67%	65%	48%	**58%**

STRATEGIC PERFORMANCE EXCELLENCE

#	Indicators	3Q 2015	4Q 2015	1Q 2016	2Q 2016	Average
13	I felt free to complain without fear of retaliation.	54%	56%	69%	60%	**60%**
14	I felt safe to refuse medication or treatment during my hospital stay.	49%	54%	62%	46%	**53%**
15	My complaints and grievances were addressed.	63%	65%	63%	55%	**62%**
16	I participated in planning my discharge.	66%	38%	75%	43%	**56%**
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	52%	38%	63%	30%	**46%**
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	47%	54%	63%	32%	**49%**
19	The surroundings and atmosphere at the hospital helped me get better.	61%	60%	68%	63%	**63%**
20	I felt I had enough privacy in the hospital.	66%	58%	64%	61%	**62%**
21	I felt safe while I was in the hospital.	72%	69%	62%	62%	**66%**
22	The hospital environment was clean and comfortable.	74%	74%	66%	63%	**69%**
23	Staff were sensitive to my cultural background.	65%	65%	61%	52%	**61%**
24	My family and/or friends were able to visit me.	68%	73%	69%	64%	**69%**
25	I had a choice of treatment options.	60%	52%	64%	56%	**58%**
26	My contact with my doctor was helpful.	55%	62%	66%	58%	**60%**
27	My contact with nurses and therapists was helpful.	57%	53%	66%	64%	**60%**
28	If I had a choice of hospitals, I would still choose this one.	54%	60%	55%	45%	**54%**
29	Did anyone tell you about your rights?	74%	77%	71%	51%	**68%**
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	60%	69%	63%	54%	**62%**
31	Do you know someone who can help you get what you want or stand up for your rights?	77%	77%	74%	77%	**76%**
32	My pain was managed.	65%	75%	62%	75%	**69%**
	Overall Score	**65%**	**63%**	**67%**	**63%**	**65%**

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

Responsible Party: Michael Migliore, Director of Pharmacy

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

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

Type of Measure: Quality Assurance

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

Data Analysis: None of the 6 controlled substance discrepancies were due to anything other than simple miscounts. All of the controlled substances have been accounted for, resulting in a 0% loss of controlled substances for the second quarter.

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

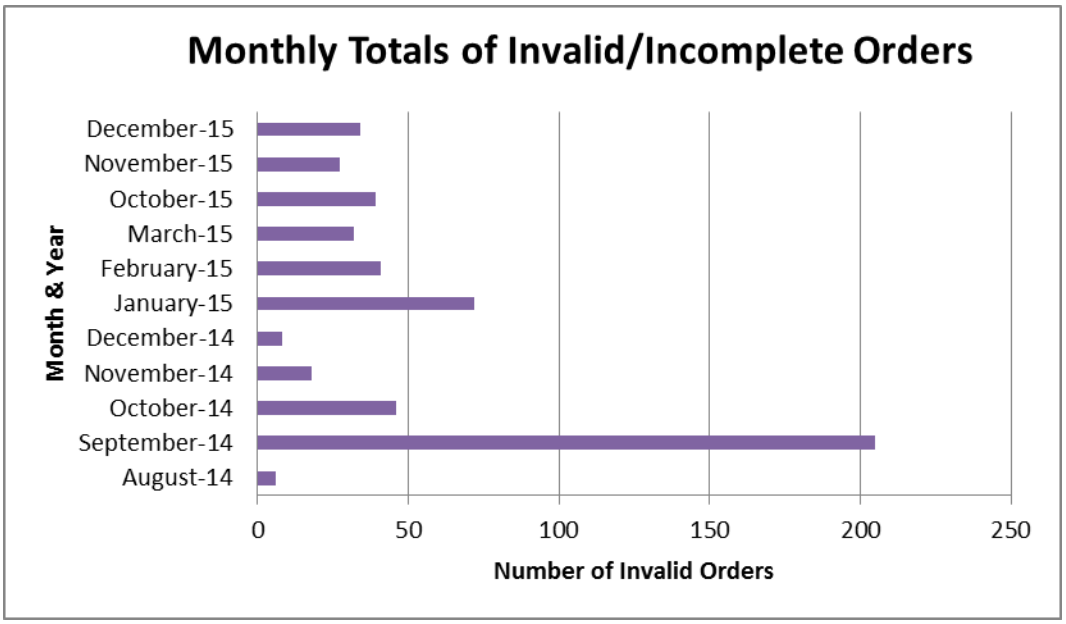
Comments: Baseline for FY2014 was 0.88%. There has been a great improvement during FY2015 with a baseline of 0.19% and this is expected to continue throughout FY2016.

STRATEGIC PERFORMANCE EXCELLENCE

II. **Measure Name: Invalid Orders**

Measure Description: Incomplete/invalid orders.

Type of Measure: Performance Improvement



Background: Whenever an invalid order is received in the pharmacy it is documented, copied, and returned to the appropriate unit so that the prescriber can remedy it. The staff pharmacist then makes contact with the unit to ensure they are aware of the particular issue that invalidated the order. The hospital has a zero tolerance policy for invalid orders. Each order must include: drug name, strength, administration route, dosing frequency, provider signature, order time and date, accurate allergy and adverse drug reaction information, and indication. The data collection system was enhanced during the last quarter when there was a significant number of new staff in the pharmacy.

Data Analysis: For the second quarter the number of invalid orders has remained consistent, averaging 33 invalid orders per month, compared to a baseline average of 48. The most common reason for invalid orders was incorrect allergy and adverse drug reaction information on the order forms, closely followed by missing indications.

Action Plan: Whenever an incomplete order is received by the pharmacy the staff pharmacist contacts the unit, and whenever possible the prescriber themselves, immediately for timely resolution. Whenever not a case of simple oversight, continue providing re-education to providers to ensure optimal patient care.

STRATEGIC PERFORMANCE EXCELLENCE

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

Measure Description: Monthly comprehensive compliance audits of 38 criteria

Type of Measure: Quality Assurance

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

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

Audit Compliance Findings: The audits for all the units have been completed for the quarter. Criteria found upon inspection that could be improved:

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

Comments: The previous version of this report noted that the audits were 97%, however that was a compliance statistic. Pharmacy's responsibility is to ensure the completion of the medication room audits and for that measure we remain at a steadfast 100%.

STRATEGIC PERFORMANCE EXCELLENCE

IV. **Measure Name: Fiscal Accountability**

Measure Description: Monthly and tracking of dispensed discharge prescriptions

Type of Measure: Quality Assurance

	Results						
	Unit	**Baseline FY 2015**	**3Q 2015**	**4Q 2015**	**1Q 2016**	**2Q 2016**	**YTD**
Actual	All	$15764 for 861 Rx's	$4474 for 295 Rx's	$5266 for 261 Rx's	$5281 for 368 Rx's	$3719 for 312 Rx's	**$18740 for 1236 Rx's**

Data Analysis: Riverview Psychiatric Center has an Extended Hospital Pharmacy license, meaning it can dispense to both in and outpatients. The majority of the outpatient prescriptions are for a 7-day supply of discharge medications. Special approval is required from administration when a great than 7 day supply is needed. The discharge prescriptions serve to cover the patient's needs until they are able to obtain medications in the community.

Action Plan: Advanced discharge planning would allow for patients to obtain prescription coverage prior to discharge. This would dramatically reduce the volume of outpatient prescriptions provided by the pharmacy and thereby decrease expenditures.

Comments: Riverview can save money by working on the action plan above.

STRATEGIC PERFORMANCE EXCELLENCE

Psychology

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

I. Measure Name: Outpatient Readiness Scale (ORS)

Measure Description: 90% of NCR inpatients will have an ORS completed and updated every 6 months

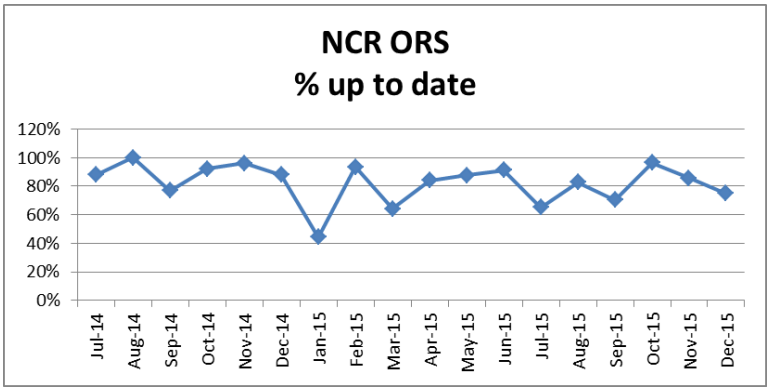
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**Q1-2016**	**Q2-2016**	**Q3-2016**	**Q4-2016**	**YTD**
Target	Percent of assessments up to date	4Q FY 2015 21/24 87%	75/100 75%	90/100 90%	90/100 90%	90/100 90%	**360/400 90%**
Actual			53/73 73%	71/83 86%			**124/156 79%**

Data Analysis: Assessments of NCR patients using the ORS was initiated in January 2014. The population of interest was fully evaluated by July 2014. Updated assessments of NCR patients since that time have varied from a low of 40% in January 2015 to a high of 96% in October 2015. The average for the 4th quarter 2015 was 87%; in comparison, the average for the 2nd quarter 2016 was 86%. Due to relatively low numbers, the absence of one score can drop the percentage rate by up to 4 percent. As an example, in October 2015 the rate was 96%.

Action Plan: Continue to encourage teams to take initiative to complete the ORS. Tracking of due dates needs to be accomplished to avoid times where patients are not up to date.

Comments: This data is of inpatients only



STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Outpatient Readiness Scale (ORS)

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

Type of Measure: Performance improvement

Results							
	Unit	**Baseline**	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
Target	Percent of OPS recipients evaluated with ORS	2Q FY 2015 New initiative 2%	75/100 75%	75/100 75%	75/100 75%	75/100 75%	**300/400 75%**
Actual			5/23 22%				**5/23 22%**

Data Analysis: This is a new initiative and will require training and follow-up with the OPS treatment team. Preliminary efforts have helped produce modest results in the first month.

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

III. Measure Name: Brief Intake Assessment

Measure Description: The target is 90% of hospital admissions will have a Brief Intake Assessment completed within 7 days of admission.

Type of Measure: Performance Improvement

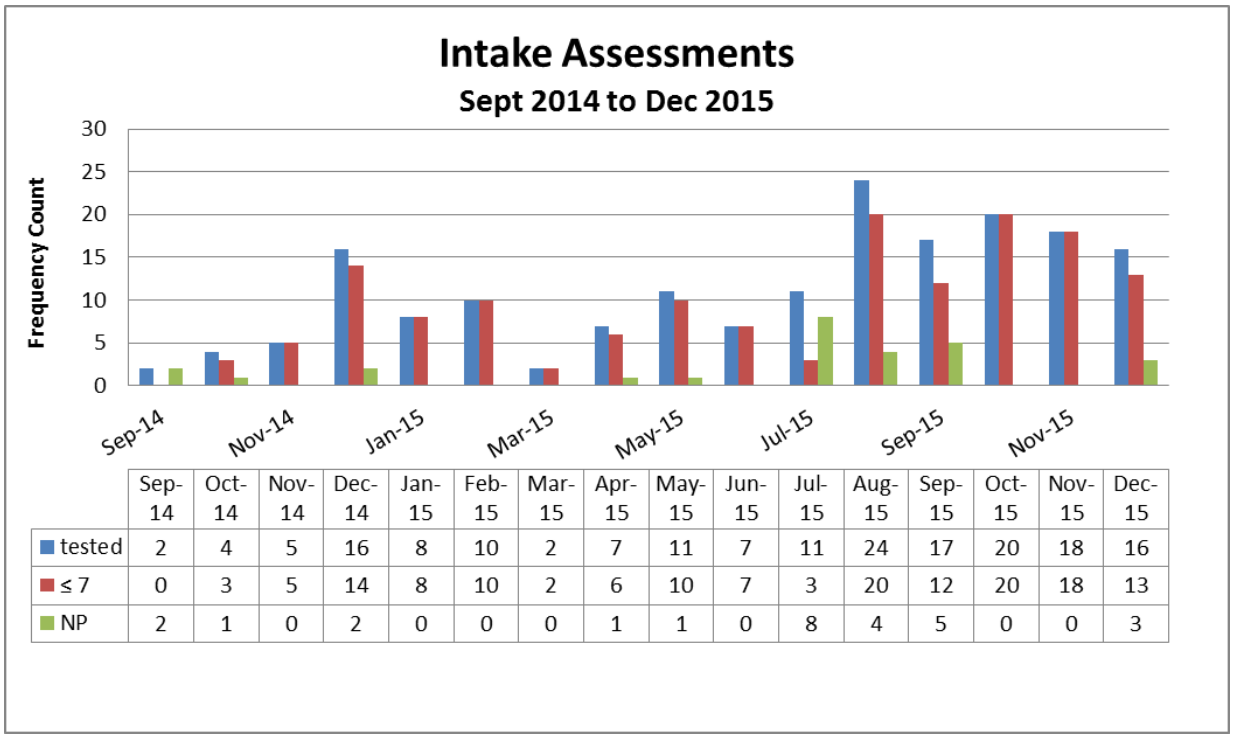
Results							
	Unit	**Baseline**	**Q1-16**	**Q2-16**	**Q3-16**	**Q4-16**	**YTD**
Target	Percent of assessments completed within 7 working days	4Q FY 2015 25/45 55% tested	75/100 75%	75/100 75%	75/100 75%	75/100 75%	**300/400 75%**
Actual			52/64 81%	54/59 92%			**106/123 86%**

STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: **T**he data as presented above represents the testing of all admissions over the quarter. Baseline during 4Q 2015 was only 55% of admissions. While the goal is to establish a 90% rate of assessment on intake, there is also a sub-goal to have the assessments completed and shared with the treatment team within 7 days. The charts below show the outcome of that effort.

Action Plan: Maintain this goal but increase the value of the information by assuring that staff are briefed on the results during treatment team meeting. Psychology staff will ensure that the primary care provider is given a copy of the assessment and that it is shared with the treatment team in a timely manner.

Comments: The chart below shows total number of assessments and breaks down those less than 7 days and those completed beyond 7 days (labeled NP)



	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
tested	2	4	5	16	8	10	2	7	11	7	11	24	17	20	18	16
≤ 7	0	3	5	14	8	10	2	6	10	7	3	20	12	20	18	13
NP	2	1	0	2	0	0	0	1	1	0	8	4	5	0	0	3

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

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

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

I. Measure Name: Occupational Therapy Service Orders

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

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

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

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

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient receiving OT services has an MD order	FY 2015 97%	100%	100%	100%	100%	**100%**
Actual			100% 25/25	100% 29/29			**100% 54/54**

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

Action Plan: Review the results of the audit with Occupational Therapy staff.

STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Vocational Services Documentation

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

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

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

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

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient working in the Voc. Rehab. Program has required documentation	60%	100%	100%	100%	100%	**100%**
Actual			50% 6/12	81% 9/11			**65%** **15/23**

Data Analysis: Nov/Dec 2015 & Jan 2016- Charts were audited using the Rehab. Services – Vocational Services tool. There were only 2 charts in which a weekly note was not done on time.

Action Plan: Continue with the monthly audits to assist with attaining the goal of 100 % so that the Vocational documentation can reach the goal of 4 consecutive quarters of 100%

STRATEGIC PERFORMANCE EXCELLENCE

Safety & Security

Responsible Party: Philip Tricarico, Safety Officer

I. Measure Name: Grounds Safety & Security Incidents

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

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**3Q2015**	**4Q2015**	**1Q2016**	**2Q2016**	**Total**
Target	# of Incidents	*Baseline of 10	16	4	2	4	**26**
Actual			4	2	4	2	**12**

Summary of Events: The Q2 Target was (4). Our actual number was (2). We exceeded our goal! We have not had any issues this quarter with state owned pickup trucks and the contraband they frequently contained. We have been working with Capitol Police, Fleet Management and the Department of Conservation (agency the trucks are assigned to). There has been significant improvement in how often we are finding contraband items in these trucks. We will continue to work with all parties as we seek to resolve this issue. Another problem area appears to be our fleet of rental vehicles. Even though Security asks every person who returns a vehicle if it is locked, we had two incidents of cars left unlocked. These vehicles contain state credit cards and other items of value. Our approach has been to treat this as a supervisory issue. Although we had no issues this quarter a new system was implemented, by maintenance, for checking cars in and out. We will monitor and remain vigilant as we all get used to the new system. We are pleased that in all of the events, our Security staff or clinical staff had discovered/processed the event before there was a negative impact to the patients. The reporting, which follows below, continues to provide a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our aggressive rounds by Securitas continue to prove its worth with regard to

STRATEGIC PERFORMANCE EXCELLENCE

Security's presence and patrol techniques. The stability and longevity of our Security staff along with its cohesiveness with the Clinical component of the hospital has proven to be most effective in our management of practices.

Safety & Security Incidents:

Event	Date	Time	Location	Disposition	Comments
1. Safety Concern (Unlocked, garbage dumpster, contraband in dumpster)	11/12/15	0208	Rear of Building	Relocked Dumpster	Dumpster locking arm out of position. Repositioned and relocked.
2. Security Concern (Suspicious person outside near front lobby entrance)	11/26/15	1303	Front of Building	Capitol Police ordered the person to leave	Male was walking aimlessly in front of the lobby area. He was contemplating coming in to visit his wife (a patient here). The man admitted to drinking and was acting "strange". Capitol Police arrived and took over the situation.

STRATEGIC PERFORMANCE EXCELLENCE

Social Work

Responsible Party: Stephanie George-Roy, LCSW, Director of Social Work

I. Measure Name: Social Work Community Connections

Measure Description: The Social Work Department will ensure that 100% of the time patients will be offered to have social work assist them in securing correctional, familial, and natural or community provider participation in their treatment during their admission to Riverview Psychiatric Center to facilitate continuity in discharge planning back to the community.

Type of Measure: Quality Assurance

Methodology: The Social Worker will engage with patient during Service Integration Meeting within 3 days of admission to ensure that the patient is informed of the opportunity to have external self-identified recovery supports participate in their treatment services at RPC.

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

Results							
	Unit	**Baseline**	**1Q2016**	**2Q2016**	**3Q2016**	**4Q2016**	**YTD**
Target	Each patient is offered assistance with securing identified recovery supports from the community	N/A new for FY 16	100%	100%	100%	100%	**100%**
Actual			100% 61/61	100% 47/47			**100% 108/108**

Data Analysis: In chart audits completed over the second quarter 47 patients completed the Service Integration Meeting with their assigned social worker and were asked to identify recovery supports from the community. Two patients declined (49 total admissions in the quarter) to participate in the Service Integration meeting and declined on follow up.

Action Plan: Review the results of the audit with Social Work staff and continue with chart audits and documenting results.

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: 07/01/2015 To 09/30/2015 **Report Run Date: 1/13/2016**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection "Date worker assigned". The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a wait list for service. The CFSN is used in conjunction with the date of assignment to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare 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 703

For those who received the service:

Average number of days waiting: 10 days

Percent waiting 30 days or less: 89.8%

Percent waiting 90 days or less: 99.4%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
AMHI Class N	672	670	2	601	67	4	11
AMHI Class Y	31	29	2	30	1	0	3
Totals	**703**	**699**	**4**	**631**	**68**	**4**	**10**

District	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
District 1	77	77	0	59	16	2	22
District 2	168	168	0	154	13	1	8
District 3	91	90	1	83	8	0	10
District 4	64	64	0	59	5	0	7
District 5	163	162	1	141	21	1	12
District 6	114	112	2	111	3	0	5
District 7	15	15	0	14	1	0	9
District 8	4	4	0	4	0	0	12
Unknown	7	7	0	6	1	0	11
Totals	**703**	**699**	**4**	**631**	**68**	**4**	**10**

APS Healthcare

Department of Health and Human Services
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Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
Alternative Wellness Services	2	2	0	2	0	0	0
AngleZ Behavioral Health Services-17 ACM	14	14	0	14	0	0	1
Assistance Plus	54	51	3	52	2	0	4
Catholic Charities Maine	116	116	0	109	6	1	7
Charlotte White Center	14	14	0	14	0	0	4
Common Ties	59	59	0	58	1	0	7
Community Care	40	40	0	39	1	0	4
Community Health & Counseling Services	48	47	1	47	1	0	4
Counseling Services Inc.	26	26	0	15	9	2	30
Health Affiliates Maine	2	2	0	2	0	0	15
Higher Ground Services	5	5	0	5	0	0	12
Kennebec Behavioral Health	95	95	0	72	22	1	18
MAS Home Care of Maine	27	27	0	25	2	0	10
Medical Care Development	1	1	0	1	0	0	9
Mid Coast Mental Health	45	45	0	41	4	0	7
Northern Lighthouse	1	1	0	1	0	0	28
OHI	2	2	0	2	0	0	2
Providence	1	1	0	1	0	0	0
Sweetser	55	55	0	45	10	0	18
The Opportunity Alliance	92	92	0	84	8	0	10
Tri-County Mental Health	4	4	0	2	2	0	25
Totals	**703**	**699**	**4**	**631**	**68**	**4**	**10**

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: 07/01/2015 To 09/30/2015 **Report Run Date: 1/13/2016**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection "Date worker assigned". The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a wait list for service. The CFSN is used in conjunction with the date of assignment to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare 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: 238

For those who received the service:

Average number of days waiting: 22 days

Percent waiting 30 days or less: 70.6%

Percent waiting 90 days or less: 95.4%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
AMHI Class N	232	42	190	163	58	11	22
AMHI Class Y	6	1	5	5	1	0	7
Totals	**238**	**43**	**195**	**168**	**59**	**11**	**22**

District	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
District 1	23	8	15	10	11	2	43
District 2	46	8	38	16	24	6	44
District 3	38	7	31	29	9	0	19
District 4	31	6	25	21	9	1	22
District 5	42	6	36	39	2	1	8
District 6	46	7	39	44	2	0	5
District 7	5	0	5	5	0	0	1
District 8	2	0	2	1	1	0	28
Unknown	5	1	4	3	1	1	39
Totals	**238**	**43**	**195**	**168**	**59**	**11**	**22**

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Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
Ascentria Care Alliance	1	1	0	1	0	0	0
Assistance Plus	23	3	20	23	0	0	4
Catholic Charities Maine	13	3	10	7	4	2	37
Charlotte White Center	4	0	4	4	0	0	2
Common Ties	13	2	11	13	0	0	7
Community Care	44	5	39	42	2	0	4
Community Counseling Center	3	0	3	0	3	0	50
Community Health & Counseling Services	4	2	2	4	0	0	0
Counseling Services Inc.	11	3	8	3	7	1	51
Healthy Healing Counseling Inc	1	1	0	1	0	0	0
Kennebec Behavioral Health	21	3	18	19	1	1	16
Mid Coast Mental Health	16	4	12	11	5	0	19
Sweetser	41	10	31	19	16	6	40
The Opportunity Alliance	27	5	22	11	15	1	37
Tri-County Mental Health	16	1	15	10	6	0	24
Totals	**238**	**43**	**195**	**168**	**59**	**11**	**22**

APS Healthcare

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

Report 67

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

Report Dates: 07/01/2015 To 09/30/2015 **Run Date: 01/14/2016**

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 support services:** Community support services is a group of mental health services providing support in the community to persons with serious mental illness. It includes CI, CRS, ACT and Adult Behavioral Health Homes
- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Adult Assertive Community Treatment (ACT)** provides individualized intensive integrated community-based services that are delivered by a multi-disciplinary team of practitioners who are available twenty-four(24) hours a day.
- **Behavioral Health Home (BHH)** is a service designed to integrate the systems of care of behavioral health and physical health.
- **Community Rehabilitation Services (CRS)** are delivered by a team, with primary case management for each member assigned to one team member.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection “Date worker assigned”. The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a waiting list for service. When there is a CFSN, it is used in conjunction with the start date of the service to determine the number of days the member waited.
- **Referral Date** is a field in CareConnection that the Provider may fill in when a member applies for a service. If the member is not put on a waiting list, (i.e. no CFSN) the referral date is used with the date of assignment to determine the number of days the member waited.
- **Courtesy Review -** APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.

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

Total number of non-hospitalized members admitted to any community support service: 2,597

Total assigned within 3 working days: 1,854	% assigned within 3 working days: 71%
Total assigned in 4 - 7 working days: 240	% assigned in 4 -7 working days: 9%
Total assigned within 7 working days: 2,094	% assigned within 7 working days: 81%
Total assigned after 8 or more working days: 503	% assigned after 8 or more working days: 19%

Service	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
H0040 - Adult Assertive Community Treatment - ACT	18	6	30	54
H2015 - Community Integration (CI)	1,494	202	386	2,082
H2018 - Community Rehabilitation Services (CRS)	12	0	1	13
T2022HB - Behavioral Health Homes - Adult	330	32	86	448
Total	**1,854**	**240**	**503**	**2,597**

Gender	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Female	1,161	149	335	1,645
Male	693	91	168	952
Total	**1,854**	**240**	**503**	**2,597**

Adult Age Groups	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
18-20	105	10	24	139
21-24	120	26	41	187
25-64	1,530	192	416	2,138
65-74	75	12	16	103
Over 75 Years Old	24	0	6	30
Total	**1,854**	**240**	**503**	**2,597**

AMHI Class	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	1,739	232	483	2,454
AMHI Class Y	115	8	20	143
Total	**1,854**	**240**	**503**	**2,597**

District	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	149	18	74	241
District 2/ Cumberland County	324	48	129	501
District 3/ Androscoggin, Franklin, and Oxford Counties	397	52	104	553
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	156	18	39	213
District 5/ Somerset and Kennebec Counties	354	56	88	498
District 6/ Piscataquis and Penobscot Counties	308	24	35	367
District 7/ Washington and Hancock Counties	59	10	16	85
District 8/ Aroostook County	92	11	12	115
Unknown	15	3	6	24
Total	**1,854**	**240**	**503**	**2,597**

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Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	41	7	5	53
Allies	10	0	0	10
Alternative Services	13	0	0	13
Alternative Wellness Services	50	5	3	58
AngleZ Behavioral Health Services-17 ACM	28	6	2	36
Aroostook Mental Health Services	46	2	4	52
Ascentria Care Alliance	16	0	3	19
Assistance Plus	29	2	13	44
Behavior Health Solutions for Me	1	0	0	1
Break of Day, Inc	16	2	0	18
Bright Future Healthier You	23	0	1	24
Broadreach Family & Community Services	13	0	2	15
Catholic Charities Maine	93	25	18	136
Central Maine Family Counseling	24	1	1	26
Charlotte White Center	12	1	2	15
Choices	11	0	0	11
Common Ties	37	23	22	82
Community Care	45	3	1	49
Community Counseling Center	34	5	29	68
Community Health & Counseling Services	92	10	24	126
Cornerstone Behavioral Healthcare	24	1	1	26
Counseling Services Inc.	87	4	40	131
Crisis and Counseling Centers	1	0	0	1
Direct Community Care	6	0	0	6
Dirigo Counseling Clinic	34	0	2	36
Easter Seals Maine	1	1	0	2
Employment Specialist of Maine	0	2	4	6
Evergreen Behavioral Services	18	0	2	20
Facing Change	23	0	1	24
Fellowship Health Resources	2	0	0	2
Fullcircle Supports Inc	37	1	0	38
Graham Behavioral Services	16	1	2	19
Healing Hearts LLC	9	0	0	9
Health Affiliates Maine	166	1	4	171
HealthReach network	3	0	2	5
Healthy Healing Counseling Inc	66	3	1	70
Higher Ground Services	7	2	2	11
Kennebec Behavioral Health	66	7	49	122
Learning Works	4	2	6	12
Life by Design	42	7	4	53
Maine Behavioral Health Organization	21	4	12	37
Maine Immigrant and Refugee Services	13	6	5	24
Maine Vocational & Rehabilitation Assoc.	8	4	3	15
Manna Inc	4	2	2	8
MAS Home Care of Maine	33	9	13	55
Medical Care Development	2	1	0	3
Merrymeeting	3	1	2	6
Mid Coast Mental Health	45	3	3	51
Motivational Services	16	2	2	20
Northeast Occupational Exchange	42	1	3	46

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Northern Lighthouse	5	0	2	7
Northern Maine General	0	0	1	1
Ocean Way Mental Health Agency	3	0	0	3
OHI	8	0	0	8
Oxford County Mental Health Services	18	3	5	26
Paramount Behavioral Services,Inc	37	6	3	46
Partnerships for Nonprofits, dba Reach	5	0	0	5
Penobscot Community Health Center	6	0	0	6
Protea Integrated Health & Wellness	38	6	0	44
Providence	4	0	2	6
Riverview	6	0	0	6
Rumford Group Homes	9	0	1	10
Sequel Care of Maine	20	3	7	30
Shalom House	22	1	5	28
Sinfonia Family Services	1	0	0	1
Smart Child & Family Services	3	4	4	11
Spurwink	1	0	0	1
St. Andre Homes	4	0	0	4
Sunrise Opportunities	7	0	0	7
Sweetser	91	12	42	145
The Opportunity Alliance	60	27	71	158
The Umbrella Agency	2	0	0	2
Tri-County Mental Health	55	20	65	140
Volunteers of America	4	1	0	5
York County Shelter Program	12	0	0	12
Total	**1,854**	**240**	**503**	**2,597**

APS Healthcare

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

Report 69

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

Report Dates: 07/01/2015 To 09/30/2015 **Run Date: 01/14/2016**

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 support services:** Community support services is a group of mental health services providing support in the community to persons with serious mental illness. It includes CI, CRS, ACT and Adult Behavioral Health Homes
- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Adult Assertive Community Treatment (ACT)** provides individualized intensive integrated community-based services that are delivered by a multi-disciplinary team of practitioners who are available twenty-four(24) hours a day.
- **Behavioral Health Home (BHH)** is a service designed to integrate the systems of care of behavioral health and physical health.
- **Community Rehabilitation Services (CRS)** are delivered by a team, with primary case management for each member assigned to one team member.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection “Date worker assigned”. The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a waiting list for service. When there is a CFSN, it is used in conjunction with the start date of the service to determine the number of days the member waited.
- **Referral Date** is a field in CareConnection that the Provider may fill in when a member applies for a service. If the member is not put on a waiting list, (i.e. no CFSN) the referral date is used with the date of assignment to determine the number of days the member waited.
- **Courtesy Review -** APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.

What This Report Measures: The number of hospitalized members authorized for any type of community support services and whether they a.) were assigned to a case manager within 2 working days, b.) Waited 3 - 7 working days to be assigned or c.) waited longer than 8 days but were eventually assigned to a case manager.

Total number of non-hospitalized members admitted to any community support service: 70

Total assigned within 2 working days: 38	% assigned within 2 working days: 54%
Total assigned in 3 - 7 working days: 12	% assigned in 3 -7 working days:17 %
Total assigned within 7 working days: 50	% assigned within 7 working days: 71%
Total assigned after 8 or more working days: 20	% assigned after 8 or more working days: 29%

Service	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
H0040 - Adult Assertive Community Treatment - ACT	0	6	9	15
H2015 - Community Integration (CI)	19	2	7	28
H2018 - Community Rehabilitation Services (CRS)	3	0	0	3
T2022HB - Behavioral Health Homes - Adult	16	4	4	24
Total	**38**	**12**	**20**	**70**

Gender	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Female	15	4	10	29
Male	23	8	10	41
Total	**38**	**12**	**20**	**70**

AMHI Class	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	30	11	13	54
AMHI Class Y	8	1	7	16
Total	**38**	**12**	**20**	**70**

District	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	1	1	1	3
District 2/ Cumberland County	8	3	10	21
District 3/ Androscoggin, Franklin, and Oxford Counties	2	2	2	6
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	2	1	2	5
District 5/ Somerset and Kennebec Counties	8	0	0	8
District 6/ Piscataquis and Penobscot Counties	15	3	2	20
District 7/ Washington and Hancock Counties	1	1	3	5
District 8/ Aroostook County	1	1	0	2
Total	**38**	**12**	**20**	**70**

Providers	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	11	2	0	13
Aroostook Mental Health Services	0	1	0	1
Assistance Plus	1	0	1	2
Break of Day, Inc	1	0	0	1
Catholic Charities Maine	0	0	1	1
Common Ties	0	1	0	1
Community Counseling Center	1	2	6	9
Community Health & Counseling Services	3	1	4	8
Fellowship Health Resources	1	0	0	1
Graham Behavioral Services	1	0	0	1
Kennebec Behavioral Health	2	0	0	2
Learning Works	0	0	1	1
Maine Vocational & Rehabilitation Assoc.	1	0	1	2
Motivational Services	1	0	0	1
Northeast Occupational Exchange	1	0	0	1
OHI	4	0	0	4
Paramount Behavioral Services,Inc	1	0	0	1
Shalom House	4	0	0	4
Sweetser	3	2	1	6
The Opportunity Alliance	0	0	2	2
Tri-County Mental Health	1	2	2	5
Volunteers of America	1	1	1	3
Total	**38**	**12**	**20**	**70**