Department of Health and Human Service
Office of Adult Mental Health Services
Third Quarter State Fiscal Year 2012 (January, February, March 2012)
Report on Compliance Plan Standards: Community
May 1, 2012

	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 May 2012* and *Unmet Needs by CSN for FY'12 Quarter 2 (October, November, December 2011)*
I.3	Certify that a system is in place for Community Service Networks (CSNs) and related mechanisms to improve continuity of care	The Department's certification of August 19, 2009 was approved on October 7, 2009.
I.4	Certify that a system is in place for Consumer councils	The Department's certification of December 2, 2009 was approved on December 22, 2009.
I.5	Certify that a system is in place for new vocational services	The Department certification of September 17, 2011 was approved November 21, 2011.
I.6	Certify that a system is in place for realignment of housing and support services	All components of the Consent Decree Plan of October 2006 related to the Realignment of Housing and Support Services were completed as of July 2009. Certification was submitted March 10, 2010. The Certification Request was withdrawn May 14, 2010.
I.7	Certify that a system is in place for a Quality Management system that includes specific components as listed on pages 5 and 6 of the plan	Department of Health and Human Services Office of Adult Mental Health Services Quality Management Plan/Community Based Services (April 2008) has been implemented; a copy of plan was submitted with the May 1, 2008 Quarterly Report.
II.1	Provide documentation that unmet needs data and information (data source list page 4 of compliance plan) is used in planning for resource development and preparing budget requests	Unmet needs reports are posted on the OAMHS website on a quarterly basis in order to inform discussions and recommendations to the Department for meeting unmet needs. Budget submissions to the Governor and the Legislature are in part built on data regarding unmet needs. This is reflected in the financial documents submitted to DAFS.
II.2	Demonstrate reliability of unmet needs data based on evaluation	See *Cover: Unmet Needs May 2012* and the *Performance and Quality Improvement Standards: April 2012* for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data.

II.3	Submission of budget proposals for adult mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs *(Amended language 9/29/09)*	A written presentation to the committees of jurisdiction for the Supplemental Budget for FY13 and FY13 was submitted to the Court Master and Plaintiff's Counsel prior to presenting it to the Joint Standing Committees on Health and Human Services and Appropriations and Financial Affairs. The Acting Director of the Office of Adult Mental Health Services presented documentation showing the estimated costs of providing services to individuals with serious and persistent mental illness as directed by the AMHI Consent Decree on January 3, February 1, and March 20, 2012.
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 for update.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	*MaineCare and Grant Expenditures Report for FY11 were* emailed to Court Master and Plaintiff's Counsel this quarter. A copy of this report is included as Document 15.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs May 2012* and the *Performance and Quality Improvement Standards: April 2012* for examples of the Department Utilizing the QM system.
III.1a	Document through quarterly or annual reports the data collected and activities to assure reliability (including ability of EIS to produce accurate data)	This quarterly report documents significant data collection and review activities of the OAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	See compliance standards II.3 and II.4 above for examples of how quality management data was used to support budget requests for systems improvement.
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Based on contract reviews done in the Third quarter of FY'12, 100 % of the agencies reviewed in OAMHS Field Service Offices (Bangor, Augusta, and Portland) have protocols/procedures in place for client notification of rights, with documentation in provider files maintained within the regional offices. Based in licensing surveys, 100% of licensed mental health agencies have protocols/policies in place for client notification of the *Rights of Recipients.*
IV.2	If results from the DIG Survey fall below	The percentage for standard 4.2 from the 2011 DIG

	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)*	Survey was 89.4% (up from 88.6%in 2010), slightly below the standard of 90%. This data was shared with the CCSM after the last quarterly report in November. A copy of the Draft is Submitted as Document 14.
IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension	Standard met Calendar Years 2006, 2007, 2008 and 2009; the 1st and 3rd quarters of calendar year (CY) 2010 (data not available for the 2nd quarter); and the 2nd, 3rd and 4th quarters of CY'11 (no Level II grievances reported in the 1st quarter of CY 2011) Grievance Tracking data is updated and reported on every 6 months. Quarter 2's information remains in the report.
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if hearing is to be held or if parties concur.	Reporting began in the 1st quarter of calendar year 2008. Standard met, when there was a level III grievance, at 100% through the 3rd quarter of calendar year (CY) 2011 (data not available for the 2nd quarter CY10). Standard not met in the 4th quarter CY11 (1 level 3 grievance). Grievance Tracking data is updated and reported on every 6 months. Quarter 2's information remains in the *Performance and Quality Improvement Standards: April 2012* report.
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: April 2012,* Standard 5-2.
IV.6	90% non-hospitalized class members assigned worker within 3 days of request - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: April 2012,* Standard 5-3.
IV.7	95% of class members in hospital or community not assigned within 2 or 3 days, assigned within an additional 7 days - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: April 2012,* Standard 5-4.
IV.8	90% of class members enrolled in CSS with initial ISP completed within 30 days of enrollment - *must be met for 3 out of 4 quarters*	The standard met since the 3rd quarters of FY'08 . See attached *Performance and Quality Improvement Standards: April 2012,* Standard 5-5

IV.9	90% of class members had their 90 day ISP review(s) completed within that time period - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: April 2012*, Standard 5-6.
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. As the data has been consistent over time and the feedback and interaction with providers had lessened greatly, reports are now created quarterly and available to providers upon request. Providers were notified of this change on May 18, 2011. Providers are notified when reports are run. Some do request copies. Feedback has been minimal.
IV.11	Data collected once a year shows that no > 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	Once-a-year report (completed January 2012) showed that 4.9% of class members enrolled in CS did not have their ISP reviewed before the next annual review. Those not completed appear to be data errors between APS Healthcare and EIS and provider error in discharging clients and updating ISP dates.
IV.12	Certify in quarterly reports that DHHS is meeting its obligation re: quarterly mailings	On May 14, 2010, the court approved a Stipulated Order that requires mailings to be done only semi-annually in 2010, moving to annually in 2011 and thereafter, as long as the number of unverified addresses remains at or below 15%. The most recent mailing was sent in early December 2011. Percentage of unverified addresses remains below 15%. See attached *Location Effort Report: Calendar Year 2011*.
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - *must be met for 3 out of 4 quarters*	Standard met since the beginning of FY'10 though FY12 Second Quarter. Standard was 88.2 % for the FY12 third quarter. See attached *Class Member Treatment Planning Review*, Question 2A
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be met for 3 out of 4 quarters*	Standard has been met continuously since the first quarter of FY'08. See attached *Performance and Quality Improvement Standards: April 2012*, Standard 7-1a and *Class Member Treatment Planning Review*, Question 2B
IV.15	90% of ISPs reviewed have a crisis plan or	Standard met since the beginning of FY'09

	documentation as to why one wasn't developed - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: April 2012,* Standard 7-1c (does the consumer have a crisis plan) and *Class Member Treatment Planning Review,* Question 2F
IV.16	QM system documents that OAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	See attached *Class Member Treatment Planning Review,* Question 6.a.1 that addresses plans of correction.
IV.17	In 90% of ISPs reviewed, interim plans developed when resource needs not available within expected response times - *must be met for 3 out of 4 quarters*	Standard met the 1st and 2nd quarters of FY'12 See attached *Performance and Quality Improvement Standards: April 2012,* Standard 8-2 and *Class Member Treatment Plan Review,* Question 3F.
IV.18	90% of ISPs review included service agreement/treatment plan - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: April 2012,* Standard 9-1 and *Class Member Treatment Plan Review,* Questions 4B & C.
IV.19	90% of ACT/ICI/CI providers statewide meet prescribed case load ratios - *must be met for 3 out of 4 quarters* Note: As of 7/1/08, ICI is no longer a service provided by DHHS.	Community Integration -- standard met since the 2nd quarter FY'08. ACT – standard met for the 2nd, 3rd and 4th quarters FY'10; the 1st, 2nd and 4th quarters FY'11; and first, second, and third quarters FY'12. See attached *Performance and Quality Improvement Standards: April 2012,* Standard 10.1 and 10-2
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - *must be met for 3 out of 4 quarters*	ICMs' work is focused on community forensic and outreach services. Individual ICMs no longer carry caseloads. Should this change in the future, OAMHS will resume reporting on caseload ratios.
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads *must be met for 3 out of 4 quarters*	The Office of Elder Services (OES) had three vacant positions due to retirement: two positions have been filled and the third has been approved and interviews scheduled. OES has one newly vacant 20 hour/week caseworker position that is being relocated to Aroostook County to alleviate the high caseloads. See attached *Performance and Quality Improvement Standards: April 2012,* Standard 10-5.
IV.21	Independent review of the ISP process finds	

	that ISPs met a reasonable level of compliance as defined in Attachment B of the Compliance Plan	
IV.22	5% or fewer class members have ISP-identified unmet residential support - *must be met for 3 out of 4 quarters* **and**	Standard met for the 4th quarter FY'08; the 1st, 3rd and 4th quarters of FY'09; all quarters of FY'10 and FY'11; and the 1st quarter of FY'12. See attached *Performance and Quality Improvement Standards: April 2012*, Standard 12-1
IV.23	**EITHER** quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status **and**	Reporting on this standard is done yearly, and was last done in July 2011. Unmet residential support need data for the past year (FY10 Quarter 4, FY11 Quarter 1, 2, & 3) shows that unmet residential support needs for non-class members did not exceed by 15 percentage points those of class members.
IV.24	Meet RPC discharge standards (below); **or** if not met document reasons and demonstrate that failure not due to lack of residential support services • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	Standard met since the beginning of FY'08 See attached *Performance and Quality Improvement Standards: April 2012*, Standards 12-2, 12-3 and 12-4
IV.25	10% or fewer class members have ISP-identified unmet needs for housing resources - *must be met for 3 out of 4 quarters* **and**	Standard met for quarters 3 and 4 FY'09 and 1st, 2nd and 3rd quarters of FY'10. Percentage for the 4th quarter FY'10 was 10.8%, just above the standard. Standard met for all quarters FY'11 and the 1st and 2nd quarter of FY12. See attached *Performance and Quality Improvement Standards: April 2012*, Standard 14-1
IV.26	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of housing resources. • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination	Standard 14-4 met since the beginning of FY'09, except for Q3 FY'10 Standard 14-5 met for the 2nd, 3rd and 4th quarters FY'09; the 2nd and 4th quarters of FY'10; all quarters of FY'11; and the 1st and 2nd quarters of FY12 Standard 14-6 met for the 2nd and 4th quarters FY'09;

	• 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	the 2nd and 4th quarters FY'10; all of FY'11; and the 1st and 2nd quarters of FY'12. See attached *Performance and Quality Improvement Standards: April 2012*, Standard 14-4, 14-5 & 14-6
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Standard met 2007, 2008, 2009 and 2010 (annual review). OAMHS submitted an amendment request to the court master to modify this requirement on November 23, 2011. The court master approved OAMHS' request to hold the 2011 annual review in abeyance pending a decision on the amendment request. Results reported in *Performance and Quality Improvement Standards: May 2010 Report*, Standard 15-1
IV.28	90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in attachment C to the Compliance Plan	In FY'10: 1st quarter 88.2% (15 of 17); 2nd quarter 81.8% (9 of 11); 3rd quarter 82.4% (14 of 17); and 4th quarter 90.9% (20 of 22). In FY'11: 88% (22 of 25) in the 1st quarter; 75% (9 of 12) in the 2nd quarter; 78.9% (15 of 19) in the 3rd quarter and 80% (12 of 15) in the 4th quarter. In FY12: 76.2% (16 of 21) in the 1st quarter. 63.6% (14 of 22) in the 2nd quarter See attached *Performance and Quality Improvement Standards: April 2012*, Standard 16-1 and *Community Hospital Utilization Review – Class Members 2nd Quarter of Fiscal Year 2012*.
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	See IV.30 below
IV.30	Evaluates compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	With the curtailment in FY 2010 and the elimination of funding for involuntary hospitalizations other than MaineCare in FY 2011 and FY12, contracts with hospitals are no longer needed. OAMHS is establishing agreements with the hospitals covering the key compliance issues. The status of hospital contracts: • Acadia and Maine Med-P6. Field Service Managers are with the Attorney General's

		office to identify the cost of AAG coverage at involuntary commitment hearings for these 2 hospitals. • Maine General Medical Center, Southern Maine Medical Center, and St. Mary's contracts are in place. • Midcoast Hospital and Penobscot Medical Center are either at DAFS-Purchases or awaiting signature from the provider. • Spring Harbor- Field Service Manager actively working on the contract. Despite not having agreements in place with all of the hospitals, OAMHS has continued the process with hospitals that it has historically performed – no objections have been received from the hospitals. The Office continues to perform reviews for involuntary hospitalizations with our Field Office Nurses. See Discussion after 17.5 in the Consent Decree Performance and Quality Improvement Standards: April 2012
IV.31	UR Nurses review all involuntary admissions funded by DHHS, take corrective action when they identify deficiencies and send notices of any violations to the licensing division and to the hospital	OAMHS reviews emergency involuntary admissions at the following hospitals: MaineGeneral 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.	3rd Quarter FY'12: No Rights of Recipients violations.
IV.33	• 90% of the time corrective action was taken when blue papers were not completed in accordance with terms • 90% of the time corrective action was taken when 24 hour certifications were not completed in accordance with terms • 90% of the time corrective action was taken when patient rights were not maintained	Standards met for FY'08, FY'09, FY'10 and FY'11; Standards met for the 1st quarter of FY'12. Standards met for the 2nd quarter of FY12 See attached *Performance and Quality Improvement Standards: April 2012*, Standards 17-2a, 17-3a and 17-4a and *Community Hospital Utilization Review – Class Members 2nd Quarter of Fiscal Year 2012*.
IV.34	QM system documents that if hospitals have fallen below the performance standard for any of the following, OAMHS made the information public through CSNs, addressed in contract reviews with hospitals and CSS providers, and took appropriate corrective action to enforce responsibilities	The report displaying data by hospital for community hospitals accepting emergency involuntary clients is shared quarterly by posting reports on the CSN section of the Office's website. See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital:*

	• obtaining ISPs (90%) • creating treatment and discharge plan consistent with ISPs (90%) • involving CIWs in treatment and discharge planning (90%)	*Class Members 2nd Quarter of Fiscal Year 2012*.
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*	In FY'10, standard met for the 1st quarter: slightly above for the 2nd (25.7%), 3rd (25.7%) and 4th (26.1%) quarters. In FY'11, standard met for the 1st quarter, with the 2nd (25.6%), 3rd (26.2%) and 4th (26.4%) quarters' results being slightly above the standard. In FY'12: standard met for the first quarter at 25.5%. standard met for the second quarter at 23% See attached *Performance and Quality Improvement Standards: April 2012*, Standard 19-1 and *Adult Mental Health Quarterly Crisis Report Second Quarter, State Fiscal Year 2012 Summary Report*.
IV.36	90% of crisis phone calls requiring face-to-face assessments are responded to within an average of 30 minutes from the end of the phone call – *must be met for 3 out of 4 quarters*	Starting with July 2008 reporting from providers, OAMHS collects data on the total number of minutes for the response time (calculated from the determination of need for face to face contact or when the individual is ready and able to be seen to when the individual is actually seen) and figures an average. FY12: First quarter- Average statewide was met with the average being 28.3 minutes. Second quarter- was met with the average being 26.1 minutes. See attached *Adult Mental Health Quarterly Crisis Report Second Quarter, State Fiscal Year 2012 Summary Report.*
IV.37	90% of all face-to-face assessments result in resolution for the consumer within 8 hours of initiation of the face-to-face assessment – *must be met for 3 out of 4 quarters*	Standard has been met since the 2nd quarter of FY'08. See attached *Adult Mental Health Quarterly Crisis Report Second Quarter, State Fiscal Year 2012 Summary Report*.
IV.38	90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – *must be met for 3 out of 4 quarters*	Standard has been met since the 1st quarter of FY'08. See attached *Performance and Quality Improvement Standards: April 2012*, Standard 19-4 and *Adult Mental Health Quarterly Crisis Report Second*

		Quarter, State Fiscal Year 2012 Summary Report.
IV.39	Compliance Standard deleted 1/19/2011.	
IV.40	Department has implemented the components of the CD plan related to vocational services	As of quarter 3 FY'10, the Department has implemented all components of the CD Plan related to Vocational Services.
IV.41	QM system shows that the Department conducts further review and takes appropriate corrective action if PS 26.3 data shows that the number of consumers under age 62 and employed in supportive or competitive employment falls below 10%. *(Amended language 1/19/11)*	2011 Adult Health and Well-Being Survey: 13.8% of consumers in supported and competitive employment (full or part time). The *2011 Adult Health and Well-being Survey* is attached (Document 14).
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: April 2012,* Standard 21-1
IV.43	**EITHER** quarterly unmet mental health treatment needs for one year for qualified non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet mental health treatment need data for the past year (FY10 Quarter, 4, FY11 Quarters 1,2, & 3)) shows that unmet mental health treatment needs for non-class members did not exceed by 15 percentage points those of class members. • Q4 class members 17.09%, non-class members 16.09% • Q1: class members 16.1%, non-class members 17.81% • Q2: class members 15.37%, non-class members 18.85% • Q3: class members 13.93%, non-class members 18.01%
IV.44	QM documentation shows that the Department conducts further review and takes appropriate corrective action if results from the DIG survey fall below the levels identified in Standard # 22-1 (the domain average of positive responses to the statements in the Perception of Access Domain is at or above 85%) *(Amended language 1/19/11)* **and**	2011 Adult Health and Well-Being Survey: 77% domain average of positive responses. The *2011 Adult Health and Well-being Survey* is attached as Document 14.
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	Standard met since the beginning of FY'08 See attached *Performance and Quality Improvement Standards: April 2012,* Standards 21-2, 21-3 and 21-4

	• 90% within 45 days (with certain exceptions by agreement of parties and court master)	
IV.46	OAMHS lists in quarterly reports the programs sponsored that are designed to improve quality of life and community inclusion, including support of peer centers, social clubs, community connections training, wellness programs and leadership and advocacy training programs – list must cover prescribed topics and audiences that fit parameters of ¶105.	See attached *Performance and Quality Improvement Standards: April 2012*, Standard 30
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – *must be met for 3 out of 4 quarters*	Standard met for all quarters of FY'08, FY'09, FY'10 and FY'11. Standard met for the 1st and 2nd quarter FY'12 See attached *Performance and Quality Improvement Standards: April 2012,* Standard 28
IV.48	Provide documentation in quarterly reports of funding, developing, recruiting, and supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	See attached *Performance and Quality Improvement Standards: April 2012*, Standard 23-1 and 23-2
IV.49	Certify that all contracts with providers include a requirement to refer family members to family support services, and produce documentation that contract reviews include evaluation of compliance with this requirement.	100% of contracts include this requirement. Annual contract reviews completed in the 3rd quarter of FY'12 in all 3 regions addressed this standard with documentation contained in contract files maintained by the regional office.
IV.50	Lists in quarterly reports the number and types of mental health informational workshops, forums and presentations geared to general public that are designed to reduce myths/stigma and foster community integration (cover prescribed list and fit audience parameters)	See attached *Performance and Quality Improvement Standards: April 2012*, Standard 34.1 and attached *Public Education Report October-December 2011.*