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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November 1, 2013

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

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

Dear Dan:

Enclosed, pursuant to paragraph 280 of the Settlement Agreement, please find the Substance Abuse and Adult Mental Health Services Quarterly Report for the quarter ending Sept 30, 2013.

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

Sincerely,

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

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

Department of Health & Human Services, Office of Adult Mental Health Services
Bates v. DHHS Consent Decree
July, August, September: 1st Quarter, SFY 2014
CONSENT DECREE REPORT

SUMMARY
(Section 1A)

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

	DOCUMENT	DESCRIPTION
1	**Cover Letter, Quarterly Report:** November 1, 2013 *Section 1* Microsoft Word or Adobe PDF	Letter to Dan Wathen, Court Master, submitting the Quarterly Report pursuant to paragraph 280 of the Settlement Agreement for the quarter ending September 30, 2013.
2	**First Quarter Fiscal Year 2014 Report on Compliance Plan Standards: Community** *Section 2* Microsoft Word or Adobe PDF	Lists and updates the information pertaining to standards approved in October 2007 for evaluating and measuring DHHS compliance with the terms and principles of the Settlement Agreement.
3	**Performance and Quality Improvement Standards** *Section 3* Adobe PDF	Details the status of the Department's compliance with 34 specific performance and quality improvement standards (many are multi-part) required by the Consent Decree October 2006 Plan for this reporting quarter. Reporting includes the baseline, current level, performance standard, and compliance standard for each, including graphs.
4	**Public Education – Standard 34.1** *Section 4* Excel Version or Adobe PDF	Amplifies Standard 34.1 of the Performance and Quality Improvement Standards above, detailing the mental health workshops, forums, and presentations made, including levels of participation
5	**Performance Quality and Improvement Standards, Appendix: Adult Mental Health Data Sources** *Section 5* Microsoft Word or Adobe PDF **Consent Decree Performance and Quality Improvement Standard 5.** *Section 5A* Adobe PDF	Lists and describes all of the data sources used for measuring and reporting the Department's compliance on the Performance and Quality Improvement Standards. Aggregate report of assignment time to service and completion time of Individual Support Plans (ISPs). Data gathered from Contact for Service Notifications, Prior Authorizations, and Continued Stay Requests via APS Care Connections.

	DOCUMENT	DESCRIPTION
6	**Cover: Unmet Needs and Quality Improvement Initiative** *Section 6* Microsoft Word or Adobe PDF	Provides a brief introduction to the unmet needs report as well as some definitions of the data, initial findings and next steps. Also includes information on the quality improvement initiatives undertaken by SAMHS.
7	**Unmet Needs by CSN for FY13 Q4** *Section 7* Adobe PDF	Quarterly report drawn from the Enterprise Information System (EIS) by CSN (based on client zip code), from resource need data entered by community support case managers (CI, ACT, CRS) concerning consumers (class members and non-class members) who indicate a need for a resource that is not immediately available. Providers are required to enter the information electronically upon enrollment of a client in Community Support Services and update the information from their clients' Individual Service Plans (ISPs) every 90 days via an RDS (Resource Data Summary) entered as a component of prior authorization and continuing stay requests made to APS Healthcare via their online system, CareConnections.
8	**BRAP Waitlist Monitoring Report,** *Section 8* Microsoft Word or Adobe PDF	Describes status of the DHHS Bridging Rental Assistance Program's (BRAP) waitlist, focusing on the numbers served over time by priority status.
9	**Class Member Treatment Planning Review for the 1st Quarter of Fiscal Year 2014** *Section 9* Adobe PDF	Aggregate report of document reviews completed on a random sample of class member ISPs by Consent Decree Coordinators following a standardized protocol.
10	**Community Hospital Utilization Review for the 4th Quarter of Fiscal Year 2013: Class Members** *Section 10* Adobe PDF	Aggregate report of Utilization Review (UR) of all persons with MaineCare or without insurance coverage admitted into emergency involuntary, community hospital based beds. UR data is reported one quarter behind to allow sufficient time for reviews and data entry to be completed.
11	**Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members for the 4th Quarter Fiscal Year 2013** *Section 11* Adobe PDF	Report drawn from UR data that details, by hospital, the percentage of ISPs obtained, ISPs consistent with the hospital treatment and discharge plan, and case manager involvement in hospital treatment and discharge planning. UR data is reported one quarter behind to allow sufficient time for reviews and data entry to be completed.
12	**DHHS Integrated Child/Adult Quarterly Crisis Report: 1st Quarter, Fiscal Year 2014** *Section 12*	Aggregate quarterly report of crisis data submitted by crisis providers to the Office of Quality Improvement on a monthly basis.

	DOCUMENT	DESCRIPTION
	Adobe PDF	
13	**Riverview Psychiatric Center Performance Improvement Report** *Section 13* Microsoft Word or Adobe PDF	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* Adobe PDF	For members on the Community Integration waitlist who were authorized for this service, how long they waited. These reports count the number of days from the date the CFSN was opened to the date the service was authorized. The reports are run 2 quarters behind, therefore, those who were entered on the waitlist will have started the service.

Department of Health and Human Service
Office of Substance Abuse and Mental Health Services
First Quarter State Fiscal Year 2014
Report on Compliance Plan Standards: Community
November 1, 2013

	Compliance Standard	Report/Update
I.1	Implementation of all the system development steps in October 2006 Plan	As of March 2010, all 119 original components of the system development portion of the Consent Decree Plan of October 2006 have been accomplished or deleted per amendment.
I.2	Certify that a system is in place for identifying unmet needs	See attached *Cover: Unmet Needs November 2013* and *Unmet Needs by CSN for FY13 Q4. Found in Section 7.*
I.3	Certify that a system is in place for Community Service Networks (CSNs) and related mechanisms to improve continuity of care	The Department's certification of August 19, 2009 was approved on October 7, 2009.
I.4	Certify that a system is in place for Consumer councils	The Department's certification of December 2, 2009 was approved on December 22, 2009.
I.5	Certify that a system is in place for new vocational services	The Department certification of September 17, 2011 was approved November 21, 2011.
I.6	Certify that a system is in place for realignment of housing and support services	All components of the Consent Decree Plan of October 2006 related to the Realignment of Housing and Support Services were completed as of July 2009. Certification was submitted March 10, 2010. The Certification Request was withdrawn May 14, 2010.
I.7	Certify that a system is in place for a Quality Management system that includes specific components as listed on pages 5 and 6 of the plan	Department of Health and Human Services Office of Adult Mental Health Services Quality Management Plan/Community Based Services (April 2008) has been implemented; a copy of plan was submitted with the May 1, 2008 Quarterly Report. A new quality improvement plan for 2013-2018 is being developed with anticipated release in the fall of 2013.
II.1	Provide documentation that unmet needs data and information (data source list page 4 of compliance plan) is used in planning for resource development and preparing budget requests	Unmet needs reports are posted on the SAMHS website on a quarterly basis in order to inform discussions and recommendations to the Department for meeting unmet needs. Budget submissions to the Governor and the Legislature are in part built on data regarding unmet needs. This is reflected in the financial documents submitted to DAFS.
II.2	Demonstrate reliability of unmet needs data based on evaluation	See *Cover: Unmet Needs and Quality Improvement Initiatives November 2013* and the *Performance and Quality Improvement Standards: November 2013* for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data. SAMHS will undertake a review of the reliability of the unmet needs data in the fall of 2013. From this review, a plan will be developed to provider training and technical assistance on identifying, recording and

		implementing services for unmet needs.
II.3	Submission of budget proposals for adult mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs *(Amended language 9/29/09)*	The Director of SAMHS provides the Court Master with an updated projection of needs and associated costs as part of his ongoing updates regarding Consent Decree Obligations.
II.4	Submission of the written presentation given to the legislative committees with jurisdiction over DHHS … which must include the budget requests that were made by the Department to satisfy its obligations under the Consent Decree Plan and that were not included in the Governor's proposed budget, an explanation of support and importance of the requests and expression of support … *(Amended language 9/29/09)*	See above.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	MaineCare and Grant Expenditure Report for FY11 and FY12 was provided in the May 2013 report.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs November 2013* and the *Performance and Quality Improvement Standards: November 2013* for examples of the Department Utilizing the QM system.
III.1a	Document through quarterly or annual reports the data collected and activities to assure reliability (including ability of EIS to produce accurate data)	This quarterly report documents significant data collection and review activities of the SAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	See compliance standards II.3 and II.4 above for examples of how quality management data was used to support budget requests for systems improvement.
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Contract and licensing reviews are conducted as licenses expire. A report from DLRS is included; during the last quarter 21 of 21 agencies had protocol/procedures in place for client notification of rights.
IV.2	If results from the DIG Survey fall below levels established for Performance and Quality Improvement Standard 4.2, 90% of consumers report they were given information about their rights, the Department: (i) consults with the Consumer Council System of Maine (CCSM); (ii) takes corrective action a determined necessary by CCSM; and (iii) develops that corrective action in consultation with CCSM. *(Amended language 1/19/11)*	The percentage for standard 4.2 from the 2012 DIG Survey was 89.9% (up from 88.6%in 2010). These data are posted on the SAMHS website and provided to the Consumer Council of Maine. SAMHS staff have been meeting to address the methodology used for the survey and to boost consumer participation in the survey to be distributed in the fall of 2013.
IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension.	Grievances have been responded to consistently over time. During the first quarter there was 1 Level II grievances filed; It was responded to within the 5 day period (100% compliance).
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if	Reporting began in the 1st quarter of calendar year 2008. Standard has been consistently addressed. There have

	hearing is to be held or if parties concur.	been no Level III grievances filed in FY13.
IV.5	90% hospitalized class members assigned worker within 2 days of request - *must be met for 3 out of 4* quarters	See attached *Performance and Quality Improvement Standards: November 2013,* 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: November 2013,* 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: November 2013,* 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: November 2013,* Standard 5-5. This standard has not been met for the past 4 quarters.
IV.9	90% of class members had their 90 day ISP review(s) completed within that time period - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2013,* Standard 5-6. This standard has not been met for the past 4 quarters.
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. As the data has been consistent over time and the feedback and interaction with providers had lessened greatly, reports are now created quarterly and available to providers upon request. Providers were notified of this change on May 18, 2011. Providers are notified when reports are run. Some do request copies. Feedback has been minimal.
IV.11	Data collected once a year shows that no > 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	The 2012 data analysis indicates that out of 1,398 records for review, that 84 (6%) did not have an ISP review within the prescribed time frame.
IV.12	Certify in quarterly reports that DHHS is meeting its obligation re: quarterly mailings	On May 14, 2010, the court approved a Stipulated Order that requires mailings to be done only semi-annually in 2010, moving to annually in 2011 and thereafter, as long as the number of unverified addresses remains at or below 15%. The most recent mailing was sent in early December 2012. Percentage of unverified addresses remains below 15%.
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - *must be met for 3 out of 4 quarters*	See Section 9 *Class Member Treatment Planning Review,* Question 2A. This standard has been met in 4 out of the 4 quarters. The current percentage is 92.0%.
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2013,* Standard 7-1a and *Class Member Treatment Planning Review,* Question 2B

		Standard has been met continuously since the first quarter of FY08.
IV.15	90% of ISPs reviewed have a crisis plan or documentation as to why one wasn't developed - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November2013,* Standard 7-1c (does the consumer have a crisis plan) and *Class Member Treatment Planning Review,* Question 2F Standard met since the beginning of FY09
IV.16	QM system documents that SAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	See Section 9 *Class Member Treatment Planning Review,* Question 6.a.1 that addresses plans of correction. In 52.0% of cases, SAMHS required a correction action plan from providers.
IV.17	In 90% of ISPs reviewed, interim plans developed when resource needs not available within expected response times - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2013,* Standard 8-2 and *Class Member Treatment Plan Review,* Question 3F. This standard has been met in 4 out of the 4 quarters.
IV.18	90% of ISPs review included service agreement/treatment plan - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2013,* Standard 9-1 and *Class Member Treatment Plan Review,* Questions 4B & C. This standard has not been met in 3 of the past 4 quarters.
IV.19	90% of ACT/ICI/CI providers statewide meet prescribed case load ratios - *must be met for 3 out of 4 quarters* Note: As of 7/1/08, ICI is no longer a service provided by DHHS.	See attached *Performance and Quality Improvement Standards: November 2013,* Standard 10.1 and 10-2 Community Integration -- standard met since the 2nd quarter FY08. ACT – standard met for the 2nd, 3rd and 4th quarters FY10; the 1st, 2nd and 4th quarters FY11; all 4 quarters of FY12, and all 4 quarters of FY13, and 1st quarter FY14
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - *must be met for 3 out of 4 quarters*	ICMs' work is focused on community forensic and outreach services. Individual ICMs no longer carry caseloads. Should this change in the future, SAMHS will resume reporting on caseload ratios.
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2013,* Standard 10-5. This standard has not been met in the last 4 quarters.
IV.21	Independent review of the ISP process finds that ISPs met a reasonable level of compliance as defined in Attachment B of the Compliance Plan	
IV.22	5% or fewer class members have ISP-identified unmet residential support - *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: November 2013,* Standard 12-1 Standard met for the 4th quarter FY08; the 1st, 3rd and 4th quarters of FY09; all quarters of FY10 and FY11; all 4 quarters of FY12 and all 4 in FY13.

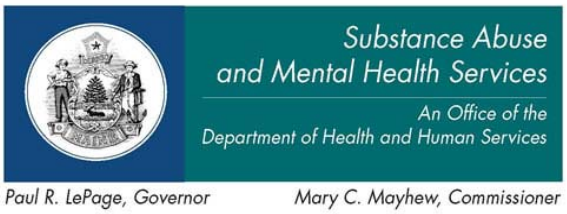
IV.23	**EITHER** quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status **and**	Unmet residential supports do not exceed 15 percentage points of Class Members. Reporting for this standard will be done again in July 2014. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.24	Meet RPC discharge standards (below); **or** if not met document reasons and demonstrate that failure not due to lack of residential support services • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: November2013*, 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: November 2013*, Standard 14-1 Standard met in FY13 and 22 out of the last 26 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: November 2013*, Standard 14-4, 14-5 & 14-6 Standard 14-4 met since the beginning of FY09, except for Q3 FY10. Standard 14-5 met for the 2nd, 3rd and 4th quarters FY09; the 2nd and 4th quarters of FY10; all quarters of FY11; all 4 quarters of FY12; all 4 quarters of FY13and 1st quarter of FY 14. Standard 14-6 met for the 2nd and 4th quarters FY09; the 2nd and 4th quarters FY10; all of FY11; 4 quarters of FY12, 4 quarters of FY13, and 1st quarter FY 14.
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Results reported in *Performance and Quality Improvement Standards: July 2010 Report*, Standard 15-1 This standard has been met since 2007. SAMHS submitted an amendment request to the court master to modify this requirement on November 23, 2011. The court master approved SAMHS' request to hold the 2011 annual review in abeyance pending a decision on the amendment request.
IV.28	90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in attachment C to the Compliance Plan	See attached *Performance and Quality Improvement Standards: November2013*, Standard 16-1 and *Community Hospital Utilization Review – Class Members 4th Quarter of Fiscal Year 2013*.

		In FY10: 1st quarter 88.2% (15 of 17); 2nd quarter 81.8% (9 of 11); 3rd quarter 82.4% (14 of 17); and 4th quarter 90.9% (20 of 22). In FY11: 88% (22 of 25) in the 1st quarter; 75% (9 of 12) in the 2nd quarter; 78.9% (15 of 19) in the 3rd quarter and 80% (12 of 15) in the 4th quarter. In FY12: 76.2% (16 of 21) in the 1st quarter 63.6% (14 of 22) in the 2nd quarter 77.8% (7 of 9) in the 3rd quarter 73.7% (14 of 19) in the 4th quarter IN FY13: 100% (19 of 19) in the 1st quarter 92.9% (13 of 14) in the 2nd quarter 86.7% (13 of 15) in the 3rd quarter 90.0% (18 of 20) in the 4th quarter
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	See IV.30 below
IV.30	Evaluates compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	All involuntary hospital contracts are in place.
IV.31	UR Nurses review all involuntary admissions funded by DHHS, take corrective action when they identify deficiencies and send notices of any violations to the licensing division and to the hospital	SAMHS reviews emergency involuntary admissions at the following hospitals: Maine General Medical Center, Spring Harbor, St. Mary's, Mid-Coast Hospital, Southern Maine Medical Center, PenBay Medical Center, Maine Medical Center/P6 and Acadia. See Standard IV.33 below regarding corrective actions.
IV.32	Licensing reviews of hospitals include an evaluation of compliance with patient rights and require a plan of correction to address any deficiencies.	11 Complaints Received 10 Complaints investigated 1 Substantiated 1 Plan of correction sought 0 Rights of Recipients Violations
IV.33	• 90% of the time corrective action was taken when blue papers were not completed in accordance with terms • 90% of the time corrective action was taken when 24 hour certifications were not completed in accordance with terms • 90% of the time corrective action was taken when patient rights were not maintained	See attached *Performance and Quality Improvement Standards: November 2013,* Standards 17-2a, 17-3a and 17-4a and *Community Hospital Utilization Review – Class Members 4th Quarter of Fiscal Year 2013*. Standards met for FY08, FY09, FY10, FY11, and FY12 Standards met for FY13
IV.34	QM system documents that if hospitals have fallen below the performance standard for any of the following, SAMHS made the	See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members 4th Quarter of Fiscal Year 2013*.

	information public through CSNs, addressed in contract reviews with hospitals and CSS providers, and took appropriate corrective action to enforce responsibilities • obtaining ISPs (90%) • creating treatment and discharge plan consistent with ISPs (90%) • involving CIWs in treatment and discharge planning (90%)	The report displaying data by hospital for community hospitals accepting emergency involuntary clients is shared quarterly by posting reports on the CSN section of the Office's website. Standard 18.2 met for the past 4 quarters. Standard met for obtaining ISPs and creating treatment and discharge plans consistent with ISP; involving CWs in treatment and discharge planning was at 100% in FY13.
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: November 2013,* Standard 19-1 and *Adult Mental Health Quarterly Crisis Report First Quarter, State Fiscal Year 2014 Summary Report*. In FY10, standard met for the 1st quarter: slightly above for the 2nd (25.7%), 3rd (25.7%) and 4th (26.1%) quarters. In FY11, standard met for the 1st quarter, with the 2nd (25.6%), 3rd (26.2%) and 4th (26.4%) quarters' results being slightly above the standard. In FY12, standard met all 4 quarters. In FY 13, standard met all 4 quarters. In FY 14, standard met 1st quarter
IV.36	90% of crisis phone calls requiring face-to-face assessments are responded to within an average of 30 minutes from the end of the phone call – *must be met for 3 out of 4 quarters*	See attached *Adult Mental Health Quarterly Crisis Report First Quarter, State Fiscal Year 2014 Summary Report.* Starting with July 2008 reporting from providers, SAMHS collects data on the total number of minutes for the response time (calculated from the determination of need for face to face contact or when the individual is ready and able to be seen to when the individual is actually seen) and figures an average. Average statewide calls requiring face to face assessments are responded to within an average of 30 minutes from the end of the phone call was met for all 4 Quarters in FY12, 4 quarters in FY13 and 1st quarter of FY14.
IV.37	90% of all face-to-face assessments result in resolution for the consumer within 8 hours of initiation of the face-to-face assessment – *must be met for 3 out of 4 quarters*	See attached *Adult Mental Health Quarterly Crisis Report First Quarter, State Fiscal Year 2014 Summary Report.* Standard has been met since the 2nd quarter of FY08.
IV.38	90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2013,* Standard 19-4 and *Adult Mental Health Quarterly Crisis Report First Quarter, State Fiscal Year 2014 Summary Report.* Standard has been met since the 1st quarter of FY08.
IV.39	Compliance Standard deleted 1/19/2011.	
IV.40	Department has implemented the components of the CD plan related to vocational services	As of quarter 3 FY10, the Department has implemented all components of the CD Plan related to Vocational Services.

IV.41	QM system shows that the Department conducts further review and takes appropriate corrective action if PS 26.3 data shows that the number of consumers under age 62 and employed in supportive or competitive employment falls below 10%. *(Amended language 1/19/11)*	2011 Adult Health and Well-Being Survey: 13.8% of consumers in supported and competitive employment (full or part time). The Director of the Office of Quality Improvement and staff from Office of Adult Mental Health quality management presented the findings at a Health Forum on July 18, 2013. The Department has requested feedback on recommendations from the Consumer Council on how they would like to see the data utilized.
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: November 2013,* Standard 21-1 This standard has not been met for the prior 4 quarters.
IV.43	**EITHER** quarterly unmet mental health treatment needs for one year for qualified non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet mental health treatment needs do not exceed 15 percentage points of Class Members. Reporting for this standard will be done again in July 2014. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.44	QM documentation shows that the Department conducts further review and takes appropriate corrective action if results from the DIG survey fall below the levels identified in Standard # 22-1 (the domain average of positive responses to the statements in the Perception of Access Domain is at or above 85%) *(Amended language 1/19/11)* **and**	2011 Adult Health and Well-Being Survey: 77% domain average of positive responses. The Director of the Office of Quality Improvement and staff from Office of Adult Mental Health quality management will present the results of the 2012 survey will be presented at an APS Forum in the fall of 2013. The Department has requested feedback on recommendations from the Consumer Counsel on how they would like to see the data utilized.
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: November 2013,* Standards 21-2, 21-3 and 21-4 Standard met since the beginning of FY08
IV.46	SAMHS lists in quarterly reports the programs sponsored that are designed to improve quality of life and community inclusion, including support of peer centers, social clubs, community connections training, wellness programs and leadership and advocacy training programs – list must	See attached *Performance and Quality Improvement Standards: November 2013,* Standard 30

	cover prescribed topics and audiences that fit parameters of ¶105.	
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: November2013,* Standard 28 This standard has been consistently met since FY08.
IV.48	Provide documentation in quarterly reports of funding, developing, recruiting, and supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	See attached *Performance and Quality Improvement Standards: November 2013,* Standard 23-1 and 23-2. NAMI Maine is the provider of the family support services.
IV.49	Certify that all contracts with providers include a requirement to refer family members to family support services, and produce documentation that contract reviews include evaluation of compliance with this requirement.	100% of contracts include this requirement. Documentation is maintained by the regional offices.
IV.50	Lists in quarterly reports the number and types of mental health informational workshops, forums and presentations geared to general public that are designed to reduce myths/stigma and foster community integration (cover prescribed list and fit audience parameters)	See attached *Performance and Quality Improvement Standards: November 2013,* Standard 34.1 and attached *Public Education Report for the past quarter.*



Consent Decree Performance and Quality Improvement Standards: November 2013

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

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

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

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

Definitions:

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

Calendar and Fiscal Year Definitions:

CY: Calendar Year - January 1 - December 31.

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

Compliance and Performance Standards: Summary Sheet
July - September 2013

Standard 1. Rights Dignity and Respect

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

Standard 2. Rights Dignity and Respect

Response to Level II Grievances within 5 days

Standard 3. Rights Dignity and Respect

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

Standard 4. Rights Dignity and Respect

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

Standard 5. Timeliness of ISP and CI/CSS Assignment

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

Standard 7. CI/CSS/ Individualized Support Planning

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

Standard 8. CI/CSS Individualized Support Planning

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

Standard 9. ISP Service Agreements

ISPs that require Service Agreements that have current Service Agreements

Compliance and Performance Standards: Summary Sheet
July - September 2013

Standard 10. Case Load Ratios

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

Standard 11. CI/CSS Individualized Support Planning

Paragraph 74. Needs of Class Members not in Service

Standard 12. Housing & Residential Support Services

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

Standard 13. Housing & Residential Support Services

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

Standard 14. Housing & Residential Support Services

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

Standard 15. Housing & Residential Services

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

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

Inpatient admissions reasonably near community residence.

Compliance and Performance Standards: Summary Sheet
July - September 2013

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

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

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

3. Admissions in which 24 hour certification completed.

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

4. Admission in which patients' rights were maintained

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

5. Admissions for which medical necessity has been established.

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

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

Standard 19. Crisis intervention Services

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

Standard 20. Crisis Intervention Services

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

Standard 21. Treatment Services

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

5.Class Members use an array of Mental Health Services

Standard 22. Treatment Services

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

Standard 23. Family Support Services

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

Compliance and Performance Standards: Summary Sheet
July - September 2013

Standard 24. Family Support Services

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

Standard 25. Family Support Services

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

Standard 26. Vocational Employment Services

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

Standard 27. Vocational Employment Services

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

Standard 28. Transportation

Class Members with ISPs - Unmet transportation needs.

Standard 29. Transportation

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

Standard 30. Rec/Soc/Avocational/Spiritual Opportunities

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

Standard 31. Rec/Soc/Avoc/Spirtual

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

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

Standard 32. Individual Outcomes

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

Compliance and Performance Standards: Summary Sheet
July - September 2013

Standard 33. Recovery

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

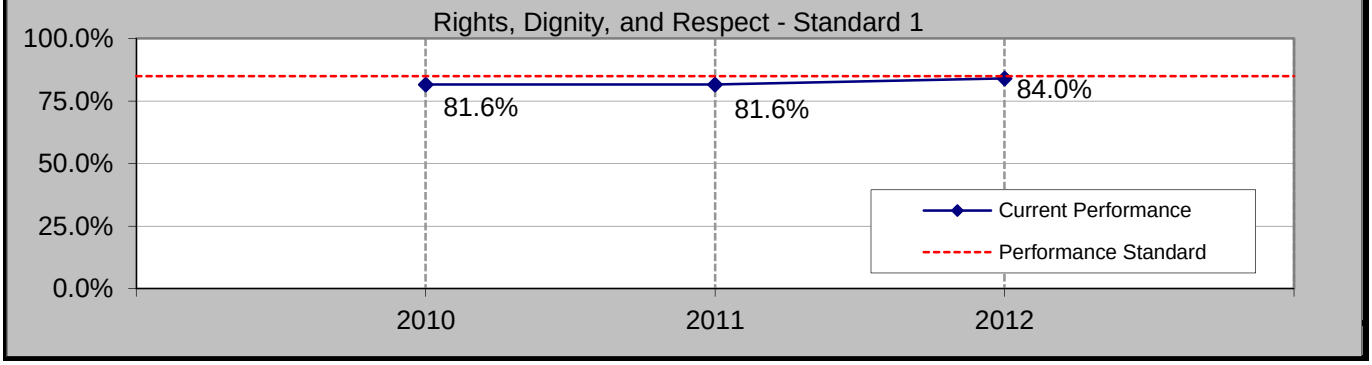
Standard 34. Public Education

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

Rights, Dignity, and Respect

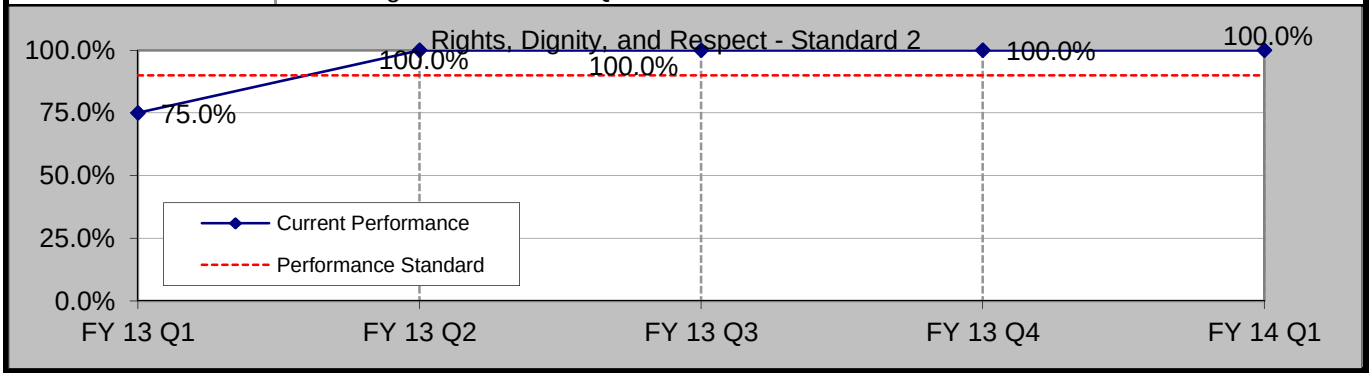
Standard 1 - Treated with respect for their individuality

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



Standard 2 - Grievances are addressed in a timely manner

Standard 2	
Measurement	Response to Level II Grievances within 5 days or agreed upon extension
Standard	Performance: 90% Within 5 days or during extension
Data Source	DHHS Grievance Tracking System
Current Level	1 level II grievances FY14 Q1

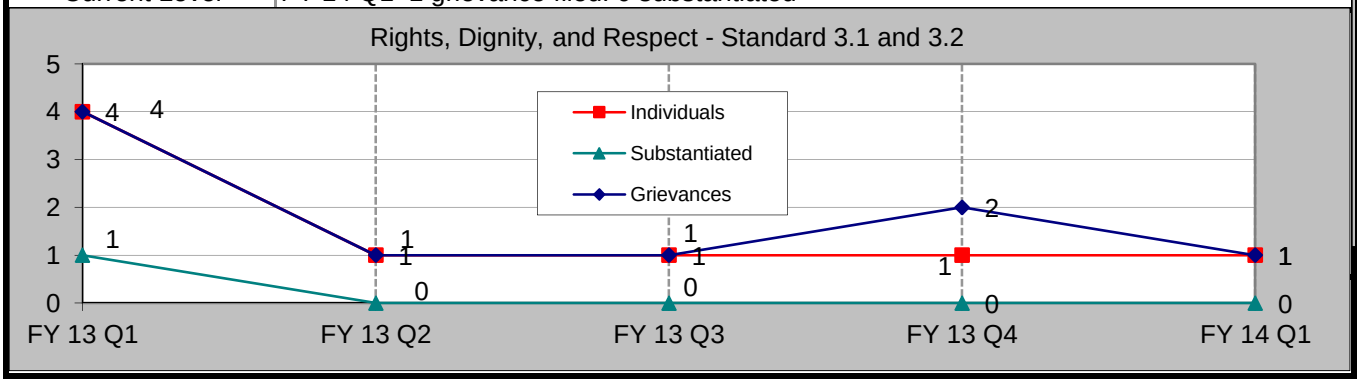


Rights, Dignity, and Respect

Standard 3 - Demonstrate rights are respected and maintained

Standard 3.1	
Measurement	Number of Level II grievances filed and number unduplicated people
Standard	No numerical standards necessary, ongoing monitoring of grievance trends.
Data Source	DHHS Grievance Tracking System
Current Level	FY 14 Q1 1 grievance filed. 1 individuals

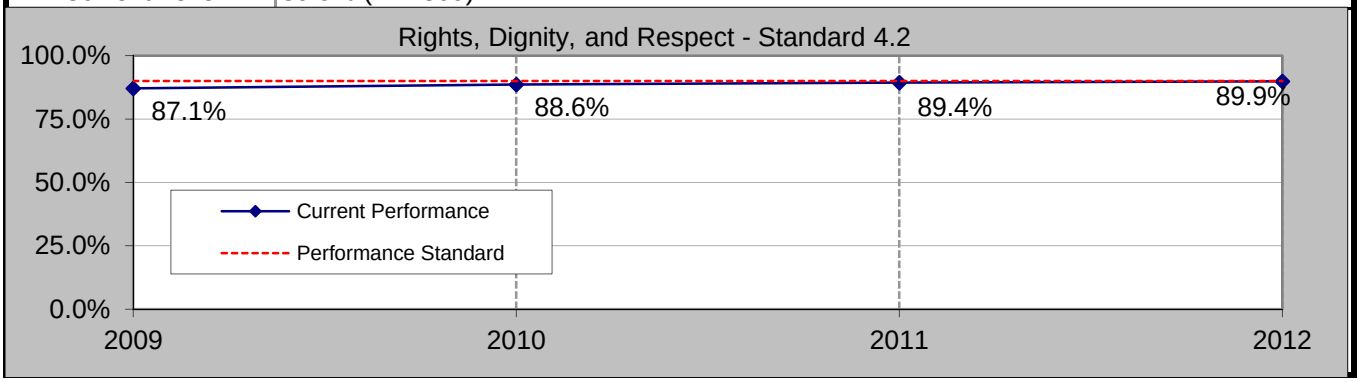
Standard 3.2	
Measurement	Number of Level II grievances filed where violation is substantiated
Standard	No numerical standards necessary, ongoing monitoring of grievance trends.
Data Source	DHHS Grievance Tracking System
Current Level	FY 14 Q1 1 grievance filed. 0 substantiated



Rights, Dignity, and Respect

Standard 4 - Class Members are informed of their rights

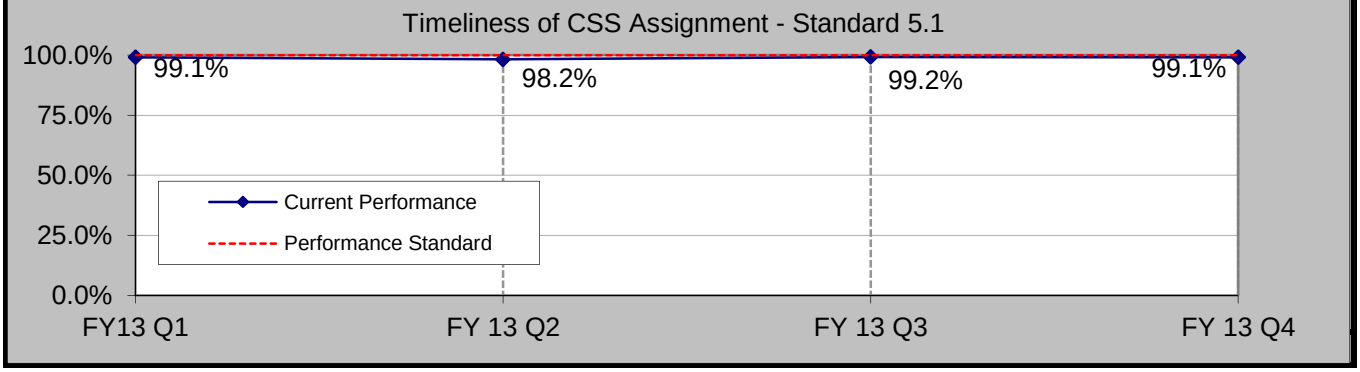
Standard 4.2	
Measurement	Percent of consumers reporting they were given information about their rights.
Standard	Performance: 90%
	Compliance: See explanation below.
Data Source	Adult Mental Health and Well Being Survey Q22
Current Level	89.9% (N=1309)



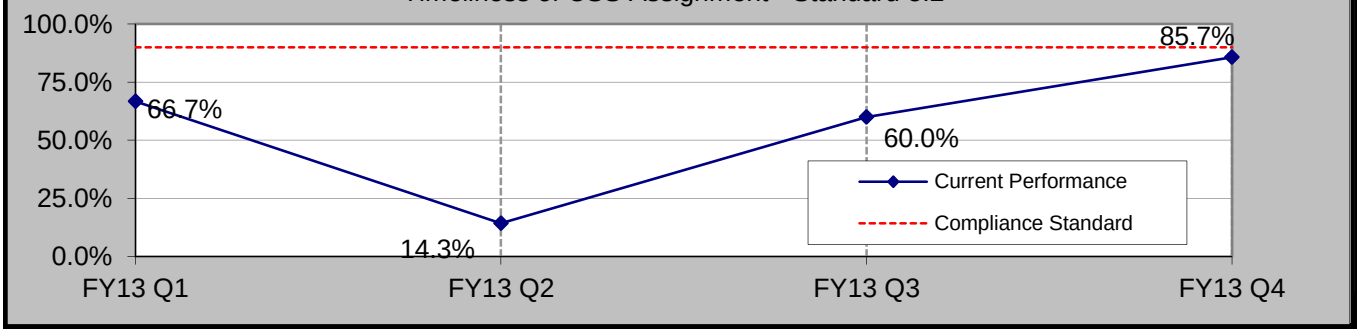
Community Integration / Community Support Services / Individualized Support Planning

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

Standard 5.1	
Measurement	Percentage of class members requesting a worker who were assigned one.
Standard	Performance: 100%
Data Source	APS Healthcare
Current Level	99.1% (111 out of 112)

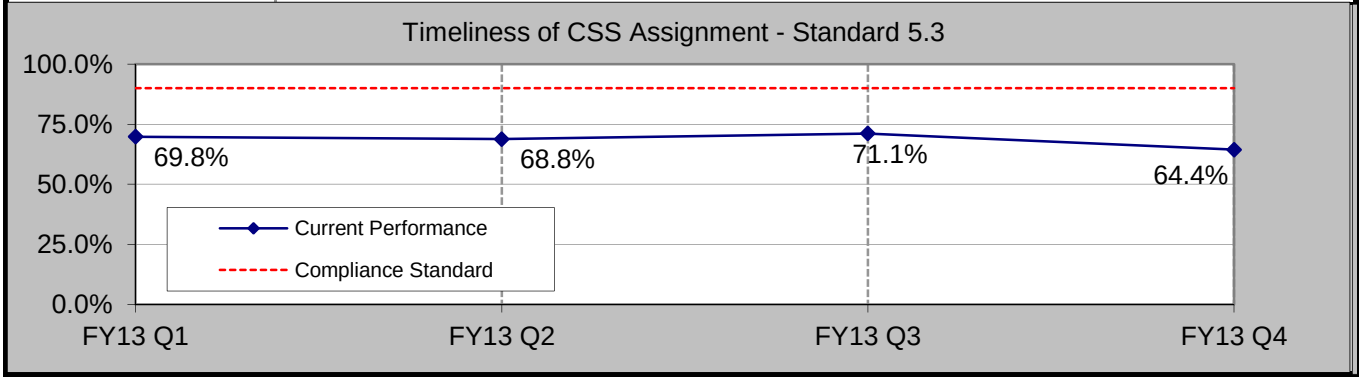


Standard 5.2	
Measurement	Percentage of hospitalized class members who were a assigned a worker within 2 working days.
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	APS Healthcare
Current Level	85.7% (6 out of 7)

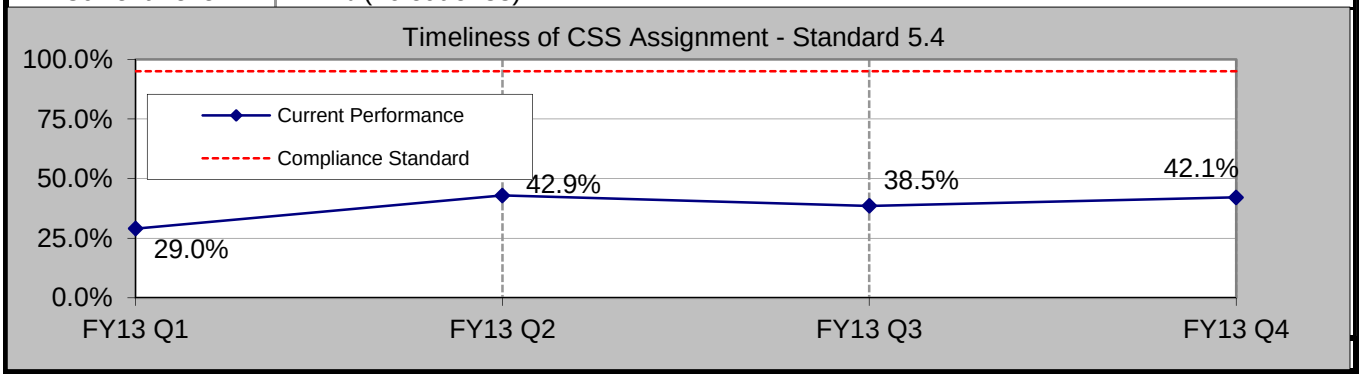


Community Integration / Community Support Services / Individualized Support Planning

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	64.4% (67 out of 104)

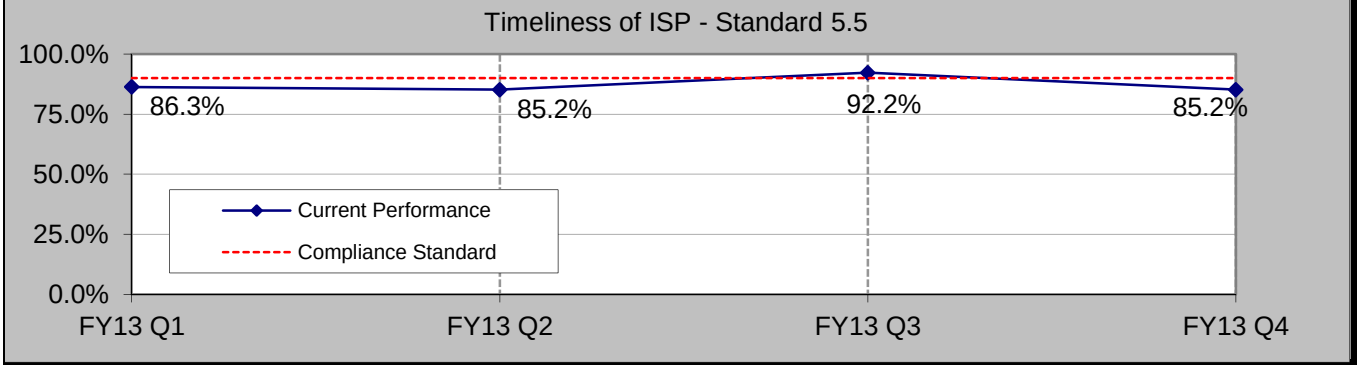


Standard 5.4	
Measurement	Percent of class members in hospital or community not assigned on time but were assigned within an additional 7 working days.
Standard	Performance: 100% Compliance: 95%
Data Source	APS Healthcare
Current Level	42.1% (16 out of 38)

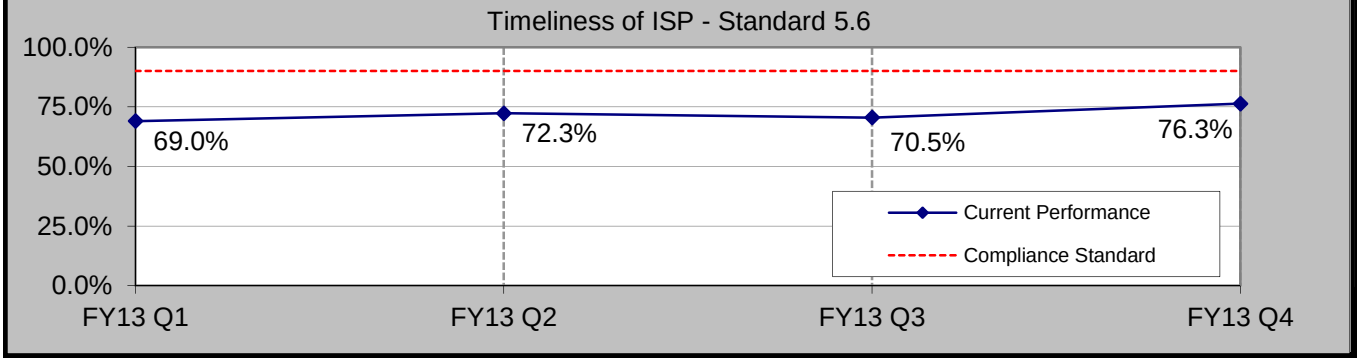


Community Integration / Community Support Services / Individualized Support Planning

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	85.2% (46 out of 54)

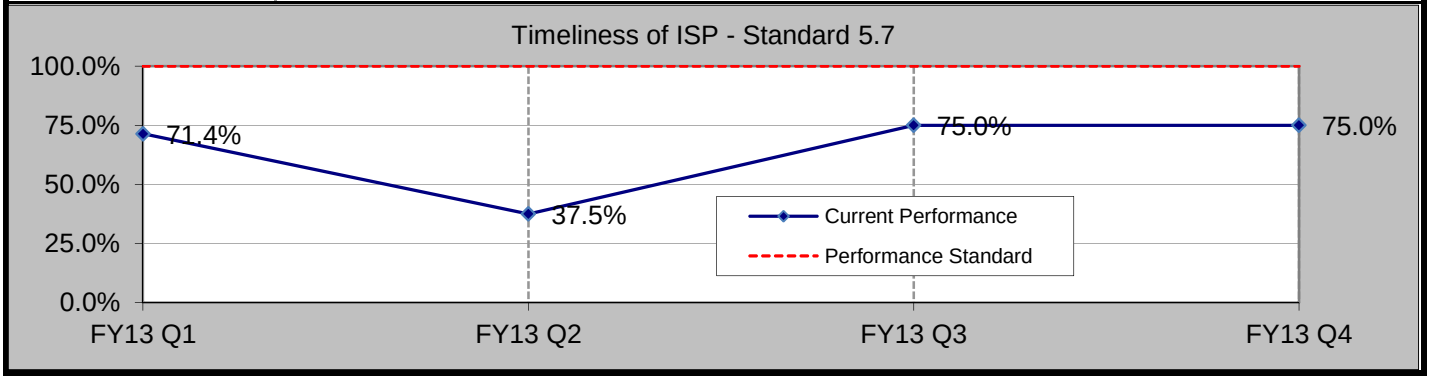


Standard 5.6	
Measurement	90 day class member ISP reviews completed within specified timeframe.
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	76.3% (810 out of 1062)

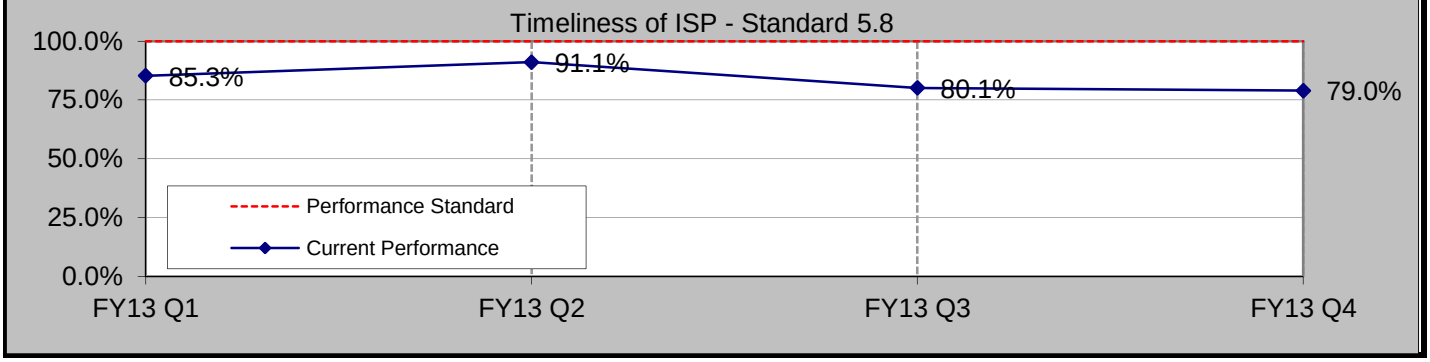


Community Integration / Community Support Services / Individualized Support Planning

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	75.0% (6 out of 8)



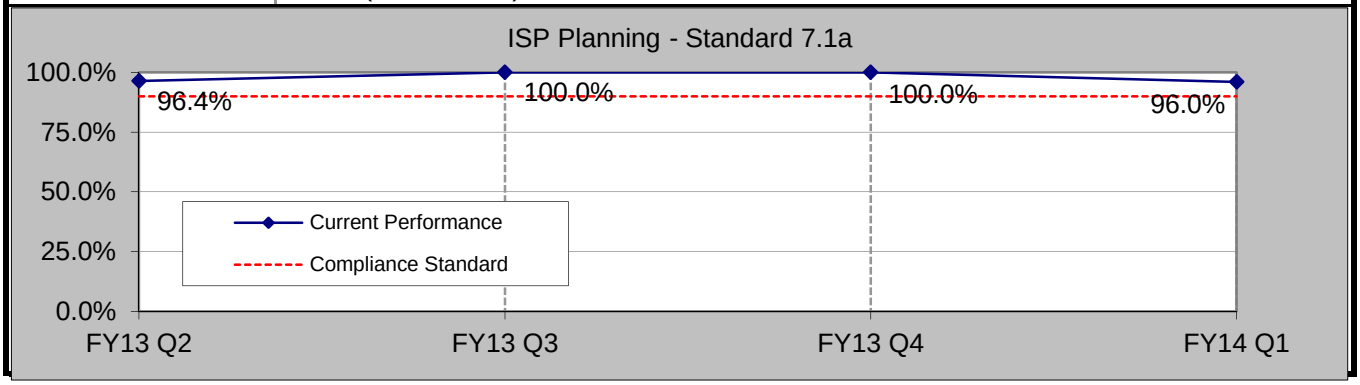
Standard 5.8	
Measurement	Class member ISPs that were not reviewed within 90 days but were reviewed within 120 working
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	79.0% (199 out of 252)



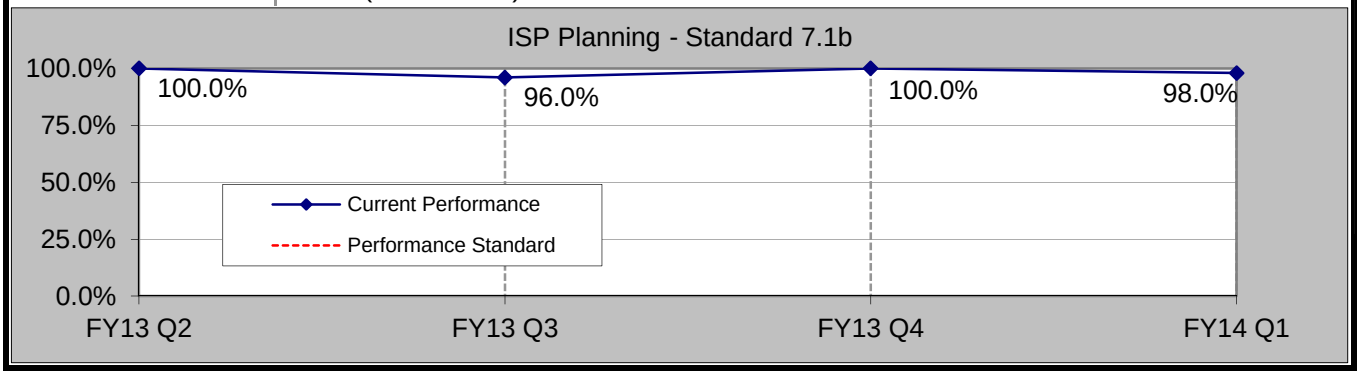
Community Integration / Community Support Services / Individualized Support Planning

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

Standard 7.1a	
Measurement	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?
Standard	Performance: 95% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	96.0% (48 out of 50)

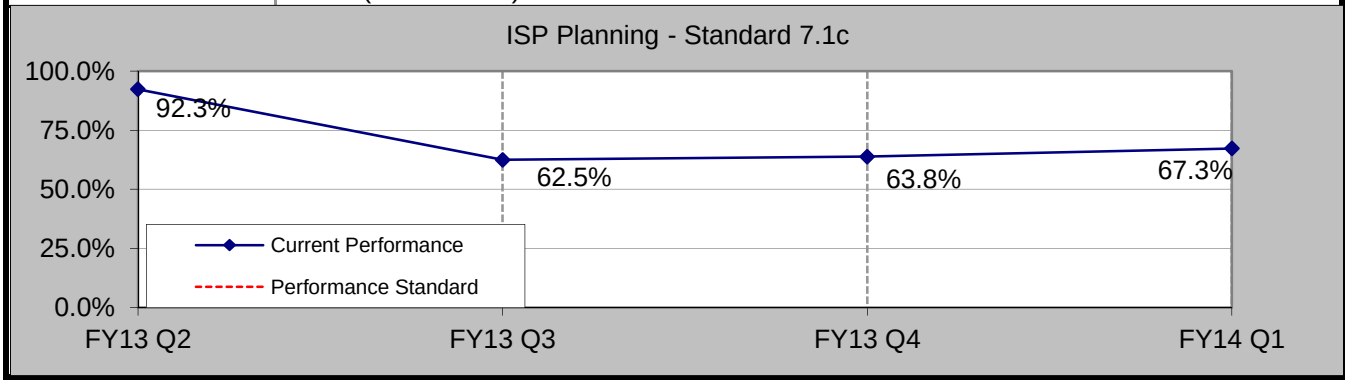


Standard 7.1b	
Measurement	Does record document the individual's potential need for crisis intervention and resolution services was considered during treatment planning?
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	98.0% (49 out of 50)

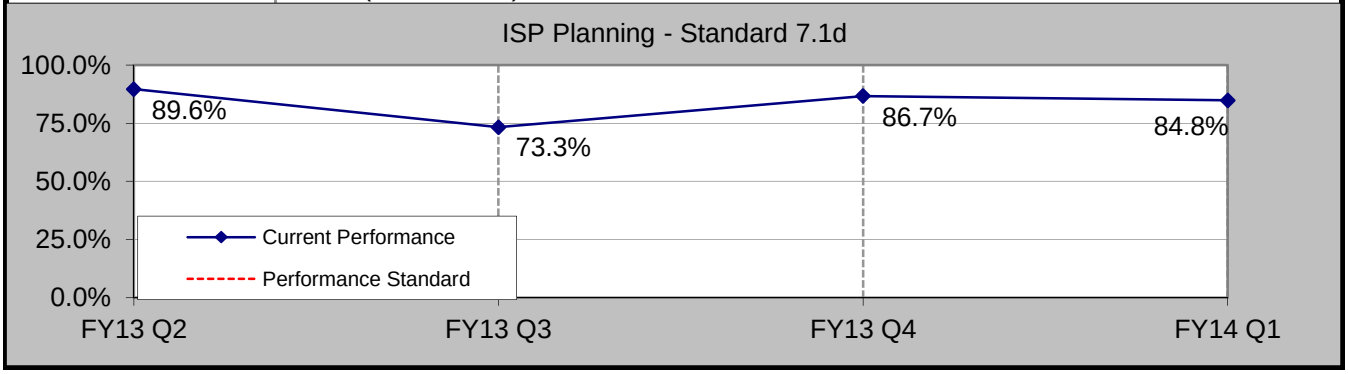


Community Integration / Community Support Services / Individualized Support Planning

Standard 7.1c	
Measurement	Does the record document that the consumer has a crisis plan?
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	67.3% (33 out of 49)



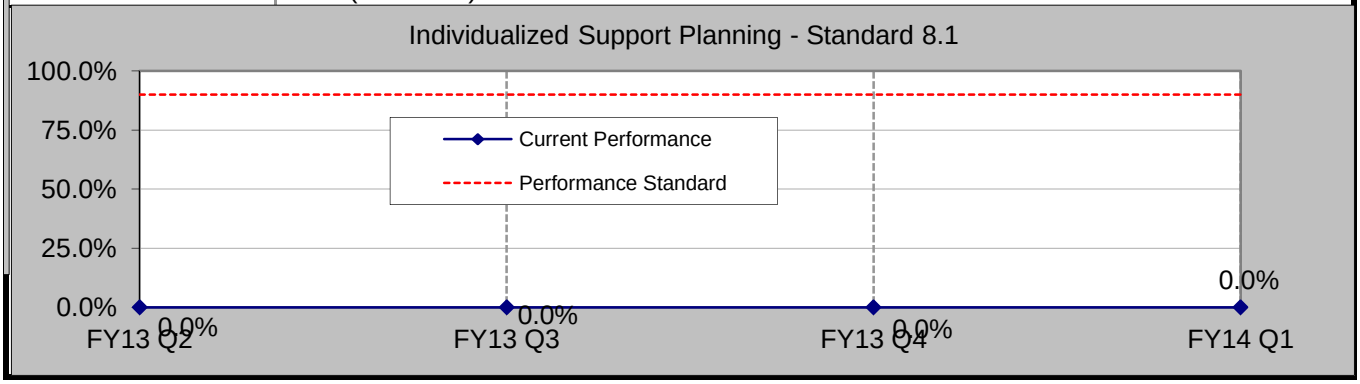
Standard 7.1d	
Measurement	If the consumer has a crisis plan, "has the crisis plan been reviewed as required, every 3 months?"
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	84.8% (28 out of 33)



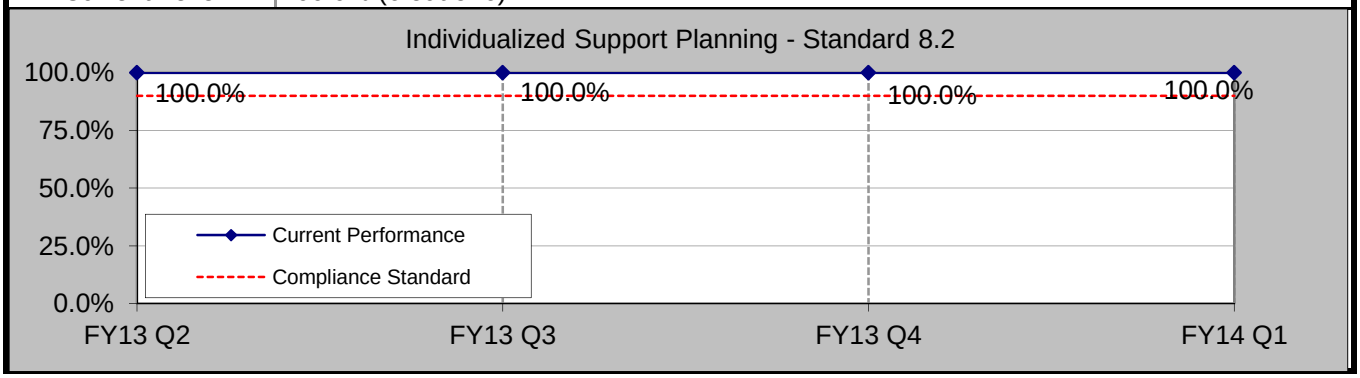
Community Integration / Community Support Services / Individualized Support Planning

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

Standard 8.1	
Measurement	ISPs reviewed in which there is evidence that the ISP team reconvened after an unmet need was identified.
Standard	Performance: 90%
Data Source	Class Member Treatment Planning Review
Current Level	0.0% (0 out of 6)



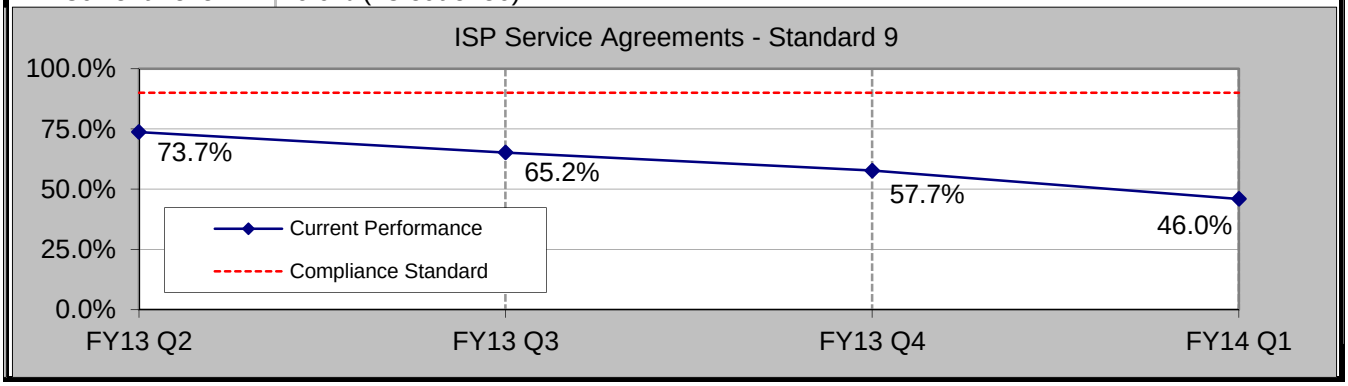
Standard 8.2	
Measurement	ISPs reviewed with identified unmet needs in which interim plans are established.
Standard	Performance: 95% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	100.0% (6 out of 6)



Community Integration / Community Support Services / Individualized Support Planning

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

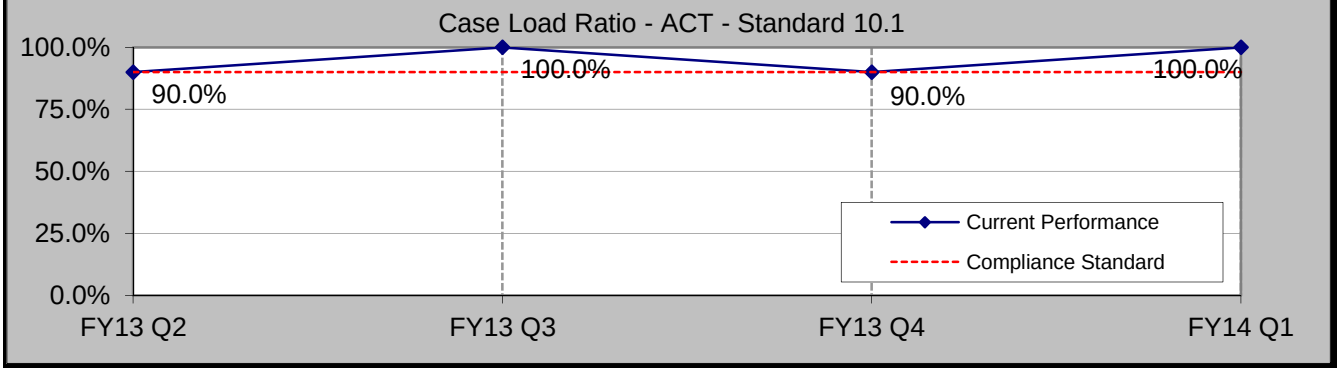
Standard 9	
Measurement	ISPs with services identified and with a treatment plan signed by each provider.**
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	46.0% (23 out of 50)



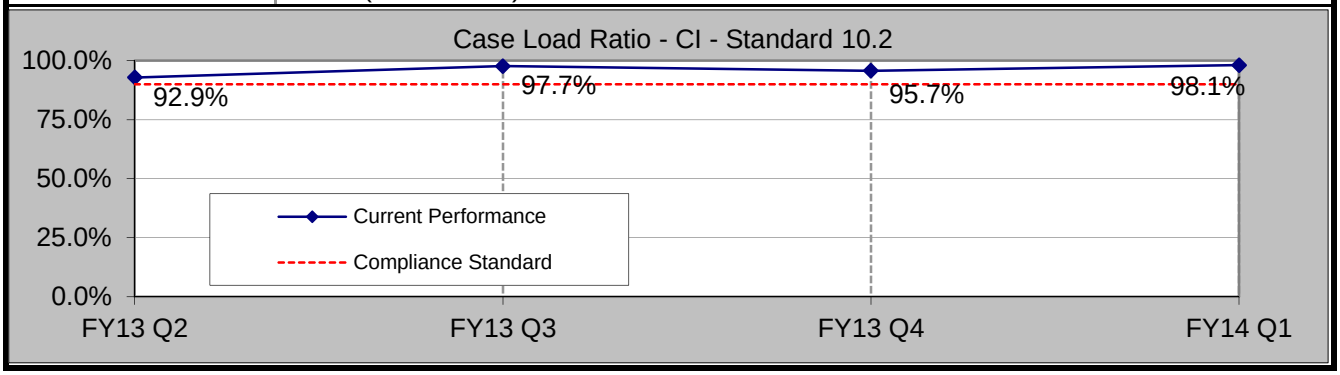
Community Integration / Community Support Services / Individualized Support Planning

Standard 10 - Case Load Ratio

Standard 10.1 - ACT	
Measurement	ACT Providers with average caseloads of 10 or fewer.
Standard	Compliance: 90% of all ACT Teams
Data Source	Agency Community Support Census/Staffing Ratio Database
Current Level	100% (9 out of 9)



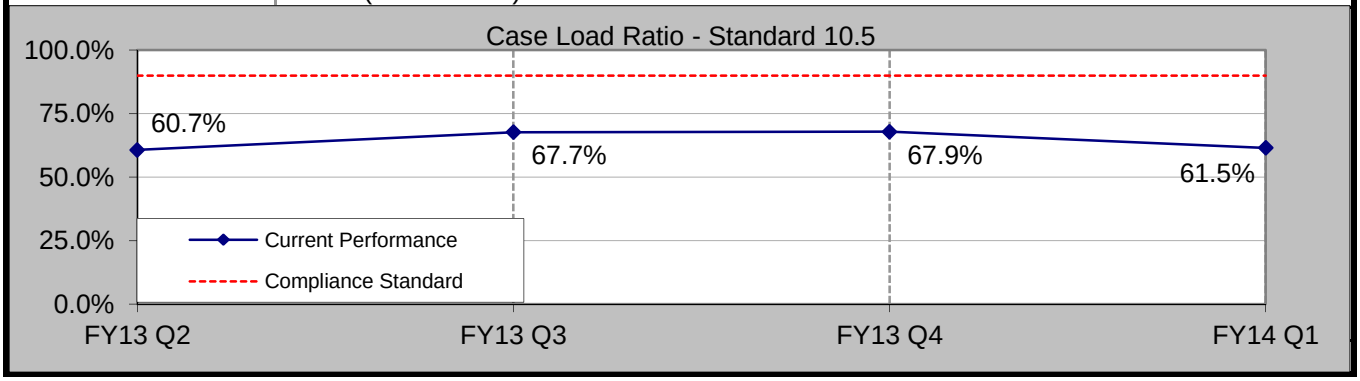
Standard 10.2 - CI	
Measurement	Community Integration Providers with average caseloads of 40 or fewer.
Standard	Compliance: 90% of all CIW Providers
Data Source	Agency Community Support Census/Staffing Ratio Database
Current Level	98.1% (53 out of 54)



Community Integration / Community Support Services / Individualized Support Planning

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

Standard 10.5 - OADS	
Measurement	Office of Aging and Disability Services Case Managers with average caseload of 25 or fewer.
Standard	Compliance: 90% of all OADS Case Managers with Class Member Public Wards
Data Source	MAPSIS Case Counts for Workers with Class Members Public Wards
Current Level	61.5% (16 out of 26)



Community Integration / Community Support Services / Individualized Support Planning

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

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

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

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

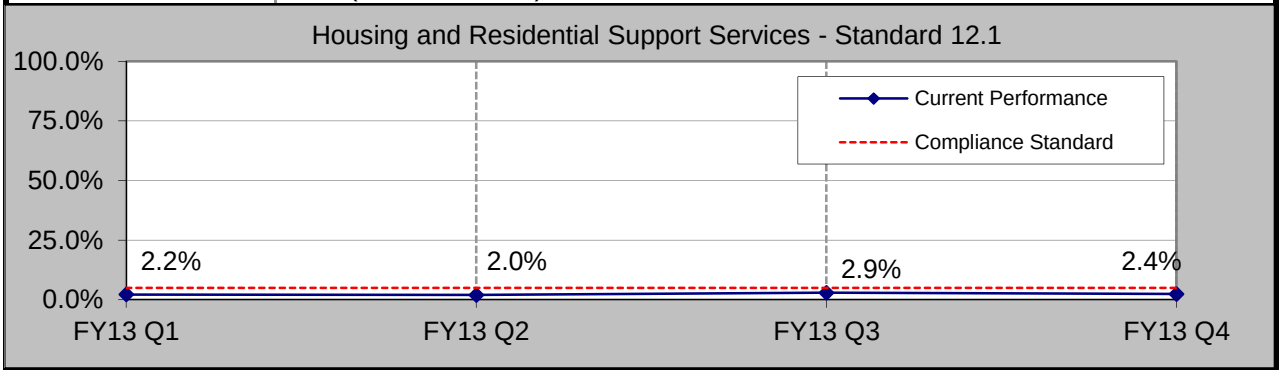
Number of Callers with resource needs Apr 1 - June 30, 2013				
	Region 1	Region 2	Region 3	Total
Unique Individuals:	0	0	0	0
Unmet Needs:	0	0	0	0

Unmet Needs by Domain Apr 1 ~ June 31, 2013	
ISP Domain Areas	**State**
Mental Health Services	0
MH Crisis Planning Resources	0
Peer, Recovery & Support Resources	0
Substance Abuse Services	0
Housing Resources	0
Health Care Resources	0
Legal Resources	0
Financial Security Resources	0
Education Resources	0
Vocation Employment Resources	0
Living Skills Resources	0
Transportation Resources	0
Personal Growth/Community Participation Resources	0
Total	0

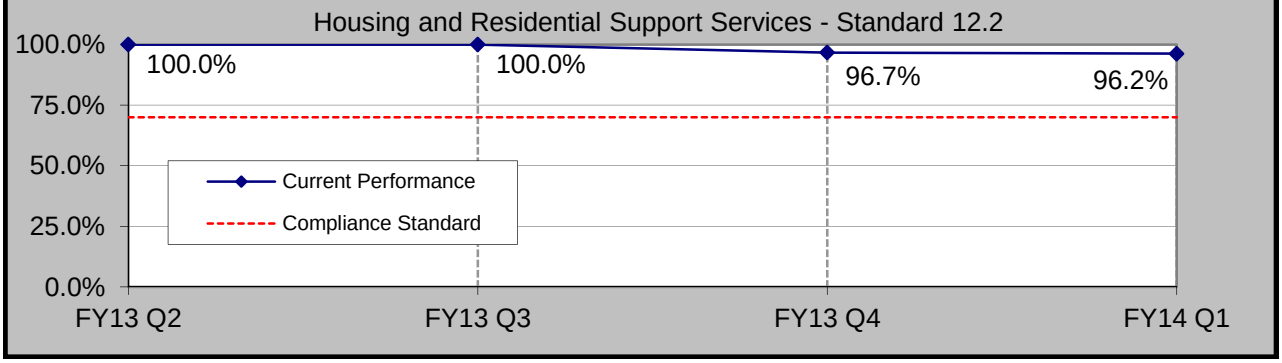
Community Resources and Treatment Services
Housing and Residential

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

Standard 12.1	
Measurement	Class members in community with ISPs with unmet residential support needs.
Standard	Compliance: 5% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	2.4% (28 out of 1187)

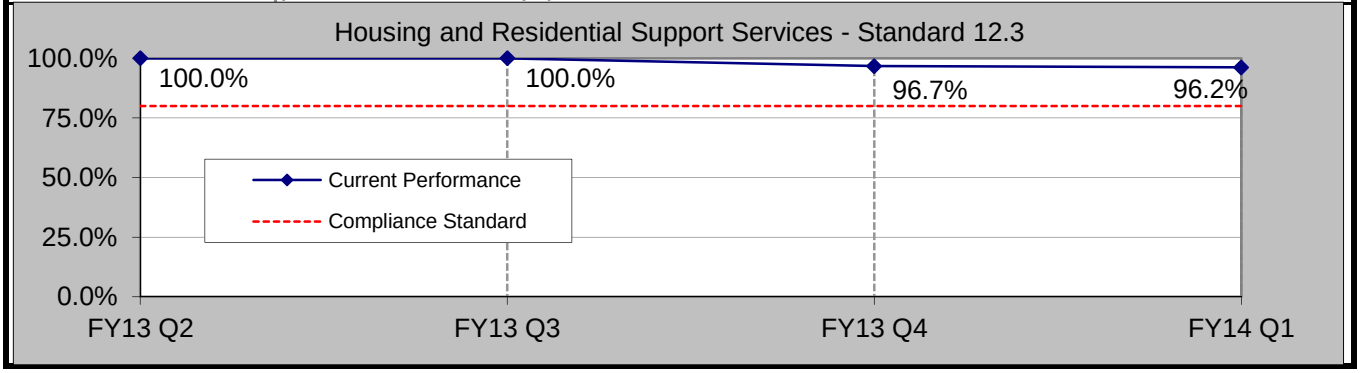


Standard 12.2	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	96.2% FY14 Q1 (Lack of residential supports did not impede discharge for 25 out of 26 patients within 7 days)

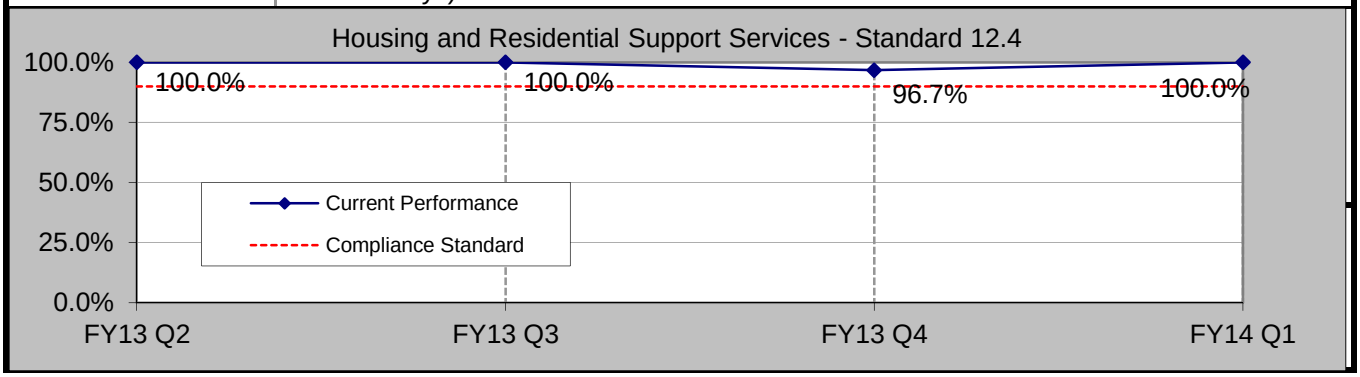


Community Resources and Treatment Services
Housing and Residential

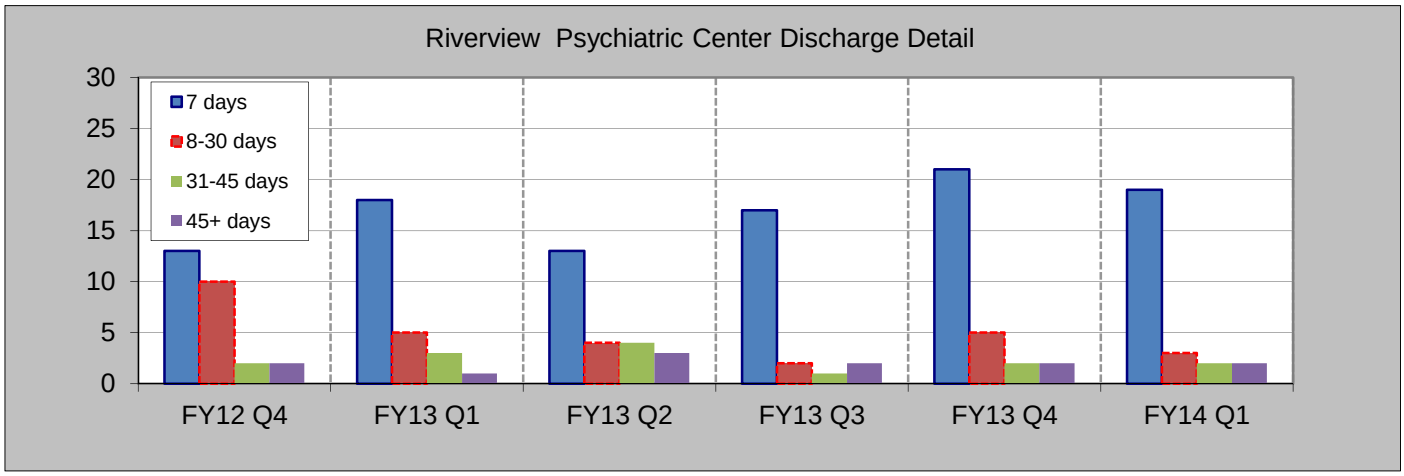
Standard 12.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	96.2% FY14 Q1 (Lack of residential supports did not impede discharge for 25 out of 26 patients within 30 days)



Standard 12.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Perfomance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 Q1 (Lack of residential supports did not impede discharge any patients within 45 days)



Community Resources and Treatment Services
Housing and Residential



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

26 Civil Patients discharged in quarter

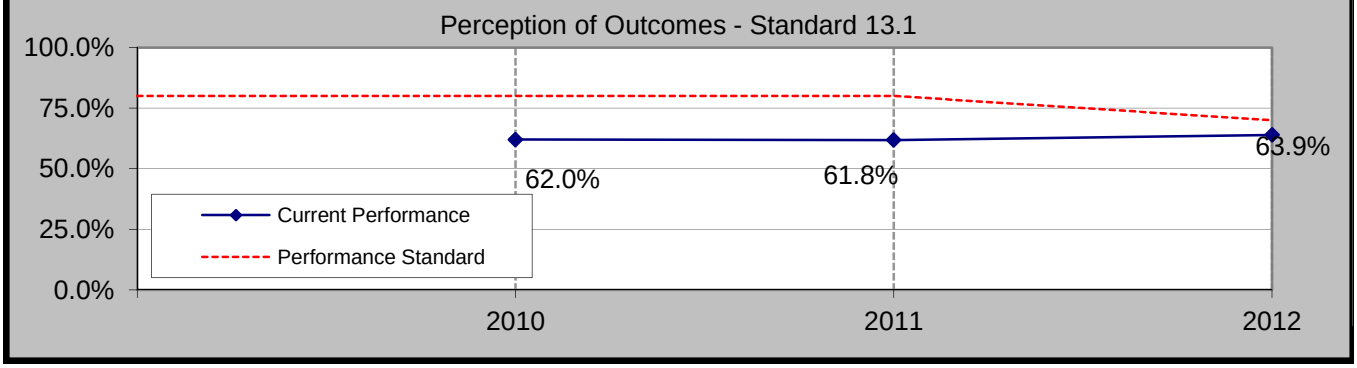
19 discharged at 7 days (73.1%)
3 discharged 8-30 days (11.5%)
2 discharged 31-45 days (7.7%)
2 discharged post 45 days (7.7%)

Lack of Residential Supports impeded discharge for 1 patient (3.8%)

1 patient discharged within 31-45 days post clinical readiness for discharge

Community Resources and Treatment Services
Housing and Residential

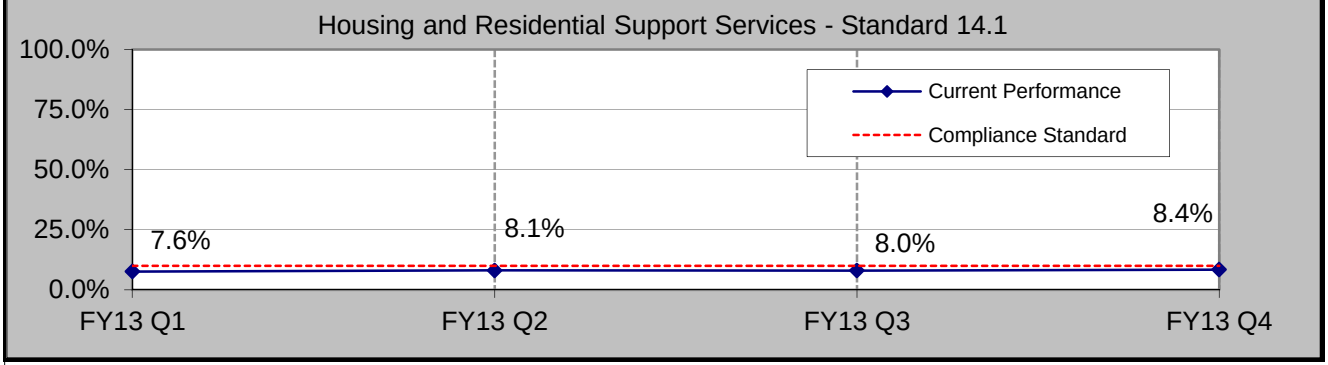
Standard 13.1	
Measurement	Domain average of positive responses to the questions in the Perception of Outcomes domain
Standard	Performance: at or above 70%
Data Source	Adult Mental Health and Well Being Survey
Current Level	63.9% (N=1338)



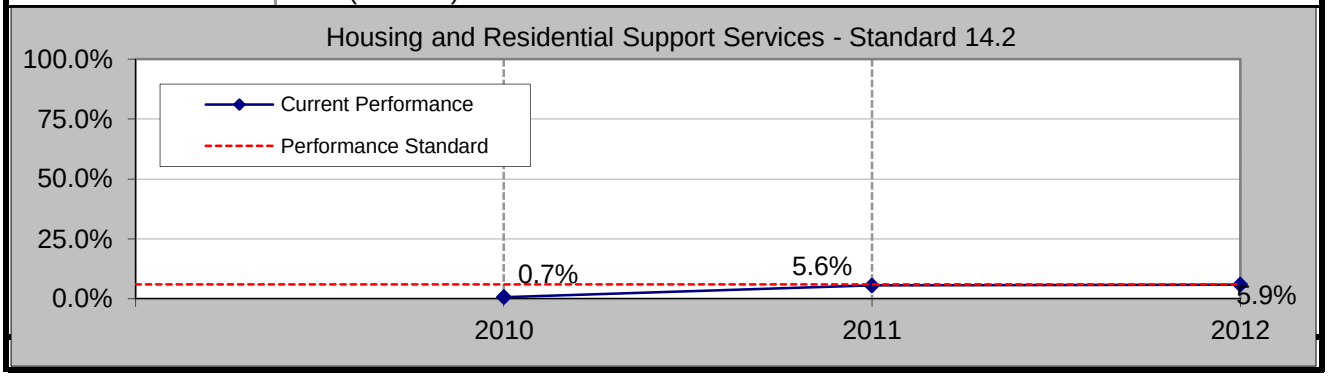
Community Resources and Treatment Services
Housing and Residential

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

Standard 14.1	
Measurement	Class members with ISPs with unmet housing needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	8.4% (100 out of 1187)

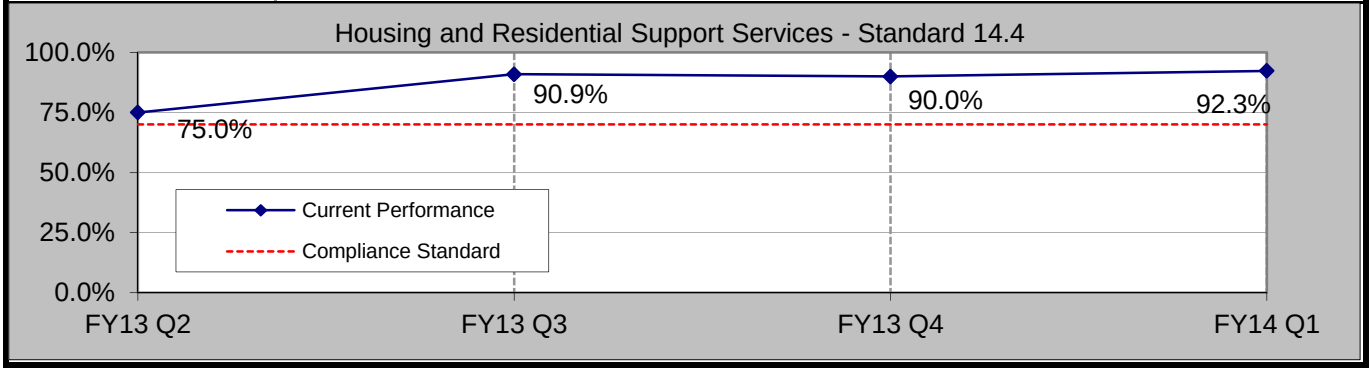


Standard 14.2	
Measurement	Percentage of respondents who experienced homelessness over 12-month period.
Standard	Performance: 6% or fewer
Data Source	Adult Mental Health and Well Being Survey, living situation data
Current Level	5.9% (N=1275)



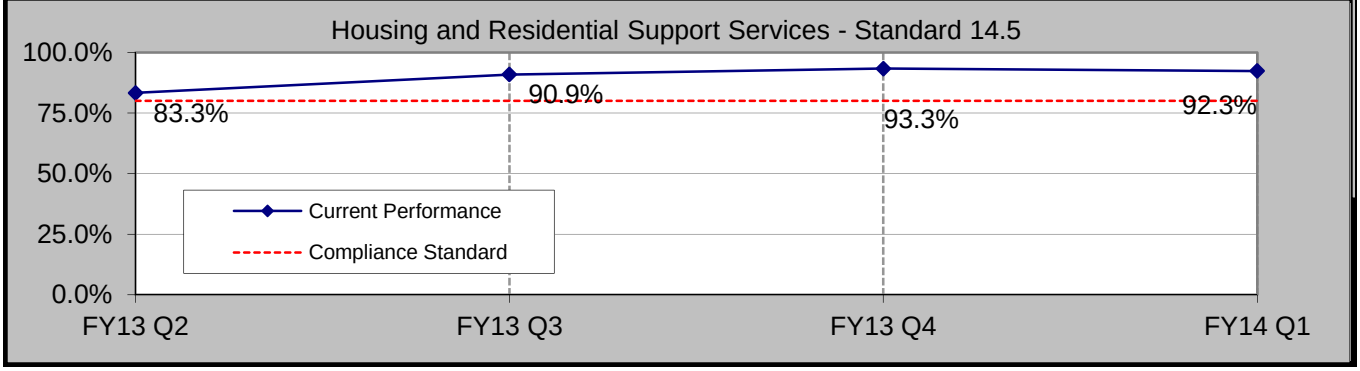
Community Resources and Treatment Services
Housing and Residential

Standard 14.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	92.3% FY14 Q1. (Lack of housing alternatives did not impede discharge for 24 out of 26 patients within 7 days)

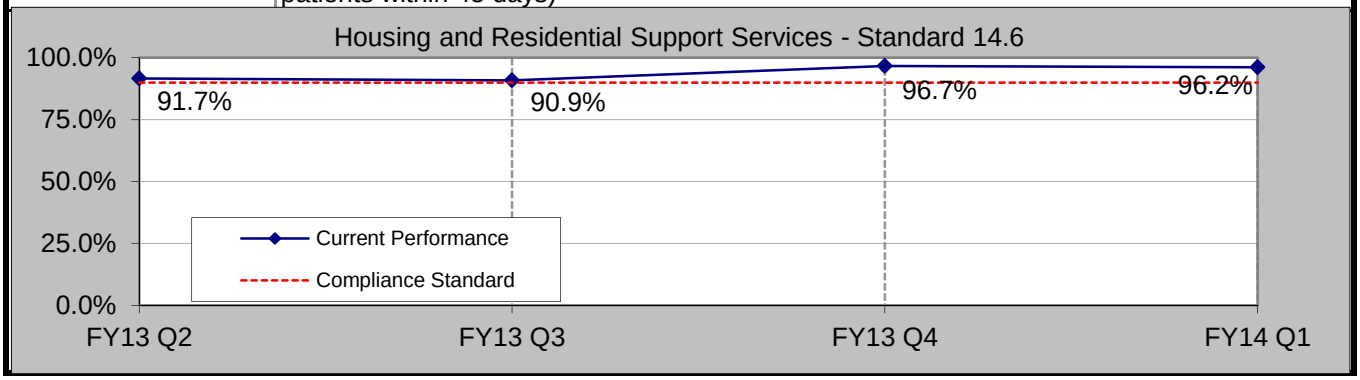


Community Resources and Treatment Services
Housing and Residential

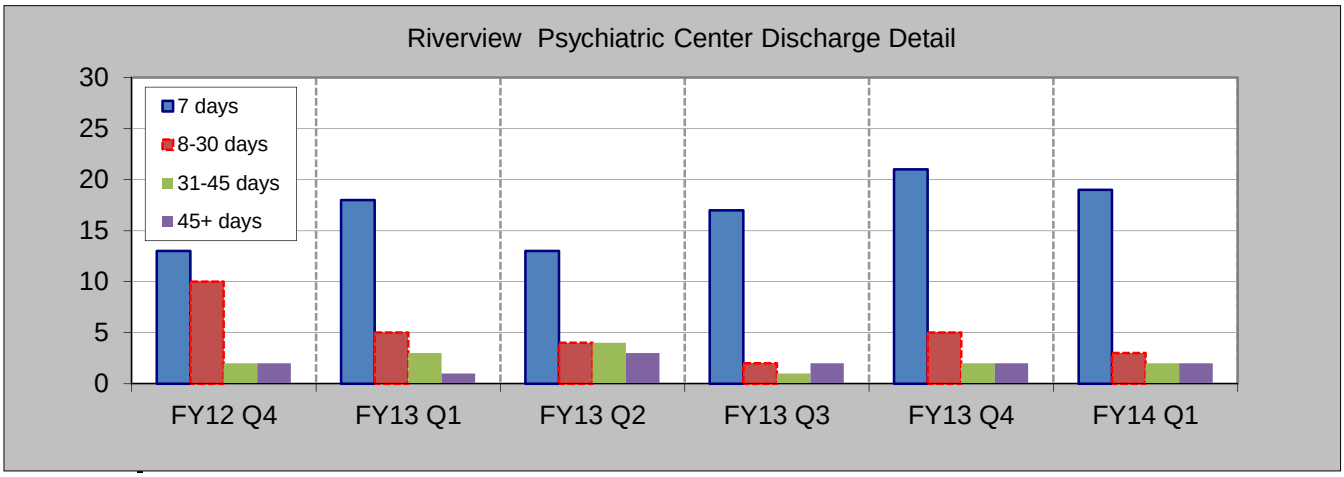
Standard 14.5	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	92.3% FY14 Q1 (Lack of housing alternatives did not impede discharge for 24 out of 26 patients within 30 days)



Standard 14.6	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	96.2% FY14 Q1 (Lack of housing alternatives did not impede discharge for 25 out of 26 patients within 45 days)



Community Resources and Treatment Services
Housing and Residential



26 Civil Patients discharged in quarter

19 discharged at 7 days (73.1%)
3 discharged 8-30 days (11.5%)
2 discharged 31-45 days (7.7%)
2 discharged post 45 days (7.7%)

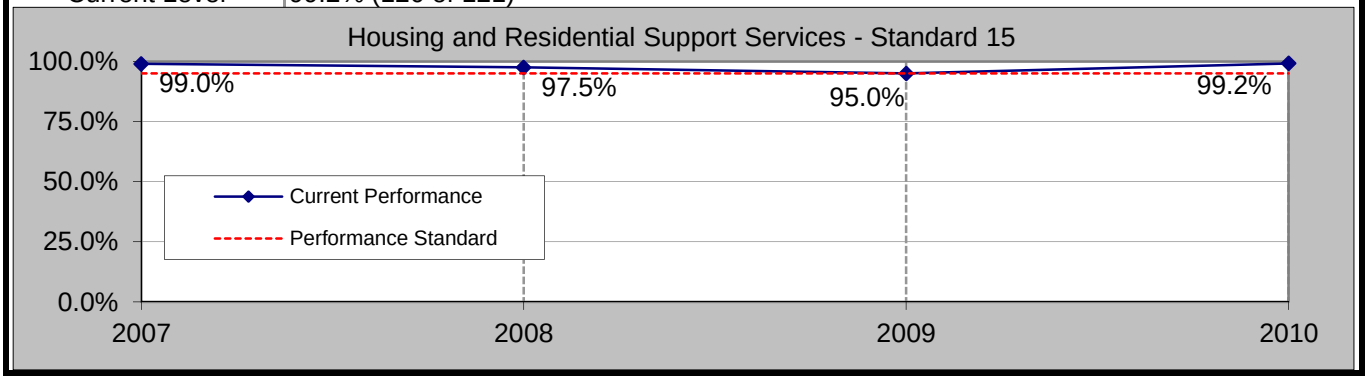
Housing Alternatives impeded discharge for 2 patients (7.7%)

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

Community Resources and Treatment Services
Housing and Residential

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

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

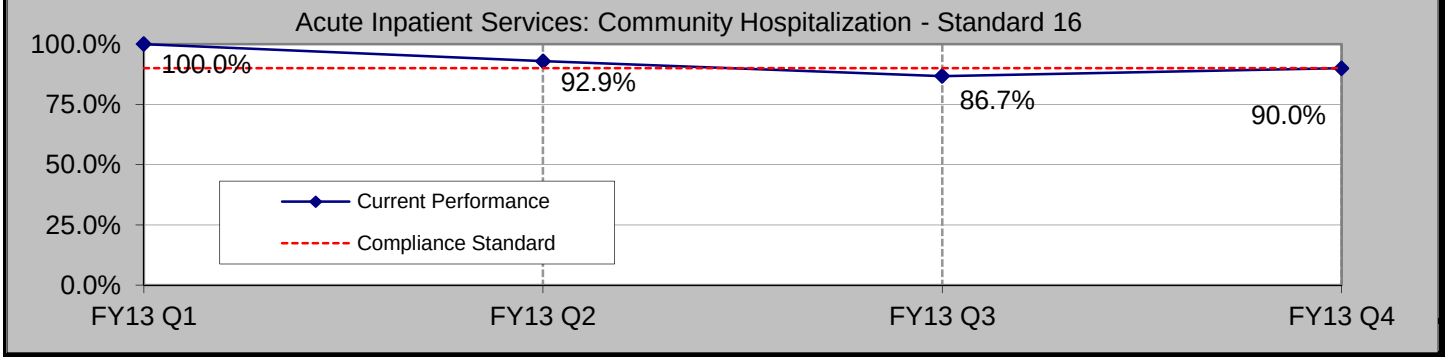


The protocol for obtaining the informed consent of Class Members to live in homes with greater than 8 beds (Settlement Agreement Paragraph 96) is followed annually to track data for this standard. SAMHS submitted an amendment request to modify this requirement on November 23, 2011. While the request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

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

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

Standard 16	
Measurement	Class Member admissions determined to be reasonably near an individual's local community of residence.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	UR Database/EIS
Current Level	90.0% (18 out of 20)

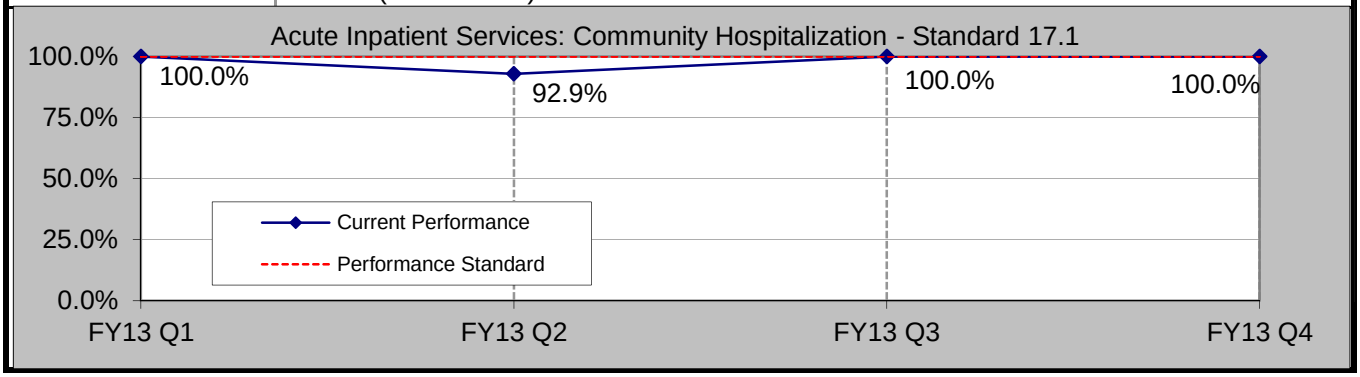


Reasonably Near is defined by Attachment C to the October 29, 2007 approved Compliance Standards.

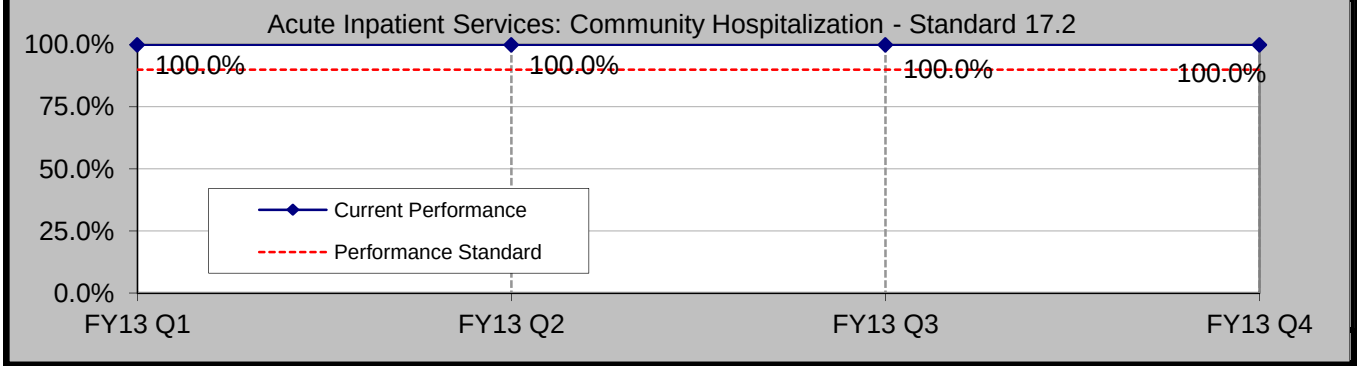
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

Standard 17.1	
Measurement	Class member involuntary admissions to community inpatient units have blue paper on file.
Standard	Performance: 100%
Data Source	UR Database/EIS
Current Level	100.0% (20 out of 20)

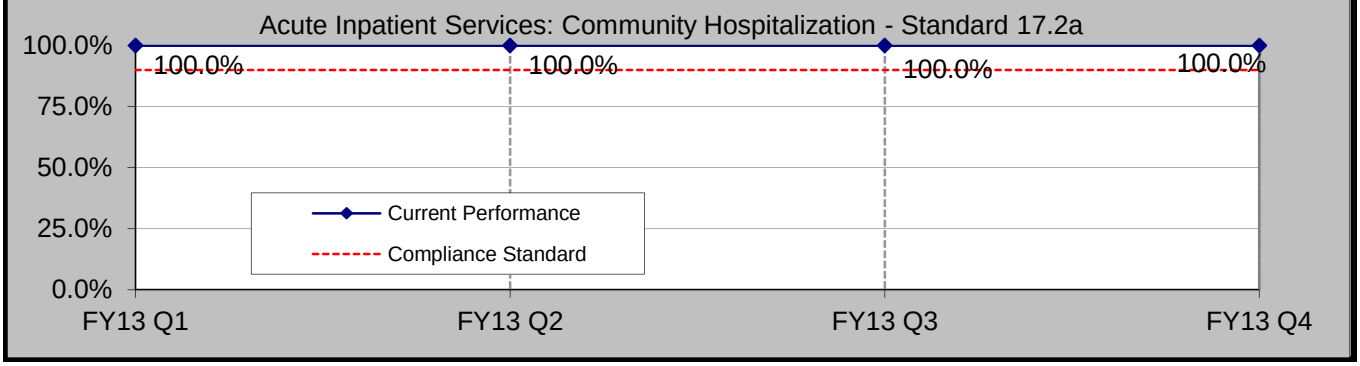


Standard 17.2	
Measurement	Blue paper was completed and in accordance with terms.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (20 out of 20)

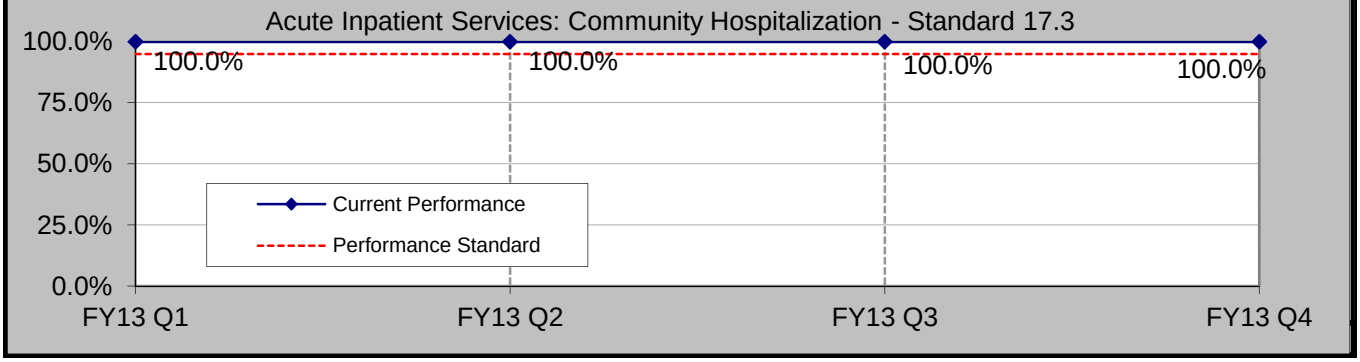


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

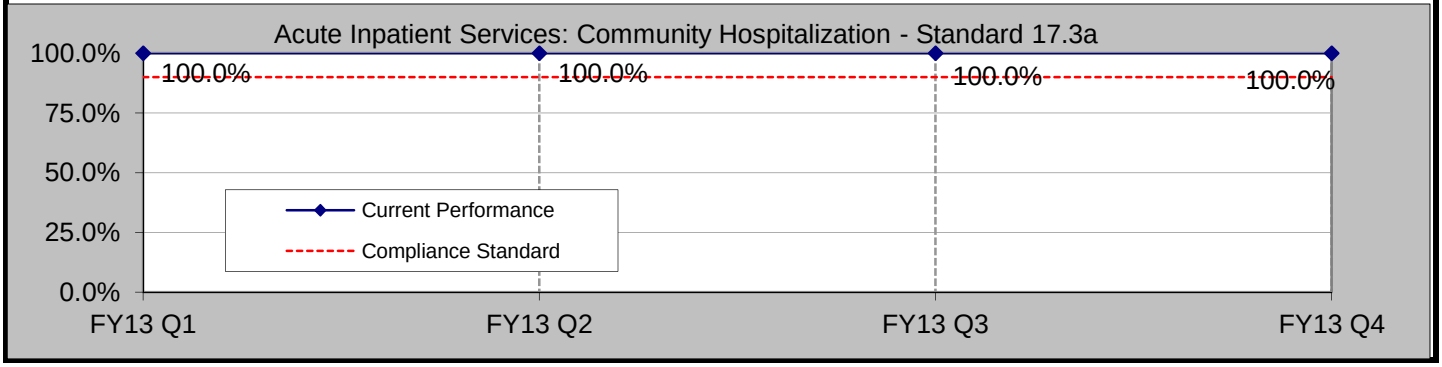


Standard 17.3	
Measurement	Class member involuntary admissions to community inpatient units in which 24 hour certification was completed.
Standard	Performance: 95%
Data Source	UR Database/EIS
Current Level	100.0% (19 out of 19)

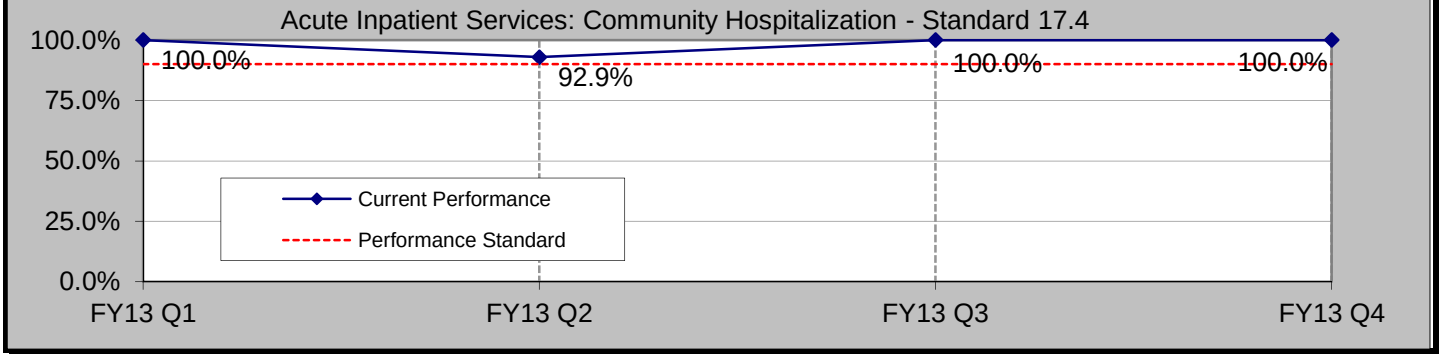


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

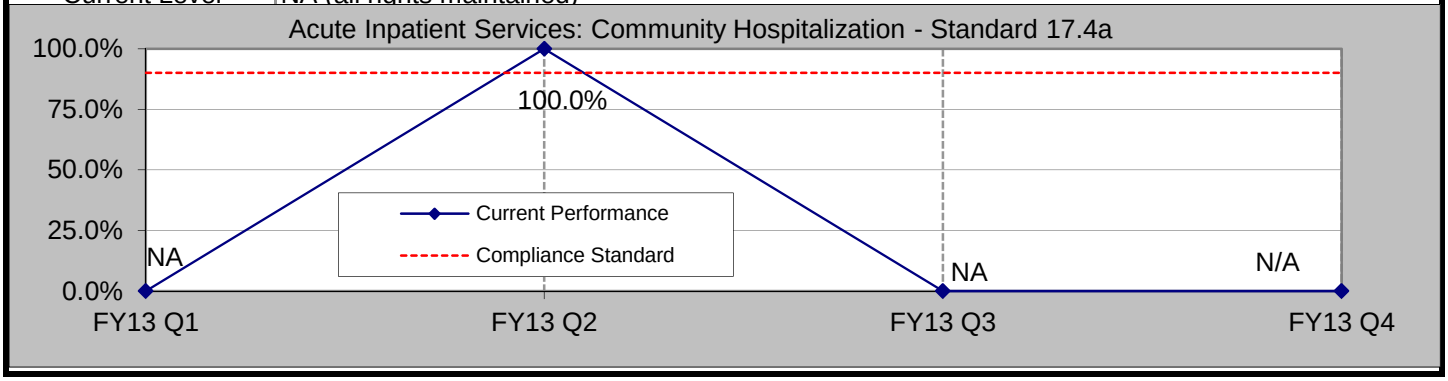


Standard 17.4	
Measurement	Class member involuntary admissions to community inpatient units in which patients' rights were maintained.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (20 out of 20)

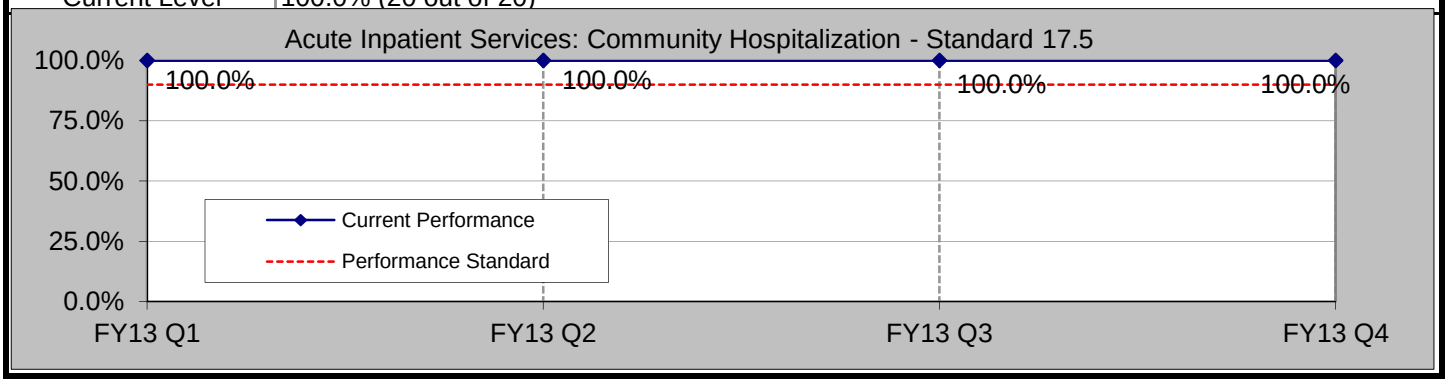


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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



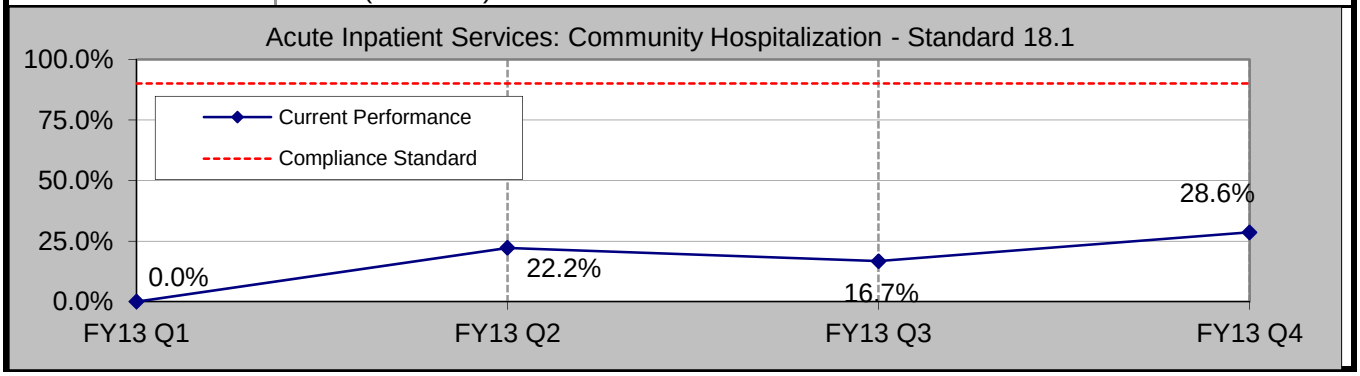
Standard 17.5	
Measurement	Class member involuntary admissions for which medical necessity has been established.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (20 out of 20)



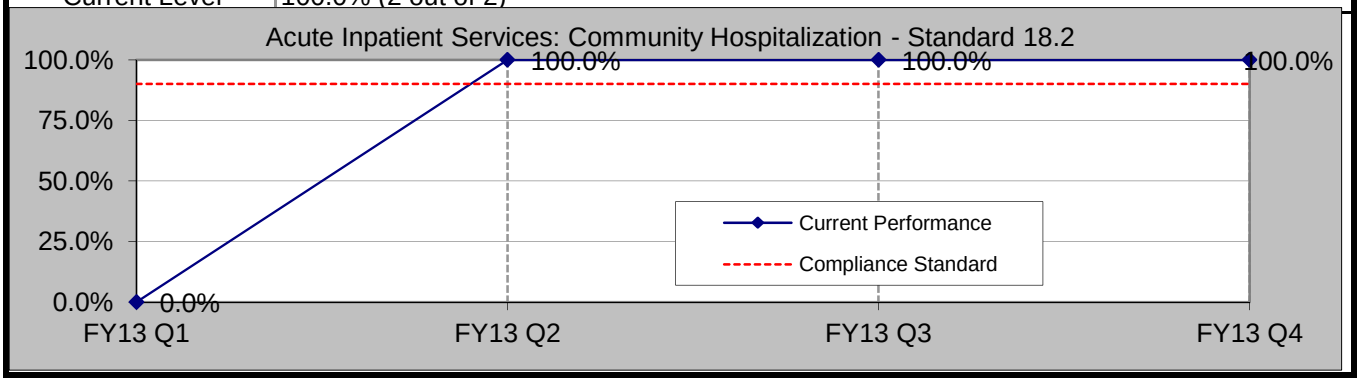
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

Standard 18.1	
Measurement	Class members admitted with ISPs for whom hospital obtained ISP.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	28.6% (2 out of 7)

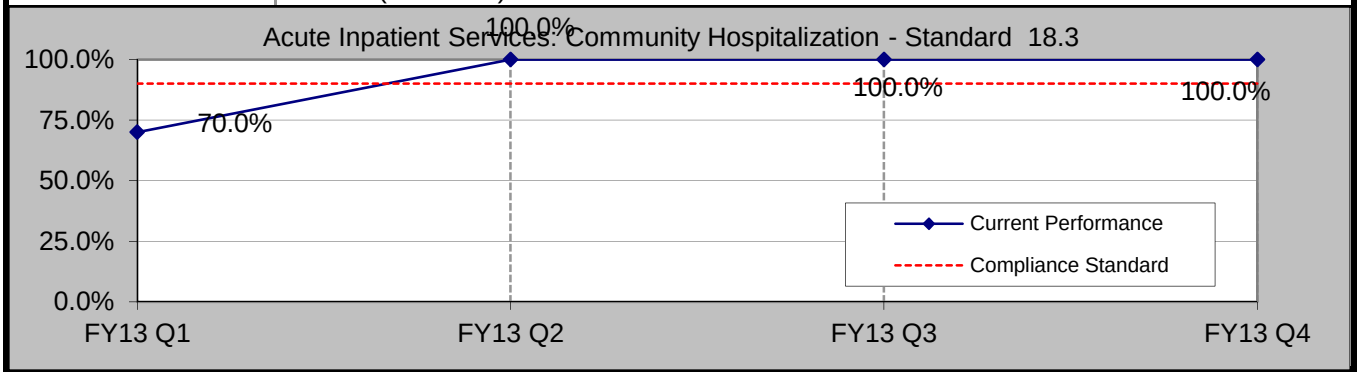


Standard 18.2	
Measurement	Treatment and discharge plan were determined to be consistent with ISP goals and objectives.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (2 out of 2)



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

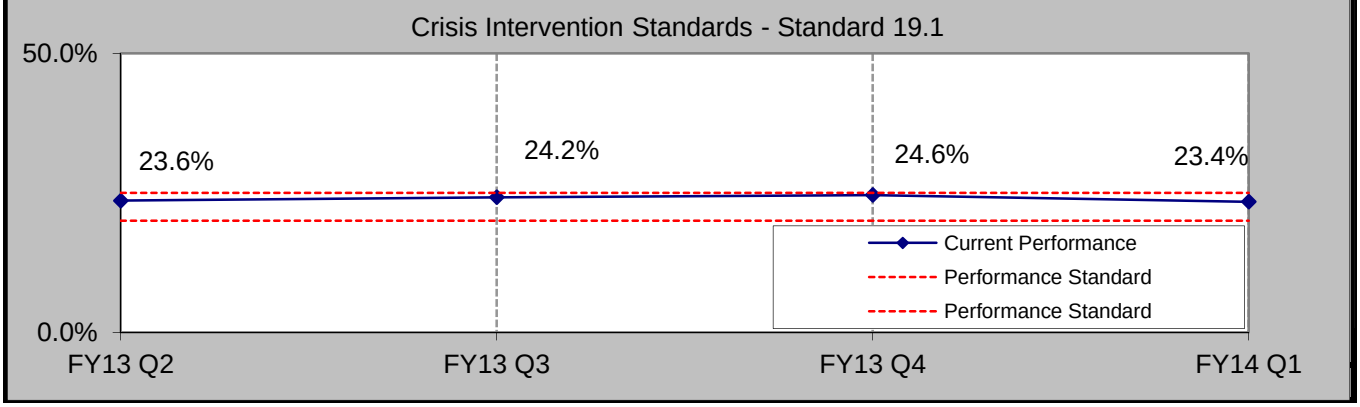
Standard 18.3	
Measurement	CI/ICI/ICM/ACT worker participated in hospital treatment and discharge planning.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (7 out of 7)



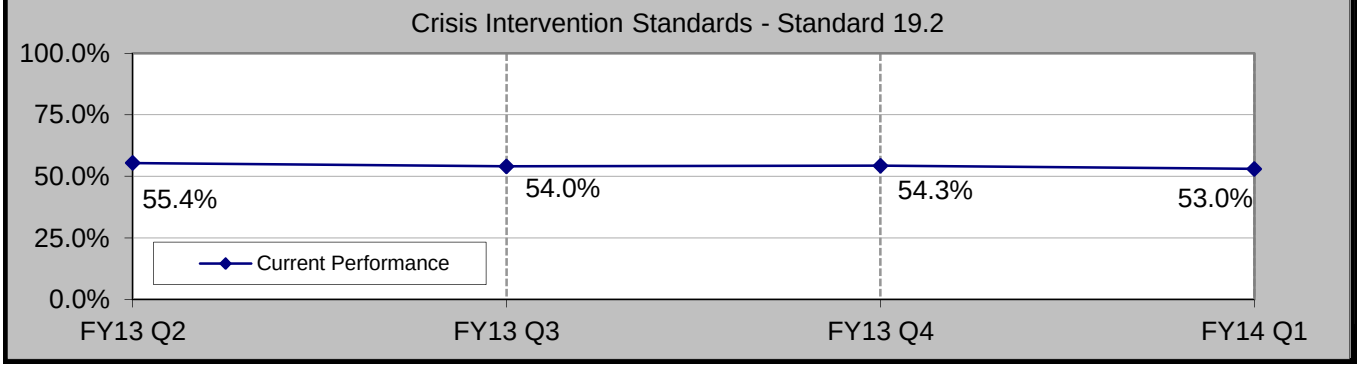
Community Resources and Treatment Services
Crisis Intervention Services

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

Standard 19.1	
Measurement	Face to face crisis contacts that result in hospitalizations.
Standard	Performance: No more than 20 - 25% are hospitalized as result of crisis intervention.
Data Source	Quarterly Crisis Contract Performance Data
Current Level	23.4% (938 out of 4206)

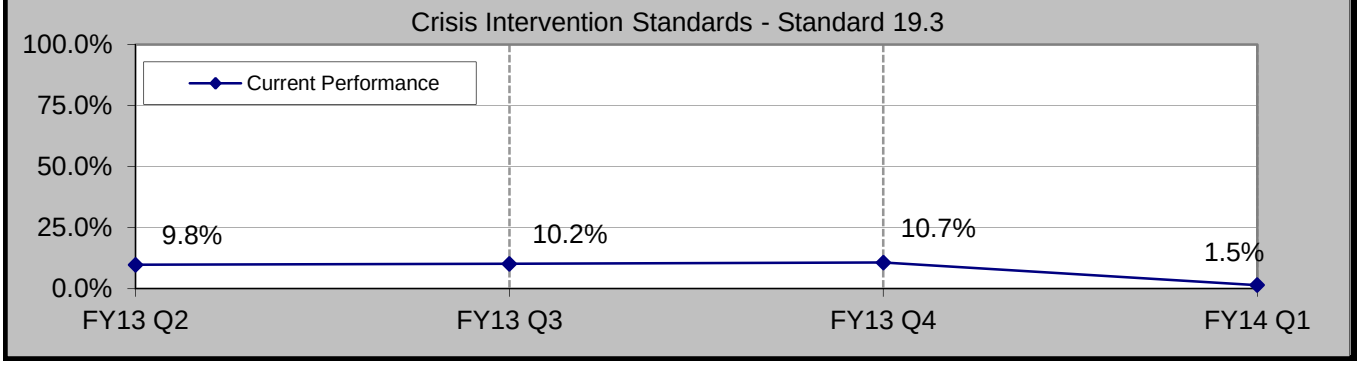


Standard 19.2	
Measurement	Face to face crisis contacts that result in follow-up and/or referral to community based services.
Standard	To Be Established
Data Source	Quarterly Crisis Contract Performance Data
Current Level	53.0.0% (2229 out of 4206)

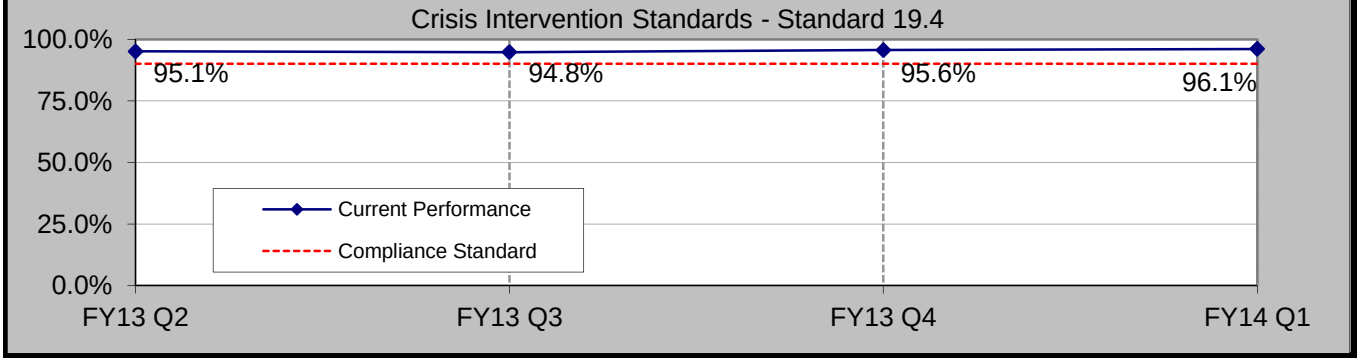


Community Resources and Treatment Services
Crisis Intervention Services

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	1.5% (63 out of 4209)



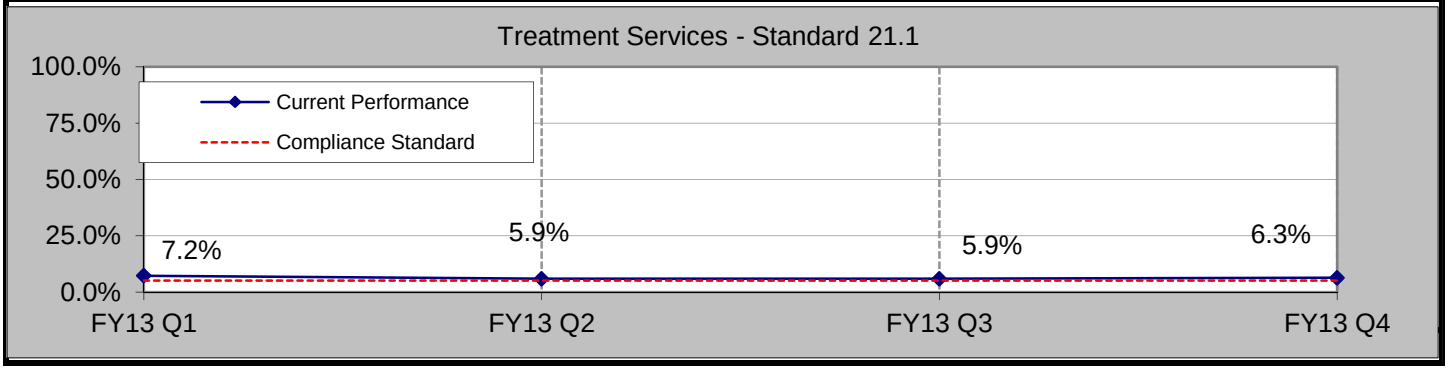
Standard 19.4	
Measurement	Face to face crisis contacts in which client has a CI worker and worker was notified about the crisis.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	Quarterly Crisis Contract Performance Data
Current Level	96.1% (1031 out of 1073)



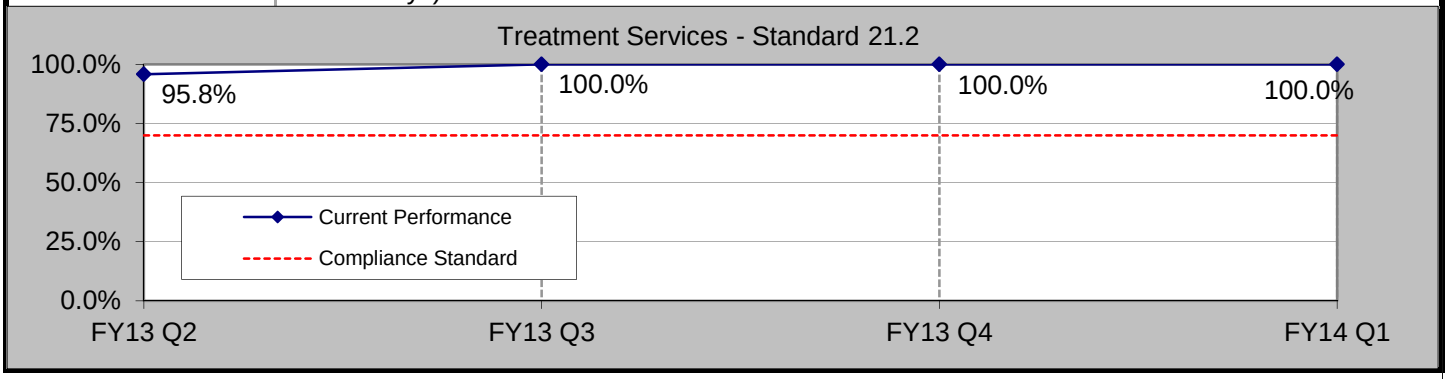
Community Resources and Treatment Services
Treatment Services

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

Standard 21.1	
Measurement	Class members with ISPs with unmet mental health treatment needs
Standard	Compliance: 5% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	6.3% (75 out of 1187)

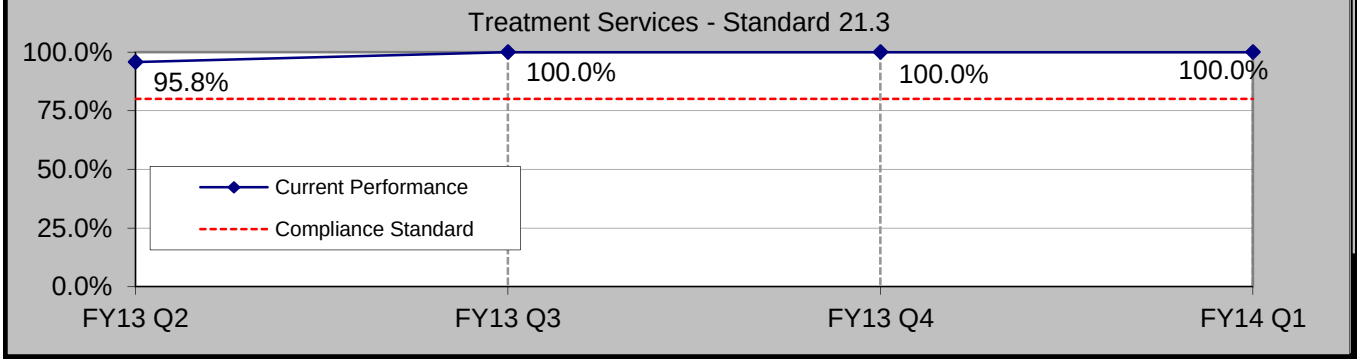


Standard 21.2	
measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 Q1 (Lack of mental health treatment did not impede discharge for any patients within 7 days)

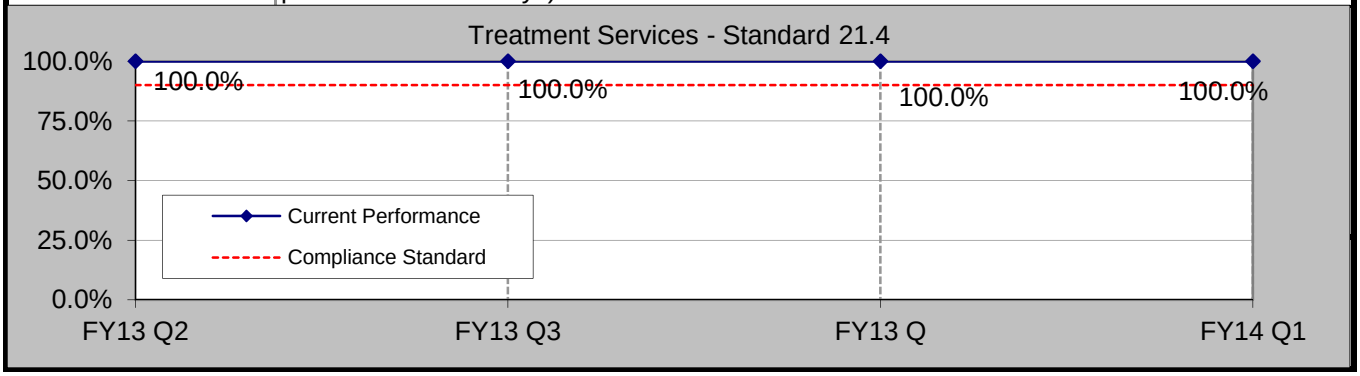


Community Resources and Treatment Services
Treatment Services

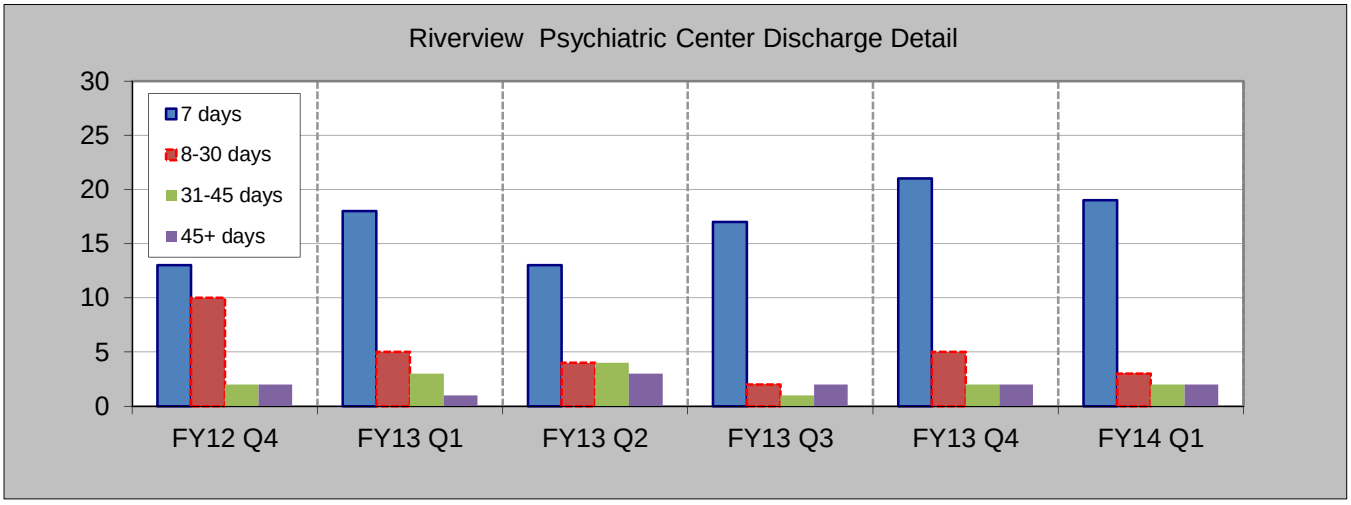
Standard 21.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination
Standard	Performance: 96% (within 30 days of that determination) Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 Q1 (Lack of mental health treatment did not impede discharge for any patients within 30 days)



Standard 21.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination
Standard	Performance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY14 Q1 (Lack of mental health treatment did not impede discharge for any patients within 45 days)



Community Resources and Treatment Services
Treatment Services



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

<u>26 Civil Patients discharged in quarter</u>

19 discharged at 7 days (73.1%)
3 discharged 8-30 days (11.5%)
2 discharged 31-45 days (7.7%)
2 discharged post 45 days (7.7%)

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

Community Resources and Treatment Services
Treatment Services

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

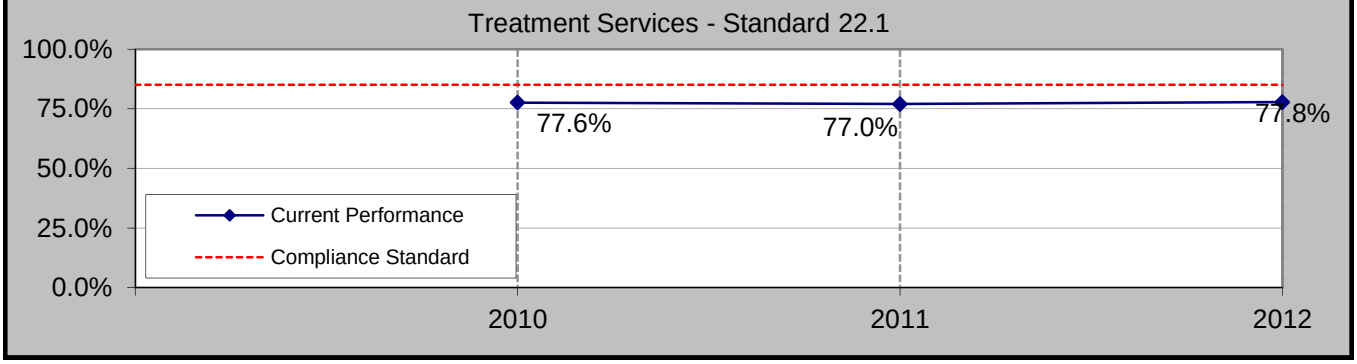
MaineCare Data FY 2012			
Mental Health Treatment Services Received	**Total Number**	**Total Number of Class Members**	**Percent of Class Members**
Assertive Community Treatment	891	306	34.3%
Community Integration	13,647	1,219	8.9%
Communty Rehabilitation	164	64	39.0%
Crisis Services	5,612	567	10.1%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

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

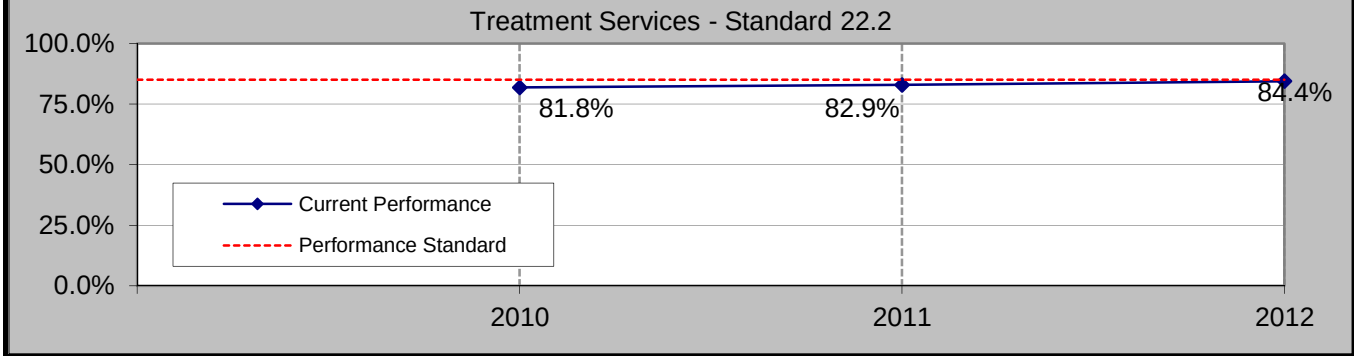
Community Resources and Treatment Services
Treatment Services

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

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



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



Community Resources and Treatment Services
Family Support Services

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

Standard 23.1	
Measurement	Number of education programs developed and delivered meeting Settlement Agreement requirements
Standard	No standard necessary
Data Source	NAMI
Current Level	5 family to family classes: Q4 FY 13

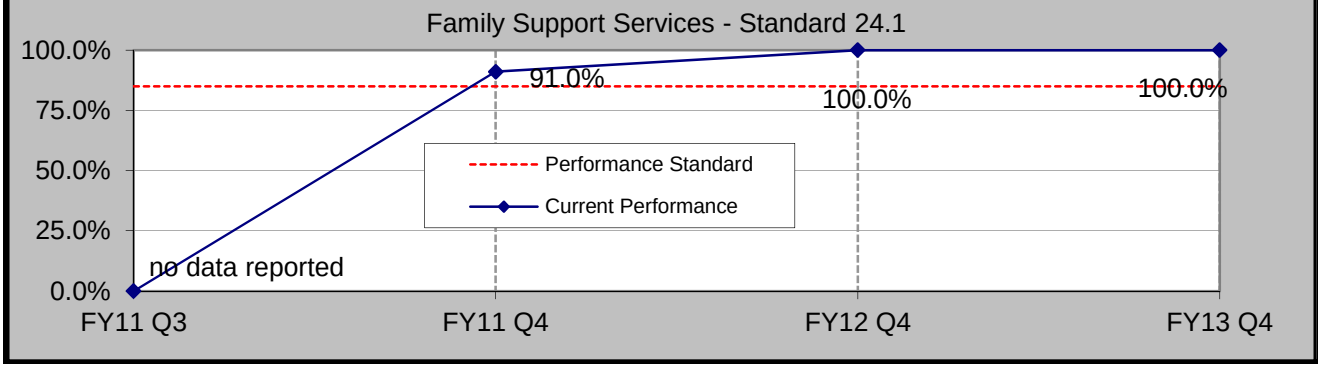
Standard 23.2	
Measurement	Number and distribution of family support services provided
Standard	No standard necessary
Data Source	NAMI
Current Level	34 family support groups, 16 sites: Q4 FY 13

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

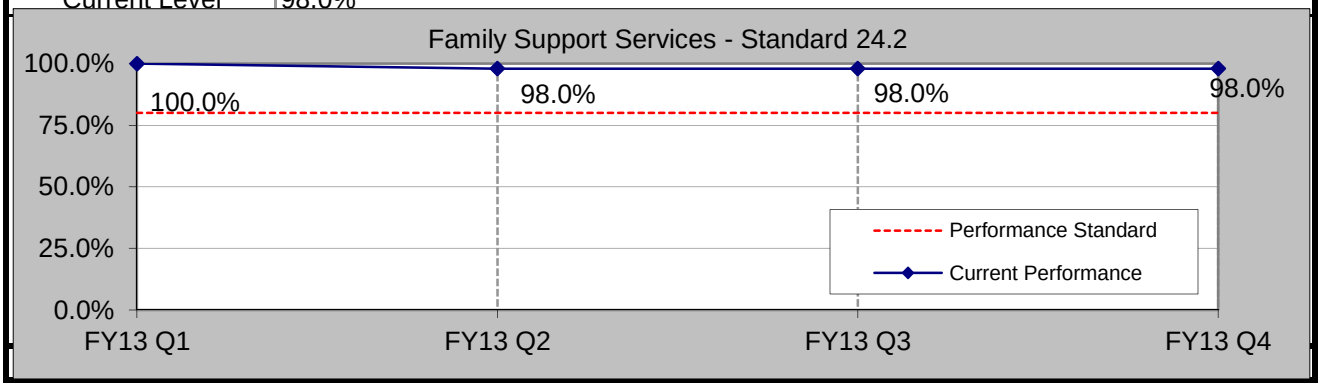
Community Resources and Treatment Services
Family Support Services

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

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



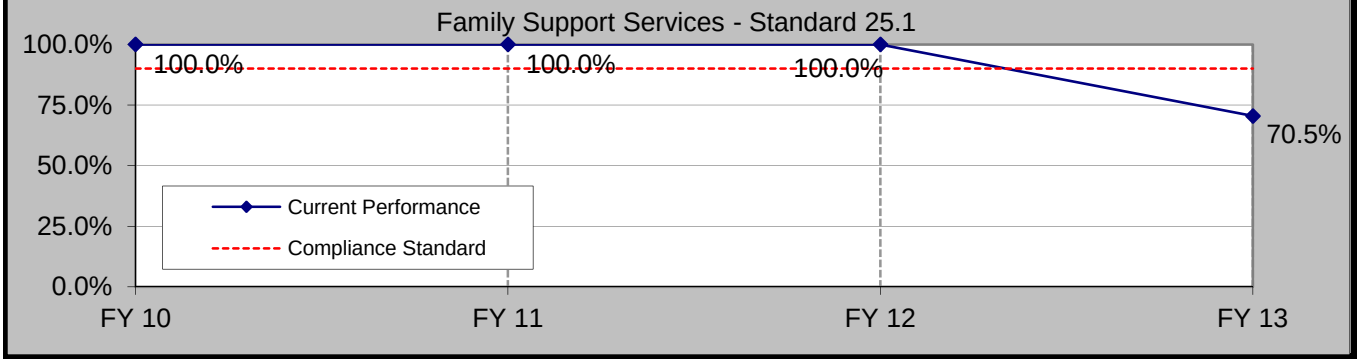
Standard 24.2	
Measurement	Percentage of program participants reporting satisfaction with education programs.
Standard	Performance: 80%
Data Source	NAMI
Current Level	98.0%



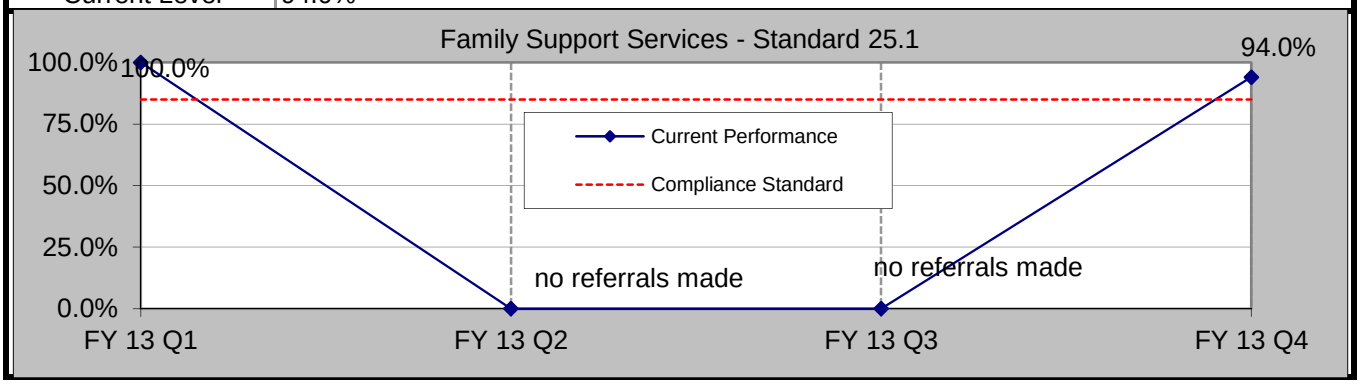
Community Resources and Treatment Services
Family Support Services

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

Standard 25.1	
Measurement	Agency contracts reviewed with documented evidence of referral mechanism to family support services.
Standard	Compliance: 90%
Data Source	Contract Reviews
Current Level	70.5 % (103 of 146)



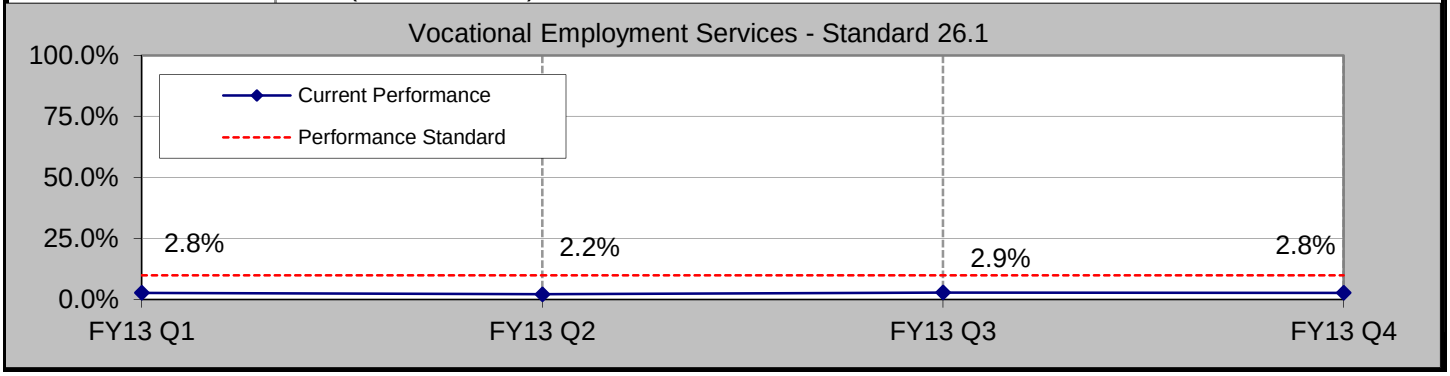
Standard 25.2	
Measurement	Families receiving referrals for family support services reporting satisfaction with referral process.
Standard	Performance: 85%
Data Source	NAMI
Current Level	94.0%



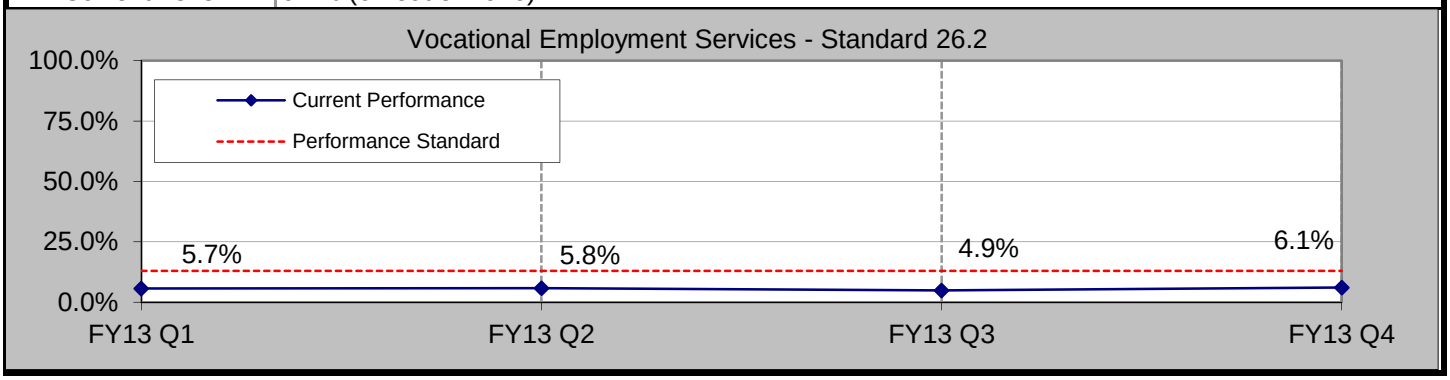
Community Resources and Treatment Services
Vocational Employment Services

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

Standard 26.1	
Measurement	Class members with ISP identified unmet vocational/employment support needs.
Standard	Performance: 10% or fewer
Data Source	ISP RDS Data
Current Level	2.8% (33 out of 1187)

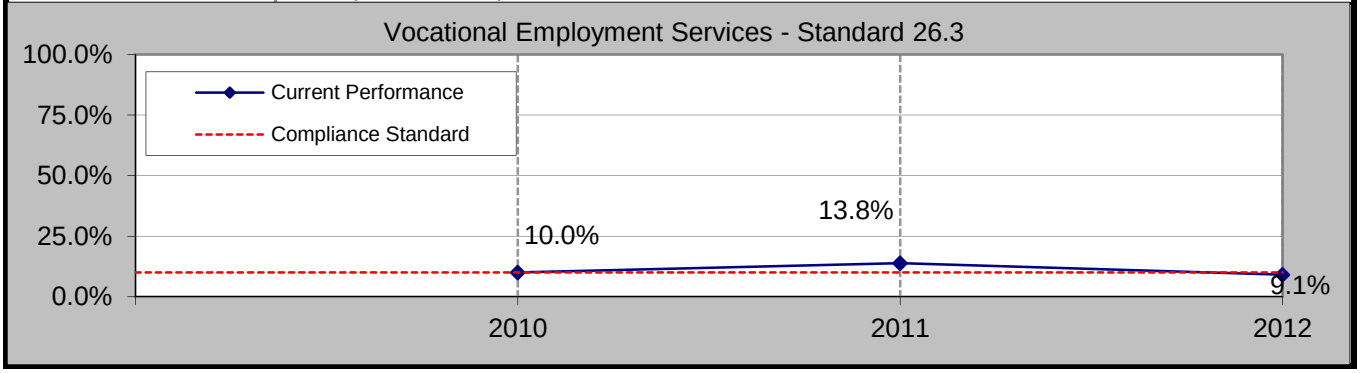


Standard 26.2	
Measurement	Class members younger than age 62 in competitive employment in the community.
Standard	Performance: 15% of class members employed in competitive employment. Compliance: 13% or Baseline (10.8%).
Data Source	ISP RDS Data
Current Level	6.1% (62 out of 1016)



Community Resources and Treatment Services
Vocational Employment Services

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



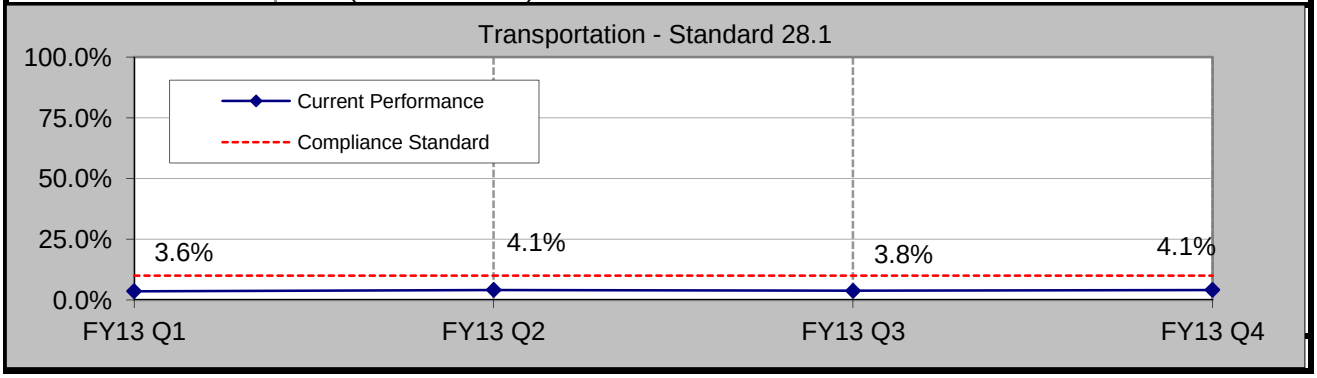
Discussion:

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

Community Resources and Treatment Services
Transportation

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

Standard 28.1	
Measurement	Percentage of class members with ISP identified unmet transportation needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	4.1% (49 out of 1187)



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

Standard 30.1	
Measurement	Number of social clubs/peer centers and participants by region.
Standard	Qualitative evaluation; no numerical standard required.
Data Source	Treatment and Recovery
Current Level	17818 total visits, 2981 unduplicated clients (13 of 14 social clubs/peer centers reporting for FY 13 Q4.)

Standard 30.2	
Measurement	Number of other peer support programs and participation.
Standard	Qualitative evaluation; no numerical standard required.
Data Source	Treatment and Recovery
Current Level	28 Peer Support programs statewide during FY 2013 Q4. (includes social clubs/peer centers): Participation data is not collected for the Statewide Initiatives noted below.

Peer Support Groups funded by DHHS 2013 Q3:

Peer Centers and Social Clubs:

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

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

Statewide:

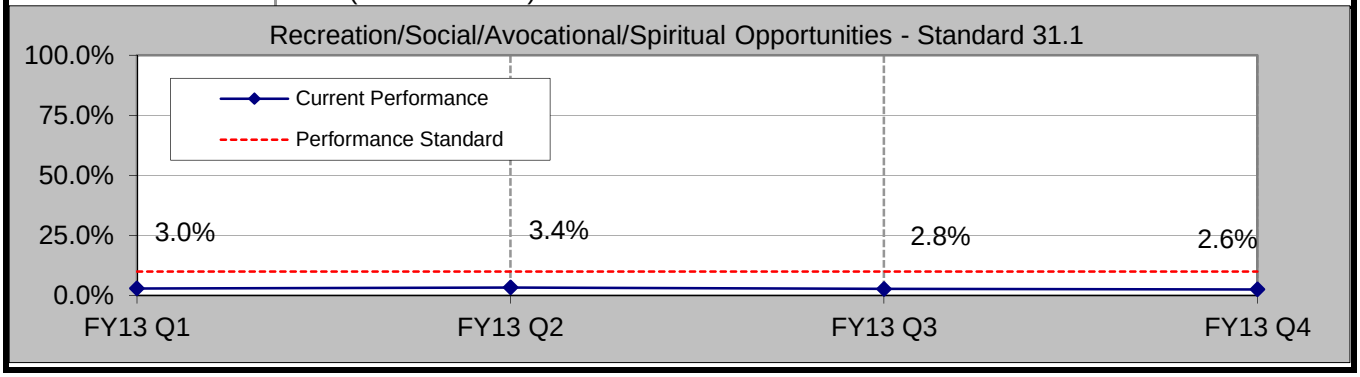
Community Connections: Community based recreational opportunities and leisure planning
MAPSRC (Maine Association of Psychosocial Rehabilitation Centers)

NAMI Support Groups primarily attended by consumers:

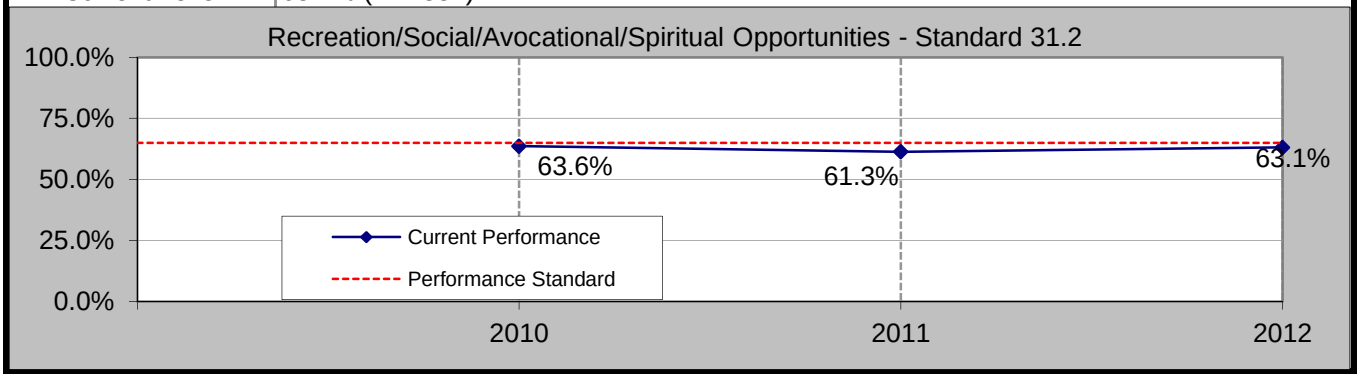
Augusta, Bangor, Biddeford, Brunswick, Damariscotta, Lewiston, Farmington, Rockland, Sanford, Waterville.

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

Standard 31.1	
Measurement	ISP identified class member unmet needs in recreational, social, avocational and spiritual areas.
Standard	Performance: 10% or fewer
Data Source	ISP RDS Data
Current Level	2.6% (31 out of 1187)



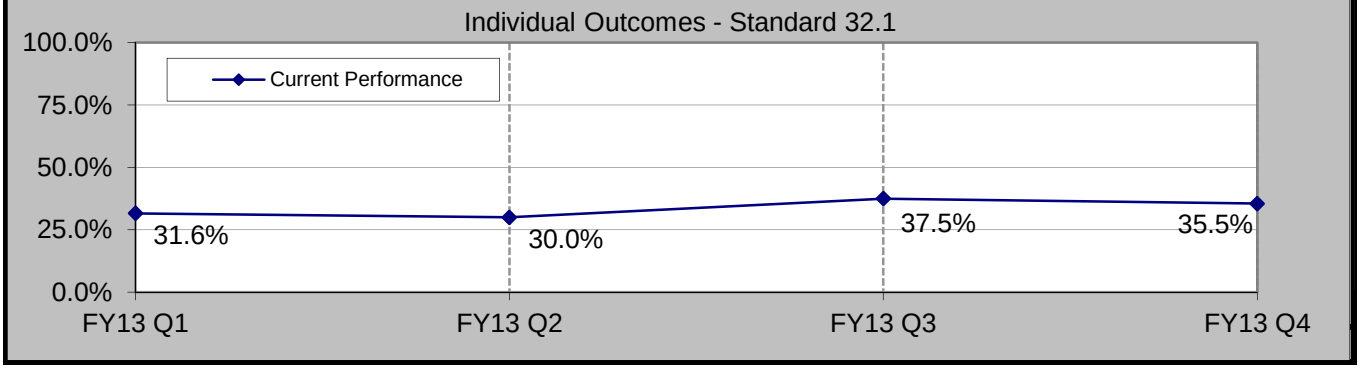
Standard 31.2	
Measurement	Domain average of positive responses in the Social Connectedness domain
Standard	Performance: At or above 65%
Data Source	Adult Mental Health and Well Being Survey
Current Level	63.1% (N=1332)



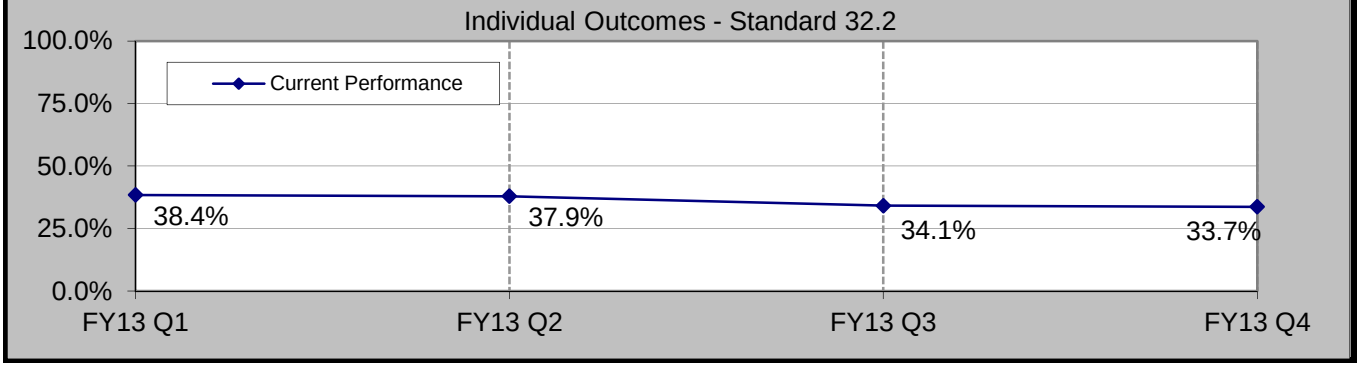
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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

Standard 32.1	
Measurement	Class Members demonstrating functional improvement on LOCUS between baseline and 12 month re-certification
Standard	Standard to be established.
Data Source	Enrollment data (Based on overall composite score.)
Current Level	35.5% (145 out of 409)

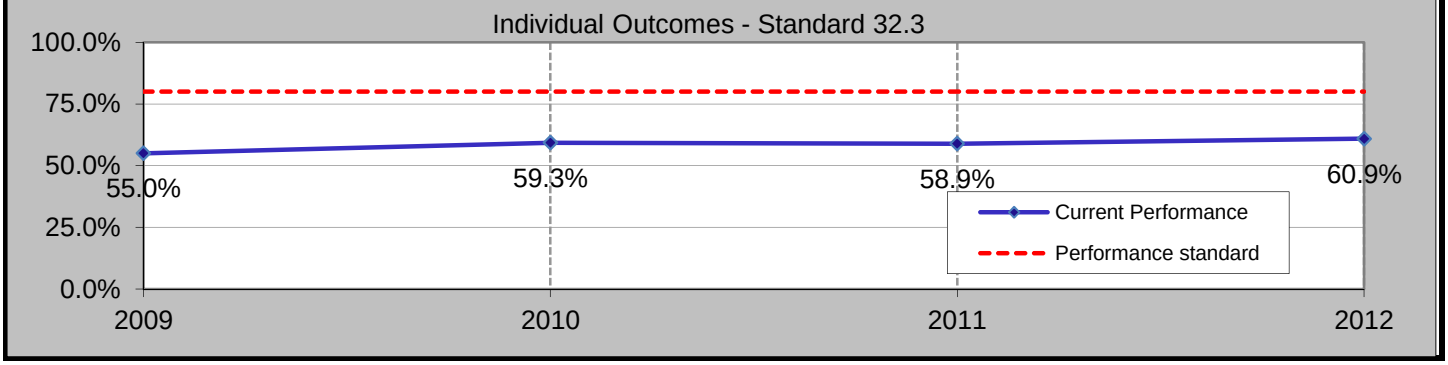


Standard 32.2	
Measurement	Class Members who have maintained level of functioning between baseline and 12 month re-certification.
Standard	Standard to be established.
Data Source	Enrollment data (Based on overall composite score.)
Current Level	33.7% (138 out of 409)



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

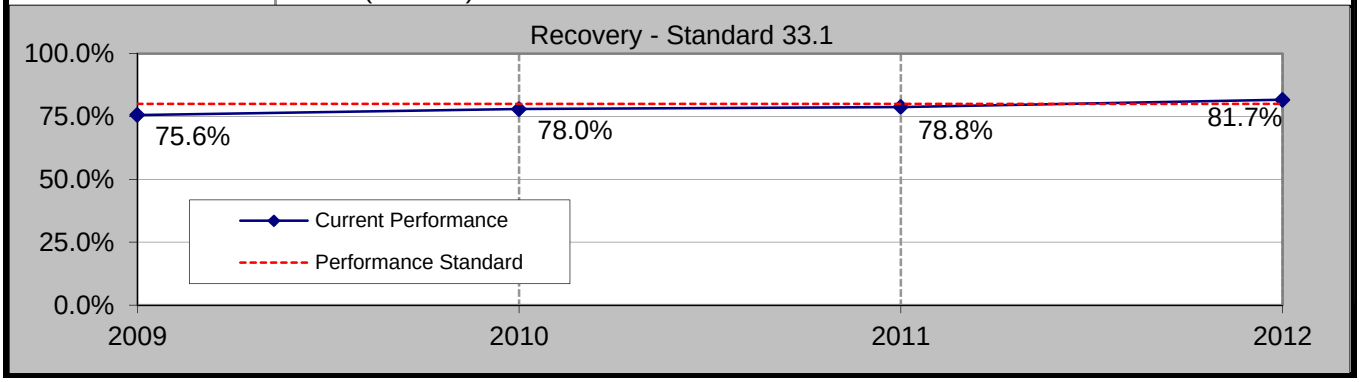
Standard 32.3	
Measurement	Consumers reporting positively on functional outcomes on Adult Mental Health and Well Being Survey outcome items.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	60.9% (N=1349)



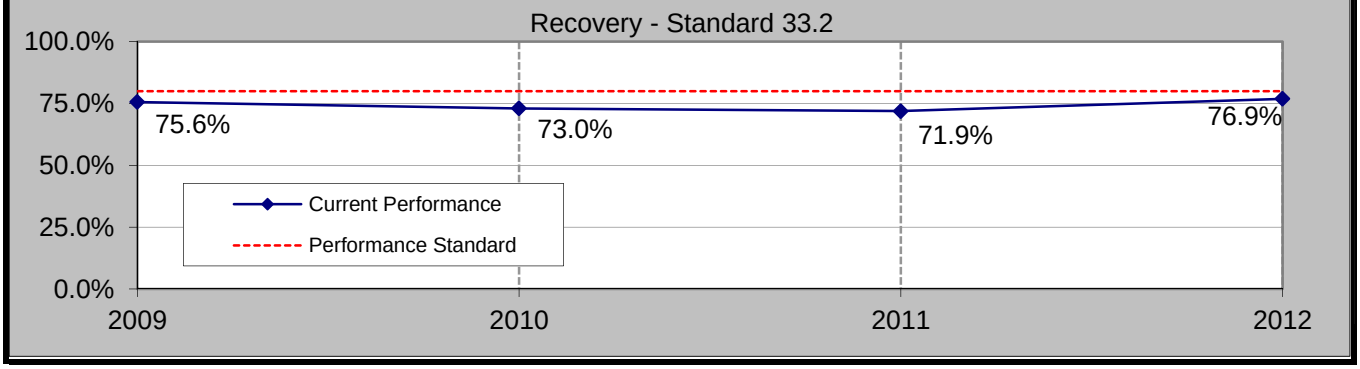
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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

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



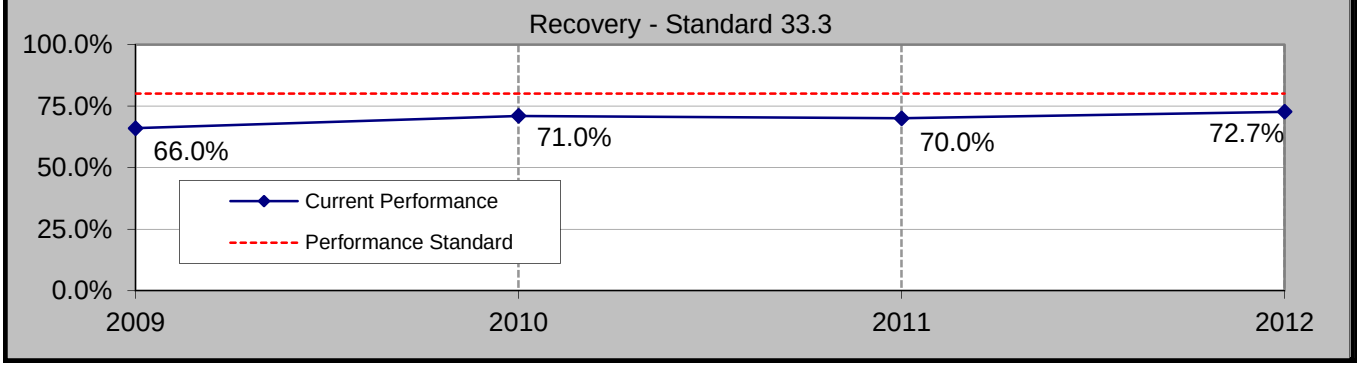
Standard 33.2	
Measurement	Consumers reporting that agency staff believe that they can grow, change and recover
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	76.9% (N=1271)



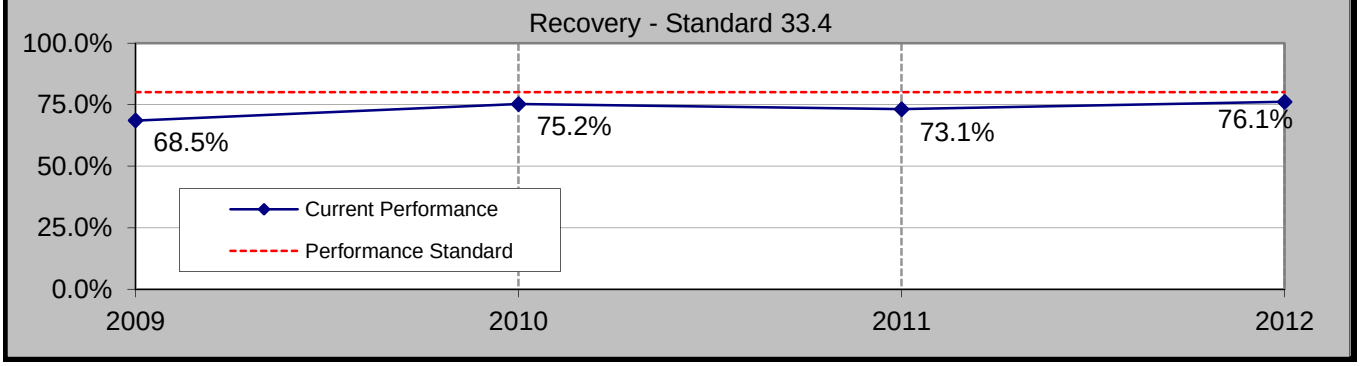
System Outcomes: Supporting the Recovery of Adults with Mental Illness

Recovery

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

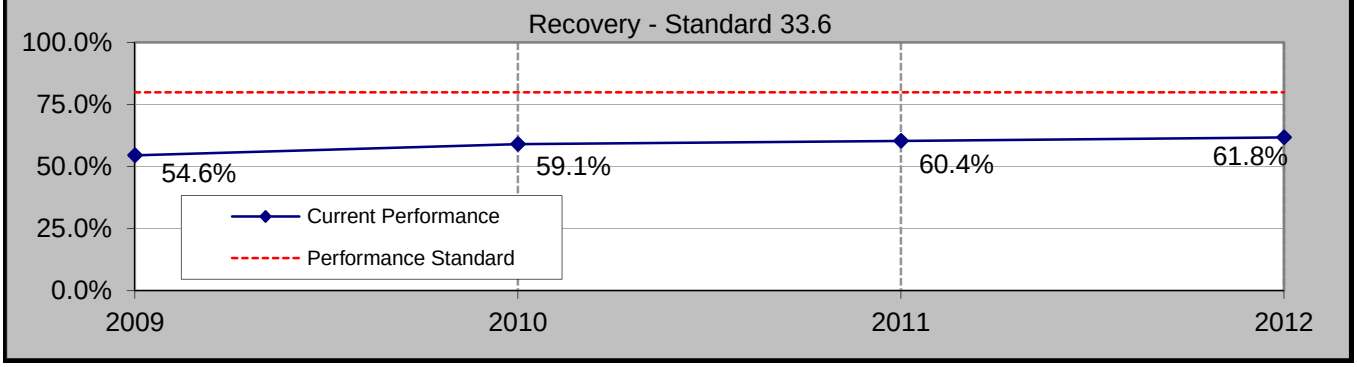


Standard 33.4	
Measurement	Consumers reporting that providers offered opportunities to learn skills to strengthen and maintain wellness.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey Q16
Current Level	76.1% (N=1292)



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

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



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

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

Standard 34.1	
Measurement	# of mental health workshops, forums, and presentations geared toward general public and level of participation.
Standard	Qualitative evaluation required, no numerical standard necessary.
Data Source	NAMI
Current Level	40 FY 13 Q4

Standard 34.2	
Measurement	Number and type of info packets, publications, press releases, etc. distributed to public audiences.
Standard	Qualitative evaluation required, no numerical standard necessary.
Data Source	NAMI
Current Level	2755 FY 13 Q4

Public Education- Standard 34
July - Sept 2013 (See Note Below)

Note: Contracted agencies are allowed one month after the quarter to submit performance indicator data.
As a result, NAMI Maine is submitting performance indicator data for April-June 2013

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

Measure Method One:

Date & Location of Public Education Program	Audience: Public Service Agency	Audience: RPC and/or DDPC staff	Audience: Community Members	Audience: Other (Please Specify)	Total # of Participants	Topic: Addressing Myths & Stigma	Topic: Promoting Community Integration	Topic: Rights of MH Consumers and/or their Families	Topic: Other (Please Specify)	Total # Presentations/ # Participants This Quarter
										40/1006
7/1/13 Augusta			x	Consumers	2	x	x	x	Peer Support 101	
7/15/2013 Augusta			x	Consumers	11	x	x		Building Connection	
7/12,7/19,7/26, 8/9,8/16,8/23 Webinars	x			Consumers	9	x	x	x	Pathways to Recovery	
7/23, 25, 30, 8/1, 8, 13,15,22,29 Augusta	x		x	Consumers	21	x	x	x	CIPSS Training	
8/9 Augusta	x		x	Consumers	3	x	x	x	Peer Support 101	
8/12/13 Springvale	x			Consumers	8	x	x	x	Peer Support 101	
8/16/13 Portland				Consumers	4	x	x	x	Peer Support 101	
8/19/13 Augusta				Consumers	6		x		Self care	
9/9/13 Augusta				Consumers	11	x			Grief	
9/17/13 Portland				Consumers	6	x	x	x	Healthy Conections	

9/24/13 Augusta	x			Consumers	14	x	x	x	Peer Support within Traditional Services	
09/13/13-Acadia Bangor	x	x	x		36	x	x	x	Music as Therapy: Across the Life Span	
09/27/13-Acadia Bangor	x	x	x		44	x	x	x	Cultural Sensitivity & Awareness	
9/10/13 - RPC	14		1		15				Does Mandatory Outpatient Committal Stabilize Patients	
10/24/13 - RPC	13		1		14				Trauma and Stressor Related Disorders	
3 CIT Cumberland, Piscataquis & York Counties	x			Law Enforcement/ corrections, first responders	87	X	X	X	40 hour CIT	
3 Gatekeeper Trainings (Augusta, Bangor, Lewiston)	x		x	school, community, primary care	85	x	x		6.5 hr suicide prevention trg	
1 Suicide Assessment for Clinicians	x				22	x	x	x	6 hour Suicide Assessment for Clinicians	
Respite provider Orientations			x		30	x	x	x	4 hr for Family Respite Providers	
CIT	x		x	YMCA staff	63		x		2 de-escalation trainings	
6 Suicide Awareness Sessions	x		x		375	x			Statewide (Schools, College, and Private Companies)	
Criminal Justice Academy Training	x			Law enforcement trainees	45	x	x		Officers in training	
Family to Family training			x	Family Members	76	x	x	x	Five 12 wk trgs	
Three NAMI Peer Leadership Trgs			x	Consumers	14	x	x	x		

Family to Family Teacher training			x	Family members	5	x	x	x	12 day trg volunteers to offer family to family classes	

Performance Indicators and Quality Improvement Standards

APPENDIX: ADULT MENTAL HEALTH DATA SOURCES

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

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

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

Community Hospital Utilization Review Summary:

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

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

Community Support Enrollment Data:

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

Community Support Services Census/Staffing Data:

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

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

Grievance Tracking Data:

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

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

Class Member Treatment Planning Review:

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

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

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

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

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

Quarterly Contract Performance Indicator Data:

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

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

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 Standard 5

Report for: 2013 Q4
(April, May, June 2013)
(Class Members)

Measurement			
Method 1	Percent of class members requesting a worker who were assigned one.		
	2013 Q1	99.1%	(115 of 116)
	2013 Q2	98.2%	(108 of 110)
	2013 Q3	99.2%	(131 of 132)
	2013 Q4	99.1%	(111 of 112)
Method 2	Percent of hospitalized class members who were assigned a worker within 2 days.		
	2013 Q1	66.7%	(4 of 6)
	2013 Q2	14.3%	(1 of 7)
	2013 Q3	60.0%	(6 of 10)
	2013 Q4	85.7%	(6 of 7)
Method 3	Percent of non-hospitalized class members assigned a worker within 3 days.		
	2013 Q1	69.8%	(67 of 96)
	2013 Q2	68.8%	(64 of 93)
	2013 Q3	71.1%	(86 of 121)
	2013 Q4	64.4%	(67 of 104)
Method 4	Percent of class members in hospital or community not assigned on time but were assigned within 1-7 additional days.		
	2013 Q1	29.0%	(9 of 31)
	2013 Q2	42.9%	(15 of 35)
	2013 Q3	38.5%	(15 of 39)
	2013 Q4	42.1%	(16 of 38)
Method 5	ISP completed within 30 days of service request.		
	2013 Q1	86.3%	(44 of 51)
	2013 Q2	85.2%	(46 of 54)
	2013 Q3	92.2%	(47 of 51)
	2013 Q4	85.2%	(46 of 54)
Method 6	90 Day ISP review completed within specified timeframe.		
	2013 Q1	69.0%	(773 of 1,121)
	2013 Q2	72.3%	(787 of 1,089)
	2013 Q3	70.5%	(697 of 989)
	2013 Q4	76.3%	(810 of 1,062)
Method 7	Initial ISPs not developed within 30 days, but were developed within 60 days.		
	2013 Q1	71.4%	(5 of 7)
	2013 Q2	37.5%	(3 of 8)
	2013 Q3	75.0%	(3 of 4)
	2013 Q4	75.0%	(6 of 8)
Method 8	ISPs that were not reviewed within 90 days, but were reviewed within 120 days.		
	2013 Q1	85.3%	(297 of 348)
	2013 Q2	91.1%	(275 of 302)
	2013 Q3	80.1%	(234 of 292)
	2013 Q4	79.0%	(199 of 252)

As of: Oct 9, 2013 Run By: Brandi.Giguere
Starting with Fiscal Year 2008, Quarter 1 (July, August, September 2008) all calculations are based on 'working days' to time of assignment.

Method 4 percentages were updated FY12 Q4 to reflect a calculation error in the previous quarter.

Starting with Fiscal Year 2013, Quarter 3 (January, February, March 2013) method 4 through method 8 were updated to reflect more accurate data.

Department of Health and Human Services (DHHS)
Office of Substance Abuse and Mental Health Services (SAMHS)
Report on Unmet Needs and Quality Improvement Initiatives
November 2013

Attached Report:

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Quarter 4

Population Covered:

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

Data Sources:

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

Unmet Resource Need Definition

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

Quality Improvement Measures

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

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

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

Ongoing Quality Improvement Initiatives

Crisis Reports. At the directive of the Commissioner, SAMHS revised its Crisis Reports and required individual encounter reporting as of July 1, 2013. All of the prior crisis data variables continued to be reported but now on an individual level. Providers will still report the aggregate number of telephone calls they receive. SAMHS staff worked with the Maine Crisis Network providers to create variables for the crisis screening/assessment reasons for face to face encounters. Meetings were held with providers and technical assistance has been provided by the Data and Quality Management staff.
Identified Need: A,B,D

Critical Incident Reporting. SAMHS has three systems and portals for providers to report on critical incidents involving consumers. These systems and portals are a legacy from the merger of Adult Mental Health Services and the Office of Substance Abuse. A taskforce of quality management, treatment, and intervention staff have met and are developing a new streamlined system for reporting of critical incidents. By September 1st, providers will use a single form and have a single portal for submitting information. Procedures to review and provide feedback to agencies are being developed to ensure consistent messaging.
Identified Need: A,B,D,E,F,G,

SAMHS Website - Reports. During the first week of July, SAMHS started posting APS, Crisis Management, and Waitlist reports on its website. Providers had been notified of this change at the monthly stakeholder calls. In addition, providers were notified by email when the initial reports were posted. The schedule for posting reports is being fine-tuned, but generally reports are posted each Thursday.
Identified Need: A,B,C,D,E,F,I,J,K

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

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

Commissioner's Unmet Needs Workgroup. Commissioner Mayhew has appointed a workgroup to examine the performance and compliance standards under the approved Consent Decree Plan and SAMHS's ability to meet the compliance standards. The workgroup has reviewed data from CY2006 to the present to determine patterns of compliance with the standards. The data have been analyzed and recommendations are being developed to present to Commissioner Mayhew and Director Cousins on levels of compliance and strategies to address unmet needs.
Identified Need: A,B,C,D,E,F,G,H,I,J,K,L,M

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

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

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

Contract Review Initiative. The Data/Quality Management staff are working with field service teams to ensure they have up-to-date, accurate service encounter data when they review progress toward meeting contract goals and establishing benchmarks for new contracts. A set of encounter data variables has been identified and are being tested in FY13. A review of the process will occur in early FY14 to determine which data to include for expansion of this initiative to all SAMHS contractors.
Identified Need: A, B, D, E, I, J, L

Mental Health Rehabilitation/Crisis Service Provider Review. The Mental Health Rehabilitation/ Crisis Service Provider (MHRT/CSP) certification was developed by the crisis providers (Maine Crisis Network) over the past several years in collaboration with DHHS—adult mental health and children's behavioral health and the Muskie School. The MHRT/CSP is now

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

NIATx Quality Improvement Initiative. NIATx has been deployed in six provider agencies to address wait list and time to assignment issues in provider agencies. SAMHS has contracted with a NIATx trainer who is providing on-site training and technical assistance. The model involves targeted changes using a rapid improvement methodology. A SAMHS central office NIATx team has been formed and has been trained in using the model with employees. The Data/Quality Management Office is addressing the data needs for providers and central office staff to ensure they have the necessary data/quality management tools to measure their successes. It is anticipated that in FY14, the number of agencies using NIATx will be expanded.
Identified Need: A,B

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

Wait List Graphs. On a weekly basis, the Data/Management staff update graphs of number of people on wait lists for CI, ACT and DLSS. Also, graphs for time to assignment are produced that provide further information on these three services. Two new reports were developed and distributed as of 7/1/13. The first report is by service, by provider which lists number on waitlist by agency, and the length of time on the waitlist. The second report is a YTD comparison with the prior year for Community Integration services. These reports are sent to management and field service staff to monitor trends in services over the past six months.
Identified Need: A

Substance Abuse and Mental Health Services
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Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Quarter 4

(April, May, June 2013)

Purpose of Report:

This report examines:

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

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

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

Data collection and reporting:

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

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

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

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

Report Run: Oct 10, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

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

CSN	Counties	Distinct People
CSN 1	Aroostook	380
CSN 2	Hancock, Penobscot, Piscataquis & Washington	1,864
CSN 3	Kennebec & Somerset	2,090
CSN 4	Knox, Lincoln, Sagadahoc & Waldo	844
CSN 5	Androscoggin, Franklin & Oxford	2,076
CSN 6	Cumberland	2,124
CSN 7	York	542
Not Assigned	No legal address	303
Statewide		10,223

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

	2013 Q1			2013 Q2			2013 Q3			2013 Q4		
	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	101	348	29.0%	116	386	30.1%	137	395	34.7%	128	380	33.7%
CSN 2	476	1,767	26.9%	460	1,707	26.9%	432	1,763	24.5%	435	1,864	23.3%
CSN 3	326	1,972	16.5%	357	1,985	18.0%	358	2,008	17.8%	377	2,090	18.0%
CSN 4	228	809	28.2%	238	815	29.2%	237	837	28.3%	222	844	26.3%
CSN 5	656	1,891	34.7%	626	1,939	32.3%	617	1,934	31.9%	638	2,076	30.7%
CSN 6	554	1,956	28.3%	592	1,958	30.2%	608	2,028	30.0%	648	2,124	30.5%
CSN 7	157	460	34.1%	179	549	32.6%	153	544	28.1%	176	542	32.5%
N/A	102	356	28.7%	96	325	29.5%	100	330	30.3%	88	303	29.0%
Total	2,600	9,559	27.2%	2,664	9,664	27.6%	2,642	9,839	26.9%	2,712	10,223	26.5%

Report Run: Oct 10, 2013

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

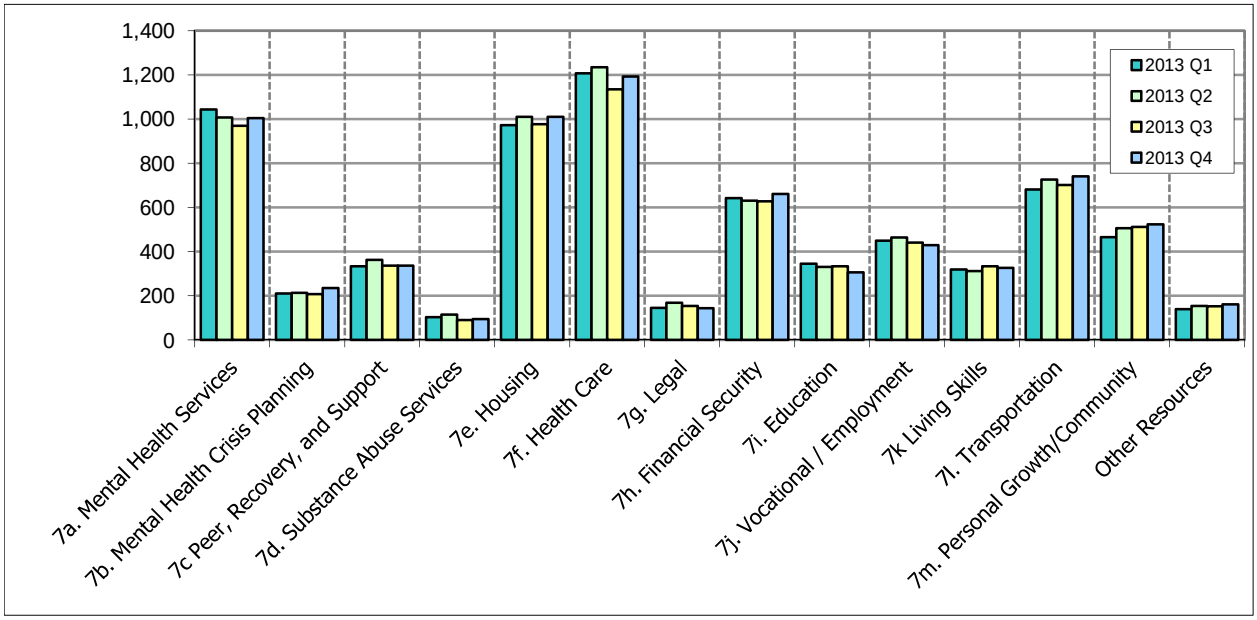

Table 3: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q1	2013 Q2	2013 Q3	2013 Q4
7a. Mental Health Services	1,044	1,007	970	1,005
7b. Mental Health Crisis Planning	210	214	207	235
7c Peer, Recovery, and Support	334	363	337	337
7d. Substance Abuse Services	103	115	91	95
7e. Housing	972	1,011	977	1,010
7f. Health Care	1,207	1,235	1,135	1,193
7g. Legal	146	168	154	144
7h. Financial Security	642	630	628	661
7i. Education	346	331	334	306
7j. Vocational / Employment	450	464	441	429
7k Living Skills	319	312	334	326
7l. Transportation	682	726	701	741
7m. Personal Growth/Community	465	506	512	524
Other Resources	140	154	153	162
Total Statewide Unmet Needs	2,600	2,664	2,642	2,712

Report Run: Oct 10, 2013

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

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

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	9,559	9,664	9,839	10,223
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	36	36	49	59
7a-iii Dialectical Behavioral Therapy	34	32	31	39
7a-iv Family Psycho-Educational Treatment	8	8	11	16
7a-v Group Counseling	36	32	41	34
7a-vi Individual Counseling	454	429	396	408
7a-vii Inpatient Psychiatric Facility	5	2	5	6
7a-viii Intensive Case Management	21	22	26	24
7a-x Psychiatric Medication Management	486	482	460	478
Total Unmet Resource Needs	1,044	1,007	970	1,005
Distinct Clients with Unmet Resource Needs	832	801	788	846
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	159	160	149	179
7b-ii Mental Health Advance Directives	51	54	58	56
Total Unmet Resource Needs	210	214	207	235
Distinct Clients with Unmet Resource Needs	192	192	186	220
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	51	45	42	40
7c-ii Recovery Workbook Group	1	3	4	4
7c-iii Social Club	116	127	112	109
7c-iv Peer-Run Trauma Recovery Group	36	39	36	34
7c-v Wellness Recovery and Action Planning	18	22	25	24
7c-vi Family Support	112	127	118	126
Total Unmet Resource Needs	334	363	337	337
Distinct Clients with Unmet Resource Needs	279	301	271	277
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	86	97	71	77
7d-ii Residential Treatment Substance Abuse Services	17	18	20	18
Total Unmet Resource Needs	103	115	91	95
Distinct Clients with Unmet Resource Needs	97	111	86	93

Report Run: Oct 10, 2013

Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	9,559	9,664	9,839	10,223
7e. Housing				
7e-i Supported Apartment	117	112	118	115
7e-ii Community Residential Facility	37	31	35	35
7e-iii Residential Treatment Facility (group home)	17	15	13	13
7e-iv Assisted Living Facility	40	47	43	42
7e-v Nursing Home	4	5	4	4
7e-vi Residential Crisis Unit	1	2	2	2
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	756	799	762	799
Total Unmet Resource Needs	972	1,011	977	1,010
Distinct Clients with Unmet Resource Needs	898	937	896	932
7f. Health Care				
7f-i Dental Services	620	639	597	616
7f-ii Eye Care Services	254	253	227	231
7f-iii Hearing Services	64	58	57	62
7f-iv Physical Therapy	35	39	38	38
7f-v Physician/Medical Services	234	246	216	246
Total Unmet Resource Needs	1,207	1,235	1,135	1,193
Distinct Clients with Unmet Resource Needs	878	914	873	920
7g. Legal				
7g-i Advocate	84	100	95	93
7g-ii Guardian (private)	47	52	42	40
7g-iii Guardian (public)	15	16	17	11
Total Unmet Resource Needs	146	168	154	144
Distinct Clients with Unmet Resource Needs	134	155	146	136
7h. Financial Security				
7h-i Assistance with Managing Money	382	367	358	365
7h-ii Assistance with Securing Public Benefits	222	222	230	254
7h-iii Representative Payee	38	41	40	42
Total Unmet Resource Needs	642	630	628	661
Distinct Clients with Unmet Resource Needs	573	570	560	589

Report Run: Oct 10, 2013

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

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	9,559	9,664	9,839	10,223
7i. Education				
7i-i Adult Education (other than GED)	64	74	80	66
7i-ii GED	82	87	95	85
7i-iii Literacy Assistance	30	34	29	29
7i-iv Post High School Education	141	110	105	102
7i-v Tuition Reimbursement	29	26	25	24
Total Unmet Resource Needs	346	331	334	306
Distinct Clients with Unmet Resource Needs	319	305	310	283
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	49	45	42	43
7j-ii Club House and/or Peer Vocational Support	27	26	22	26
7j-iii Competitive Employment (no supports)	65	69	67	64
7j-iv Supported Employment	42	41	46	42
7j-v Vocational Rehabilitation	267	283	264	254
Total Unmet Resource Needs	450	464	441	429
Distinct Clients with Unmet Resource Needs	399	411	394	378
7k. Living Skills				
7k-i Daily Living Support Services	207	217	226	222
7k-ii Day Support Services	32	26	29	31
7k-iii Occupational Therapy	10	13	8	9
7k-iv Skills Development Services	70	56	71	64
Total Unmet Resource Needs	319	312	334	326
Distinct Clients with Unmet Resource Needs	291	289	308	304
7l. Transportation				
7l-i Transportation to ISP-Identified Services	341	365	356	361
7-ii Transportation to Other ISP Activities	183	196	191	195
7-iii After Hours Transportation	158	165	154	185
Total Unmet Resource Needs	682	726	701	741
Distinct Clients with Unmet Resource Needs	494	511	509	526
7m. Personal Growth/Community				
7m-i Avocational Activities	25	20	23	24

Report Run: Oct 10, 2013

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

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	9,559	9,664	9,839	10,223
7m. Personal Growth/Community				
7m-ii Recreation Activities	129	137	138	141
7m-iii Social Activities	258	289	297	311
7m-iv Spiritual Activities	53	60	54	48
Total Unmet Resource Needs	465	506	512	524
Distinct Clients with Unmet Resource Needs	345	367	372	391
Other Resources				
Other Resources	140	154	153	162
Total Unmet Resource Needs	140	154	153	162
Distinct Clients with Unmet Resource Needs	140	154	153	162
Statewide Totals				
Total Unmet Resource Needs	7,060	7,236	6,974	7,168
Distinct Clients With any Unmet Resource Need	2,600	2,664	2,642	2,712
Distinct Clients with a RDS	9,559	9,664	9,839	10,223

Report Run: Oct 10, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

CSN 1 - Aroostook

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

2013 Q1			2013 Q2			2013 Q3			2013 Q4		
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
101	348	29.0%	116	386	30.1%	137	395	34.7%	128	380	33.7%

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

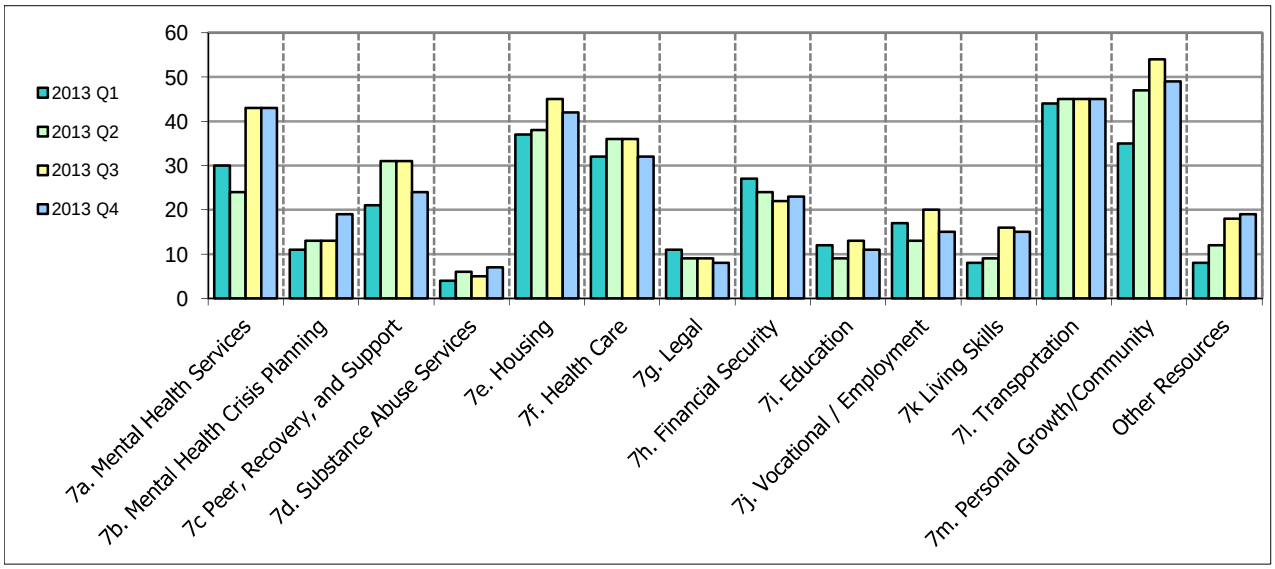

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q1	2013 Q2	2013 Q3	2013 Q4
7a. Mental Health Services	30	24	43	43
7b. Mental Health Crisis Planning	11	13	13	19
7c Peer, Recovery, and Support	21	31	31	24
7d. Substance Abuse Services	4	6	5	7
7e. Housing	37	38	45	42
7f. Health Care	32	36	36	32
7g. Legal	11	9	9	8
7h. Financial Security	27	24	22	23
7i. Education	12	9	13	11
7j. Vocational / Employment	17	13	20	15
7k Living Skills	8	9	16	15
7l. Transportation	44	45	45	45
7m. Personal Growth/Community	35	47	54	49
Other Resources	8	12	18	19
Total CSN 1 Unmet Needs	297	316	370	352

Report Run: Oct 10, 2013

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	348	386	395	380
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	0	0	0	0
7a-iii Dialectical Behavioral Therapy	3	3	6	7
7a-iv Family Psycho-Educational Treatment	0	0	1	2
7a-v Group Counseling	1	0	5	3
7a-vi Individual Counseling	9	4	7	8
7a-vii Inpatient Psychiatric Facility	1	1	1	0
7a-viii Intensive Case Management	0	0	1	0
7a-x Psychiatric Medication Management	16	16	22	23
Total Unmet Resource Needs	30	24	43	43
Distinct Clients with Unmet Resource Needs	25	20	36	36
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	7	10	8	15
7b-ii Mental Health Advance Directives	4	3	5	4
Total Unmet Resource Needs	11	13	13	19
Distinct Clients with Unmet Resource Needs	9	12	11	18
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	1	2	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	13	20	20	14
7c-iv Peer-Run Trauma Recovery Group	0	3	2	2
7c-v Wellness Recovery and Action Planning	2	1	1	2
7c-vi Family Support	5	6	6	6
Total Unmet Resource Needs	21	31	31	24
Distinct Clients with Unmet Resource Needs	19	26	26	21
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	3	5	5	7
7d-ii Residential Treatment Substance Abuse Services	1	1	0	0
Total Unmet Resource Needs	4	6	5	7
Distinct Clients with Unmet Resource Needs	4	6	5	7

Report Run: Oct 10, 2013

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	348	386	395	380
7e. Housing				
7e-i Supported Apartment	8	7	11	10
7e-ii Community Residential Facility	0	0	0	1
7e-iii Residential Treatment Facility (group home)	4	3	2	1
7e-iv Assisted Living Facility	3	2	1	2
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	22	26	31	28
Total Unmet Resource Needs	37	38	45	42
Distinct Clients with Unmet Resource Needs	31	35	39	36
7f. Health Care				
7f-i Dental Services	9	10	14	14
7f-ii Eye Care Services	4	7	3	2
7f-iii Hearing Services	3	2	1	1
7f-iv Physical Therapy	2	1	2	2
7f-v Physician/Medical Services	14	16	16	13
Total Unmet Resource Needs	32	36	36	32
Distinct Clients with Unmet Resource Needs	27	32	33	29
7g. Legal				
7g-i Advocate	8	8	7	6
7g-ii Guardian (private)	1	0	2	2
7g-iii Guardian (public)	2	1	0	0
Total Unmet Resource Needs	11	9	9	8
Distinct Clients with Unmet Resource Needs	11	8	9	7
7h. Financial Security				
7h-i Assistance with Managing Money	15	13	12	13
7h-ii Assistance with Securing Public Benefits	12	11	10	10
7h-iii Representative Payee	0	0	0	0
Total Unmet Resource Needs	27	24	22	23
Distinct Clients with Unmet Resource Needs	24	23	22	22

Report Run: Oct 10, 2013

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	348	386	395	380
7i. Education				
7i-i Adult Education (other than GED)	2	1	4	2
7i-ii GED	4	5	4	4
7i-iii Literacy Assistance	2	2	1	1
7i-iv Post High School Education	3	1	3	3
7i-v Tuition Reimbursement	1	0	1	1
Total Unmet Resource Needs	12	9	13	11
Distinct Clients with Unmet Resource Needs	12	9	13	11
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	4	1	2	1
7j-ii Club House and/or Peer Vocational Support	1	1	1	1
7j-iii Competitive Employment (no supports)	0	1	2	1
7j-iv Supported Employment	4	2	6	2
7j-v Vocational Rehabilitation	8	8	9	10
Total Unmet Resource Needs	17	13	20	15
Distinct Clients with Unmet Resource Needs	14	11	16	14
7k. Living Skills				
7k-i Daily Living Support Services	4	5	6	5
7k-ii Day Support Services	2	1	2	2
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	2	3	8	8
Total Unmet Resource Needs	8	9	16	15
Distinct Clients with Unmet Resource Needs	8	8	15	14
7l. Transportation				
7l-i Transportation to ISP-Identified Services	23	21	25	24
7-ii Transportation to Other ISP Activities	7	8	8	10
7-iii After Hours Transportation	14	16	12	11
Total Unmet Resource Needs	44	45	45	45
Distinct Clients with Unmet Resource Needs	35	32	36	34
7m. Personal Growth/Community				
7m-i Avocational Activities	2	0	1	0

Report Run: Oct 10, 2013

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	348	386	395	380
7m. Personal Growth/Community				
7m-ii Recreation Activities	8	14	15	16
7m-iii Social Activities	22	29	35	31
7m-iv Spiritual Activities	3	4	3	2
Total Unmet Resource Needs	35	47	54	49
Distinct Clients with Unmet Resource Needs	27	35	42	38
Other Resources				
Other Resources	8	12	18	19
Total Unmet Resource Needs	8	12	18	19
Distinct Clients with Unmet Resource Needs	8	12	18	19
CSN 1 Totals				
Total Unmet Resource Needs	297	316	370	352
Distinct Clients With any Unmet Resource Need	101	116	137	128
Distinct Clients with a RDS	348	386	395	380

Report Run: Oct 10, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

CSN 2 - Hancock, Washington, Penobscot, Piscataquis

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

2013 Q1			2013 Q2			2013 Q3			2013 Q4		
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
476	1,767	26.9%	460	1,707	26.9%	432	1,763	24.5%	435	1,864	23.3%

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

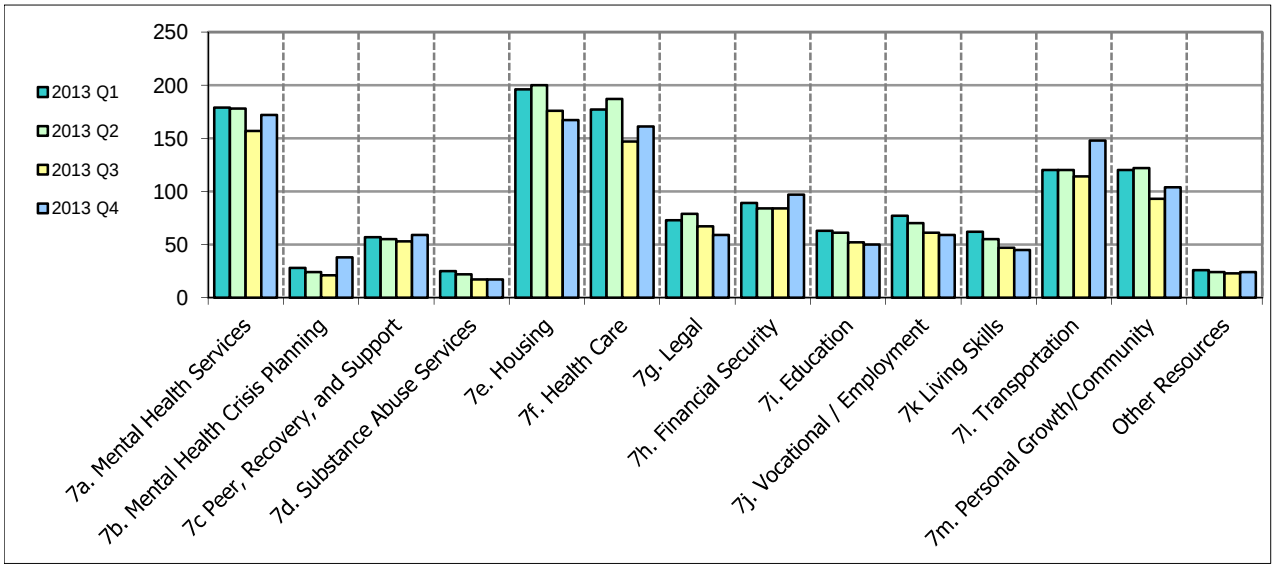

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q1	2013 Q2	2013 Q3	2013 Q4
7a. Mental Health Services	179	178	157	172
7b. Mental Health Crisis Planning	28	24	21	38
7c Peer, Recovery, and Support	57	55	53	59
7d. Substance Abuse Services	25	22	17	17
7e. Housing	196	200	176	167
7f. Health Care	177	187	147	161
7g. Legal	73	79	67	59
7h. Financial Security	89	84	84	97
7i. Education	63	61	52	50
7j. Vocational / Employment	77	70	61	59
7k Living Skills	62	55	47	45
7l. Transportation	120	120	114	148
7m. Personal Growth/Community	120	122	93	104
Other Resources	26	24	23	24
Total CSN 2 Unmet Needs	1,292	1,281	1,112	1,200

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

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,767	1,707	1,763	1,864
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	2	2	3
7a-iii Dialectical Behavioral Therapy	2	2	1	2
7a-iv Family Psycho-Educational Treatment	2	4	4	5
7a-v Group Counseling	8	9	9	6
7a-vi Individual Counseling	88	87	72	74
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	1	1	1	1
7a-x Psychiatric Medication Management	76	73	68	81
Total Unmet Resource Needs	179	178	157	172
Distinct Clients with Unmet Resource Needs	137	135	123	133
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	26	22	18	34
7b-ii Mental Health Advance Directives	2	2	3	4
Total Unmet Resource Needs	28	24	21	38
Distinct Clients with Unmet Resource Needs	28	23	19	36
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	6	6	6	6
7c-ii Recovery Workbook Group	0	1	1	1
7c-iii Social Club	21	14	16	13
7c-iv Peer-Run Trauma Recovery Group	8	11	11	12
7c-v Wellness Recovery and Action Planning	8	8	6	7
7c-vi Family Support	14	15	13	20
Total Unmet Resource Needs	57	55	53	59
Distinct Clients with Unmet Resource Needs	43	38	36	41
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	24	19	13	14
7d-ii Residential Treatment Substance Abuse Services	1	3	4	3
Total Unmet Resource Needs	25	22	17	17
Distinct Clients with Unmet Resource Needs	24	20	15	15

Report Run: Oct 10, 2013

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,767	1,707	1,763	1,864
7e. Housing				
7e-i Supported Apartment	21	23	13	16
7e-ii Community Residential Facility	6	4	6	5
7e-iii Residential Treatment Facility (group home)	1	1	0	1
7e-iv Assisted Living Facility	6	9	9	7
7e-v Nursing Home	1	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	161	163	148	138
Total Unmet Resource Needs	196	200	176	167
Distinct Clients with Unmet Resource Needs	180	186	166	156
7f. Health Care				
7f-i Dental Services	76	89	63	67
7f-ii Eye Care Services	53	44	37	33
7f-iii Hearing Services	5	5	7	5
7f-iv Physical Therapy	7	7	7	7
7f-v Physician/Medical Services	36	42	33	49
Total Unmet Resource Needs	177	187	147	161
Distinct Clients with Unmet Resource Needs	121	134	118	125
7g. Legal				
7g-i Advocate	31	30	31	25
7g-ii Guardian (private)	38	44	32	31
7g-iii Guardian (public)	4	5	4	3
Total Unmet Resource Needs	73	79	67	59
Distinct Clients with Unmet Resource Needs	62	69	61	54
7h. Financial Security				
7h-i Assistance with Managing Money	54	47	43	49
7h-ii Assistance with Securing Public Benefits	32	36	40	43
7h-iii Representative Payee	3	1	1	5
Total Unmet Resource Needs	89	84	84	97
Distinct Clients with Unmet Resource Needs	84	77	73	84

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

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,767	1,707	1,763	1,864
7i. Education				
7i-ii GED	10	7	5	4
7i-iii Literacy Assistance	4	5	5	3
7i-iv Post High School Education	33	30	25	26
7i-v Tuition Reimbursement	7	12	8	9
Total Unmet Resource Needs	63	61	52	50
Distinct Clients with Unmet Resource Needs	59	53	48	46
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	10	8	7	8
7j-ii Club House and/or Peer Vocational Support	3	2	2	2
7j-iii Competitive Employment (no supports)	16	17	18	19
7j-iv Supported Employment	7	7	7	8
7j-v Vocational Rehabilitation	41	36	27	22
Total Unmet Resource Needs	77	70	61	59
Distinct Clients with Unmet Resource Needs	67	60	52	50
7k. Living Skills				
7k-i Daily Living Support Services	42	36	35	31
7k-ii Day Support Services	5	3	3	4
7k-iii Occupational Therapy	2	2	1	1
7k-iv Skills Development Services	13	14	8	9
Total Unmet Resource Needs	62	55	47	45
Distinct Clients with Unmet Resource Needs	52	47	40	39
7l. Transportation				
7l-i Transportation to ISP-Identified Services	63	58	52	66
7-ii Transportation to Other ISP Activities	21	22	25	36
7-iii After Hours Transportation	36	40	37	46
Total Unmet Resource Needs	120	120	114	148
Distinct Clients with Unmet Resource Needs	94	92	85	96
7m. Personal Growth/Community				
7m-i Avocational Activities	7	7	7	9

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

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

Report of Unmet Resource Needs

CSN 2
Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,767	1,707	1,763	1,864
7m. Personal Growth/Community				
7m-ii Recreation Activities	38	41	31	33
7m-iii Social Activities	68	67	51	57
7m-iv Spiritual Activities	7	7	4	5
Total Unmet Resource Needs	120	122	93	104
Distinct Clients with Unmet Resource Needs	84	81	63	71
Other Resources				
Other Resources	26	24	23	24
Total Unmet Resource Needs	26	24	23	24
Distinct Clients with Unmet Resource Needs	26	24	23	24
CSN 2 Totals				
Total Unmet Resource Needs	1,292	1,281	1,112	1,200
Distinct Clients With any Unmet Resource Need	476	460	432	435
Distinct Clients with a RDS	1,767	1,707	1,763	1,864

Report Run: Oct 10, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

CSN 3 - Kennebec and Somerset

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

2013 Q1			2013 Q2			2013 Q3			2013 Q4		
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
326	1,972	16.5%	357	1,985	18.0%	358	2,008	17.8%	377	2,090	18.0%

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

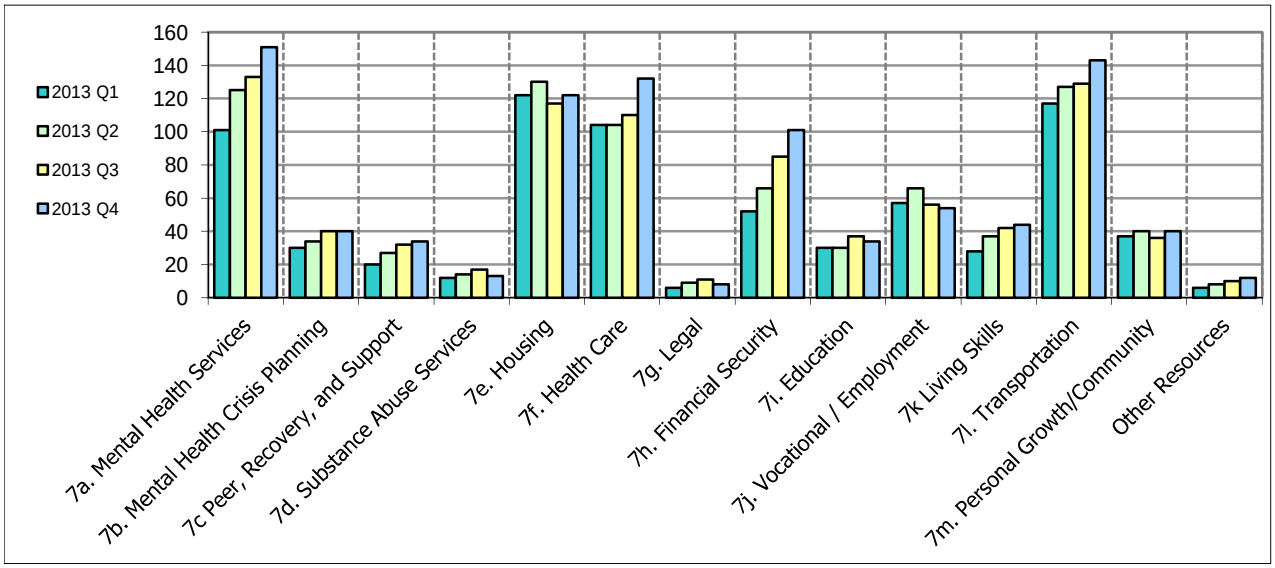

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q1	2013 Q2	2013 Q3	2013 Q4
7a. Mental Health Services	101	125	133	151
7b. Mental Health Crisis Planning	30	34	40	40
7c Peer, Recovery, and Support	20	27	32	34
7d. Substance Abuse Services	12	14	17	13
7e. Housing	122	130	117	122
7f. Health Care	104	104	110	132
7g. Legal	6	9	11	8
7h. Financial Security	52	66	85	101
7i. Education	30	30	37	34
7j. Vocational / Employment	57	66	56	54
7k Living Skills	28	37	42	44
7l. Transportation	117	127	129	143
7m. Personal Growth/Community	37	40	36	40
Other Resources	6	8	10	12
Total CSN 3 Unmet Needs	722	817	855	928

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

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,972	1,985	2,008	2,090
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	3	5	4	2
7a-iii Dialectical Behavioral Therapy	0	0	0	3
7a-iv Family Psycho-Educational Treatment	2	1	1	1
7a-v Group Counseling	2	2	3	4
7a-vi Individual Counseling	41	52	55	65
7a-vii Inpatient Psychiatric Facility	1	1	1	1
7a-viii Intensive Case Management	1	0	2	1
7a-x Psychiatric Medication Management	51	64	67	74
Total Unmet Resource Needs	101	125	133	151
Distinct Clients with Unmet Resource Needs	76	96	104	113
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	23	24	27	30
7b-ii Mental Health Advance Directives	7	10	13	10
Total Unmet Resource Needs	30	34	40	40
Distinct Clients with Unmet Resource Needs	26	27	32	35
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	3	4	4
7c-ii Recovery Workbook Group	0	1	1	1
7c-iii Social Club	6	11	9	10
7c-iv Peer-Run Trauma Recovery Group	3	0	1	1
7c-v Wellness Recovery and Action Planning	0	1	2	1
7c-vi Family Support	10	11	15	17
Total Unmet Resource Needs	20	27	32	34
Distinct Clients with Unmet Resource Needs	19	25	29	31
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	7	10	10	9
7d-ii Residential Treatment Substance Abuse Services	5	4	7	4
Total Unmet Resource Needs	12	14	17	13
Distinct Clients with Unmet Resource Needs	12	14	15	13

Report Run: Oct 10, 2013

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

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,972	1,985	2,008	2,090
7e. Housing				
7e-ii Community Residential Facility	5	4	4	3
7e-iii Residential Treatment Facility (group home)	1	2	3	2
7e-iv Assisted Living Facility	3	2	2	1
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	105	112	100	110
Total Unmet Resource Needs	122	130	117	122
Distinct Clients with Unmet Resource Needs	114	122	109	117
7f. Health Care				
7f-i Dental Services	53	53	57	63
7f-ii Eye Care Services	14	18	21	24
7f-iii Hearing Services	10	7	8	12
7f-iv Physical Therapy	1	1	1	3
7f-v Physician/Medical Services	26	25	23	30
Total Unmet Resource Needs	104	104	110	132
Distinct Clients with Unmet Resource Needs	88	87	92	108
7g. Legal				
7g-i Advocate	3	4	5	4
7g-ii Guardian (private)	1	2	2	2
7g-iii Guardian (public)	2	3	4	2
Total Unmet Resource Needs	6	9	11	8
Distinct Clients with Unmet Resource Needs	6	7	9	6
7h. Financial Security				
7h-i Assistance with Managing Money	32	36	35	41
7h-ii Assistance with Securing Public Benefits	17	26	42	52
7h-iii Representative Payee	3	4	8	8
Total Unmet Resource Needs	52	66	85	101
Distinct Clients with Unmet Resource Needs	46	60	72	89

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

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,972	1,985	2,008	2,090
7i. Education				
7i-i Adult Education (other than GED)	4	3	5	6
7i-ii GED	10	12	17	11
7i-iii Literacy Assistance	7	6	5	8
7i-iv Post High School Education	7	7	8	7
7i-v Tuition Reimbursement	2	2	2	2
Total Unmet Resource Needs	30	30	37	34
Distinct Clients with Unmet Resource Needs	28	27	35	30
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	5	7	4	3
7j-ii Club House and/or Peer Vocational Support	9	7	6	11
7j-iii Competitive Employment (no supports)	6	4	3	1
7j-iv Supported Employment	1	4	2	3
7j-v Vocational Rehabilitation	36	44	41	36
Total Unmet Resource Needs	57	66	56	54
Distinct Clients with Unmet Resource Needs	49	56	51	48
7k. Living Skills				
7k-i Daily Living Support Services	23	30	39	39
7k-ii Day Support Services	0	1	1	2
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	5	6	2	3
Total Unmet Resource Needs	28	37	42	44
Distinct Clients with Unmet Resource Needs	28	37	42	43
7l. Transportation				
7l-i Transportation to ISP-Identified Services	68	85	85	87
7-ii Transportation to Other ISP Activities	30	26	25	32
7-iii After Hours Transportation	19	16	19	24
Total Unmet Resource Needs	117	127	129	143
Distinct Clients with Unmet Resource Needs	84	98	101	104
7m. Personal Growth/Community				
7m-i Avocational Activities	0	1	1	0

Report Run: Oct 10, 2013

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,972	1,985	2,008	2,090
7m. Personal Growth/Community				
7m-ii Recreation Activities	9	7	6	5
7m-iii Social Activities	25	30	28	35
7m-iv Spiritual Activities	3	2	1	0
Total Unmet Resource Needs	37	40	36	40
Distinct Clients with Unmet Resource Needs	29	34	31	37
Other Resources				
Other Resources	6	8	10	12
Total Unmet Resource Needs	6	8	10	12
Distinct Clients with Unmet Resource Needs	6	8	10	12
CSN 3 Totals				
Total Unmet Resource Needs	722	817	855	928
Distinct Clients With any Unmet Resource Need	326	357	358	377
Distinct Clients with a RDS	1,972	1,985	2,008	2,090

Report Run: Oct 10, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

CSN 4 - Knox, Lincoln, Sagadahoc, Waldo

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

2013 Q1			2013 Q2			2013 Q3			2013 Q4		
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
228	809	28.2%	238	815	29.2%	237	837	28.3%	222	844	26.3%

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

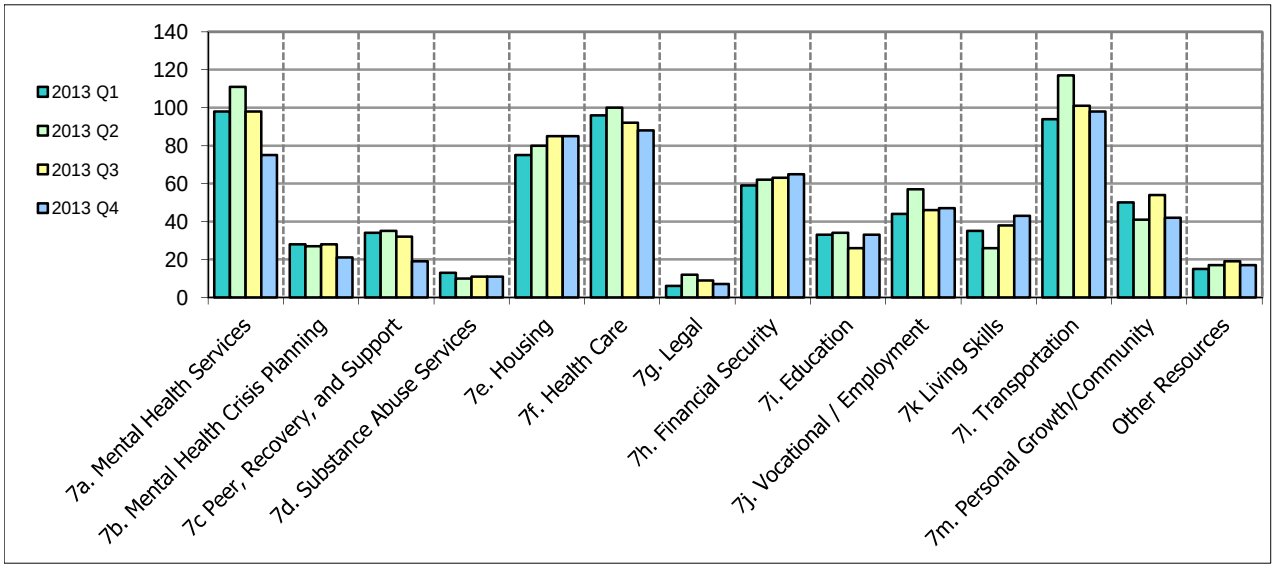

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q1	2013 Q2	2013 Q3	2013 Q4
7a. Mental Health Services	98	111	98	75
7b. Mental Health Crisis Planning	28	27	28	21
7c Peer, Recovery, and Support	34	35	32	19
7d. Substance Abuse Services	13	10	11	11
7e. Housing	75	80	85	85
7f. Health Care	96	100	92	88
7g. Legal	6	12	9	7
7h. Financial Security	59	62	63	65
7i. Education	33	34	26	33
7j. Vocational / Employment	44	57	46	47
7k Living Skills	35	26	38	43
7l. Transportation	94	117	101	98
7m. Personal Growth/Community	50	41	54	42
Other Resources	15	17	19	17
Total CSN 4 Unmet Needs	680	729	702	651

Report Run: Oct 10, 2013

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

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	809	815	837	844
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	4	6	3	3
7a-iii Dialectical Behavioral Therapy	1	1	1	0
7a-iv Family Psycho-Educational Treatment	0	0	0	0
7a-v Group Counseling	4	3	1	2
7a-vi Individual Counseling	42	49	47	40
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	1	0	1	2
7a-x Psychiatric Medication Management	46	52	45	28
Total Unmet Resource Needs	98	111	98	75
Distinct Clients with Unmet Resource Needs	75	82	72	62
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	22	22	23	15
7b-ii Mental Health Advance Directives	6	5	5	6
Total Unmet Resource Needs	28	27	28	21
Distinct Clients with Unmet Resource Needs	25	25	26	20
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	10	6	3	2
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	8	7	9	4
7c-iv Peer-Run Trauma Recovery Group	5	4	5	3
7c-v Wellness Recovery and Action Planning	0	0	0	0
7c-vi Family Support	11	18	15	10
Total Unmet Resource Needs	34	35	32	19
Distinct Clients with Unmet Resource Needs	31	32	27	18
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	11	8	9	10
7d-ii Residential Treatment Substance Abuse Services	2	2	2	1
Total Unmet Resource Needs	13	10	11	11
Distinct Clients with Unmet Resource Needs	12	9	10	11

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

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	809	815	837	844
7e. Housing				
7e-i Supported Apartment	13	8	13	9
7e-ii Community Residential Facility	1	1	2	3
7e-iii Residential Treatment Facility (group home)	3	3	2	3
7e-iv Assisted Living Facility	4	5	6	6
7e-v Nursing Home	0	0	2	2
7e-vi Residential Crisis Unit	0	0	1	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	54	63	59	61
Total Unmet Resource Needs	75	80	85	85
Distinct Clients with Unmet Resource Needs	70	77	74	75
7f. Health Care				
7f-i Dental Services	58	53	52	46
7f-ii Eye Care Services	15	16	23	19
7f-iii Hearing Services	5	7	4	6
7f-iv Physical Therapy	4	4	1	1
7f-v Physician/Medical Services	14	20	12	16
Total Unmet Resource Needs	96	100	92	88
Distinct Clients with Unmet Resource Needs	77	77	71	70
7g. Legal				
7g-i Advocate	4	9	6	5
7g-ii Guardian (private)	2	3	3	2
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	6	12	9	7
Distinct Clients with Unmet Resource Needs	6	12	9	7
7h. Financial Security				
7h-i Assistance with Managing Money	36	40	44	36
7h-ii Assistance with Securing Public Benefits	17	16	14	21
7h-iii Representative Payee	6	6	5	8
Total Unmet Resource Needs	59	62	63	65
Distinct Clients with Unmet Resource Needs	52	56	57	57

Report Run: Oct 10, 2013

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

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	809	815	837	844
7i. Education				
7i-i Adult Education (other than GED)	3	7	5	5
7i-ii GED	10	10	8	12
7i-iii Literacy Assistance	0	0	0	1
7i-iv Post High School Education	15	11	10	13
7i-v Tuition Reimbursement	5	6	3	2
Total Unmet Resource Needs	33	34	26	33
Distinct Clients with Unmet Resource Needs	32	32	24	32
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	4	6	4	5
7j-ii Club House and/or Peer Vocational Support	0	1	0	1
7j-iii Competitive Employment (no supports)	8	9	10	9
7j-iv Supported Employment	3	5	4	5
7j-v Vocational Rehabilitation	29	36	28	27
Total Unmet Resource Needs	44	57	46	47
Distinct Clients with Unmet Resource Needs	42	52	43	40
7k. Living Skills				
7k-i Daily Living Support Services	28	21	32	33
7k-ii Day Support Services	2	2	1	3
7k-iii Occupational Therapy	0	0	1	1
7k-iv Skills Development Services	5	3	4	6
Total Unmet Resource Needs	35	26	38	43
Distinct Clients with Unmet Resource Needs	33	26	36	39
7l. Transportation				
7l-i Transportation to ISP-Identified Services	51	61	51	52
7-ii Transportation to Other ISP Activities	34	42	37	32
7-iii After Hours Transportation	9	14	13	14
Total Unmet Resource Needs	94	117	101	98
Distinct Clients with Unmet Resource Needs	58	69	59	62
7m. Personal Growth/Community				
7m-i Avocational Activities	3	2	2	4

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	809	815	837	844
7m. Personal Growth/Community				
7m-ii Recreation Activities	12	8	10	10
7m-iii Social Activities	28	26	37	27
7m-iv Spiritual Activities	7	5	5	1
Total Unmet Resource Needs	50	41	54	42
Distinct Clients with Unmet Resource Needs	37	33	42	34
Other Resources				
Other Resources	15	17	19	17
Total Unmet Resource Needs	15	17	19	17
Distinct Clients with Unmet Resource Needs	15	17	19	17
CSN 4 Totals				
Total Unmet Resource Needs	680	729	702	651
Distinct Clients With any Unmet Resource Need	228	238	237	222
Distinct Clients with a RDS	809	815	837	844

Report Run: Oct 10, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

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

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

2013 Q1			2013 Q2			2013 Q3			2013 Q4		
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
656	1,891	34.7%	626	1,939	32.3%	617	1,934	31.9%	638	2,076	30.7%

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

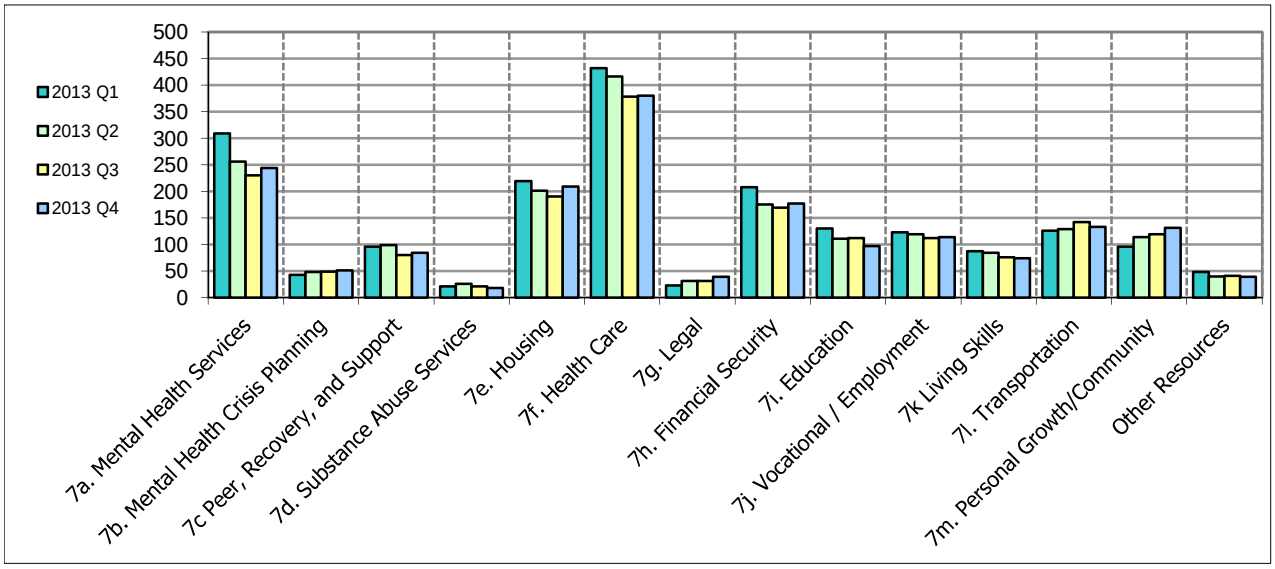

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q1	2013 Q2	2013 Q3	2013 Q4
7a. Mental Health Services	309	256	230	244
7b. Mental Health Crisis Planning	43	48	49	51
7c Peer, Recovery, and Support	96	99	80	84
7d. Substance Abuse Services	21	26	21	18
7e. Housing	219	201	190	209
7f. Health Care	432	416	378	380
7g. Legal	23	31	31	39
7h. Financial Security	208	175	169	177
7i. Education	130	111	112	97
7j. Vocational / Employment	123	119	112	114
7k Living Skills	87	84	76	74
7l. Transportation	126	129	142	133
7m. Personal Growth/Community	96	114	119	131
Other Resources	48	40	41	39
Total CSN 5 Unmet Needs	1,961	1,849	1,750	1,790

Report Run: Oct 10, 2013

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

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,891	1,939	1,934	2,076
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	9	3	5	8
7a-iii Dialectical Behavioral Therapy	18	11	11	15
7a-iv Family Psycho-Educational Treatment	2	1	2	4
7a-v Group Counseling	10	3	9	6
7a-vi Individual Counseling	120	106	88	84
7a-vii Inpatient Psychiatric Facility	1	0	2	2
7a-viii Intensive Case Management	2	1	0	4
7a-x Psychiatric Medication Management	147	131	113	121
Total Unmet Resource Needs	309	256	230	244
Distinct Clients with Unmet Resource Needs	252	209	191	211
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	21	26	23	27
7b-ii Mental Health Advance Directives	22	22	26	24
Total Unmet Resource Needs	43	48	49	51
Distinct Clients with Unmet Resource Needs	38	43	46	49
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	12	10	10	10
7c-ii Recovery Workbook Group	0	0	1	1
7c-iii Social Club	23	27	18	22
7c-iv Peer-Run Trauma Recovery Group	14	8	5	3
7c-v Wellness Recovery and Action Planning	1	2	4	6
7c-vi Family Support	46	52	42	42
Total Unmet Resource Needs	96	99	80	84
Distinct Clients with Unmet Resource Needs	83	89	69	76
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	18	25	19	16
7d-ii Residential Treatment Substance Abuse Services	3	1	2	2
Total Unmet Resource Needs	21	26	21	18
Distinct Clients with Unmet Resource Needs	20	26	21	18

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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 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,891	1,939	1,934	2,076
7e. Housing				
7e-ii Community Residential Facility	7	5	4	4
7e-iii Residential Treatment Facility (group home)	3	1	1	2
7e-iv Assisted Living Facility	6	7	4	5
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	1	1	1	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	189	175	167	183
Total Unmet Resource Needs	219	201	190	209
Distinct Clients with Unmet Resource Needs	209	191	179	198
7f. Health Care				
7f-i Dental Services	234	226	202	200
7f-ii Eye Care Services	91	85	76	83
7f-iii Hearing Services	28	25	24	22
7f-iv Physical Therapy	10	12	16	13
7f-v Physician/Medical Services	69	68	60	62
Total Unmet Resource Needs	432	416	378	380
Distinct Clients with Unmet Resource Needs	292	290	271	277
7g. Legal				
7g-i Advocate	19	29	26	34
7g-ii Guardian (private)	2	1	1	1
7g-iii Guardian (public)	2	1	4	4
Total Unmet Resource Needs	23	31	31	39
Distinct Clients with Unmet Resource Needs	22	31	31	39
7h. Financial Security				
7h-i Assistance with Managing Money	121	111	110	111
7h-ii Assistance with Securing Public Benefits	78	55	50	58
7h-iii Representative Payee	9	9	9	8
Total Unmet Resource Needs	208	175	169	177
Distinct Clients with Unmet Resource Needs	186	162	158	163

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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 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,891	1,939	1,934	2,076
7i. Education				
7i-i Adult Education (other than GED)	24	27	27	23
7i-ii GED	28	31	39	32
7i-iii Literacy Assistance	10	10	10	7
7i-iv Post High School Education	57	38	28	27
7i-v Tuition Reimbursement	11	5	8	8
Total Unmet Resource Needs	130	111	112	97
Distinct Clients with Unmet Resource Needs	116	104	103	89
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	9	6	9	8
7j-ii Club House and/or Peer Vocational Support	11	10	9	8
7j-iii Competitive Employment (no supports)	14	12	10	10
7j-iv Supported Employment	12	11	12	11
7j-v Vocational Rehabilitation	77	80	72	77
Total Unmet Resource Needs	123	119	112	114
Distinct Clients with Unmet Resource Needs	111	109	101	105
7k. Living Skills				
7k-i Daily Living Support Services	60	61	52	56
7k-ii Day Support Services	10	9	9	8
7k-iii Occupational Therapy	5	8	3	3
7k-iv Skills Development Services	12	6	12	7
Total Unmet Resource Needs	87	84	76	74
Distinct Clients with Unmet Resource Needs	80	77	72	72
7l. Transportation				
7l-i Transportation to ISP-Identified Services	48	47	54	45
7-ii Transportation to Other ISP Activities	39	43	48	45
7-iii After Hours Transportation	39	39	40	43
Total Unmet Resource Needs	126	129	142	133
Distinct Clients with Unmet Resource Needs	95	88	102	95
7m. Personal Growth/Community				
7m-i Avocational Activities	4	3	3	3

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,891	1,939	1,934	2,076
7m. Personal Growth/Community				
7m-iii Social Activities	45	57	59	71
7m-iv Spiritual Activities	20	26	21	24
Total Unmet Resource Needs	96	114	119	131
Distinct Clients with Unmet Resource Needs	69	74	77	92
Other Resources				
Other Resources	48	40	41	39
Total Unmet Resource Needs	48	40	41	39
Distinct Clients with Unmet Resource Needs	48	40	41	39
CSN 5 Totals				
Total Unmet Resource Needs	1,961	1,849	1,750	1,790
Distinct Clients With any Unmet Resource Need	656	626	617	638
Distinct Clients with a RDS	1,891	1,939	1,934	2,076

Report Run: Oct 10, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

CSN 6 - Cumberland

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

2013 Q1			2013 Q2			2013 Q3			2013 Q4		
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
554	1,956	28.3%	592	1,958	30.2%	608	2,028	30.0%	648	2,124	30.5%

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

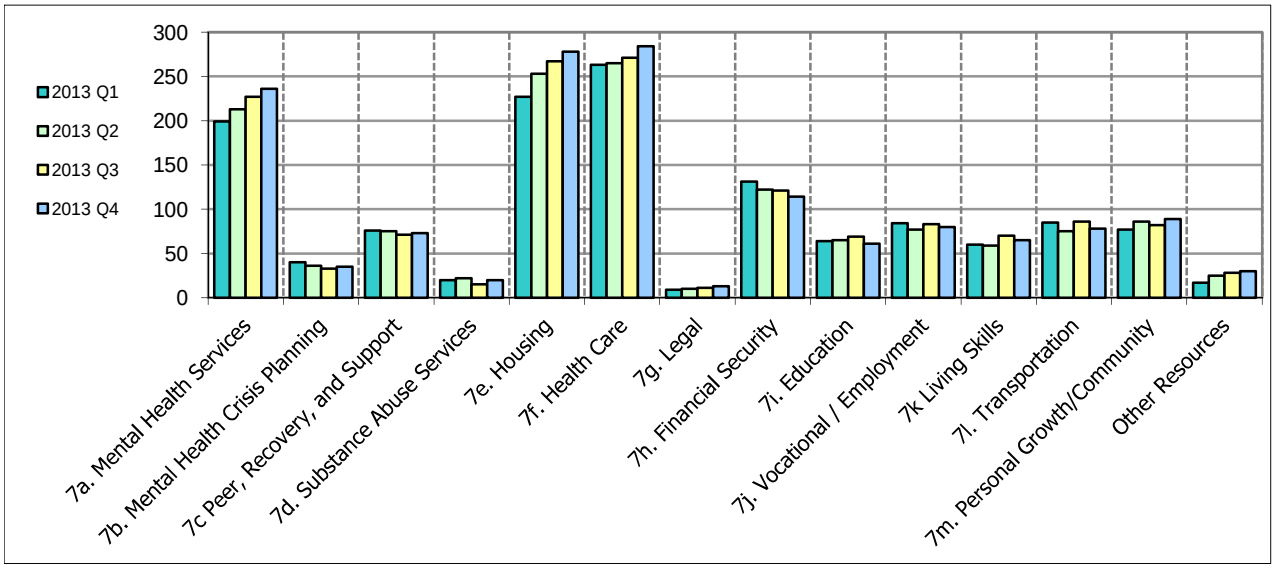

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q1	2013 Q2	2013 Q3	2013 Q4
7a. Mental Health Services	199	213	227	236
7b. Mental Health Crisis Planning	40	36	33	35
7c Peer, Recovery, and Support	76	75	71	73
7d. Substance Abuse Services	20	22	15	20
7e. Housing	227	253	267	278
7f. Health Care	263	265	271	284
7g. Legal	9	10	11	13
7h. Financial Security	131	122	121	114
7i. Education	64	65	69	61
7j. Vocational / Employment	84	77	83	80
7k Living Skills	60	59	70	65
7l. Transportation	85	75	86	78
7m. Personal Growth/Community	77	86	82	89
Other Resources	17	25	28	30
Total CSN 6 Unmet Needs	1,352	1,383	1,434	1,456

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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 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,956	1,958	2,028	2,124
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	13	13	29	37
7a-iii Dialectical Behavioral Therapy	4	8	6	3
7a-iv Family Psycho-Educational Treatment	0	1	2	2
7a-v Group Counseling	9	11	10	10
7a-vi Individual Counseling	80	77	72	78
7a-vii Inpatient Psychiatric Facility	2	0	0	2
7a-viii Intensive Case Management	13	15	19	15
7a-x Psychiatric Medication Management	78	88	89	89
Total Unmet Resource Needs	199	213	227	236
Distinct Clients with Unmet Resource Needs	146	160	165	189
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	34	30	30	30
7b-ii Mental Health Advance Directives	6	6	3	5
Total Unmet Resource Needs	40	36	33	35
Distinct Clients with Unmet Resource Needs	37	33	31	33
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	18	15	13	16
7c-ii Recovery Workbook Group	1	1	1	0
7c-iii Social Club	33	32	27	29
7c-iv Peer-Run Trauma Recovery Group	3	5	5	6
7c-v Wellness Recovery and Action Planning	7	8	9	7
7c-vi Family Support	14	14	16	15
Total Unmet Resource Needs	76	75	71	73
Distinct Clients with Unmet Resource Needs	58	57	52	55
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	16	17	11	14
7d-ii Residential Treatment Substance Abuse Services	4	5	4	6
Total Unmet Resource Needs	20	22	15	20
Distinct Clients with Unmet Resource Needs	18	22	15	20

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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 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,956	1,958	2,028	2,124
7e. Housing				
7e-i Supported Apartment	43	46	53	48
7e-ii Community Residential Facility	13	13	14	16
7e-iii Residential Treatment Facility (group home)	4	3	3	3
7e-iv Assisted Living Facility	16	17	17	18
7e-v Nursing Home	2	2	1	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	149	172	179	192
Total Unmet Resource Needs	227	253	267	278
Distinct Clients with Unmet Resource Needs	204	225	237	249
7f. Health Care				
7f-i Dental Services	142	145	152	169
7f-ii Eye Care Services	54	54	48	47
7f-iii Hearing Services	10	10	11	12
7f-iv Physical Therapy	7	6	7	5
7f-v Physician/Medical Services	50	50	53	51
Total Unmet Resource Needs	263	265	271	284
Distinct Clients with Unmet Resource Needs	196	201	210	226
7g. Legal				
7g-i Advocate	6	6	7	11
7g-ii Guardian (private)	1	1	1	1
7g-iii Guardian (public)	2	3	3	1
Total Unmet Resource Needs	9	10	11	13
Distinct Clients with Unmet Resource Needs	9	10	11	13
7h. Financial Security				
7h-i Assistance with Managing Money	80	72	65	62
7h-ii Assistance with Securing Public Benefits	39	38	43	42
7h-iii Representative Payee	12	12	13	10
Total Unmet Resource Needs	131	122	121	114
Distinct Clients with Unmet Resource Needs	117	114	110	106

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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 6
(Cumberland)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,956	1,958	2,028	2,124
7i. Education				
7i-i Adult Education (other than GED)	19	22	23	17
7i-ii GED	14	15	15	13
7i-iii Literacy Assistance	6	6	6	7
7i-iv Post High School Education	22	21	24	23
7i-v Tuition Reimbursement	3	1	1	1
Total Unmet Resource Needs	64	65	69	61
Distinct Clients with Unmet Resource Needs	58	60	63	57
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	10	8	8	8
7j-ii Club House and/or Peer Vocational Support	2	2	3	2
7j-iii Competitive Employment (no supports)	16	16	16	15
7j-iv Supported Employment	8	6	7	7
7j-v Vocational Rehabilitation	48	45	49	48
Total Unmet Resource Needs	84	77	83	80
Distinct Clients with Unmet Resource Needs	75	71	77	70
7k. Living Skills				
7k-i Daily Living Support Services	31	34	38	36
7k-ii Day Support Services	6	6	8	8
7k-iii Occupational Therapy	3	3	1	2
7k-iv Skills Development Services	20	16	23	19
Total Unmet Resource Needs	60	59	70	65
Distinct Clients with Unmet Resource Needs	56	56	64	59
7l. Transportation				
7l-i Transportation to ISP-Identified Services	41	38	47	45
7-ii Transportation to Other ISP Activities	24	20	24	16
7-iii After Hours Transportation	20	17	15	17
Total Unmet Resource Needs	85	75	86	78
Distinct Clients with Unmet Resource Needs	64	61	67	66
7m. Personal Growth/Community				
7m-i Avocational Activities	4	3	3	2

Report Run: Oct 10, 2013

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

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	1,956	1,958	2,028	2,124
7m. Personal Growth/Community				
7m-ii Recreation Activities	20	22	23	25
7m-iii Social Activities	42	47	43	52
7m-iv Spiritual Activities	11	14	13	10
Total Unmet Resource Needs	77	86	82	89
Distinct Clients with Unmet Resource Needs	60	67	64	70
Other Resources				
Other Resources	17	25	28	30
Total Unmet Resource Needs	17	25	28	30
Distinct Clients with Unmet Resource Needs	17	25	28	30
CSN 6 Totals				
Total Unmet Resource Needs	1,352	1,383	1,434	1,456
Distinct Clients With any Unmet Resource Need	554	592	608	648
Distinct Clients with a RDS	1,956	1,958	2,028	2,124

Report Run: Oct 10, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q4

CSN 7 - York

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

2013 Q1			2013 Q2			2013 Q3			2013 Q4		
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
157	460	34.1%	179	549	32.6%	153	544	28.1%	176	542	32.5%

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

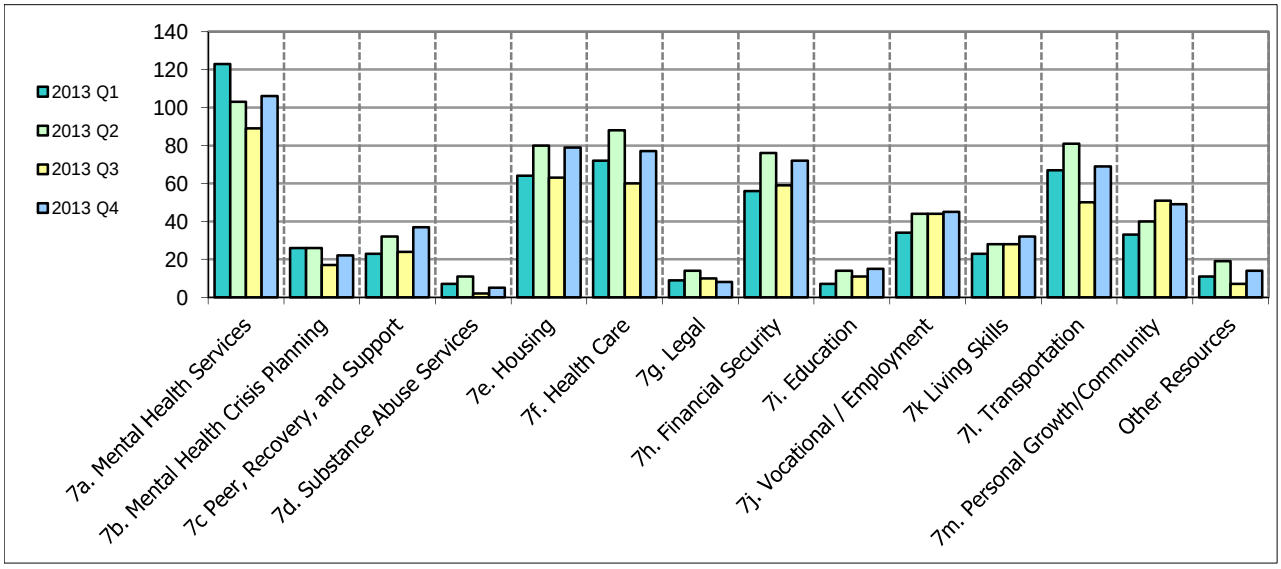

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q1	2013 Q2	2013 Q3	2013 Q4
7a. Mental Health Services	123	103	89	106
7b. Mental Health Crisis Planning	26	26	17	22
7c Peer, Recovery, and Support	23	32	24	37
7d. Substance Abuse Services	7	11	2	5
7e. Housing	64	80	63	79
7f. Health Care	72	88	60	77
7g. Legal	9	14	10	8
7h. Financial Security	56	76	59	72
7i. Education	7	14	11	15
7j. Vocational / Employment	34	44	44	45
7k Living Skills	23	28	28	32
7l. Transportation	67	81	50	69
7m. Personal Growth/Community	33	40	51	49
Other Resources	11	19	7	14
Total CSN 7 Unmet Needs	555	656	515	630

Report Run: Oct 10, 2013

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

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	460	549	544	542
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	4	7	3	5
7a-iii Dialectical Behavioral Therapy	2	4	4	7
7a-iv Family Psycho-Educational Treatment	2	1	1	1
7a-v Group Counseling	1	4	4	3
7a-vi Individual Counseling	57	41	37	42
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	2	2	1	0
7a-x Psychiatric Medication Management	55	44	39	48
Total Unmet Resource Needs	123	103	89	106
Distinct Clients with Unmet Resource Needs	86	72	64	76
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	24	23	15	21
7b-ii Mental Health Advance Directives	2	3	2	1
Total Unmet Resource Needs	26	26	17	22
Distinct Clients with Unmet Resource Needs	25	24	16	21
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	2	2	4	2
7c-ii Recovery Workbook Group	0	0	0	1
7c-iii Social Club	10	12	5	12
7c-iv Peer-Run Trauma Recovery Group	1	7	6	6
7c-v Wellness Recovery and Action Planning	0	2	2	1
7c-vi Family Support	10	9	7	15
Total Unmet Resource Needs	23	32	24	37
Distinct Clients with Unmet Resource Needs	19	25	20	29
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	6	9	2	5
7d-ii Residential Treatment Substance Abuse Services	1	2	0	0
Total Unmet Resource Needs	7	11	2	5
Distinct Clients with Unmet Resource Needs	6	10	2	5

Report Run: Oct 10, 2013

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	460	549	544	542
7e. Housing				
7e-i Supported Apartment	9	5	5	9
7e-ii Community Residential Facility	2	3	3	2
7e-iii Residential Treatment Facility (group home)	1	2	2	1
7e-iv Assisted Living Facility	2	5	3	2
7e-v Nursing Home	0	2	0	0
7e-vi Residential Crisis Unit	0	1	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	50	62	50	65
Total Unmet Resource Needs	64	80	63	79
Distinct Clients with Unmet Resource Needs	58	72	59	74
7f. Health Care				
7f-i Dental Services	31	41	31	34
7f-ii Eye Care Services	17	18	12	14
7f-iii Hearing Services	3	2	2	4
7f-iv Physical Therapy	4	7	3	7
7f-v Physician/Medical Services	17	20	12	18
Total Unmet Resource Needs	72	88	60	77
Distinct Clients with Unmet Resource Needs	51	64	45	56
7g. Legal				
7g-i Advocate	9	12	9	8
7g-ii Guardian (private)	0	0	0	0
7g-iii Guardian (public)	0	2	1	0
Total Unmet Resource Needs	9	14	10	8
Distinct Clients with Unmet Resource Needs	9	14	10	8
7h. Financial Security				
7h-i Assistance with Managing Money	33	37	38	46
7h-ii Assistance with Securing Public Benefits	20	32	20	24
7h-iii Representative Payee	3	7	1	2
Total Unmet Resource Needs	56	76	59	72
Distinct Clients with Unmet Resource Needs	45	58	45	56

Report Run: Oct 10, 2013

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

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	460	549	544	542
7i. Education				
7i-i Adult Education (other than GED)	1	4	3	3
7i-ii GED	3	5	2	7
7i-iii Literacy Assistance	1	4	1	2
7i-iv Post High School Education	2	1	4	2
7i-v Tuition Reimbursement	0	0	1	1
Total Unmet Resource Needs	7	14	11	15
Distinct Clients with Unmet Resource Needs	7	13	11	13
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	5	8	7	9
7j-ii Club House and/or Peer Vocational Support	1	2	0	1
7j-iii Competitive Employment (no supports)	3	8	4	6
7j-iv Supported Employment	3	2	5	4
7j-v Vocational Rehabilitation	22	24	28	25
Total Unmet Resource Needs	34	44	44	45
Distinct Clients with Unmet Resource Needs	27	35	35	36
7k. Living Skills				
7k-i Daily Living Support Services	13	22	17	19
7k-ii Day Support Services	1	1	0	1
7k-iii Occupational Therapy	0	0	2	2
7k-iv Skills Development Services	9	5	9	10
Total Unmet Resource Needs	23	28	28	32
Distinct Clients with Unmet Resource Needs	21	26	27	30
7l. Transportation				
7l-i Transportation to ISP-Identified Services	32	40	27	31
7-ii Transportation to Other ISP Activities	23	26	14	17
7-iii After Hours Transportation	12	15	9	21
Total Unmet Resource Needs	67	81	50	69
Distinct Clients with Unmet Resource Needs	41	50	36	50
7m. Personal Growth/Community				
7m-i Avocational Activities	4	3	4	4

Report Run: Oct 10, 2013

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

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

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	460	549	544	542
7m. Personal Growth/Community				
7m-ii Recreation Activities	10	13	12	11
7m-iii Social Activities	17	22	30	29
7m-iv Spiritual Activities	2	2	5	5
Total Unmet Resource Needs	33	40	51	49
Distinct Clients with Unmet Resource Needs	24	30	37	35
Other Resources				
Other Resources	11	19	7	14
Total Unmet Resource Needs	11	19	7	14
Distinct Clients with Unmet Resource Needs	11	19	7	14
CSN 7 Totals				
Total Unmet Resource Needs	555	656	515	630
Distinct Clients With any Unmet Resource Need	157	179	153	176
Distinct Clients with a RDS	460	549	544	542

Report Run: Oct 10, 2013

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

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	356	325	330	303
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	1	0	3	1
7a-iii Dialectical Behavioral Therapy	4	3	2	2
7a-iv Family Psycho-Educational Treatment	0	0	0	1
7a-v Group Counseling	1	0	0	0
7a-vi Individual Counseling	17	13	18	17
7a-vii Inpatient Psychiatric Facility	0	0	1	1
7a-viii Intensive Case Management	1	3	1	1
7a-x Psychiatric Medication Management	17	14	17	14
Total Unmet Resource Needs	41	33	42	37
Distinct Clients with Unmet Resource Needs	35	27	33	26
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	2	3	5	7
7b-ii Mental Health Advance Directives	2	3	1	2
Total Unmet Resource Needs	4	6	6	9
Distinct Clients with Unmet Resource Needs	4	5	5	8
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	2	0	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	2	4	8	5
7c-iv Peer-Run Trauma Recovery Group	2	1	1	1
7c-v Wellness Recovery and Action Planning	0	0	1	0
7c-vi Family Support	2	2	4	1
Total Unmet Resource Needs	7	9	14	7
Distinct Clients with Unmet Resource Needs	7	9	12	6
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	1	4	2	2
7d-ii Residential Treatment Substance Abuse Services	0	0	1	2
Total Unmet Resource Needs	1	4	3	4
Distinct Clients with Unmet Resource Needs	1	4	3	4

Report Run: Oct 10, 2013

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

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	356	325	330	303
7e. Housing				
7e-i Supported Apartment	2	1	2	3
7e-ii Community Residential Facility	3	1	2	1
7e-iii Residential Treatment Facility (group home)	0	0	0	0
7e-iv Assisted Living Facility	0	0	1	1
7e-v Nursing Home	1	1	1	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	26	26	28	22
Total Unmet Resource Needs	32	29	34	28
Distinct Clients with Unmet Resource Needs	32	29	33	27
7f. Health Care				
7f-i Dental Services	17	22	26	23
7f-ii Eye Care Services	6	11	7	9
7f-iii Hearing Services	0	0	0	0
7f-iv Physical Therapy	0	1	1	0
7f-v Physician/Medical Services	8	5	7	7
Total Unmet Resource Needs	31	39	41	39
Distinct Clients with Unmet Resource Needs	26	29	33	29
7g. Legal				
7g-i Advocate	4	2	4	0
7g-ii Guardian (private)	2	1	1	1
7g-iii Guardian (public)	3	1	1	1
Total Unmet Resource Needs	9	4	6	2
Distinct Clients with Unmet Resource Needs	9	4	6	2
7h. Financial Security				
7h-i Assistance with Managing Money	11	11	11	7
7h-ii Assistance with Securing Public Benefits	7	8	11	4
7h-iii Representative Payee	2	2	3	1
Total Unmet Resource Needs	20	21	25	12
Distinct Clients with Unmet Resource Needs	19	20	23	12

Report Run: Oct 10, 2013

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

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

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	356	325	330	303
7i. Education				
7i-i Adult Education (other than GED)	2	3	4	2
7i-ii GED	3	2	5	2
7i-iii Literacy Assistance	0	1	1	0
7i-iv Post High School Education	2	1	3	1
7i-v Tuition Reimbursement	0	0	1	0
Total Unmet Resource Needs	7	7	14	5
Distinct Clients with Unmet Resource Needs	7	7	13	5
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	2	1	1	1
7j-ii Club House and/or Peer Vocational Support	0	1	1	0
7j-iii Competitive Employment (no supports)	2	2	4	3
7j-iv Supported Employment	4	4	3	2
7j-v Vocational Rehabilitation	6	10	10	9
Total Unmet Resource Needs	14	18	19	15
Distinct Clients with Unmet Resource Needs	14	17	19	15
7k. Living Skills				
7k-i Daily Living Support Services	6	8	7	3
7k-ii Day Support Services	6	3	5	3
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	4	3	5	2
Total Unmet Resource Needs	16	14	17	8
Distinct Clients with Unmet Resource Needs	13	12	12	8
7l. Transportation				
7l-i Transportation to ISP-Identified Services	15	15	15	11
7-ii Transportation to Other ISP Activities	5	9	10	7
7-iii After Hours Transportation	9	8	9	9
Total Unmet Resource Needs	29	32	34	27
Distinct Clients with Unmet Resource Needs	23	21	23	19
7m. Personal Growth/Community				
7m-i Avocational Activities	1	1	2	2

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

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 4
(April, May, June 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Distinct Clients with a RDS	356	325	330	303
7m. Personal Growth/Community				
7m-ii Recreation Activities	5	4	5	8
7m-iii Social Activities	11	11	14	9
7m-iv Spiritual Activities	0	0	2	1
Total Unmet Resource Needs	17	16	23	20
Distinct Clients with Unmet Resource Needs	15	13	16	14
Other Resources				
Other Resources	9	9	7	7
Total Unmet Resource Needs	9	9	7	7
Distinct Clients with Unmet Resource Needs	9	9	7	7
CSN Not Assigned Totals				
Total Unmet Resource Needs	237	241	285	220
Distinct Clients With any Unmet Resource Need	102	96	100	88
Distinct Clients with a RDS	356	325	330	303

Report Run: Oct 10, 2013

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

Department of Health and Human Services
Substance Abuse and Mental Health Services
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Bridging Rental Assistance Program (BRAP)
Monitoring Report
Quarter 2 FY2014 (July,August,September 2013)

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

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

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

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

- Priority #1 applicants (Discharge from a psychiatric hospital within the last 6 months). Riverview and Dorothea Dix consumers are typically not waiting more than 5 days from the date of a completed application. Priority 1 applicants waiting for a BRAP voucher have decreased from 12 to 1 person, down 92%.
- Priority #2 applicants (Homeless) have decreased from 206 to92 persons down 55%
- Priority #3 applicants (Substandard Housing) have increased from 2 to 3 persons up 50%.
- Priority #4 applicants (Community Residential Facility) have also decreased from 15 to 9 persons, down 40%.
- Persons on the waitlist greater than 90 days have decreased from 195 to 16 persons, down 92%.

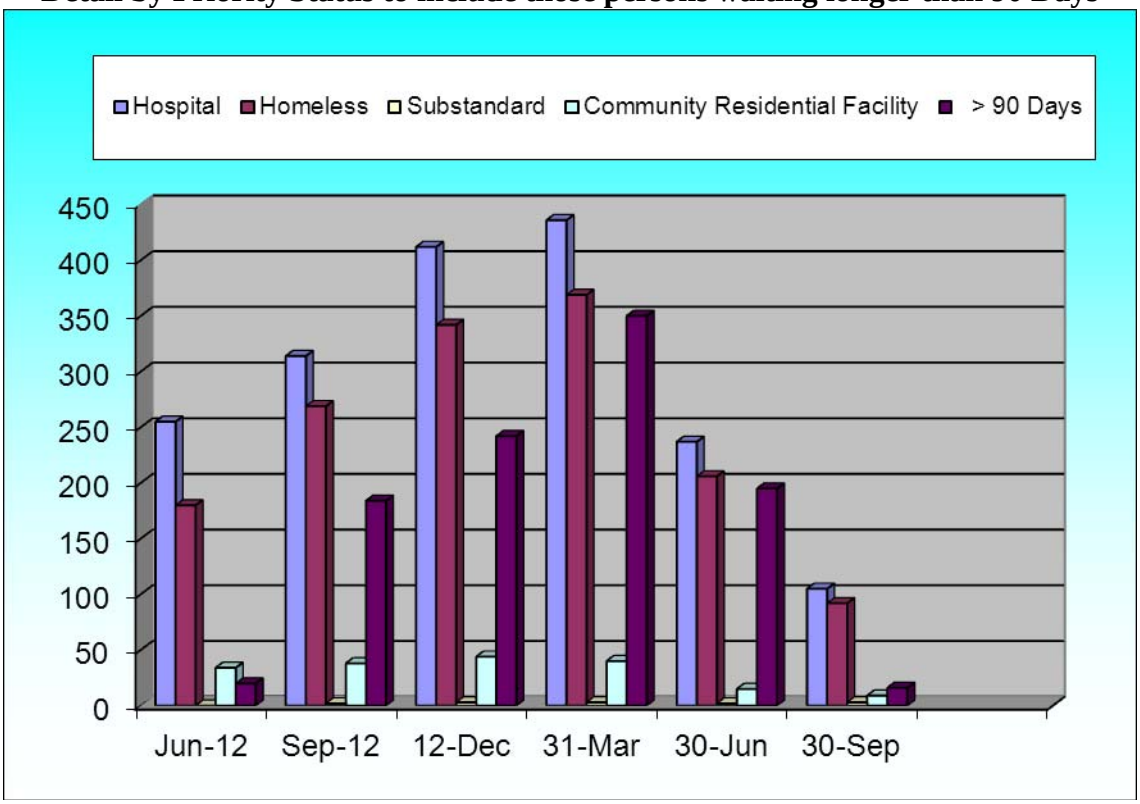
Since inception of the wait list, there has been a total of 2,450 BRAP vouchers awarded broken down as follows: Priority #1, 1,123; Priority #2, 1,060; Priority #3, 31; Priority #4, 221. Note that 15 vouchers have been awarded to persons with no priority. In the last quarter 150 vouchers were awarded.

The current BRAP census as of September 30, 2013 is 1,007 vouchers issued—first time in program history we have exceeded the 1,000 milestone in meeting consumer's Supported Housing needs through BRAP. The overall budget for FY 14 increased to $5,018,508 which is allowing us to better meet the waitlist needs and push for expantion into more rural areas where vouchers have not been traditionally available or utilized due to housing stock as well as community education and partnership. This is being done through our established administrative agents as well as the developing relationships with the PATH program, Continuums of Care, and Homeless Councils.

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

SAMHS administers a substantial number of Shelter Plus Care vouchers, more than any other state on a per-capita basis. The census was 890 as of September 30, 2013. This program is funded by the U.S. Department of Housing and Urban Development and has seen significant growth over the last decade, the result of SAMHS aggressively applying for and receiving new grants each year. The FY2014 annual budget for Shelter Plus Care is $7.9 million. The total dollars for all SPC grants (one year renewals to 5 year new contracts) administered by SAMHS is $14,101,781. Shelter Plus Care (SPC) provides permanent rental subsidies (housing vouchers) and supportive services (provided by MaineCare) to literally homeless individuals with: severe and persistent mental illness (63%), chronic substance abuse and mental illness (30%), and chronic substance abuse and HIV/AIDS (7%).

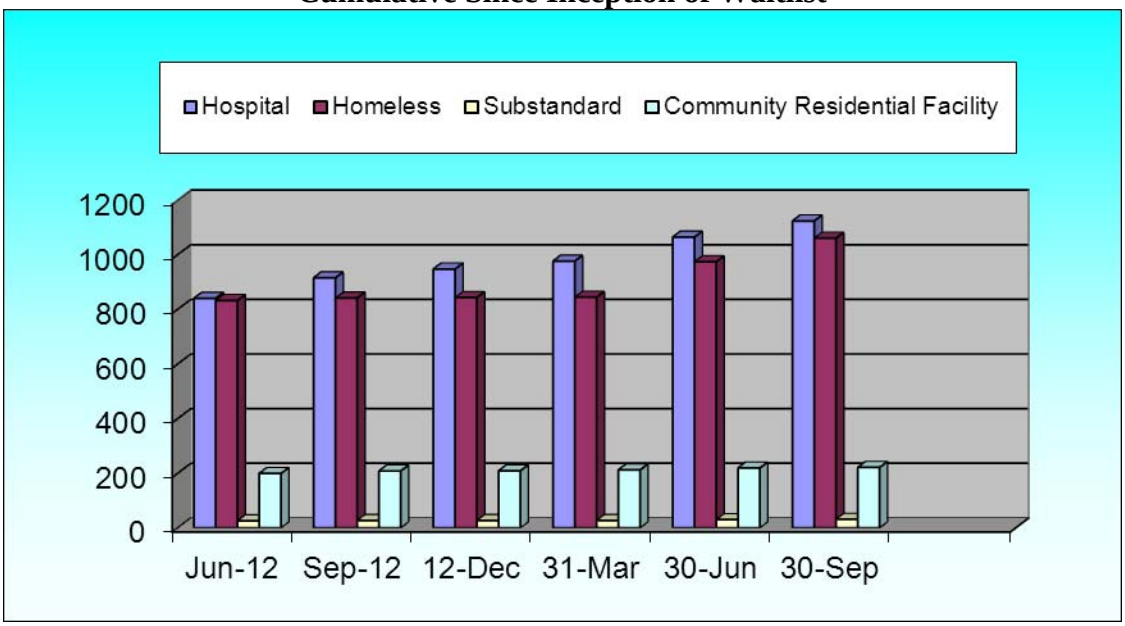
BRAP Waitlist Status--Graph:
Detail by Priority Status to include those persons waiting longer than 90 Days



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

Reporting Period	Jun-12	Sep-12	12-Dec	31-Mar	30-Jun	30-Sep	% Change relative to Last Report
Total number of persons waiting for BRAP	255	314	412	436	237	105	-56%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	41	5	23	22	12	1	-92%
Priority 2—Homeless (HUD Transitional Definition)	180	269	342	369	206	92	-55%
Priority 3—Sub-standard Housing	0	2	3	3	2	3	50%
Priority 4—Leaving a Community Residential living facility	34	38	44	40	15	9	-40%
Total number of persons on wait list more than 90 days awaiting voucher	20	184	242	350	195	16	-92%

BRAP Awards—Graph
Cumulative Since Inception of Waitlist



BRAP Awards—Table
Cumulative Since Inception of Waitlist

Reporting Periods	Jun-12	Sep-12	12-Dec	31-Mar	30-Jun	30-Sep	% Change relative to Last Report
Cumulative number of persons awarded BRAP	1908	2003	2038	2071	2300	2450	6%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	840	915	947	976	1064	1123	5%
Priority 2—Homeless (HUD Transitional Definition)	832	841	843	844	974	1060	8%
Priority 3—Sub-standard Housing	26	27	27	27	30	31	3%
Priority 4—Leaving a DHHS funded living facility	199	208	209	212	219	221	1%

Note: 15 persons awarded with no priority

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

Class Member Treatment Planning

For the 1 st Quarter of Fiscal Year 2014

(July, August, September, 2013)

	Total Plans Reviewed	2013 Q2 55	2013 Q3 50	2013 Q4 49	2014 Q1 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% 18 of 18	100.0% 18 of 18	90.0% 9 of 10	100.0% 16 of 16
1B	Does the record document that the agency has planned with and educated the consumer regarding releases of information during each treatment plan review?	96.2% 51 of 53	85.4% 41 of 48	85.7% 42 of 49	80.4% 37 of 46
1C	Does the record document that the consumer has a primary care physician (PCP)?	88.7% 47 of 53	92.0% 46 of 50	91.8% 45 of 49	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?	85.1% 40 of 47	91.3% 42 of 46	80.0% 36 of 45	80.0% 36 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?	98.2% 54 of 55	98.0% 49 of 50	95.9% 47 of 49	92.0% 46 of 50
2B	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?	96.4% 53 of 55	100.0% 50 of 50	100.0% 49 of 49	96.0% 48 of 50
2C	Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?	98.2% 54 of 55	98.0% 49 of 50	95.9% 47 of 49	94.0% 47 of 50
2D	Does the record document that the individual's potential need for crisis intervention and resolution services was considered with the consumer during treatment planning?	100.0% 55 of 55	96.0% 48 of 50	100.0% 49 of 49	98.0% 49 of 50
2E	Does the record document that the consumer has a crisis plan?	92.3% 48 of 52	62.5% 30 of 48	63.8% 30 of 47	67.3% 33 of 49
2F	If 2E. is no, is the reason documented?	100.0% 4 of 4	100.0% 18 of 18	100.0% 17 of 17	100.0% 16 of 16
2G	If 2E. is yes, has the crisis plan been reviewed as required every three months?	89.6% 43 of 48	73.3% 22 of 30	86.7% 26 of 30	84.8% 28 of 33
2H	If 2E. is yes, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?	100.0% 4 of 4	50.0% 3 of 6	77.8% 7 of 9	100.0% 7 of 7
2I	Does the record document that the consumer has a mental health advance directive?	12.7% 7 of 55	4.1% 2 of 49	8.3% 4 of 48	4.1% 2 of 49
2J	If 2I. is yes, has the advance directive been reviewed at least annually by the CSW and consumer?	0.0% 0 of 7	0.0% 0 of 2	0.0% 0 of 4	0.0% 0 of 2

2K	If 2I. is no, is the reason why documented?	100.0%	48	of	48	100.0%	47	of	47	100.0%	44	of	44	100.0%	47	of	47
III Needed Resources																	
3A	Does the record document that natural supports (family/friends) are being accessed as a resource?	N/A	0	of	0	N/A	0	of	0	N/A	0	of	0	N/A	0	of	0
3B	If 3A. is no, has the worker discussed with the consumer the consideration of natural supports as a resource?	N/A	0	of	0	N/A	0	of	0	N/A	0	of	0	N/A	0	of	0
3C	Does the record document that generic resources (those resources that anyone can access) are being accessed?	100.0%	2	of	2	66.7%	2	of	3	50.0%	1	of	2	75.0%	3	of	4
3D	If 3C. is no, has the worker discussed with the consumer the consideration of generic resources as a resource?	N/A	0	of	0	0.0%	0	of	1	0.0%	0	of	1	0.0%	0	of	1
3E	Does the record document a resource need that has not been provided according to/within the expected response time?	80.0%	8	of	10	50.0%	3	of	6	60.0%	3	of	5	54.5%	6	of	11
3F	Does the treatment plan reflect interim planning?	100.0%	8	of	8	100.0%	3	of	3	100.0%	3	of	3	100.0%	6	of	6
3G	Does the record document that the treatment team reconvened after the unmet need was identified?	0.0%	0	of	8	0.0%	0	of	3	0.0%	0	of	3	0.0%	0	of	6
IV Service Agreements																	
4A	Does the record document that service agreements are required for this plan? (see paragraph 69 protocol for definitions)	34.5%	19	of	55	47.9%	23	of	48	53.1%	26	of	49	46.0%	23	of	50
4B	If 4A. is yes, have service agreements been acquired?	73.7%	14	of	19	73.9%	17	of	23	73.1%	19	of	26	56.5%	13	of	23
4C	If 4A. is yes, are the service agreements current?	73.7%	14	of	19	65.2%	15	of	23	57.7%	15	of	26	47.8%	11	of	23
V Vocational Services																	
5A	Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?	98.2%	54	of	55	98.0%	49	of	50	100.0%	48	of	48	95.8%	46	of	48
5B	Does the record document that the vocational domain is being addressed with the consumer at each 90 day treatment plan review?	98.2%	54	of	55	93.8%	45	of	48	85.4%	41	of	48	89.6%	43	of	48
VI Comments																	
6A	Plan of correction requested?	27.3%	15	of	55	30.0%	15	of	50	53.1%	26	of	49	52.0%	26	of	50
6A.1.	Plan of correction for section 2A. (required when not all domains assessed) included?	0.0%	0	of	1	0.0%	0	of	1	0.0%	0	of	2	0.0%	0	of	4
6C	Plan of correction received?	66.7%	10	of	15	13.3%	2	of	15	34.6%	9	of	26	30.8%	8	of	26
6D	Were corrections made to the satisfaction of the CDC?	100.0%	10	of	10	100.0%	2	of	2	100.0%	9	of	9	100.0%	8	of	8

Report Run by: Brandi.Giguere Report Run on: Oct 8, 2013 at 9:00:51 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 Admissions

All Clients

For the 4th Quarter of Fiscal Year 2013

(April, May, June, 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Total Admissions	129	132	132	123
Hospital				
Hospitalized in Local Area	81.4% (105 of 129)	87.1% (115 of 132)	85.6% (113 of 132)	84.6% (104 of 123)
Hospitalization Made Voluntary	79.8% (103 of 129)	75.8% (100 of 132)	75.8% (100 of 132)	71.5% (88 of 123)
Legal Status				
Blue Paper on File	99.2% (128 of 129)	99.2% (131 of 132)	100.0% (132 of 132)	99.2% (122 of 123)
Blue Paper Complete/Accurate	100.0% (128 of 128)	100.0% (131 of 131)	100.0% (132 of 132)	100.0% (122 of 122)
If not complete, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
24 Hr. Certification Required	87.6% (113 of 129)	90.9% (120 of 132)	81.8% (108 of 132)	87.8% (108 of 123)
24 Hr. Certification on file	100.0% (113 of 113)	99.2% (119 of 120)	100.0% (108 of 108)	100.0% (108 of 108)
24 Hr. Certification Complete/Accurate	99.1% (112 of 113)	100.0% (119 of 119)	100.0% (108 of 108)	100.0% (108 of 108)
If not, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Quality Care				
Medical Necessity Established	100.0% (129 of 129)	100.0% (132 of 132)	100.0% (132 of 132)	100.0% (123 of 123)
Active Treatment Within Guidelines	100.0% (129 of 129)	100.0% (132 of 132)	100.0% (132 of 132)	100.0% (123 of 123)
Patient's Rights Maintained	99.2% (128 of 129)	97.7% (129 of 132)	100.0% (132 of 132)	98.4% (121 of 123)
If not maintained, follow up per policy	100.0% (1 of 1)	100.0% (2 of 2)	N/A (0 of 0)	0.0% (0 of 1)
Inappropriate Use of Blue Paper	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Individual Service Plans				
Receiving Case Management Services	19.4% (25 of 129)	28.8% (38 of 132)	22.0% (29 of 132)	17.9% (22 of 123)
Case Manager Involved with Discharge Planning	84.0% (21 of 25)	94.7% (36 of 38)	93.1% (27 of 29)	100.0% (22 of 22)
Total Clients who Authorized Hospital to Obtain ISP	88.0% (22 of 25)	97.4% (37 of 38)	100.0% (29 of 29)	100.0% (22 of 22)
Hospital Obtained ISP when authorized	0.0% (0 of 22)	8.1% (3 of 37)	6.9% (2 of 29)	18.2% (4 of 22)
Treatment and Discharge Plan Consistant with ISP	N/A (0 of 0)	100.0% (3 of 3)	100.0% (2 of 2)	100.0% (4 of 4)

Report Run: Oct 9, 2013

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

Community Hospital Utilization Review for Involuntary Admissions

Class Members

For the 4th Quarter of Fiscal Year 2013

(April, May, June, 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Total Admissions	24	14	15	20
Hospital				
Hospitalized in Local Area	87.5% (21 of 24)	92.9% (13 of 14)	86.7% (13 of 15)	90.0% (18 of 20)
Hospitalization Made Voluntary	75.0% (18 of 24)	50.0% (7 of 14)	53.3% (8 of 15)	65.0% (13 of 20)
Legal Status				
Blue Paper on File	100.0% (24 of 24)	92.9% (13 of 14)	100.0% (15 of 15)	100.0% (20 of 20)
Blue Paper Complete/Accurate	100.0% (24 of 24)	100.0% (13 of 13)	100.0% (15 of 15)	100.0% (20 of 20)
If not complete, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
24 Hr. Certification Required	87.5% (21 of 24)	100.0% (14 of 14)	86.7% (13 of 15)	95.0% (19 of 20)
24 Hr. Certification on file	100.0% (21 of 21)	92.9% (13 of 14)	100.0% (13 of 13)	100.0% (19 of 19)
24 Hr. Certification Complete/Accurate	100.0% (21 of 21)	100.0% (13 of 13)	100.0% (13 of 13)	100.0% (19 of 19)
If not, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Quality Care				
Medical Necessity Established	100.0% (24 of 24)	100.0% (14 of 14)	100.0% (15 of 15)	100.0% (20 of 20)
Active Treatment Within Guidelines	100.0% (24 of 24)	100.0% (14 of 14)	100.0% (15 of 15)	100.0% (20 of 20)
Patient's Rights Maintained	100.0% (24 of 24)	92.9% (13 of 14)	100.0% (15 of 15)	100.0% (20 of 20)
If not maintained, follow up per policy	N/A (0 of 0)	100.0% (1 of 1)	N/A (0 of 0)	N/A (0 of 0)
Inappropriate Use of Blue Paper	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Individual Service Plans				
Receiving Case Management Services	50.0% (12 of 24)	64.3% (9 of 14)	40.0% (6 of 15)	35.0% (7 of 20)
Case Manager Involved with Discharge Planning	75.0% (9 of 12)	100.0% (9 of 9)	100.0% (6 of 6)	100.0% (7 of 7)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (12 of 12)	100.0% (9 of 9)	100.0% (6 of 6)	100.0% (7 of 7)
Hospital Obtained ISP when authorized	0.0% (0 of 12)	22.2% (2 of 9)	16.7% (1 of 6)	28.6% (2 of 7)
Treatment and Discharge Plan Consistant with ISP	N/A (0 of 0)	100.0% (2 of 2)	100.0% (1 of 1)	100.0% (2 of 2)

Report Run: Oct 9, 2013

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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: All Clients

For the 4th Quarter of Fiscal Year 2013

(April, May, June, 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Number of Admissions	129	132	132	123
Involuntarily Admitted Clients who were Receiving CSS Services	25	38	29	22
Number of ISPs Hospitals were Authorized to Obtain	22	37	29	22
Number of ISPs Hospitals Obtained	0	3	2	4

FY QTR	Hospital	Admissions	Receiving Community Support Services	Hospital Obtained ISP when authorized	Treatment and Discharge Plan Consistant with ISP	Case Worker Involved with Treatment and Discharge Planning
2013 Q1	**Acadia**	30	6.7% (2 of 30)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Waterville	5	0.0% (0 of 5)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Maine Medical Center	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	10	30.0% (3 of 10)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	PenBay Medical Center	8	0.0% (0 of 8)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	13	23.1% (3 of 13)	0.0% (0 of 3)	N/A (0 of 0)	0.0% (0 of 3)
	Spring Harbor	51	27.5% (14 of 51)	0.0% (0 of 11)	N/A (0 of 0)	92.9% (13 of 14)
	St. Mary's	11	18.2% (2 of 11)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
2013 Q2	**Acadia**	23	21.7% (5 of 23)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	Maine General - Waterville	7	42.9% (3 of 7)	66.7% (2 of 3)	100.0% (2 of 2)	100.0% (3 of 3)
	Maine Medical Center	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Mid-coast Hospital	11	18.2% (2 of 11)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	PenBay Medical Center	16	50.0% (8 of 16)	0.0% (0 of 8)	N/A (0 of 0)	100.0% (8 of 8)
	Select	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	20	20.0% (4 of 20)	0.0% (0 of 4)	N/A (0 of 0)	75.0% (3 of 4)
	Spring Harbor	39	38.5% (15 of 39)	7.1% (1 of 14)	100.0% (1 of 1)	93.3% (14 of 15)
	St. Mary's	13	7.7% (1 of 13)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
2013 Q3	**Acadia**	23	30.4% (7 of 23)	14.3% (1 of 7)	100.0% (1 of 1)	100.0% (7 of 7)
	Maine General - Waterville	9	11.1% (1 of 9)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Mid-coast Hospital	10	50.0% (5 of 10)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	PenBay Medical Center	6	16.7% (1 of 6)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Select	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	28	7.1% (2 of 28)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Spring Harbor	46	21.7% (10 of 46)	0.0% (0 of 10)	N/A (0 of 0)	80.0% (8 of 10)
	St. Mary's	9	33.3% (3 of 9)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
2013 Q4	**Acadia**	17	17.6% (3 of 17)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Maine General - Waterville	14	28.6% (4 of 14)	100.0% (4 of 4)	100.0% (4 of 4)	100.0% (4 of 4)
	Mid-coast Hospital	4	25.0% (1 of 4)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	7	14.3% (1 of 7)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Select	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	11	18.2% (2 of 11)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Spring Harbor	54	14.8% (8 of 54)	0.0% (0 of 8)	N/A (0 of 0)	100.0% (8 of 8)
	St. Mary's	15	20.0% (3 of 15)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)

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

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

Community Hospital Utilization Review for Involuntary Admissions

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

For the 4th Quarter of Fiscal Year 2013

(April, May, June, 2013)

	2013 Q1	2013 Q2	2013 Q3	2013 Q4
Number of Admissions	24	14	15	20
Involuntarily Admitted Clients who were Receiving CSS Services	12	9	6	7
Number of ISPs Hospitals were Authorized to Obtain	12	9	6	7
Number of ISPs Hospitals Obtained	0	2	1	2

FY QTR	Hospital	Admissions	Receiving Community Support Services	Hospital Obtained ISP when authorized	Treatment and Discharge Plan Consistant with ISP	Case Worker Involved with Treatment and Discharge Planning
2013 Q1	**Acadia**	2	50.0% (1 of 2)	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	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	PenBay Medical Center	4	0.0% (0 of 4)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	4	75.0% (3 of 4)	0.0% (0 of 3)	N/A (0 of 0)	0.0% (0 of 3)
	Spring Harbor	9	77.8% (7 of 9)	0.0% (0 of 7)	N/A (0 of 0)	100.0% (7 of 7)
	St. Mary's	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
2013 Q2	**Acadia**	2	100.0% (2 of 2)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Waterville	2	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	PenBay Medical Center	4	75.0% (3 of 4)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Southern Maine Medical Center	3	33.3% (1 of 3)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Spring Harbor	2	50.0% (1 of 2)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	St. Mary's	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
2013 Q3	**Acadia**	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Maine General - Waterville	3	33.3% (1 of 3)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Mid-coast Hospital	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	PenBay Medical Center	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	8	50.0% (4 of 8)	0.0% (0 of 4)	N/A (0 of 0)	100.0% (4 of 4)
2013 Q4	**Acadia**	2	50.0% (1 of 2)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Maine General - Waterville	3	66.7% (2 of 3)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	PenBay Medical Center	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	12	33.3% (4 of 12)	0.0% (0 of 4)	N/A (0 of 0)	100.0% (4 of 4)
	St. Mary's	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)

Report Run: Oct 9, 2013

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Adult 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 Monthly - Crisis Report

Crisis Report for Quarter 1 FY14

July, August and September 2013 - State Wide

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

										Totals
Gender	Children	Males	405	Females	391					796
	Adults	Males	1716	Females	1870					3586
Age Range	Children	< 5y.O.	15	5 - 9	115	10 - 14	307	15-17	359	4382
	Adults	18 - 21	360	22 - 35	1110	36 - 60	1752	>60	364	
Payment Source	Children	MaineCare	576	Private Ins.	191	Uninsured	26	Medicare	3	
	Adults	MaineCare	1843	Private Ins.	613	Uninsured	822	Medicare	308	

II. Summery Of All Crisis Contacts

	Children	Adults
a. Total number of telephone contacts.	6129	37662
b. Total number of initial face to face contacts	931	4206
c. Number in IIb. who are children/youth with MENTAL RETARDATION/AUTISM/PERVASIVE DEV. DIS.	92	
d. Number of face to face contacts that are ongoing support for crisis resolution / stabilization	132	1436

III. Crisis Contact Infomation

	Children		Adults	
a. Total number of initial face to face contacts in which wellness plan, crisis plan, ISP or advanced directive plan previously developed with the individual was used.	123	13.21%	63	1.50%
b. Number of face to face contacts who have a Community Support Worker (CI,CRS,ICM, ACT,TCM)	383	41.14%	1073	25.51%
c. Number of face to face contacts who have a Community Support Worker that was notified of crisis.	374	40.17%	1031	96.09%
d. SUM time in minutes for all face to face contacts in IIb 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.			109946	26.14%
e. Number of face to face contacts in Emergency Department with final disposition within 8 hours.			2261	53.76%
f. Number of face to face contacts not in Emergency Department with final dispositon within 8 hours.			1546	36.76%

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.	799	1 to 2 Hours	109	2 to 4 Hours	15	More Than 4 Hours	2
Percent	85.82%	Percent	11.71%	Percent	1.61%	Percent	0.21%

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

Less Than 3 Hours	392	3 to 6 Hours	431	6 to 8 Hours	36	8 to 14 Hours	26	> 14	43
Percent	42.11%	Percent	42.11%	Percent	3.87%	Percent	2.79%	Percent	4.62%

IV. Site Of Face To Face Contacts Number of face to face seen in:

	Children		Adults	
a. Primary Care Residence (Home)	127	13.64%	303	7.20%
b. Family/Relative/Other Residence	25	2.69%	25	0.59%
c. Other Community Setting (Work School Police Dept, Public Place)	29	3.11%	108	2.57%
d. SNF, Nursing Home, Boarding Home	1	0.11%	17	0.40%
e. Residential Program (Congregate Community Residence , Apartment Program)	13	1.40%	69	1.64%
f. Homeless Shelter	6	0.64%	29	0.69%
g. Provider Office	19	2.04%	120	2.85%
h. Crisis office	124	13.32%	741	17.62%
i. Emergency Department	570	61.22%	2571	61.13%
j. Other Hospital Location	16	1.72%	156	3.71%
k. Incarcerated (local jail, State Prison, Juvenile Correction Facility)	1	0.11%	67	1.59%

V. Crisis Resolution (Mutually Exclusive Exhaustive)

Totals:	931	100%	4206	100%

	Children		Adults	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	28	3.01%	268	6.37%
b. Crisis stabilization with referral to new provider for mental health/substance abuse follow up.	180	19.33%	802	19.07%
c. Crisis stabilization with referral back to current provider for mental health/subst abuse follow up.	339	36.41%	1427	33.93%
d. Admission to Crisis Stabilization Unit	150	16.11%	512	12.17%
e. Inpatient Hospitalization-Medical	5	0.54%	105	2.50%
f. Voluntary Psychiatric Hospitalization	226	24.27%	794	18.88%
g. Involuntary Psychiatric Hospitalization	2	0.21%	189	4.49%
h. Admission to Detox Unit	1	0.11%	109	2.59%
Totals:	931	100%	4206	100%

Integrated Monthly - Crisis Report

VI.	Crisis Assessment Criteria
Depression	907
Anxiety	597
Behavioral Issues--youth	469
Suicidal Ideation or Act	1317
Homicidal Ideation or Act	44
Self-Injury/Assaultive Behavior	109
Medical Attention Needed	45
Mental Health Symptom Decompensating	383
Grief and Loss	48
Domestic Abuse	24
Acute Stress	310
Deliberate Self Harm	36
No medical Based Change in Mental Status	21
Sexual Assault	5
Psychosis	385
Total	**5137**

Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE

FIRST STATE FISCAL QUARTER 2014
July, August, September 2013

Mary Louise McEwen, RN, MBA
Superintendent

October 21, 2013

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Glossary of Terms, Acronyms & Abbreviations

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

Glossary of Terms, Acronyms & Abbreviations

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

INTRODUCTION

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

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

There are three major sections that make up this report:

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

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

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

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

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

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CONSENT DECREE

Consent Decree Plan

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

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

Client Rights

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

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

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

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

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
1. Level II grievances responded to by RPC on time.	100% 5/5	100% 1/1	0/0	50% 3/6
2. Level I grievances responded to by RPC on time.	60% 64/106	95% 96/101	98% 58/59	98% 59/60

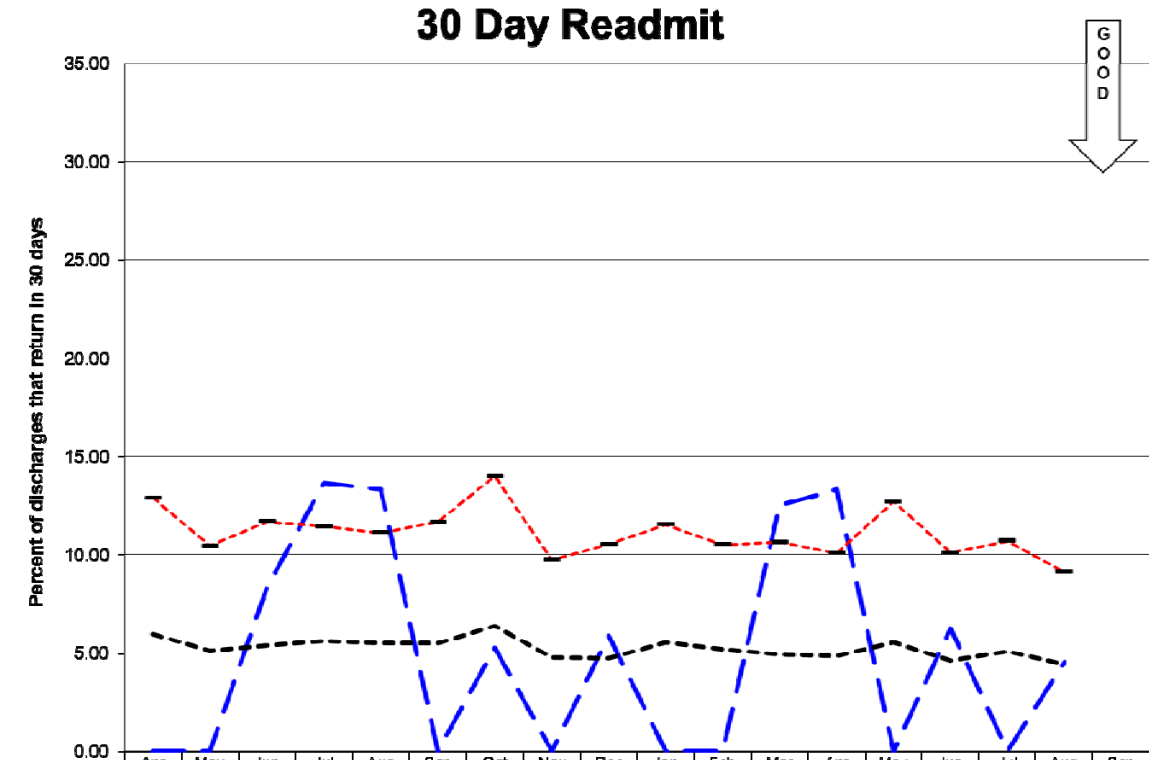
Admissions

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

Legal Status on Admission	2Q2013	3Q2013	4Q2013	1Q2014
ICDCC	9	20	17	30
ICRDCC				
INVOL CRIM	34	21		
INVOL CRIM – Forensic Evaluation			16	24
INVOL CRIM – IST			3	5
INVOL CRIM – NCR				3
INVOL CRIM – Jail Transfer				
INVOL-CIV		1		1
PCHDCC			3	
PCHDCC+M	1	1		
PCHDSS-PTP-R			1	
VOL		7	3	

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.00	0.00	8.33	13.64	13.33	0.00	5.26	0.00	5.88	0.00	0.00	12.50	13.33	0.00	6.25	0.00	4.55	
N:I Mean	5.97	5.11	5.39	5.62	5.51	5.50	6.37	4.78	4.75	5.53	5.21	4.94	4.84	5.54	4.62	5.08	4.44	
+1 StDev	12.89	10.45	11.69	11.43	11.11	11.66	14	9.75	10.53	11.54	10.51	10.84	10.08	12.69	10.1	10.69	9.13	

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

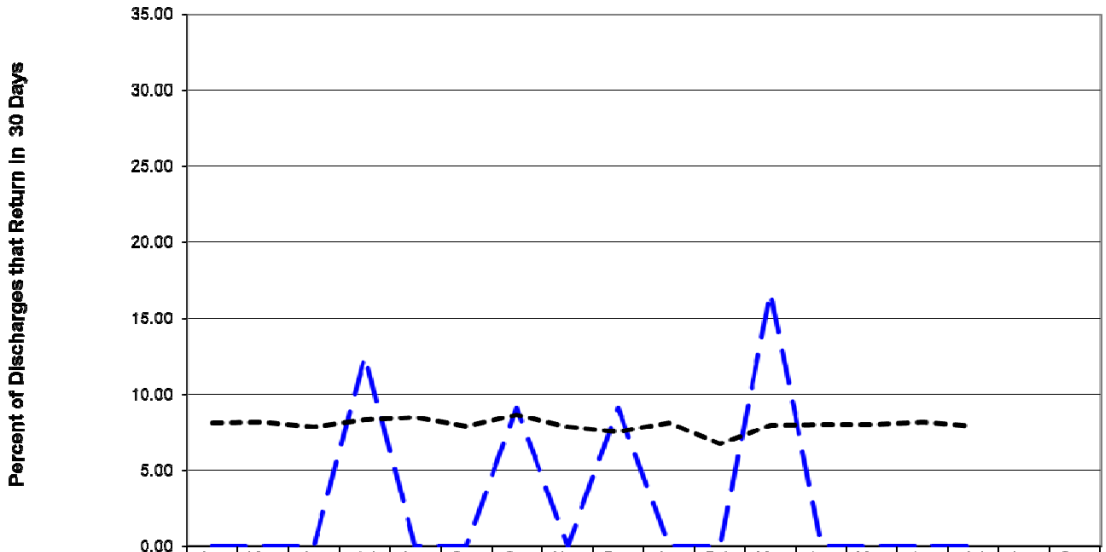
The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility stratified by forensic or civil classifications. For example, a rate of 10.0 means that 10% of all discharges were readmitted within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

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

CONSENT DECREE

30 Day Readmit

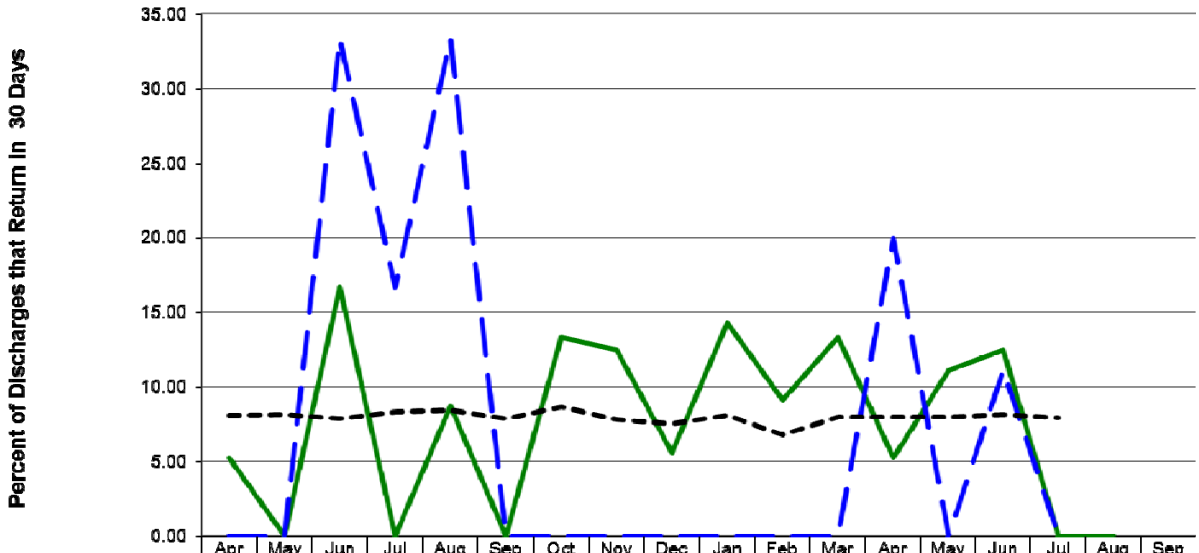
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.00	0.00	0.00	12.50	0.00	0.00	9.09	0.00	9.09	0.00	0.00	16.67	0.00	0.00	0.00	0.00		
National Mean	8.11	8.15	7.84	8.34	8.45	7.88	8.65	7.83	7.54	8.11	6.79	7.98	7.99	7.99	8.14	7.9		

30 Day Readmit

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Dorothea Dix	5.26	0.00	16.67	0.00	8.70	0.00	13.33	12.50	5.56	14.29	9.09	13.33	5.26	11.11	12.50	0.00	0.00	
Riverview	0.00	0.00	33.33	16.67	33.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	20.00	0.00	11.11	0.00		
National Mean	8.11	8.15	7.84	8.34	8.45	7.88	8.65	7.83	7.54	8.11	6.79	7.98	7.99	7.99	8.14	7.9		

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

REVIEW OF READMISSION OCCURRING WITHIN 60 DAYS

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	n/a 0/0	100% 2/2	100% 3/3	100% 2/2

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

CONSENT DECREE

REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review: a. Length of stay in community b. Type of residence (i.e.: group home, apartment, etc) c. Geographic location of residence d. Community support network e. Client demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with ACT Team	100% 3 clients were re-admitted to RPC;all were NCR, two due to increased psychiatric symptoms, one for using illicit substance in the forensic group home.	100% 3 clients were returned to RPC; two for substance use and 1 for psychiatric decompensating.	100% 5 clients were returned to RPC; 4 for psychiatric symptoms, one for relapse while in supervised apartment.	100% 2 clients were returned to RPC for psychiatric instability,
2. ACT Team will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%	100%	

Current Quarter Summary

1. Both readmissions were male, between the ages of 40 and 50, median age being 45; one PTP admitted in Q41013 remains in the hospital, as do two NCR patients. One client readmitted is socioeconomically disadvantaged, one is not. All clients re-admitted appeared to be medication adherent and had been attending appointments as scheduled with the ACT Team.
2. The ACT Team and the inpatient unit of RPC (Lower Saco, Upper Saco, Lower Kennebec and Upper Kennebec) worked collaboratively to minimize the time spent in Riverview while maximizing the opportunity for success upon their return to their community placements.

CONSENT DECREE

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

Client Admission Diagnoses	1Q13	2Q13	3Q13	1Q14	TOT
ADJUSTMENT DIS W MIXED DISTURBANCE OF EMOTIONS & CONDUCT	1				0
ADJUSTMENT DISORDER WITH DEPRESSED MOOD	1	1			1
ADJUSTMENT DISORDER WITH ANXIETY			1		1
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD		3	1	2	6
ADJUSTMENT REACTION NOS	2	1	1	1	4
ALCOHOL ABUSE-IN REMISS		1			1
ANXIETY STATE NOS			1		1
ATTN DEFICIT W HYPERACT			1	1	2
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC	1				0
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH					1
BIPOLAR DISORDER, UNSPECIFIED	6	5	5	9	23
DELUSIONAL DISORDER		1	2		3
DEPRESS DISORDER-UNSPEC					1
DEPRESSIVE DISORDER NEC		2	2	6	11
DRUG ABUSE NEC-IN REMISS		1			1
IMPULSE CONTROL DIS NOS	1	1	2		4
INTERMITT EXPLOSIVE DIS		1	1	2	4
MOOD DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE	1	1			1
OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER	1				0
OTH PERSISTENT MENTAL DIS DUE TO COND CLASSIFIED ELSEWHERE		1			1
PARANOID SCHIZO-CHRONIC	7	5	8	10	28
PARANOID SCHIZO-UNSPEC			1	2	3
PERSON FEIGNING ILLNESS		1		1	2
POSTTRAUMATIC STRESS DISORDER	2	3	3	4	12
PSYCHOSIS NOS	6	4	4	5	20
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	9	6	9	12	39
SCHIZOPHRENIA NOS-CHR	1		1		1
SCHIZOPHRENIA NOS-UNSPEC			2		4
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED			1		1
UNSPECIFIED EPISODIC MOOD DISORDER	7	6	4	8	23
Total Admissions	46	44	50	63	199
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0.0%	4.5%	0%	0%	1%

Peer Supports

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

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

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

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
1. Attendance at Comprehensive Treatment Team meetings. (v9)	87% 342/395	87% 354/406	87% 362/418	84% 408/488
2. Attendance at Service Integration meetings. (v8)	100% 31/31	98% 48/49	79% 26/33	95% 53/56
3. Contact during admission. (v8)	100% 44/44	100% 50/50	100% 46/46	100% 56/56

Treatment Planning

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

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

Individual social worker was addressed regarding timeliness of documentation for areas 4a and 4b.

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

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	97% 44/45	93% 43/45	96% 44/45	96% 29/30
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload	93% 14/15	95% 14/15	100% 15/15	N/A
3. Treatment plans will have measurable goals and interventions listing client strengths and areas of need related to transition to the community or transition back to a correctional facility.	96% 58/60	96% 58/60	91% 55/60	100% 30/30

No issues in this area.

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

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

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

CONSENT DECREE

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

V13) The treatment plans reflect

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

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

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

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

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

Medications

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

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

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

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

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

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

CONSENT DECREE

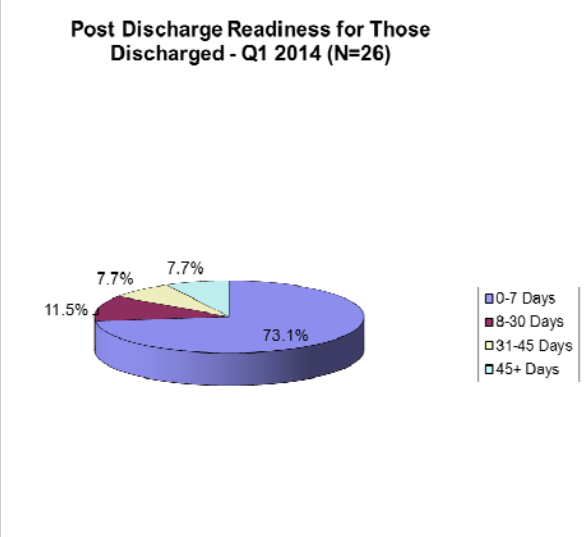
Discharges

Quarterly performance data shows that in 3 consecutive quarters:

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

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

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



Cumulative percentages & targets are as follows:

Within 7 days = (19) 73.1% (target 70%)
Within 30 days = (22) 84.6% (target 80%)
Within 45 days = (24) 92.3% (target 90%)
Post 45 days = (2) 7.7% (target 0%)

Barriers to Discharge Following Clinical Readiness

Residential Supports (1%)

1 client discharged 41 days post clinical readiness

Housing (10%)

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

Treatment Services (0)

No barriers in this area

The previous four quarters are displayed in the table below

		Within 7 days	Within 30days	Within 45 days	45 +days
Target >>		70%	80%	90%	< 10%
4Q2013	N=30	70%	86.7%	93.3%	6.7%
3Q2013	N=22	77.3%	86.4%	90.0%	9.1%
2Q2013	N-24	54.2%	70.9%	87.6%	12.5%
1Q2013	N=27	66.7%	85.2%	96.3%	3.7%

CONSENT DECREE

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

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

V21a) For patients who have been found not criminally responsible or not guilty by reason of insanity, appropriate interventions include timely reviews of progress toward the maximum levels allowed by court order; and the record reflects timely reviews of progress toward the maximum levels allowed by court order;

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

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

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
1. The Client Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 12/12	100% 12/12	100% 13/13	100% 12/12
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 12/12	100% 12/12	100% 13/13	100% 12/12
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	100% 12/12	100% 12/12	100% 13/13	91% 11/12
3. Each week the Social Work team and Director will meet and discuss current housing options provided by the respective regions and prioritize referrals.	100% 12/12	100% 12/12	100% 13/13	91% 11/12

The meeting was cancelled one week in the quarter due to a CMS visit. A two week report was sent out the following week.

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	2Q2013	3Q2013	4Q2013	1Q2014
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	100% 3/3	87% 7/8	80% 8/10	12% 1/8
2. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	100% 5/5	100$ 9/9	100% 4/4	100% 2/2
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually				

Area 1. The unit PSD and the Social Work Director have meet with the Superintendent to address this issue in the next quarter.

Staffing and Staff Training

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

Indicators	1Q2014	2Q2014	3Q2014	4Q2014	2014 Total
1. Riverview and Contract staff will attend CPR training bi-annually.	*40/46				87%
2. Riverview and Contract staff will attend NAPPI training annually.	*101/120				84%
3. Riverview and Contract staff will attend Annual training.	*11/25				73%

1Q 2014

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

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

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

Goal: SD will provide opportunities for employees to gain, develop, and renew skills knowledge and aptitudes.
Objective: 100% of employees will be provided with an opportunity both formal and informal training and/or learning experiences that contribute to individual growth and improved performance in current position.
SD will survey staff annually and develop trainings to address training needs as identified by staff.
Current Status: 1Q 2014
Employee Education needs survey distributed to employees in March of 2013.
As a result of identified needs, the training entitled ***Personality Disorder Characteristics and Effective* Interventions** was developed and presented in August 2013.
August 19 & 26, 2013:Susan C. Righthand, Ph.D, a nationally recognized speaker and consultant in the field of psychological assessment and treatment of sex offenders, conducted a *two part* training entitled: ***Working Effectively with Adult Sexual Offenders:*** *Characteristics, Assessment, and Interventions* available to all Riverview Psychiatric Center Employees.
August 20, 2013: Dr. Kenneth Beattie provided an in-service entitled: ***The Psychology of Working with Emotionally Challenging and Emotionally Challenged Clients.*** This training was developed in response to the Employee Education needs survey distributed to employees in March of 2013 and made available to all Riverview Psychiatric Center employees.
August 5, 2013, ***Single Wrist Restraint Application*** training was held to provide an opportunity to practice skills taught in the Initial NAPPI course provided to New Employees and NAPPI Recertification Class provided on a monthly basis through-out the year to Riverview Psychiatric Center employees. Over sixty unit staff attended.

Goal: SD will develop and implement a comprehensive mentoring program to assist new employees in gaining the skills necessary to do their job.
Objective: 100% of new Mental Health Workers will be paired with a mentor and will satisfactorily complete 12 competency areas on the unit orientation prior to being assigned regular duties requiring direct care of patients.
Current Status: 1Q 2014
100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

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

DATE	HRS	TITLE	PRESENTER
3Q2012	14	Jan- March 2012	Winter Semester (see1Q13 Quarterly Report)
4Q2012	11	Apr – June 2012	Spring Semester (see1Q13 Quarterly Report)
1Q2013	3	Jul – Sep 2012	Summer Hiatus (see1Q13 Quarterly Report)
2Q2013	9	Oct – Dec 2012	Fall Semester (see2Q13 Quarterly Report)
3Q2013	11	Jan – Mar 2013	Winter Semester (see 3Q13 Quarterly Report)
4Q2013	12	Apr – June 2013	Spring Semester (see 4Q13 Quarterly Report)
8/19/13 or 8/26/13	3.5	Working Effectively with Adult Sexual Offenders: Characteristics, Assessment and Interventions	Susan Righthand, PhD
8/20/13	1	The Psychology of Working with Emotionally-Challenging & Emotionally-Challenged Clients	Ken Beattie, PhD
9/26/13	1	If alcohol kills millions of brain cells, how come it never kills the ones that make people want to drink?	Jennifer Brotsky, PsyD Paula Jursa, LCPC, LADC, CCS

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

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

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

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

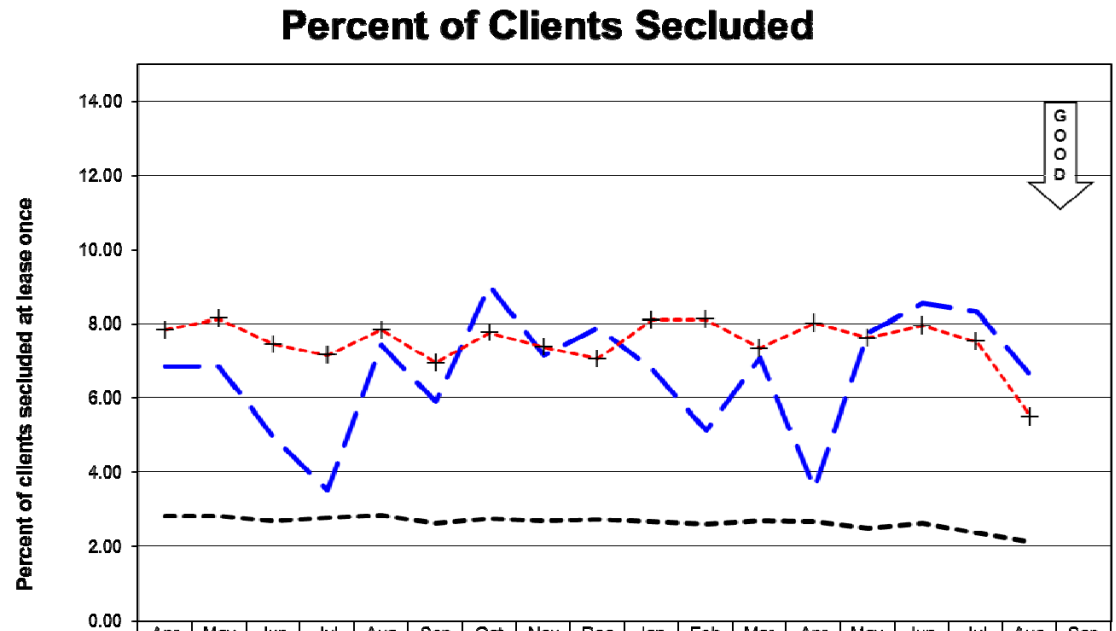
V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors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

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

CONSENT DECREE

Use of Seclusion and Restraints

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	6.84	6.84	4.96	3.51	7.44	5.88	9.01	7.14	7.89	6.78	5.13	7.08	3.57	7.76	8.55	8.33	6.61	
Ntl Mean	2.82	2.81	2.69	2.78	2.84	2.62	2.76	2.70	2.74	2.66	2.61	2.68	2.66	2.50	2.62	2.37	2.13	
+1 StDev	7.84	8.13	7.45	7.15	7.84	6.95	7.76	7.37	7.06	8.1	8.11	7.34	8.01	7.62	7.95	7.52	5.49	

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

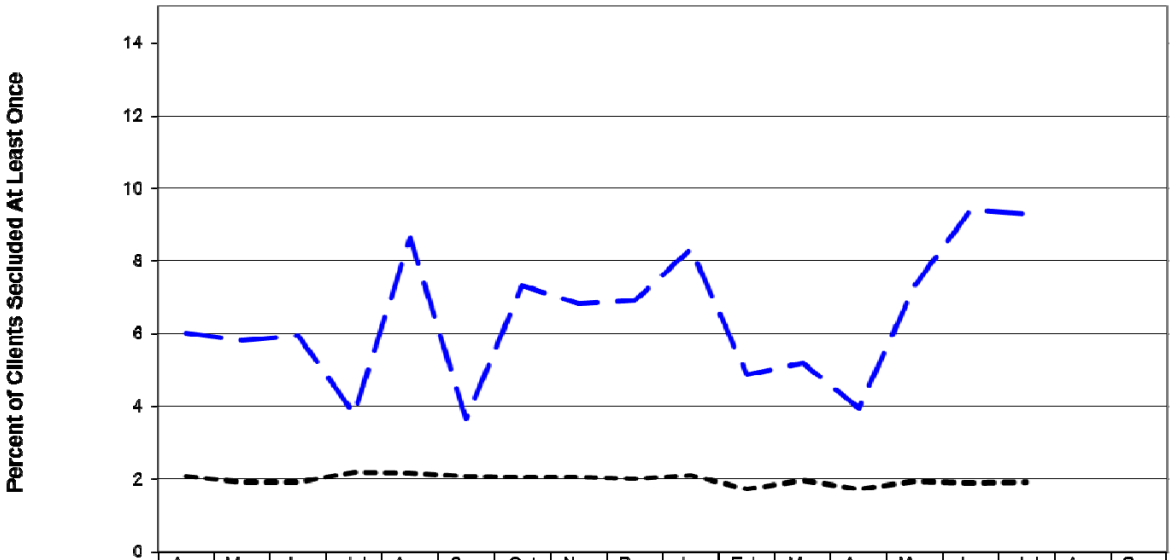
The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

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

CONSENT DECREE

Percent of Clients Secluded

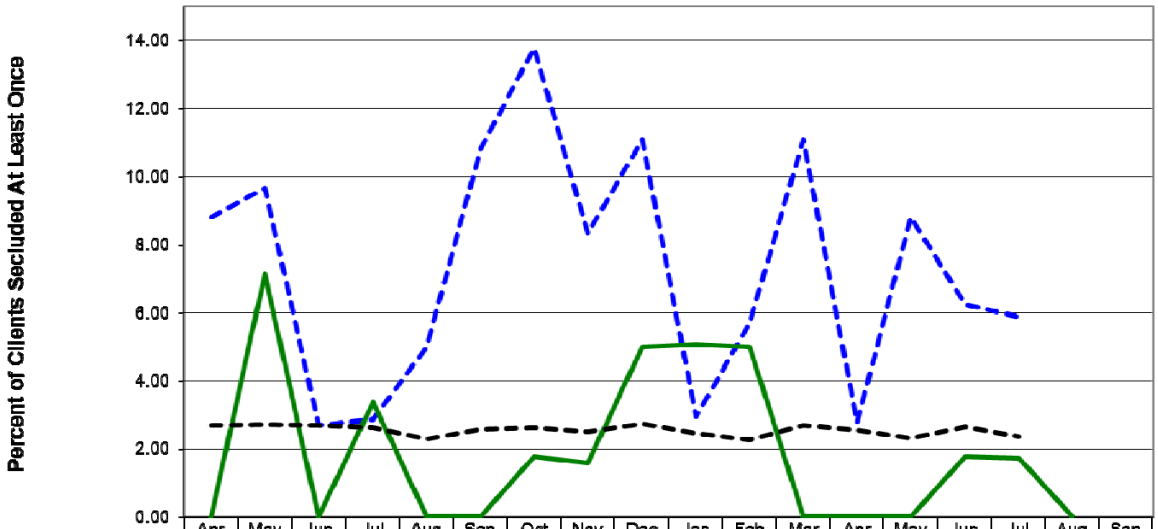
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	6.02	5.81	5.95	3.8	8.64	3.66	7.32	6.82	6.9	8.33	4.68	5.19	3.95	7.32	9.41	9.3		
Ntl Mean	2.08	1.9	1.92	2.18	2.16	2.08	2.05	2.05	1.99	2.09	1.73	1.95	1.72	1.94	1.89	1.91		

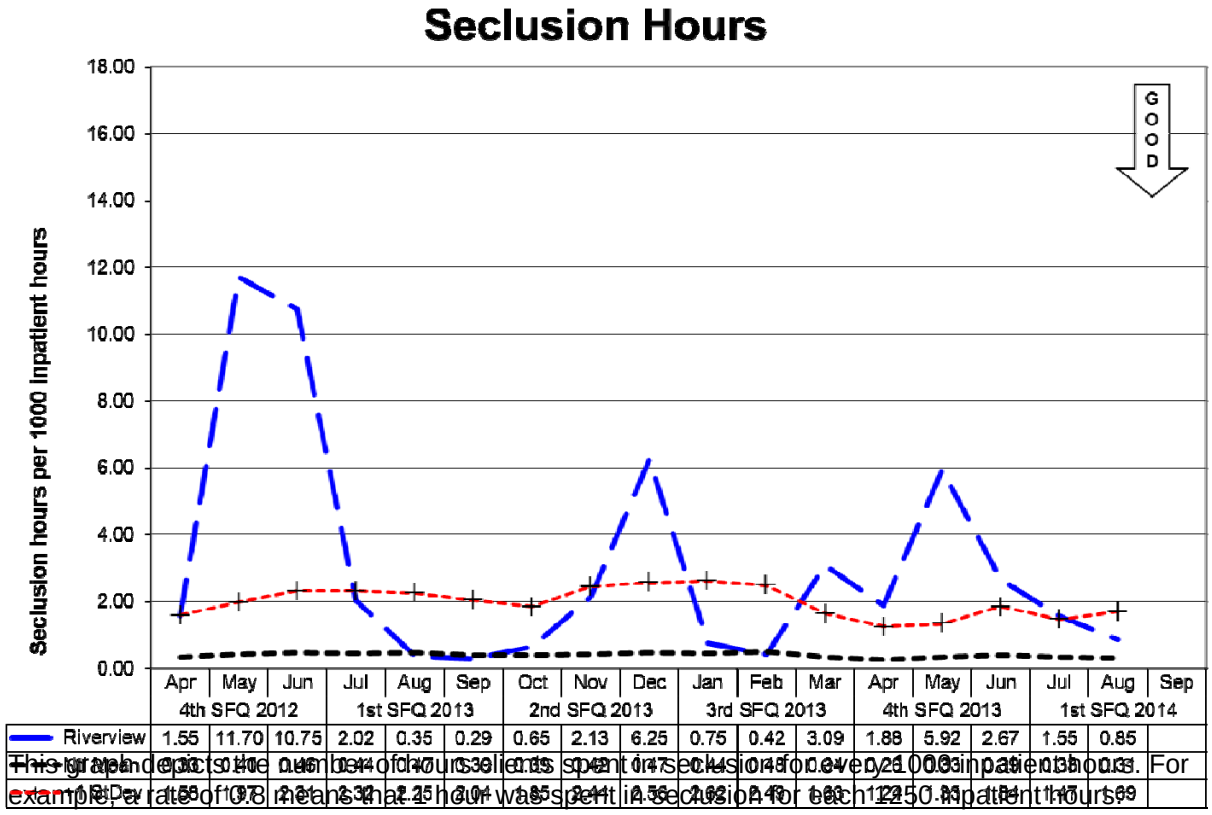
Percent of Clients Secluded

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	8.62	9.66	2.7	2.86	5	10.81	13.79	8.33	11.11	2.94	5.71	11.11	2.78	8.62	6.25	5.66		
Dorothea Dix	0.00	7.14	0.00	3.39	0.00	0.00	1.79	1.59	5.00	5.08	5.00	0.00	0.00	0.00	1.79	1.72	0.00	
Ntl Mean	2.69	2.72	2.69	2.63	2.29	2.56	2.62	2.5	2.74	2.46	2.26	2.69	2.56	2.31	2.66	2.36		

CONSENT DECREE



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

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

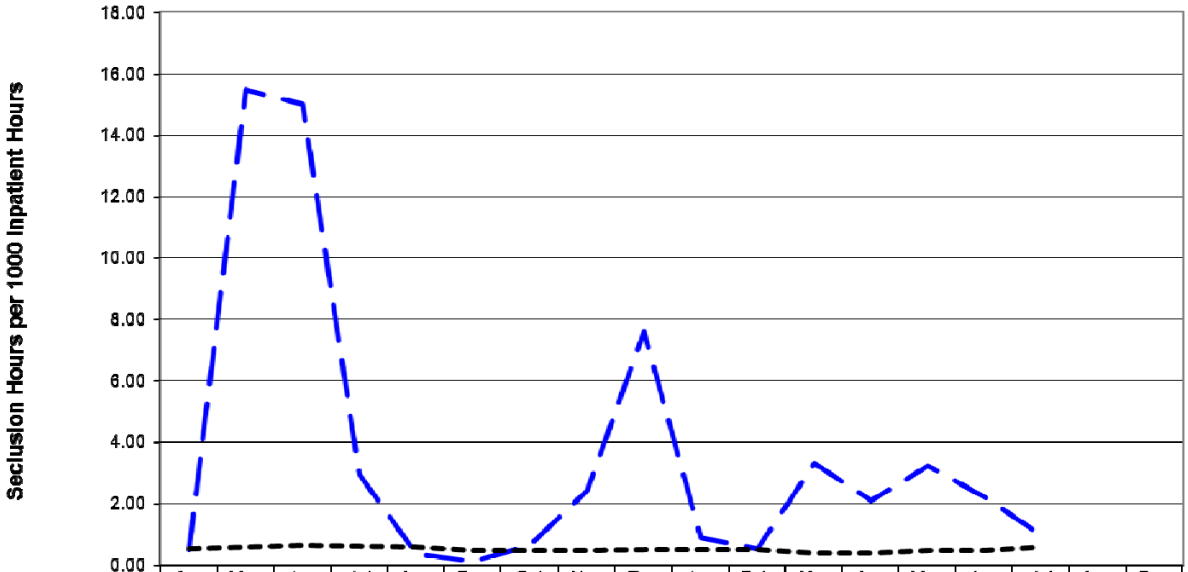
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

CONSENT DECREE

Seclusion Hours

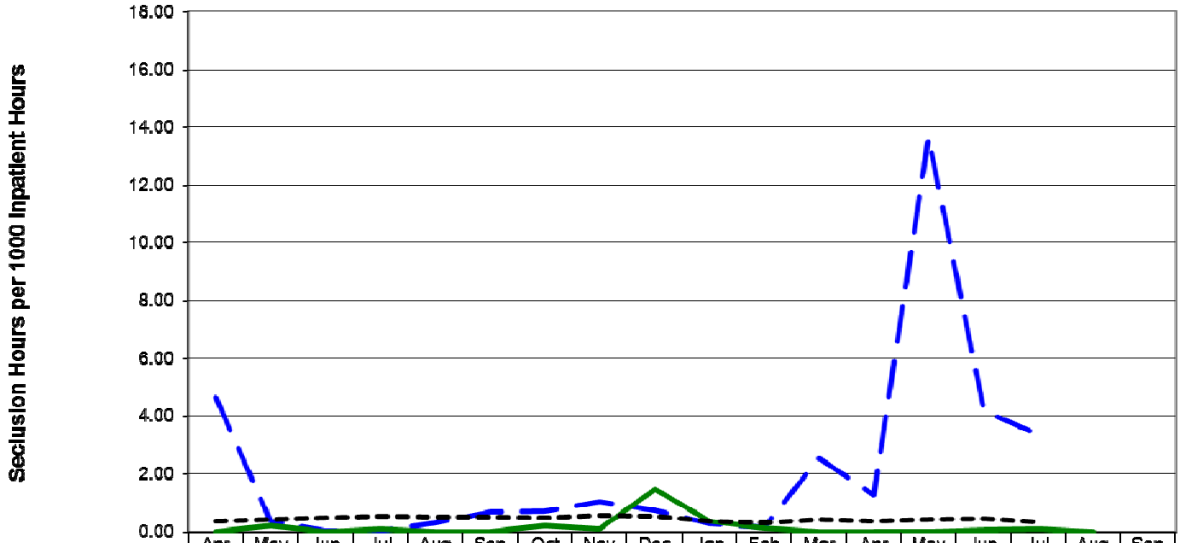
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.5	15.47	15.01	2.94	0.37	0.12	0.63	2.43	7.6	0.9	0.52	3.32	2.11	3.23	2.2	0.97		
Ntl Mean	0.52	0.57	0.64	0.62	0.59	0.46	0.47	0.48	0.51	0.5	0.5	0.39	0.4	0.46	0.46	0.58		

Seclusion Hours

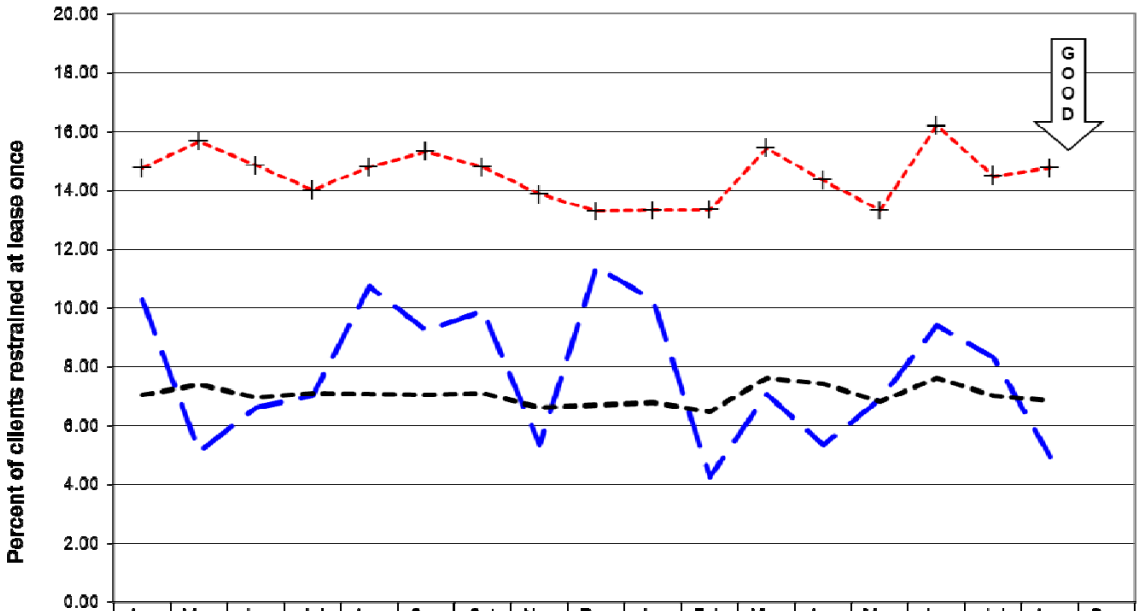
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	4.64	0.35	0.03	0.04	0.29	0.68	0.71	1.04	0.74	0.26	0.16	2.53	1.26	13.65	4.18	3.37		
Dorothea Dix	0.00	0.22	0.00	0.10	0.00	0.00	0.20	0.09	1.47	0.35	0.13	0.00	0.00	0.00	0.06	0.09	0.00	
Ntl Mean	0.37	0.4	0.47	0.54	0.51	0.49	0.46	0.57	0.54	0.36	0.3	0.4	0.36	0.4	0.43	0.34		

CONSENT DECREE

Percent of Clients Restrained



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	10.26	5.13	6.61	7.02	10.74	9.24	9.91	5.36	11.40	10.26	4.27	7.08	5.36	6.90	9.40	6.33	4.96	
Ntl Mean	7.04	7.39	6.95	7.10	7.08	7.04	7.12	6.62	6.69	6.76	6.46	7.63	7.43	6.61	7.63	7.02	6.65	
+1 StDev	14.76	15.66	14.84	14.01	14.78	15.32	14.76	13.66	13.29	13.32	13.33	15.43	14.34	13.32	16.2	14.48	14.76	

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

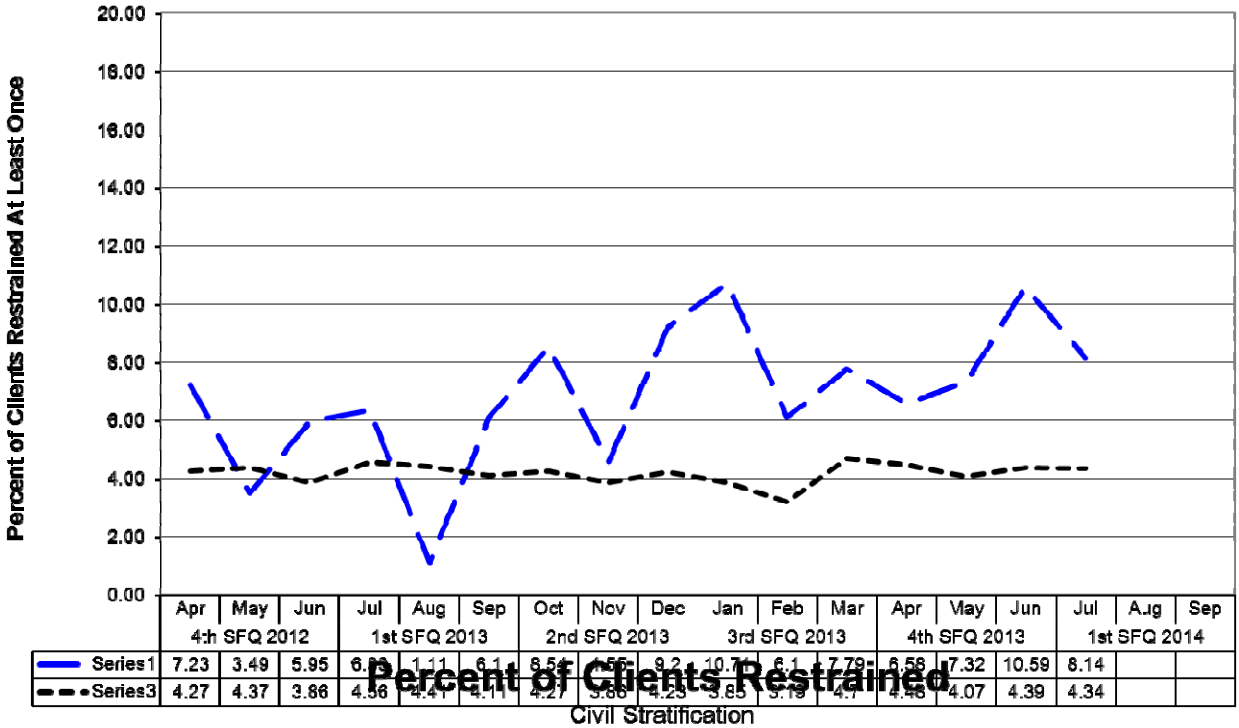
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

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

CONSENT DECREE

Percent of Clients Restrained

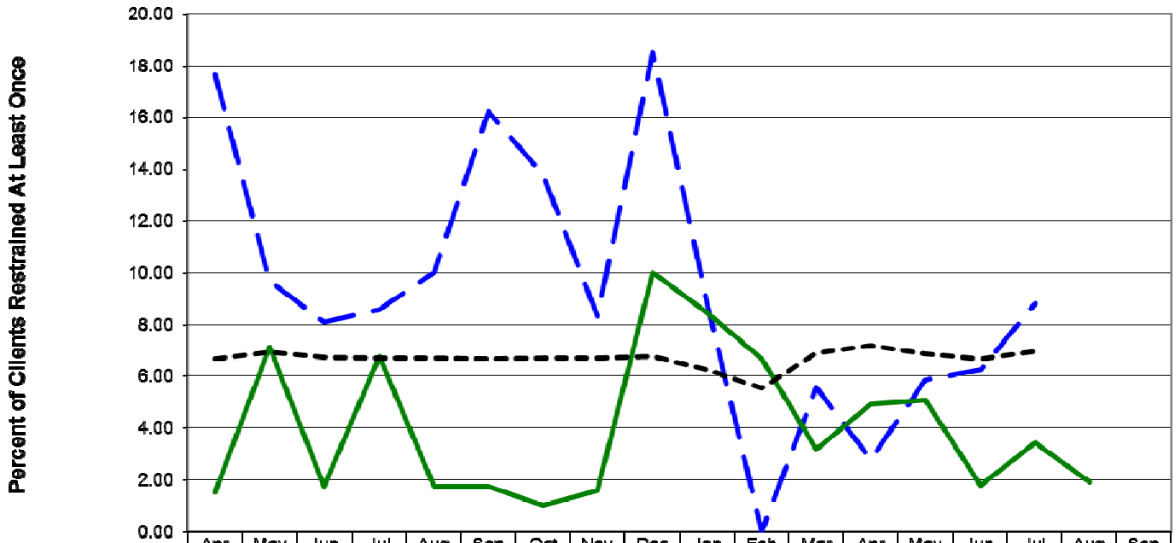
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	7.23	3.49	5.95	6.56	1.11	6.1	8.54	4.56	9.2	10.79	6.1	7.79	6.58	7.32	10.59	8.14		
Series3	4.27	4.37	3.86	4.56	4.41	4.11	4.27	3.86	4.23	3.85	3.19	4.7	4.48	4.07	4.39	4.34		

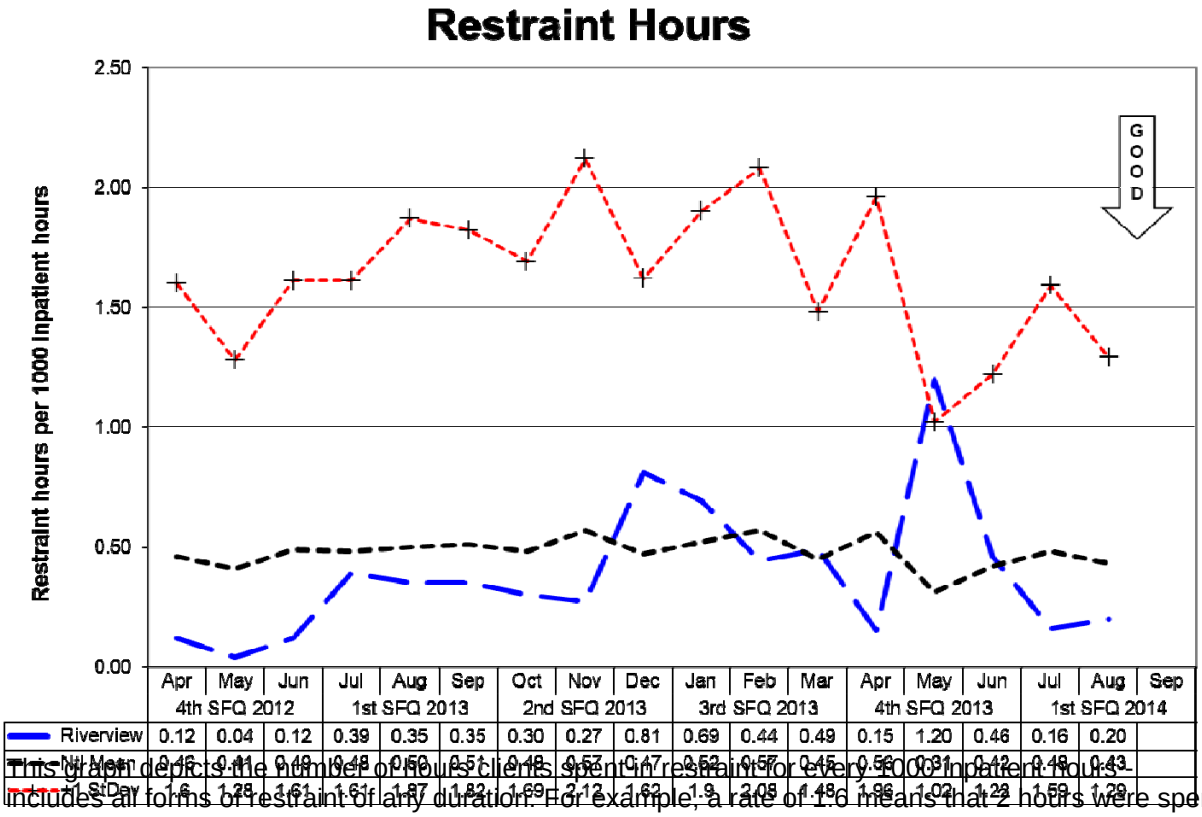
Percent of Clients Restrained

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	17.65	9.68	8.11	8.57	10	16.22	13.79	8.33	18.52	8.82	0	5.56	2.78	5.88	6.25	8.82		
Dorothea Dix	1.54	7.14	1.75	6.78	1.75	1.75	1.00	1.59	10.00	6.47	6.67	3.17	4.92	5.08	1.79	3.45	1.92	
Ntl Mean	6.67	6.95	6.75	6.72	6.7	6.66	6.72	6.72	6.78	6.27	5.55	6.9	7.18	6.87	6.68	6.98		

CONSENT DECREE



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

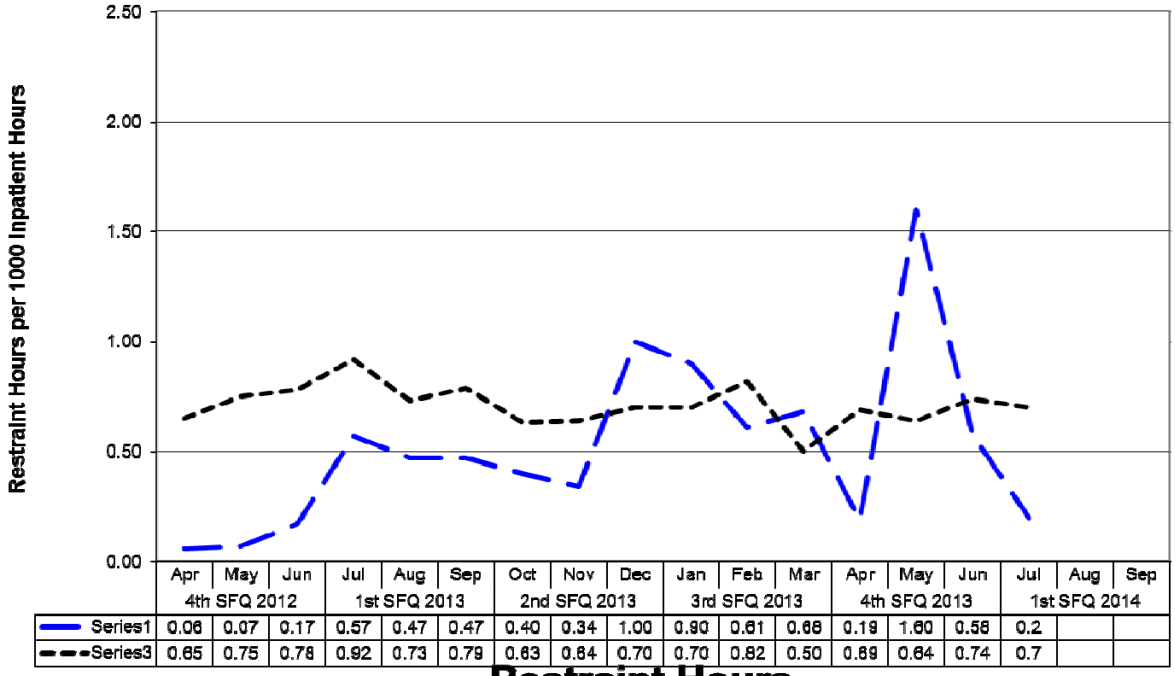
The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

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

CONSENT DECREE

Restraint Hours

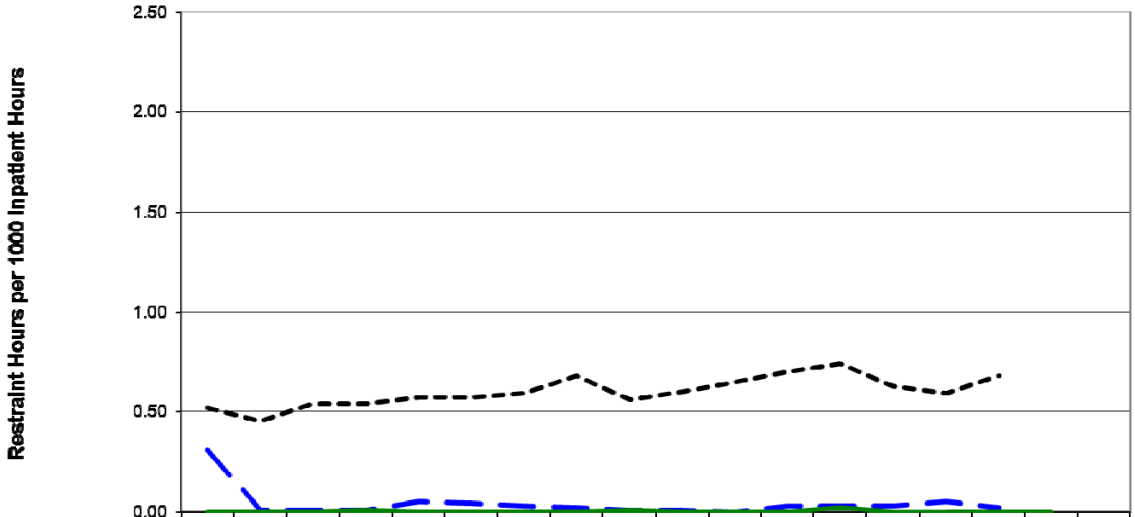
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	0.06	0.07	0.17	0.57	0.47	0.47	0.40	0.34	1.00	0.90	0.61	0.68	0.19	1.60	0.56	0.2		
Series3	0.65	0.75	0.78	0.92	0.73	0.79	0.63	0.64	0.70	0.70	0.82	0.50	0.69	0.64	0.74	0.7		

Restraint Hours

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.31	0.01	0.01	0.01	0.05	0.04	0.03	0.02	0.01	0.01	0	0.03	0.03	0.03	0.05	0.02		
Dorothea Dix	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.02	0.00	0.00	0.00	0.00	
Ntl Mean	0.52	0.45	0.54	0.54	0.57	0.57	0.59	0.68	0.56	0.60	0.65	0.70	0.74	0.63	0.59	0.68		

CONSENT DECREE

Confinement Event Detail

1st Quarter 2014

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR00006963	22		37	59	36.2%	36.2%
MR00000657	26	23	4	53	32.5%	68.7%
MR00006799	1	1	4	6	3.7%	72.4%
MR00004080	2	1	2	5	3.1%	75.5%
MR00004637	1		4	5	3.1%	78.5%
MR00000814		2	2	4	2.5%	81.0%
MR00004271			4	4	2.5%	83.4%
MR00007340	2		2	4	2.5%	85.9%
MR00003726	1		2	3	1.8%	87.7%
MR00004287	1		2	3	1.8%	89.6%
MR00000025	1	1		2	1.2%	90.8%
MR00000091	1		1	2	1.2%	92.0%
MR00007323	2			2	1.2%	93.3%
MR00007326	1		1	2	1.2%	94.5%
MR00007375	1		1	2	1.2%	95.7%
MR00000029			1	1	0.6%	96.3%
MR00000076			1	1	0.6%	96.9%
MR00006978		1		1	0.6%	97.5%
MR00007200			1	1	0.6%	98.2%
MR00007341	1			1	0.6%	98.8%
MR00007389			1	1	0.6%	99.4%
MR00007394			1	1	0.6%	100.0%
	63	29	71	163		

29% (22/77) of average hospital population experienced some form of confinement event during the 1st fiscal quarter 2014. Five of these clients (6% of the average hospital population) accounted for 79% of the containment events.

The trend in frequency of confinement event, specifically the increase in the trend related to mechanical restraints is due to a few high acute clients requiring special management to ensure the safety of the milieu.

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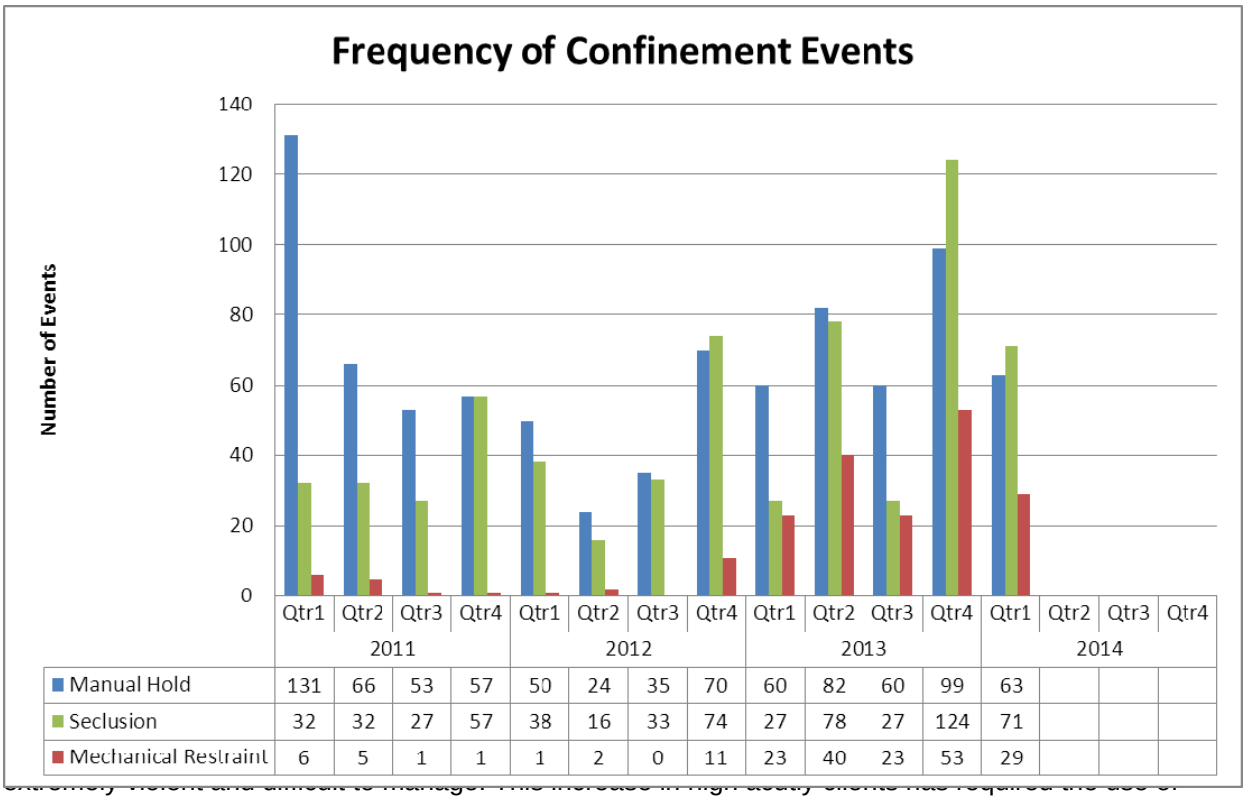

	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
	2011				2012				2013				2014			
Manual Hold	131	66	53	57	50	24	35	70	60	82	60	99	63			
Seclusion	32	32	27	57	38	16	33	74	27	78	27	124	71			
Mechanical Restraint	6	5	1	1	1	2	0	11	23	40	23	53	29			

specialized management techniques that ensure the safety of these clients, other clients, and staff while attempting to maintain a therapeutic mileau.

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

V28) Riverview demonstrates that, based on a review of two quarters of data, for 95% of seclusion events, seclusion was employed only when absolutely necessary to protect the patient from causing physical harm to self or others or for the management of violent behavior;

Factors of Causation Related to Seclusion Events

	1Q13	2Q13	3Q13	4Q13	1Q14
Danger to Others/Self	23	78	50	124	71
Danger to Others	4				
Danger to Self			1		
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	27	78	51	124	71

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

	1Q13	2Q13	3Q13	4Q13	1Q14
Danger to Others/Self	22	40	40	53	29
Danger to Others	1				
Danger to Self					
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	23	40	40	53	29

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 28 & 29

Confinement Events Management

Seclusion Events (71) 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%

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 medical director and advocate.	90%	100%
The record reflects that, for persons with mental retardation, the regulations governing seclusion of clients with mental retardation were met.	85%	100%
The medical order for seclusion was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events (29) Events

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

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

CONSENT DECREE

Client Elopements

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

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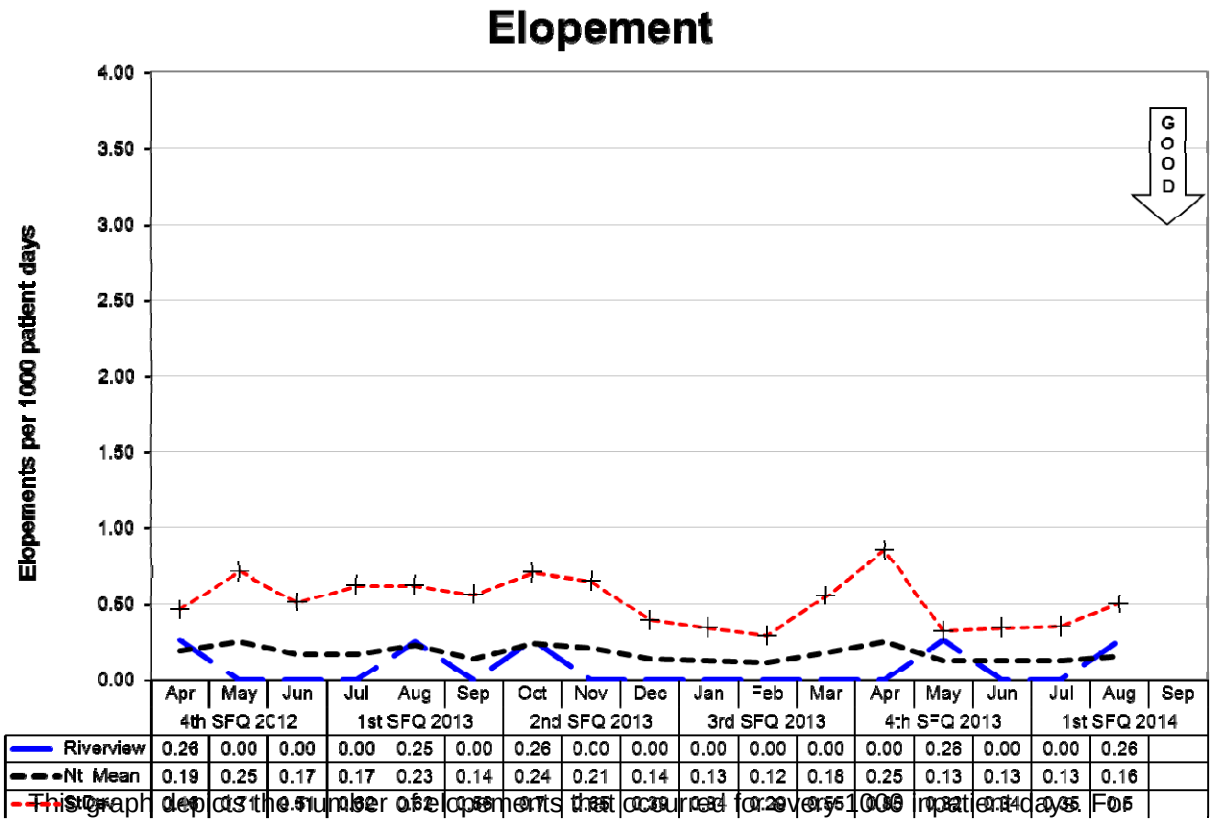


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.26	0.00	0.00	0.00	0.25	0.00	0.26	0.00	0.00	0.00	0.00	0.00	0.00	0.26	0.00	0.00	0.26	
Nt Mean	0.19	0.25	0.17	0.17	0.23	0.14	0.24	0.21	0.14	0.13	0.12	0.16	0.25	0.13	0.13	0.13	0.16	
StDev	0.11	0.15	0.12	0.12	0.08	0.11	0.09	0.09	0.08	0.08	0.08	0.09	0.14	0.09	0.09	0.09	0.05	

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

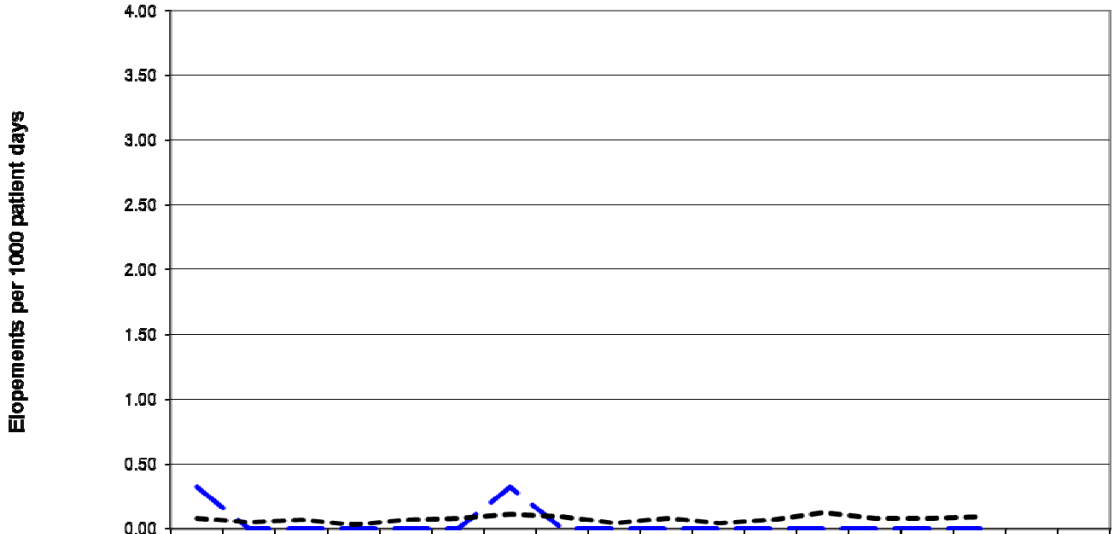
An elopement is defined as any time a client is “absent from a location defined by the client’s privilege status regardless of the client’s leave or legal status.”

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

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

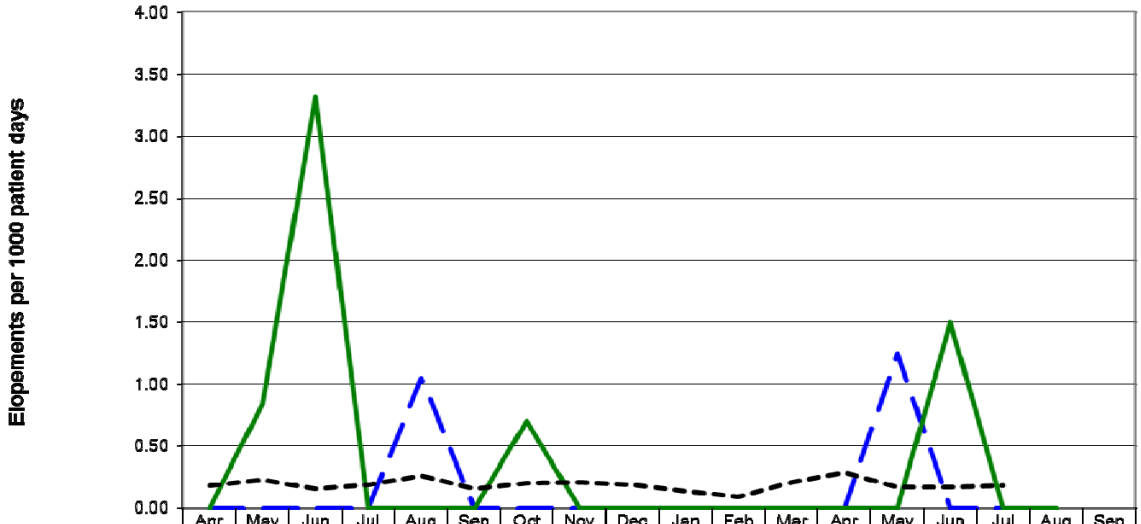
CONSENT DECREE

Elopement
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	0.32	0.00	0.00	0.00	0.00	0.00	0.32	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Series3	0.08	0.05	0.07	0.03	0.07	0.08	0.11	0.09	0.04	0.08	0.04	0.07	0.12	0.08	0.08	0.09		

Elopement
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.00	0.00	0.00	0.00	1.05	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.25	0.00	0.00		
Dorothea Dix	0.00	0.84	3.32	0.00	0.00	0.00	0.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.50	0.00	0.00	
Ntl Mean	0.18	0.23	0.16	0.19	0.26	0.16	0.20	0.21	0.19	0.14	0.09	0.21	0.29	0.17	0.17	0.18		

Client Injuries

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

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

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

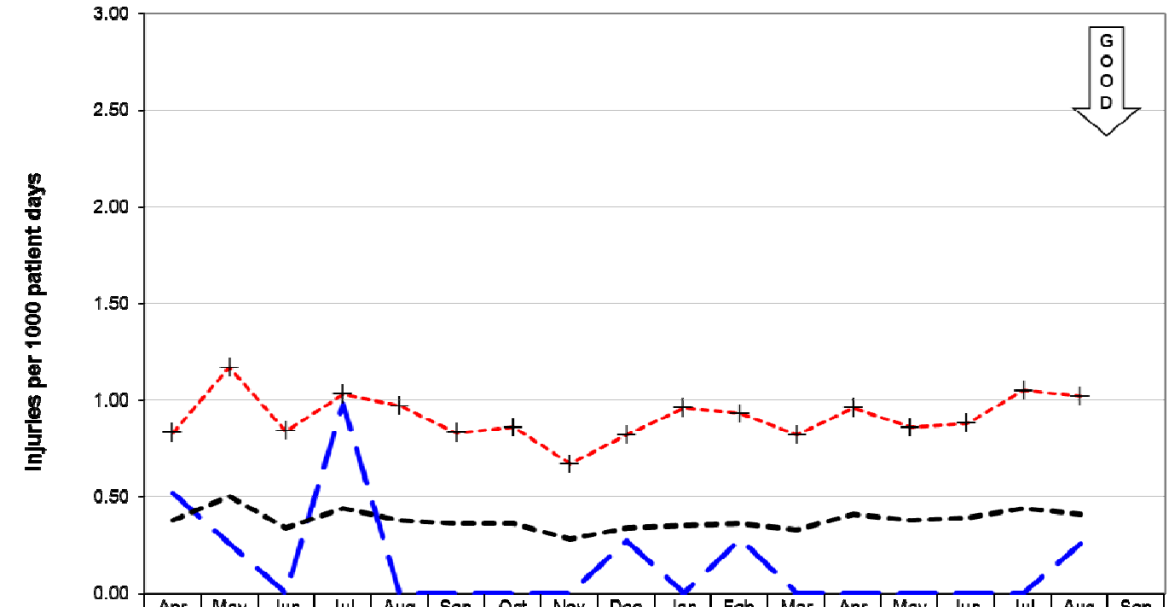
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

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

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

CONSENT DECREE

Client Injury Rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	0.52	0.26	0.00	0.98	0.00	0.00	0.00	0.00	0.27	0.00	0.28	0.00	0.00	0.00	0.00	0.00	0.26	
Ntl Mean	0.38	0.50	0.34	0.44	0.38	0.36	0.36	0.28	0.34	0.35	0.36	0.33	0.41	0.38	0.39	0.44	0.41	
+1 StDev	0.83	1.17	0.84	1.03	0.97	0.83	0.86	0.67	0.82	0.96	0.93	0.82	0.96	0.86	0.88	1.05	1.02	

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

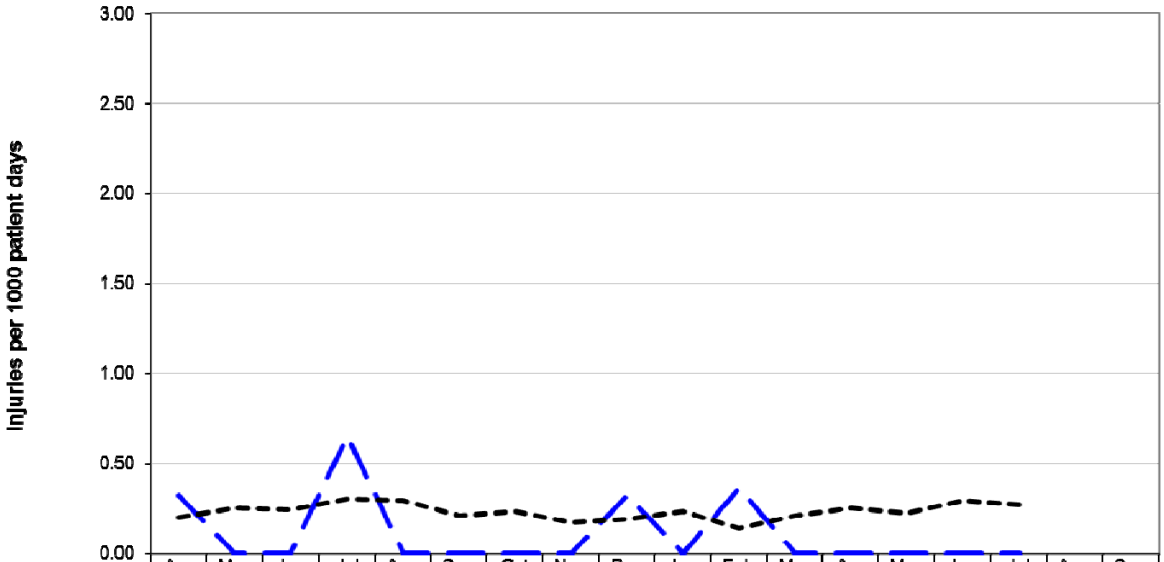
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

CONSENT DECREE

Client Injury Rate

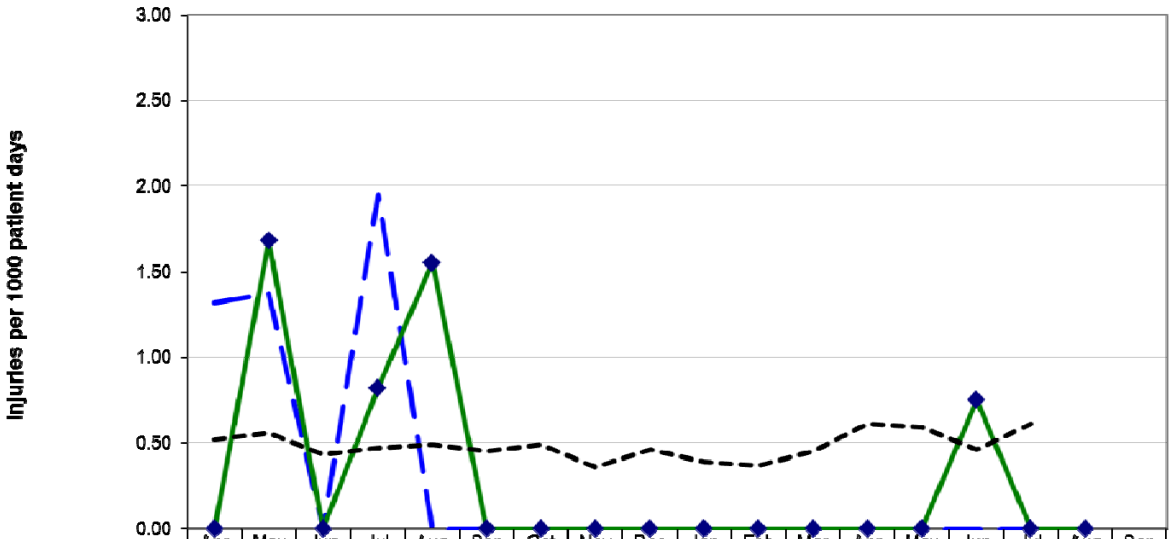
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	0.32	0.00	0.00	0.65	0.00	0.00	0.00	0.00	0.32	0.00	0.36	0.00	0.00	0.00	0.00	0.00		
Series3	0.20	0.25	0.24	0.30	0.29	0.21	0.23	0.17	0.19	0.23	0.14	0.21	0.25	0.22	0.29	0.27		

Client Injury Rate

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	1.32	1.37	0.00	1.95	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Dorothea Dix	0.00	1.68	0.00	0.82	1.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.75	0.00	0.00	
Ntl Mean	0.52	0.56	0.43	0.47	0.49	0.45	0.49	0.36	0.46	0.39	0.37	0.45	0.61	0.59	0.46	0.61		

CONSENT DECREE

Severity of injury by Month

Severity	JULY	AUG	SEP	1Q2014
No Treatment	28	27	20	75
Minor First Aid				
Medical Intervention Required				
Hospitalization Required				
Death Occurred				
Total	28	27	20	75

Type and Cause of Injury by Month

Type - Cause	JULY	AUG	SEP	1Q2014
Accident – Fall Unwitnessed	5	2	1	8
Accident – Fall Witnessed	4	2		6
Accident – Other			1	1
Assault – Client to Client	12	19	13	44
Self-Injurious Behavior	7	4	5	16

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

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

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

Patient Abuse, Neglect, Exploitation, Injury or Death

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

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

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

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

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with The Joint Commission on November 15-19, 2010. A triennial accreditation survey is expected to occur in November 2013 or earlier.

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

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

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

V35) Riverview maintains its hospital license;

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

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

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

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

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

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

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

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

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

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

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

Assessment

Treatment Planning and Implementation

Hope and Empowerment

Patient Driven Care

Patient Safety

Continuity and Transition of Care

Outcomes

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

JOINT COMMISSION

Admissions Screening (HBIPS 1)

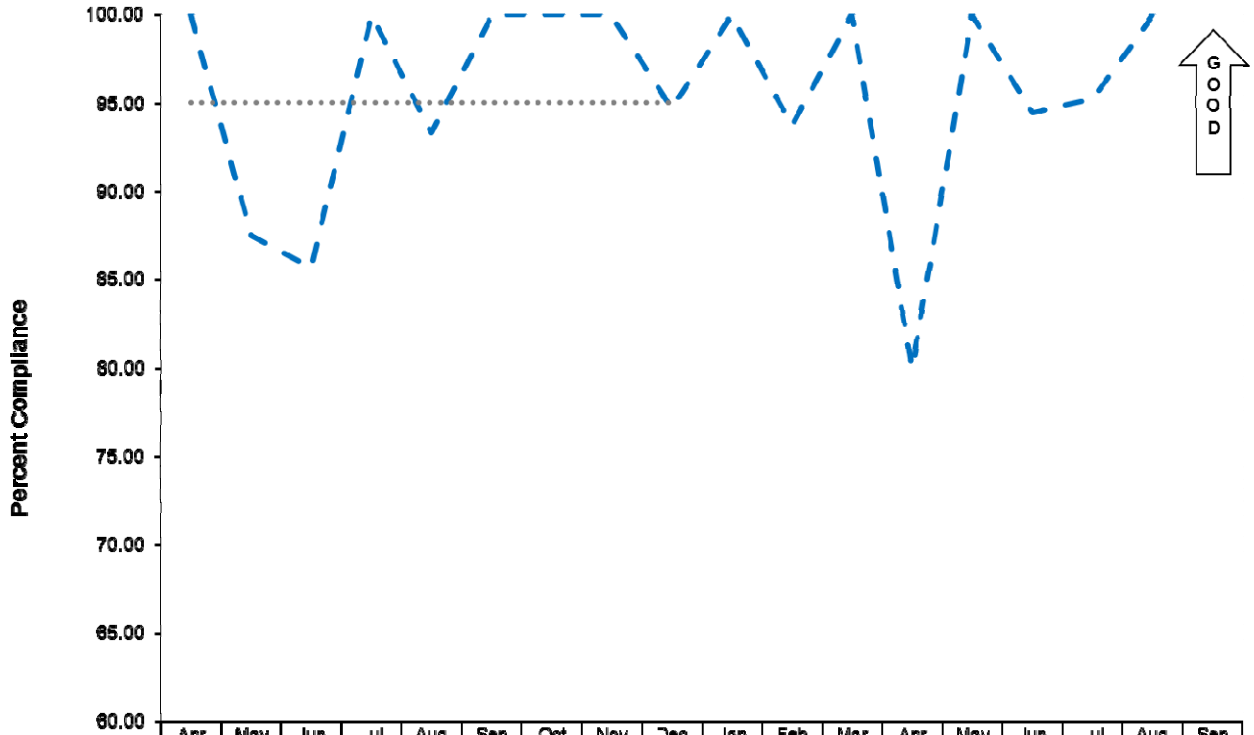
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

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

Rationale

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			's: SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			's: SFQ 2014		
RPC Rate	100.00	87.50	85.71	100.00	93.33	100.00	100.00	100.00	94.74	100.00	93.75	100.00	90.00	100.00	94.44	95.25	100.00	
TJC Target	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00									

JOINT COMMISSION

Physical Restraint (HBIPS 2)

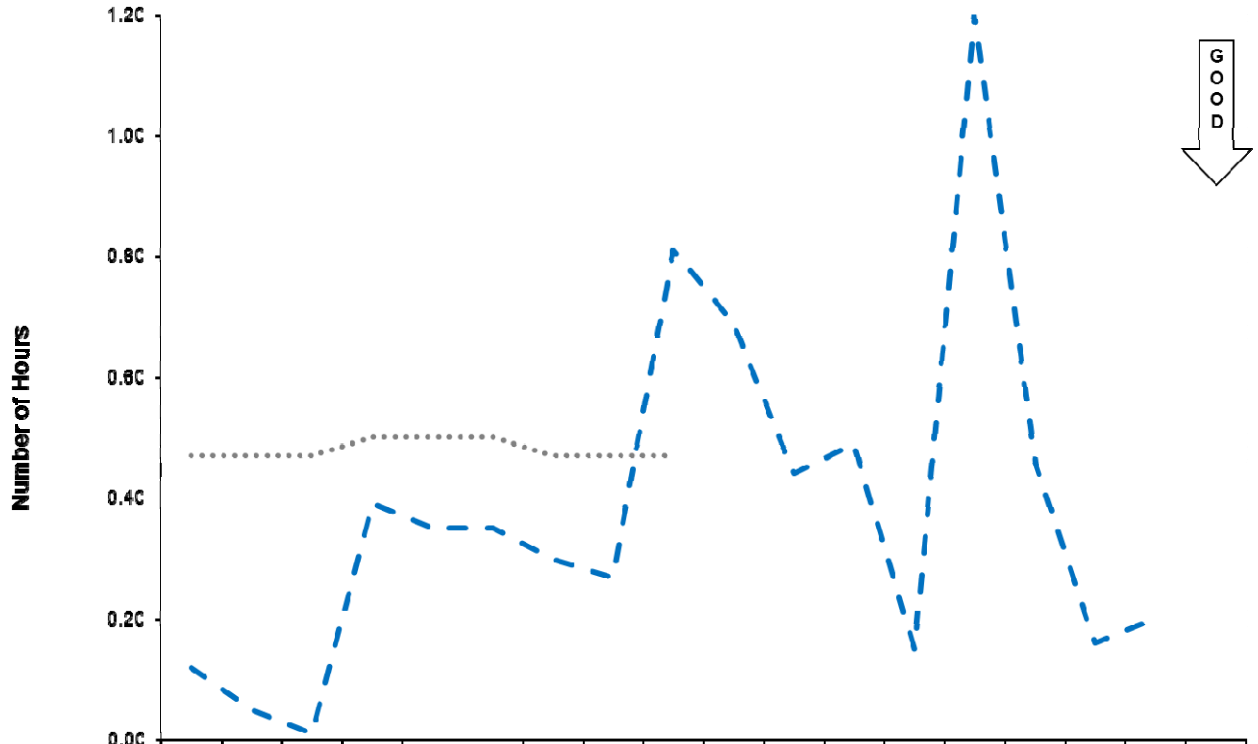
Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint

Rationale

Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
RPC Rate	0.12	0.05	0.01	0.39	0.35	0.35	0.30	0.27	0.81	0.69	0.44	0.49	0.15	1.20	0.45	0.16	0.20	
TJC Target	0.47	0.47	0.47	0.50	0.50	0.50	0.47	0.47	0.47									

JOINT COMMISSION

Seclusion (HBIPS 3)

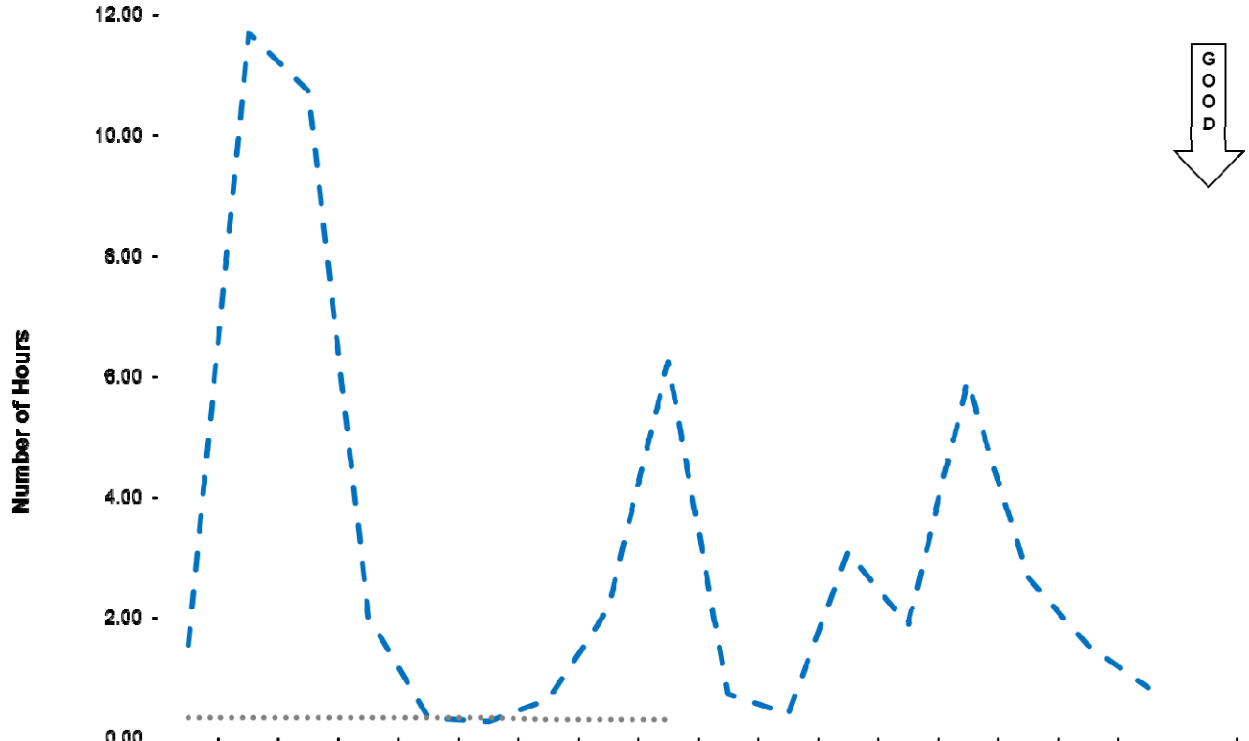
Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion

Rationale

Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
RPC Rate	1.55	11.70	10.75	2.02	0.35	0.29	0.65	2.13	6.25	0.75	0.42	3.09	1.88	5.92	2.67	1.55	0.85	
TJC Target	0.35	0.35	0.35	0.36	0.36	0.36	0.32	0.32	0.32									

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

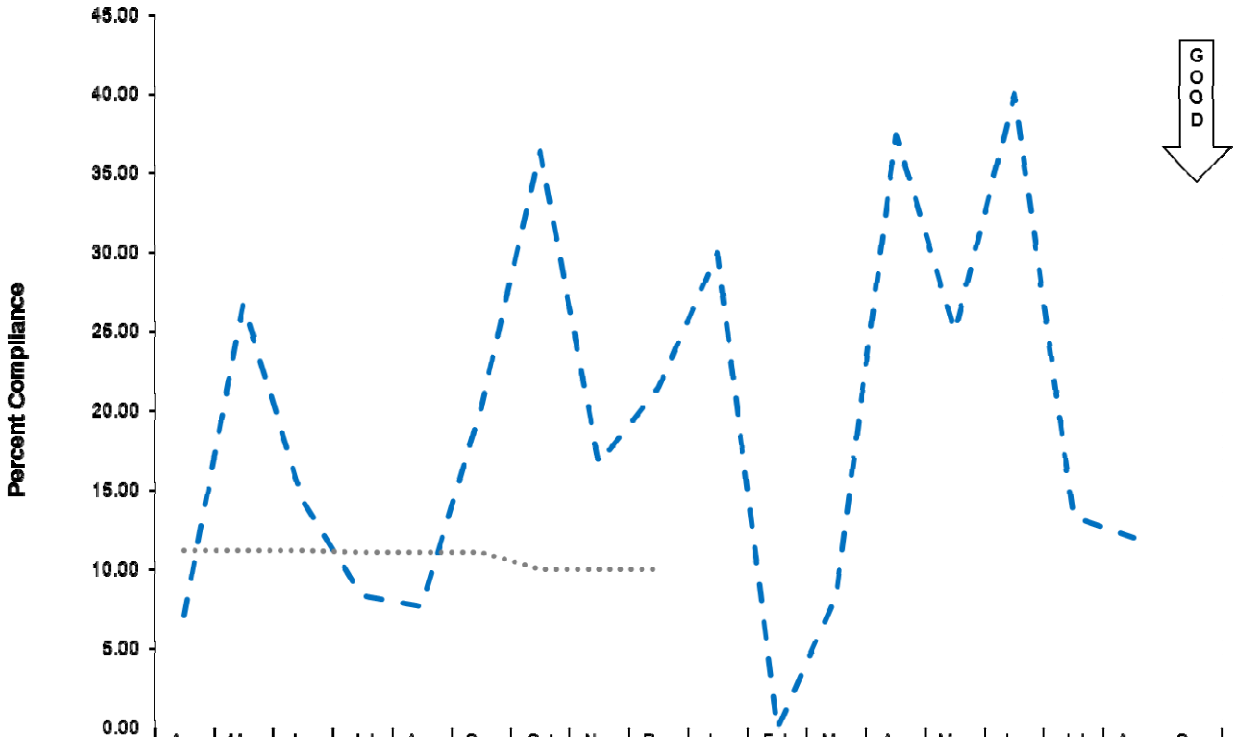
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

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)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	7.14	26.67	14.29	8.33	7.69	20.00	36.36	16.67	21.43	30.00	0.00	8.33	37.50	25.00	40.00	13.33	12.00	
Series3	11.20	11.20	11.20	11.10	11.10	11.10	10.00	10.00	10.00									

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

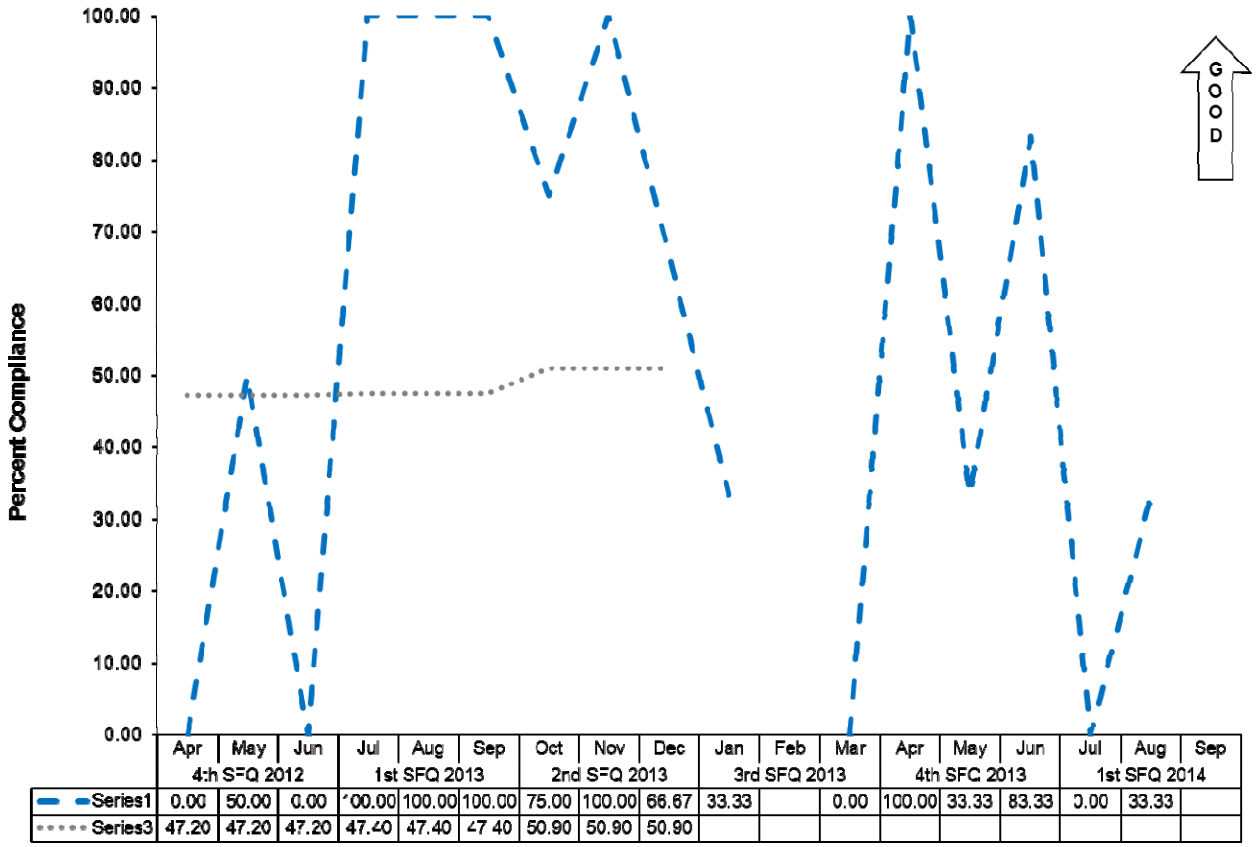
Rationale

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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	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	0.00	50.00	0.00	100.00	100.00	100.00	75.00	100.00	66.67	33.33		0.00	100.00	33.33	83.33	0.00	33.33	
Series3	47.20	47.20	47.20	47.40	47.40	47.40	50.90	50.90	50.90									

JOINT COMMISSION

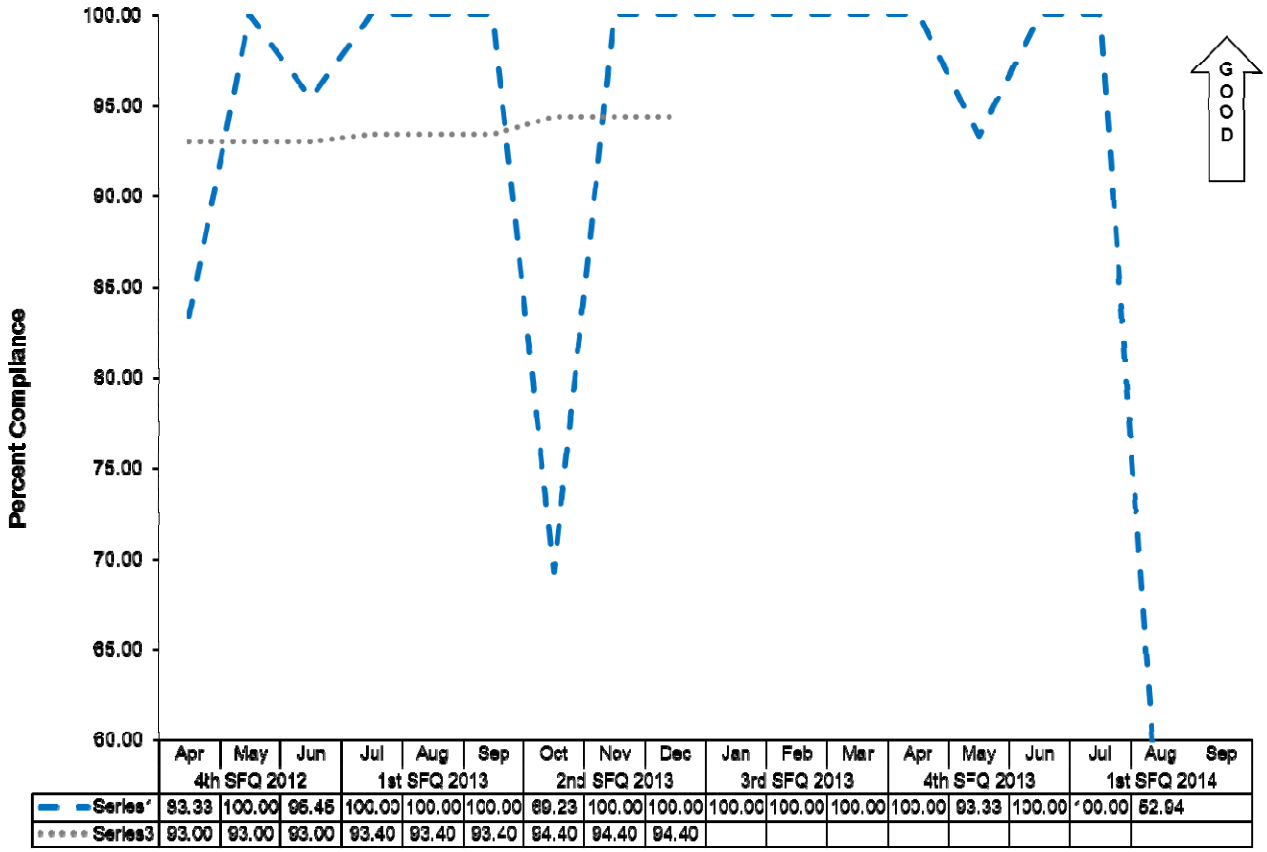
Post Discharge Continuing Care Plan (HBIPS 6)

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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	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series'	93.33	100.00	95.45	100.00	100.00	100.00	89.23	100.00	100.00	100.00	100.00	100.00	100.00	93.33	100.00	'00.00	52.94	
Series3	93.00	93.00	93.00	93.40	93.40	93.40	94.40	94.40	94.40									

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

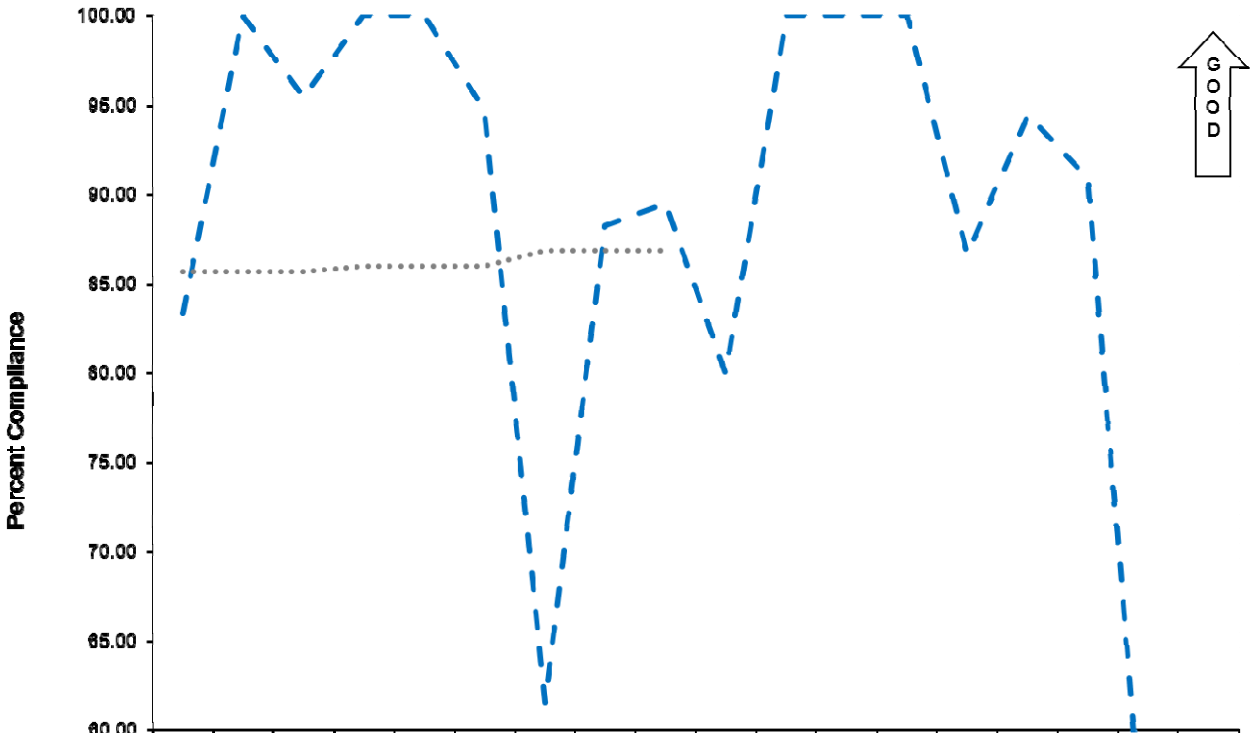
To Next Level of Care Provider on Discharge

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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	4th SFQ 2012			1st SFQ 2013			2nd SFQ 20'3			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Series1	83.33	100.00	95.45	100.00	100.00	94.74	61.54	88.24	89.47	80.00	100.00	100.00	100.00	86.67	94 44	90.91	50.00	
Series3	85.70	85.70	85.70	86.00	86.00	86.00	86.90	86.90	86.90									

JOINT COMMISSION

Management of Contracted Care, Treatment and Services

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.

Final Report of FY 2014 Clinical Contracts		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Stephanie George-Roy Director of Social Services	One indicator did not meet expectations; this indicator stated that all grievances are responded to on time. 4 of 66 grievances were not responded to on time in 1Q2014. A new Director for Amistad was recently hired; the lack of on time grievances may have been related to having this position vacant. All other indicators met or exceeded standards.
Community Dental, Region II	Dr. William Nelson Medical Director	All indicators met standards.
Comprehensive Pharmacy Services	Dr. William Nelson Medical Director	All indicators met standards.
Dartmouth Medical School	MaryLouise McEwen Superintendent	All indicators met or exceeded standards.
Disability Rights Center	MaryLouise McEwen Superintendent	All indicators met standards.
Healthreach	Dr. William Nelson Medical Director	All indicators met standards.
Kennebec County Correctional Facility	MaryLouise McEwen Superintendent	All indicators met or exceeded standards.
Liberty Staffing	Dr. William Nelson Medical Director	All indicators met standards.
MaineGeneral Medical Center – Laboratory Services	Dr. William Nelson Medical Director	All indicators met standards.
MD-IT	Amy Tasker Health Information Management Director	Indicator met standards.
Medical Staffing and Services of Maine, Inc.	Dr. William Nelson Medical Director	All indicators met standards.
Motivational Services	Dr. William Nelson Medical Director	All indicators met standards.
Occupational Therapy Consultation and Rehab Services	Janet Barrett Director of Rehabilitation	All indicators met standards.
Securitas Security Services	Robert Patnaude Director of Security	All indicators met or exceeded standards
Spring Harbor	Dr. William Nelson Medical Director	All indicators met or exceeded standards.

JOINT COMMISSION

Capital Community Clinic

Adverse Reactions to Sedation or Anesthesia

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

Dental Clinic Timeout/Identification of Client

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
National Patent Safety Goals Goal 1: Improve the accuracy of Client Identification. Capital Community Dental Clinic assures accurate client identification by: asking the client to state his/her name and date of birth. A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the dental assistant.	**October** 100% 5/5 **November** 100% 3/3 **December** 100% 4/4 **Total** 100% 12/12	**January** 100% 7/7 **February** 100% 3/3 **March** 100% 9/9 **Total** 100% 19/19	**April** 100% 2/2 **May** 100% 7/7 **June** 100% 7/7 **Total** 100% 16/16	**July** 100% 6/6 **August** 100% 2/2 **September** 100% 4/4 **Total** 100% 12/12

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	2Q2013	3Q2013	4Q2013	1Q2014
1. All clients with tooth extractions, will be assessed and have teaching post procedure, on the following topics, as provided by the Dentist or Dental Assistant • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. 3. Post dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications	**October** 100% 5/5 **November** 100% 3/3 **December** 100% 4/4 **Total** 100% 12/12	**January** 100% 7/7 **February** 100% 3/3 **March** 100% 9/9 **Total** 100% 19/19I	**April** 100% 2/2 **May** 100% 7/7 **June** 100% 7/7 **Total** 100% 16/16	**July** 100% 6/6 **August** 100% 2/2 **September** 100% 4/4 **Total** 100% 12/12

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.

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the third quarter of the fiscal year, per 1000 patient days	3.8	100 %	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	0.48	100%	1 SD within the mean

Data:
Sinusitis: 1 →URI
Latent TB: 1→URI
Question Diverticulitis: 1 GI→
Genital Herpes: 1 →Reproductive
Prostatitis: 1 → Reproductive
Dental: 1
Skin: 13

- *Superficial* Abraison→laceration→pulled sutures out→ER
- Skin abraison
- Boil – History of MRSA
- Right Inguinal Intertriginous Monilial Dermatitis
- Paronychia Rt, Great Toe
- Chronic Folliculitis – flare up
- Severe Intertrigo of pannus with ulceration & eythema
- Right 3rd Finger Paronychis
- Impetiginous lesion on face
- Intertrigo in both groins
- Onychomycosis & gryposis of toe nails
- Athlete's Foot
- Impetigo

Ear: 2
UTI: 1
Wound: 3

- Sebaceious Gland-prophylaxis post op: 2
- Left ingrown toemail, partial excision
- Severe intertrigo with ulceration and erythema

Prophylactic/treatment for bladder cancer→BCG→not counted as an infection

Hospital Associated Infections (HAI): 3 - 0.48

Community Acquired Infections (CAI): 21 –2.3
Self Injury: 1 – 0.15
Total Infections: 25 – 3.8

Summary: Hospital associated infection rates remain low and within one standard deviation of the mean. No trending. No unusual infections.

Action Plan: Continue total house surveillance (client and employee). The flu season is rapidly approaching. Encourage hand hygiene, respiratory hygiene and influenza vaccination.

JOINT COMMISSION

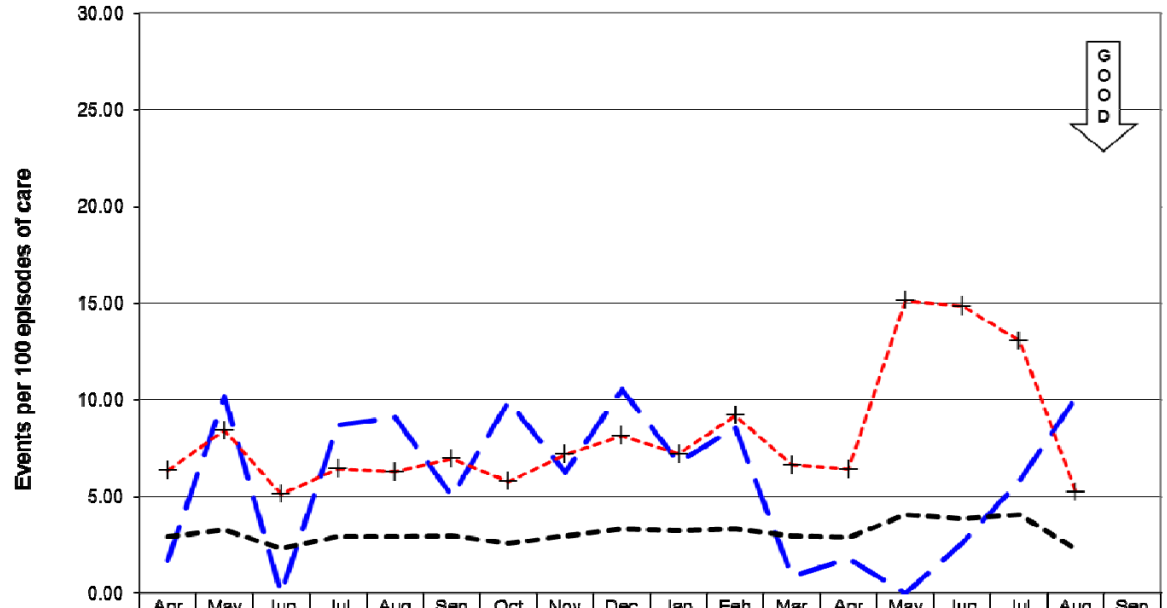
Medication Management

Medication Errors and Adverse Reactions

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

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

Medication Errors



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	1.71	10.17	0.00	8.70	9.09	5.04	9.91	6.25	10.53	6.78	8.55	0.88	1.79	0.00	2.56	5.79	10.14	
Ntl Mean	2.93	3.26	2.30	2.94	2.92	2.99	2.56	2.97	3.34	3.24	3.32	2.97	2.87	4.06	3.83	4.05	2.26	
+1 StDev	6.34	8.43	5.13	6.43	6.29	6.96	5.77	7.17	8.13	7.2	9.19	6.62	6.4	15.12	14.84	13.06	5.21	

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

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

Prescribing

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

Dispensing

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

Administration

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

Complex

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

Review, Reporting and Follow-up Process

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

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

JOINT COMMISSION

Medication Management - Administration Process
Medication Errors Related to Staffing Effectiveness

Date	OMIT	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
7/1/2013 & 7/2/2013	N	Wrong dose x 1	N	Y	N	LS	4 RN, 8 MHW
7/3/2013	N	Extra dose Haldol	Y	Y	Y	LK	3 RN, 1 LPN, 7 MHW
7/24/2013	N	Wrong form	N	Y	N	LS	2 RN, 6 MHW
7/24/2013	N	Wrong dose Tramadol	N	Y	N	UK	1 RN, 4 MHW
7/24/2013	Y	Simvastatin x1	N	N	N	UK	2 RN, 4 MHW
7/26/2013	Y	Darunavir omitted x1	Y	N	N	LS	3 RN, 1 LPN, 8 MHW
7/26/2013	Y	Mepron omitted x1	Y	Y	N	LS	3 RN, 8 MHW
7/30/2013	N	Extra dose / Ativan	N	N	Y	UK	2 RN, 4 MHW
7/31/2013	Y	Vicoden x1	N	N	N	US	2 RN, 6 MHW
8/2/2013	Y	Colace x1	N	N	N	LK	3 RN, 1 LPN, 7 MHW
8/6/2013	Y	Omission x 1	N	Y	N	LS	3 RN, 7 MHW
8/15/2013	N	Wrong dose	N	N	Y	LS	3 RN, 8 MHW
8/16/2013	N	Wrong time	N	N	N	LK	3 RN, 1 LPN, 7 MHW
8/21/2013	Y	Omission x1	Y	N	N	LS	4 RN, 6 MHW
8/26/2013	N	Wrong dose	N	N	N	UK	2 RN, 4 MHW
8/26/2013	N	Wrong time x 3 meds	N	N	Y	LS	3 RN, 1 LPN, 7 MHW
8/27/2013	N	Wrong time	N	N	N	UK	3 RN, 4 MHW
8/27/2013	Y	Omission x1	N	Y	N	LK	2 RN, 5 MHW
8/27/2013	N	Wrong dose	N	N	N	US	2 RN, 4 MHW
8/29/2013	Y	Concerta omitted x 1	Y	Y	N	LK	2 RN, 5 MHW
8/29/2013	N	Without valid order	N	N	N	US	2 RN, 4 MHW
8/31/2013	N	Wrong dose	N	N	N	US	2 RN, 5 MHW
8/31/2013	N	Med without valid order	N	N	N	US	2 RN, 5 MHW
9/6/2013	N	Med without valid order	N	N	N	US	1 RN, 1 LPN, 4 MHW
9/6/2013	Y	Omission x1	N	N	N	LS	4 RN 1 LPN 7 MHW
9/9/2013	Y	Omission x1	N	Y	N	LS	3 RN, 1 LPN, 7 MHW
9/9/2013	Y	Synthroid	Y	N	N	LS	2 RN, 6 MHW
9/9/2013	N	Wrong dose x2	N	N	N	US	2 RN, 3 MHW
9/14/2013	N	Prescribing	N	Y	N	LS	2 RN, 4 MHW
9/14/2013	Y	Omission x2	Y	Y	N	LK	3 RN, 1 LPN, 7 MHW
9/15/2013	N	Wrong form	N	N	N	LS	3 RN, 7 MHW
9/25/2013 & 9/26/2013	Y	Omission x1	N	Y	N	UK	3 RN, 1 LPN, 4 MHW
Totals	**14**		**7**	**11**	**4**	LS: 13	US: 7 LK: 6 UK: 6
Percent	**44%**		**22%**	**34%**	**13%**	**40%**	**22% 19% 19%**

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

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Summary

There were a total of 32 medication errors this quarter (28 last quarter and 20 the quarter before). 14 of the med errors were omissions. 9 errors were dose related. 3 errors involved wrong time. 3 were errors of medications given without a valid order. 2 errors were wrong form given and there was 1 prescribing error due to a “range order”. Six of the medication errors were committed by staff floating to another unit or by staff who have been designated as “floats.” 11 of the 32 errors were by new staff here at RPC.

Actions

All nursing related medication errors were noted to have appropriate staffing levels. One of the actions to consider may be to return to a designated medication nurse for each unit. Nurse Pharmacy Committee meets monthly and is working towards identifying issues with medication management and identifying solutions to issues identified. Medication errors are reviewed weekly by Pharmacist, Medical Director, Risk Manager and Executive Nurse after the RN IV on the unit reviews the error with the staff person responsible for individual teaching and issue / process identification. Two of the nurses received counseling from their immediate supervisor.

JOINT COMMISSION

Medication Management - Dispensing Process

Medication Management	Unit	Baseline (July-Sept)	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Controlled Substances Loss Data *Daily Pyxis-CII Safe Compare Report*	All	0%	0%	0%	0%	0%	0%	Goal of "0" discrepancies between Pyxis and CII Safe transactions
Quarterly Results								
Monthly CII Safe Vendor Receipt Report	Rx	0	0	0	0	0	0	*No discrepancies between CII Safe and vendor transactions for December.
Quarterly Results				0*	0	0		
Monthly Pyxis Controlled Drug discrepancies	All	9	0	0	0	0	0	Goal of "0" discrepancies involving controlled drugs dispensed from Pxyis
Quarterly Results			9	13	9	12		
Med Mgmt Monitoring								
Measures of drug reactions, adverse drug events and other management data	Rx	17/ year	0	0	0	0		1 ADR reported in Q4
Quarterly Results			3	1	3	1		
Resource Documentation Reports of Clinical Interventions	Rx	134 reports in 2012						100% of all clinical interventions are documented
Quarterly Results			16	36	69	64		

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

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Inpatient Consumer Survey

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

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

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

Rate of Response for the Inpatient Consumer Survey

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

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

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

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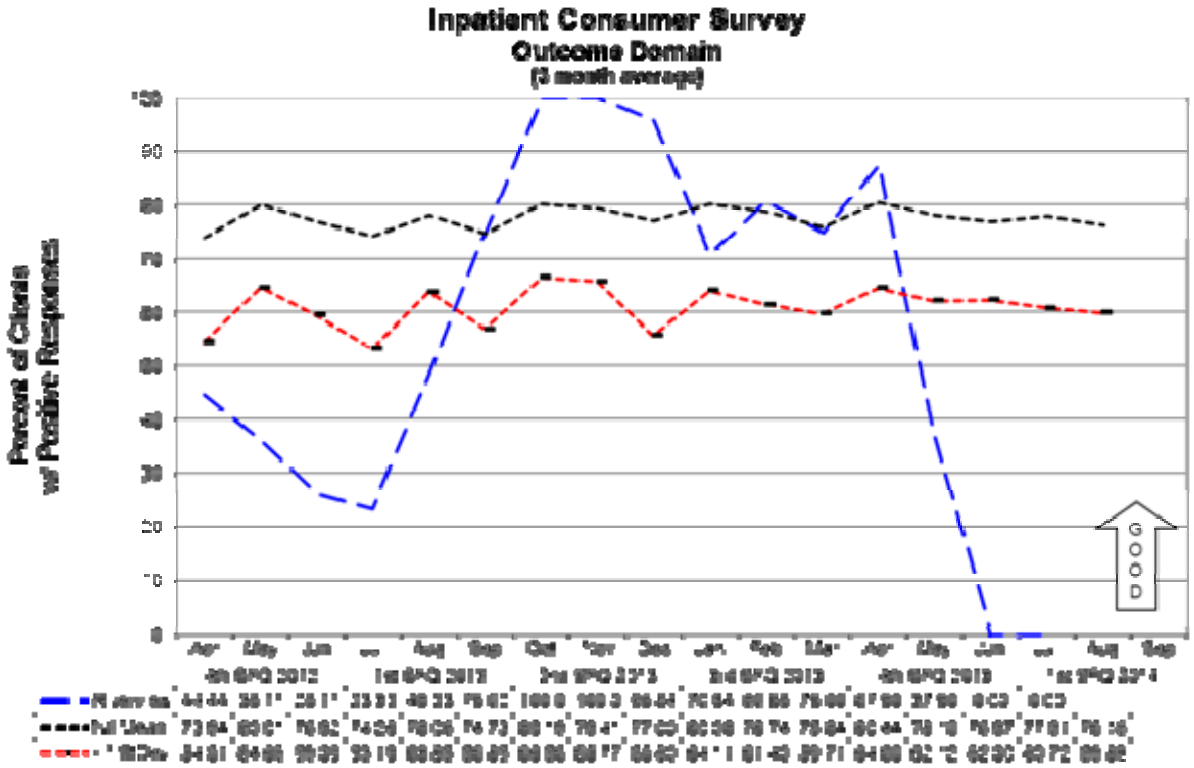

Outcome Domain Questions

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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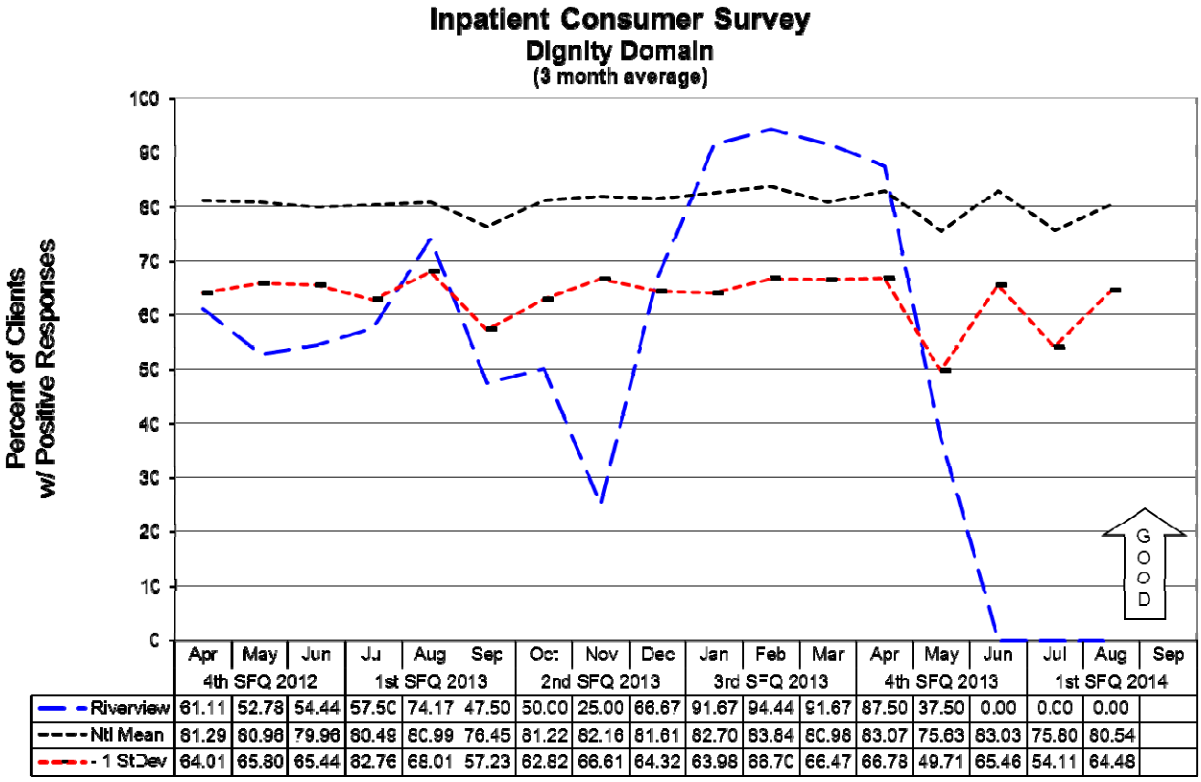

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	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	61.11	52.78	54.44	57.50	74.17	47.50	50.00	25.00	66.67	91.67	94.44	91.67	87.50	37.50	0.00	0.00	0.00	
Ntl Mean	81.29	80.98	79.96	80.48	80.99	76.45	81.22	82.16	81.61	82.70	83.64	80.98	83.07	75.63	83.03	75.80	80.54	
1 StDev	64.01	65.80	65.44	62.76	68.01	57.23	62.62	66.61	64.32	63.98	66.70	66.47	66.78	49.71	65.46	54.11	64.48	

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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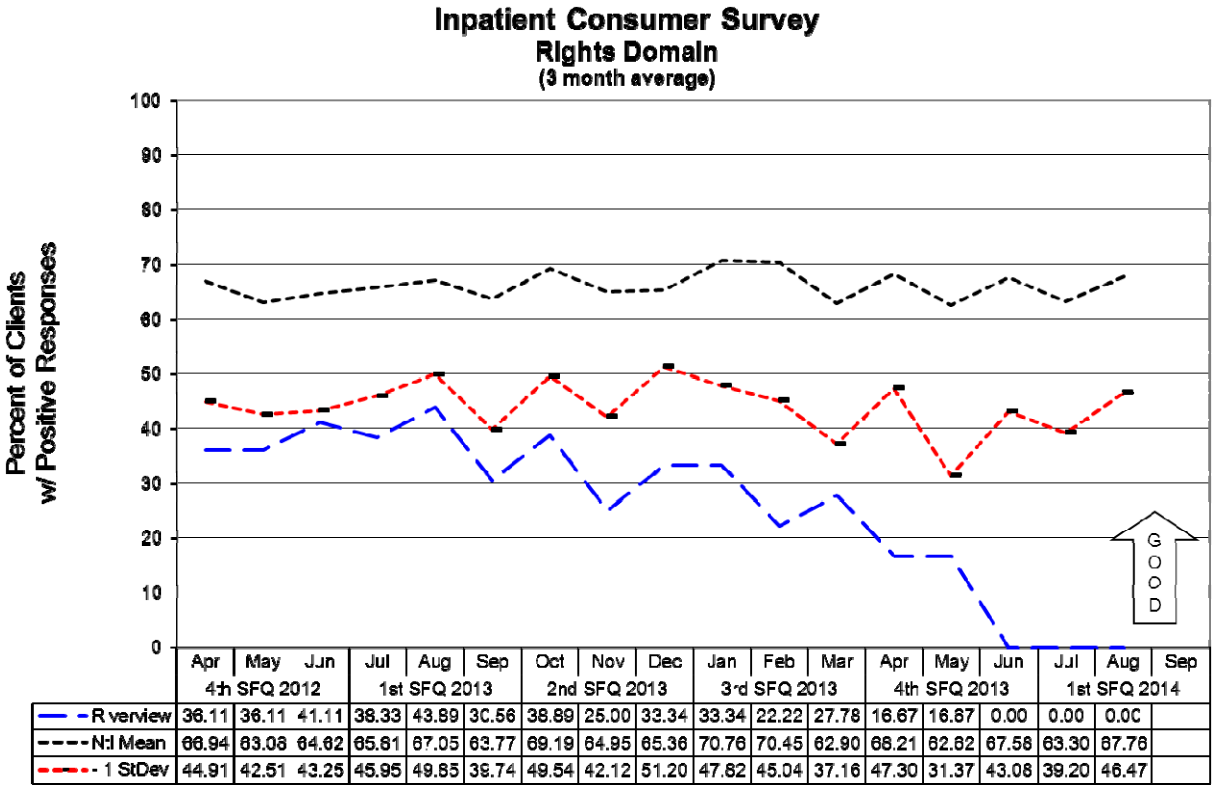

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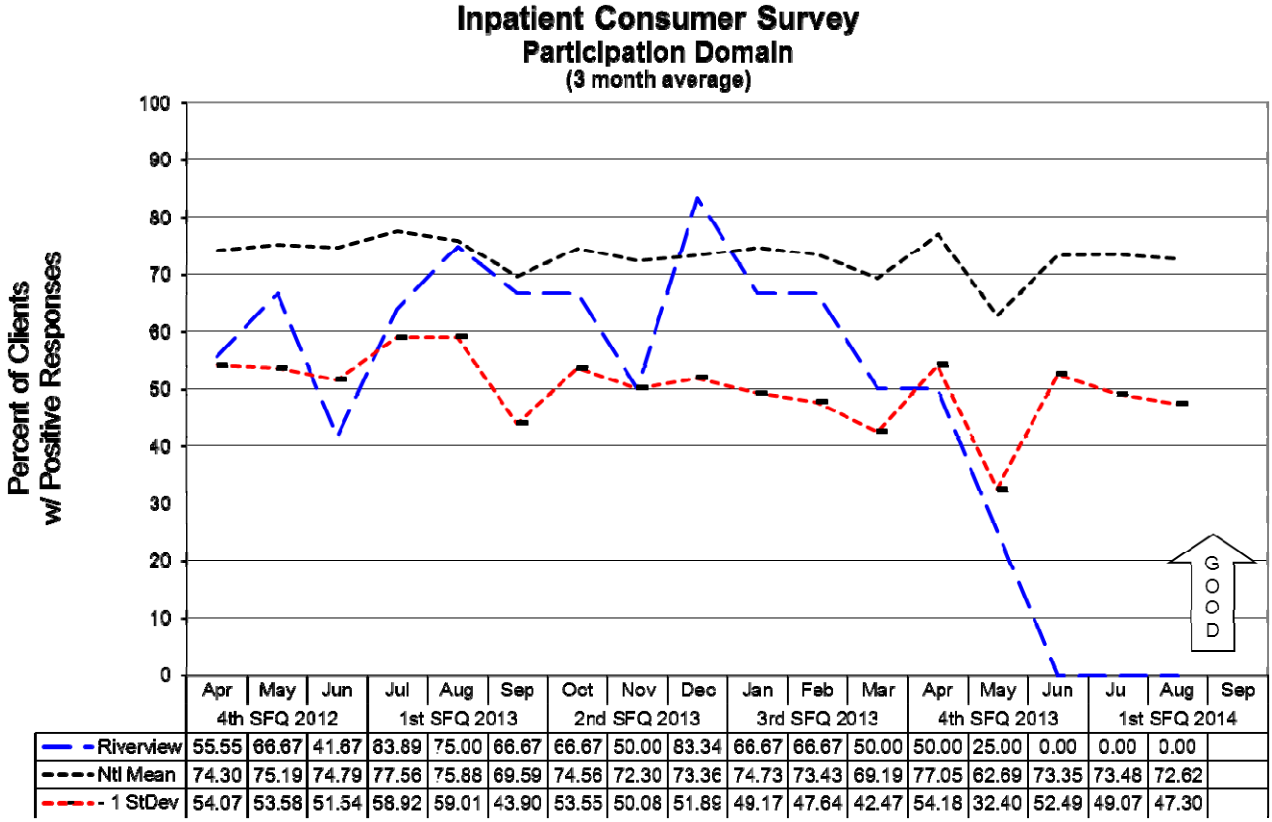
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
R verview	36.11	36.11	41.11	38.33	43.89	30.56	38.89	25.00	33.34	33.34	22.22	27.78	16.67	16.67	0.00	0.00	0.00	
N:l Mean	66.94	63.08	64.62	65.61	67.05	63.77	69.19	64.95	65.36	70.76	70.45	62.90	68.21	62.62	67.58	63.30	67.76	
1 StDev	44.91	42.51	43.25	45.95	49.85	38.74	49.54	42.12	51.20	47.82	45.04	37.16	47.30	31.37	43.08	39.20	46.47	

Rights Domain Questions

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

JOINT COMMISSION

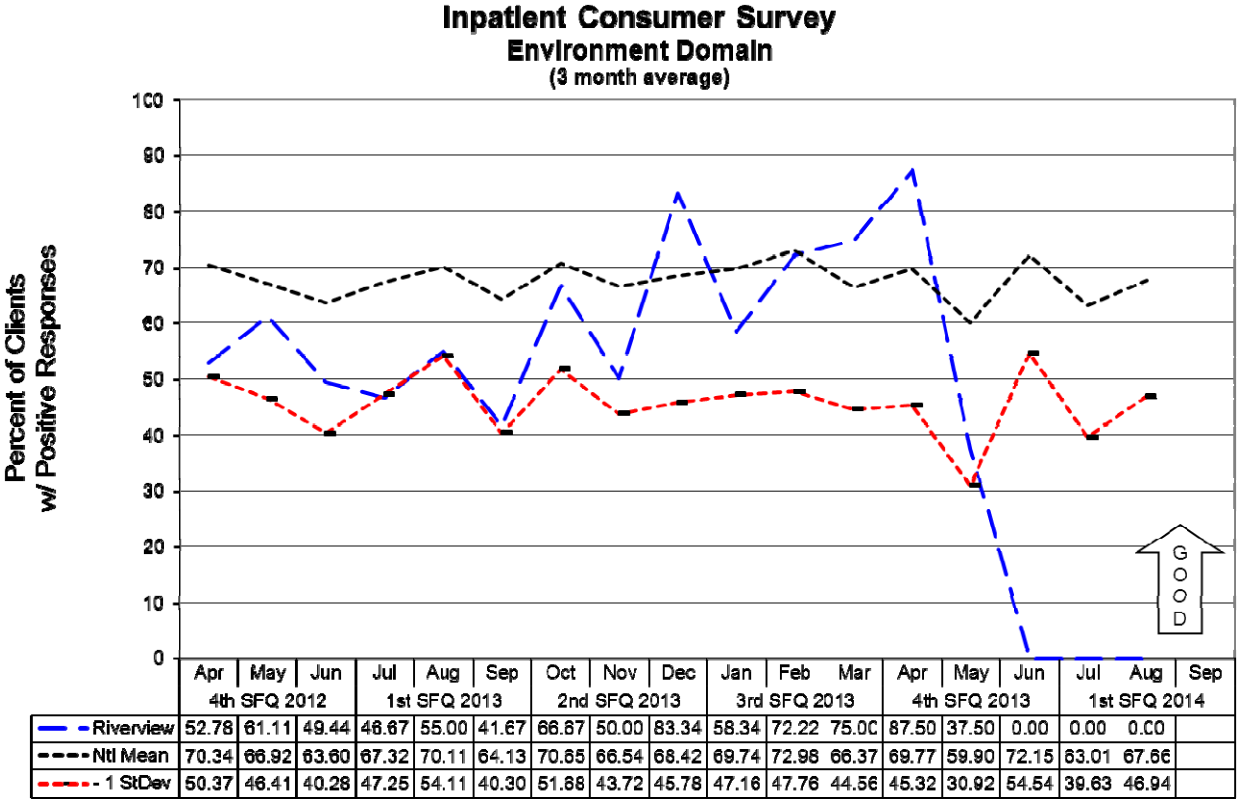


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Ju	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	55.55	66.67	41.67	83.89	75.00	66.67	66.67	50.00	83.34	66.67	66.67	50.00	50.00	25.00	0.00	0.00	0.00	
Ntl Mean	74.30	75.19	74.79	77.56	75.88	69.59	74.56	72.30	73.36	74.73	73.43	69.19	77.05	62.69	73.35	73.48	72.62	
1 StDev	54.07	53.58	51.54	58.92	59.01	43.90	53.55	50.08	51.89	49.17	47.64	42.47	54.18	32.40	52.49	49.07	47.30	

Participation Domain Questions

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

JOINT COMMISSION



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013			4th SFQ 2013			1st SFQ 2014		
Riverview	52.78	61.11	49.44	46.67	55.00	41.67	66.67	50.00	83.34	58.34	72.22	75.00	87.50	37.50	0.00	0.00	0.00	
Ntl Mean	70.34	66.92	63.60	67.32	70.11	64.13	70.65	66.54	68.42	69.74	72.98	66.37	69.77	59.90	72.15	63.01	67.66	
1 StDev	50.37	46.41	40.28	47.25	54.11	40.30	51.88	43.72	45.78	47.16	47.76	44.56	45.32	30.92	54.54	39.63	46.94	

Environment Domain

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

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

JOINT COMMISSION

Pain Management

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

Indicator	3Q2013	4Q2013	1Q2014	2Q2014
Pre-administration	91%	68%	70%	
Post-administration	81%	59%	60%	

SUMMARY

Both “Pre” and “Post” assessments were up slightly from last quarter but still significantly lower than the previous quarter. The number of pain medications given this quarter was up again, (last quarter 2350). There were only 1011 pain meds given in second quarter of FY 2013. There have also been significant changes in staffing personnel and assignments these past two quarters as well as a new staff person doing the audits of pain management. Neither of these factors should affect the percentages; however it is a change that needs to be looked at.

ACTIONS

Will meet with the nurse IVs to set up a system for more frequent monitoring of the assessing process. We will meet with all the nurses and reiterate the importance of assessing pain pre and post analgesics. Will review the audit process with the newly assigned staff to determine whether or not there has been a change in the way that we audit the information. Did follow up with pharmacy to see whether they could identify possible reasons for the increase in PRN pain medications being used. Pharmacy could not explain the significant increase over the last two quarters in the pain meds used .

JOINT COMMISSION

Fall Reduction Strategies

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

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

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

Type of Fall by Client and Month

Fall Type	Client	APR	MAY	JUN	4Q2013
Un-witnessed	MR00000016		1		1
	MR00000814	1			1
	MR00004287	1			1
	MR00006828			1	1
	MR00006963*	2			2
	MR00007323*	1	1		2
Witnessed	MR00000076		1		1
	MR00000477	1			1
	MR00004637		1		1
	MR00006963*	1			1
	MR00007323*	2			2

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

Review, Reporting and Follow-up Process

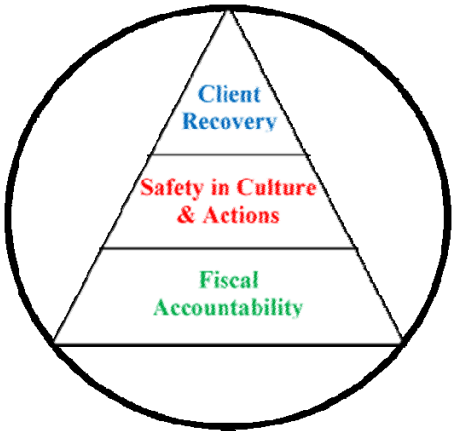
The Falls Assessment and Prevention Process Review Team (PRT) meets monthly to evaluate the causation factors related to the falls reported on the units and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices.

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

STRATEGIC PERFORMANCE EXCELLENCE

Priority Focus Areas for Strategic Performance Excellence

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



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

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

STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

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

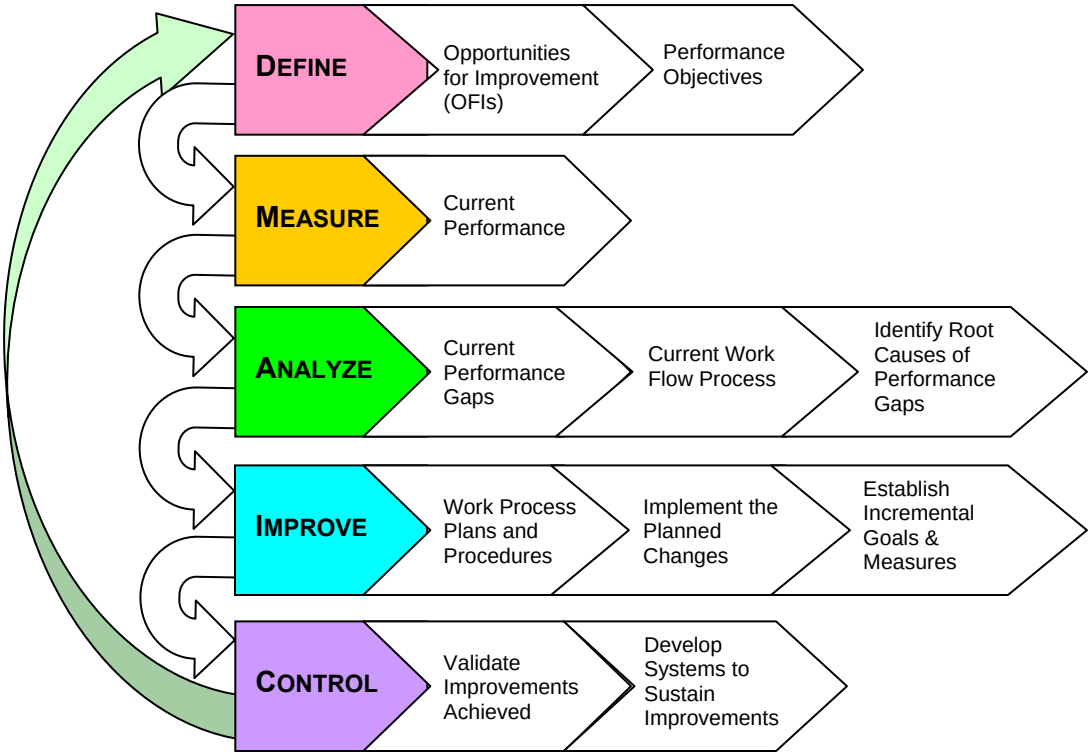
Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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

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

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

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



STRATEGIC PERFORMANCE EXCELLENCE

Admissions

DEFINE

OPPORTUNITIES FOR IMPROVEMENT (OFI'S)

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

PERFORMANCE OBJECTIVES

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

MEASURE

Based on a survey:

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

ANALYZE

CURRENT PERFORMANCE GAPS:

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

CURRENT WORK FLOW PROCESS:

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

IDENTIFY ROOT CAUSES OF PERFORMANCE GAPS:

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

STRATEGIC PERFORMANCE EXCELLENCE

IMPROVE:

WORK PROCESS PLANS AND PROCEDURES:

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

IMPLEMENT THE PLANNED PROCEDURES:

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

CONTROL:

VALIDATE IMPROVEMENTS ACHIEVED

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

DEVELOP SYSTEMS TO SUSTAIN IMPROVEMENTS:

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

Admissions Pilot PSFA Form

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

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Process Improvement Activities

1Q2014

- Over the past few months the admissions department has made additional changes to the PASF form, working in collaboration with medical records. The new PASF form now has a section that addressing preferred language for both written and verbal for new admissions.
- Admissions continues to collaborate with medical records to streamline the admission process for the units. Many of the admission forms have been updated to include signature pages with both date and times on the form.
- We have also worked with medical records to update the SBAR form so it can now be used to replace the nursing discharge paperwork previously used.
- The Health Info Net paperwork has been added to the admission packets.
- We have been able to decrease both the wait time and the list for forensic referrals.
- We are continuing to build relationships with the jails, keeping open communication so information is passed on in a timely manner.
- I have worked with RN's on the unit to complete a training on Admissions for those who asked for a refresher.
- Lower Saco unit guidelines were updated to include the rules regarding the decertified unit.
- All clients were discharged from the Lower Saco unit and readmitted to the decertified Lower Saco Unit.
- Our civil referral list has been manageable and we have continued to get them in, in a timely manner.
- Admissions continues to work with the education department on orienting new employees and students.
- Admissions has collaborated with medical records to get all the admissions packets on the common drive for staff to utilize.

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions

Hand Hygiene Compliance: In an effort to monitor, sustain and improve hand hygiene compliance, the Dietary department measures its results through observations of Dietary staff when returning from a scheduled break.

2nd Quarter 2013			3rd Quarter 2013			4th Quarter 2013			1st Quarter 2014			Goal
Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 10%	Findings	Compliance	Target – Q3 + 10%	Findings	Compliance	Target	Findings	Compliance	
70%	18/34	53%	63%	41/49	84%	94%	22/26	85%	85%	16/30	53%	80-90%

Data

16 compliant observations / 30 hand hygiene observations = 53% hand hygiene compliance rate

Summary

- Hand hygiene compliance has decreased by 32%.
- Hand hygiene observations have marginally increased; 22 observations last quarter to 30 observations this first quarter.
- Utilizing an alternate means of data collection in the month of July did not increase the occurrences of hand hygiene observations. Self-documentation proved to be cumbersome and time consuming for the employees. Thus, the accuracy of the log cannot be validated.
- Self-documentation was not used as a means of data collection in the months of August and September.
- Reformatting the Hand Hygiene Tool simplified the observation process and aided with the increase of observations for the months of August and September.

Action Plan

- Continue use of the improved Hand Hygiene Tool.
- Encourage employees to adhere to hand hygiene via verbal interaction.
- Food Service Manager provide employee education in the month of October: Interactive Hand Hygiene education.

- The Dietetic Services Manager will review the following publication:

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

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Measuring Hand Hygiene Adherence: Overcoming the Challenges
Authored by The Joint Commission in collaboration with The Association for Professionals in Infection Control and Epidemiology, Inc., The Centers for Disease Control and Prevention, The Institute for Healthcare Improvement, The National Foundation for Infectious Diseases, The Society for Healthcare Epidemiology of America, and The World Health Organization World Alliance for Patient Safety

- Additionally, the Food Service Manager will present this quarterly report at the departmental staff meeting and IPEC meeting.

Strategic Objective: Safety in Culture and Actions

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

1st Quarter 2014			2nd Quarter 2014			3rd Quarter 2014			4th Quarter 2014			
Established Baseline	Findings	Compliance	Target	Findings	Compliance	Target	Findings	Compliance	Target	Findings	Compliance	Goal
93.5%	29/13	93.5%	94%			94%			94%			90-95%

Data
29 Nutrition screens completed within 24 hours of admissions
31 Total Admissions = 93.5% of nutrition screens completed within 24 hours of admission

Summary
- The Registered Dietitian reviewed the nutrition screens of 31 client admissions for this quarter
- Upon review, the RD discovered 4 nutrition screens incomplete
- RD spoke with the admitting nurse and requested completion of the screen resulting in two of the four being complete within 24 hours of admission

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

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

INDICATOR

GROUNDS SAFETY/SECURITY INCIDENTS

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

Monitoring would be performed by;

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

METHODS OF REPORTING: Reporting would occur by one or all of the following methods;

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

UNIT

Hospital grounds as defined above

BASELINE

To be determined after compilation of data during the months from July 2013 to June 2014.

2014 Q1-Q4 TARGETS

Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

Department: Safety & Security

Responsible Party: Bob Patnaude, Safety Officer

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q1 Target Actual	Q2 Target Actual	Q3 Target Actual	Q4 Target Actual	Goal	Comments
Grounds Safety & Security Incidents Safety/Security incidents occurring on the grounds at Riverview, which include "*Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches*	# of Incidents	* Baseline of 10	(16) -5% (24)	(24) -5%			Baseline -5%	****See below

SUMMARY OF EVENTS

The Q4 Target was (16)-5%. Our actual number was (24); a significant increase again this quarter. ****Although we would like to report that our incident rate has decreased, we are pleased that in all the cases, our Security staff or clinical staff have discovered items before those items get into the hands of anyone who would have an ill intent with the items. In fact, one incident was reported by a responsible client. We feel that the reporting, which follows below, continues to provide a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our aggressive rounds by Security continues to prove its' worth with regard to Security's presence and patrol techniques.

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
1. Safety Threat (Item Posey key) found outside by Door #5	7/7/13	0835	By door #5	Turned over to RN and then NOD	1. Security found during rounds 2. RN and NOD immediately notified 3. Safety Notified 4. IR # 4045 completed
2. Safety Threat (Metal Coffee Mug)	7/7/13	1330	Saco Yard	Given to NOD	1. MHW found during yard break 2. Item turned over to NOD 3. IR # 5069 completed/Safety notified 4. Cup later picked up by owner/advised
3. Property Damage (Sign light broken)	7/9/13	1800	Facility Sign	Maintenance secured and replaced	1. NOD notified 2. Maintenance secured and later replaced 3. IR # 1141 completed/Safety notified
4. Safety Threat (Plastic dental pick by bench outside Sebago Room)	7/10/13	1200	Sitting area by Staff Entrance	Security removed	1. Security found during rounds 2. Secured items 3. IR # 517 completed/Safety notified
5. Security Threat (Fire gate by sheds not locked)	7/13/13	0145	Fire Lane	Security secured	1. Security discovered during rounds 2. Security secured 3. Operations and NOD notified IR # 519 completed/Safety notified

Environment of Care

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
6. Safety Concern (Key found near cargo containers)	7/15/13	1100	By cargo container	Secured by Security, turned into Operations lost & found	1. Security discovered during rounds 2. Security checked with facilities/unsure who it belongs to 3. Turned into Operations/lost & found 4. IR # 520 completed/Safety notified
7. Safety Concern (Items, spool of wire, rope, piece of wood)	7/16/13	0120	Parking lot #4, lower lot	Secured by Security	1. Security found during rounds 2. NOD notified 3. IR # 521 completed/Safety notified 4. Email sent out to determine owner/not located
8. Security Concern (Outsider by staff entrance seeking assistance)	7/17/13	0331	Staff Entrance	Security called Capital Police and Augusta Police, transported to shelter	1. Operations notified Security 2. Security assessed 3. NOD notified 4. Capitol Police called 5. Person transported to shelter by APD 6. IR # 522 completed/Safety notified
9. Safety Concern (Metal shims by fence, adjacent to loading dock)	7/17/13	0700	Fence along loading dock/ chiller	Security turned over to Maintenance	1. Security discovered during rounds 2. Turned over to Maintenance 3. IR # 523 completed/Safety notified
10. Safety Threat (Items in open back of truck) (2 claw hammers)	7/20/13	0930	Staff Lot	Securing secured, email sent, owner secured	1. Security discovered during rounds 2. Email sent for owner to respond 3. Owner secured 4. IR # 525 completed/Safety notified
11. Safety Concern (Items in open back of truck) (Ratchet strap)	7/20/13	2330	Staff Lot	Security secured	1. Security discovered during rounds 2. Secured at Security 3. Email to locate owner/NOD notified 4. No response/turned over to Operations 5. IR # 526 completed/Safety notified
12. Safety Concern (Electrical Box unlocked and padlock laying on top)	7/24/13	0645	By Admissions A Door	Security Secured	1. Security discovered during rounds 2. Maintenance locked box 3. Turned over to Maintenance Supervision to ascertain who is responsible 4. IR # 528 completed/Safety notified
13. Safety Concern (Gunshots from AMHI campus)	7/24/13	2353	AMHI Campus	Security monitored	1. Security discovered during rounds 2. Capitol Police on scene immediately 3. Nothing further/NOD notified 4. IR # 5029 completed/Safety notified

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
14. Safety Concern (Items in back of staff vehicle) (Ratchet straps, bungee cord, golf tees)	7/25/13	0925	Staff Lot	Security removed items and secured, Owner later secured	1. Security discovered during rounds 2. Email sent/NOD notified 3. Secured items/Owner later picked up 4. Security spoke to owner 5. IR # 530 completed/Safety notified
15. Safety Concern (Beer can in back of staff vehicle)	7/28/13	0153	Staff Lot	Security secured	1. Security discovered during rounds 2. Security secured/Owner identified 3. Disposed by Security 4. IR # 531 completed/Safety, NOD notified
16. Safety Concern (Soda can outside by generator room)	7/29/13	1400	Outside by generator room	Security disposed of	1. Security discovered during rounds 2. Security disposed of 3. Maintenance Supervisor notified 4. IR # 533 completed/Safety notified
17. Security Concern (Rifle in plain view of staff vehicle)	7/30/13	0920	Staff Lot	Security stood by, called Capitol Police	1. Security notified by other staff person 2. Responded and stood by for Police to respond 3. Owner identified by police/Report taken 4. Capitol Police took possession 5. IR # 535 completed/Safety notified
18. Safety Concern (Items in back of staff vehicle) (Heavy metal chain with books)	7/30/13	0940	Staff Lot	Security stood by, Owner removed items	1. Security discovered during rounds 2. Stood by while owner responded 3. Owner removed items and secured 4. Immediate supervisor spoke to staff owner 5. IR # 536 completed/Safety notified
19. Safety Concern (Vehicle had broken window)	8/6/13	1340	Staff Lot	Security stood by, Owner removed	1. Security notified Operations 2. Stood by while owner responded 3. Discovered window broken by grounds crew weed whacking 4. Grounds supervisor spoke to crew 5. IR # 539 completed/Safety notified
20. Safety Concern (State vehicle with window down)	8/17/13	0138	State Vehicle Lot	Security closed window	1. Security discovered during rounds 2. Security obtained keys and secured 3. Last known driver's supervisor notified IR # 543 completed/Safety notified

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
21. Security Concern (Suspicious person on property)	8/19/13	2100	Adjacent to walkway	Security called Police	1. Security notified by staff of suspicious person 2. Security called police 3. Police escorted from property 4. IR # 544 completed/Safety notified
22. Safety Concern (Items in back of staff vehicle) (cans)	8/21/13	1705	Staff Lot	Security secured	1. Security discovered during rounds 2. Owner located 3. Owner secured property 4. IR # 545 completed/Safety notified
23. Safety Concern (Items on ground) (2 ½" pin)	9/9/13	1300	Visitor's Lot	Security secured	1. Staff discovered/turned into Security 2. NOD notified 3. IR # 1178 completed/Safety notified
24. Hit and Run Accident	9/10/13	1630	Staff Lot	Capitol Police Called	1. Staff discovered midday 2. Safety and Capitol Police notified 3. IR # 551 completed
25. Safety Concern (Storage shed missing screen)	9/26/13	0934	Storage shed	Maintenance notified	1. Security discovered during rounds 2. Maintenance and Safety notified by email 3. IR # 545 completed/Safety notified
26. Safety Concern (Items in open back of truck) (Wrenches, hammer, golf clubs)	9/26/13	0935	Staff Lot	Safety and Security secured	1. Security discovered during rounds 2. Safety and Capitol Police notified to ID 3. Did not ID owner immediately after emails sent 4. Safety and Security brought items in 5. Incident presented to IP/Vehicle ID issue 6. Staff Person later identified and secured 7. IR # 558 completed

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Objectives	*2Q2013*	*3Q2013*	*4Q2013*	*1Q2014*
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	*45% 19 of 42*	*67% 28 of 42*	*60% 25/42*	*71% 30/41*
2. SBAR information completed from the units to the Harbor Mall.	*67% 28 of 42*	*76% 32 of 42*	*88% 37/42*	*86% 36/42*

DEFINE

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

MEASURE

Indicator number one has increased from 60% last quarter to 71% for this quarter. Indicator number two has decreased from 88% last quarter to 86% this quarter.

ANALYZE

Overall compliance has increased from 74 % last quarter to 79% this quarter. For indicator number one the designated time for the sheets to be received is not in compliance. The amount of time the sheets are late has decreased. Continue to concentrate on both indicators to improve current performance gaps.

IMPROVE

I met with the Nurse IV on US to review June's data since they had the most HOC sheets that were not received on time or not received at all. On July 17th I reviewed the results of April/May/June quarterly report at Nursing Leadership.

CONTROL

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

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Documentation of Client Encounters in Support of Superbills Submitted

Define

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

Measure

14 providers submitted superbills to the Health Information department for quarter 1.

Analyze

A total of eight superbills submitted were duplicates coming from four different providers this quarter (JK-3, KB -2, GD-1, EH-1, BK-1). Eight superbills had date of service discrepancies i.e.; missing DOS and two of those with incorrect dates submitted by 6 providers (JK-3, EH-1, GD-1, BM-1, SU-1, PM-1). Twelve superbills were submitted missing the procedures codes by five providers (KB- 1, GD- 5, MD- 1, AR - 2, BM- 1, JJ – 1, PM- 1).

Improve

Superbills are all being returned to the providers for correction. Continue to work with providers on appropriate/consistent documentation.

Control

100% of the superbills are being audited.

Process Deficiencies Identified	2Q2013	3Q2013	4Q2013	1Q2014
Superbill Submission without supporting documentation	72% 18/25	35% 9/26	4% 1/24	0%
Superbills with incorrect information		69% 18/26	75% 18/24	71% 20/28
Duplicate Superbills	76% 19/25	8% 2/26	13% 3/24	29% 8/28

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Release of Information for Concealed Carry Permits

Define

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

Measure

To evaluate the validity of the perceived delays a process was established to measure the date the application was signed by the application and the date the application was received for processing by the hospital. This measure produces data on the number of days the application is in the hands of the issuing agency before being referred to the hospitals for review. In addition, the date that application was returned to the issuing agency is also recorded to measure the delay in processing by the hospital.

Analyze

Data collected for the 1st quarter 2014 showed the following results:

- Maine State Police forwarded the greatest number of applications, a total of 2243 applications for the quarter with an average processing delay prior to receipt by the hospital of 133 days. The maximum delay for any application was 1568 days as measured from the date the application was signed by the applicant to the date received by the hospital.
- The average number of days for hospital processing of applications was 9 days. The maximum number of days was 45.

Improve

Several improvements have been implemented to facilitate the workflow within the department including the immediate sorting of the applications as they arrive so the alphabetic records can be reviewed more efficiently.

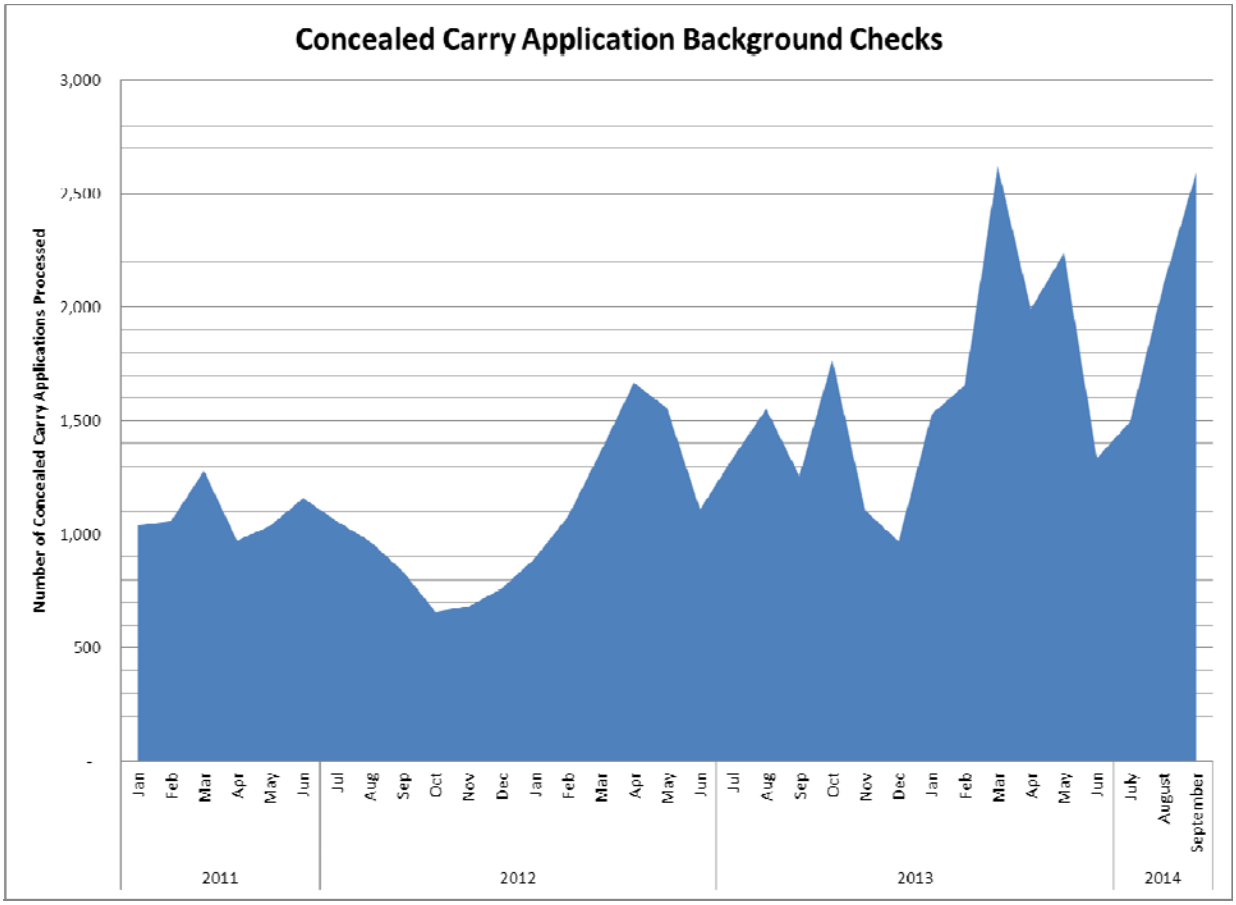
Other improvements being considered include transforming the existing archival records to a digital format. Barriers to be considered in this change include the significant time and fiscal impact required.

Control

While not always the case, many of the significant delays in processing the concealed carry applications originate with the workflow of the issuing agency. Ongoing monitoring of the process will be conducted and staff input on improvements will be solicited for the purpose of enhancing the timeliness of applications processes by hospital staff.

FY 2013/2014	Oct	Nov	Dec	Jan`	Feb	Mar	Apr	May	Jun	July	Aug	Sep
# Applications Received	1757	1104	970	1529	1657	2623	1993	2239	1336	1497	2096	2596
Avg Receipt Delay	--	--	--	--	--	35	26	42	66	82	76	30
Max Receipt Delay	--	--	--	--	--	381	451	504	1694	1568	258	508
Avg Processing Time	--	--	--	--	--	11	8	13	15	13	11	3
Max Processing Time	--	--	--	--	--	13	11	20	19	45	15	7

STRATEGIC PERFORMANCE EXCELLENCE



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

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Define

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

Measure

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

Analyze

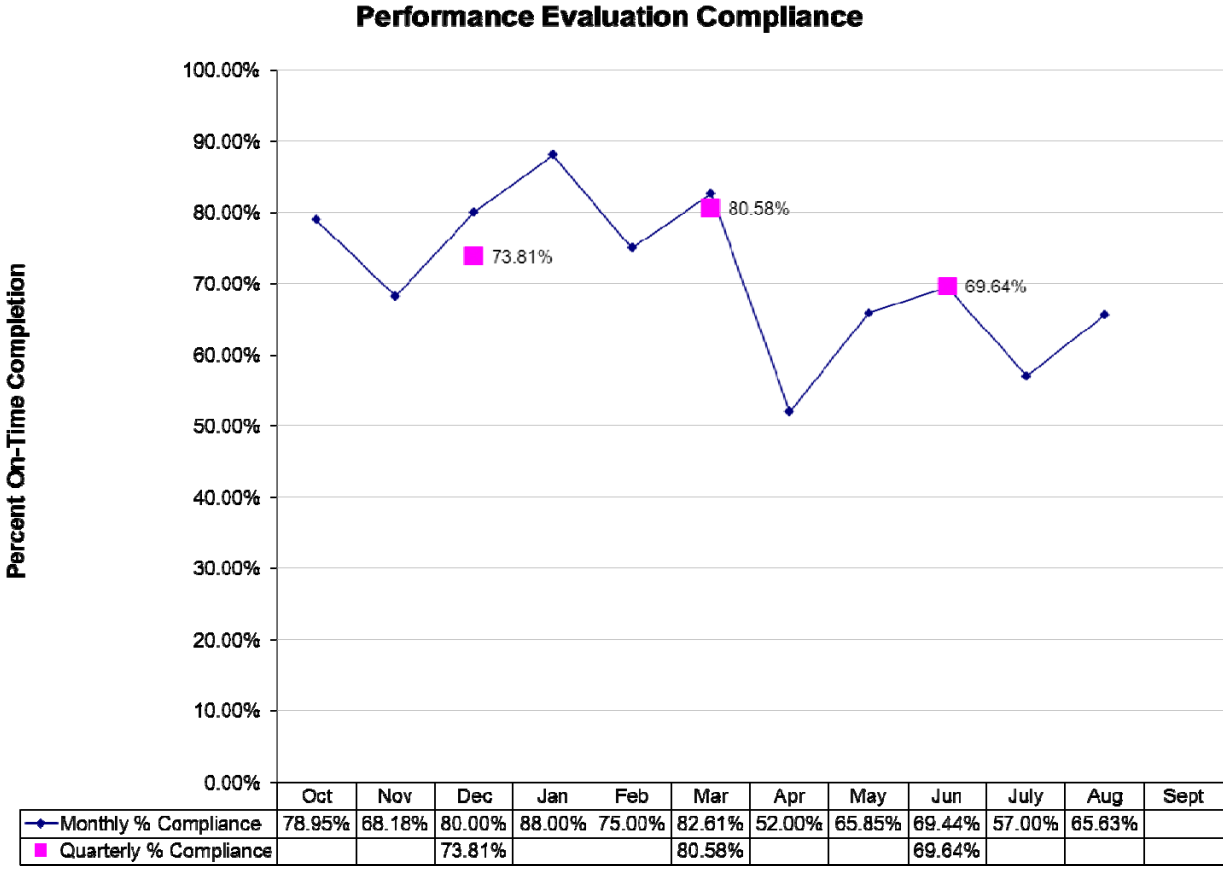
A thorough analysis of the root causes for lack of compliance with this performance standard is indicated. This analysis

Improve

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

Control

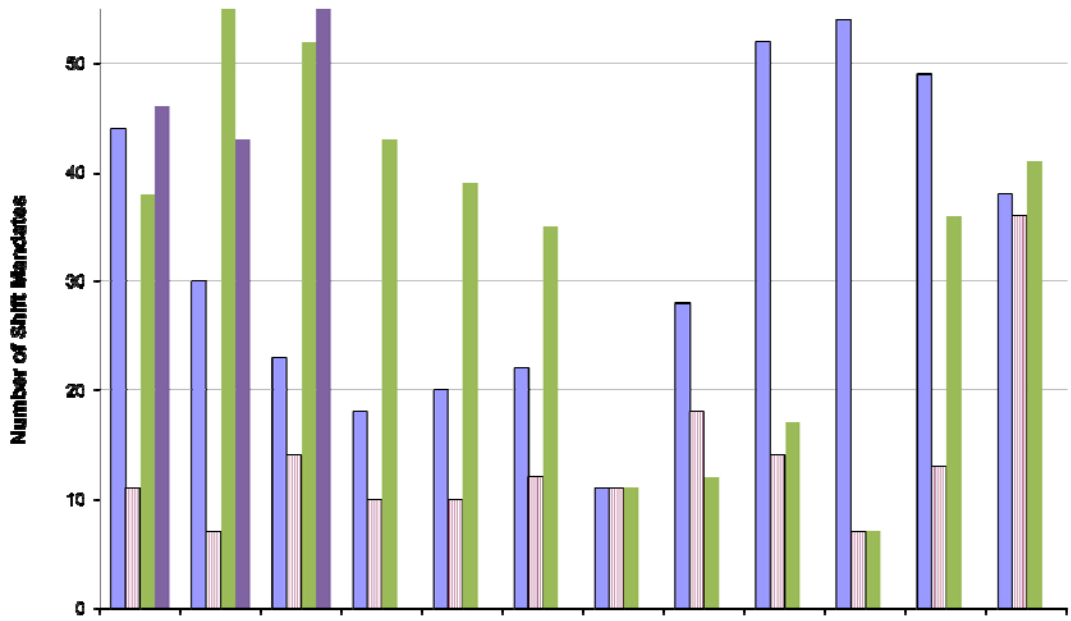
Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept
Monthly % Compliance	78.95%	68.18%	80.00%	88.00%	75.00%	82.61%	52.00%	65.85%	69.44%	57.00%	65.63%	
Quarterly % Compliance			73.81%			80.58%			69.64%			

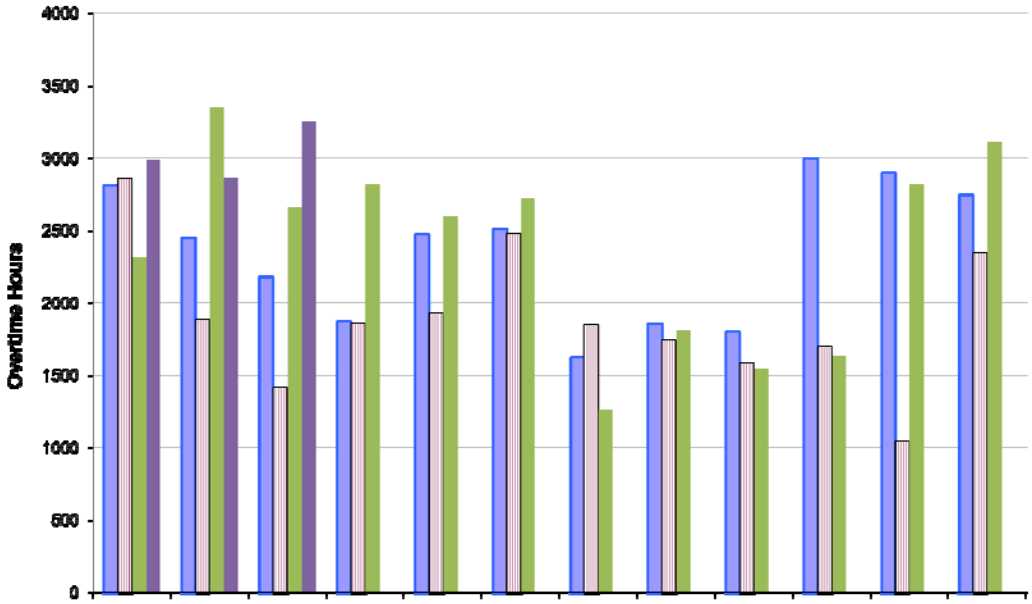
STRATEGIC PERFORMANCE EXCELLENCE

Monthly Mandated Shifts



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY 2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2013	38	81	52	43	39	35	11	12	17	7	36	41
FY 2014	46	43	69									

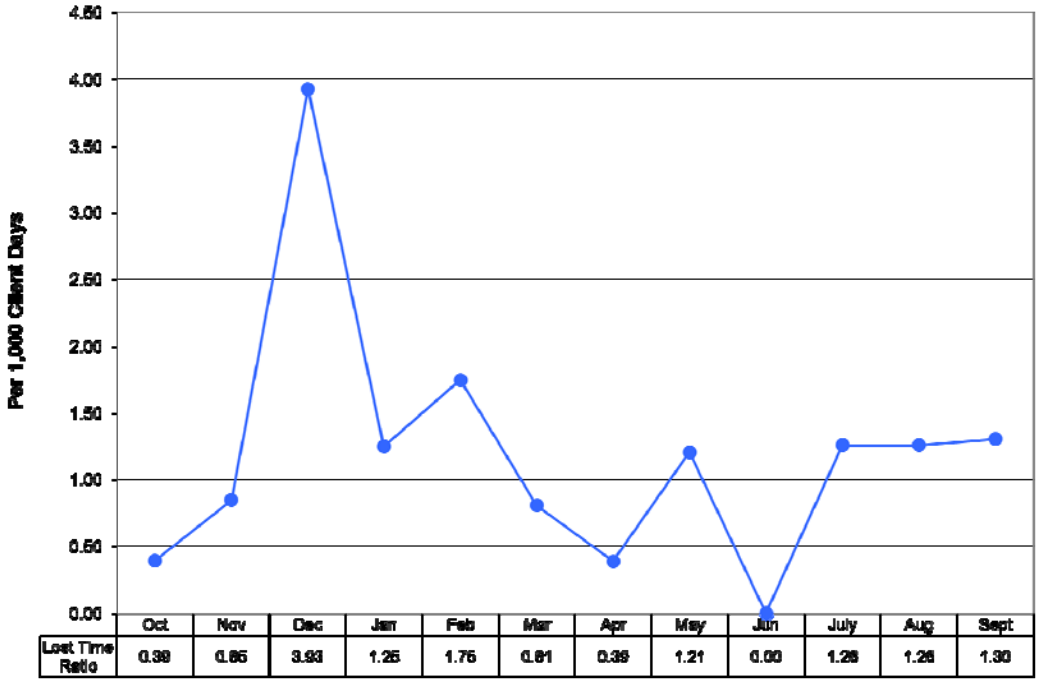
Monthly Overtime



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	2812	2451	2178	1866	2473	2507	1618	1853	1798	2999	2896	2743
FY 2011	2859	1865	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2013	2319	3350	2657	2817	2599	2720	1269	1812	1539	1629	2822	3109
FY 2014	2983	2861	3251									

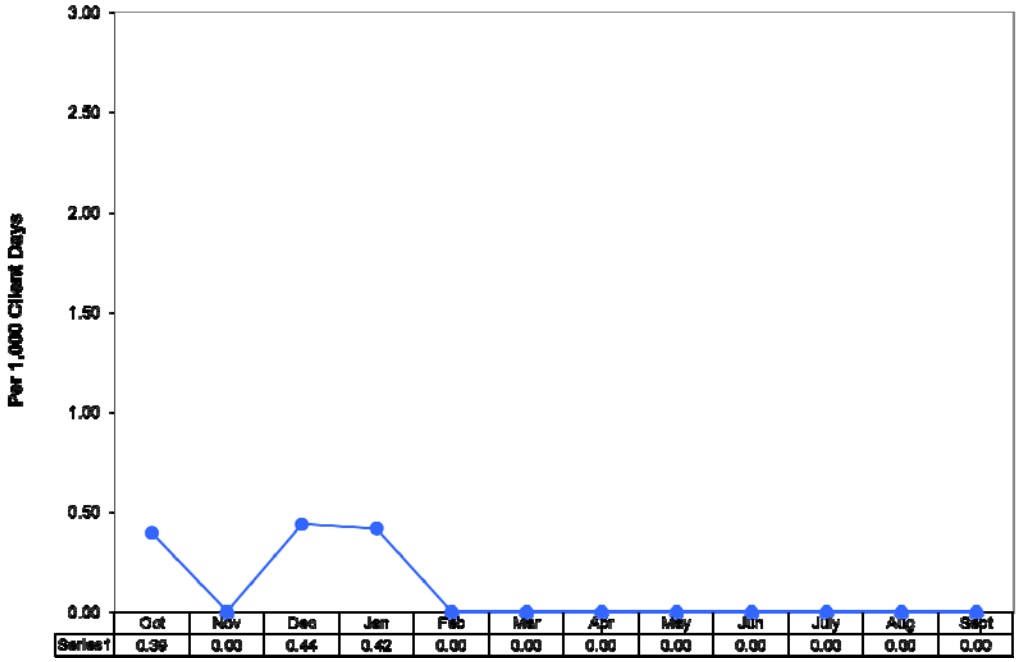
STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept
Lost Time Ratio	0.39	0.85	3.93	1.25	1.75	0.81	0.39	1.21	0.00	1.26	1.26	1.30

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept
Series1	0.39	0.00	0.44	0.42	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Timeliness of Psychological Testing

Data Collection
All requests for psychological testing or evaluation were reviewed during the time period of July, August, and September 2013. The date of medical staff request, date the requested service was initiated by the appropriate psychologist, and date of final completion of requested task (including a written report) were determined and compared to target norms.

Findings
During the period there were 4 requests for psychological testing or evaluation. All of the evaluations were initiated by the psychologist within 7 days of request and exceeded threshold of 90%. Two of three requests (67%) were completed within 30 days (the 4th request was pending at the end of the quarter) after initiation. We did note that the client who took longer than 30 days to complete was intermittently declining to complete the tests.

Analysis
There was a definite decline in the number of requested psychological tests this quarter no doubt partially influenced by a temporary reduction in the number of psychologists following the resignation of the Director. However the timeliness of initiation of testing remained above threshold, and time to completion was below threshold of 90%, but attributable to one client who was disinclined to cooperate with the process.

Plan
We will continue this monitor especially in light of a reduction (hopefully temporary) in force of the Psychology Department. We will continue to work with the Psychology Department to most efficiently use their limited resources and to work with the Medical Staff to make certain only necessary referrals are made to the Department

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Polyantipsychotic Medication Monitoring

Data Collection

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

Findings

Over the quarter we found that 59 of 183 clients (32.2%) receiving at least one antipsychotic medication were receiving more than one such agent, and by definition was a case of polypharmacy. Within this overall percentage we noted that in July the percentage was 37.3, in August it was 33.3, and in September it was 26.6. The average justification percentage for the 59 total clients was 89.8%. Again we noted improvement over the quarter with justifications in August and September above the threshold of 90%.

Analysis

We were just below our target of 90% justified for the quarter at 89.8%. The trend line showed improvement over the quarter and was above threshold in September at 94%. A secondary finding was that the overall percentage clients receiving polypharmacy had also significantly declined from baseline. We also had reduced significantly the numbers of clients receiving ultrahigh numbers of medications (greater than 3 antipsychotics). The medical staff performance did improve on this monitor over the quarter.

Plan

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

Medical Staff
Antibiotic Use Monitoring

Data Collection

During the quarter we created an antibiotic monitoring form consisting of a special doctor's order sheet with details of the antibiotic indication, drug, and strength, and giving agreed upon prescribing guidelines to the medical staff. The guidelines were approved by the Medical Executive Committee and disseminated to all medical staff. The monitoring form was first used beginning late in September. In September only four orders for antibiotics had been initiated by medical staff. We have not yet analyzed the findings on these few forms, thinking we will have a 100% review by the Medical Services Department going forward and including the results of this quarter in next quarter's data.

Plan

This is the first quarter for this monitor and most of the activity was related to setting up the infrastructure to allow proper monitoring. Going forward we will collect all antibiotic orders and peer review the proper use and indications for the antibiotic. Our threshold for this monitor is that 90% of all antibiotic orders will meet clinical guidelines as developed by the Medical Executive Committee.

Medical Staff
Metabolic Monitoring of Atypical Antipsychotics

Data Collection

The pharmacy completed its initial data base of metabolic monitoring parameters for all clients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all clients included BMI and BP plus lab results including HDL cholesterol, trigycerides, fasting blood sugar, and hemoglobin A1c. Also collected were the dates of the last tests and the names of the atypical drugs each client was receiving. The data collection was completed by September 30 and presented to all medical staff. The pharmacy plans to continuously update the data base as new clients are admitted and as new data elements are recorded in the medical record and/or received from laboratory reports. A written copy of the data base will be presented monthly, in writing, to all medical staff members although they may access it at any time via the pharmacy drive on the computer.

Findings

During the monitoring period there were 52 clients receiving at least one atypical antipsychotic agent. Data was completely recorded for all desired data elements for 38 of 52 (or 73%) clients. Missing data elements were primarily related to lab studies, with only one client missing BMI data.

Analysis

At 73% we were below our target of 95% of clients on antipsychotics having a complete metabolic profile available to the pharmacist and to the medical staff. This was primarily due to missing laboratory values in the data base. Upon conversations with medical staff some of these missing data elements were because the labs had been obtained at referring hospitals just prior to admission to RPC and were not readily available to the pharmacy data base manager. At the P and T Committee we discussed how medical staff could forward such data to the pharmacy, and other ways to improve the data base.

Plan

This is a new monitor for the medical staff and the above data should be considered a baseline value. Much effort was expended over the quarter to get the data base up and running. Going forward we will refine our data entry techniques and make other improvements to the data base. We will continue this monitor until we have successfully input 95% of clients on a consistent basis for two quarters.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing

INDICATOR

Mandate Occurrences

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

Monitoring would be performed by;

- Staffing Office Database Tracking System

METHODS OF REPORTING

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

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

UNIT

Mandate shift occurrences

BASELINE

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

MONTHLY TARGETS

Baseline –10% each month

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Mandates

Staffing Improvement Task Force

Department:	Nursing	**Responsible Party:**	Coleen Cutler, Acting DON; Staffing Improvement Task Force

Safety in Culture and Actions	**Baseline Aug 2012**	**Mth 1: Sep 2012**	**Mth 2: Oct 2012**	**Mth 3: Nov 2012**	**Mth 4: Dec 2012**	Goal	Comments
Mandate Occurrences - Nurses When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	24	10	5	0	6	16 (10% reduction monthly x4 from baseline)	Goal exceeded.
Mandate Occurrences – Mental Health Workers When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	53	38	36	34	28	35 (10% reduction monthly x4 from baseline)	Goal exceeded
Safety in Culture and Actions	**Mth 5 Jan 2013**	**Mth 6 Feb 2013**	**Mth 7 Mar 2013**	**Mth 8 April 2013**	**Mth 9 May 2013**	**Mth 10 June 2013**	
Mandate Occurrences - Nurses	1	2	1	0	1	4	Goal Exceeded
Mandate Occurrences – Mental Health Workers	8	8	15	7	35	41	Increase in MHW mandates – increased acuity and 1-1 coverage ordered
Safety in Culture and Actions	**Mth 11 July 2013**	**Mth 12 Aug 2013**	**Mth 13 Sep 2013**				
Mandate Occurrences - Nurses	4	5	3				Increase due to vacancies and leaves.
Mandate Occurrences – Mental Health Workers	37	55	37				Increase due to increased acuity, 1:1 coverage, vacancies, workers comp and FML

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

INDICATOR

Client Satisfaction Survey Return Rate

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

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

METHODS OF REPORTING

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

UNIT

All client care/residential units

BASELINE

Determined from previous year's data.

QUARTERLY TARGETS

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

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Inpatient Client Survey – Improving the Rate of Return

Department: Peer Support Responsible Party: Chris Monahan

Strategic Objectives								
Client Recovery	Unit	Baseline	Q1	Q2	Q3	Q4	Goal	Comments
CSS Return Rate	LK	15%	ND	9%	8%	5%	50%	
The client satisfaction survey is the primary tool for collecting data on how clients feel about the services they are provided at the hospital. Data collection has been low on all units and the way in which the surveys are administered has challenges based on the unit operations and performance of the peer support worker.	LS	5%	ND	0%	0%	4%	50%	*Percentages are calculated based on number of people eligible to receive a survey vs. the number of people who completed the surveys.*
	UK	45%	ND	44%	27%	39%	50%	
	US	30%	ND	78%	60%	100%	50%	

STRATEGIC PERFORMANCE EXCELLENCE

Summary of Inpatient Client Survey Results

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

Summary

Due to employee turnover we have started a new method for calculating results in the 1st quarter of 2014. We will continue to use this method going forward and will be comparing changes in results from quarter to quarter.

1 = Strongly Disagree = 0%
2 = Disagree = 25%
3 = Neutral = 50%
4 = Agree = 75%
5 = Strongly Agree = 100%

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

Safety in Culture and Actions

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

Fiscal Accountability

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

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

Safety in Culture & Actions	Unit	Baseline (Sept-Oct)	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Pyxis CII Safe Comparison *Daily and monthly comparison of Pyxis vs CII Safe transactions*	Rx							Goal of no discrepancies between Pyxis and CII Safe transactions.
Quarterly Results								
Veriform Medication Room Audits *Monthly comprehensive audits of 14 criteria*	All	Apr-June 100%	100%	100%	100%	100%	90%	Overall compliance is 99% for Q4
Quarterly Results			92%	99%	98%	99%		
Pyxis Discrepancies *Monthly monitoring and trending of Pxyis discrepancies.*	All	Aug-Nov 107/mo	107	107	50	50	50/mo	Target goal is 50/month discrepancies after 6 months of Pyxis use
Quarterly Results			128	96	156	376		*March 2013
Pyxis Overrides – Controlled Drugs *Monthly monitoring and trending of Pyxis overrides for Controlled Drugs*	All	Aug-Nov 25/month	25	25	10	10	10	Target goal is 10/month after 6 months of Pyxis use
Quarterly Results			32	17	79	54		
Fiscal Accountability	Unit	July-Dec Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions *Monitoring and Tracking of dispensed Discharge Prescriptions*	Rx	$12412 361 drugs	$5809 345 drugs	$19015 377 drugs	$4977 297 drugs	$3959 317 drugs		Significant costs are incurred in providing discharge drugs.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services

Define

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

Measure

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

Analyze

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

Improve

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

Control

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	12/14	84%	14 weekly
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	4/7	57%	5/group
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	4/7	57%	5/group
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	5/10	50%	100%
5. **The client can identify distress tolerance tools on the unit**	5/10	50%	100%
7. **The client is able to state who his primary staff is**	10/10	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

There are on unit groups conducted by the direct care staff on lower Kennebec 7 days a week. There is one group on the day shift and one on the evening shift. The RNs do a clinical centered group Monday through Friday and the MHWs do a leisure orientated group each shift on the weekend. We are currently meeting the threshold and the average attendance on the day shift has improved by one client from the average of 6 attending last quarter to 7 this quarter. Staff has added the intervention of going back to clients who initially refuse and re ask and encourage participation. On 3-11 we are still meeting the threshold but the numbers attending have decreased from 6 last quarter to 5 this quarter. In addition, the RN4 does one group per week on the 7-3 shift. 8 out of 10 client's treatment plans included on unit groups. This is an increase from the last quarter when the numbers were 5 out of 10. Chart reviews by the RN4 and PSD have reflected a need to improve this number and treatment plans were up dated to address this inclusion. Identification of distress tolerance tools has remained at 50%. There has been a decrease in Client's ability to identify their primary RN and MHW from 9/10 last quarter to 8/10 this quarter.

ACTIONS

We are meeting the goal for the number of on unit groups and participation. We anticipate no change in structure or format but will continue to welcome and encourage feedback from Clients and Staff for additions and or improvements. Resumption of Bingo with prizes on the 3-11 shifts, in response to Client's request, may increase the participation in the 3-11 group attendance. The 3rd quarter figures reflect a need to inform Clients and Staff about distress tolerance tools. The 50% figure indicates an underutilization of these tools. An effort will be made to encourage the use of these tools and include them in the plan of care. Staff on lower Kennebec was advised to greet their assigned clients at the beginning of the shift and introduce themselves as the primary worker for the shift.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	14 7	100%	14
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	6/6	100%	5/group
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	6/6	100%	5/group
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	9/10	90%	100%
5. **The client can identify distress tolerance tools on the unit**	4/10	40%	100%
7. **The client is able to state who his primary staff is**	6/10	60%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

The number of weekly on unit groups on the day shift is 14. This exceeds the threshold of 7. On Sundays, the religious services, gym time and on unit groups overlap. This provides Clients with a choice of which to attend. The Clients on UK suggested that these activities be scheduled at different times during the day. Some benefits were identified with having a choice of more than one group to attend. One client preferred to not have the groups overlap. It was suggested that the direct care staff could hold additional gym times in the afternoon. Currently the gym time on Sunday mornings is conducted by the TRS staff.

ACTIONS

The RNs on the unit conduct groups that are clinical in nature rather than leisure Monday through Friday. The MHWs conduct weekend groups that are more leisure based. Bingo groups once a week with prizes will resume for the next quarter. This is in response to a request made by the Clients. Attendance for the on unit groups has improved from 57% last quarter to 100%+ this quarter. This may be the result of reinforcing where the groups are posted on the unit and additional attempts by the staff to encourage the clients to attend beyond an initial refusal. Chart audits reflected that improvement was evident in capturing on unit groups on the treatment plans. The plans will continue to be reviewed by the RN4 which will include these specific criteria. The identification of distress tolerance tools has decreased from 80% last quarter to 40 % for this time frame. A contributing factor to this might be the term distress tolerance. Data collecting for the next quarter will include the description of coping tools which is consistent with the treatment plans and more commonly used when referring to these tools. In addition hand held game boy devices and games will be purchased and available to the clients. The game boys were identified by the clients as beneficial to promote relaxation and reduce stress. Identification of primary staff has decreased from 100% last quarter to 60% this quarter. The staff have been instructed to be more deliberate in greeting the clients at the beginning of the shift and introducing themselves.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	Main/SCU 36 / 12 27 / 10	 100% 100%	 **7 / 7 = 14** **7 / 7 = 14**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	6 / 1.5		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	6 / 1		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	10	100%	100%
5. **The client can identify distress tolerance tools on the unit**	20/30	67%	100%
6. **The client is able to state who his primary staff is**	30/30	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

The Lower Saco unit shifted to all treatment being delivered on the unit during this past quarter. The Lower Saco unit improved significantly with on-unit groups by MHWS and professional staff. Documentation in both Meditech and the hard copy record reflect this treatment delivery.

ACTIONS

The on-unit groups have been increased dramatically since mid-May 2013 and this will be maintained. The number of groups offered since last quarter increased slightly and the level of attendance improved dramatically, again because in part all treatment is delivered on the unit. The team coordinator is incorporating these on-unit groups in to the Rx plans. Some of our distress tolerance equipment (like MP3 headsets) has been difficult to obtain, though we are working with the supplier to make these available

.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 14 12	 100% 100%	Days/ Even. 7 / 7 = 14
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	4/14	29%	N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	6/12	50%	N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	4	40%	100%
5. **The client can identify distress tolerance tools on the unit**	30/30	100%	100%
7. **The client is able to state who his primary staff is**	30/30	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

The Upper Saco unit has continued to increase offering on-unit groups. Documentation by nursing in Meditech continues to improve. TR documentation is evident in all charts for both on and off unit treatment activity. Nearly all of the clients on Upper Saco attend the hospital treatment mall and there is a high level of participation and attendance with this off-unit treatment.

ACTIONS

Continued efforts are being made to offer groups to those clients that have less activity at the hospital treatment mall. We now have a new treatment team coordinator who is now including planned on-unit treatment groups in the client treatment plans.

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Vocational Incentive Program Treatment Plans *The objective of this improvement project is to ensure vocational treatment plans are initiated on all clients within 5 days of beginning work and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.*	55%	92%	95%	98%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	2 charts of all those reviewed did not have an updated plan and this was remedied within 24 hrs after reported to the job coach
Quarterly Results		95					

Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Recreational Therapy Assessments & Treatment Plans *The objective of this improvement project is to ensure that Recreational Therapy assessments are completed within 7 days of admission and that a treatment plan is initiated after the assessment and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.*	75%					The treatment plans will be reviewed more regularly and updated at each client treatment team meeting or if there is any change in client status	All assessments reviewed were done within allotted time frame but there were 10 charts that did not have an updated treatment plan on a long term care unit. Unit RT notified and plans were updated
Quarterly Results		85%					

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery & Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Occupational Therapy referrals and doctors orders. *The objective of this improvement project is to ensure each client receiving Occupational Therapy Services from RPC OT staff has a doctor's order as well as a referral form completed prior to the initiation of services.*	33%	50% 39 of 43	75%	100%	100%	To increase the percentage of referrals and doctor's orders by 25 % each quarter until we attain 100% compliance.	The 3 clients who did not have a MD order prior to the initiation of services were clients who were already receiving services prior to the approval of the new forms and procedures
Quarterly Results		91 %					

APS Healthcare

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

Report Number: 27 and 28

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

(Includes MaineCare members and Courtesy Reviews done by APS)

Report Dates: 04/01/2013 To 06/30/2013

Report Source: Authorization data from APS CareConnection®

Definitions:

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

What This Report Measures: The number of non-hospitalized members authorized for Community Integration (CI) and whether they a. were assigned to a case manager in the CI service within 3 working days, b.) Waited 4 - 7 working days to be assigned to a CI worker or c.) waited longer than 8 days but were eventually assigned to the CI service.

Total number of non-hospitalized members applying for CI: 2,054
Total assigned within 3 working days: 1,231
Total assigned in 4 - 7 working days: 309
Total assigned within 7 working days: 1,540
Total assigned after 8 or more working days: 514

% assigned within 3 working days: 60%
% assigned in 4 -7 working days: 15%
% assigned within 7 working days: 75%
% assigned after 8 or more working days: 25%

All Members	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Total MaineCare	1,231	309	514	2,054
Total	**1,231**	**309**	**514**	**2,054**

Gender	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Female	750	207	346	1,303
Male	481	102	168	751
Total	**1,231**	**309**	**514**	**2,054**

Adult Age Groups	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
18-20	100	23	41	164
21-24	100	21	42	163
25-64	984	248	405	1,637
65-74	35	10	19	64
Over 75 Years Old	12	7	7	26
Total	**1,231**	**309**	**514**	**2,054**

SMI	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
SMI	1,231	309	514	2,054
Total	**1,231**	**309**	**514**	**2,054**

AMHI Class	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	1,164	293	493	1,950
AMHI Class Y	67	16	21	104
Total	**1,231**	**309**	**514**	**2,054**

District	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	69	22	67	158
District 2/ Cumberland County	212	88	119	419
District 3/ Androscoggin, Franklin, and Oxford Counties	236	57	97	390
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	127	29	61	217
District 5/ Somerset and Kennebec Counties	228	52	67	347
District 6/ Piscataquis and Penobscot Counties	221	44	75	340
District 7/ Washington and Hancock Counties	58	5	9	72
District 8/ Aroostook County	68	9	12	89
Unknown	12	3	7	22
Total	**1,231**	**309**	**514**	**2,054**

APS Healthcare

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

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	16	0	5	21
Allies	11	10	10	31
Alternative Services	15	1	0	16
AngleZ Behavorial Health Services - ACM	58	7	9	74
Aroostook Mental Health Services	41	4	5	50
Assistance Plus	12	18	30	60
Behavior Health Solutions for Me	2	0	0	2
Break of Day, Inc	5	5	19	29
Broadreach Family & Community Services	19	0	0	19
Catholic Charities Maine	57	44	32	133
Charlotte White Center	4	3	17	24
Choices	23	0	0	23
Common Ties	46	26	21	93
Community Care	9	14	13	36
Community Counseling Center	46	24	25	95
Community Health & Counseling Services	125	8	8	141
Connections for Kids	3	0	0	3
Cornerstone Behavioral Healthcare - CM	26	3	4	33
Counseling Services Inc.	44	20	63	127
Direct Community Care	15	0	0	15
Dirigo Counseling Clinic	24	0	0	24
Employment Specialist of Maine	0	2	7	9
Fullcircle Supports Inc	14	1	4	19
Goodwill Industries of Northern New England	1	0	0	1
Graham Behavioral Services	14	0	0	14
Harbor Family Services	7	2	2	11
Healing Hearts LLC	17	0	0	17
Health Affiliates Maine	108	1	0	109
HealthReach network	1	0	0	1
Higher Ground Services	5	0	0	5
Kennebec Behavioral Health	68	0	3	71
Life by Design	12	4	3	19
Lutheran Social Services	10	1	0	11
Maine Behavioral Health Organization	47	3	3	53
Maine Vocational & Rehabilitation Assoc.	9	1	0	10
Manna Inc	10	0	2	12
Mid Coast Mental Health	17	8	17	42
Motivational Services	4	3	1	8
Northeast Occupational Exchange	13	16	48	77
Northern Maine General - Community Support	2	0	0	2
Ocean Way Mental Health Agency	5	0	0	5
OHI	1	0	4	5
Oxford County Mental Health Services	12	2	7	21
Port Resources-Sec 17	7	0	0	7
Rumford Group Homes	11	0	0	11
Shalom House	14	1	1	16
Smart Child & Family Services	3	1	2	6
St. Andre Homes	4	0	0	4
Stepping Stones	13	1	1	15

Sunrise Opportunities	4	0	1	5
Sweetser	84	10	20	114
The Opportunity Alliance	37	28	41	106
Tri-County Mental Health	58	28	62	148
Umbrella Mental Health Services	18	9	24	51
Total	**1,231**	**309**	**514**	**2,054**

APS Healthcare

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

Report Number: 29 and 30

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

(Includes MaineCare members and Courtesy Reviews done by APS)

Report Dates: 04/01/2013 To 06/30/2013

Report Source: Authorization data from APS CareConnection®

Definitions:

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

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

Total number of hospitalized members applying for CI: 44

Total assigned within 2 working days: 32 — % assigned within 2 working days: 73%

Total assigned in 3 - 7 working days: 4 — % assigned in 3 -7 working days:9 %

Total assigned within 7 working days: 36 — % assigned within 7 working days: 82%

Total assigned after 8 or more working days: 8 — % assigned after 8 or more working days: 18%

Gender	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Female	15	4	3	22
Male	17	0	5	22
Total	**32**	**4**	**8**	**44**

SMI	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
SMI	32	4	8	44
Total	**32**	**4**	**8**	**44**

AMHI Class	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	26	4	7	37
AMHI Class Y	6	0	1	7
Total	**32**	**4**	**8**	**44**

District	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	2	1	0	3
District 2/ Cumberland County	8	0	0	8
District 3/ Androscoggin, Franklin, and Oxford Counties	5	1	3	9
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	2	1	2	5
District 5/ Somerset and Kennebec Counties	6	0	0	6
District 6/ Piscataquis and Penobscot Counties	8	1	3	12
District 8/ Aroostook County	1	0	0	1
Total	**32**	**4**	**8**	**44**

Providers	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	2	0	2	4
Allies	0	0	1	1
Alternative Services	1	0	0	1
AngleZ Behavorial Health Services - ACM	1	0	0	1
Aroostook Mental Health Services	1	0	0	1
Assistance Plus	1	1	0	2
Catholic Charities Maine	6	0	0	6
Charlotte White Center	1	0	0	1
Common Ties	1	0	2	3
Community Counseling Center	2	0	0	2
Community Health & Counseling Services	4	0	0	4
Cornerstone Behavioral Healthcare - CM	2	0	0	2
Counseling Services Inc.	0	1	0	1
Graham Behavioral Services	1	0	0	1
Health Affiliates Maine	1	0	0	1
Kennebec Behavioral Health	2	0	0	2
Maine Behavioral Health Organization	1	0	0	1
Mid Coast Mental Health	1	0	0	1
Northeast Occupational Exchange	0	1	1	2
Shalom House	1	0	0	1
Sweetser	0	0	1	1
The Opportunity Alliance	0	1	0	1
Tri-County Mental Health	3	0	1	4
Total	**32**	**4**	**8**	**44**

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: 04/01/2013 To 06/30/2013 **Report Run Date:10/14/2013**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a wait list for service. The CFSN is used in conjunction with the authorization start date of the service to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare funds.

What This Report Measures: For members on the CI wait list who were authorized for the service, how long they waited. This report counts the number of days from the date the CFSN was opened to the date the service was authorized. The report is run 2 quarters ago so nearly everyone who was entered on the wait list will have started the service. If someone on the MaineCare waitlist is authorized for the state-funded service, it is counted as being authorized for the service.

Number of people who were authorized for CI from the MaineCare wait list during the quarter 716

For those who received the service: Average number of days waiting: 12 days

Percent waiting 30 days or less: 90% Percent waiting 90 days or less: 99%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
AMHI Class N	670	661	9	598	68	4	13
AMHI Class Y	46	46	0	43	3	0	9
Totals	**716**	**707**	**9**	**641**	**71**	**4**	**12**

CSN	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
CSN 1 Aroostook	11	10	1	10	1	0	7
CSN 2 Hancock, Washington, Penobscot, and Piscataquis	53	50	3	50	3	0	10
CSN 3 Kennebec and Somerset	148	148	0	136	11	1	10
CSN 4 Knox, Lincoln, Sagadahoc, and Waldo	82	82	0	68	13	1	16
CSN 5 Androscoggin, Franklin, and Oxford	94	94	0	80	14	0	15
CSN 6 Cumberland	228	223	5	214	14	0	10
CSN 7 York	91	91	0	75	14	2	19
Unknown	9	9	0	8	1	0	13
Totals	**716**	**707**	**9**	**641**	**71**	**4**	**12**

APS Healthcare

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

Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
Acadia Healthcare	11	11	0	10	1	0	13
Alternative Services	1	1	0	1	0	0	0
AngleZ Behavorial Health Services - ACM	51	51	0	50	1	0	5
Aroostook Mental Health Services	8	7	1	7	1	0	8
Assistance Plus	67	67	0	61	6	0	12
Break of Day, Inc	2	2	0	2	0	0	14
Catholic Charities Maine	116	114	2	111	4	1	9
Charlotte White Center	2	2	0	2	0	0	14
Community Care	20	18	2	19	1	0	7
Community Counseling Center	37	37	0	37	0	0	8
Counseling Services Inc.	101	100	1	84	16	1	18
Fullcircle Supports Inc	2	2	0	2	0	0	2
Higher Ground Services	3	3	0	3	0	0	10
Life by Design	4	4	0	4	0	0	3
Mid Coast Mental Health	21	20	1	14	6	1	29
Shalom House	6	6	0	6	0	0	4
Sunrise Opportunities	1	1	0	1	0	0	16
Sweetser	2	2	0	2	0	0	13
The Opportunity Alliance	97	96	1	95	2	0	8
Tri-County Mental Health	83	82	1	63	19	1	19
Umbrella Mental Health Services	81	81	0	67	14	0	15
Totals	**716**	**707**	**9**	**641**	**71**	**4**	**12**

APS Healthcare

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

Quarterly Report 60a2 Reasons Members Are Removed from MaineCare Waitlist for CI Without Being Authorized for CI
Report Dates: 04/01/2013 To 06/30/2013

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnecton whenever a member is put on a wait list for service. The CFSN is used in conjunction with the authorization start date of the service to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.

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

Number of people who were removed from the MaineCare CI wait list waitlist by providers without being authorized for the service: 288
Number of people with information about the reason for removal from the waitlist entered: 152

Reasons for removal from the waitlist	# of members
client is not eligible for this service	8
client relocated out of area	2
error	8
transfer	45
unable to contact	60
withdrawal request by client	18
other: admitted to ACT	2
other: auth to be changed	1
other: can not determine eligibility, no MH diagnosis	1
other: client lives outside coverage area	1
other: client will remain hospitalized	1
other: No staff availability	1
other: Provider discharged member with plan to provide CI service. Actual service started more than 7 days later	1
other: Provider referred to CI but no CI authorization in place	3
Total	**152**

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: 04/01/2013 To 06/30/2013 **Report Run Date:10/10/2013**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a wait list for service. The CFSN is used in conjunction with the authorization start date of the service to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare funds.

What This Report Measures: For members on the State-funded CI wait list who were authorized for the service, how long they waited. This report counts the number of days from the date the CFSN was opened to the date the service was authorized. The report is run 2 quarters ago so nearly everyone who was entered on the wait list will have started the service. If someone on the state-funded waitlist is authorized for the MaineCare service, it is counted as being authorized for the service.

Number of people who were authorized for CI from the state-funded wait list during the quarter: 166

For those who received the service: Average number of days waiting: 26 days

Percent waiting 30 days or less: 67% Percent waiting 90 days or less: 96%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
AMHI Class N	159	30	129	105	47	7	27
AMHI Class Y	7	3	4	7	0	0	9
Totals	**166**	**33**	**133**	**112**	**47**	**7**	**26**

CSN	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
CSN 1 Aroostook	2	0	2	2	0	0	9
CSN 2 Hancock, Washington, Penobscot, and Piscataquis	3	1	2	2	1	0	24
CSN 3 Kennebec and Somerset	14	2	12	9	5	0	29
CSN 4 Knox, Lincoln, Sagadahoc, and Waldo	20	7	13	9	11	0	38
CSN 5 Androscoggin, Franklin, and Oxford	40	7	33	28	11	1	22
CSN 6 Cumberland	69	16	53	54	13	2	19
CSN 7 York	16	0	16	6	6	4	54
Unknown	2	0	2	2	0	0	6
Totals	**166**	**33**	**133**	**112**	**47**	**7**	**26**

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Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
AngleZ Behavorial Health Services - ACM	2	2	0	0	2	0	54
Assistance Plus	19	1	18	10	9	0	37
Break of Day, Inc	6	3	3	6	0	0	0
Catholic Charities Maine	14	8	6	12	2	0	13
Common Ties	5	0	5	5	0	0	6
Community Care	1	0	1	0	1	0	58
Community Counseling Center	16	0	16	16	0	0	6
Cornerstone Behavioral Healthcare - CM	2	1	1	2	0	0	7
Counseling Services Inc.	13	1	12	3	5	5	65
Life by Design	2	0	2	2	0	0	9
Mid Coast Mental Health	3	1	2	0	3	0	68
Oxford County Mental Health Services	5	0	5	4	1	0	14
Sweetser	14	4	10	6	8	0	38
The Opportunity Alliance	34	6	28	31	3	0	12
Tri-County Mental Health	30	6	24	15	13	2	34
Totals	**166**	**33**	**133**	**112**	**47**	**7**	**26**

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Quarterly Report 60b2 Reasons Members Are Removed from State-Funded Waitlist for CI Without Being Authorized for CI
Report Dates: 04/01/2013 To 06/30/2013

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnecton whenever a member is put on a wait list for service. The CFSN is used in conjunction with the authorization start date of the service to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.

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

Number of people who were removed from the state-funded CI wait list waitlist by providers without being authorized for the service: 153
Number of people with information about the reason for removal from the waitlist entered: 59

Reasons for removal from the waitlist	# of members
client relocated out of area	2
duplicate	2
transfer	16
unable to contact	27
withdrawal request by client	7
other: client already receiving CI	4
other: client has limited MaineCare	1
Total	**59**