Department of Health & Human Services, Office of Adult Mental Health Services
Bates v. DHHS Consent Decree
July, August, September, 2014: 1st Quarter, SFY 2015
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 2015, covering the period from July through September, 2014. A link to the PDF version of each document is provided on the SAMHS website.

	DOCUMENT	DESCRIPTION
1	**Cover Letter, Quarterly Report:** September, 2014 *Section 1*	Letter to Dan Wathen, Court Master, submitting the Quarterly Report pursuant to paragraph 280 of the Settlement Agreement for the quarter ending September 30, 2014.
2	**Report on Compliance Plan Standards: Community** *Section 2*	Lists and updates the information pertaining to standards approved in October 2007 for evaluating and measuring DHHS compliance with the terms and principles of the Settlement Agreement.
3	**Performance and Quality Improvement Standards** *Section 3*	Details the status of the Department's compliance with 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*	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* **Consent Decree Performance and Quality Improvement Standard 5.** *Section 5A*	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.
6	**Cover: Unmet Needs and Quality Improvement Initiative**	Provides a brief introduction to the unmet needs report as well as some definitions of the data, initial findings and next steps. Also

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

	DOCUMENT	DESCRIPTION
14	**APS Healthcare Reports** *Section 14*	For members on the Community Integration waitlist who were authorized for this service, how long they waited. These reports count the number of days from the date the CFSN was opened to the date the service was authorized. The reports are run 2 quarters behind, therefore, those who were entered on the waitlist will have started the service.

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
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-2595; Fax: (207) 287-4334
TTY Users: Dial 711 (Maine Relay)

November 1, 2014

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

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

Dear Dan:

Enclosed, pursuant to paragraph 280 of the Settlement Agreement, please find the Substance Abuse and Adult Mental Health Services Quarterly Report for the quarter ending September 30, 2014.

The Department continued to report on performance standard items from which it was excused on May 8, 2014. The following items will no longer be included in future reports: Performance Standards 2,3.1,3.2, 7.1a, 7.1b, 7.1c,7.1d, 10.1, 10.2, 11.1, 11.2, 15, 17.1, 17.2, 17.2a, 17.3,17.3a, 17.4,17.4a,17.5, 21.5, 23.1,23.2, 24.1, 24.2, 25.1, 25.2, 30.1, 30.2, 33.1, 34.1, and 34.2.

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 and Human Service
Office of Substance Abuse and Mental Health Services
First Quarter State Fiscal Year 2015
Report on Compliance Plan Standards: Community
November 1, 2014

	Compliance Standard	Report/Update
I.1	Implementation of all the system development steps in October 2006 Plan	As of March 2010, all 119 original components of the system development portion of the Consent Decree Plan of October 2006 have been accomplished or deleted per amendment.
I.2	Certify that a system is in place for identifying unmet needs	See attached *Cover: Unmet Needs November 2014* and *Unmet Needs by CSN for FY14 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 2015-2020 is being developed and should be available for review in 2015.
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 2014* and the *Performance and Quality Improvement Standards: November 2014* for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data. SAMHS continues to review the reliability of the unmet needs data to ensure proper identifying, recording and implementation of services for unmet needs.
II.3	Submission of budget proposals for adult	The Director of SAMHS provides the Court Master with

	mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs *(Amended language 9/29/09)*	an updated projection of needs and associated costs as part of his ongoing updates regarding Consent Decree Obligations.
II.4	Submission of the written presentation given to the legislative committees with jurisdiction over DHHS … which must include the budget requests that were made by the Department to satisfy its obligations under the Consent Decree Plan and that were not included in the Governor's proposed budget, an explanation of support and importance of the requests and expression of support … *(Amended language 9/29/09)*	See above.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	MaineCare and Grant Expenditure Report for FY 13 provided in the May 2014 report.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs November 2014* and the *Performance and Quality Improvement Standards: November 2014* for examples of the Department Utilizing the QM system.
III.1a	Document through quarterly or annual reports the data collected and activities to assure reliability (including ability of EIS to produce accurate data)	This quarterly report documents significant data collection and review activities of the SAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	See compliance standard II.4 above for examples of how quality management data was used to support budget requests for systems improvement. Unmet need reports have been used to identify where additional funds are needed for delivery of services.
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Contract and licensing reviews are conducted as licenses expire. A report from DLRS is available; during the last quarter 33 of 33 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 2013 DIG Survey was 88.3%. These data are posted on the SAMHS website and provided to the Consumer Council of Maine. SAMHS met to address the methodology used for the survey and to boost consumer participation in the survey to be distributed in October of 2014.
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 fourth quarter there was 9 Level II grievances filed; 9 responded to within the 5 day period.
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if hearing is to be held or if parties concur.	Reporting began in the 1st quarter of calendar year 2008. Standard has been consistently addressed. There were no Level III grievances filed in FY14. There were 2

		filed FY 15 Q1
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 2014* Standard 5-2. This standard has not been met for the past 4 quarters.
IV.6	90% non-hospitalized class members assigned worker within 3 days of request - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2014,* Standard 5-3. This standard has not been met for the past 4 quarters.
IV.7	95% of class members in hospital or community not assigned within 2 or 3 days, assigned within an additional 7 days - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2014,* Standard 5-4. This standard has not been met for the past 4 quarters.
IV.8	90% of class members enrolled in CSS with initial ISP completed within 30 days of enrollment - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2014,* Standard 5-5. This standard has not been met for the past 4 quarters.
IV.9	90% of class members had their 90 day ISP review(s) completed within that time period - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2014,* Standard 5-6. This standard has not been met for the past 4 quarters.
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. As the data has been consistent over time and the feedback and interaction with providers had lessened greatly, reports are now created quarterly and available to providers upon request. Providers were notified of this change on May 18, 2011. Providers may request these reports
IV.11	Data collected once a year shows that > 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	The 2014 data analysis indicates that out of 1,407 records for review, that 142 (10.1%) 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%. Percentage of unverified addresses for the December 2013 mailing remained below 15%. Most recent mailing was completed December 2013 and the report was provided in the February report.
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - *must be met for 3 out of 4 quarters*	See Section 9 *Class Member Treatment Planning Review,* Question 2A. This standard has been met in 4 out of the 4 quarters. The current percentage is 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 2014,* 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: November 2014*, Standard 7-1c (does the consumer have a crisis plan) and *Class Member Treatment Planning Review*, Question 2F Standard met since the beginning of FY09
IV.16	QM system documents that SAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	See Section 9 *Class Member Treatment Planning Review*, Question 6.a.1 that addresses plans of correction. In 100.0 % 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 2014*, Standard 8-2 and *Class Member Treatment Plan Review*, Question 3F. This standard has been met in 1 out of the last 4 quarters.
IV.18	90% of ISPs review included service agreement/treatment plan - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2014*, Standard 9-1 and *Class Member Treatment Plan Review*, Questions 4B & C. This standard has not been met in 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 2014*, Standard 10.1 and 10-2 Community Integration -- standard met since the 2nd quarter FY08. ACT – standard met for the 2nd, 3rd and 4th quarters FY10; the 1st, 2nd and 4th quarters FY11; FY 12, FY13, and FY14. Standard not met 1st quarter FY 15.
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 2014*, Standard 10-5. This standard has not been met in the last 4 quarters.
IV.21	Independent review of the ISP process finds that ISPs met a reasonable level of compliance as defined in Attachment B of the Compliance Plan	
IV.22	5% or fewer class members have ISP-identified unmet residential support - *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: November 2014*, Standard 12-1 Standard met for the 4th quarter FY08; the 1st, 3rd and 4th quarters of FY09; all quarters of FY10 and FY11; all 4 quarters of FY12, FY13; and FY 14.

IV.23	**EITHER** quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status **and**	Unmet residential supports needs for non-class members do not exceed 15 percentage points of the same for Class Members. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.24	Meet RPC discharge standards (below); **or** 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: November 2014,* Standards 12-2, 12-3 and 12-4 Standard met since the beginning of FY08.
IV.25	10% or fewer class members have ISP-identified unmet needs for housing resources - *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: November 2014,* Standard 14-1 Standard met in FY 2014 Q3 and 26 out of the last 30 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 2014,* Standard 14-4, 14-5 & 14-6 Standard 14-4 met since the beginning of FY09, except for Q3 FY10. Standard 14-5 met for the 2nd, 3rd and 4th quarters FY09; the 2nd and 4th quarters of FY10; FY11; FY12 FY13 and FY 14. Standard 14-6 met for the 2nd and 4th quarters FY09; the 2nd and 4th quarters FY10; FY11; FY12, FY13, and FY 14 and 1st quarter FY 15.
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: November 2014,* Standard 16-1 and *Community Hospital Utilization Review – Class Members 4th Quarter of Fiscal Year 2014*.

		In FY12: 76.2% (16 of 21) in the 1st quarter, 63.6% (14 of 22) in the 2nd quarter, 77.8% (7 of 9) in the 3rd quarter, 73.7% (14 of 19) in the 4th quarter IN FY13: 100% (19 of 19) in the 1st quarter 92.9% (13 of 14) in the 2nd quarter 86.7% (13 of 15) in the 3rd quarter 90.0% (18 of 20) in the 4th quarter IN FY 14: 27.3%(3 of 11) in the 1st quarter 76.5% (13 of 17) in the 2nd quarter 84.6 % (11 of 13) in the 3rd quarter 100.0 % (12 of 12) in the 3rd 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.	20 Complaints Received 15 Complaints investigated 0 Substantiated (of the 15 complaints) 1 Plan of correction sought (During the investigation an addition violation was found that needed a plan of correction) 1 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 2014*, Standards 17-2a, 17-3a and 17-4a and *Community Hospital Utilization Review – Class Members 4th Quarter of Fiscal Year 2014*. Standards met for FY08, FY09, FY10, FY11, and FY12 Standards met for FY13, and FY 14
IV.34	QM system documents that if hospitals have fallen below the performance standard for any of the following, SAMHS made the information public through CSNs, addressed in contract reviews with hospitals	See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members 4th Quarter of Fiscal Year 2014*. The report displaying data by hospital for community hospitals accepting emergency involuntary clients is

	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%)	shared quarterly by posting reports on the CSN section of the Office's website. Standard 18.1 has not been met for the past 4 quarters. Standard 18.2 has been met for the past 4 quarters Standard 18.3 has been met for the past 4 quarters
IV.35	No more than 20-25% of face-to-face crisis contacts result in hospitalization – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2014*, Standard 19-1 and *Adult Mental Health Quarterly Crisis Report First Quarter, State Fiscal Year 2015 Summary Report*. In FY12, standard met all 4 quarters. In FY 13, standard met all 4 quarters. In FY 14, standard met 1st quarter, 2nd quarter slightly above standard (26.3%), met 3rd quarter and 4th quarter slightly above standard (26.1%) In FY 15 standard met
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 Fourth Quarter, State Fiscal Year 2015 Summary Report*. Starting with July 2008 reporting from providers, SAMHS collects data on the total number of minutes for the response time (calculated from the determination of need for face to face contact or when the individual is ready and able to be seen to when the individual is actually seen) and figures an average. Average statewide calls requiring face to face assessments are responded to within an average of 30 minutes from the end of the phone call was met for all 4 Quarters in FY12, 4 quarters in FY13 and 1st and 2nd quarter of FY14. Standard not met 3rd quarter FY14. Standard met FY14 Q4. Standard not met 1st quarter FY 15
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 2015 Summary Report*. Standard has been met since the 2nd quarter of FY08 until FY 15 quarter 1 when standard was slightly below (87.2%).
IV.38	90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2013*, Standard 19-4 and *Adult Mental Health Quarterly Crisis Report First Quarter, State Fiscal Year 2015 Summary Report*. Standard not met 3 out of 4 quarters.
IV.39	Compliance Standard deleted 1/19/2011.	
IV.40	Department has implemented the components of the CD plan related to 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)*	2013 Adult Health and Well-Being Survey: 2.5 % of consumers in supported and competitive employment (full or part time).
IV.42	5% or fewer class members have unmet needs for mental health treatment services – *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: November 2014*, Standard 21-1 This standard has not been met for the prior 4 quarters.
IV.43	**EITHER** quarterly unmet mental health treatment needs for one year for qualified non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet mental health treatment needs for non-class members do not exceed 15 percentage points of the same for Class Members. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.44	QM documentation shows that the 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**	2013 Adult Health and Well-Being Survey: 77.1% domain average of positive responses.
IV.45	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of mental health treatment services in the community • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: November 2014*, 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 cover prescribed topics and audiences that fit parameters of ¶105.	See attached *Performance and Quality Improvement Standards: November 2014*, Standard 30
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: November 2014*, Standard 28 This standard has been consistently met since FY08.
IV.48	Provide documentation in quarterly reports	See attached *Performance and Quality Improvement*

	of funding, developing, recruiting, and supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	*Standards: August 2014*, Standard 23-1 and 23-2. NAMI Maine is the provider of the family support services.
IV.49	Certify that all contracts with providers include a requirement to refer family members to family support services, and produce documentation that contract reviews include evaluation of compliance with this requirement.	100% of contracts include this requirement. Documentation is maintained by the regional offices.
IV.50	Lists in quarterly reports the number and types of mental health informational workshops, forums and presentations geared to general public that are designed to reduce myths/stigma and foster community integration (cover prescribed list and fit audience parameters)	See attached *Performance and Quality Improvement Standards: November2014*, Standard 34.1 and attached *Public Education Report* for the past quarter.

Consent Decree Performance and Quality Improvement Standards: November 2014

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

Starting fiscal year 2012, quarter 3, standard 5.1, 5.2, 5.3 and 5.4 will now be calculated by APS Healthcare.

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.

DHHS Office of Substance Abuse and Mental Health Services

Compliance and Performance Standards: Summary Sheet
July - September 2014

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 2014

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 2014

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 2014

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 2014

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.

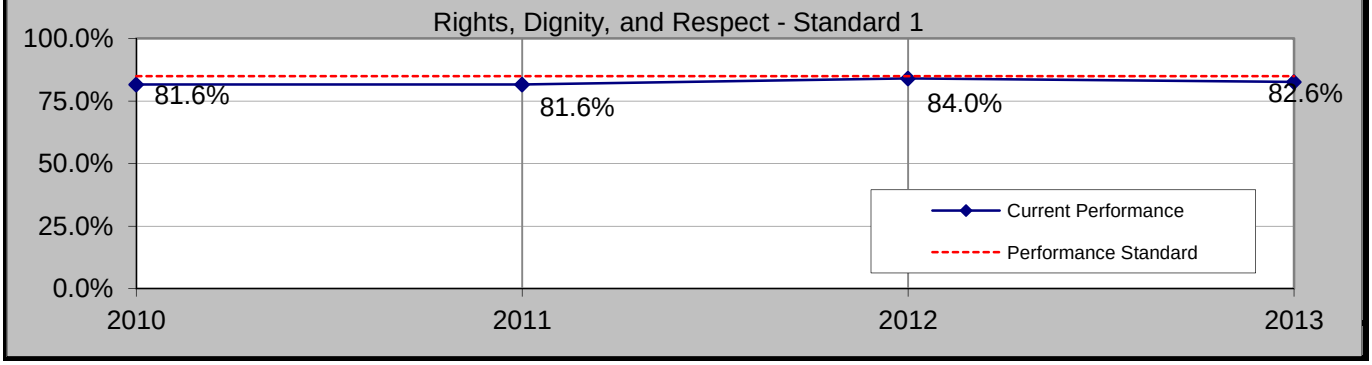
Standard 34. Public Education

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

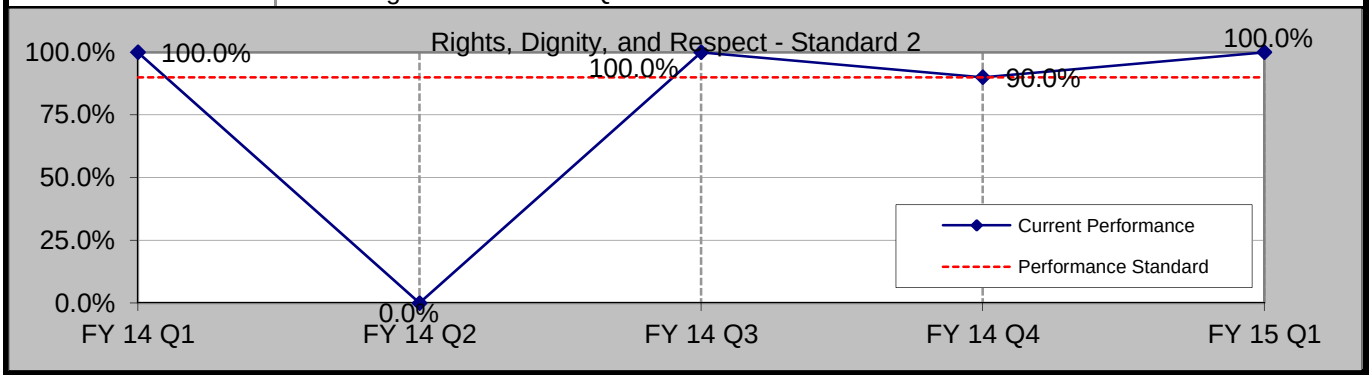
Standard 1 - Treated with respect for their individuality

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	82.6 %



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	9 level II grievances FY15 Q1

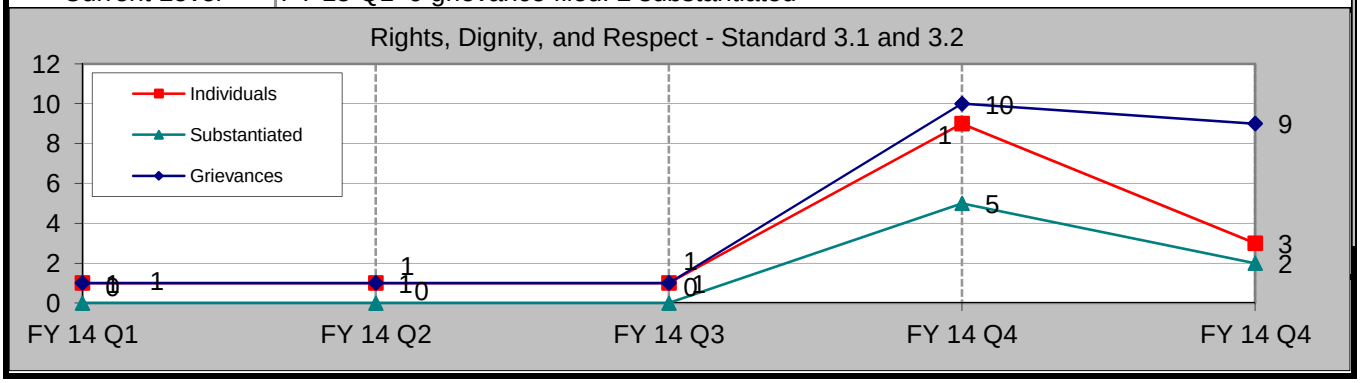


Rights, Dignity, and Respect

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 15 Q1 9 grievance filed. 3 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 15 Q1 9 grievance filed. 2 substantiated

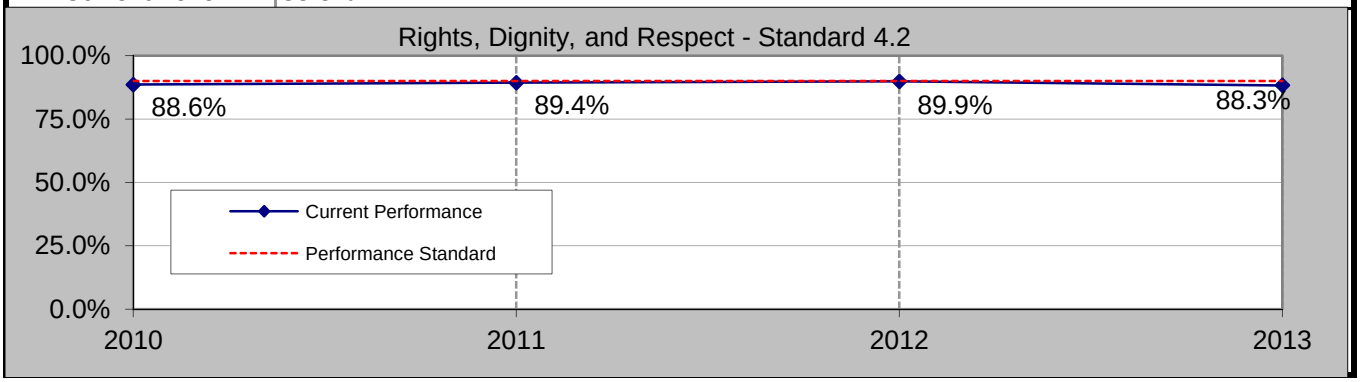


DHHS Office of Substance Abuse and Mental Health Services

Rights, Dignity, and Respect

Standard 4 - Class Members are informed of their rights

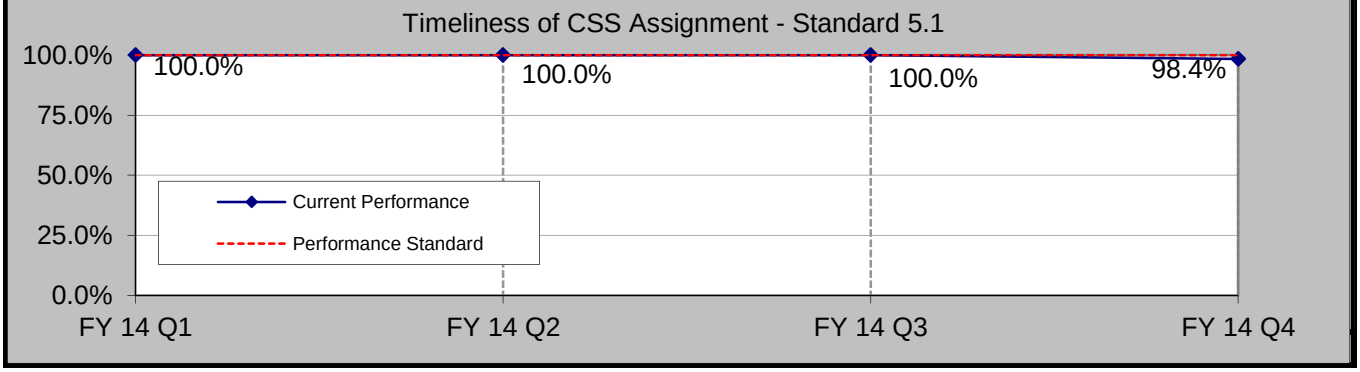
Standard 4.2	
Measurement	Percent of consumers reporting they were given information about their rights.
Standard	Performance: 90%
	Compliance: See explanation below.
Data Source	Adult Mental Health and Well Being Survey Q22
Current Level	88.3%



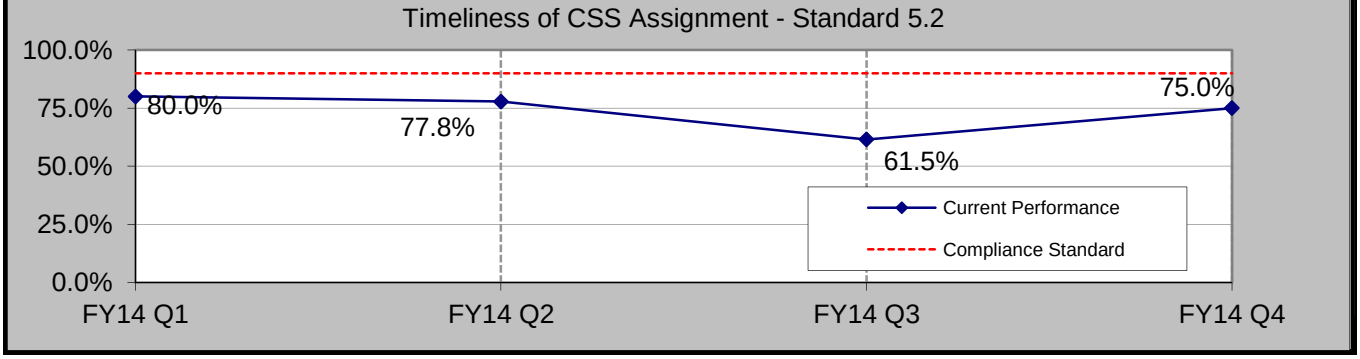
Community Integration / Community Support Services / Individualized Support Planning

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	98.4% (123 out of 125)

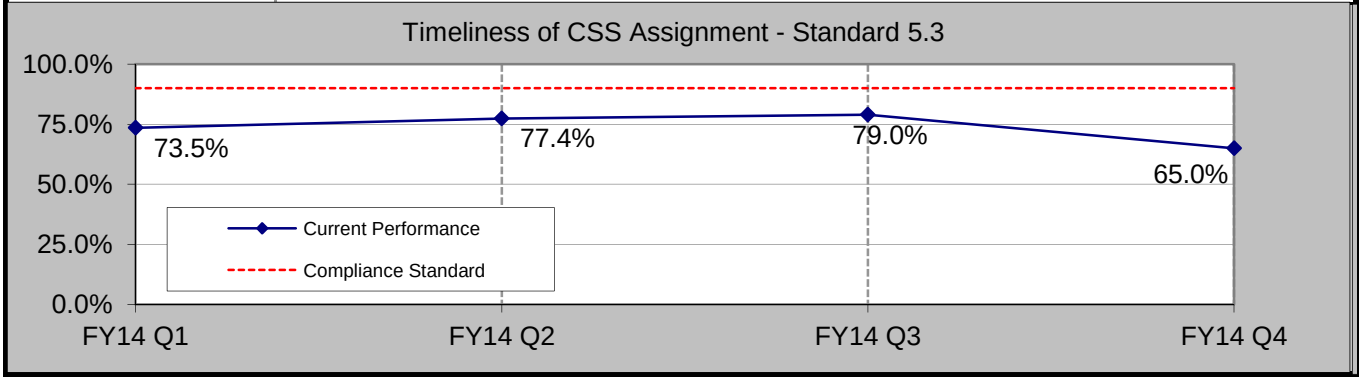


Standard 5.2	
Measurement	Percentage of hospitalized class members who were a assigned a worker within 2 working days.
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	APS Healthcare
Current Level	75.0% (15 out of 20)

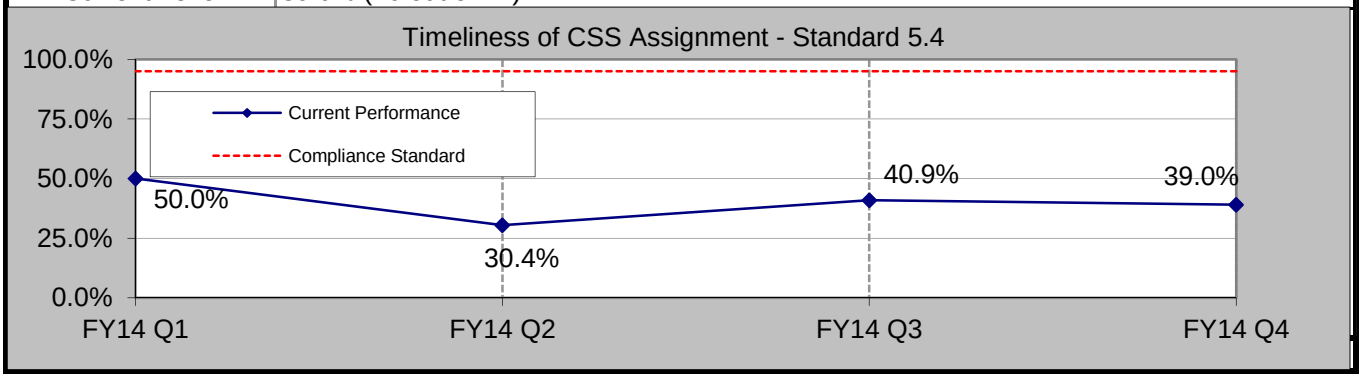


Community Integration / Community Support Services / Individualized Support Planning

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	65.0% (67 out of 103)



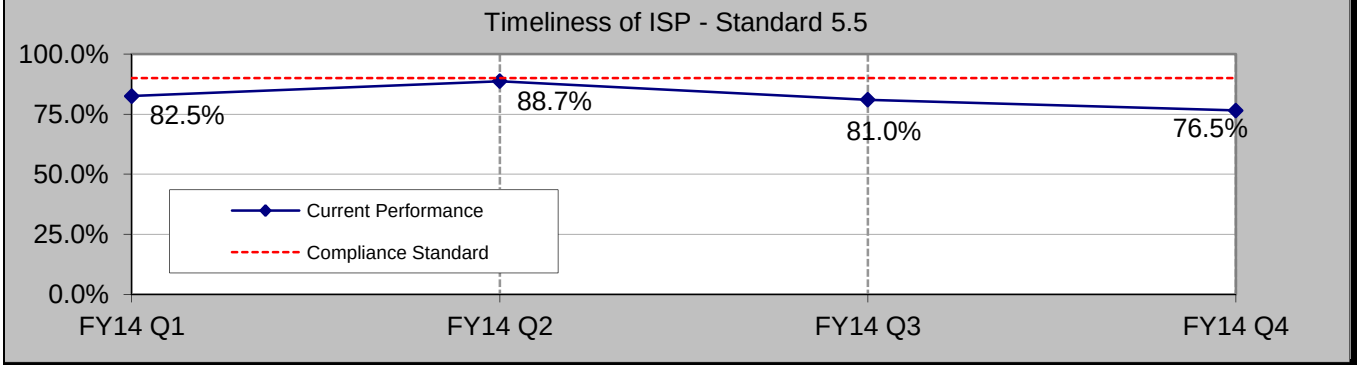
Standard 5.4	
Measurement	Percent of class members in hospital or community not assigned on time but were assigned within an additional 7 working days.
Standard	Performance: 100%
	Compliance: 95%
Data Source	APS Healthcare
Current Level	39.0% (16 out of 41)



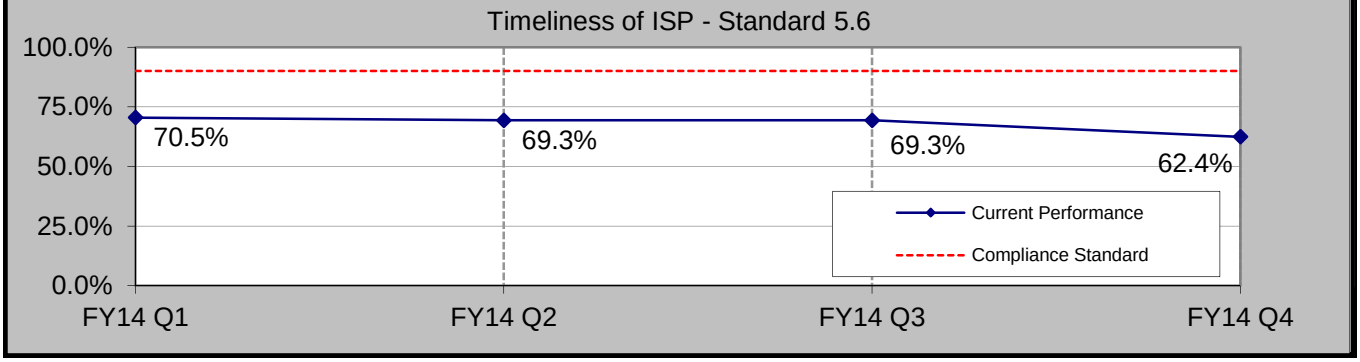
Standards 5.1 -5.4 – Calculations are now based on days from Contact for Service Notification to date of assignment. The first 3 quarters have been re-calculated using this formula.

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	76.8% (43 out of 56)

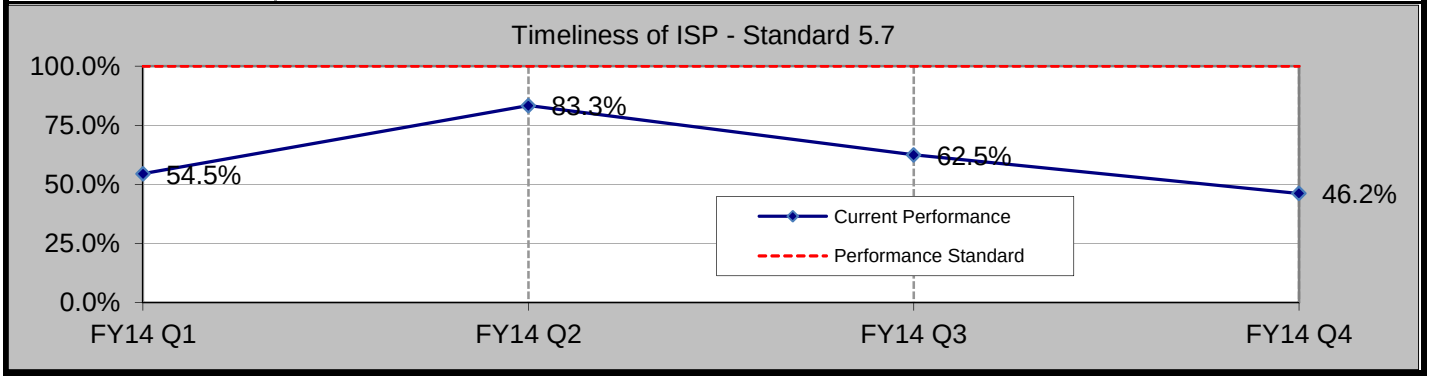


Standard 5.6	
Measurement	90 day class member ISP reviews completed within specified timeframe.
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	62.4% (600 out of 961)

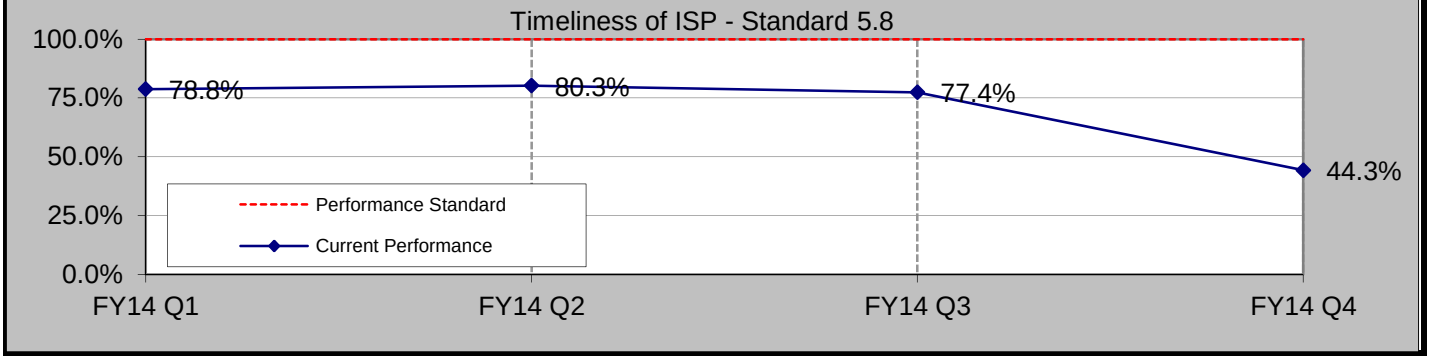


Community Integration / Community Support Services / Individualized Support Planning

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	46.2% (6 out of 13)



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	44.3% (160 out of 361)



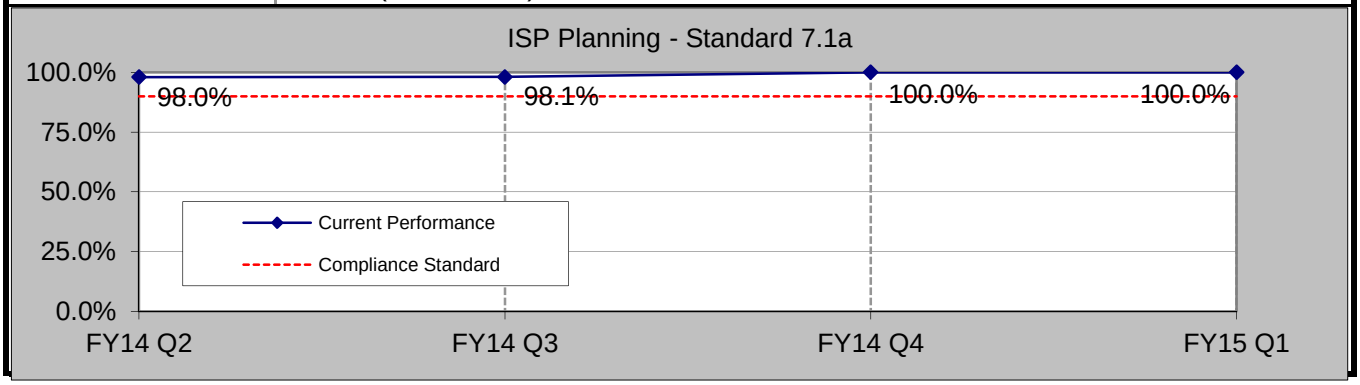
Discussion:

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

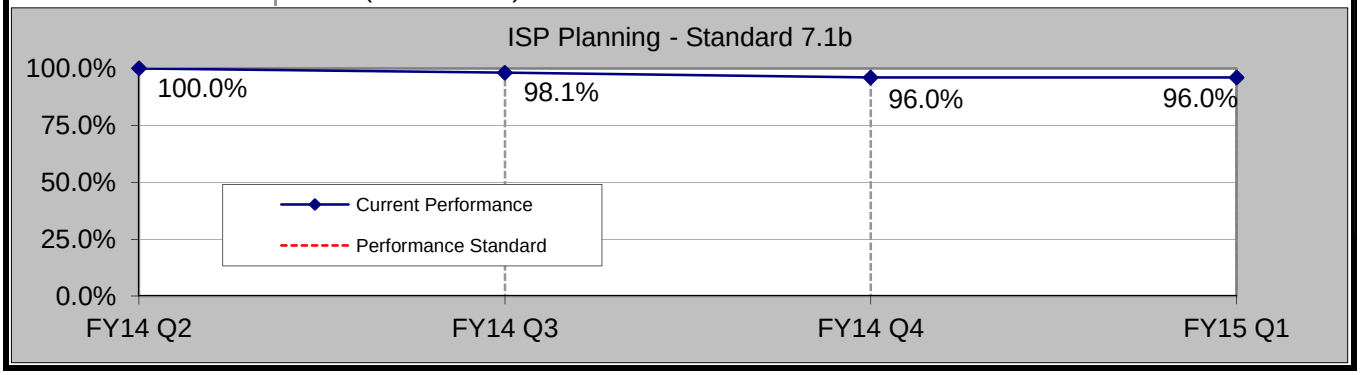
Community Integration / Community Support Services / Individualized Support Planning

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	100.0% (24 out of 24)

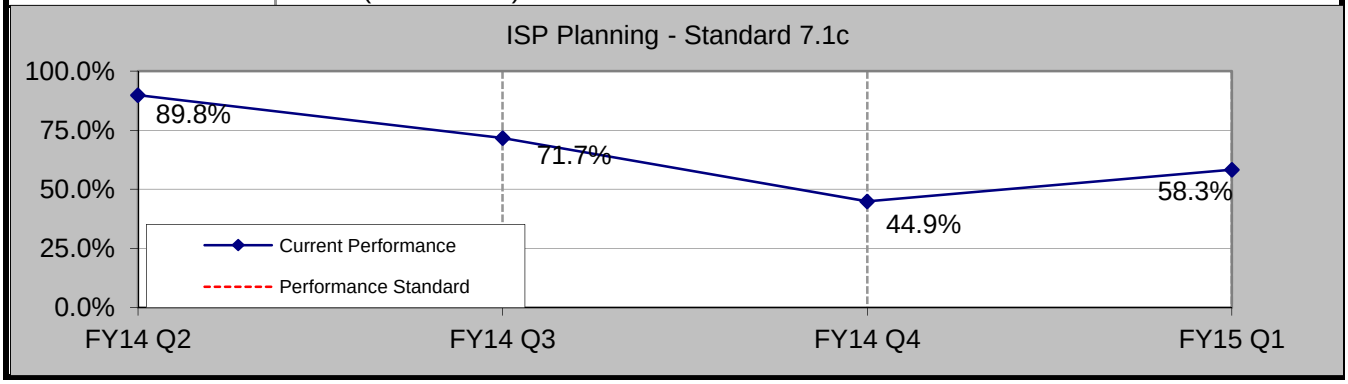


Standard 7.1b	
Measurement	Does record document the individual's potential need for crisis intervention and resolution services was considered during treatment planning?
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	96.0% (24 out of 25)

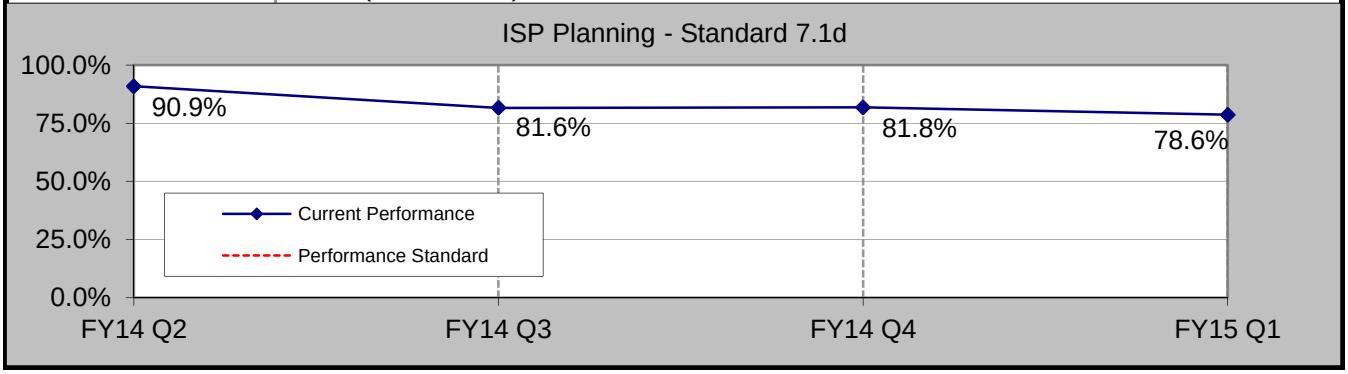


Community Integration / Community Support Services / Individualized Support Planning

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	58.3% (14 out of 24)



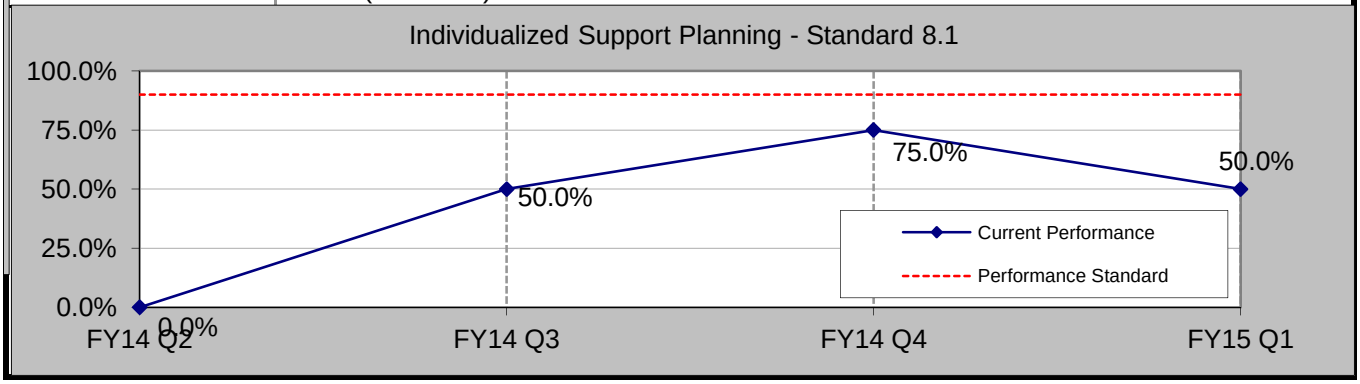
Standard 7.1d	
Measurement	If the consumer has a crisis plan, "has the crisis plan been reviewed as required, every 3 months?"
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	78.6% (11 out of 24)



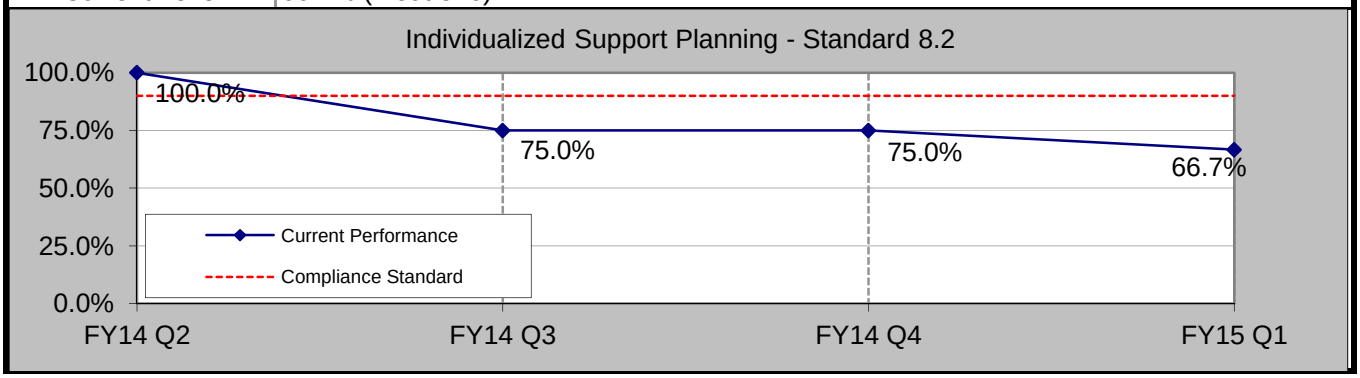
Community Integration / Community Support Services / Individualized Support Planning

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	50.0% (3 out of 6)



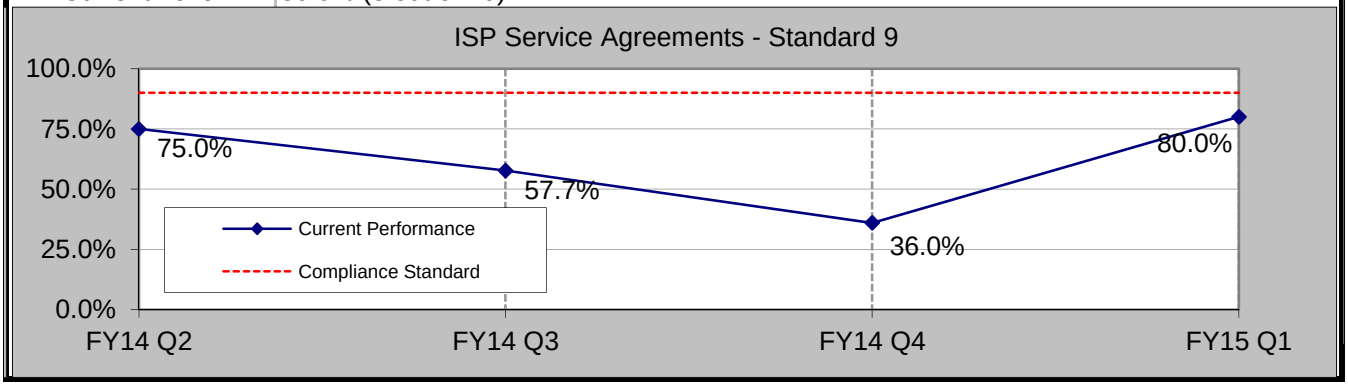
Standard 8.2	
Measurement	ISPs reviewed with identified unmet needs in which interim plans are established.
Standard	Performance: 95% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	66.7% (4 out of 6)



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	80.0% (8 out of 10)



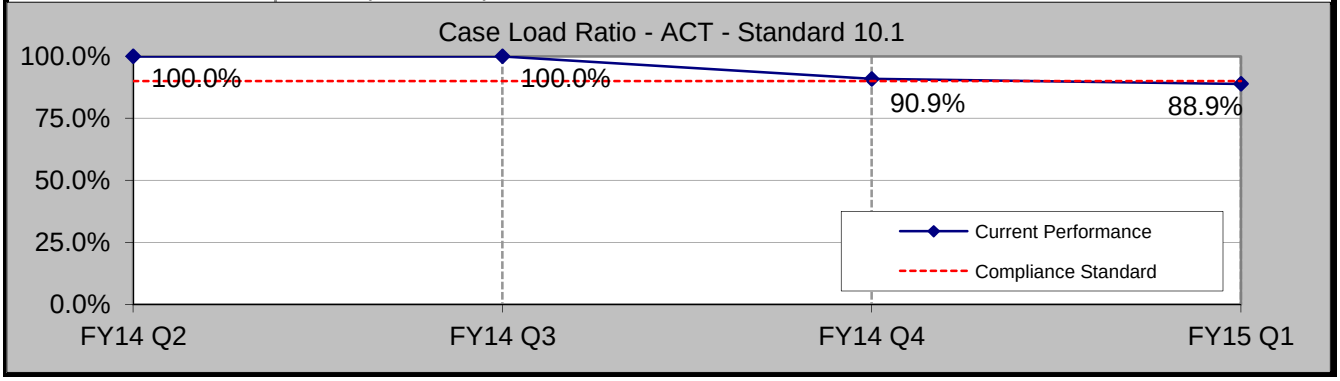
Discussion:

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

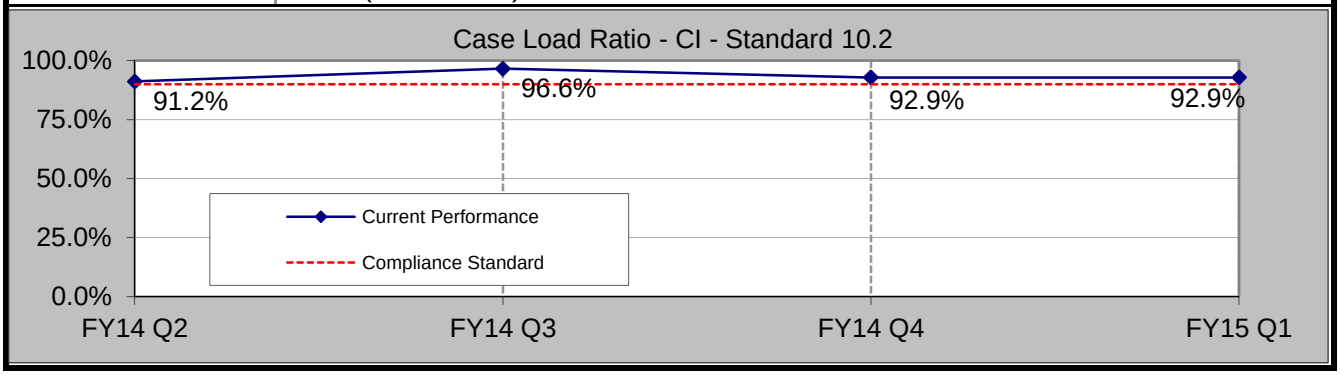
Community Integration / Community Support Services / Individualized Support Planning

Standard 10 - 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	88.9% (8 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	98.2% (54 out of 55)



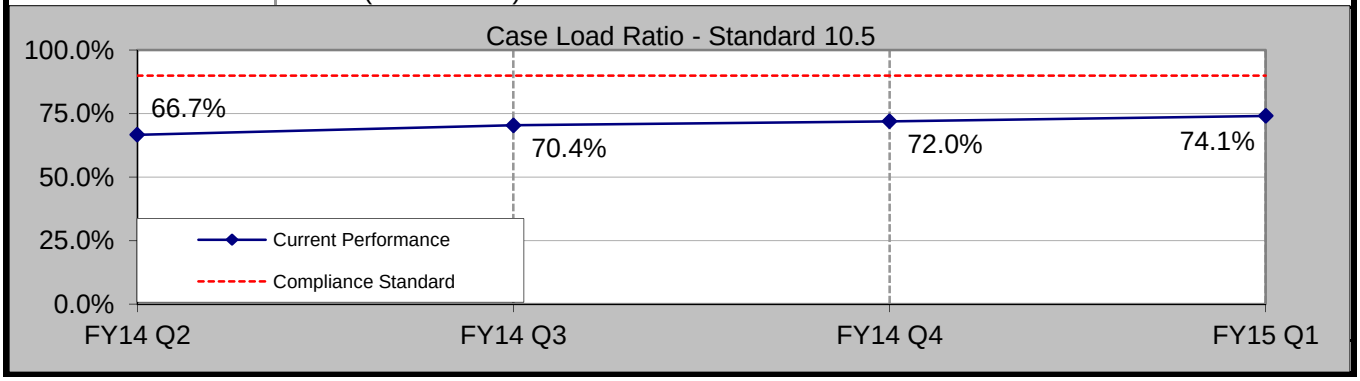
Discussion;

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

Community Integration / Community Support Services / Individualized Support Planning

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

Standard 10.5 - OADS	
Measurement	Office of Aging and Disability Services Case Managers with average caseload of 25 or fewer.
Standard	Compliance: 90% of all OADS Case Managers with Class Member Public Wards
Data Source	MAPSIS Case Counts for Workers with Class Members Public Wards
Current Level	74.1% (20 out of 27)



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 contacts with resource needs Apr 1 - Jun 30, 2014				
	Region 1	Region 2	Region 3	Total
Unique Individuals:	0	9	7	16
Unmet Needs:	0	8	7	15

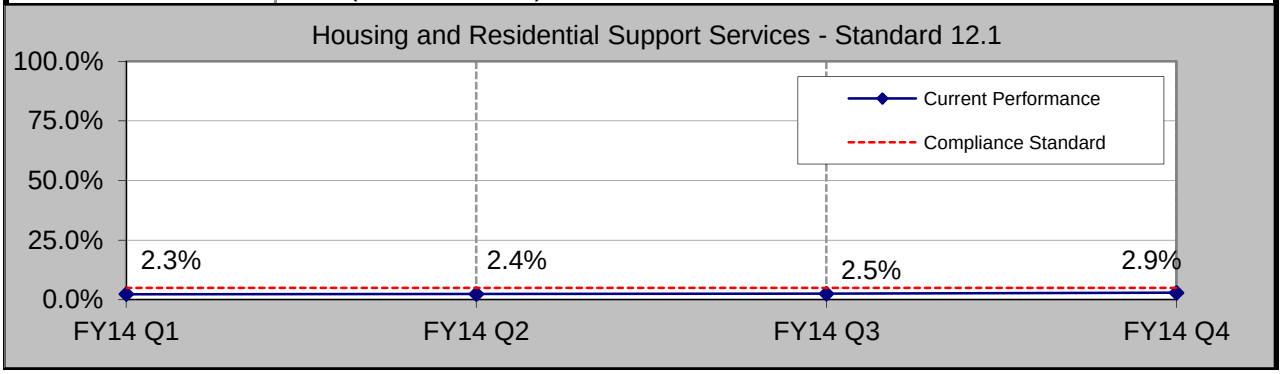
Unmet Needs by Domain Apr 1 - Jun 30, 2014	
ISP Domain Areas	**State**
Mental Health Services	0
MH Crisis Planning Resources	0
Peer, Recovery & Support Resources	0
Substance Abuse Services	0
Housing Resources	14
Health Care Resources	0
Legal Resources	1
Financial Security Resources	0
Education Resources	0
Vocation Employment Resources	0
Living Skills Resources	0
Transportation Resources	0
Personal Growth/Community Participation Resources	0
Total	15

Unmet needs have increased due to a more complete collection of the data.

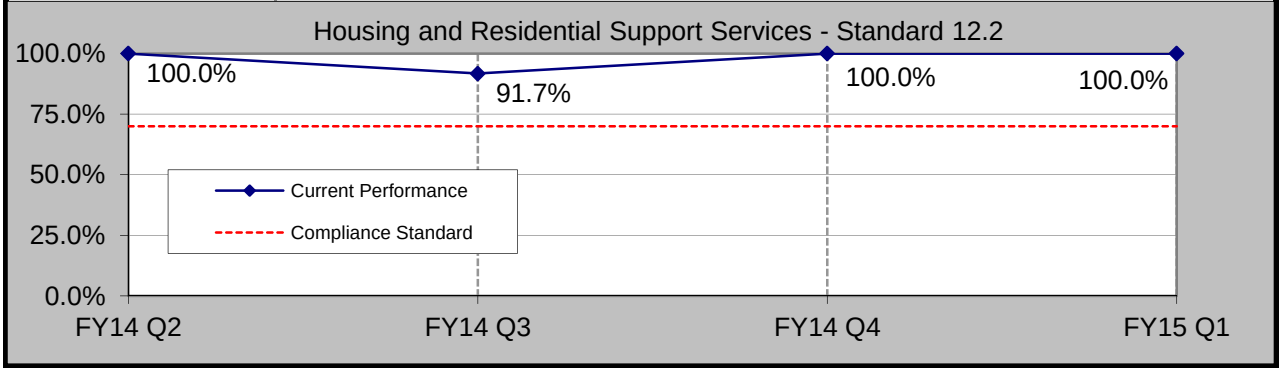
Community Resources and Treatment Services
Housing and Residential

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	2.9% (31 out of 1079)

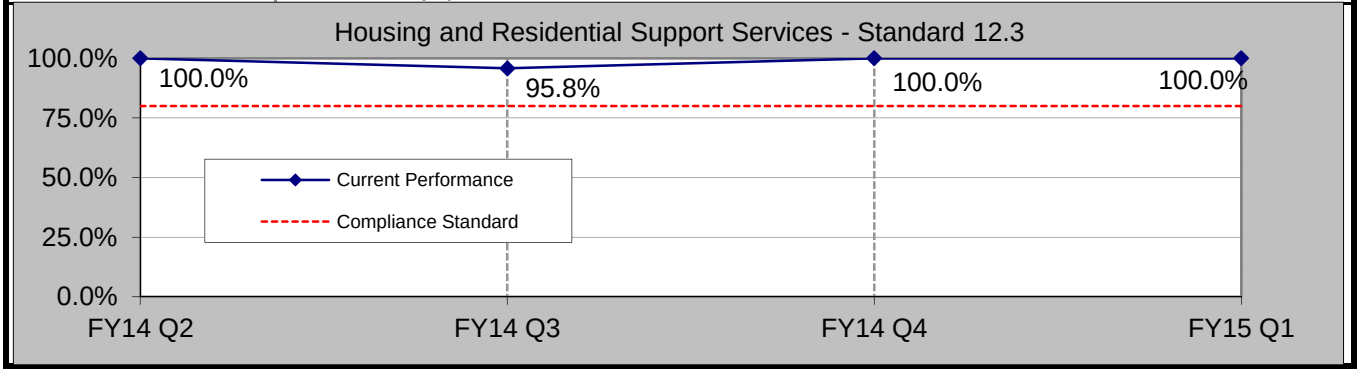


Standard 12.2	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY15 Q1 (Lack of residential supports did not impede discharge for any patients within 7 days)

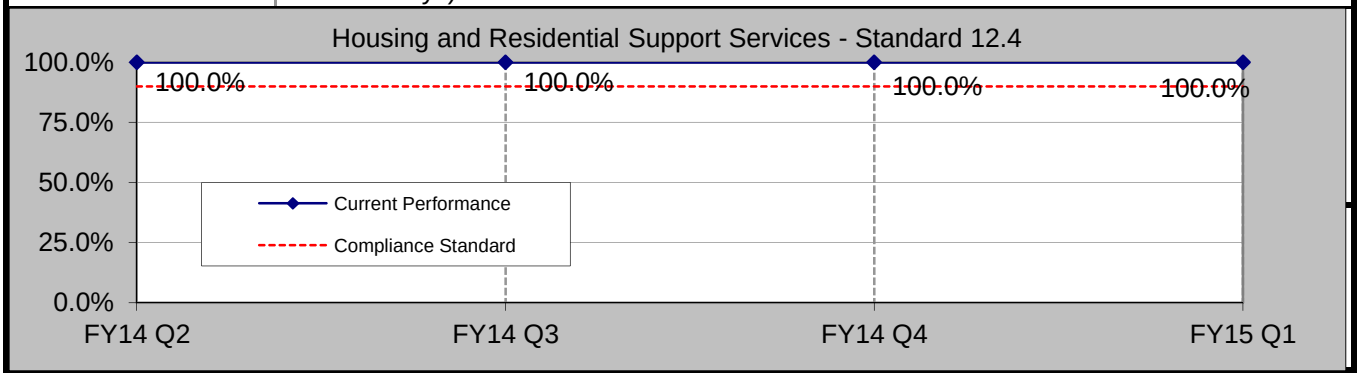


Community Resources and Treatment Services
Housing and Residential

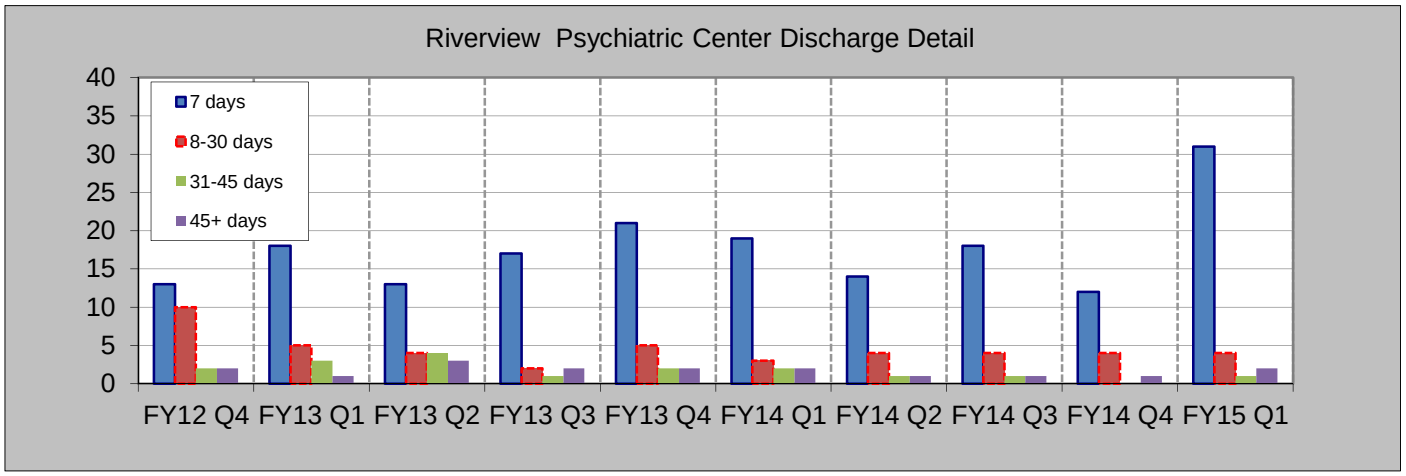
Standard 12.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY15 Q1 (Lack of residential supports did not impede discharge for any patients within 30 days)



Standard 12.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Perfomance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY15 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 12.2, 12.3, 12.4:

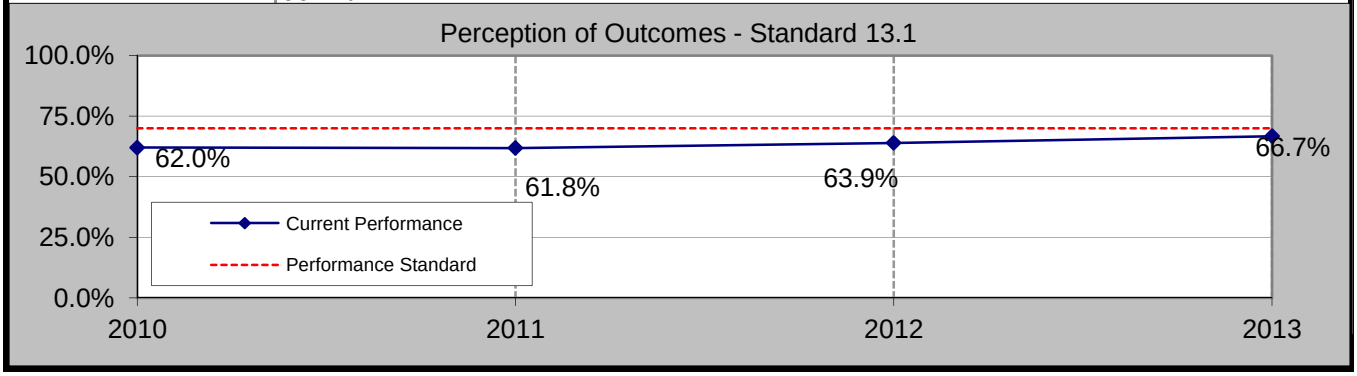
38 Civil Patients discharged in quarter

31 discharged at 7 days (81.6%)
4 discharged 8-30 days (10.5%)
1 discharged 31-45 days (2.6%)
2 discharged post 45 days (5.3%)

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

Community Resources and Treatment Services
Housing and Residential

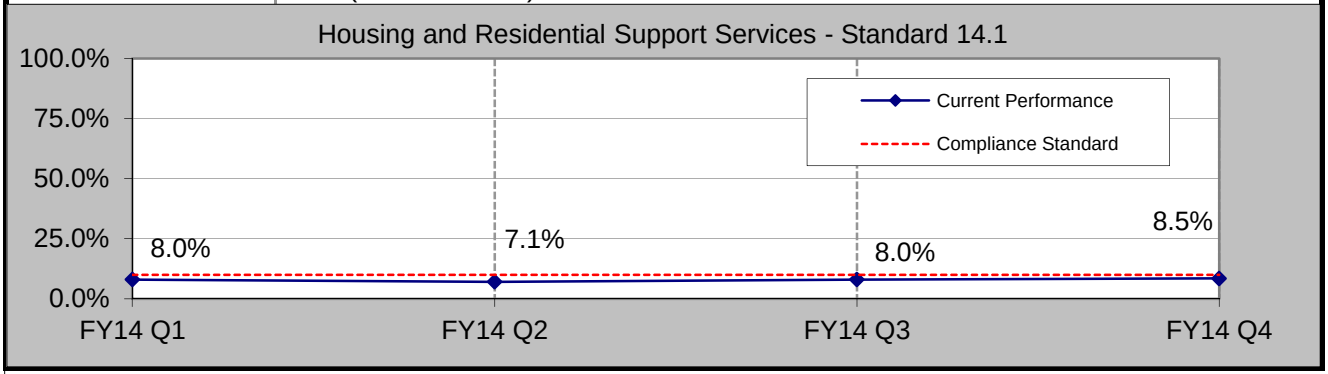
Standard 13.1	
Measurement	Domain average of positive responses to the questions in the Perception of Outcomes domain
Standard	Performance: at or above 70%
Data Source	Adult Mental Health and Well Being Survey
Current Level	66.7%



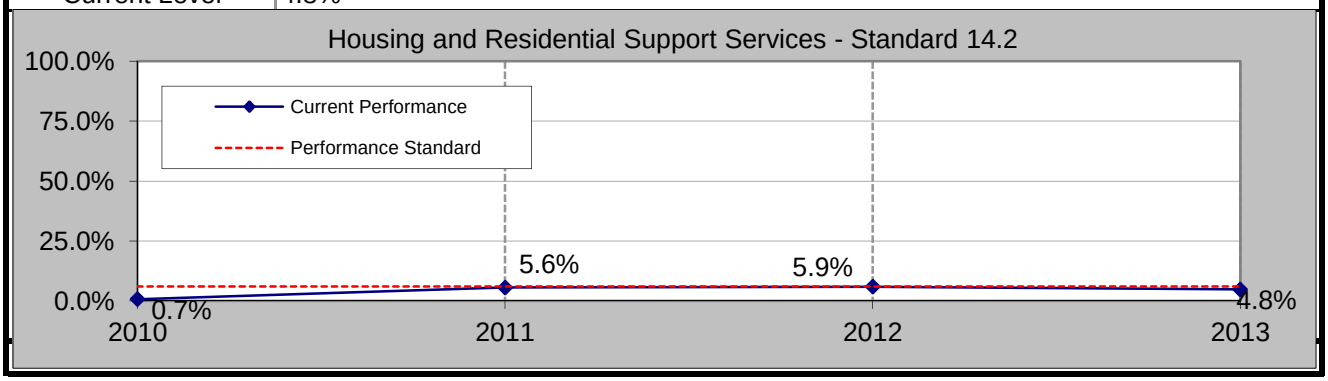
Community Resources and Treatment Services
Housing and Residential

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	8.5% (92 out of 1079)



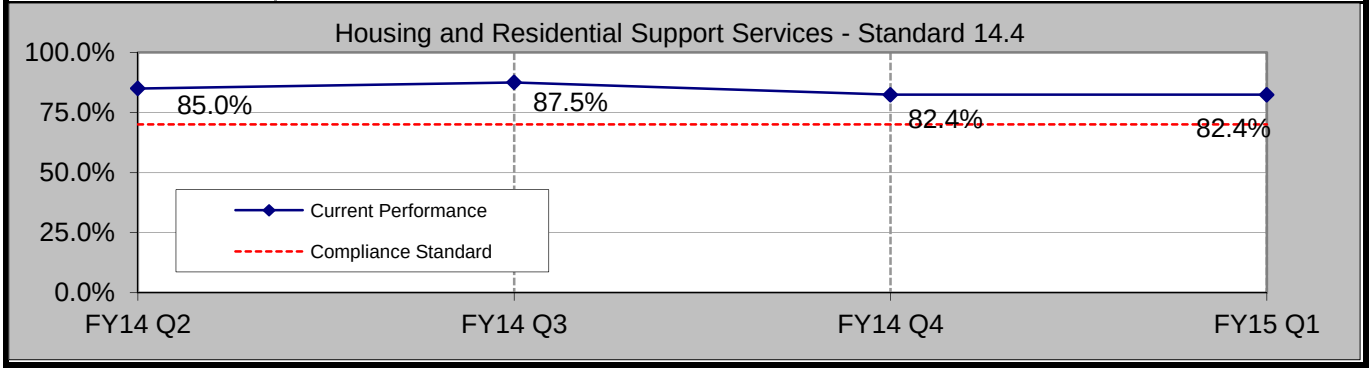
Standard 14.2	
Measurement	Percentage of respondents who experienced homelessness over 12-month period.
Standard	Performance: 6% or fewer
Data Source	Adult Mental Health and Well Being Survey, living situation data
Current Level	4.8%



DHHS Office of Substance Abuse and Mental Health Services

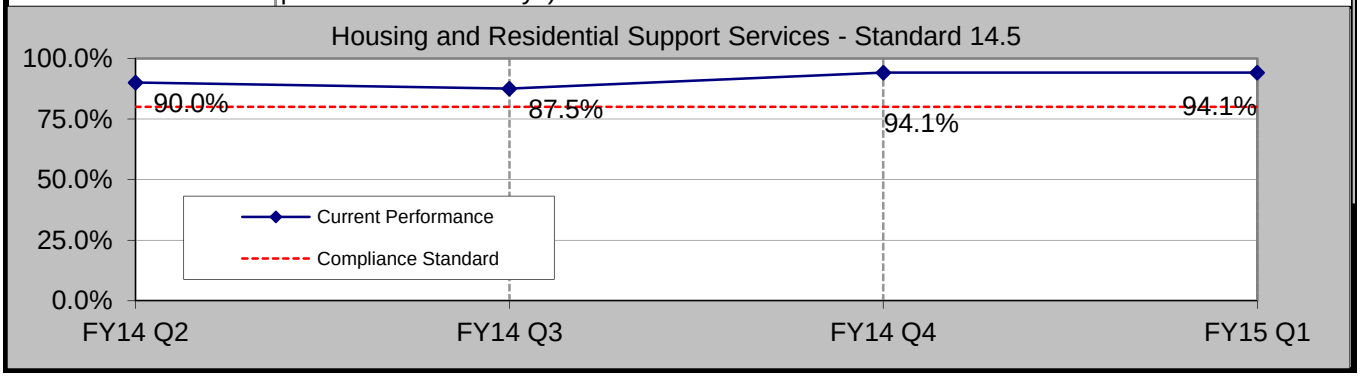
Community Resources and Treatment Services
Housing and Residential

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	81.6% FY15 Q1. (Lack of housing alternatives did not impede discharge for 31 out of 38 patients within 7 days)

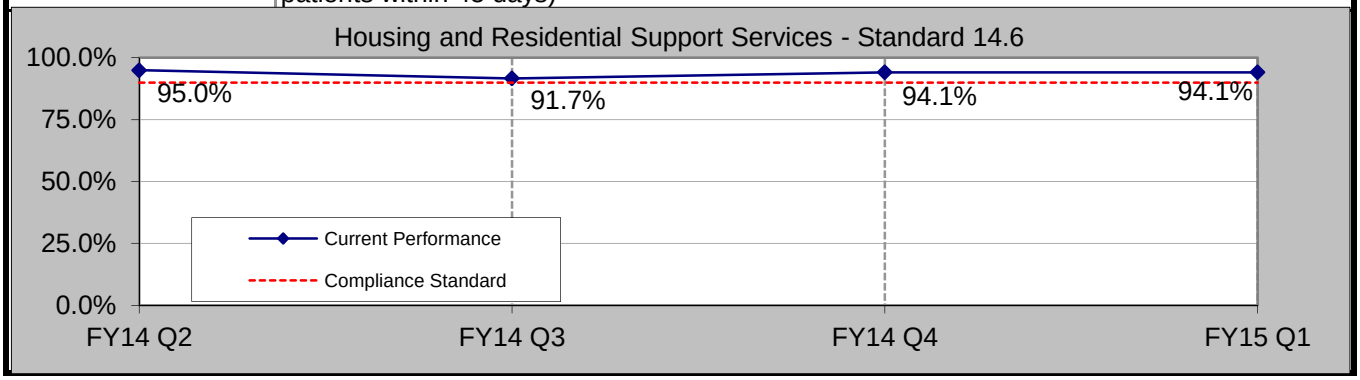


Community Resources and Treatment Services
Housing and Residential

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	92.1% FY15 Q1 (Lack of housing alternatives did not impede discharge for 35 out of 38 patients within 30 days)

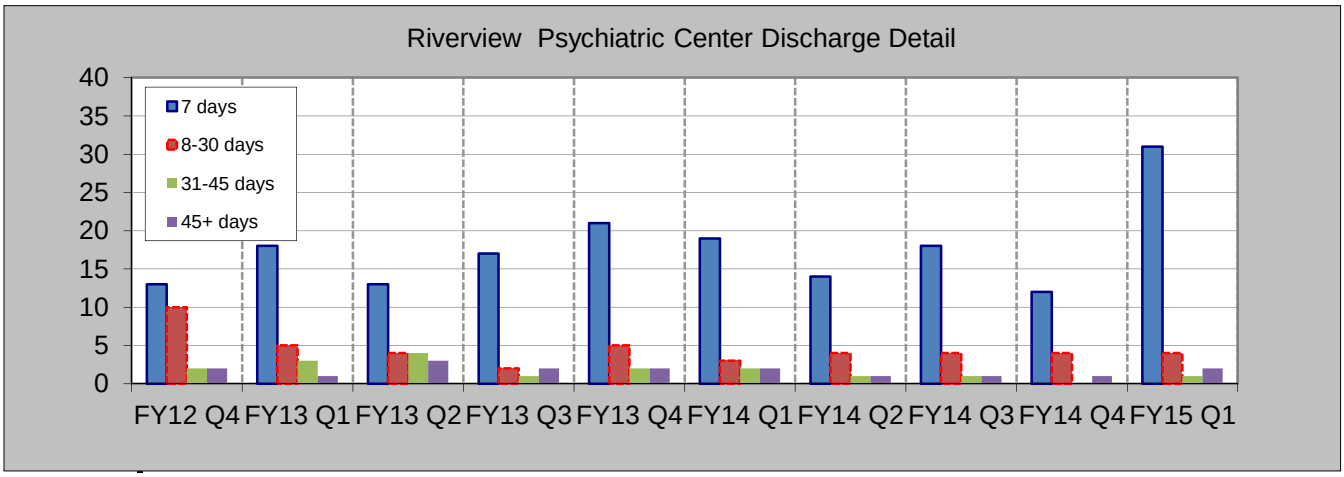


Standard 14.6	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 100% (within 45 days of that determination) Compliance: 90% (within 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	94.7% FY15 Q1 (Lack of housing alternatives did not impede discharge for 36 out of 38 patients within 45 days)



DHHS Office of Substance Abuse and Mental Health Services

Community Resources and Treatment Services
Housing and Residential



38 Civil Patients discharged in quarter

31 discharged at 7 days (81.6%)
4 discharged 8-30 days (10.5%)
1 discharged 31-45 days (2.6%)
2 discharged post 45 days (5.3%)

Housing Alternatives impeded discharge for 7 patients (44.7%)

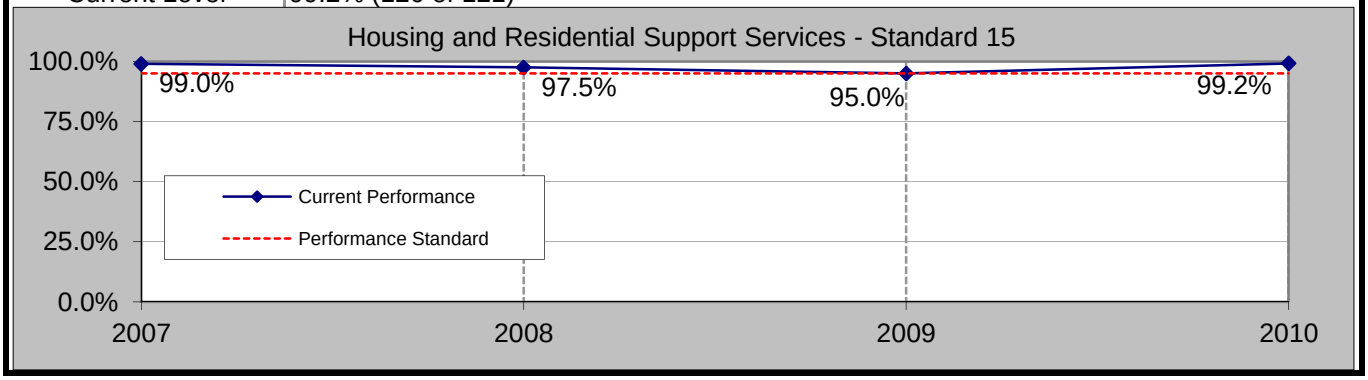
4 patients discharged within 8-30 days post clinical readiness for discharge
1 patient discharged 31- 45 days post clinical readiness for discharge
2 patient discharged greater than 45 days post clinical readiness for discharge

DHHS Office of Substance Abuse and Mental Health Services

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)



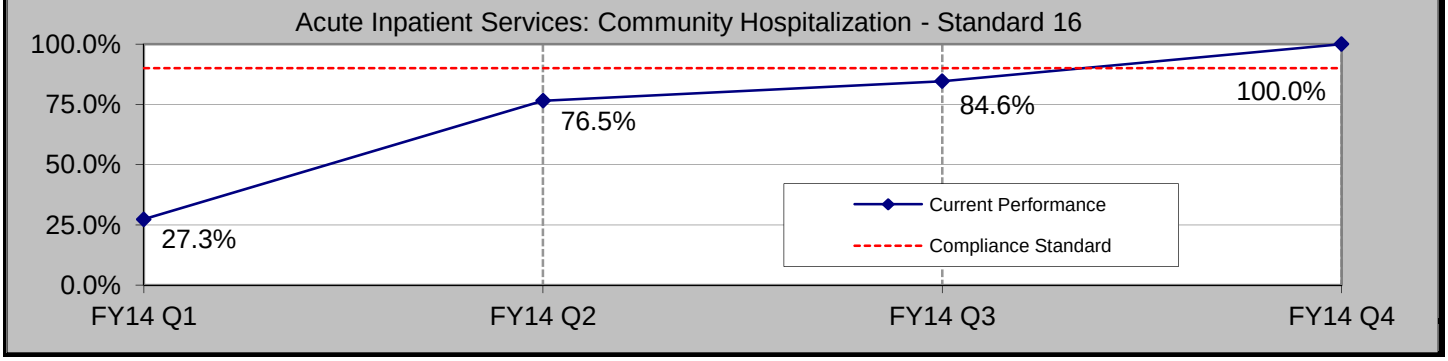
The protocol for obtaining the informed consent of Class Members to live in homes with greater than 8 beds (Settlement Agreement Paragraph 96) is followed annually to track data for this standard. SAMHS submitted an amendment request to modify this requirement on November 23, 2011. While the request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

DHHS Office of Substance Abuse and Mental Health Services

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

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

Standard 16	
Measurement	Class Member admissions determined to be reasonably near an individual's local community of residence.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	UR Database/EIS
Current Level	100.0% (12 out of 12)



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

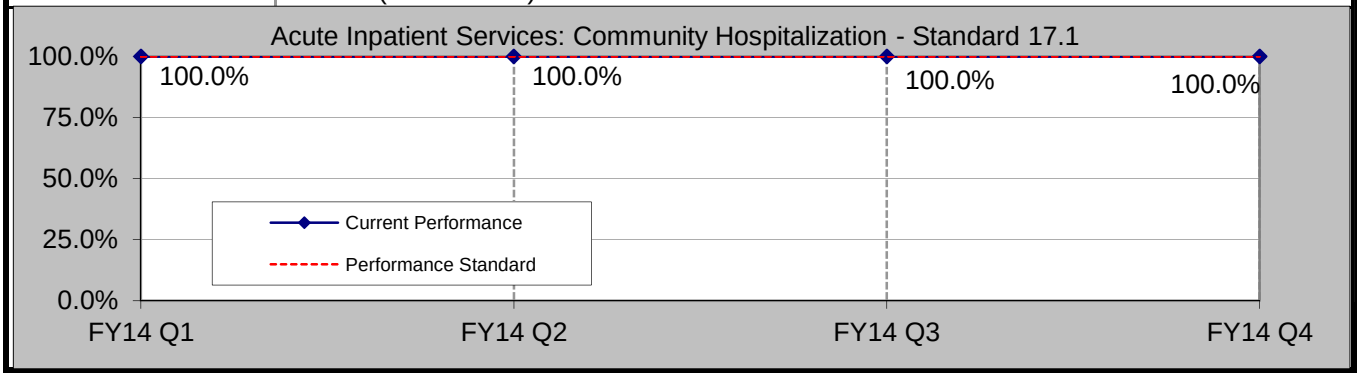
Discussion:

Standard 16 FY14 Q1: Data has been double checked manually and percentage reported is accurate. Persons needing hospitalization during the quarter were placed in the nearest **available** hospital bed. This could result in admissions outside the individual's catchment area. Measure will continue to be monitored to verify if a reflection of larger trend or an anomaly.

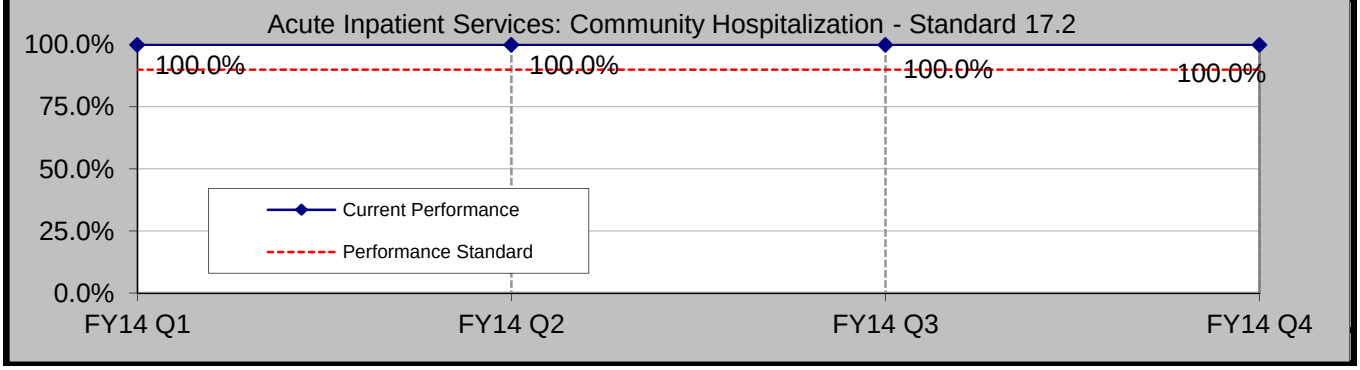
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

Standard 17.1	
Measurement	Class member involuntary admissions to community inpatient units have blue paper on file.
Standard	Performance: 100%
Data Source	UR Database/EIS
Current Level	100.0% (12 out of 12)

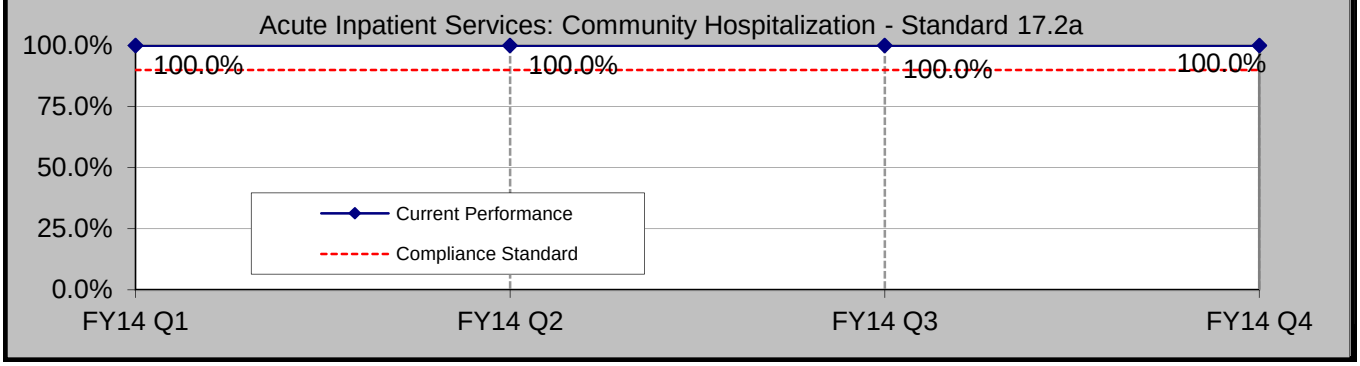


Standard 17.2	
Measurement	Blue paper was completed and in accordance with terms.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (12 out of 12)

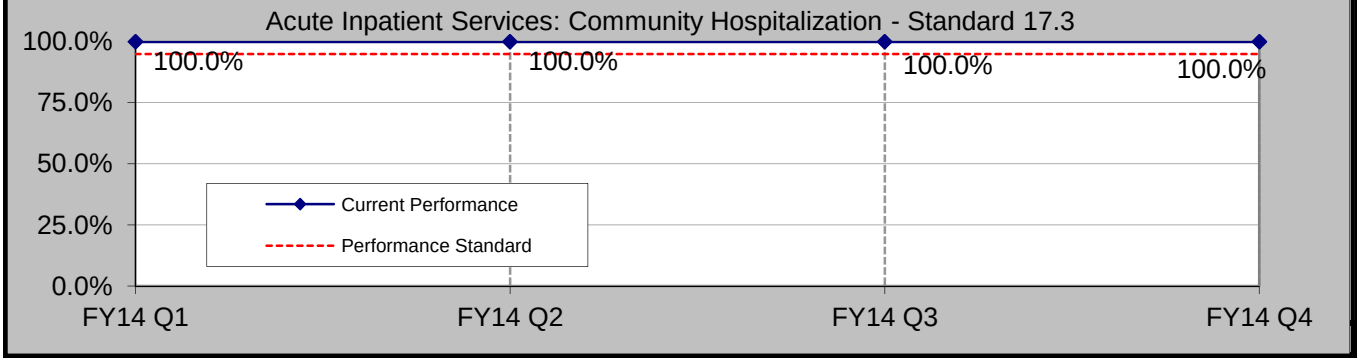


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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)

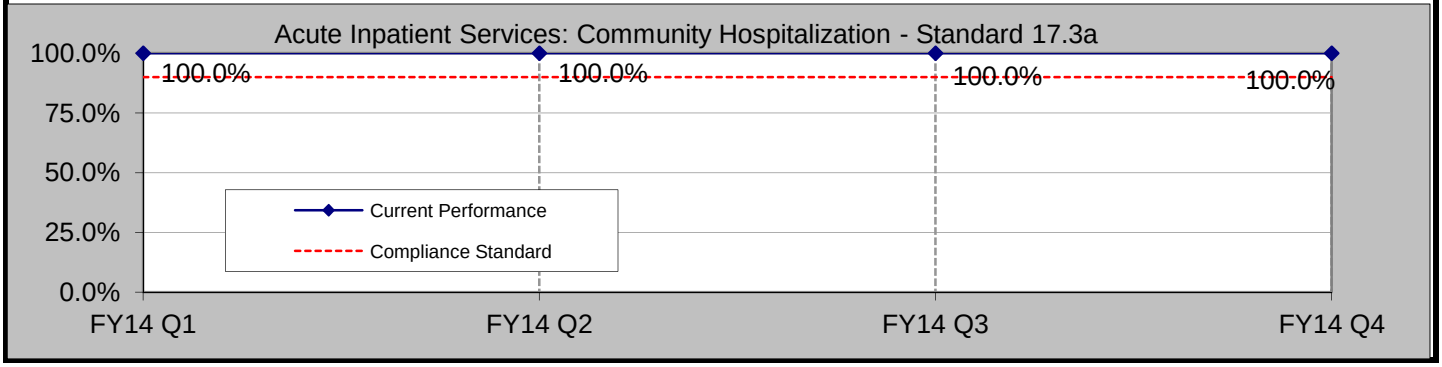


Standard 17.3	
Measurement	Class member involuntary admissions to community inpatient units in which 24 hour certification was completed.
Standard	Performance: 95%
Data Source	UR Database/EIS
Current Level	100.0% (12 out of 12)

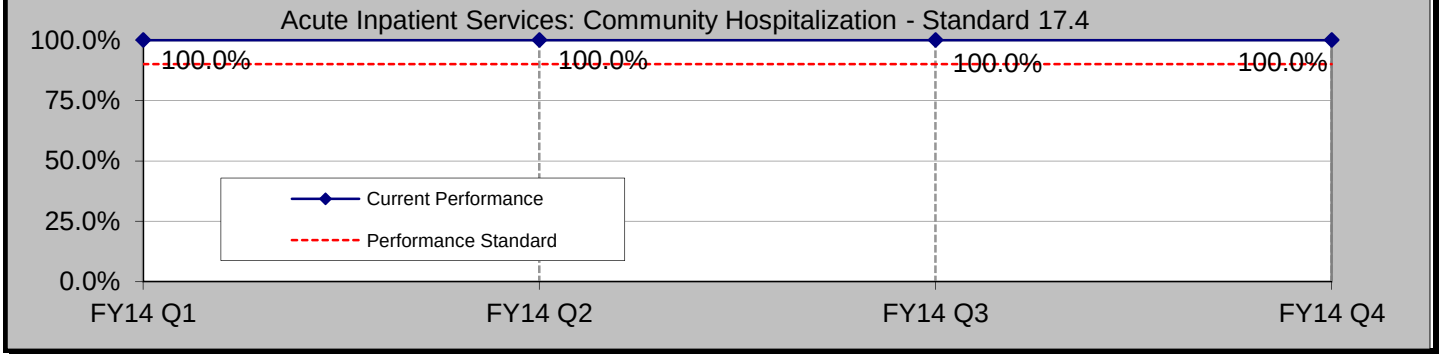


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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)

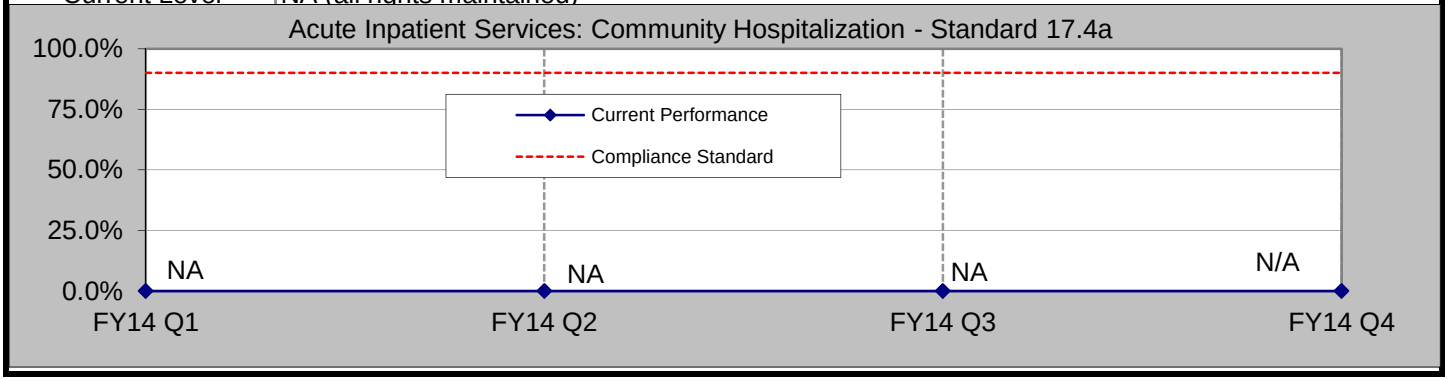


Standard 17.4	
Measurement	Class member involuntary admissions to community inpatient units in which patients' rights were maintained.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (12 out of 12)

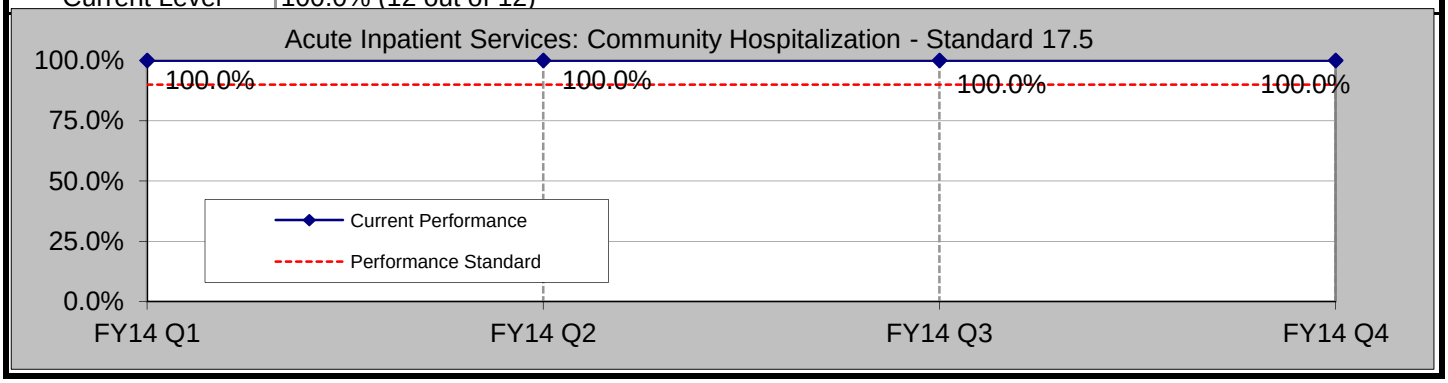


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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)



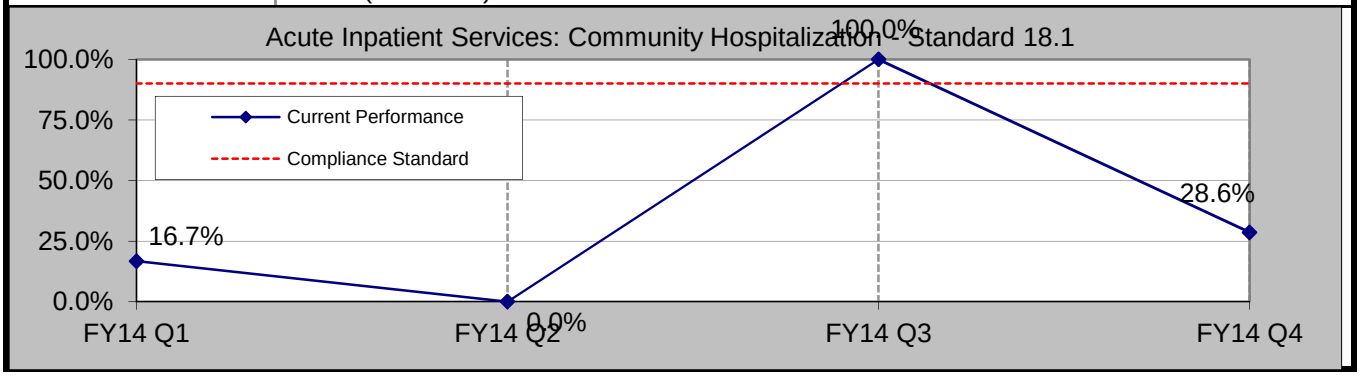
Standard 17.5	
Measurement	Class member involuntary admissions for which medical necessity has been established.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (12 out of 12)



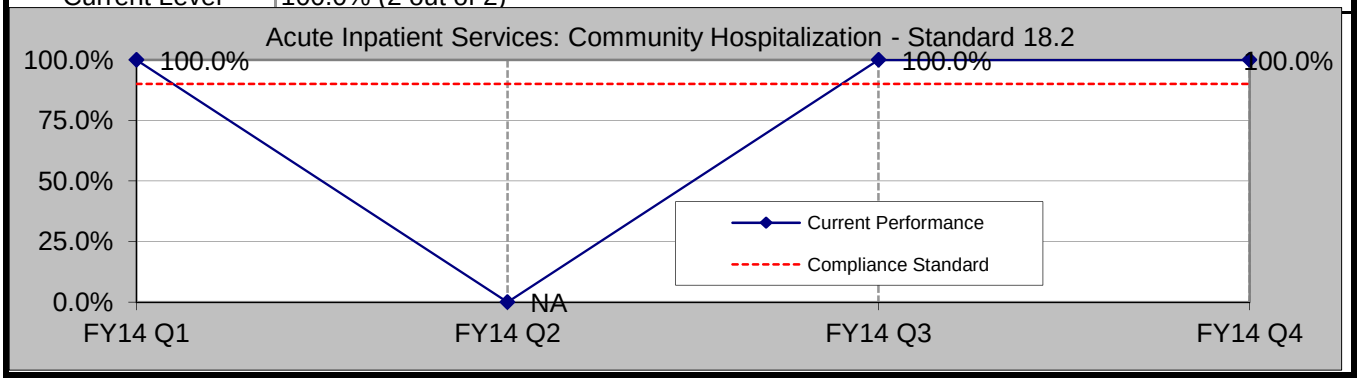
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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)

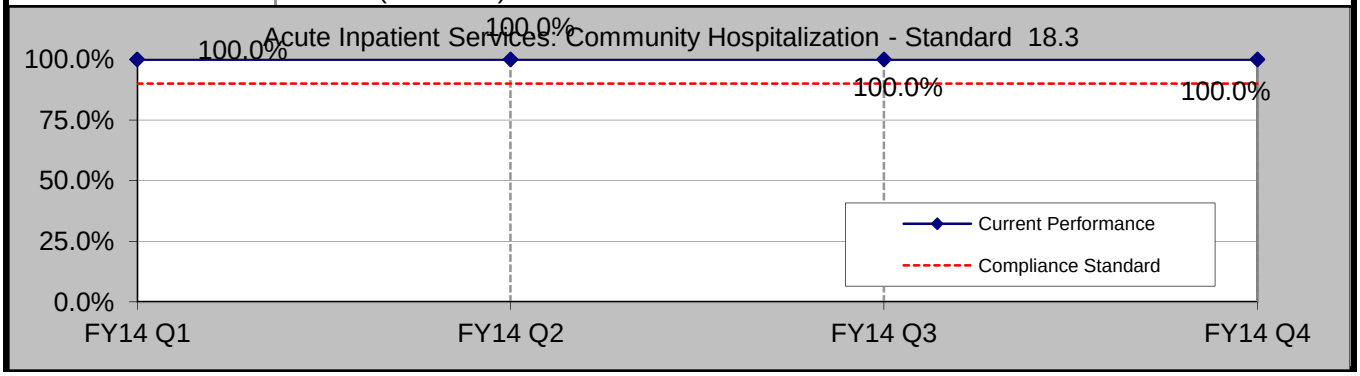


Standard 18.2	
Measurement	Treatment and discharge plan were determined to be consistent with ISP goals and objectives.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (2 out of 2)



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)

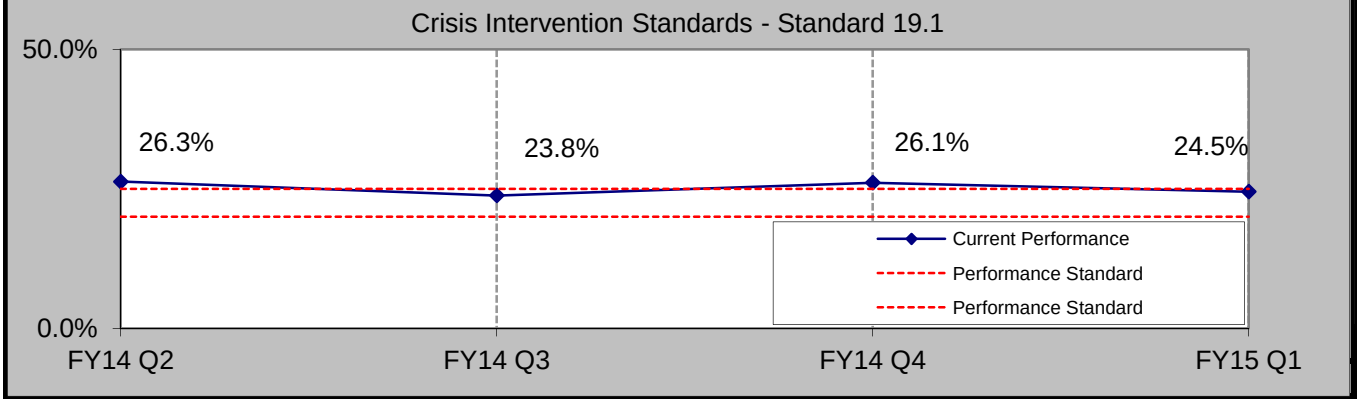


DHHS Office of Substance Abuse and Mental Health Services

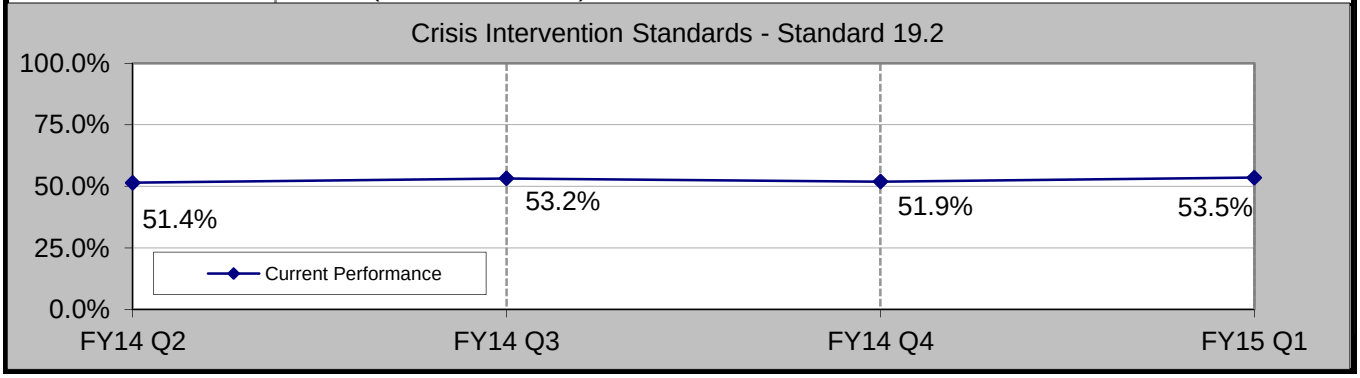
Community Resources and Treatment Services
Crisis Intervention Services

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	24.5% (1012 out of 4139)

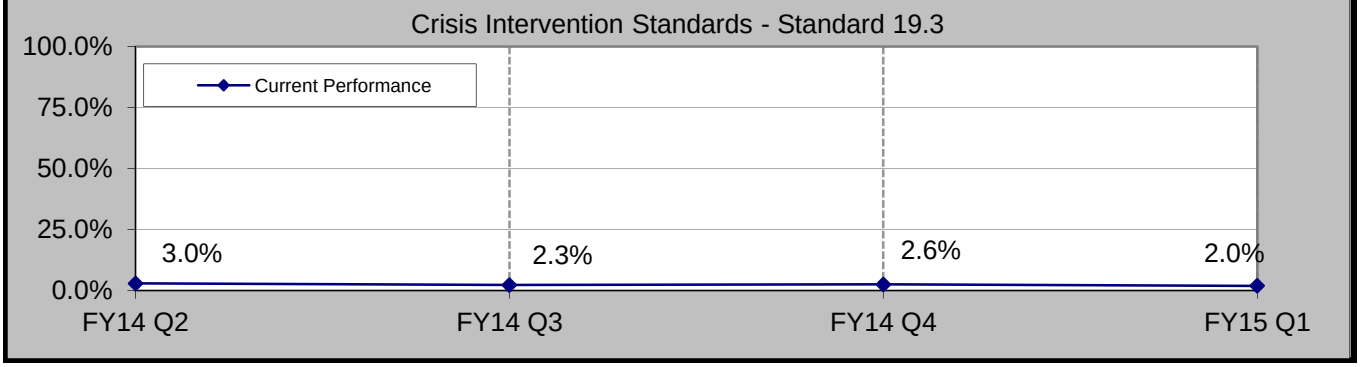


Standard 19.2	
Measurement	Face to face crisis contacts that result in follow-up and/or referral to community based services.
Standard	To Be Established
Data Source	Quarterly Crisis Contract Performance Data
Current Level	53.5 % (2215 out of 4139)

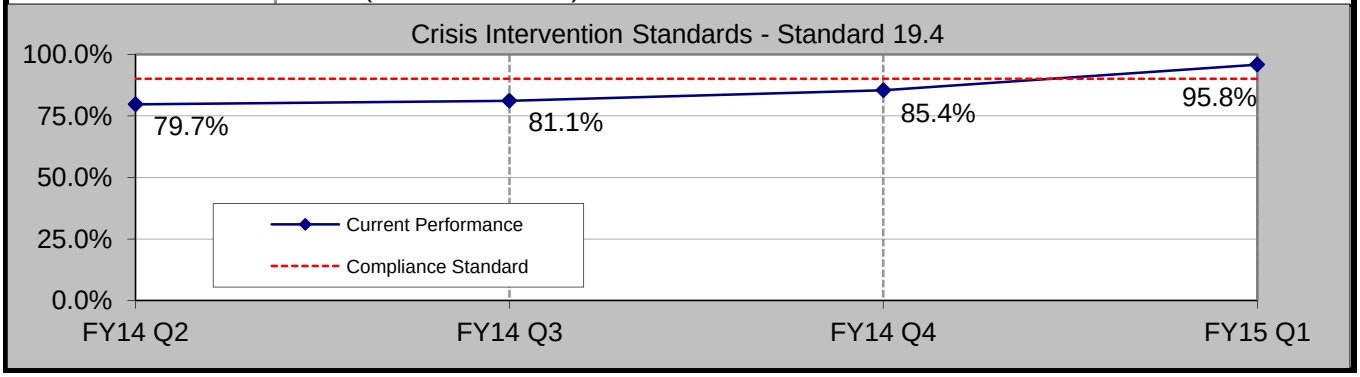


Community Resources and Treatment Services
Crisis Intervention Services

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	2.0% (80 out of 4139)



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	95.8% (1107 out of 1156)



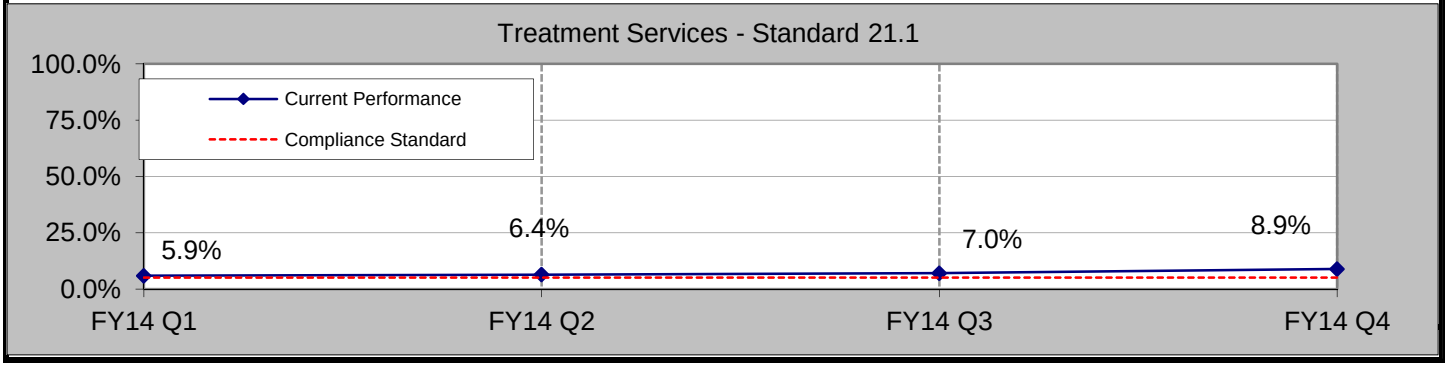
Discussion:

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

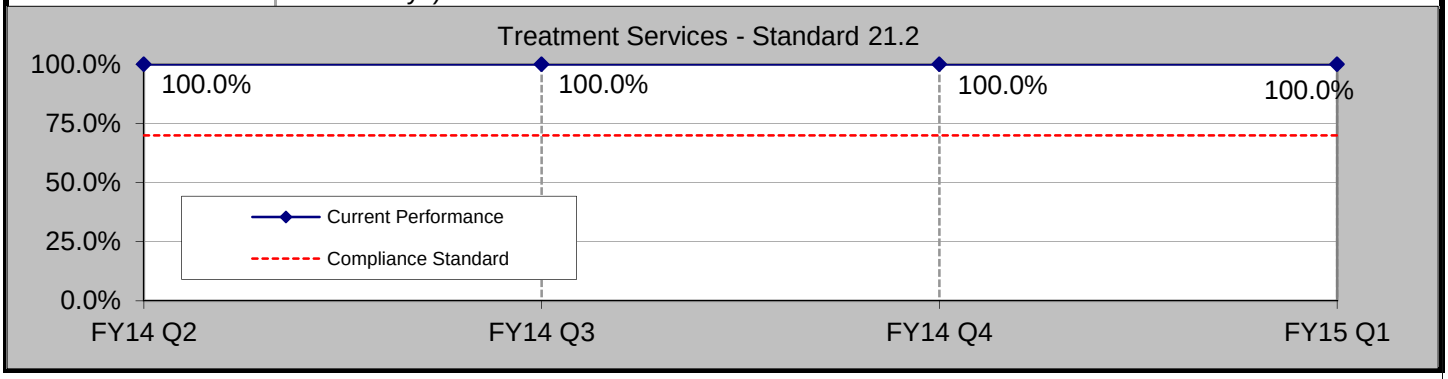
Community Resources and Treatment Services
Treatment Services

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

Standard 21.1	
Measurement	Class members with ISPs with unmet mental health treatment needs
Standard	Compliance: 5% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	8.5% (92 out of 1079)

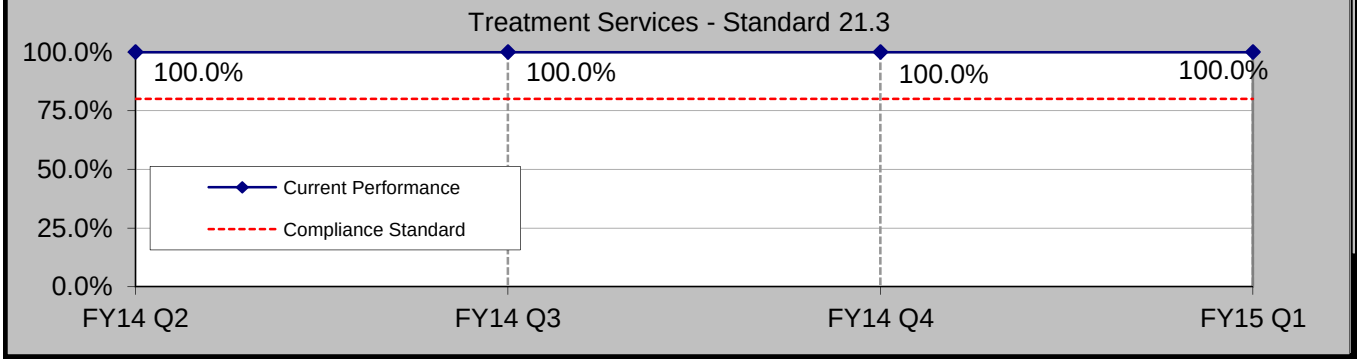


Standard 21.2	
measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY15 Q1 (Lack of mental health treatment did not impede discharge for any patients within 7 days)

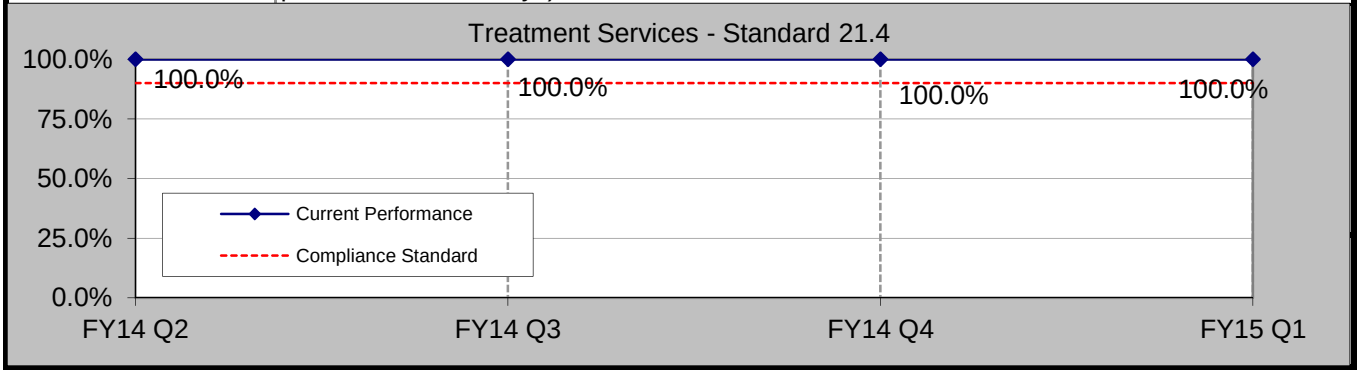


Community Resources and Treatment Services
Treatment Services

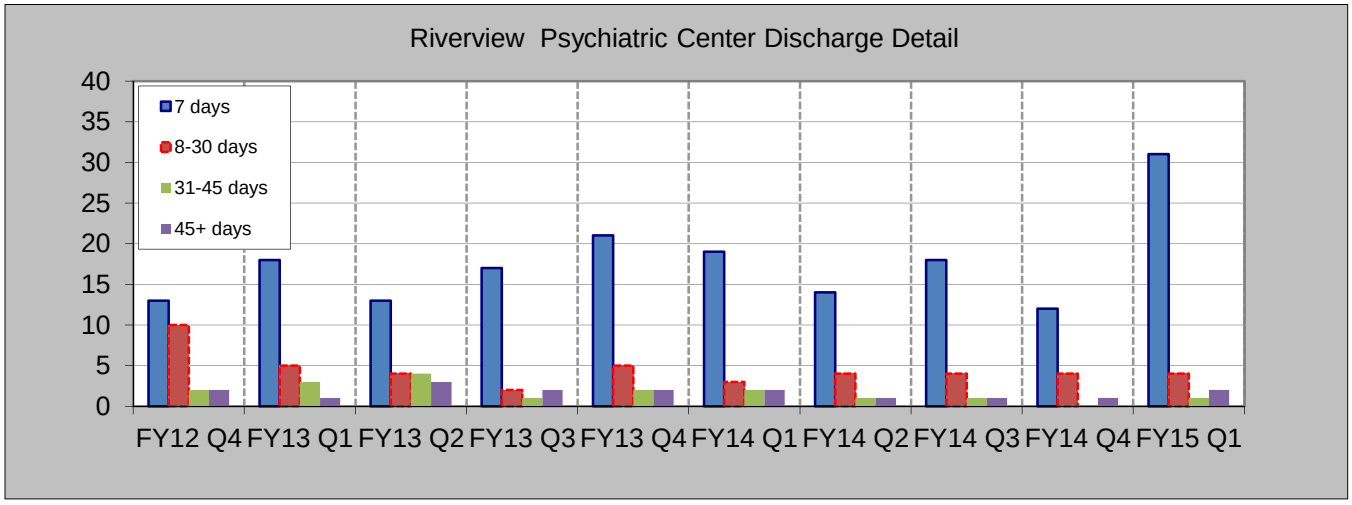
Standard 21.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination
Standard	Performance: 96% (within 30 days of that determination) Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY15 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% FY15 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

38 Civil Patients discharged in quarter

31 discharged at 7 days (81.6%)
4 discharged 8-30 days (10.5%)
1 discharged 31-45 days (2.6%)
2 discharged post 45 days (5.3%)

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

Community Resources and Treatment Services
Treatment Services

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

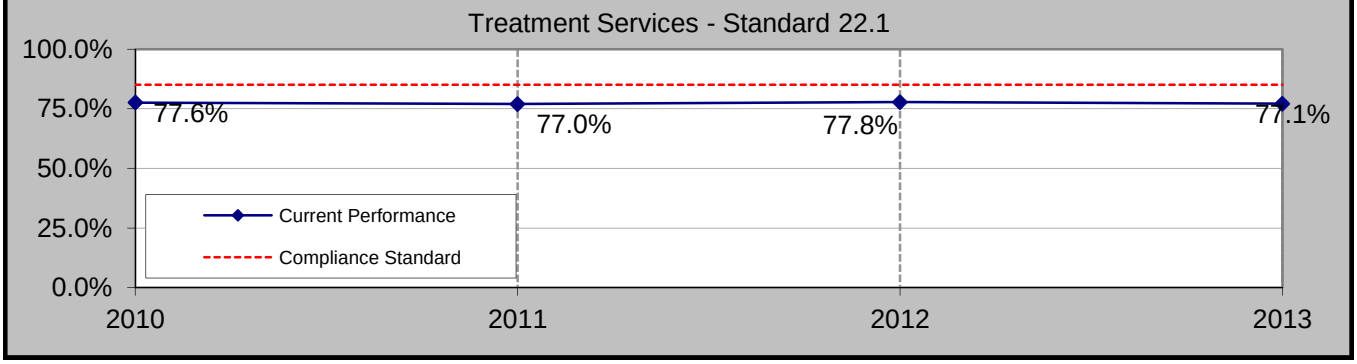
MaineCare Data FY 2013			
Mental Health Treatment Services Received	**Total Number**	**Total Number of Class Members**	**Percent of Class Members**
Assertive Community Treatment	863	285	33.0%
Community Integration	14,670	1,170	8.0%
Communty Rehabilitation	185	64	34.6%
Crisis Services	5,186	543	10.5%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

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

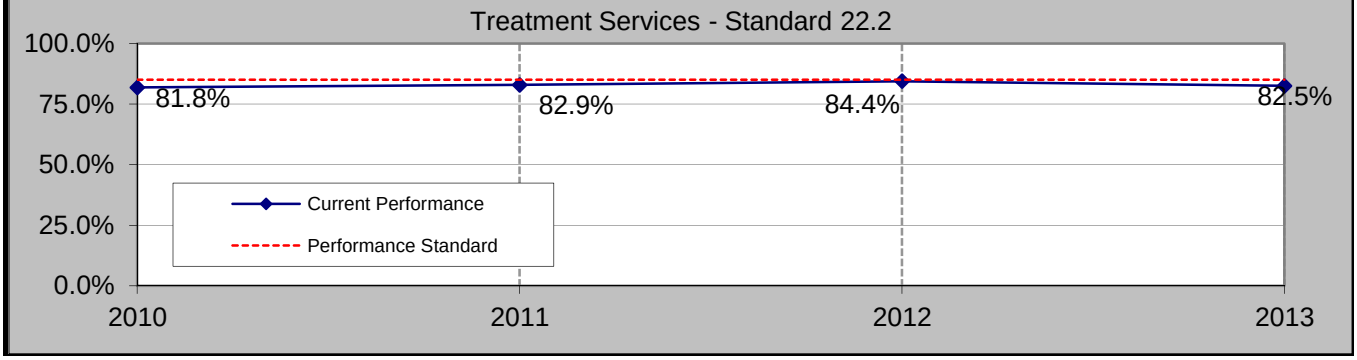
Community Resources and Treatment Services
Treatment Services

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

Standard 22.1	
Measurement	Domain average of positive responses in the Perception of access domain
Standard	Performance: At or above 85%
	Compliance: OAMHS conducts review, takes action if results fall below defined levels.
Data Source	Adult Mental Health and Well Being Survey
Current Level	77.1%



Standard 22.2	
Measurement	Domain average of positive responses in the General Satisfaction domain
Standard	Performance: at or above 85%
Data Source	Adult Mental Health and Well Being Survey
Current Level	82.5%



DHHS Office of Substance Abuse and Mental Health Services

Community Resources and Treatment Services
Family Support Services

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

Standard 23.1	
Measurement	Number of education programs developed and delivered meeting Settlement Agreement requirements
Standard	No standard necessary
Data Source	NAMI
Current Level	3 family to family classes: Q4 FY 14

Standard 23.2	
Measurement	Number and distribution of family support services provided
Standard	No standard necessary
Data Source	NAMI
Current Level	46 family support groups, 17 sites: Q4 FY 14

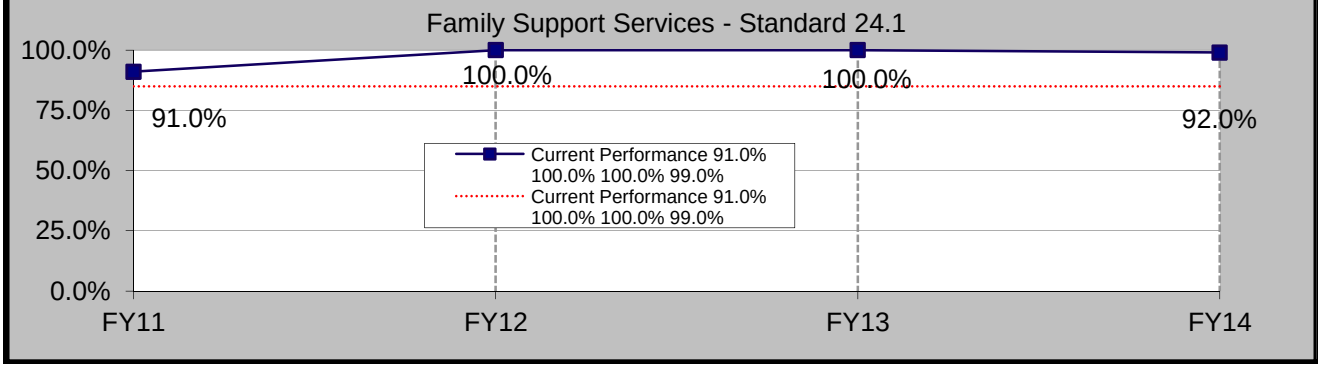
Note: Contracted agencies are allowed one month after the end of the quarter to submit performance indicator data.

DHHS Office of Substance Abuse and Mental Health Services

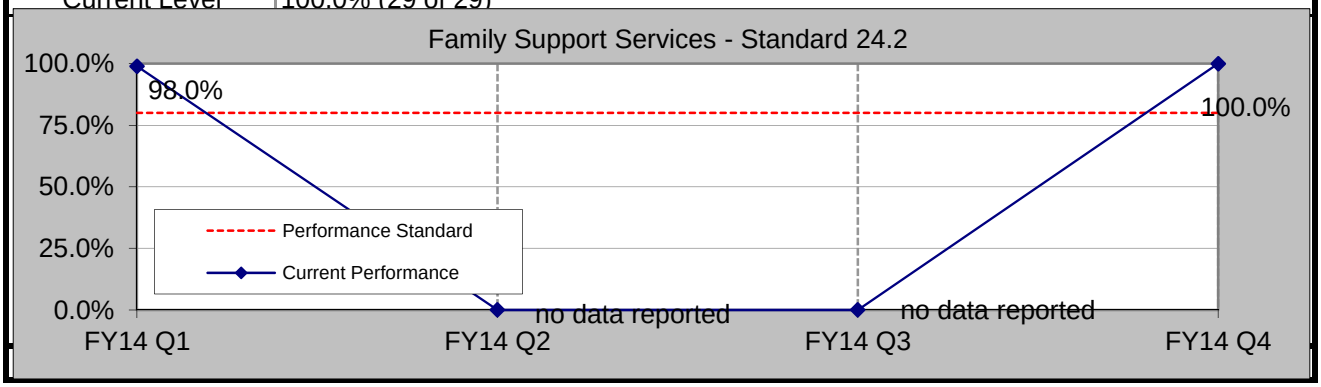
Community Resources and Treatment Services
Family Support Services

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	99.0% (98 of 99)



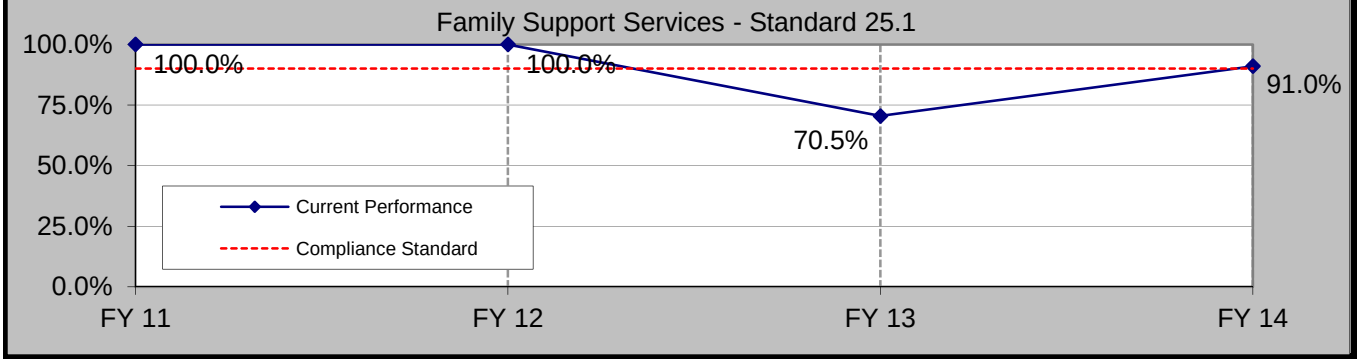
Standard 24.2	
Measurement	Percentage of program participants reporting satisfaction with education programs.
Standard	Performance: 80%
Data Source	NAMI
Current Level	100.0% (29 of 29)



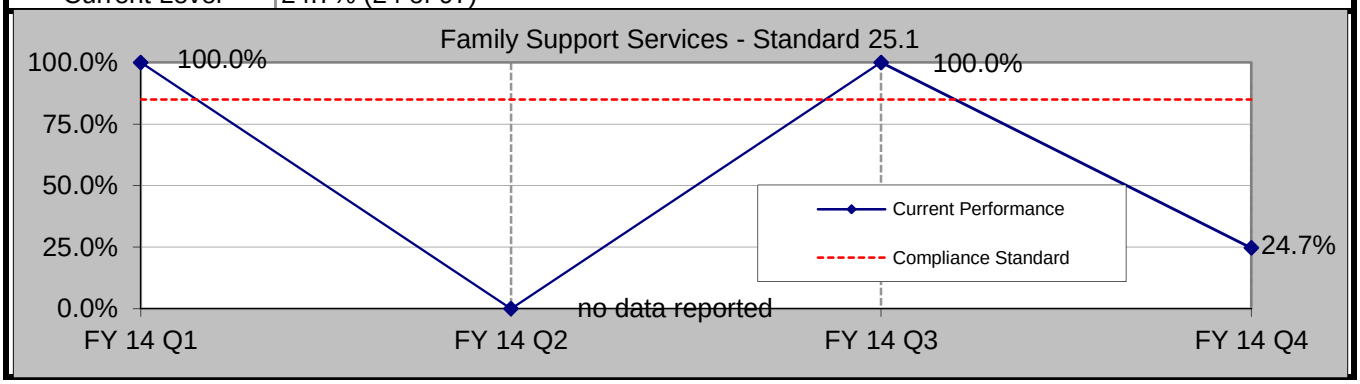
Community Resources and Treatment Services
Family Support Services

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	91.0% (121 of 133)



Standard 25.2	
Measurement	Families receiving referrals for family support services reporting satisfaction with referral process.
Standard	Performance: 85%
Data Source	NAMI
Current Level	24.7% (24 of 97)

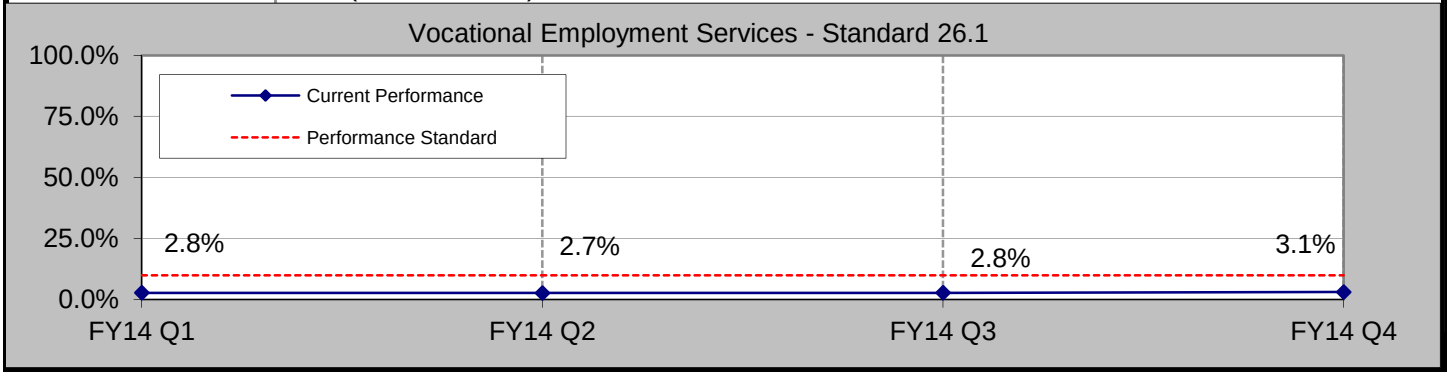


DHHS Office of Substance Abuse and Mental Health Services

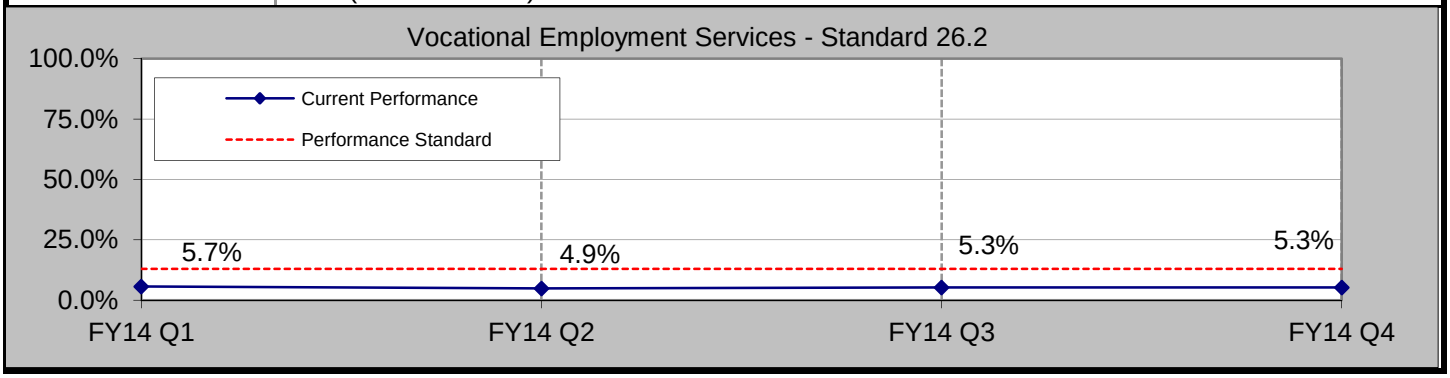
Community Resources and Treatment Services
Vocational Employment Services

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	3.1% (33 out of 1079)

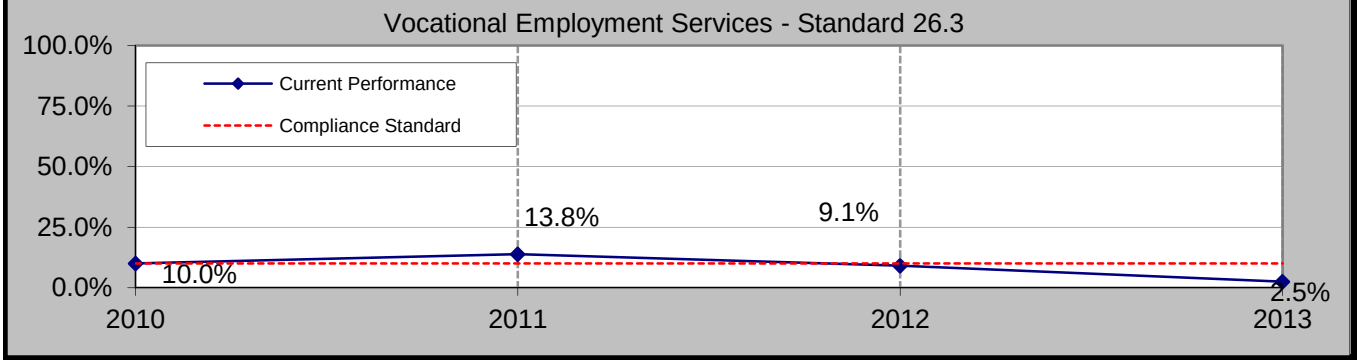


Standard 26.2	
Measurement	Class members younger than age 62 in competitive employment in the community.
Standard	Performance: 15% of class members employed in competitive employment. Compliance: 13% or Baseline (10.8%).
Data Source	ISP RDS Data
Current Level	5.3% (68 out of 1281)



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	2.5%



Discussion:

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

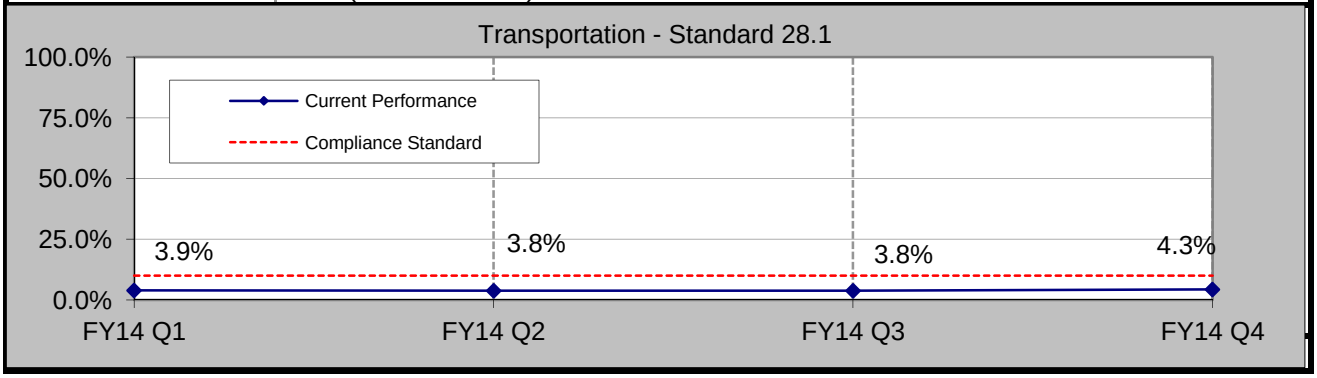
The response rate for the Adult Mental Health survey was very low in 2013. The Department is working on performance measures in contracts around employment.

DHHS Office of Substance Abuse and Mental Health Services

Community Resources and Treatment Services
Transportation

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

Standard 28.1	
Measurement	Percentage of class members with ISP identified unmet transportation needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	4.3% (46 out of 1079)



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	18427 total visits, 2135 unduplicated clients (10 of 14 social clubs/peer centers reporting for FY 14 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	11 Peer Support programs statewide during FY 2014 Q4. (includes social clubs/peer centers): Participation data is not collected for the Statewide Initiatives noted below.

Peer Support Groups funded by DHHS FY2014 Q3:

Peer Centers and Social Clubs:

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:

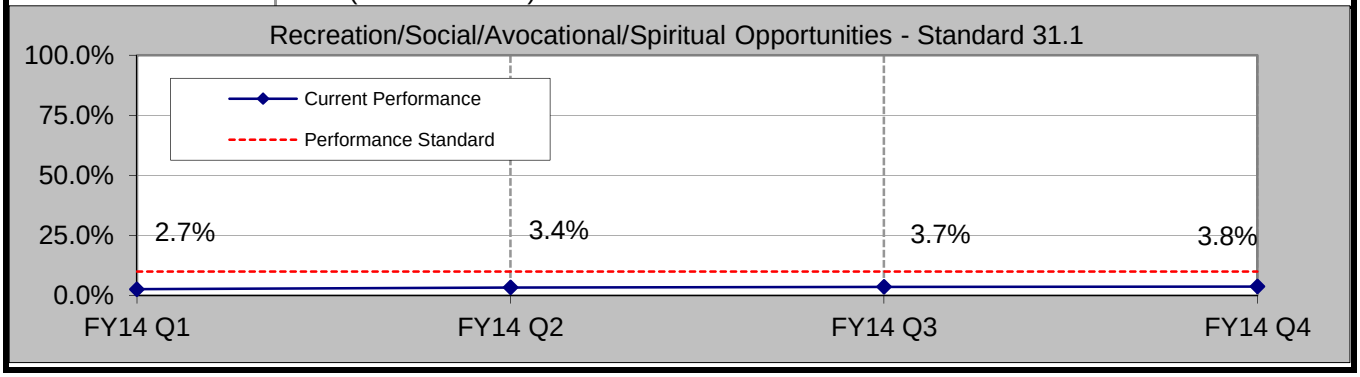
Community Connections: Community based recreational opportunities and leisure planning
MAPSRC (Maine Association of Psychosocial Rehabilitation Centers)

NAMI Support Groups primarily attended by consumers:

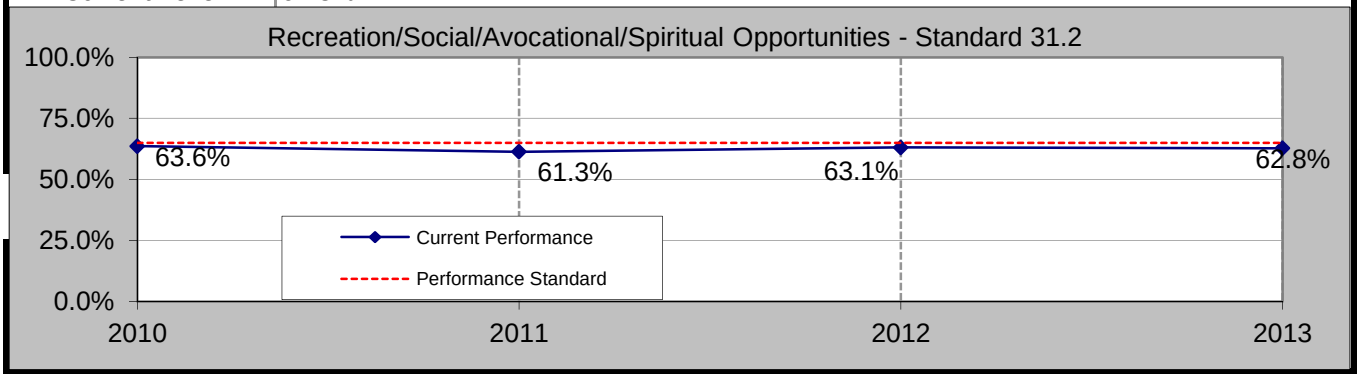
Augusta, Bangor, Biddeford, Damariscotta, Dover Foxcroft, Ellsworth, Farmington, Harrington, Houlton, Lewiston, Machias, Norway, Rockland, Sanford, South Paris, and Waterville.

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

Standard 31.1	
Measurement	ISP identified class member unmet needs in recreational, social, avocational and spiritual areas.
Standard	Performance: 10% or fewer
Data Source	ISP RDS Data
Current Level	3.8% (41 out of 1079)



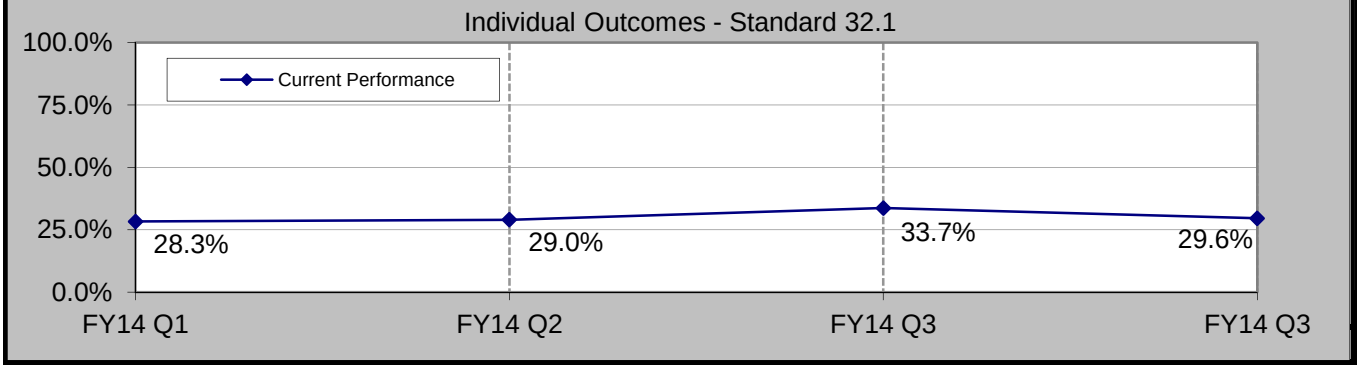
Standard 31.2	
Measurement	Domain average of positive responses in the Social Connectedness domain
Standard	Performance: At or above 65%
Data Source	Adult Mental Health and Well Being Survey
Current Level	62.8%



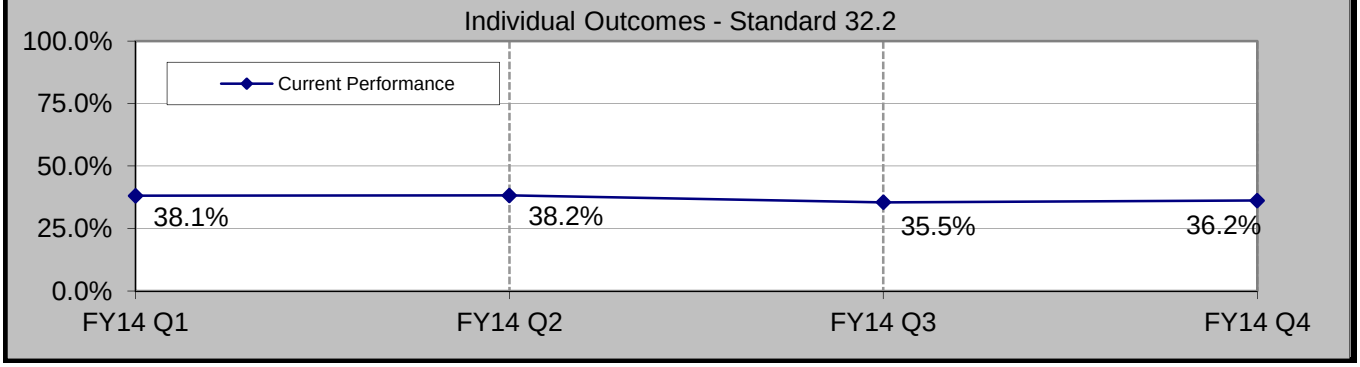
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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	33.7% (127 out of 377)

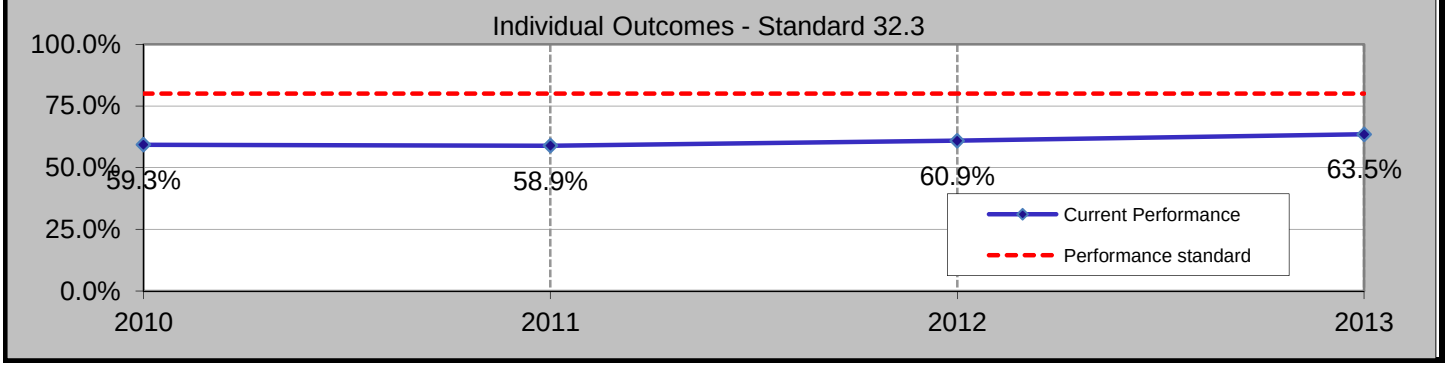


Standard 32.2	
Measurement	Class Members who have maintained level of functioning between baseline and 12 month re-certification.
Standard	Standard to be established.
Data Source	Enrollment data (Based on overall composite score.)
Current Level	36.2% (478 out of 1319)



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

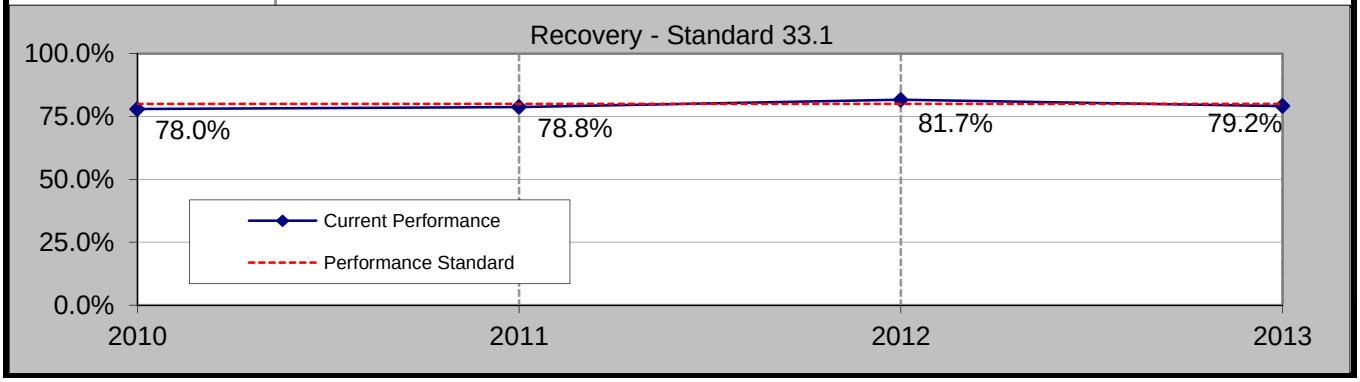
Standard 32.3	
Measurement	Consumers reporting positively on functional outcomes on Adult Mental Health and Well Being Survey outcome items.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	63.5%



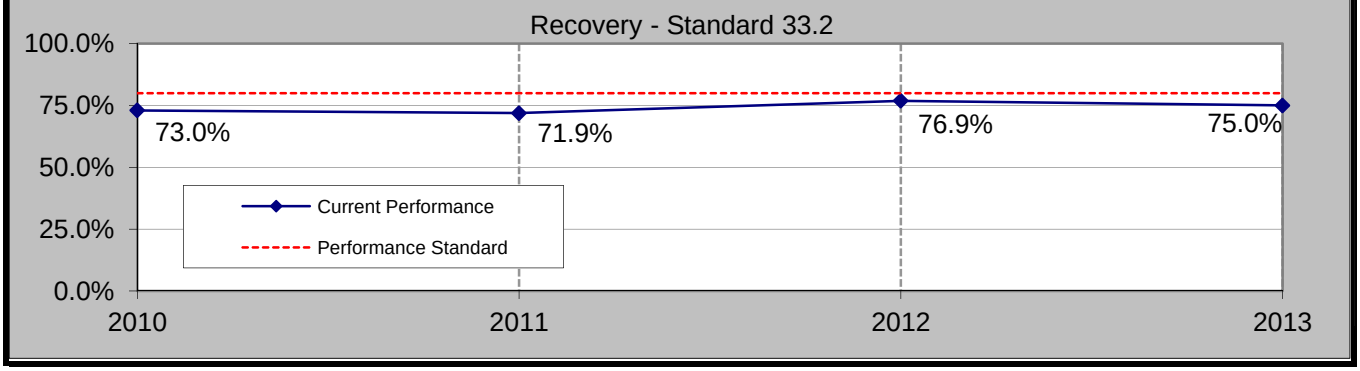
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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	79.2%

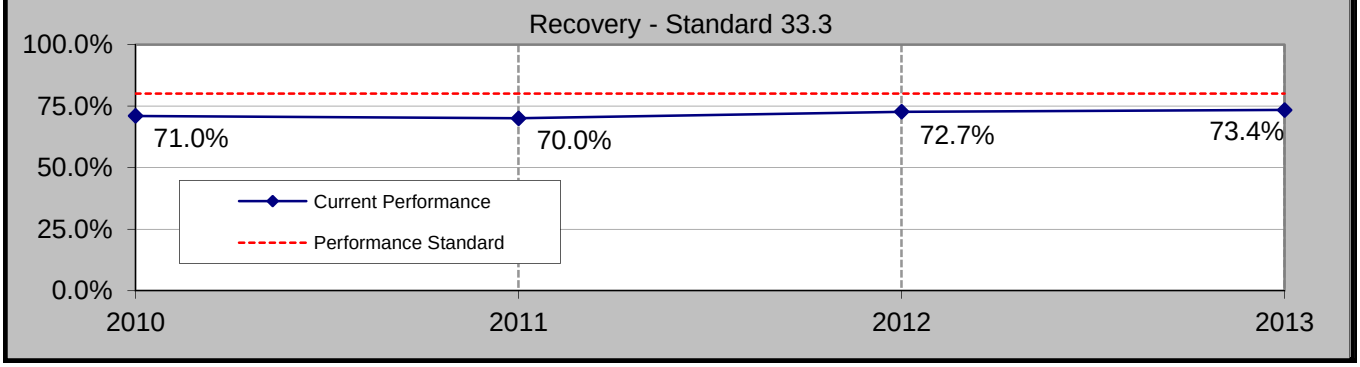


Standard 33.2	
Measurement	Consumers reporting that agency staff believe that they can grow, change and recover
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey
Current Level	75.0%

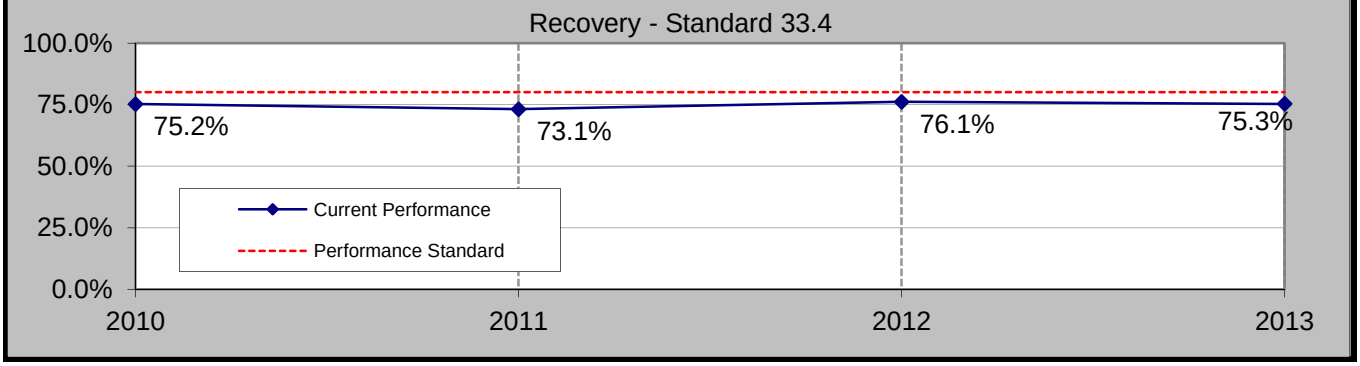


System Outcomes: Supporting the Recovery of Adults with Mental Illness
Recovery

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	73.4%

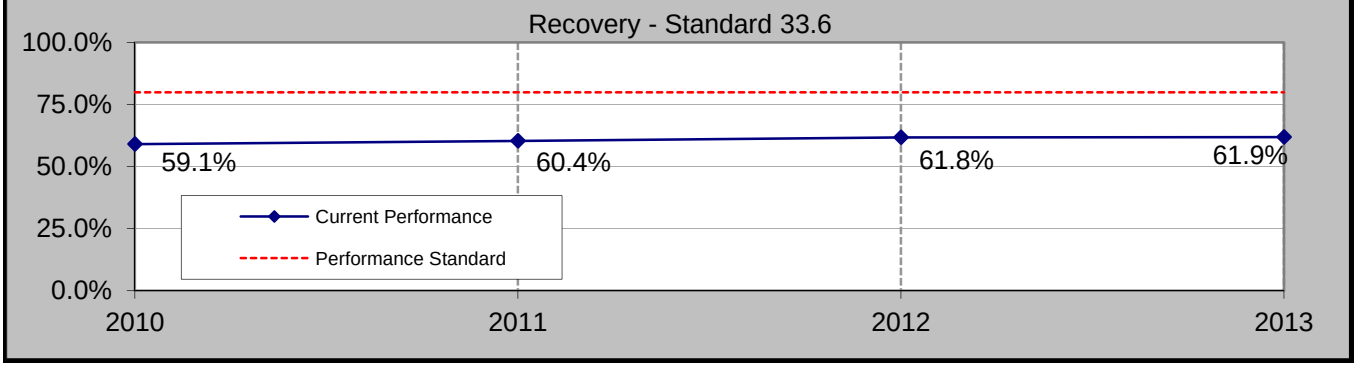


Standard 33.4	
Measurement	Consumers reporting that providers offered opportunities to learn skills to strengthen and maintain wellness.
Standard	Performance: 80%
Data Source	Adult Mental Health and Well Being Survey Q16
Current Level	75.3%



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	61.9%

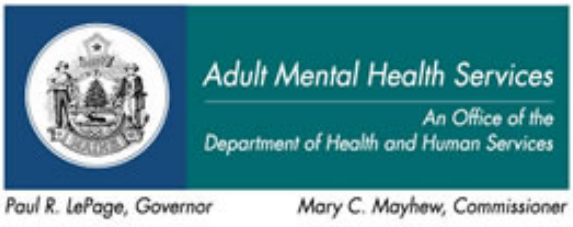


System Outcomes: Supporting the Recovery of Adults with Mental Illness
Public Education

Standard 34.1	
Measurement	# of mental health workshops, forums, and presentations geared toward general public and level of participation.
Standard	Qualitative evaluation required, no numerical standard necessary.
Data Source	NAMI
Current Level	6 FY14 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	20,595 FY14 Q4

Go to Table of Contents



Public Education - Standard 34.1

FOURTH QUARTER FY14

(APR, MAY, JUN 2014)

CLASS NAME/TOPIC	DATE	LOCATION	ATTENDEES
CIPSS Core Training	Apr 3,10,17,24,May 1,8,15,22	Augusta	26
CIPSS Core Training	May 14,21,28,Jun 4,11,18,25	Bangor	17
Peer Support 101	Apr 4	Augusta	7
Peer Support 101	Apr 11	Augusta	10
Peer Support 101	Apr 15	Bangor	12
Building Connection	Apr 18	Portland	14
Boundaries	May 5	Augusta	15
TCMHS Mental Health Peer Event	May 9	Lewiston	20
Peer Support 101	Jun 16	Portland	8
Peer Support 101	Jun 20	Rumford	6
Understanding and Practicing Mutuality	Jun 26	Augusta	16
Peer Support 101	Jun 27	Lewiston	6
Understanding and Practicing Mutuality	Jun 30	Augusta	15
MH Supports and Services	Apr 23	Portland	10
Family and Peer Perspectives	Apr 28	Augusta	60
MH/Local Supports/Recovery	May 19	Hallowell	20
Hospital Discharge Supports/Recovery	Jun 4	Augusta	5
NAMI Program and Supports	Jun 6	Augusta	16
Hospital Discharge Supports/Recovery	Jun 20	Augusta	4

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 Behavioral Health Homes) maintained and reported from the Department's EIS (Enterprise Information System). Data is collected by APS Healthcare as part of its prior authorization process and fed into EIS twice a month.
Target Population: Adult Mental Health Consumers receiving Community Support.
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, CRS and BHH)
Approximate Sample Size: As of the 3rd quarter FY11, sample size has been decreased to 50 per quarter, utilizing the random sampling methodology as previously developed. This allows the new SAMHS Division of Quality Management the time to assess and develop a new system of document reviews, not solely focused on treatment planning, that can be implemented across program areas and provide data for a wider group of individuals utilizing mental health services.

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, CRS and BHH).

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

Quarterly Contract Performance Indicator Data:

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

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

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

Attached Report:

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 4

Population Covered:

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

Data Sources:

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

Unmet Resource Need Definition

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

Quality Improvement Measures

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

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

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

Ongoing Quality Improvement Initiatives

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. All providers met the Performance Measure this quarter and received their incentive payment. Identified Need: A,B,D

Critical Incident Reporting. SAMHS had three systems and portals for providers to report on critical incidents involving consumers. These systems and portals are a legacy from the merger of Adult Mental Health Services and the Office of Substance Abuse. The rollout of a streamlined Critical Incident reporting process took place in October with training and a go live date which occurred in November. Critical Incidents are now received through a dedicated email address, fax, and with phone support. Identified Need: A,B,D,E,F,G,

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

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

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

Commissioner's Unmet Needs Workgroup. Commissioner Mayhew has appointed a workgroup to examine the performance and compliance standards under the approved Consent Decree Plan and SAMHS's ability to meet the compliance standards. The workgroup has reviewed data from FY2006 to the present to determine patterns of compliance with the standards. The data have been analyzed and recommendations have been made to the Commissioner, Court Master, and Plaintiffs' Attorney. Currently there are two uncontested motions regarding the Settlement Agreement before Justice Horton. One is a motion regarding Paragraph 257 to change the caseloads for caseworks assigned to class member public wards from not to exceed 25 cases to not to exceed 40 cases. The other is a motion regarding location efforts to maintain a current list of class member addresses, but

to remove requirements for mailings to class members unless the number of unverified addresses falls below 15% and court master believes mailings are necessary to improve accuracy of the list. Additional funding request of $5,797,300 has been put forward for FY16-FY17 for 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). Annually Quality Management staff do inspections of Rental Properties and PNMI. Identified Need: A,E,K,M

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

Mental Health Rehabilitation/Crisis Service Provider Review. The Mental Health Rehabilitation/ Crisis Service Provider (MHRT/CSP) certification was developed by the crisis providers (Maine Crisis Network) over the past several years in collaboration with DHHS (adult mental health and children's behavioral health) and the Muskie School. The MHRT/CSP is now ready to be implemented with providers. A review team consisting of two representatives from the Maine Crisis Network, two representatives from Children's Behavioral Health and two representatives from SAMHS will work together to conduct reviews at contracted agencies. Muskie staff collected the data and has produced a summary report which is in review at this time.
Identified Need: B

NIATx Quality Improvement Initiative. NIATx has been deployed in seven 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.

The following are the activities that the State Niatx group has been engaged in along with the assistance of APS Healthcare and the Muskie Institute.

- APS Health Care now sends an email reminder to the provider agency staff for all clients on a waitlist over 30 days.
- APS Healthcare reporting methods were revised to more accurately reflect the consent decree requirements for 5.2 – 5.4.
- A staff member is now contacting persons who have been on the waitlist for more than 60 days to ascertain if they wish to stay on the waitlist. The staff has been unable to reach the majority of them. When the staff reaches them he asks if they wish to stay on the waitlist or if they would like assistance in getting services now. He has been able to get all of those who wish assistance in to services. The list is then reviewed to see if any persons have gotten services or have been removed from the list. If they are still waiting, a letter is sent with a two week wait period for response to that letter. The person is administratively closed if there is no response from the letter.
- The Niatx team has been working with The Muskie Institute on MHRT/C workforce development.
- Four new agencies have been asked to join the Niatx collaborative. There will be a Niatx training webinar 10/27/14.

Identified Need: A,B

SAMHS Quality Management Plan 2015-20120 A team in the Data and Quality Management division is undertaking the development of a new SAMHS comprehensive quality management plan for 2015-2020 . 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 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. There has been significant progress on the plan this quarter. The expectation is to have a draft complete by the end of November.
Identified Need: A,B,C,D,E,F,G,H,I,J,K,L,M

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

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

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 4
Apr, May, Jun, 2014

Purpose of Report:

This report examines:

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

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

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

Data collection and reporting:

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

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

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

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

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 4

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

CSN	Counties	Distinct People
CSN 1	Aroostook	421
CSN 2	Hancock, Penobscot, Piscataquis & Washington	1,531
CSN 3	Kennebec & Somerset	2,036
CSN 4	Knox, Lincoln, Sagadahoc & Waldo	876
CSN 5	Androscoggin, Franklin & Oxford	1,957
CSN 6	Cumberland	1,897
CSN 7	York	806
Not Assigned	No legal address	323
Statewide		9,847

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

	2014 Q1			2014 Q2			2014 Q3			2014 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	134	406	33.0%	141	427	33.0%	129	379	34.0%	132	421	31.4%
CSN 2	472	1,896	24.9%	473	1,831	25.8%	427	1,618	26.4%	376	1,531	24.6%
CSN 3	386	2,087	18.5%	364	2,090	17.4%	300	1,814	16.5%	325	2,036	16.0%
CSN 4	212	795	26.7%	202	849	23.8%	183	751	24.4%	237	876	27.1%
CSN 5	636	2,011	31.6%	618	2,080	29.7%	572	1,828	31.3%	586	1,957	29.9%
CSN 6	654	2,095	31.2%	660	2,056	32.1%	574	1,835	31.3%	624	1,897	32.9%
CSN 7	161	530	30.4%	208	597	34.8%	203	554	36.6%	325	806	40.3%
N/A	123	427	28.8%	107	431	24.8%	95	353	26.9%	91	323	28.2%
Total	2,778	10,247	27.1%	2,773	10,361	26.8%	2,483	9,132	27.2%	2,696	9,847	27.4%

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 4

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

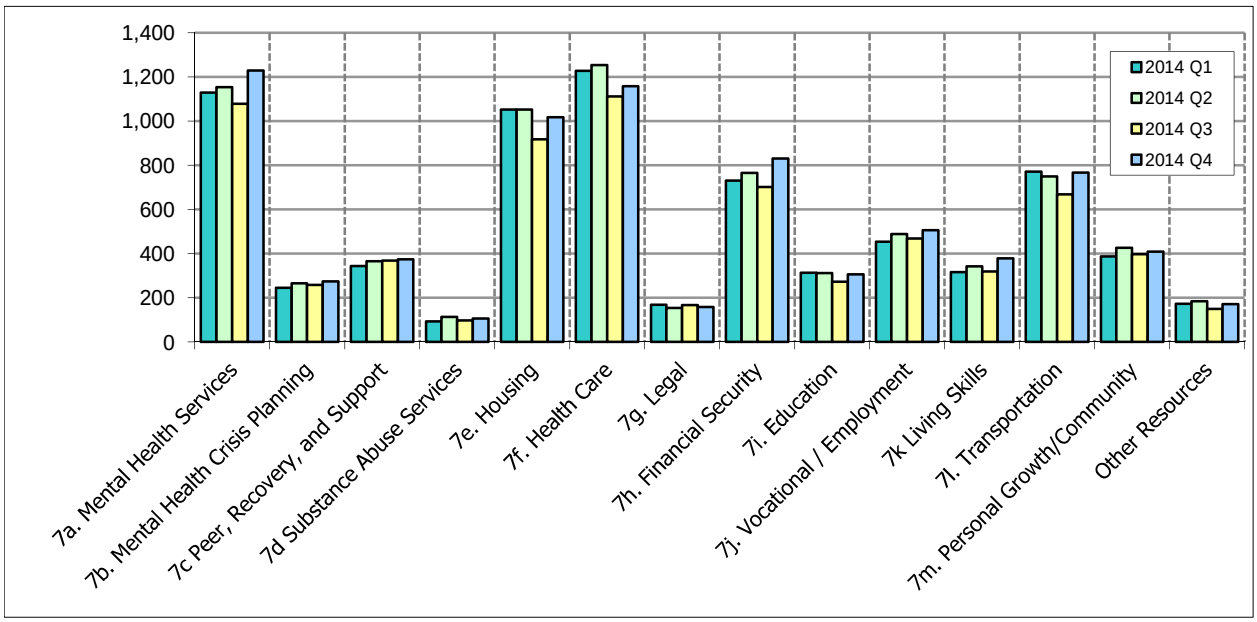


Table 3: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2014 Q1	2014 Q2	2014 Q3	2014 Q4
7a. Mental Health Services	1,129	1,153	1,079	1,229
7b. Mental Health Crisis Planning	245	266	258	274
7c Peer, Recovery, and Support	344	365	369	375
7d Substance Abuse Services	93	113	98	106
7e. Housing	1,052	1,053	918	1,017
7f. Health Care	1,227	1,254	1,112	1,158
7g. Legal	169	154	167	158
7h. Financial Security	730	766	701	830
7i. Education	314	312	273	306
7j. Vocational / Employment	454	489	469	506
7k Living Skills	317	343	319	378
7l. Transportation	771	749	669	767
7m. Personal Growth/Community	387	427	398	409
Other Resources	173	184	150	171
Total Statewide Unmet Needs	7,551	7,793	7,158	7,848

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

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

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	10,247	10,361	9,132	9,847
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	64	79	69	96
7a-iii Dialectical Behavioral Therapy	40	44	47	63
7a-iv Family Psycho-Educational Treatment	18	11	11	12
7a-v Group Counseling	44	53	41	51
7a-vi Individual Counseling	491	520	460	530
7a-vii Inpatient Psychiatric Facility	6	6	7	6
7a-viii Intensive Case Management	32	37	36	54
7a-x Psychiatric Medication Management	498	482	477	513
Total Unmet Resource Needs	1,129	1,153	1,079	1,229
Distinct Clients with Unmet Resource Needs	909	945	885	993
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	188	212	204	215
7b-ii Mental Health Advance Directives	57	54	54	59
Total Unmet Resource Needs	245	266	258	274
Distinct Clients with Unmet Resource Needs	224	244	238	248
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	41	40	45	48
7c-ii Recovery Workbook Group	7	5	7	5
7c-iii Social Club	114	121	124	131
7c-iv Peer-Run Trauma Recovery Group	32	42	35	29
7c-v Wellness Recovery and Action Planning	32	35	35	31
7c-vi Family Support	118	122	123	131
Total Unmet Resource Needs	344	365	369	375
Distinct Clients with Unmet Resource Needs	279	293	288	296
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	76	97	87	88
7d-ii Residential Treatment Substance Abuse Services	17	16	11	18
Total Unmet Resource Needs	93	113	98	106
Distinct Clients with Unmet Resource Needs	90	110	97	103

Report Run: Oct 14, 2014

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

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

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	10,247	10,361	9,132	9,847
7e. Housing				
7e-i Supported Apartment	114	127	105	119
7e-ii Community Residential Facility	41	33	28	38
7e-iii Residential Treatment Facility (group home)	13	17	14	18
7e-iv Assisted Living Facility	49	56	48	55
7e-v Nursing Home	6	4	5	3
7e-vi Residential Crisis Unit	1	2	2	2
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	828	814	716	782
Total Unmet Resource Needs	1,052	1,053	918	1,017
Distinct Clients with Unmet Resource Needs	961	962	840	924
7f. Health Care				
7f-i Dental Services	633	638	560	600
7f-ii Eye Care Services	234	251	230	220
7f-iii Hearing Services	53	50	41	41
7f-iv Physical Therapy	42	41	39	44
7f-v Physician/Medical Services	265	274	242	253
Total Unmet Resource Needs	1,227	1,254	1,112	1,158
Distinct Clients with Unmet Resource Needs	927	936	821	863
7g. Legal				
7g-i Advocate	113	109	120	110
7g-ii Guardian (private)	41	34	38	34
7g-iii Guardian (public)	15	11	9	14
Total Unmet Resource Needs	169	154	167	158
Distinct Clients with Unmet Resource Needs	159	145	160	148
7h. Financial Security				
7h-i Assistance with Managing Money	409	413	376	479
7h-ii Assistance with Securing Public Benefits	270	304	275	308
7h-iii Representative Payee	51	49	50	43
Total Unmet Resource Needs	730	766	701	830
Distinct Clients with Unmet Resource Needs	645	671	604	718

Report Run: Oct 14, 2014

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

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

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	10,247	10,361	9,132	9,847
7i. Education				
7i-i Adult Education (other than GED)	66	67	52	62
7i-ii GED	89	77	81	85
7i-iii Literacy Assistance	27	27	27	31
7i-iv Post High School Education	115	120	95	114
7i-v Tuition Reimbursement	17	21	18	14
Total Unmet Resource Needs	314	312	273	306
Distinct Clients with Unmet Resource Needs	297	291	246	270
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	37	43	52	37
7j-ii Club House and/or Peer Vocational Support	38	44	42	42
7j-iii Competitive Employment (no supports)	68	73	73	100
7j-iv Supported Employment	48	54	52	58
7j-v Vocational Rehabilitation	263	275	250	269
Total Unmet Resource Needs	454	489	469	506
Distinct Clients with Unmet Resource Needs	396	421	392	428
7k. Living Skills				
7k-i Daily Living Support Services	217	224	208	244
7k-ii Day Support Services	24	26	23	31
7k-iii Occupational Therapy	14	11	9	12
7k-iv Skills Development Services	62	82	79	91
Total Unmet Resource Needs	317	343	319	378
Distinct Clients with Unmet Resource Needs	294	313	290	331
7l. Transportation				
7l-i Transportation to ISP-Identified Services	383	390	354	384
7-ii Transportation to Other ISP Activities	205	196	158	196
7-iii After Hours Transportation	183	163	157	187
Total Unmet Resource Needs	771	749	669	767
Distinct Clients with Unmet Resource Needs	532	537	478	529
7m. Personal Growth/Community				
7m-i Avocational Activities	27	31	30	20

Report Run: Oct 14, 2014

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

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

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	10,247	10,361	9,132	9,847
7m. Personal Growth/Community				
7m-iii Social Activities	309	337	330	342
7m-iv Spiritual Activities	62	66	59	60
Total Unmet Resource Needs	533	592	576	573
Distinct Clients with Unmet Resource Needs	387	427	398	409
Other Resources				
Other Resources	173	184	150	171
Total Unmet Resource Needs	173	184	150	171
Distinct Clients with Unmet Resource Needs	173	184	150	171
Statewide Totals				
Total Unmet Resource Needs	7,551	7,793	7,158	7,848
Distinct Clients With any Unmet Resource Need	2,778	2,773	2,483	2,696
Distinct Clients with a RDS	10,247	10,361	9,132	9,847

Report Run: Oct 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 4

CSN 1 - Aroostook

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

2014 Q1			2014 Q2			2014 Q3			2014 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
134	406	33.0%	141	427	33.0%	129	379	34.0%	132	421	31.4%

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

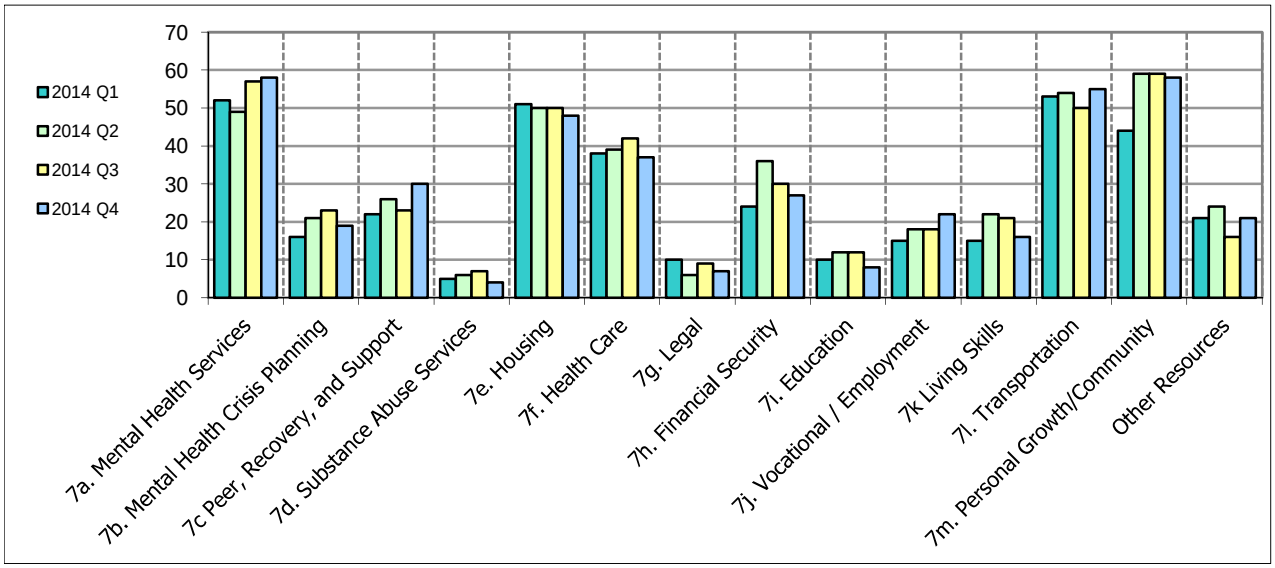


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2014 Q1	2014 Q2	2014 Q3	2014 Q4
7a. Mental Health Services	52	49	57	58
7b. Mental Health Crisis Planning	16	21	23	19
7c Peer, Recovery, and Support	22	26	23	30
7d. Substance Abuse Services	5	6	7	4
7e. Housing	51	50	50	48
7f. Health Care	38	39	42	37
7g. Legal	10	6	9	7
7h. Financial Security	24	36	30	27
7i. Education	10	12	12	8
7j. Vocational / Employment	15	18	18	22
7k Living Skills	15	22	21	16
7l. Transportation	53	54	50	55
7m. Personal Growth/Community	44	59	59	58
Other Resources	21	24	16	21
Total CSN 1 Unmet Needs	376	422	417	410

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	406	427	379	421
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	0	0	2	1
7a-iii Dialectical Behavioral Therapy	4	4	3	6
7a-iv Family Psycho-Educational Treatment	0	0	0	1
7a-v Group Counseling	6	4	4	6
7a-vi Individual Counseling	13	15	16	15
7a-vii Inpatient Psychiatric Facility	1	0	0	0
7a-viii Intensive Case Management	0	1	1	2
7a-x Psychiatric Medication Management	28	25	31	27
Total Unmet Resource Needs	52	49	57	58
Distinct Clients with Unmet Resource Needs	44	40	48	47
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	11	17	19	16
7b-ii Mental Health Advance Directives	5	4	4	3
Total Unmet Resource Needs	16	21	23	19
Distinct Clients with Unmet Resource Needs	13	19	21	17
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	1	1	2
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	16	20	18	19
7c-iv Peer-Run Trauma Recovery Group	1	2	2	3
7c-v Wellness Recovery and Action Planning	2	2	2	2
7c-vi Family Support	2	1	0	4
Total Unmet Resource Needs	22	26	23	30
Distinct Clients with Unmet Resource Needs	21	24	21	24
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	5	6	7	4
7d-ii Residential Treatment Substance Abuse Services	0	0	0	0
Total Unmet Resource Needs	5	6	7	4
Distinct Clients with Unmet Resource Needs	5	6	7	4

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	406	427	379	421
7e. Housing				
7e-i Supported Apartment	10	14	11	10
7e-ii Community Residential Facility	2	1	2	2
7e-iii Residential Treatment Facility (group home)	3	2	2	2
7e-iv Assisted Living Facility	4	6	5	5
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	32	27	30	29
Total Unmet Resource Needs	51	50	50	48
Distinct Clients with Unmet Resource Needs	41	39	42	42
7f. Health Care				
7f-i Dental Services	17	16	20	16
7f-ii Eye Care Services	7	7	10	8
7f-iii Hearing Services	1	2	0	0
7f-iv Physical Therapy	1	0	3	2
7f-v Physician/Medical Services	12	14	9	11
Total Unmet Resource Needs	38	39	42	37
Distinct Clients with Unmet Resource Needs	30	29	29	28
7g. Legal				
7g-i Advocate	6	4	6	5
7g-ii Guardian (private)	3	1	2	1
7g-iii Guardian (public)	1	1	1	1
Total Unmet Resource Needs	10	6	9	7
Distinct Clients with Unmet Resource Needs	9	6	9	7
7h. Financial Security				
7h-i Assistance with Managing Money	13	15	13	15
7h-ii Assistance with Securing Public Benefits	11	21	16	12
7h-iii Representative Payee	0	0	1	0
Total Unmet Resource Needs	24	36	30	27
Distinct Clients with Unmet Resource Needs	24	33	26	25

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	406	427	379	421
7i. Education				
7i-i Adult Education (other than GED)	0	0	0	0
7i-ii GED	4	4	5	3
7i-iii Literacy Assistance	1	2	1	1
7i-iv Post High School Education	4	5	5	4
7i-v Tuition Reimbursement	1	1	1	0
Total Unmet Resource Needs	10	12	12	8
Distinct Clients with Unmet Resource Needs	10	12	12	8
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	2	2	3	2
7j-ii Club House and/or Peer Vocational Support	1	1	0	1
7j-iii Competitive Employment (no supports)	0	1	1	2
7j-iv Supported Employment	3	6	5	7
7j-v Vocational Rehabilitation	9	8	9	10
Total Unmet Resource Needs	15	18	18	22
Distinct Clients with Unmet Resource Needs	13	15	15	16
7k. Living Skills				
7k-i Daily Living Support Services	6	10	8	7
7k-ii Day Support Services	0	0	0	0
7k-iii Occupational Therapy	0	0	1	0
7k-iv Skills Development Services	9	12	12	9
Total Unmet Resource Needs	15	22	21	16
Distinct Clients with Unmet Resource Needs	13	19	18	14
7l. Transportation				
7l-i Transportation to ISP-Identified Services	28	29	26	25
7-ii Transportation to Other ISP Activities	10	11	9	11
7-iii After Hours Transportation	15	14	15	19
Total Unmet Resource Needs	53	54	50	55
Distinct Clients with Unmet Resource Needs	37	38	35	35
7m. Personal Growth/Community				
7m-i Avocational Activities	2	4	5	3

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	406	427	379	421
7m. Personal Growth/Community				
7m-ii Recreation Activities	9	13	16	15
7m-iii Social Activities	29	37	35	36
7m-iv Spiritual Activities	4	5	3	4
Total Unmet Resource Needs	44	59	59	58
Distinct Clients with Unmet Resource Needs	33	45	40	42
Other Resources				
Other Resources	21	24	16	21
Total Unmet Resource Needs	21	24	16	21
Distinct Clients with Unmet Resource Needs	21	24	16	21
CSN 1 Totals				
Total Unmet Resource Needs	376	422	417	410
Distinct Clients With any Unmet Resource Need	134	141	129	132
Distinct Clients with a RDS	406	427	379	421

Report Run: Oct 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q3

CSN 2 - Hancock, Washington, Penobscot, Piscataquis

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

2014 Q1			2014 Q2			2014 Q3			2014 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
472	1,896	24.9%	473	1,831	25.8%	427	1,618	26.4%	376	1,531	24.6%

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

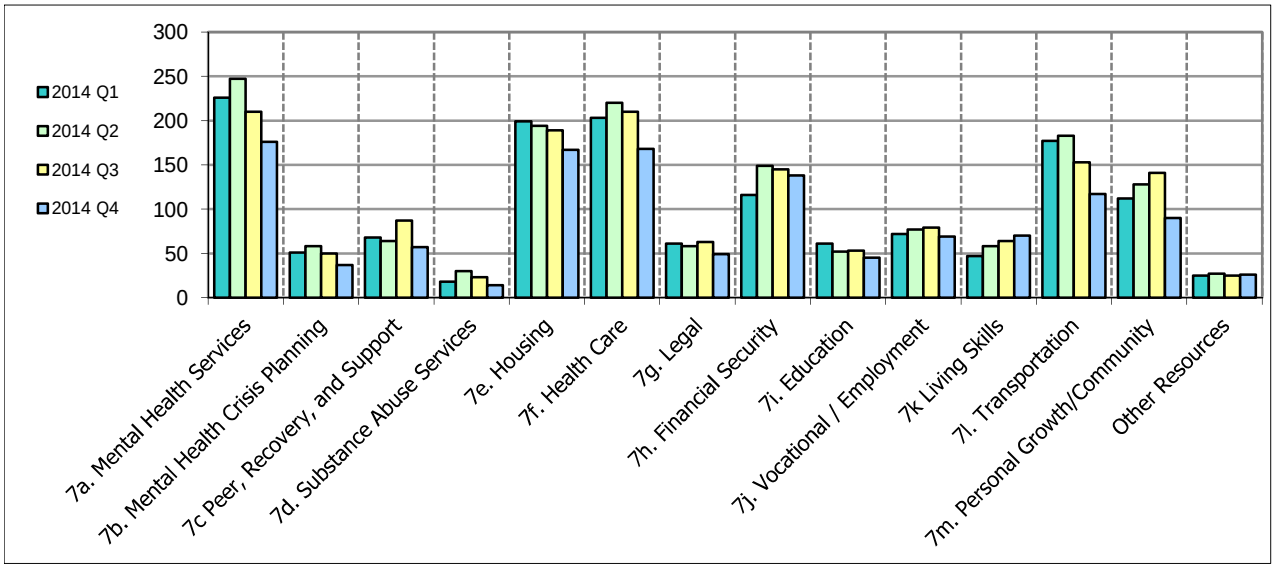


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2014 Q1	2014 Q2	2014 Q3	2014 Q4
7a. Mental Health Services	226	247	210	176
7b. Mental Health Crisis Planning	51	58	50	37
7c Peer, Recovery, and Support	68	64	87	57
7d. Substance Abuse Services	18	30	23	14
7e. Housing	199	194	189	167
7f. Health Care	203	220	210	168
7g. Legal	61	58	63	49
7h. Financial Security	116	149	145	138
7i. Education	61	52	53	45
7j. Vocational / Employment	72	77	79	69
7k Living Skills	47	58	64	70
7l. Transportation	177	183	153	117
7m. Personal Growth/Community	112	128	141	90
Other Resources	25	27	25	26
Total CSN 2 Unmet Needs	1,436	1,545	1,492	1,223

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	1,896	1,831	1,618	1,531
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	3	7	5	1
7a-iii Dialectical Behavioral Therapy	3	1	3	0
7a-iv Family Psycho-Educational Treatment	6	4	3	4
7a-v Group Counseling	7	13	13	11
7a-vi Individual Counseling	108	124	94	84
7a-vii Inpatient Psychiatric Facility	1	2	2	0
7a-viii Intensive Case Management	5	8	9	7
7a-x Psychiatric Medication Management	93	88	81	69
Total Unmet Resource Needs	226	247	210	176
Distinct Clients with Unmet Resource Needs	159	175	146	119
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	44	52	41	28
7b-ii Mental Health Advance Directives	7	6	9	9
Total Unmet Resource Needs	51	58	50	37
Distinct Clients with Unmet Resource Needs	47	54	46	33
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	6	5	8	4
7c-ii Recovery Workbook Group	1	0	1	1
7c-iii Social Club	17	15	24	14
7c-iv Peer-Run Trauma Recovery Group	9	10	9	5
7c-v Wellness Recovery and Action Planning	9	9	11	5
7c-vi Family Support	26	25	34	28
Total Unmet Resource Needs	68	64	87	57
Distinct Clients with Unmet Resource Needs	48	51	61	39
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	16	27	21	11
7d-ii Residential Treatment Substance Abuse Services	2	3	2	3
Total Unmet Resource Needs	18	30	23	14
Distinct Clients with Unmet Resource Needs	18	28	23	13

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	1,896	1,831	1,618	1,531
7e. Housing				
7e-i Supported Apartment	27	21	15	16
7e-ii Community Residential Facility	6	4	6	3
7e-iii Residential Treatment Facility (group home)	0	0	1	0
7e-iv Assisted Living Facility	9	13	12	8
7e-v Nursing Home	0	0	1	0
7e-vi Residential Crisis Unit	0	1	2	2
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	157	155	152	138
Total Unmet Resource Needs	199	194	189	167
Distinct Clients with Unmet Resource Needs	186	181	173	154
7f. Health Care				
7f-i Dental Services	84	90	84	71
7f-ii Eye Care Services	44	46	53	39
7f-iii Hearing Services	7	7	7	7
7f-iv Physical Therapy	9	11	11	10
7f-v Physician/Medical Services	59	66	55	41
Total Unmet Resource Needs	203	220	210	168
Distinct Clients with Unmet Resource Needs	145	159	148	117
7g. Legal				
7g-i Advocate	27	31	31	23
7g-ii Guardian (private)	30	25	29	23
7g-iii Guardian (public)	4	2	3	3
Total Unmet Resource Needs	61	58	63	49
Distinct Clients with Unmet Resource Needs	57	52	59	46
7h. Financial Security				
7h-i Assistance with Managing Money	68	79	84	86
7h-ii Assistance with Securing Public Benefits	40	60	51	47
7h-iii Representative Payee	8	10	10	5
Total Unmet Resource Needs	116	149	145	138
Distinct Clients with Unmet Resource Needs	102	120	119	108

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	1,896	1,831	1,618	1,531
7i. Education				
7i-i Adult Education (other than GED)	10	7	8	8
7i-ii GED	8	5	6	6
7i-iii Literacy Assistance	4	3	2	0
7i-iv Post High School Education	29	29	29	28
7i-v Tuition Reimbursement	10	8	8	3
Total Unmet Resource Needs	61	52	53	45
Distinct Clients with Unmet Resource Needs	57	49	48	42
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	8	11	10	6
7j-ii Club House and/or Peer Vocational Support	3	4	10	4
7j-iii Competitive Employment (no supports)	22	21	17	19
7j-iv Supported Employment	7	7	9	12
7j-v Vocational Rehabilitation	32	34	33	28
Total Unmet Resource Needs	72	77	79	69
Distinct Clients with Unmet Resource Needs	59	62	63	57
7k. Living Skills				
7k-i Daily Living Support Services	32	34	36	39
7k-ii Day Support Services	3	3	3	3
7k-iii Occupational Therapy	3	2	2	2
7k-iv Skills Development Services	9	19	23	26
Total Unmet Resource Needs	47	58	64	70
Distinct Clients with Unmet Resource Needs	41	51	52	57
7l. Transportation				
7l-i Transportation to ISP-Identified Services	84	92	81	53
7-ii Transportation to Other ISP Activities	46	43	34	29
7-iii After Hours Transportation	47	48	38	35
Total Unmet Resource Needs	177	183	153	117
Distinct Clients with Unmet Resource Needs	110	120	101	73
7m. Personal Growth/Community				
7m-i Avocational Activities	10	10	11	3

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 2

ancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	1,896	1,831	1,618	1,531
7m. Personal Growth/Community				
7m-ii Recreation Activities	31	41	47	26
7m-iii Social Activities	58	63	71	55
7m-iv Spiritual Activities	13	14	12	6
Total Unmet Resource Needs	112	128	141	90
Distinct Clients with Unmet Resource Needs	74	85	89	62
Other Resources				
Other Resources	25	27	25	26
Total Unmet Resource Needs	25	27	25	26
Distinct Clients with Unmet Resource Needs	25	27	25	26
CSN 2 Totals				
Total Unmet Resource Needs	1,436	1,545	1,492	1,223
Distinct Clients With any Unmet Resource Need	472	473	427	376
Distinct Clients with a RDS	1,896	1,831	1,618	1,531

Report Run: Oct 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 4

CSN 3 - Kennebec and Somerset

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

2014 Q1			2014 Q2			2014 Q3			2014 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
386	2,087	18.5%	364	2,090	17.4%	300	1,814	16.5%	325	2,036	16.0%

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

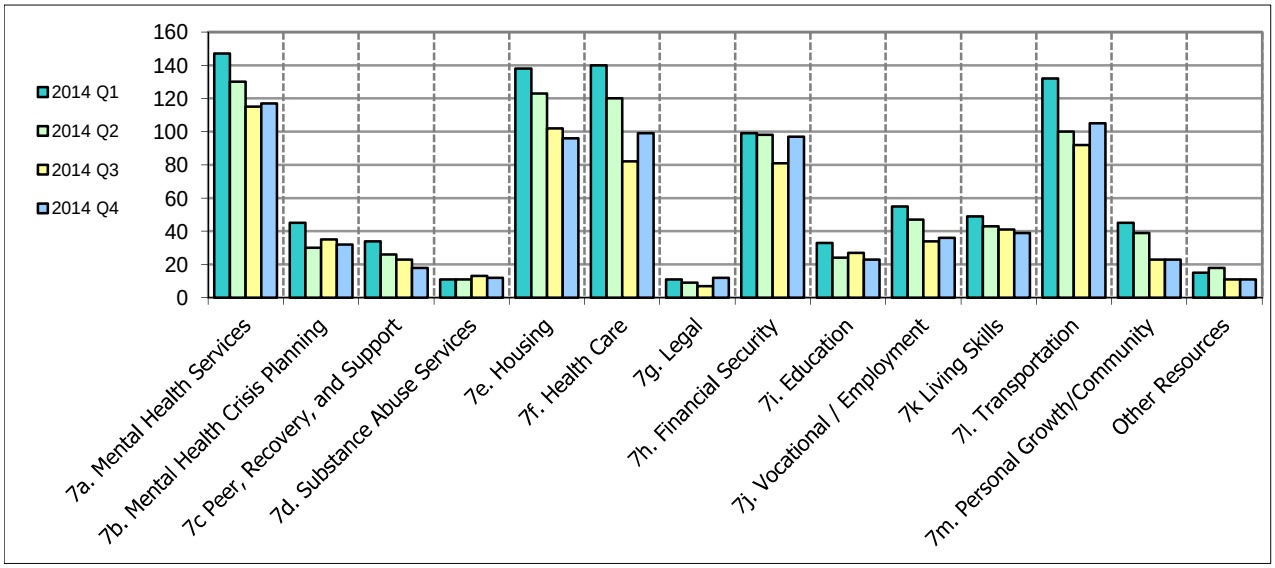


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2014 Q1	2014 Q2	2014 Q3	2014 Q4
7a. Mental Health Services	147	130	115	117
7b. Mental Health Crisis Planning	45	30	35	32
7c Peer, Recovery, and Support	34	26	23	18
7d. Substance Abuse Services	11	11	13	12
7e. Housing	138	123	102	96
7f. Health Care	140	120	82	99
7g. Legal	11	9	7	12
7h. Financial Security	99	98	81	97
7i. Education	33	24	27	23
7j. Vocational / Employment	55	47	34	36
7k Living Skills	49	43	41	39
7l. Transportation	132	100	92	105
7m. Personal Growth/Community	45	39	23	23
Other Resources	15	18	11	11
Total CSN 3 Unmet Needs	954	818	686	720

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,087	2,090	1,814	2,036
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	4	3	2	2
7a-iii Dialectical Behavioral Therapy	2	2	2	3
7a-iv Family Psycho-Educational Treatment	1	1	1	0
7a-v Group Counseling	5	1	1	4
7a-vi Individual Counseling	62	49	47	46
7a-vii Inpatient Psychiatric Facility	1	1	2	2
7a-viii Intensive Case Management	2	1	0	3
7a-x Psychiatric Medication Management	70	72	60	57
Total Unmet Resource Needs	147	130	115	117
Distinct Clients with Unmet Resource Needs	107	97	85	91
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	31	21	26	24
7b-ii Mental Health Advance Directives	14	9	9	8
Total Unmet Resource Needs	45	30	35	32
Distinct Clients with Unmet Resource Needs	39	26	30	27
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	3	4	3	4
7c-ii Recovery Workbook Group	2	0	0	0
7c-iii Social Club	9	5	3	2
7c-iv Peer-Run Trauma Recovery Group	2	2	1	2
7c-v Wellness Recovery and Action Planning	2	2	3	1
7c-vi Family Support	16	13	13	9
Total Unmet Resource Needs	34	26	23	18
Distinct Clients with Unmet Resource Needs	29	21	21	16
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	8	9	10	9
7d-ii Residential Treatment Substance Abuse Services	3	2	3	3
Total Unmet Resource Needs	11	11	13	12
Distinct Clients with Unmet Resource Needs	11	11	12	11

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,087	2,090	1,814	2,036
7e. Housing				
7e-i Supported Apartment	7	9	8	6
7e-ii Community Residential Facility	9	4	2	3
7e-iii Residential Treatment Facility (group home)	1	1	0	2
7e-iv Assisted Living Facility	2	3	5	3
7e-v Nursing Home	0	0	1	2
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	119	106	86	80
Total Unmet Resource Needs	138	123	102	96
Distinct Clients with Unmet Resource Needs	132	119	97	91
7f. Health Care				
7f-i Dental Services	67	60	36	50
7f-ii Eye Care Services	28	25	17	16
7f-iii Hearing Services	10	8	5	6
7f-iv Physical Therapy	4	2	1	0
7f-v Physician/Medical Services	31	25	23	27
Total Unmet Resource Needs	140	120	82	99
Distinct Clients with Unmet Resource Needs	113	101	69	83
7g. Legal				
7g-i Advocate	6	5	4	6
7g-ii Guardian (private)	1	1	2	3
7g-iii Guardian (public)	4	3	1	3
Total Unmet Resource Needs	11	9	7	12
Distinct Clients with Unmet Resource Needs	9	7	6	8
7h. Financial Security				
7h-i Assistance with Managing Money	43	42	36	45
7h-ii Assistance with Securing Public Benefits	46	49	36	45
7h-iii Representative Payee	10	7	9	7
Total Unmet Resource Needs	99	98	81	97
Distinct Clients with Unmet Resource Needs	93	92	70	84

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,087	2,090	1,814	2,036
7i. Education				
7i-i Adult Education (other than GED)	5	5	3	4
7i-ii GED	9	8	9	5
7i-iii Literacy Assistance	7	3	4	5
7i-iv Post High School Education	10	6	9	7
7i-v Tuition Reimbursement	2	2	2	2
Total Unmet Resource Needs	33	24	27	23
Distinct Clients with Unmet Resource Needs	30	22	26	20
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	3	2	2	3
7j-ii Club House and/or Peer Vocational Support	9	10	5	7
7j-iii Competitive Employment (no supports)	3	3	3	2
7j-iv Supported Employment	4	3	2	2
7j-v Vocational Rehabilitation	36	29	22	22
Total Unmet Resource Needs	55	47	34	36
Distinct Clients with Unmet Resource Needs	48	44	32	32
7k. Living Skills				
7k-i Daily Living Support Services	40	34	32	27
7k-ii Day Support Services	1	2	2	4
7k-iii Occupational Therapy	1	0	0	0
7k-iv Skills Development Services	7	7	7	8
Total Unmet Resource Needs	49	43	41	39
Distinct Clients with Unmet Resource Needs	48	42	40	37
7l. Transportation				
7l-i Transportation to ISP-Identified Services	82	65	62	72
7-ii Transportation to Other ISP Activities	29	20	17	21
7-iii After Hours Transportation	21	15	13	12
Total Unmet Resource Needs	132	100	92	105
Distinct Clients with Unmet Resource Needs	98	82	73	81
7m. Personal Growth/Community				
7m-i Avocational Activities	0	1	1	2

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,087	2,090	1,814	2,036
7m. Personal Growth/Community				
7m-ii Recreation Activities	7	5	2	5
7m-iii Social Activities	36	31	20	15
7m-iv Spiritual Activities	2	2	0	1
Total Unmet Resource Needs	45	39	23	23
Distinct Clients with Unmet Resource Needs	39	33	21	17
Other Resources				
Other Resources	15	18	11	11
Total Unmet Resource Needs	15	18	11	11
Distinct Clients with Unmet Resource Needs	15	18	11	11
CSN 3 Totals				
Total Unmet Resource Needs	954	818	686	720
Distinct Clients With any Unmet Resource Need	386	364	300	325
Distinct Clients with a RDS	2,087	2,090	1,814	2,036

Report Run: Oct 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 4

CSN 4 - Knox, Lincoln, Sagadahoc, Waldo

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

2014 Q1			2014 Q2			2014 Q3			2014 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
212	795	26.7%	202	849	23.8%	183	751	24.4%	237	876	27.1%

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

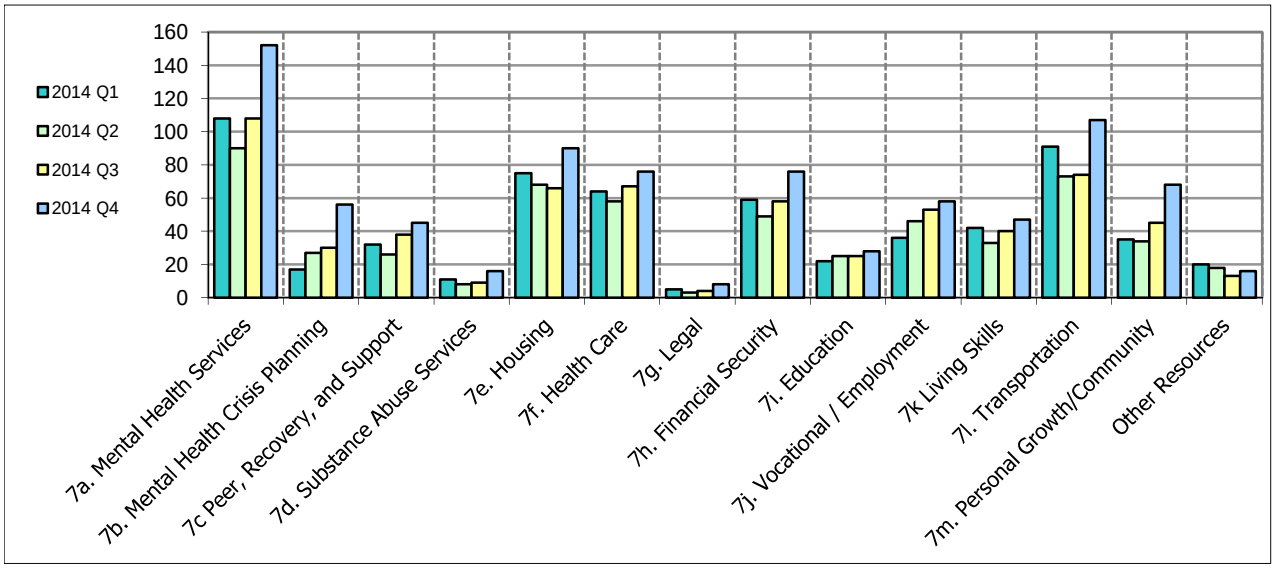


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2014 Q1	2014 Q2	2014 Q3	2014 Q4
7a. Mental Health Services	108	90	108	152
7b. Mental Health Crisis Planning	17	27	30	56
7c Peer, Recovery, and Support	32	26	38	45
7d. Substance Abuse Services	11	8	9	16
7e. Housing	75	68	66	90
7f. Health Care	64	58	67	76
7g. Legal	5	3	4	8
7h. Financial Security	59	49	58	76
7i. Education	22	25	25	28
7j. Vocational / Employment	36	46	53	58
7k Living Skills	42	33	40	47
7l. Transportation	91	73	74	107
7m. Personal Growth/Community	35	34	45	68
Other Resources	20	18	13	16
Total CSN 4 Unmet Needs	617	558	630	843

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	795	849	751	876
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	10	12	19
7a-iii Dialectical Behavioral Therapy	3	0	2	1
7a-iv Family Psycho-Educational Treatment	1	1	1	3
7a-v Group Counseling	3	4	3	5
7a-vi Individual Counseling	47	36	45	75
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	3	3	3	3
7a-x Psychiatric Medication Management	49	36	42	46
Total Unmet Resource Needs	108	90	108	152
Distinct Clients with Unmet Resource Needs	86	72	79	115
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	13	21	29	46
7b-ii Mental Health Advance Directives	4	6	1	10
Total Unmet Resource Needs	17	27	30	56
Distinct Clients with Unmet Resource Needs	16	24	30	51
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	8	5	5	7
7c-ii Recovery Workbook Group	1	1	1	0
7c-iii Social Club	5	6	11	15
7c-iv Peer-Run Trauma Recovery Group	2	1	1	0
7c-v Wellness Recovery and Action Planning	2	3	2	3
7c-vi Family Support	14	10	18	20
Total Unmet Resource Needs	32	26	38	45
Distinct Clients with Unmet Resource Needs	27	18	29	37
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	10	8	9	16
7d-ii Residential Treatment Substance Abuse Services	1	0	0	0
Total Unmet Resource Needs	11	8	9	16
Distinct Clients with Unmet Resource Needs	11	8	9	16

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	795	849	751	876
7e. Housing				
7e-i Supported Apartment	9	9	11	16
7e-ii Community Residential Facility	3	3	2	3
7e-iii Residential Treatment Facility (group home)	4	4	3	4
7e-iv Assisted Living Facility	5	5	2	5
7e-v Nursing Home	2	1	0	0
7e-vi Residential Crisis Unit	1	1	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	51	45	48	62
Total Unmet Resource Needs	75	68	66	90
Distinct Clients with Unmet Resource Needs	64	57	60	77
7f. Health Care				
7f-i Dental Services	36	35	34	43
7f-ii Eye Care Services	11	12	13	11
7f-iii Hearing Services	3	2	2	2
7f-iv Physical Therapy	1	0	3	1
7f-v Physician/Medical Services	13	9	15	19
Total Unmet Resource Needs	64	58	67	76
Distinct Clients with Unmet Resource Needs	50	46	53	62
7g. Legal				
7g-i Advocate	3	2	3	7
7g-ii Guardian (private)	2	1	1	1
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	5	3	4	8
Distinct Clients with Unmet Resource Needs	5	3	4	7
7h. Financial Security				
7h-i Assistance with Managing Money	32	28	29	45
7h-ii Assistance with Securing Public Benefits	20	18	26	27
7h-iii Representative Payee	7	3	3	4
Total Unmet Resource Needs	59	49	58	76
Distinct Clients with Unmet Resource Needs	45	43	47	63

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	795	849	751	876
7i. Education				
7i-i Adult Education (other than GED)	3	2	2	4
7i-ii GED	8	8	11	10
7i-iii Literacy Assistance	0	0	1	2
7i-iv Post High School Education	11	14	11	12
7i-v Tuition Reimbursement	0	1	0	0
Total Unmet Resource Needs	22	25	25	28
Distinct Clients with Unmet Resource Needs	22	23	24	26
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	4	6	7	3
7j-ii Club House and/or Peer Vocational Support	2	1	1	1
7j-iii Competitive Employment (no supports)	2	3	7	11
7j-iv Supported Employment	6	5	2	5
7j-v Vocational Rehabilitation	22	31	36	38
Total Unmet Resource Needs	36	46	53	58
Distinct Clients with Unmet Resource Needs	29	37	45	48
7k. Living Skills				
7k-i Daily Living Support Services	29	25	32	40
7k-ii Day Support Services	1	1	1	1
7k-iii Occupational Therapy	1	1	0	0
7k-iv Skills Development Services	11	6	7	6
Total Unmet Resource Needs	42	33	40	47
Distinct Clients with Unmet Resource Needs	37	30	36	43
7l. Transportation				
7l-i Transportation to ISP-Identified Services	49	40	42	62
7-ii Transportation to Other ISP Activities	28	20	22	32
7-iii After Hours Transportation	14	13	10	13
Total Unmet Resource Needs	91	73	74	107
Distinct Clients with Unmet Resource Needs	56	47	49	68
7m. Personal Growth/Community				
7m-i Avocational Activities	3	2	1	0

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	795	849	751	876
7m. Personal Growth/Community				
7m-ii Recreation Activities	9	9	14	16
7m-iii Social Activities	21	21	27	41
7m-iv Spiritual Activities	2	2	3	11
Total Unmet Resource Needs	35	34	45	68
Distinct Clients with Unmet Resource Needs	27	25	32	45
Other Resources				
Other Resources	20	18	13	16
Total Unmet Resource Needs	20	18	13	16
Distinct Clients with Unmet Resource Needs	20	18	13	16
CSN 4 Totals				
Total Unmet Resource Needs	617	558	630	843
Distinct Clients With any Unmet Resource Need	212	202	183	237
Distinct Clients with a RDS	795	849	751	876

Report Run: Oct 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 4

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

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

2014 Q1			2014 Q2			2014 Q3			2014 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
636	2,011	31.6%	618	2,080	29.7%	572	1,828	31.3%	586	1,957	29.9%

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

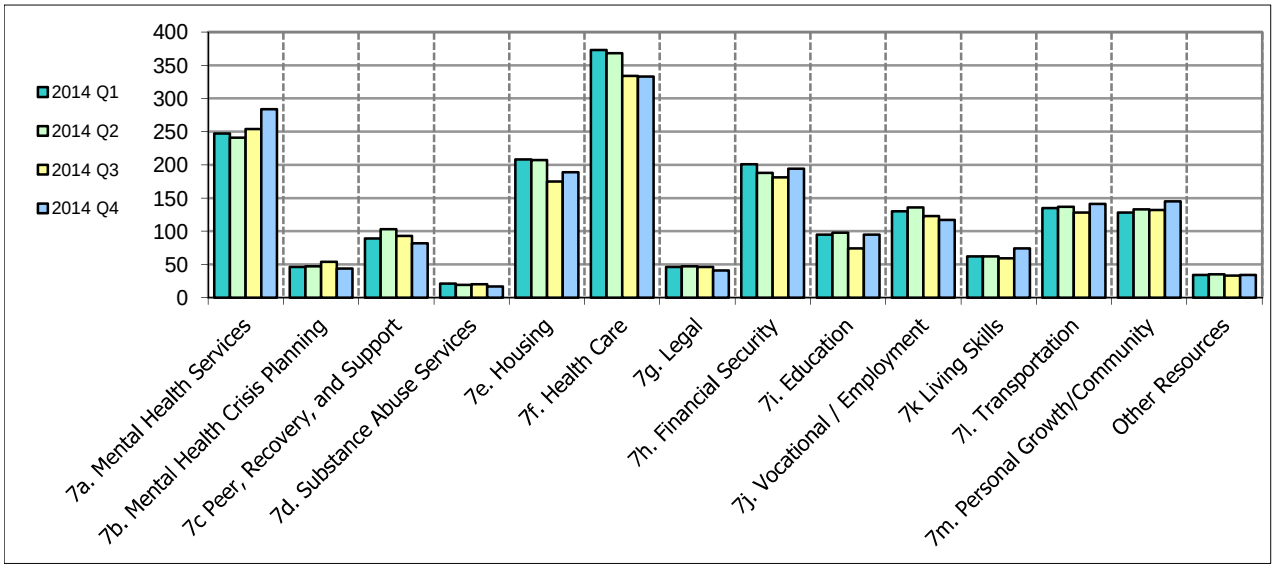


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2014 Q1	2014 Q2	2014 Q3	2014 Q4
7a. Mental Health Services	247	241	254	284
7b. Mental Health Crisis Planning	46	47	54	44
7c Peer, Recovery, and Support	89	103	93	82
7d. Substance Abuse Services	21	19	20	17
7e. Housing	208	207	175	189
7f. Health Care	373	368	334	333
7g. Legal	46	47	46	41
7h. Financial Security	201	188	181	194
7i. Education	95	98	74	95
7j. Vocational / Employment	130	136	123	117
7k Living Skills	62	62	59	74
7l. Transportation	135	137	128	141
7m. Personal Growth/Community	128	133	132	145
Other Resources	34	35	33	34
Total CSN 5 Unmet Needs	1,815	1,821	1,706	1,790

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,011	2,080	1,828	1,957
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	6	6	10	18
7a-iii Dialectical Behavioral Therapy	22	23	25	25
7a-iv Family Psycho-Educational Treatment	5	2	2	1
7a-v Group Counseling	8	9	7	5
7a-vi Individual Counseling	100	102	95	111
7a-vii Inpatient Psychiatric Facility	2	2	2	2
7a-viii Intensive Case Management	5	2	5	8
7a-x Psychiatric Medication Management	99	95	108	114
Total Unmet Resource Needs	247	241	254	284
Distinct Clients with Unmet Resource Needs	208	212	214	226
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	30	28	34	28
7b-ii Mental Health Advance Directives	16	19	20	16
Total Unmet Resource Needs	46	47	54	44
Distinct Clients with Unmet Resource Needs	44	43	50	42
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	11	8	10	6
7c-ii Recovery Workbook Group	2	3	3	2
7c-iii Social Club	29	32	32	26
7c-iv Peer-Run Trauma Recovery Group	8	10	9	7
7c-v Wellness Recovery and Action Planning	5	7	5	7
7c-vi Family Support	34	43	34	34
Total Unmet Resource Needs	89	103	93	82
Distinct Clients with Unmet Resource Needs	78	88	81	72
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	18	18	18	14
7d-ii Residential Treatment Substance Abuse Services	3	1	2	3
Total Unmet Resource Needs	21	19	20	17
Distinct Clients with Unmet Resource Needs	21	19	20	17

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,011	2,080	1,828	1,957
7e. Housing				
7e-i Supported Apartment	12	16	13	11
7e-ii Community Residential Facility	3	4	2	3
7e-iii Residential Treatment Facility (group home)	2	1	3	2
7e-iv Assisted Living Facility	3	6	5	4
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	188	180	152	169
Total Unmet Resource Needs	208	207	175	189
Distinct Clients with Unmet Resource Needs	197	195	164	180
7f. Health Care				
7f-i Dental Services	191	197	169	175
7f-ii Eye Care Services	79	78	72	73
7f-iii Hearing Services	17	17	14	14
7f-iv Physical Therapy	14	12	9	12
7f-v Physician/Medical Services	72	64	70	59
Total Unmet Resource Needs	373	368	334	333
Distinct Clients with Unmet Resource Needs	268	265	237	233
7g. Legal				
7g-i Advocate	43	42	44	38
7g-ii Guardian (private)	0	2	1	1
7g-iii Guardian (public)	3	3	1	2
Total Unmet Resource Needs	46	47	46	41
Distinct Clients with Unmet Resource Needs	46	47	46	41
7h. Financial Security				
7h-i Assistance with Managing Money	130	119	104	108
7h-ii Assistance with Securing Public Benefits	64	61	66	80
7h-iii Representative Payee	7	8	11	6
Total Unmet Resource Needs	201	188	181	194
Distinct Clients with Unmet Resource Needs	184	172	164	175

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,011	2,080	1,828	1,957
7i. Education				
7i-i Adult Education (other than GED)	23	24	16	25
7i-ii GED	38	32	25	30
7i-iii Literacy Assistance	5	10	8	10
7i-iv Post High School Education	26	27	20	24
7i-v Tuition Reimbursement	3	5	5	6
Total Unmet Resource Needs	95	98	74	95
Distinct Clients with Unmet Resource Needs	90	91	63	76
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	7	6	11	9
7j-ii Club House and/or Peer Vocational Support	10	15	15	11
7j-iii Competitive Employment (no supports)	12	10	11	14
7j-iv Supported Employment	12	18	15	11
7j-v Vocational Rehabilitation	89	87	71	72
Total Unmet Resource Needs	130	136	123	117
Distinct Clients with Unmet Resource Needs	119	121	105	102
7k. Living Skills				
7k-i Daily Living Support Services	43	46	43	50
7k-ii Day Support Services	9	6	5	6
7k-iii Occupational Therapy	3	2	2	1
7k-iv Skills Development Services	7	8	9	17
Total Unmet Resource Needs	62	62	59	74
Distinct Clients with Unmet Resource Needs	60	59	57	70
7l. Transportation				
7l-i Transportation to ISP-Identified Services	50	62	57	53
7-ii Transportation to Other ISP Activities	44	42	37	45
7-iii After Hours Transportation	41	33	34	43
Total Unmet Resource Needs	135	137	128	141
Distinct Clients with Unmet Resource Needs	96	103	88	91
7m. Personal Growth/Community				
7m-i Avocational Activities	4	3	3	5

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,011	2,080	1,828	1,957
7m. Personal Growth/Community				
7m-ii Recreation Activities	34	33	27	33
7m-iii Social Activities	66	71	76	82
7m-iv Spiritual Activities	24	26	26	25
Total Unmet Resource Needs	128	133	132	145
Distinct Clients with Unmet Resource Needs	86	90	89	101
Other Resources				
Other Resources	34	35	33	34
Total Unmet Resource Needs	34	35	33	34
Distinct Clients with Unmet Resource Needs	34	35	33	34
CSN 5 Totals				
Total Unmet Resource Needs	1,815	1,821	1,706	1,790
Distinct Clients With any Unmet Resource Need	636	618	572	586
Distinct Clients with a RDS	2,011	2,080	1,828	1,957

Report Run: Oct 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 4

CSN 6 - Cumberland

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

2014 Q1			2014 Q2			2014 Q3			2014 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
654	2,095	31.2%	660	2,056	32.1%	574	1,835	31.3%	624	1,897	32.9%

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

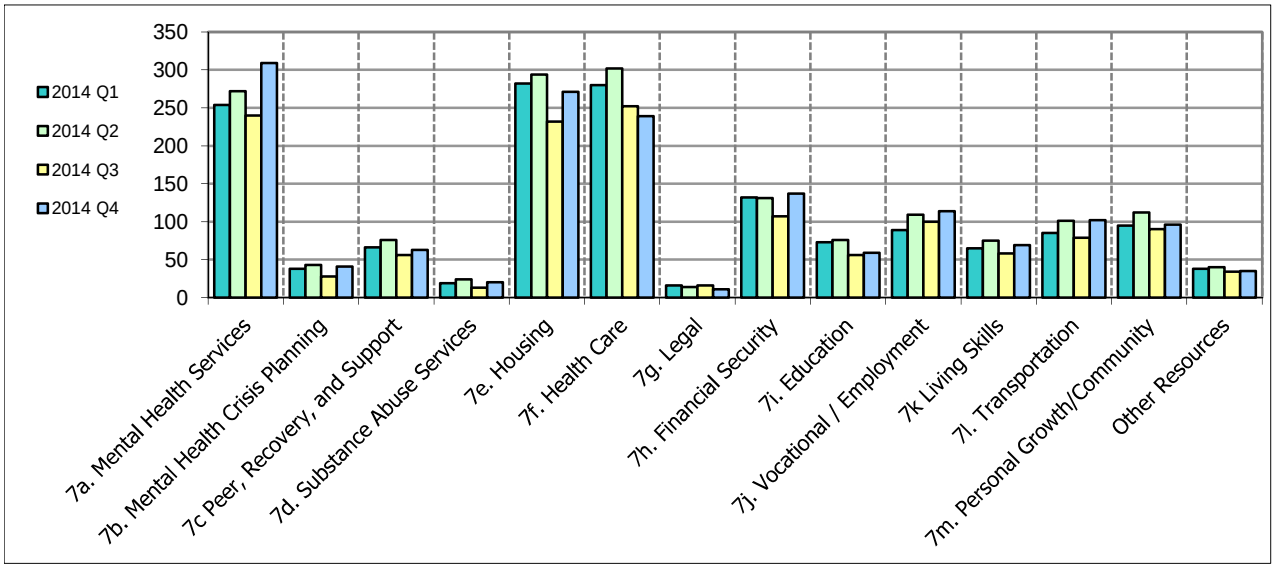


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2014 Q1	2014 Q2	2014 Q3	2014 Q4
7a. Mental Health Services	254	272	240	309
7b. Mental Health Crisis Planning	38	43	28	41
7c Peer, Recovery, and Support	66	76	56	63
7d. Substance Abuse Services	19	24	13	20
7e. Housing	282	294	232	271
7f. Health Care	280	302	252	239
7g. Legal	16	14	16	11
7h. Financial Security	132	131	107	137
7i. Education	73	76	56	59
7j. Vocational / Employment	89	109	100	114
7k Living Skills	65	75	58	69
7l. Transportation	85	101	79	102
7m. Personal Growth/Community	95	112	90	96
Other Resources	38	40	34	35
Total CSN 6 Unmet Needs	1,532	1,669	1,361	1,566

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,095	2,056	1,835	1,897
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	36	38	31	43
7a-iii Dialectical Behavioral Therapy	4	3	3	4
7a-iv Family Psycho-Educational Treatment	2	3	3	3
7a-v Group Counseling	10	14	8	13
7a-vi Individual Counseling	98	103	91	112
7a-vii Inpatient Psychiatric Facility	1	1	1	1
7a-viii Intensive Case Management	16	16	17	24
7a-x Psychiatric Medication Management	87	94	86	109
Total Unmet Resource Needs	254	272	240	309
Distinct Clients with Unmet Resource Needs	190	205	183	225
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	32	38	25	37
7b-ii Mental Health Advance Directives	6	5	3	4
Total Unmet Resource Needs	38	43	28	41
Distinct Clients with Unmet Resource Needs	35	39	26	38
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	9	15	12	15
7c-ii Recovery Workbook Group	0	1	2	1
7c-iii Social Club	26	30	21	27
7c-iv Peer-Run Trauma Recovery Group	6	7	5	2
7c-v Wellness Recovery and Action Planning	9	8	5	5
7c-vi Family Support	16	15	11	13
Total Unmet Resource Needs	66	76	56	63
Distinct Clients with Unmet Resource Needs	47	55	40	46
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	12	16	9	14
7d-ii Residential Treatment Substance Abuse Services	7	8	4	6
Total Unmet Resource Needs	19	24	13	20
Distinct Clients with Unmet Resource Needs	17	24	13	20

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,095	2,056	1,835	1,897
7e. Housing				
7e-i Supported Apartment	37	43	35	40
7e-ii Community Residential Facility	13	11	9	16
7e-iii Residential Treatment Facility (group home)	3	8	5	6
7e-iv Assisted Living Facility	20	17	12	21
7e-v Nursing Home	3	2	2	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	206	213	169	187
Total Unmet Resource Needs	282	294	232	271
Distinct Clients with Unmet Resource Needs	250	263	208	242
7f. Health Care				
7f-i Dental Services	177	175	156	144
7f-ii Eye Care Services	42	55	46	36
7f-iii Hearing Services	10	9	9	3
7f-iv Physical Therapy	6	6	4	4
7f-v Physician/Medical Services	45	57	37	52
Total Unmet Resource Needs	280	302	252	239
Distinct Clients with Unmet Resource Needs	228	231	194	195
7g. Legal				
7g-i Advocate	14	12	13	7
7g-ii Guardian (private)	0	1	1	2
7g-iii Guardian (public)	2	1	2	2
Total Unmet Resource Needs	16	14	16	11
Distinct Clients with Unmet Resource Needs	16	14	16	11
7h. Financial Security				
7h-i Assistance with Managing Money	69	70	55	78
7h-ii Assistance with Securing Public Benefits	48	49	43	46
7h-iii Representative Payee	15	12	9	13
Total Unmet Resource Needs	132	131	107	137
Distinct Clients with Unmet Resource Needs	117	120	97	127

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,095	2,056	1,835	1,897
7i. Education				
7i-i Adult Education (other than GED)	19	20	16	12
7i-ii GED	19	18	18	16
7i-iii Literacy Assistance	6	6	7	8
7i-iv Post High School Education	28	29	13	20
7i-v Tuition Reimbursement	1	3	2	3
Total Unmet Resource Needs	73	76	56	59
Distinct Clients with Unmet Resource Needs	70	72	52	55
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	6	10	10	8
7j-ii Club House and/or Peer Vocational Support	4	5	3	5
7j-iii Competitive Employment (no supports)	21	23	22	27
7j-iv Supported Employment	12	11	14	15
7j-v Vocational Rehabilitation	46	60	51	59
Total Unmet Resource Needs	89	109	100	114
Distinct Clients with Unmet Resource Needs	78	94	83	94
7k. Living Skills				
7k-i Daily Living Support Services	41	41	34	41
7k-ii Day Support Services	6	8	6	9
7k-iii Occupational Therapy	4	4	2	3
7k-iv Skills Development Services	14	22	16	16
Total Unmet Resource Needs	65	75	58	69
Distinct Clients with Unmet Resource Needs	60	70	54	61
7l. Transportation				
7l-i Transportation to ISP-Identified Services	45	52	42	58
7-ii Transportation to Other ISP Activities	22	31	19	25
7-iii After Hours Transportation	18	18	18	19
Total Unmet Resource Needs	85	101	79	102
Distinct Clients with Unmet Resource Needs	70	76	63	81
7m. Personal Growth/Community				
7m-i Avocational Activities	3	3	3	2

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	2,095	2,056	1,835	1,897
7m. Personal Growth/Community				
7m-ii Recreation Activities	31	37	27	29
7m-iii Social Activities	52	65	53	61
7m-iv Spiritual Activities	9	7	7	4
Total Unmet Resource Needs	95	112	90	96
Distinct Clients with Unmet Resource Needs	71	86	68	76
Other Resources				
Other Resources	38	40	34	35
Total Unmet Resource Needs	38	40	34	35
Distinct Clients with Unmet Resource Needs	38	40	34	35
CSN 6 Totals				
Total Unmet Resource Needs	1,532	1,669	1,361	1,566
Distinct Clients With any Unmet Resource Need	654	660	574	624
Distinct Clients with a RDS	2,095	2,056	1,835	1,897

Report Run: Oct 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 4

CSN 7 - York

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

2014 Q1			2014 Q2			2014 Q3			2014 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
161	597	27.0%	208	554	37.5%	203	554	36.6%	325	806	40.3%

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

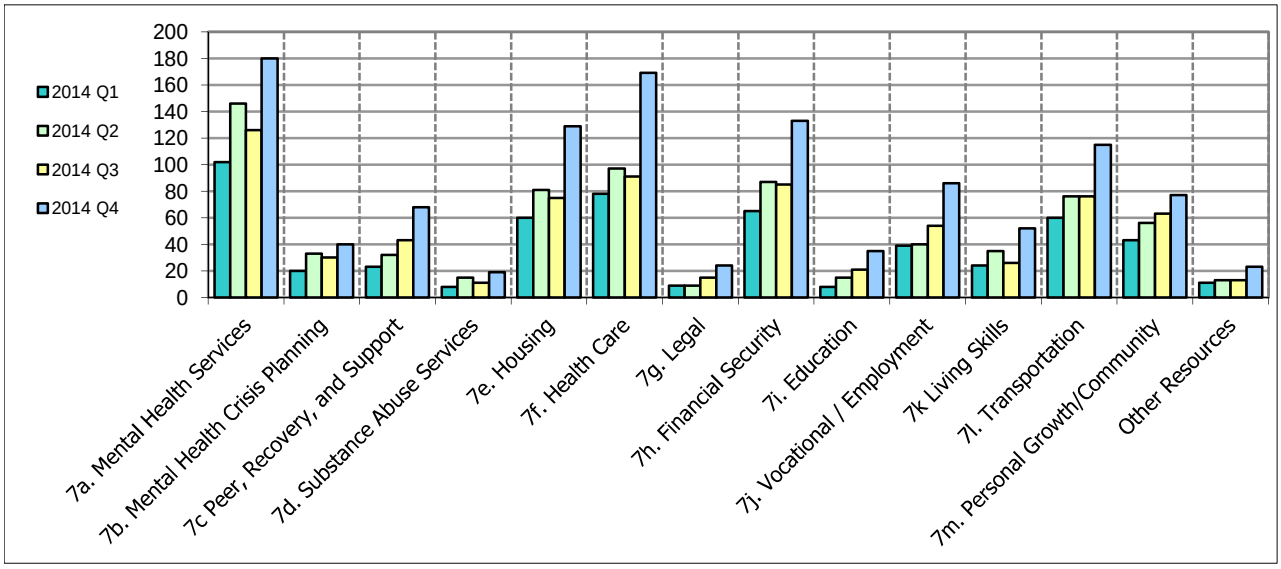


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2014 Q1	2014 Q2	2014 Q3	2014 Q4
7a. Mental Health Services	102	146	126	180
7b. Mental Health Crisis Planning	20	33	30	40
7c Peer, Recovery, and Support	23	32	43	68
7d. Substance Abuse Services	8	15	11	19
7e. Housing	60	81	75	129
7f. Health Care	78	97	91	169
7g. Legal	9	9	15	24
7h. Financial Security	65	87	85	133
7i. Education	8	15	21	35
7j. Vocational / Employment	39	40	54	86
7k Living Skills	24	35	26	52
7l. Transportation	60	76	76	115
7m. Personal Growth/Community	43	56	63	77
Other Resources	11	13	13	23
Total CSN 7 Unmet Needs	550	735	729	1,150

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	530	597	554	806
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	11	12	6	11
7a-iii Dialectical Behavioral Therapy	2	9	9	23
7a-iv Family Psycho-Educational Treatment	2	0	0	0
7a-v Group Counseling	3	5	4	7
7a-vi Individual Counseling	39	64	56	64
7a-vii Inpatient Psychiatric Facility	0	0	0	1
7a-viii Intensive Case Management	0	4	1	3
7a-x Psychiatric Medication Management	45	52	50	71
Total Unmet Resource Needs	102	146	126	180
Distinct Clients with Unmet Resource Needs	72	102	99	133
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	18	30	26	34
7b-ii Mental Health Advance Directives	2	3	4	6
Total Unmet Resource Needs	20	33	30	40
Distinct Clients with Unmet Resource Needs	19	32	28	36
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	3	2	6	9
7c-ii Recovery Workbook Group	1	0	0	1
7c-iii Social Club	9	11	13	26
7c-iv Peer-Run Trauma Recovery Group	3	7	7	9
7c-v Wellness Recovery and Action Planning	1	1	5	5
7c-vi Family Support	6	11	12	18
Total Unmet Resource Needs	23	32	43	68
Distinct Clients with Unmet Resource Needs	22	28	31	53
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	7	13	11	16
7d-ii Residential Treatment Substance Abuse Services	1	2	0	3
Total Unmet Resource Needs	8	15	11	19
Distinct Clients with Unmet Resource Needs	7	14	11	18

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	530	597	554	806
7e. Housing				
7e-i Supported Apartment	5	9	7	18
7e-ii Community Residential Facility	3	3	2	7
7e-iii Residential Treatment Facility (group home)	0	1	0	2
7e-iv Assisted Living Facility	3	3	4	6
7e-v Nursing Home	1	1	1	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	48	64	61	96
Total Unmet Resource Needs	60	81	75	129
Distinct Clients with Unmet Resource Needs	55	76	69	112
7f. Health Care				
7f-i Dental Services	32	42	41	81
7f-ii Eye Care Services	14	18	14	32
7f-iii Hearing Services	2	1	1	6
7f-iv Physical Therapy	6	8	7	13
7f-v Physician/Medical Services	24	28	28	37
Total Unmet Resource Needs	78	97	91	169
Distinct Clients with Unmet Resource Needs	54	69	63	118
7g. Legal				
7g-i Advocate	9	8	13	20
7g-ii Guardian (private)	0	0	1	1
7g-iii Guardian (public)	0	1	1	3
Total Unmet Resource Needs	9	9	15	24
Distinct Clients with Unmet Resource Needs	9	9	13	22
7h. Financial Security				
7h-i Assistance with Managing Money	36	44	48	84
7h-ii Assistance with Securing Public Benefits	27	35	30	41
7h-iii Representative Payee	2	8	7	8
Total Unmet Resource Needs	65	87	85	133
Distinct Clients with Unmet Resource Needs	51	68	67	112

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	530	597	554	806
7i. Education				
7i-i Adult Education (other than GED)	2	6	5	4
7i-ii GED	1	2	5	11
7i-iii Literacy Assistance	2	2	4	4
7i-iv Post High School Education	3	5	7	16
7i-v Tuition Reimbursement	0	0	0	0
Total Unmet Resource Needs	8	15	21	35
Distinct Clients with Unmet Resource Needs	7	13	16	32
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	6	5	8	6
7j-ii Club House and/or Peer Vocational Support	8	7	8	13
7j-iii Competitive Employment (no supports)	5	9	10	24
7j-iv Supported Employment	3	3	4	5
7j-v Vocational Rehabilitation	17	16	24	38
Total Unmet Resource Needs	39	40	54	86
Distinct Clients with Unmet Resource Needs	32	32	41	75
7k. Living Skills				
7k-i Daily Living Support Services	15	23	16	33
7k-ii Day Support Services	2	3	3	5
7k-iii Occupational Therapy	2	2	2	5
7k-iv Skills Development Services	5	7	5	9
Total Unmet Resource Needs	24	35	26	52
Distinct Clients with Unmet Resource Needs	22	28	23	39
7l. Transportation				
7l-i Transportation to ISP-Identified Services	30	39	36	50
7-ii Transportation to Other ISP Activities	14	22	18	27
7-iii After Hours Transportation	16	15	22	38
Total Unmet Resource Needs	60	76	76	115
Distinct Clients with Unmet Resource Needs	41	52	53	84
7m. Personal Growth/Community				
7m-i Avocational Activities	2	6	4	4

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	530	597	554	806
7m. Personal Growth/Community				
7m-ii Recreation Activities	8	13	17	22
7m-iii Social Activities	29	32	36	43
7m-iv Spiritual Activities	4	5	6	8
Total Unmet Resource Needs	43	56	63	77
Distinct Clients with Unmet Resource Needs	34	41	44	57
Other Resources				
Other Resources	11	13	13	23
Total Unmet Resource Needs	11	13	13	23
Distinct Clients with Unmet Resource Needs	11	13	13	23
CSN 7 Totals				
Total Unmet Resource Needs	550	735	729	1,150
Distinct Clients With any Unmet Resource Need	161	208	203	325
Distinct Clients with a RDS	530	597	554	806

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	427	431	353	323
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	3	1	1
7a-iii Dialectical Behavioral Therapy	0	2	0	1
7a-iv Family Psycho-Educational Treatment	1	0	1	0
7a-v Group Counseling	2	3	1	0
7a-vi Individual Counseling	24	27	16	23
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	1	2	0	4
7a-x Psychiatric Medication Management	27	20	19	20
Total Unmet Resource Needs	57	57	38	49
Distinct Clients with Unmet Resource Needs	43	42	31	37
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	9	5	4	2
7b-ii Mental Health Advance Directives	3	2	4	3
Total Unmet Resource Needs	12	7	8	5
Distinct Clients with Unmet Resource Needs	11	7	7	4
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	0	0	0	1
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	3	2	2	2
7c-iv Peer-Run Trauma Recovery Group	1	3	1	1
7c-v Wellness Recovery and Action Planning	2	3	2	3
7c-vi Family Support	4	4	1	5
Total Unmet Resource Needs	10	12	6	12
Distinct Clients with Unmet Resource Needs	7	8	4	9
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	0	0	2	4
7d-ii Residential Treatment Substance Abuse Services	0	0	0	0
Total Unmet Resource Needs	0	0	2	4
Distinct Clients with Unmet Resource Needs	0	0	2	4

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	427	431	353	323
7e. Housing				
7e-i Supported Apartment	7	6	5	2
7e-ii Community Residential Facility	2	3	3	1
7e-iii Residential Treatment Facility (group home)	0	0	0	0
7e-iv Assisted Living Facility	3	3	3	3
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	27	24	18	21
Total Unmet Resource Needs	39	36	29	27
Distinct Clients with Unmet Resource Needs	36	32	27	26
7f. Health Care				
7f-i Dental Services	29	23	20	20
7f-ii Eye Care Services	9	10	5	5
7f-iii Hearing Services	3	4	3	3
7f-iv Physical Therapy	1	2	1	2
7f-v Physician/Medical Services	9	11	5	7
Total Unmet Resource Needs	51	50	34	37
Distinct Clients with Unmet Resource Needs	39	36	28	27
7g. Legal				
7g-i Advocate	5	5	6	4
7g-ii Guardian (private)	5	3	1	2
7g-iii Guardian (public)	1	0	0	0
Total Unmet Resource Needs	11	8	7	6
Distinct Clients with Unmet Resource Needs	8	7	7	6
7h. Financial Security				
7h-i Assistance with Managing Money	18	16	7	18
7h-ii Assistance with Securing Public Benefits	14	11	7	10
7h-iii Representative Payee	2	1	0	0
Total Unmet Resource Needs	34	28	14	28
Distinct Clients with Unmet Resource Needs	29	23	14	24

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	427	431	353	323
7i. Education				
7i-i Adult Education (other than GED)	4	3	2	5
7i-ii GED	2	0	2	4
7i-iii Literacy Assistance	2	1	0	1
7i-iv Post High School Education	4	5	1	3
7i-v Tuition Reimbursement	0	1	0	0
Total Unmet Resource Needs	12	10	5	13
Distinct Clients with Unmet Resource Needs	11	9	5	11
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	1	1	0
7j-ii Club House and/or Peer Vocational Support	1	1	0	0
7j-iii Competitive Employment (no supports)	3	3	2	1
7j-iv Supported Employment	1	1	1	1
7j-v Vocational Rehabilitation	12	10	4	2
Total Unmet Resource Needs	18	16	8	4
Distinct Clients with Unmet Resource Needs	18	16	8	4
7k. Living Skills				
7k-i Daily Living Support Services	11	11	7	7
7k-ii Day Support Services	2	3	3	3
7k-iii Occupational Therapy	0	0	0	1
7k-iv Skills Development Services	0	1	0	0
Total Unmet Resource Needs	13	15	10	11
Distinct Clients with Unmet Resource Needs	13	14	10	10
7l. Transportation				
7l-i Transportation to ISP-Identified Services	15	11	8	11
7-ii Transportation to Other ISP Activities	12	7	2	6
7-iii After Hours Transportation	11	7	7	8
Total Unmet Resource Needs	38	25	17	25
Distinct Clients with Unmet Resource Needs	24	19	16	16
7m. Personal Growth/Community				
7m-i Avocational Activities	3	2	2	1

Report Run: Oct 14, 2014

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

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 4
(April, May, June 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Distinct Clients with a RDS	427	431	353	323
7m. Personal Growth/Community				
7m-ii Recreation Activities	6	7	7	5
7m-iii Social Activities	18	17	12	9
7m-iv Spiritual Activities	4	5	2	1
Total Unmet Resource Needs	31	31	23	16
Distinct Clients with Unmet Resource Needs	23	22	15	9
Other Resources				
Other Resources	9	9	5	5
Total Unmet Resource Needs	9	9	5	5
Distinct Clients with Unmet Resource Needs	9	9	5	5
CSN Not Assigned Totals				
Total Unmet Resource Needs	335	304	206	242
Distinct Clients With any Unmet Resource Need	123	107	95	91
Distinct Clients with a RDS	427	431	353	323

Report Run: Oct 14, 2014

Go to Table of Contents

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
32 Blossom Lane, Marquardt Building, 2nd Floor
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-4243; Fax: (207) 287-1022
TTY Users: Dial 711 (Maine Relay)

Bridging Rental Assistance Program (BRAP)
Monitoring Report
Quarter 1 FY2015 (July, August, September 2014)

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.

- Priority #1 applicants (Discharge from a psychiatric hospital within the last 6 months). Riverview and Dorothea Dix consumers are typically not waiting more than 3 business days from the date of a completed application. Statewide priority 1 vouchers decreased from 26 to 17.
- Priority #2 applicants (Homeless) have increased from 207 to 227 persons.
- Priority #3 applicants (Substandard Housing) remained at 4 persons.
- Priority #4 applicants (Community Residential Facility) decreased from 21 to 17 persons.
- Persons on the waitlist greater than 90 days have substantially increased from 12 persons to 188 persons—over the next quarter, state staff will attempt contact with these persons to confirm their whereabouts and determine their continued desire to remain on the waitlist.

Since inception of the wait list, there has been a total of 2,914 BRAP vouchers awarded broken down as follows: Priority #1, 1,369; Priority #2, 1,229; Priority #3, 38; Priority #4, 258. Note that 20 vouchers have been awarded to persons with no priority. In the last quarter 106 vouchers were awarded.

The BRAP census as of September 30, 2014 is 791 vouchers with an additional 100 persons looking.

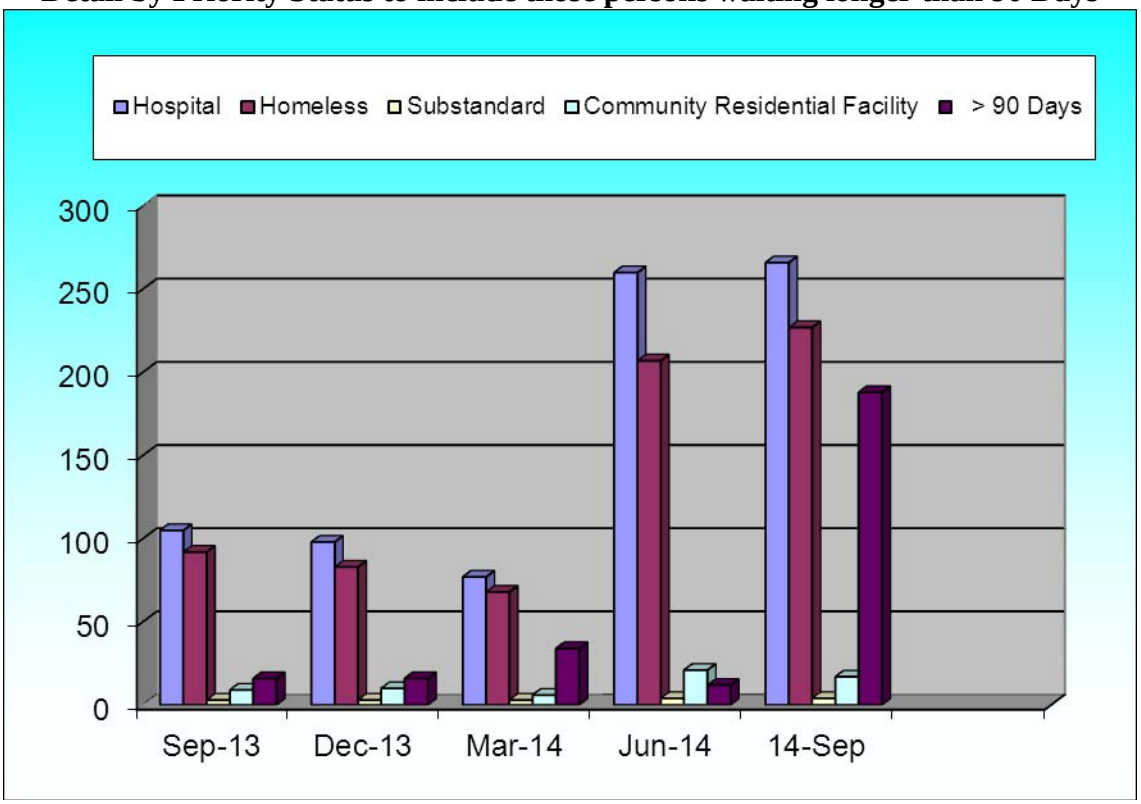
The overall BRAP budget for FY 15 is now a part of the baseline budget at SAMHS and remains at $5,372,414.00. Depending on regional demand for vouchers, we anticipate the census being able to support between 930 to 975 vouchers at any given time statewide.

The number of persons on the program for greater than 24 months remains steady at 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 to criminal history. 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 as of September 30, 2014 is 990 vouchers. 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. Despite reductions in overall HUD funding, the City of Portland requested that DHHS submit a new Shelter Plus Care application that, if funded, will provide housing and supports for 17 Chronically homeless persons in Portland.

Go to Table of Contents

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

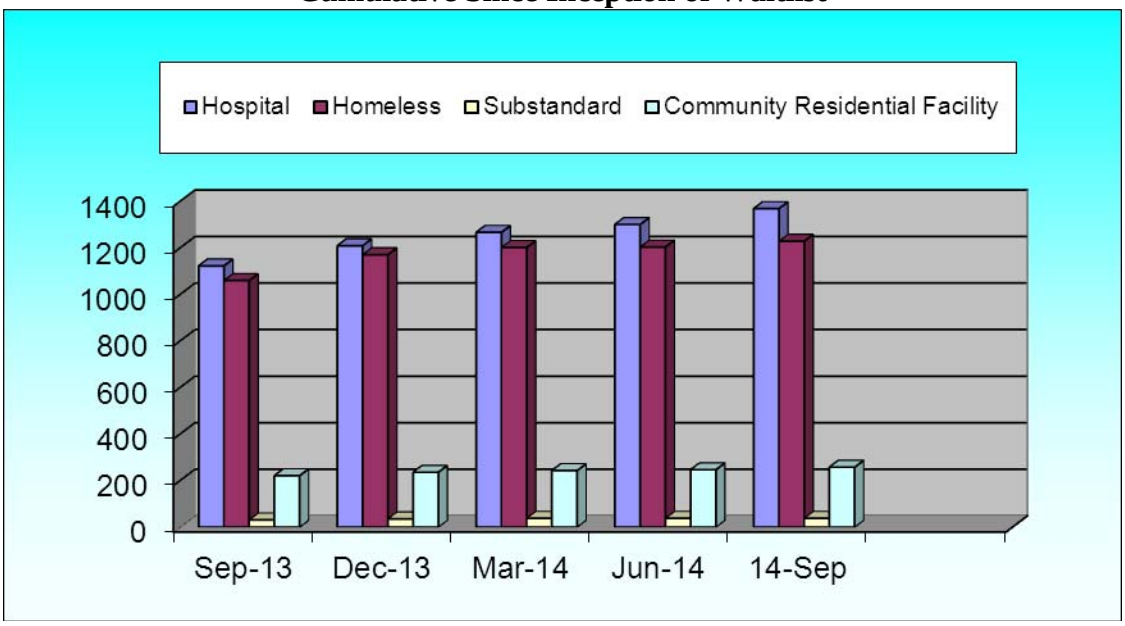


BRAP Waitlist Status—Table:
Detail by Priority Status to include those persons waiting longer than 90 Days

Reporting Period	Sep-13	Dec-13	Mar-14	Jun-14	14-Sep	% Change relative to Last Report
Total number of persons waiting for BRAP	105	98	77	260	266	2%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	1	2	0	26	17	-35%
Priority 2—Homeless (HUD Transitional Definition)	92	83	68	207	227	9%
Priority 3—Sub-standard Housing	3	3	3	4	4	0%
Priority 4—Leaving a Community Residential living facility	9	10	6	21	17	-19%
Total number of persons on wait list more than 90 days awaiting voucher	16	16	34	12	188	94%

Go to Table of Contents

BRAP Awards—Graph
Cumulative Since Inception of Waitlist



BRAP Awards—Table
Cumulative Since Inception of Waitlist

Reporting Periods	Sep-13	Dec-13	Mar-14	Jun-14	14-Sep	% Change relative to Last Report
Cumulative number of persons awarded BRAP	2450	2668	2767	2808	2914	4%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	1123	1210	1267	1301	1369	5%
Priority 2—Homeless (HUD Transitional Definition)	1060	1171	1202	1204	1229	2%
Priority 3—Sub-standard Housing	31	36	38	38	38	0%
Priority 4—Leaving a DHHS funded living facility	221	236	243	247	258	4%

*Note: 20 persons awarded with no priority

Go to Table of Contents

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

Class Member Treatment Planning Review

For the 1st Quarter of Fiscal Year 2015

(July, August, September, 2014)

		2014 Q2	2014 Q3	2014 Q4	2015 Q1
Total Plans Reviewed		49	53	51	25
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?	93.8% 15 of 16	100.0% 16 of 16	100.0% 12 of 12	100.0% 5 of 5
1B	Does the record document that the agency has planned with and educated the consumer regarding releases of information during each treatment plan review?	72.9% 35 of 48	88.2% 45 of 51	74.0% 37 of 50	95.8% 23 of 24
1C	Does the record document that the consumer has a primary care physician (PCP)?	98.0% 48 of 49	88.7% 47 of 53	96.1% 49 of 51	88.0% 22 of 25
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?	77.1% 37 of 48	83.0% 39 of 47	89.8% 44 of 49	86.4% 19 of 22
II Treatment Plan					
2A	Does the record document that the domains of housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional/psychological, and psychiatric were assessed with the consumer in treatment planning?	100.0% 49 of 49	100.0% 52 of 52	100.0% 50 of 50	92.0% 23 of 25
2B	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?	98.0% 48 of 49	98.1% 52 of 53	100.0% 51 of 51	100.0% 24 of 24
2C	Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?	98.0% 48 of 49	98.1% 52 of 53	100.0% 51 of 51	100.0% 24 of 24
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% 49 of 49	98.1% 52 of 53	96.0% 48 of 50	96.0% 24 of 25
2E	Does the record document that the consumer has a crisis plan?	89.8% 44 of 49	71.7% 38 of 53	44.9% 22 of 49	58.3% 14 of 24
2F	If 2E. is no, is the reason documented?	100.0% 5 of 5	100.0% 15 of 15	100.0% 27 of 27	100.0% 10 of 10
2G	If 2E. is yes, has the crisis plan been reviewed as required every three months?	90.9% 40 of 44	81.6% 31 of 38	81.8% 18 of 22	78.6% 11 of 14
2H	If 2E. is yes, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?	87.5% 7 of 8	40.0% 4 of 10	33.3% 1 of 3	71.4% 5 of 7
2I	Does the record document that the consumer has a mental health advance directive?	4.1% 2 of 49	5.7% 3 of 53	2.0% 1 of 51	20.8% 5 of 24
2J	If 2I. is yes, has the advance directive been reviewed at least annually by the CSW and consumer?	100.0% 2 of 2	0.0% 0 of 3	0.0% 0 of 1	40.0% 2 of 5
2K	If 2I. is no, is the reason why documented?	100.0% 47 of 47	100.0% 50 of 50	100.0% 50 of 50	100.0% 19 of 19
III Needed Resources					
3A	Does the record document that natural supports (family/friends) are being accessed as a resource?	100.0% 49 of 49	90.6% 48 of 53	98.0% 48 of 49	76.0% 19 of 25

Go to Table of Contents

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	100.0%	5 of 5	100.0%	1 of 1	100.0%	6 of 6
3C	Does the record document that generic resources (those resources that anyone can access) are being accessed?	100.0%	49 of 49	94.3%	50 of 53	100.0%	51 of 51	96.0%	24 of 25
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 3	N/A	0 of 0	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?	12.2%	6 of 49	7.5%	4 of 53	8.0%	4 of 50	25.0%	6 of 24
3F	Does the treatment plan reflect interim planning?	100.0%	6 of 6	75.0%	3 of 4	75.0%	3 of 4	66.7%	4 of 6
3G	Does the record document that the treatment team reconvened after the unmet need was identified?	100.0%	6 of 6	50.0%	2 of 4	75.0%	3 of 4	50.0%	3 of 6
IV Service Agreements									
4A	Does the record document that service agreements are required for this plan? (see paragraph 69 protocol for definitions)	57.1%	28 of 49	49.1%	26 of 53	51.0%	25 of 49	40.0%	10 of 25
4B	If 4A. is yes, have service agreements been acquired?	78.6%	22 of 28	80.8%	21 of 26	48.0%	12 of 25	80.0%	8 of 10
4C	If 4A. is yes, are the service agreements current?	75.0%	21 of 28	57.7%	15 of 26	36.0%	9 of 25	80.0%	8 of 10
V Vocational Services									
5A	Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?	100.0%	47 of 47	100.0%	53 of 53	100.0%	51 of 51	100.0%	24 of 24
5B	Does the record document that the vocational domain is being addressed with the consumer at each 90 day treatment plan review?	81.6%	40 of 49	94.3%	50 of 53	90.2%	46 of 51	88.0%	22 of 25
VI Comments									
6A	Plan of correction requested?	30.6%	15 of 49	37.7%	20 of 53	51.0%	26 of 51	16.0%	4 of 25
6A.1.	Plan of correction for section 2A. (required when not all domains assessed) included?	N/A	0 of 0	N/A	0 of 0	N/A	0 of 0	100.0%	2 of 2
6C	Plan of correction received?	93.3%	14 of 15	70.0%	14 of 20	69.2%	18 of 26	75.0%	3 of 4
6D	Were corrections made to the satisfaction of the CDC?	92.9%	13 of 14	100.0%	14 of 14	100.0%	18 of 18	100.0%	3 of 3

Report Run by: Brandi.Giguere Report Run on: Oct 9, 2014 at 1:09:34 PM

Go to Table of Contents

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 2014

(April, May, June, 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Total Admissions	119	115	105	114
Hospital				
Hospitalized in Local Area	84.0% (100 of 119)	80.9% (93 of 115)	81.9% (86 of 105)	86.8% (99 of 114)
Hospitalization Made Voluntary	81.5% (97 of 119)	80.9% (93 of 115)	79.0% (83 of 105)	76.3% (87 of 114)
Legal Status				
Blue Paper on File	100.0% (119 of 119)	100.0% (115 of 115)	100.0% (105 of 105)	100.0% (114 of 114)
Blue Paper Complete/Accurate	99.2% (118 of 119)	100.0% (115 of 115)	100.0% (105 of 105)	99.1% (113 of 114)
If not complete, Follow up per policy	100.0% (1 of 1)	N/A (0 of 0)	N/A (0 of 0)	100.0% (1 of 1)
24 Hr. Certification Required	89.9% (107 of 119)	87.8% (101 of 115)	91.4% (96 of 105)	86.0% (98 of 114)
24 Hr. Certification on file	100.0% (107 of 107)	99.0% (100 of 101)	100.0% (96 of 96)	100.0% (98 of 98)
24 Hr. Certification Complete/Accurate	100.0% (107 of 107)	100.0% (100 of 100)	100.0% (96 of 96)	100.0% (98 of 98)
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	99.2% (118 of 119)	100.0% (115 of 115)	100.0% (105 of 105)	99.1% (113 of 114)
Active Treatment Within Guidelines	100.0% (119 of 119)	100.0% (115 of 115)	100.0% (105 of 105)	100.0% (114 of 114)
Patient's Rights Maintained	97.5% (116 of 119)	99.1% (114 of 115)	99.0% (104 of 105)	96.5% (110 of 114)
If not maintained, follow up per policy	100.0% (3 of 3)	N/A (0 of 0)	0.0% (0 of 1)	100.0% (4 of 4)
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	18.5% (22 of 119)	27.8% (32 of 115)	25.7% (27 of 105)	32.5% (37 of 114)
Case Manager Involved with Discharge Planning	95.5% (21 of 22)	100.0% (32 of 32)	100.0% (27 of 27)	100.0% (37 of 37)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (22 of 22)	100.0% (32 of 32)	100.0% (27 of 27)	100.0% (37 of 37)
Hospital Obtained ISP when authorized	18.2% (4 of 22)	6.2% (2 of 32)	3.7% (1 of 27)	10.8% (4 of 37)
Treatment and Discharge Plan Consistant with ISP	75.0% (3 of 4)	100.0% (2 of 2)	100.0% (1 of 1)	100.0% (4 of 4)

Report Run: Oct 22, 2014

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

Go to Table of Contents

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

Community Hospital Utilization Review for Involuntary Admissions

Class Members

For the 4th Quarter of Fiscal Year 2014

(April, May, June, 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Total Admissions	13	18	13	12
Hospital				
Hospitalized in Local Area	38.5% (5 of 13)	72.2% (13 of 18)	84.6% (11 of 13)	100.0% (12 of 12)
Hospitalization Made Voluntary	46.2% (6 of 13)	77.8% (14 of 18)	69.2% (9 of 13)	58.3% (7 of 12)
Legal Status				
Blue Paper on File	100.0% (13 of 13)	100.0% (18 of 18)	100.0% (13 of 13)	100.0% (12 of 12)
Blue Paper Complete/Accurate	100.0% (13 of 13)	100.0% (18 of 18)	100.0% (13 of 13)	100.0% (12 of 12)
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	92.3% (12 of 13)	88.9% (16 of 18)	92.3% (12 of 13)	100.0% (12 of 12)
24 Hr. Certification on file	100.0% (12 of 12)	100.0% (16 of 16)	100.0% (12 of 12)	100.0% (12 of 12)
24 Hr. Certification Complete/Accurate	100.0% (12 of 12)	100.0% (16 of 16)	100.0% (12 of 12)	100.0% (12 of 12)
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% (13 of 13)	100.0% (18 of 18)	100.0% (13 of 13)	100.0% (12 of 12)
Active Treatment Within Guidelines	100.0% (13 of 13)	100.0% (18 of 18)	100.0% (13 of 13)	100.0% (12 of 12)
Patient's Rights Maintained	100.0% (13 of 13)	94.4% (17 of 18)	100.0% (13 of 13)	100.0% (12 of 12)
If not maintained, follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Inappropriate Use of Blue Paper	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Individual Service Plans				
Receiving Case Management Services	46.2% (6 of 13)	72.2% (13 of 18)	76.9% (10 of 13)	58.3% (7 of 12)
Case Manager Involved with Discharge Planning	100.0% (6 of 6)	100.0% (13 of 13)	100.0% (10 of 10)	100.0% (7 of 7)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (6 of 6)	100.0% (13 of 13)	100.0% (10 of 10)	100.0% (7 of 7)
Hospital Obtained ISP when authorized	16.7% (1 of 6)	0.0% (0 of 13)	10.0% (1 of 10)	28.6% (2 of 7)
Treatment and Discharge Plan Consistant with ISP	100.0% (1 of 1)	N/A (0 of 0)	100.0% (1 of 1)	100.0% (2 of 2)

Report Run: Oct 22, 2014

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

Go to Table of Contents

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

Community Hospital Utilization Review for Involuntary Admissions

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

For the 4th Quarter of Fiscal Year 2014

(April, May, June, 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Number of Admissions	119	115	105	114
Involuntarily Admitted Clients who were Receiving CSS Services	22	32	27	37
Number of ISPs Hospitals were Authorized to Obtain	22	32	27	37
Number of ISPs Hospitals Obtained	4	2	1	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
2014 Q1	Acadia	22	13.6% (3 of 22)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Maine General - Waterville	8	37.5% (3 of 8)	100.0% (3 of 3)	100.0% (3 of 3)	100.0% (3 of 3)
	Mid-coast Hospital	12	8.3% (1 of 12)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	5	20.0% (1 of 5)	100.0% (1 of 1)	0.0% (0 of 1)	100.0% (1 of 1)
	Southern Maine Medical Center	21	14.3% (3 of 21)	0.0% (0 of 3)	N/A (0 of 0)	66.7% (2 of 3)
	Spring Harbor	41	24.4% (10 of 41)	0.0% (0 of 10)	N/A (0 of 0)	100.0% (10 of 10)
	St. Mary's	10	10.0% (1 of 10)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
2014 Q2	Acadia	37	32.4% (12 of 37)	0.0% (0 of 12)	N/A (0 of 0)	100.0% (12 of 12)
	Maine General - Augusta	11	18.2% (2 of 11)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	Maine Medical Center	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	3	0.0% (0 of 3)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	PenBay Medical Center	9	11.1% (1 of 9)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	10	40.0% (4 of 10)	0.0% (0 of 4)	N/A (0 of 0)	100.0% (4 of 4)
	Spring Harbor	35	34.3% (12 of 35)	0.0% (0 of 12)	N/A (0 of 0)	100.0% (12 of 12)
	St. Mary's	9	0.0% (0 of 9)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
2014 Q3	Acadia	35	20.0% (7 of 35)	0.0% (0 of 7)	N/A (0 of 0)	100.0% (7 of 7)
	Maine General - Augusta	2	50.0% (1 of 2)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Mid-coast Hospital	7	42.9% (3 of 7)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	PenBay Medical Center	5	0.0% (0 of 5)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	6	0.0% (0 of 6)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	42	31.0% (13 of 42)	0.0% (0 of 13)	N/A (0 of 0)	100.0% (13 of 13)
	St. Mary's	8	37.5% (3 of 8)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
2014 Q4	Acadia	29	44.8% (13 of 29)	7.7% (1 of 13)	100.0% (1 of 1)	100.0% (13 of 13)
	Maine General - Augusta	8	37.5% (3 of 8)	100.0% (3 of 3)	100.0% (3 of 3)	100.0% (3 of 3)
	Mid-coast Hospital	7	42.9% (3 of 7)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	PenBay Medical Center	5	20.0% (1 of 5)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	12	25.0% (3 of 12)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Spring Harbor	44	25.0% (11 of 44)	0.0% (0 of 11)	N/A (0 of 0)	100.0% (11 of 11)
	St. Mary's	9	33.3% (3 of 9)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)

Report Run: Oct 22, 2014

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

Go to Table of Contents

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

Community Hospital Utilization Review for Involuntary Admissions

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

For the 4th Quarter of Fiscal Year 2014

(April, May, June, 2014)

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Number of Admissions	13	18	13	12
Involuntarily Admitted Clients who were Receiving CSS Services	6	13	10	7
Number of ISPs Hospitals were Authorized to Obtain	6	13	10	7
Number of ISPs Hospitals Obtained	1	0	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
2014 Q1	**Acadia**	3	66.7% (2 of 3)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Waterville	1	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Mid-coast Hospital	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	PenBay Medical Center	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	5	60.0% (3 of 5)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	St. Mary's	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
2014 Q2	**Acadia**	5	40.0% (2 of 5)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Augusta	1	0.0% (0 of 1)	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)
	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	3	66.7% (2 of 3)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Spring Harbor	7	100.0% (7 of 7)	0.0% (0 of 7)	N/A (0 of 0)	100.0% (7 of 7)
2014 Q3	**Acadia**	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Maine General - Augusta	1	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Mid-coast Hospital	1	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	7	71.4% (5 of 7)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	St. Mary's	2	100.0% (2 of 2)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
2014 Q4	**Acadia**	2	100.0% (2 of 2)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Augusta	3	66.7% (2 of 3)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	Spring Harbor	7	42.9% (3 of 7)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)

Report Run: Oct 22, 2014

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

Go to Table of Contents

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

Maine Department of Health and Human Services

Integrated Quarterly Crisis Report

STATEWIDE with GRAPHS

Quarter M (July, August, September) SCY 201p

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

Gender	Children	Males	558	Females	611				
	Adults	Males	2,431	Females	2,635				
Age Range	Children	< 5	13	5 - 9	147	10 - 14	476	15-17	533
	Adults	18 - 21	445	22 - 35	1,481	36 - 60	2,604	>60	536
Payment Source	Children	MaineCare	847	Private Ins.	261	Uninsured	61	Medicare	0
	Adults	MaineCare	2,646	Private Ins.	746	Uninsured	1,380	Medicare	294

II. Summary Of All Crisis Contacts

	Children	Adults
a. Total number of telephone contacts	6,020	35,983
b. Total number of all Initial face-to-face contacts	988	4,139
c. Number in II.b. who are children/youth with Mental Retardation/Autism/Pervasive Dev. Disorder	92	
d. Number of face-to-face contacts that are ongoing support for crisis resolution/stabilization	173	1,169

III. Initial Crisis Contact Infomation

	Children		Adults	
a. Total number of Initial face-to-face contacts in which a wellness plan, crisis plan, ISP or advanced directive plan previously developed with the individual was used	93	9.4%	83	2.0%
b. Number of Initial face-to-face contacts who have a Community Support Worker (CI,CRS,ICM, ACT,TCM)	373	37.8%	1,156	27.9%
c. Number of Initial face-to-face contacts who have a Comm. Support Worker that was notified of crisis	364	97.6%	1,107	95.8%
d. SUM time in minutes for all Initial face-to-face contacts in II.b. from determination of need for face-to-face contact or when individual was ready and able to be seen to Initial face-to-face contact			126,825	31
e. Number of Initial face-to-face contacts in Emergency Department with final disp. within 8 hours			2,132	51.5%
f. Number of Initial face-to-face contacts not in Emergency Department with final disp. within 8 hours			1,479	35.7%

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.	854	1 to 2 Hours	103	2 to 4 Hours	20	More Than 4 Hours	11	
Percent	86.4%	Percent	10.4%	Percent	2.0%	Percent	1.1%	

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

Less Than 3 Hours	382	3 to 6 Hours	449	6 to 8 Hours	48	8 to 14 Hours	46	> 14	63
Percent	38.7%	Percent	45.4%	Percent	4.9%	Percent	4.7%	Percen	6.4%

IV. Site Of Initial Face¤To¤Face Contacts

	Children		Adults	
a. Primary Care Residence (Home)	158	16.0%	358	8.6%
b. Family/Relative/Other Residence	55	5.6%	40	1.0%
c. Other Community Setting (Work, School, Police Dept, Public Place)	46	4.7%	119	2.9%
d. SNF, Nursing Home, Boarding Home	0	0.0%	20	0.5%
e. Residential Program (Congregate Community Residence, Apartment Program)	7	0.7%	63	1.5%
f. Homeless Shelter	5	0.5%	32	0.8%
g. Provider Office	35	3.5%	173	4.2%
h. Crisis Office	85	8.6%	558	13.5%
i. Emergency Department	593	60.0%	2,554	61.7%
j. Other Hospital Location	4	0.4%	155	3.7%
k. Incarcerated (Local Jail, State Prison, Juvenile Correction Facility)	0	0.0%	67	1.6%
Totals:	988	100%	4,139	100%

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

	Children		Adults	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	16	1.6%	205	5.0%
b. Crisis stabilization with referral to new provider for mental health/substance abuse follow up	191	19.3%	872	21.1%
c. Crisis stabilization with referral back to current provider for mental health/substane abuse follow up	356	36.0%	1,343	32.4%
d. Admission to Crisis Stabilization Unit	143	14.5%	484	11.7%
e. Inpatient Hospitalization Medical	9	0.9%	112	2.7%
f. Voluntary Psychiatric Hospitalization	269	27.2%	867	20.9%
g. Involuntary Psychiatric Hospitalization	4	0.4%	145	3.5%
h. Admission to Detox Unit	0	0.0%	111	2.7%
Totals:	988	100%	4,139	100%

Go to Table of Contents

Riverview PSYCHIATRIC CENTER

QUARTERLY REPORT ON

ORGANIZATIONAL PERFORMANCE EXCELLENCE

FIRST STATE FISCAL QUARTER 2015
July, August, September 2014

Robert J. Harper
Acting Superintendent

October 22, 2014

THIS PAGE INTENTIALLY LEFT BLANK

Table of Contents

Table of Contents

Glossary of Terms, Acronyms & Abbreviations

ADC	Automated Dispensing Cabinets (for medications)
ADON	Assistant Director of Nursing
AOC	Administrator on Call
CCM	Continuation of Care Management (Social Work Services)
CCP	Continuation of Care Plan
CH/CON	Charges/Convicted
CMS	Centers for Medicare & Medicaid Services
CIVIL	Voluntary, No Criminal Justice Involvement
CIVIL-INVOL	Involuntary Civil Court Commitment (No Criminal Justice Involvement)
CoP	Community of Practice or Conditions of Participation (CMS)
CPI	Continuous Process (or Performance) Improvement
CPR	Cardio-Pulmonary Resuscitation
CSP	Comprehensive Service Plan
DCC	Involuntary District Court Committed
DCC-PTP	Involuntary District Court Committed, Progressive Treatment Plan
GAP	Goal, Assessment, Plan Documentation
HOC	Hand off 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
LEGHOLD	Legal Hold
LPN	License Practical Nurse
TJC	The Joint Commission (formerly JCAHO, Joint Commission on Accreditation of Healthcare Organizations)
MAR	Medication Administration Record
MHW	Mental Health Worker
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

Glossary of Terms, Acronyms & Abbreviations

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
PPR	Periodic Performance Review – a self-assessment based upon TJC standards that are conducted annually by each department head.
PSD	Program Services Director
PTP	Progressive Treatment Plan
PRET	Pretrial Evaluation
R.A.C.E.	Rescue/Alarm/Confine/Extinguish
RN	Registered Nurse
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)
STAGE III	60 Day Forensic Evaluation
URI	Upper respiratory infection
UTI	Urinary tract infection
VOL	Voluntary – Self
VOL-OTHER	Voluntary – Others (Guardian)

INTRODUCTION

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

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

There are three major sections that make up this report:

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

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

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

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

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

. **THIS PAGE INTENTIALLY LEFT BLANK**

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	2Q2014	3Q2014	4Q2014	1Q2015
1. Clients are routinely informed of their rights upon admission	100% 45/45 (100%, 15/15 for Lower Saco)	100% 44/45 (100%, 15/15 for Lower Saco)	100% 26/32 (97%, 27/29 for Lower Saco)	97% 44/45 (100%, 14/15 for Lower Saco)

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.

3Q2014: 1 refused
4Q2014: 3 refused, 3 lacked capacity - Lower Saco: 1 refused, 1 not accounted for
1Q2015: Lower Saco - 1 refused

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	2Q2014	3Q2014	4Q2014	1Q2015
1. Level II grievances responded to by RPC on time.	100% 1/1	N/A	100% 2/2	100% 1/1
2. Level I grievances responded to by RPC on time.	100% 61/61	97% 67/69	100% 51/51	100% 86/86

CONSENT DECREE

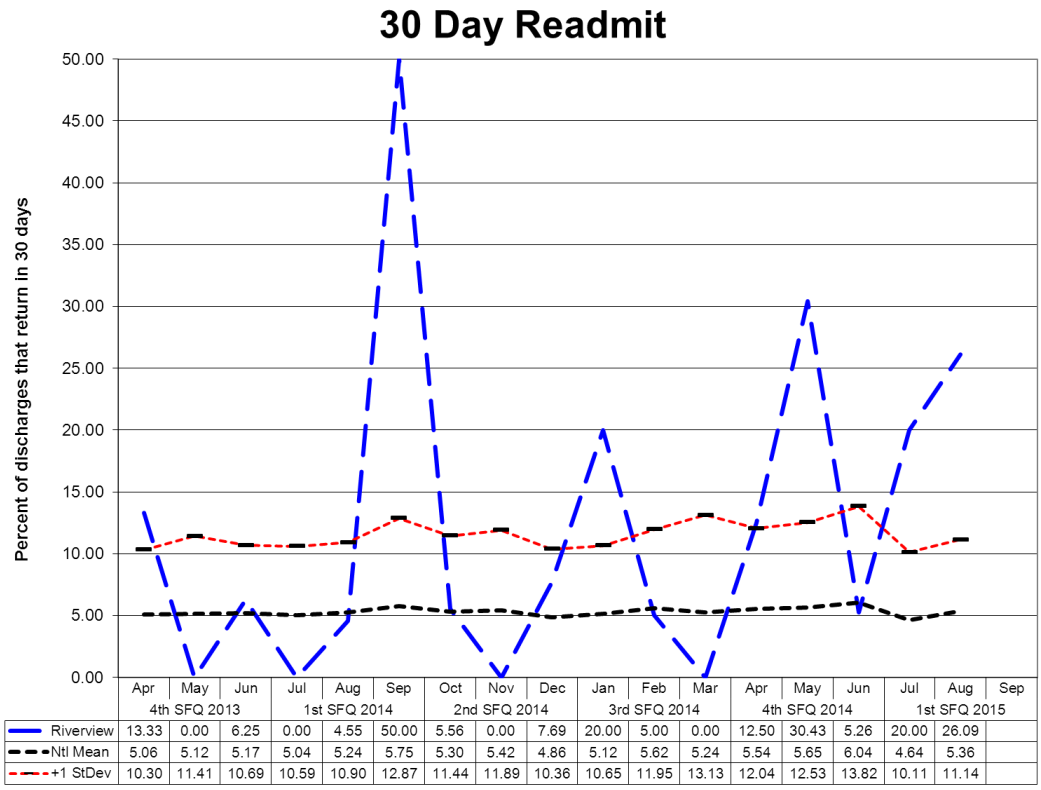
Admissions

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

Legal Status on Admission	2Q2014	3Q2014	4Q2014	1Q2015	Total
CIVIL TOTAL	**19**	**31**	**26**	**35**	**111**
VOL		1			**1**
CIVIL-INVOL	2		1	8	**11**
DCC	15	28	24	25	**92**
DCC PTP	2	2	1	2	**7**
FORENSIC TOTAL	**28**	**30**	**25**	**33**	**116**
STAGE III	19	19	18	20	**76**
JAIL TRANS		2	2	1	**4**
IST	7	8	5	7	**27**
NCR	2	1	0	5	**8**
GRAND TOTAL	**47**	**61**	**51**	**68**	**227**

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 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	13.33	0.00	6.25	0.00	4.55	50.00	5.56	0.00	7.69	20.00	5.00	0.00	12.50	30.43	5.26	20.00	26.09	
Ntl Mean	5.06	5.12	5.17	5.04	5.24	5.75	5.30	5.42	4.86	5.12	5.62	5.24	5.54	5.65	6.04	4.64	5.36	
+1 StDev	10.30	11.41	10.69	10.59	10.90	12.87	11.44	11.89	10.36	10.65	11.95	13.13	12.04	12.53	13.82	10.11	11.14	

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

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

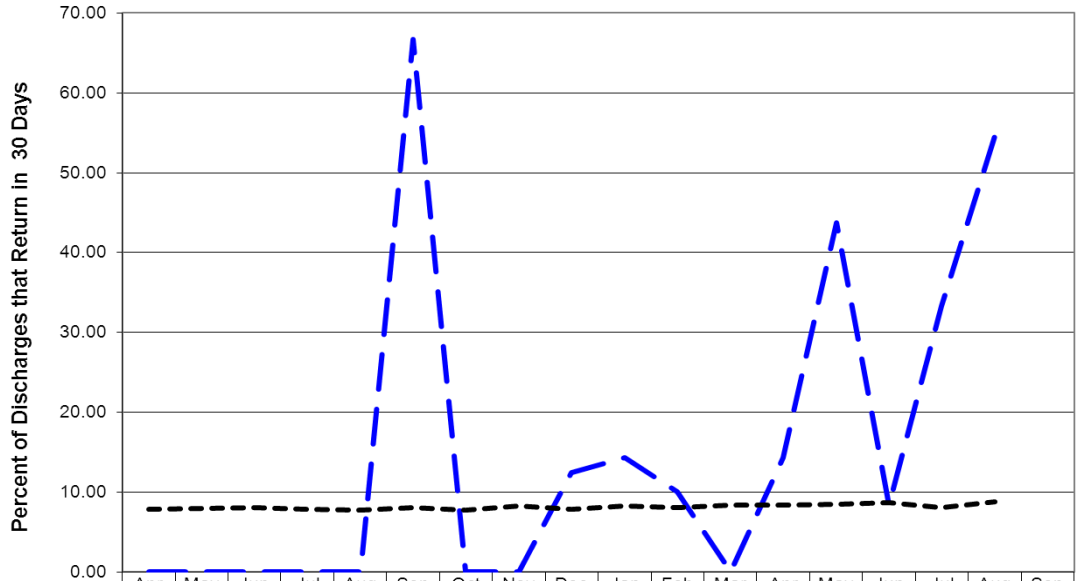
Reasons for client readmission are varied and may include decompensating or lack of compliance with a PTP to name a few. Specific causes for readmission are reviewed with each client upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient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

Note: In August 2013 the Lower Saco unit was decertified; patients had to be discharged and readmitted in our Meditech Electronic Medical Record System, even though they were not actually discharged from the hospital. This caused the numbers in August 2013 to increase. Starting in August 2013 and going forward anytime that a patient transfers units in the hospital (either from or to Lower Saco) we must now discharge them and readmit them in Meditech, which causes them to show up in this graph as a 30 Day Readmission, even though technically they never left the hospital.

CONSENT DECREE

30 Day Readmit

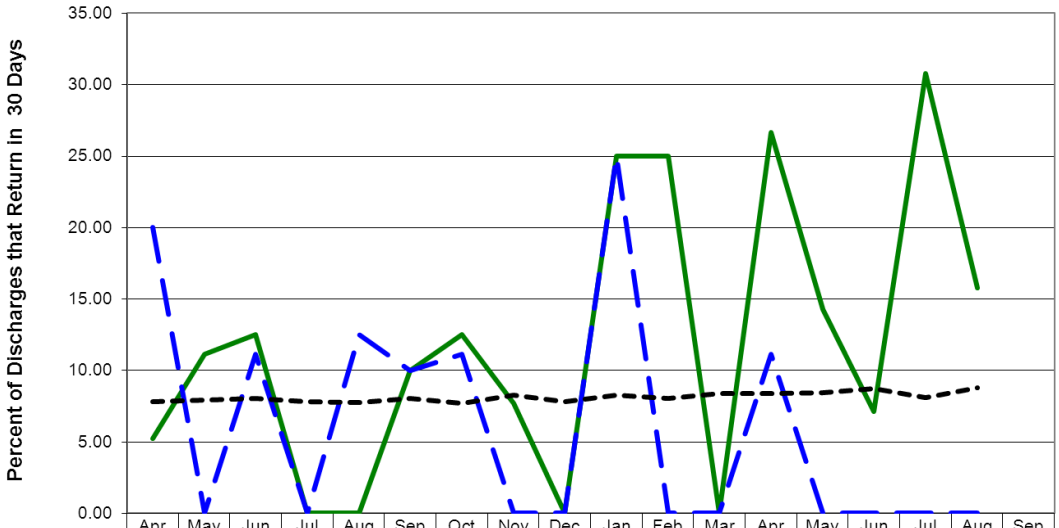
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	0.00	66.67	0.00	0.00	12.50	14.29	10.00	0.00	14.29	43.75	8.33	33.33	54.55	
National Mean	7.81	7.92	8.02	7.81	7.73	8.07	7.71	8.27	7.82	8.30	8.07	8.39	8.41	8.44	8.72	8.08	8.76	

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 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Dorothea Dix	5.26	11.11	12.50	0.00	0.00	10.00	12.50	7.69	0.00	25.00	25.00	0.00	26.67	14.29	7.14	30.77	15.79	
Riverview	20.00	0.00	11.11	0.00	12.50	10.00	11.11	0.00	0.00	25.00	0.00	0.00	11.11	0.00	0.00	0.00	0.00	
National Mean	7.81	7.92	8.02	7.81	7.73	8.07	7.71	8.27	7.82	8.30	8.07	8.39	8.41	8.44	8.72	8.08	8.76	

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	2Q2014	3Q2014	4Q2014	1Q2015
Director of Social Services reviews all readmissions occurring within 60 days of the last discharge and for each client who spent fewer than 30 days in the community, evaluated the circumstances of the readmission to determine an indicated need for resources or a change in treatment and discharge planning or the need for alternative resources. In cases where such a need or change was indicated that corrective action was taken.	100% 1/1	N/A	100% 1/1	100% 3/3

CONSENT DECREE

REDUCTION OF RE-HOSPITALIZATION FOR OUTPATIENT TREATMENT CLIENTS

Indicators	2Q2014	3Q2014	4Q2014	1Q2015
1. The Program Service Director of Outpatient Treatment 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 Outpatient Treatment	100% 1 client was returned to RPC for psychiatric instability due to substance abuse relapse	100% 1 client was returned to DDPC for psychiatric instability, client remains in DDPC	100% 1 client returned to RPC for psychiatric instability from group home, remains in RPC on Upper Saco	100% 2 clients returned to RPC for psychiatric instability manifested by assault of staff in their residence. Both remain in RPC.
2. Outpatient Treatment will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.	100%	100%	100%	100% Attendance at all treatment team meetings.

Summary:

Area 1) Both patients were male, in their mid to late 60's, both in residential care where medication was managed for them. Both are socially isolated and dependent upon fixed income. Both were over 10 miles from RPC Outpatient Treatment (formerly known as ACT). Patient #1 had been in their placement for approximately 1 year and Patient #2 had been at their placement for less than 6 months (this client had never fully stabilized in his community placement).

Area 2) RPC Outpatient Treatment is working closely with the Upper Saco unit to discharge Patient #1 back to his community placement in Waterville by the end of September. Patient #2 remains at RPC awaiting a referral to an outpatient setting.

Note: The ACT Team is now called Outpatient Treatment.

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	2Q14	3Q14	4Q14	1Q15	TOT
ADJUST DISORDER WITH MIXED ANXIETY & DEPRESSED MOOD	1				**1**
ANXIETY STATE NOS			3	1	**4**
ATTN DEFICIT W HYPERACT	1				**1**
BIPOLAR DISORDER, SINGLE MANIC EPISODE, UNSPEC		1			**1**
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC				1	**1**
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPEC	3			1	**4**
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH		2		1	**3**
BIPOLAR DISORDER, UNSPECIFIED	2	5	3	6	**16**
DELUSIONAL DISORDER		1	2	2	**5**
DEPRESS DISORDER-UNSPEC				1	**1**
DEPRESSIVE DISORDER NEC	3	4		5	**12**
DRUG ABUSE NEC-IN REMISS		1			**1**
FACTITIOUS DIS W PREDOMINANTLY PSYCHOLOGICAL SIGNS & SYMPTOM	1				**1**
FACTITIOUS ILL NEC/NOS	1				**1**
HEBEPHRENIA-UNSPEC	1			1	**2**
IMPULSE CONTROL DIS NOS	1				**1**
INTERMITT EXPLOSIVE DIS		1	1		**2**
MILD INTELLECTUAL DISABILITIES		1			**1**
OTH AND UNSPECIFIED BIPOLAR DISORDERS, OTHER			1	2	**3**
PARANOID SCHIZO-CHRONIC	3	2	6	8	**19**
PARANOID SCHIZO-UNSPEC	1	4	1		**6**
PERSON FEIGNING ILLNESS	1				**1**
POSTTRAUMATIC STRESS DISORDER		5	1	4	**10**
PSYCHOSIS NOS	10	11	8	6	**35**
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	11	12	12	16	**51**
SCHIZOPHRENIA NOS-CHR		1	2	2	**5**
SCHIZOPHRENIA NOS-UNSPEC		1	1	1	**3**
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED	1		2	1	**4**
UNSPECIFIED ALCOHOL-INDUCTED MENTAL DISORDERS				1	**1**
UNSPECIFIED EPISODIC MOOD DISORDER	5	9	8	8	**30**
UNSPECIFIED TRANSIENT MENTAL DIS IN COND CLASSIFIED ELSEWHERE	1				**1**
Total Admissions	**47**	**61**	**51**	**68**	**227**
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	**0.00%**	**1.64%**	**0.00%**	**0.00%**	**0.44%**

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	2Q2014	3Q2014	4Q2014	1Q2015
1. Attendance at Comprehensive Treatment Team meetings. (v9)	86% 352/411	86% 395/458	89% 417/466	*45% 183/404
2. Attendance at Service Integration meetings. (v8)	100% 41/41	86% 55/64	100% 46/46	100% 80/80
3. Contact during admission. (v8)	100% 57/57	100% 64/64	100% 62/62	100% 80/80

*Note: In mid-July some of the indicators in the Peer Support contract were changed so that the Peer Support staff would have more time for community integration with patients. Peer Support received a copy of the consent decree plan in September and only then became aware of the 80% standard. The Peer Support contract was then changed back to meet this standard.

Treatment Planning

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

Indicators	2Q2014	3Q2014	4Q2014	1Q2015
1. Service Integration meeting and form completed by the end of the 3rd day	100% 30/30	100% 30/30	100% 30/30	100% 30/30
2.Client Participation in Service Integration meeting.	100% 30/30	100% 30/30	100% 30/30	93% 28/30
3.Social Worker Participation in Service Integration meeting.	100% 30/30	100% 30/30	100% 30/30	100% 30/30
4.Client's Family Member and/or Natural Support (e.g., peer support, advocacy, attorney) participation in Service Integration meeting	90% 27/30	100% 30/30	80% 24/30	100% 30/30
5 .Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	93% 28/30	93% 28/30	86% 26/30	86% 26/30
6. 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	100% 30/30
7. Annual Psychosocial Assessment completed and current in chart	100% 15/15	100% 15/15	100% 15/15	100% 30/30

Summary:

Area 2) Two clients declined to meet for the Service Integration Meeting both were followed up with and did meet but not within designated timeframe.

Area 5) Three Comprehensive Psychosocial Assessments were not completed within the 7 day timeframe they were completed at 9, 10 and 13 days respectively. One assessment was not completed at all for one readmission for the Lower Kennebec unit and the patient was in the hospital for a total of ten days. This was discovered during a closed chart audit and the Social Work Director in consultation with the Medical Records Director completed an assessment based on admission assessment documentation and it was put into the closed record with the current October date of completion.

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

Indicators	2Q2014	3Q2014	4Q2014	1Q2015
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	93% 28/30	86% 26/30	83% 25/30	88% 40/45
2. 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.	100% 30/30	96% 29/30	86% 26/30	100% 45/45

Summary:

Area 1) There were 5 records that did not indicate a note was done during a weekly period. This was impacted by staffing issues within the Social Work Department and it is being addressed at staff meeting and in supervision.

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

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

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

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

V13) The treatment plans reflect

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

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

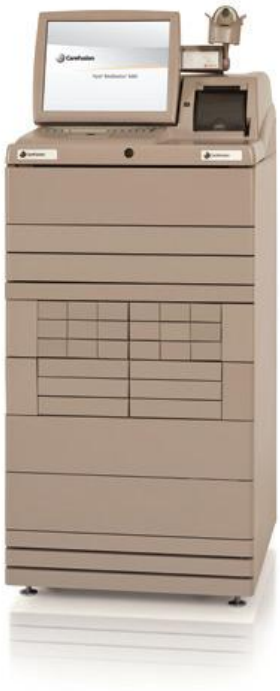
V15) If the record reflects limitations on a patient's rights listed in ¶159, those limitations were imposed consistent with the Rights of Recipients of Mental Health Services

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

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

Medications

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



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

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

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

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

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

CONSENT DECREE

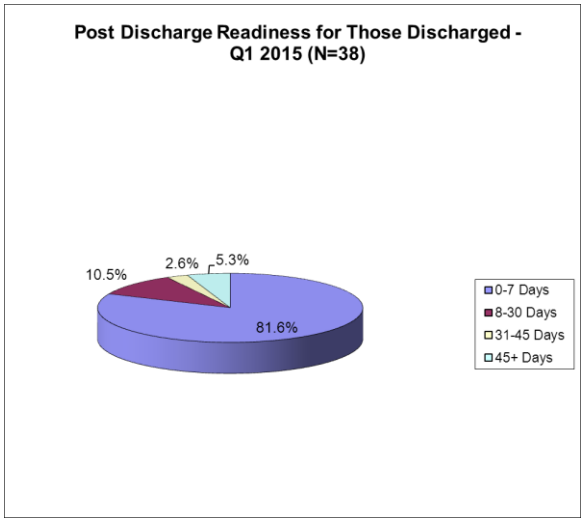
Discharges

Quarterly performance data shows that in 3 consecutive quarters:

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

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

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



Cumulative percentages & targets are as follows:

Within 7 days = (31) 81.6% (target 70%)
Within 30 days = (35) 92.1% (target 80%)
Within 45 days = (36) 94.7% (target 90%)
Post 45 days = (2) 5.3% (target 0%)

Barriers to Discharge Following Clinical Readiness

Residential Supports (0)

No barriers in this area

Treatment Services (0)

No barriers in this area

Housing (5) 13%

2 clients discharged 8-30 days post clinical readiness/housing barrier (18 & 22 days)
1 client discharged 31-45 days post clinical readiness/housing barrier (44 days)
2 clients discharged 45+days post clinical readiness/housing barrier (47 & 74 days)

Other (2) 5%

2 clients discharged 8-30 days post clinical readiness due to care coordination for discharge (9 and 15 days)

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%
4Q2014	N=17	70.6%	94.1%	94.1%	5.9%
3Q2014	N=24	73.1%	84.6%	92.3%	7.7%
2Q2014	N=20	73.1%	84.6%	92.3%	7.7%
1Q2014	N=26	73.1%	84.6%	92.3%	7.7%

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

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

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

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

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

Indicators	2Q2014	3Q2014	4Q2014	1Q2015
1. The Client Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 11/11	100% 9/9	91% 11/12	100% 13/13
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 11/11	100% 9/9	91% 11/12	76% 10/13
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	100% 11/11	100% 9/9	91% 11/12	76% 10/13
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% 11/11	100% 9/9	91% 11/12	100% 13/13

Summary:

Areas 2 and 3) The report was not sent out during the quarter on 3 occasions due to the Director being out on FMLA and technical issues with the document.

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	2Q2014	3Q2014	4Q2014	1Q2015
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	0% 0/4	0% 0/2	50% 3/6	25% 1/4
2. The assigned **CCM** will review the new court order with the client and document the meeting in a progress note or treatment team note.	100% 4/4	100% 3/3	100% 4/4	100% 6/6
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually	100% 92/92	N/A	N/A	N/A

Summary:

Area 1) Four Institutional Reports were done in the quarter and one was completed within the 10 day timeframe and the other three were completed 13 days, 17days and 36 days respectively.

Staffing and Staff Training

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

Indicators	1Q2015	2Q2015	3Q2015	4Q2015	YTD Findings
1. Riverview and Contract staff will attend CPR training bi-annually.	100% 62/62				100%
2. Riverview and Contract staff will attend Annual training.	96% 109/113				96%
3. Riverview and contract staff will attend MOAB training bi-annually	92% 389/424				92%

1Q2015

1. Employees who are out of compliance have been notified and corrective action is being taken.
2. MOAB was initiated in January 2014. Since the initiation date 398 staff have been trained leaving 35 employees still in need of training. MOAB is offered at least monthly.

Goal #1: 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:

1Q2015: Motivational Interviewing was provided in September 2014.

Goal #2: 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:

1Q2015: 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
DATE	HRS	TITLE	PRESENTER
3Q2012	14	January - March 2012	Winter Semester (see1Q13 Quarterly Report)
4Q2012	11	April – June 2012	Spring Semester (see1Q13 Quarterly Report)
1Q2013	3	July – September 2012	Summer Hiatus (see1Q13 Quarterly Report)
2Q2013	9	October – December 2012	Fall Semester (see2Q13 Quarterly Report)
3Q2013	11	January – March 2013	Winter Semester (see 3Q13 Quarterly Report)
4Q2013	12	April – June 2013	Spring Semester (see 4Q13 Quarterly Report)
1Q2014	5.5	July - September 2013	Summer Semester (see 1Q14 Quarterly Report)
2Q2014	7	October – December 2013	Fall Semester (see 2Q14 Quarterly Report)
3Q2014	15	January – March 2014	Winter Semester (see 3Q14 Quarterly Report)
4Q2014	16	April – June 2014	Spring Semester (see 4Q14 Quarterly Report)
7/15/2014	1	Peer Review Committee	Brendan Kirby, MD
8/6/2014	1	MOAB Training	Shawn McFarland
8/19/2014	1	Peer Review Committee	Miriam Davidson, PMHNP
8/28/2014	1	When home is no longer home: some guidelines for mental health professionals when working with refugees from Somalia	Jennifer Brotsky, PsyD
9/4/2014	1	Treatment Planning	Art DiRocco, PhD, Brendan Kirby, MD, Lisa Manwaring
9/11/2014	1	Review of a Long Term Riverview Patient	Art DiRocco, PhD Noel Ngai, Psychology Intern
9/16/2014	1	Peer Review Committee	Brendan Kirby, Md
9/17/2014	1	Metabolic Monitoring	Miranda Cole, PharmD
9/18/2014	1	Review of a Long Term Riverview Patient, Part II	Art DiRocco, PhD Noel Ngai, Psychology Intern
9/22/2014	4	Motivational Interviewing: The Basics	Stephen R. Andrew, LCSW, LADC, CCS, CGP
9/23/2014	4	Motivational Interviewing: The Basics	Stephen R. Andrew, LCSW, LADC, CCS, CGP
9/25/2014	1	Seizures, Psychosis or Something Else?	David Dettmann, DO

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

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

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

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

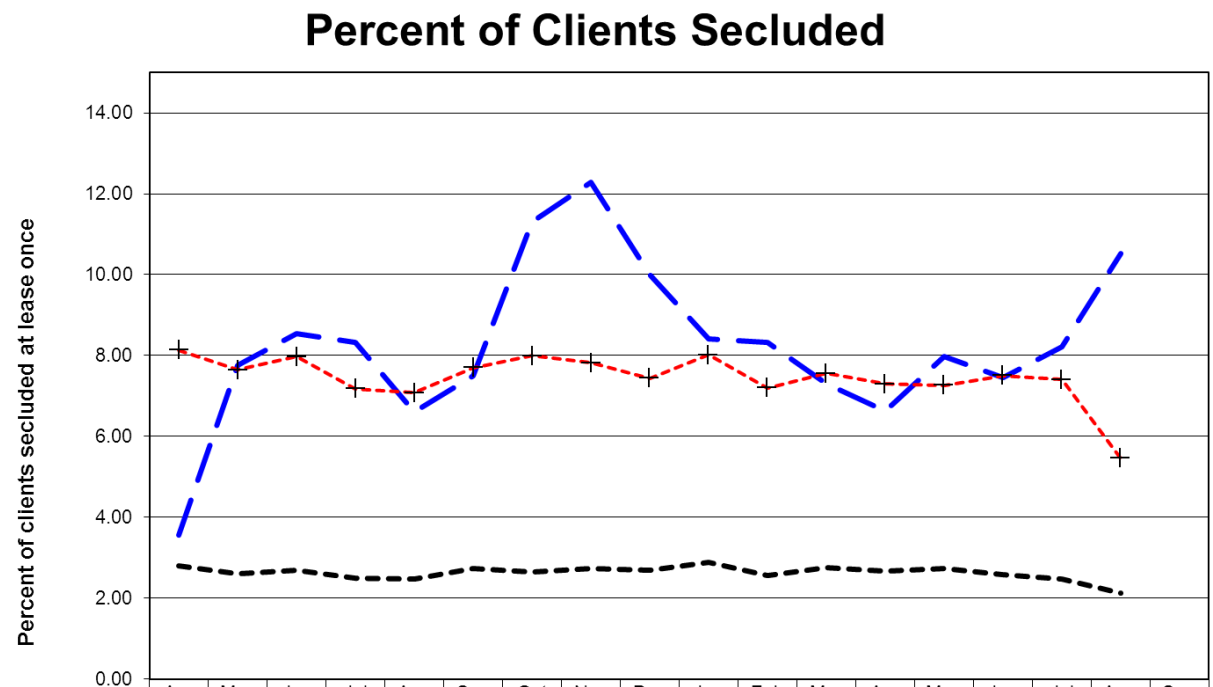
V26) The evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that staffing was sufficient to provide patients access to activities necessary to achieve the patients' treatment goals, and to enable patients to exercise daily and to recreate outdoors 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 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	3.57	7.76	8.55	8.33	6.61	7.50	11.30	12.28	10.00	8.40	8.33	7.30	6.62	7.97	7.46	8.21	10.53	
Ntl Mean	2.79	2.61	2.69	2.49	2.48	2.73	2.65	2.74	2.69	2.89	2.56	2.76	2.66	2.74	2.58	2.47	2.13	
+1 StDev	8.13	7.64	7.97	7.18	7.08	7.70	7.99	7.82	7.44	8.01	7.20	7.56	7.30	7.26	7.50	7.41	5.46	

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

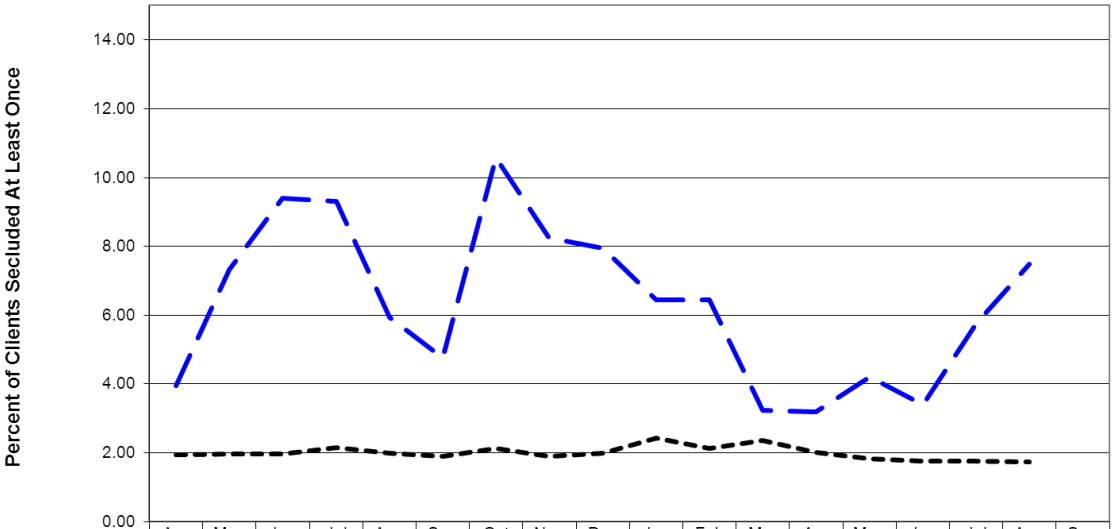
The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example; rates of 3.0 means that 3% of the unique clients served were secluded at least once.

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

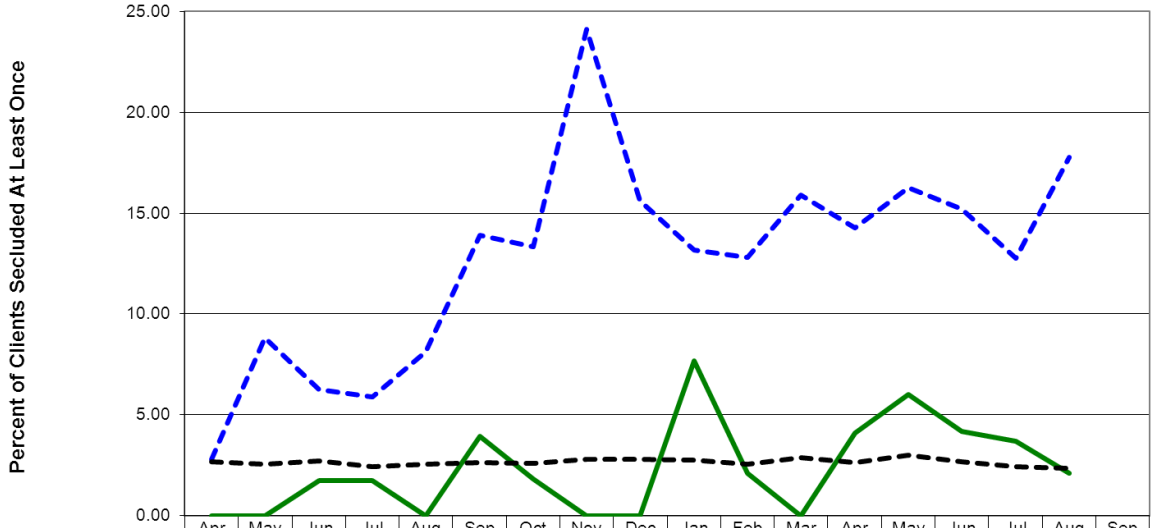
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	3.95	7.32	9.41	9.30	5.95	4.76	10.59	8.24	7.95	6.45	6.45	3.23	3.19	4.21	3.41	5.75	7.48	
Ntl Mean	1.94	1.97	1.97	2.15	1.99	1.89	2.14	1.89	1.99	2.44	2.12	2.35	2.02	1.82	1.76	1.77	1.74	

Percent of Clients Secluded

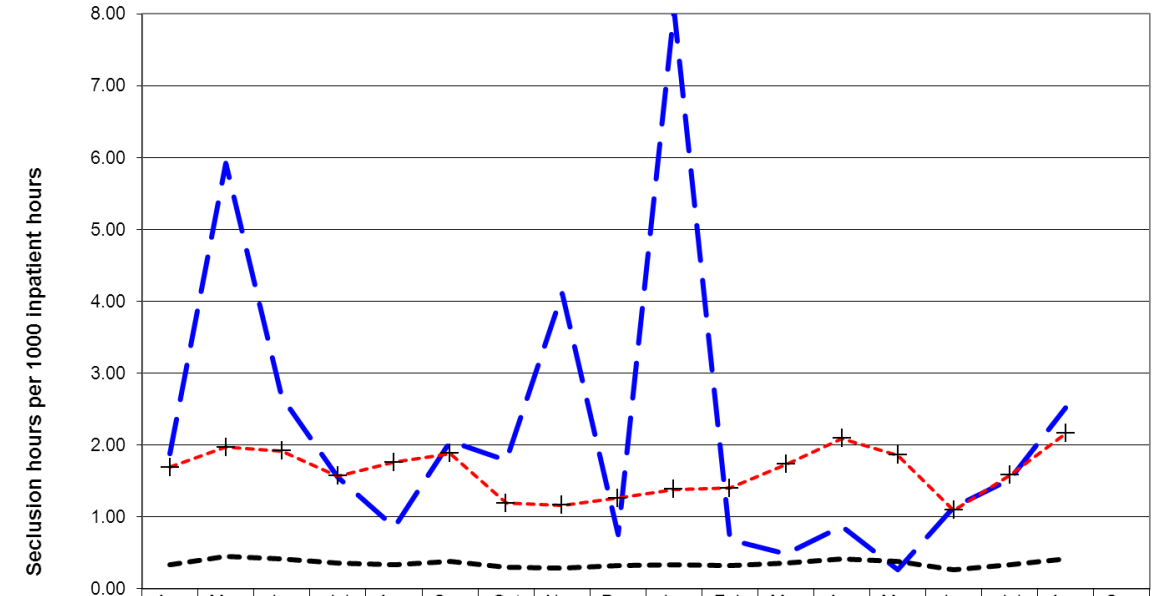
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	2.78	8.82	6.25	5.88	8.11	13.89	13.33	24.14	15.62	13.16	12.82	15.91	14.29	16.28	15.22	12.77	17.78	
Dorothea Dix	0.00	0.00	1.75	1.72	0.00	3.92	1.82	0.00	0.00	7.69	2.08	0.00	4.08	6.00	4.17	3.70	2.08	
Ntl Mean	2.68	2.53	2.71	2.43	2.54	2.62	2.57	2.77	2.79	2.76	2.56	2.86	2.62	2.98	2.66	2.41	2.33	

CONSENT DECREE

Seclusion Hours



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	1.88	5.92	2.67	1.55	0.86	2.05	1.79	4.11	0.75	8.05	0.68	0.48	0.87	0.27	1.14	1.52	2.52	
Ntl Mean	0.34	0.45	0.41	0.36	0.34	0.38	0.30	0.29	0.32	0.34	0.32	0.36	0.41	0.38	0.26	0.34	0.41	
+1 StDev	1.69	1.97	1.92	1.57	1.76	1.88	1.19	1.16	1.26	1.38	1.40	1.73	2.09	1.86	1.09	1.58	2.16	

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.

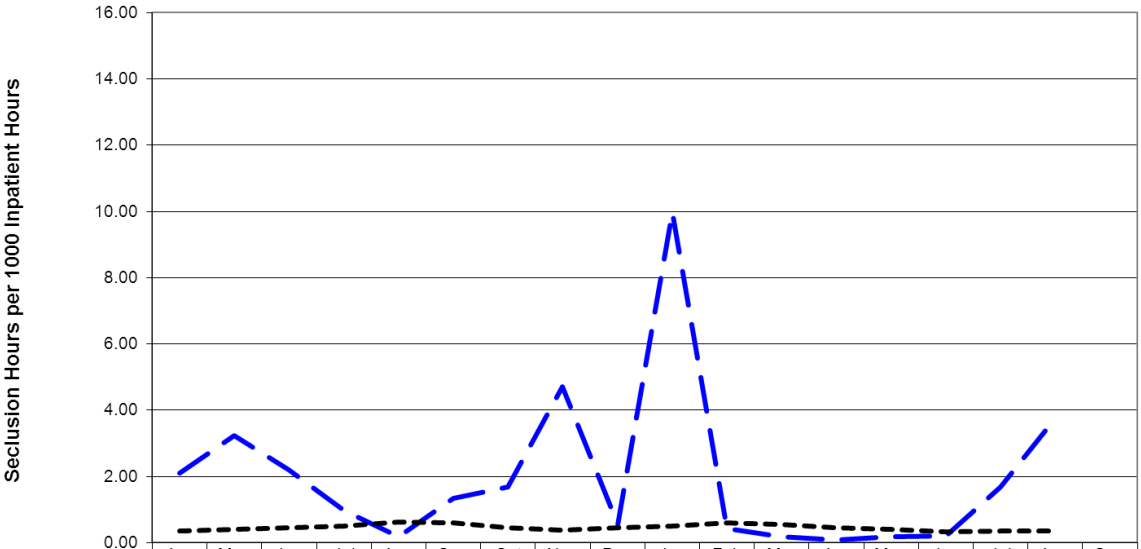
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

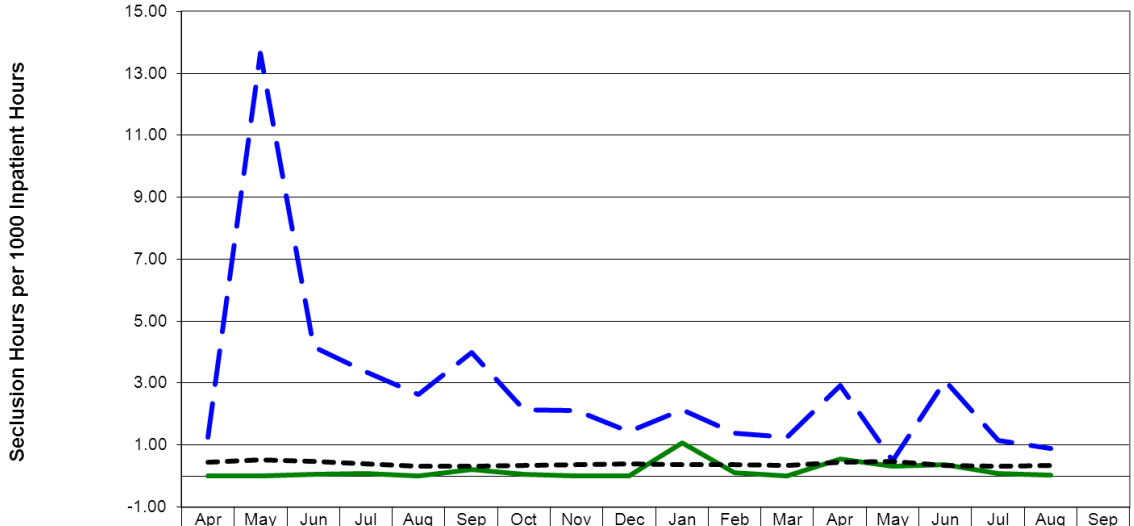
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	2.11	3.23	2.20	0.97	0.19	1.34	1.67	4.71	0.54	9.99	0.43	0.17	0.09	0.18	0.20	1.68	3.74	
Ntl Mean	0.36	0.40	0.45	0.51	0.61	0.60	0.44	0.37	0.45	0.51	0.60	0.56	0.46	0.40	0.33	0.36	0.36	

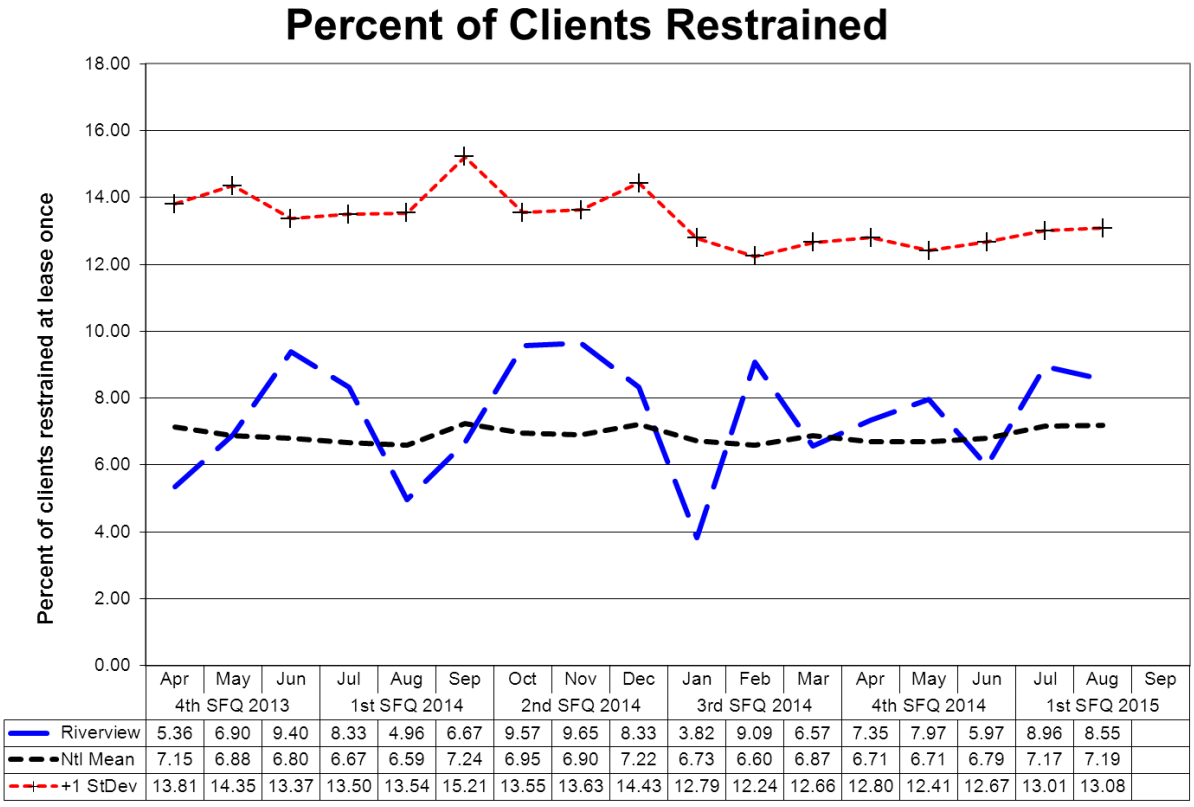
Seclusion Hours

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	1.26	13.65	4.18	3.37	2.63	3.98	2.14	2.12	1.43	2.14	1.38	1.26	2.92	0.49	3.09	1.15	0.90	
Dorothea Dix	0.00	0.00	0.06	0.09	0.00	0.22	0.05	0.00	0.00	1.08	0.10	0.00	0.56	0.31	0.36	0.09	0.03	
Ntl Mean	0.44	0.53	0.46	0.40	0.32	0.32	0.33	0.38	0.39	0.36	0.36	0.33	0.44	0.46	0.35	0.32	0.33	

CONSENT DECREE



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	5.36	6.90	9.40	8.33	4.96	6.67	9.57	9.65	8.33	3.82	9.09	6.57	7.35	7.97	5.97	8.96	8.55	
Ntl Mean	7.15	6.88	6.80	6.67	6.59	7.24	6.95	6.90	7.22	6.73	6.60	6.87	6.71	6.71	6.79	7.17	7.19	
+1 StDev	13.81	14.35	13.37	13.50	13.54	15.21	13.55	13.63	14.43	12.79	12.24	12.66	12.80	12.41	12.67	13.01	13.08	

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.

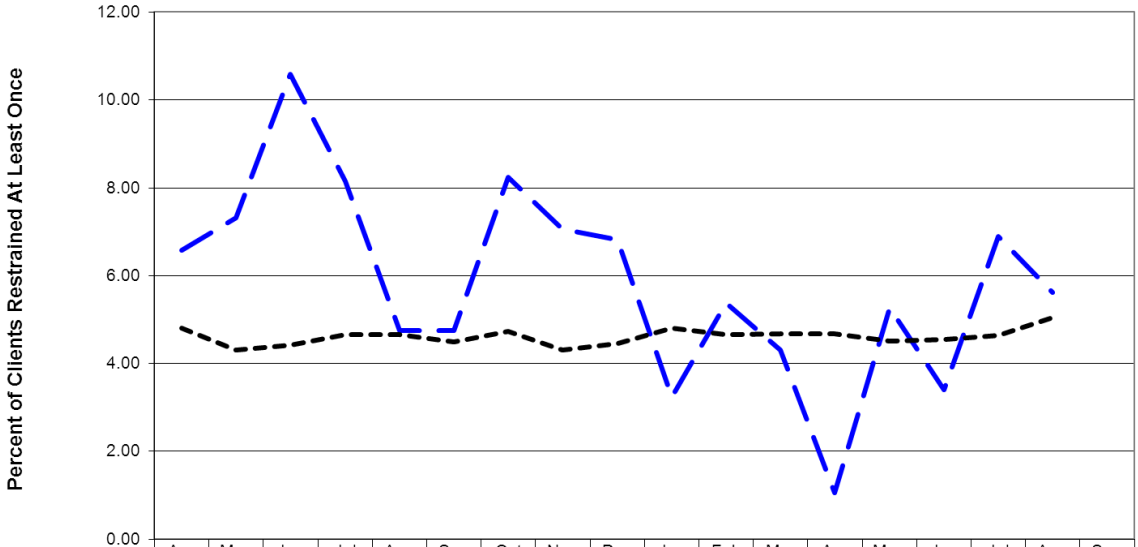
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example; a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

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

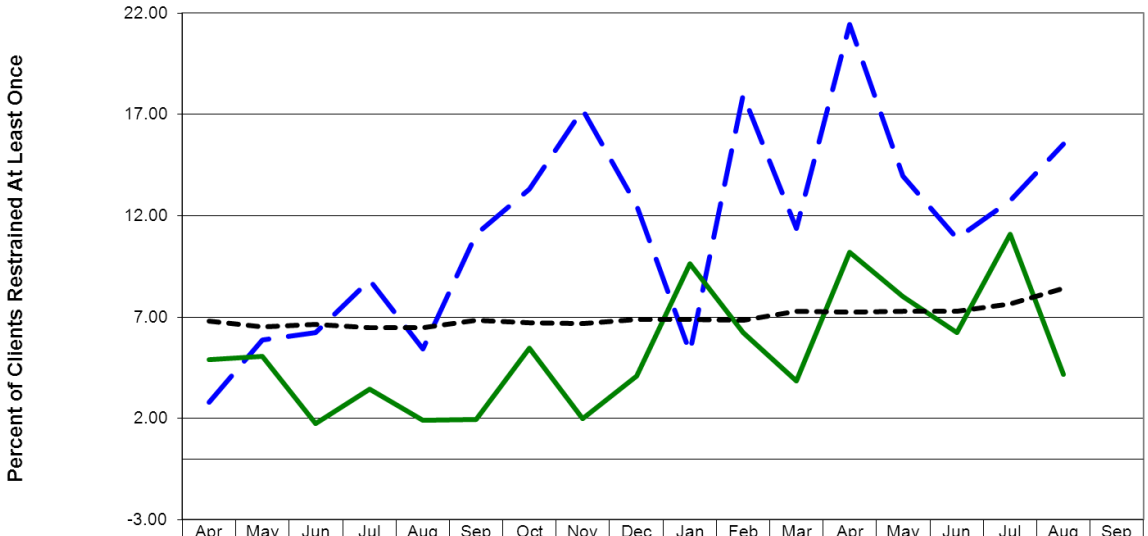
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	6.58	7.32	10.59	8.14	4.76	4.76	8.24	7.06	6.82	3.23	5.38	4.30	1.06	5.26	3.41	6.90	5.61	
Ntl Mean	4.81	4.30	4.42	4.66	4.66	4.49	4.73	4.31	4.46	4.81	4.66	4.67	4.68	4.51	4.54	4.64	5.05	

Percent of Clients Restrained

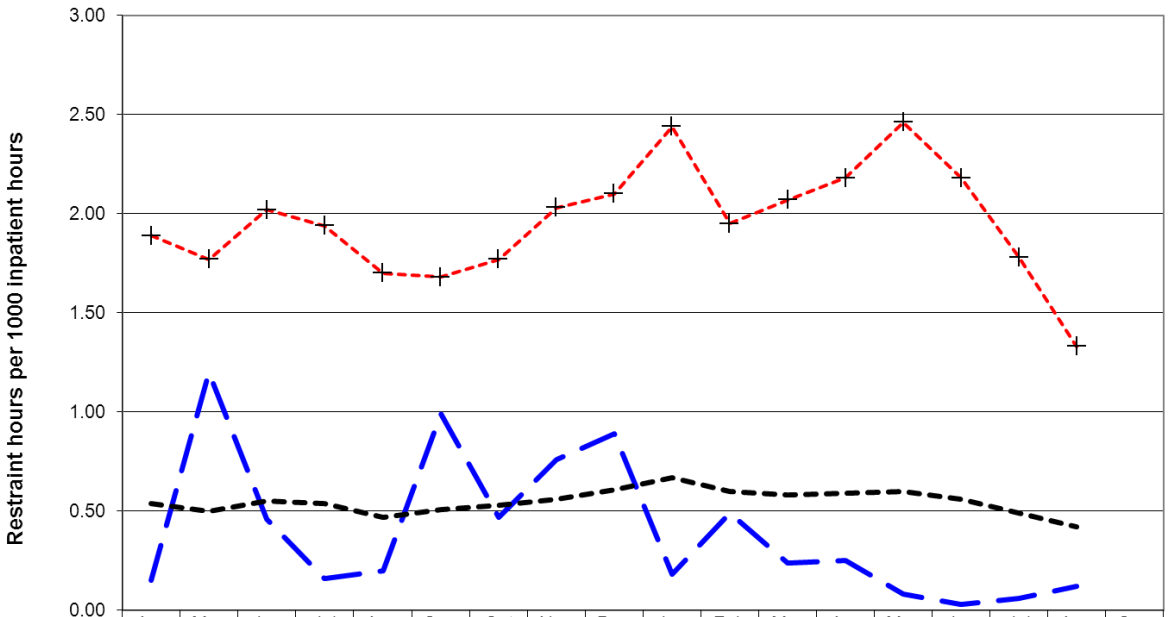
Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	2.78	5.88	6.25	8.82	5.41	11.11	13.33	17.24	12.50	5.26	17.95	11.36	21.43	13.95	10.87	12.77	15.56	
Dorothea Dix	4.92	5.08	1.75	3.45	1.92	1.96	5.45	2.00	4.08	9.62	6.25	3.85	10.20	8.00	6.25	11.11	4.17	
Ntl Mean	6.80	6.50	6.66	6.46	6.49	6.85	6.72	6.69	6.89	6.88	6.86	7.29	7.26	7.30	7.27	7.66	8.43	

CONSENT DECREE

Restraint Hours



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.15	1.20	0.46	0.16	0.20	0.99	0.47	0.76	0.89	0.18	0.49	0.24	0.25	0.08	0.03	0.06	0.12	
Ntl Mean	0.54	0.50	0.55	0.54	0.47	0.51	0.53	0.56	0.61	0.67	0.60	0.58	0.59	0.60	0.56	0.49	0.42	
+1 StDev	1.89	1.77	2.02	1.94	1.70	1.68	1.77	2.03	2.10	2.44	1.95	2.07	2.18	2.46	2.18	1.78	1.33	

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 those 2 hours were spent in restraint for each 1250 inpatient hours.

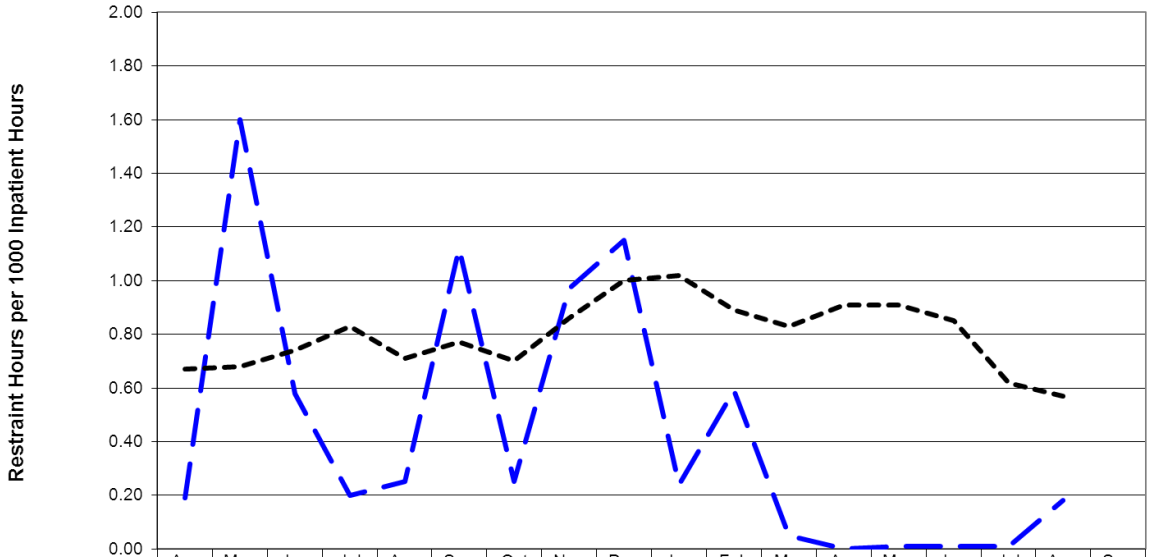
The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example; a rate of 1.6 means those 2 hours were spent in restraint for each 1250 inpatient hours.

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

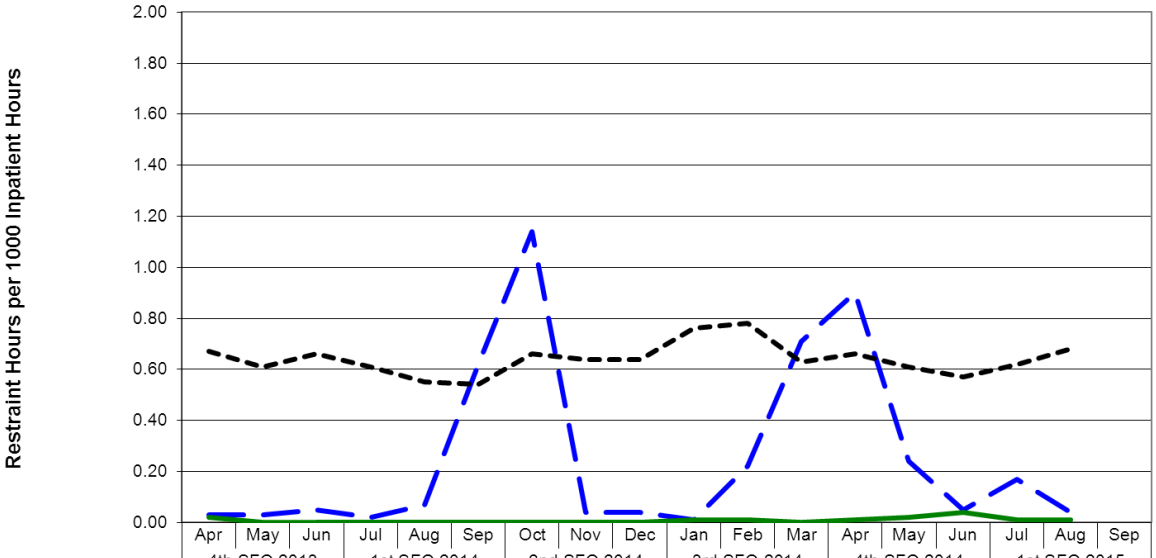
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.19	1.60	0.58	0.20	0.25	1.12	0.25	0.97	1.15	0.24	0.59	0.05	0.00	0.01	0.01	0.01	0.18	
Ntl Mean	0.67	0.68	0.74	0.83	0.71	0.77	0.70	0.86	1.00	1.02	0.89	0.83	0.91	0.91	0.85	0.62	0.57	

Restraint Hours

Civil Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.03	0.03	0.05	0.02	0.07	0.62	1.14	0.04	0.04	0.01	0.22	0.71	0.90	0.24	0.05	0.17	0.04	
Dorothea Dix	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.00	0.01	0.02	0.04	0.01	0.01	
Ntl Mean	0.67	0.61	0.66	0.61	0.55	0.54	0.66	0.64	0.64	0.76	0.78	0.63	0.66	0.61	0.57	0.62	0.68	

CONSENT DECREE

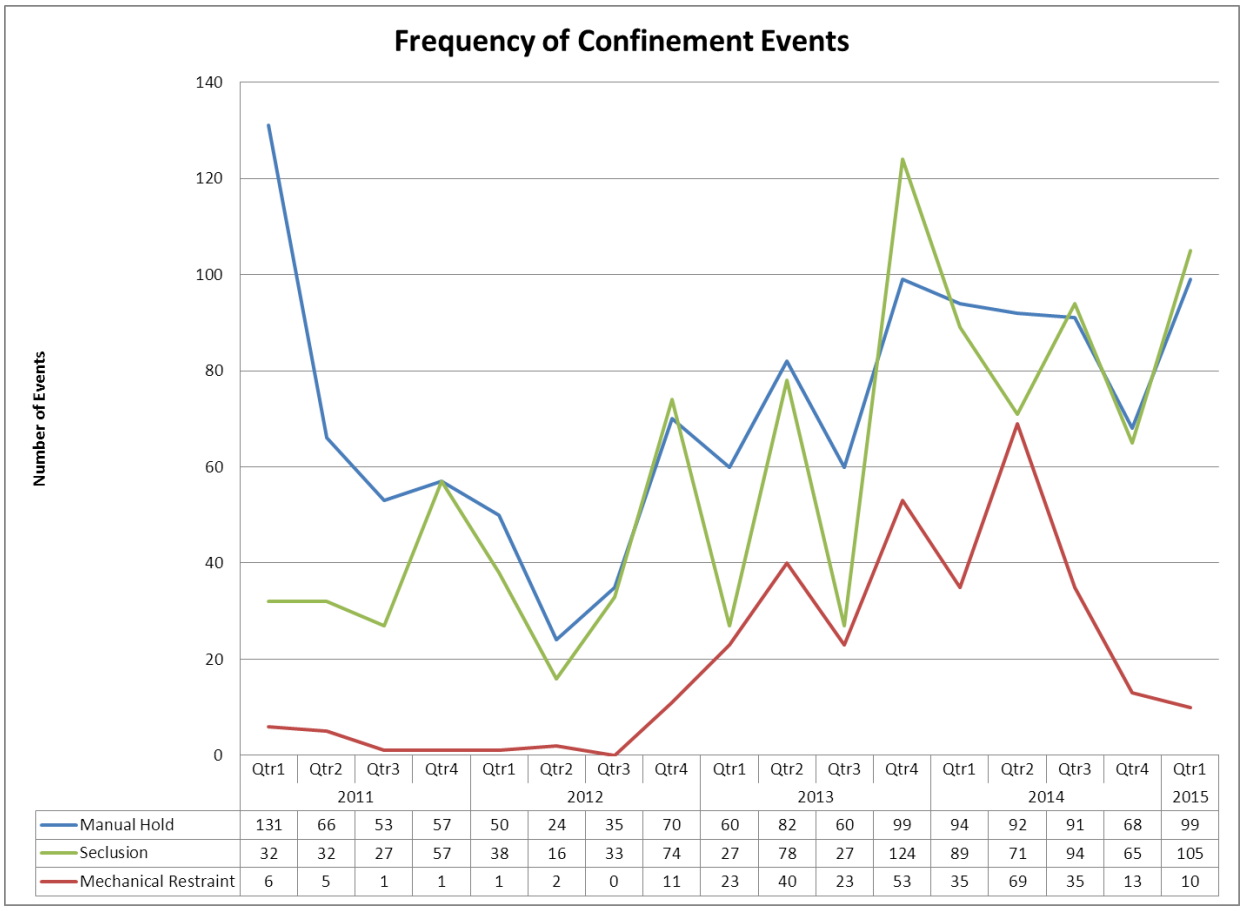
Confinement Event Detail

1st Quarter 2015

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR00003374	23		30	53	24.78%	24.78%
MR00004647	11	5	5	21	9.81%	34.59%
MR00000657	7	3	9	19	8.88%	43.47%
MR00002187	10		6	16	7.48%	50.95%
MR00007495	8	1	5	14	6.54%	57.49%
MR00007564	6		4	10	4.67%	62.16%
MR00006563	2		7	9	4.21%	66.37%
MR00000763	4		3	7	3.27%	69.64%
MR00005199	3		3	6	2.80%	72.44%
MR00000029	2	1	3	6	2.80%	75.25%
MR00007559	4		2	6	2.80%	78.05%
MR00007127	4		1	5	2.34%	80.39%
MR00007607	2		3	5	2.34%	82.72%
MR00007580	1		3	4	1.87%	84.59%
MR00004296			3	3	1.40%	85.99%
MR00007394	2		1	3	1.40%	87.39%
MR00007484	1		2	3	1.40%	88.79%
MR00005625	1		2	3	1.40%	90.19%
MR00006714	1		2	3	1.40%	91.59%
MR00007363	1		1	2	0.93%	92.53%
MR00007480	1		1	2	0.93%	93.46%
MR00005737	1			1	0.47%	93.93%
MR00005213	1			1	0.47%	94.39%
MR00000068	1			1	0.47%	94.86%
MR00005068	1			1	0.47%	95.33%
MR00007625	1			1	0.47%	95.80%
MR00000091			1	1	0.47%	96.26%
MR00000104			1	1	0.47%	96.73%
MR00000698			1	1	0.47%	97.20%
MR00000852			1	1	0.47%	97.67%
MR00001416			1	1	0.47%	98.13%
MR00005737			1	1	0.47%	98.60%
MR00006145			1	1	0.47%	99.07%
MR00006231			1	1	0.47%	99.53%
MR00007468			1	1	0.47%	100.00%
	99	**10**	**105**	**214**		

45% (35/78) of average hospital population experienced some form of confinement event during the 1st fiscal quarter 2015. Five of these clients (6% of the average hospital population) accounted for 57.5% of the containment events.

CONSENT DECREE



	Qtr1 2011	Qtr2 2011	Qtr3 2011	Qtr4 2011	Qtr1 2012	Qtr2 2012	Qtr3 2012	Qtr4 2012	Qtr1 2013	Qtr2 2013	Qtr3 2013	Qtr4 2013	Qtr1 2014	Qtr2 2014	Qtr3 2014	Qtr4 2014	Qtr1 2015
Manual Hold	131	66	53	57	50	24	35	70	60	82	60	99	94	92	91	68	99
Seclusion	32	32	27	57	38	16	33	74	27	78	27	124	89	71	94	65	105
Mechanical Restraint	6	5	1	1	1	2	0	11	23	40	23	53	35	69	35	13	10

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

	2Q14	3Q14	4Q14	1Q15	Total
Danger to Others/Self	88	92	63	17	**260**
Danger to Others			3	88	**91**
Danger to Self					
% Dangerous Precipitation	100%	100%	100%	100%	**100%**
Total Events	**88**	**92**	**66**	**105**	**351**

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

	2Q14	3Q14	4Q14	1Q15	Total
Danger to Others/Self	51	35	12	4	**102**
Danger to Others				4	**4**
Danger to Self	1		1	2	**4**
% Dangerous Precipitation	100%	100%	100%	100%	**100%**
Total Events	**52**	**35**	**13**	**10**	**110**

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

See Pages 30 & 31

CONSENT DECREE

Confinement Events Management

Seclusion Events (105) 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

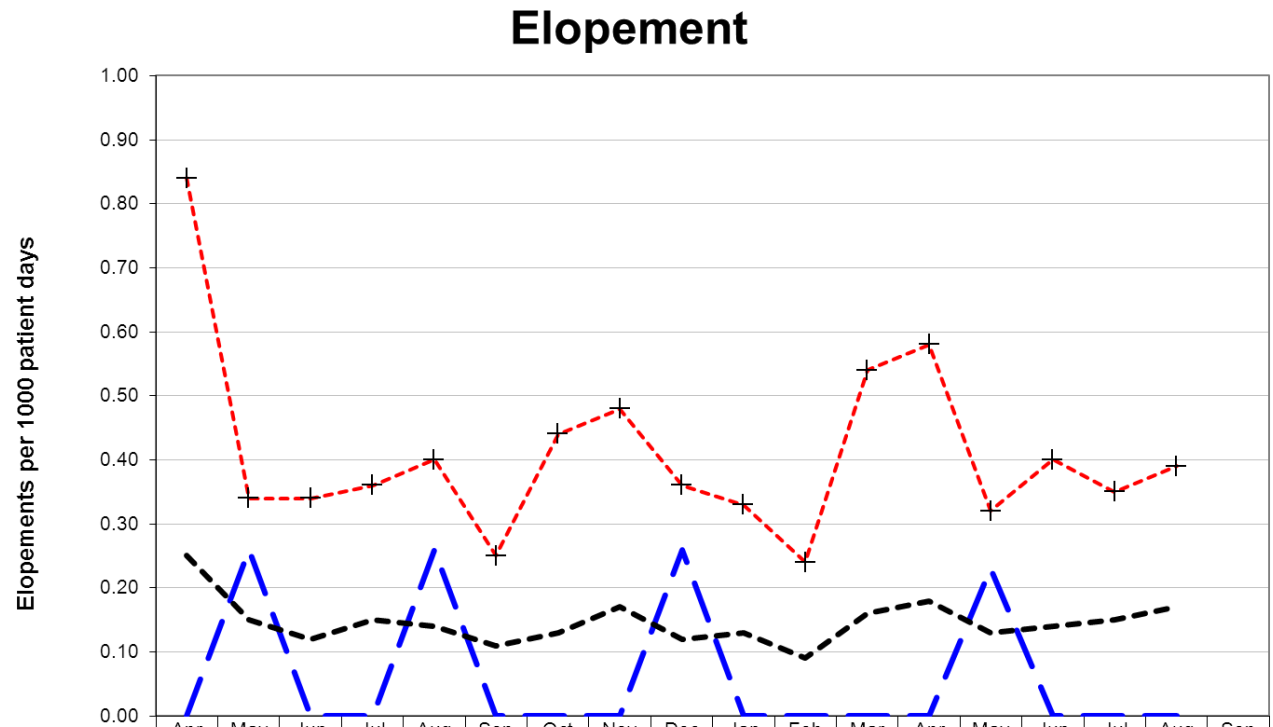
Mechanical Restraint Events (10) Events

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

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

Client Elopements

V31) Quarterly performance data shows that, in 5 out of 6 quarters, the number of client elopements 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 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.26	0.00	0.00	0.26	0.00	0.00	0.00	0.26	0.00	0.00	0.00	0.00	0.23	0.00	0.00	0.00	
Ntl Mean	0.25	0.15	0.12	0.15	0.14	0.11	0.13	0.17	0.12	0.13	0.09	0.16	0.18	0.13	0.14	0.15	0.17	
StDev	0.84	0.34	0.34	0.36	0.40	0.25	0.44	0.48	0.36	0.33	0.24	0.54	0.58	0.32	0.40	0.35	0.39	

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.”

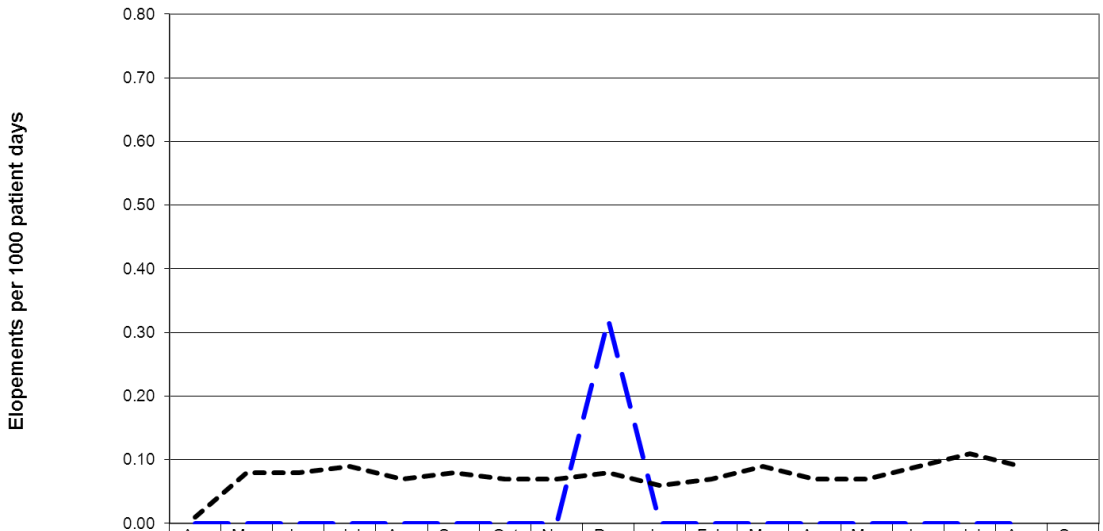
The following graphs depict the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

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

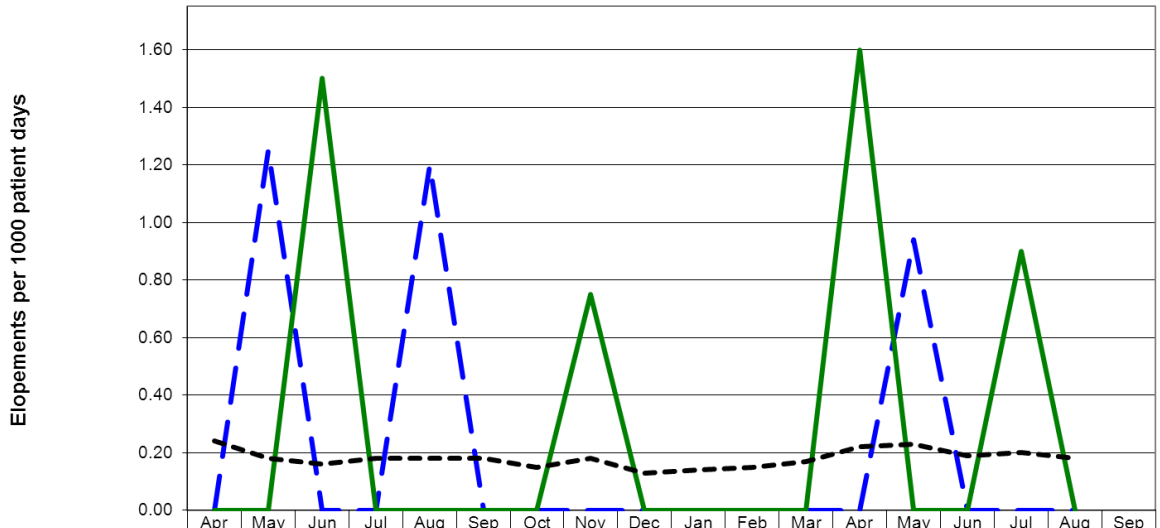
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.00	0.00	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	
Ntl Mean	0.01	0.08	0.08	0.09	0.07	0.08	0.07	0.07	0.08	0.06	0.07	0.09	0.07	0.07	0.09	0.11	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 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	1.25	0.00	0.00	1.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.94	0.00	0.00	0.00	
Dorothea Dix	0.00	0.00	1.50	0.00	0.00	0.00	0.00	0.75	0.00	0.00	0.00	0.00	1.60	0.00	0.00	0.90	0.00	
Ntl Mean	0.24	0.18	0.16	0.18	0.18	0.18	0.15	0.18	0.13	0.14	0.15	0.17	0.22	0.23	0.19	0.20	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

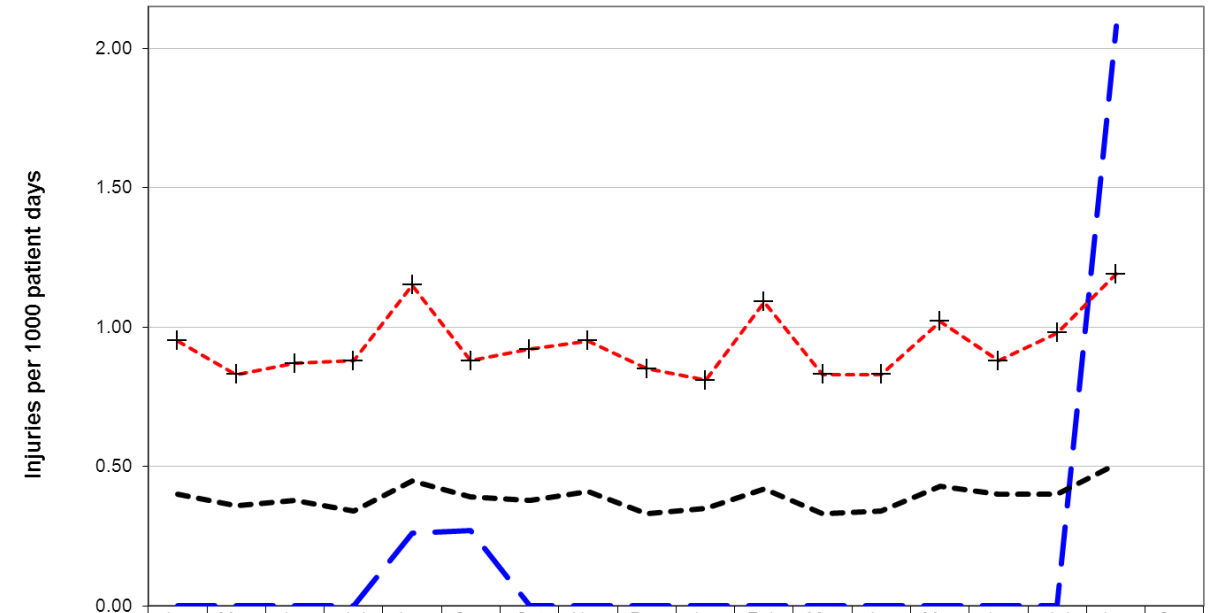
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

- 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 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	0.26	0.27	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.08	
Ntl Mean	0.40	0.36	0.38	0.34	0.45	0.39	0.38	0.41	0.33	0.35	0.42	0.33	0.34	0.43	0.40	0.40	0.51	
+1 StDev	0.95	0.83	0.87	0.88	1.15	0.88	0.92	0.95	0.85	0.81	1.09	0.83	0.83	1.02	0.88	0.98	1.19	

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.

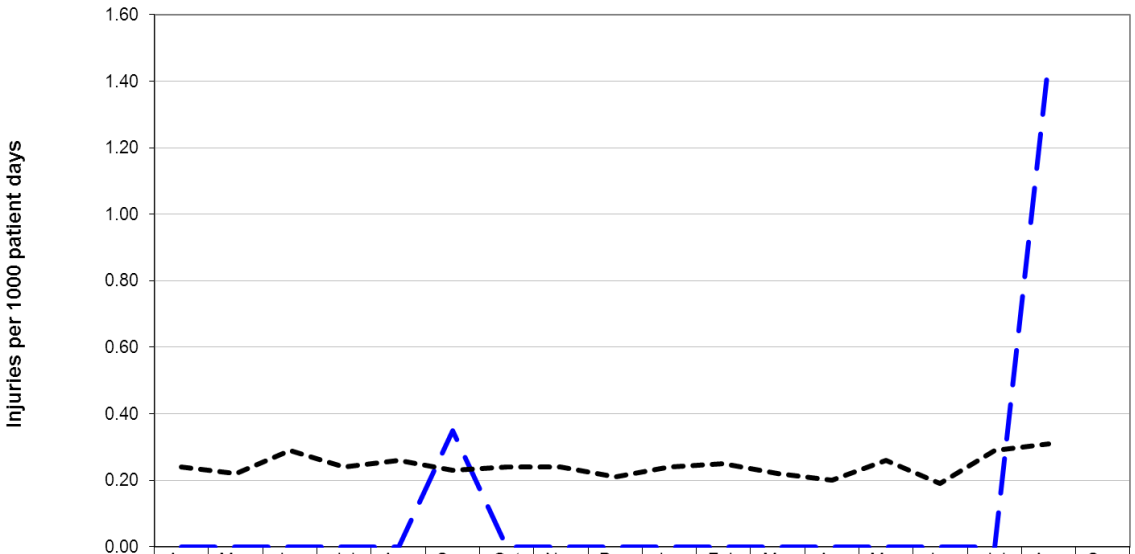
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

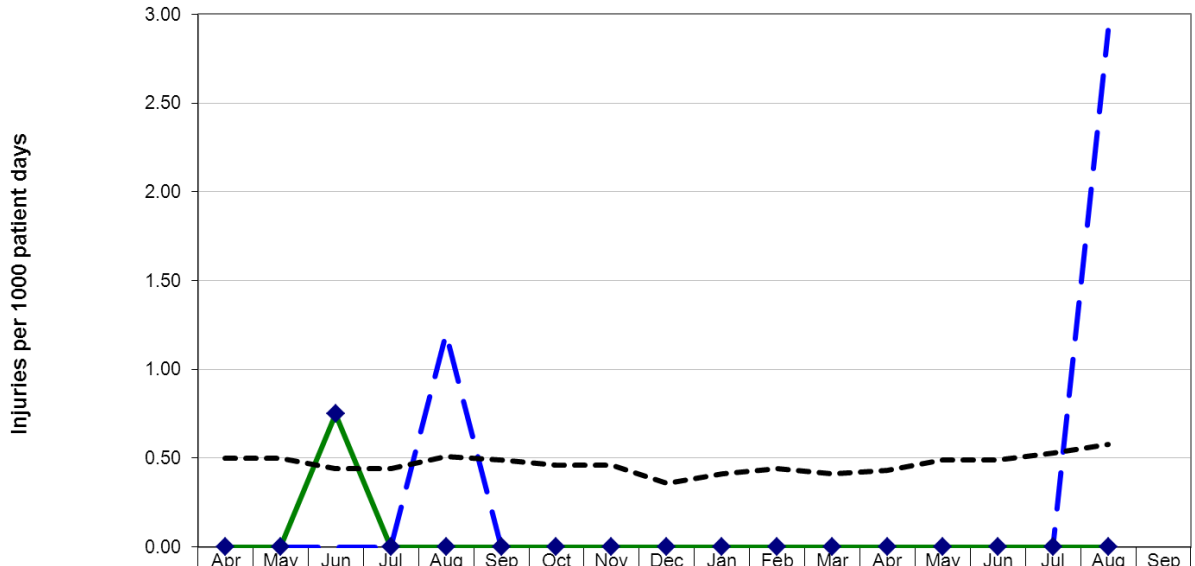
Forensic Stratification



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	0.00	0.35	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.46	
Ntl Mean	0.24	0.22	0.29	0.24	0.26	0.23	0.24	0.24	0.21	0.24	0.25	0.22	0.20	0.26	0.19	0.29	0.31	

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 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	0.00	0.00	0.00	0.00	1.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.91	
Dorothea Dix	0.00	0.00	0.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.50	0.50	0.44	0.44	0.51	0.49	0.46	0.46	0.36	0.41	0.44	0.41	0.43	0.49	0.49	0.53	0.58	

CONSENT DECREE

Severity of Injury by Month

Severity	JULY	AUG	SEPT	1Q2015
No Treatment	7	3	8	**18**
Minor First Aid	1	1	1	**3**
Medical Intervention Required	2	5	4	**11**
Hospitalization Required			1	**1**
Death Occurred				
Total	**10**	**9**	**14**	**33**

Type and Cause of Injury by Month

Type - Cause	JULY	AUG	SEPT	1Q2015
Accident – Environmental	1			**1**
Accident – Fall Unwitnessed	3	6	2	**11**
Accident – Fall Witnessed	4	2	5	**11**
Accident – Other	1		5	**6**
Medical		1	1	**2**
Self-Injurious Behavior	1			**1**
Unknown			1	**1**
Total	**10**	**9**	**14**	**33**

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.

Note: Numbers in previous reports were higher as we included both incidents and injuries in these figures. This report only includes injuries.

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	2Q2014	3Q2014	4Q2014	1Q2015
Abuse Physical	9	7	9	7
Abuse Sexual	2	3	15	5
Abuse Verbal	1	4	2	4
Coercion/Exploitation				4
Neglect		1		1

Note: Previous quarter's data has been adjusted as we removed allegations of patient abuse, neglect, and exploitation that occurred outside of the hospital from the numbers.

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

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

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with The Joint Commission on November 11-13, 2013. The Joint Commission conducted an unannounced visit on July 28-29, 2014. The hospital maintains its accreditation with the Joint Commission. The hospital will conduct a required annual self-assessment in October 2014. A triennial accreditation survey is expected to occur in November 2016 or earlier.

The hospital has 13 Measures of Success that are being monitored for the Joint Commission.

V35) Riverview maintains its hospital license;

Riverview maintains licensing status as required through the Maine Department of Health and Human Services Division of Licensing and Regulatory Services.

V36) The hospital seeks CMS certification;

The hospital was terminated from the Medicare Provider Agreement on September 2, 2013 for failing to show evidence of substantial compliance in eight areas by August 27, 2013. The hospital reapplied for certification in December 2013 and a 3 day site visit was conducted in May 2014. CMS found the hospital out of substantial compliance in one area and the hospital was denied certification. In July, a Performance Improvement Team was appointed to address Treatment Planning which was the one area of substantial non-compliance. Also, in July, the hospital applied for another certification visit. The hospital expects that visit to occur in the Fall of 2014.

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. The Advisory Board approved the Integrated Plan for Performance Excellence in August 2014 including Maine Division of Licensing and Regulatory Services required language that the hospital will comply with all federal and state hospital Conditions of Participation.

.

CONSENT DECREE

Maine Department of Licensing and Regulatory Services
Conditional License Requirements
Status Update
June 2014

Riverview Psychiatric Center's was provided a conditional license on September 13, 2013 in response to the CMS de-certification. The hospital was provided conditions of participation to maintain the license. On May 13, 2014 an addendum to the conditional license was given to the hospital.

The hospital shall ensure that patients are free from abuse, including neglect, in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital will create and maintain a formal, documented, and proactive approach to identify events and occurrences that may contribute to abuse and neglect. During orientation and through an ongoing training program, the hospital will provide all employees with information regarding abuse and neglect, and related reporting requirements, including prevention, intervention, and detection. The hospital will ensure, in a timely and thorough manner, objective investigations of all allegations of abuse, neglect, or mistreatment. The hospital shall ensure that any incidents of abuse, neglect, or mistreatment are reported and analyzed, and the appropriate corrective action occurs.	The hospital has a policy on protecting patients from abuse and neglect. It is maintained with all hospital polices. The hospital continues to use an Incident Reporting System. All incident reports are reviewed daily. Fact findings and investigations are conducted on suspected cases of abuse or neglect. All incidents of suspected abuse and neglect are reported to APS. All new employees are training in the policies regarding abuse, neglect and exploitation. They also receive training on risk management and identifying and reporting incidents through the Incident Reporting system.
The hospital shall ensure that restraint or seclusion may only be imposed to ensure the immediate physical safety of a patient, a staff member, or others and must be discontinued at the earliest possible time in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure the decision to use restraint or seclusion is driven by a documented and comprehensive individual patient assessment. The hospital shall ensure that once the unsafe situation ends, the use of restraint or seclusion is discontinued at the earliest possible time. The hospital shall monitor the utilization of restraint and seclusion. The hospital shall ensure that weapons (including pepper spray and Tasers) are not utilized in the application of healthcare restraint or seclusion.	The hospital policy on restraint and seclusion states that they may only be used to ensure the immediate physical safety of patients, staff, and others. Restraints and seclusions are used only when other de-escalation techniques have failed. Restraints and seclusion, by policy and practice, are ended at the earliest possible time. The Incident Reporting form used by the hospital requires staff to document the times used for any seclusion and restraint. All seclusion restraint events are documented on Incident Report forms. These are reviewed on a daily basis and follow-up is initiated as required. The hospital maintains a data base of all seclusion and restraint events; these are analyzed and reported in the quarterly report. The hospital staff will not use nor will they give

	permission to use weapons, including pepper spray and Tasers, in application of healthcare restraint or seclusion.
The hospital shall ensure that a registered nurse supervises and evaluates the nursing care for each patient, in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure that the nursing care for each patient is evaluated on admission and on an ongoing basis in accordance with accepted standards of nursing practice and hospital policies.	Buck Pushard, Director of Nursing, supervises and evaluates the nursing care for patients. All patients receive an assessment at admission and on an ongoing basis as required by standards of practice and in accordance with policies.
The hospital shall ensure that the least restrictive intervention which is effective will be utilized in cases of restraint or seclusion in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure that less restrictive interventions have been determined by staff to be ineffective to protect the patient or others from harm prior to the introduction of more restrictive measures.	Hospital policy on seclusion and restraint require the use of least restrictive means for patient intervention. Documentation is required that least restrictive means are used and are ineffective before more restrictive means are implemented.
The hospital shall ensure that orders for restraint or seclusion are never written as a standing order, or on an as needed basis, in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure that the ongoing authorization of restraint or seclusion is not permitted.	By hospital policy, restraint and seclusion orders are never written as a standing order or PRN. Each incident of restraint or seclusion requires a separate order. Medical Staff have been trained on this policy.
The hospital shall ensure that all medical records are accurately written, in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure that all medical records accurately and completely document all orders, test results, evaluations, care plans, treatments, interventions, care provided, and the patient's response to those treatments, interventions, and care.	The hospital policy on medical records requires accuracy of reporting. All orders, test results, evaluations, care plans, treatments, interventions, care provided and the patient's response to those treatments, interventions and care are included in the medical records. All staff and contractors receive training on documentation.
The hospital shall ensure that the Medical Staff is responsible for the quality of medical care provided to patients in accordance with the Regulations and the Conditions of Participation	The Medical Staff by-laws state that the medical staff is responsible for the quality and medical care provided to patients. The hospital meets staffing standards set by the Conditions of

for Hospitals, and that the Governing Body has a sufficient method for ensuring the delivery of quality medical care. This will include all patients regardless of their location.	Participation and the Consent Decree.
The hospital shall ensure that performance improvement activities track medical errors and adverse patient events, analyze their causes, and implement preventative actions and mechanisms that include feedback and learning throughout the hospital in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital shall ensure that the event analysis includes what happened, why it happened, and what can be done to prevent recurrence. The hospital shall ensure that an action plan is developed to include a specific plan for corrective action which incorporates evidence-based practice, responsibility for implementation, dates for completion, and ongoing monitoring of the implemented corrective actions.	All medical errors and adverse events are tracked and analyzed. Dr. Kirby, Clinical Director, reviews all errors and reports them to medical staff. The hospital uses The Joint Commission model for root cause analyses for adverse events at the hospital. Results from any root cause analyses are reported to the Executive Leadership Committee and Medical Leadership at the hospital. Action plans are developed, implemented and reviewed for compliance.
The Governing Body shall ensure that the hospital is operated in compliance with the hospital's policies and procedures in accordance with the Regulations and the Conditions of Participation for Hospitals. The hospital will ensure effective policy management through an enterprise-level process.	The Governing Board was trained in April on the High Reliability framework for Healthcare Institutions. This Joint Commission framework is being implemented throughout the hospital for quality improvement. Leadership has been trained and High Reliability is included in all employee orientation. The hospital's proposed QAPI plan will be reviewed by the Advisory Board at their August meeting seeking approval including discussion about other continuous quality improvement methodologies to be used.
The monitoring of the requirements of the Conditional License shall be included in the facility's quality assurance and performance improvement program and made available to the Department upon request.	The results of the Conditional License were reported at the IPEC meeting in June and are included in the performance improvement plan. Progress in meeting the standards will be reviewed at each meeting.
Subject to the Department's approval, the hospital shall obtain the services of a qualified consultant as described further herein. During the remainder of this amended Conditional License, the hospital shall consult with the qualified consultant to:	The hospital has a contract with Dartmouth Medical School to provide consultation and guidance. Drs. Paul Gorman and Will Torrey have visited the hospital and produced an initial report of findings. The Department has a contract with Holly Harmon,

Monitor the hospital to determine compliance with the amended Conditional License, Rules and applicable laws. Each month, the qualified consultant shall submit a written report to the Department, which contains detailed information about the conditions described herein, any recommendations or suggestions submitted to the hospital, and progress notes on the hospital's compliance with the Regulations and the Conditions of Participation; and Provide routine consultation and guidance to promote lasting culture change, to develop and maintain an organizational culture which advocates safety, quality, patient rights, and the Rights of Recipients of Mental Health Services.	R.N., to provide technical assistance to the hospital on quality improvement.

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 initi

data to The Joint Commission on behalf of accredited hospitals and long term care organizations. Since that time, home care and behavioral healthcare organizations have been included in the ORYX initiative.

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

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

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

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

Assessment

Treatment Planning and Implementation

Hope and Empowerment

Patient Driven Care

Patient Safety

Continuity and Transition of Care

Outcomes

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

JOINT COMMISSION

Admissions Screening (HBIPS 1)

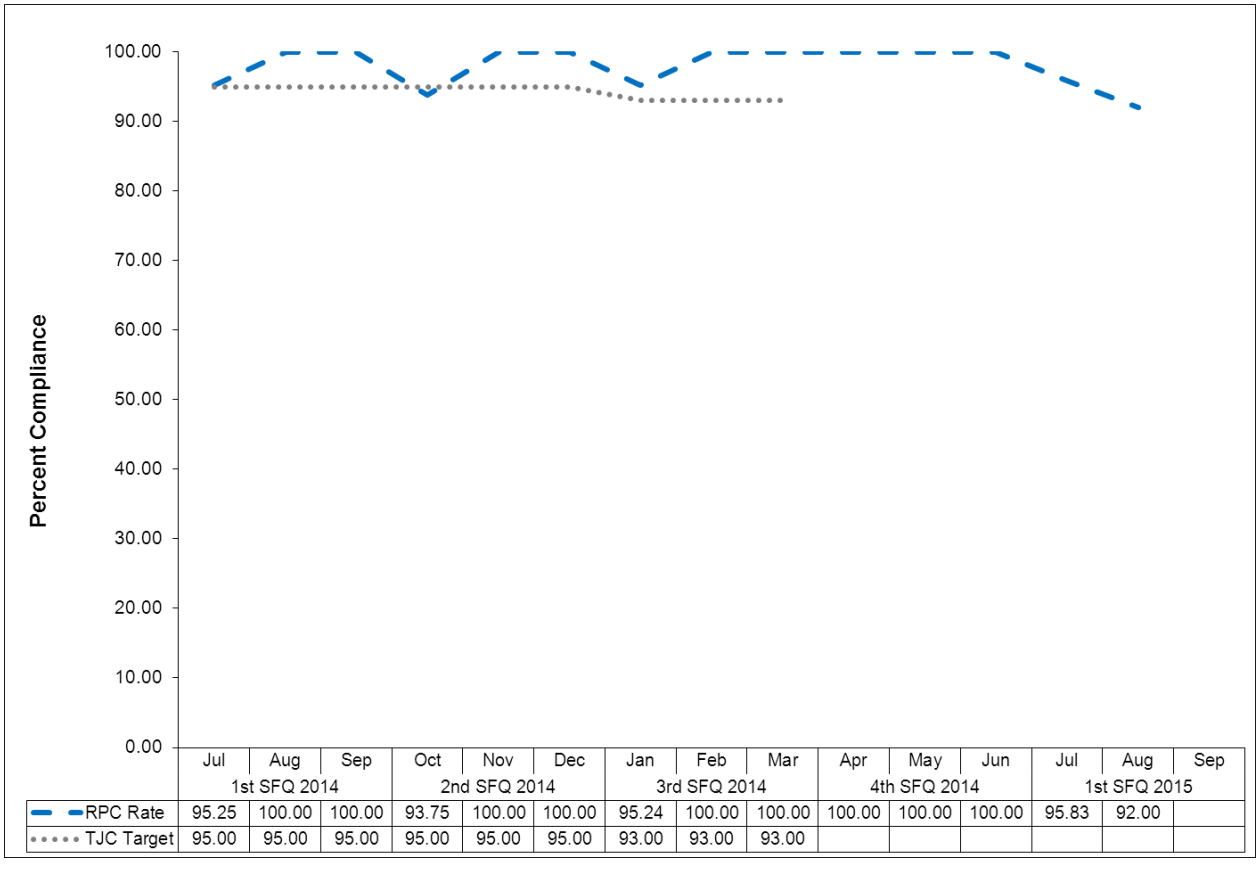
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	95.25	100.00	100.00	93.75	100.00	100.00	95.24	100.00	100.00	100.00	100.00	100.00	95.83	92.00	
TJC Target	95.00	95.00	95.00	95.00	95.00	95.00	93.00	93.00	93.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

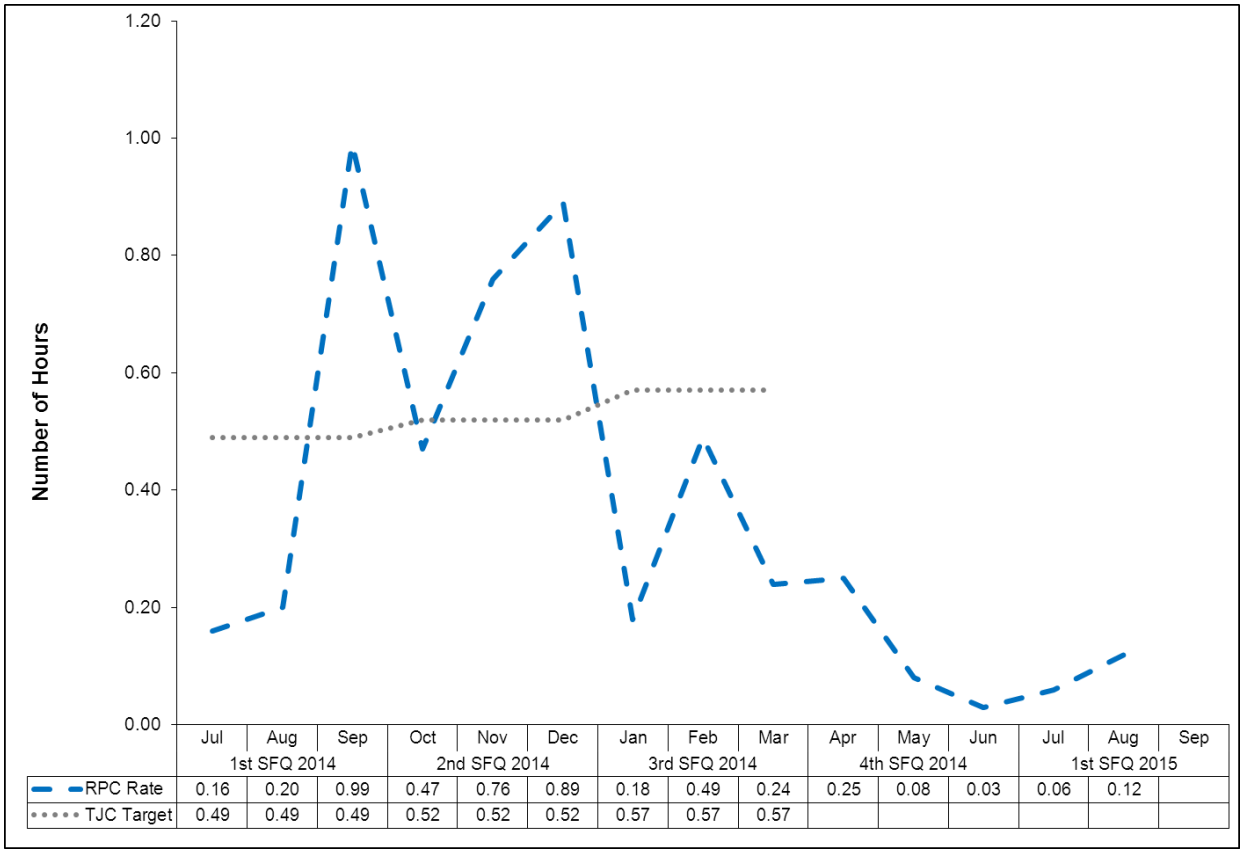
Hours of Use

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	0.16	0.20	0.99	0.47	0.76	0.89	0.18	0.49	0.24	0.25	0.08	0.03	0.06	0.12	
TJC Target	0.49	0.49	0.49	0.52	0.52	0.52	0.57	0.57	0.57						

JOINT COMMISSION

Seclusion (HBIPS 3)

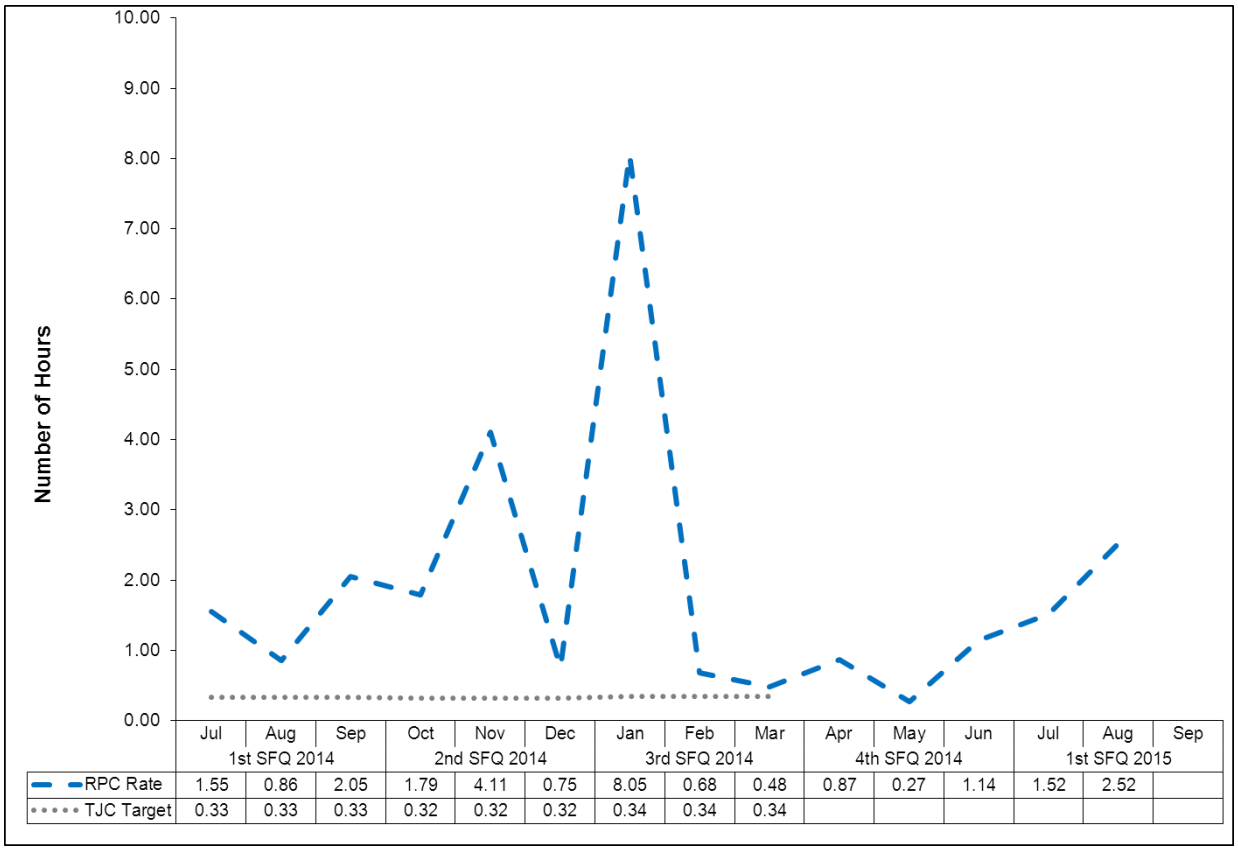
Hours of Use

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	1.55	0.86	2.05	1.79	4.11	0.75	8.05	0.68	0.48	0.87	0.27	1.14	1.52	2.52	
TJC Target	0.33	0.33	0.33	0.32	0.32	0.32	0.34	0.34	0.34						

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

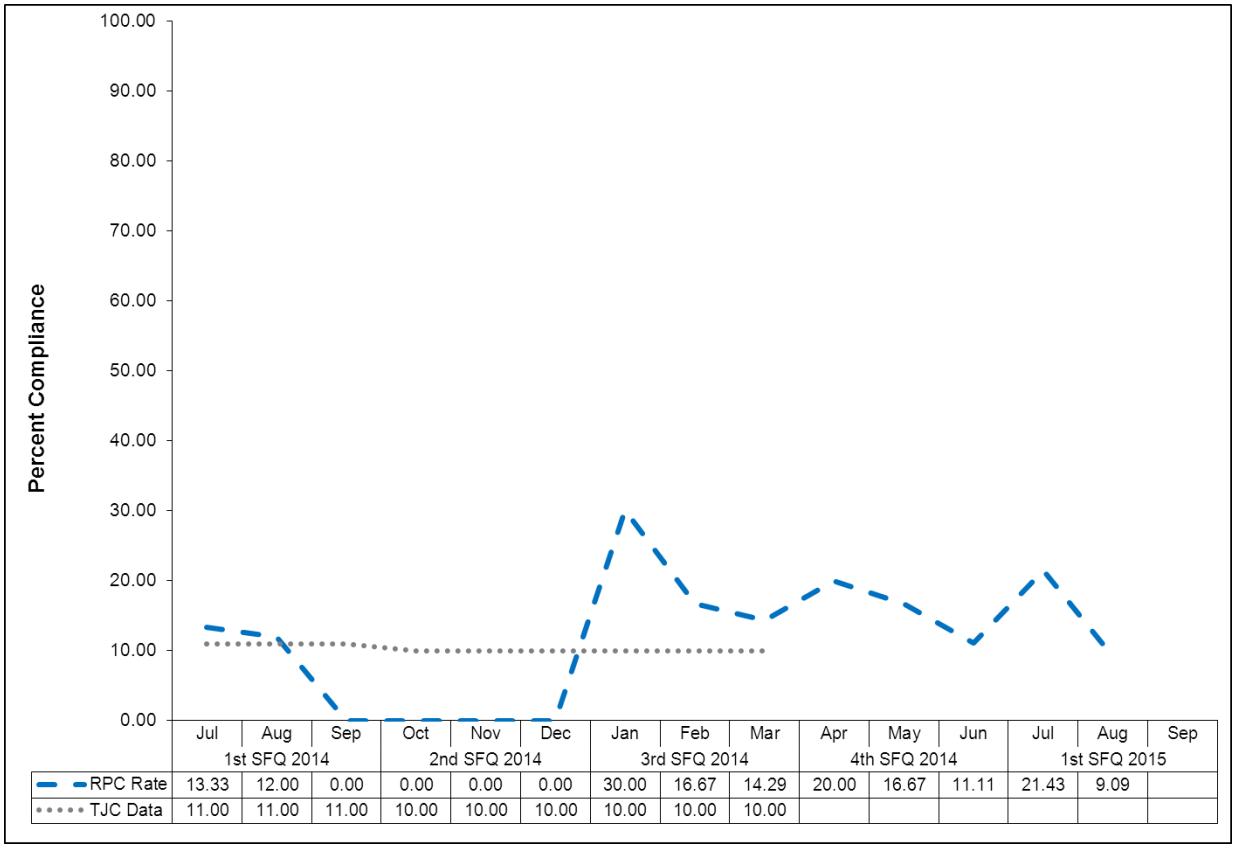
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

Rationale

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

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	13.33	12.00	0.00	0.00	0.00	0.00	30.00	16.67	14.29	20.00	16.67	11.11	21.43	9.09	
TJC Data	11.00	11.00	11.00	10.00	10.00	10.00	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

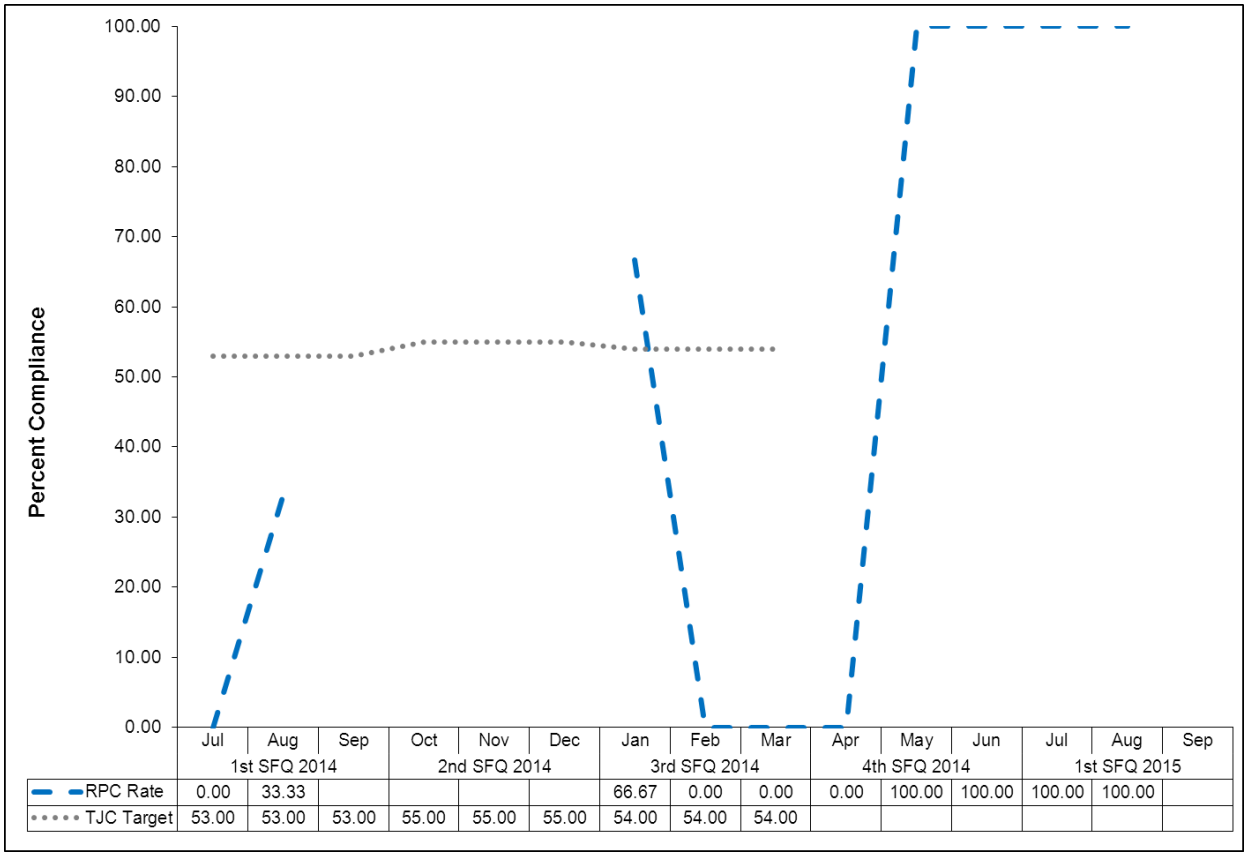
Rationale

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)



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	0.00	33.33					66.67	0.00	0.00	0.00	100.00	100.00	100.00	100.00	
TJC Target	53.00	53.00	53.00	55.00	55.00	55.00	54.00	54.00	54.00						

Note: when the rate is blank for a month it means that no patients in that month were discharged on multiple antipsychotic medications.

JOINT COMMISSION

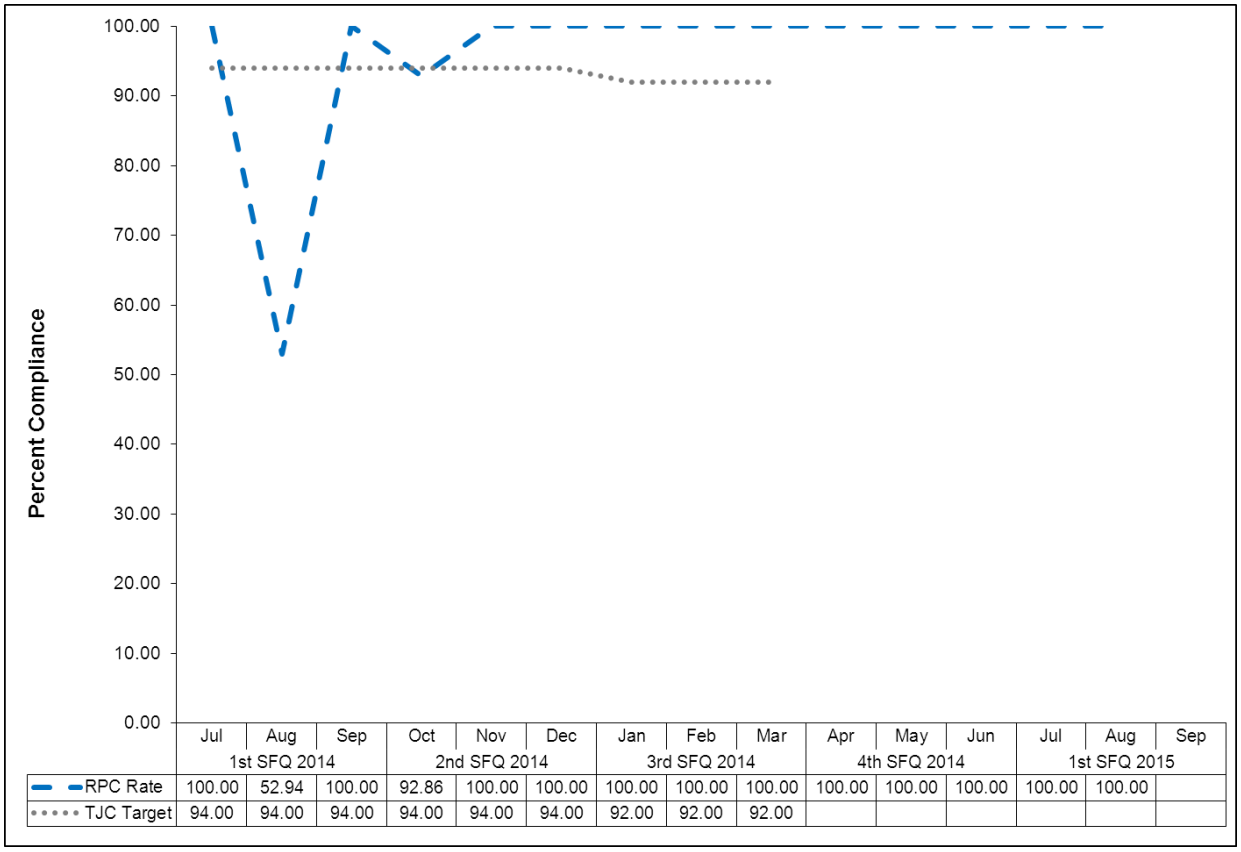
Post Discharge Continuing Care Plan (HBIPS 6)

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	100.00	52.94	100.00	92.86	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	
TJC Target	94.00	94.00	94.00	94.00	94.00	94.00	92.00	92.00	92.00						

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

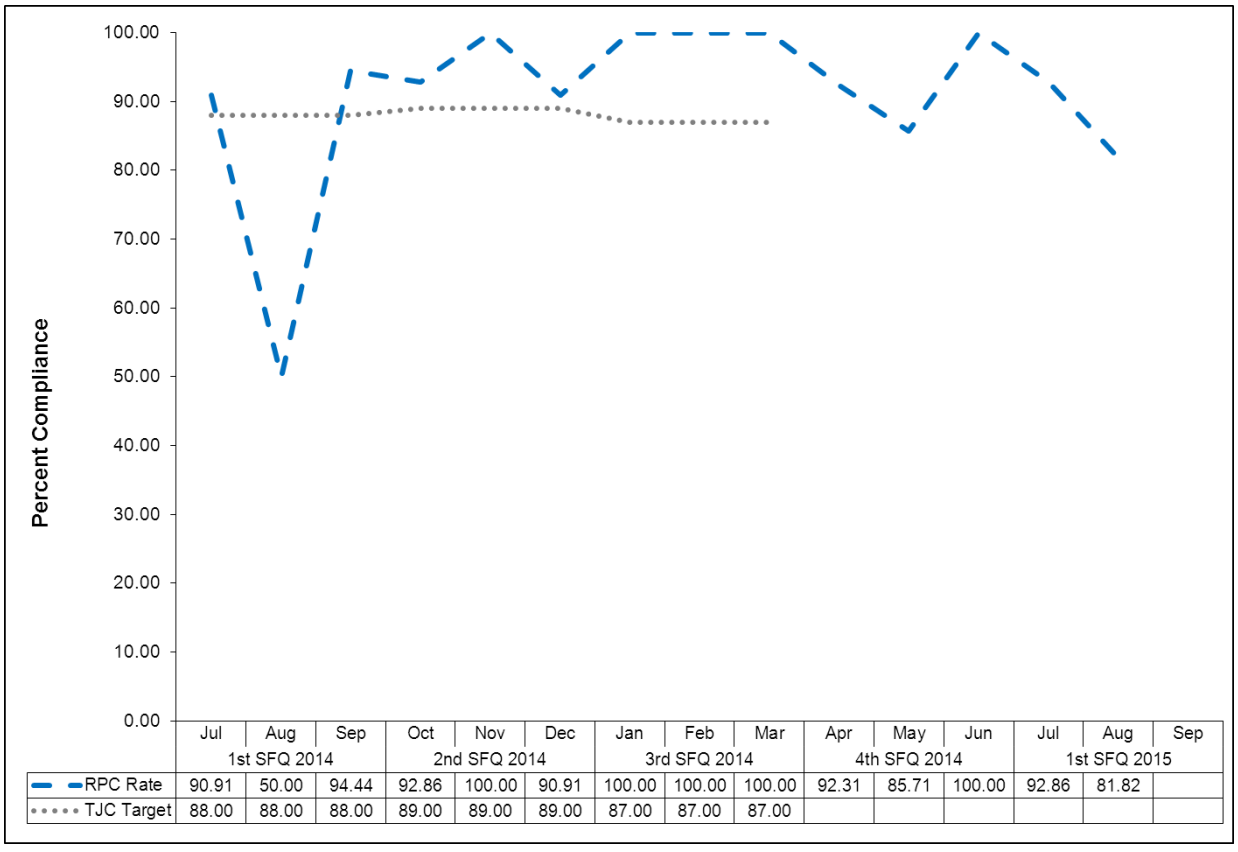
To Next Level of Care Provider on Discharge

Description

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

Rationale

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



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
RPC Rate	90.91	50.00	94.44	92.86	100.00	90.91	100.00	100.00	100.00	92.31	85.71	100.00	92.86	81.82	
TJC Target	88.00	88.00	88.00	89.00	89.00	89.00	87.00	87.00	87.00						

JOINT COMMISSION

Contract Performance Indicators

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

FY 2015 Quarter 1 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Amistad Peer Support Services	Stephanie George-Roy Director of Social Services	One indicator did not meet standards, all others exceeded standards.
Community Dental, Region II	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Comprehensive Pharmacy Services	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Com-Tec Security	Debora Proctor Executive Housekeeper	All indicators met standards.
Cummins Northeast	Richard Levesque Director of Support Services	No services provided during timeframe.
Dartmouth Medical School	Robert J. Harper Acting Superintendent	All indicators exceeded standards.
Disability Rights Center	Robert J. Harper Acting Superintendent	All indicators met standards.
G & E Roofing	Richard Levesque Director of Support Services	Indicator exceeded standard.
Goodspeed & O'Donnell	Dr. Brendan Kirby Clinical Director	No services provided during timeframe.
Holly Harmon Consulting Services	Ricker Hamilton Deputy Commissioner of Programs	All indicators exceeded standards.
Lavallee Brensinger Architects	Richard Levesque Director of Support Services	All indicators met or exceeded standards.
Liberty Healthcare – After Hours Coverage	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Liberty Healthcare – Physician Staffing	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Maine General Community Care/Healthreach	Dr. Brendan Kirby Medical Director	All indicators met standards.
Maine General Medical Center – Laboratory Services	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Main Security Surveillance	Debora Proctor Executive Housekeeper	All indicators met standards.
MD-IT Transcription Service	Amy Tasker Director of Health Information	All indicators met standards.
Mechanical Services	Richard Levesque Director of Support Services	All indicators met standards.
Medical Staffing and Services of Maine	Dr. Brendan Kirby Clinical Director	All indicators met standards.
Motivational Services	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.

JOINT COMMISSION

FY 2015 Quarter 1 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Occupational Therapy Consultation and Rehabilitation Services	Janet Barrett Director of Rehabilitation	All indicators exceeded standards.
Otis Elevator	Richard Levesque Director of Support Services	All indicators met standards.
Pine Tree Legal Assistance	Dr. Brendan Kirby Clinical Director	No services provided during timeframe.
Project Staffing – Outpatient Services Coordinator	Mary Beyer Program Service Director, Outpatient Services	Position started on 9/22/14, no evaluation was completed for this timeframe.
Project Staffing – Barber	Janet Barrett Director of Rehabilitation	Indicator met standard.
Project Staffing – Multi Cultural Training Specialist	Janet Barrett Director of Rehabilitation	Indicator exceeded standard.
Project Staffing – Per Diem Nurses	Roland Pushard Director of Nursing	All indicators met standards.
Project Staffing – Post Doctoral Fellowship	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Project Staffing – Pre-Doctoral Intern	Dr. Brendan Kirby Clinical Director	All indicators met or exceeded standards.
Project Staffing – Recovery Training Specialist	Susan Bundy Staff Development Coordinator	Indicator met standard.
Project Staffing – Teacher	Janet Barrett Director of Rehabilitation	All indicators met standards.
Protection One	Richard Levesque Director of Support Services	No services provided during timeframe.
Securitas Security Services	Philip Tricarico Safety Compliance Officer	All indicators met or exceeded standards.
Unifirst Corporation	Richard Levesque Director of Support Services	All indicators met standards.
Waste Management	Debora Proctor Executive Housekeeper	1 indicator did not meet standard, all others met 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	2Q2014	3Q2014	4Q2014	1Q2015	Total
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% 3/3 **November** 100% 1/1 **December** 100% 2/2 **Total** 100% 6/6	**January** 100% 2/2 **February** 100% 2/2 **March** 100% 7/7 **Total** 100% 11/11	**April** 100% 11/11 **May** N/A 0/0 **June** 100% 2/2 **Total** 100% 13/13	**July** 100% 5/5 **August** 100% 2/2 **September** 100% 3/3 **Total** 100% 10/10	100% 40/40

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	2Q2014	3Q2014	4Q2014	1Q2015	Total
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% 3/3 **November** 100% 1/1 **December** 100% 2/2 **Total** 100% 6/6	**January** 100% 2/2 **February** 100% 2/2 **March** 100% 7/7 **Total** 100% 11/11	**April** 100% 11/11 **May** N/A 0/0 **June** 100% 2/2 **Total** 100% 13/13	**July** 100% 5/5 **August** 100% 2/2 **September** 100% 3/3 **Total** 100% 10/10	100% 40/40

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.

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

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

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

Upper Kennebec, Lower Kennebec, Upper Saco

Indicators	1Q15 Findings	1Q15 Compliance	Threshold Percentile
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	9/4.8	100%	1 SD within the mean

*9 (total # of HAI / 1864 (patient days) x 1000 (calculation is per 1000 inpatient days) = 4.8

Patient Days: 1,864
Total Infections: 20
Total Hospital Acquired Infections: 9
Total Community Acquired Infections: 11
Total Idiosyncratic Infections: 0

Lower Kennebec:

- Cellulitis – HAI
- Onychogryposis and mycosis of all toe nails – CAI
- Seborrheic dermatitis – CAI
- HIV – CAI
- Dental Abscess – CAI
- Liquid diarrhea>bacterial overgrowth in upper gut – CAI.
- Sinusitis – HAI
- Pneumonia hx of lung infections- HAI

Upper Kennebec:

- Paronychia of right index finger – CAI
- UTI - HAI
- Sore Throat with history of Strept – Treat empirically – CAI
- Candida Pruritis secondery to antibiotic use – CAI
- Dental infection requiring multiple extractions – CAI
- Bacteremia secondery to poor glucose control – CAI

Upper Kennebec, continued:

- Sinusitis – HAI
- Recurrent Sore Throat with a hx of Strep Pharyngitis – not counted

Upper Saco:

- URI with acute viral rhinosinusitis – HAI
- Acne flare – CAI (already counted previously)
- URI – pharyngitis with dysphagia/atypical pneumonitis – HAI
- Laryngitis with abnormal vocal cords>Monilial infection - HAI
- Conjunctivitis – HAI
- Dental infection multiple extraction required, appt. scheduled.-CAI

Plan: Ongoing surveillance; and encourage good respiratory and hand hygiene.

Lower Saco

Indicators	1Q15 Findings	1Q15 Compliance	Threshold Percentile
Total number of infections (rate) per 1000 patient days.	11/20.7*	1 SD with the mean	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	0	1 SD within the mean	1 SD within the mean

*11 (total # of infections) / 531 (patient days) x 1000 (calculation is per 1000 inpatient days) = 20.7

Patient Days: 531
Total Infections: 11
Total Hospital Acquired Infections: 0
Total Community Acquired Infections: 9
Total Idiosyncratic Infections: 2

Lower Saco Main Unit:

- Prostatitis-CAI
- Tinea Pedis-CAI
- Tinea Pedis-CAI
- Bilateral Conjunctivitis-CAI
- Chronic HIV – CAI
- Dental infection – CAI
- Right toe cellulitis-CAI

Lower Saco SCU:

- Dental-CAI
- Right Otitis Media with small effusion left ear-CAI
- Superficial abrasion to the left forearm and forehead/prophylactic treatment – Idiosyncratic - CAI
- Human Bite – Idiosyncratic- CAI

Plan: Continue total house surveillance

JOINT COMMISSION

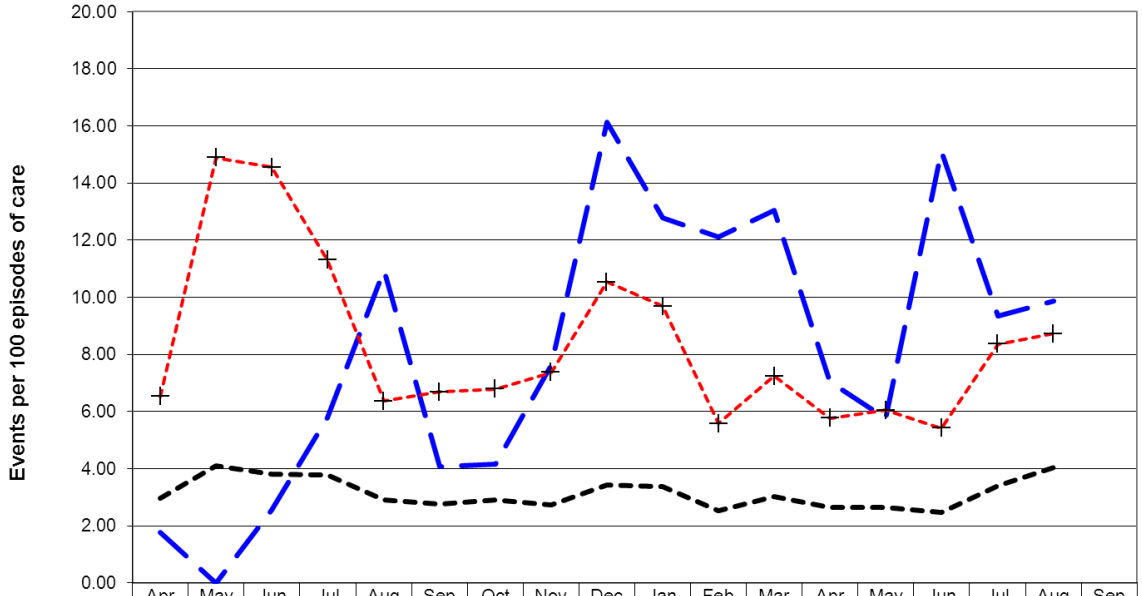
Medication Management

Medication Errors and Adverse Reactions

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

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

Medication Errors



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview	1.79	0.00	2.56	5.79	10.95	4.07	4.17	7.63	16.13	12.78	12.12	13.04	7.04	5.76	15.11	9.35	9.86	
Ntl Mean	2.97	4.12	3.81	3.80	2.91	2.77	2.92	2.74	3.45	3.39	2.52	3.03	2.65	2.66	2.48	3.41	4.06	
+1 StDev	6.53	14.89	14.56	11.31	6.37	6.69	6.79	7.38	10.53	9.69	5.59	7.25	5.78	6.05	5.43	8.36	8.73	

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

JOINT COMMISSION

Medication Management – Medication Variances

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

Prescribing

An error of prescribing occurs when there is an incorrect selection of drug, drug dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician or other legitimate prescriber. Errors may occur due to improper evaluation of indications, contraindications, known allergies, existing drug therapy and other factors. Illegible prescriptions or medication orders that lead to 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	Staff Mix
7/1/2014	Y	Lactobacillus	N	N	N	LS	4 RN, 0 LPN, 6 MHW
7/10/2014	N	Wrong time	N	Y	N	UK	3 RN, 0 LPN, 4 MHW
7/10/2014	N	Wrong time	N	N	N	US	3 RN, 0 LPN, 4 MHW
7/12/2014	N	Wrong dose	N	N	N	LS	2 RN, 0 LPN, 5 MHW
7/19/2014	Y	Clonidine	N	N	N	LS	2 RN, 0 LPN, 4 MHW
7/25/2014	Y	Risperdal	N	N	N	LK	3 RN, 1 LPN, 7 MHW
7/28/2014	Y	x 4 meds	N	N	N	US	3 RN, 1 LPN, 4 MHW
8/5/2014	Y	Synthroid	N	N	N	LS	2 RN, 0 LPN, 7 MHW
8/8/2014	Y	Penicillin	N	Y	N	UK	4 RN, 0 LPN, 5 MHW
8/13/2014	Y	Vitamin C	N	N	N	UK	2 RN, 1 LPN, 4 MHW
8/13/2014	Y	Zyprexa	Y	Y	N	LK	4 RN, 0 LPN, 7 MHW
8/14/2014	N	Expired x 5 doses	N	Y	N	US	2 RN, 1 LPN, 5 MHW
8/14/2014	Y	Tegretol	N	N	N	LS	3 RN, 1 LPN, 6 MHW
8/21/2014	N	Wrong time	N	N	N	UK	3 RN, 0 LPN, 4 MHW
8/21/2014	Y	Magnesium	N	N	N	LS	3 RN, 1 LPN, 7 MHW
8/25/2014	N	Wrong dose	N	N	N	UK	2 RN, 1 LPN, 4 MHW
8/27/2014	Y	Risperdal	Y	N	N	US	2 RN, 0 LPN, 3 MHW
8/31/2014	N	Wrong time x 3	N	N	N	US	3 RN, 0 LPN, 4 MHW
9/1/2014	N	Wrong dose	N	N	N	UK	3 RN, 1 LPN, 4 MHW
9/3/2014	N	Wrong med	N	N	N	US	3 RN, 0 LPN, 4 MHW
9/6/2014	N	Wrong med	N	N	N	LS	2 RN, 1 LPN, 7 MHW
9/24/2014	Y	Prolixin	N	N	N	UK	3 RN, 1 LPN, 4 MHW
Totals	**15**		**2**	**8**	**0**	**LS: 7**	**US: 15**	**LK: 2**	**UK: 7**
Percent	**48%**		**6%**	**26%**	**0%**	**23%**	**48%**	**6%**	**23%**

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

JOINT COMMISSION

Summary

There were a total of 31 medication errors this quarter:

15	omissions
3	wrong dose given
6	given at wrong time
2	wrong medication given
5	given after order expired

Actions

All nursing related medication errors were noted to have appropriate staffing levels. Medication errors are reviewed weekly with pharmacy, nursing administration and the Medical Director. New systems are being looked at to track as well as alert nurses to minimivf2ze medication errors by having pop up screens for when a medication is too soon to be given, etc. The RN IV or clinical manger on the unit reviews medication errors with staff assigned to their unit if an error is committed.

JOINT COMMISSION

Medication Management - Dispensing Process

Medication Management	Unit	Baseline 2014	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Controlled Substance Loss Data *Daily Pyxis-CII Safe Compare Report*	All	0.875%	0%	0%	0%	0%	0%	No discrepancies between Pyxis and CII Safe transactions in July & August
Quarterly Results			0%					
Monthly CII Safe Vendor Receipt	Rx	0	0	0	0	0	0	No discrepancies between CII Safe and vendor transactions for July & August
Quarterly Results			0					
Monthly Pyxis Controlled Drug discrepancies	All	22	0	0	0	0	0	Goal of "0" discrepancies involving controlled drugs dispensed from Pxyis trended from Knowledge Portal for July & August
Quarterly Results			41 (21/mo)					
Medication Management Monitoring Measures of drug reactions, adverse drug events and other management data	Rx	8/year	0	0	0	0		2 ADR's reported in July & August
Quarterly Results			2					
Resource Documentation Reports of Clinical Interventions	Rx	395 reports in 2014						*To be reported in total for Q1 in October
Quarterly Results			*N/A					

JOINT COMMISSION

Medication Management	Unit	Baseline 2014	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Psychiatric Emergency Process Monthly audit of all psych emergencies measured against 9 criteria	All	90%	100%	100%	100%	100%	100%	Goal of 100% compliance as measured by monthly audit tool
Quarterly Results			94% (July & Aug)					Written notification of the end of PE still needs improvement
Contract KPI's								
Operational Audit *Weekly audit of 3 operational indicators from CPS contract*	Rx		100%	100%	100%	100%	100%	Goal of 100% compliance as measured by monthly audit tool for July and August *July 18, July 31 and August 21
Quarterly Results			100%			100%		

JOINT COMMISSION

Pharmacy Services

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

Lower Saco								
Medication Management	Unit	Baseline Oct 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Controlled Substance Loss Data Monthly CII Safe Transactions Report Generated and Reviewed	Lower Saco	100%	100%	100%	100%	100%	100%	Goal of 100% compliance in tracking CII Safe transactions
Quarterly Results			100% (July & Aug)					
Monthly CII Safe Transactions Report Separately Maintained	Rx	100%	100%	100%	100%	100%	100%	CII Safe Transaction Reports separately maintained for Lower Saco
Quarterly Results			100% (July & Aug)					
After-Hours Drug Access Monitoring Monitor daily after-hours drug distribution reports	Rx	100%	100%	100%	100%	100%	100%	Monitor Knowledge Portal after hours drug distribution reports to ensure compliance with policy
Quarterly Results			100% (July & Aug)					

JOINT COMMISSION

Inpatient Consumer Survey

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

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

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

Rate of Response for the Inpatient Consumer Survey

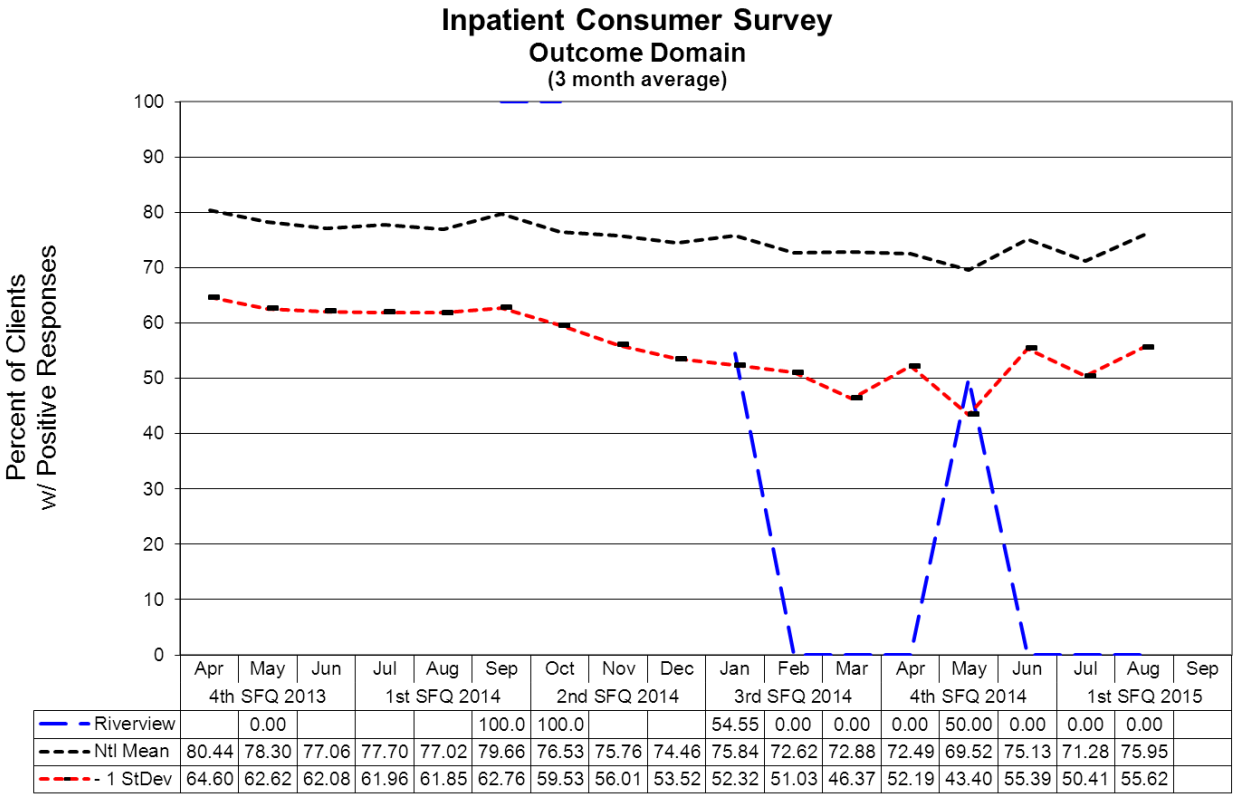
Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic clients, the process of administering the inpatient survey is difficult to administer. Whenever possible the peer support staff work to gather information from clients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

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

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

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

JOINT COMMISSION

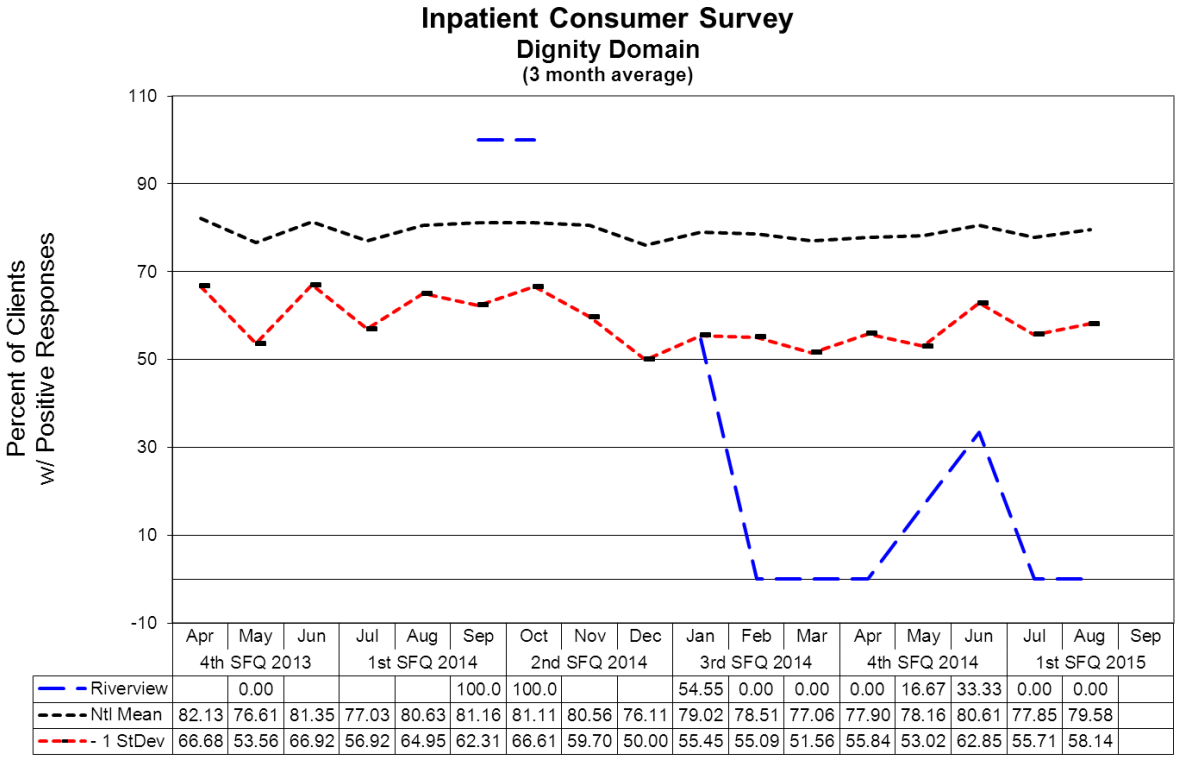


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview		0.00				100.0	100.0			54.55	0.00	0.00	0.00	50.00	0.00	0.00	0.00	
Ntl Mean	80.44	78.30	77.06	77.70	77.02	79.66	76.53	75.76	74.46	75.84	72.62	72.88	72.49	69.52	75.13	71.28	75.95	
- 1 StDev	64.60	62.62	62.08	61.96	61.85	62.76	59.53	56.01	53.52	52.32	51.03	46.37	52.19	43.40	55.39	50.41	55.62	

Outcome Domain Questions

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

JOINT COMMISSION

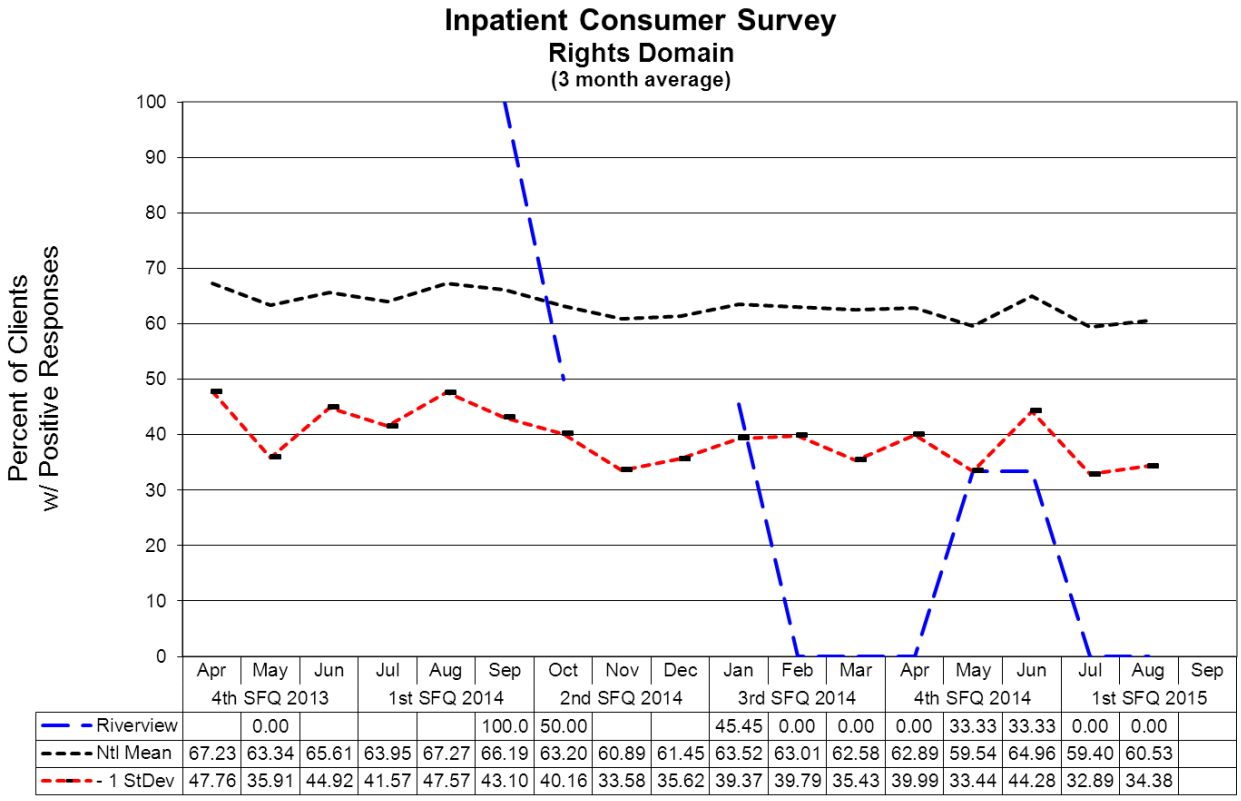


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview		0.00				100.0	100.0			54.55	0.00	0.00	0.00	16.67	33.33	0.00	0.00	
Ntl Mean	82.13	76.61	81.35	77.03	80.63	81.16	81.11	80.56	76.11	79.02	78.51	77.06	77.90	78.16	80.61	77.85	79.58	
1 StDev	66.68	53.56	66.92	56.92	64.95	62.31	66.61	59.70	50.00	55.45	55.09	51.56	55.84	53.02	62.85	55.71	58.14	

Dignity Domain Questions

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

JOINT COMMISSION

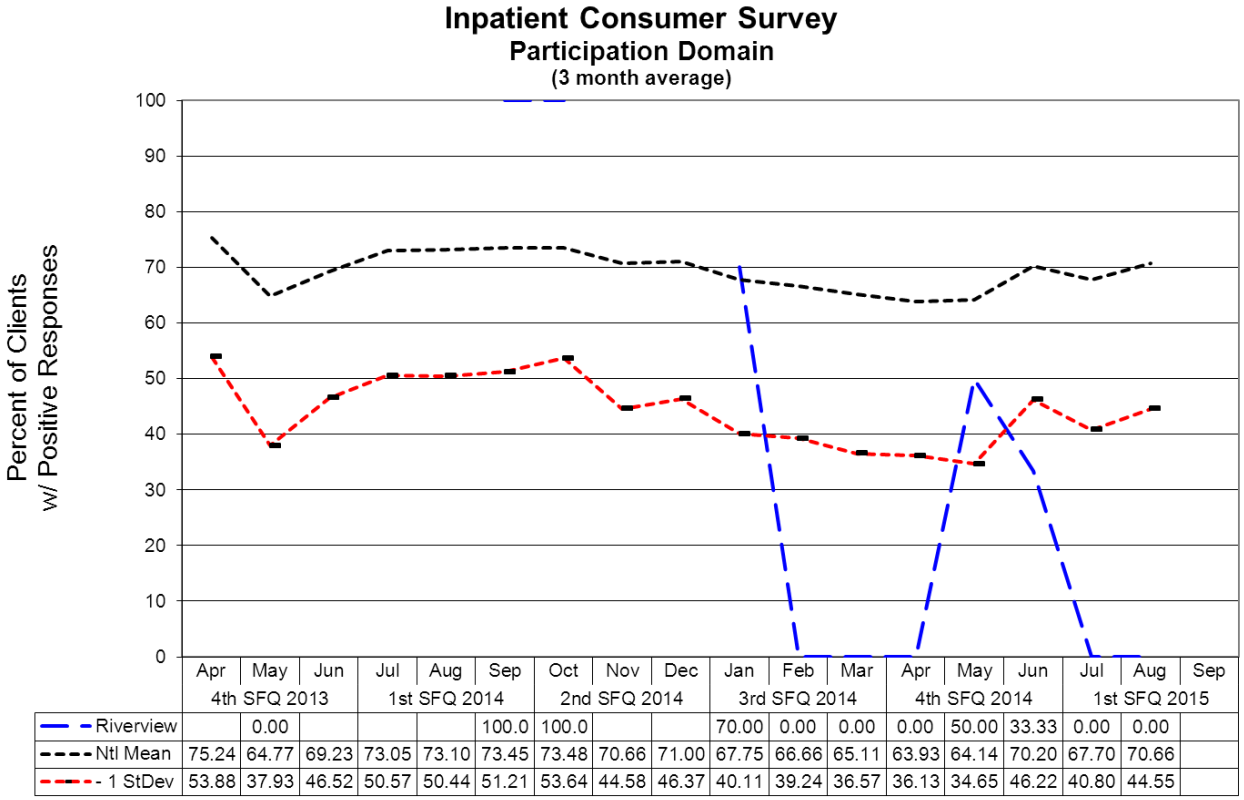


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview		0.00				100.0	50.00			45.45	0.00	0.00	0.00	33.33	33.33	0.00	0.00	
Ntl Mean	67.23	63.34	65.61	63.95	67.27	66.19	63.20	60.89	61.45	63.52	63.01	62.58	62.89	59.54	64.96	59.40	60.53	
- 1 StDev	47.76	35.91	44.92	41.57	47.57	43.10	40.16	33.58	35.62	39.37	39.79	35.43	39.99	33.44	44.28	32.89	34.38	

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



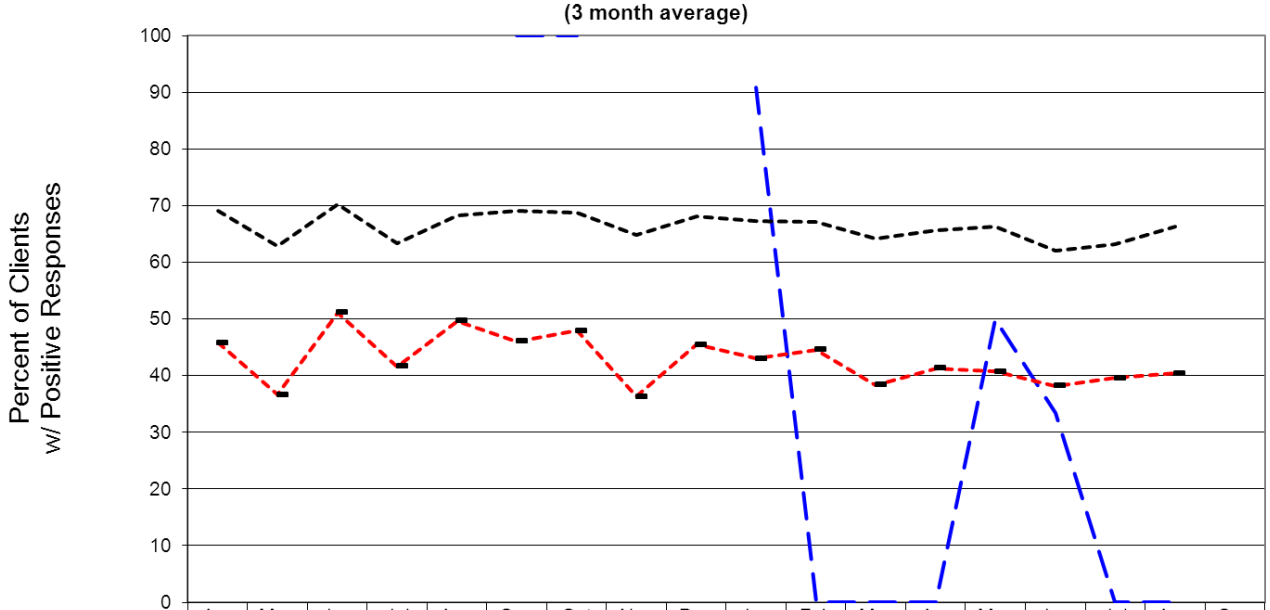
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview		0.00				100.0	100.0			70.00	0.00	0.00	0.00	50.00	33.33	0.00	0.00	
Ntl Mean	75.24	64.77	69.23	73.05	73.10	73.45	73.48	70.66	71.00	67.75	66.66	65.11	63.93	64.14	70.20	67.70	70.66	
1 StDev	53.88	37.93	46.52	50.57	50.44	51.21	53.64	44.58	46.37	40.11	39.24	36.57	36.13	34.65	46.22	40.80	44.55	

Participation Domain Questions

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

JOINT COMMISSION

Inpatient Consumer Survey
Environment Domain
(3 month average)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	4th SFQ 2013			1st SFQ 2014			2nd SFQ 2014			3rd SFQ 2014			4th SFQ 2014			1st SFQ 2015		
Riverview		0.00				100.0	100.0			90.91	0.00	0.00	0.00	50.00	33.33	0.00	0.00	
Ntl Mean	69.06	62.93	70.31	63.35	68.22	69.05	68.81	64.83	68.08	67.23	67.09	64.18	65.73	66.29	61.99	63.15	66.23	
- 1 StDev	45.84	36.67	51.16	41.59	49.61	46.05	47.95	36.30	45.48	43.06	44.60	38.36	41.30	40.75	38.20	39.58	40.44	

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.

JOINT COMMISSION

Pain Management

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

Indicator	2Q2014	3Q2014	4Q2014	1Q2015
Pre-administration	74% 2774/3749	88% 3217/3652	90% 2811/3114	84% 2481/2965
Post-administration	63% 2362/3749	78% 2866/3652	80% 2477/3114	72% 2126/2965

SUMMARY

Total number of PRN pain medications administered continues to decrease since last quarter (2965 compared to 3114). Nurse documentation regarding PRN pain medication has declined since last quarter (both pre-assessment and post-assessment of patient), with percentages of compliance being the lowest of the 2014 calendar year to date.

ACTIONS

Will meet with clinical managers to let them know nursing needs to increase vigilance regarding pre and post assessment of patient’s pain. If documentation does not improve, will educate individual nurses as necessary on the importance of documentation in this area. Will recommend having the oncoming shift check with the off going shift for any pain meds given that may need an assessment. Pharmacy is looking at future possibilities with Pyxis to see if a program can be installed that will alert nurses that an assessment is due/ needed.

JOINT COMMISSION

Fall Reduction Strategies

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

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

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

Type of Fall by Client and Month

Fall Type	Client	JULY	AUGUST	SEPT	1Q2015
Un-witnessed	MR00007480		3		3
	MR00003191*		2		2
	MR00000016*	1			1
	MR00007468		1		1
	MR00007045			1	1
	MR00007127	1			1
	MR00007452	1			1
	MR00007032			1	1
Witnessed	MR00003191*	2		1	3
	MR00007448	1		2	3
	MR00000016*	1		1	2
	MR00006966		1		1
	MR00007363			1	1
	MR00004647		1		1

* 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.

JOINT COMMISSION

Measures of Success

CTS.01.04.01
For organizations that serve adults with serious mental illness. The organization documents whether the adult has a psychiatric advance directive.

Responsible for Reporting: Program Service Director, Outpatient Services

Corrective Action Taken:

WHO: The Program Service Director, Outpatient Services, is ultimately responsible for the corrective action and overall and ongoing compliance.

WHAT: Staff training was conducted in bi-weekly administrative meeting directing all case managers to use standard Disability Rights Psychiatric (Mental Health) Advanced Directive form and to date completion or declination to complete directive.

WHEN: Care, Treatment and Services issue was discussed with case managers in all-staff meeting 12-27-13, document to be used was copied and placed in admission and annual documentation folder.

HOW: The Program Director and Team Leader will perform bi-weekly reviews of charts to assess ongoing compliance, reporting findings to staff in bi-weekly administrative meetings.
Evaluation Method: Plan for assessing effectiveness of the corrective action taken:
• Sample size: Based on an ADC of 50, 30 records will be selected using random selection.
• Random sampling method used will be to identify six charts from 5 total shelves by selecting every other chart from right to left until 30 are identified.
• Frequency of the audit will be bi-weekly, reviewing six to eight charts per session, totaling up to 48 charts reviewed by the end of four months.
• Monitor for four consecutive months (expectation a minimum of 90% compliance)
• 30 = total number of charts reviewed for psychiatric advanced directives
• 28= total number of psychiatric advanced directives present in the chart or documented as having been offered but declined by client.
• The audit results will be reported by the program Director and Team Leader to the staff at each administrative meeting, the IPEC Committee, as well as to the Social Work Program Director.

RESULTS:

Feb	March	April	May	June	July	Aug	Sept
58%	82%	78%	79%	100%	78%	90%	100%

JOINT COMMISSION

Measures of Success

CTS.02.02.07
The organization reassesses each individual served, as needed

Responsible for Reporting: Program Service Director, Outpatient Services

Corrective Action Taken:

WHO: The ACT Program Director is ultimately responsible for the corrective action and overall ongoing compliance.

WHAT: Staff training was conducted in bi-weekly administrative meeting identifying the discovery of Annual Comprehensive Assessments being worded exactly the same as the previous year, and the necessity of writing new annual assessments for each client including any changes in progress or functioning. It was also identified that there was a missing Annual Comprehensive Assessment in one reviewed record, the standard of keeping at least the current and past year's Annual Comprehensive Evaluation was reiterated.

WHEN: This corrective action was also conducted in a bi-weekly administrative meeting on 12-27-13. No further procedures or policies were needed.

HOW: The Program Director and Team Leader will perform bi-weekly reviews of records to assess ongoing compliance, reporting findings to staff in bi-weekly administrative meetings for immediate correction, if indicated.
Evaluation Method: Plan for assessing effectiveness of the corrective action taken:
• Sample size: Based on an ADC of 50, 30 records will be selected using random selection.
• Random sampling method used will be to identify six charts from 5 total shelves by selecting every other chart from left to right until 30 are identified.
• Frequency of the audit will be bi-weekly, reviewing six to eight charts per session, totaling up to 48 charts reviewed by the end of four months.
• Monitor for four consecutive months (expectation a minimum of 90% compliance)
• 30 = total number of charts reviewed for presence and accuracy of Comprehensive Annual Assessment
• 28= minimum total number of Comprehensive Annual Assessments present in the chart and distinct from previous year.
• The audit results will be reported by the program Director and Team Leader to the staff at each administrative meeting, the IPEC Committee, as well as to the Social Work Program Director.

RESULTS:

Feb	March	April	May	June	July	Aug	Sept
83%	100%	78%	100%	92%	100%	90%	100%

JOINT COMMISSION

Measures of Success

HR.01.06.01
Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation.

Responsible for Reporting: HR Director

RESULTS:

	Dec 2014	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014	July 2014	Aug 2014	Total
Performance evaluations completed on time (with competency assessment)	24	13	19	11	12	29	21	16	22	**167**
Total # of performance evaluations due (with competency assessment)	39	32	42	32	32	35	32	27	50	**321**
Evaluation Compliance	**62%**	**41%**	**45%**	**34%**	**38%**	**83%**	**66%**	**59%**	**44%**	**52%**

*Data not yet available for September 2014

JOINT COMMISSION

Measures of Success

PC.02.03.03
The hospital helps the patient with his or her personal hygiene and grooming activities.

Responsible for Reporting: Director of Nursing

Hand Hygiene Measure: Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 30 days per month.

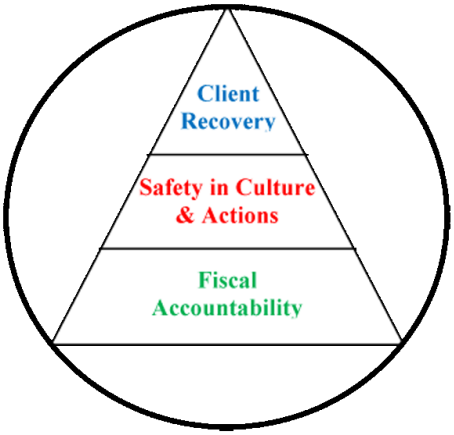
Results:

	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014	July 2014	Aug 2014	Sep 2014	Mean Rate
Lower Kennebec	68%	82%	61%	65%	96%	100%	100%	97%	100%	**85%**
Lower Kennebec SCU	10%	18%	25%	95%	96%	94%	100%	100%	98%	**71%**
Upper Kennebec	46%	46%	46%	100%	100%	100%	100%	89%	93%	**80%**
Upper Saco	97%	94%	97%	100%	90%	96%	98%	96%	96%	**96%**
Lower Saco	99%	38%	82%	97%	99%	97%	93%	98%	87%	**88%**
Lower Saco SCU	14%	43%	1%	38%	96%	96%	99%	100%	93%	**64%**
Mean Rate	**56%**	**54%**	**52%**	**83%**	**96%**	**97%**	**98%**	**97%**	**95%**	**81%**

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

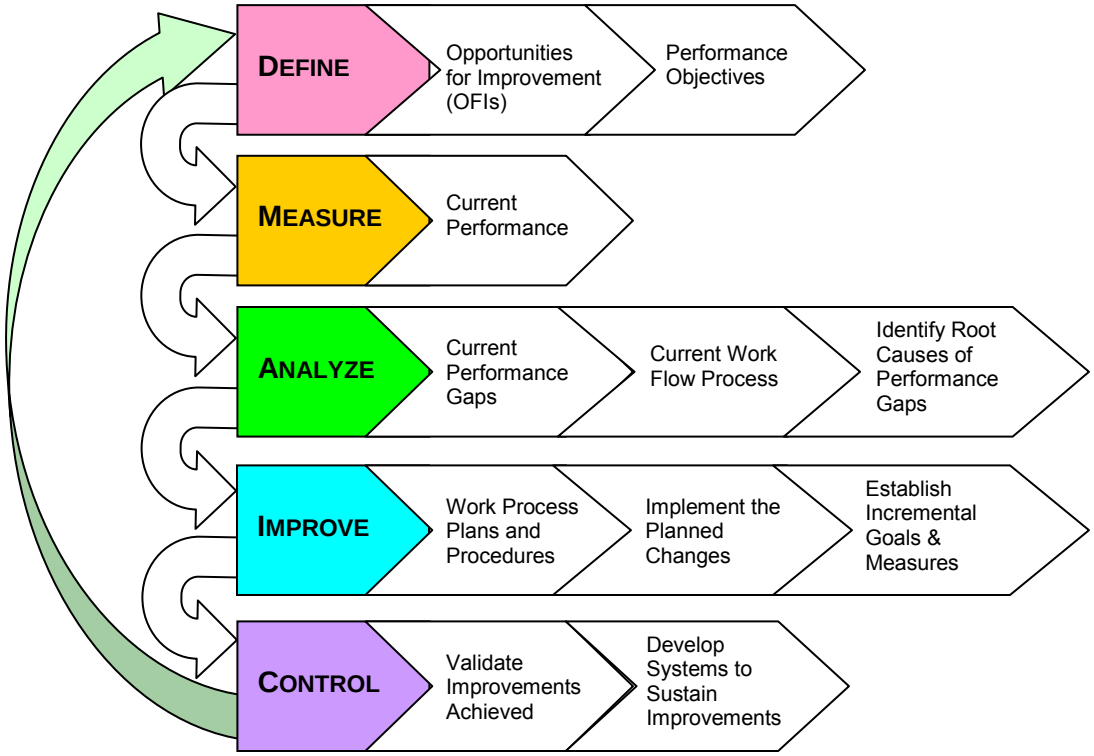
Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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.

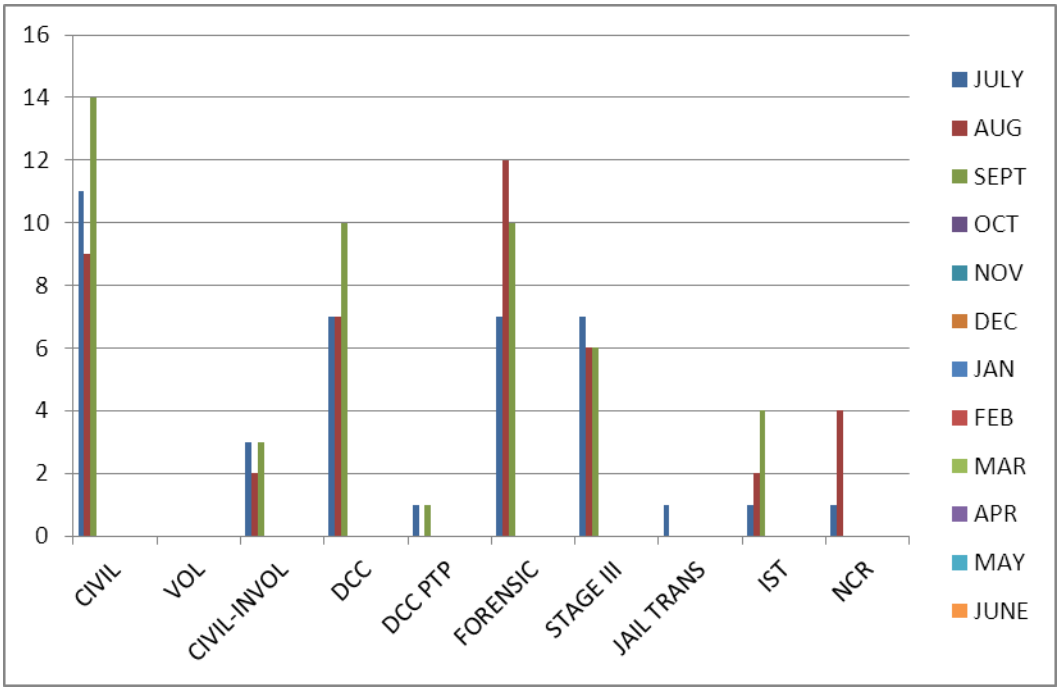
Each Department Determines Unique Opportunities and Methods
to Address the Hospital Goals
The Quarterly Report Consists of the Following



STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office Quarterly Report
1Q2015

Admission Data Graph



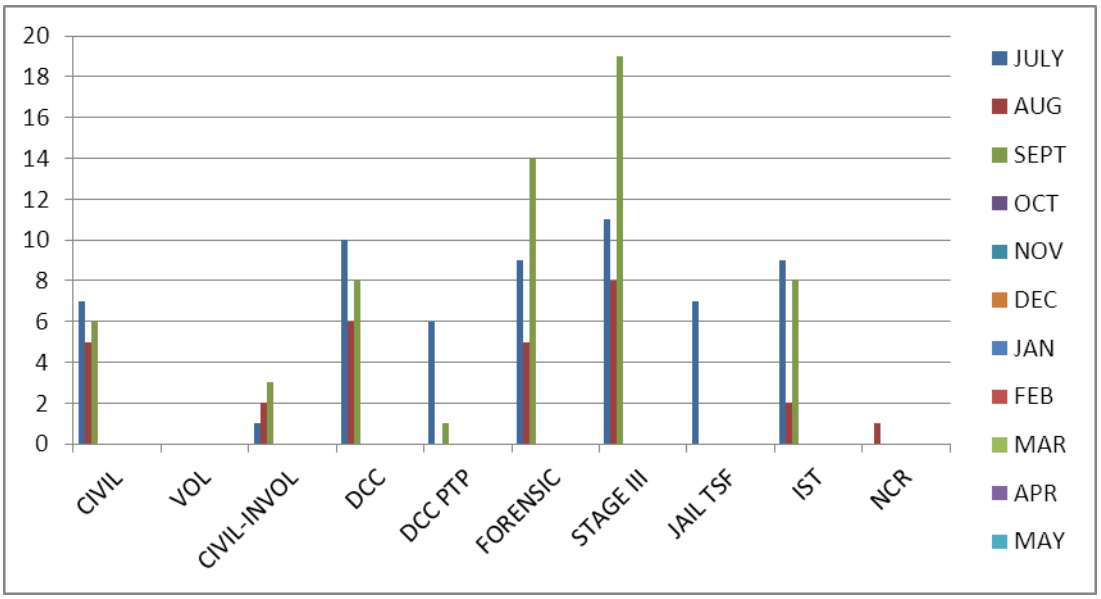
Admission Data

ADMISSIONS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL	**11**	**9**	**15**										**35**
VOL	0	0	0										0
CIVIL-INVOL	3	2	3										8
DCC	7	7	11										25
DCC PTP	1	0	1										2
FORENSIC	**10**	**12**	**11**										**33**
STAGE III	7	6	7										20
JAIL TRANS	1	0	0										1
IST	1	2	4										7
NCR	1	4	0										5
TOTAL	**21**	**21**	**26**										**68**

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office Quarterly Report, continued.

Average Number of Days Waiting



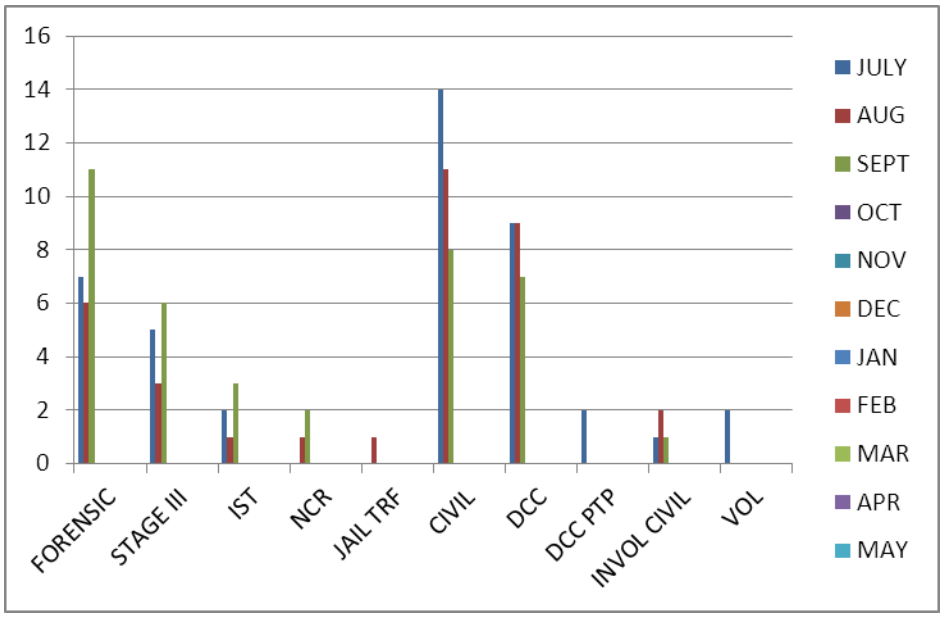
Average Number of Days Waiting Data

WAIT	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
CIVIL	**7**	**5**	**6**										**18**
VOL	0	0	0										0
CIVIL-INVOL	1	2	3										6
DCC	10	6	8										24
DCC PTP	6	0	1										7
FORENSIC	**9**	**5**	**14**										**28**
STAGE III	11	8	19										38
JAIL TSF	7	0	0										7
IST	9	2	8										19
NCR	0	1	0										1
TOTAL	**8**	**5**	**9**										**22**

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office Quarterly Report, continued.

Discharge Graph

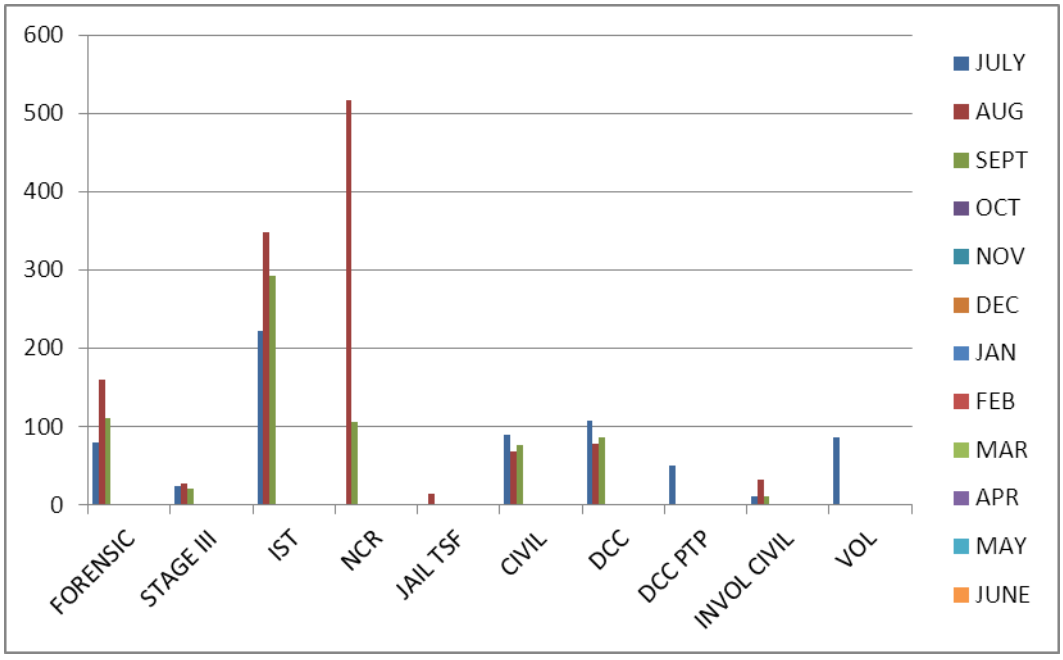


Discharge Data

DISCHARGES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
FORENSIC	**7**	**6**	**11**										**24**
STAGE III	5	3	6										14
IST	2	1	3										6
NCR	0	1	2										3
JAIL TRF	0	1	0										1
CIVIL	**14**	**11**	**8**										**33**
DCC	9	9	7										25
DCC PTP	2	0	0										2
INVOL CIVIL	1	2	1										4
VOL	2	0	0										2
TOTAL	**21**	**17**	**19**										**57**

Admissions Office Quarterly Report, continued.

Length of Stay Graph



Length of Stay Data

LOS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTAL
FORENSIC	**80**	**160**	**111**										**351**
STAGE III	24	27	21										72
IST	222	348	293										863
NCR	0	517	106										623
JAIL TSF	0	14	0										14
CIVIL	**90**	**69**	**77**										**236**
DCC	108	78	86										272
DCC PTP	51	0	0										51
INVOL CIVIL	12	32	12										56
VOL	87	0	0										87
TOTAL	**85**	**101**	**96**										**282**

STRATEGIC PERFORMANCE EXCELLENCE

Capital Community Clinic
Performance Improvement and Quality Assurance Plan
FY 2015

I. Performance Indicators:

- Plaque Score evaluate patients oral hygiene at each appointment
  - Aid with oral hygiene education
  - Aid to discuss with staff and caretakers
  - Monitor at home hygiene
- Periodontal charting
  - Complete periodontal charting yearly to evaluate periodontal status

II. Quality Assurance Measures:

- Formulate a yearly treatment
  - Cross out/date treatment as completed
  - Write NV at the end of each progress note
- Take blood pressure and pulse at the start of each dental appointment
- Signed consent for all RCTs and EXTs
  - Completed by patient, dentist and assistant
- Time out taken prior to ALL extractions
  - Dentist initials time out and writes the initials of the assistant
- Patient re-identified by date of birth at the start of each appointment

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions

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

	1st Quarter 2015			2nd Quarter 2015			3rd Quarter 2015			4th Quarter 2015			
Baseline	Target – Baseline	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 12%	Findings	Compliance	Target – Q3 + 12%	Findings	Compliance	Goal
53%	58%	138/ 238	58%										80-90%

Data:
138 compliant observations /238 hand hygiene observations =58% hand hygiene compliance rate

Summary:

- Hand hygiene compliance has increased by 5%.
- Hand hygiene observations have increased; from 187 observations last quarter to 238 observations this first quarter.
- Assigned additional staff to observe Hand Hygiene practices which increased the total number of observations, thus increased validity of the compliance rate.
- Updated hand hygiene signage and placed them in different locations.

Action Plan:

- Continue use of the current Hand Hygiene Tool.
- Switch the current observers.
- Encourage employees to adhere to hand hygiene via verbal interaction/reminders.
- The Food Service Manager will present this quarterly report at the departmental staff meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions

Nutrition Screen Completion: In an effort to monitor, improve and sustain timely completion of the nutrition screen for all admissions to RPC. 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 2015			2nd Quarter 2015			3rd Quarter 2015			4th Quarter 2015			
Baseline	Target – Baseline	Findings	Compliance	Target – Q1 + 3%	Findings	Compliance	Target – Q2 + 2%	Findings	Compliance	Target – Q3 + 3%	Findings	Compliance	Goal
96%	96%	75/80	94%										95-100%

Data:

75 Nutrition screens completed w/in 24 hours of admission
80 Total Admissions = 94% of nutrition screens completed within 24 hours of admission

Summary:

- The Registered Dietitian reviewed the nutrition screens of the 80 admissions for this quarter.
- Upon review, the RD discovered 5 nutrition screens incomplete.
- Three incomplete nutrition screens were documented on the Lower Kennebec unit; one was documented on the Lower Saco unit and one was documented on Upper Saco.
- RD spoke with a nurse on each unit to facilitate completion of the screen. **Lower Kennebec**: one of the screens could have been completed within the 24 hour parameter. However, the nurse refused stating she was too busy. The other two incomplete screens were not seen by the RD until outside of 24 hours of admission. **Lower Saco:** nutrition screen was never completed. **Upper Saco:** Nutrition screen completed outside of the 24 hour parameter.

Action Plan:

- RD will continue correspondence with unit nursing staff upon the discovery of incomplete nutrition screens and request completion, as appropriate.
- RD will continue to correspond with the admission nurse to assure completion of the nutrition screens.
- Present quarterly report at departmental staff meeting and IPEC meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

INDICATOR

GROUNDS SAFETY/SECURITY INCIDENTS

DEFINITION

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: 5% each Q

2014-2015 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	Q4/14 Target Actual	Q1/15 Target Actual	Q2/15 Target Actual	Q3/15 Target Actual	Q4/15 Target Actual	Goal
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	(10) -5% (6)	(6) -5% (13)	(13) -5%	Q2 Actual -5%	Q3 Actual -5%	Baseline -5%

SUMMARY OF EVENTS

The Q1 Target was (5). Our actual number was (13). Although we had a significant increase in incidents for this quarter we showed significant improvement for fiscal 2014. Overall our incidents were down 24%. In reviewing the increase in incidents for this quarter one area still is proving to be a concern. Vehicles and the parking lot accounted for 6 of our 13 incidents. Unlocked doors were also an issue, accounting for 4 incidents. We have instituted new protocols in how the police are called and have begun meeting with and improving our relations with Capital Police. Specifically, through our meetings, Capital Police were very helpful in dealing with item 12 below. We haven't had any problems with this area since September 17. We are pleased that in all of the events, our Security staff or clinical staff had discovered/processed the event before there was a negative impact to the Organization. Our aggressive rounds by Security continues to prove its' worth with regard to Security's presence and patrol techniques. The stability and longevity of our Security staff along with its' cohesiveness with the Clinical component of the hospital has proven to be most effective in our management of practices.

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
1. Security concern (unlocked door)	7/2/14	2015	Lower Saco hallway leading to center courtyard	Security was able to lock and secure door	1. Discovered during routine rounds. 2. See IR #671
2. Security concern (unlocked state car)	7/3/14	2135	Parking lot	Cars were locked	1. Security discovered during routine rounds 2. See IR #672
3. Security concern (unlocked state car)	7/3/14	No time given	Parking lot	Car was locked	1. Security discovered during routine rounds 2. See IR #674

STRATEGIC PERFORMANCE EXCELLENCE

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
4. Safety concern (shards of glass)	7/5/14	1640	Saco Yard	Security secured and disposed of items per NOD	1. Security discovered during fresh air break 2. See IR #673
5. Security concern (unlocked door)	7/6/14	1330	Lower Saco hallway leading to center courtyard	Security was able to lock and secure door	1. Discovered during routine rounds 2. See IR #675
6. Safety concern (patient smoking outside)	7/15/14	1556	Smoking area	Security questioned the patient and patient ceased smoking	1. Security received a call alerting them to the situation 2. Security questioned the patient who was cooperative and complied with the request to stop smoking 3. Client escorted back to Upper Kennebec
7. Safety concern (smoldering ashes in can)	7/22/14	0549	Smoking area	Security extinguished the smoldering fire	1. Operations asked security to check on a cigarette disposal ash can that was smoking 2. Security found it to be on fire and extinguished it with water from empty soda bottles
8. Security concern (suspicious vehicle with two occupants)	7/27/14	2150	Employee parking lot	Asked them to leave, they complied, Capitol PD notified	1. Security asked occupants if they could be of assistance, they said they were just looking for a place to hang out 2. Security asked them to leave and they complied 3. Capitol PD notified and would watch for vehicle
9. Security concern (driver's license found)	7/27/14	2250	Employee parking lot	Visitor notified to pick up driver's license at security	1. Employee turned a driver's license they found in the parking over to security, it belonged to a visitor 2. Visitor was notified to pick the license up at security
10. Security concern (unlocked door)	9/12/14	1648	Loading dock	Door locked	1. Security found door unlocked during rounds 2. Security locked door
11. Safety concern (tin can top found)	9/14/14	1445	Employee parking lot	Item disposed of	1. Tin can top found in employee parking lot 2. Item disposed of in secure area

STRATEGIC PERFORMANCE EXCELLENCE

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
12. Safety and security concern (contraband items in back of state owned pickup trucks)	9/17/14	0118	Lower parking are (on river side)	Capitol Police notified	1. Multiple contraband items found in back of state owned pickup trucks (shovel, rake, bungee cords, aluminum cans, canoe paddles) 2. Capitol Police notified 3. RPC to follow up with Central Fleet Management
13. Security concern (unlocked door)	9/26/14	1645	Generator room off parking area	Door locked	1. Security found the exterior door the generator room unlocked 2. Security locked and secured the door

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Objectives	2Q2014	3Q2014	4Q2014	1Q2015
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	69% 29/42	79% 33/42	71% 30/42	71% 30/42
2. SBAR information completed from the units to the Harbor Mall.	88% 37/42	81% 34/42	79% 33/42	81% 34/42

Unit: All three units July, August, and September 2014
Accountability Area: Harbor Mall
Aspect: Harbor Mall Hand-off Communication
Overall Compliance: 77%

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 remained the same at 71% for both last quarter and this quarter. Indicator number two has increased from 79% last quarter to 81% this quarter.

ANALYZE: Overall compliance has increased from 75% last quarter to 77% for this quarter. Indicator number one increased all three months. Indicator number two increased all three months. Twelve HOC sheets were late for both last quarter and this quarter. Continue to concentrate on both indicators to improve current performance gaps.

IMPROVE: I will review the results 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.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Documentation and Timeliness

Upper Saco, Lower Kennebec, Upper Kennebec

Indicators	1Q15 Findings	1Q15 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes. *One record with no documented H&P located in paper record of EMR. See Closed chart audit for September for further details.*	There were 41 discharges in quarter 1 2015. Of those, 40 were completed within 30 days.	98%	80%
Discharge summaries will be completed within 15 days of discharge.	41 out of 39 discharge summaries were completed within 15 days of discharge during quarter 1 2015.	95%	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	9 forms were approved/ revised in quarter 1 2015 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 809 dictated reports, 809 were completed within 24 hours.	100%	90%

Summary: The indicators are based on the review of all discharged records. There was 98% compliance with 30 day record completion. Weekly “charts needing attention” lists are distributed to medical staff, including the Medical Director, along with the Superintendent, Risk Manager and the Quality Improvement Manager. There was 100% compliance with timely & accurate medical transcription services.

Actions: Continue to monitor.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Documentation and Timeliness

Lower Saco

Indicators	1Q15 Findings	1Q15 Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 30 discharges in quarter 1 2015. Of those, 30 were completed within 30 days.	100%	80%
Discharge summaries will be completed within 15 days of discharge.	30 out of 30 discharge summaries were completed within 15 days of discharge during quarter 1 2015.	100 %	100%
All forms/revisions to be placed in the medical record will be approved by the Medical Records Committee.	9 forms were approved/ revised in quarter 4 2014 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 826 dictated reports, 826 were completed within 24 hours.	100%	90%

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

Actions: Continue to monitor.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Confidentiality

Indicators	1Q15 Findings	1Q15 Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	3599 requests for information (158 requests for client information and 3441 police checks) were released for quarter 1 2015.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	23 new employees/contract staff in quarter 1 2015.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident report during quarter 1 2015.	100%	100%

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

No problems were found in Quarter 1 2015 related to release of information from the Health Information department and training of new employees/contract staff, however compliance with current law and HIPAA regulations need to be strictly adhered to requiring training, education and policy development at all levels.

Actions: The above indicators will continue to be monitored.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Medical Record Compliance

Indicators	September 2014 Findings	Compliance	Threshold Percentile
All Progress notes are authenticated within 7 days	462 progress notes were created for September. Out of those 4 were not authenticated within 7 days.	98%	90%
Discharge Instructions are in a manner that the client and/or family member/caregiver understand.	25 Closed records were reviewed, 16 of those included the D/C pharmacy labels, 21 were documented that medication teaching was Completed In Client Friendly Language at Discharge	84%	90%

Summary: Indicators are based on 100% of progress notes created per month. Physicians' progress notes are audited to ensure authentication is occurring within 7 days of availability in the EMR per RPC's Medical Record Completion Policy (MS.3.20).

The indicators for the Discharge Instructions (consolidated aftercare form) are based on 100% of discharges occurring each month over 4 consecutive months.

Actions: The above indicators will be reviewed for 4 consecutive months (beginning in January 2014) providing review yields 90% threshold or above per TJC corrective action plan.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Release of Information for Concealed Carry Permits

Define

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

Analyze

Data collected for the 1st quarter 2015 showed that we received 1861 applications. This is a decrease from last quarter (4th quarter 2014) when we received 2325 applications.

Improve

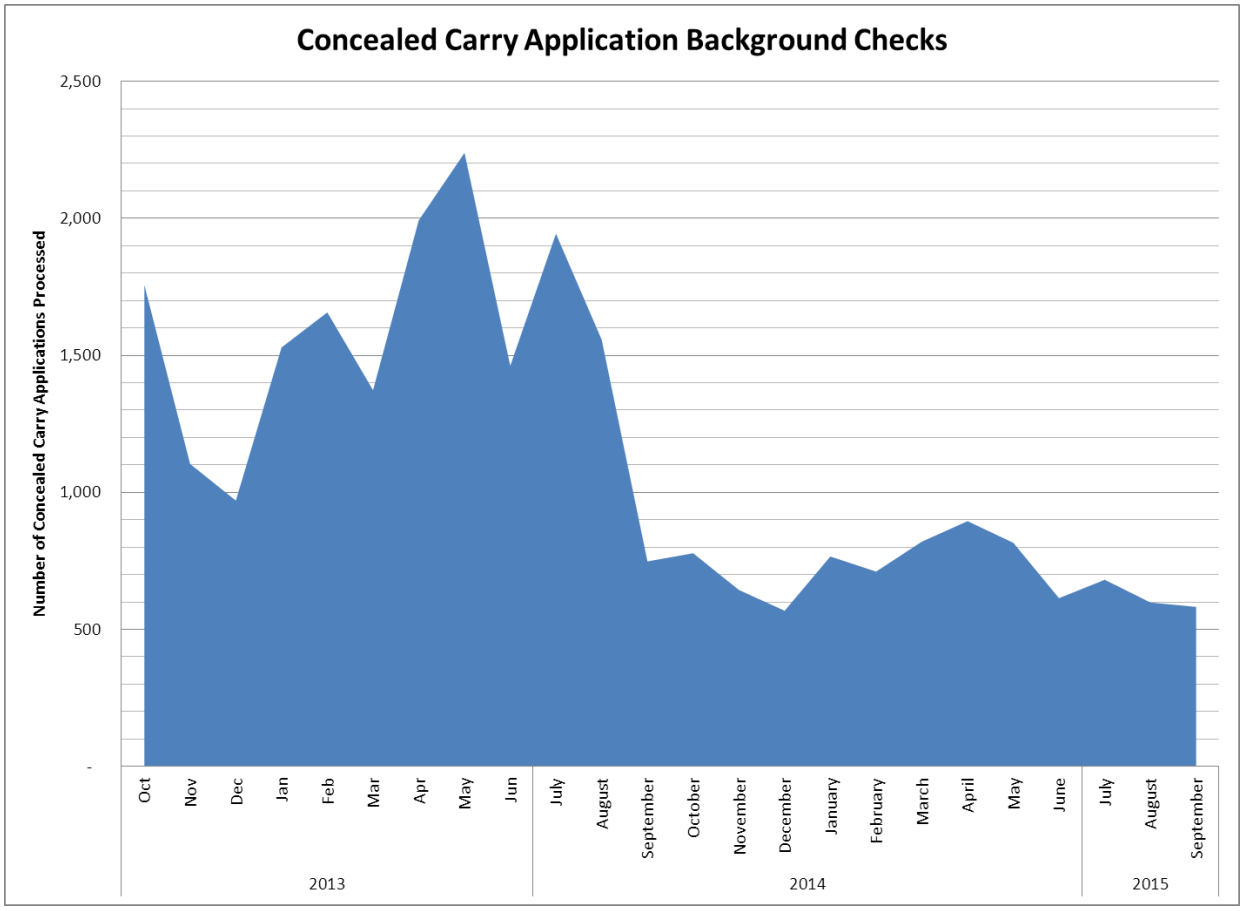
The process has been streamlined as we have been working with the state police by eliminating the mailing of the applications from them to RPC and DDPC. RPC has reactivated the medical records email to receive lists of the applicants from the state police that include the DOB and any alias they may have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

NOTE: At the end of the reporting period, there were 0 police checks outstanding for Riverview Psychiatric Center. We are now processing requests for concealed weapons checks via an emailed listing from the State Police.

OIT has also created a new patient index in which we are in the process of consolidating sources we search into this one system. Over time this will decrease time spent searching as we will no longer have to search several sources. This is ongoing.

Year	FY 2014									FY 2015		
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
# Applications Received	778	644	568	766	711	820	895	816	614	681	598	582

STRATEGIC PERFORMANCE EXCELLENCE



STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Define

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

Measure

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

Analyze

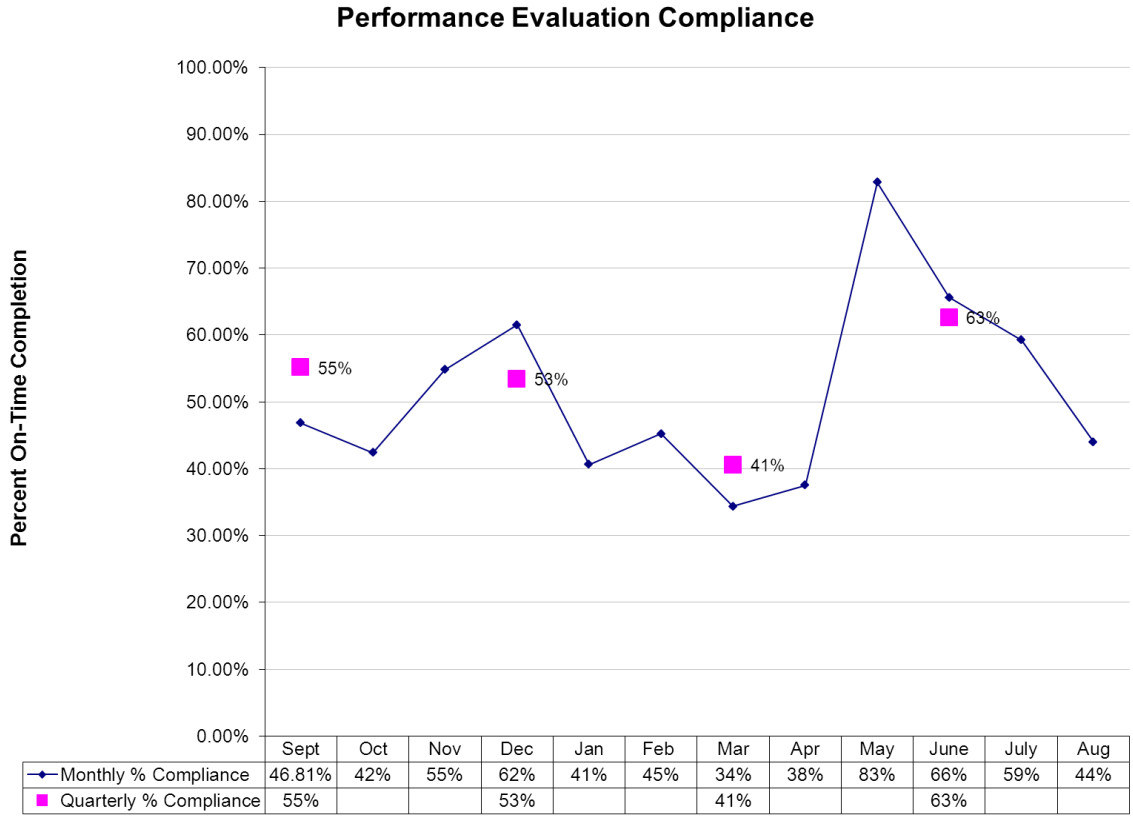
A thorough analysis of the root causes for lack of compliance with this performance standard is indicated.

Improve

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

Control

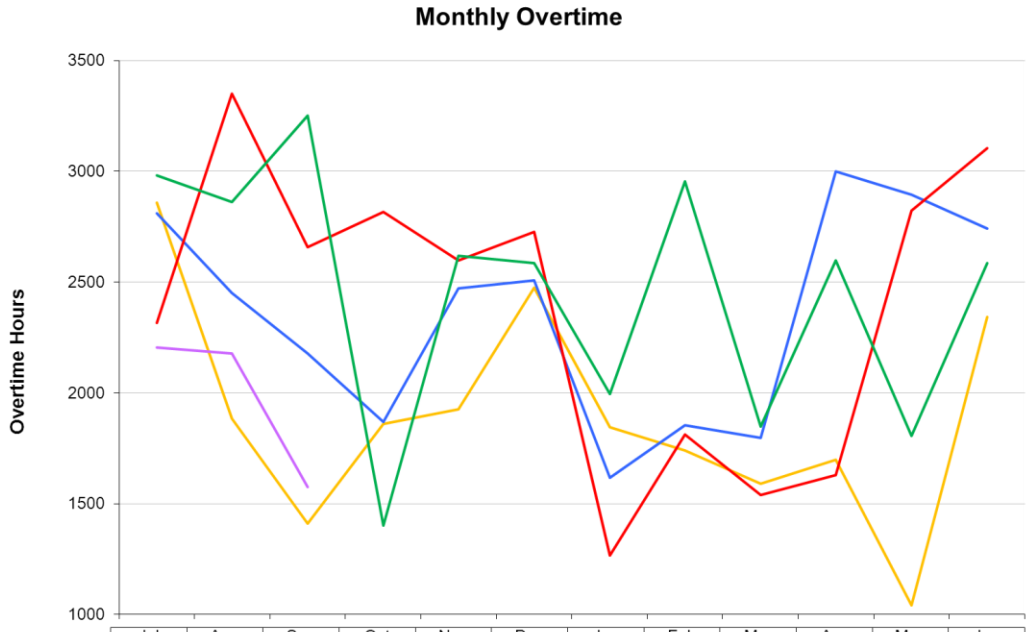
Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.



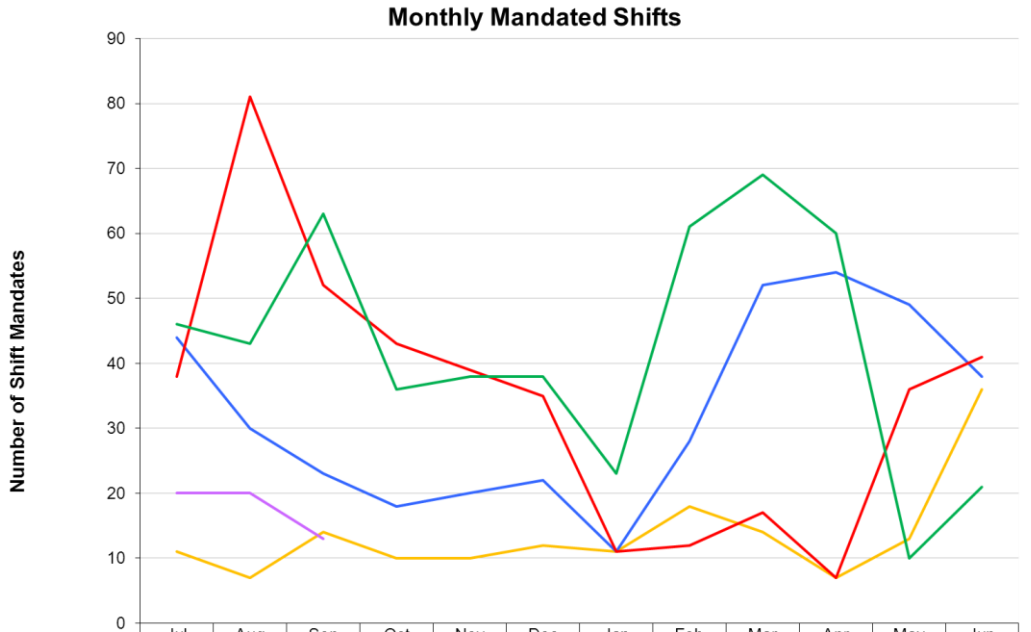
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Monthly % Compliance	46.81%	42%	55%	62%	41%	45%	34%	38%	83%	66%	59%	44%
Quarterly % Compliance	55%			53%			41%			63%		

*Data not yet available for September 2014

STRATEGIC PERFORMANCE EXCELLENCE



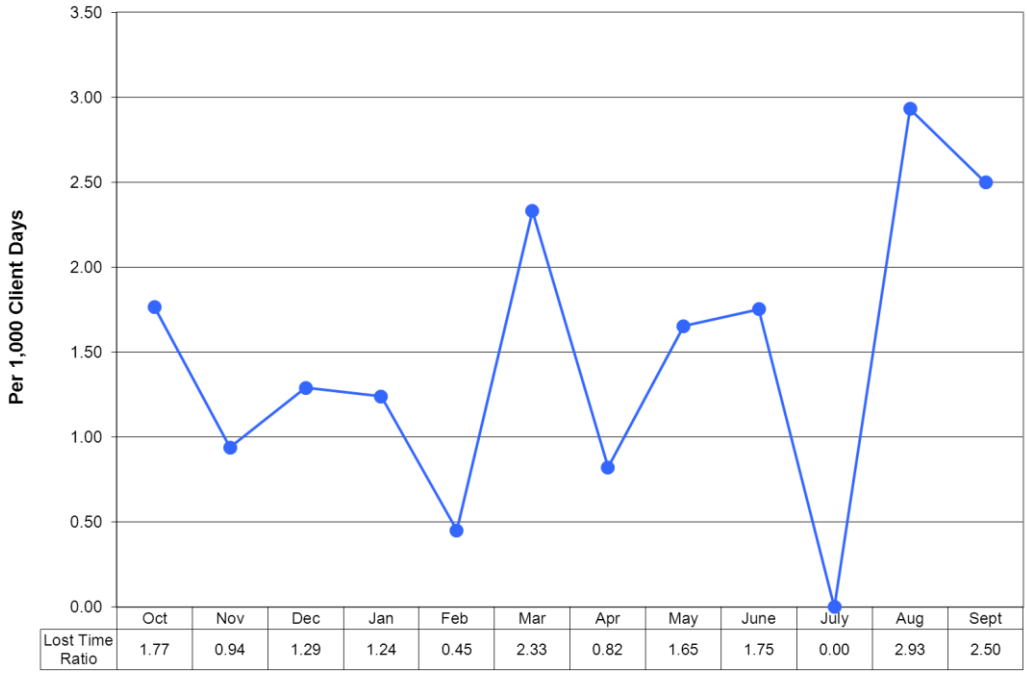
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2011	2859	1885	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2012	2812	2451	2178	1868	2473	2507	1618	1853	1798	2999	2896	2743
FY 2013	2316	3350	2657	2817	2599	2726	1266	1812	1539	1629	2822	3106
FY 2014	2983	2861	3251	1400	2620	2586	1994	2954	1848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



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

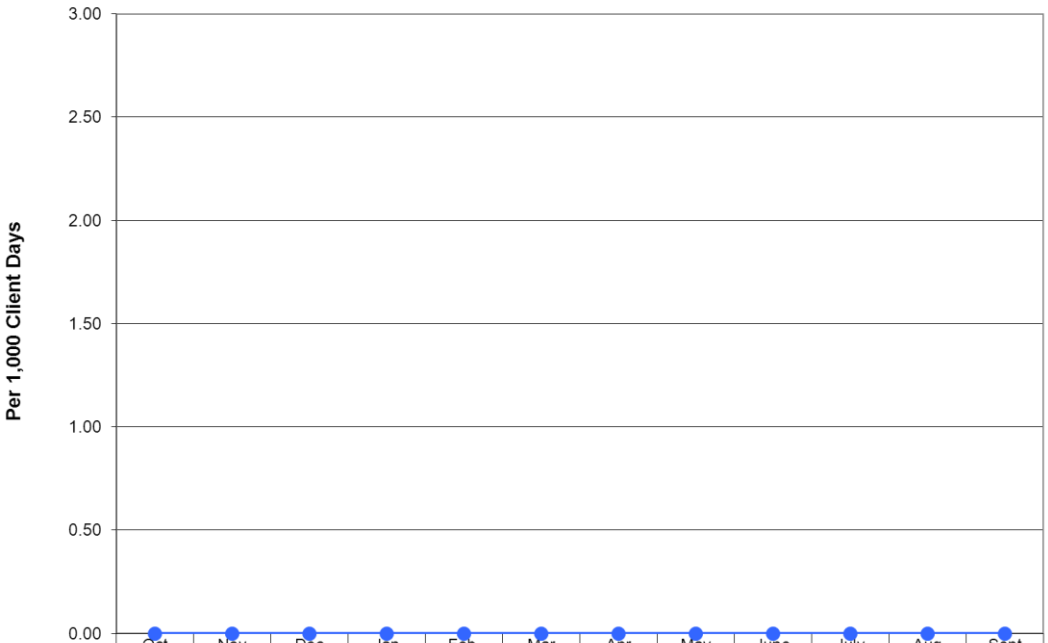
STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Lost Time Ratio	1.77	0.94	1.29	1.24	0.45	2.33	0.82	1.65	1.75	0.00	2.93	2.50

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Lost Time Ratio	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Quality Improvement Plan
2014-2015

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

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

SAFE
EFFECTIVE
PATIENT CENTERED
TIMELY
EFFICIENT
EQUITABLE
DESIGNED TO IMPROVE CLINICAL OUTCOMES

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

1. **Peer Review Activities**:
   a. Regularly scheduled internal peer review by full time medical staff occurs on a monthly basis at the Peer Review and Quality Assurance Committee. The group of assembled clinicians will review case histories and treatment plans, and offer recommendations for possible changes in treatment plans, for any patient judged by the attending physician or psychologist, or others (including nursing, administration, the risk manager, or the Clinical Director) , and upon request, to not be exhibiting a satisfactory response to their medical, psychological, or psychiatric regimens. Our goal is to discuss a case monthly. Detailed minutes of these reviews will be maintained, and the effectiveness of the reviews will be determined by recording feedback from the reviewed clinician as to the helpfulness of the recommendations, and by subsequent reports of any clinical improvements or changes noted in the patients discussed over time. Such intensive case reviews can also serve as the generator of new clinical monitors if frequent or systematic problem areas are uncovered.

In addition all medical staff members (full and part-time) will have a minimum of one chart every other month peer reviewed and rated for clinical pertinence of diagnosis and treatment as well as for documentation. These may include admission histories and physicals, discharge summaries, and progress notes. The results of these chart audits are available to the reviewed practitioners and trends will be monitored by the Clinical Director as part of performance review and credentialing decisions.

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

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

2. **MEC Subcommittee and IPEC Indicator Monitoring Activities**:

The subcommittees of the MEC and the Integrated Performance Excellence Committee are the primary methods by which the medical staff monitor and analyze for trends all hospital-wide quality performance data as well as trends more specific to medical staff performance. The subcommittees, in turn, report their findings on a monthly basis to the Medical Executive Committee and to the Clinical Director for any needed action. The respective committees monitor the following indicators:

a. Integrated Performance Excellence Committee (this is not a subcommittee of the Medical Staff but the Clinical Director serves as a member and is the primary liaison to the Medical Executive Committee).
   - Psychiatric Emergencies
   - Seclusion and Restraint Events
   - Staff or Patient Injuries
   - Priority I Incident Reports
   - Other clinical/administrative department monitoring activity

b. Pharmacy and Therapeutics Committee:
   - Medication Errors Including Unapproved abbreviations
   - Adverse Drug Reactions
   - Pharmacy Interventions
   - Antibiotic Monitoring
   - Medication Use Evaluations
   - Psychiatric Emergency process

c. Medical Records Committee:
   - Chart Completion Rate/Delinquencies
   - Clinical Pertinence of Documentation of Closed Records

d. Infection Control Committee:
   - Infection Rates (hospital acquired and community acquired)
   - Staff Vaccination Rates/Titers

e. Utilization Management Committee:
   - Admission Denials
   - Timeliness of Discharges After Denials

f. Peer Review and Quality Assurance Committee:
- Hospital-wide Core Measures and NASMHPD Data
- Patient Satisfaction Surveys
- Administrative concerns about quality
- Special quality improvement monitors for the current year (see also the Appendix and number 6 below).
- Reports from the Human Rights Committee regarding patient rights and safety issues
- Specific case reviews

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

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

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Quality Improvement Reporting Schedule to Medical Executive Committee

IPEC:	Med. Director reports monthly
Pharmacy & Therapeutics Committee:	Chair reports monthly
Medical Records Committee:	Chair reports monthly
Infection Control Committee:	Chair reports monthly
Utilization Management Committee:	Chair reports bi-monthly
Medical Executive Committee Direct Indicators:	Clinical Director reports monthly, directly to individual provider and to the MEC
Internal Peer Review outcomes:	Clinical Director reports monthly to the Med Staff QA and Peer Review Committee, to the MEC, and to individual practitioners as necessary

APPENDIX

October, 2014

MEDICAL STAFF PHARMACY INDICATORS

MULTIPLE ANTI-PSYCHOTICS DURING HOSPITALIZATION: We continue the indicator looking at multiple antipsychotic prescriptions during the hospitalization. This performance improvement indicator has resulted in a 10 percent to 20 percent drop of multiple antipsychotic prescribing. In addition, as of the latest performance improvement meeting, no patients in the hospital are on three or more antipsychotic medications. Further, medical staff have been educated and reminded of the intent to minimize the number of people being discharged on more than one antipsychotic and that, when this occurs, it should be for one of the approved indications; i.e., three or more monotherapy trials, cross titration, or adjunctive treatment with Clozaril.

METABOLIC MONITOR: generation antipsychotics, completion of the database resulted in discussion and decision that medical staff education was the next appropriate intervention. On September 17, 2014, Miranda Cole Ph.D., Pharmacist, presented to the medical staff a monogram entitled 'Metabolic Monitoring for Patients on Antipsychotic Medications'. The response from medical staff was very positive and the upshot will be a further meeting between Dr Cole and Dr Kirby to operationalize the material discussed into a performance improvement indicator. Baseline indicates that we are 55 percent to 60 percent compliant with ensuring that our patients meet the current recommendations for metabolic monitoring. Decisions to be made include: responsibility for this testing between psychiatry and primary care physicians; whether waist circumference, a more accurate measure of metabolic problems, will be incorporated; and a decision as to when the annual monitoring for longer term patients should occur. It is hoped at October's performance improvement meeting that a suitable indicator will have been formulated at that time, and clearly it is hoped we can readily display marked improvement over our baseline.

ANTIBIOTIC PRESCRIBING: We have achieved 100 percent compliance for over 4 months with the new antibiotic order forms. This part of the performance indicator is appropriately concluded. Discussion as to whether appropriate choice of antibiotic, when necessary, should be a performance improvement indicator was discussed; however, feedback from the non-psychiatric physicians in the hospital indicated that there would be little to be gained from such a monitor as the vast majority of antibiotic choice is appropriate based on the new system. With this monitor ending, creation of a new performance improvement monitor in the pharmacy category will be discussed and implemented, again starting at the next performance improvement meeting.

PROPOSED INDICATOR - PATIENTS ON EXTREME NUMBERS OF MEDICATIONS: The monitor will focus on individuals in the hospital who are on a multitude of medications and a decision as to whether to review all patients who are one or two standard deviations above the norm will be taken when the initial data has been gathered.

ORDERS ENDING PSYCHIATRIC EMERGENCIES: Finally, a performance improvement indicator, which is run by pharmacy of direct relevance to medical staff, is ensuring that an order to end a psychiatric emergency is placed on the chart and that the emergency is not simply allowed lapse after 72 hours. Initial figures indicate that we are at a 50 percent success rate on this issue at baseline and we are monitoring the response to both e-mail and face-to-face medical staff education.
With the creation of the database looking at necessary metabolic monitoring for individuals on second-

STRATEGIC PERFORMANCE EXCELLENCE

PSYCHOLOGY FOCUSED MEDICAL STAFF PERFORMANCE IMPROVEMENT:

The COTREI, an evaluative tool for mental health acquitees, has been implemented on all inpatient NCR patients and has been carried out both by the psychiatric provider and a psychologist. Our next performance improvement indicator is to show evidence that information from this tool is incorporated into the treatment plans of all inpatients in the NCR recovery program. Dr. Kirby and Dr. DiRocco continue to meet to discuss implementation of the next phase of this indicator.

DENTAL CLINIC INDICATORS:

Dental clinic has now commenced two indicators. This occurred as a result of Dr. Kirby meeting with Dr. Ingrid Prikryl, the dentist in our clinic. Having reviewed the quality assurance and performance improvement indicators, explanation as to what performance improvement is and how it differs from, but is related to quality assurance was undertaken. Coming out of this discussion, four indicators were considered, two of which were found to be clearly appropriate for performance improvement monitoring. Both indicators are in the baseline data collection stage.

TOTAL PLAQUE SCORES: The first will be an evaluation of total plaque score on patients, followed by research with intervention and re-measurement for improvement in oral hygiene of the patient population attending the dental clinic. Research on improving hygiene in chronic psychiatric populations will be sought to define likely useful information to bring about such improvement.

PERIODONTAL CHARTING: The second issue relates to ensuring that periodontal charting by staff improves to a level ensuring that such charting occurs once a year. Currently, it appears from baseline documentation that the baseline may be starting out well below 50 percent and rapid improvement will be expected on this monitor.

FURTHER INDICATOR:

A further indicator has been added tracking the behavior of after-hours physician's assistant staff. With the engagement of our new lead physician's assistant for after-hours staff, Reid Kincaid, a monitor has been set up to look at and ensure appropriate signature of telephone orders by after-hours staff prior to leaving the building. This will be associated with the possibility, in extreme cases, that after-hours staff would lose the privilege to be able to give telephone orders, if they were not compliant with ensuring appropriate signatures by the end of their shift.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Poly Antipsychotic Medication Monitoring

	July	August	September
Census	96	95	104
Antipsychotic Orders for Clients			
No Antipsychotics	13 (14%)	14 (15%)	18 (17%)
Mono-antipsychotic therapy	60 (63%)	59 (62%)	66 (63%)
Two Antipsychotics	18 (19%)	22 (23%)	20 (19%)
Three Antipsychotics	5 (5%)	0	0
Four Antipsychotics	0	0	0
At least 1 antipsychotic	83 (86%)	81 (85%)	86 (83%)
Total on Poly-antipsychotic therapy	23 (24%)	22 (23%)	20 (19%)
Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics	28% (23/83)	27% (22/81)	23% (20/86)
More than 2 antipsychotics	5 (5%)	0	0
Poly-Antipsychotic therapy breakdown			
SGA + FGA	11 (48%)	21 (95%)	17 (85%)
2 SGAs (“Pine” + “Done”)	6 (26%)	1 (5%)	1 (5%)
Other (2 antipsychotic regimens)	1 (4%)	0	2 (10%)
Other 2 Antipsychotic Regimen Details	1) Chlorpromazine + fluphenazine	N/A	1) Fluphenazine + chlorpromazine 2) Fluphenazine + haloperidol
3+ Antipsychotic Regimens	1) Haloperidol + quetiapine + risperidone 2) Loxapine + olanzapine + thiothixene 3) Chlorpromazine + olanzapine + perphenazine 4) Haloperidol + olanzapine + paliperidone 5) Ziprasidone + haloperidol + quetiapine	N/A	N/A
Justifiable Poly-Antipsychotic Therapy	91%	100%	98%

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

Data Collection

All medication profiles in the hospital were reviewed for the months of July, August and September. We were particularly interested in the proportion of patients 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.

Findings

Over the quarter we found that about 85% of patients were receiving at least one antipsychotic medication. That is an increase in the overall number of patients receiving at least one antipsychotic. Of these patients, about 26%, a three percent decrease from last quarter (29%), were receiving more than one such agent, and by definition was a case of polypharmacy. Within this overall percentage we noted that the individual percentages for each month are as follows: July (28%), August (27%) and September (23%). The percentage of individuals' prescribed poly-antipsychotic therapy has steadily decreased since January 2014 at 33% to September 2014 at 23%. For two months in this quarter, August and September, there were no patients prescribed more than 2 antipsychotics at one time (this includes PRN or "as needed" orders). August was the first month to have no patients prescribed more than two antipsychotics and for all regimens to be justified appropriately according to the HBIPS-5 and clinically/pharmacologically. September also had no instances of more than two antipsychotics ordered. However, there were a couple of instances where the justification of poly-antipsychotic therapy was not provided. Justified poly-antipsychotic therapy for each month is as follows: July (91%), August (100%), September (98%).

Analysis

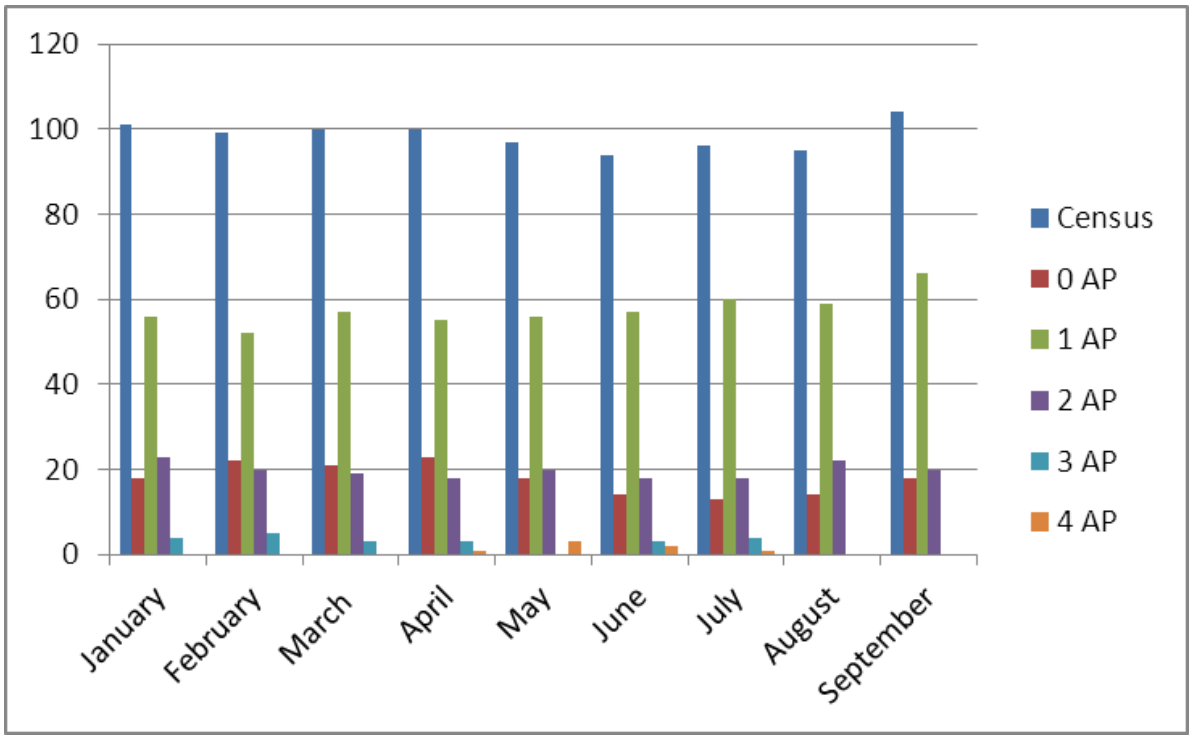
We have improved performance to reaching our goal of above 90% for each month of this quarter. The average for the quarter is 96% of justified poly-antipsychotic therapy. There was impressive improvement seen in this quarter with the increase in justified polyantipsychotic therapy as well as having two months with no patients prescribed more than 2 antipsychotics. This could be due to the increased awareness of providers with reporting at the Peer Review Committee and the Pharmacy & Therapeutics (P&T) Committee, as well as the implementation of the electronic justification form notifications.

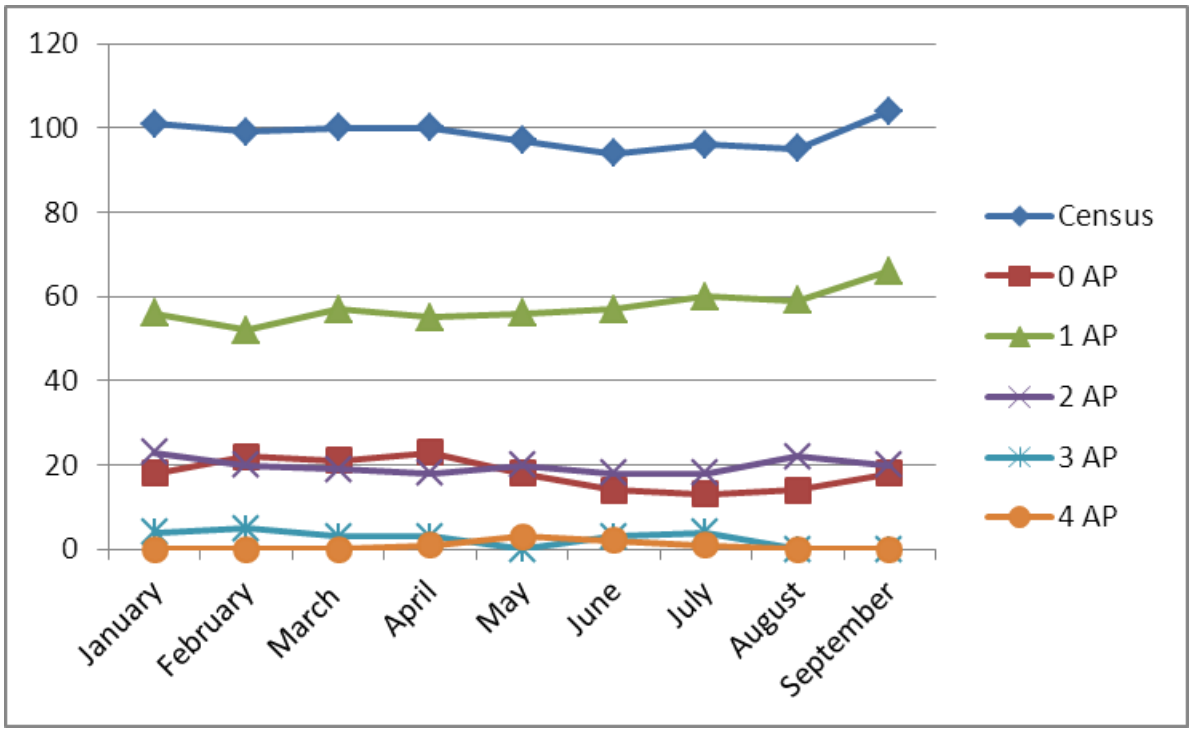
Plan

We will continue to monitor polyantipsychotic therapy 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 notify prescribers electronically of patients with multiple antipsychotic orders both on admission and with new orders. We will continue to prospectively gather data on polyantipsychotic therapy and follow-up with prescribers regarding the documented plan of action. It is our goal to continue this pattern of justified polyantipscyhotic therapy and zero occurrences of more than two antipsychotics prescribed at the same time.

STRATEGIC PERFORMANCE EXCELLENCE

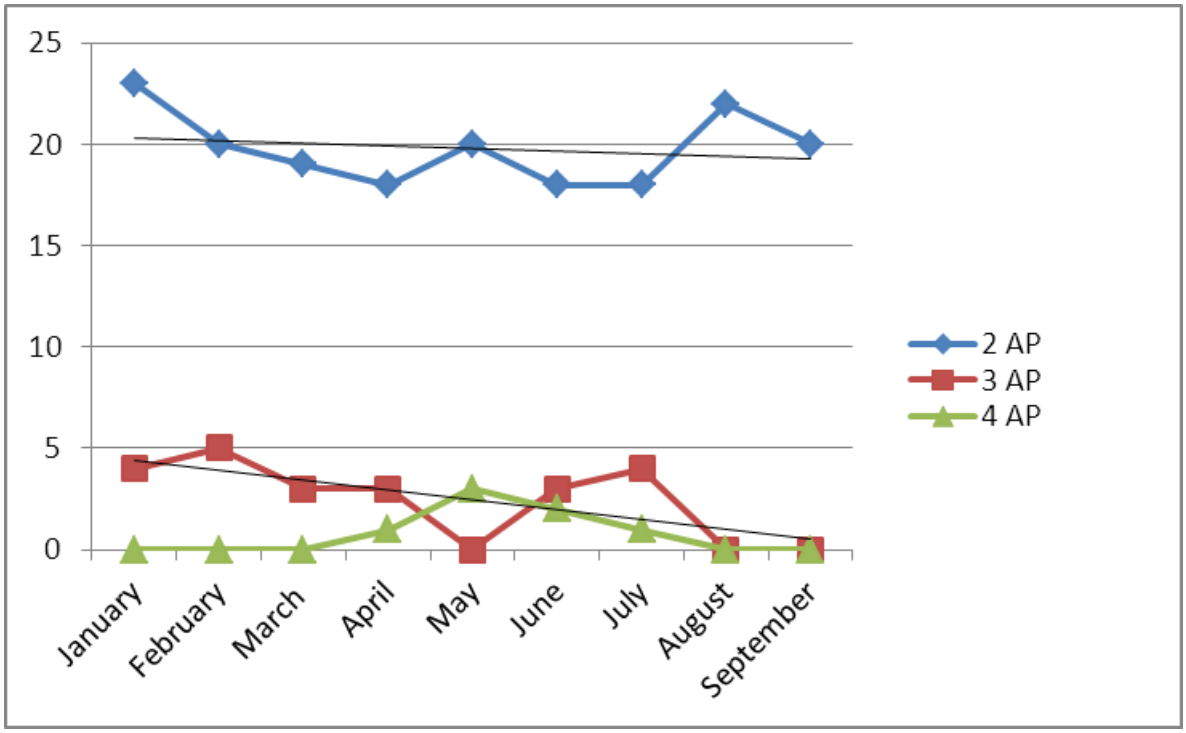
Census & Number of Patients with 0, 1, 2, 3, & 4 Orders for Antipsychotics





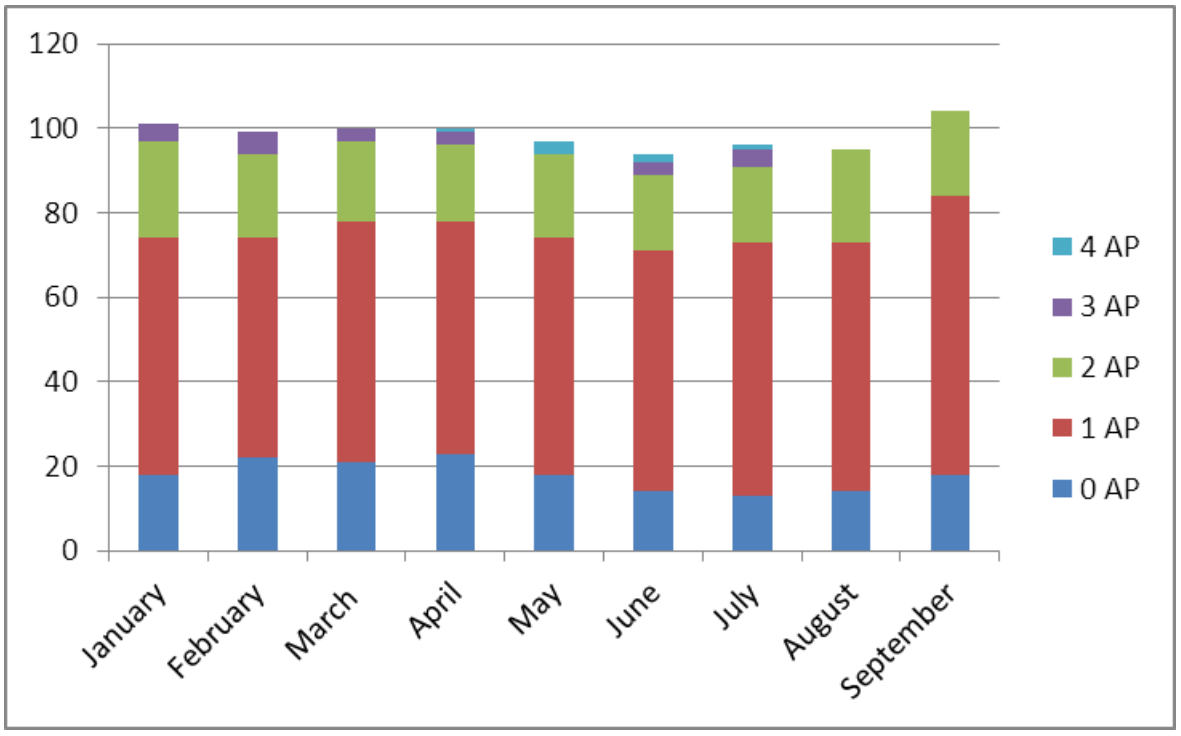
STRATEGIC PERFORMANCE EXCELLENCE

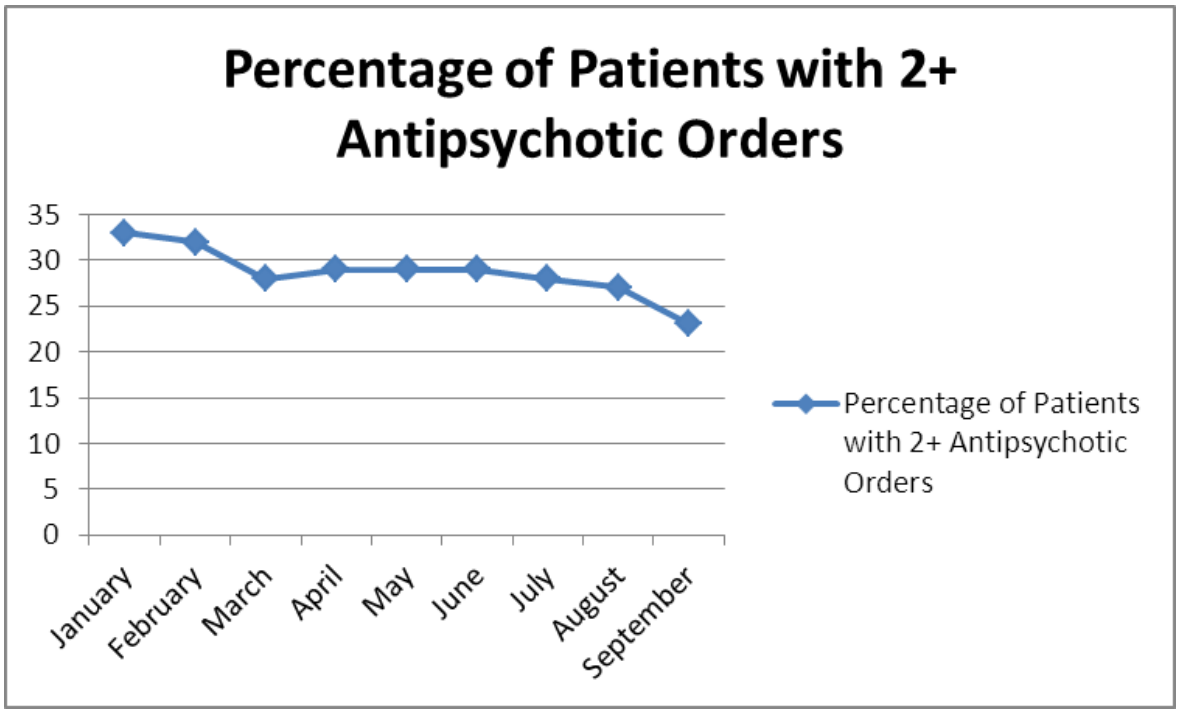
Number of Patients with 2+ Antipsychotic Orders per Month



STRATEGIC PERFORMANCE EXCELLENCE

Number of Concurrent Antipsychotic Orders Per Patient Per Month





STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Antibiotic Use Monitoring

Data Collection

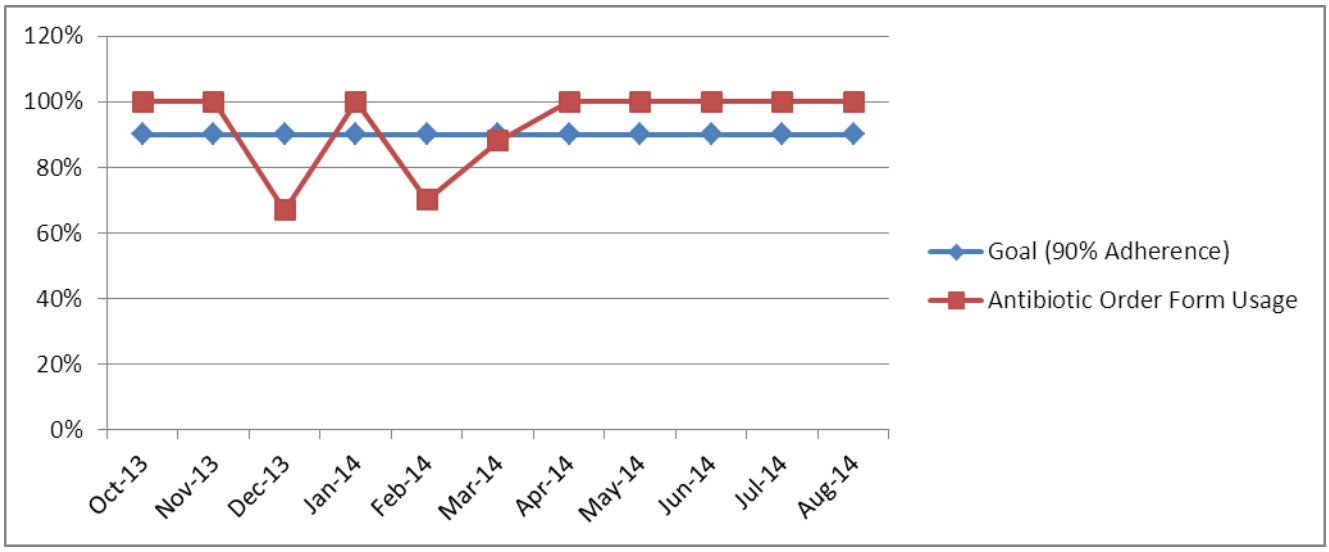
Data collection on the use of the Antibiotic Order Sheet was continued through the month of August. During the month of September where the results through August were presented to the Peer Review and Pharmacy and Therapeutics (P&T) Committee this monitor was retired due to 100% adherence of the Medical Staff utilization of the form for five consecutive months.

Findings

During the monitoring period there was an adherence rate of 100% for all months. Re-evaluation of the previous quarter's data on adherence to the Antibiotic Order Sheet increased the rate to 100% for each month. This was due to erroneous inclusion of medications not classified as antibiotics according to the AHFS classification. This information was reported to the Peer Review and P&T Committees.

Medical Staff Performance Improvement Indicator: Antibiotic Stewardship
Goal: 90% Adherence to Antibiotic Order Form for 4 Consecutive Months

	Oct '13	Nov '13	Dec '13	Jan '14	Feb '14	Mar '14	Apr '14	May '14	Jun '14	Jul '14	Aug '14	Sept '14
Goal (90% Adherence)	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Antibiotic Order Form Usage	100%	100%	67%	100%	70%	88%	100%	100%	100%	100%	100%	Retired



Plan

This monitor has been retired as of September 2014. We will continue to utilize the Antibiotic Order Sheet to order antibiotics and continue to assess the appropriate selection of antibiotic. We will also continue to regularly evaluate and update the guidance information on the form as necessary.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff
Metabolic Monitoring of Atypical Antipsychotics

Data Collection

The pharmacy completed data collection of metabolic monitoring parameters for all patients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all patients included BMI (Body Mass Index) and BP (blood pressure) plus lab results including HDL cholesterol, triglycerides, fasting blood sugar, and hemoglobin A1c. Also collected were the dates of the last tests and the names of the atypical drugs each patient was receiving. During this data collection period, education was provided to the medical staff on Metabolic Monitoring on September 17, 2014 as our findings have remained fairly consistent throughout the evaluation of this monitor.

Findings

During the monitoring period there were 105 patients receiving at least one atypical antipsychotic agent. Data was completely recorded for all desired data elements for about 56% of patients prescribed second generation antipsychotics for the quarter, consistent with previous reports. Twenty nine patients, or 28%, were missing enough data elements that their metabolic status was unable to be determined. About half of these were due to lab work refusals and newly admitted patients on the few days before the close of the quarter. As shown in the charts below, the majority of missing parameters require lab work (Glucose, A1c, HDL, Triglycerides) and it is missing for mostly new admissions. Conversely, the majority of missing weights and blood pressures are for patients that have been at the hospital for a longer period of time. There seems to be an alarmingly high number of patients missing a hemoglobin A1c value, however many of these patients do have fasting glucose levels that do not warrant obtaining an A1c. Therefore the second hemoglobin A1c parameter in the chart that indicates 22 values missing is more representative of patients either have no fasting blood glucose, a suspiciously high fasting blood glucose or known diabetes that would warrant us to check the A1c level.

Medical Staff Performance Improvement Indicator:

Metabolic Monitoring 2014

	April	May	June	July – September 2014
# of Patients on SGA	60	68	69	105
# of Patients with Complete/Up-to-date Parameters	34 (57%)	39 (57%)	45 (65%)	59 (56%)
# of Patients Missing/ Not Up-to-date Parameters	26 (43%)	29 (43%)	24 (35%)	46 (44%)
# of Patients Meeting Criteria for Metabolic Syndrome	14 (23%)	24 (35%)	25 (36%)	32 (30%)
# of Patients without Metabolic Syndrome	40 (67%)	33 (49%)	33 (48%)	44 (42%)
# Unable to Determine	6 (10%)	11 (16%)	11 (16%)	29 (28%)

STRATEGIC PERFORMANCE EXCELLENCE

Missing Parameter	Total	Current Patients	New Admissions	Lower Kennebec	Lower Saco	Upper Kennebec	Upper Saco
Weight	8	8	0	0	1	1	6
Blood Pressure	4	4	0	2	0	0	2
Glucose	22	10	12	11	7	4	0
HDL	26	10	16	10	11	5	0
Triglycerides	26	10	16	10	11	5	0
Hemoglobin A1c (also missing Glucose or glucose levels warrant A1c level)	22	11	11	11	8	3	0
Hemoglobin A1c (Total)	66	35	31	25	24	12	5

Missing Parameter	Lower Kennebec (LK)	LK SCU	LK New Admits	Lower Saco (LS)	LS SCU	LS New Admits
Weight	0	0	0	1	0	0
Blood Pressure	2	0	0	0	0	0
Glucose	1	2	8	2	1	4
HDL	0	2	8	2	1	8
Triglycerides	0	2	8	2	1	8
Hemoglobin A1c (also missing Glucose or glucose levels warrant A1c level)	2	2	7	2	2	4
Hemoglobin A1c (Total)	6	2	17	6	4	14

Refusals – 14 (30% of the patients with incomplete information)

Analysis

We are still below our target of 95% of patients on atypical antipsychotics having a complete metabolic profile available to the pharmacist and to the medical staff. A large contributing factor continues to be patient refusals of lab work. Another factor identified has been the proximity of admission to the end of the quarter. Additionally, there are some patients that have second generation antipsychotics ordered on a PRN or "as needed" basis, which means they may or may not regularly be taking the medication. Education was provided to the Medical Staff during this quarter on Metabolic Monitoring. However its timing was towards the end of the quarter (9/17/2014) which allowed for little to no impact on the results described in this quarterly report. It is expected that this education will impact the evaluation of this monitor during the next quarter.

Plan

Going forward, our plan will be to review the recommended metabolic monitoring frequency for each client to optimize the monitoring and prevent unnecessary lab work. We will continue to monitor the data elements of metabolic monitoring for each client prescribed a second generation antipsychotic. We will also continue to refine and improve our data entry. We will explore the concept of a metabolic clinic to better assess, identify, monitor, educate and treat clients at risk for metabolic syndrome. We will work to develop a schedule for blood draws for monitoring and perhaps add an order-set for lab work for patients prescribed second generation antipsychotics. We will utilize the APA and ADA guidelines to determine each client's recommended frequency of monitoring. We will explore the literature to determine action steps once a client is identified as having metabolic syndrome. We will collaborate with the Medical Staff on a notification process to alert them of when a patient is due or delinquent with metabolic monitoring.

Medical Staff
Polytherapy Monitoring

Data Collection

Polytherapy is defined as “combined treatment of multiple conditions with multiple medications”. This differs from polypharmacy, the “treatment of a single condition with multiple medications from the same pharmacologic class or with the same mechanism of action” which our other monitor, Poly-antipsychotic therapy, addresses. Polypharmacy can lead to complex medication regimens and increases the chances of drug-drug interactions potentially negatively impacting or inhibiting another drug from exerting it intended therapeutic effect. When five or more medications are taken together there is almost a 100% chance of a drug-drug interaction. We have assessed a baseline group of patients with regards to their total number of medications prescribed and further broken it down to number of scheduled medications and number of PRN or “as needed” medications.

Findings

At baseline 78 patients were evaluated for their total number of medications prescribed, their total number of scheduled medications and their total number of PRN orders.

	Average	Range
Total Orders	11.4	4 - 37
Scheduled	5.5	0 - 21
PRNs	6	1 - 22

Medication Number Range	Number of Patients
< 5	4
5 – 9	28
10 – 14	33
15 – 19	4
20 – 24	3
25 – 29	2
> 30	1

Plan

Our plan is to identify a strategy to reduce polytherapy. This will include identification of obtainable goals in reduction of polytherapy, development of a process, and identification of the patients to address initially (the outliers with highest number of medications ordered). This monitor will be reported and discussed with the Medical Staff at the Peer Review and Pharmacy & Therapeutics (P&T) Committees.

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

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

MONTHLY TARGETS

10% reduction monthly x4 from baseline

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Mandates

Staffing Improvement Task Force

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

	New Baseline Sept 2013	FY14 Q2			FY14 Q3			FY14 Q4			FY15 Q1			Goal
		Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014	July 2014	Aug2014	Sep 2014	
Nursing Mandates	14	4	8	9	3	12	15	21	2	8	4	2	1	9 (10% reduction monthly x4 from baseline)
Mental Health Worker (MHW) Mandates	49	32	30	29	20	49	54	39	8	13	16	18	12	32 (10% reduction monthly x4 from baseline)

Nursing mandates decreased from 31 last quarter to 7 this quarter.
MHW mandates decreased from 60 last quarter to 46 this quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

July – September 2014

Lower Kennebec

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	34 of 34	100%
2. All sections completed or deferred within document	34 of 34	100%
3. Initial Safety Treatment Plan initiated	34 of 34	100%
4. All sheets required signature authenticated by assessing RN	34 of 34	100%
5. Medical Care Plan initiated if Medical problems identified	10 of 34 21 n/a 2 ref.	97%
6. Informed Consent sheet signed	32 of 34 2 ref.	100%
7. Potential for violence assessment upon admission	34 of 34	100%
8. Suicide potential assessed upon admission	34 of 34	100%
9. Fall Risk assessment completed upon admission	33 of 34 1 n/a	100%
10. Score of 5 or above incorporated into problem need list	6 of 34 28 n/a	100%
11. Dangerous Risk Tool done upon admission	33 of 34	97%
12. Score of 11 or above incorporated into Safety Problem	19 of 34 13 n/a 1 ref.	100%
13. Evidence that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	33 of 34 1 ref.	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

July – September 2014

Upper Kennebec

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	4 of 4	100%
2. All sections completed or deferred within document	4 of 4	100%
3. Initial Safety Treatment Plan initiated	4 of 4	100%
4. All sheets required signature authenticated by assessing RN	4 of 4	100%
5. Medical Care Plan initiated if Medical problems identified	4 n/a	100%
6. Informed Consent sheet signed	4 of 4	100%
7. Potential for violence assessment upon admission	4 of 4	100%
8. Suicide potential assessed upon admission	4 of 4	100%
9. Fall Risk assessment completed upon admission	4 of 4	100%
10. Score of 5 or above incorporated into problem need list	4 n/a	100%
11. Dangerous Risk Tool done upon admission	4 of 4	100%
12. Score of 11 or above incorporated into Safety Problem	4 n/a	100%
13. Evidence that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	4 of 4	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

July – September 2014

Lower Saco

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	32 of 32	100%
2. All sections completed or deferred within document	32 of 32	100%
3. Initial Safety Treatment Plan initiated	30 of 32	94%
4. All sheets required signature authenticated by assessing RN	31 of 32	97%
5. Medical Care Plan initiated if Medical problems identified	4 of 32 27 n/a	97%
6. Informed Consent sheet signed	28 of 32 2 ref.	94%
7. Potential for violence assessment upon admission	32 of 32	100%
8. Suicide potential assessed upon admission	32 of 32	100%
9. Fall Risk assessment completed upon admission	32 of 32	100%
10. Score of 5 or above incorporated into problem need list	4 of 32 28 n/a	100%
11. Dangerous Risk Tool done upon admission	31 of 32	97%
12. Score of 11 or above incorporated into Safety Problem	18 of 32 11 n/a	91%
13. Evidence that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	29 of 32 2 ref.	97%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

July – September 2014

Upper Saco

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	7 of 7	100%
2. All sections completed or deferred within document	7 of 7	100%
3. Initial Safety Treatment Plan initiated	6 of 7	86%
4. All sheets required signature authenticated by assessing RN	7 of 7	100%
5. Medical Care Plan initiated if Medical problems identified	3 of 7 3 n/a	86%
6. Informed Consent sheet signed	7 of 7	100%
7. Potential for violence assessment upon admission	7 of 7	100%
8. Suicide potential assessed upon admission	7 of 7	100%
9. Fall Risk assessment completed upon admission	7 of 7	100%
10. Score of 5 or above incorporated into problem need list	1 of 7 6 n/a	100%
11. Dangerous Risk Tool done upon admission	7 of 7	100%
12. Score of 11 or above incorporated into Safety Problem	2 of 7 3 n/a	71%
13. Evidence that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	7 of 7	100%

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Initial Chart Compliance

July – September 2014

Total – All Units

Indicator	Findings	Compliance
1. Universal Assessment completed by RN within 24 hours	77 of 77	100%
2. All sections completed or deferred within document	77 of 77	100%
3. Initial Safety Treatment Plan initiated	74 of 77	98%
4. All sheets required signature authenticated by assessing RN	76 of 77	100%
5. Medical Care Plan initiated if Medical problems identified	17 of 77 54 n/a 2 ref.	95%
6. Informed Consent sheet signed	71 of 77 4 ref.	97%
7. Potential for violence assessment upon admission	77 of 77	100%
8. Suicide potential assessed upon admission	77 of 77	100%
9. Fall Risk assessment completed upon admission	75 of 77 2 ref.	100%
10. Score of 5 or above incorporated into problem need list	11 of 77 66 n/a	100%
11. Dangerous Risk Tool done upon admission	75 of 77	97%
12. Score of 11 or above incorporated into Safety Problem	39 of 77 31 n/a 1 ref.	92%
13. Evidence that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the settlement agreement is found in the document of the charts reviewed.	73 of 77 3 ref.	99%

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: Bobbi Lin

Strategic Objectives								
Client Recovery	Unit	Baseline	FY14 Q2	FY14 Q3	FY14 Q4	FY15 Q1	Goal	Comments
CSS Return Rate	LK	15%	18%	10%	12%	23%	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%	8%	10%	0%	23%	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%	47%	50%	12%	36%	50%	
	US	30%	33%	30%	100%	0%	50%	

STRATEGIC PERFORMANCE EXCELLENCE

Summary of Inpatient Client Survey Results

#	Indicators	2Q2014 Findings	3Q2014 Findings	4Q2014 Findings	1Q2015 Findings	Average Score
1	I am better able to deal with crisis.	69%	73%	59%	66%	**67%**
2	My symptoms are not bothering me as much.	71%	63%	59%	63%	**64%**
3	The medications I am taking help me control symptoms that used to bother me.	75%	83%	59%	72%	**72%**
4	I do better in social situations.	73%	65%	53%	67%	**65%**
5	I deal more effectively with daily problems.	69%	68%	53%	67%	**64%**
6	I was treated with dignity and respect.	75%	73%	63%	67%	**70%**
7	Staff here believed that I could grow, change and recover.	69%	80%	63%	72%	**71%**
8	I felt comfortable asking questions about my treatment and medications.	69%	70%	56%	67%	**66%**
9	I was encouraged to use self-help/support groups.	77%	70%	66%	69%	**71%**
10	I was given information about how to manage my medication side effects.	63%	65%	47%	61%	**59%**
11	My other medical conditions were treated.	71%	75%	57%	73%	**69%**
12	I felt this hospital stay was necessary.	63%	65%	44%	64%	**59%**
13	I felt free to complain without fear of retaliation.	53%	50%	47%	69%	**55%**
14	I felt safe to refuse medication or treatment during my hospital stay.	63%	55%	56%	42%	**54%**
15	My complaints and grievances were addressed.	65%	68%	56%	70%	**65%**
16	I participated in planning my discharge.	73%	65%	72%	72%	**71%**
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	73%	65%	63%	58%	**65%**
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	71%	63%	59%	63%	**64%**
19	The surroundings and atmosphere at the hospital helped me get better.	69%	65%	66%	66%	**67%**
20	I felt I had enough privacy in the hospital.	71%	63%	63%	64%	**65%**
21	I felt safe while I was in the hospital.	75%	75%	59%	67%	**69%**
22	The hospital environment was clean and comfortable.	75%	78%	59%	70%	**71%**
23	Staff were sensitive to my cultural background.	83%	55%	59%	52%	**62%**
24	My family and/or friends were able to visit me.	77%	78%	59%	61%	**69%**
25	I had a choice of treatment options.	73%	60%	50%	70%	**63%**
26	My contact with my doctor was helpful.	77%	68%	47%	63%	**64%**
27	My contact with nurses and therapists was helpful.	79%	78%	66%	72%	**74%**
28	If I had a choice of hospitals, I would still choose this one.	69%	48%	56%	55%	**57%**
29	Did anyone tell you about your rights?	71%	63%	59%	58%	**63%**
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	67%	45%	47%	66%	**56%**
31	Do you know someone who can help you get what you want or stand up for your rights?	71%	70%	69%	80%	**73%**
32	My pain was managed.	65%	65%	59%	58%	**62%**
	Overall Score	**71%**	**66%**	**58%**	**65%**	**65%**

Summary: the survey return rate is low due to patients declining to fill them out.

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 quarterly 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 quarterly 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. Additionally, adverse drug reactions and clinical interventions are monitored, documented and analyzed for review by the P&T Committee. ADR's are reported monthly and Clinical Interventions are reported on a quarterly basis.

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

Pharmacy

Responsible Party: Garry Miller, R.Ph.

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline 2014	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Pyxis CII Safe Comparison *Daily and monthly comparison of Pyxis vs CII Safe transactions*	Rx	0.875%	0%	0%	0%	0%		No discrepancies between Pyxis and CII Safe transactions during July & August
Quarterly Results			0%					
Veriform Medication Room Audits *Monthly comprehensive audits of criteria*	All	98%	100%	100%	100%	100%	90%	Overall compliance is 97% for July and August
Quarterly Results			97%					
Pyxis Discrepancies *Monthly monitoring and trending of Pxyis discrepancies.*	All	22/mo	25	25	25	25	25/mo	Trending of monthly data from Knowledge Portal for July & August
Quarterly Results			38 (19/mo)					
Fiscal Accountability	Unit	Baseline 2014	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions *Monitoring and Tracking of dispensed Discharge Prescriptions*	Rx	$3998 343 drugs	$3293 135 drugs					Significant costs are incurred in providing discharge drugs.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services

Define

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

Measure

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

Analyze

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

Improve

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

Control

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

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

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	Main / SCU 7 7	 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**)**	8 Avg.		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	8 Avg.		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	22/30	73%	100%
5. **The client can identify distress tolerance tools on the unit**	24/30	80%	100%
6. **The client is able to state who his primary staff is**	26/30	86%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

LK has improved in consistency unit groups and attendance. Acuity has been a factor in the sporadic attendance. We continue to look at ways to decrease the acuity as well as increase client interest / participation in unit groups. “What is Recovery” a new group facilitated by nursing has sparked some interest. Acuity Specialists on the unit also free up some staff for group participation.

ACTIONS

We will continue to try to increase not only client participation in groups but also in relating the client’s Recovery Goals to the groups offered and documenting on the group participation and progress towards goals as well.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 7 7	100%	 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**)**	6/7	85%	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**)**	6/7	85%	N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	10/10	100	100%
5. **The client can identify distress tolerance tools on the unit (re named coping tools)**	8/10	80%	100%
6. **The client is able to state who his primary staff is**	9/10	90%	100%

EVALUATION OF EFFECTIVENESS

On unit groups are offered once on day shift and once on evenings daily by RN. The percentage of treatment plans increased this quarter from 80 to 85 percent. Clients seem to enjoy the current groups at this time.

ISSUES

Consistent group leaders on the day shift have become an issue due to float nurses and schedules.

ACTIONS

Upper Kennebec now has two full time day RN with two more orienting and that should help with the consistency.

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 35 / 10 25 / 7	 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)	3.5 / 1.5		N/A
3. Number of clients attending evening groups on unit or facilitated by evening staff (# of clients in all of evenings groups divided by # of evening groups provided)	3.0 / 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	30/30	100%	100%
6. The client is able to state who his primary staff is	30/30	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

The Lower Saco unit on-unit groups by MHWS and professional staff is on-going and well established. The on-unit groups have been a regular part of each client's daily activity and are incorporated in their Rx plans. A high level of acuity on any given day can negatively impact levels of attendance and interest.

ACTIONS

RT staff members are very important in providing leisure and therapy groups to Lower Saco clients, which needs to be maintained. The unit is offering many more groups weekly than the threshold; the acuity specialist positions continue to address acuity situations and have helped maintain overall quality of groups.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 14 7	 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**)**	1.5 avg/ 14 groups		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	3 avg/ 9 groups		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%
6. **The client is able to state who his primary staff is**	30/30	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

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

ACTIONS

Additional efforts need to be made to get all on-unit offered groups in individual treatment plans. Continued efforts are being made to offer to those patients that have less activity at the hospital treatment mall. Treatment planning for on-unit groups and follow-up documentation issues are being identified with the new nurse leader.

STRATEGIC PERFORMANCE EXCELLENCE

Psychology Department

Department: Psychology Services Responsible Party: Arthur DiRocco, PhD

Current Psychology Performance Improvement Goal

The psychology department completed phase one of a performance improvement activity which resulted in the assessment of all NCR patients currently in residence at Riverview Psychiatric Center. The data collected from these assessments will be used in the next phase of the performance improvement activity to identify treatment needs and to provide a measure of outcomes for this population of patients.

Medical Staff Performance Improvement Activity

Target Goal: 90% of NCR Treatment plans will have one or more treatment goals identified and measured by treatment team use of COTREI within 4 months from October 1st, 2014.

Strategic Objectives						
NCR Patient Recovery	**Baseline**	**Oct '14 Target**	**Nov '14 Target**	**Dec '14 Target**	**Jan '15 Target**	**Goal**
Utilization of COTREI to assist in Treatment Team Planning and Goals for NCR patients The COTREI will be administered to each NCR patient at Riverview Psychiatric Recovery Center (RPRC). Areas of need identified by COTREI will be incorporated into NCR patient's treatment plan. Performance improvement will be assessed by documentation of at least one goal derived from the COTREI in 90% of NCR patients' treatment plans within 4 months of the October 1st, 2014 starting date.	5%	25%	50%	85%	100%	NCR patients will be assessed using the COTREI within 60 days of admission' every 8 months after starting their residency at RPC; and at the time of a new institutional report for a court petition.

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Recreational Therapy Assessments & Treatment Plans *The objective of this improvement project is to ensure that Recreational Therapy assessments are completed within 7 days of admission and that a treatment plan is initiated after the assessment and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.*	100 %	45/45 charts				The treatment plan intervention will be reviewed every 2 weeks and updated at each client treatment team meeting if necessary or if there is any change in patient status	Our target for this indicator was reached at the end of last year but when the treatment plan processed changed we will continue to monitor the plans to ensure continued progress for 2 quarters this year
Quarterly Results		100%					

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% (original)	100% 27 of 27	100%	100%	100%	To maintain percentage of referrals and doctor's orders at 100 % compliance for 4 consecutive quarters.	100% compliance was achieved at the end of last year and will be monitored until we have the 4 consecutive quarters.
Quarterly Results		100%					

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: 04/01/2014 To 06/30/2014

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.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection "Date worker assigned". The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a waiting list for service. When there is a CFSN, it is used in conjunction with the start date of the service to determine the number of days the member waited.
- **Referral Date** is a field in CareConnection that the Provider may fill in when a member applies for a service. If the member is not put on a waiting list, (i.e. no CFSN) the referral date is used with the date of assignment to determine the number of days the member waited.
- **Courtesy Review -** APS completes courtesy reviews when a member is not MaineCare eligible at the tme of admission, but is expected to be served using either MaineCare and/or state funds.

What This Report Measures: The number of non-hospitalized members authorized for 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: 2,253

Total assigned within 3 working days: 1,449	% assigned within 3 working days: 64%
Total assigned in 4 - 7 working days: 259	% assigned in 4 -7 working days: 11%
Total assigned within 7 working days: 1,708	% assigned within 7 working days: 76%
Total assigned after 8 or more working days: 545	% assigned after 8 or more working days: 24%

Gender	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Female	917	164	358	1,439
Male	532	95	187	814
Total	**1,449**	**259**	**545**	**2,253**

Adult Age Groups	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
18-20	97	14	26	137
21-24	118	17	35	170
25-64	1,152	214	466	1,832
65-74	53	11	14	78
Over 75 Years Old	29	3	4	36
Total	**1,449**	**259**	**545**	**2,253**

AMHI Class	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	1,383	246	522	2,151
AMHI Class Y	66	13	23	102
Total	**1,449**	**259**	**545**	**2,253**

District	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	106	36	55	197
District 2/ Cumberland County	310	66	194	570
District 3/ Androscoggin, Franklin, and Oxford Counties	327	52	71	450
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	104	20	50	174
District 5/ Somerset and Kennebec Counties	270	33	54	357
District 6/ Piscataquis and Penobscot Counties	217	32	61	310
District 7/ Washington and Hancock Counties	34	5	18	57
District 8/ Aroostook County	68	13	36	117
Unknown	13	2	6	21
Total	**1,449**	**259**	**545**	**2,253**

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	5	0	1	6
Allies	15	4	20	39
Alternative Services	15	0	0	15
Alternative Wellness Services	9	0	2	11
Aroostook Mental Health Services	40	3	1	44
Assistance Plus	40	5	19	64
Behavior Health Solutions for Me	6	1	2	9
Break of Day, Inc	39	4	6	49
Broadreach Family & Community Services	21	1	2	24
Catholic Charities Maine	54	25	22	101
Charlotte White Center	8	5	8	21
Choices	18	0	0	18
Common Ties	58	22	15	95
Community Care	17	2	2	21
Community Counseling Center	25	1	16	42
Community Health & Counseling Services	72	14	28	114
Connections for Kids	1	0	0	1
Cornerstone Behavioral Healthcare - CM	2	0	0	2
Counseling Services Inc.	65	31	41	137
Direct Community Care	25	3	2	30
Dirigo Counseling Clinic	18	4	0	22
Employment Specialist of Maine	3	0	2	5
Evergreen Behavioral Services	6	3	1	10
Fellowship Health Resources	0	1	0	1
Fullcircle Supports Inc	38	0	1	39
Goodwill Industries of Northern New England	1	0	0	1
Graham Behavioral Services	22	6	1	29
Harbor Family Services	1	1	5	7
Healing Hearts LLC	3	0	1	4
Health Affiliates Maine	172	0	6	178

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
HealthReach network	1	0	0	1
Higher Ground Services	10	0	2	12
Kennebec Behavioral Health	80	5	25	110
Life by Design	18	8	19	45
Lutheran Social Services	17	1	0	18
Maine Behavioral Health Organization	46	1	7	54
Maine Vocational & Rehabilitation Assoc.	13	5	2	20
Manna Inc	9	0	4	13
MAS Home Care of Maine - Westbrook	4	0	0	4
Medical Care Development-CSS	4	0	0	4
Merrymeeting Behavioral Health Associates-Adult Case Mgmt	6	1	4	11
Mid Coast Mental Health	18	4	11	33
Motivational Services	2	1	1	4
Northeast Occupational Exchange	37	5	9	51
Northern Maine General - Community Support	4	1	12	17
Ocean Way Mental Health Agency	3	0	1	4
OHI	5	0	1	6
Oxford County Mental Health Services	16	3	3	22
Port Resources-Sec 17	2	0	0	2
Providence	19	13	66	98
Riverview	3	0	0	3
Rumford Group Homes	13	0	0	13
Sequel Care of Maine	17	1	0	18
Shalom House	20	4	2	26
Smart Child & Family Services	3	0	7	10
Somali Bantu Youth Association of Maine	7	4	3	14
St. Andre Homes	5	1	0	6
Stepping Stones	18	2	2	22
Sunrise Opportunities	7	0	1	8
Sweetser	87	12	44	143
The Opportunity Alliance	90	32	77	199
Tri-County Mental Health	62	19	38	119
York County Shelter Program	4	0	0	4
Total	**1,449**	**259**	**545**	**2,253**

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: 04/01/2014 To 06/30/2014

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.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection "Date worker assigned". The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a waiting list for service. When there is a CFSN, it is used in conjunction with the start date of the service to determine the number of days the member waited.
- **Referral Date** is a field in CareConnection that the Provider may fill in when a member applies for a service. If the member is not put on a waiting list, (i.e. no CFSN) the referral date is used with the date of assignment to determine the number of days the member waited.
- **Courtesy Review -** APS completes courtesy reviews when a member is not MaineCare eligible at the tme of admission, but is expected

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 longer than 8 days but were eventually assigned to the service

Total number of hospitalized members applying for CI: 60

Total assigned within 2 working days: 39 — % assigned within 2 working days: 65%

Total assigned in 3 - 7 working days: 8 — % assigned in 3 -7 working days:13 %

Total assigned within 7 working days: 47 — % assigned within 7 working days: 78%

Total assigned after 8 or more working days: 13 — % assigned after 8 or more working days: 22%

Gender	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Female	25	5	9	39
Male	14	3	4	21
Total	**39**	**8**	**13**	**60**

AMHI Class	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	24	5	11	40
AMHI Class Y	15	3	2	20
Total	**39**	**8**	**13**	**60**

District	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
District 2/ Cumberland County	11	0	2	13
District 3/ Androscoggin, Franklin, and Oxford Counties	5	3	0	8
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	6	1	0	7
District 5/ Somerset and Kennebec Counties	12	3	5	20
District 6/ Piscataquis and Penobscot Counties	3	0	5	8
District 7/ Washington and Hancock Counties	1	1	0	2
District 8/ Aroostook County	1	0	1	2
Total	**39**	**8**	**13**	**60**

Providers	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Allies	0	0	1	1
Alternative Wellness Services	1	0	0	1
Aroostook Mental Health Services	0	0	1	1
Assistance Plus	1	0	1	2
Break of Day, Inc	1	0	0	1
Catholic Charities Maine	3	1	0	4
Charlotte White Center	0	0	1	1
Common Ties	2	2	0	4
Community Counseling Center	2	0	0	2
Community Health & Counseling Services	0	0	2	2
Cornerstone Behavioral Healthcare - CM	1	0	0	1
Counseling Services Inc.	1	0	0	1
Fullcircle Supports Inc	0	0	1	1
Graham Behavioral Services	3	0	0	3
Health Affiliates Maine	1	0	0	1
Kennebec Behavioral Health	3	1	3	7
Lutheran Social Services	1	0	0	1
Maine Vocational & Rehabilitation Assoc.	2	0	0	2
Mid Coast Mental Health	2	1	0	3
Motivational Services	3	2	0	5
Northern Maine General - Community Support	1	0	0	1
Ocean Way Mental Health Agency	1	0	0	1
OHI	1	0	1	2
Oxford County Mental Health Services	1	0	0	1
Sequel Care of Maine	1	0	0	1
Shalom House	4	0	0	4
Somali Bantu Youth Association of Maine	0	1	0	1
Sweetser	3	0	0	3
The Opportunity Alliance	0	0	2	2
Total	**39**	**8**	**13**	**60**

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: 04/01/2014 To 06/30/2014 **Report Run Date: 10/16/20**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection "Date worker assigned". The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a wait list for service. The CFSN is used in conjunction with the date of assignment to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare funds.

What This Report Measures: For members on the CI wait list who were authorized for the service, how long they waited. This report counts the number of days from the date the CFSN was opened to the date the service was authorized. The report is run 2 quarters ago so nearly everyone who was entered on the wait list will have started the service. If someone on the MaineCare waitlist is authorized for the state-funded service, it is counted as being authorized for the service.

Number of people who were authorized for CI from the MaineCare wait list during the quarter 878

For those who received the service:
Percent waiting 30 days or less: 87%
Average number of days waiting: 12 days
Percent waiting 90 days or less: 100%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
AMHI Class N	835	825	10	723	109	3	12
AMHI Class Y	43	43	0	39	4	0	8
Totals	**878**	**868**	**10**	**762**	**113**	**3**	**12**

District	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
District 1	118	118	0	105	13	0	13
District 2	249	248	1	208	39	2	13
District 3	136	135	1	116	20	0	12
District 4	73	69	4	62	10	1	13
District 5	136	134	2	124	12	0	9
District 6	115	113	2	101	14	0	10
District 7	33	33	0	30	3	0	11
District 8	14	14	0	12	2	0	12
Unknown	4	4	0	4	0	0	5
Totals	**878**	**868**	**10**	**762**	**113**	**3**	**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 days	# auth in > 91 days	Average # days waiting
Assistance Plus	46	46	0	42	4	0	8
Catholic Charities Maine	114	113	1	112	2	0	5
Common Ties	63	63	0	63	0	0	3
Community Care	22	21	1	19	3	0	7
Community Counseling Center	41	41	0	16	24	1	39
Community Health & Counseling Services	108	107	1	93	15	0	12
Counseling Services Inc.	88	88	0	83	5	0	8
Direct Community Care	2	2	0	2	0	0	0
Higher Ground Services	10	10	0	10	0	0	4
Kennebec Behavioral Health	88	86	2	77	11	0	11
Life by Design	11	11	0	10	1	0	10
Mid Coast Mental Health	31	28	3	28	3	0	6
OHI	6	6	0	6	0	0	0
Shalom House	25	25	0	25	0	0	4
Sweetser	58	58	0	40	16	2	30
The Opportunity Alliance	107	105	2	95	12	0	11
Tri-County Mental Health	58	58	0	41	17	0	20
Totals	**878**	**868**	**10**	**762**	**113**	**3**	**12**

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: 04/01/2014 To 06/30/2014 **Report Run Date: 10/16/20**

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Prior Authorization (PA)** Whenever a provider is requesting to begin a service with a member, they are required to submit a request for prior authorization (PA) in APS CareConnection.
- **Date of Assignment:** When providers submit a prior authorization (PA), they are required to fill in APS CareConnection "Date worker assigned". The date worker assigned indicates the day that a specific CI case worker has been assigned to begin providing the service to the member.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a wait list for service. The CFSN is used in conjunction with the date of assignment to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare funds.

What This Report Measures: For members on the State-funded CI wait list who were authorized for the service, how long they waited. This report counts the number of days from the date the CFSN was opened to the date the service was authorized. The report is run 2 quarters ago so nearly everyone who was entered on the wait list will have started the service. If someone on the state-funded waitlist is authorized for the MaineCare service, it is counted as being authorized for the service.

Number of people who were authorized for CI from the state-funded wait list during the quarter: 142

For those who received the service:

Average number of days waiting: 23 days

Percent waiting 30 days or less: 68%

Percent waiting 90 days or less: 97%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
AMHI Class N	135	28	107	92	39	4	23
AMHI Class Y	7	2	5	5	2	0	22
Totals	**142**	**30**	**112**	**97**	**41**	**4**	**23**

District	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
District 1	23	3	20	6	15	2	53
District 2	42	13	29	30	11	1	23
District 3	23	5	18	17	5	1	18
District 4	14	3	11	10	4	0	14
District 5	15	3	12	11	4	0	17
District 6	18	3	15	16	2	0	8
District 7	2	0	2	2	0	0	0
District 8	5	0	5	5	0	0	4
Totals	**142**	**30**	**112**	**97**	**41**	**4**	**23**

APS Healthcare

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

Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
Aroostook Mental Health Services	1	0	1	1	0	0	0
Assistance Plus	2	0	2	2	0	0	4
Catholic Charities Maine	4	1	3	4	0	0	4
Common Ties	7	1	6	7	0	0	4
Community Care	16	2	14	14	2	0	5
Community Counseling Center	2	1	1	2	0	0	9
Community Health & Counseling Services	2	1	1	2	0	0	16
Counseling Services Inc.	17	2	15	3	12	2	59
Direct Community Care	1	0	1	1	0	0	11
Evergreen Behavioral Services	1	1	0	1	0	0	0
Harbor Family Services	1	1	0	1	0	0	0
Kennebec Behavioral Health	9	2	7	7	2	0	15
Life by Design	3	0	3	3	0	0	7
Mid Coast Mental Health	4	0	4	3	1	0	14
Shalom House	4	2	2	2	2	0	27
Smart Child & Family Services	2	0	2	0	1	1	87
Sweetser	13	4	9	5	8	0	34
The Opportunity Alliance	33	9	24	27	6	0	18
Tri-County Mental Health	20	3	17	12	7	1	26
Totals	**142**	**30**	**112**	**97**	**41**	**4**	**23**