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 The Certification Request was withdrawn May 14, 2010.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.