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August 16, 2011

Michele Lumbert, Clerk
Kennebec County Superior Court
95 State Street
Augusta, ME 04330

Re: Paul Bates, et al. v. Mary Mayhew, Commissioner, Department of Health and Human Services, et al.
Docket No. CV-89-088

Dear Michele:

Enclosed you will find for filing a Progress Report running through August 1, 2011, in the above-captioned matter.

I have discussed this report with counsel and we jointly request that Judge Horton schedule a conference with counsel sometime in late September or early October. I have supplied Judge Horton with a copy of this letter and report.

Sincerely yours,

Daniel E. Wathen

DEW/wt
Enclosure
cc/w/enc: Justice Andrew M. Horton
Katherine Greason, AAG
Phyllis Gardiner, Esq.
Helen Bailey, Esq.

STATE OF MAINE
KENNEBEC, ss

SUPERIOR COURT
CIVIL ACTION
DOCKET NO. CV-89-088

PAUL BATES, et al,

Plaintiffs

v.

MARY MAYHEW, COMMISSIONER, DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al,

Defendants

COURT MASTER'S PROGRESS REPORT PURSUANT TO PARAGRAPH 299

The following report covers the period from December 1, 2010 to August 1, 2011. I have extended the usual six-month reporting period in order to include important legislative and administrative developments with respect to the biennial budget.

Introduction

I have previously reported the progress that has been made at Riverview Psychiatric Center over the past several years and have documented the need for additional community mental health services for clients no longer requiring inpatient treatment and awaiting discharge from Riverview to an appropriate community placement. Progress continues at Riverview and the Administration and the Legislature have demonstrated their commitment by funding an adequate remedy for any remaining issues of constitutional or statutory significance at the hospital. Accordingly, in this report I recommend that the Court exercise its supervisory powers under the consent decree and consider withdrawing active supervision of Riverview Psychiatric Center, subject to certain conditions (including the Department's continued quarterly reporting

with reference to the hospital and the ability of the Court to reinstate active supervision in the future should circumstances change). Withdrawal of active supervision at Riverview would not terminate the Consent Decree nor Riverview's performance obligations thereunder. The operation of Riverview would remain subject to the continuing jurisdiction of the Court, and the Consent Decree would remain enforceable.

Active supervision of the community-based mental health system, however, should continue at least until the Department demonstrates that core mental health services identified in the approved Consent Decree Plan are reasonably available throughout the geographic areas of the State and that it has the ability to assign caseworkers in a timely fashion to clients in hospitals and in the community..

Background

Because this report recommends that the Court consider the withdrawal of active supervision of the Riverview Psychiatric Center, a brief background is in order. The 1990 Consent Decree and incorporated Settlement Agreement (sometimes, collectively, the Consent Decree) were grounded in allegations that the Department had failed to meet certain constitutional, statutory, and regulatory standards and had thereby deprived AMHI clients of certain fundamental rights, including freedom from restraint, adequate medical care, treatment in the least restrictive setting, and accessible community support services. *See, e.g.,* U.S. Const. amend. XIV; Me. Const. art. I, §§1, 6-A; 34-B M.R.S. §§ 1430, 3003, 3004. I will not relate the twenty-year history of the case here, for that is well-known to the parties and has been thoroughly set forth elsewhere, including in *Bates v. Dept. of Behavioral and Developmental Services*, 2004 ME 154, 863 A.2d 890. The important milestone in that history for purposes of the Court's supervision today is the

most recent comprehensive workplan developed by the Department (in conjunction with stakeholders) and approved in 2006, which described in detail the steps the Department must take to demonstrate substantial compliance with the Consent Decree ("2006 Plan").

The 2006 Plan is based on the principles of individualized treatment, respect for clients, flexibility, and community-based support set forth in the Consent Decree, but also incorporates "contemporary thinking on the necessary ingredients for reforming mental health services," including legislative changes. (*See* 2006 Plan at 2, 6, 42.) The Plan establishes performance and compliance standards tied to the Consent Decree provisions and statutory requirements; these standards provide a means of measuring the Department's progress towards compliance with the Consent Decree. In very summary form, the standards address the following goals:

Riverview Psychiatric Center

- Consumer-centered, innovative, recovery-focused hospital-based care appropriately integrated with community-based care
  (e.g., individualized inpatient treatment plan within seven days of admission; engagement of peer support specialists; minimal use of seclusion and physical restraints; competent and qualified staff; timely responses to client grievances)

- High quality mental health care within the least restrictive and most appropriate setting
  (e.g., appropriate admission procedures; coordination with community providers for the timely transition into appropriate community placements (within 7 and no more than 45 days from date of clinical readiness); development of additional community-based resources)

- Professional administration that ensures delivery of appropriate care within available fiscal resources
  (e.g., monitor and evaluate hospital functions through consistent and timely reporting; reduce medication errors, client elopements, and client injuries; ensure appropriate administering of antipsychotic medications)

2006 Plan at 83-98.

Community Mental Health System

- Rights, Dignity, and Respect
  (e.g., treating clients with respect as individuals; addressing grievances in timely fashion; informing clients of their rights)

- Community Integration/Community Support Services/Individualized Support Planning
  (e.g., timely assignment of case managers; consideration of client's physical and psychological needs; services provided by state-licensed agencies)

- Community Resources and Treatment Services
  (e.g., adequate and flexible array of residential support services and housing alternatives; housing near community services; effective crisis intervention services 24/7; family support; vocational support; transportation; recreation)

- System Outcomes: Supporting the Recovery of Adults with Mental Illness
  (e.g., functional improvements in clients' lives; recovery support; public education programs)

2006 Plan at 61-79.

In assessing the need to continue active supervision for both Riverview and the community-based health system, I have considered the goals and standards in the 2006 Plan, the Consent Decree, and applicable laws. In this evaluation, I have been guided by the principles enunciated by the United States Supreme Court in *Horne v. Flores,* 557 U.S. __, 129 S.Ct. 2579 (2009), and other consent decree cases[1] that have considered the circumstances justifying reduction or termination of court supervision of state programs. While *Horne* and other decisions have dealt with these issues in the context of federalism concerns and the federal Rule 60(b)(5) standard for relief from judgment – questions not present here – the *Horne* principle that a court should take a flexible approach when evaluating whether it should continue to monitor a state's compliance with constitutional and statutory obligations is instructive and persuasive, if not controlling. In short, the

[1] *See, e.g., Consumer Advisory Board v. Harvey*, 697 F. Supp.2d 131, 137 (D. Me. 2010) ("*Horne* teaches that federal courts must take a flexible approach ... to ensure 'that responsibility for discharging the State's obligations is returned promptly to the State and its officials' when circumstances warrant.").

rationale is that the ordinary processes of democratic governance should be disturbed by ongoing court enforcement of a consent decree only so long as there are ongoing constitutional and statutory violations.[2] Even though in this Report I do not recommend termination of the Consent Decree, I have followed *Horne*'s flexible approach to evaluate the need for continued active supervision of the Riverview facility, and asked whether the Department has met the objectives, if not the precise letter, of the 1990 Consent Decree and 2006 Plan and whether it has implemented a "durable remedy" to the constitutional and statutory violations these documents sought to cure. *Horne*, 129 S. Ct. at 2595.

Overview of Conditions

Riverview Psychiatric Center

At the end of 2010, I asked Elizabeth Jones, the former court-appointed receiver of AMHI and an experienced authority on psychiatric hospitals to conduct a site visit to Riverview. After reviewing a number of randomly selected treatment plans and progress notes, Ms. Jones spent two days interviewing clients and staff, including peer support workers and advocates. At the conclusion of her visit, she noted no serious shortcomings or deficiencies and commented that the discharge process at Riverview works extremely well. She made a number of recommendations that have been discussed with the Superintendent and implemented appropriately.

In my last Progress Report as it relates to Riverview, dated December 25, 2010, I observed that although some of the goals in the 1990 Consent Decree remained to be

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[2] The Law Court may have anticipated the ruling in *Horne* when, in *dictum*, it questioned the degree to which the department heads and clients of the departments could unilaterally bind the State in the absence of legislative authorization. See *Bates v. Dept.* at 907. At the very least, it would seem imprudent to seek to continue active court supervision solely on the basis of provisions in the settlement agreement that are unrelated to violations of law.

accomplished, considerable progress had been made by the Department in several critical areas, as evidenced by the steps it has taken to implement the 2006 Plan for Riverview to meet the Consent Decree objectives. I outlined the key areas where, at that time, deficiencies identified in the 2006 Plan had been satisfactorily resolved at Riverview: in addition to having the new modern physical facility, it is no longer overpopulated and is even below capacity with no waiting list for admission on either the civil or forensic side (from time to time wait lists are experienced on both sides of the hospital); clients are provided Individualized Support Plans; its elopement, medication error rate and readmissions within 30 days continue to remain below the national mean; restraint and seclusion policies are in place and the hospital performs within one standard deviation of the national mean; an improved monitoring system for the use of prn medications when used coercively for behavior control has been implemented; there has been significant improvement in the completion of employee performance evaluation reports, AIMS[3] testing for adverse reactions to psychotropic medications, and the timely filing of institutional reports for forensic clients; the discharge process is managed by a very capable staff; discharge for civil clients is now timely and effective and continues to improve; the discharge process on the forensic side of the hospital is also greatly improved although inhibited by the unavailability of non-MaineCare funding for community services. I recommended that in order to meet the State's obligations assumed under the Consent Decree, Riverview's budget and staffing should continue to be maintained at then current levels.

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[3] Abnormal Involuntary Movement Scale

Since my last report, progress has continued at Riverview. Although key performance indicators ebb and flow, they are monitored and responded to appropriately. Most importantly, budget and staffing have been maintained. Riverview, with its mix of long- and short-term civil and forensic clients, presents a challenging environment for management. Processes are in place to effectively deal with the inevitable complaints and grievances. For example, the Superintendent holds a forum on a monthly basis, in the absence of staff, with clients and peer service workers and encourages the discussion of any concerns that clients might have with respect to hospital operations. Typically, the Superintendent will report back at the next forum on any matters that were discussed without immediate resolution. I attend most of these sessions and there is a very open and honest discussion of issues that arise, including any complaints regarding disrespect on the part of staff.

The lingering question of constitutional dimension involves the inability of the hospital, on occasion, to release clients to less restrictive community-based programs due to insufficient funding of community services for clients ineligible for MaineCare services. The incidence of clients being stuck in the hospital awaiting community placement, after achieving clinical readiness, has been reduced significantly. For the past several months there have been no more than one or two civil clients at any given point in time whose discharge was delayed beyond forty-five days. Forensic clients often experience more delay, even after satisfying court-imposed restraints, because of funding and placement issues.

Although the discharge performance of the hospital generally represents a significant improvement over past history, more exacting adherence to the discharge

criteria set forth in the approved 2006 Plan and the underlying legal standard is required. *See Olmstead v. L.C.*, 527 U.S. 581, 587 (1999) (community placement is required "when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual; and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities"). The funding described below demonstrates the State's commitment to obtain full compliance with these discharge standards.

Community Mental Health System

With regard to the community mental health system, my last report identified the primary deficiency as the unavailability of mental health services for the segment of the population that is not eligible for MaineCare. In the last two years, the withdrawal of State funding for clients ineligible for MaineCare has hampered the Department's ability to expand these services to the level envisioned by the Consent Decree. Indeed, in this area, the Department has lost some of the ground it once held by shifting costs too aggressively to Medicaid, virtually destroying the safety net of services that was previously available for that portion of the low income population ineligible for MaineCare. Thus, in order to address the unmet needs in the community and in clients awaiting discharge from Riverview, I encouraged and endorsed the Department's request for an additional $4.6 million in the Department's annual budget for non-MaineCare services, and $1 million for additional rental assistance for both MaineCare and non-MaineCare clients.

A summary of the progress reported by the Department in the community mental health system is set forth in the attached Report on Compliance Plan Standards. It is significant to note all 119 of the system development components set forth in the 2006 Plan are reported as completed or deleted. Although only two of the compliance standards have been certified as completed, there is substantial progress, if not compliance, with respect to a majority of them. The principal areas of continuing concern relate to the Department's inability to assign caseworkers in a timely fashion to either those who are hospitalized or in the community and its inability to reliably measure and address the unmet service needs of persons with severe and persistent mental illness. Both of these problems are in large part a function of funding.

Budget Developments

The regular session of the Maine Legislature recently enacted a budget for FY 2012 and 2013 and it has been signed by the Governor. The budget includes in the first year of the biennium an appropriation of an additional $5,659,250 for both mental health services for individuals not eligible for MaineCare and for housing services "in order to conform to the consent decree." In the second year, only the housing services were included for $995,000. Part XX of the budget document, however, requires the Department to report to the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services no later than February 1, 2012, regarding the implementation of the additional FY12 funding for mental health services. The report is required to include recommendations from the Court Master with reference to funding for FY13. Although full funding is secured for only one year of services, I am satisfied that both the Administration and the Legislature

have expressed a commitment to provide a "durable remedy" and to fund the mental health services that are reasonably required to prevent any ongoing violations of law. In this year of tight resources, the Legislature deferred the full funding of the second year in order to have the benefit of the experience gained during the first half of the first year of the biennium. I am currently working with the Department to allocate the additional funds among the various categories of mental health services and to insure that the funds are prioritized and readily available to address the needs of those awaiting discharge from Riverview. The remaining funds, which should be the major portion, will be used in the community to address the needs of those with severe and persistent mental illness who are assigned to wait lists for mental health services. The report to the legislative committees in February will be crucial in securing adequate funding for the second year of the biennium.

Conclusion

I conclude that we have reached the point where active Court supervision of the Riverview Psychiatric Center is no longer necessary to enforce the terms of the Consent Decree. This conclusion is based on the operational progress that has been made at Riverview over a number of years, the demonstrated commitment of the officials of our State to maintain the staff and budget of the hospital and to fund the community services that are necessary to permit timely discharges to less restrictive community placements, and adequate mechanisms in place to maintain progress and ensure continued compliance.

Progress to date: As described earlier in this Report, Riverview has largely achieved each of the three broad goals in the 2006 Plan although there is a continuing

need to reduce the use of seclusion and restraint and to further promote the implementation of recovery principles.

State commitment: The staff and budget of the hospital have been maintained even in a period of declining state revenue. The recently enacted budget includes the full appropriation for both mental health services for individuals not eligible for MaineCare and for housing services for the first full year of FY12 that was requested by the Department, and there is a process in place to secure the appropriation required for the second full year. I am satisfied that the Department and the Administration are committed to maintaining the staff and budget of the hospital and providing the necessary funding to meet their Consent Decree obligations.

Adequate mechanisms: Adequate mechanisms in the form of systems developed by the Department to monitor Riverview's responsiveness to client needs and measure performance in the areas covered by the 2006 Plan, as well as new and pre-existing statutes that protect the rights of hospital clients and provide avenues to pursue prompt remedies, are now in place and will help ensure continued quality of care at Riverview. These mechanisms include:

- Monitoring and reporting systems are in place as set forth in the quarterly reports of the hospital.
- Independent client advocates affiliated with the Disability Rights Center of Maine, peer service workers on hospital staff, and regular client access to counsel for the plaintiffs under the Consent Decree are available.
- The Americans with Disabilities Act (ADA), enacted at almost the same time as the entry of the Consent Decree, was for that reason not one of the statutes the Department was alleged to have violated, but nonetheless applies to the Department's activities today. Construed by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999), the ADA prevents the Department from discriminating against institutionalized individuals in administering its community-based treatment programs. *Id.* at 587, 603 n. 14, 607; *see also Bates v. Dept. of Behavioral & Developmental Servs.*, 2004 ME 154 ¶59.

- The Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997a *et seq.*, protects the constitutional and federal statutory rights of persons confined in certain institutions owned or operated by, or on behalf of, state or local governments. The Act authorizes the U.S. Attorney General to investigate covered facilities to determine whether there is a pattern or practice of violations of residents' federal rights. Investigations often involve issues such as the adequacy of discharge planning and necessary support services when patients return to the community.

- The Consumer Council System of Maine established by statute in 2007 is specifically charged with providing an effective consumer voice to promote high quality mental health services, and particularly with regard to the Consent Decree. *See* 34-B M.R.S. § 3611(1)(" The council system exists as an independent public instrumentality of the State to provide guidance and advice from consumers of adult mental health services provided or funded by the State regarding the delivery of effective and appropriate adult mental health services consistent with the State's comprehensive mental health services plan and to comply with the consent decree and incorporated settlement agreement in the case of *Paul Bates, et al. v. Robert Glover, et al.*, Kennebec County Superior Court, Civil Action Docket No. CV-89-88 dated August 2, 1990."). As an example, one of its assigned duties is "assessment of the quality of services and delivery systems" of the Department. *Id.* § 3611(3)(B).

- The Joint Commission (TJC, formerly the Joint Commission on Accreditation of Healthcare Organizations) periodically inspects the hospital unannounced for the purposes of accreditation. The last survey was in November of 2010. Surveys usually occur every three years but may be repeated after 18 months.

- Center for Medicare and Medicaid Services (CMS) has its own survey procedure that may involve unannounced visits or review and acceptance of TJC survey. The last full federal survey was in November of 2007.

- The hospital is licensed by DHHS as an acute care hospital on an annual basis. The DHHS licensing division responds to complaints from anyone and reports of sentinel events or client abuse by the hospital. With the exception of sentinel events, visits are unannounced and occur on average every two months.

- The ACT team operated by the hospital is also licensed by the State and subject to unannounced review.

I suggest to the Court that these measures, taken together, represent a durable remedy to the constitutional and statutory deficiencies addressed in the Consent Decree and 2006 Plan with regard to the Riverview Psychiatric Center. *See Horne*, 129 S. Ct. at

2595.[4] I accordingly recommend that the Court exercise its general supervisory authority pursuant to ¶ 12 of the Consent Decree (Settlement Agreement)[5] to suspend active supervision of the Riverview Psychiatric Center.

Although improvements have also been made by the Department in the community-based health system, I do not recommend that active supervision of the Court be withdrawn at this point in time. The reliability of the Department's unmet needs reports has not been established and is questionable. Although the needs of clients at Riverview can easily be verified, the unmet needs in the greater community deserve further investigation. In fact, the methodology used to estimate the budget request focused on the number of persons affected by the cuts in non-MaineCare services since FY08 rather than an estimate of current needs. Finally, the rates that are paid for community mental health services have been revised. Thus the Department will have to arrive at a reasonable estimate of needs, allocate the additional funds to meet those needs, and distribute those funds in an efficient manner to achieve maximum benefit. In short, additional work remains in order to effectively measure and address the unmet needs in the community and to assure the timely assignment of case managers.

The Consent Decree should remain in effect, however, even with respect to Riverview. This would permit plaintiffs to seek injunctive relief if necessary under ¶ 7 of

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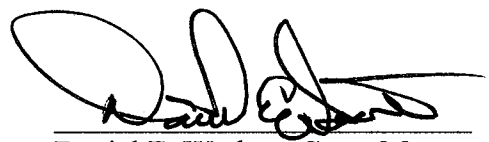
[4] *See also, e.g., Consumer Advisory Board v. Harvey*, 697 F. Supp.2d at 138 (finding substantial compliance by State, combined with adequate mechanisms in statutes and oversight organizations and State's demonstrated commitment to achieving compliance, was durable remedy justifying termination of Pineland Consent Decree).

[5] Paragraph 12 provides: "Until the Agreement's termination pursuant to the terms of the Consent Decree, the parties hereby consent to the court's continuing supervision in this matter, until further order of the Court, and to its authority to interpret the provisions of this Agreement, to review and adopt plans necessary to implementation of its terms, to modify its terms as may be needed to effect its purposes, and to take appropriate actions within its equitable powers to ensure its enforcement and the fulfillment of its terms and purposes."

the Consent Decree and ¶ 303 of the Settlement Agreement, and would allow reimposition of active supervision at Riverview if warranted. The Department should continue to submit quarterly reports of both Riverview (supplemented by weekly civil discharge plan and community standards reports) and community-based services, pursuant to ¶ 280 of the Settlement Agreement, to the Court Master and counsel for the plaintiffs.

Dated: August 16, 2011



Daniel E. Wathen, Court Master

Department of Health and Human Service
Office of Adult Mental Health Services
Fourth Quarter State Fiscal Year 2011 (April, May and June 2011)
Report on Compliance Plan Standards: Community
August 1, 2011

	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 July 2011* and *Unmet Needs by CSN for FY'11 Q3 (January, February, March 2011)*
I.3	Certify that a system is in place for Community Service Networks (CSNs) and related mechanisms to improve continuity of care	The Department's certification of August 19, 2009 was approved on October 7, 2009.
I.4	Certify that a system is in place for Consumer councils	The Department's certification of December 2, 2009 was approved on December 22, 2009.
I.5	Certify that a system is in place for new vocational services	All vocational components of the October 2006 Plan were completed in March 2010 and the Department will be seeking certification within the 1st quarter of FY2012.
I.6	Certify that a system is in place for realignment of housing and support services	All components of the Consent Decree Plan of October 2006 related to the Realignment of Housing and Support Services were completed as of July 2009. Certification was submitted March 10, 2010. The Certification Request was withdrawn May 14, 2010.
I.7	Certify that a system is in place for a Quality Management system that includes specific components as listed on pages 5 and 6 of the plan	Department of Health and Human Services Office of Adult Mental Health Services Quality Management Plan/Community Based Services (April 2008) has been implemented; a copy of plan was submitted with the May 1, 2008 Quarterly Report.
II.1	Provide documentation that unmet needs data and information (data source list page 4 of compliance plan) is used in planning for resource development and preparing budget requests	Unmet needs reports are posted on the OAMHS CSN 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	

II.3	Submission of budget proposals for adult mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs *(Amended language 9/29/09)*	The DHHS submission of the budget for FY2012/2013 included the requested funding suggested by the Court Master, a total of an additional $4.6 million for services and $1 million for BRAP. This was discussed with the Court Master.
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)*	Both the Commissioner and the Director of the DHHS Office of Adult Mental Health Services testified in favor of the additional funding noted in II,3 above. The final outcome of the legislative session was that for FY'12 and FY'13, funding for BRAP has been included. However, the approximately $4.6 million for other services was funded for FY'12 only with a report due to the legislature in January 2012 to demonstrate the continuing need for FY 2013.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	*MaineCare and Grant Expenditures Report for FY10* emailed to Court Master and Plaintiff's Counsel on 2/16/11.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs by CSN July 2011* for examples of the Department Utilizing the QM system.
III.1a	Document through quarterly or annual reports the data collected and activities to assure reliability (including ability of EIS to produce accurate data)	This quarterly report documents significant data collection and review activities of the OAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Based on contract reviews done in the 3rd quarter of FY'11, 100 % of the agencies reviewed in OAMHS Field Service Offices (Bangor, Augusta, Portland) have protocols/procedures in place for client notification of rights, with documentation in provider files maintained within the regional offices. Based in licensing surveys, 100% of licensed mental health agencies have protocols/policies in place for client notification of the *Rights of Recipients.*
IV.2	If results from the DIG Survey fall below 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 2010 DIG Survey was 88.6%, slightly below the standard of 90%. The data was shared with the CCSM

IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension	Standard met Calendar Years 2006, 2007, 2008 and 2009; the 1st and 3rd quarters of calendar year (CY) 2010 (data not available for the 2nd quarter); and the 2nd quarter CY'11 (no Level II grievances reported in the 1st quarter of CY 2011) See attached *Performance and Quality Improvement Standards: July 2011*, Standard 2
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. The standard has been met, when there was a level III grievance, at 100% through the 2nd quarter of calendar year (CY) 2011 (data not available for the 2nd quarter CY10).
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: July 2011*, Standard 5-2.
IV.6	90% non-hospitalized class members assigned worker within 3 days of request - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: July 2011,* Standard 5-3.
IV.7	95% of class members in hospital or community not assigned within 2 or 3 days, assigned within an additional 7 days - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: July 2011,* Standard 5-4.
IV.8	90% of class members enrolled in CSS with initial ISP completed within 30 days of enrollment - *must be met for 3 out of 4 quarters*	The standard was met for the 3rd and 4th quarters FY'08, all 4 quarters of FY'09 and FY'10, and the 1st, 2nd and 3rd quarters of FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 5-5
IV.9	90% of class members had their 90 day ISP review(s) completed within that time period - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: July 2011*, Standard 5-6.
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. As the data has been consistent over time and the feedback and interaction with providers had lessened greatly, reports are now created quarterly and available to providers upon request. Providers were notified of this change on May 18, 2011.
IV.11	Data collected once a year shows that no > 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	Once-a-year report (completed January 2011) showed that 1.8% of class members enrolled in CS did not have their ISP reviewed before the next annual review. Those not completed appear to be data errors between APS Healthcare and EIS.
IV.12	Certify in quarterly reports that DHHS is meeting its obligation re: quarterly mailings	On May 14, 2010, the court approved a Stipulated Order that requires mailings to be done only semi-annually in 2010, moving to annually in 2011 and thereafter, as long as the number of unverified addresses remains at or

		below 15%. The most recent class member mailing occurred in December 2010. The percentage of unverified addresses at that time remained below 15% at 10.8%. The next mailing will be in November 2011.
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - *must be met for 3 out of 4 quarters*	Standard met for all quarters of FY'10 and FY'11. See attached *Class Member Treatment Planning Review*, Question 2A
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be met for 3 out of 4 quarters*	Standard has been met continuously since the first quarter of FY'08. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 7-1a and *Class Member Treatment Planning Review,* Question 2B
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*	Standard met for all quarters of FY'09, FY'10, and FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 7-1c (does the consumer have a crisis plan) and *Class Member Treatment Planning Review*, Question 2F
IV.16	QM system documents that OAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	See attached *Class Member Treatment Planning Review*, Question 6.a.1 that addresses plans of correction.
IV.17	In 90% of ISPs reviewed, interim plans developed when resource needs not available within expected response times - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: July 2011*, Standard 8-2 and *Class Member Treatment Plan Review,* Question 3F.
IV.18	90% of ISPs review included service agreement/treatment plan - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: July 2011*, Standard 9-1 and *Class Member Treatment Plan Review,* Questions 4B & C.
IV.19	90% of ACT/ICI/CI providers statewide meet prescribed case load ratios - *must be met for 3 out of 4 quarters* Note: As of 7/1/08, ICI is no longer a service provided by DHHS.	Community Integration -- standard met since the 2nd quarter FY'08. ACT – standard met for the 2nd, 3rd and 4th quarters FY'10 and the 1st, 2nd and 4th quarters FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 10.1 and 10-2
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - *must be met for 3 out of 4 quarters*	ICMs' work is focused on community forensic and outreach services. Individual ICMs no longer carry caseloads. Should this change in the future, OAMHS will resume reporting on caseload ratios.
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads	In this last legislative session, 1 new caseworker line was approved for the Office of Elder Services (OES).

	(pg 10) *must be met for 3 out of 4 quarters*	The position will be available in the fall. This should help to reduce caseload size. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 10-5.
IV.21	Independent review of the ISP process finds that ISPs met a reasonable level of compliance as defined in Attachment B of the Compliance Plan	
IV.22	5% or fewer class members have ISP-identified unmet residential support - *must be met for 3 out of 4 quarters* **and**	Standard met for the 4th quarter FY'08; the 1st, 3rd and 4th quarters of FY'09; all quarters of FY'10; and the 1st, 2nd and 3rd quarters of FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 12-1
IV.23	**EITHER** quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status **and**	Unmet residential support need data for the past year (FY'10 Q4, FY'11 Q's 1, 2 and 3) shows that unmet residential support needs for non-class members did not exceed by 15 percentage points those of class members. • Q4: class members 6.04%, non-class members 4.66% • Q1: class members 5.25%, non-class members 4.47% • Q2: class members 4.76%, non-class members 4.06% • Q3: class members 5.01%, non-class members 3.9%
IV.24	Meet RPC discharge standards (below); **or** if not met document reasons and demonstrate that failure not due to lack of residential support services • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	Standard met for 4 quarters of FY'08, FY'09, FY'10 and FY'11 See attached *Performance and Quality Improvement Standards: July2011*, Standards 12-2, 12-3 and 12-4
IV.25	10% or fewer class members have ISP-identified unmet needs for housing resources - *must be met for 3 out of 4 quarters* **and**	Standard met for quarters 3 and 4 FY'09 and 1st, 2nd and 3rd quarters of FY'10. Percentage for the 4th quarter FY'10 was 10.8%, just above the standard. Standard met for the 1st, 2nd and 3rd quarters FY'11 (10.5%, 10.2% and 8.3%). See attached *Performance and Quality Improvement Standards: July 2011*, Standard 14-1
IV.26	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of housing resources. • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain	Standard 14-4 met for all quarters of FY'09; the 1st, 2nd and 4th quarters of FY'10; and all quarters of FY'11 Standard 14-5 met for the 2nd, 3rd and 4th quarters FY'09; the 2nd and 4th quarters of FY'10; and all quarters of FY'11 Standard 14-6 met for the 2nd and 4th quarters FY'09; the 2nd and 4th quarters FY'10; and all of FY'11.

	exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: April 2011*, Standard 14-4, 14-5 & 14-6
IV.27	Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol	Standard met 2007, 2008, 2009 and 2010 (annual review). Results reported in *Performance and Quality Improvement Standards: January 2010 Report*, Standard 15-1
IV.28	90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in attachment C to the Compliance Plan	In FY'10: 1st quarter 88.2% (15 of 17); 2nd quarter 81.8% (9 of 11); 3rd quarter 82.4% (14 of 17); and 4th quarter 90.9% (20 of 22). In FY'11, 88% (22 of 25) in the 1st quarter; 75% (9 of 12) in the 2nd quarter; and 78.9% (15 of 19) in the 3rd quarter. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 16-1 and *Community Hospital Utilization Review – Class Members 3rd Quarter of Fiscal Year 2011.*
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	See IV.30 below
IV.30	Evaluates compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	With the curtailment in FY 2010 and the elimination of funding for involuntary hospitalizations other than MaineCare in FY 2011, there currently are no contracts with hospitals in place. After some discussion as to how to proceed, it was determined that OAMHS will seek to establish agreements with the hospitals covering the key issues. A draft agreement was finalized with the Attorney General's Office and has been shared with MaineGeneral Hospital. Once the agreement is completed with MaineGeneral, OAMHS will use the finalized agreement as the basis for each of the other hospital agreements. Despite not having agreements in place, OAMHS is continuing the process with hospitals that it has historically performed – no objections have been received from the hospitals. The Office continues to perform reviews for involuntary hospitalizations with our Field Office Nurses.
IV.31	UR Nurses review all involuntary admissions funded by DHHS, take corrective action when they identify deficiencies and send notices of any violations to the licensing division and to the hospital	OAMHS reviews emergency involuntary admissions at the following hospitals: MaineGeneral, Spring Harbor, St. Mary's, Mid-Coast Hospital, Southern Maine Medical Center, PenBay Medical Center, 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.	4th Quarter FY'11: No Rights of Recipients violations.
IV.33	• 90% of the time corrective action was taken when blue papers were not completed in accordance with terms • 90% of the time corrective action was taken when 24 hour certifications were not completed in accordance with terms • 90% of the time corrective action was taken when patient rights were not maintained	Standards met for FY'08, FY'09, and FY'10; and 1st, 2nd and 3rd quarters FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standards 17-2a, 17-3a and 17-4a and *Community Hospital Utilization Review – Class Members 3rd Quarter of Fiscal Year 2011.*
IV.34	QM system documents that if hospitals have fallen below the performance standard for any of the following, OAMHS made the information public through CSNs, addressed in contract reviews with hospitals and CSS providers, and took appropriate corrective action to enforce responsibilities • obtaining ISPs (90%) • creating treatment and discharge plan consistent with ISPs (90%) • involving CIWs in treatment and discharge planning (90%)	See attached *Performance and Quality Improvement Standards: July 2011*, Standards 18-1, 18-2 and 18-3 for data by hospital. The report displaying data by hospital for community hospitals accepting emergency involuntary clients is shared quarterly by posting reports on the CSN section of the Office's website. See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members 3rd Quarter of Fiscal Year 2011.*
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*	Standard met for the 1st Quarter of FY'11, with the 2nd and 3rd quarters' results being slightly above the standard at 26%. In FY'10, standard met for the 1st quarter: slightly above at 25.7% for the 3rd quarter and 26% for the 4th quarter. Beginning with the 1st quarter of FY'09, the hospitalization rate has generally run between 1 to 3 percentage points higher than the standard. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 19-1 and *Adult Mental Health Quarterly Crisis Report Third Quarter, State, Fiscal Year 2011 Summary Report.*
IV.36	90% of crisis phone calls requiring face-to-face assessments are responded to within an average of 30 minutes from the end of the phone call – *must be met for 3 out of 4 quarters*	Starting with July 2008 reporting from providers, OAMHS collects data on the total number of minutes for the response time (calculated from the determination of need for face to face contact or when the individual is ready and able to be seen to when the individual is actually seen) and figures an average. Average statewide for the third quarter of FY'11 was 36.7 minutes. See attached *Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2011 Summary*

		Report.
IV.37	90% of all face-to-face assessments result in resolution for the consumer within 8 hours of initiation of the face-to-face assessment – *must be met for 3 out of 4 quarters*	Standard has been met since the 2nd quarter of FY'08. See attached *Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2011 Summary Report.*
IV.38	90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – *must be met for 3 out of 4 quarters*	Standard has been met since the 1st quarter of FY'08. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 19-4 and *Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2011 Summary Report.*
IV.39	Compliance Standard deleted per amendment request approved January 19, 2011.	
IV.40	Department has implemented the components of the CD plan related to vocational services	As of quarter 3 FY'10, the Department has implemented all components of the CD Plan related to Vocational Services.
IV.41	QM system shows that the Department conducts further review and takes appropriate corrective action if PS 26.3 data shows that the number of consumers under age 62 and employed in supportive or competitive employment falls below 10%. *(Amended language 1/19/11)*	2010 Adult Health and Well-Being Survey: 10% of consumers in supported and competitive employment (full or part time). See attached *2010 Adult Health and Well-being Survey*
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: July 2011*, Standard 21-1
IV.43	**EITHER** quarterly unmet mental health treatment needs for one year for qualified non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet mental health treatment need data for the past year (FY'10 Q4, FY'11 Q's 1, 2 and 3) shows that unmet mental health treatment needs for non-class members did not exceed by 15 percentage points those of class members. • Q4: class members 17.09%, non-class members 16.09% • Q1: class members 16.1%, non-class members 17.81% • Q2: class members 15.37%, non-class members 18.85% • Q3: class members 13.93%, non-class members 18.01%
IV.44	QM documentation shows that the Department conducts further review and takes appropriate corrective action if results from the DIG survey fall below the levels identified in Standard # 22-1 (the domain average of positive responses to the statements in the Perception of Access	2010 Adult Health and Well-Being Survey: 77.6% domain average of positive responses.

	Domain is at or above 85%) *(Amended language 1/19/11)* **and**	
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)	Standard met for 4 quarters of FY'08, FY'09, FY'10 and FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standards 21-2, 21-3 and 21-4
IV.46	OAMHS lists in quarterly reports the programs sponsored that are designed to improve quality of life and community inclusion, including support of peer centers, social clubs, community connections training, wellness programs and leadership and advocacy training programs – list must cover prescribed topics and audiences that fit parameters of ¶105.	See attached *Performance and Quality Improvement Standards: July 2011*, Standard 30
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – *must be met for 3 out of 4 quarters*	Standard met for all quarters of FY'08, FY'09 and FY'10; and the 1st, 2nd and 3rd quarters of FY'11. See attached *Performance and Quality Improvement Standards: July 2011*, Standard 28
IV.48	Provide documentation in quarterly reports of funding, developing, recruiting, and supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	See attached *Performance and Quality Improvement Standards: July 2011*, Standard 23-1 and 23-2
IV.49	Certify that all contracts with providers include a requirement to refer family members to family support services, and produce documentation that contract reviews include evaluation of compliance with this requirement.	100% of contracts include this requirement. Annual contract reviews completed in the 3rd quarter of FY'11 in all 3 regions addressed this standard with documentation contained in contract files maintained by the regional office.
IV.50	Lists in quarterly reports the number and types of mental health informational workshops, forums and presentations geared to general public that are designed to reduce myths/stigma and foster community integration (cover prescribed list and fit audience parameters)	See attached *Performance and Quality Improvement Standards: July 2011*, Standard 34 and attached *Public Education Report April-June 2011.*