

Department of Health & Human Services, Office of Adult Mental Health Services
 Bates v. DHHS Consent Decree
 January, February, March 2014: 3rd Quarter, SFY 2014
[CONSENT DECREE REPORT](#)

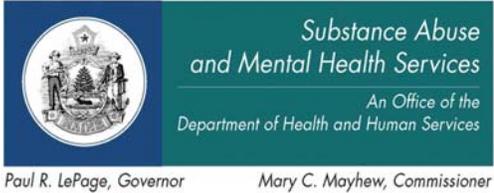
SUMMARY
 (Section 1A)

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

DOCUMENT	DESCRIPTION
1 Cover Letter, Quarterly Report: May, 2014 Section 1 Microsoft Word or Adobe PDF	Letter to Dan Wathen, Court Master, submitting the Quarterly Report pursuant to paragraph 280 of the Settlement Agreement for the quarter ending March 31, 2014.
2 Report on Compliance Plan Standards: Community Section 2 Microsoft Word or Adobe PDF	Lists and updates the information pertaining to standards approved in October 2007 for evaluating and measuring DHHS compliance with the terms and principles of the Settlement Agreement.
3 Performance and Quality Improvement Standards Section 3 Adobe PDF	Details the status of the Department's compliance with 34 specific performance and quality improvement standards (many are multi-part) required by the Consent Decree October 2006 Plan for this reporting quarter. Reporting includes the baseline, current level, performance standard, and compliance standard for each, including graphs.
4 Public Education – Standard 34.1 Section 4 Excel Version or Adobe PDF	Amplifies Standard 34.1 of the Performance and Quality Improvement Standards above, detailing the mental health workshops, forums, and presentations made, including levels of participation
5 Performance Quality and Improvement Standards, Appendix: Adult Mental Health Data Sources Section 5 Microsoft Word or Adobe PDF Consent Decree Performance and Quality Improvement Standard 5. Section 5A	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	Provides a brief introduction to the unmet needs report as well as

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

DOCUMENT		DESCRIPTION
	Microsoft Word or Adobe PDF	
14	APS Healthcare Reports <i>Section 14</i> Adobe PDF	For members on the Community Integration waitlist who were authorized for this service, how long they waited. These reports count the number of days from the date the CFSN was opened to the date the service was authorized. The reports are run 2 quarters behind, therefore, those who were entered on the waitlist will have started the service.
15	Adult Mental Health Services Utilization and Expenditure Summary - SFY 2012 - SFY 2013 Microsoft Excel * Adobe PDF *	Annual report of MaineCare expenditures and grant funds expended down by service area as defined by compliance standard II.5



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May 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 March 31, 2013.

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

Sincerely,

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

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

**Department of Health and Human Service
Office of Substance Abuse and Mental Health Services
Third Quarter State Fiscal Year 2014
Report on Compliance Plan Standards: Community
May 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 <i>Cover: Unmet Needs May 2014</i> and <i>Unmet Needs by CSN for FY14 Q2. Found in Section 7.</i>
I.3	Certify that a system is in place for Community Service Networks (CSNs) and related mechanisms to improve continuity of care	The Department's certification of August 19, 2009 was approved on October 7, 2009.
I.4	Certify that a system is in place for Consumer councils	The Department's certification of December 2, 2009 was approved on December 22, 2009.
I.5	Certify that a system is in place for new vocational services	The Department certification of September 17, 2011 was approved November 21, 2011.
I.6	Certify that a system is in place for realignment of housing and support services	All components of the Consent Decree Plan of October 2006 related to the Realignment of Housing and Support Services were completed as of July 2009. Certification was submitted March 10, 2010. The Certification Request was withdrawn May 14, 2010.
I.7	Certify that a system is in place for a Quality Management system that includes specific components as listed on pages 5 and 6 of the plan	Department of Health and Human Services Office of Adult Mental Health Services Quality Management Plan/Community Based Services (April 2008) has been implemented; a copy of plan was submitted with the May 1, 2008 Quarterly Report. A new quality improvement plan for 2013-2018 is being developed.
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 <i>Cover: Unmet Needs and Quality Improvement Initiatives May 2014</i> and the <i>Performance and Quality Improvement Standards: May 2014</i> for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data. SAMHS is reviewing the reliability of the unmet needs data. From this review, a plan will be developed to provider training and technical assistance on identifying, recording and implementing services for unmet needs.
II.3	Submission of budget proposals for adult	The Director of SAMHS provides the Court Master

	mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs (<i>Amended language 9/29/09</i>)	with an updated projection of needs and associated costs as part of his ongoing updates regarding Consent Decree Obligations.
II.4	Submission of the written presentation given to the legislative committees with jurisdiction over DHHS ... which must include the budget requests that were made by the Department to satisfy its obligations under the Consent Decree Plan and that were not included in the Governor's proposed budget, an explanation of support and importance of the requests and expression of support ... (<i>Amended language 9/29/09</i>)	See above.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	MaineCare and Grant Expenditure Report for FY11 and FY12 was provided in the May 2013 report. FY 13 report provided in the May 2014 report.
III.1	Demonstrate utilizing QM System	See attached <i>Cover: Unmet Needs May 2014</i> and the <i>Performance and Quality Improvement Standards: May 2014</i> for examples of the Department Utilizing the QM system.
III.1a	Document through quarterly or annual reports the data collected and activities to assure reliability (including ability of EIS to produce accurate data)	This quarterly report documents significant data collection and review activities of the SAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	See compliance standards II.3 and II.4 above for examples of how quality management data was used to support budget requests for systems improvement.
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Contract and licensing reviews are conducted as licenses expire. A report from DLRS is available; during the last quarter 29 of 29 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. (<i>Amended language 1/19/11</i>)	The percentage for standard 4.2 from the 2012 DIG Survey was 89.9% (up from 88.6% in 2010). These data are posted on the SAMHS website and provided to the Consumer Council of Maine. SAMHS met to address the methodology used for the survey and to boost consumer participation in the survey to be distributed in the fall of 2014. 2013 data will be provided in the July 2014 report.
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 third quarter there was 1 Level II grievances filed; It was 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 1 st quarter of calendar year 2008. Standard has been consistently addressed. There have been no Level III grievances filed in FY14.
IV.5	90% hospitalized class members assigned	See attached <i>Performance and Quality Improvement</i>

	worker within 2 days of request - <u>must be met for 3 out of 4 quarters</u>	<i>Standards: May 2014 Standard 5-2.</i> 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 - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: May 2014, Standard 5-3.</i> 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 - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: May 2014, Standard 5-4.</i> 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 - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: May 2014, Standard 5-5.</i> 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 - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: May 2014, Standard 5-6.</i> This standard has not been met for the past 4 quarters.
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. As the data has been consistent over time and the feedback and interaction with providers had lessened greatly, reports are now created quarterly and available to providers upon request. Providers were notified of this change on May 18, 2011. Providers are notified when reports are run. Some do request copies. Feedback has been minimal.
IV.11	Data collected once a year shows that no > 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	The 2013 data analysis indicates that out of 1,432 records for review, that 127 (8.9%) 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 2012 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 - <u>must be met for 3 out of 4 quarters</u>	See Section 9 <i>Class Member Treatment Planning Review, Question 2A.</i> This standard has been met in 4 out of the 4 quarters. The current percentage is 100.0%.
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: May 2014, Standard 7-1a and Class Member Treatment Planning Review, Question 2B</i>

		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 - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: May 2014</i> , Standard 7-1c (does the consumer have a crisis plan) and <i>Class Member Treatment Planning Review</i> , 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 <i>Class Member Treatment Planning Review</i> , Question 6.a.1 that addresses plans of correction. In 37.7% 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 - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: May 2014</i> , Standard 8-2 and <i>Class Member Treatment Plan Review</i> , Question 3F. This standard has been met in 3 out of the last 4 quarters.
IV.18	90% of ISPs review included service agreement/treatment plan - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: May 2014</i> , Standard 9-1 and <i>Class Member Treatment Plan Review</i> , 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 - <u>must be met for 3 out of 4 quarters</u> Note: As of 7/1/08, ICI is no longer a service provided by DHHS.	See attached <i>Performance and Quality Improvement Standards: May 2014</i> , Standard 10.1 and 10-2 Community Integration -- standard met since the 2 nd quarter FY08. ACT – standard met for the 2 nd , 3 rd and 4 th quarters FY10; the 1 st , 2 nd and 4 th quarters FY11; FY 12, FY13, and 1 st , 2 nd and 3 rd quarter FY14
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - <u>must be met for 3 out of 4 quarters</u>	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 <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: May 2014</i> , 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 - <u>must be met for 3 out of 4 quarters</u> and	See attached <i>Performance and Quality Improvement Standards: May 2014</i> , Standard 12-1 Standard met for the 4 th quarter FY08; the 1 st , 3 rd and 4 th quarters of FY09; all quarters of FY10 and FY11; all 4 quarters of FY12, FY13; and 1 st and 2 nd quarters FY 14.

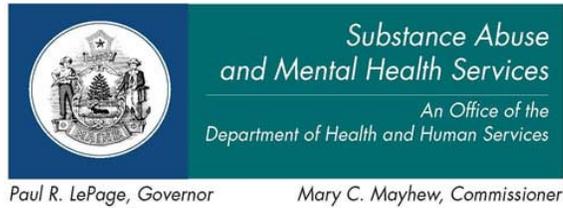
IV.23	<p>EITHER quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members OR if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status and</p>	<p>Unmet residential supports do not exceed 15 percentage points of Class Members.</p> <p>Reporting for this standard will be done again in July 2014. See attached report Consent Decree Compliance Standards IV.23 and IV.43</p>
IV.24	<p>Meet RPC discharge standards (below); or if not met document reasons and demonstrate that failure not due to lack of residential support services</p> <ul style="list-style-type: none"> • 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) 	<p>See attached <i>Performance and Quality Improvement Standards: May 2014</i>, Standards 12-2, 12-3 and 12-4</p> <p>Standard met since the beginning of FY08.</p>
IV.25	<p>10% or fewer class members have ISP-identified unmet needs for housing resources - <u>must be met for 3 out of 4 quarters</u> and</p>	<p>See attached <i>Performance and Quality Improvement Standards: May 2014</i>, Standard 14-1</p> <p>Standard met in FY 2014 Q2 and 24 out of the last 28 quarters.</p>
IV.26	<p>Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of housing resources.</p> <ul style="list-style-type: none"> • 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) 	<p>See attached <i>Performance and Quality Improvement Standards: May 2014</i>, Standard 14-4, 14-5 & 14-6</p> <p>Standard 14-4 met since the beginning of FY09, except for Q3 FY10.</p> <p>Standard 14-5 met for the 2nd, 3rd and 4th quarters FY09; the 2nd and 4th quarters of FY10; FY11; FY12 FY13 and 1st, 2nd and 3rd quarter of FY 14.</p> <p>Standard 14-6 met for the 2nd and 4th quarters FY09; the 2nd and 4th quarters FY10; FY11; FY12, FY13, and 1st, 2nd and 3rd quarters FY 14.</p>
IV.27	<p>Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol</p>	<p>Results reported in <i>Performance and Quality Improvement Standards: July 2010 Report</i>, Standard 15-1</p> <p>This standard has been met since 2007.</p> <p>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.</p>
IV.28	<p>90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in attachment C to the Compliance Plan</p>	<p>See attached <i>Performance and Quality Improvement Standards: May 2014</i>, Standard 16-1 and <i>Community Hospital Utilization Review – Class Members 2nd Quarter of Fiscal Year 2014</i>.</p>

		<p>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</p> <p>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</p> <p>IN FY 14: 27.3%(3 of 11) in the 1st quarter 76.5% (13 of 17) in the 2nd quarter</p>
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	<p>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.</p> <p>See Standard IV.33 below regarding corrective actions.</p>
IV.32	Licensing reviews of hospitals include an evaluation of compliance with patient rights and require a plan of correction to address any deficiencies.	<p>15 Complaints Received 10 Complaints investigated 2 Substantiated 1 Plan of correction sought (plan already in place) 2 Rights of Recipients Violations</p>
IV.33	<ul style="list-style-type: none"> • 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 	<p>See attached <i>Performance and Quality Improvement Standards: May 2014</i>, Standards 17-2a, 17-3a and 17-4a and <i>Community Hospital Utilization Review – Class Members 2nd Quarter of Fiscal Year 2014</i>.</p> <p>Standards met for FY08, FY09, FY10, FY11, and FY12 Standards met for FY13, and 1st and 2nd Quarter FY 14</p>
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 and CSS providers, and took appropriate	<p>See attached report <i>Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members 2nd Quarter of Fiscal Year 2014</i>. The report displaying data by hospital for community hospitals accepting emergency involuntary clients is shared quarterly by posting reports on the CSN section</p>

	<p>corrective action to enforce responsibilities</p> <ul style="list-style-type: none"> • obtaining ISPs (90%) • creating treatment and discharge plan consistent with ISPs (90%) • involving CIWs in treatment and discharge planning (90%) 	<p>of the Office's website.</p> <p>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</p>
IV.35	<p>No more than 20-25% of face-to-face crisis contacts result in hospitalization – <u>must be met for 3 out of 4 quarters</u></p>	<p>See attached <i>Performance and Quality Improvement Standards: May 2013</i>, Standard 19-1 and <i>Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2014 Summary Report</i>.</p> <p>In FY11, standard met for the 1st quarter, with the 2nd (25.6%), 3rd (26.2%) and 4th (26.4%) quarters' results being slightly above the standard. In FY12, standard met all 4 quarters. In FY 13, standard met all 4 quarters. In FY 14, standard met 1st quarter, 2nd quarter slightly above standard (26.3%), met 3rd quarter.</p>
IV.36	<p>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 – <u>must be met for 3 out of 4 quarters</u></p>	<p>See attached <i>Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2014 Summary Report</i>.</p> <p>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.</p> <p>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.</p>
IV.37	<p>90% of all face-to-face assessments result in resolution for the consumer within 8 hours of initiation of the face-to-face assessment – <u>must be met for 3 out of 4 quarters</u></p>	<p>See attached <i>Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2014 Summary Report</i>.</p> <p>Standard has been met since the 2nd quarter of FY08.</p>
IV.38	<p>90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – <u>must be met for 3 out of 4 quarters</u></p>	<p>See attached <i>Performance and Quality Improvement Standards: May 2013</i>, Standard 19-4 and <i>Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2014 Summary Report</i>.</p> <p>Standard not met 3 out of 4 quarters.</p>
IV.39	<p>Compliance Standard deleted 1/19/2011.</p>	
IV.40	<p>Department has implemented the components of the CD plan related to vocational services</p>	<p>As of quarter 3 FY10, the Department has implemented all components of the CD Plan related to Vocational Services.</p>
IV.41	<p>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</p>	<p>2012 Adult Health and Well-Being Survey: 9.1% of consumers in supported and competitive employment (full or part time).</p>

	age 62 and employed in supportive or competitive employment falls below 10%. (<i>Amended language 1/19/11</i>)	The Director of the Office of Quality Improvement and staff from Office of Adult Mental Health quality management presented the findings at a Health Forum on July 18, 2013. SAMHS and the Consumer Counsel continue to meet on a monthly basis which provides a foundation for sharing information.
IV.42	5% or fewer class members have unmet needs for mental health treatment services – <u>must be met for 3 out of 4 quarters</u> and	See attached <i>Performance and Quality Improvement Standards: May 2014</i> , Standard 21-1 This standard has not been met for the prior 4 quarters.
IV.43	EITHER quarterly unmet mental health treatment needs for one year for qualified non-class members do not exceed by 15 percentage points those of class members OR if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet mental health treatment needs do not exceed 15 percentage points of Class Members. Reporting for this standard will be done again in July 2014. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.44	QM documentation shows that the Department conducts further review and takes appropriate corrective action if results from the DIG survey fall below the levels identified in Standard # 22-1 (the domain average of positive responses to the statements in the Perception of Access Domain is at or above 85%) (<i>Amended language 1/19/11</i>) and	2012 Adult Health and Well-Being Survey: 77.8% domain average of positive responses. The Director of the Office of Quality Improvement and staff from Office of Adult Mental Health quality management will present the results of the 2012 survey will be presented at an APS Forum in the fall of 2013. The Department has requested feedback on recommendations from the Consumer Counsel on how they would like to see the data utilized. There has been no formal feedback as requested but SAMHS and the Consumer Counsel continue to meet on a monthly basis which provides a foundation for sharing information.
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 <ul style="list-style-type: none"> • 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 <i>Performance and Quality Improvement Standards: May 2014</i> , 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	See attached <i>Performance and Quality Improvement Standards: May 2014</i> , Standard 30

	and advocacy training programs – list must cover prescribed topics and audiences that fit parameters of ¶105.	
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – <i>must be met for 3 out of 4 quarters</i>	See attached <i>Performance and Quality Improvement Standards: May 2014</i> , Standard 28 This standard has been consistently met since FY08.
IV.48	Provide documentation in quarterly reports of funding, developing, recruiting, and supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	See attached <i>Performance and Quality Improvement Standards: May 2014</i> , 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 <i>Performance and Quality Improvement Standards: May 2014</i> , Standard 34.1 and attached <i>Public Education Report for the past quarter</i> .



Consent Decree Performance and Quality Improvement Standards: May 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 measured: 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
January- March 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

DHHS Office of Substance Abuse and Mental Health Services
Compliance and Performance Standards: Summary Sheet
January- March 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
January- March 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

DHHS Office of Substance Abuse and Mental Health Services
Compliance and Performance Standards: Summary Sheet
January- March 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/Spiritual

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
January- March 2014**

Standard 33. Recovery

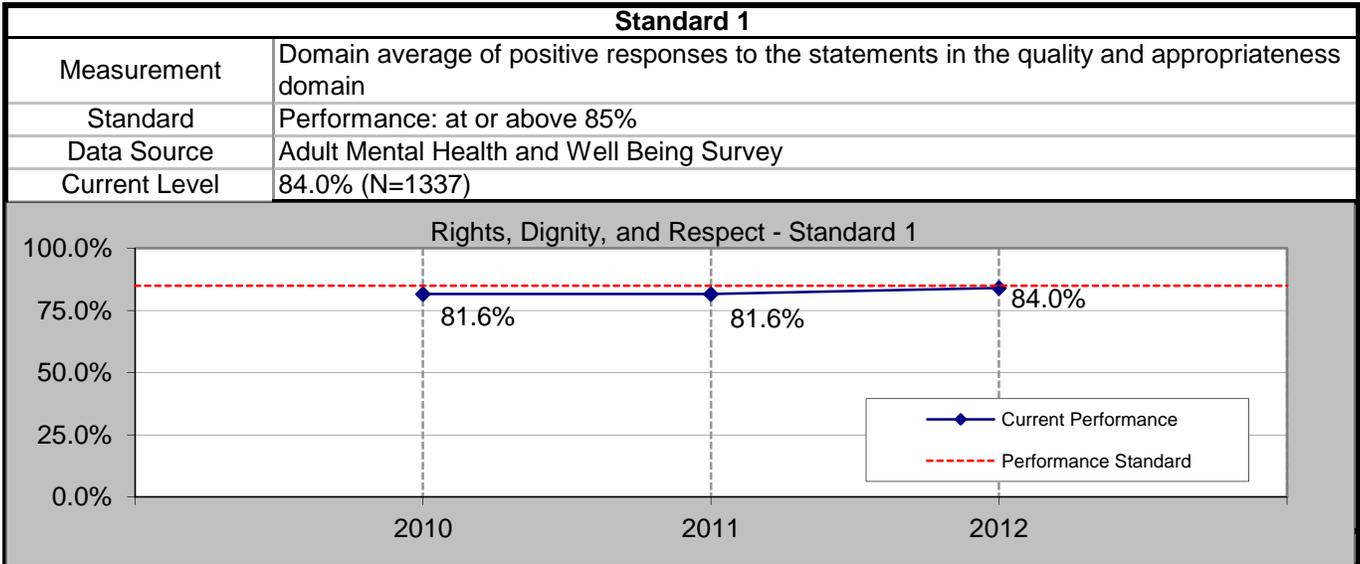
1. Consumers reporting staff helped them to take charge of managing illness.
2. Consumers reporting staff believed they could grow, change, recover
3. Consumers reporting staff supported their recovery efforts
4. Deleted: Consumers reporting that providers offered learning opportunities: questions eliminated 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

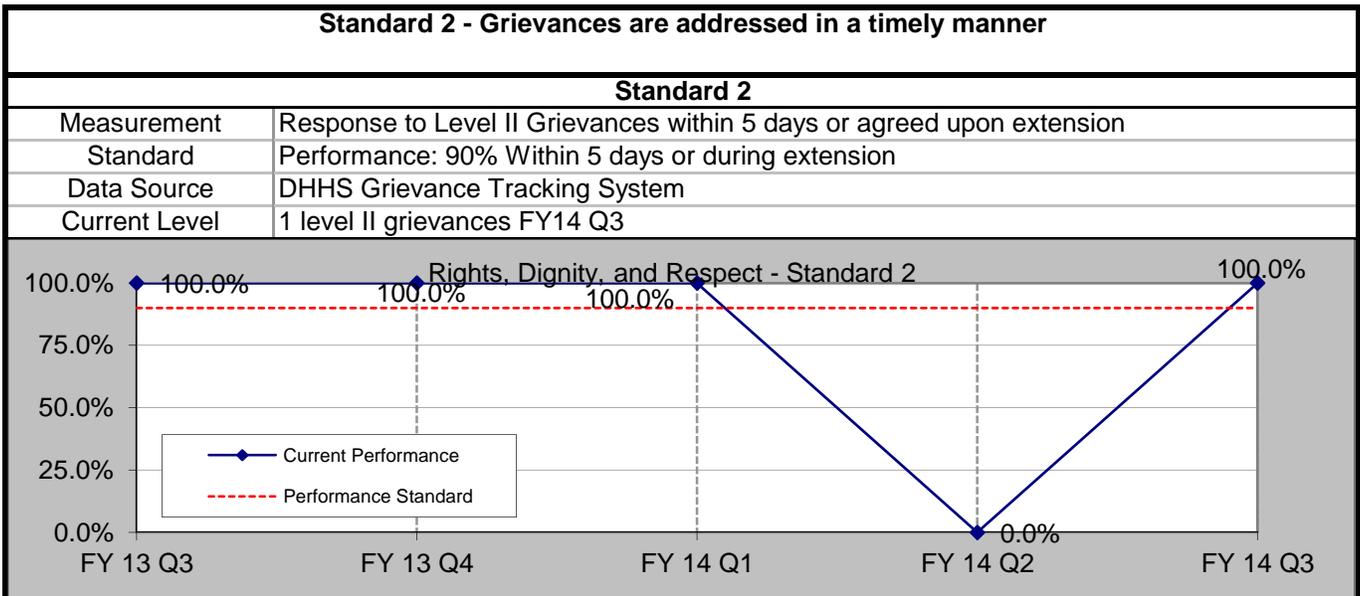
1. # MH workshops, forums and presentations geared to public participation.
2. #, type of information packets, publications, and press releases distributed to public.

Rights, Dignity, and Respect

Standard 1 - Treated with respect for their individuality

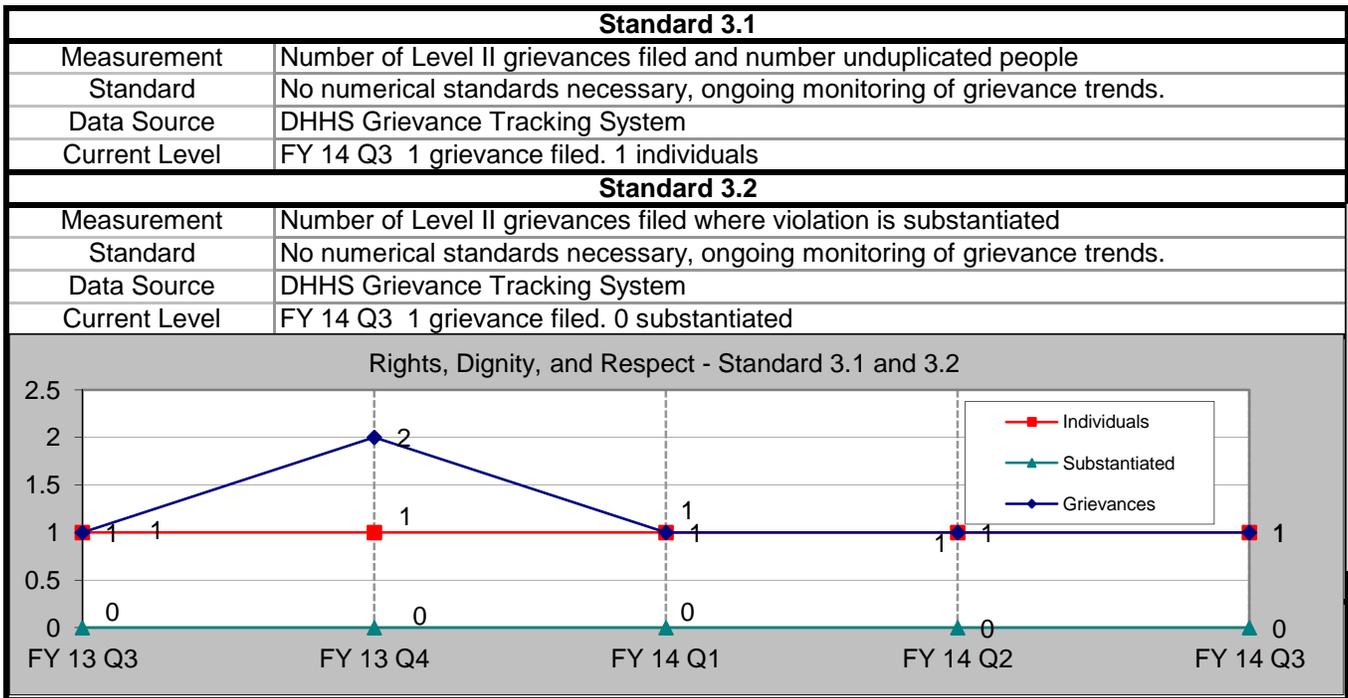


Standard 2 - Grievances are addressed in a timely manner



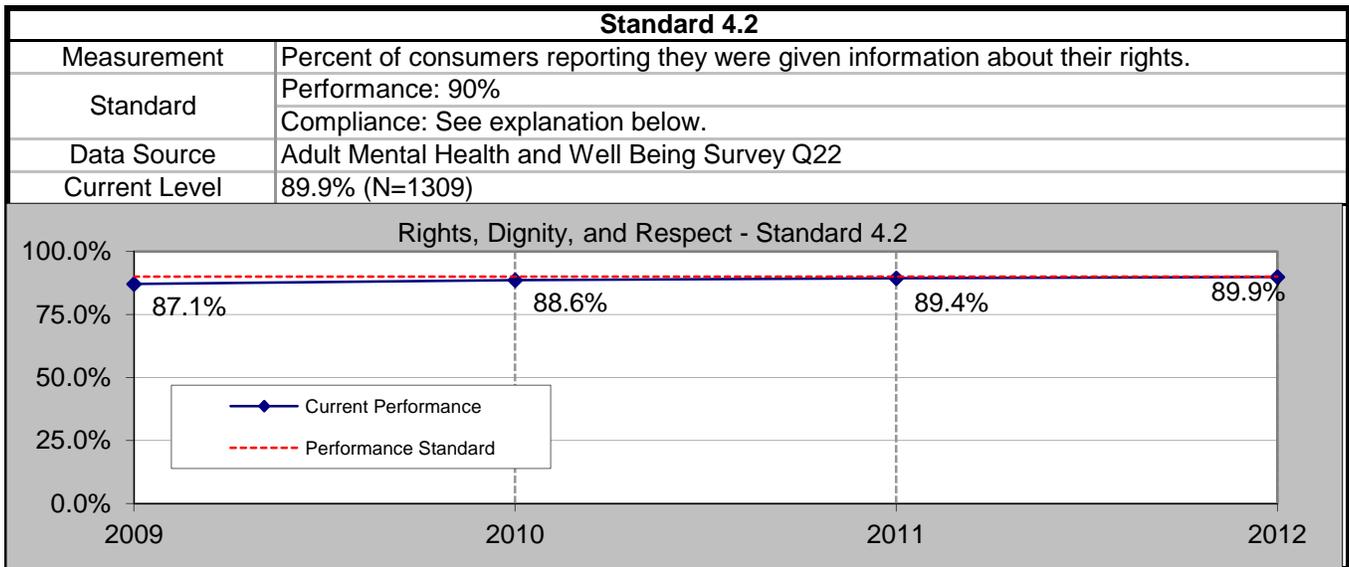
Rights, Dignity, and Respect

Standard 3 - Demonstrate rights are respected and maintained



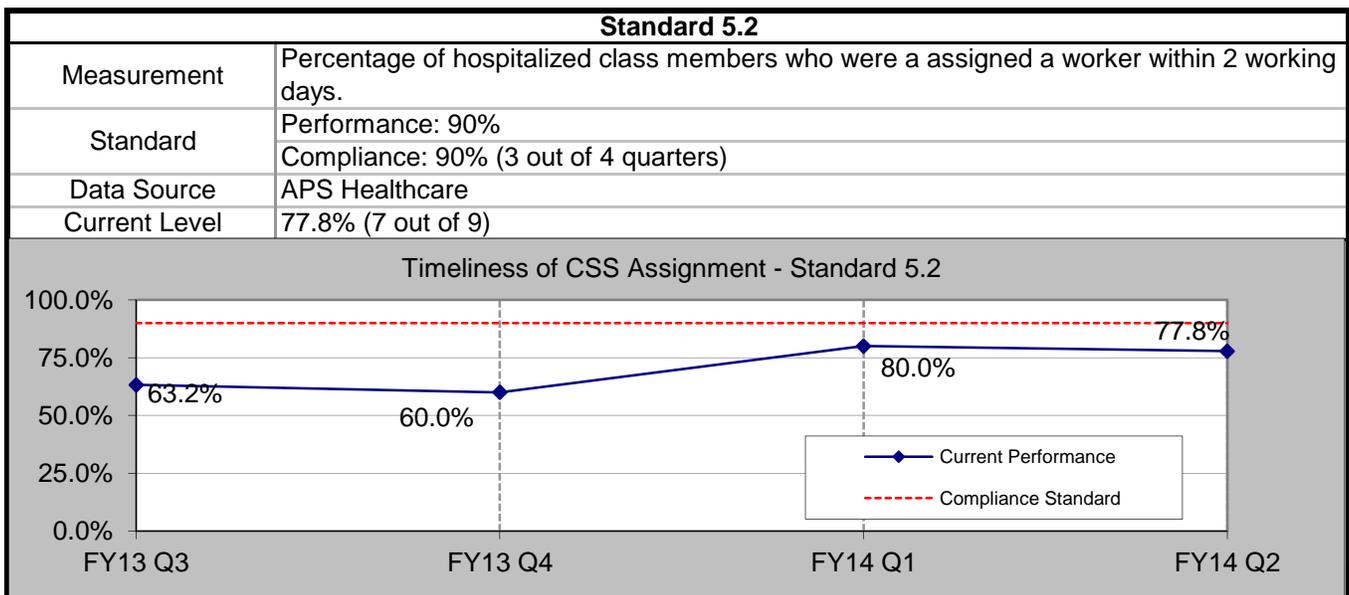
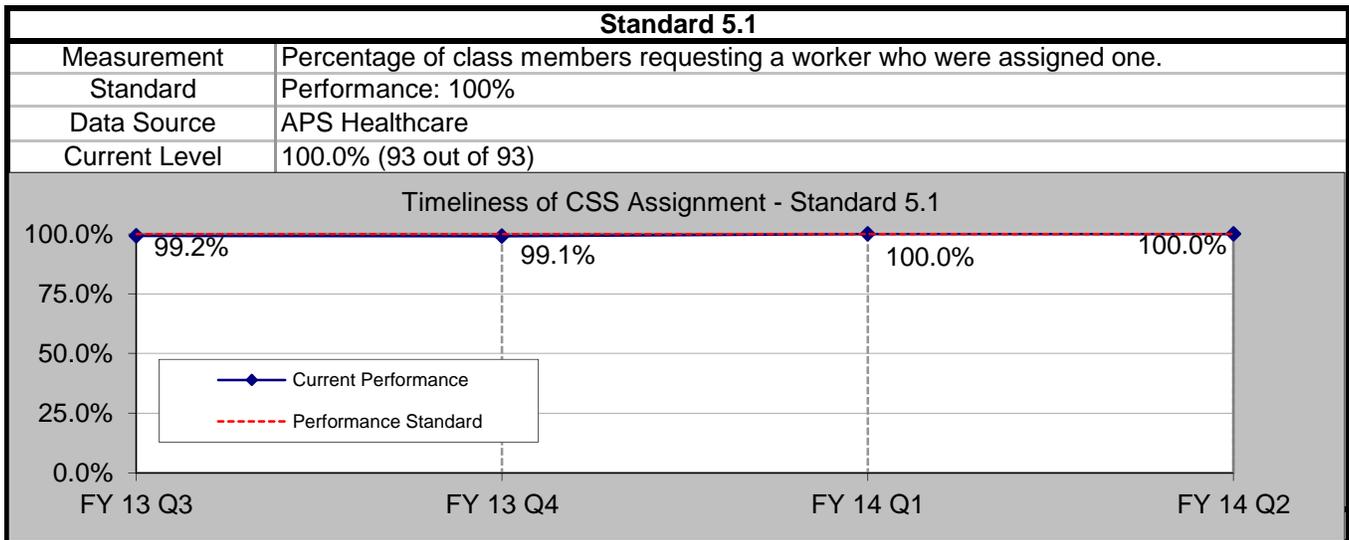
Rights, Dignity, and Respect

Standard 4 - Class Members are informed of their rights

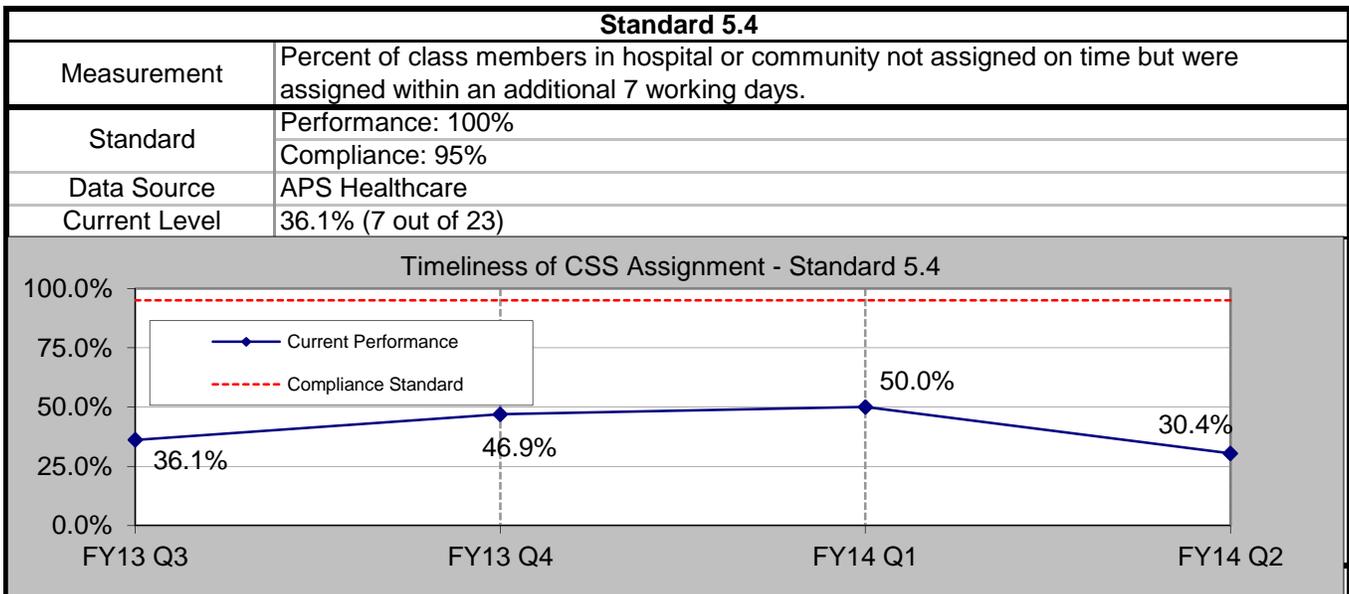
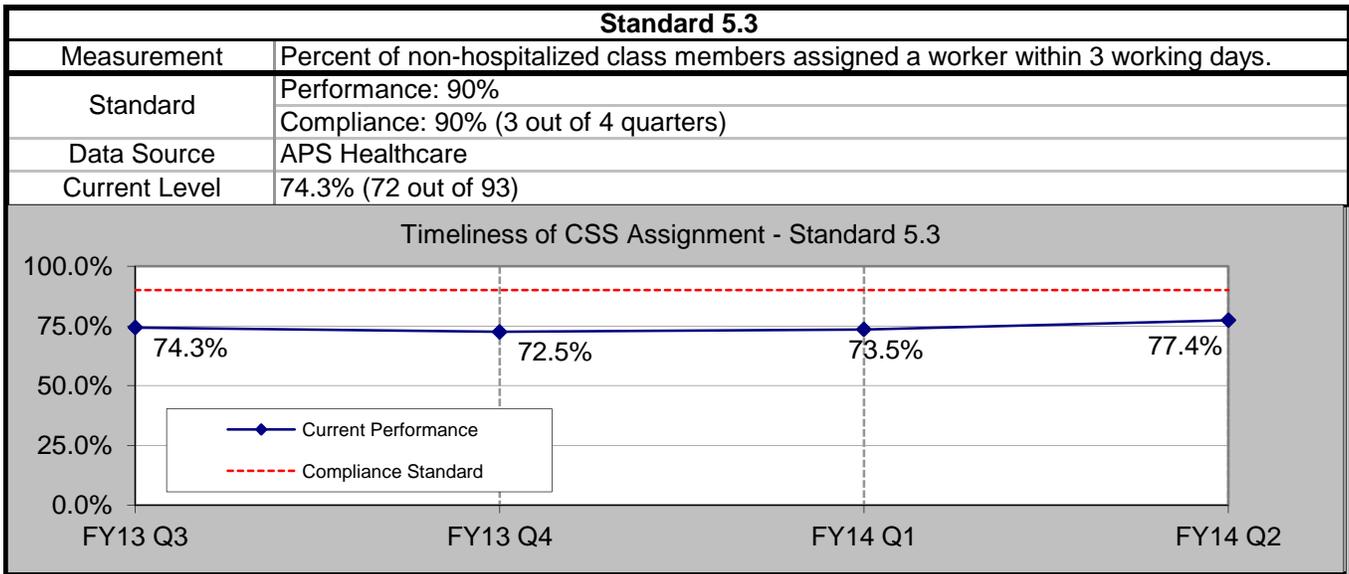


Community Integration / Community Support Services / Individualized Support Planning

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

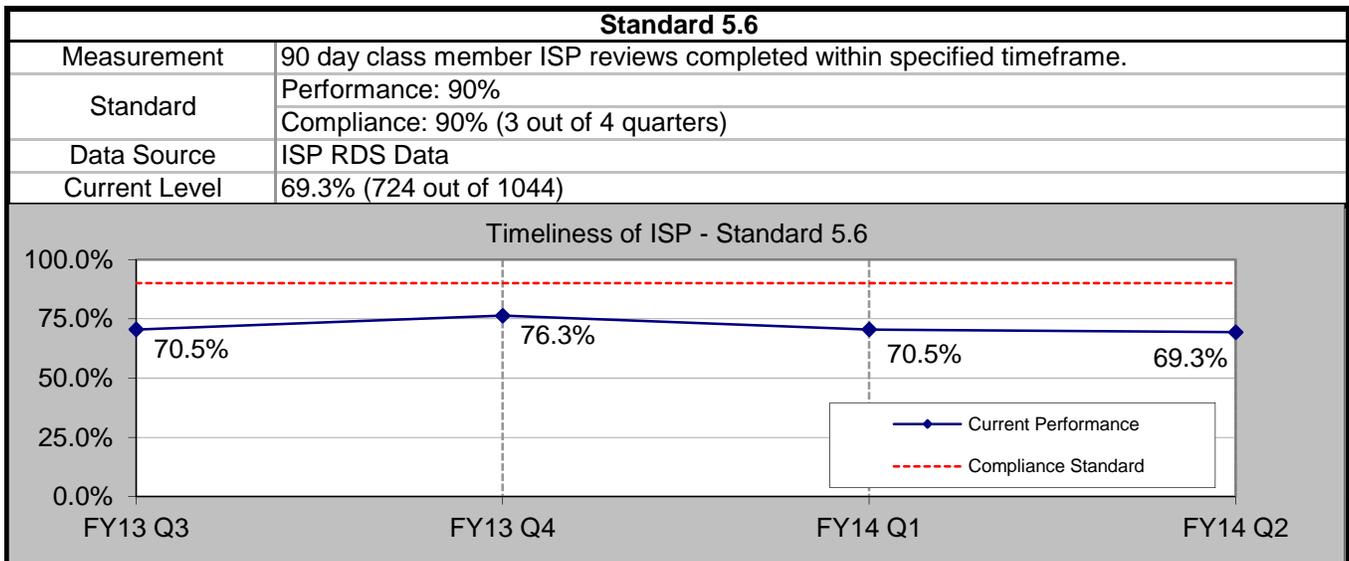
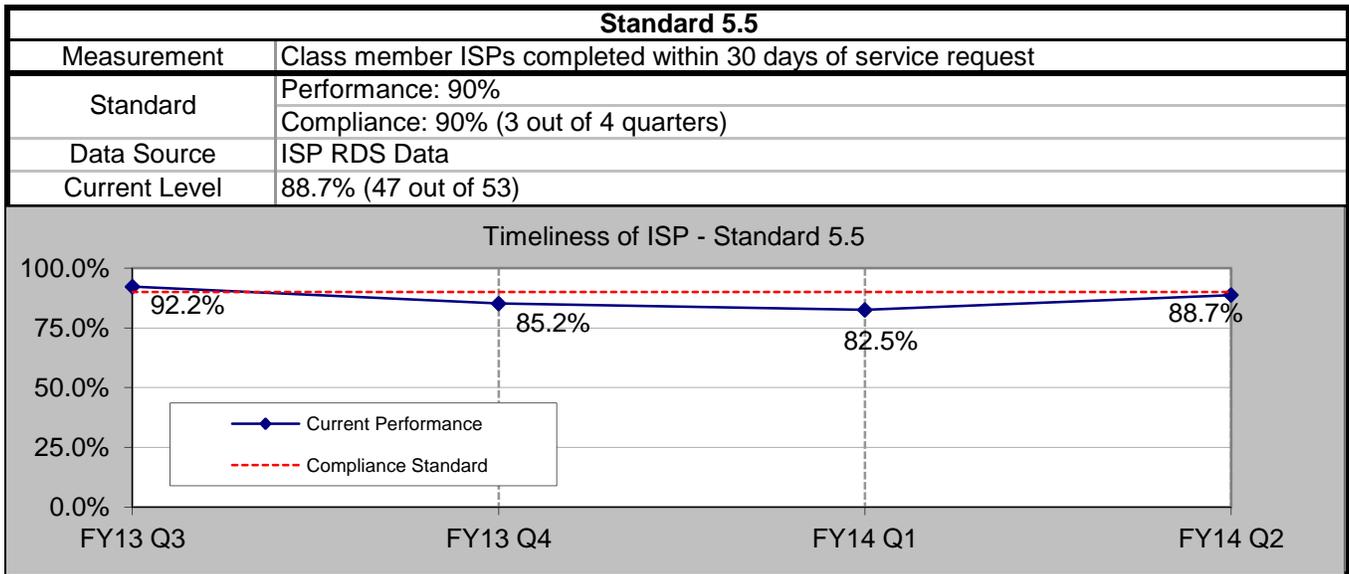


**Community Integration / Community Support Services /
Individualized Support Planning**

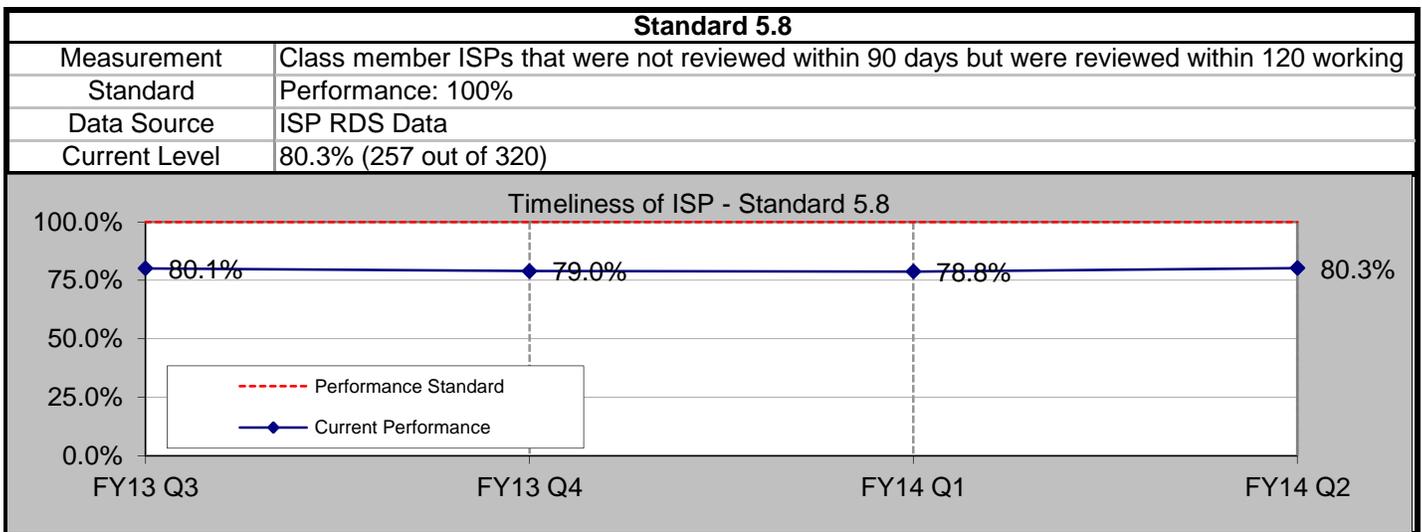
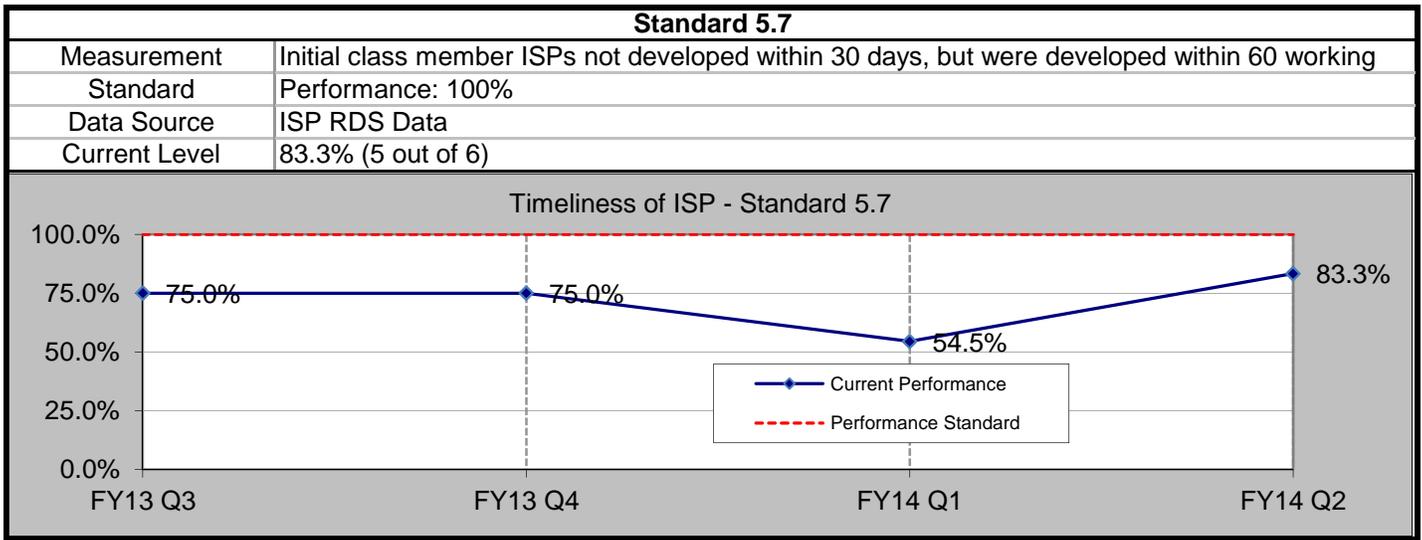


Standards 5.1 -5.4 – Calculations are now based on days from Contact for Service Notification to date of assignment. The first 3 quarters have been re-calculated using this formula.

Community Integration / Community Support Services / Individualized Support Planning



Community Integration / Community Support Services / Individualized Support Planning

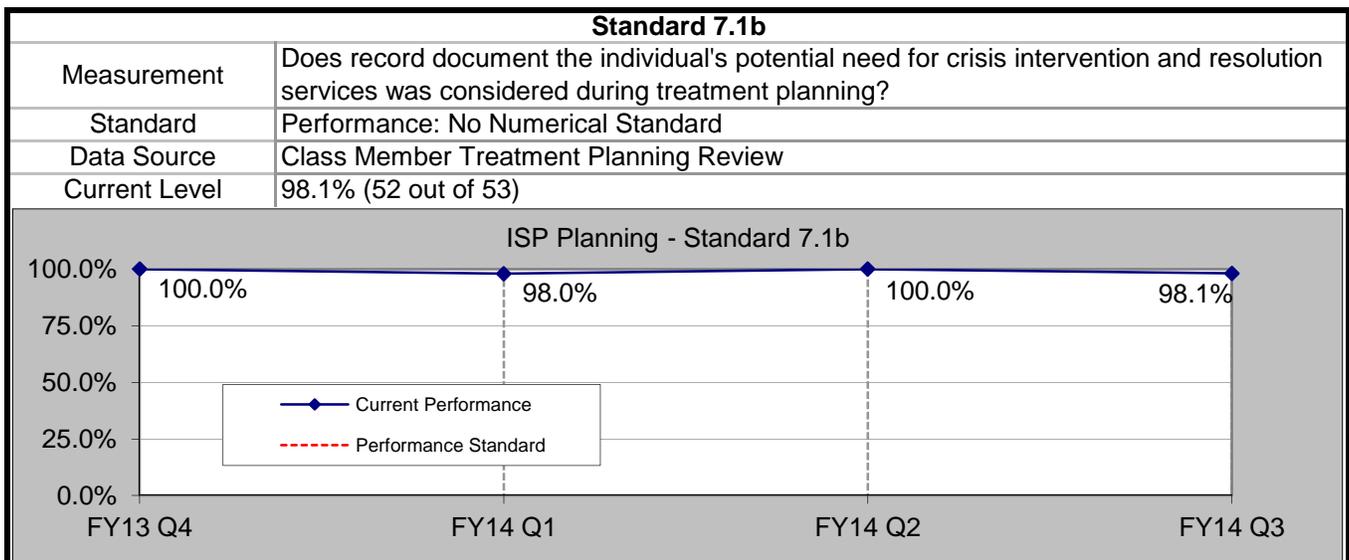
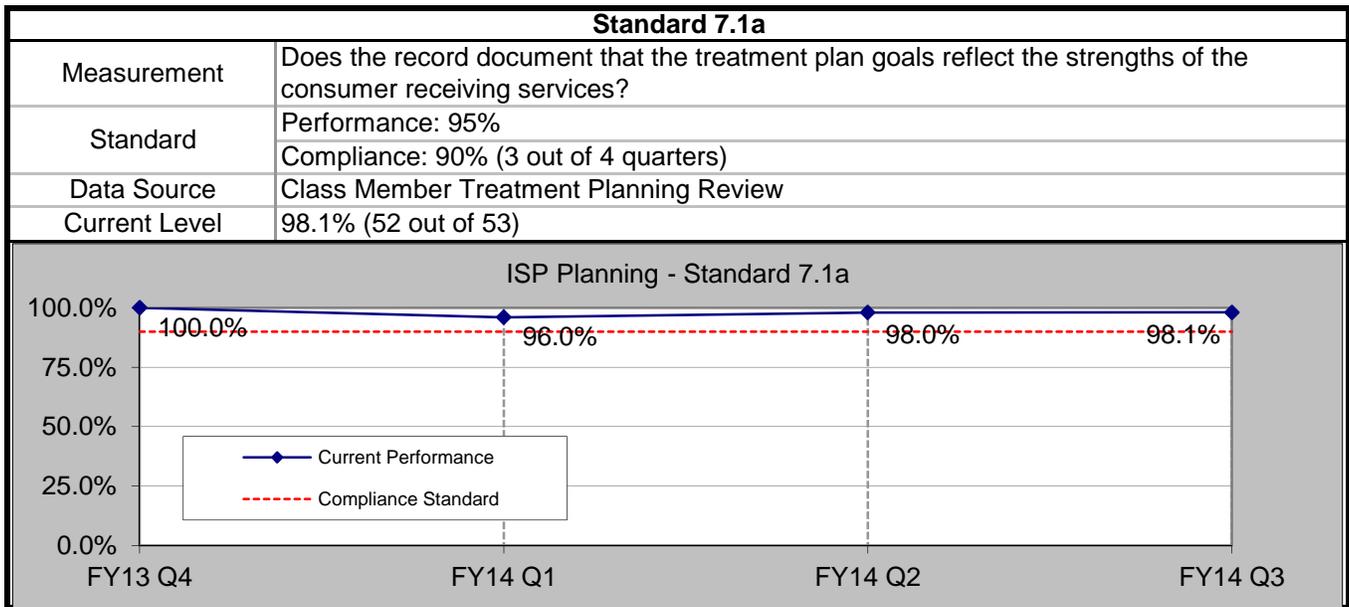


Discussion:

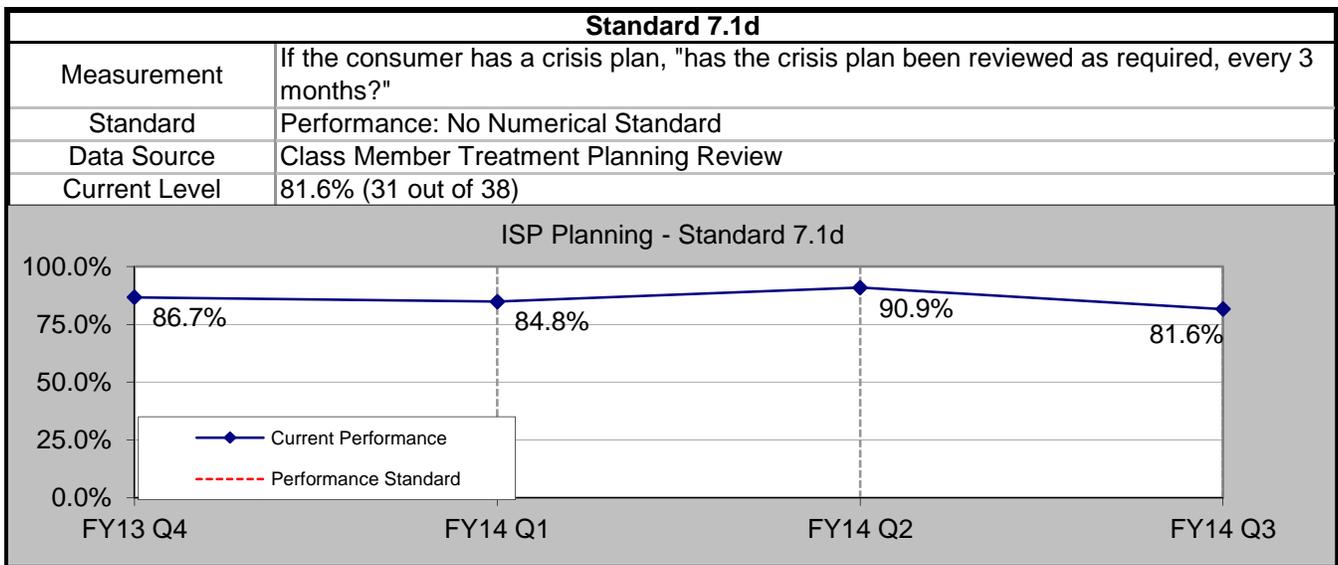
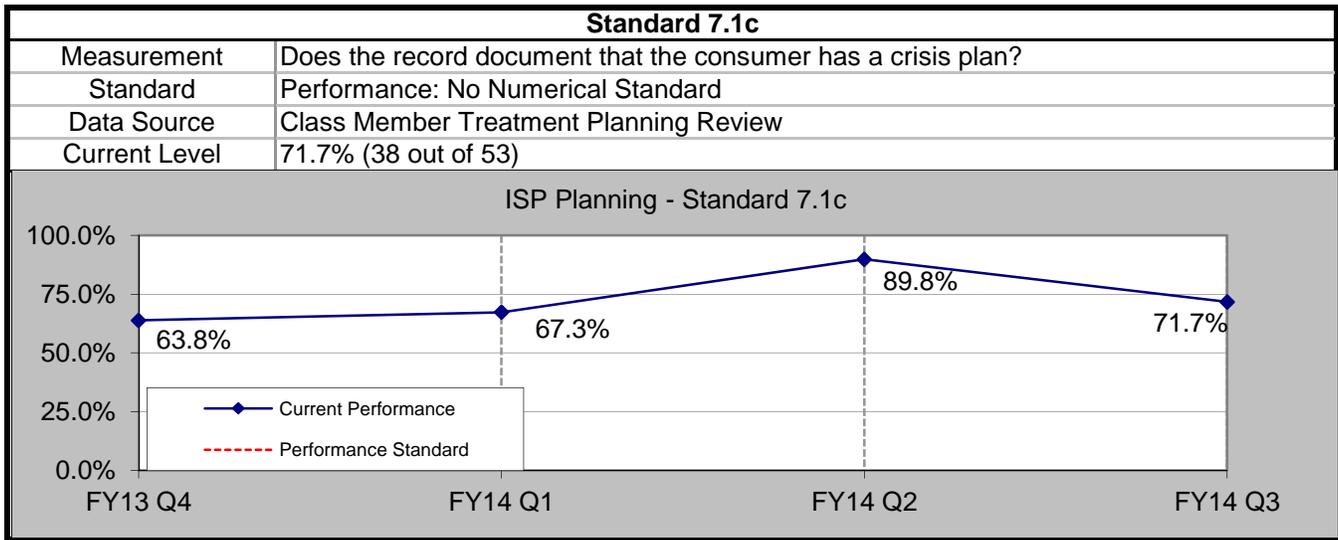
Standards 5.1 - 5.8: Field Quality Managers have completed additional agency trainings around assignment times. Assignment time performance measures are now included in Rider E of agency contracts. Data Quality Management Team will identify outliers for follow up by the treatment team and provider agencies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

Community Integration / Community Support Services / Individualized Support Planning

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

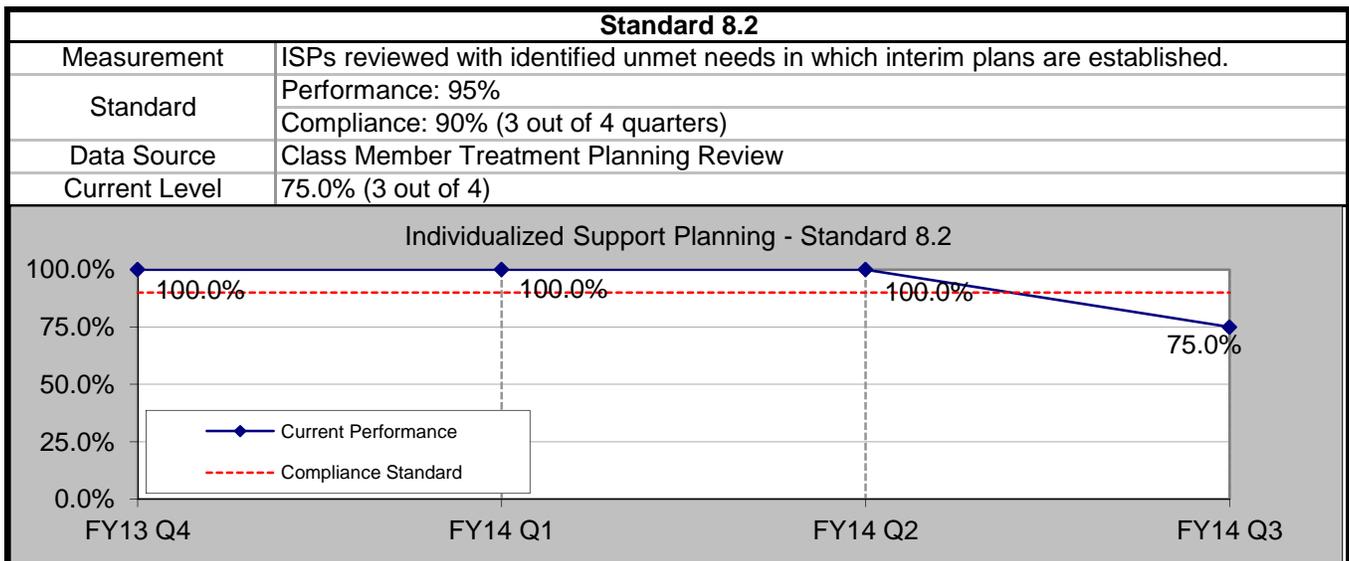
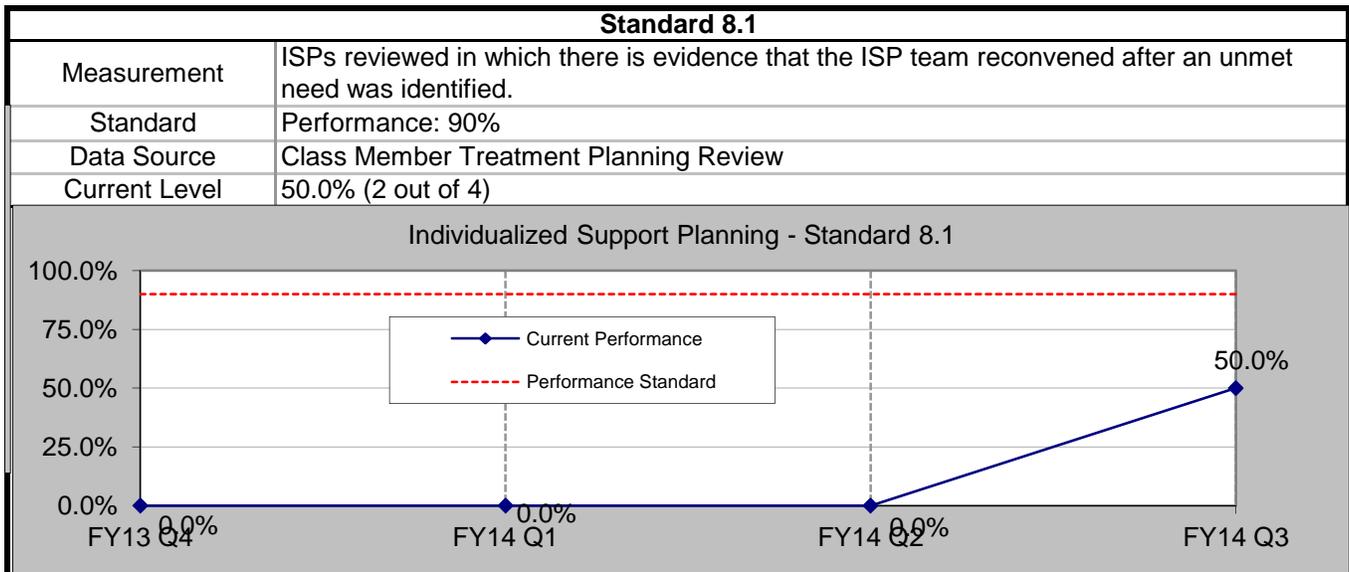


**Community Integration / Community Support Services /
Individualized Support Planning**



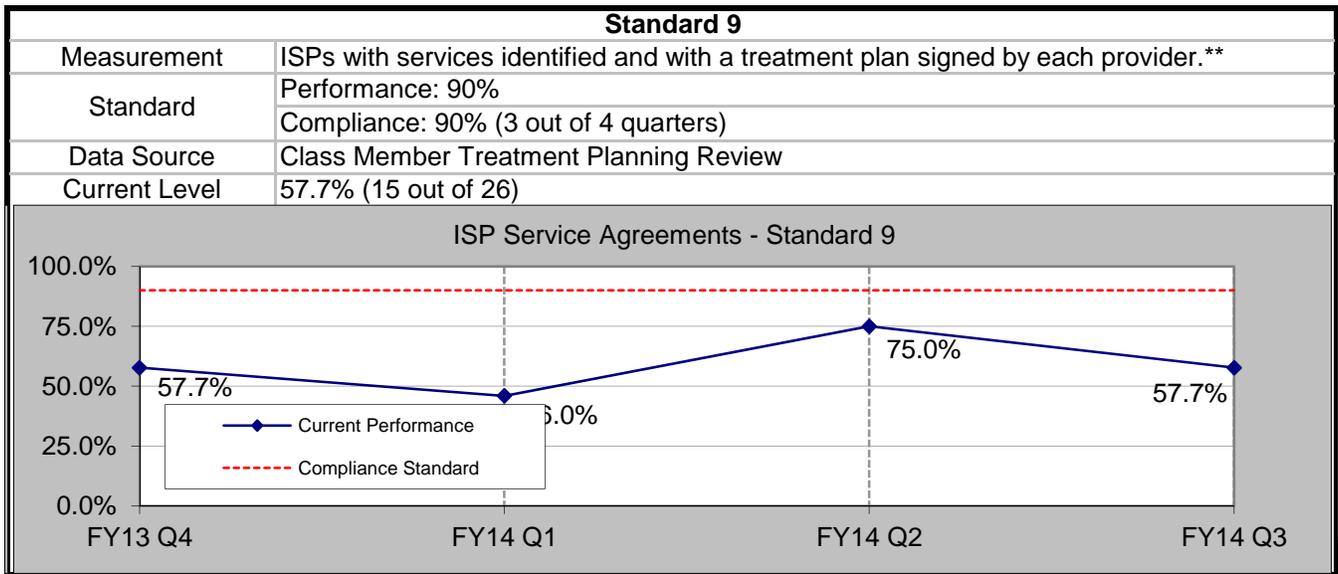
Community Integration / Community Support Services / Individualized Support Planning

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



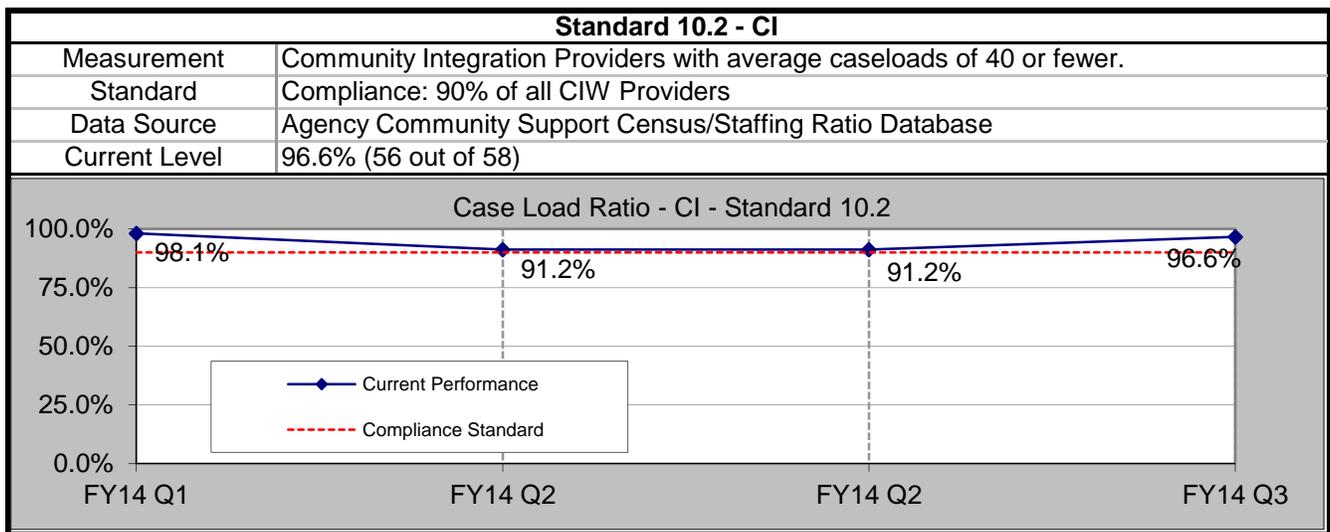
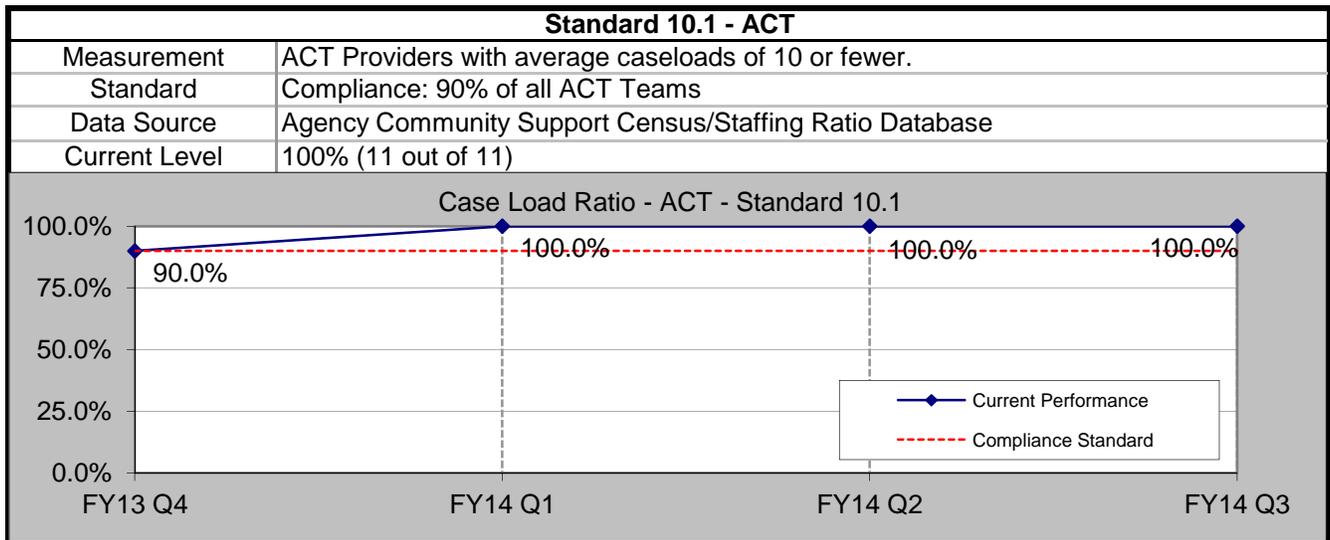
Community Integration / Community Support Services / Individualized Support Planning

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



Community Integration / Community Support Services / Individualized Support Planning

Standard 10 - Case Load Ratio

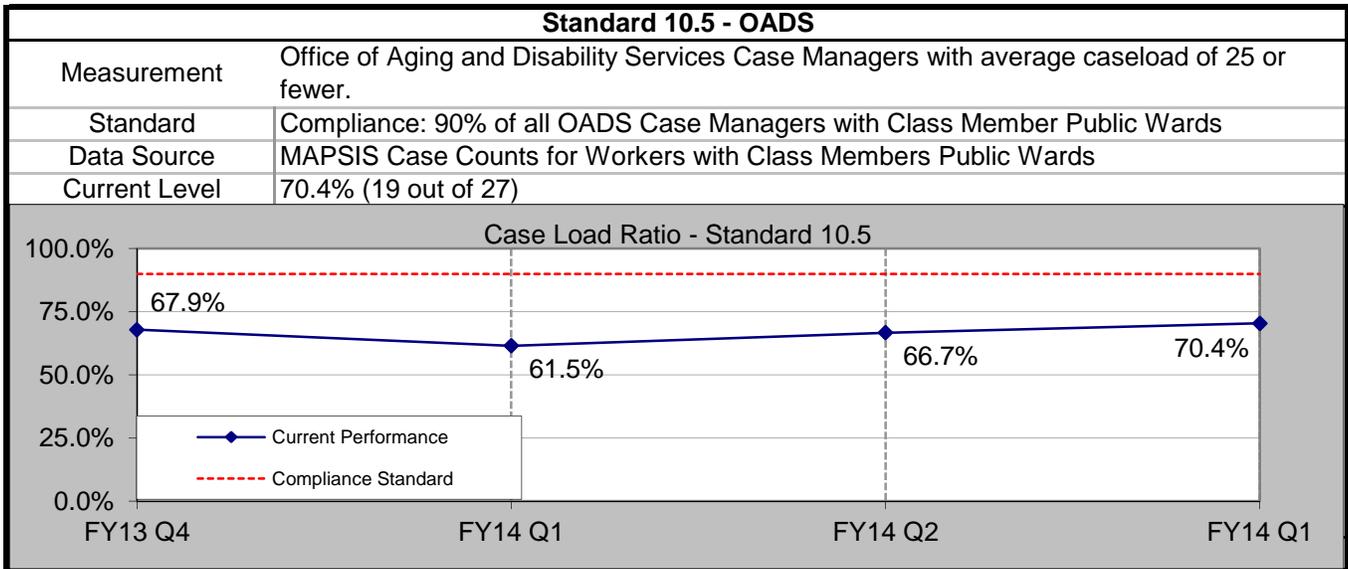


Discussion:

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 to 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.



**Community Integration / Community Support Services /
Individualized Support Planning**

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

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

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

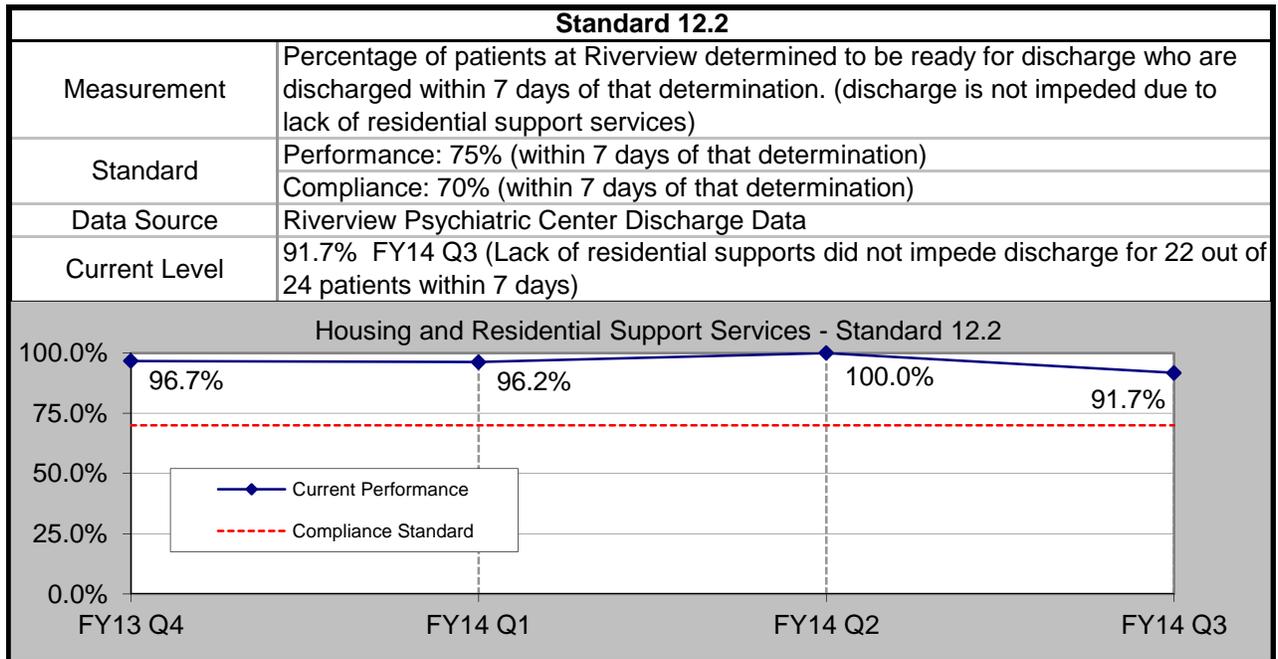
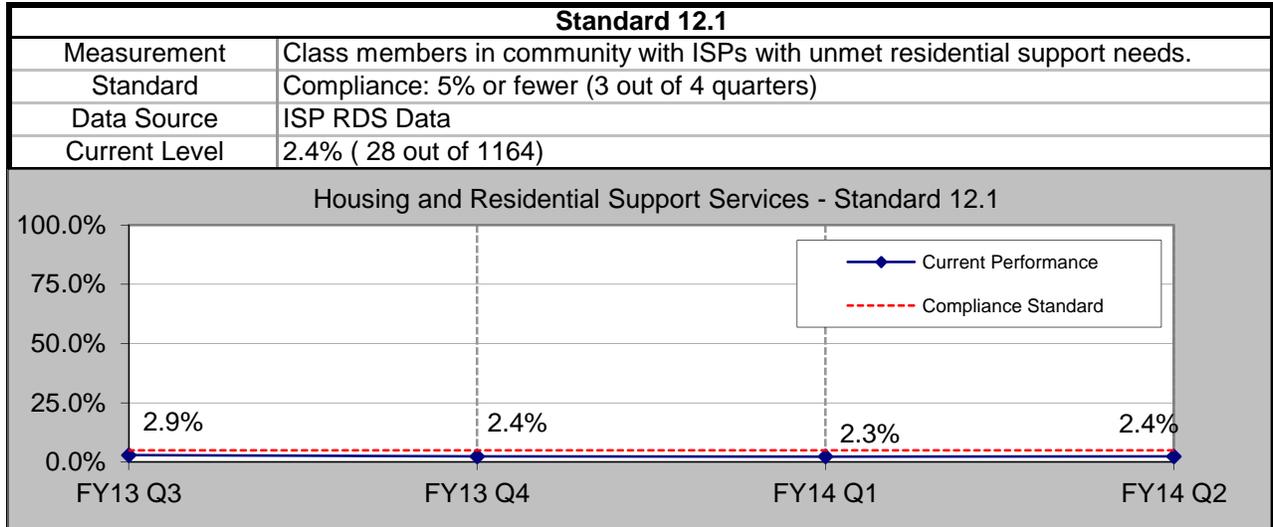
The total of unique individuals for all regions may not equal the total unique individuals for the State as an individual may make a request of a CDC in more than one region.

Number of Callers with resource needs Oct 1 - Dec 31, 2013				
	Region 1	Region 2	Region 3	Total
Unique Individuals:	0	2	0	2
Unmet Needs:	0	0	0	0

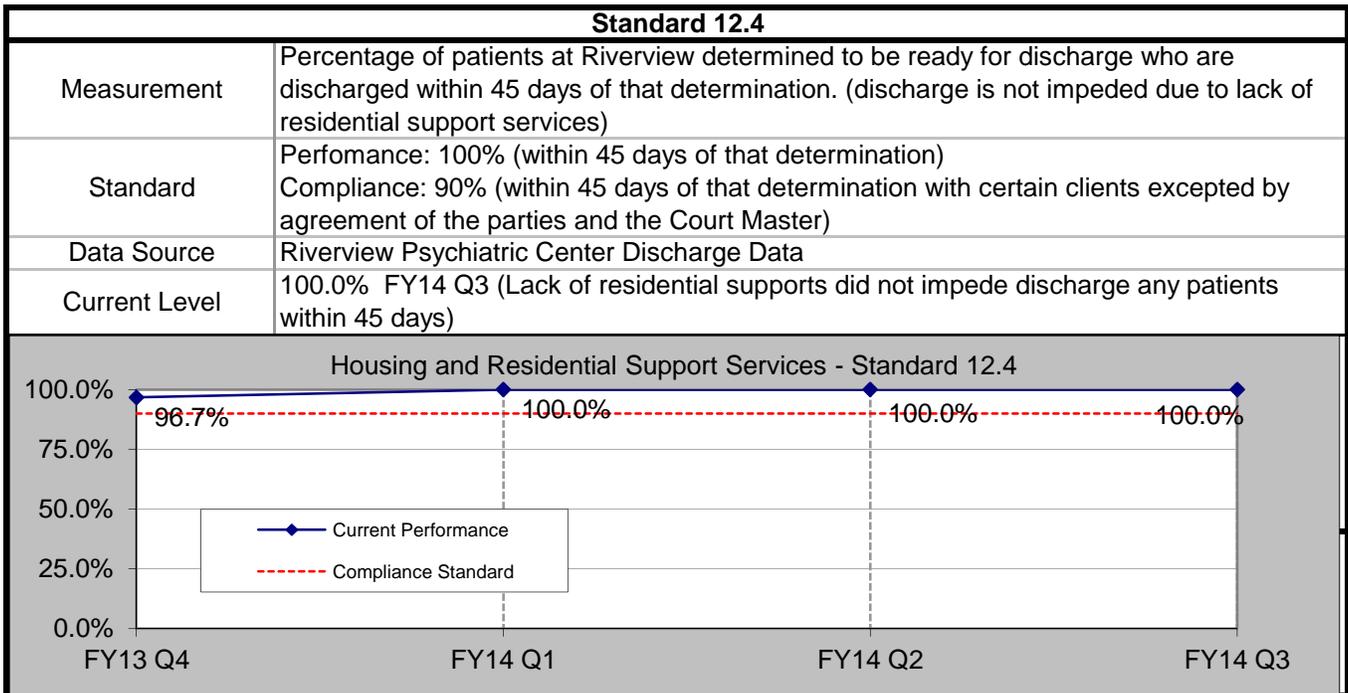
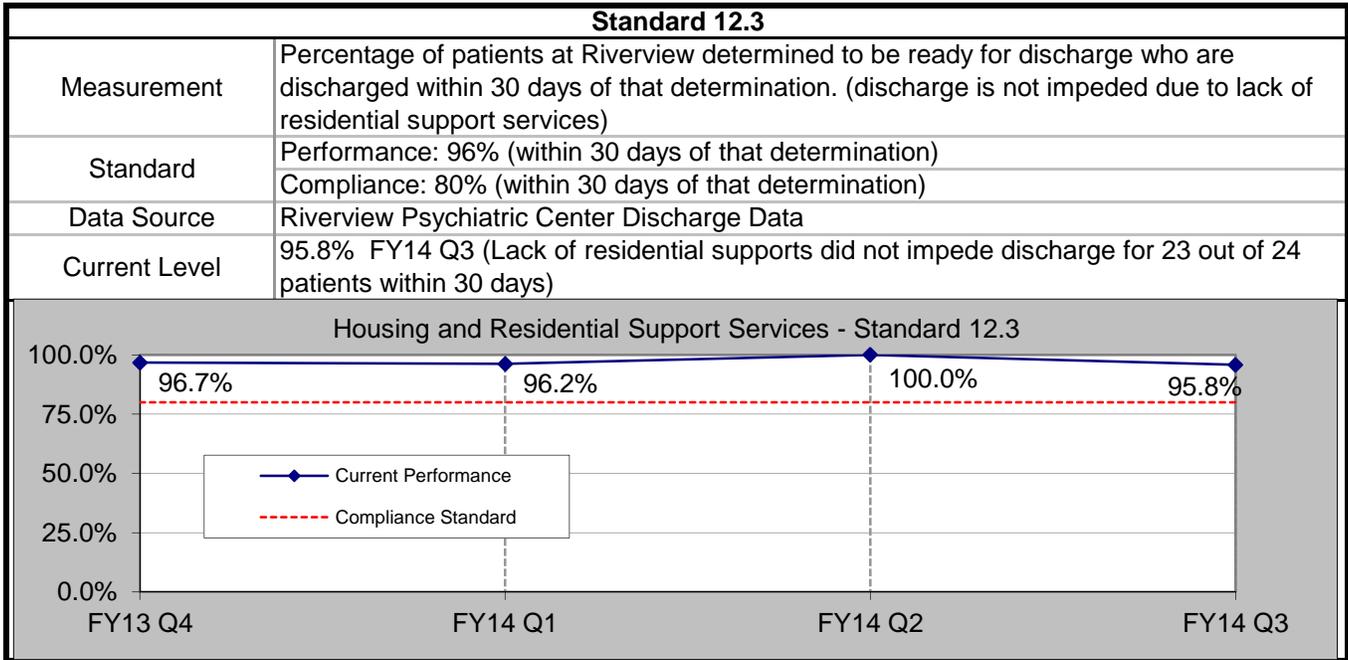
Unmet Needs by Domain Oct 1 - Dec 31, 2013	
ISP Domain Areas	State
Mental Health Services	0
MH Crisis Planning Resources	0
Peer, Recovery & Support Resources	0
Substance Abuse Services	0
Housing Resources	0
Health Care Resources	0
Legal Resources	0
Financial Security Resources	0
Education Resources	0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

**Community Resources and Treatment Services
Housing and Residential**

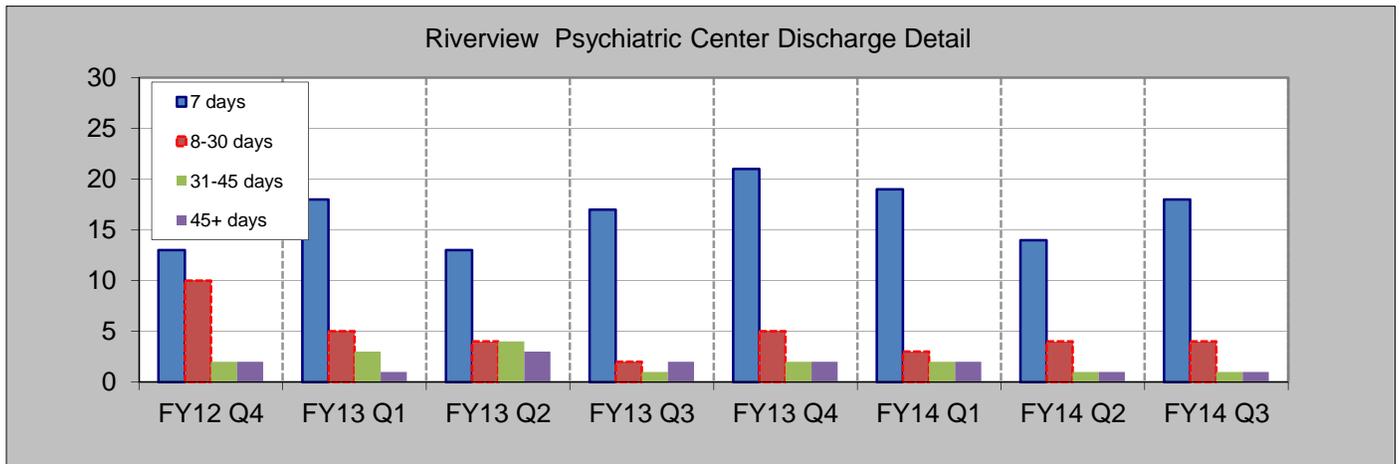
Standard 12 - Residential Support services adequate to meet ISP needs of those ready for discharge



**Community Resources and Treatment Services
Housing and Residential**



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:

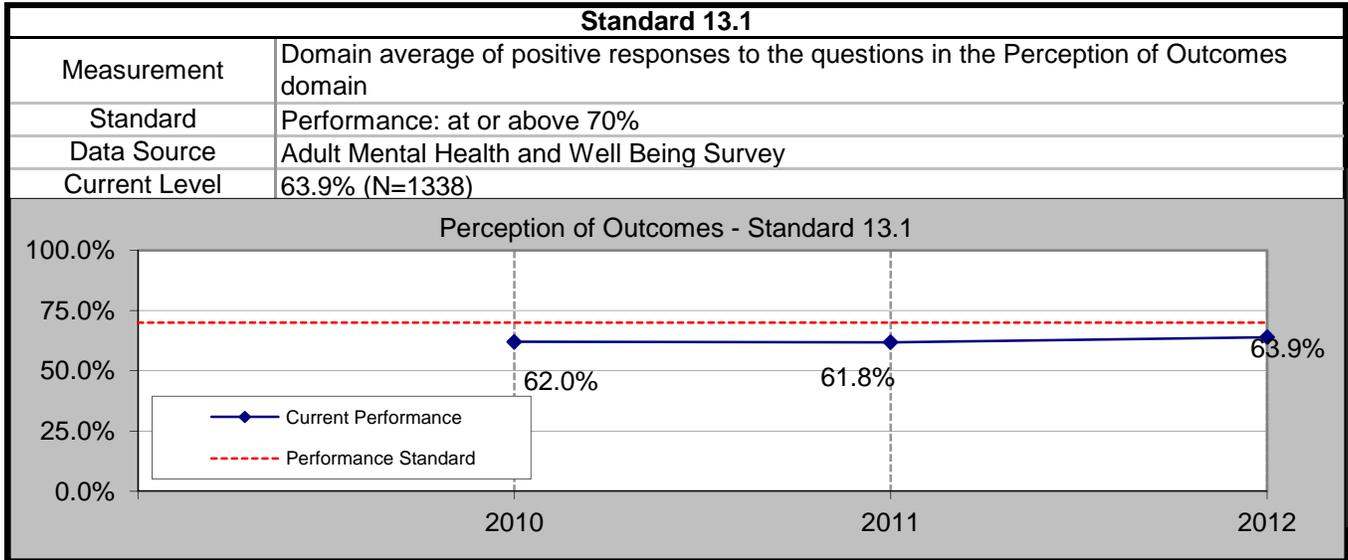
24 Civil Patients discharged in quarter

- 18 discharged at 7 days (75.0%)
- 4 discharged 8-30 days (16.7%)
- 1 discharged 31-45 days (4.2%)
- 1 discharged post 45 days (4.2%)

Residential Supports impeded discharge for 2 patients post clinical readiness for discharge.

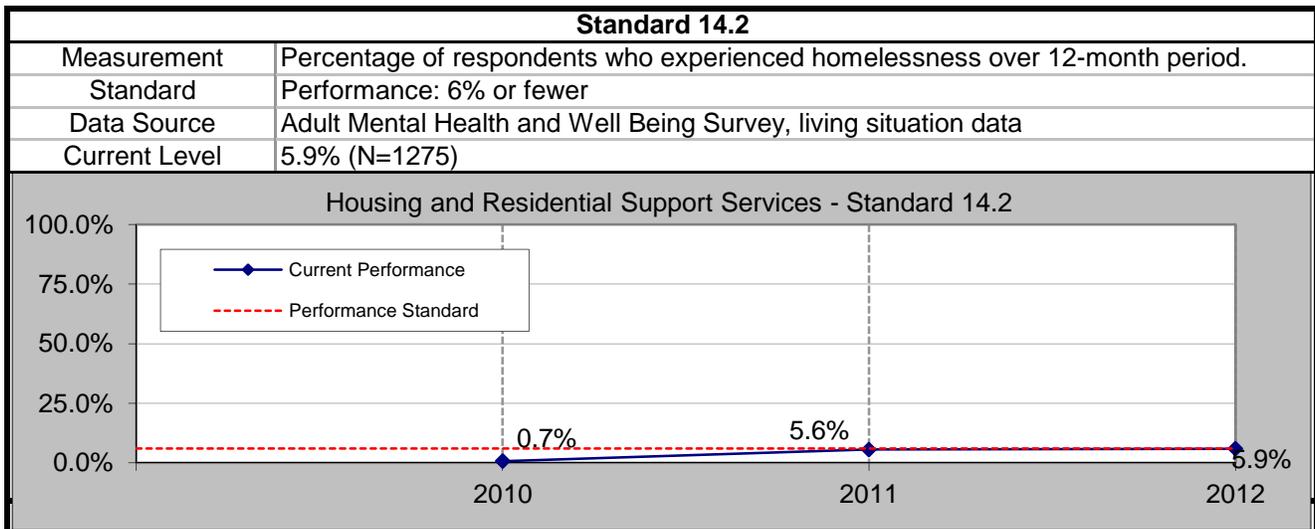
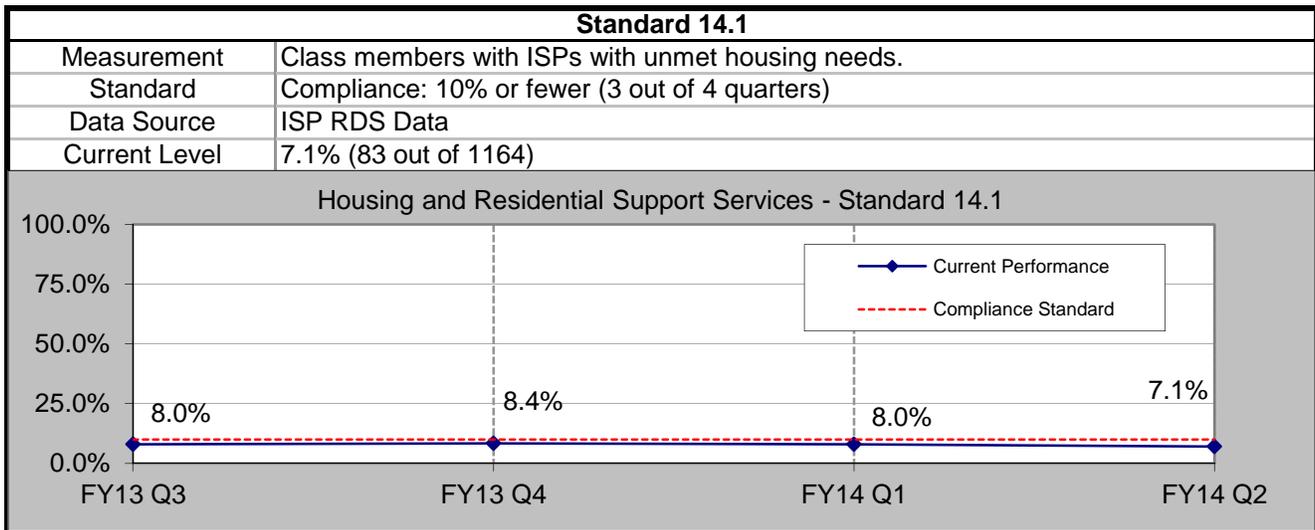
- 1 patient discharged within 7-30 days post clinical readiness for discharge
- 1 patient discharged within 31-45 days post clinical readiness for discharge

**Community Resources and Treatment Services
Housing and Residential**

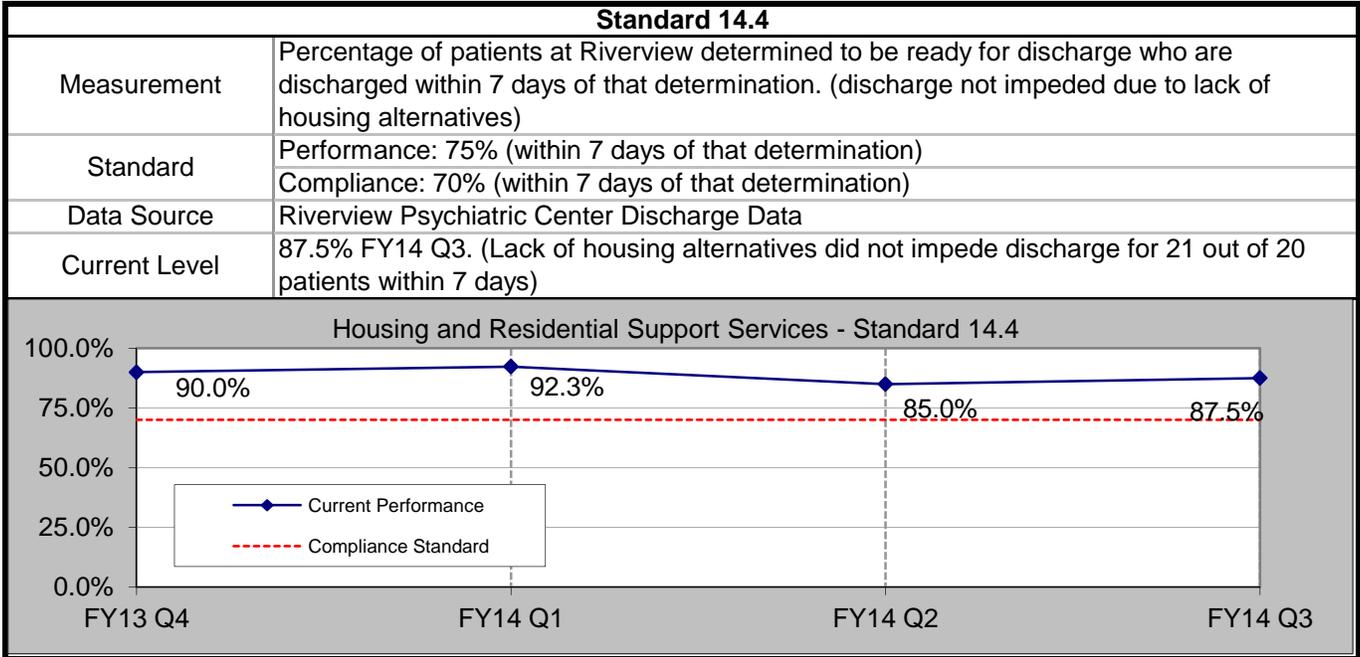


**Community Resources and Treatment Services
Housing and Residential**

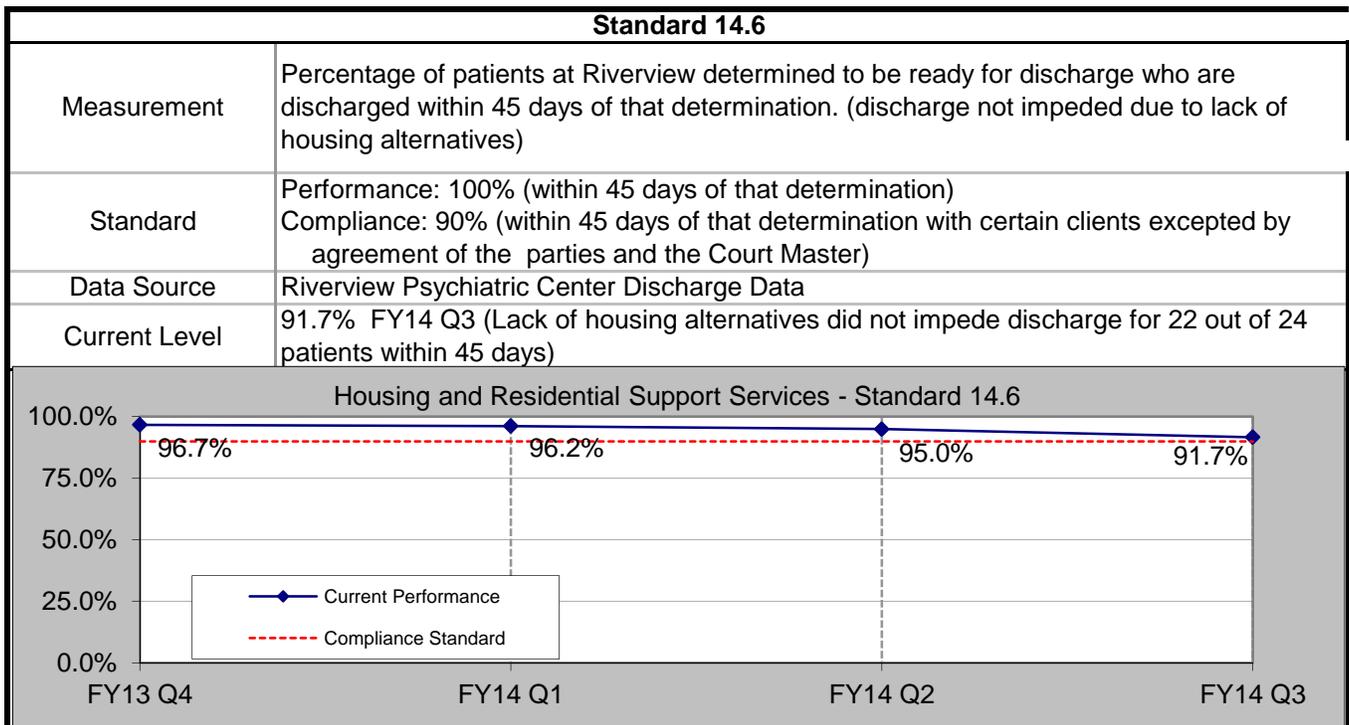
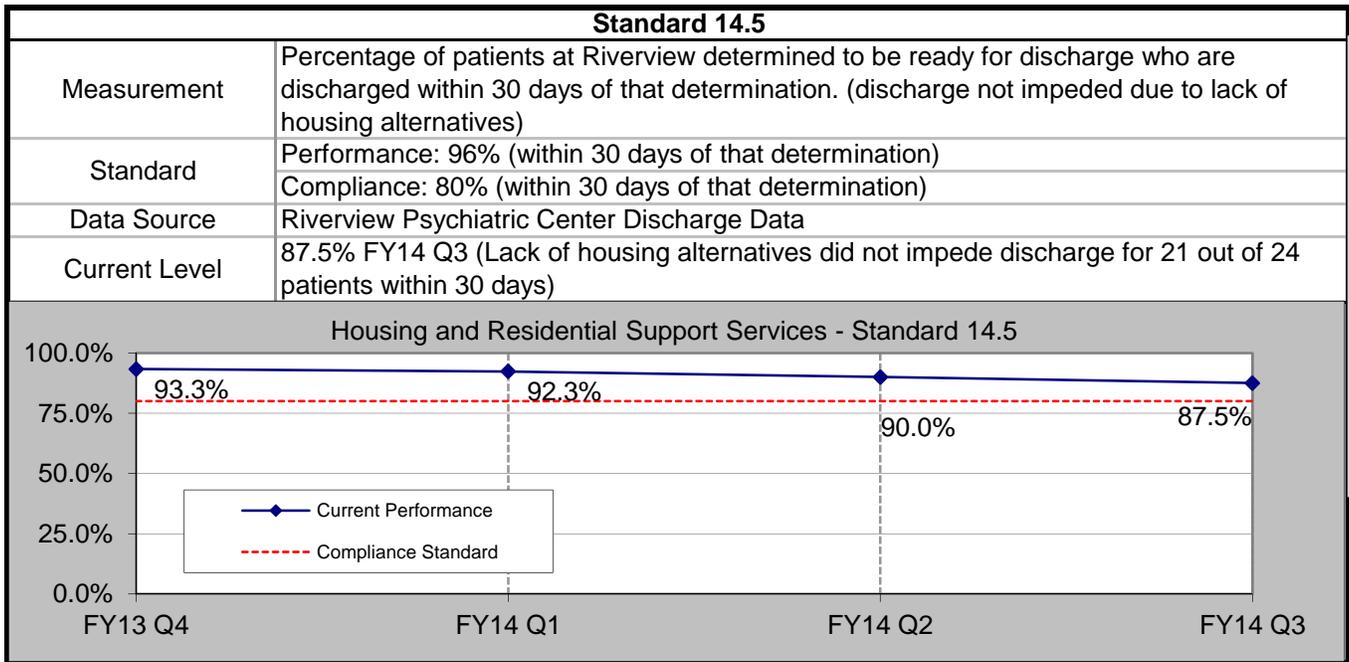
Standard 14 - Demonstrate an array of housing alternatives available to meet class member needs.



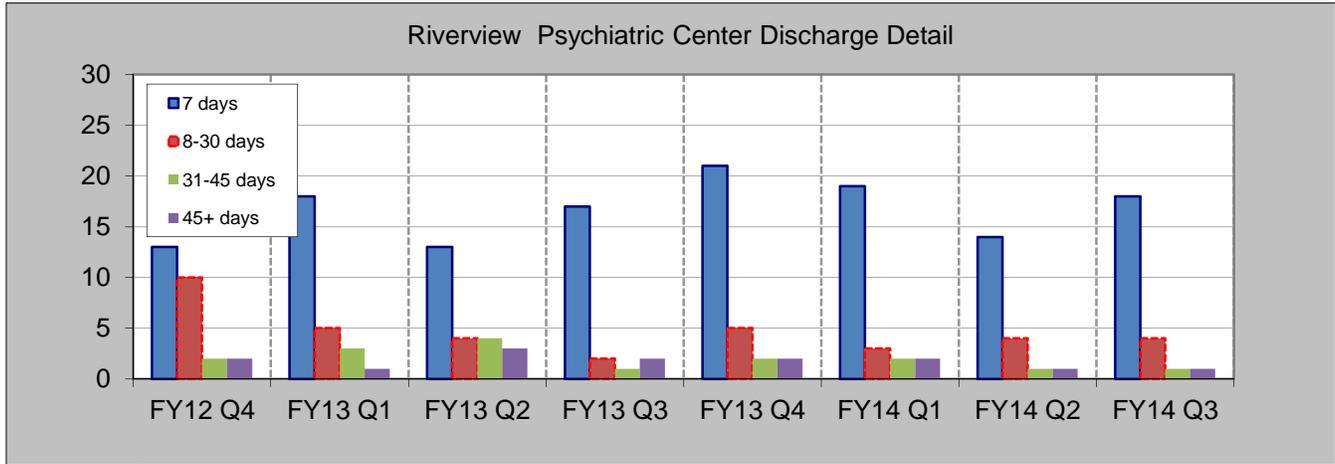
**Community Resources and Treatment Services
Housing and Residential**



**Community Resources and Treatment Services
Housing and Residential**



**Community Resources and Treatment Services
Housing and Residential**



24 Civil Patients discharged in quarter

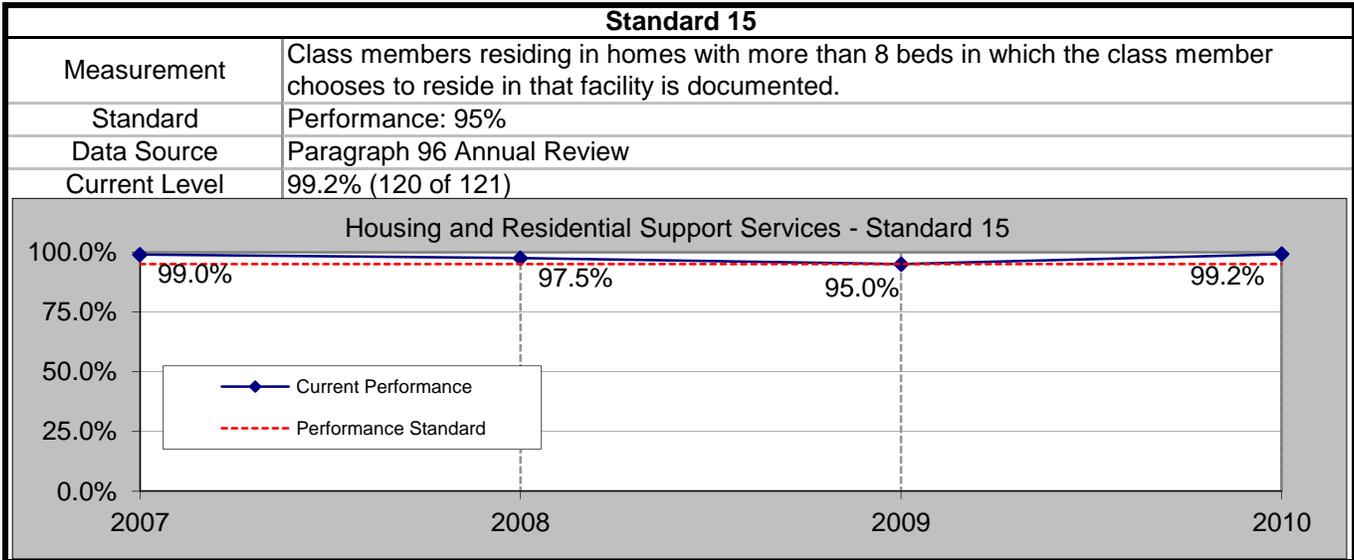
- 18 discharged at 7 days (75.0%)
- 4 discharged 8-30 days (16.7%)
- 1 discharged 31-45 days (4.2%)
- 1 discharged post 45 days (4.2%)

Housing Alternatives impeded discharge for 3 patients (15.0%)

- 1 patient discharged within 7-30 days post clinical readiness for discharge
- 1 patient discharged within 31-45 days post clinical readiness for discharge
- 1 patient discharged greater than 45 days post clinical readiness for discharge

**Community Resources and Treatment Services
Housing and Residential**

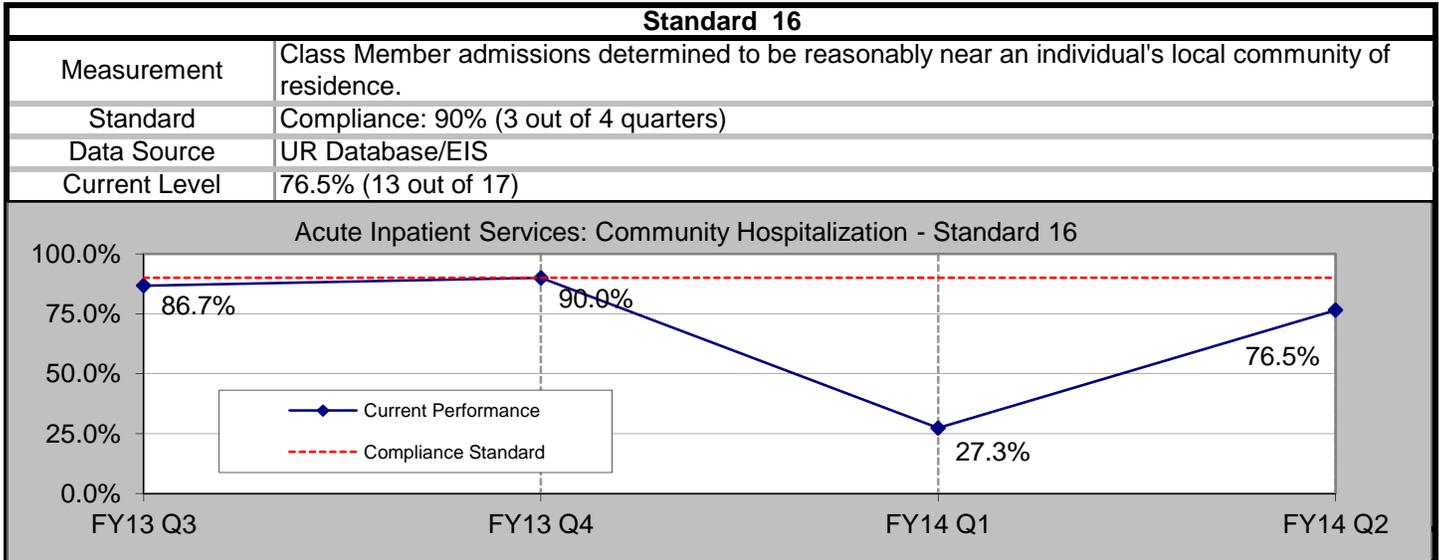
Standard 15 - Housing where community services are located / Homes with more than 8 beds



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

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

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



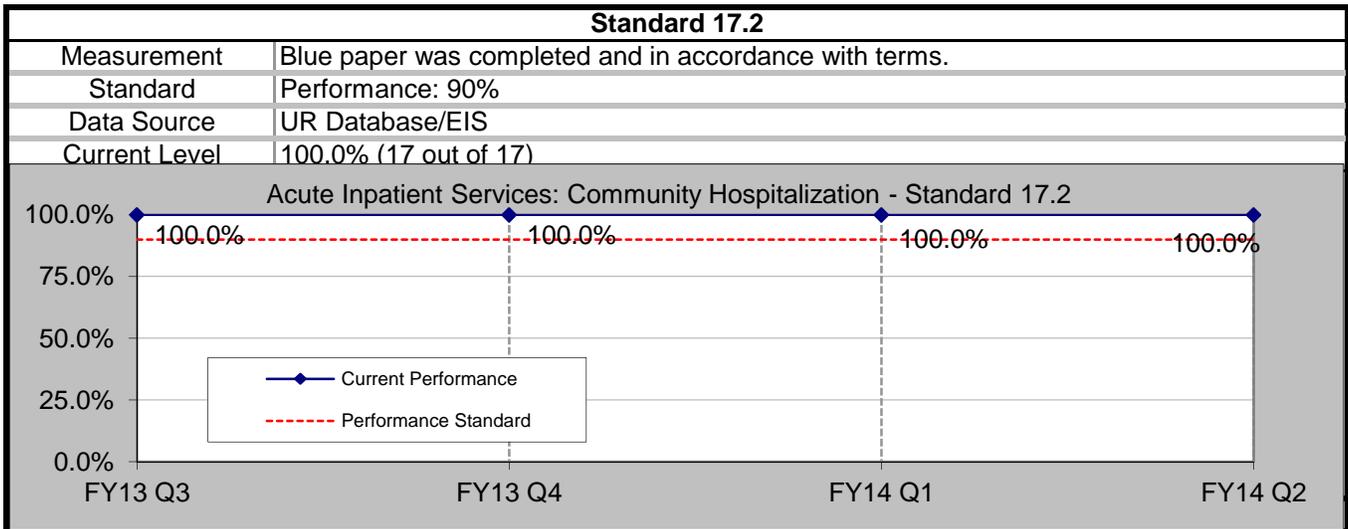
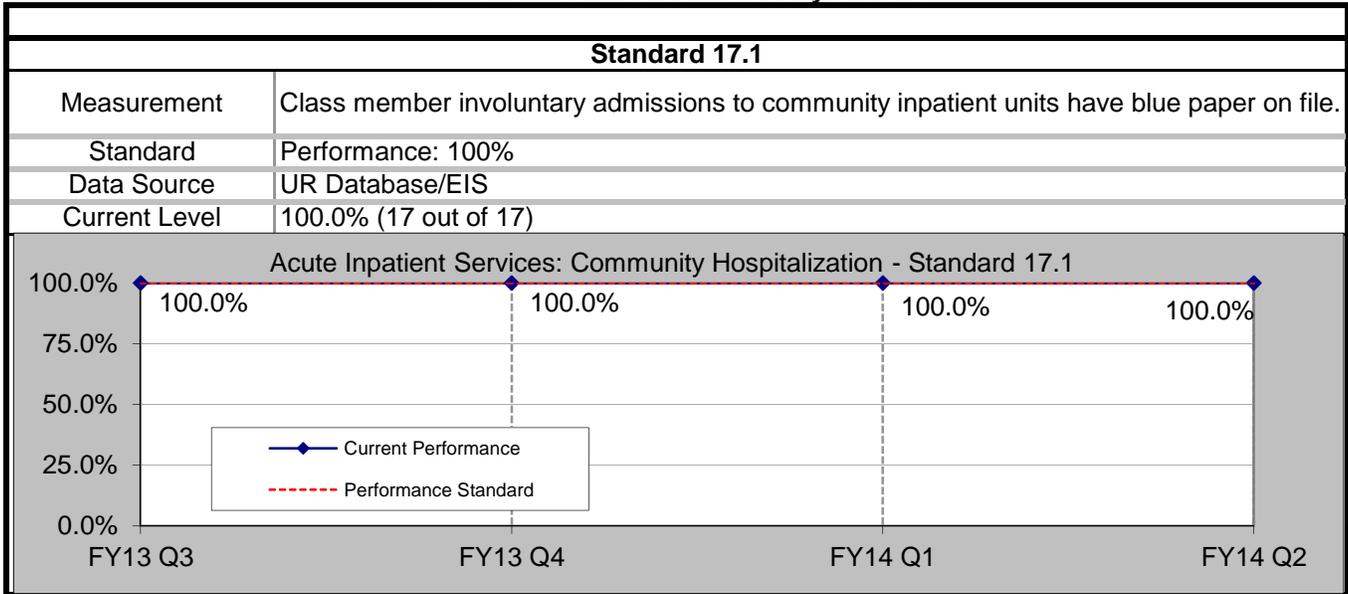
Reasonably Near is defined by Attachment C to the October 29, 2007 approved Compliance Standards.

Discussion:

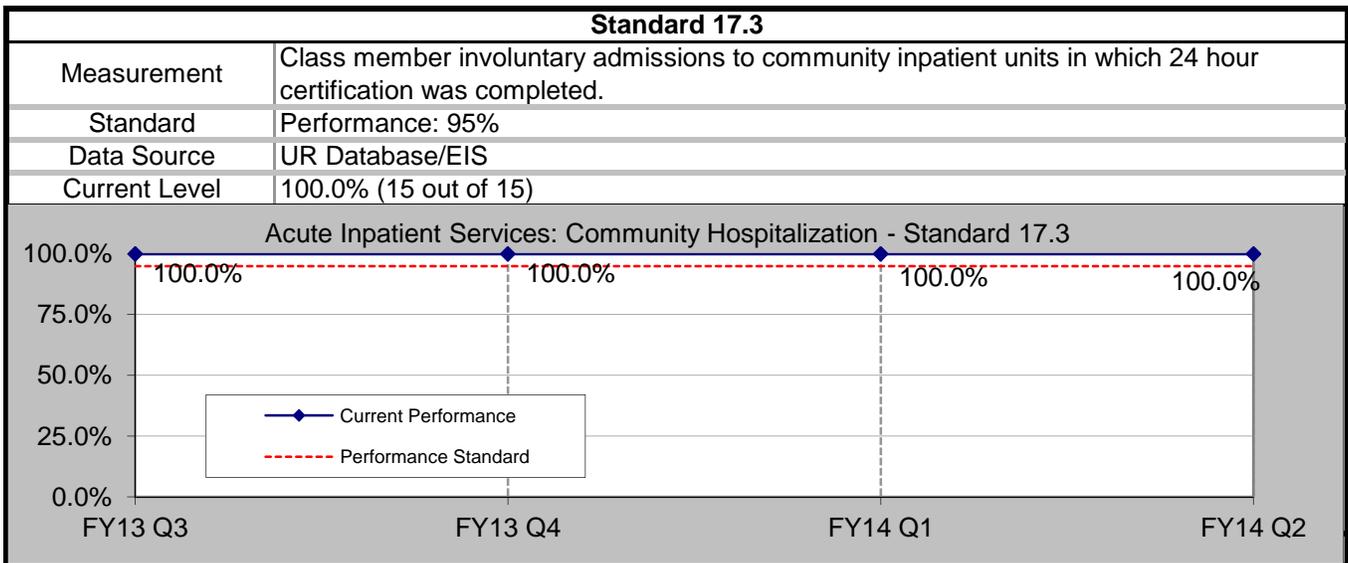
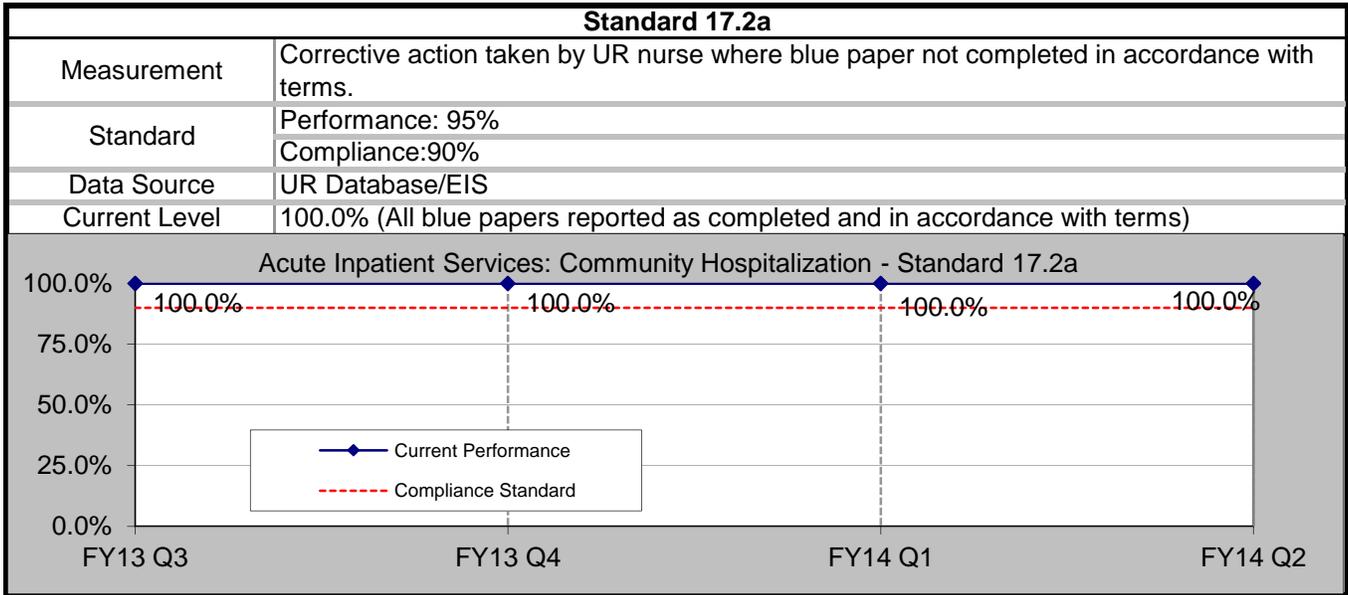
Standard 16 FY14 Q1: Data has been double checked manually and percentage reported is accurate. Persons needing hospitalization during the quarter were placed in the nearest **available** hospital bed. This could result in admissions outside the individual's catchment area. Measure will continue to be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

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

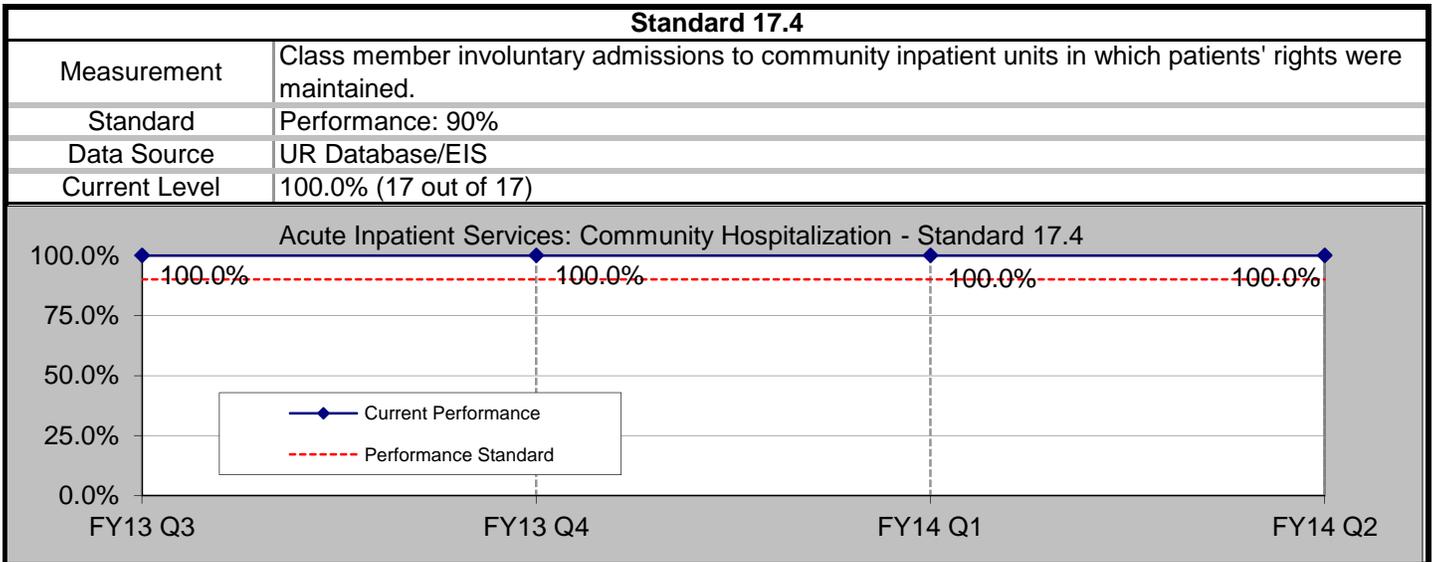
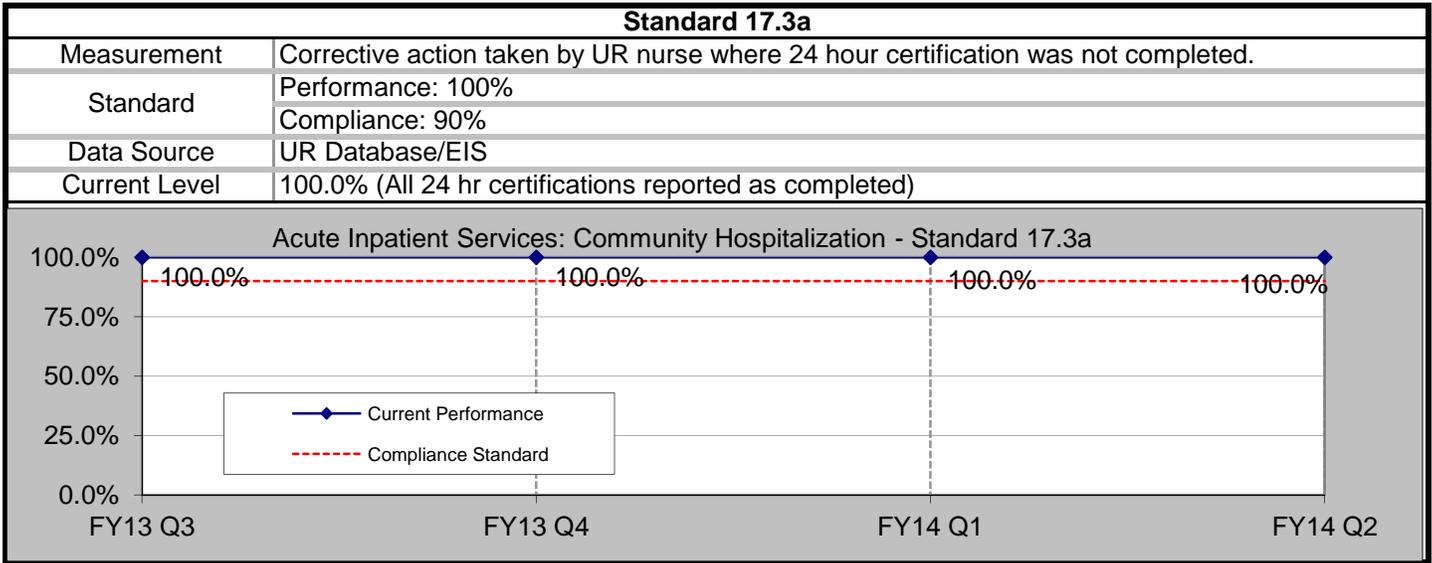
Standard 17 - Class member admissions to community involuntary inpatient units are in accordance with law and meet medical necessity criteria



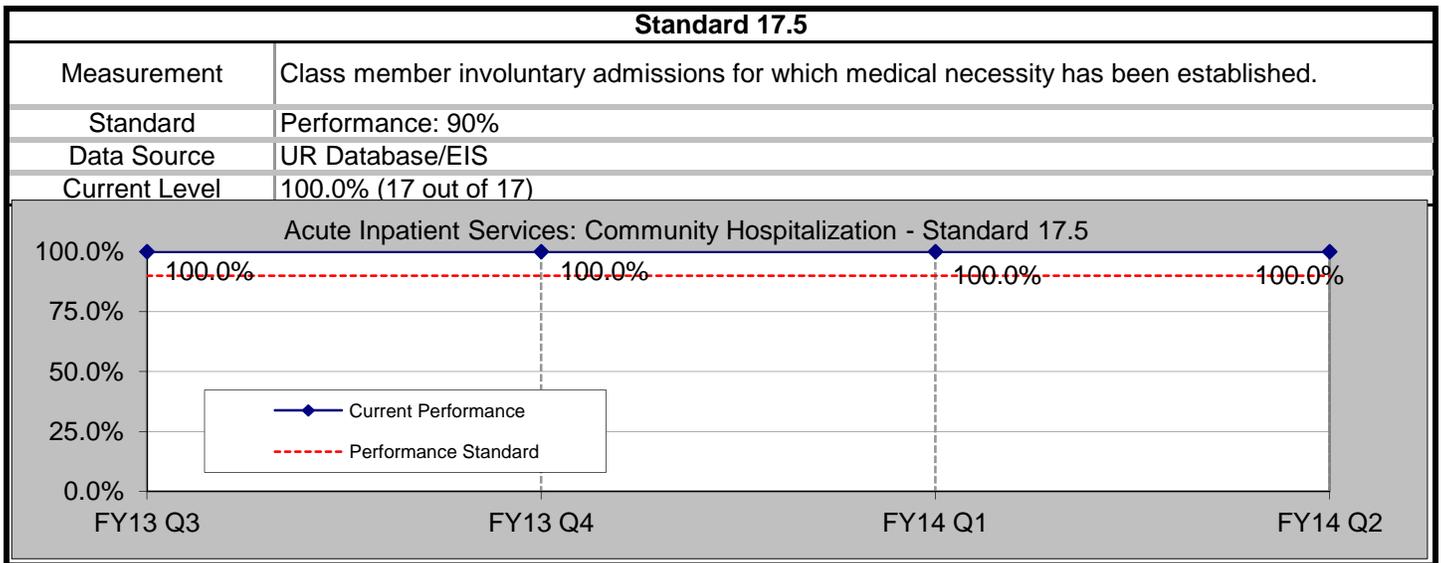
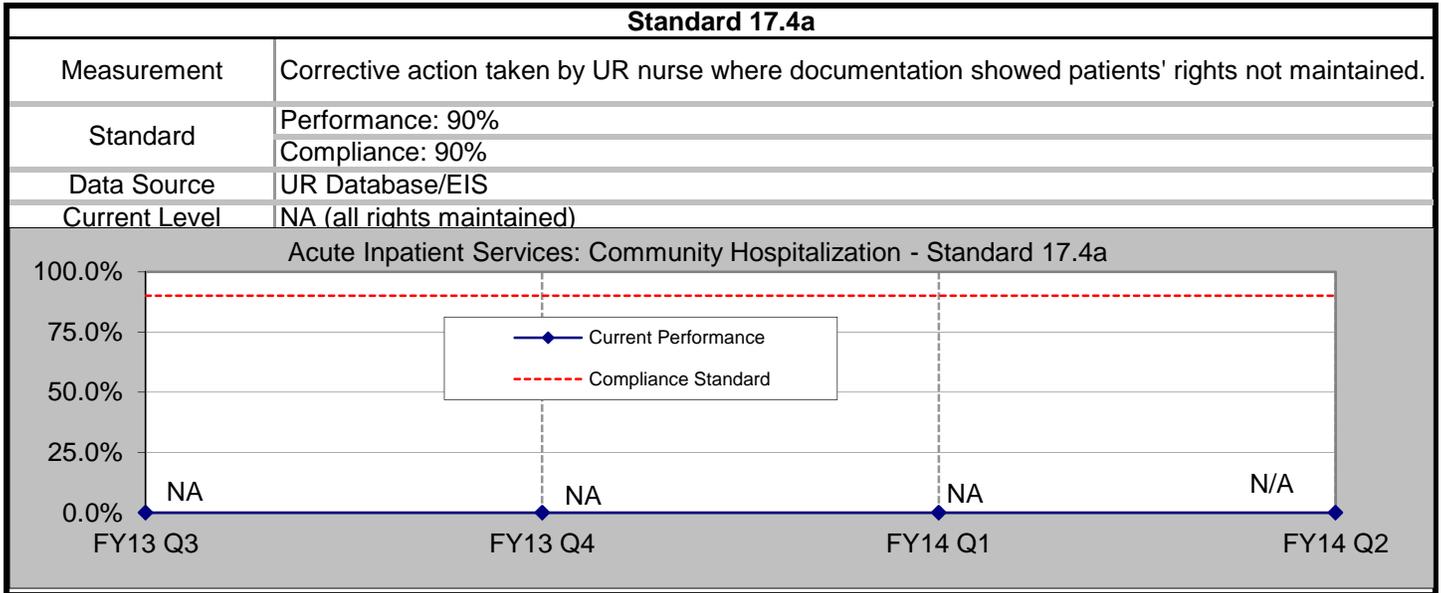
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization



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

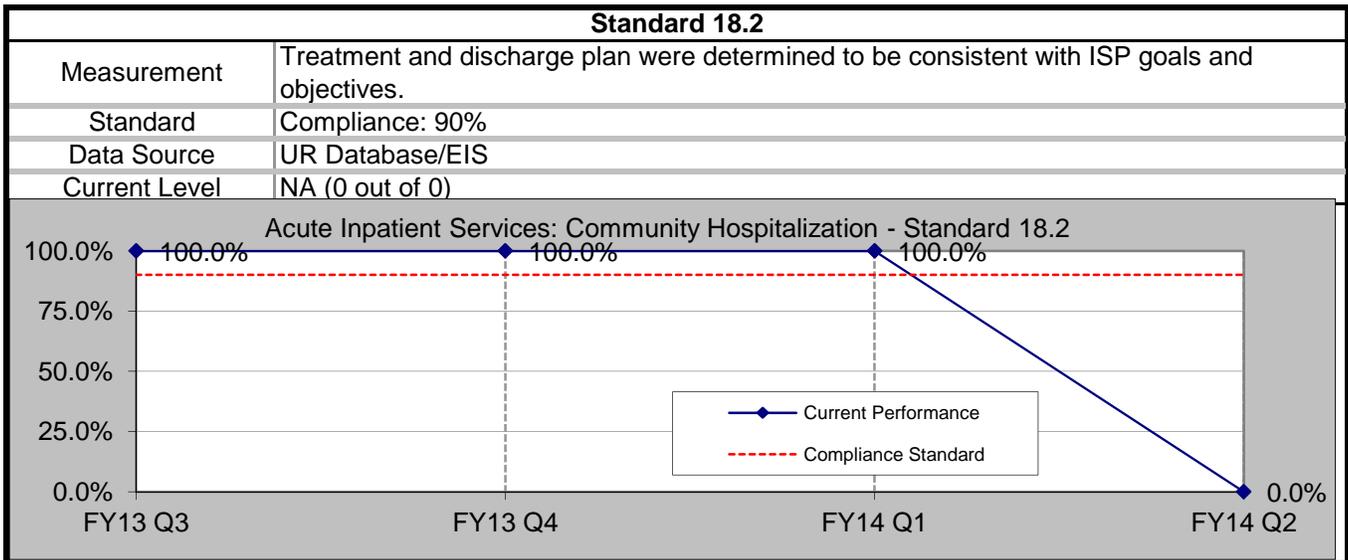
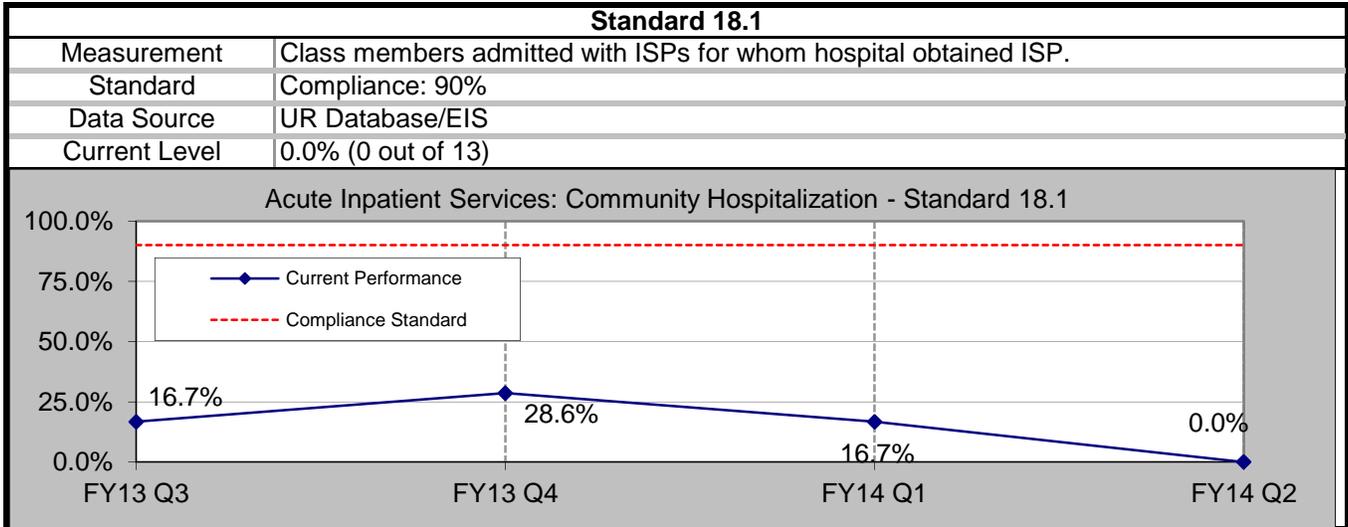


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

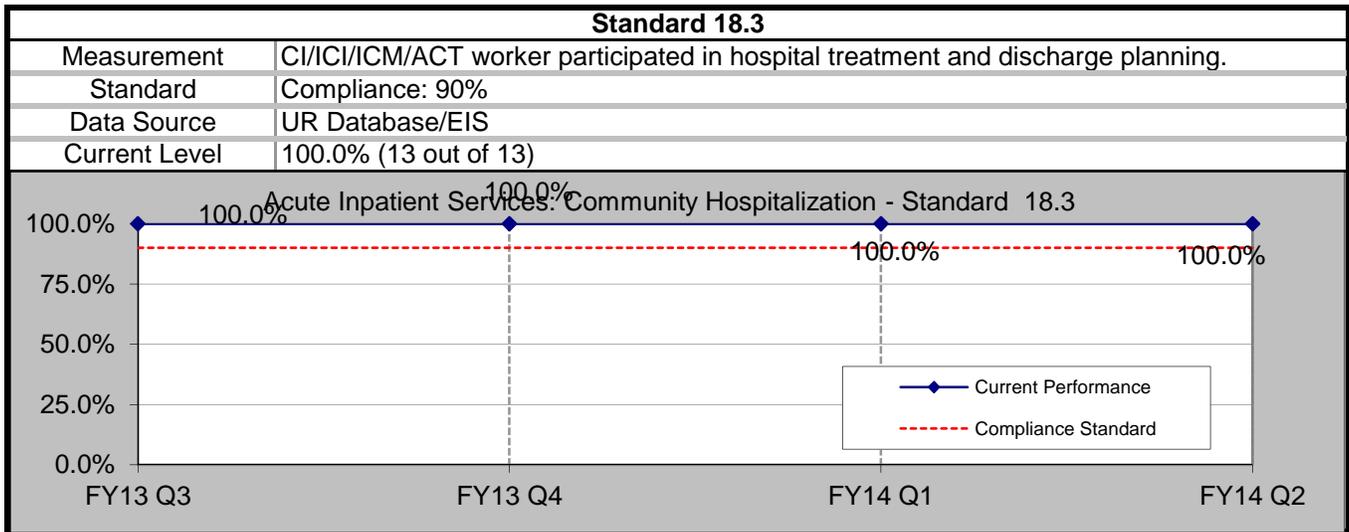


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

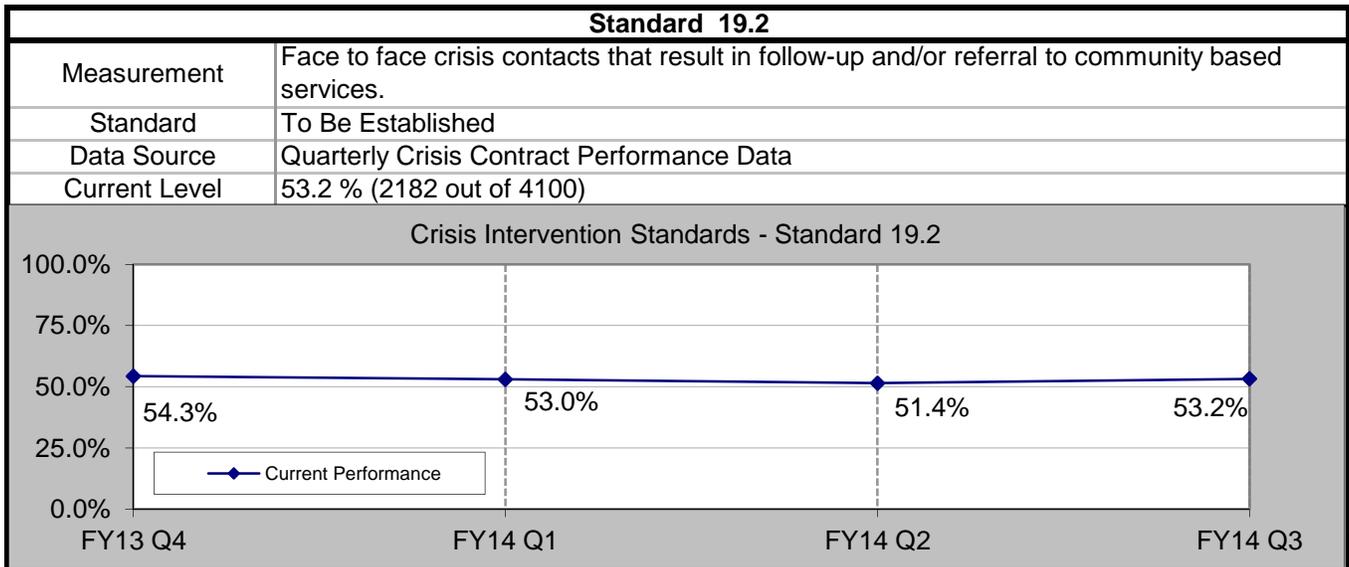
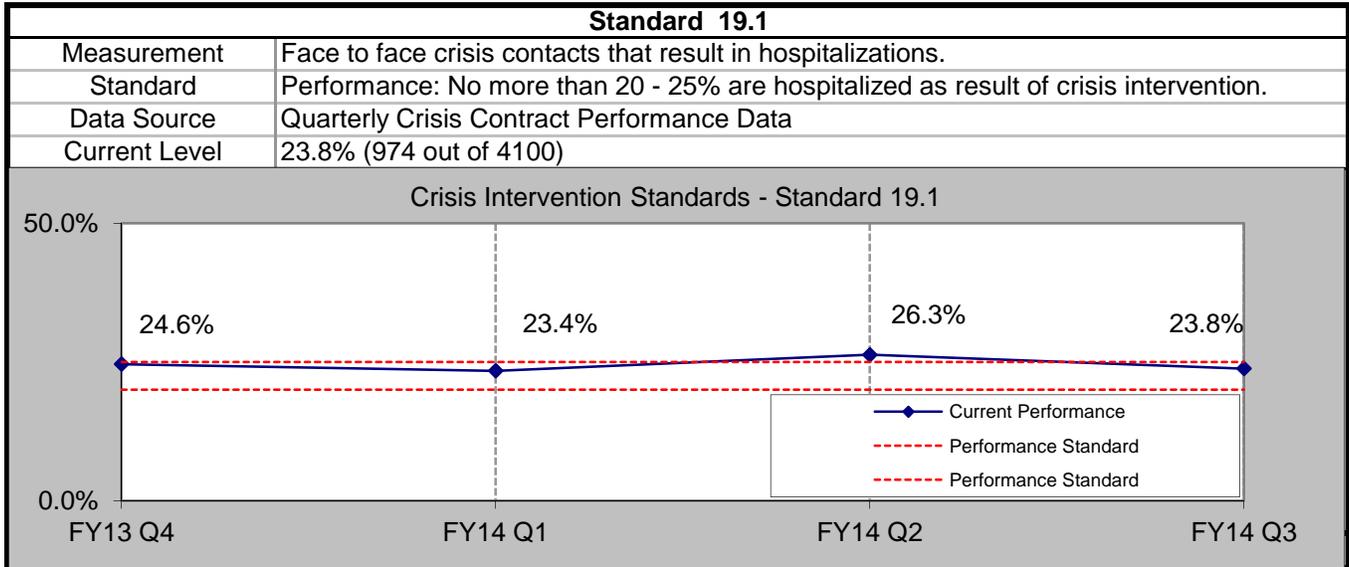


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

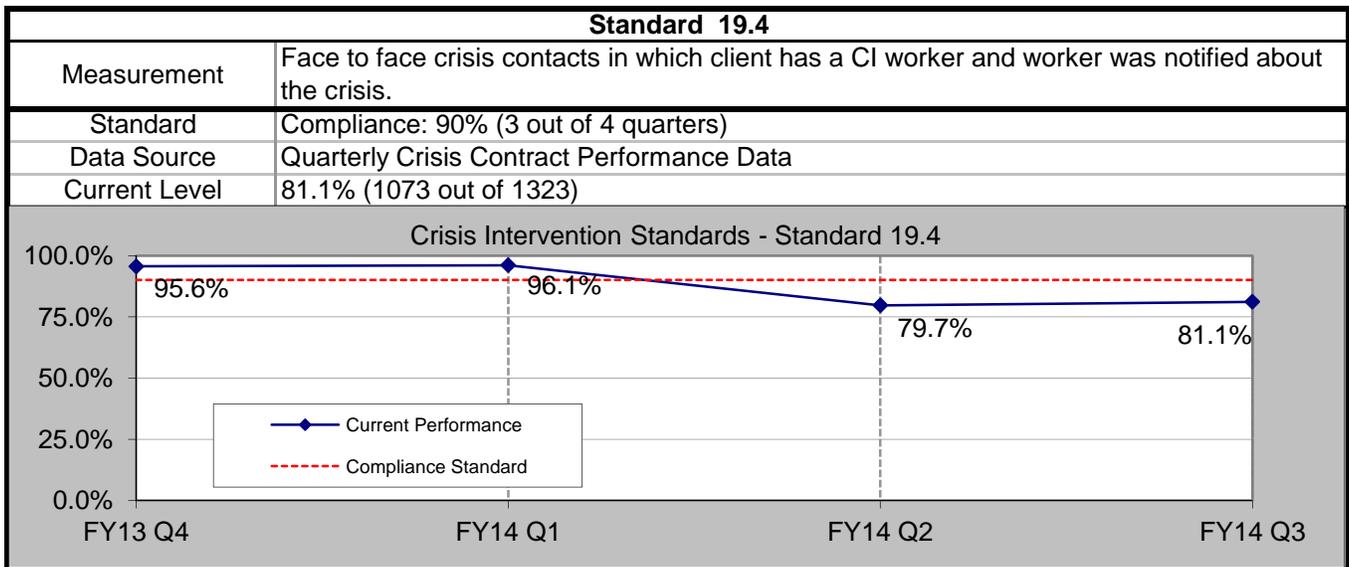
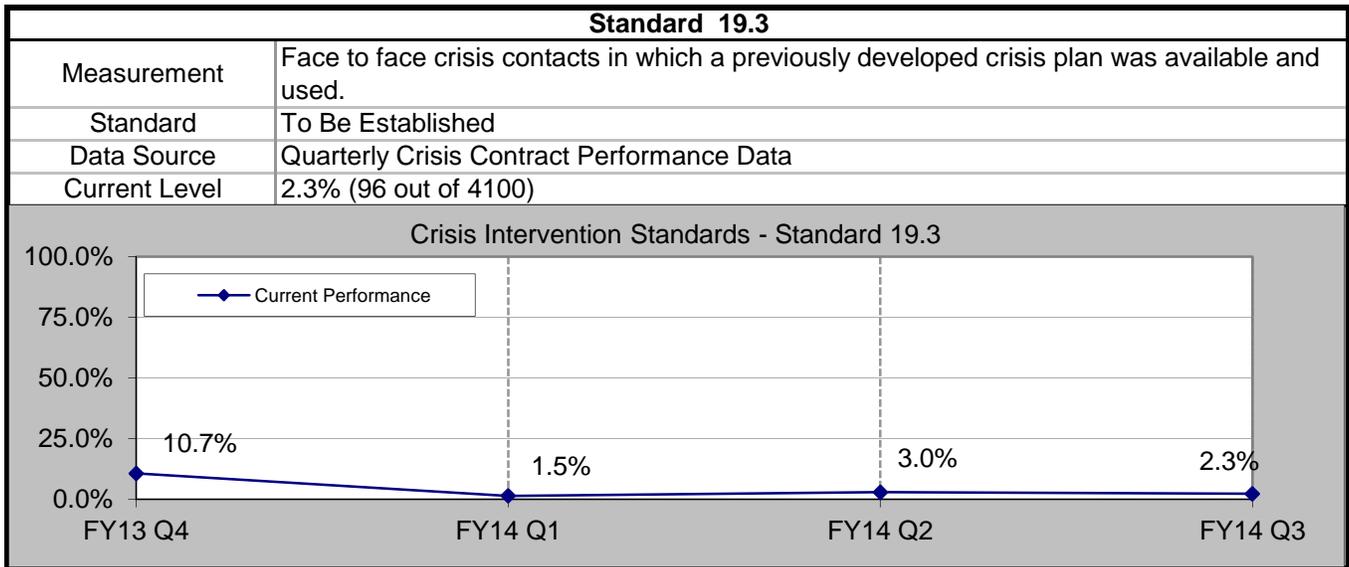


**Community Resources and Treatment Services
Crisis Intervention Services**

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



**Community Resources and Treatment Services
Crisis Intervention Services**

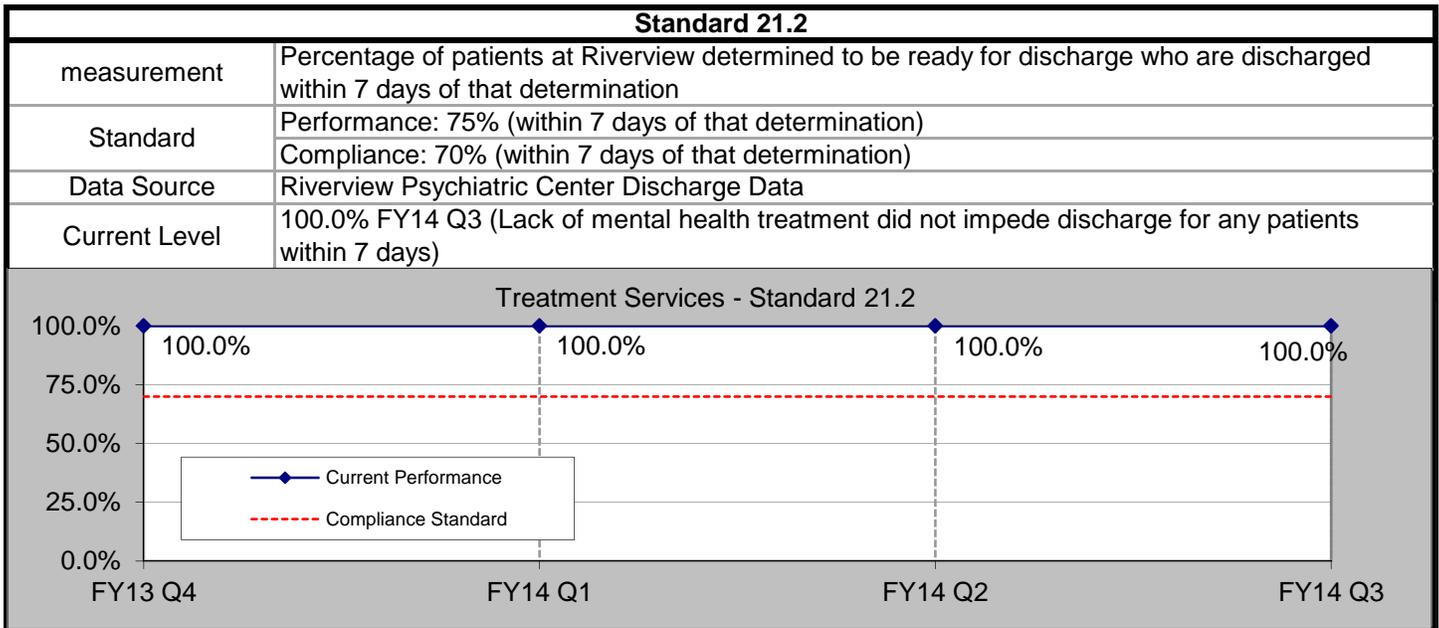
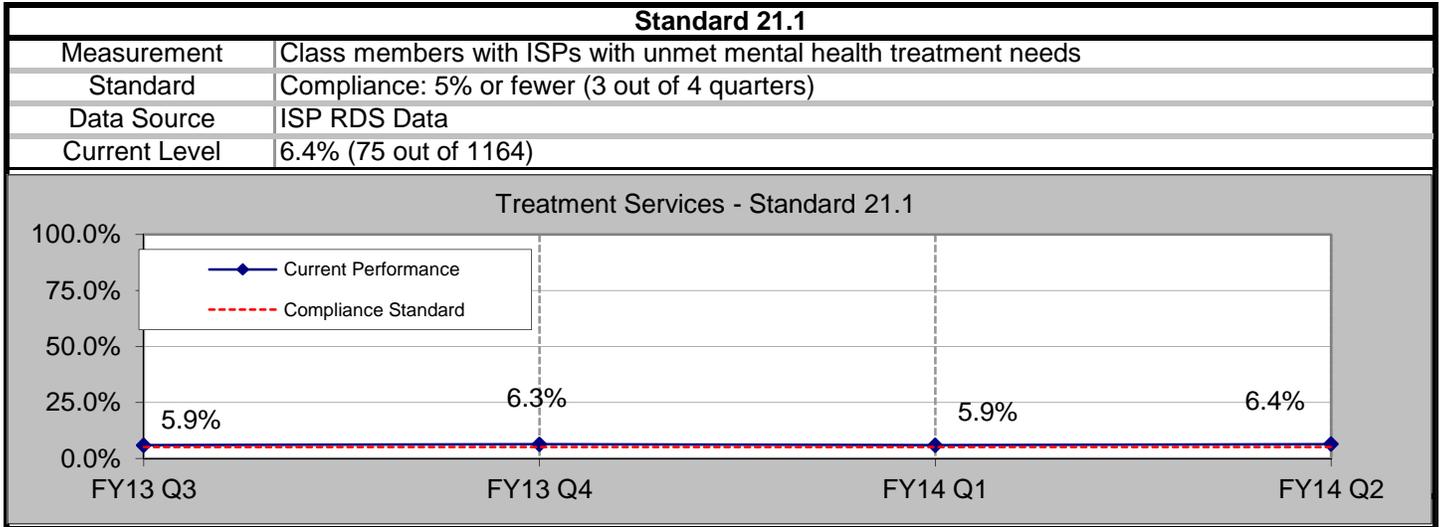


Discussion:

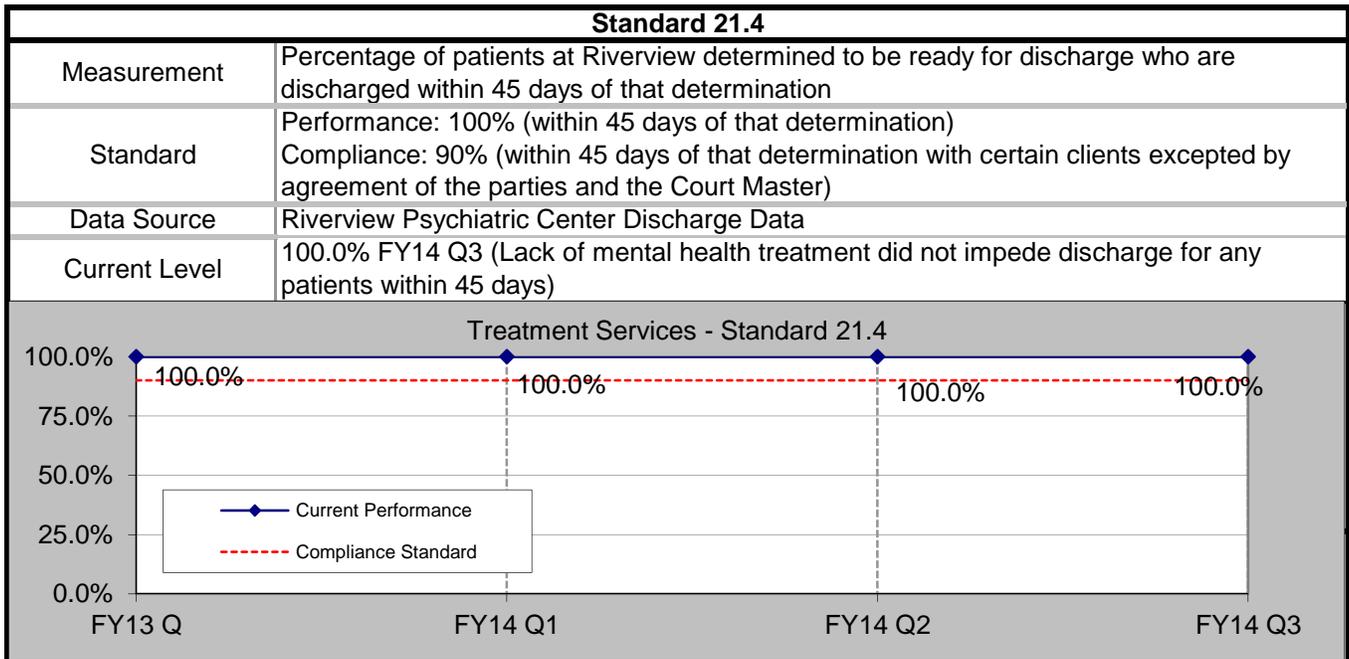
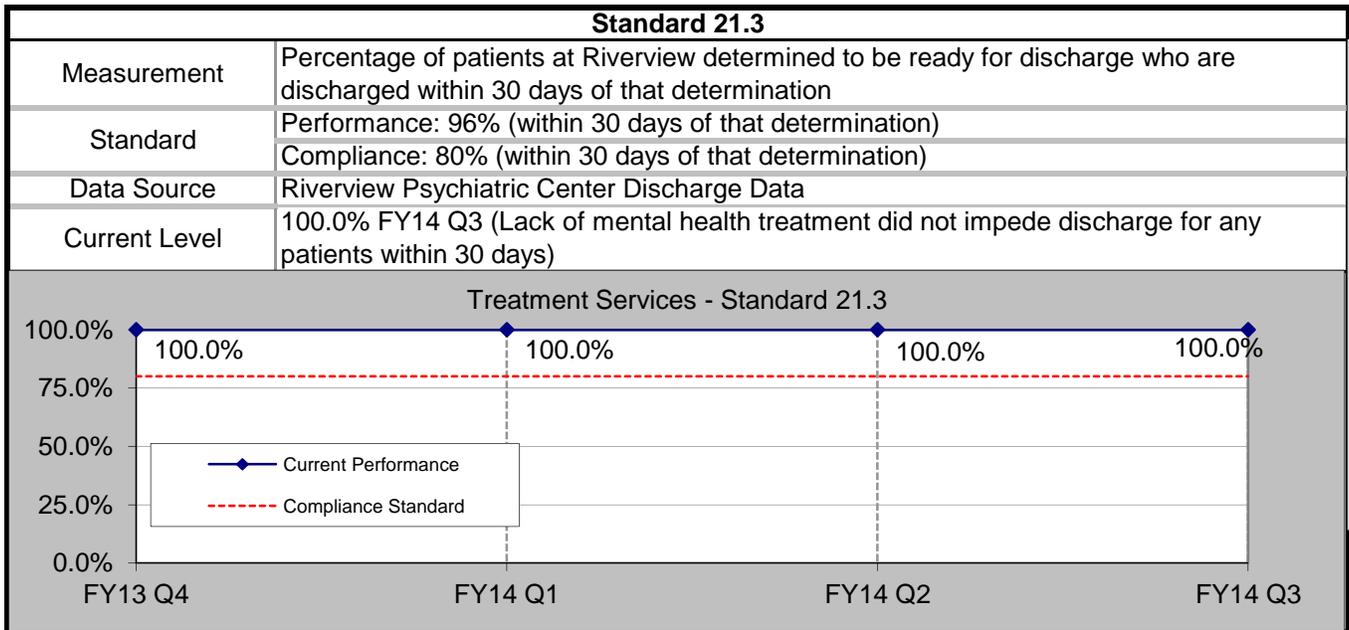
Standard 19.4: The department recently modified the reporting tool and process for capturing this data and is currently working with providers to collect more accurate data. Continue to monitor.

**Community Resources and Treatment Services
Treatment Services**

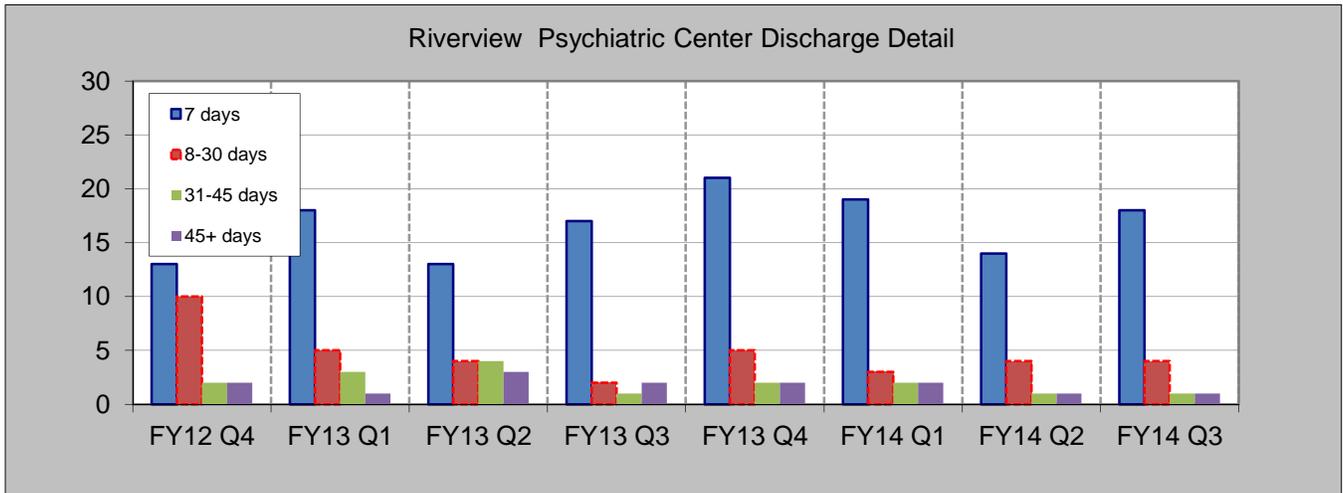
Standard 21 - An array of mental health treatment services are available and sufficient to meet ISP needs of class members and the needs of hospitalized class members ready for discharge.



**Community Resources and Treatment Services
Treatment Services**



**Community Resources and Treatment Services
Treatment Services**



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

24 Civil Patients discharged in quarter

- 18 discharged at 7 days (75.0%)
- 4 discharged 8-30 days (16.7%)
- 1 discharged 31-45 days (4.2%)
- 1 discharged post 45 days (4.2%)

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

**Community Resources and Treatment Services
Treatment Services**

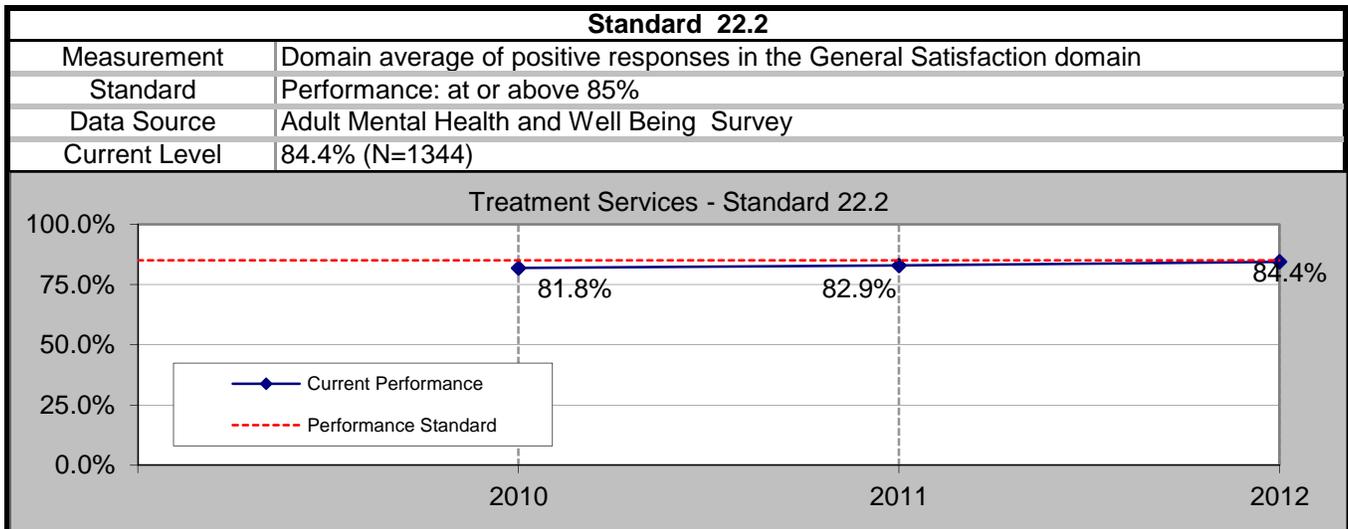
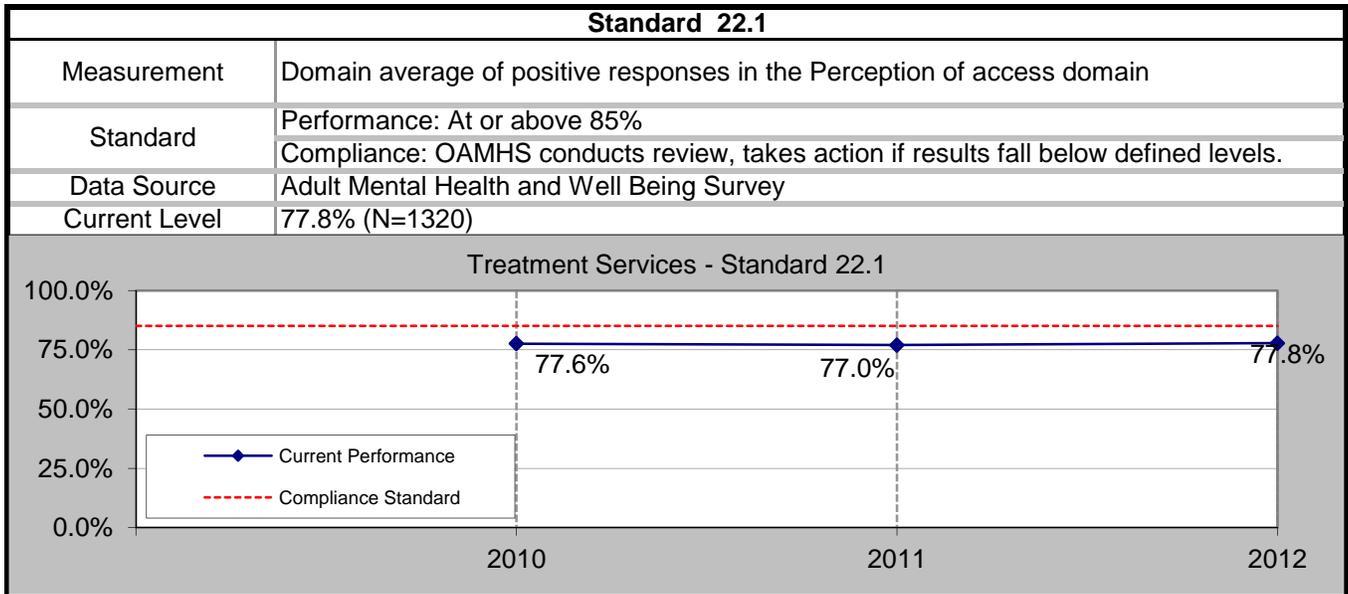
Standard 21.5	
Measurement	MaineCare data demonstrates by mental health service category that class members use an array of mental health treatment services.
Standard	No Numerical Standard Necessary
Data Source	Paid Claims data

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%
Community 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.



**Community Resources and Treatment Services
Family Support Services**

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

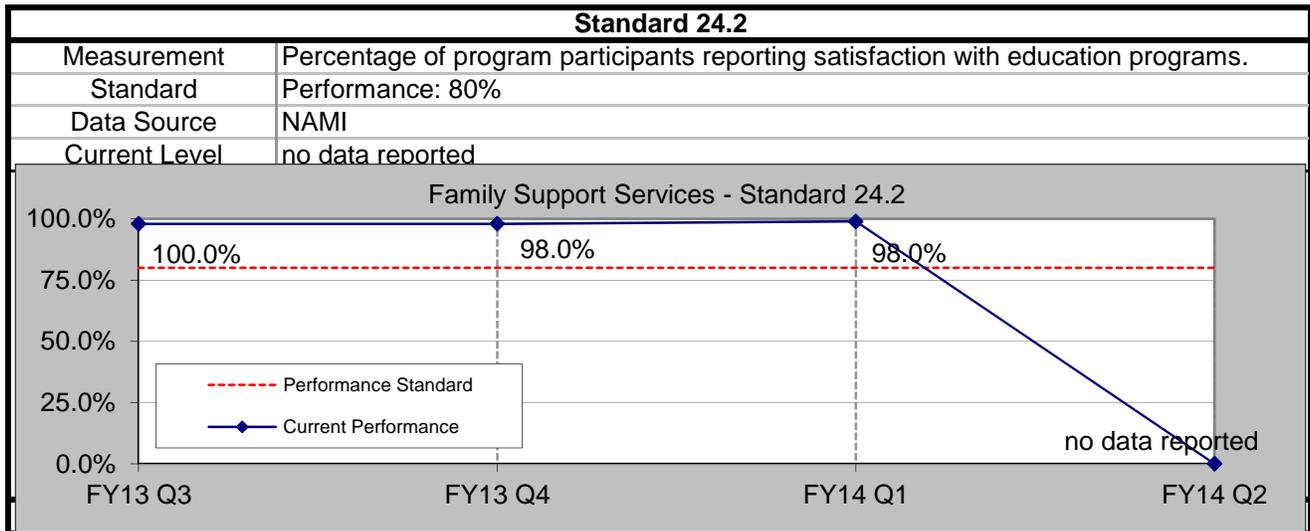
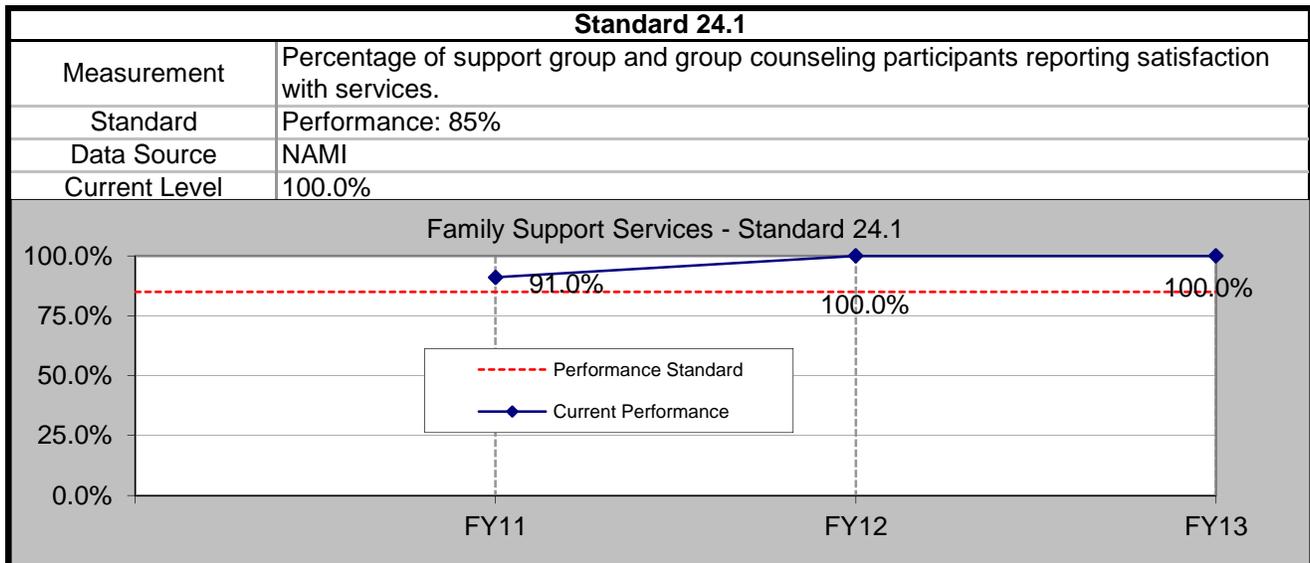
Standard 23.1	
Measurement	Number of education programs developed and delivered meeting Settlement Agreement requirements
Standard	No standard necessary
Data Source	NAMI
Current Level	3 family to family classes: Q2 FY 14

Standard 23.2	
Measurement	Number and distribution of family support services provided
Standard	No standard necessary
Data Source	NAMI
Current Level	26 family support groups, 16 sites: Q2 FY 14

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

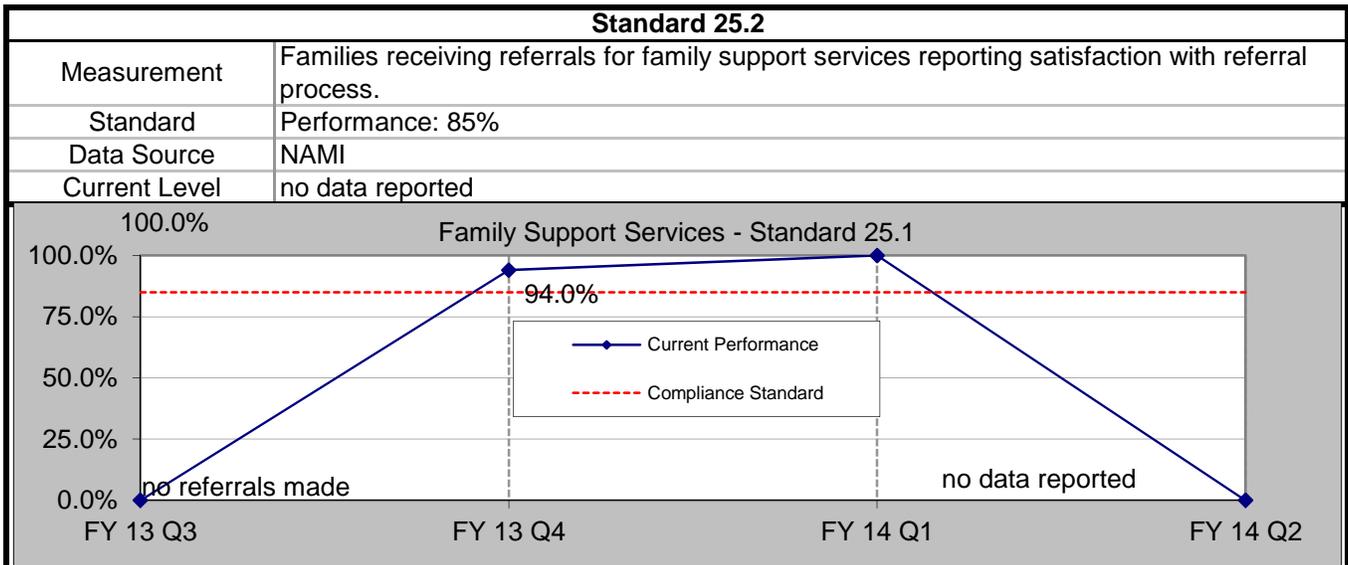
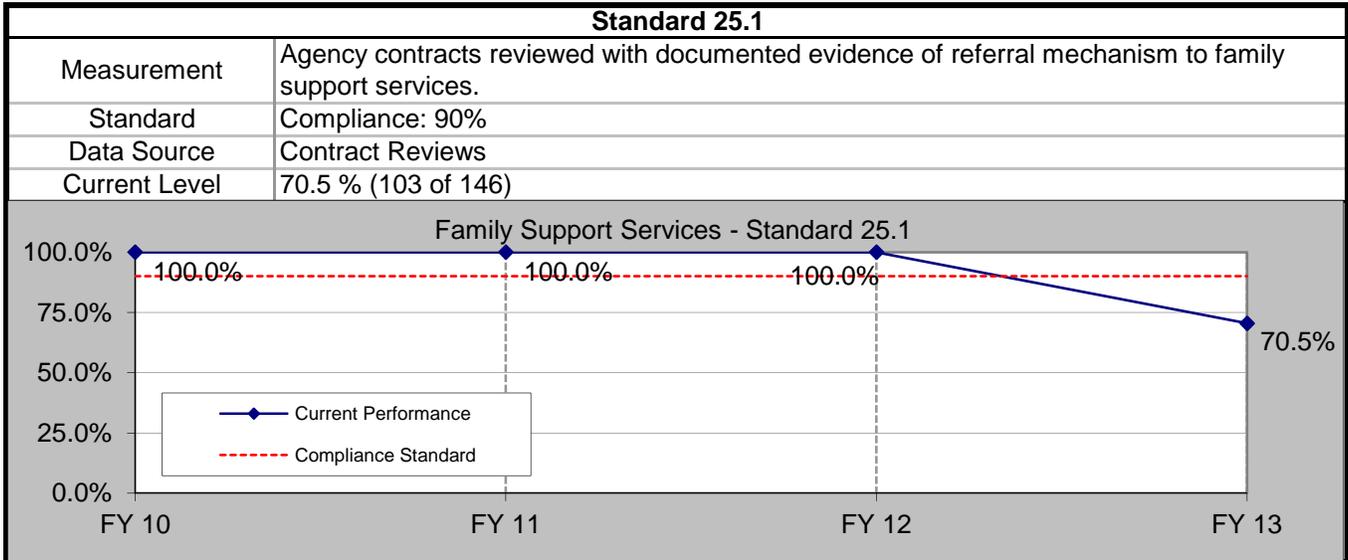
**Community Resources and Treatment Services
Family Support Services**

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



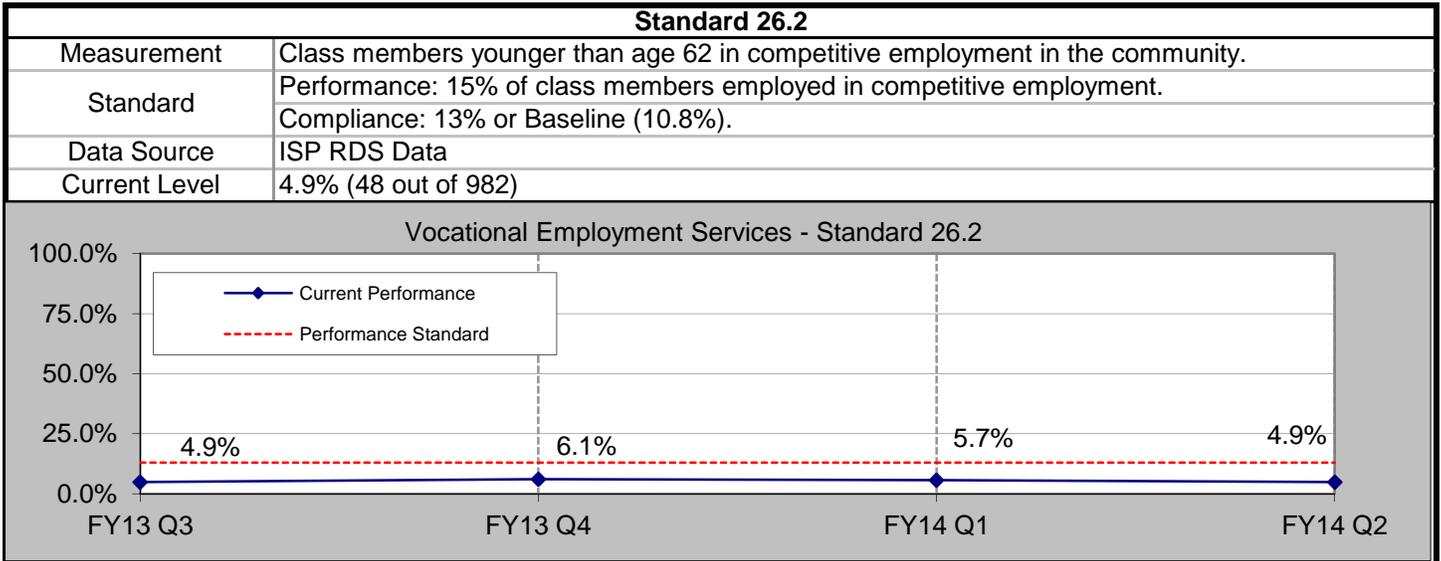
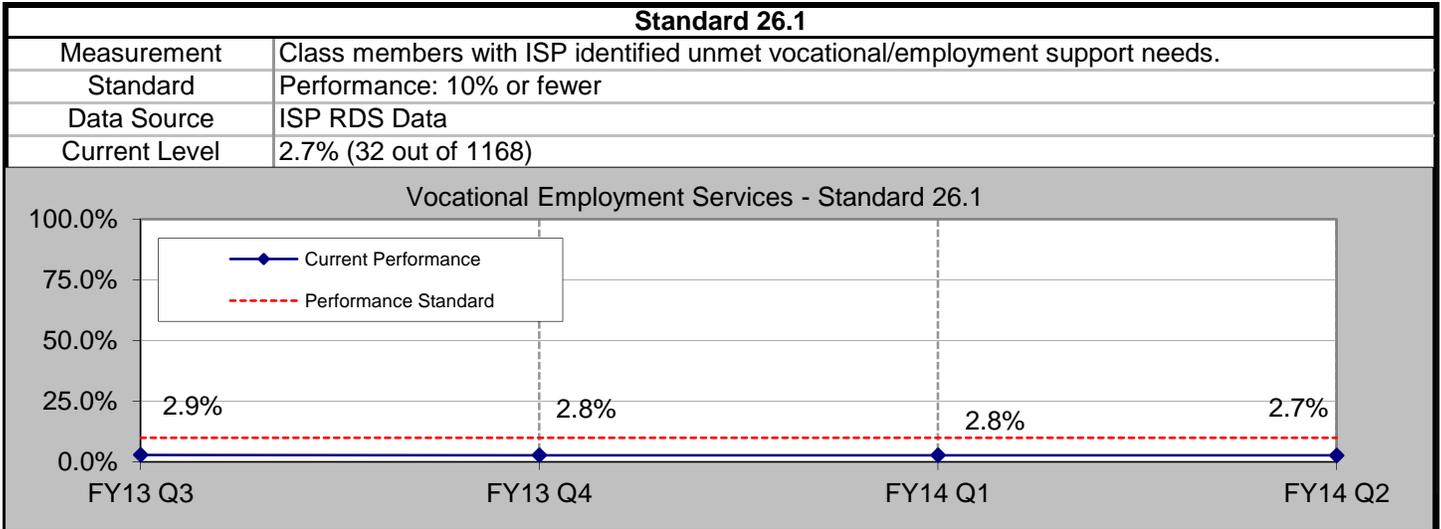
**Community Resources and Treatment Services
Family Support Services**

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

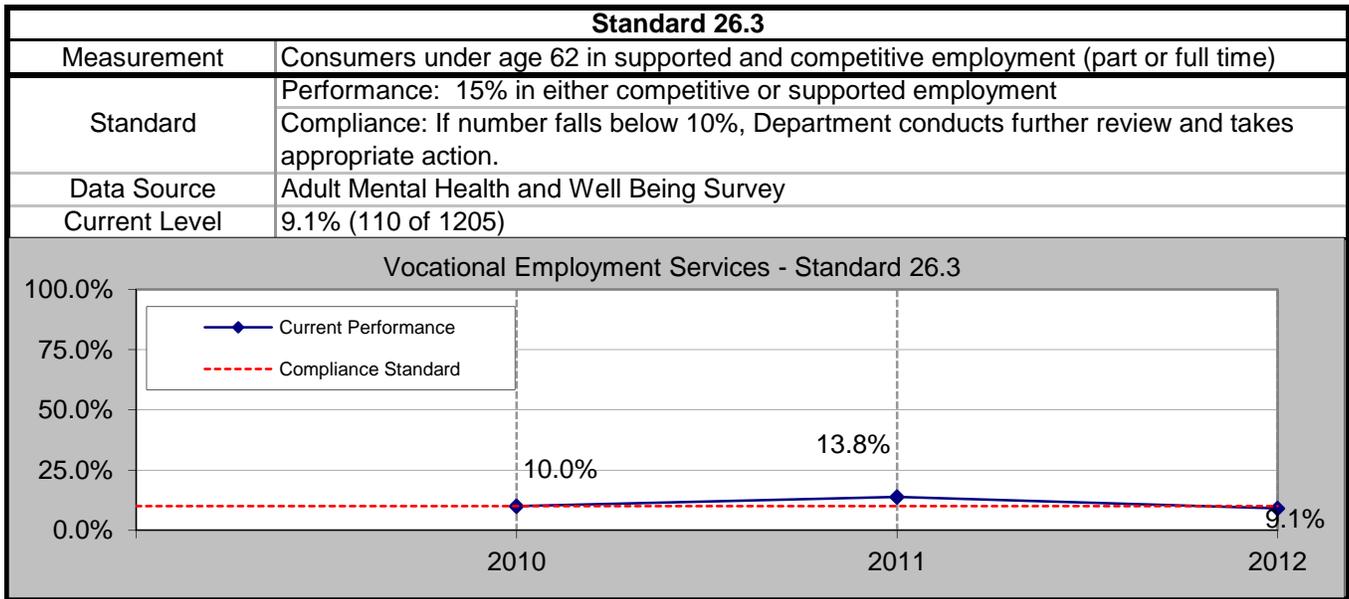


**Community Resources and Treatment Services
Vocational Employment Services**

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



**Community Resources and Treatment Services
Vocational Employment Services**



Discussion:

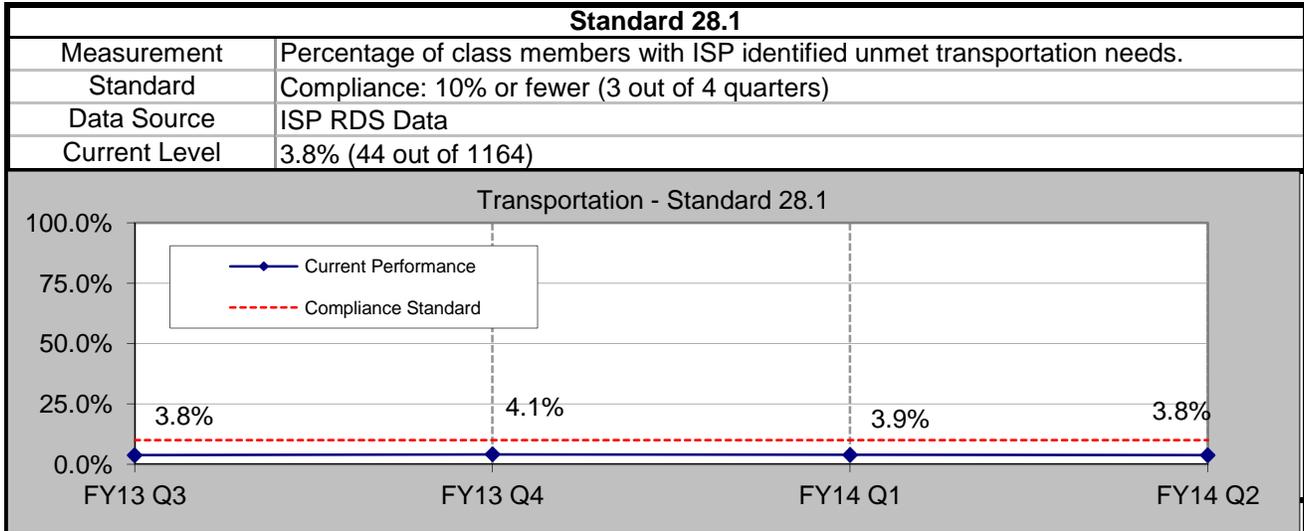
This standard factored out those persons responding to the Adult Mental Health and Well Being Survey employment questions who are 62 and older, indicated they were retired or indicated they were not looking for work

The response rate for the Adult Mental Health survey was very low in 2012 and the department is currently working on a plan to have a higher response rate.

Standard 26.3: Vocational performance standard has been discussed during fidelity reviews. The job of the vocational specialist to involve client has also been discussed.

**Community Resources and Treatment Services
Transportation**

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



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	35034 total visits, 2498 unduplicated clients (13 of 13 social clubs/peer centers reporting for FY 14 Q2.)

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	9 Peer Support programs statewide during FY 2014 Q2. (includes social clubs/peer centers): Participation data is not collected for the Statewide Initiatives noted below.

Peer Support Groups funded by DHHS FY2014 Q1:

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

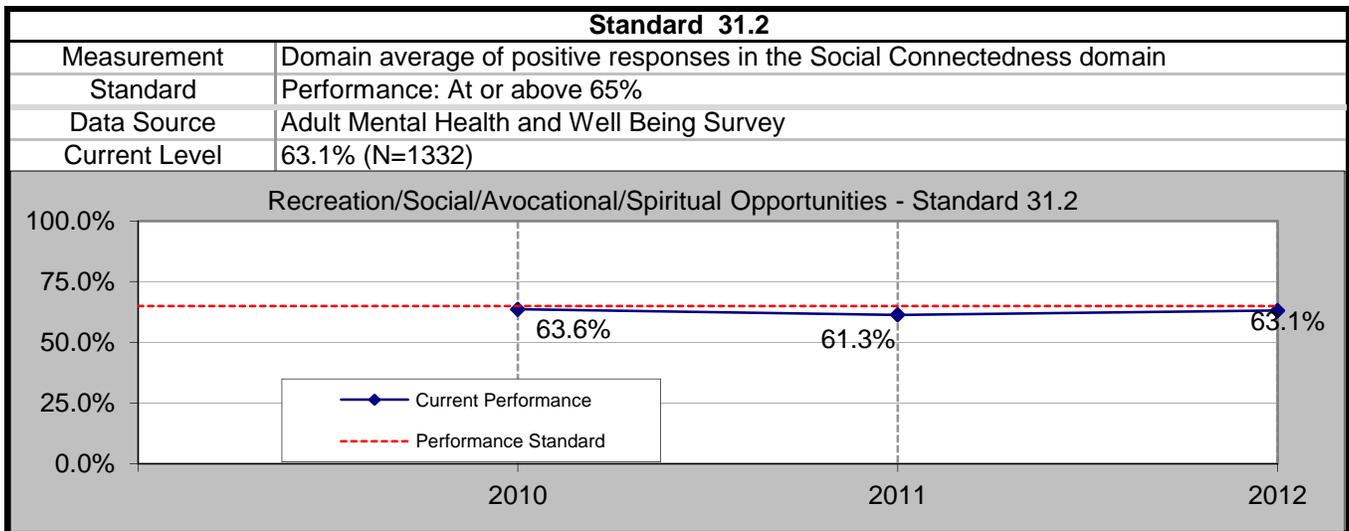
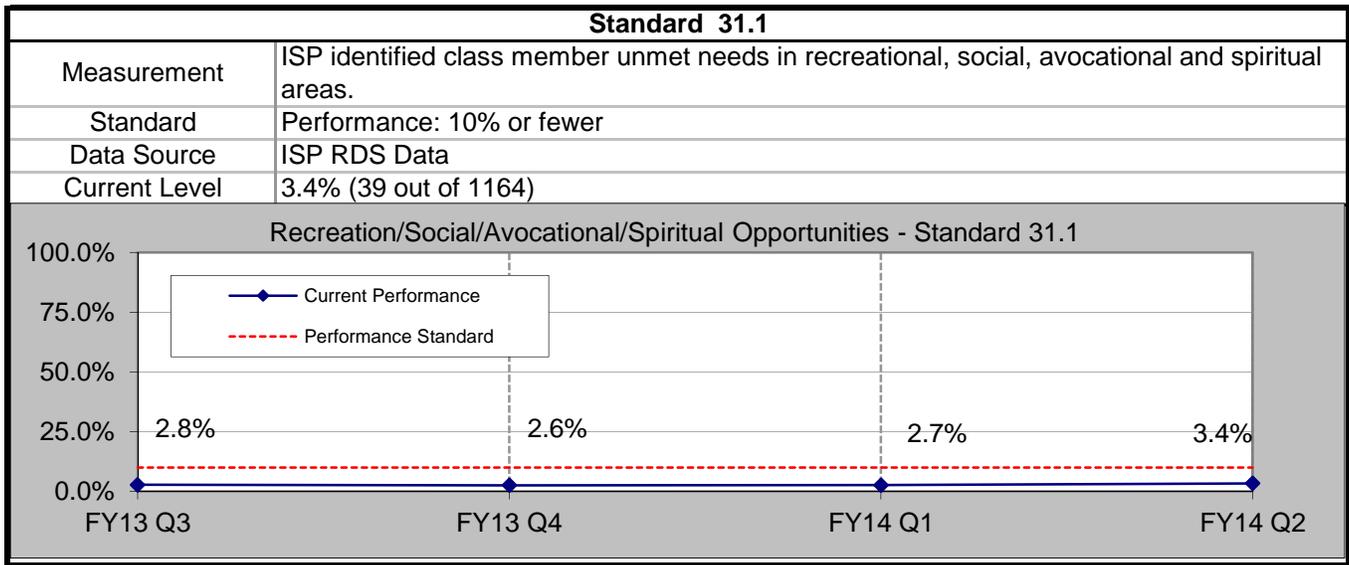
Statewide:

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

NAMI Support Groups primarily attended by consumers:

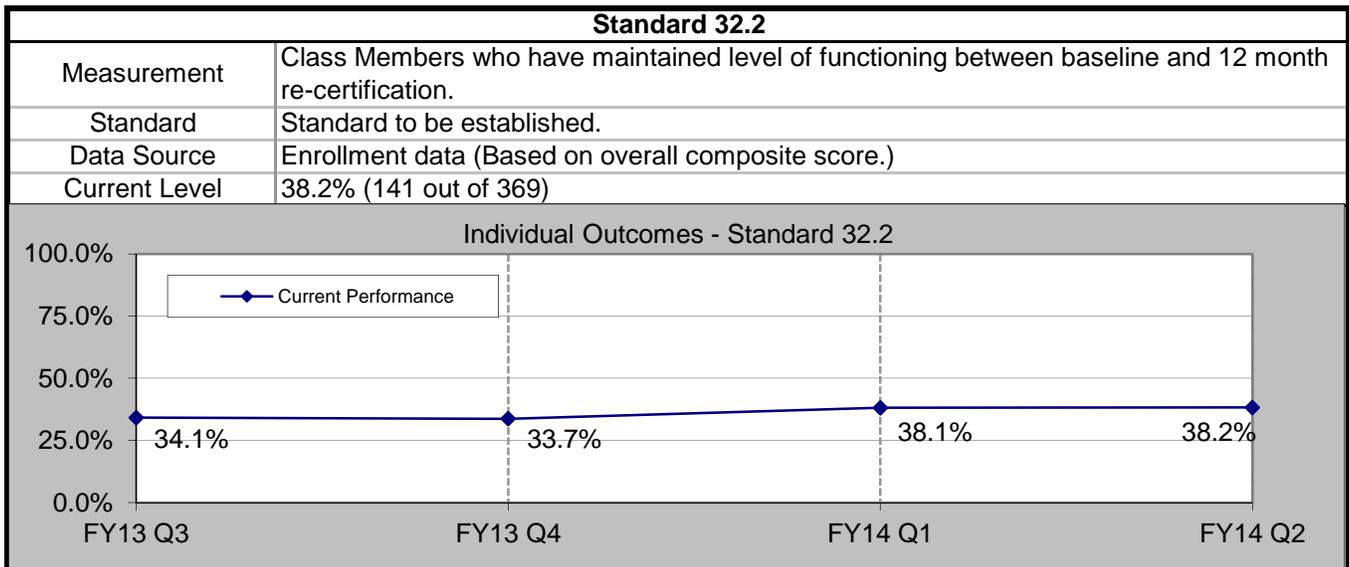
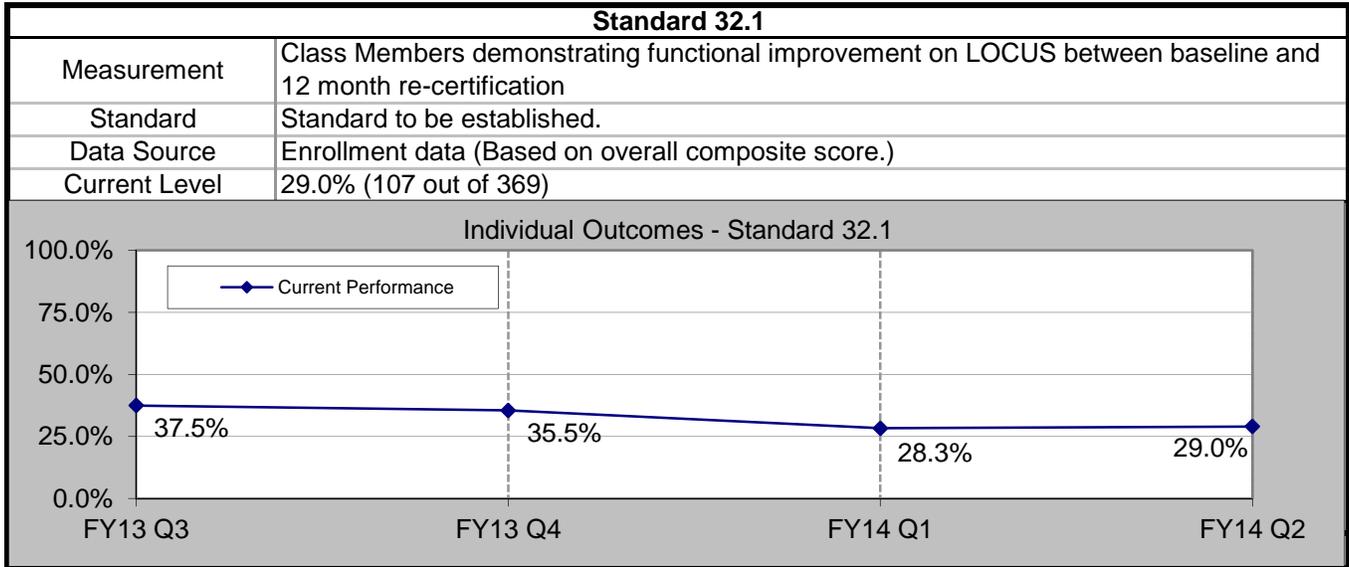
Augusta, Bangor, Biddeford, Damariscotta, Dover-Foxcroft, Ellsworth, Farmington, Harrington, Houlton, Lewiston, Machias, Norway, Rockland, Sanford, South Paris, and Waterville.

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

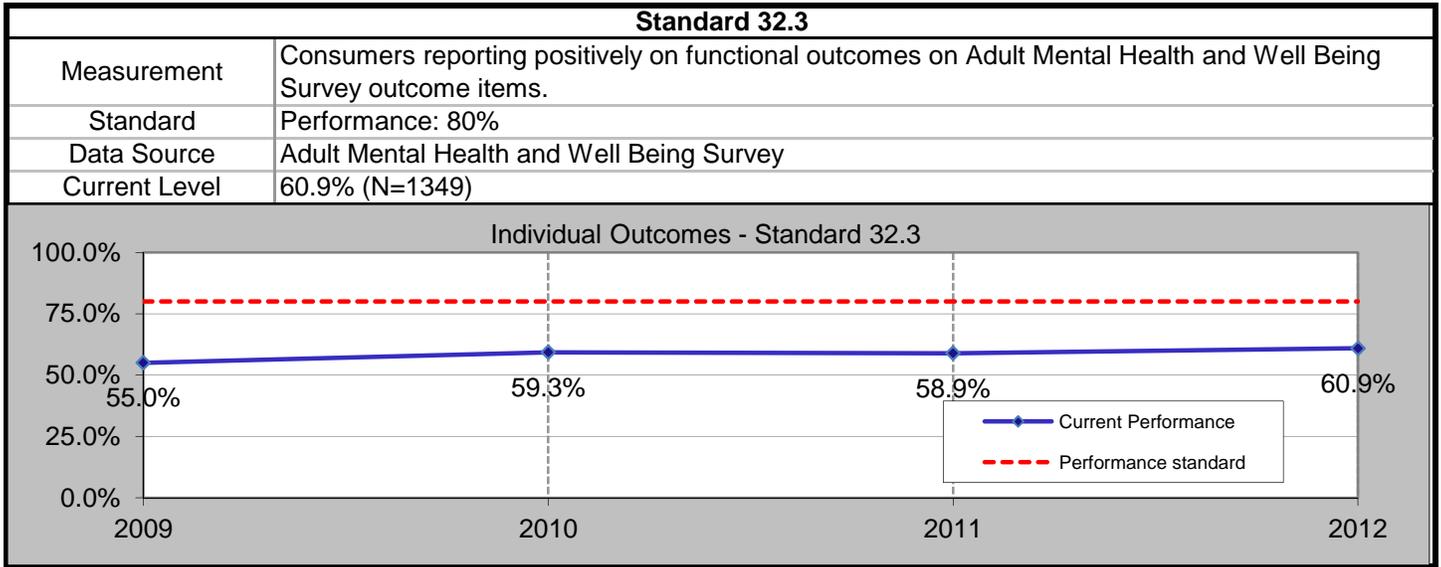


System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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

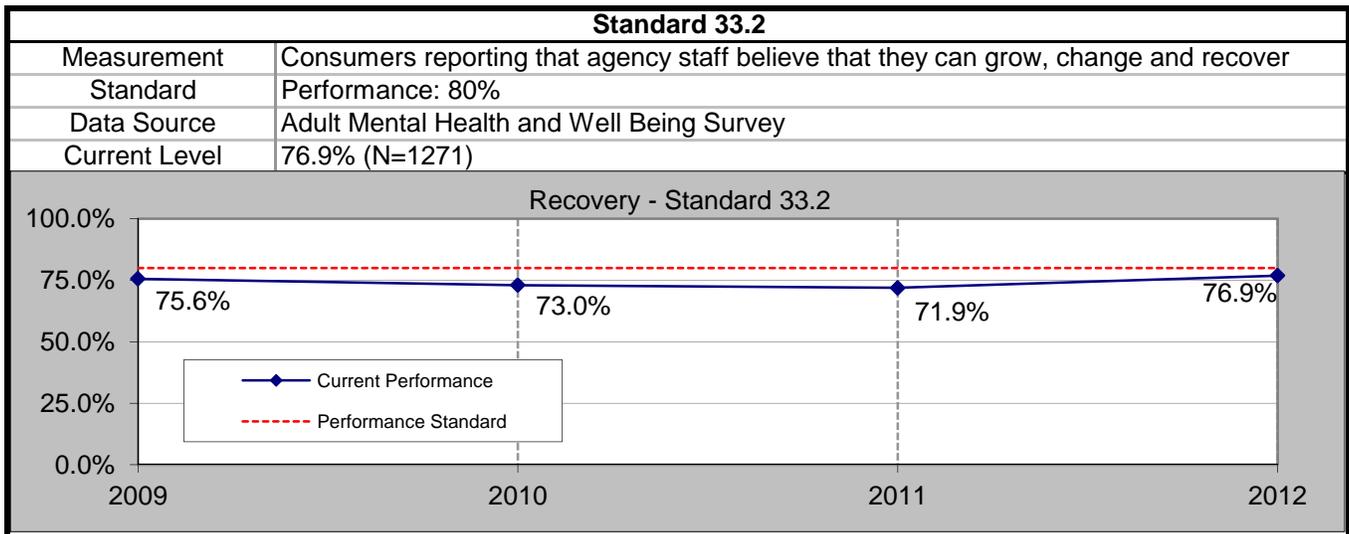
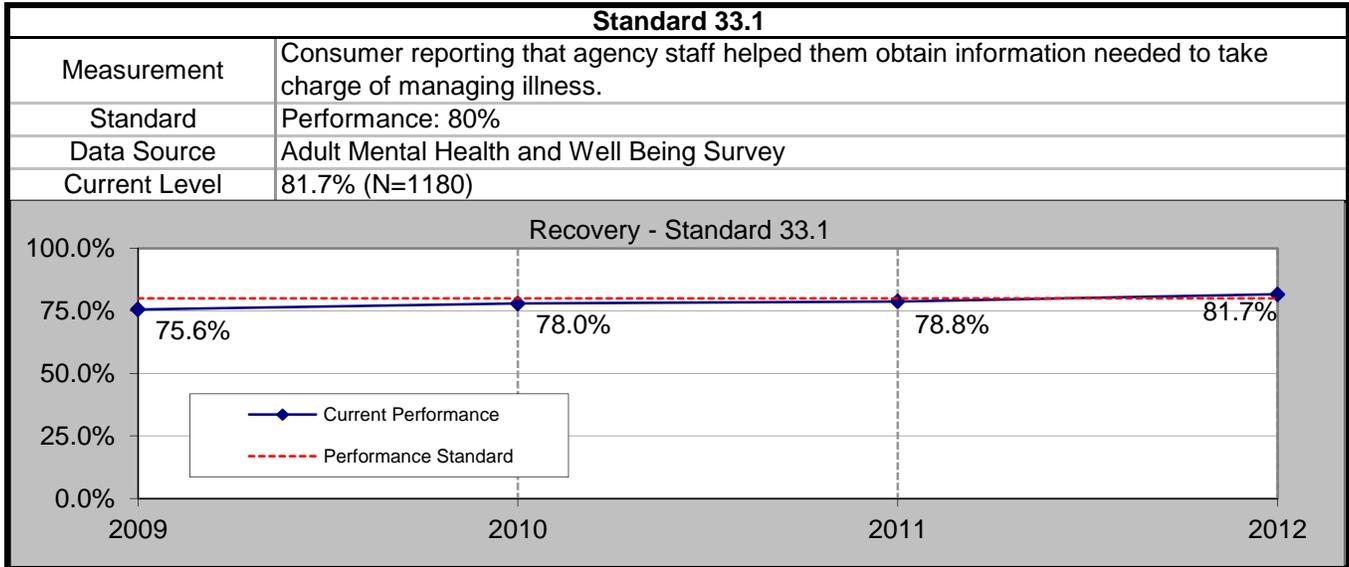


**System Outcomes: Supporting the Recovery of Adults with Mental Illness
Recovery**

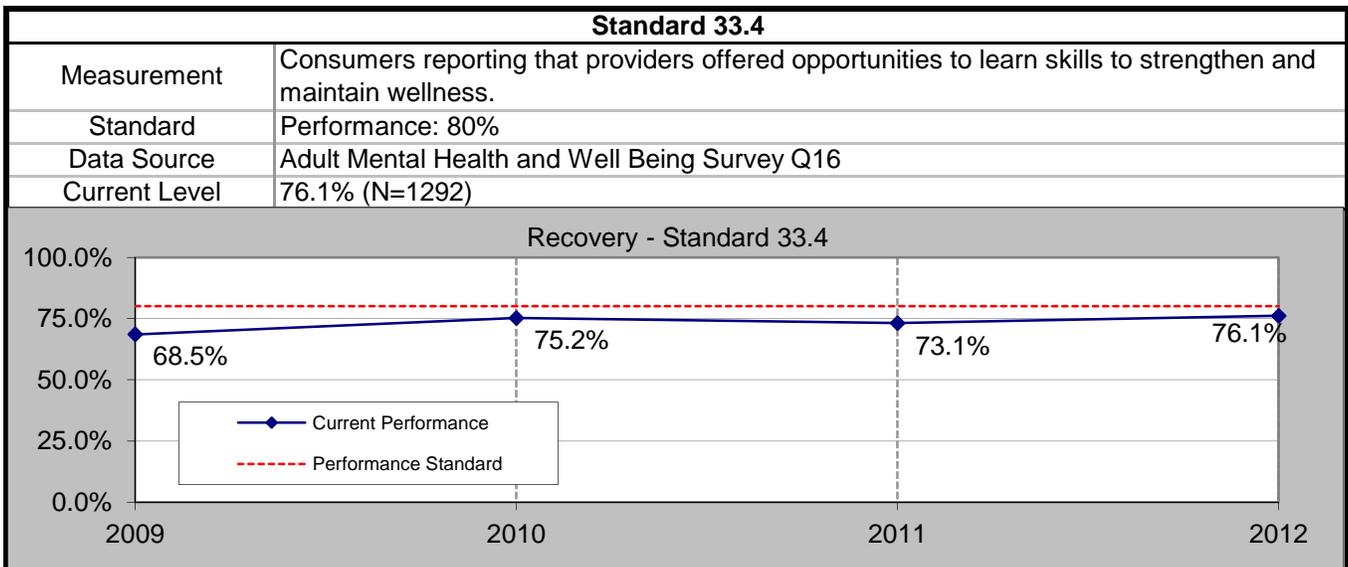
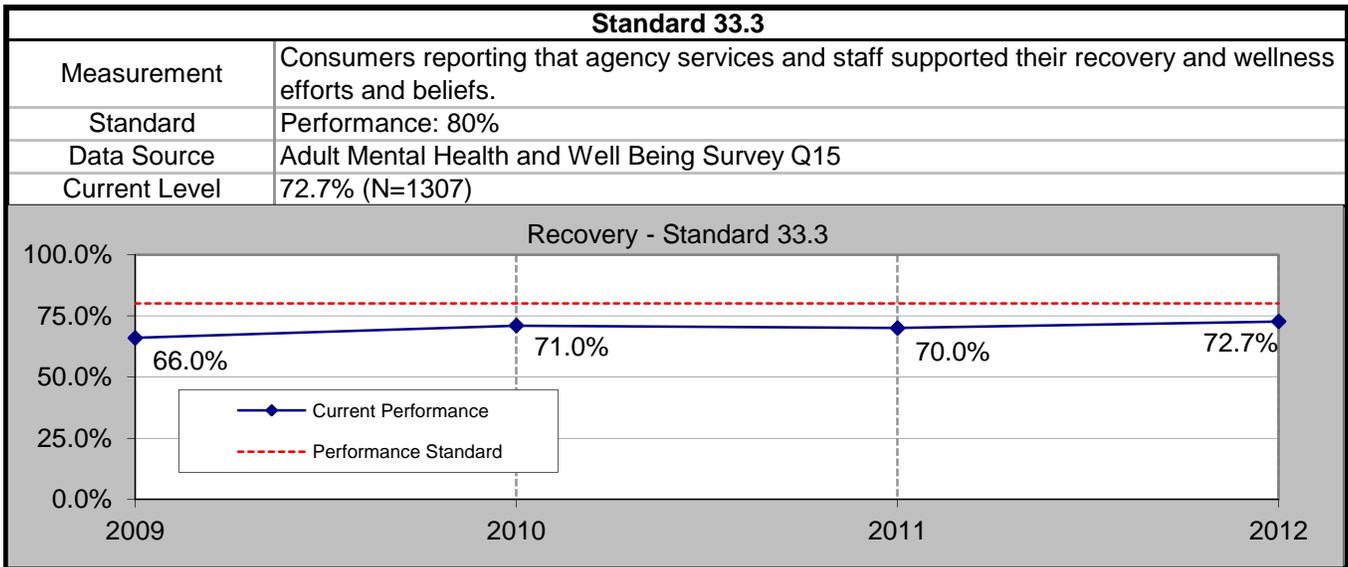


System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

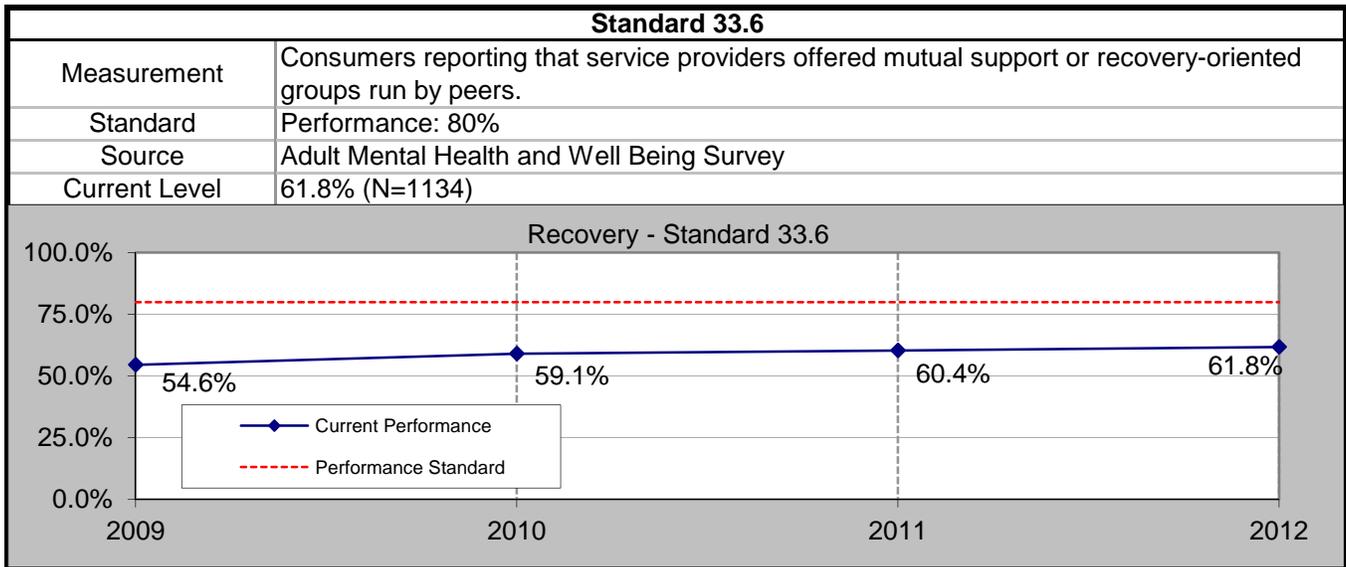
Standard 33 - Demonstrate that consumers are supported in their recovery process



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



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



**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	50 FY14 Q2

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	158 FY14 Q2

**Public Education- Standard 34
January - March 2014**

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

Measure Method One:

<i>Name, Date & Location of Public Education Program</i>	<i>Audience: Public Service Agency</i>	<i>Audience: RPC and/or DDPC staff</i>	<i>Audience: Community Members</i>	<i>Audience: Other (Please Specify)</i>	<i>Total # of Participants</i>	<i>Topic: Addressing Myths & Stigma</i>	<i>Topic: Promoting Community Integration</i>	<i>Topic: Rights of MH Consumers and/or their Families</i>	<i>Topic: Other (Please Specify)</i>	<i>Total # Presentations/ # Participants This Quarter</i>
Cumberland County CIT, October 21-25, Cape Elizabeth Fire Station, Cape Elizabeth	X				21	X	X	X		4 CIT presentations/ 81 participants
Cumberland County CIT, November 18-22, Cape Elizabeth Fire Station, Cape Elizabeth	X				26	X	X	X		
Kennebec County CIT, Dec 2-6, Kennebec County Sheriff's Office, Augusta	X				17	X	X	X		

York County CIT, December 9-13, Sanford PD, Sanford	X				17	X	X	X		
Suicide Prevention Gatekeeper Training (Farmington 10/3/13)	X		X	School staff	22	X	X			5 Gatekeeper Trainings to 124 participants
Suicide Prevention Gatekeeper Training (Caribou 10/7/13)	X		X	School staff	21	X	X			
Suicide Prevention Gatekeeper Training (Machias 10/21/13)	X		X	School staff	24	X	X			
Suicide Prevention Gatekeeper Training (Bangor 11/7/13)	X		X	School staff	36	X	X			
Suicide Prevention Gatekeeper Training (Lewiston 12/9/13)	X		X	School staff	21	X	X			
Suicide Assessment Training for Clinicians (Caribou 10/8/13)	X			Private practice and primary care staff	5	X	X	X		2 Clinical Assessment Trainings to 15 participants
Suicide Assessment Training for Clinicians (Bangor 11/19/13)	X			Private practice and primary care staff	10	X	X	X		
Suicide Prevention Training of the Trainer (Caribou 10/8/13)	X		X	School staff	7				Training school/agency staff and community members to present Suicide Awareness Sessions	4 Training of the Trainer Trainings to 40 participants

Suicide Prevention Training of the Trainer (Machias 10/22/13)	X		X	School staff	12				Training school/agency staff and community members to present Suicide Awareness Sessions	
Suicide Prevention Training of the Trainer (Millinocket 12/2/13)	X		X	School staff	10				Training school/agency staff and community members to present Suicide Awareness Sessions	
Suicide Prevention Training of the Trainer (Bangor 12/17/13)	X		X	School staff	11				Training school/agency staff and community members to present Suicide Awareness Sessions	
Middle School Lessons (Hallowell 12/17/14)				School staff	11	X				1 Middle School Lessons Training to 11 participants
Working with Court Litigants with Mental Illness (Bangor Federal Court 12/13/13)	X			Federal Court clerks & staff	30	X			Working with the needs of consumers in court.	1 training to 30 participants
Veterans Resource Fair, Lewiston, 11/16/13			X	Veterans and their families	60	X	X	X		1 training to 60 participants
So. Maine Community College, Nurses Club, South Portland, 10-29-13				Nursing students and their teaching staff	30	X	X	X	Overview of Mental Health System	1 training to 30 participants

Family-to-Family 12-week Education Course, Augusta 9/16/13 to 12/3/13			X	Family members	14	X	X	X	Communications, problem solving, empathy workshops; current research; advocacy; medications and other treatments; recovery; how to cope with worry and stress; dealing with crisis.	One 12-week course with 14 graduates
Family-to-Family 12-week Education Course,Westbrook 9/30/13 to 12/9/13			X	Family members	18	X	X	X	Communications, problem solving, empathy workshops; current research; advocacy; medications and other treatments; recovery; how to cope with worry and stress; dealing with crisis.	One 12-week course with 18 graduates
Family-to-Family 12-week Education Course,Waterville 10/24/13 to 1/16/14			X	Family members	9	X	X	X	Communications, problem solving, empathy workshops; current research; advocacy; medications and other treatments; recovery; how to cope with worry and stress; dealing with crisis.	One 12-week course with 9 graduates
NAMI 101 with recovery 10/24/13 at LINC Wellness Center in Augusta	X		X	Peers	7	X	X	X		1 presentation with 7 participants

MH for high school students, 10/21/13, Hallowell (Halldale HS)				High school students	30	X	X	X	Mental Health 101	2 presentations to 30 participants total
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Performance Indicators and Quality Improvement Standards

APPENDIX: ADULT MENTAL HEALTH DATA SOURCES

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

Data Type/Method: Mail Survey

Target Population: All people who receive a publicly-funded mental health service where eligibility includes having a serious mental illness (SMI).

Approximate Sample Size (responses): 1300-1500

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

Community Hospital Utilization Review Summary:

Data Type/Method: Service Review/Document Review

Target Population: Individuals admitted to community inpatient psychiatric hospitals on an emergency involuntary basis.

Approximate Sample Size: 150 per quarter.

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

Community Support Enrollment Data:

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

Target Population: Adult Mental Health Consumers receiving Community Support.

Approximate Sample Size: 1500 class members of the total consumers enrolled in Community Support.

Community Support Services Census/Staffing Data:

Data Type/Method: Provider Completed Survey; Completed by supervisors of Assertive Community Treatment (ACT) and Community Integration (CI).

Target Population: Consumers receiving CI/ACT from DHHS/SAMHS contracted agencies.

Approximate Sample Size: Collected from all providers of these services on a quarterly basis.

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

Grievance Tracking Data:

Data Type/Method: Information pertaining to Level II and Level III Grievances.

Target Population: Consumers receiving any community based mental health service licensed, contracted or funded by DHHS and consumers who are patients at Riverview Psychiatric Center or Dorothea Dix Psychiatric Center.

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

Class Member Treatment Planning Review:

Data Type/Method: Service Review/Document Review

Target Population: Class Members receiving Community Support Services (ACT, CI)

Approximate Sample Size: As of the 3rd quarter FY11, sample size has been decreased to 50 per quarter, utilizing the random sampling methodology as previously developed. This allows the new SAMHS Division of Quality Management the time to assess and develop a new system of document reviews, not solely focused on treatment planning, that can be implemented across program areas and provide data for a wider group of individuals utilizing mental health services.

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

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

Data Type/Method: ISP RDS submitted by Community Support providers and collected by APS

Healthcare as a component of their authorization process. Data is then fed into EIS twice a month.

Target Population: Adult Mental Health Consumers who receive Community Support Services (ACT, CI, and CRS).

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

Quarterly Contract Performance Indicator Data:

Data Type/Method: Performance Indicators

Target Population: All consumers receiving DHHS/SAMHS contracted services.

Approximate Sample Size: All consumers receiving DHHS/SAMHS contracted services.

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



Paul R. LaPage, Governor

Mary C. Mayhew, Commissioner

Consent Decree Performance and Quality Improvement Standard 5

Report for: 2014 Q2

(October, November, December 2013)

Measurement

(Class Members)

Method 1	Percent of class members requesting a worker who were assigned one.		
	2013 Q3	99.2%	(131 of 132)
	2013 Q4	99.1%	(111 of 112)
	2014 Q1	100.0%	(120 of 120)
	2014 Q2	100.0%	(102 of 102)
Method 2	Percent of hospitalized class members who were assigned a worker wi		
	2013 Q3	63.2%	(12 of 19)
	2013 Q4	60.0%	(6 of 10)
	2014 Q1	80.0%	(8 of 10)
	2014 Q2	77.8%	(7 of 9)
Method 3	Percent of non-hospitalized class members assigned a worker within 3 days.		
	2013 Q3	74.3%	(84 of 113)
	2013 Q4	72.5%	(74 of 102)
	2014 Q1	73.5%	(83 of 113)
	2014 Q2	77.4%	(72 of 93)
Method 4	Percent of class members in hospital or community not assigned on time but were assigned within 1-7 additional days.		
	2013 Q3	36.1%	(13 of 36)
	2013 Q4	46.9%	(15 of 32)
	2014 Q1	50.0%	(16 of 32)
	2014 Q2	30.4%	(7 of 23)
Method 5	ISP completed within 30 days of service request.		
	2013 Q3	89.1%	(49 of 55)
	2013 Q4	83.3%	(45 of 54)
	2014 Q1	80.9%	(55 of 68)
	2014 Q2	88.7%	(47 of 53)
Method 6	90 Day ISP review completed within specified timeframe.		
	2013 Q3	69.2%	(731 of 1,056)
	2013 Q4	69.8%	(780 of 1,118)
	2014 Q1	71.3%	(792 of 1,111)
	2014 Q2	69.3%	(724 of 1,044)

Method 7	Initial ISPs not developed within 30 days, but were developed within 60 days.		
	2013 Q3	33.3%	(2 of 6)
	2013 Q4	55.6%	(5 of 9)
	2014 Q1	46.2%	(6 of 13)
	2014 Q2	83.3%	(5 of 6)

Method 8	ISPs that were not reviewed within 90 days, but were reviewed within 120 days.		
	2013 Q3	79.7%	(259 of 325)
	2013 Q4	83.1%	(281 of 338)
	2014 Q1	90.6%	(289 of 319)
	2014 Q2	80.3%	(257 of 320)

As of: Apr 8, 2014 Run By: Brandi.Giguere

Standards 5.1 -5.4 – Calculations for this quarter and going forward are now based on a new formula. We are calculating days from 'Contact for Service Notification' to 'date of assignment'. The first 3 quarters have also been re-calculated using this formula.

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

Attached Report:

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 2

Population Covered:

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

Data Sources:

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

Unmet Resource Need Definition

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

Quality Improvement Measures

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

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

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

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. Outcomes include withholding two contract incentive payments due to providers not meeting standards.

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. We are currently building a web access portal and will begin testing late in the third quarter with implementation ready for roll-out in the new fiscal year 15.

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.

Identified Need: A,B,C,D,E,F,G,H,I,J,K,L,M

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

Identified Need: A, B, C, D

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

Identified Need: A,E,K,M

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

Identified Need: E, H, K

Contract Review Initiative. The Data/Quality Management staff are working with field service teams to ensure they have up-to-date, accurate service encounter data when they review progress toward meeting contract goals and establishing benchmarks for new contracts. A set of encounter data variables has been identified and 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 is building SQL query tools 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 collecting the data to generate a summary report.

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. One outcome of this initiative is that APS Health Care now sends an email reminder to the provider agency staff for all clients on a waitlist over 30 days. Another outcome is that APS Healthcare reporting methods were revised to more accurately reflect the consent decree requirements for 5.2 – 5.4.

Identified Need: A,B

SAMHS Quality Management Plan 2013-2018. A team in the Data and Quality Management division is undertaking the development of a new SAMHS comprehensive quality management plan for 2013-2018. The team members are engaging with division leaders in the four pillars of SAMHS services (prevention, intervention, treatment and recovery) to develop profiles of programs, specific initiatives, evidence based or promising practice services being offered and standardized performance measures. The 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. Now that the new Data Quality Manager has been hired the plan will be a top priority.

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

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Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Quarter 2

Oct, Nov, Dec 2013

Purpose of Report:

This report examines:

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

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

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

Data collection and reporting:

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

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

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

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

Report Run: Apr 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q2

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

CSN	Counties	Distinct People
CSN 1	Aroostook	426
CSN 2	Hancock, Penobscot, Piscataquis & Washington	1,809
CSN 3	Kennebec & Somerset	2,076
CSN 4	Knox, Lincoln, Sagadahoc & Waldo	848
CSN 5	Androscoggin, Franklin & Oxford	2,079
CSN 6	Cumberland	2,076
CSN 7	York	559
Not Assigned	No legal address	372
Statewide		10,245

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

	2013 Q3			2013 Q4			2014 Q1			2014 Q2		
	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	136	395	34.4%	132	387	34.1%	136	407	33.4%	141	426	33.1%
CSN 2	427	1,769	24.1%	425	1,865	22.8%	468	1,889	24.8%	472	1,809	26.1%
CSN 3	352	1,997	17.6%	380	2,100	18.1%	382	2,074	18.4%	357	2,076	17.2%
CSN 4	237	823	28.8%	216	831	26.0%	213	795	26.8%	203	848	23.9%
CSN 5	611	1,920	31.8%	626	2,045	30.6%	638	2,022	31.6%	618	2,079	29.7%
CSN 6	599	1,999	30.0%	645	2,112	30.5%	663	2,117	31.3%	666	2,076	32.1%
CSN 7	163	560	29.1%	193	572	33.7%	160	520	30.8%	200	559	35.8%
N/A	126	418	30.1%	114	386	29.5%	115	389	29.6%	96	372	25.8%
Total	2,651	9,881	26.8%	2,731	10,298	26.5%	2,775	10,213	27.2%	2,753	10,245	26.9%

Report Run: Apr 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q2

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

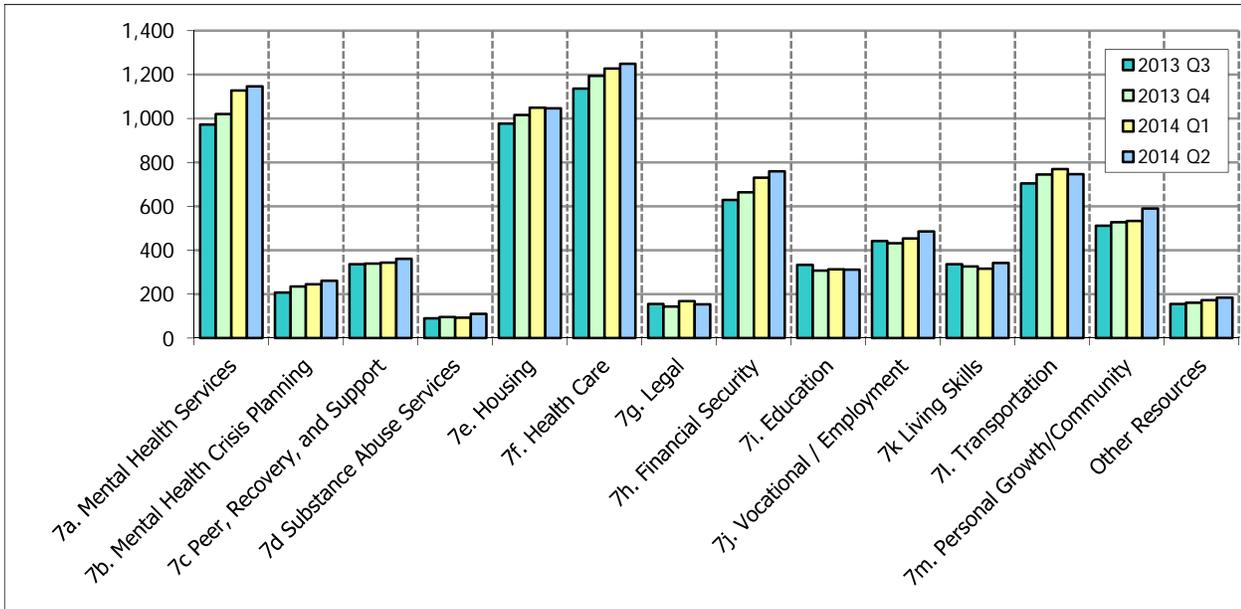


Table 3: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q3	2013 Q4	2014 Q1	2014 Q2
7a. Mental Health Services	972	1,020	1,127	1,147
7b. Mental Health Crisis Planning	207	235	245	262
7c. Peer, Recovery, and Support	337	339	344	361
7d. Substance Abuse Services	91	96	93	111
7e. Housing	977	1,016	1,050	1,046
7f. Health Care	1,136	1,195	1,227	1,250
7g. Legal	155	144	169	154
7h. Financial Security	629	664	730	759
7i. Education	334	308	314	312
7j. Vocational / Employment	442	432	454	486
7k. Living Skills	336	326	317	342
7l. Transportation	704	745	770	746
7m. Personal Growth/Community	512	528	533	590
Other Resources	155	162	173	184
Total Statewide Unmet Needs	6,987	7,210	7,546	7,750

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	9,881	10,298	10,213	10,245
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	51	62	64	77
7a-iii Dialectical Behavioral Therapy	31	40	40	44
7a-iv Family Psycho-Educational Treatment	11	16	18	11
7a-v Group Counseling	41	34	44	53
7a-vi Individual Counseling	397	415	491	518
7a-vii Inpatient Psychiatric Facility	5	6	6	6
7a-viii Intensive Case Management	26	24	32	37
7a-x Psychiatric Medication Management	461	485	496	478
Total Unmet Resource Needs	972	1,020	1,127	1,147
Distinct Clients with Unmet Resource Needs	791	863	907	937
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	149	179	188	209
7b-ii Mental Health Advance Directives	58	56	57	53
Total Unmet Resource Needs	207	235	245	262
Distinct Clients with Unmet Resource Needs	186	220	224	240
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	42	40	41	40
7c-ii Recovery Workbook Group	4	4	7	5
7c-iii Social Club	112	110	114	119
7c-iv Peer-Run Trauma Recovery Group	36	34	32	42
7c-v Wellness Recovery and Action Planning	25	24	32	35
7c-vi Family Support	118	127	118	120
Total Unmet Resource Needs	337	339	344	361
Distinct Clients with Unmet Resource Needs	271	279	279	290
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	71	78	76	95
7d-ii Residential Treatment Substance Abuse Services	20	18	17	16
Total Unmet Resource Needs	91	96	93	111
Distinct Clients with Unmet Resource Needs	86	94	90	108

Report Run: Apr 14, 2014



*Substance Abuse
and Mental Health Services*
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Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

Statewide
(All CSNs)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	9,881	10,298	10,213	10,245
7e. Housing				
7e-i Supported Apartment	118	116	114	127
7e-ii Community Residential Facility	35	35	41	33
7e-iii Residential Treatment Facility (group home)	13	13	13	17
7e-iv Assisted Living Facility	43	42	49	56
7e-v Nursing Home	4	4	6	4
7e-vi Residential Crisis Unit	2	2	1	2
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	762	804	826	807
Total Unmet Resource Needs	977	1,016	1,050	1,046
Distinct Clients with Unmet Resource Needs	896	937	959	955
7f. Health Care				
7f-i Dental Services	598	616	633	635
7f-ii Eye Care Services	227	232	234	250
7f-iii Hearing Services	57	62	53	50
7f-iv Physical Therapy	38	38	42	41
7f-v Physician/Medical Services	216	247	265	274
Total Unmet Resource Needs	1,136	1,195	1,227	1,250
Distinct Clients with Unmet Resource Needs	874	922	927	933
7g. Legal				
7g-i Advocate	95	93	113	109
7g-ii Guardian (private)	43	40	41	34
7g-iii Guardian (public)	17	11	15	11
Total Unmet Resource Needs	155	144	169	154
Distinct Clients with Unmet Resource Needs	147	136	159	145
7h. Financial Security				
7h-i Assistance with Managing Money	358	368	409	408
7h-ii Assistance with Securing Public Benefits	230	254	270	303
7h-iii Representative Payee	41	42	51	48
Total Unmet Resource Needs	629	664	730	759
Distinct Clients with Unmet Resource Needs	561	592	645	665

Report Run: Apr 14, 2014



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

Statewide

(All CSNs)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	9,881	10,298	10,213	10,245
7i. Education				
7i-i Adult Education (other than GED)	80	67	66	67
7i-ii GED	95	86	89	77
7i-iii Literacy Assistance	29	29	27	27
7i-iv Post High School Education	105	102	115	120
7i-v Tuition Reimbursement	25	24	17	21
Total Unmet Resource Needs	334	308	314	312
Distinct Clients with Unmet Resource Needs	310	285	297	291
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	42	43	37	42
7j-ii Club House and/or Peer Vocational Support	22	26	38	44
7j-iii Competitive Employment (no supports)	67	66	68	72
7j-iv Supported Employment	46	41	48	54
7j-v Vocational Rehabilitation	265	256	263	274
Total Unmet Resource Needs	442	432	454	486
Distinct Clients with Unmet Resource Needs	395	381	396	419
7k. Living Skills				
7k-i Daily Living Support Services	228	221	217	223
7k-ii Day Support Services	29	32	24	26
7k-iii Occupational Therapy	8	9	14	11
7k-iv Skills Development Services	71	64	62	82
Total Unmet Resource Needs	336	326	317	342
Distinct Clients with Unmet Resource Needs	310	304	294	312
7l. Transportation				
7l-i Transportation to ISP-Identified Services	358	362	382	389
7l-ii Transportation to Other ISP Activities	192	197	205	195
7l-iii After Hours Transportation	154	186	183	162
Total Unmet Resource Needs	704	745	770	746
Distinct Clients with Unmet Resource Needs	511	529	531	534
7m. Personal Growth/Community				
7m-i Avocational Activities	23	24	27	31

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

Statewide

(All CSNs)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	9,881	10,298	10,213	10,245
7m. Personal Growth/Community				
7m-ii Recreation Activities	138	141	135	158
7m-iii Social Activities	297	315	309	335
7m-iv Spiritual Activities	54	48	62	66
Total Unmet Resource Needs	512	528	533	590
Distinct Clients with Unmet Resource Needs	372	395	387	425
Other Resources				
Other Resources	155	162	173	184
Total Unmet Resource Needs	155	162	173	184
Distinct Clients with Unmet Resource Needs	155	162	173	184
Statewide Totals				
Total Unmet Resource Needs	6,987	7,210	7,546	7,750
Distinct Clients With any Unmet Resource Need	2,651	2,731	2,775	2,753
Distinct Clients with a RDS	9,881	10,298	10,213	10,245

Report Run: Apr 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q2

CSN 1 - Aroostook

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

2013 Q3			2013 Q4			2014 Q1			2014 Q2		
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
136	395	34.4%	132	387	34.1%	136	407	33.4%	141	426	33.1%

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

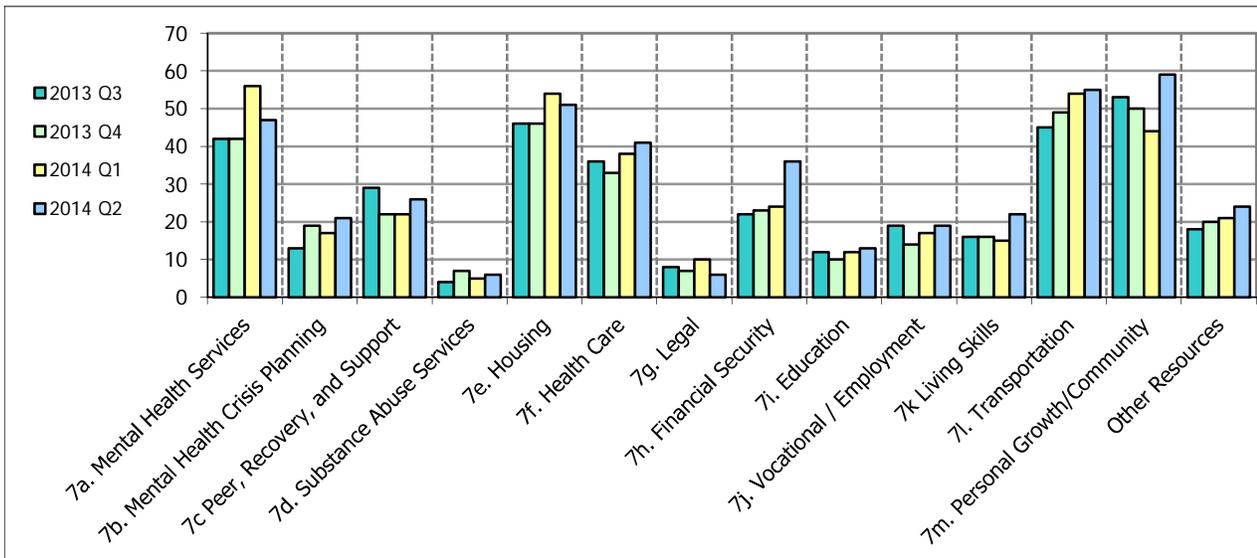


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q3	2013 Q4	2014 Q1	2014 Q2
7a. Mental Health Services	42	42	56	47
7b. Mental Health Crisis Planning	13	19	17	21
7c Peer, Recovery, and Support	29	22	22	26
7d. Substance Abuse Services	4	7	5	6
7e. Housing	46	46	54	51
7f. Health Care	36	33	38	41
7g. Legal	8	7	10	6
7h. Financial Security	22	23	24	36
7i. Education	12	10	12	13
7j. Vocational / Employment	19	14	17	19
7k Living Skills	16	16	15	22
7l. Transportation	45	49	54	55
7m. Personal Growth/Community	53	50	44	59
Other Resources	18	20	21	24
Total CSN 1 Unmet Needs	363	358	389	426

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	395	387	407	426
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	0	0	0	0
7a-iii Dialectical Behavioral Therapy	6	7	5	4
7a-iv Family Psycho-Educational Treatment	1	2	1	0
7a-v Group Counseling	4	2	6	4
7a-vi Individual Counseling	7	8	14	15
7a-vii Inpatient Psychiatric Facility	1	0	1	0
7a-viii Intensive Case Management	1	0	0	1
7a-x Psychiatric Medication Management	22	23	29	23
Total Unmet Resource Needs	42	42	56	47
Distinct Clients with Unmet Resource Needs	35	36	45	38
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	8	15	12	17
7b-ii Mental Health Advance Directives	5	4	5	4
Total Unmet Resource Needs	13	19	17	21
Distinct Clients with Unmet Resource Needs	11	18	14	19
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	2	0	1	1
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	19	13	16	20
7c-iv Peer-Run Trauma Recovery Group	2	2	1	2
7c-v Wellness Recovery and Action Planning	1	2	2	2
7c-vi Family Support	5	5	2	1
Total Unmet Resource Needs	29	22	22	26
Distinct Clients with Unmet Resource Needs	25	20	21	24
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	4	7	5	6
7d-ii Residential Treatment Substance Abuse Services	0	0	0	0
Total Unmet Resource Needs	4	7	5	6
Distinct Clients with Unmet Resource Needs	4	7	5	6

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	395	387	407	426
7e. Housing				
7e-i Supported Apartment	11	10	11	14
7e-ii Community Residential Facility	0	2	2	1
7e-iii Residential Treatment Facility (group home)	2	2	3	2
7e-iv Assisted Living Facility	1	2	4	6
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	30	34	28
Total Unmet Resource Needs	46	46	54	51
Distinct Clients with Unmet Resource Needs	40	38	43	40
7f. Health Care				
7f-i Dental Services	14	14	17	17
7f-ii Eye Care Services	3	3	7	8
7f-iii Hearing Services	1	1	1	2
7f-iv Physical Therapy	2	2	1	0
7f-v Physician/Medical Services	16	13	12	14
Total Unmet Resource Needs	36	33	38	41
Distinct Clients with Unmet Resource Needs	33	30	30	30
7g. Legal				
7g-i Advocate	7	6	6	4
7g-ii Guardian (private)	1	1	3	1
7g-iii Guardian (public)	0	0	1	1
Total Unmet Resource Needs	8	7	10	6
Distinct Clients with Unmet Resource Needs	8	6	9	6
7h. Financial Security				
7h-i Assistance with Managing Money	12	13	13	15
7h-ii Assistance with Securing Public Benefits	10	10	11	21
7h-iii Representative Payee	0	0	0	0
Total Unmet Resource Needs	22	23	24	36
Distinct Clients with Unmet Resource Needs	22	22	24	33

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	395	387	407	426
7i. Education				
7i-i Adult Education (other than GED)	4	2	1	0
7i-ii GED	3	3	5	5
7i-iii Literacy Assistance	1	1	1	2
7i-iv Post High School Education	3	3	4	5
7i-v Tuition Reimbursement	1	1	1	1
Total Unmet Resource Needs	12	10	12	13
Distinct Clients with Unmet Resource Needs	12	10	12	13
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	0	3	2
7j-ii Club House and/or Peer Vocational Support	1	1	1	1
7j-iii Competitive Employment (no supports)	2	1	0	1
7j-iv Supported Employment	6	2	3	6
7j-v Vocational Rehabilitation	9	10	10	9
Total Unmet Resource Needs	19	14	17	19
Distinct Clients with Unmet Resource Needs	15	13	15	16
7k. Living Skills				
7k-i Daily Living Support Services	6	5	7	11
7k-ii Day Support Services	2	3	0	0
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	8	8	8	11
Total Unmet Resource Needs	16	16	15	22
Distinct Clients with Unmet Resource Needs	15	15	13	19
7l. Transportation				
7l-i Transportation to ISP-Identified Services	25	25	28	29
7l-ii Transportation to Other ISP Activities	8	11	11	12
7l-iii After Hours Transportation	12	13	15	14
Total Unmet Resource Needs	45	49	54	55
Distinct Clients with Unmet Resource Needs	36	36	38	39
7m. Personal Growth/Community				
7m-i Avocational Activities	1	0	2	4

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	395	387	407	426
7m. Personal Growth/Community				
7m-ii Recreation Activities	15	16	9	13
7m-iii Social Activities	34	32	29	37
7m-iv Spiritual Activities	3	2	4	5
Total Unmet Resource Needs	53	50	44	59
Distinct Clients with Unmet Resource Needs	41	39	33	45
Other Resources				
Other Resources	18	20	21	24
Total Unmet Resource Needs	18	20	21	24
Distinct Clients with Unmet Resource Needs	18	20	21	24
CSN 1 Totals				
Total Unmet Resource Needs	363	358	389	426
Distinct Clients With any Unmet Resource Need	136	132	136	141
Distinct Clients with a RDS	395	387	407	426

Report Run: Apr 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q2

CSN 2 - Hancock, Washington, Penobscot, Piscataquis

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

2013 Q3			2013 Q4			2014 Q1			2014 Q2		
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
427	1,769	24.1%	425	1,865	22.8%	468	1,889	24.8%	472	1,809	26.1%

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

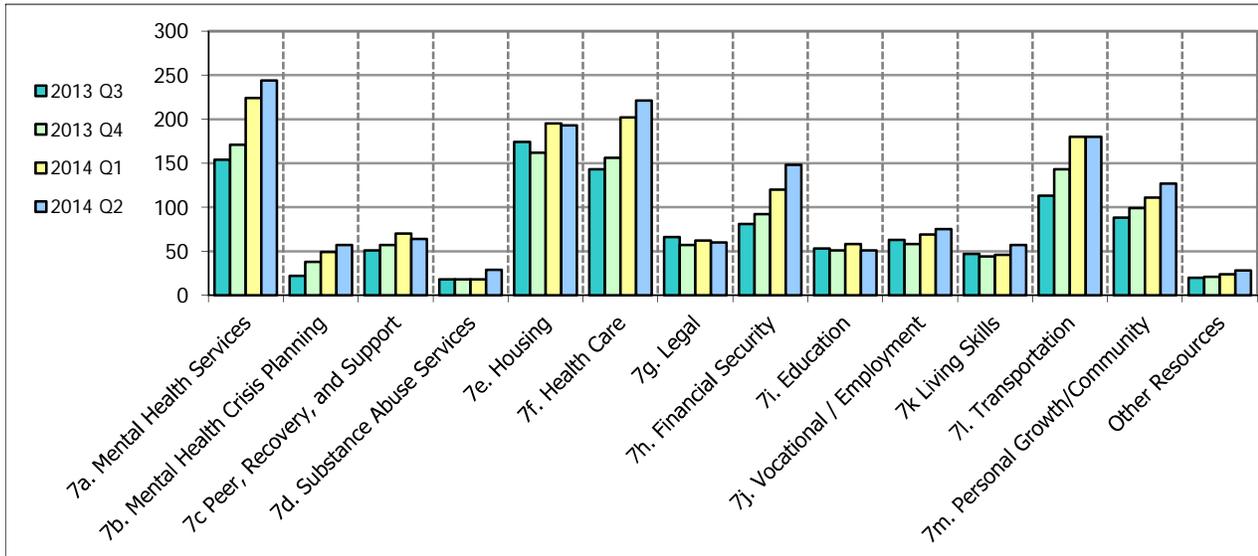


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q3	2013 Q4	2014 Q1	2014 Q2
7a. Mental Health Services	154	171	224	244
7b. Mental Health Crisis Planning	22	38	49	57
7c Peer, Recovery, and Support	51	57	70	64
7d. Substance Abuse Services	18	18	18	29
7e. Housing	174	162	195	193
7f. Health Care	143	156	202	221
7g. Legal	66	57	62	60
7h. Financial Security	81	92	120	148
7i. Education	53	51	58	51
7j. Vocational / Employment	63	58	69	75
7k Living Skills	47	44	46	57
7l. Transportation	113	143	180	180
7m. Personal Growth/Community	88	99	111	127
Other Resources	20	21	24	28
Total CSN 2 Unmet Needs	1,093	1,167	1,428	1,534

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 2

(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,769	1,865	1,889	1,809
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	3	3	7
7a-iii Dialectical Behavioral Therapy	1	2	2	1
7a-iv Family Psycho-Educational Treatment	4	5	5	4
7a-v Group Counseling	10	7	8	13
7a-vi Individual Counseling	70	74	109	122
7a-vii Inpatient Psychiatric Facility	0	0	0	1
7a-viii Intensive Case Management	1	1	5	8
7a-x Psychiatric Medication Management	66	79	92	88
Total Unmet Resource Needs	154	171	224	244
Distinct Clients with Unmet Resource Needs	121	131	158	174
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	19	34	41	50
7b-ii Mental Health Advance Directives	3	4	8	7
Total Unmet Resource Needs	22	38	49	57
Distinct Clients with Unmet Resource Needs	20	36	45	53
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	6	6	6	5
7c-ii Recovery Workbook Group	1	1	1	0
7c-iii Social Club	16	13	17	15
7c-iv Peer-Run Trauma Recovery Group	10	11	9	10
7c-v Wellness Recovery and Action Planning	5	6	9	9
7c-vi Family Support	13	20	28	25
Total Unmet Resource Needs	51	57	70	64
Distinct Clients with Unmet Resource Needs	35	40	50	51
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	14	15	17	27
7d-ii Residential Treatment Substance Abuse Services	4	3	1	2
Total Unmet Resource Needs	18	18	18	29
Distinct Clients with Unmet Resource Needs	16	16	18	27

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 2

(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,769	1,865	1,889	1,809
7e. Housing				
7e-i Supported Apartment	13	16	26	21
7e-ii Community Residential Facility	6	4	6	4
7e-iii Residential Treatment Facility (group home)	0	0	0	0
7e-iv Assisted Living Facility	9	7	9	13
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	146	135	154	154
Total Unmet Resource Needs	174	162	195	193
Distinct Clients with Unmet Resource Needs	164	153	183	180
7f. Health Care				
7f-i Dental Services	60	64	83	90
7f-ii Eye Care Services	38	33	44	47
7f-iii Hearing Services	6	4	7	7
7f-iv Physical Therapy	7	7	9	11
7f-v Physician/Medical Services	32	48	59	66
Total Unmet Resource Needs	143	156	202	221
Distinct Clients with Unmet Resource Needs	114	119	144	160
7g. Legal				
7g-i Advocate	30	24	27	32
7g-ii Guardian (private)	33	31	31	26
7g-iii Guardian (public)	3	2	4	2
Total Unmet Resource Needs	66	57	62	60
Distinct Clients with Unmet Resource Needs	61	53	58	54
7h. Financial Security				
7h-i Assistance with Managing Money	41	46	70	79
7h-ii Assistance with Securing Public Benefits	39	41	42	59
7h-iii Representative Payee	1	5	8	10
Total Unmet Resource Needs	81	92	120	148
Distinct Clients with Unmet Resource Needs	71	80	103	119

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 2

(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,769	1,865	1,889	1,809
7i. Education				
7i-i Adult Education (other than GED)	9	8	9	7
7i-ii GED	6	5	6	4
7i-iii Literacy Assistance	5	3	4	3
7i-iv Post High School Education	25	26	29	29
7i-v Tuition Reimbursement	8	9	10	8
Total Unmet Resource Needs	53	51	58	51
Distinct Clients with Unmet Resource Needs	49	47	54	48
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	8	9	7	11
7j-ii Club House and/or Peer Vocational Support	2	2	3	4
7j-iii Competitive Employment (no supports)	18	19	22	21
7j-iv Supported Employment	7	7	7	7
7j-v Vocational Rehabilitation	28	21	30	32
Total Unmet Resource Needs	63	58	69	75
Distinct Clients with Unmet Resource Needs	54	49	56	60
7k. Living Skills				
7k-i Daily Living Support Services	35	30	31	33
7k-ii Day Support Services	3	4	3	3
7k-iii Occupational Therapy	1	1	3	2
7k-iv Skills Development Services	8	9	9	19
Total Unmet Resource Needs	47	44	46	57
Distinct Clients with Unmet Resource Needs	40	38	40	50
7l. Transportation				
7l-i Transportation to ISP-Identified Services	52	64	85	91
7l-ii Transportation to Other ISP Activities	25	35	46	41
7l-iii After Hours Transportation	36	44	49	48
Total Unmet Resource Needs	113	143	180	180
Distinct Clients with Unmet Resource Needs	84	93	110	118
7m. Personal Growth/Community				
7m-i Avocational Activities	6	8	10	10

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 2

ancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,769	1,865	1,889	1,809
7m. Personal Growth/Community				
7m-ii Recreation Activities	29	31	31	41
7m-iii Social Activities	49	55	58	63
7m-iv Spiritual Activities	4	5	12	13
Total Unmet Resource Needs	88	99	111	127
Distinct Clients with Unmet Resource Needs	61	69	74	85
Other Resources				
Other Resources	20	21	24	28
Total Unmet Resource Needs	20	21	24	28
Distinct Clients with Unmet Resource Needs	20	21	24	28
CSN 2 Totals				
Total Unmet Resource Needs	1,093	1,167	1,428	1,534
Distinct Clients With any Unmet Resource Need	427	425	468	472
Distinct Clients with a RDS	1,769	1,865	1,889	1,809

Report Run: Apr 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q2

CSN 3 - Kennebec and Somerset

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

2013 Q3			2013 Q4			2014 Q1			2014 Q2		
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
352	1,997	17.6%	380	2,100	18.1%	382	2,074	18.4%	357	2,076	17.2%

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

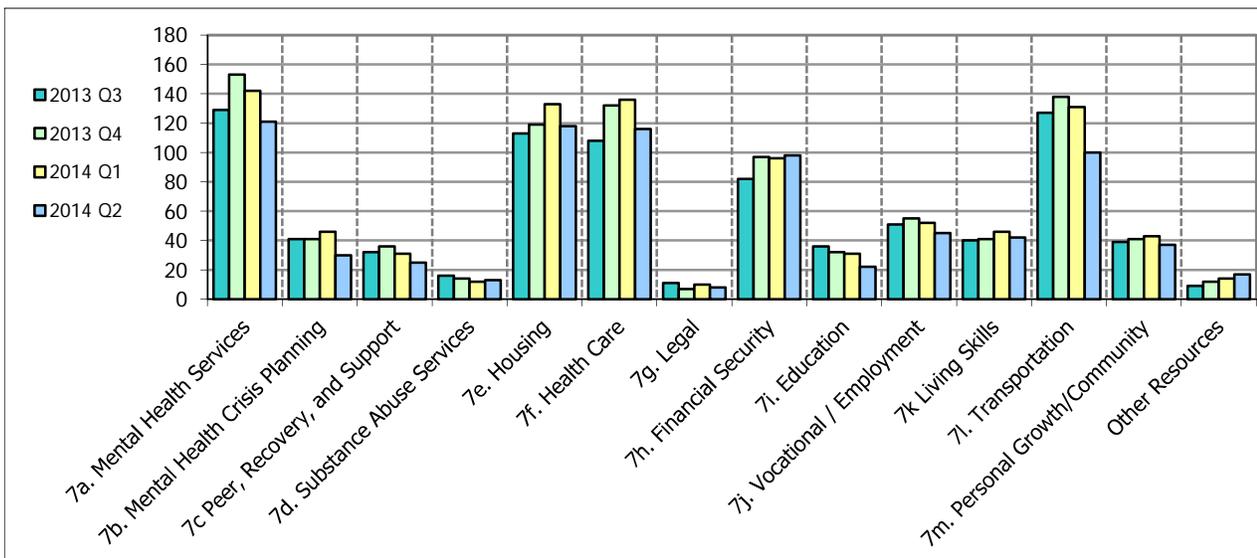


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q3	2013 Q4	2014 Q1	2014 Q2
7a. Mental Health Services	129	153	142	121
7b. Mental Health Crisis Planning	41	41	46	30
7c Peer, Recovery, and Support	32	36	31	25
7d. Substance Abuse Services	16	14	12	13
7e. Housing	113	119	133	118
7f. Health Care	108	132	136	116
7g. Legal	11	7	10	8
7h. Financial Security	82	97	96	98
7i. Education	36	32	31	22
7j. Vocational / Employment	51	55	52	45
7k Living Skills	40	41	46	42
7l. Transportation	127	138	131	100
7m. Personal Growth/Community	39	41	43	37
Other Resources	9	12	14	17
Total CSN 3 Unmet Needs	834	918	923	792

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,997	2,100	2,074	2,076
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	4	3	4	3
7a-iii Dialectical Behavioral Therapy	0	3	2	2
7a-iv Family Psycho-Educational Treatment	1	1	1	1
7a-v Group Counseling	4	5	4	1
7a-vi Individual Counseling	54	66	61	46
7a-vii Inpatient Psychiatric Facility	1	1	1	1
7a-viii Intensive Case Management	2	2	2	1
7a-x Psychiatric Medication Management	63	72	67	66
Total Unmet Resource Needs	129	153	142	121
Distinct Clients with Unmet Resource Needs	99	114	105	92
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	28	31	32	21
7b-ii Mental Health Advance Directives	13	10	14	9
Total Unmet Resource Needs	41	41	46	30
Distinct Clients with Unmet Resource Needs	33	36	40	26
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	4	4	3	4
7c-ii Recovery Workbook Group	1	1	2	0
7c-iii Social Club	8	10	7	4
7c-iv Peer-Run Trauma Recovery Group	1	1	2	2
7c-v Wellness Recovery and Action Planning	2	1	2	2
7c-vi Family Support	16	19	15	13
Total Unmet Resource Needs	32	36	31	25
Distinct Clients with Unmet Resource Needs	29	33	27	21
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	10	10	8	10
7d-ii Residential Treatment Substance Abuse Services	6	4	4	3
Total Unmet Resource Needs	16	14	12	13
Distinct Clients with Unmet Resource Needs	15	14	12	13

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,997	2,100	2,074	2,076
7e. Housing				
7e-i Supported Apartment	8	6	7	8
7e-ii Community Residential Facility	4	3	8	3
7e-iii Residential Treatment Facility (group home)	2	1	1	1
7e-iv Assisted Living Facility	2	1	1	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)	97	108	116	103
Total Unmet Resource Needs	113	119	133	118
Distinct Clients with Unmet Resource Needs	106	115	128	115
7f. Health Care				
7f-i Dental Services	55	64	67	61
7f-ii Eye Care Services	20	23	26	22
7f-iii Hearing Services	8	12	10	8
7f-iv Physical Therapy	1	3	3	1
7f-v Physician/Medical Services	24	30	30	24
Total Unmet Resource Needs	108	132	136	116
Distinct Clients with Unmet Resource Needs	90	110	113	101
7g. Legal				
7g-i Advocate	6	4	5	4
7g-ii Guardian (private)	1	1	1	1
7g-iii Guardian (public)	4	2	4	3
Total Unmet Resource Needs	11	7	10	8
Distinct Clients with Unmet Resource Needs	9	5	8	6
7h. Financial Security				
7h-i Assistance with Managing Money	34	38	42	40
7h-ii Assistance with Securing Public Benefits	41	51	45	51
7h-iii Representative Payee	7	8	9	7
Total Unmet Resource Needs	82	97	96	98
Distinct Clients with Unmet Resource Needs	70	87	91	92

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,997	2,100	2,074	2,076
7i. Education				
7i-i Adult Education (other than GED)	5	5	4	4
7i-ii GED	15	10	9	8
7i-iii Literacy Assistance	5	7	7	3
7i-iv Post High School Education	9	8	9	5
7i-v Tuition Reimbursement	2	2	2	2
Total Unmet Resource Needs	36	32	31	22
Distinct Clients with Unmet Resource Needs	34	29	28	20
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	3	3	2	2
7j-ii Club House and/or Peer Vocational Support	5	11	9	10
7j-iii Competitive Employment (no supports)	4	3	4	4
7j-iv Supported Employment	2	3	3	2
7j-v Vocational Rehabilitation	37	35	34	27
Total Unmet Resource Needs	51	55	52	45
Distinct Clients with Unmet Resource Needs	46	49	46	42
7k. Living Skills				
7k-i Daily Living Support Services	37	37	37	33
7k-ii Day Support Services	1	2	1	2
7k-iii Occupational Therapy	0	0	1	0
7k-iv Skills Development Services	2	2	7	7
Total Unmet Resource Needs	40	41	46	42
Distinct Clients with Unmet Resource Needs	40	41	45	41
7l. Transportation				
7l-i Transportation to ISP-Identified Services	83	84	81	66
7l-ii Transportation to Other ISP Activities	25	31	29	20
7l-iii After Hours Transportation	19	23	21	14
Total Unmet Resource Needs	127	138	131	100
Distinct Clients with Unmet Resource Needs	99	102	97	82
7m. Personal Growth/Community				
7m-i Avocational Activities	1	0	0	1

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,997	2,100	2,074	2,076
7m. Personal Growth/Community				
7m-ii Recreation Activities	6	4	6	4
7m-iii Social Activities	30	36	36	31
7m-iv Spiritual Activities	2	1	1	1
Total Unmet Resource Needs	39	41	43	37
Distinct Clients with Unmet Resource Needs	33	37	37	31
Other Resources				
Other Resources	9	12	14	17
Total Unmet Resource Needs	9	12	14	17
Distinct Clients with Unmet Resource Needs	9	12	14	17
CSN 3 Totals				
Total Unmet Resource Needs	834	918	923	792
Distinct Clients With any Unmet Resource Need	352	380	382	357
Distinct Clients with a RDS	1,997	2,100	2,074	2,076

Report Run: Apr 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q2

CSN 4 - Knox, Lincoln, Sagadahoc, Waldo

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

2013 Q3			2013 Q4			2014 Q1			2014 Q2		
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
237	823	28.8%	216	831	26.0%	213	795	26.8%	203	848	23.9%

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

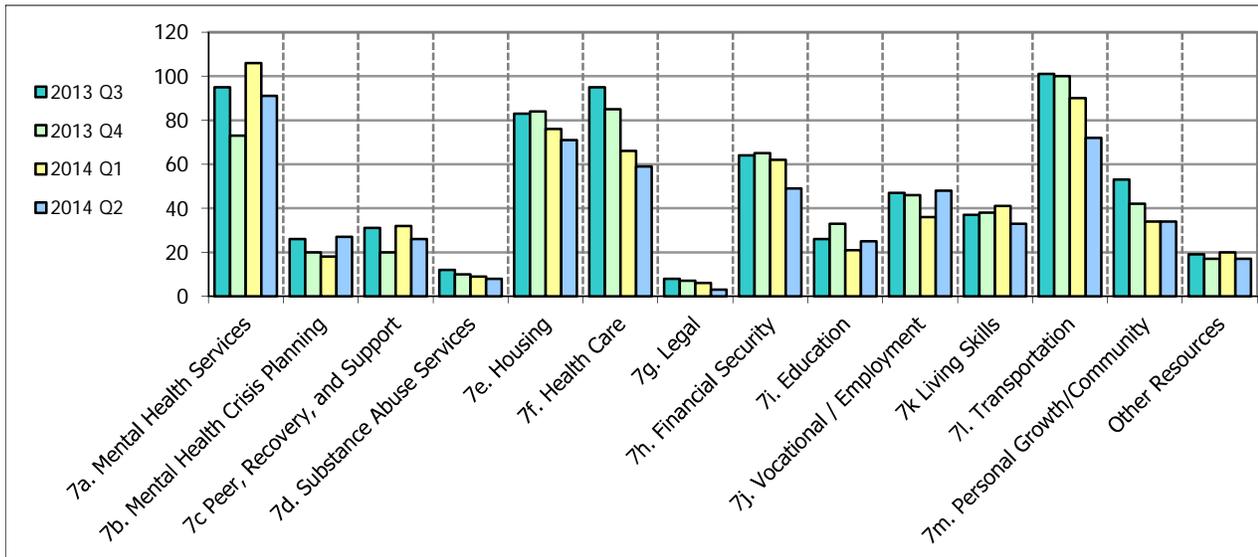


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q3	2013 Q4	2014 Q1	2014 Q2
7a. Mental Health Services	95	73	106	91
7b. Mental Health Crisis Planning	26	20	18	27
7c Peer, Recovery, and Support	31	20	32	26
7d. Substance Abuse Services	12	10	9	8
7e. Housing	83	84	76	71
7f. Health Care	95	85	66	59
7g. Legal	8	7	6	3
7h. Financial Security	64	65	62	49
7i. Education	26	33	21	25
7j. Vocational / Employment	47	46	36	48
7k Living Skills	37	38	41	33
7l. Transportation	101	100	90	72
7m. Personal Growth/Community	53	42	34	34
Other Resources	19	17	20	17
Total CSN 4 Unmet Needs	697	640	617	563

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 4

(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	823	831	795	848
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	3	3	2	10
7a-iii Dialectical Behavioral Therapy	1	0	3	0
7a-iv Family Psycho-Educational Treatment	0	0	1	1
7a-v Group Counseling	1	1	3	4
7a-vi Individual Counseling	46	40	46	37
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	1	2	3	3
7a-x Psychiatric Medication Management	43	27	48	36
Total Unmet Resource Needs	95	73	106	91
Distinct Clients with Unmet Resource Needs	71	61	85	73
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	21	14	14	21
7b-ii Mental Health Advance Directives	5	6	4	6
Total Unmet Resource Needs	26	20	18	27
Distinct Clients with Unmet Resource Needs	24	19	17	24
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	3	2	8	5
7c-ii Recovery Workbook Group	0	0	1	1
7c-iii Social Club	9	4	5	6
7c-iv Peer-Run Trauma Recovery Group	5	3	2	1
7c-v Wellness Recovery and Action Planning	0	0	2	3
7c-vi Family Support	14	11	14	10
Total Unmet Resource Needs	31	20	32	26
Distinct Clients with Unmet Resource Needs	26	19	27	18
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	9	9	8	7
7d-ii Residential Treatment Substance Abuse Services	3	1	1	1
Total Unmet Resource Needs	12	10	9	8
Distinct Clients with Unmet Resource Needs	10	10	9	8

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 4

(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	823	831	795	848
7e. Housing				
7e-i Supported Apartment	12	9	9	9
7e-ii Community Residential Facility	2	3	3	3
7e-iii Residential Treatment Facility (group home)	2	3	4	4
7e-iv Assisted Living Facility	5	6	4	4
7e-v Nursing Home	2	2	2	1
7e-vi Residential Crisis Unit	1	1	1	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	59	60	53	49
Total Unmet Resource Needs	83	84	76	71
Distinct Clients with Unmet Resource Needs	73	74	65	60
7f. Health Care				
7f-i Dental Services	55	44	37	36
7f-ii Eye Care Services	23	18	12	12
7f-iii Hearing Services	4	6	3	2
7f-iv Physical Therapy	1	1	1	0
7f-v Physician/Medical Services	12	16	13	9
Total Unmet Resource Needs	95	85	66	59
Distinct Clients with Unmet Resource Needs	74	67	51	47
7g. Legal				
7g-i Advocate	5	5	3	2
7g-ii Guardian (private)	3	2	3	1
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	8	7	6	3
Distinct Clients with Unmet Resource Needs	8	7	6	3
7h. Financial Security				
7h-i Assistance with Managing Money	43	38	34	29
7h-ii Assistance with Securing Public Benefits	15	20	20	17
7h-iii Representative Payee	6	7	8	3
Total Unmet Resource Needs	64	65	62	49
Distinct Clients with Unmet Resource Needs	57	57	48	43

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 4

(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	823	831	795	848
7i. Education				
7i-i Adult Education (other than GED)	5	5	2	2
7i-ii GED	8	12	8	8
7i-iii Literacy Assistance	0	1	0	0
7i-iv Post High School Education	10	13	11	14
7i-v Tuition Reimbursement	3	2	0	1
Total Unmet Resource Needs	26	33	21	25
Distinct Clients with Unmet Resource Needs	24	32	21	23
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	4	4	4	6
7j-ii Club House and/or Peer Vocational Support	0	0	2	1
7j-iii Competitive Employment (no supports)	10	9	2	4
7j-iv Supported Employment	4	5	6	5
7j-v Vocational Rehabilitation	29	28	22	32
Total Unmet Resource Needs	47	46	36	48
Distinct Clients with Unmet Resource Needs	44	39	29	38
7k. Living Skills				
7k-i Daily Living Support Services	31	28	28	25
7k-ii Day Support Services	1	3	1	1
7k-iii Occupational Therapy	1	1	1	1
7k-iv Skills Development Services	4	6	11	6
Total Unmet Resource Needs	37	38	41	33
Distinct Clients with Unmet Resource Needs	35	34	36	30
7l. Transportation				
7l-i Transportation to ISP-Identified Services	50	53	48	39
7l-ii Transportation to Other ISP Activities	37	33	27	20
7l-iii After Hours Transportation	14	14	15	13
Total Unmet Resource Needs	101	100	90	72
Distinct Clients with Unmet Resource Needs	58	63	56	46
7m. Personal Growth/Community				
7m-i Avocational Activities	2	4	3	2

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 4

(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	823	831	795	848
7m. Personal Growth/Community				
7m-ii Recreation Activities	10	10	9	9
7m-iii Social Activities	36	27	20	21
7m-iv Spiritual Activities	5	1	2	2
Total Unmet Resource Needs	53	42	34	34
Distinct Clients with Unmet Resource Needs	41	34	26	25
Other Resources				
Other Resources	19	17	20	17
Total Unmet Resource Needs	19	17	20	17
Distinct Clients with Unmet Resource Needs	19	17	20	17
CSN 4 Totals				
Total Unmet Resource Needs	697	640	617	563
Distinct Clients With any Unmet Resource Need	237	216	213	203
Distinct Clients with a RDS	823	831	795	848

Report Run: Apr 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q2

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

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

2013 Q3			2013 Q4			2014 Q1			2014 Q2		
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
611	1,920	31.8%	626	2,045	30.6%	638	2,022	31.6%	618	2,079	29.7%

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

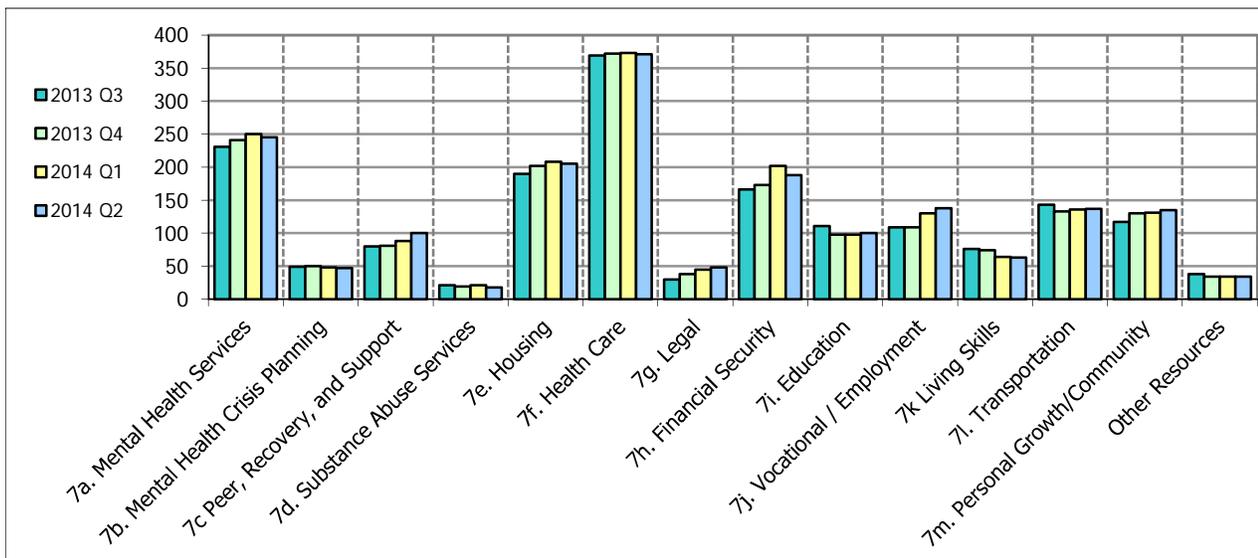


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q3	2013 Q4	2014 Q1	2014 Q2
7a. Mental Health Services	231	241	250	245
7b. Mental Health Crisis Planning	49	50	48	47
7c. Peer, Recovery, and Support	80	81	88	100
7d. Substance Abuse Services	21	19	21	18
7e. Housing	190	202	208	205
7f. Health Care	369	372	373	371
7g. Legal	30	38	45	48
7h. Financial Security	166	173	202	188
7i. Education	111	98	98	100
7j. Vocational / Employment	109	109	130	138
7k. Living Skills	76	74	64	63
7l. Transportation	143	133	136	137
7m. Personal Growth/Community	117	130	131	135
Other Resources	38	34	34	34
Total CSN 5 Unmet Needs	1,730	1,754	1,828	1,829

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 5

(Androscoquin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,920	2,045	2,022	2,079
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	4	7	5	5
7a-iii Dialectical Behavioral Therapy	12	15	22	23
7a-iv Family Psycho-Educational Treatment	2	4	5	2
7a-v Group Counseling	7	5	8	9
7a-vi Individual Counseling	90	82	102	104
7a-vii Inpatient Psychiatric Facility	2	2	2	2
7a-viii Intensive Case Management	0	3	5	2
7a-x Psychiatric Medication Management	114	123	101	98
Total Unmet Resource Needs	231	241	250	245
Distinct Clients with Unmet Resource Needs	191	210	210	214
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	23	26	32	29
7b-ii Mental Health Advance Directives	26	24	16	18
Total Unmet Resource Needs	49	50	48	47
Distinct Clients with Unmet Resource Needs	46	48	46	43
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	10	10	11	8
7c-ii Recovery Workbook Group	1	1	2	3
7c-iii Social Club	18	22	30	32
7c-iv Peer-Run Trauma Recovery Group	5	3	7	9
7c-v Wellness Recovery and Action Planning	4	6	5	7
7c-vi Family Support	42	39	33	41
Total Unmet Resource Needs	80	81	88	100
Distinct Clients with Unmet Resource Needs	69	73	77	85
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	19	17	18	17
7d-ii Residential Treatment Substance Abuse Services	2	2	3	1
Total Unmet Resource Needs	21	19	21	18
Distinct Clients with Unmet Resource Needs	21	19	21	18

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 5

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

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,920	2,045	2,022	2,079
7e. Housing				
7e-i Supported Apartment	15	15	14	17
7e-ii Community Residential Facility	4	4	4	5
7e-iii Residential Treatment Facility (group home)	1	2	2	1
7e-iv Assisted Living Facility	4	5	3	6
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	1	1	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	165	175	185	176
Total Unmet Resource Needs	190	202	208	205
Distinct Clients with Unmet Resource Needs	179	191	196	192
7f. Health Care				
7f-i Dental Services	200	197	192	196
7f-ii Eye Care Services	74	80	79	78
7f-iii Hearing Services	21	22	19	20
7f-iv Physical Therapy	16	13	14	12
7f-v Physician/Medical Services	58	60	69	65
Total Unmet Resource Needs	369	372	373	371
Distinct Clients with Unmet Resource Needs	266	270	268	265
7g. Legal				
7g-i Advocate	25	33	42	43
7g-ii Guardian (private)	1	1	0	2
7g-iii Guardian (public)	4	4	3	3
Total Unmet Resource Needs	30	38	45	48
Distinct Clients with Unmet Resource Needs	30	38	45	48
7h. Financial Security				
7h-i Assistance with Managing Money	108	108	129	119
7h-ii Assistance with Securing Public Benefits	48	57	65	61
7h-iii Representative Payee	10	8	8	8
Total Unmet Resource Needs	166	173	202	188
Distinct Clients with Unmet Resource Needs	155	157	184	171

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 5

(Androscoffin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,920	2,045	2,022	2,079
7i. Education				
7i-i Adult Education (other than GED)	26	23	23	24
7i-ii GED	40	33	39	32
7i-iii Literacy Assistance	11	8	7	11
7i-iv Post High School Education	26	26	26	28
7i-v Tuition Reimbursement	8	8	3	5
Total Unmet Resource Needs	111	98	98	100
Distinct Clients with Unmet Resource Needs	102	89	93	93
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	9	8	7	6
7j-ii Club House and/or Peer Vocational Support	9	8	10	15
7j-iii Competitive Employment (no supports)	9	9	12	10
7j-iv Supported Employment	13	11	13	19
7j-v Vocational Rehabilitation	69	73	88	88
Total Unmet Resource Needs	109	109	130	138
Distinct Clients with Unmet Resource Needs	98	100	119	123
7k. Living Skills				
7k-i Daily Living Support Services	52	55	45	47
7k-ii Day Support Services	9	8	9	6
7k-iii Occupational Therapy	3	3	3	2
7k-iv Skills Development Services	12	8	7	8
Total Unmet Resource Needs	76	74	64	63
Distinct Clients with Unmet Resource Needs	72	71	62	60
7l. Transportation				
7l-i Transportation to ISP-Identified Services	55	45	51	62
7l-ii Transportation to Other ISP Activities	48	45	43	40
7l-iii After Hours Transportation	40	43	42	35
Total Unmet Resource Needs	143	133	136	137
Distinct Clients with Unmet Resource Needs	103	94	97	103
7m. Personal Growth/Community				
7m-i Avocational Activities	3	3	4	3

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 5

(Androscoggin, Franklin, Oxford)
(includes: Bridgton, Harrison, Naples, Casco)

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,920	2,045	2,022	2,079
7m. Personal Growth/Community				
7m-ii Recreation Activities	35	34	34	33
7m-iii Social Activities	59	70	67	71
7m-iv Spiritual Activities	20	23	26	28
Total Unmet Resource Needs	117	130	131	135
Distinct Clients with Unmet Resource Needs	76	91	88	91
Other Resources				
Other Resources	38	34	34	34
Total Unmet Resource Needs	38	34	34	34
Distinct Clients with Unmet Resource Needs	38	34	34	34
CSN 5 Totals				
Total Unmet Resource Needs	1,730	1,754	1,828	1,829
Distinct Clients With any Unmet Resource Need	611	626	638	618
Distinct Clients with a RDS	1,920	2,045	2,022	2,079

Report Run: Apr 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q2

CSN 6 - Cumberland

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

2013 Q3			2013 Q4			2014 Q1			2014 Q2		
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
599	1,999	30.0%	645	2,112	30.5%	663	2,117	31.3%	666	2,076	32.1%

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

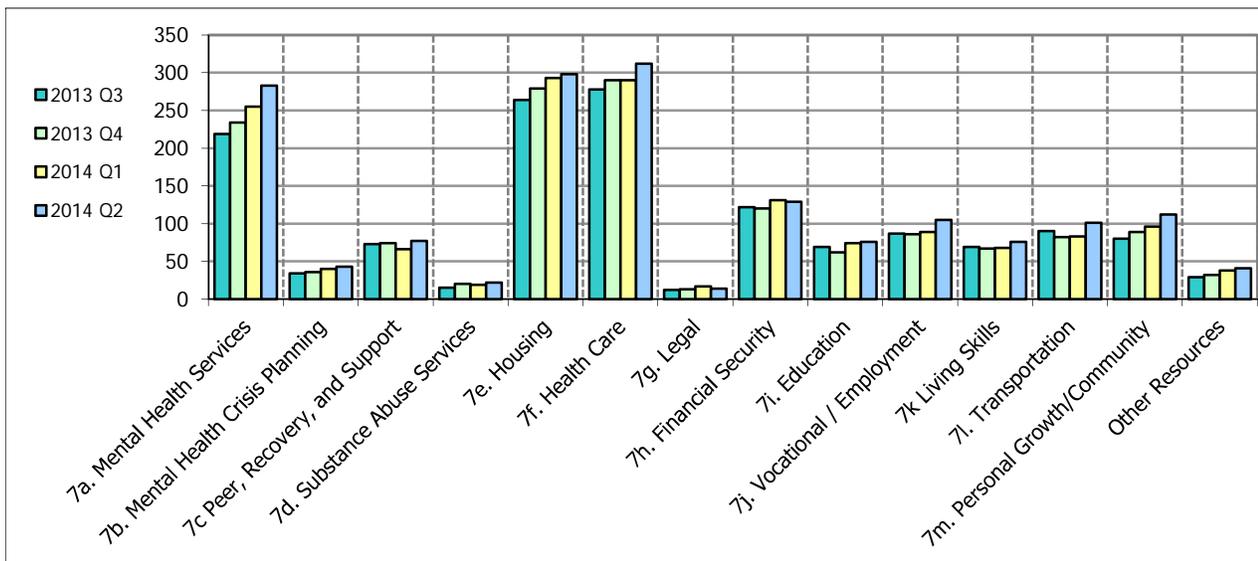


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q3	2013 Q4	2014 Q1	2014 Q2
7a. Mental Health Services	219	234	255	283
7b. Mental Health Crisis Planning	34	36	40	43
7c. Peer, Recovery, and Support	73	74	66	77
7d. Substance Abuse Services	15	20	19	22
7e. Housing	264	279	293	298
7f. Health Care	278	290	290	312
7g. Legal	12	13	17	14
7h. Financial Security	122	120	131	129
7i. Education	69	62	74	76
7j. Vocational / Employment	87	86	89	105
7k. Living Skills	69	67	68	76
7l. Transportation	90	82	83	101
7m. Personal Growth/Community	80	89	96	112
Other Resources	29	32	38	41
Total CSN 6 Unmet Needs	1,441	1,484	1,559	1,689



Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,999	2,112	2,117	2,076
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	28	36	38	41
7a-iii Dialectical Behavioral Therapy	5	4	4	3
7a-iv Family Psycho-Educational Treatment	2	2	2	3
7a-v Group Counseling	10	10	10	14
7a-vi Individual Counseling	70	79	97	105
7a-vii Inpatient Psychiatric Facility	0	1	1	1
7a-viii Intensive Case Management	17	13	15	15
7a-x Psychiatric Medication Management	87	89	88	101
Total Unmet Resource Needs	219	234	255	283
Distinct Clients with Unmet Resource Needs	161	188	192	212
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	31	31	33	37
7b-ii Mental Health Advance Directives	3	5	7	6
Total Unmet Resource Needs	34	36	40	43
Distinct Clients with Unmet Resource Needs	32	34	36	38
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	13	16	9	15
7c-ii Recovery Workbook Group	1	0	0	1
7c-iii Social Club	28	29	26	30
7c-iv Peer-Run Trauma Recovery Group	5	6	6	7
7c-v Wellness Recovery and Action Planning	9	7	9	8
7c-vi Family Support	17	16	16	16
Total Unmet Resource Needs	73	74	66	77
Distinct Clients with Unmet Resource Needs	54	56	47	56
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	11	14	13	16
7d-ii Residential Treatment Substance Abuse Services	4	6	6	6
Total Unmet Resource Needs	15	20	19	22
Distinct Clients with Unmet Resource Needs	15	20	17	22

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,999	2,112	2,117	2,076
7e. Housing				
7e-i Supported Apartment	52	47	39	46
7e-ii Community Residential Facility	13	15	13	11
7e-iii Residential Treatment Facility (group home)	4	4	3	7
7e-iv Assisted Living Facility	16	17	23	19
7e-v Nursing Home	1	1	3	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	178	195	212	214
Total Unmet Resource Needs	264	279	293	298
Distinct Clients with Unmet Resource Needs	232	249	258	266
7f. Health Care				
7f-i Dental Services	156	173	184	181
7f-ii Eye Care Services	50	50	42	57
7f-iii Hearing Services	12	12	10	9
7f-iv Physical Therapy	7	5	7	7
7f-v Physician/Medical Services	53	50	47	58
Total Unmet Resource Needs	278	290	290	312
Distinct Clients with Unmet Resource Needs	213	230	236	239
7g. Legal				
7g-i Advocate	8	11	16	13
7g-ii Guardian (private)	1	1	0	1
7g-iii Guardian (public)	3	1	1	0
Total Unmet Resource Needs	12	13	17	14
Distinct Clients with Unmet Resource Needs	12	13	17	14
7h. Financial Security				
7h-i Assistance with Managing Money	66	65	68	68
7h-ii Assistance with Securing Public Benefits	44	44	47	49
7h-iii Representative Payee	12	11	16	12
Total Unmet Resource Needs	122	120	131	129
Distinct Clients with Unmet Resource Needs	110	111	117	118

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,999	2,112	2,117	2,076
7i. Education				
7i-i Adult Education (other than GED)	24	18	21	20
7i-ii GED	14	13	19	18
7i-iii Literacy Assistance	6	7	5	6
7i-iv Post High School Education	24	23	28	29
7i-v Tuition Reimbursement	1	1	1	3
Total Unmet Resource Needs	69	62	74	76
Distinct Clients with Unmet Resource Needs	63	58	71	72
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	9	9	6	9
7j-ii Club House and/or Peer Vocational Support	4	3	4	5
7j-iii Competitive Employment (no supports)	16	16	21	22
7j-iv Supported Employment	6	7	11	10
7j-v Vocational Rehabilitation	52	51	47	59
Total Unmet Resource Needs	87	86	89	105
Distinct Clients with Unmet Resource Needs	81	76	78	92
7k. Living Skills				
7k-i Daily Living Support Services	37	38	44	42
7k-ii Day Support Services	8	8	6	8
7k-iii Occupational Therapy	1	2	4	4
7k-iv Skills Development Services	23	19	14	22
Total Unmet Resource Needs	69	67	68	76
Distinct Clients with Unmet Resource Needs	63	61	63	71
7l. Transportation				
7l-i Transportation to ISP-Identified Services	50	47	45	52
7l-ii Transportation to Other ISP Activities	25	18	22	31
7l-iii After Hours Transportation	15	17	16	18
Total Unmet Resource Needs	90	82	83	101
Distinct Clients with Unmet Resource Needs	70	68	69	76
7m. Personal Growth/Community				
7m-i Avocational Activities	3	3	3	3

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	1,999	2,112	2,117	2,076
7m. Personal Growth/Community				
7m-ii Recreation Activities	24	26	31	37
7m-iii Social Activities	41	51	53	65
7m-iv Spiritual Activities	12	9	9	7
Total Unmet Resource Needs	80	89	96	112
Distinct Clients with Unmet Resource Needs	62	70	72	86
Other Resources				
Other Resources	29	32	38	41
Total Unmet Resource Needs	29	32	38	41
Distinct Clients with Unmet Resource Needs	29	32	38	41
CSN 6 Totals				
Total Unmet Resource Needs	1,441	1,484	1,559	1,689
Distinct Clients With any Unmet Resource Need	599	645	663	666
Distinct Clients with a RDS	1,999	2,112	2,117	2,076

Report Run: Apr 14, 2014

Statewide Report of Unmet Resource Needs for Fiscal Year 2014 Q2

CSN 7 - York

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

2013 Q3			2013 Q4			2014 Q1			2014 Q2		
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
163	560	29.1%	193	572	33.7%	160	520	30.8%	200	559	35.8%

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

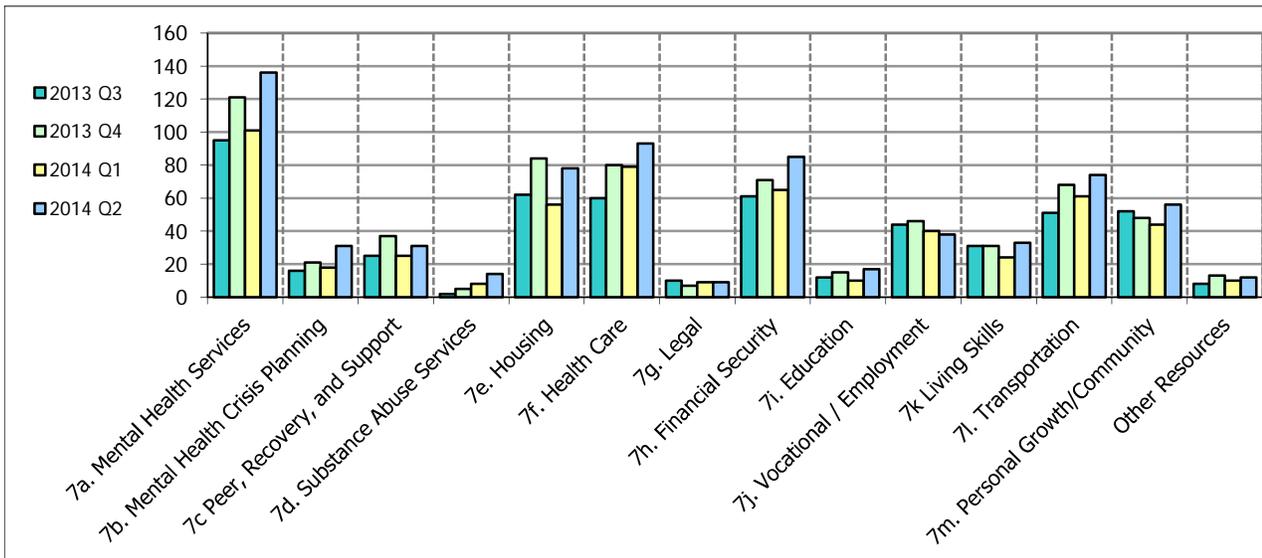


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2013 Q3	2013 Q4	2014 Q1	2014 Q2
7a. Mental Health Services	95	121	101	136
7b. Mental Health Crisis Planning	16	21	18	31
7c. Peer, Recovery, and Support	25	37	25	31
7d. Substance Abuse Services	2	5	8	14
7e. Housing	62	84	56	78
7f. Health Care	60	80	79	93
7g. Legal	10	7	9	9
7h. Financial Security	61	71	65	85
7i. Education	12	15	10	17
7j. Vocational / Employment	44	46	40	38
7k. Living Skills	31	31	24	33
7l. Transportation	51	68	61	74
7m. Personal Growth/Community	52	48	44	56
Other Resources	8	13	10	12
Total CSN 7 Unmet Needs	529	647	550	707

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	560	572	520	559
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	4	8	10	8
7a-iii Dialectical Behavioral Therapy	4	7	2	9
7a-iv Family Psycho-Educational Treatment	1	1	2	0
7a-v Group Counseling	4	3	3	5
7a-vi Individual Counseling	39	47	40	62
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	2	2	1	5
7a-x Psychiatric Medication Management	41	53	43	47
Total Unmet Resource Needs	95	121	101	136
Distinct Clients with Unmet Resource Needs	69	89	70	94
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	14	20	17	29
7b-ii Mental Health Advance Directives	2	1	1	2
Total Unmet Resource Needs	16	21	18	31
Distinct Clients with Unmet Resource Needs	15	20	18	31
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	4	2	3	2
7c-ii Recovery Workbook Group	0	1	1	0
7c-iii Social Club	6	13	10	10
7c-iv Peer-Run Trauma Recovery Group	6	6	3	7
7c-v Wellness Recovery and Action Planning	2	1	1	1
7c-vi Family Support	7	14	7	11
Total Unmet Resource Needs	25	37	25	31
Distinct Clients with Unmet Resource Needs	21	30	23	27
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	2	5	7	12
7d-ii Residential Treatment Substance Abuse Services	0	0	1	2
Total Unmet Resource Needs	2	5	8	14
Distinct Clients with Unmet Resource Needs	2	5	7	13

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	560	572	520	559
7e. Housing				
7e-i Supported Apartment	5	10	5	9
7e-ii Community Residential Facility	4	3	3	3
7e-iii Residential Treatment Facility (group home)	2	1	0	2
7e-iv Assisted Living Facility	3	2	2	2
7e-v Nursing Home	0	0	0	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	48	68	46	61
Total Unmet Resource Needs	62	84	56	78
Distinct Clients with Unmet Resource Needs	58	78	52	72
7f. Health Care				
7f-i Dental Services	31	37	32	39
7f-ii Eye Care Services	11	13	15	17
7f-iii Hearing Services	2	4	2	1
7f-iv Physical Therapy	3	6	6	8
7f-v Physician/Medical Services	13	20	24	28
Total Unmet Resource Needs	60	80	79	93
Distinct Clients with Unmet Resource Needs	45	60	54	66
7g. Legal				
7g-i Advocate	9	7	9	8
7g-ii Guardian (private)	0	0	0	0
7g-iii Guardian (public)	1	0	0	1
Total Unmet Resource Needs	10	7	9	9
Distinct Clients with Unmet Resource Needs	10	7	9	9
7h. Financial Security				
7h-i Assistance with Managing Money	39	47	36	43
7h-ii Assistance with Securing Public Benefits	20	22	27	35
7h-iii Representative Payee	2	2	2	7
Total Unmet Resource Needs	61	71	65	85
Distinct Clients with Unmet Resource Needs	47	56	51	66

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	560	572	520	559
7i. Education				
7i-i Adult Education (other than GED)	3	4	2	7
7i-ii GED	3	6	1	2
7i-iii Literacy Assistance	1	2	2	2
7i-iv Post High School Education	4	2	5	6
7i-v Tuition Reimbursement	1	1	0	0
Total Unmet Resource Needs	12	15	10	17
Distinct Clients with Unmet Resource Needs	12	13	9	15
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	7	9	6	5
7j-ii Club House and/or Peer Vocational Support	0	1	8	7
7j-iii Competitive Employment (no supports)	4	6	5	9
7j-iv Supported Employment	5	4	3	2
7j-v Vocational Rehabilitation	28	26	18	15
Total Unmet Resource Needs	44	46	40	38
Distinct Clients with Unmet Resource Needs	35	37	33	31
7k. Living Skills				
7k-i Daily Living Support Services	20	19	15	22
7k-ii Day Support Services	0	1	2	3
7k-iii Occupational Therapy	2	1	2	2
7k-iv Skills Development Services	9	10	5	6
Total Unmet Resource Needs	31	31	24	33
Distinct Clients with Unmet Resource Needs	30	30	22	27
7l. Transportation				
7l-i Transportation to ISP-Identified Services	27	30	30	38
7l-ii Transportation to Other ISP Activities	14	16	15	22
7l-iii After Hours Transportation	10	22	16	14
Total Unmet Resource Needs	51	68	61	74
Distinct Clients with Unmet Resource Needs	37	50	42	51
7m. Personal Growth/Community				
7m-i Avocational Activities	4	2	2	6

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	560	572	520	559
7m. Personal Growth/Community				
7m-ii Recreation Activities	12	10	9	14
7m-iii Social Activities	31	31	29	31
7m-iv Spiritual Activities	5	5	4	5
Total Unmet Resource Needs	52	48	44	56
Distinct Clients with Unmet Resource Needs	38	36	35	41
Other Resources				
Other Resources	8	13	10	12
Total Unmet Resource Needs	8	13	10	12
Distinct Clients with Unmet Resource Needs	8	13	10	12
CSN 7 Totals				
Total Unmet Resource Needs	529	647	550	707
Distinct Clients With any Unmet Resource Need	163	193	160	200
Distinct Clients with a RDS	560	572	520	559

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	418	386	389	372
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	6	2	2	3
7a-iii Dialectical Behavioral Therapy	2	2	0	2
7a-iv Family Psycho-Educational Treatment	0	1	1	0
7a-v Group Counseling	1	1	2	3
7a-vi Individual Counseling	21	19	22	27
7a-vii Inpatient Psychiatric Facility	1	2	1	1
7a-viii Intensive Case Management	2	1	1	2
7a-x Psychiatric Medication Management	25	19	28	19
Total Unmet Resource Needs	58	47	57	57
Distinct Clients with Unmet Resource Needs	44	34	42	40
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	5	8	7	5
7b-ii Mental Health Advance Directives	1	2	2	1
Total Unmet Resource Needs	6	10	9	6
Distinct Clients with Unmet Resource Needs	5	9	8	6
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	0	0	0	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	8	6	3	2
7c-iv Peer-Run Trauma Recovery Group	2	2	2	4
7c-v Wellness Recovery and Action Planning	2	1	2	3
7c-vi Family Support	4	3	3	3
Total Unmet Resource Needs	16	12	10	12
Distinct Clients with Unmet Resource Needs	12	8	7	8
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	2	1	0	0
7d-ii Residential Treatment Substance Abuse Services	1	2	1	1
Total Unmet Resource Needs	3	3	1	1
Distinct Clients with Unmet Resource Needs	3	3	1	1

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	418	386	389	372
7e. Housing				
7e-i Supported Apartment	2	3	3	3
7e-ii Community Residential Facility	2	1	2	3
7e-iii Residential Treatment Facility (group home)	0	0	0	0
7e-iv Assisted Living Facility	3	2	3	3
7e-v Nursing Home	1	1	1	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	37	33	26	22
Total Unmet Resource Needs	45	40	35	32
Distinct Clients with Unmet Resource Needs	44	39	34	30
7f. Health Care				
7f-i Dental Services	27	23	21	15
7f-ii Eye Care Services	8	12	9	9
7f-iii Hearing Services	3	1	1	1
7f-iv Physical Therapy	1	1	1	2
7f-v Physician/Medical Services	8	10	11	10
Total Unmet Resource Needs	47	47	43	37
Distinct Clients with Unmet Resource Needs	39	36	31	25
7g. Legal				
7g-i Advocate	5	3	5	3
7g-ii Guardian (private)	3	3	3	2
7g-iii Guardian (public)	2	2	2	1
Total Unmet Resource Needs	10	8	10	6
Distinct Clients with Unmet Resource Needs	9	7	7	5
7h. Financial Security				
7h-i Assistance with Managing Money	15	13	17	15
7h-ii Assistance with Securing Public Benefits	13	9	13	10
7h-iii Representative Payee	3	1	0	1
Total Unmet Resource Needs	31	23	30	26
Distinct Clients with Unmet Resource Needs	29	22	27	23

Report Run: Apr 14, 2014



Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 2

(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	418	386	389	372
7i. Education				
7i-i Adult Education (other than GED)	4	2	4	3
7i-ii GED	6	4	2	0
7i-iii Literacy Assistance	0	0	1	0
7i-iv Post High School Education	4	1	3	4
7i-v Tuition Reimbursement	1	0	0	1
Total Unmet Resource Needs	15	7	10	8
Distinct Clients with Unmet Resource Needs	14	7	9	7
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	1	2	1
7j-ii Club House and/or Peer Vocational Support	1	0	1	1
7j-iii Competitive Employment (no supports)	4	3	2	1
7j-iv Supported Employment	3	2	2	3
7j-v Vocational Rehabilitation	13	12	14	12
Total Unmet Resource Needs	22	18	21	18
Distinct Clients with Unmet Resource Needs	22	18	20	17
7k. Living Skills				
7k-i Daily Living Support Services	10	9	10	10
7k-ii Day Support Services	5	3	2	3
7k-iii Occupational Therapy	0	1	0	0
7k-iv Skills Development Services	5	2	1	3
Total Unmet Resource Needs	20	15	13	16
Distinct Clients with Unmet Resource Needs	15	14	13	14
7l. Transportation				
7l-i Transportation to ISP-Identified Services	16	14	14	12
7l-ii Transportation to Other ISP Activities	10	8	12	9
7l-iii After Hours Transportation	8	10	9	6
Total Unmet Resource Needs	34	32	35	27
Distinct Clients with Unmet Resource Needs	24	23	22	19
7m. Personal Growth/Community				
7m-i Avocational Activities	3	4	3	2

Report Run: Apr 14, 2014



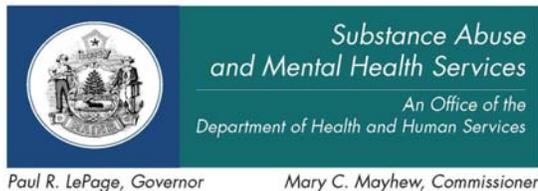
Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2014 Quarter 2
(Oct, Nov, Dec 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Distinct Clients with a RDS	418	386	389	372
7m. Personal Growth/Community				
7m-ii Recreation Activities	7	10	6	7
7m-iii Social Activities	17	13	17	16
7m-iv Spiritual Activities	3	2	4	5
Total Unmet Resource Needs	30	29	30	30
Distinct Clients with Unmet Resource Needs	20	19	22	21
Other Resources				
Other Resources	14	13	12	11
Total Unmet Resource Needs	14	13	12	11
Distinct Clients with Unmet Resource Needs	14	13	12	11
CSN Not Assigned Totals				
Total Unmet Resource Needs	351	304	316	287
Distinct Clients With any Unmet Resource Need	126	114	115	96
Distinct Clients with a RDS	418	386	389	372

Report Run: Apr 14, 2014



Department of Health and Human Services
Substance Abuse and Mental Health Services
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Bridging Rental Assistance Program (BRAP) Monitoring Report Quarter 3 FY2014 (January, February, March 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. As is reflected by the bullets below (see table and graph on last page), the BRAP program has made very efficient utilization of the influx of funds in this fiscal year.

- 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. There are no Priority 1 applicants waiting for a BRAP voucher.
- Priority #2 applicants (Homeless) have decreased from 83 to 68 persons down 18%
- Priority #3 applicants (Substandard Housing) remains at 3 persons.
- Priority #4 applicants (Community Residential Facility) have decreased from 10 to 6 persons, down 40%.
- Persons on the waitlist greater than 90 days have increased from 16 to 34 persons, up 53% --we will reach out to all persons in this category to confirm their continued interest in BRAP.

Since inception of the wait list, there has been a total of 2,767 BRAP vouchers awarded broken down as follows: Priority #1, 1,267; Priority #2, 1,202; Priority #3, 38; Priority #4, 243. Note that 17 vouchers have been awarded to persons with no priority. In the last quarter 99 vouchers were awarded.

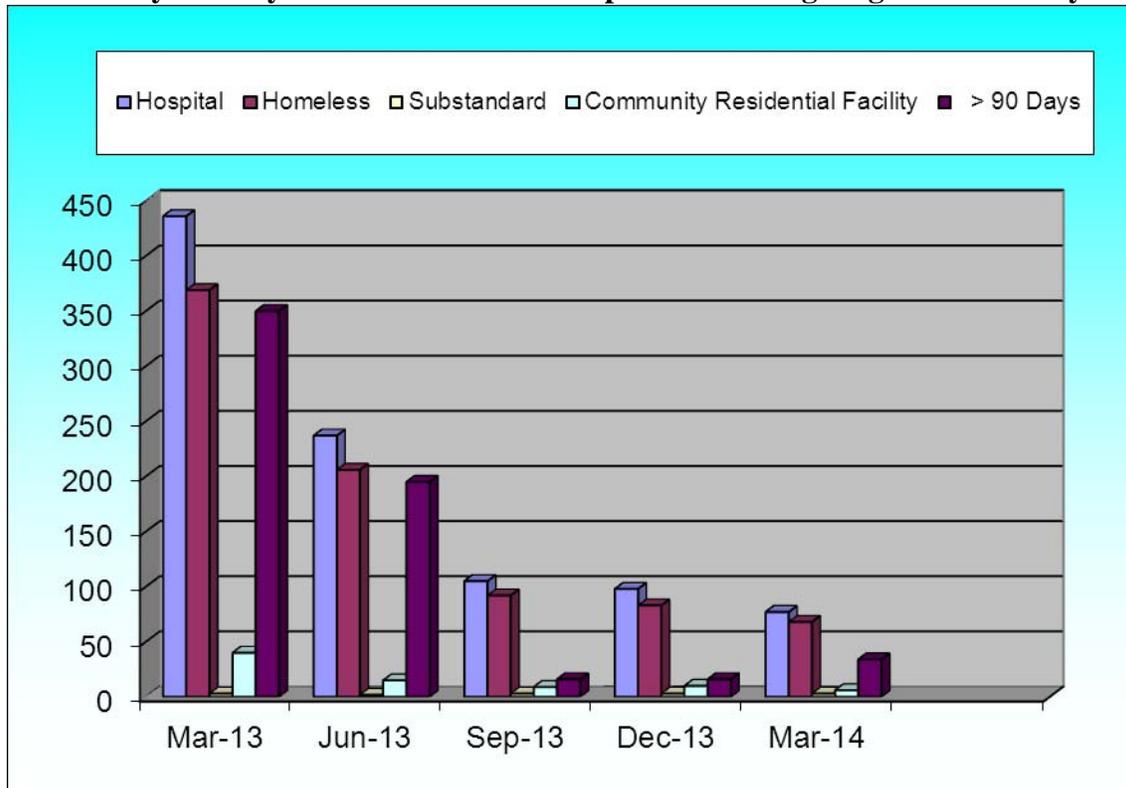
The current BRAP census as of March 31, 2014 is 1,132 vouchers issued well above our targeted goal of 930 vouchers. Due to management of voucher funding we have been able to continue progress in decreasing the waitlist. However, the number of persons waiting more than 90 days has increased substantially over the last quarter and we will be reaching out to each of these persons to determine their ongoing status. The overall budget for FY 14 increased to \$5,372,414.00 which is allowing us to better meet the waitlist needs and push for expansion into more rural areas where vouchers have not been traditionally utilized due to housing stock as well as community education and partnership. This is being done through our established administrative agents as well as the developing relationships with the PATH program, Continuums of Care, and Homeless Councils. We now have several persons housed in Washington county and continue to address the more rural parts of the State through partnering with the previously mentioned groups as well as using our existing, contracted LAA's for reaching out to those communities. Our office has met with these agencies with specific goals of increasing utilization where the clients are, rather than where the vouchers can be used by quickly finding new resources and increasing community education and partnerships.

State General Funding for FY15 has been approved by the Legislature, as a part of the SAMHS's Base, at \$5,372,414.00

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 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 was 898 as of March 31, 2014. 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. It should be noted that HUD has eliminated new project funding through an overall reduction of over 5% in this latest funding round. Maine's Shelter Plus Care program has retained its current level of federal funding. Because of HUD's elimination of funding for new projects, SAMHS did not apply for additional federal funds. The FY2014 annual budget for Shelter Plus Care is \$7.9 million. The total dollars for all SPC grants (one year renewals to 5 year new contracts) administered by SAMHS is \$14,101,781. Shelter Plus Care (SPC) provides permanent rental subsidies (housing vouchers) and supportive services (provided by MaineCare) to literally homeless individuals with: severe and persistent mental illness (63%), chronic substance abuse and mental illness (30%), and chronic substance abuse and HIV/AIDS (7%).

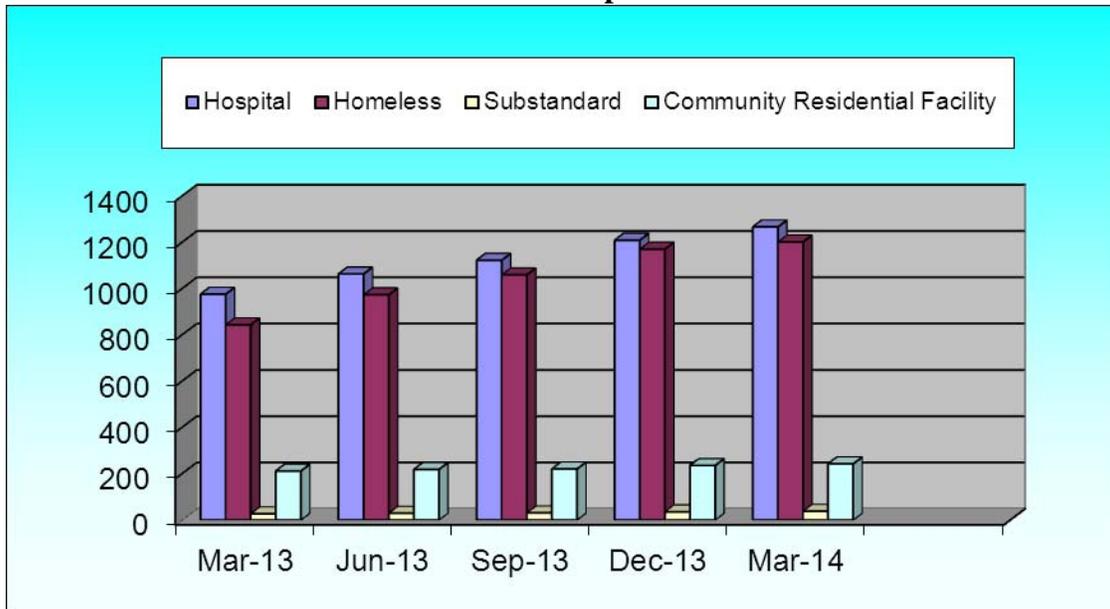
**BRAP Waitlist Status--Graph:
Detail by Priority Status to include those persons waiting longer than 90 Days**



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

Reporting Period	Mar-13	Jun-13	Sep-13	Dec-13	Mar-14	% Change relative to Last Report
Total number of persons waiting for BRAP	436	237	105	98	77	-21%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	22	12	1	2	0	-100%
Priority 2—Homeless (HUD Transitional Definition)	369	206	92	83	68	-18%
Priority 3—Sub-standard Housing	3	2	3	3	3	0%
Priority 4—Leaving a Community Residential living facility	40	15	9	10	6	-40%
Total number of persons on wait list more than 90 days awaiting voucher	350	195	16	16	34	53%

**BRAP Awards—Graph
Cumulative Since Inception of Waitlist**



**BRAP Awards—Table
Cumulative Since Inception of Waitlist**

Reporting Periods	Mar-13	Jun-13	Sep-13	Dec-13	Mar-14	% Change relative to Last Report
Cumulative number of persons awarded BRAP	2,071	2,300	2,450	2,668	2,767	4%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	976	1,064	1,123	1,210	1,267	4%
Priority 2—Homeless (HUD Transitional Definition)	844	974	1,060	1,171	1,202	3%
Priority 3—Sub-standard Housing	27	30	31	36	38	5%
Priority 4—Leaving a DHHS funded living facility	212	219	221	236	243	3%

*Note: 17 persons awarded with no priority



Class Member Treatment Planning Review

For the 3rd Quarter of Fiscal Year 2014

(January, February, March, 2014)

Total Plans Reviewed		2013 Q4 49	2014 Q1 50	2014 Q2 49	2014 Q3 53
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?	90.0% 9 of 10	100.0% 16 of 16	93.8% 15 of 16	100.0% 16 of 16
1B	Does the record document that the agency has planned with and educated the consumer regarding releases of information during each treatment plan review?	85.7% 42 of 49	80.4% 37 of 46	72.9% 35 of 48	88.2% 45 of 51
1C	Does the record document that the consumer has a primary care physician (PCP)?	91.8% 45 of 49	90.0% 45 of 50	98.0% 48 of 49	88.7% 47 of 53
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?	80.0% 36 of 45	80.0% 36 of 45	77.1% 37 of 48	83.0% 39 of 47
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?	95.9% 47 of 49	92.0% 46 of 50	100.0% 49 of 49	100.0% 52 of 52
2B	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?	100.0% 49 of 49	96.0% 48 of 50	98.0% 48 of 49	98.1% 52 of 53
2C	Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?	95.9% 47 of 49	94.0% 47 of 50	98.0% 48 of 49	98.1% 52 of 53
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	98.0% 49 of 50	100.0% 49 of 49	98.1% 52 of 53
2E	Does the record document that the consumer has a crisis plan?	63.8% 30 of 47	67.3% 33 of 49	89.8% 44 of 49	71.7% 38 of 53
2F	If 2E. is no, is the reason documented?	100.0% 17 of 17	100.0% 16 of 16	100.0% 5 of 5	100.0% 15 of 15
2G	If 2E. is yes, has the crisis plan been reviewed as required every three months?	86.7% 26 of 30	84.8% 28 of 33	90.9% 40 of 44	81.6% 31 of 38
2H	If 2E. is yes, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?	77.8% 7 of 9	100.0% 7 of 7	87.5% 7 of 8	40.0% 4 of 10
2I	Does the record document that the consumer has a mental health advance directive?	8.3% 4 of 48	4.1% 2 of 49	4.1% 2 of 49	5.7% 3 of 53
2J	If 2I. is yes, has the advance directive been reviewed at least annually by the CSW and consumer?	0.0% 0 of 4	0.0% 0 of 2	100.0% 2 of 2	0.0% 0 of 3
2K	If 2I. is no, is the reason why documented?	100.0% 44 of 44	100.0% 47 of 47	100.0% 47 of 47	100.0% 50 of 50
III Needed Resources					

3A	Does the record document that natural supports (family/friends) are being accessed as a resource?	91.8%	45 of 49	78.0%	39 of 50	100.0%	49 of 49	90.6%	48 of 53
3B	If 3A. is no, has the worker discussed with the consumer the consideration of natural supports as a resource?	100.0%	4 of 4	100.0%	11 of 11	N/A	0 of 0	100.0%	5 of 5
3C	Does the record document that generic resources (those resources that anyone can access) are being accessed?	98.0%	48 of 49	92.0%	46 of 50	100.0%	49 of 49	94.3%	50 of 53
3D	If 3C. is no, has the worker discussed with the consumer the consideration of generic resources as a resource?	0.0%	0 of 1	0.0%	0 of 4	N/A	0 of 0	0.0%	0 of 3
3E	Does the record document a resource need that has not been provided according to/within the expected response time?	10.4%	5 of 48	2.0%	1 of 50	12.2%	6 of 49	7.5%	4 of 53
3F	Does the treatment plan reflect interim planning?	60.0%	3 of 5	100.0%	1 of 1	100.0%	6 of 6	75.0%	3 of 4
3G	Does the record document that the treatment team reconvened after the unmet need was identified?	40.0%	2 of 5	200.0%	2 of 1	100.0%	6 of 6	50.0%	2 of 4
IV Service Agreements									
4A	Does the record document that service agreements are required for this plan? (see paragraph 69 protocol for definitions)	53.1%	26 of 49	46.0%	23 of 50	57.1%	28 of 49	49.1%	26 of 53
4B	If 4A. is yes, have service agreements been acquired?	73.1%	19 of 26	56.5%	13 of 23	78.6%	22 of 28	80.8%	21 of 26
4C	If 4A. is yes, are the service agreements current?	57.7%	15 of 26	47.8%	11 of 23	75.0%	21 of 28	57.7%	15 of 26
V Vocational Services									
5A	Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?	100.0%	48 of 48	95.8%	46 of 48	100.0%	47 of 47	100.0%	53 of 53
5B	Does the record document that the vocational domain is being addressed with the consumer at each 90 day treatment plan review?	85.4%	41 of 48	89.6%	43 of 48	81.6%	40 of 49	94.3%	50 of 53
VI Comments									
6A	Plan of correction requested?	53.1%	26 of 49	52.0%	26 of 50	30.6%	15 of 49	37.7%	20 of 53
6A.1.	Plan of correction for section 2A. (required when not all domains assessed) included?	100.0%	2 of 2	75.0%	3 of 4	N/A	0 of 0	N/A	0 of 0
6C	Plan of correction received?	61.5%	16 of 26	69.2%	18 of 26	93.3%	14 of 15	70.0%	14 of 20
6D	Were corrections made to the satisfaction of the CDC?	100.0%	16 of 16	100.0%	18 of 18	92.9%	13 of 14	100.0%	14 of 14

Report Run by: Brandi.Giguere Report Run on: Apr 7, 2014 at 8:49:57 AM



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Community Hospital Utilization Review for Involuntary Admissions

Class Members

For the 2nd Quarter of Fiscal Year 2014

(October, November, December, 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Total Admissions	17	20	11	17
Hospital				
Hospitalized in Local Area	88.2% (15 of 17)	90.0% (18 of 20)	27.3% (3 of 11)	76.5% (13 of 17)
Hospitalization Made Voluntary	52.9% (9 of 17)	65.0% (13 of 20)	54.5% (6 of 11)	82.4% (14 of 17)
Legal Status				
Blue Paper on File	100.0% (17 of 17)	100.0% (20 of 20)	100.0% (11 of 11)	100.0% (17 of 17)
Blue Paper Complete/Accurate	100.0% (17 of 17)	100.0% (20 of 20)	100.0% (11 of 11)	100.0% (17 of 17)
If not complete, Follow up per policy	N/A (0 of 0)			
24 Hr. Certification Required	88.2% (15 of 17)	95.0% (19 of 20)	90.9% (10 of 11)	88.2% (15 of 17)
24 Hr. Certification on file	100.0% (15 of 15)	100.0% (19 of 19)	100.0% (10 of 10)	100.0% (15 of 15)
24 Hr. Certification Complete/Accurate	100.0% (15 of 15)	100.0% (19 of 19)	100.0% (10 of 10)	100.0% (15 of 15)
If not, Follow up per policy	N/A (0 of 0)			
Quality Care				
Medical Necessity Established	100.0% (17 of 17)	100.0% (20 of 20)	100.0% (11 of 11)	100.0% (17 of 17)
Active Treatment Within Guidelines	100.0% (17 of 17)	100.0% (20 of 20)	100.0% (11 of 11)	100.0% (17 of 17)
Patient's Rights Maintained	100.0% (17 of 17)	100.0% (20 of 20)	100.0% (11 of 11)	100.0% (17 of 17)
If not maintained, follow up per policy	N/A (0 of 0)			
Inappropriate Use of Blue Paper	N/A (0 of 0)			
Individual Service Plans				
Receiving Case Management Services	41.2% (7 of 17)	35.0% (7 of 20)	54.5% (6 of 11)	76.5% (13 of 17)
Case Manager Involved with Discharge Planning	100.0% (7 of 7)	100.0% (7 of 7)	100.0% (6 of 6)	100.0% (13 of 13)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (7 of 7)	100.0% (7 of 7)	100.0% (6 of 6)	100.0% (13 of 13)
Hospital Obtained ISP when authorized	14.3% (1 of 7)	28.6% (2 of 7)	16.7% (1 of 6)	0.0% (0 of 13)
Treatment and Discharge Plan Consistant with ISP	100.0% (1 of 1)	100.0% (2 of 2)	100.0% (1 of 1)	N/A (0 of 0)

Report Run: Apr 18, 2014

For questions, contact the Data Specialist Team at the Office of Substance Abuse and Mental Health Services



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Community Hospital Utilization Review for Involuntary Admissions

All Clients

For the 2nd Quarter of Fiscal Year 2014

(October, November, December, 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Total Admissions	137	123	119	114
Hospital				
Hospitalized in Local Area	86.1% (118 of 137)	84.6% (104 of 123)	84.0% (100 of 119)	81.6% (93 of 114)
Hospitalization Made Voluntary	75.9% (104 of 137)	71.5% (88 of 123)	81.5% (97 of 119)	81.6% (93 of 114)
Legal Status				
Blue Paper on File	100.0% (137 of 137)	99.2% (122 of 123)	100.0% (119 of 119)	100.0% (114 of 114)
Blue Paper Complete/Accurate	100.0% (137 of 137)	100.0% (122 of 122)	99.2% (118 of 119)	100.0% (114 of 114)
If not complete, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	100.0% (1 of 1)	N/A (0 of 0)
24 Hr. Certification Required	82.5% (113 of 137)	87.8% (108 of 123)	89.9% (107 of 119)	87.7% (100 of 114)
24 Hr. Certification on file	100.0% (113 of 113)	100.0% (108 of 108)	100.0% (107 of 107)	99.0% (99 of 100)
24 Hr. Certification Complete/Accurate	100.0% (113 of 113)	100.0% (108 of 108)	100.0% (107 of 107)	100.0% (99 of 99)
If not, Follow up per policy	N/A (0 of 0)			
Quality Care				
Medical Necessity Established	100.0% (137 of 137)	100.0% (123 of 123)	99.2% (118 of 119)	100.0% (114 of 114)
Active Treatment Within Guidelines	100.0% (137 of 137)	100.0% (123 of 123)	100.0% (119 of 119)	100.0% (114 of 114)
Patient's Rights Maintained	100.0% (137 of 137)	98.4% (121 of 123)	97.5% (116 of 119)	100.0% (114 of 114)
If not maintained, follow up per policy	N/A (0 of 0)	0.0% (0 of 1)	100.0% (3 of 3)	N/A (0 of 0)
Inappropriate Use of Blue Paper	N/A (0 of 0)			
Individual Service Plans				
Receiving Case Management Services	23.4% (32 of 137)	17.9% (22 of 123)	18.5% (22 of 119)	28.1% (32 of 114)
Case Manager Involved with Discharge Planning	93.8% (30 of 32)	100.0% (22 of 22)	95.5% (21 of 22)	100.0% (32 of 32)
Total Clients who Authorized Hospital to Obtain ISP	100.0% (32 of 32)	100.0% (22 of 22)	100.0% (22 of 22)	100.0% (32 of 32)
Hospital Obtained ISP when authorized	6.2% (2 of 32)	18.2% (4 of 22)	18.2% (4 of 22)	6.2% (2 of 32)
Treatment and Discharge Plan Consistant with ISP	100.0% (2 of 2)	100.0% (4 of 4)	75.0% (3 of 4)	100.0% (2 of 2)

Report Run: Apr 18, 2014

For questions, contact the Data Specialist Team at the Office of Substance Abuse and Mental Health Services



Community Hospital Utilization Review for Involuntary Admissions

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

For the 2nd Quarter of Fiscal Year 2014

(October, November, December, 2013)

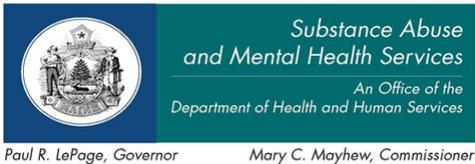
	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Number of Admissions	137	123	119	114
Involuntarily Admitted Clients who were Receiving CSS Services	32	22	22	32
Number of ISPs Hospitals were Authorized to Obtain	32	22	22	32
Number of ISPs Hospitals Obtained	2	4	4	2

FY QTR	Hospital	Admissions	Receiving Community Support Services	Hospital Obtained ISP when authorized	Treatment and Discharge Plan Consistant with ISP	Case Worker Involved with Treatment and Discharge Planning
2013 Q3	Acadia	25	32.0% (8 of 25)	12.5% (1 of 8)	100.0% (1 of 1)	100.0% (8 of 8)
	Maine General - Waterville	9	11.1% (1 of 9)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Maine Medical Center	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	10	50.0% (5 of 10)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	PenBay Medical Center	8	25.0% (2 of 8)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Select	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	28	7.1% (2 of 28)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Spring Harbor	46	21.7% (10 of 46)	0.0% (0 of 10)	N/A (0 of 0)	80.0% (8 of 10)
St. Mary's	9	33.3% (3 of 9)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)	
2013 Q4	Acadia	17	17.6% (3 of 17)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Maine General - Waterville	14	28.6% (4 of 14)	100.0% (4 of 4)	100.0% (4 of 4)	100.0% (4 of 4)
	Mid-coast Hospital	4	25.0% (1 of 4)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	7	14.3% (1 of 7)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Select	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	11	18.2% (2 of 11)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Spring Harbor	54	14.8% (8 of 54)	0.0% (0 of 8)	N/A (0 of 0)	100.0% (8 of 8)
	St. Mary's	15	20.0% (3 of 15)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
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	10	20.0% (2 of 10)	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)

Report Run: Apr 18, 2014

For questions, contact the Data Specialist Team at the Office of Substance Abuse and Mental Health Services



Community Hospital Utilization Review for Involuntary Admissions

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

For the 2nd Quarter of Fiscal Year 2014

(October, November, December, 2013)

	2013 Q3	2013 Q4	2014 Q1	2014 Q2
Number of Admissions	17	20	11	17
Involuntarily Admitted Clients who were Receiving CSS Services	7	7	6	13
Number of ISPs Hospitals were Authorized to Obtain	7	7	6	13
Number of ISPs Hospitals Obtained	1	2	1	0

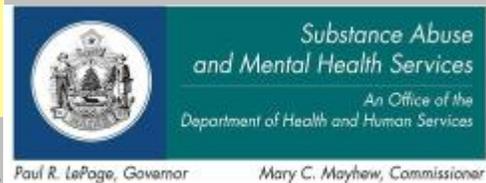
FY QTR	Hospital	Admissions	Receiving Community Support Services	Hospital Obtained ISP when authorized	Treatment and Discharge Plan Consistent with ISP	Case Worker Involved with Treatment and Discharge Planning
2013 Q3	Acadia	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Maine General - Waterville	3	33.3% (1 of 3)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Mid-coast Hospital	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	PenBay Medical Center	2	100.0% (2 of 2)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	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	9	44.4% (4 of 9)	0.0% (0 of 4)	N/A (0 of 0)	100.0% (4 of 4)
2013 Q4	Acadia	2	50.0% (1 of 2)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Maine General - Waterville	3	66.7% (2 of 3)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	PenBay Medical Center	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Spring Harbor	12	33.3% (4 of 12)	0.0% (0 of 4)	N/A (0 of 0)	100.0% (4 of 4)
	St. Mary's	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
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	4	75.0% (3 of 4)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
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 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)

Report Run: Apr 18, 2014

For questions, contact the Data Specialist Team at the Office of Substance Abuse and Mental Health Services

Maine Department of Health and Human Services

Integrated Quarterly Crisis Report



STATEWIDE with GRAPHS

Quarter 3 (January, February, March) SFY 2014

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

Gender	Children	Males	243	Females	352				
	Adults	Males	876	Females	959				
Age Range	Children	< 5	4	5 - 9	61	10 - 14	219	15-17	311
	Adults	18 - 21	181	22 - 35	548	36 - 60	896	>60	210
Payment Source	Children	MaineCare	406	Private Ins.	158	Uninsured	31	Medicare	0
	Adults	MaineCare	898	Private Ins.	304	Uninsured	535	Medicare	98

II. Summary Of All Crisis Contacts

	Children	Adults
a. Total number of telephone contacts	6,686	35,562
b. Total number of all Initial face-to-face contacts	1,281	4,100
c. Number in II.b. who are children/youth with Mental Retardation/Autism/Pervasive Dev. Disorder	112	
d. Number of face-to-face contacts that are ongoing support for crisis resolution/stabilization	73	356

III. Initial Crisis Contact Information

	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	109	8.5%	96	2.3%
b. Number of Initial face-to-face contacts who have a Community Support Worker (CI, CRS, ICM, ACT, TCM)	525	41.0%	1,323	32.3%
c. Number of Initial face-to-face contacts who have a Comm. Support Worker that was notified of crisis	430	81.9%	1,073	81.1%
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			134,488	33
e. Number of Initial face-to-face contacts in Emergency Department with final disp. within 8 hours			2,028	49.5%
f. Number of Initial face-to-face contacts not in Emergency Department with final disp. within 8 hours			1,667	40.7%

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.

	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Less Than 1 Hour.	1063	83.0%	1 to 2 Hours	174	13.6%	2 to 4 Hours	35	2.7%
Percent			Percent		Percent		Percent	0.7%
More Than 4 Hours	9	0.7%						

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

	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Less Than 3 Hours	497	38.8%	3 to 6 Hours	615	48.0%	6 to 8 Hours	46	3.6%
Percent			Percent		Percent		Percent	4.1%
8 to 14 Hours	52	4.1%	> 14	71	5.5%			

IV. Site Of Initial Face To Face Contacts

	Children		Adults	
a. Primary Care Residence (Home)	180	14.1%	449	11.0%
b. Family/Relative/Other Residence	49	3.8%	37	0.9%
c. Other Community Setting (Work, School, Police Dept, Public Place)	123	9.6%	111	2.7%
d. SNF, Nursing Home, Boarding Home	0	0.0%	15	0.4%
e. Residential Program (Congregate Community Residence, Apartment Program)	16	1.2%	65	1.6%
f. Homeless Shelter	1	0.1%	29	0.7%
g. Provider Office	33	2.6%	171	4.2%
h. Crisis Office	166	13.0%	614	15.0%
i. Emergency Department	677	52.8%	2,361	57.6%
j. Other Hospital Location	32	2.5%	179	4.4%
k. Incarcerated (Local Jail, State Prison, Juvenile Correction Facility)	4	0.3%	69	1.7%
Totals:	1,281	100%	4,100	100%

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

	Children		Adults	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	41	3.2%	211	5.1%
b. Crisis stabilization with referral to new provider for mental health/substance abuse follow up	295	23.0%	863	21.0%
c. Crisis stabilization with referral back to current provider for mental health/substance abuse follow up	444	34.7%	1,319	32.2%
d. Admission to Crisis Stabilization Unit	187	14.6%	511	12.5%
e. Inpatient Hospitalization Medical	7	0.5%	130	3.2%
f. Voluntary Psychiatric Hospitalization	304	23.7%	824	20.1%
g. Involuntary Psychiatric Hospitalization	3	0.2%	150	3.7%
h. Admission to Detox Unit	0	0.0%	92	2.2%
Totals:	1,281	100%	4,100	100%

Riverview

PSYCHIATRIC CENTER



QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE

THIRD STATE FISCAL QUARTER 2014
January, February, March 2014

Robert J. Harper
Acting Superintendent

April 23, 2014

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Glossary of Terms, Acronyms & Abbreviations

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

Glossary of Terms, Acronyms & Abbreviations

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

INTRODUCTION

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

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

There are three major sections that make up this report:

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

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CONSENT DECREE

Consent Decree Plan

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

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

Client Rights

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

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
1. Clients are routinely informed of their rights upon admission	100% 19/20 1 refusal	98% 52/55 2 refused	100% 45/45 (15/15 for Lower Saco)	100% 44/45 1 refused (15/15 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.

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	4Q2013	1Q2014	2Q2014	3Q2014
1. Level II grievances responded to by RPC on time.	0/0	50% 3/6	100% 1/1	0/0
2. Level I grievances responded to by RPC on time.	98% 58/59	98% 59/60	100% 61/61	97% 67/69

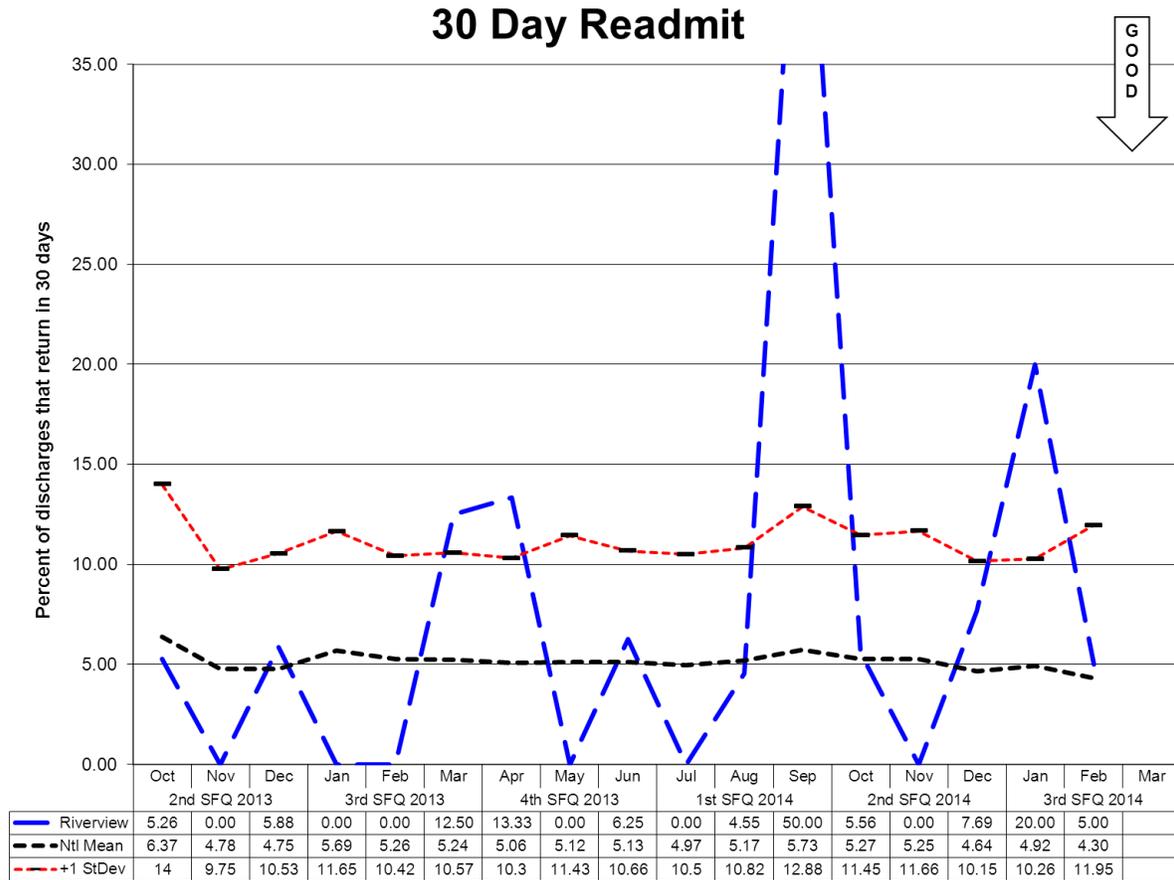
Admissions

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

Legal Status on Admission	4Q2013	1Q2014	2Q2014	3Q2014
ICDCC	17	30	15	29
ICRDCC				
INVOL CRIM				1
INVOL CRIM – Forensic Evaluation	16	24	18	19
INVOL CRIM – IST	3	5	12	8
INVOL CRIM – NCR		3	8	3
INVOL CRIM – Jail Transfer				
INVOL-CIV		1	3	3
PCHDCC	3			
PCHDCC+M				
PCHDSS-PTP-R	1			1
VOL	3		1	1

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



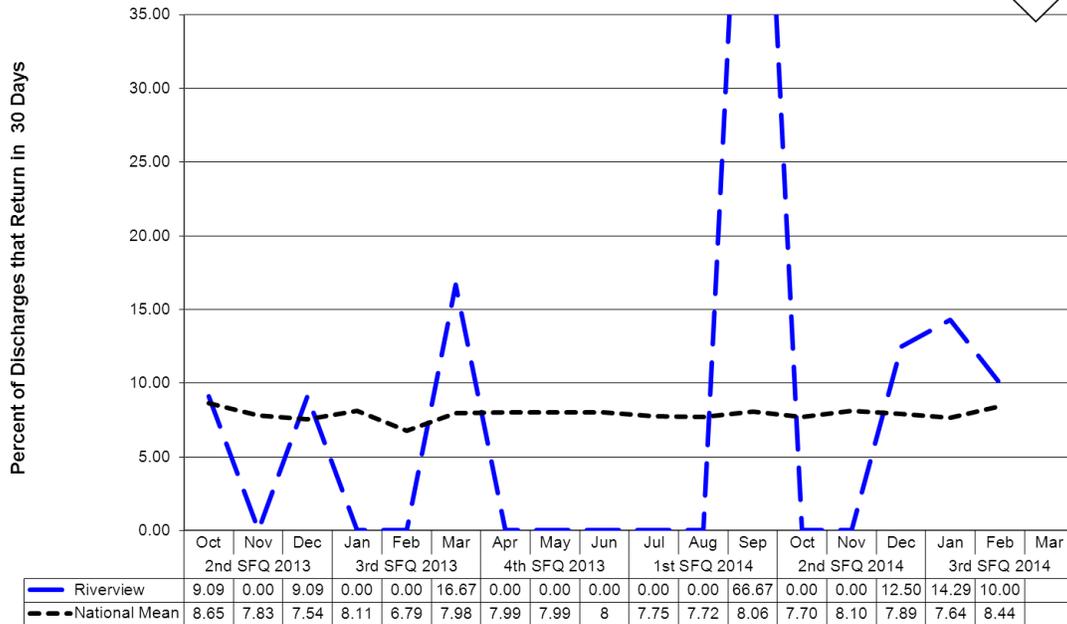
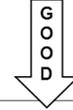
This graph depicts the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility. For example, rates of 10.0 means that 10% of all discharges were readmitted within 30 days.

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, rates of 10.0 means that 10% of all discharges were readmitted within 30 days. The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

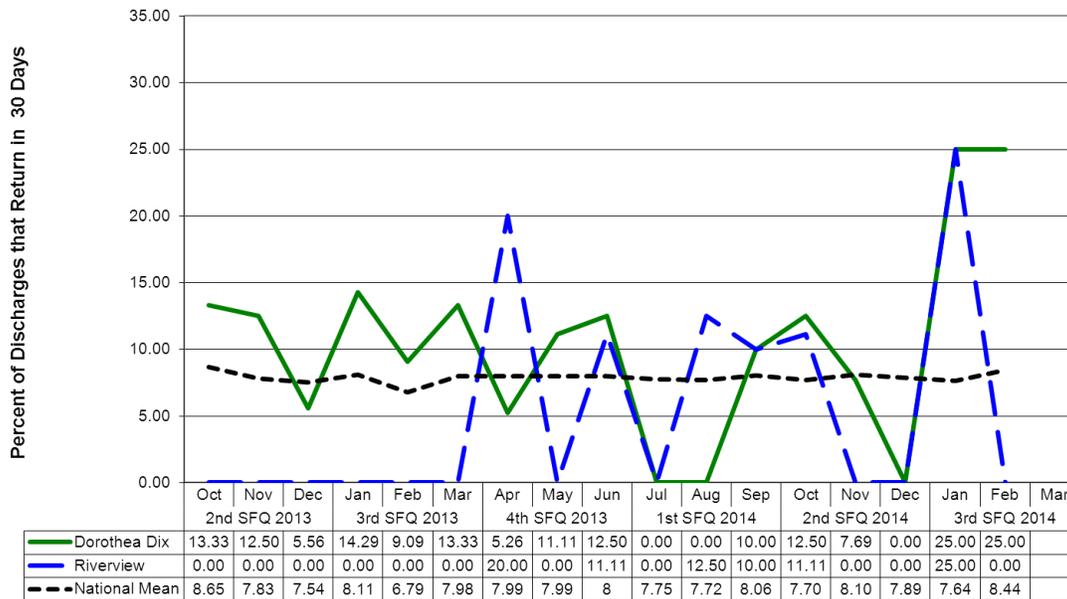
Reasons for client readmission are varied and may include decompensating or lack of compliance with a PTP to name a few. Specific causes for readmission are reviewed with each client upon their return. These graphs are intended to provide an overview of the readmission picture and do not provide sufficient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

CONSENT DECREE

30 Day Readmit Forensic Stratification



30 Day Readmit Civil Stratification



CONSENT DECREE

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	4Q2013	1Q2014	2Q2014	3Q2014
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% 3/3	100% 2/2	100% 1/1	0/0

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

CONSENT DECREE

REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
<p>1. The ACT Team Director will review all client cases of re-hospitalization from the community for patterns and trends of the contributing factors leading to re-hospitalization each quarter. The following elements are considered during the review:</p> <ul style="list-style-type: none"> a. Length of stay in community b. Type of residence (i.e.: group home, apartment, etc.) c. Geographic location of residence d. Community support network e. Client demographics (age, gender, financial) f. Behavior pattern/mental status g. Medication adherence h. Level of communication with ACT Team 	<p>100% 5 clients were returned to RPC; 4 for psychiatric symptoms, one for relapse while in supervised apartment.</p>	<p>100% 2 clients were returned to RPC for psychiatric instability,</p>	<p>100% 1 client was returned to RPC for psychiatric instability due to substance abuse relapse</p>	<p>100% 1 client was returned to DDPC for psychiatric instability, client remains in DDPC</p>
<p>2. ACT Team will work closely with inpatient treatment team to create and apply discharge plan incorporating additional supports determined by review noted in #1.</p>	<p>100%</p>	<p>100%</p>	<p>100%</p>	<p>100% Regular contact with DDPC treatment team</p>

Current Quarter Summary

1. Readmission was male, age 53; client readmitted is socioeconomically disadvantaged, had been living in his independent apartment for two years, has family support and uses resources that are available such as transportation, educational opportunities, leisure activities. Client was apparently medication adherent, and had been attending appointments as scheduled with the DDPC Clinic for medication management and psychotherapy.
2. The ACT Team and the inpatient unit of DDPC are working collaboratively toward maximizing the opportunity for success upon return to his apartment in Bangor.

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	3Q13	1Q14	2Q14	3Q14	TOT
ADJUSTMENT DISORDER WITH DEPRESSED MOOD					0
ADJUSTMENT DISORDER WITH ANXIETY	1				1
ADJUST DISORDER WITH MIXED ANXIETY & DEPRESSED MOOD	1	2	1		4
ADJUSTMENT REACTION NOS	1	1			2
ALCOHOL ABUSE-IN REMISS				1	1
ANXIETY STATE NOS	1				1
ATTN DEFICIT W HYPERACT	1	1	2		4
BIPOLAR I DISORDER, SINGLE MANIC EPISODE, UNSPECIFIED				1	1
BIPOL I, REC EPIS OR CURRENT MANIC, SEVERE, SPEC W PSYCH BEH				2	2
BIPOL I, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPEC			3		3
BIPOLAR DISORDER, UNSPECIFIED	5	9	4	5	23
DELUSIONAL DISORDER	2			2	4
DEPRESS DISORDER-UNSPEC			3		3
DEPRESSIVE DISORDER NEC	2	6		4	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
IMPULSE CONTROL DIS NOS	2		1		3
INTERMITT EXPLOSIVE DIS	1	2		1	4
MILD INTELLECTUAL DISABILITIES				1	1
MOOD DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE					0
OTH PERSISTENT MENTAL DIS DUE TO COND CLASS ELSEWHERE					0
PARANOID SCHIZO-CHRONIC	8	10	3	2	23
PARANOID SCHIZO-UNSPEC	1	2	1	4	8
PERSON FEIGNING ILLNESS		1	1		2
POSTTRAUMATIC STRESS DISORDER	3	4		5	12
PSYCHOSIS NOS	4	5	10	10	29
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	9	12	13	14	48
SCHIZOPHRENIA NOS-CHR	1		1	1	3
SCHIZOPHRENIA NOS-UNSPEC	2			1	3
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED	1		1		2
UNSPECIFIED EPISODIC MOOD DISORDER	4	8	6	9	27
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER			3		3
Total Admissions	50	63	56	64	233
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	0.00%	0.00%	0.00%	3.23%	0.86%

CONSENT DECREE

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	4Q2013	1Q2014	2Q2014	3Q2014
1. Attendance at Comprehensive Treatment Team meetings. (v9)	87% 362/418	84% 408/488	86% 352/411	86% 395/458
2. Attendance at Service Integration meetings. (v8)	79% 26/33	95% 53/56	100% 41/41	86% 55/64
3. Contact during admission. (v8)	100% 46/46	100% 56/56	100% 57/57	100% 64/64

Treatment Planning

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

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

Summary: For area 4A we had two psych-social assignments that were started but not completed within the 7 day timeframe required. Both staff were addressed in individual supervision.

CONSENT DECREE

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

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned CCM caseload.	96% 44/45	96% 29/30	93% 28/30	86% 26/30
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.	91% 55/60	100% 30/30	100% 30/30	96% 29/30

Summary: Area 1. Director addressed this issue with individual staff in supervision and with the entire team at group staff meeting.

Area 2. Director addressed issue that a plan in chart was recently timed out and due for update with individual staff member.

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

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

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

CONSENT DECREE

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

V13) the treatment plans reflect

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

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

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

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

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

CONSENT DECREE

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

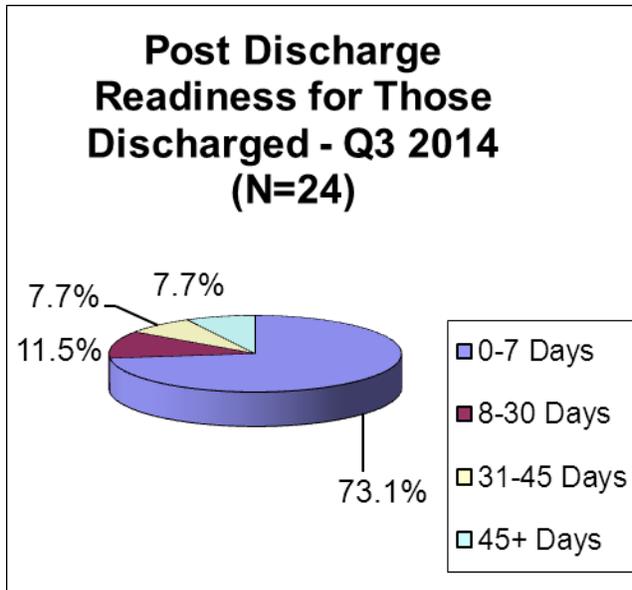
Discharges

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 = (18) 73.1% (target 70%)
- Within 30 days = (22) 84.6% (target 80%)
- Within 45 days = (23) 92.3% (target 90%)
- Post 45 days = (1) 7.7% (target 0%)

Barriers to Discharge Following Clinical Readiness

Residential Supports (2) 8%

- 1 client discharged 27 days post clinical readiness
- 1 client discharged 32 days post clinical readiness

Housing (3) 12%

- 1 client discharged 13 days post clinical readiness
- 1 client discharged 41 days post clinical readiness
- 1 client discharged 73 days post clinical readiness

Treatment Services (0) 0%

No barriers in this area

The previous four quarters are displayed in the table below

		Within 7 days	Within 30days	Within 45 days	45 +days
Target >>		70%	80%	90%	< 10%
2Q2014	N=20	73.1%	84.6%	92.3%	7.7%
1Q2014	N=26	73.1%	84.6%	92.3%	7.7%
4Q2013	N=30	70%	86.7%	93.3%	6.7%
3Q2013	N=22	77.3%	86.4%	90.0%	9.1%

CONSENT DECREE

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

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

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

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

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

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
1. The Client Discharge Plan Report will be updated/reviewed by each Social Worker minimally one time per week.	100% 13/13	100% 12/12	100% 11/11	100% 9/9
2. The Client Discharge Plan Report will be reviewed/updated minimally one time per week by the Director of Social Services.	100% 13/13	100% 12/12	100% 11/11	100% 9/9
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	100% 13/13	91% 11/12	100% 11/11	100% 9/9
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% 13/13	91% 11/12	100% 11/11	100% 9/9

Summary:

Meeting was cancelled once in the quarter due snowstorm and the Access Database was down and could not be used to distribute report for two weeks in March. A large report encompassing weeks that were missed was distributed in March when the database went back on-line.

CONSENT DECREE

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	4Q2013	1Q2014	2Q2014	3Q2014
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	80% 8/10	12% 1/8	0% 0/4	0% 0/2
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% 2/2	100% 4/4	100% 3/3
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually			100% 92/92	N/A

Summary: Area 1 a. Two reports were filed at 16 days and 25 days respectively which are outside of the 10 day standard.

CONSENT DECREE

Staffing and Staff Training

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

Indicators	1Q SFY 13-14	2Q SFY 13-14	3Q SFY 13-14	4Q SFY 13-14	YTD Findings
1. Riverview and Contract staff will attend CPR training bi-annually.	*40/46 87%	*64/67 95.5%	55/58 94.8%		92.4%
2. Riverview and Contract staff will attend NAPPI training annually.	*101/120	*137/157	*See #4. Below	*See # 4 Below	85%
3. Riverview and Contract staff will attend Annual training.	*11/25	*78/81	34/36 88%		85.5%
4. Riverview and contract staff will attend MOAB training annually	Changed to MOAB on 1/16/14	Changed to MOAB on 1/16/14	172/408 42%		42%

1Q SFY 13-14

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

One staff is out of the country,

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

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

2Q SFY 13-14

1. Three employees who are out of compliance are on leave status.

2. Eight of the employees are on leave status. The remaining twelve will be attending the next offered behavior management /physical intervention training.

3. The three the individuals who are not in compliance are on leave status.

3Q SFY 13-14

1. The three employees who are out of compliance are on leave status.

2. RPC began using MOAB as their Behavior Management Program January 16th 2014. Since that time 197/197 (active) nurses and mental health workers have received.

3. One staff is on leave status, the other staff has been informed they are out of compliance and corrective action has been taken.

CONSENT DECREE

Goal: SD will provide opportunities for employees to gain, develop and renew skills knowledge and aptitudes.

Objective: 100% of employees will be provided with an opportunity both formal and informal training and/or learning experiences that contribute to individual growth and improved performance in current position.

SD will survey staff annually and develop trainings to address training needs as identified by staff.

Current Status:

1Q SFY 13-14

Employee Education needs survey distributed to employees in March of 2013.

As a result of identified needs, the training entitled **Personality Disorder Characteristics and Effective Interventions** was developed and presented in August 2013.

August 19 & 26 2013, Susan C. Righthand, Ph.D, a nationally recognized speaker and consultant in the field of psychological assessment and treatment of sex offenders, conducted a *two part* training entitled: **Working Effectively with Adult Sexual Offenders: Characteristics, Assessment, and Interventions** available to all Riverview Psychiatric Center Employees.

August 20, 2013 Dr. Kenneth Beattie provided an in-service entitled: **The Psychology of Working with Emotionally Challenging and Emotionally Challenged Clients**. This training was developed in response to the Employee Education needs survey distributed to employees in March of 2013 and made available to all Riverview Psychiatric Center employees.

August 5, 2013, **Single Wrist Restraint Application** training was held to provide an opportunity to practice skills taught in the Initial NAPPI course provided to New Employees and NAPPI Recertification Class provided on a monthly basis through-out the year to Riverview Psychiatric Center employees. Over sixty unit staff attended.

2Q SFY 13-14

Patricia Deegan Ph D. provided **Recovery Oriented Care** training which included lessons from her own recovery from schizophrenia while teaching practical strategies for:

- Balancing the Dignity of Risk with the Duty to Care when supporting individual involvement in decision making.
- Navigating the Neglect/Overprotect Continuum, especially when folks appear to be making self-defeating choices.
- Practicing leadership-for-recovery in the workplace.

On January 18th, James Claiborn, Ph. D, provided training entitled **Understanding Behavior and Treatment Planning** in which participants learned:

How to identify, define and describe behavior.

CONSENT DECREE

How to develop interventions that reinforce behavior we want to increase and extinguish behavior we want to decrease.

STAT Drills were offered throughout the month of November and December to provide staff with the opportunity to develop and enhance behavior intervention techniques and improve overall skill level when dealing with clients having difficulty maintaining positive behavior.

3Q SFY 13-14

Staff was provided training in Policy revisions and Regulatory standards in January 2014. Additionally Recovery Oriented Care and Personal Medicine training was rolled out at the end of March 2014.

Goal: SD will develop and implement a comprehensive mentoring program to assist new employees in gaining the skills necessary to do their job.

Objective: 100% of new Mental Health Workers will be paired with a mentor and will satisfactorily complete 12 competency areas on the unit orientation prior to being assigned regular duties requiring direct care of patients.

Current Status:

1Q SFY 13-14

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

2Q SFY 13-14

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

- In addition, mentor meetings were re-initiated to assist mentors in gaining, developing and renewing skills in which to increase new employees with the opportunity to learn specific job duties associated with their position and/or care of individuals receiving services.

3Q SFY 13-14

100% of new Mental Health Workers were paired with a mentor and satisfactorily completed competency areas in the Unit Orientation.

CONSENT DECREE

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

DATE	HRS	TITLE	PRESENTER
3Q2012	14	January - March 2012	Winter Semester (see 1Q13 Quarterly Report)
4Q2012	11	April – June 2012	Spring Semester (see 1Q13 Quarterly Report)
1Q2013	3	July – September 2012	Summer Hiatus (see 1Q13 Quarterly Report)
2Q2013	9	October – December 2012	Fall Semester (see 2Q13 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)
1/2/2014	1	New Year for Riverview	Brendan Kirby MD
1/9/2014	1	Fixing Healthcare	Art DiRocco, PhD
1/30/2014	1	Lobbying for American Psychiatric Assoc.	Alex Raev, MD
2/6/2014	1	Addiction and Relapse	Ben Nordstrom, MD
2/13/2014	1	Treatment of Chronic Low Back Pain in a Psychiatric Population	Bobby Morton, PMHNP
2/20/2014	1	Treatment of Chronic Low Back Pain in a Psychiatric Population - Part II	Bobby Morton, PMHNP
2/27/2014	1	Bridging the Gap Between Cultural Sensitivity and Cultural Competence by Using Therapeutic Techniques and Common Sense	Candice Claiborne, Psychology Intern
3/6/2014	1	Treatment of Chronic Low Back Pain in a Psychiatric Population - Cognitive Behavioral Therapy	Bobby Morton, PMHNP
3/13/2014	1	Springtime for Riverview: Review of ideas outlined in New Year's session and to further the dialogue that is starting	Brendan Kirby MD
3/18/2014	1	Peer Review Committee	Medical Staff including case presentation by Miriam Davidson, PMHNP
3/20/2014	1	An Evolutionary Perspective on Antisocial Behavior	Ken Beattie, PhD
3/26/2014	3	Two Case Presentations	Miriam Davidson, PMHNP Art DiRocco, PhD Will Torrey, MD Alex DeNesnera, MD Matthew Friedman, MD
3/27/2014	1	Revisiting an Icon: The Case for Client BB	Tim Cooper, Psychology Intern

CONSENT DECREE

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.

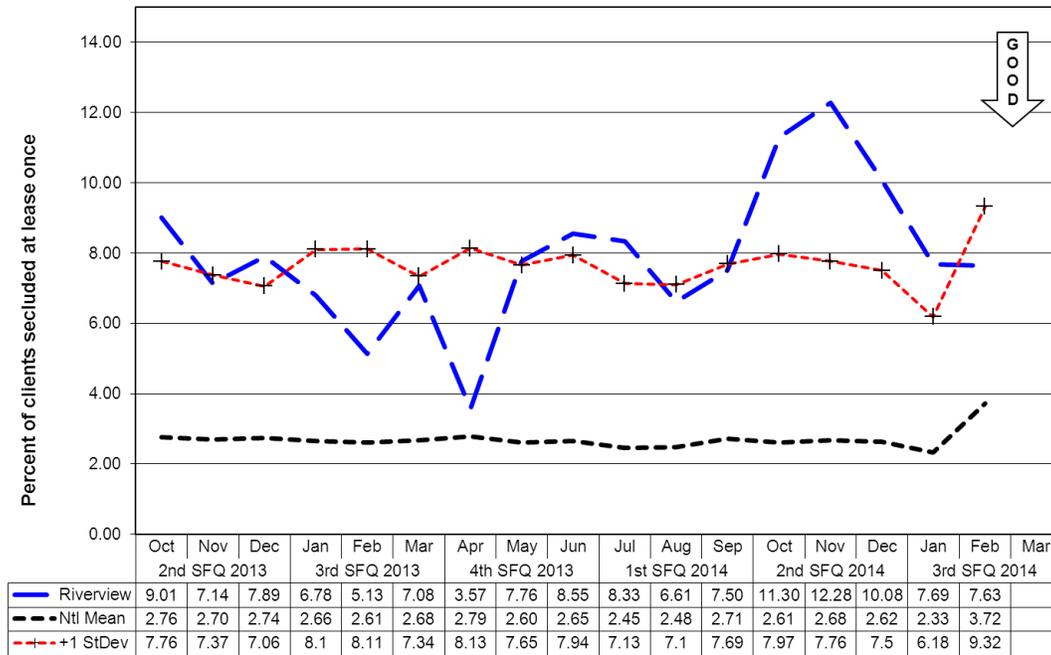
Treatment teams regularly monitor the needs of individual clients and make recommendations for ongoing treatment modalities. Staffing levels are carefully monitored to ensure that all treatment goals, exercise needs, and outdoor activities are achievable. Staffing does not present a barrier to the fulfillment 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;

Percent of Clients Secluded



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.

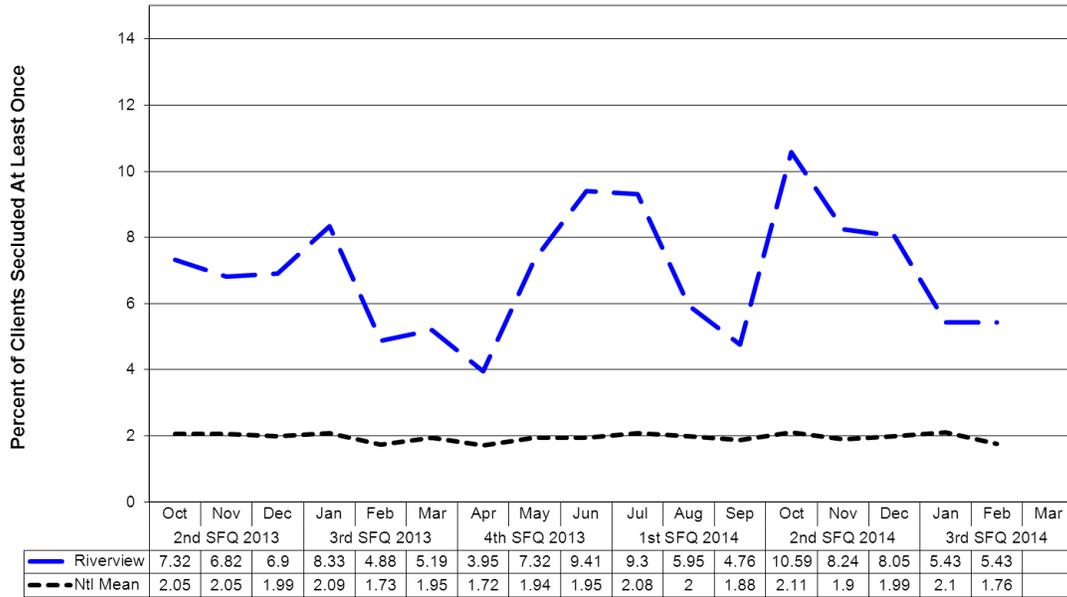
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

***Please Note: The seclusion cases for January 2014 are currently under review. Data is subject to change and if needed will be corrected in the next quarterly report.**

CONSENT DECREE

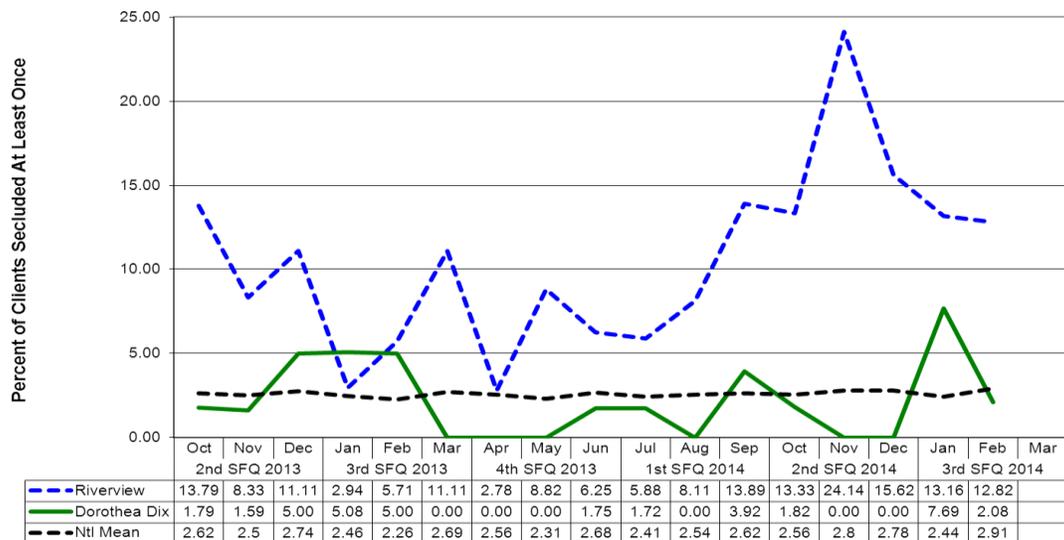
Percent of Clients Secluded

Forensic Stratification



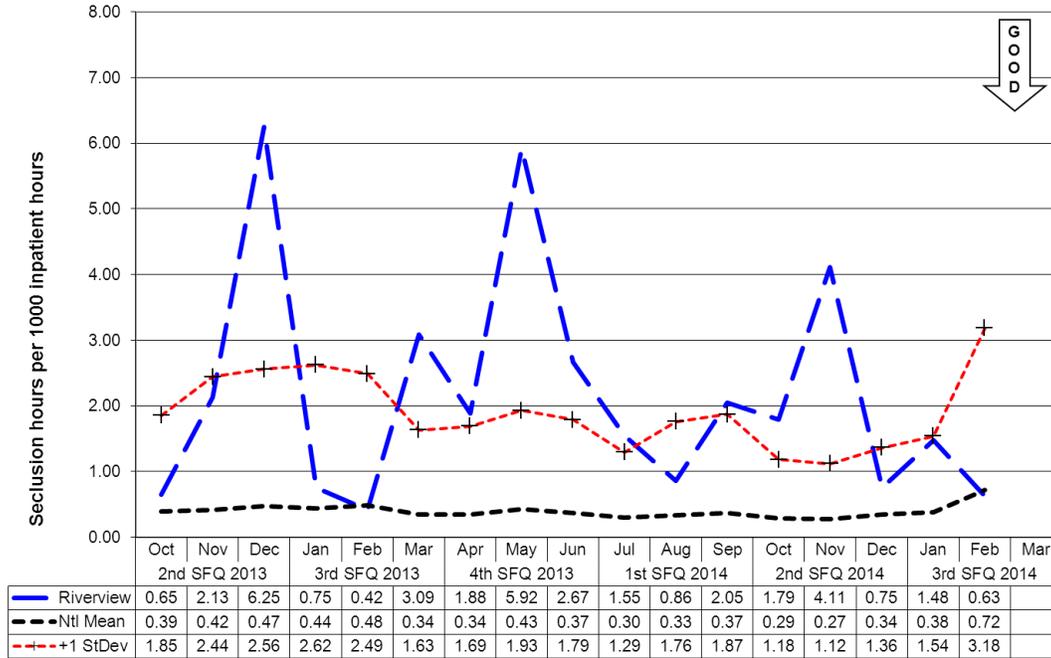
Percent of Clients Secluded

Civil Stratification



CONSENT DECREE

Seclusion Hours



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.

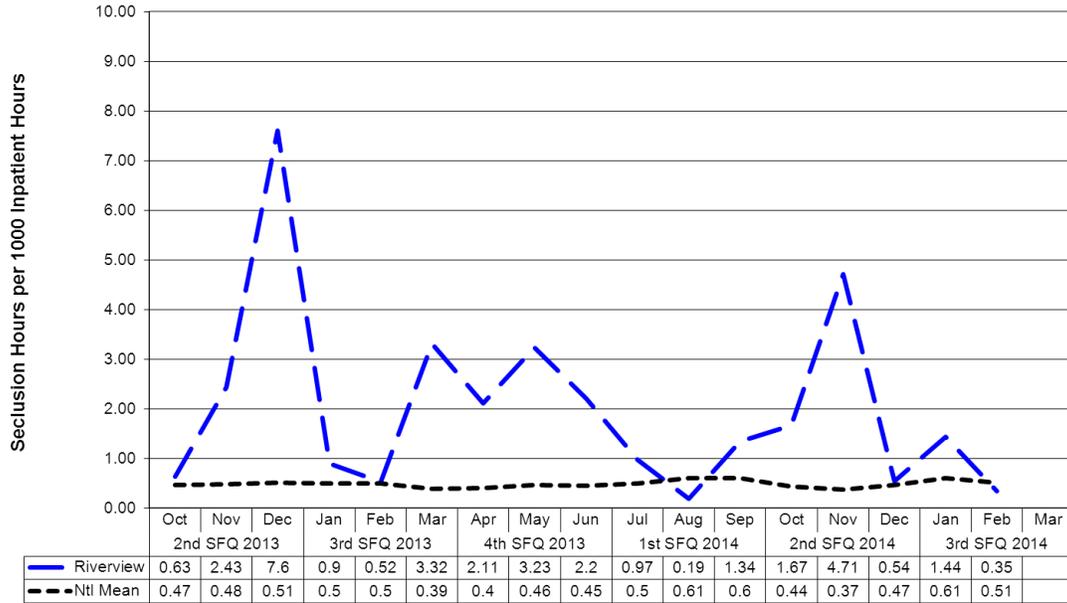
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

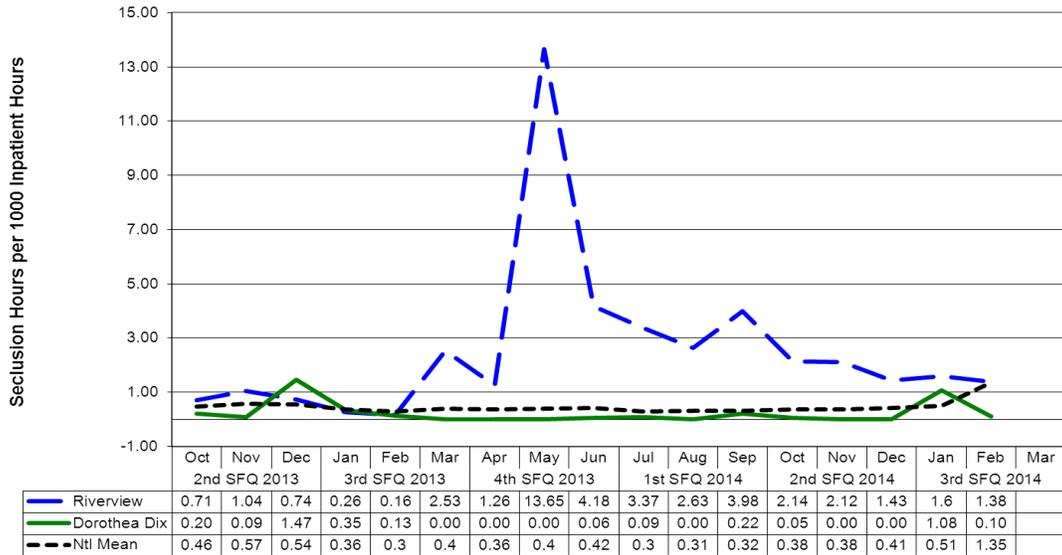
Seclusion Hours

Forensic Stratification



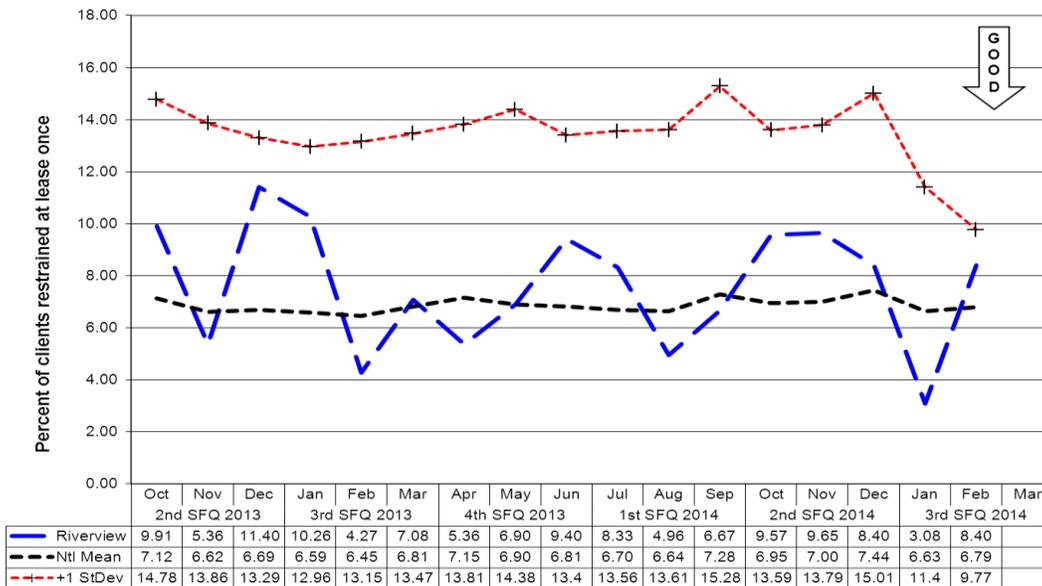
Seclusion Hours

Civil Stratification



CONSENT DECREE

Percent of Clients Restrained



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

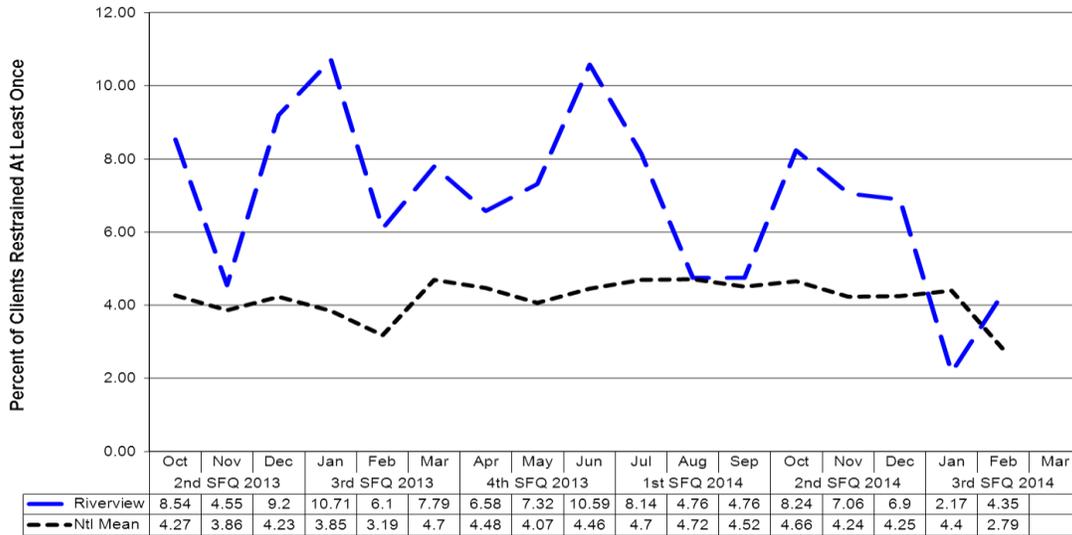
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example, rates of 4.0 means that 4% of the unique clients served were restrained at least once.

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

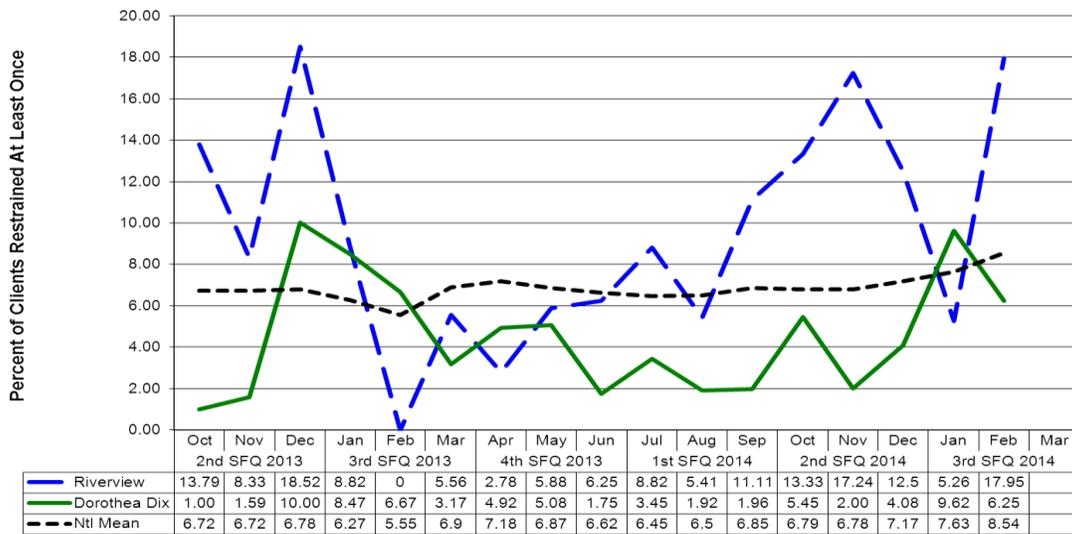
Percent of Clients Restrained

Forensic Stratification



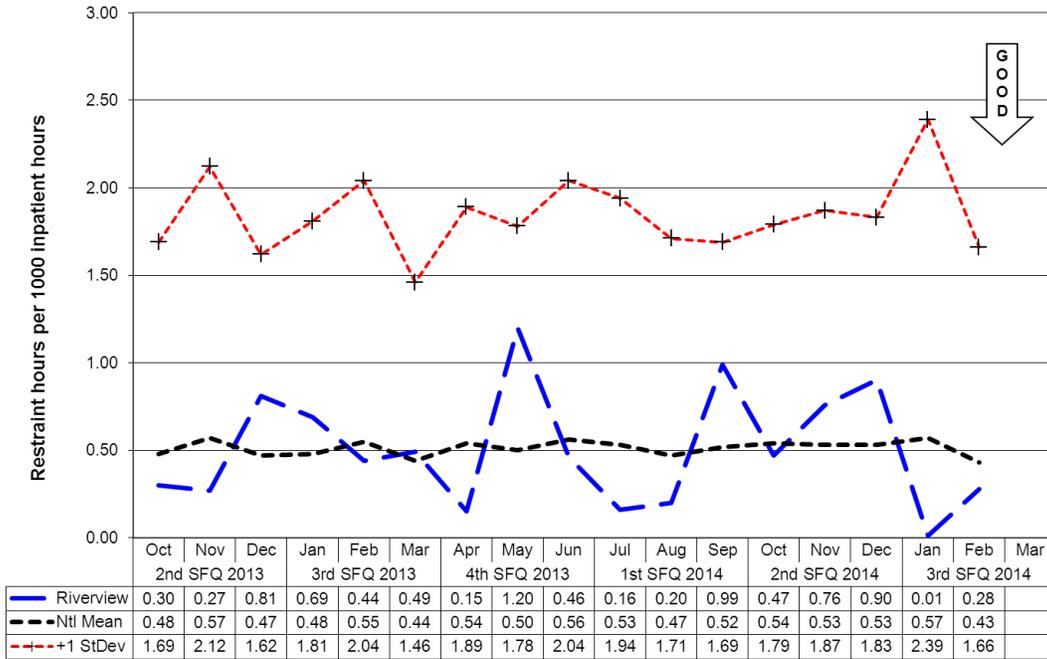
Percent of Clients Restrained

Civil Stratification



CONSENT DECREE

Restraint Hours



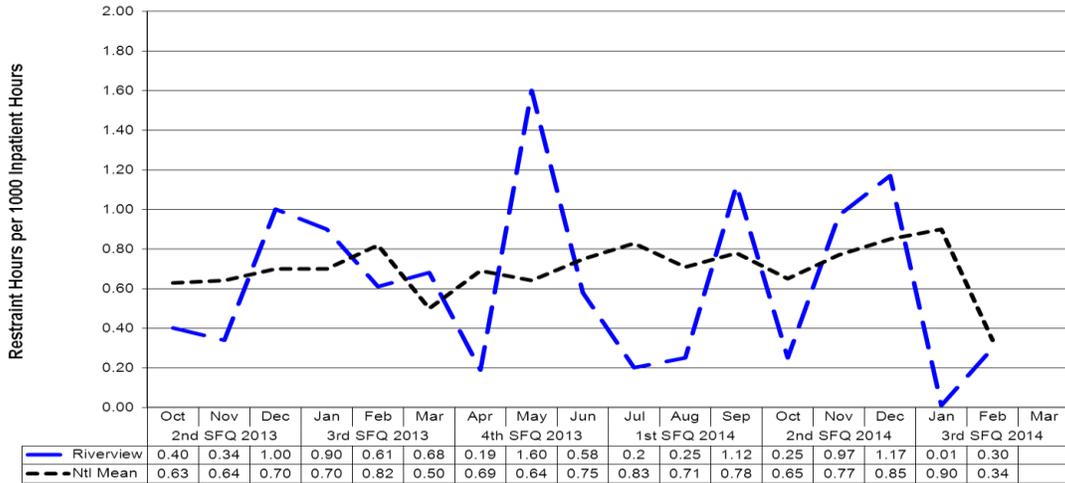
This graph depicts the number of hours clients spent in restraint for every 1000 inpatient hours - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

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

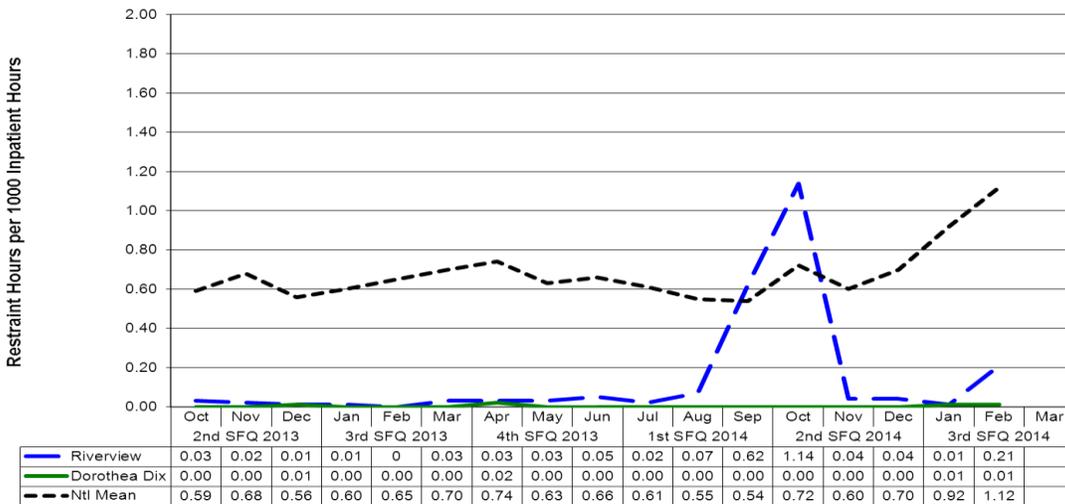
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Restraint Hours
Forensic Stratification



Restraint Hours
Civil Stratification



CONSENT DECREE

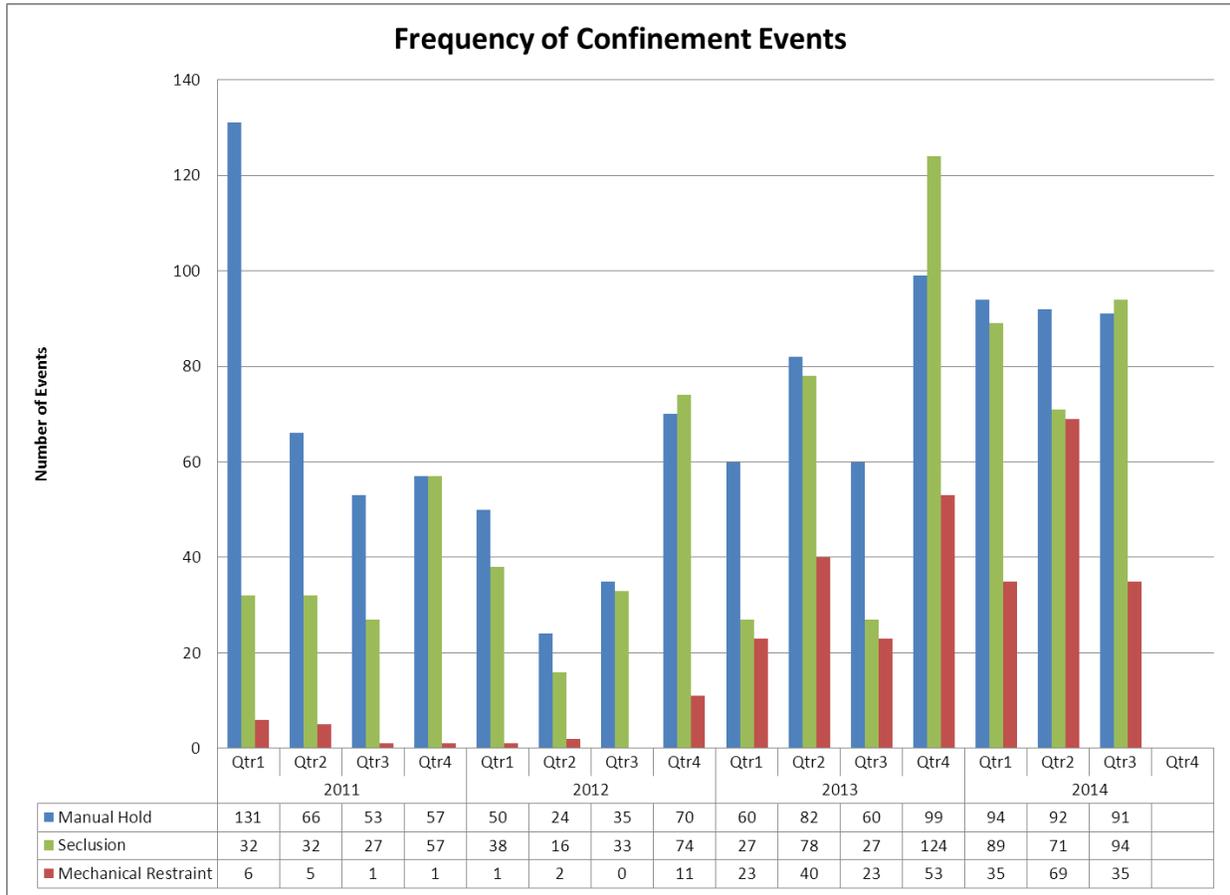
Confinement Event Detail

3rd Quarter 2014

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR3374	37	24	29	90	41.67%	41.67%
MR7495	17	9	7	33	15.28%	56.94%
MR2187	5		8	13	6.02%	62.96%
MR6963	3		8	11	5.09%	68.06%
MR7189	6		4	10	4.63%	72.69%
MR4841	2		5	7	3.24%	75.93%
MR4985	3		2	5	2.31%	78.24%
MR7032	2		3	5	2.31%	80.56%
MR7340	2		2	4	1.85%	82.41%
MR3120	1		3	4	1.85%	84.26%
MR6330			3	3	1.39%	85.65%
MR7394	3			3	1.39%	87.04%
MR5267	1		2	3	1.39%	88.43%
MR7127			3	3	1.39%	89.81%
MR0814			3	3	1.39%	91.20%
MR4814			3	3	1.39%	92.59%
MR7452	3			3	1.39%	93.98%
MR7489	1	1	1	3	1.39%	95.37%
MR6714	1		1	2	0.93%	96.30%
MR7480	1		1	2	0.93%	97.22%
MR7494			1	1	0.46%	97.69%
MR1057	1			1	0.46%	98.15%
MR7363			1	1	0.46%	98.61%
MR5206			1	1	0.46%	99.07%
MR4271			1	1	0.46%	99.54%
MR0417		1		1	0.46%	100.00%
	89	35	92	216		

33% (26/80) of average hospital population experienced some form of confinement event during the 3rd fiscal quarter 2014. Five of these clients (6% of the average hospital population) accounted for 73% of the containment events. The trend in frequency of confinement event, specifically the increase in the trend related to mechanical restraints is due to a few high acute clients requiring special management to ensure the safety of the milieu.

CONSENT DECREE



Since December 2012, Riverview has been admitting an increasing number of forensic clients that are extremely violent and difficult to manage. This increase in high acuity clients has required the use of specialized management techniques that ensure the safety of these clients, other clients, and staff while attempting to maintain a therapeutic milieu.

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

CONSENT DECREE

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

	3Q13	4Q13	1Q14	2Q14	3Q14
Danger to Others/Self	50	124	71	88	92
Danger to Others					
Danger to Self	1				
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	51	124	71	88	92

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;

Causation Related to Mechanical Restraint Events

	3Q13	4Q13	1Q14	2Q14	3Q14
Danger to Others/Self	40	53	29	51	35
Danger to Others					
Danger to Self				1	
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	40	53	29	52	35

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 29 & 30

CONSENT DECREE

Confinement Events Management

Seclusion Events (92) Events

Standard	Threshold	Compliance	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 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 lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	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 reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	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 decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	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%
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%	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 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%	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
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%			

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events (35) Events

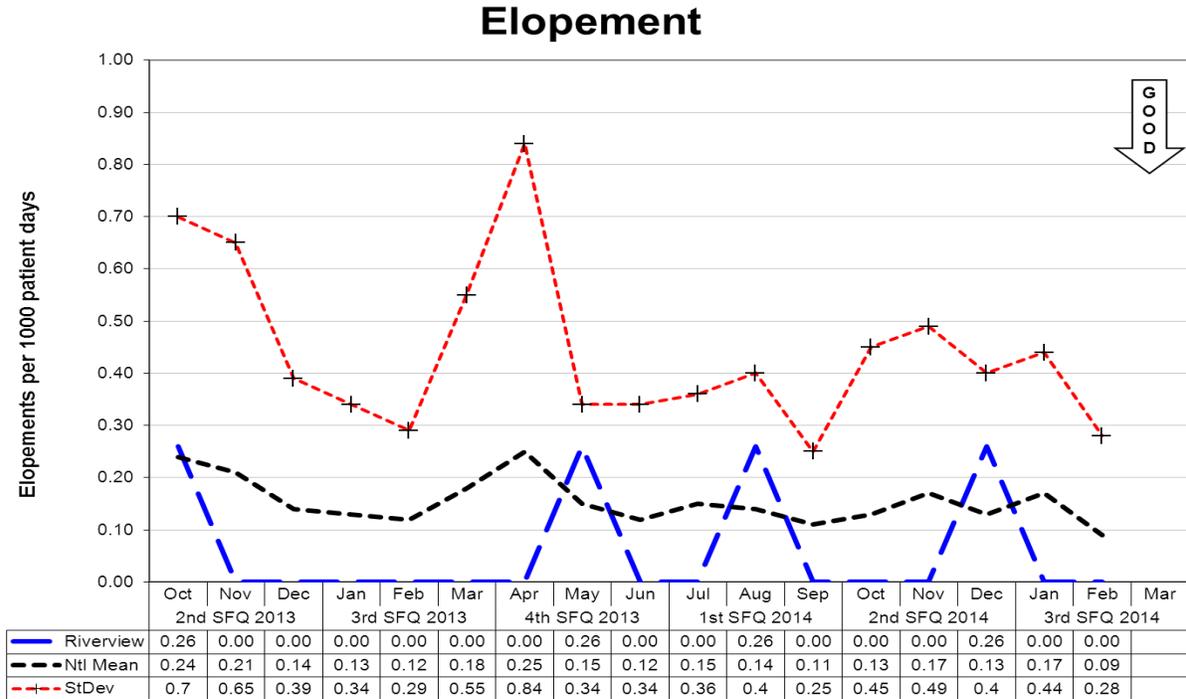
<u>Standard</u>	<u>Threshold</u>	<u>Compliance</u>
The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%
The 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%

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

CONSENT DECREE

Client Elopements

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



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.

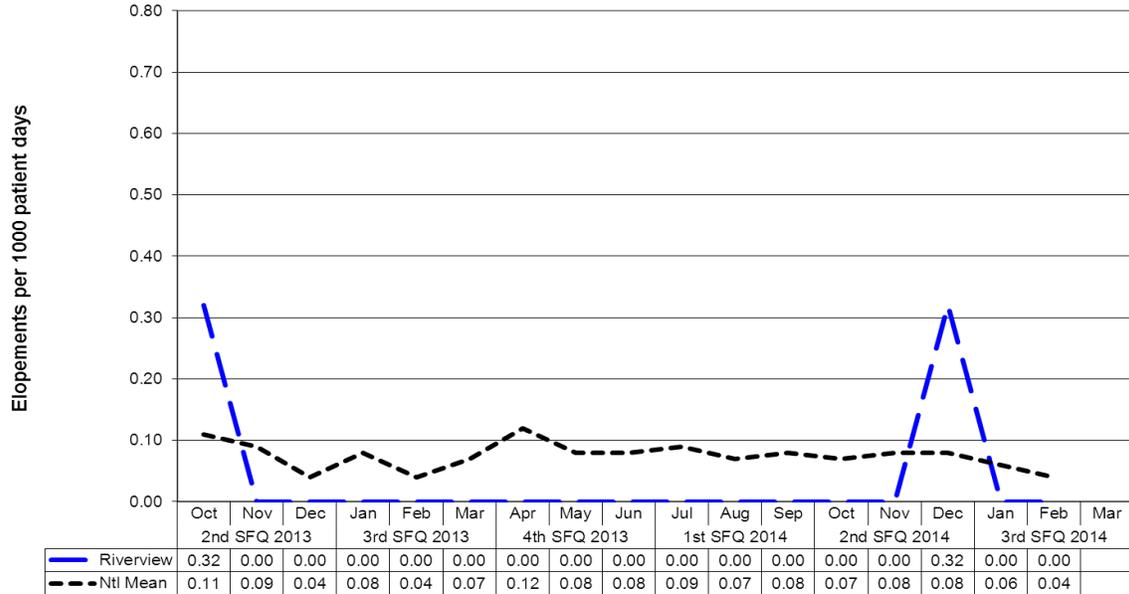
An elopement is defined as any time a client is “absent from a location defined by the client’s privilege status regardless of the client’s leave or legal status.”

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.

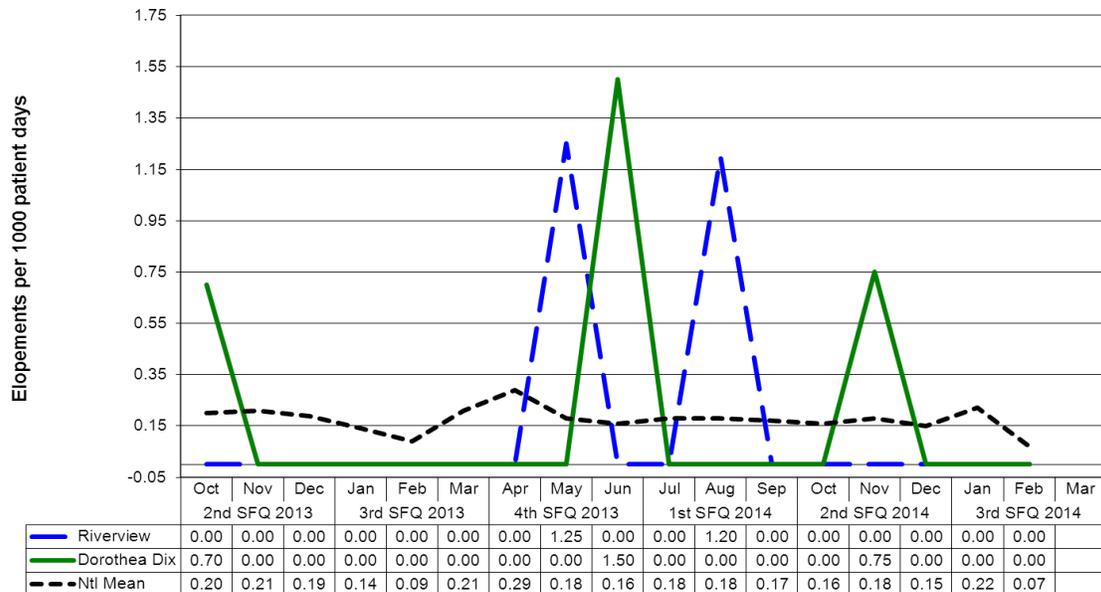
The hospital-wide results from the Dorothea Dix facility are compared to the civil population results at the Riverview facility due to the homogeneous nature of these two sample groups.

CONSENT DECREE

Eloperment Forensic Stratification



Eloperment Civil Stratification



CONSENT DECREE

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

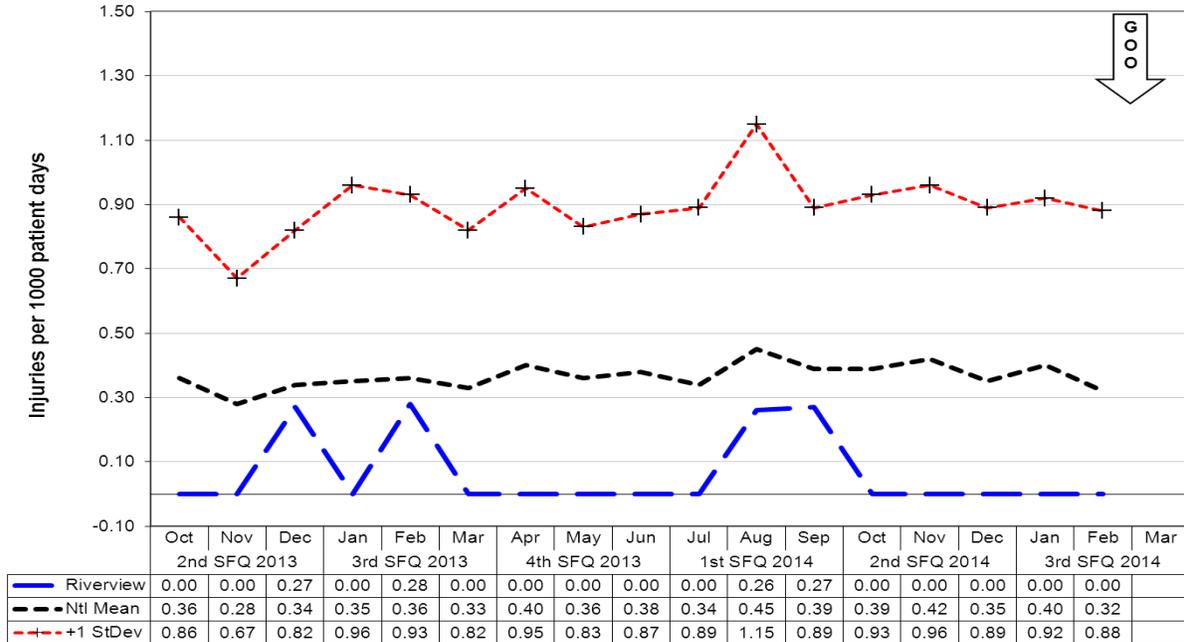
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

- 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



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.

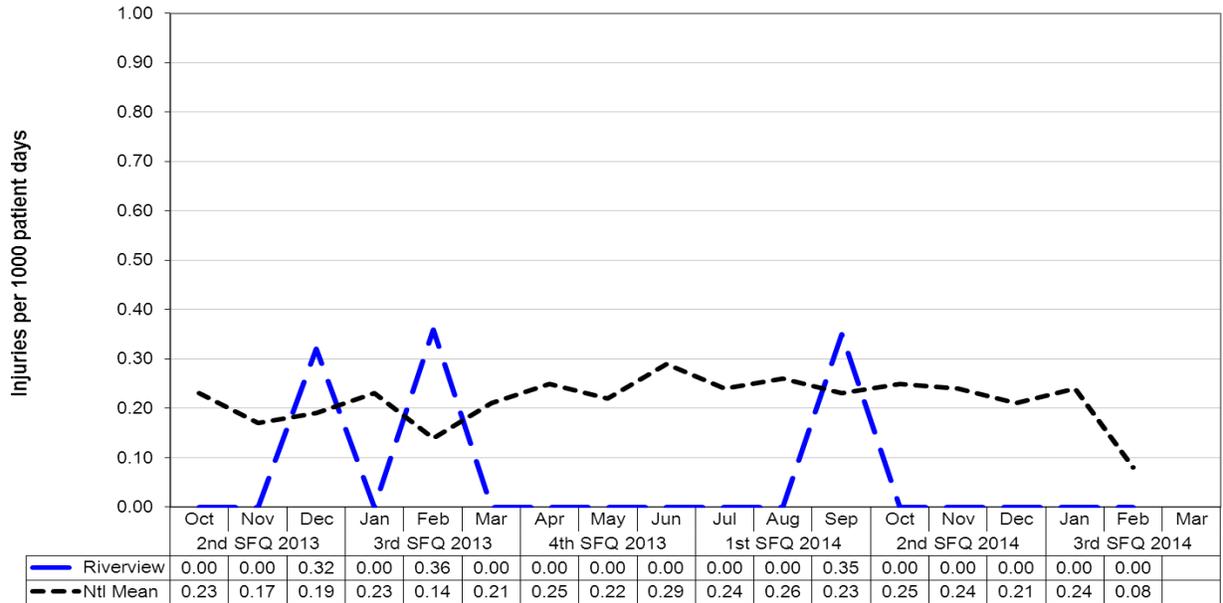
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

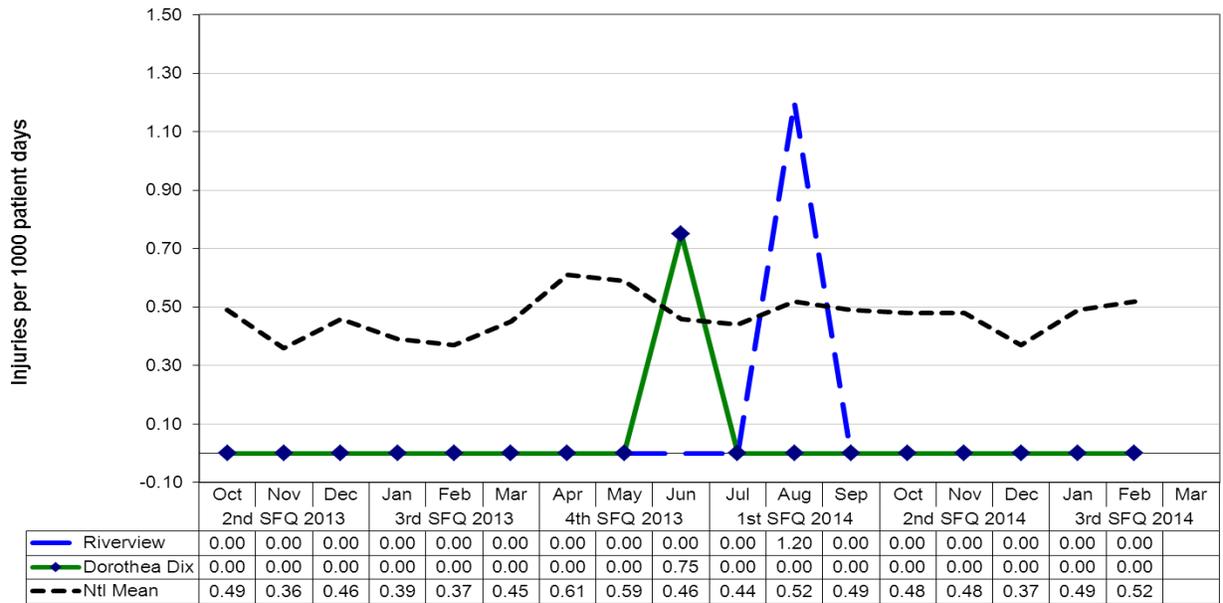
Client Injury Rate

Forensic Stratification



Client Injury Rate

Civil Stratification



CONSENT DECREE

Severity of injury by Month

Severity	JAN	FEB	MAR	3Q2014
No Treatment	33	37	47	117
Minor First Aid				
Medical Intervention Required				
Hospitalization Required				
Death Occurred				
Total	33	37	47	117

Type and Cause of Injury by Month

Type - Cause	JAN	FEB	MAR	3Q2014
Accident – Fall Unwitnessed	6	1	3	10
Accident – Fall Witnessed	4	3	5	12
Accident – Other	2	1	1	4
Assault – Client to Client	17	16	18	51
Self-Injurious Behavior	4	16	20	40
Total	33	37	47	117

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.

CONSENT DECREE

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	4Q2013	1Q2014	2Q2014	3Q2014
Abuse Physical	3	3	4	10
Abuse Sexual	5	4	2	5
Abuse Verbal		1	1	4
Coercion/Exploitation	1			
Neglect				1

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.

CONSENT DECREE

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. A triennial accreditation survey is expected to occur in November 2016 or earlier.

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

The surveyors identified four BHC and sixteen HAP areas of indirect impact that required a review and revision of hospital processes within 60 days. Three of the HAP areas were clarified within the ten days and were accepted.

V35) Riverview maintains its hospital license;

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

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

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

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

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

JOINT COMMISSION

Hospital-Based Inpatient Psychiatric Services (ORYX Data Elements)

The Joint Commission Quality Initiatives

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

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

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

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

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

Assessment

Treatment Planning and Implementation

Hope and Empowerment

Patient Driven Care

Patient Safety

Continuity and Transition of Care

Outcomes

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

JOINT COMMISSION

Admissions Screening (HBIPS 1)

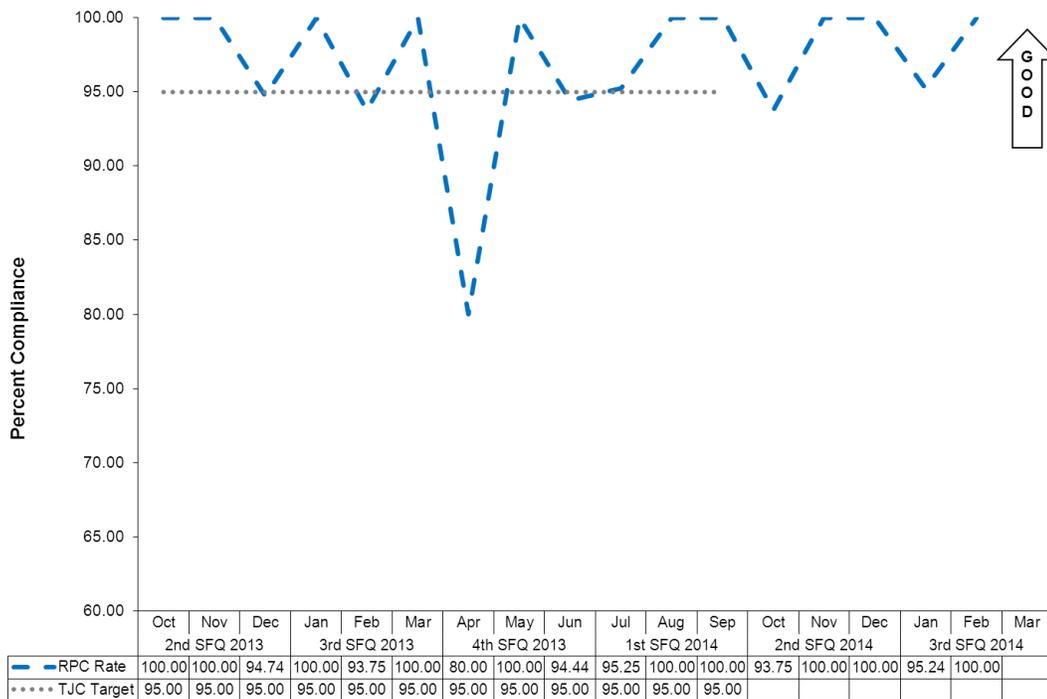
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

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.



JOINT COMMISSION

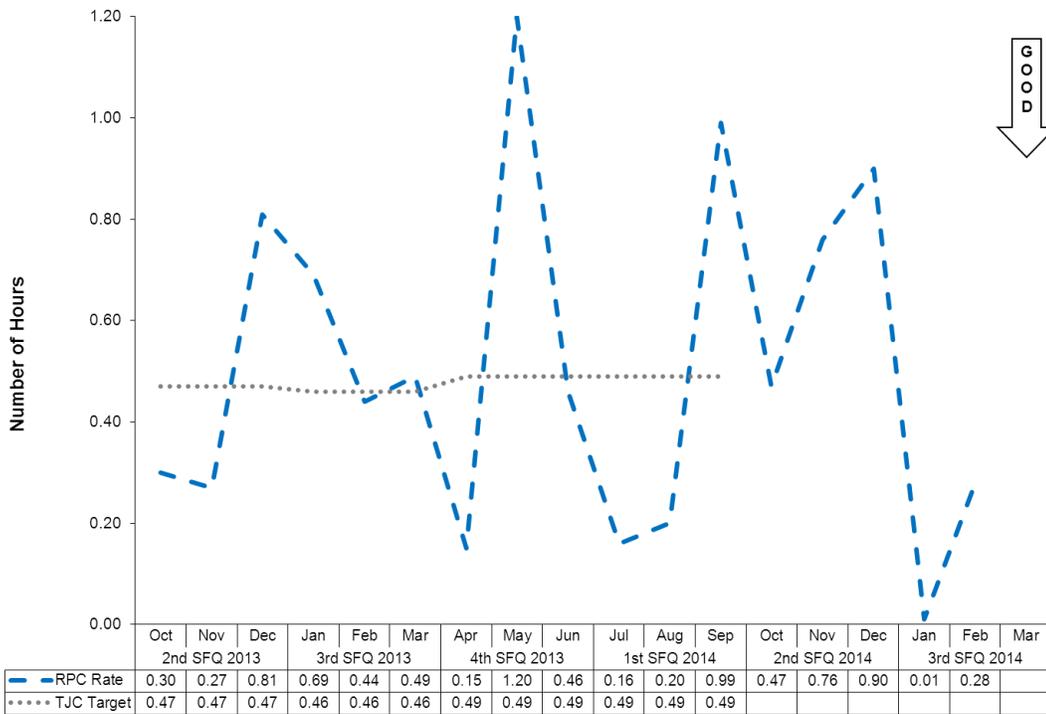
Physical Restraint (HBIPS 2) Hours of Use

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).



JOINT COMMISSION

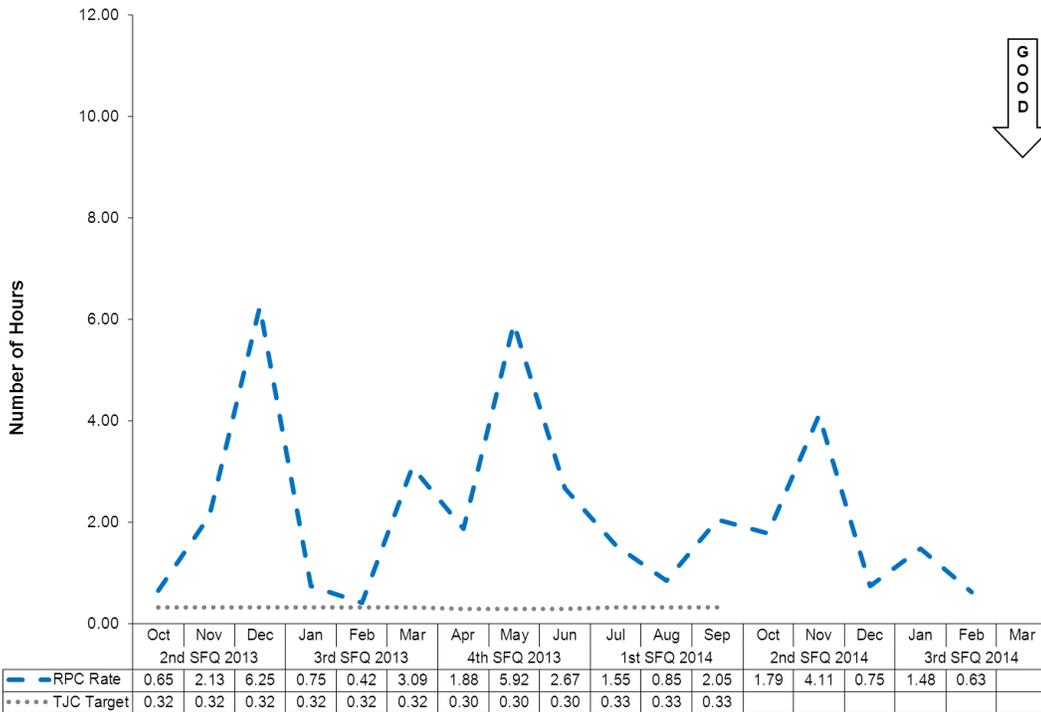
Seclusion (HBIPS 3) Hours of Use

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).



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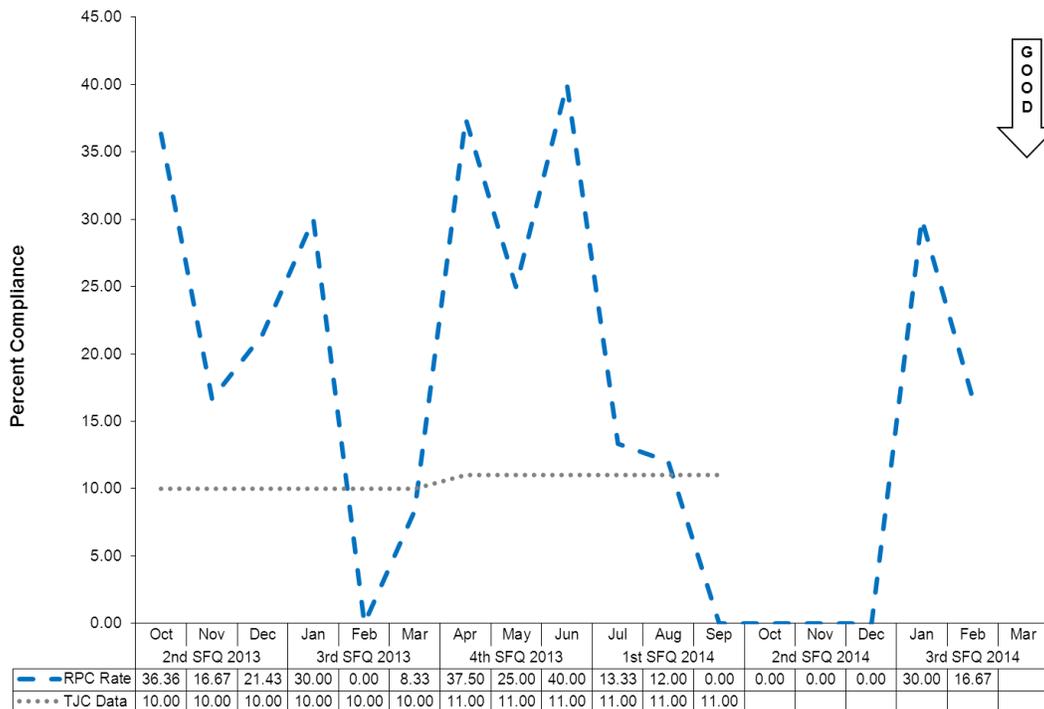
Multiple Antipsychotic Medications on Discharge (HBIPS 4)

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, Ganocy, & 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)

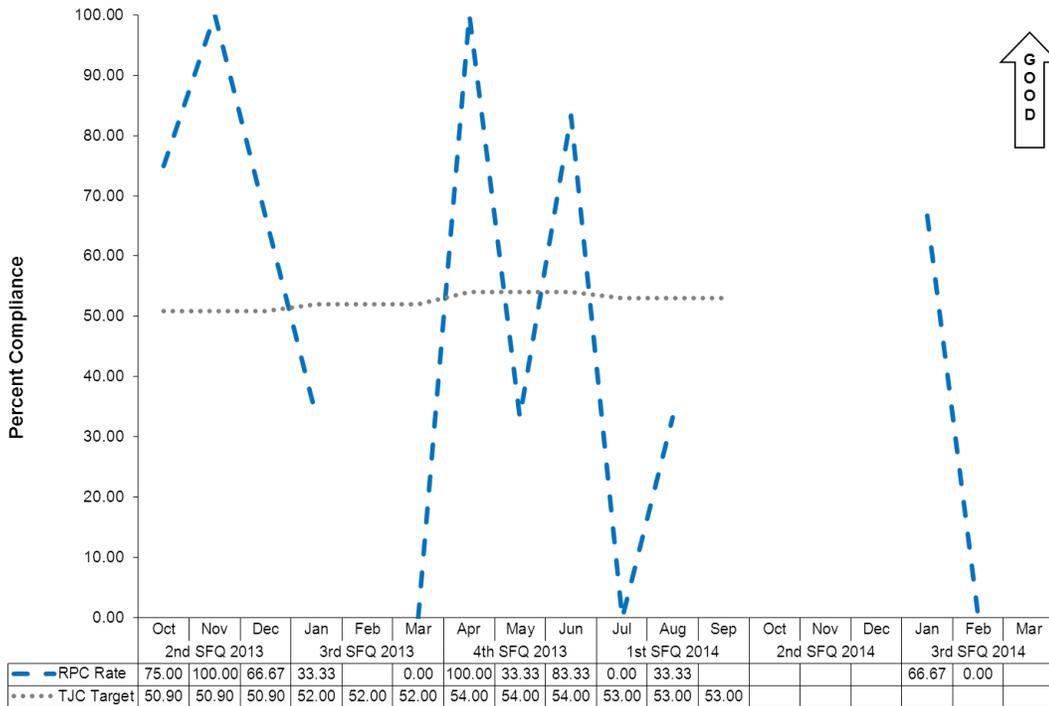
Description

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, Ganocy, & 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).

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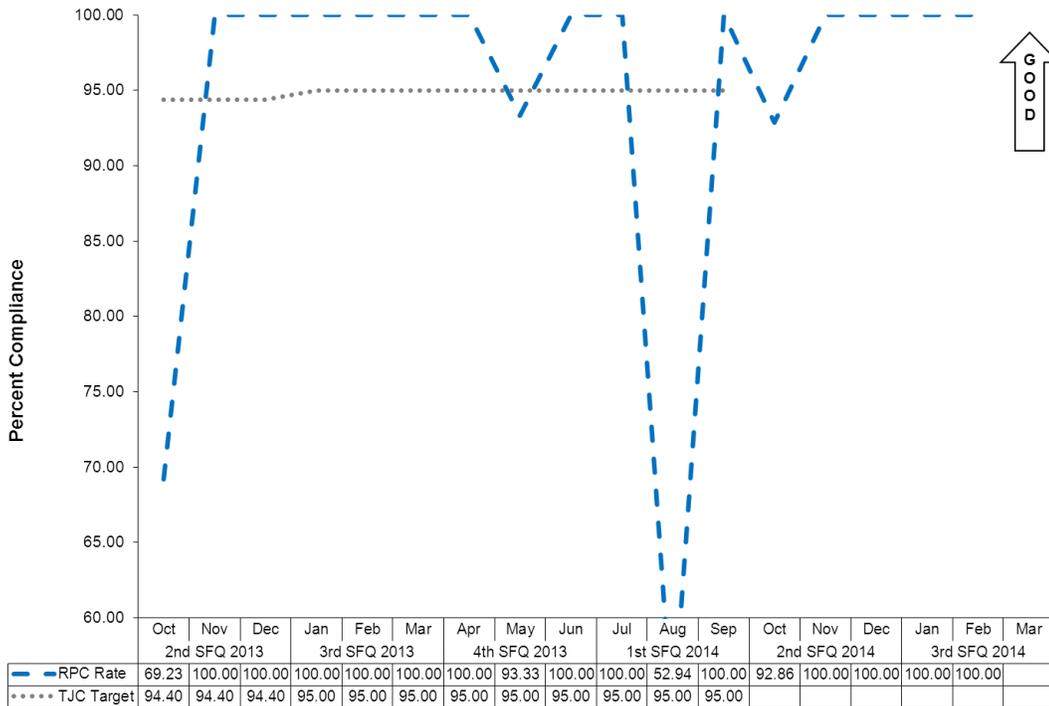
Post Discharge Continuing Care Plan (HBIPS 6)

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 [AAP], 2001).



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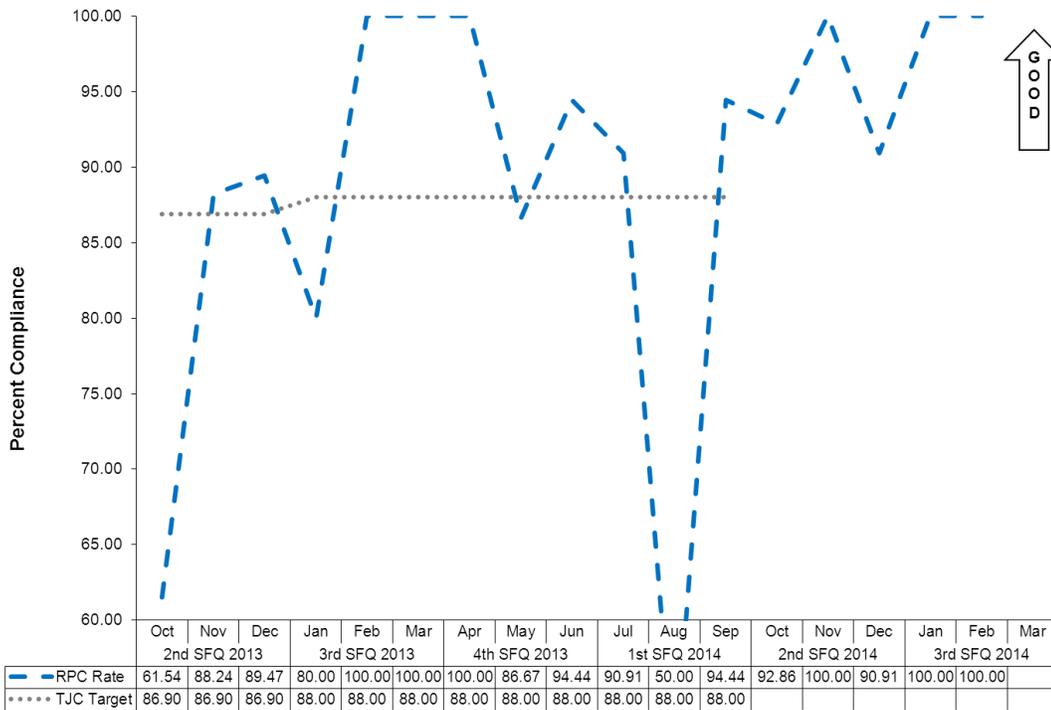
Post Discharge Continuing Care Plan Transmitted (HBIPS 7) To Next Level of Care Provider on Discharge

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 [AAP], 2001).



JOINT COMMISSION

Management of Contracted Care, Treatment and Services

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

Final Report of FY 2014 Clinical Contracts		
Contractor	Program Administrator	Summary of Performance
Amistad Peer Support Services	Stephanie George-Roy Director of Social Services	Two indicators did not meet expectations; 2 of 69 grievances were not responded to on time and Peer Support attendance at Service Integration Meetings was 94% (target is 100%).
Community Dental, Region II	Dr. Brendan Kirby Medical Director	All indicators met standards.
Comprehensive Pharmacy Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
Dartmouth Medical School	Robert J. Harper Superintendent	All indicators met or exceeded standards.
Disability Rights Center	Robert J. Harper Superintendent	All indicators met standards.
Healthreach	Dr. Brendan Kirby Medical Director	All indicators met standards.
Liberty Staffing	Dr. Brendan Kirby Medical Director	All indicators met standards.
MaineGeneral Medical Center – Laboratory Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
MD-IT	Amy Tasker Health Information Management Director	All indicators met standards.
Medical Staffing and Services of Maine, Inc.	Dr. Brendan Kirby Medical Director	All indicators met standards.
Motivational Services	Dr. Brendan Kirby Medical Director	All indicators met standards.
Occupational Therapy Consultation and Rehab Services	Janet Barrett Director of Rehabilitation	All indicators met or exceeded standards.
Securitas Security Services	Robert Patnaude Director of Security	All indicators met or exceeded standards.

JOINT COMMISSION

Capital Community Clinic Adverse Reactions to Sedation or Anesthesia

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

Dental Clinic Timeout/Identification of Client

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
National Patient Safety Goals	April 100%	July 100%	October 100%	January 100%
Goal 1: Improve the accuracy of Client Identification.	2/2	6/6	3/3	2/2
Capital Community Dental Clinic assures accurate client identification by: asking the client to state his/her name and date of birth.	May 100%	August 100%	November 100%	February 100%
	7/7	2/2	1/1	2/2
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.	June 100%	September 100%	December 100%	March 100%
	7/7	4/4	2/2	7/7
	Total 100%	Total 100%	Total 100%	Total 100%
	16/16	12/12	6/6	11/11

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	4Q2013	1Q2014	2Q2014	3Q2014
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	April 100%	July 100%	October 100%	January 100%
	2/2	6/6	3/3	2/2
• Bleeding	May 100%	August 100%	November 100%	February 100%
• Swelling	7/7	2/2	1/1	2/2
• Pain	June 100%	September 100%	December 100%	March 100%
• Muscle soreness	7/7	4/4	2/2	7/7
• Mouth care	Total 100%	Total 100%	Total 100%	Total 100%
• Diet	16/16	12/12	6/6	11/11
• 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				

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management Upper Kennebec, Lower Kennebec, Upper Saco

NPSG.07.03.01 Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the first quarter of the fiscal year, per 1000 patient days	28 – 5.02	100 %	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	11 – 1.9	100%	1 SD within the mean

HAI – Hospital Associated Infections
CAI – Community Acquired Infections

Idiosyncratic Infections – Infection secondary to self-injury

Lower Kennebec:

- External otitis – HAI
- Vaginal yeast infection – CAI
- Perianal Rash → Staph or Strep – HAI
- Bursitis & Cellulitis secondary to a fall – HAI
- Severe Onychomycosis – CAI
- Folliculitis – CAI
- Gingivitis – CAI
- Minor Abrasion – Prophylactic treatment – CAI
- UTI – HAI

Upper Saco:

- Thrush – CAI
- Dental abscess – CAI
- Tinea Pedis – CAI
- LLL Pneumonia – HAI
- Tooth Abscess – CAI
- Chronic Sinusitis – CAI
- C. difficile – HAI
- Oral Thrush – HAI
- New infiltrate>aspiration pneumonia – HAI
- Pharyngitis secondary to candida – HAI

Lower Kennebec SCU:

- Bite wound - idiosyncratic
- Laceration of left antecubital space - idiosyncratic
- Cellulitis right medial ankle - idiosyncratic
- Serous otitis - HAI

Upper Kennebec

- Dental Infection - CAI
- Dental – deep decay - CAI
- Dental abscess - CAI
- C. difficile – CAI
- Tinea Pedis - HAI
- Angular Cheilitis - CAI

Patient Days: 5576

Summary: Hospital associated infection rates remain below or within one standard deviation of the mean. One client was hospitalized at Maine General Medical Center for pneumonia when she became infected with C. difficile. She has had at least (2) incidents of recurrent pneumonia and C. difficile.

Infections are scattered throughout the hospital without evidence of cross transmission. The most common type of infection is skin infection. Skin infections are often a result of poor hygiene; or secondary to chronic medical illness i.e. diabetes.

The three (3) incidents of idiosyncratic infections were related to one client.

Plan: Continue Total House Surveillance.

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management Lower Saco

NPSG.07.03.01 Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the third quarter of the fiscal year, per 1000 patient days	27 – 17.3	100%	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	5– 3.1	100%	1 SD within the mean

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.

Patient Days: 1612

Hospital Associated Infections (HAI): 3 – 5.2

- *UTI
- *Chalazion with conjunctivitis
- *Abscess at injection site
- * Tinea pedis
- * URI

Community Associated Infections (CAI):

- *Chronic dystrophic left great toe-prophylactic treatment
- *Right second digit→erythema & abscess
- *Recurrent facial cellulitis & Folliculitis Barbae→not counted
- *Dental infection – 8
- *Post surgical prophylaxis
- *Chronic sinusitis
- *Folliculitis
- *Ingrown toe nail, early cellulitis left great toe
- *Acne Rosacea
- *Bilateral Upper Thigh Intertrigo
- * Candida Intertrigo left breast
- *Impetiginous rosacea with pustules & exudate
- *Cellulitis right ear secondary to rosacea & folliculitis
- *Laceration of forearm.-prophylactic treatment
- *Prophylactic treatment of urinary incontinence
- *Chronic dystrophic left great toe-prophylactic Rx
- *Right second digit→erythema & abscess
- *Recurrent Facial cellulitis & folliculitis Barbae>not counted
- *Post surgical prophylaxis
- *Chronic Sinusitis

Summary: The hospital associated infection rate (HAI) is within one standard deviation of the mean. No unusual infections. The community acquired infection rate (CAI) is significant for skin infections which are typically due to poor hygiene and/or chronic medical problems/conditions endogenous to the individual.

Plan: Continue total house surveillance.

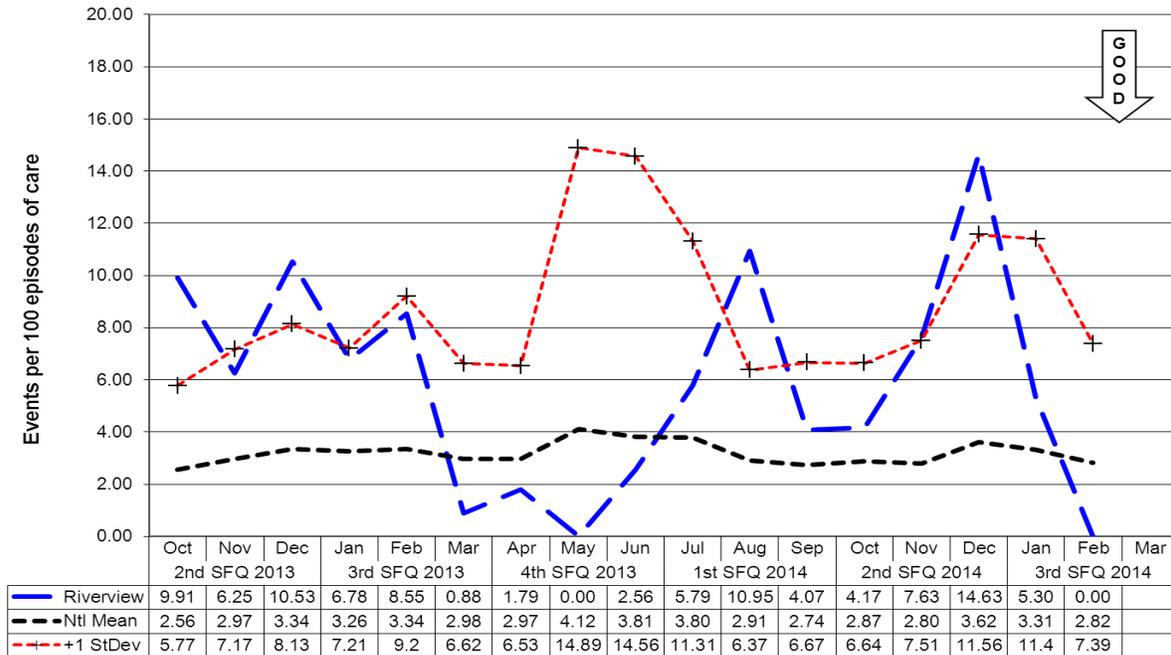
JOINT COMMISSION

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



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.

***Please Note:** Due to an error with our Electronic Medical Record, Riverview medication error rates for January and February 2014 are not accurate. Please see page 54 for a complete list of medication errors during this time period. The graph will be updated to reflect accurate data in the next quarterly report.

JOINT COMMISSION

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

<u>Date</u>	<u>OMIT</u>	<u>Co-mission</u>	<u>Float</u>	<u>New</u>	<u>O/T</u>	<u>Unit Acuity</u>	<u>Staff Mix</u>
1/5/2014	Y	TRANSCRIPTION	N	N	N	US	3 RN,5 MHW
1/11/2014	N	OMISSION X1	Y	N	N	US	3 RN,5 MHW
1/17/2014	N	TRANSCRIPTION	N	N	N	US	NOT AVAILABLE
1/17/2014	N	WRONG TIME	N	N	N	US	2 RN, 1 LPN, 4 MHW
1/17/2014	Y	TRANSCRIPTION	N	N	N	UK	NOT GIVEN
1/20/2014	N	OMISSION X1	N	N	N	UK	2 RN, 1 LPN, 4 MHW
1/20/2014	N	OMISSION X2	N	N	N	LS MAIN	NOT GIVEN
1/24/2014	Y	OMISSION X1	N	N	N	US	2 RN, 1 LPN, 6 MHW
1/27/2014	Y	MAR NOT SIGNED	N	N	N	US	NOT AVAILABLE
1/30/2014	N	OMISSION X1	Y	N	N	LK	1 RN, 1 LPN, MHW 4
2/3/2014	N	OMISSION X1	Y	N	N	LK	1 RN, 1 LPN, 4 MHW
2/3/2014	Y	OMISSION X1	N	N	N	UK	3 RN, 4 MHW
2/3/2014	N	OMISSION X1	N	N	N	LSSCU	1 RN, 4 MHW
2/4/2014	N	WRONG DOSE	N	N	N	LSSCU	4 RN, 7 MHW
2/10/2014	Y	OMISSION X1	N	N	N	US	3 RN, 6 MHW
2/11/2014	N	OMISSION X1	N	N	N	UK	NOT AVAILABLE
2/12/2014	Y	OMISSION X2	N	N	N	LK SCU	3 RN, 1 LPN, 6 MHW
2/14/2014	N	WRONG MED	N	N	N	US	3 RN, 4 MHW
2/15/2014	N	PHARMACY ERROR	N	N	N	US	NA
2/15/2014	N	WRONG TIME	N	N	N	LK	2 RN, 5 MHW
2/19/2014	N	PHARMACY ERROR	N	N	N	LS	3 RN, 1 LPN, 8 MHW
2/21/2014	Y	OMISSION X3/PA ERROR	N	N	N	US	NOT AVAILABLE
2/21/2014	Y	UNAPP ABBREV X6/PA ERROR	N	N	N	US	NA
2/21/2014	Y	PHARMACY ERROR	N	N	N	LS, LSSCU	NA
2/22/2014	N	OMISSION X1	N	N	N	UK	2 RN, 5 MHW
2/22/2014	N	WRONG DOSE ACETAMINOPHEN	N	Y	N	US	2 RN, 4 MHW
2/26/2014	y	WRONG TIME	Y	Y	N	LK	2 RN, 5 MHW
2/27/2014	N	PHARMACY ERROR	N	N	N	LS	4 RN, 1 LPN, 9 MHW
3/3/2014	N	WRONG TIME	Y	N	N	LS	4 RN, 1 LPN, 9 MHW
3/4/2014	N	WRONG TIME	N	N	N	LK	3 RN, 1 LPN, 7 MHW
3/4/2014	Y	WRONG TIME	N	N	N	US	2 RN, 6 MHW
3/5/2014	N	OMISSION X1	N	N	N	UK	2 RN, 1 LPN, 2 MHW
3/6/2014	Y	OMISSION X1	N	N	N	UK	2 RN, 1 LPN, 2 MHW
3/6/2014	N	CONTR. DRUG COUNT ERROR	N	N	N	UK	NOT AVAILABLE
3/7/2014	N	OMISSION X1	N	N	N	LSMAIN	3 RN, 3 MHW
3/11/2014	Y	PRESCRIBER ERROR	N	N	N	LS SCU	3 RN, 1 LPN, 7 MHW
3/12/2014	N	OMISSION X2	N	N	N	LK MAIN	3 RN, 1 LPN, 7 MHW
3/13/2014	N	GIVEN WITHOUT VALID ORDER	N	N	N	LS SCU	4 RN, 6 MHW
3/15/2014	N	OMISSION X2	N	N	N	LS SCU	4 RN, 1 LPN, 8 MHW
3/16/2014	N	WRONG DOSE ATIVAN	N	N	N	LS SCU	3 RN, 8 MHW

JOINT COMMISSION

Medication Management - Administration Process Medication Errors Related to Staffing Effectiveness

3/21/2014	N	WRONG TIME	N	N	N	LS MAIN	3 RN, 7 MHW		
3/24/2014	N	EXTRA DOSE TRAMADOL	Y	N	N	US	2 RN, 4 MHW		
3/24/2014	Y	PHARMACY ERROR	N	N	N	NA	3 RN, 1 LPN, 7 MHW		
3/24/2014	Y	NP PRESCRIBING ERROR	Y	Y	N	UK	2 RN, 3 MHW		
3/25/2014	N	OMISSION X1	N	N	N	US	4 RN, 1 LPN, 5 MHW		
3/26/2014	N	WRONG TIME	N	N	N	UK	3 RN, 4 MHW		
3/26/2014	Y	PRESCRIBER ERROR	N	N	N	LS MAIN	NOT AVAILABLE		
3/26/2014	Y	OMISSION X1-NOVOLOG	N	N	N	LS MAIN	3 RN, 6 MHW		
3/28/2014	Y	WRONG DOSE LACTAID	N	N	N	LK SCU	2 RN, 1 LPN, 6 MHW		
3/28/2014	Y	OMISSION X1	N	N	N	LS MAIN	1 RN, 3 MHW		
3/29/2014	Y	WRONG CLIENT	N	N	N	LS SCU	4 RN, 6 MHW		
3/30/2014	Y	EXTRA DOSE VALIUM	Y	Y	N	LS MAIN	3 RN, 7 MHW		
3/30/2014	Y	EXTRA DOSE ATIVAN	N	N	N	LS SCU	2 RN, 1 LPN, 6 MHW		
3/30/2014	Y	OMISSION X1	N	N	N	US	4 RN, 1 LPN, 5 MHW		
3/30/2014	N	OMISSION X1	N	N	N	US	4 RN, 1 LPN, 5 MHW		
Totals	24		8	4	0	LS: 19	US: 17	LK: 8	UK: 10
Percent	43.64%		14.55%	7.27%	0.00%	34.55%	30.91%	14.55%	0.18%

Summary

There were a total of 55 medication errors this quarter (44 last quarter and 38 the quarter before). 23 medication errors were omissions, 8 medications were given at the wrong time, 7 were dose related, 5 were pharmacy errors, 3 were transcription related, 3 were prescriber errors, 1 was a medication given without a valid order, 1 was given to the wrong client, 1 was given the wrong medication, 1 was related to a controlled drug count error, 1 was an PA error, and 1 was MAR not signed. 8 of the medication errors were committed by staff floating to another unit or by staff who have been designated as "floats." 4 of the 55 errors were by new staff here at RPC.

Actions

All nursing related medication errors were noted to have appropriate staffing levels. One of the actions to consider may be to return to a designated medication nurse for each unit. Nurse Pharmacy Committee meets monthly and is working towards identifying issues with medication management and identifying solutions to issues identified. Medication errors are reviewed weekly by Pharmacist, Medical Director, Risk Manager and Executive Nurse after the RN IV on the unit reviews the error with the staff person responsible for individual teaching and issue / process identification. Pharmacy is looking into different programs that can be added to Pyxis to help reduce the possibility of medications errors.

JOINT COMMISSION

Medication Management - Dispensing Process

Joint Commission Measures of Success								
Medication Management	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Controlled Substances Loss Data</u>	All		0%	0%	0%		0%	10 discrepancies between Pyxis and CII Safe transactions in Q3
<i>Daily Pyxis-CII Safe Compare Report</i>								
Quarterly Results			0.3%	0%	2.5%			
<i>Monthly CII Safe Vendor Receipt Report</i>	Rx	0	0	0	0	0	0	No discrepancies between CII Safe and vendor transactions for Q1,Q2,Q3
Quarterly Results			0	0	0			
<i>Monthly Pyxis Controlled Drug discrepancies</i>	All	11	0	0	0	0	0	Goal of "0" discrepancies involving controlled drugs dispensed from Pyxis
Quarterly Results			23	39	57			
<u>Medication Management Monitoring</u>								
<i>Measures of drug reactions, adverse drug events and other management data</i>	Rx	8/year	0	0	0	0		4 ADR's reported in Q3
Quarterly Results			1	2	4			
<i>Resource Documentation Reports of Clinical Interventions</i>	Rx	185 reports in 2013						100% of all clinical interventions are documented
Quarterly Results			79	86	120			
<u>Psychiatric Emergency Process</u>	All		N/A	N/A	100%	100%	100%	Goal of 100% compliance as measured by monthly audit tool
<i>Monthly audit of all psych emergencies measured against 9 criteria</i>								*2/1/14 to 2/25/14 and **2/26/14 to 3/24/14
Quarterly Results					*77% and **97%			

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

CMS Plan of Correction Tag #A-494 and Tag #A-506

Medication Management	Unit	Baseline Oct 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Controlled Substances Records</u>	Lower Saco	100%	100%	100%	100%	100%	100%	Goal of 100% compliance in tracking CII Safe transactions
<i>Monthly CII Safe Transactions Report Generated and Reviewed</i>								
Quarterly Results			100% (Oct)	100% (Nov&Dec)	100%			
<i>Monthly CII Safe Transactions Report Separately Maintained</i>	Rx	100%	100%	100%	100%			Transaction Reports separately maintained for Lower Saco
Quarterly Results			100% (Oct)	100% (Nov&Dec)	100%			
<u>After-Hours Drug Access Monitoring</u>								
<i>Monitor daily after-hours drug distribution reports</i>	Rx	100%	100%	100%	100%			Monitor daily after hours drug distribution reports to ensure compliance with policy
Quarterly Results			100% (Oct)	100% (Nov&Dec)	1			1 after-hours drug removed from Nitcab for Lower Saco during Q3

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

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

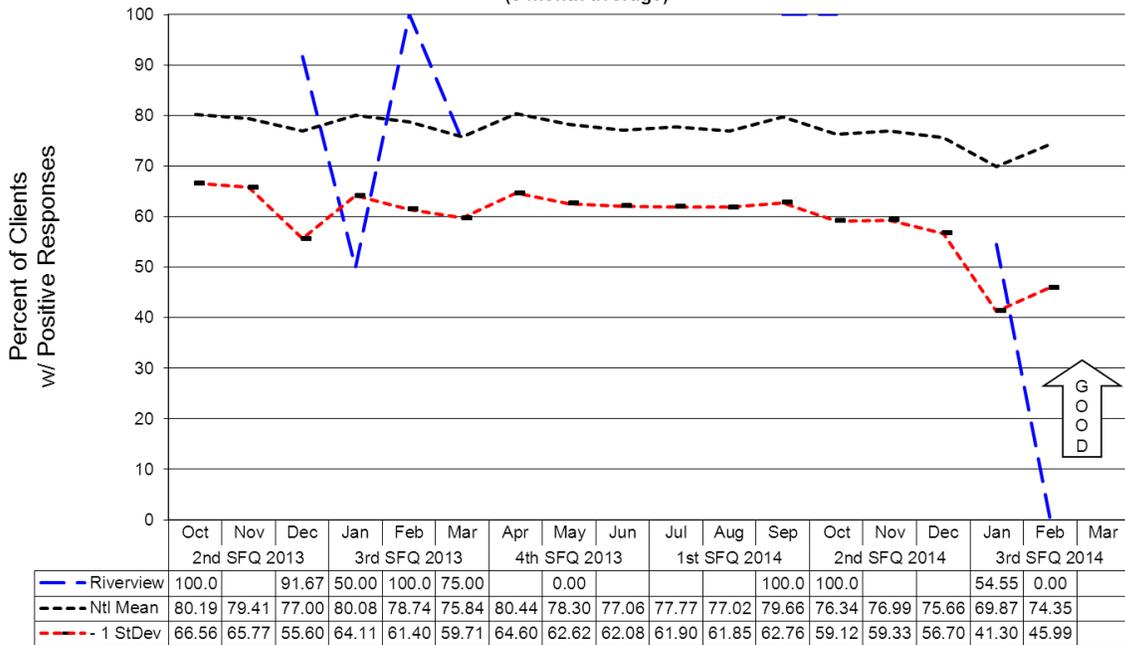
Due to the operational and safety need to refrain from complete openness regarding plans for discharge and dates of discharge for forensic clients, the process of administering the inpatient survey is difficult to administer. Whenever possible the peer support staff work to gather information from clients on their perception of the care provided to them 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 data on a forensic stratification of responses to the survey.

JOINT COMMISSION

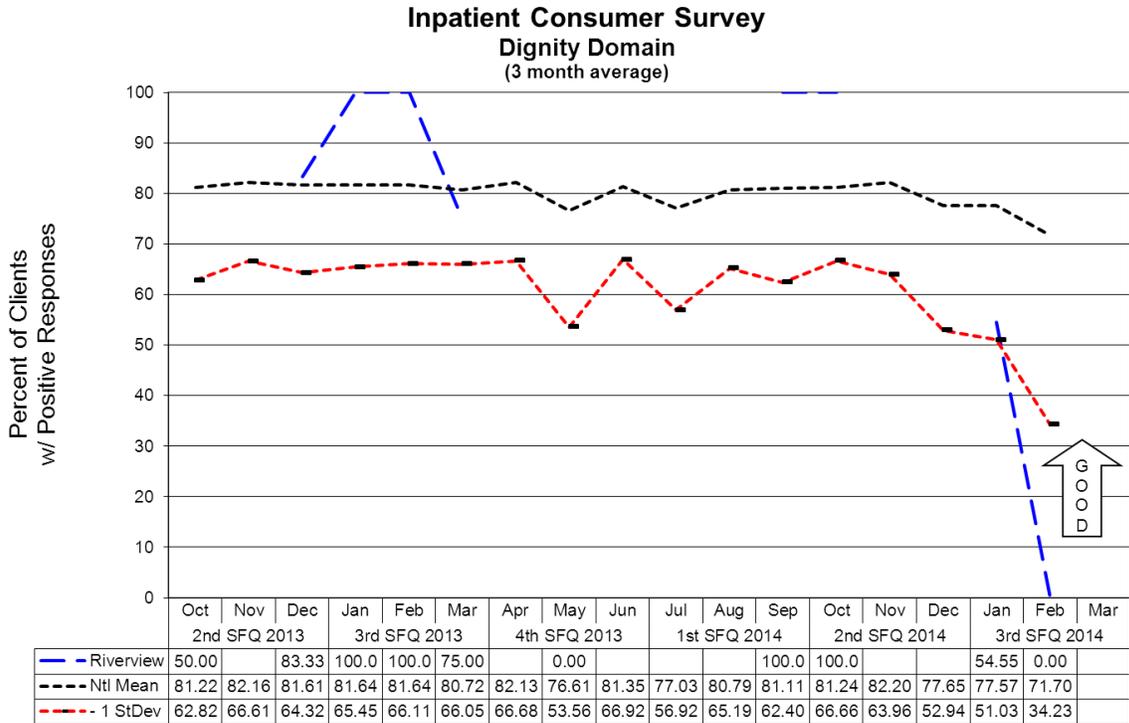
Inpatient Consumer Survey Outcome Domain (3 month average)



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

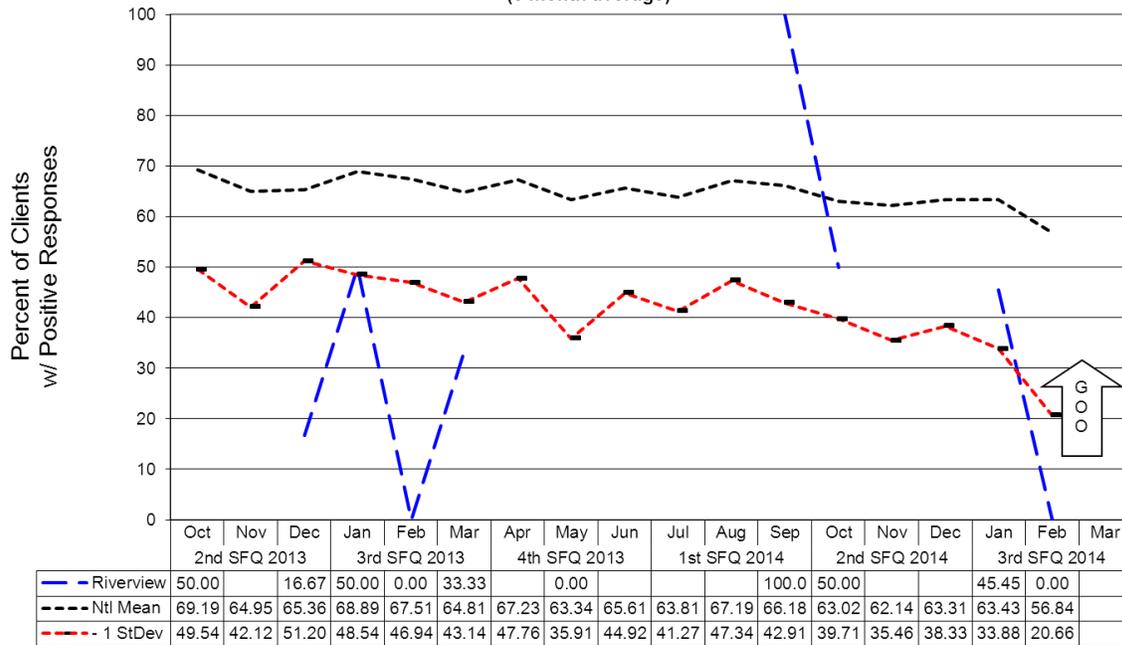


Dignity Domain Questions

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

**Inpatient Consumer Survey
Rights Domain
(3 month average)**

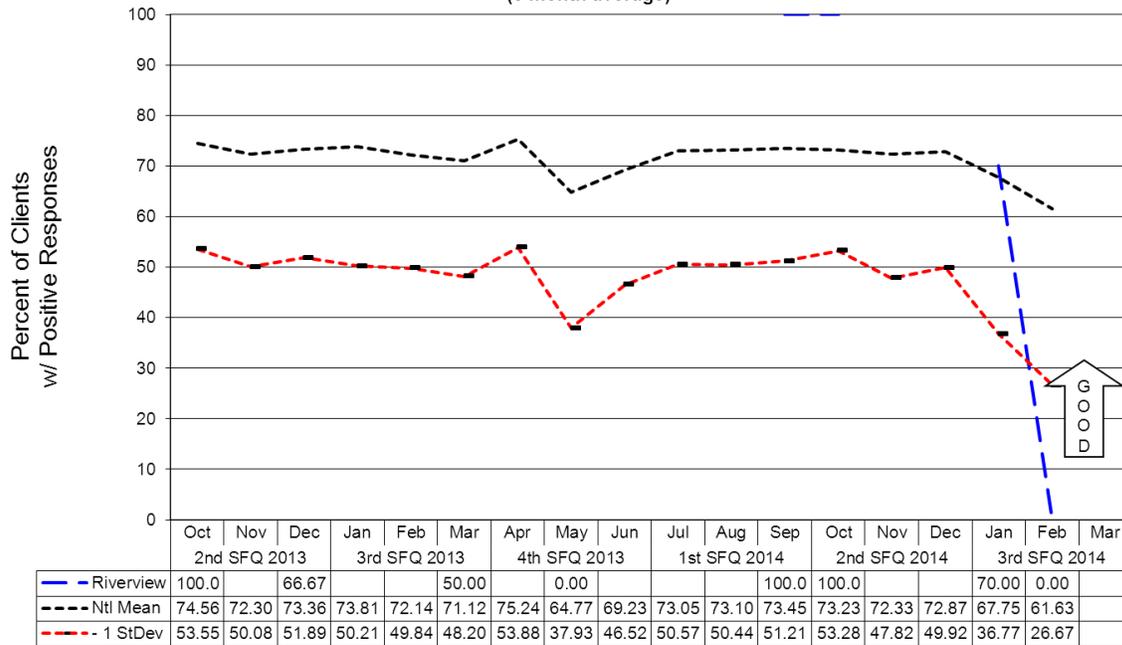


Rights Domain Questions

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

**Inpatient Consumer Survey
Participation Domain
(3 month average)**

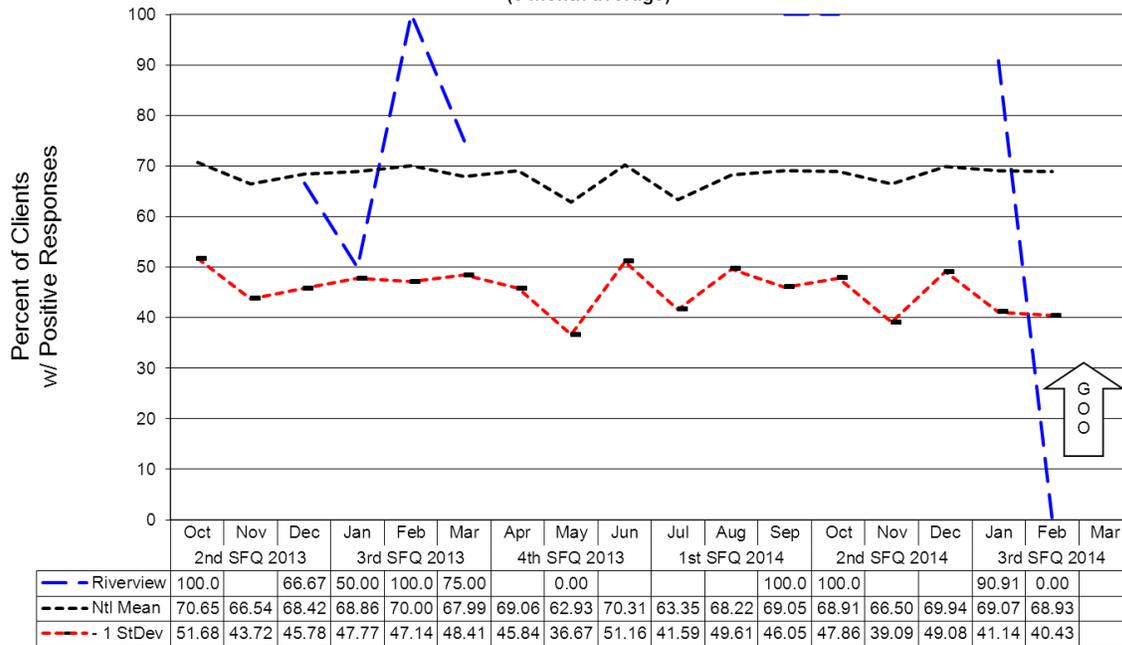


Participation Domain Questions

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)**



Environment Domain

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

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

JOINT COMMISSION

Pain Management

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

Indicator	4Q2013	1Q2014	2Q2014	3Q2014
Pre-administration	68%	70%	74% 2774 of 3749	88% 3217 out of 3652
Post-administration	59%	60%	63% 2362 of 3749	78% 2866 out of 3652

SUMMARY

Both “Pre” and “Post” assessments continue to be up from previous quarters. The number of pain medications given this quarter is slightly lower than the previous quarter (3652 PRN meds for pain this quarter compared to 3749 PRN pain meds last quarter).

ACTIONS

Will meet with the clinical managers to let them know that nursing needs to be more vigilant about assessing pre and post administration pain assessment. 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	JAN	FEB	MAR	3Q2014
Un-witnessed	MR1883			1	1
	MR7358		1		1
	MR7340		1		1
	MR6868			1	1
	MR4814*	1			1
	MR0102			1	1
	MR4946*	1			1
	MR7452		1		1
	MR7489			1	1
	MR3120*			1	1
MR6963*	2			2	

Witnessed	MR7363			1	1
	MR4814*	5			5
	MR4946*			1	1
	MR6963*	2			2
	MR3120*			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: Director of Social Work/ACT Director

Corrective Action Taken:

WHO: The ACT Program Director 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:

After monitoring 1-2-14 until present, the total records reviewed =42 from bi-weekly audits.

Of the 42 records, 21 (50%) had indicated in documentation that clients declined psychiatric advanced directives, 9 (23%) were lacking documentation and 12 (27%) had documented psychiatric advanced directives but were not all the same kind.

The Team will consistently use the DRC psychiatric advanced directives with clients from 2014 forward.

JOINT COMMISSION

Measures of Success

CTS.02.02.07

The organization reassesses each individual served, as needed

Responsible for Reporting: Director of Social Work/ACT Director

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:

42 Charts were reviewed, 70% had updated comprehensive assessments, 20% were present but outdated and 10% were missing (not entered by ACT, RPC Comprehensive Assessment was in referral packet).

Case Managers have been individually notified as well as in Administrative meeting bi-weekly, and are meeting with clients to complete missing and outdated assessments within 2-3 weeks of notification.

JOINT COMMISSION

Measures of Success

HR.01.06.01

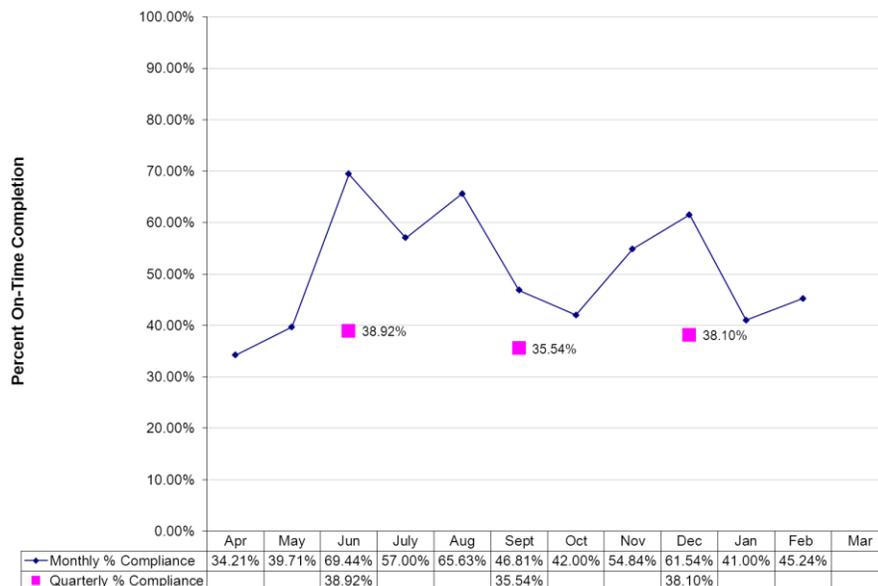
Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation.

Responsible for Reporting: HR Director

Performance appraisals are not being accepted by Human Resources without the competency attached. If the competency is not attached the entire appraisal is being handed back to the person turning it in.

	December 2014	January 2014	February 2014	Total
Performance evaluations completed on time (with competency assessment)	24	13	19	56
Performance evaluations late (with competency assessment)	39	32	42	113
Evaluation Compliance	61.54%	41%	45.24%	49.56%

Performance Evaluation Compliance



JOINT COMMISSION

Measures of Success

EC.02.01.01

The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

Responsible for Reporting: Director of Support Services

INDICATOR: Faucet Checks

FINDING: *EC.02.01.01 The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.*

OBJECTIVE: Have all bathrooms checked every 7 ½ minutes for patient safety (ligature) until faucets have been replaced with an approved anti-ligature model.

THOSE RESPONSIBLE FOR MONITORING: Clinical staff and Director of Support Services

METHODS OF MONITORING: Monitoring would be performed by:

- Direct observation for each bathroom by Clinical Staff

METHODS OF REPORTING: Reporting would occur by the following method:

- Daily activity bathroom faucet check sheets

THOSE RESPONSIBLE FOR REPORTING: Director of Support Services

UNIT: Number of actual checks / number of potential checks on all identified ligature problematic faucets on each patient unit.

Stated Goal: 90%

JOINT COMMISSION

Measures of Success

EC.02.01.01, continued.

Bathroom Faucet Checks	Unit	Stated Goal	January	Actual % for January	February	March	Actual % for Quarter
Lower Kennebec Unit							
The denominator is the total of potential checks for the month on all unit faucets in this patient area. The numerator is all faucets checked daily every 7 1/2 minutes. Any blanks on the faucet check sheet will count as a missed check. Monitoring of the checks will start January 2014 and continue for four months or until the faucets have been replaced.	# of actual checks	90% of bathroom checks completed	5947	99.9%	† See below	† See below	99.9%
	# of potential checks		5952				

SUMMARY OF EVENTS

► **The Lower Kennebec Unit met the goal of greater than 90% for this quarter.**

† All faucets that were identified as a ligature risk were all replaced by 1/31/14 on the Lower Kennebec Unit. (Work Order # 11312). There were no required checks needed after that date.

Bathroom Faucet Checks	Unit	Stated Goal	January	Actual % for January	February	Actual % for February	March	Actual % for Quarter
Upper Kennebec Unit								
The denominator is the total of potential checks for the month on all unit faucets in this patient area. The numerator is all faucets checked daily every 7 1/2 minutes. Any blanks on the faucet check sheet will count as a missed check. Monitoring of the checks will start January 2014 and continue for four months or until the faucets have been replaced.	# of actual checks	90% of bathroom checks completed	5904	99.2%	4718	99.5%	† See below	99.35%
	# of potential checks		5952	4739				

SUMMARY OF EVENTS

► **The Upper Kennebec Unit met the goal of greater than 90% for this quarter.**

† All faucets that were identified as a ligature risk were all replaced by 2/28/14 on the Upper Kennebec Unit. (Work Order # 11313). There were no required checks needed after that date.

JOINT COMMISSION

Measures of Success

EC.02.01.01, continued.

Bathroom Faucet Checks	Unit	Stated Goal	January	Actual % for January	February	Actual % for February	March	Actual % for March	Actual % for Quarter
Upper Saco Unit									
<p>The denominator is the total of potential checks for the month on all unit faucets in this patient area. The numerator is all faucets checked daily every 7 1/2 minutes. Any blanks on the faucet check sheet will count as a missed check. Monitoring of the checks will start January 2014 and continue for four months or until the faucets have been replaced.</p>	<p># of actual checks</p> <hr/> <p># of potential checks</p>	<p>90% of bathroom checks completed</p>	5934	99.7%	4704	99.3%	2688	100%	99.67%
			5952		4739		2688	† See below	

SUMMARY OF EVENTS

► **The Upper Saco Unit met the goal of greater than 90% for this quarter.**

† All faucets, but 2 bathroom locations that were identified as a ligature risk were all replaced by 3/14/14 on the Upper Saco Unit. (Work Order # 11315). The unit continues to do checks on the 2 other bathroom locations.

JOINT COMMISSION

Measures of Success

EC.02.01.01, continued.

Bathroom Faucet Checks	Unit	Stated Goal	January	Actual % for January	February	Actual % for February	March	Actual % for Quarter
Lower Saco Unit								
<p>The denominator is the total of potential checks for the month on all unit faucets in this patient area. The numerator is all faucets checked daily every 7 1/2 minutes. Any blanks on the faucet check sheet will count as a missed check. Monitoring of the checks will start January 2014 and continue for four months or until the faucets have been replaced.</p>	# of actual checks	90% of bathroom checks completed	5888	98.9%	4697	99.1%	† See asterisk below	99%
	# of potential checks		5952	4739				

SUMMARY OF EVENTS

► **The Lower Saco Unit met the goal of greater than 90% for this quarter.**

† All faucets that were identified as a ligature risk were all replaced by 2/10/14 on the Lower Saco Unit. (Work Order # 11314). There were no required checks needed after that date.

JOINT COMMISSION

Measures of Success

ED.02.06.01

Interior spaces meet the need of the patient population and are safe and suitable to the care, treatment, and services provided.

Responsible for Reporting: Director of Support Services

INDICATOR: Bedroom Ligature / Oxygen Storage Assessments

FINDING: *EC.02.06.01 Interior spaces meet the need of the patient population and are safe and suitable to the care, treatment, and services provided.*

OBJECTIVE: (1) Have all bedrooms checked throughout the hospital for any ligature risks every month
(2) Check each unit for proper oxygen storage, ensuring that empty tanks are segregated from full tanks and labelled accordingly.

THOSE RESPONSIBLE FOR MONITORING: Director of Support Services

METHODS OF MONITORING: Monitoring would be performed by:

- Direct observation of each bedroom for any ligature risks
- Direct observation of proper storage of oxygen canisters

METHODS OF REPORTING: Reporting would occur by the following method:

- Monthly activity using the Bedroom Ligature / Oxygen Storage Assessment check sheets

THOSE RESPONSIBLE FOR REPORTING: Director of Support Services

UNIT: Perform bedroom ligature / Oxygen Storage Assessments

Stated Goal: 100%

JOINT COMMISSION

Measures of Success

ED.02.06.01, continued.

Bedroom Ligature / Oxygen Storage Checks	Unit	Stated Goal	Jan	Actual % for Jan	Feb	Actual % for Feb	Mar	Actual % for Mar	Actual % for Quarter
<p>Lower Kennebec Unit</p> <p>The Director of Support Services (or his designee) will perform monthly environment of care rounds (January 2014 thru April 2014) and assess ongoing compliance for both findings. The rounds consist of inspecting every patient room for oxygen tubing or other potential ligature evident in the room and ensuring the oxygen tanks are properly stored. The Director of Support Services will report findings to the monthly meeting of the Environment of Care Committee and the monthly meeting of IPEC (quality committee) under the "safety" agenda item.</p>	Perform bedroom ligature / Oxygen Storage Assessments	100% of checks completed	Monthly Check completed	100%	Monthly Check completed	100%	Monthly Check completed	100%	100%

SUMMARY OF EVENTS

► The Lower Kennebec Unit met the goal of 100% for this quarter.

JOINT COMMISSION

Measures of Success

ED.02.06.01, continued.

Bedroom Ligature / Oxygen Storage Checks	Unit	Stated Goal	Jan	Actual % for Jan	Feb	Actual % for Feb	Mar	Actual % for Mar	Actual % for Quarter
<p>Upper Kennebec Unit</p> <p>The Director of Support Services (or his designee) will perform monthly environment of care rounds (January 2014 thru April 2014) and assess ongoing compliance for both findings. The rounds consist of inspecting every patient room for oxygen tubing or other potential ligature evident in the room and ensuring the oxygen tanks are properly stored. The Director of Support Services will report findings to the monthly meeting of the Environment of Care Committee and the monthly meeting of IPEC (quality committee) under the "safety" agenda item.</p>	Perform bedroom ligature / Oxygen Storage Assessments	100% of checks completed	Monthly Check completed	100%	Monthly Check completed	100%	Monthly Check completed	100%	100%

SUMMARY OF EVENTS

► The Upper Kennebec Unit met the goal of 100% for this quarter.

JOINT COMMISSION

Measures of Success

ED.02.06.01, continued.

Bedroom Ligature / Oxygen Storage Checks	Unit	Stated Goal	Jan	Actual % for Jan	Feb	Actual % for Feb	Mar	Actual % for Mar	Actual % for Quarter
<p>Upper Saco Unit</p> <p>The Director of Support Services (or his designee) will perform monthly environment of care rounds (January 2014 thru April 2014) and assess ongoing compliance for both findings. The rounds consist of inspecting every patient room for oxygen tubing or other potential ligature evident in the room and ensuring the oxygen tanks are properly stored. The Director of Support Services will report findings to the monthly meeting of the Environment of Care Committee and the monthly meeting of IPEC (quality committee) under the "safety" agenda item.</p>	Perform bedroom ligature / Oxygen Storage Assessments	100% of checks completed	Monthly Check completed	100%	Monthly Check completed	100%	Monthly Check completed	100%	100%

SUMMARY OF EVENTS

► The Upper Saco Unit met the goal of 100% for this quarter.

JOINT COMMISSION

Measures of Success

ED.02.06.01, continued.

Bedroom Ligature / Oxygen Storage Checks	Unit	Stated Goal	Jan	Actual % for Jan	Feb	Actual % for Feb	Mar	Actual % for Mar	Actual % for Quarter
<p>Lower Saco Unit</p> <p>The Director of Support Services (or his designee) will perform monthly environment of care rounds (January 2014 thru April 2014) and assess ongoing compliance for both findings. The rounds consist of inspecting every patient room for oxygen tubing or other potential ligature evident in the room and ensuring the oxygen tanks are properly stored. The Director of Support Services will report findings to the monthly meeting of the Environment of Care Committee and the monthly meeting of IPEC (quality committee) under the "safety" agenda item.</p>	Perform bedroom ligature / Oxygen Storage Assessments	100% of checks completed	Monthly Check completed	100%	Monthly Check completed	100%	Monthly Check completed	100%	100%

SUMMARY OF EVENTS

► The Lower Saco Unit met the goal of 100% for this quarter.

JOINT COMMISSION

Measures of Success

MM.03.01.01

The hospital stores medications according to manufacturers' recommendations, or in the absence of such recommendations, according to a pharmacist's instructions.

Responsible for Reporting: Director of Nursing

The hospital stores medications according to the manufacturer's recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

Refrigerator temperatures are monitored on each unit for four consecutive months until 90% compliance is achieved.

Unit	February		March		April	May
Lower Kennebec – Main	28/28	100%	31/31	100%		
Lower Kennebec – SCU	28/28	100%	31/31	100%		
Lower Saco – Main	28/28	100%	31/31	100%		
Lower Saco – SCU	28/28	100%	31/31	100%		
Upper Kennebec	28/28	100%	30/31	97%		
Upper Saco	27/28	96%	31/31	100%		
TOTAL	167/168	99%	185/186	99%		

JOINT COMMISSION

Measures of Success

PC.02.01.15

Care, treatment and services are provided to the patient in an interdisciplinary, collaborative manner.

Responsible for Reporting: Clinical Director

**ASPECT: CHART REVIEW EFFECTIVENESS
JANUARY, FEBRUARY, MARCH 2014**

LOWER KENNEBEC

Indicators	Findings	Compliance
1. GAP note written in appropriate manner at least every 24 hours	10 15	67%
2. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
3. Weekly Summary note completed.	7 of 15	47%
4. BMI on every Treatment Plan.	15 of 15	100%
5. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	1 of 15 14 N/A	100%
6. Multidisciplinary Teaching checklist active being completed.	14 of 15	93%
7. Dental education Teaching checklist	14 of 15	93%

**ASPECT: CHART REVIEW EFFECTIVENESS
JANUARY, FEBRUARY, MARCH 2014**

UPPER KENNEBEC

Indicators	Findings	Compliance
8. GAP note written in appropriate manner at least every 24 hours	13 of 15	87%
9. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
10. Weekly Summary note completed.	15 of 15	100%
11. BMI on every Treatment Plan.	15 of 15	100%
12. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	2 of 15 13 N/A	100%
13. Multidisciplinary Teaching checklist active being completed.	14 of 15	93%
14. Dental education Teaching checklist	14 of 15	93%

JOINT COMMISSION

Measures of Success

PC.02.01.15, continued.

**ASPECT: CHART REVIEW EFFECTIVENESS
JANUARY, FEBRUARY, MARCH 2014**

LOWER SACO

Indicators	Findings	Compliance
15. GAP note written in appropriate manner at least every 24 hours	13 of 15	87%
16. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
17. Weekly Summary note completed.	5 of 15	33%
18. BMI on every Treatment Plan.	15 of 15	100%
19. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	3 of 15 12 N/A	100%
20. Multidisciplinary Teaching checklist active being completed.	15 of 15	100%
21. Dental education Teaching checklist	13 of 15	87%

**ASPECT: CHART REVIEW EFFECTIVENESS
JANUARY, FEBRUARY, MARCH 2014**

UPPER SACO

Indicators	Findings	Compliance
22. GAP note written in appropriate manner at least every 24 hours	11 of 15	73%
23. STGs/ Interventions relate directly to content of GAP note.	15 of 15	100%
24. Weekly Summary note completed.	15 of 15	100%
25. BMI on every Treatment Plan.	15 of 15	100%
26. Diabetes education Teaching checklist shows documentation of client teaching (diabetic clients)	1 of 15 14 N/A	100%
27. Multidisciplinary Teaching checklist active being completed.	14 of 15	93%
28. Dental education Teaching checklist	11 of 15	73%

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

Unit: Lower Kennebec

Hand Hygiene Measure: Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month.

Hand Hygiene Measure: Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered at breakfast 24 days/month	7/24 =29%	21/24=88%	18/24=75%	7/24=30%			
Number of Clients	112	246	216	85			
Number of Clients offered	112	246=100%	143=66%	85=100%			
Number of Clients washed	23	88	67	36			
Compliance Rate – How many clients washed?	21%	36%	31%	42%			
	Third Quarter Client HH Rate: 35%			Fourth Quarter Client HH Rate:			
	Third Quarter Data Collection: 64%			Fourth Quarter Data Collection:			
Hand gel offered at lunch 24 days/month	7/24=29%	19/24=79%	18/24=75%	7/24=30%			
Number of Clients	105	245	196	101			
Number of Clients offered	105	245=100%	196=100%	101=100%			
Number of Clients washed	24	123	139	22			
Compliance Rate – How many washed?	23%	50%	71%	22%			
	Third Quarter Client HH Rate: 48%			Fourth Quarter Client HH Rate::			
	Third Quarter Data Collection: 61%			Fourth Quarter Data Collection:			
Hand gel offered at dinner 24 days/month	21/24=88%	22/24=92%	19/24=79%	21/24=88%			
Number of Clients	145	223	167	217			
Number of Clients offered	145	223=100%	167=100%	190=88%			
Number of Clients washed	45	80	147	162			
Compliance Rate – How many washed?	31%	36%	88%	75%			
	Third Quarter Client HH Rate 66%			Fourth Quarter Client HH Rate::			
	Third Quarter Data Collection: 86%			Fourth Quarter Client HH Rate:			

JOINT COMMISSION

Measures of Success

PC.02.03.03, continued.

Unit: Lower Kennebec SCU

Hand Hygiene Measure: Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month.

Hand Hygiene Measure: Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered at breakfast 24 days/month	6/24=25%	2/24=8%↓	3/24=13%	5/24=21%			
Number of Clients	25	5	16	24			
Number of Clients offered	25	5=100%	16=100%	18=75%			
Number of Clients washed	7	4	6	2			
Compliance Rate – How many clients washed?	28%	80%	38%	8%			
Third Quarter HH Rate: 27%				Fourth Quarter HH Rate:			
Third Quarter Data Collection: 14%				Fourth Quarter Data Collection:			
Hand gel offered at lunch 24 days/month	6/24=25%	2/24=8%↓	3/24=13%	4/24=17%			
Number of Clients	24	5	17	14			
Number of Clients offered	24	5=100%	17=100%	8=57%			
Number of Clients washed	7	4	8	4			
Compliance Rate – How many washed?	29%	80%	47%	50%			
Third Quarter HH Rate: 44%				Fourth Quarter HH Rate:			
Third Quarter Data Collection: 13%				Fourth Quarter Data Collection:			
Hand gel offered at dinner 24 days/month	9/24=38%	3/24=13%↓	7/24=21%	9/24=38%			
Number of Clients	39	11	52	64			
Number of Clients offered	39	11=100%	52=100%	64=100%			
Number of Clients washed	12	6	26	16			
Compliance Rate – How many washed?	31%	55%	50%	25%			
Third Quarter HH Rate: 39%				Fourth Quarter HH Rate:			
Third Quarter Data Collection: 24 %				Fourth Quarter Data Collection:			

JOINT COMMISSION

Measures of Success

PC.02.03.03, continued.

Unit: Upper Kennebec

Hand Hygiene Measure: Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month.

Hand Hygiene Measure: Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered at breakfast 24 days/month	↑	0	0	0			
Number of Clients		18	19	22			
Number of Clients offered		0	0	0			
Number of Clients washed		0	0	0			
9Compliance Rate - How many clients washed?		0	0	0			
		Third Quarter HH Rate: 0			Fourth Quarter HH Rate:		
		Data Collection: 0			Fourth Quarter Data Collection:		
Hand gel offered at lunch 24 days/month		0	0	0			
Number of Clients		18	19	22			
Number of Clients offered		0	0	0			
Number of Clients washed		0	0	0			
Compliance Rate – How many washed?		0	0	0			
		Third Quarter HH Rate:: 0			Fourth Quarter HH Rate:		
		Data Collection: 0			Data Collection:		
Hand gel offered at dinner 24 days/month		0	0	0			
Number of Clients		18	19	22			
Number of Clients offered		0	0	0			
Number of Clients washed	↓	0	0	0			
Compliance Rate – How many washed?		0	0	0			
		Third Quarter HH Rate: 0			Fourth Quarter HH Rate::		
		Third Quarter Data Collection: 0			Fourth Quarter Data Collection:		

JOINT COMMISSION

Measures of Success

PC.02.03.03, continued.

Unit: Lower Saco

Hand Hygiene Measure: Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month.

Hand Hygiene Measure: Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered at breakfast 24 days/month	16/24=67%	24/24=100%↑	8/24=33%↓	13/24=54%			
Number of Clients	164	335	97	160			
Number of Clients offered	164=100%	330=99%↓	69=71%↓	160=100%			
Number of Clients washed	53	141	41	65			
Compliance Rate - How many clients washed?	32%	42%	42%	41%			
	Third Quarter HH Rate: 42%				Fourth Quarter HH Rate:		
	Third Quarter Data Collection: 94%				Fourth Quarter Data Collection:		
Hand gel offered at lunch 24 days/month	12/24=50%	24/24=100%	8/24=33%	13/24=54%			
Number of Clients	127	334	99	162			
Number of Clients offered	127=100%	333=98%	71=72%	162=100%			
Number of Clients washed	48	170	48	67			
Compliance Rate – How many washed?	38%	52%↑	68%↑	41%			
	Third Quarter HH Rate: 54%				Fourth Quarter HH Rate:		
	Third Quarter Data Collection: 95%				Fourth Quarter Data Collection:		
Hand gel offered at dinner 24 days/month	18/24=75%	23/24=96%↑	11/24=46%↓	11/24=45%			
Number of Clients	189	384	136	136			
Number of Clients offered	189=100%	384=100%	136=100%	136=100%			
Number of Clients washed	44	109	56	57			
Compliance Rate – How many washed?	23%	28%↑	42%↑	42%			
	Third Quarter HH Rate: 37%				Fourth Quarter HH Rate:		
	Third Quarter Data Collection: 100%				Third Quarter Data Collection:		

JOINT COMMISSION

Measures of Success

PC.02.03.03, continued.

Unit: Lower Saco SCU

Hand Hygiene Measure: Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month.

Hand Hygiene Measure: Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered at breakfast 24 days/month	1/24=4%	4/24=17%↑	13/24=24%↑	1/24=4%			
Number of Clients	4	12	49	6			
Number of Clients offered	4	12=100%	49=100%	6=100%			
Number of Clients washed	2	9	24	2			
Compliance Rate – How many clients washed?	50%	75%↑	50%↓	33%			
		Third Quarter HH Rate: 53%			Fourth Quarter HH Rate:		
		Third Quarter Data Collection: 100%			Fourth Quarter Data Collection:		
Hand gel offered at lunch 24 days/month	↑	3/24=13%↑	9/24=38%↑	0/24=0			
Number of Clients		9	38	0			
Number of Clients offered		9=100%	38=100%	0			
Number of Clients washed		6	21	0			
Compliance Rate – How many washed?	↓	67%↑	55%↓	0			
		Third Quarter HH Rate: 0			Fourth Quarter HH Rate:		
		Third Quarter Data Collection: 0			Fourth Quarter Data Collection:		
Hand gel offered at dinner 24 days/month	1/24=4%	1/24=4%	15/24=63%	15/24=63%			
Number of Clients	4	3	69	85			
Number of Clients offered	4	3=100%	69=100%	85=100%			
Number of Clients washed	4	1	34	34			
Compliance Rate – How many washed?	100%	33%↓	49%↑	40%			
		Third Quarter HH Rate: 44%			Fourth Quarter HH Rate:		
		Third Quarter Data Collection: 100%			Fourth Quarter Data Collection:		

JOINT COMMISSION

Measures of Success

PC.02.03.03, continued.

Unit: Upper Saco

Hand Hygiene Measure: Staff will offer hand gel to clients prior to breakfast, lunch and dinner on 24 days per month

Hand Hygiene Measure: Staff will measure client hand hygiene practice at breakfast, lunch and dinner on 24 days per month.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered at breakfast 24 days/month	5/24=21%	3/24=13%↓	0	0			
Number of Clients	27	11	21	19			
Number of Clients offered	27	11=100%	0	0			
Number of Clients washed	8	2	0	0			
Compliance Rate – How many clients washed?	30%	18%	0	0			
				Third Quarter HH Rate:: 4%		Fourth Quarter HH Rate:	
				Third Quarter Data Collection:		Fourth Quarter Data Collection:	
Hand gel offered at lunch 24 days/month	4/24=17%	3/24=13%↓	0	0			
Number of Clients	39	21	21	19			
Number of Clients offered	39	21=100%	0	0			
Number of Clients washed	18	11	0	0			
Compliance Rate – How many washed?	46%	52%	0	0			
				Third Quarter HH Rate:: 0		Fourth Quarter HH Rate:	
				Third Quarter HH Rate: 0		Fourth Quarter HH Rate:	
Hand gel offered at dinner 24 days/month	1/24=4%	0	0	0			
Number of Clients	13	21	21	19			
Number of Clients offered	13	0	0	0			
Number of Clients washed	4	0	0	0			
Compliance Rate – How many washed?	31%	0	0	0			
				Third Quarter Report: 0		Fourth Quarter Report:	
				Third Quarter HH Rate: 0		Fourth Quarter Data Collection:	

JOINT COMMISSION

Measures of Success

PC.02.03.03, continued.

Unit: Treatment Mall

Hand Hygiene Measure: Staff will offer hand gel to clients prior to the mid-morning snack for twenty (20) days per month.

Hand Hygiene Measure: Staff will measure client hand hygiene practice at the mid-morning snack.

	Dec. 2013	Jan. 2014	February	March	April	May	June
Hand gel offered at the mid-morning snack	18/20=90%	21/21=100%	18/20=90%	20/20=100%			
Number of Clients	207	217	200	240			
Number of Clients offered	207	217	200	240			
Number of Clients washed	99	102	90	92			
Compliance Rate – How many clients washed?	49%	49%	45%	38%			
	Third Quarter HH Rate: 43%				Fourth Quarter HH Rate:		
	Third Quarter Data Collection: 98%				Fourth Quarter Data Collection:		

JOINT COMMISSION

Measures of Success

PC.03.03.29

Patients are debriefed after the use of restraint or seclusion for behavioral health purposes.

Responsible for Reporting: Superintendent

Month	Number of charts reviewed	Charts compliant with debriefing content and safety meetings documented in the treatment plan within 72 hours	Compliance
February 2014	31	21	67%
March 2014	37	28	75%
Total	68	49	72%

JOINT COMMISSION

Measures of Success

RC.01.02.01

Entries in the medical records are authenticated.

PC.04.01.05

The hospital provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand.

Responsible for Reporting: Clinical Director/Director of Nursing

January 2014

Indicators	Findings	Compliance	Threshold Percentile
All Progress notes are authenticated within 7 days	All progress notes are currently being authenticated within the 7 day timeframe	100%	90%
Discharge Instructions are in a manner that the client and/or family member/caregiver understand.	22 Closed records were reviewed, 19 of those included the D/C pharmacy labels, 22 were documented that medication teaching was Completed In Client Friendly Language at Discharge	100%	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.

JOINT COMMISSION

Measures of Success

RC.01.02.01, PC.04.01.05, continued

February 2014

Indicators	Findings	Compliance	Threshold Percentile
All Progress notes are authenticated within 7 days	All progress notes are being authenticated within the 7 day period	100%	90%
Discharge Instructions are in a manner that the client and/or family member/caregiver understand.	12 Closed records were reviewed, 10 of those included the D/C pharmacy labels, 11 were documented that medication teaching was Completed In Client Friendly Language at Discharge	92%	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.

JOINT COMMISSION

Measures of Success

RC.01.02.01, PC.04.01.05, continued

March 2014

Indicators	Findings	Compliance	Threshold Percentile
All Progress notes are authenticated within 7 days	All progress notes are being authenticated within the 7 day period	100%	90%
Discharge Instructions are in a manner that the client and/or family member/caregiver understand.	17 Closed records were reviewed, 17 of those included the D/C pharmacy labels, 15 were documented that medication teaching was Completed In Client Friendly Language at Discharge	88%	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

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 Center
Priority Focus Areas

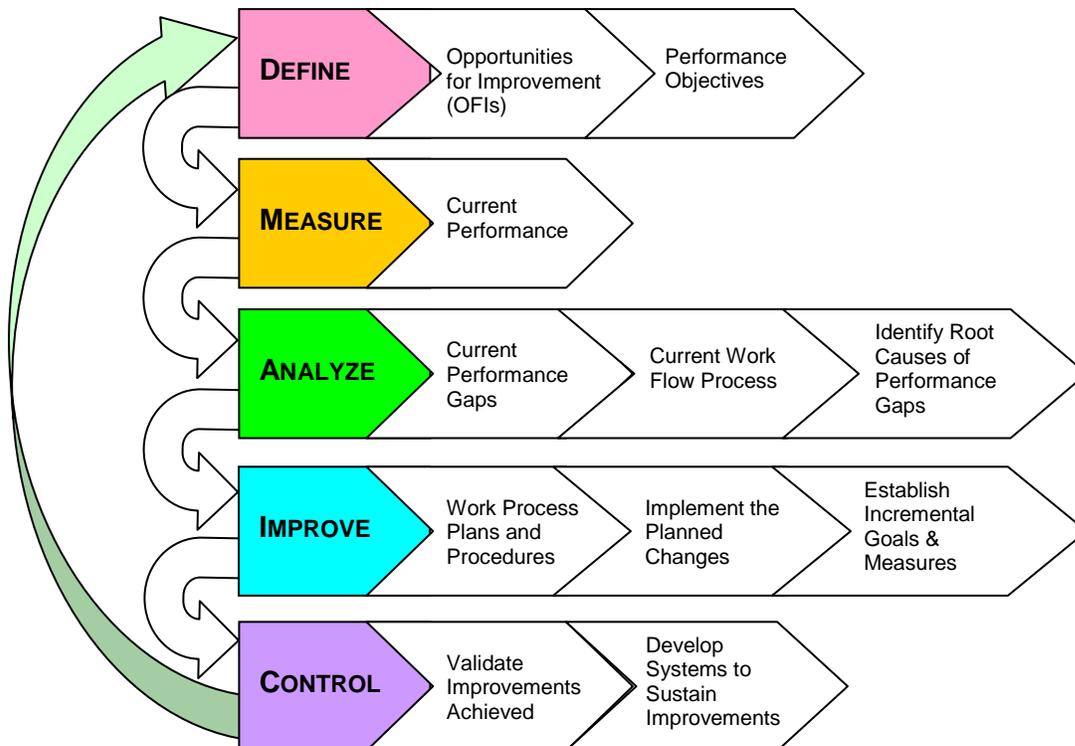


Ensure and Promote Fiscal Accountability by...
Identifying and employing efficiency in operations and clinical practice
Promoting vigilance and accountability in fiscal decision-making.

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



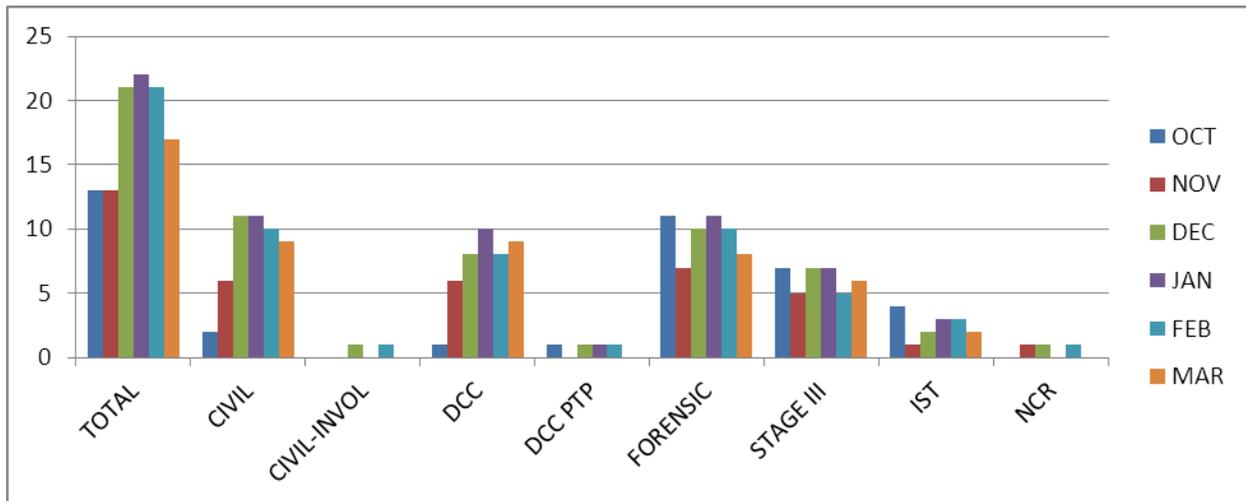
STRATEGIC PERFORMANCE EXCELLENCE

Admissions Process Improvement Activities

The Admissions office is going through another transition with staff. I, Jamie Meader, am once again working as the Admissions Coordinator starting in the beginning of March. The IMHU program is now up and running. So far we have referred 2 individuals to the program and they have been accepted. There have not been any other referrals that have met the criteria at this time. I will continue to collaborate with MSP and Dr. Fitzpatrick on any issues as they may arise.

Below are the reports for the last quarter. These contain information from October until the end of March, specifically related to Admissions, Discharges, Wait Length and Length of Stay.

Admission Data Graph



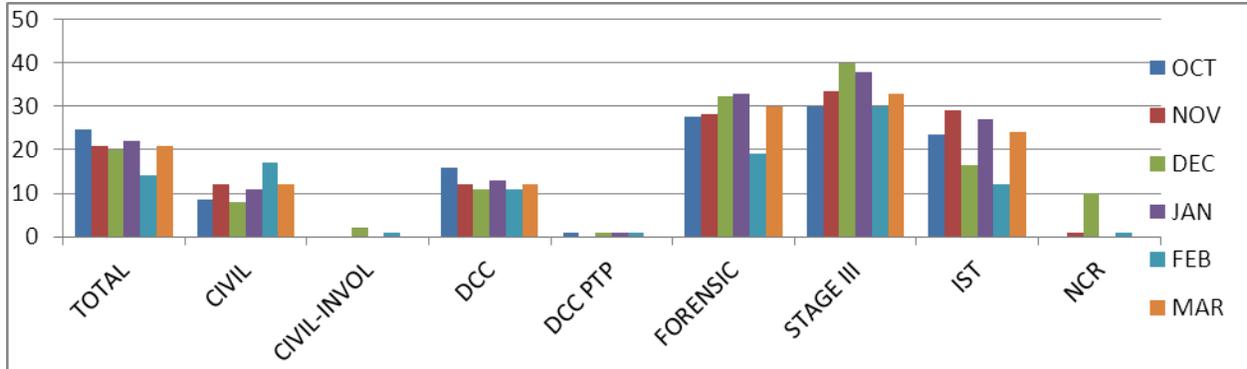
Admission Data

ADMISSIONS	OCT	NOV	DEC	JAN	FEB	MAR
TOTAL	13	13	21	22	21	17
CIVIL	2	6	11	11	10	9
CIVIL-INVOL	0	0	1	0	1	0
DCC	1	6	8	10	8	9
DCC PTP	1	0	1	1	1	0
FORENSIC	11	7	10	11	10	8
STAGE III	7	5	7	7	5	6
IST	4	1	2	3	3	2
NCR	0	1	1	0	1	0

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office

Wait Length Graph



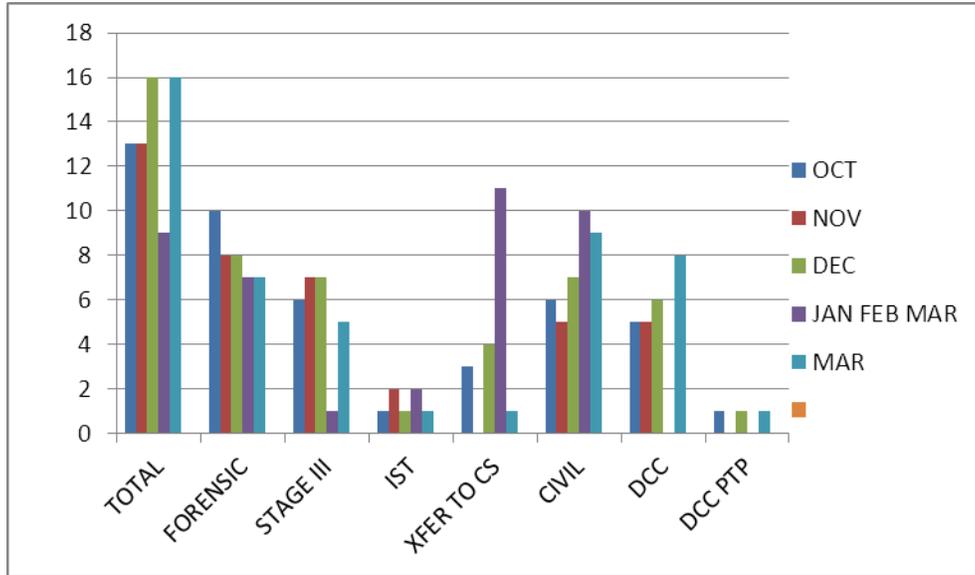
Wait Length Data

WAIT	OCT	NOV	DEC	JAN	FEB	MAR
TOTAL	25	21	20	22	14	21
CIVIL	9	12	8	11	17	12
CIVIL-INVOL	0	0	2	0	1	0
DCC	16	12	11	13	11	12
DCC PTP	1	0	1	1	1	0
FORENSIC	28	28	32	33	19	30
STAGE III	30	34	40	38	30	33
IST	24	29	17	27	12	24
NCR	0	1	10	0	1	0

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office

Discharge Data Graph



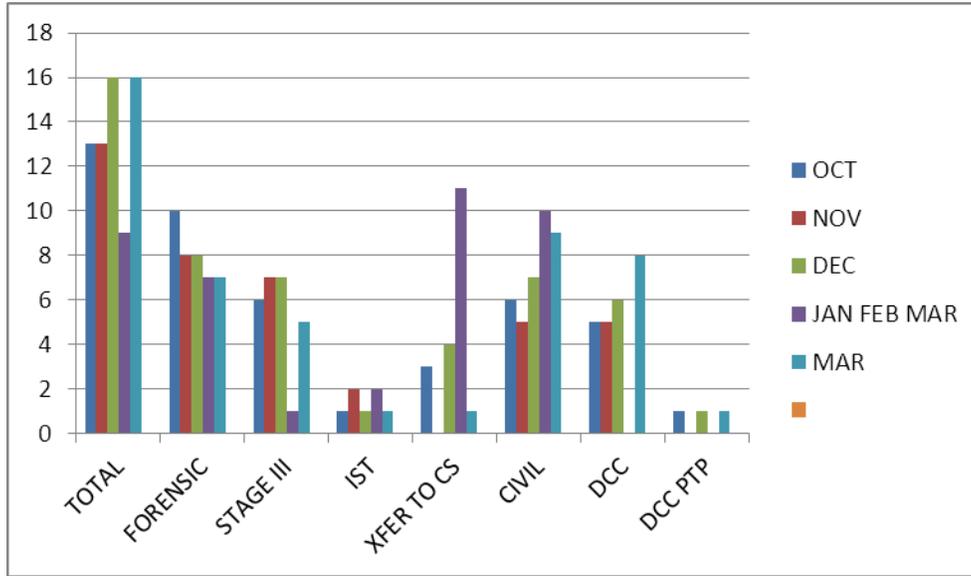
Discharge Data

DISCHARGES	OCT	NOV	DEC	JAN	FEB	MAR
TOTAL	13	13	16	22	12	16
FORENSIC	10	8	8	9	8	7
STAGE III	6	7	7	7	5	5
IST	1	2	1	1	2	1
XFER TO CS	3	0	4	2	4	1
CIVIL	6	5	7	11	4	9
DCC	5	5	6	10	3	8
DCC PTP	1	0	1	0	0	1

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Office

Length of Stay Data Graph



Length of Stay Data

LOS	OCT	NOV	DEC	JAN	FEB	MAR
FORENSIC	33	18	41	52	156	71
STAGE III	28	34	29	21	22	49
IST	118	115	63	133	73	64
CIVIL	53	89	99	58	310	91
DCC	61	89	116	72	159	96
DCC PTP	16	0	3	0	0	49

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 and sustain appropriate hand hygiene, the Dietary department measures compliance of the Dietary employees when returning from a scheduled break.													
	1st Quarter 2014			2nd Quarter 2014			3rd Quarter 2014			4th Quarter 2014			
Baseline	Target Baseline	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 12%	Findings	Compliance	Target – Q3 + 12%	Findings	Compliance	Goal
85%	85%	16/30	53%	65%	33/57	58%	70%	55/66	83%				80-90%

Data:
55 compliant observations / 66 hand hygiene observations = 83% hand hygiene compliance rate

- Summary:**
- Hand hygiene compliance has increased by 25%.
 - Hand hygiene observations have increased; 57 observations last quarter to 66 observations this first quarter. However: "The World Health Organization *Manual for Observers* recommends observing a minimum of 200 opportunities during each measurement period in each department or ward to allow for meaningful comparison before and after hand hygiene improvement interventions."
 - Updating hand hygiene signage and placing them in different locations brought attention to the task and appears to have had a positive impact on hand hygiene compliance.
 - Use of the reformatted Hand Hygiene Tool has simplified the data collection process and slightly improved the total number of observations.

- Action Plan:**
- Per the WHO recommendation, DSM will assign additional staff to observe HH practices.
 - Continue use of the improved Hand Hygiene Tool.
 - 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; decertified unit. 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.										
	2 nd Quarter 2014			3 rd Quarter 2014			4 th Quarter 2014			
Baseline 95-100%	Established Baseline	Findings	Compliance	Jan-March 2014 Target – Q2 + 1%	Findings	Compliance	April-June 2014 Target – Q3 + 0%	Findings	Compliance	Goal 95-100%
26/26					60/63	95%				95-100%

Data:

60 Nutrition screens completed w/in 24 hours of admission

63 Total Admissions = 95% of nutrition screens completed within 24 hours of admission

Summary:

- The Registered Dietitian reviewed the nutrition screens of the 63 client admissions for this quarter.
- Upon review, the RD discovered 3 nutrition screens incomplete.
- All incomplete nutrition screens were documented on the Lower Kennebec unit; two of the three clients were admitted on a Friday.

Action Plan:

- RD will continue correspondence with nursing staff regarding the discovery of an incomplete nutrition screens and request completion, as appropriate.
- Present quarterly report at departmental staff meeting and IPEC meeting.

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

INDICATOR

GROUNDS SAFETY/SECURITY INCIDENTS

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

Monitoring would be performed by;

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

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

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

UNIT

Hospital grounds as defined above

BASELINE

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

2014 Q1-Q4 TARGETS

Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

Department: Safety & Security Responsible Party: Bob Patnaude
Safety Officer

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q1 Target Actual	Q2 Target Actual	Q3 Target Actual	Q4 Target Actual	Goal	Comments
Grounds Safety & Security Incidents	# of Incidents	*Baseline of 10	(16)	(24)	(7)	(10)	Baseline -5%	
Safety/Security incidents occurring on the grounds at Riverview, which include "Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches"			-5% (24)	-5% (7)	-5% (10)	-5		

SUMMARY OF EVENTS

The Q3 Target was (7). Our actual number was (10); an increase this quarter. 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. We feel that the reporting, which follows below, continues to provide a very clear picture of Safety and Security events, how they are handled, and that the use of surveillance equipment plays an integral part in combating safety and security threats to people and property. Our aggressive rounds by Security continues to prove its' worth with regard to Security's presence and patrol techniques.

EVENT	DATE	TIME	LOCATION	DISPOSITION	COMMENTS
1. Safety Concern (Small flashlight found outside)	01/23/14	2140hrs.	Staff Parking Lot	Owner claimed	1. Security found in lot 2. Owner was corrections officer/retrieved 3. Safety notified 4. SEC IR # 611 completed
2. Safety Concern (Returning client in family's presence, smoking in non-smoking area)	01/25/14	1758hrs.	Visitor Lot	Security and Clinical staff educated family members and client	1. Security observed 2. Family and client reminded of smoking policy 3. Charge Nurse, NOD, and Safety notified 4. SEC IR #612 SEC completed
3. Security Threat (Intoxicated male on property)	01/25/14	1935hrs.	Front Lobby	Capitol Police and Augusta Police investigated	1. Male entered lobby 2. Capitol Police and Augusta PD, Safety, and NOD notified. 3. Incident investigated 4. OPS IR #1262 completed

STRATEGIC PERFORMANCE EXCELLENCE

Environment of Care

4. Security Threat (Graffiti/Slurs written on staff vehicle)	01/30/14	0507hrs	Staff Parking Lot	Capitol Police notified.	<ol style="list-style-type: none"> 1. Employee discovered 2. NOD, Safety, Operations, CFO, PD notified 3. Security disposed of item 4. IR #567 SEC completed/Safety notified
5. Security Concern (Suspicious vehicle/individual in Visitor Parking Lot)	02/08/14	0410hrs.	Visitor Parking Lot	Security and Augusta PD investigated	<ol style="list-style-type: none"> 1. Security discovered during rounds 2. Operations and Augusta PD notified 3. Individual waiting for meeting to be held in the AM 4. NOD notified 5. SEC IR # 622 SEC completed/Safety notified
6. State Vehicle maintenance (State Vehicle lights left on/battery drained)	02/22/14	1711hrs.	State Vehicle Parking Area	Security investigated Maintenance notified	<ol style="list-style-type: none"> 1. Security responded 2. Security called Maintenance who tended to issue 3. SEC IR # 629 completed/Safety notified
7. Safety Concern (large frost heave in Staff parking Lot)	02/23/14	0415hrs	Staff parking Lot	Security placed cones. Maintenance notified	<ol style="list-style-type: none"> 1. Security discovered during rounds 2. Safety Cones placed/maintenance notified 3. SEC IR # 630 completed/Safety notified
8. Safety Threat (Matches found in State Vehicle)	02/25/14	1145hrs.	State Vehicle	Disposed them Follow-up as to last know operator	<ol style="list-style-type: none"> 1. Staff discovered 2. Security disposed of 3. Follow-up with last known operator 3. SEC IR # 631 completed/Safety notified
9. Safety Concern (RPC Staff person on AMHI grounds late at night)	02/27/14	0216hrs.	AMHI Grounds	Security spoke to staff of concern	<ol style="list-style-type: none"> 1. Capitol Police discovered during rounds 2. Safety Concern relayed to staff although no prohibition against. 3. SEC IR # 634 completed/Safety notified
10. Safety Concern (Client behind Maintenance shed)	03/08/14	1445hrs.	Maint. area	Security moved client along. Nothing out of place	<ol style="list-style-type: none"> 1. Security discovered during rounds 2. Client moved along. Clinical staff and NOD notified 3. SEC IR # 636 completed/Safety notified

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

<i>Objectives</i>	<i>4Q2013</i>	<i>1Q2014</i>	<i>2Q2014</i>	<i>3Q2014</i>
<i>1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.</i>	<i>60% 25/42</i>	<i>71% 30/41</i>	<i>69% 29/42</i>	<i>79% 33/42</i>
<i>2. SBAR information completed from the units to the Harbor Mall.</i>	<i>88% 37/42</i>	<i>86% 36/42</i>	<i>88% 37/42</i>	<i>81% 34/42</i>

Unit: All three units January, February, and March 2014

Accountability Area: Harbor Mall

Aspect: Harbor Mall Hand-off Communication

Overall Compliance: 80 %

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

MEASURE: Indicator number one has increased from 69% last quarter to 79% for this quarter. Indicator number two has decreased from 88% last quarter to 81% this quarter.

ANALYZE: Overall compliance has increased from 79% for last quarter to 80% for this quarter. Indicator number one remained the same for all three months. Indicator number two decreased to 81% for March. The amount of time the sheets are late has decreased. 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	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 28 discharges in quarter 3 2014. Of those, 26 were completed by 30 days.	93%	80%
Discharge summaries will be completed within 15 days of discharge.	28 out of 28 discharge summaries were completed within 15 days of discharge during quarter 3 2014.	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 3 2014 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 803 dictated reports, 803 were completed within 24 hours.	100%	90%

Summary: The indicators are based on the review of all discharged records. There was 93% compliance with 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	Findings	Compliance	Threshold Percentile
Records will be completed within Joint Commission standards, state requirements and Medical Staff bylaws timeframes.	There were 23 discharges in quarter 3 2014. Of those, 22 were completed by 30 days.	97%	80%
Discharge summaries will be completed within 15 days of discharge.	23 out of 23 discharge summaries were completed within 15 days of discharge during quarter 3 2014.	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 3 2014 (see minutes).	100%	100%
Medical transcription will be timely and accurate.	Out of 803 dictated reports, 803 were completed within 24 hours.	100%	90%

Summary: The indicators are based on the review of all discharged records. There was 97% compliance with 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)

Confidentiality

Indicators	3Q14 Findings	3Q14 Compliance	Threshold Percentile
All client information released from the Health Information department will meet all Joint Commission, State, Federal & HIPAA standards.	5283 requests for information (115 requests for client information and 5168 police checks) were released for quarter 3 2014.	100%	100%
All new employees/contract staff will attend confidentiality/HIPAA training.	New employees/contract staff in quarter 3 2014.	100%	100%
Confidentiality/Privacy issues tracked through incident reports.	0 privacy-related incident report during quarter 3 2014.	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 3 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) 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 3rd quarter 2014 showed that we received 5168 applications. This is a decrease from last quarter (2nd quarter 2014) when we received 5328 applications.

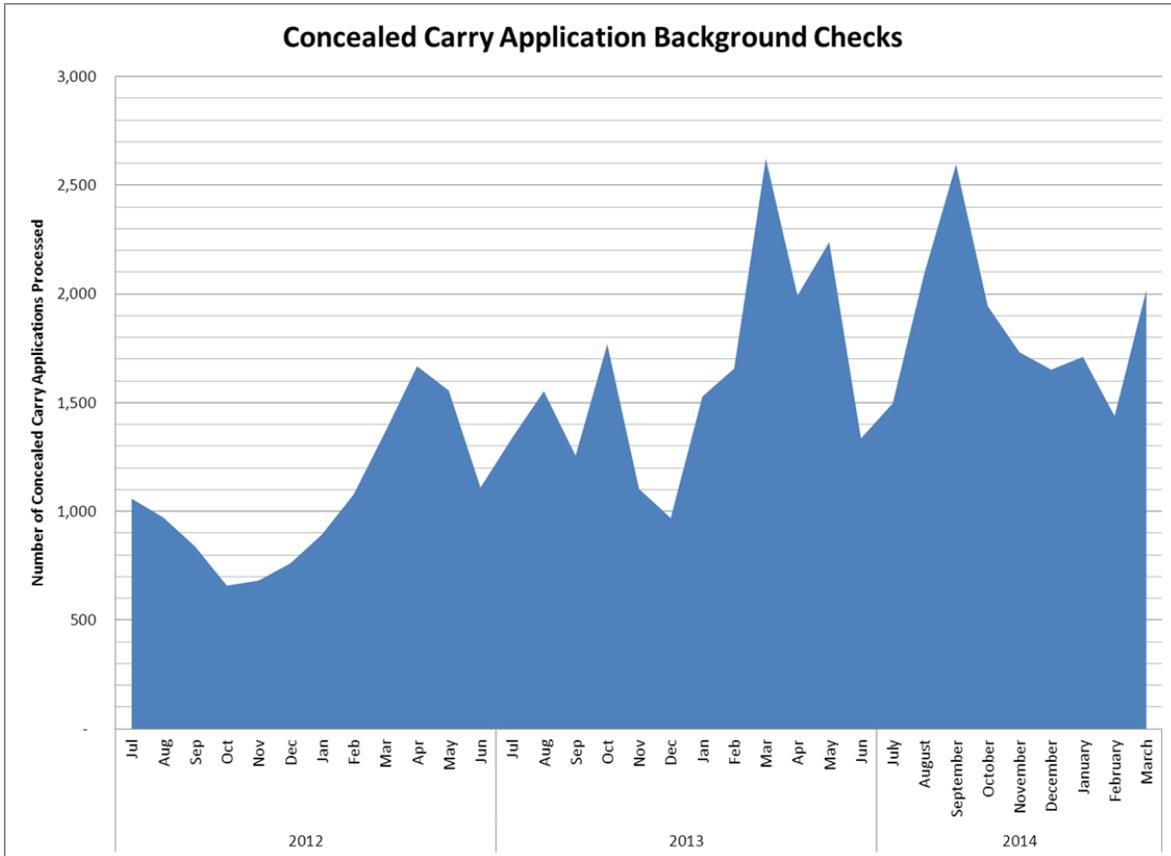
Improve

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.

FY 2013/2014	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
# Applications Received	1993	2239	1336	1497	2096	2596	1944	1732	1652	1711	1439	2018
Avg Receipt Delay	26	42	66	82	76	30	-	-	-	-	-	-
Max Receipt Delay	451	504	1694	1568	258	508	-	-	-	-	-	-
Avg Processing Time	8	13	15	13	11	3	-	-	-	-	-	-
Max Processing Time	11	20	19	45	15	7	-	-	-	-	-	-

STRATEGIC PERFORMANCE EXCELLENCE



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

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources

Define

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

Measure

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

Analyze

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

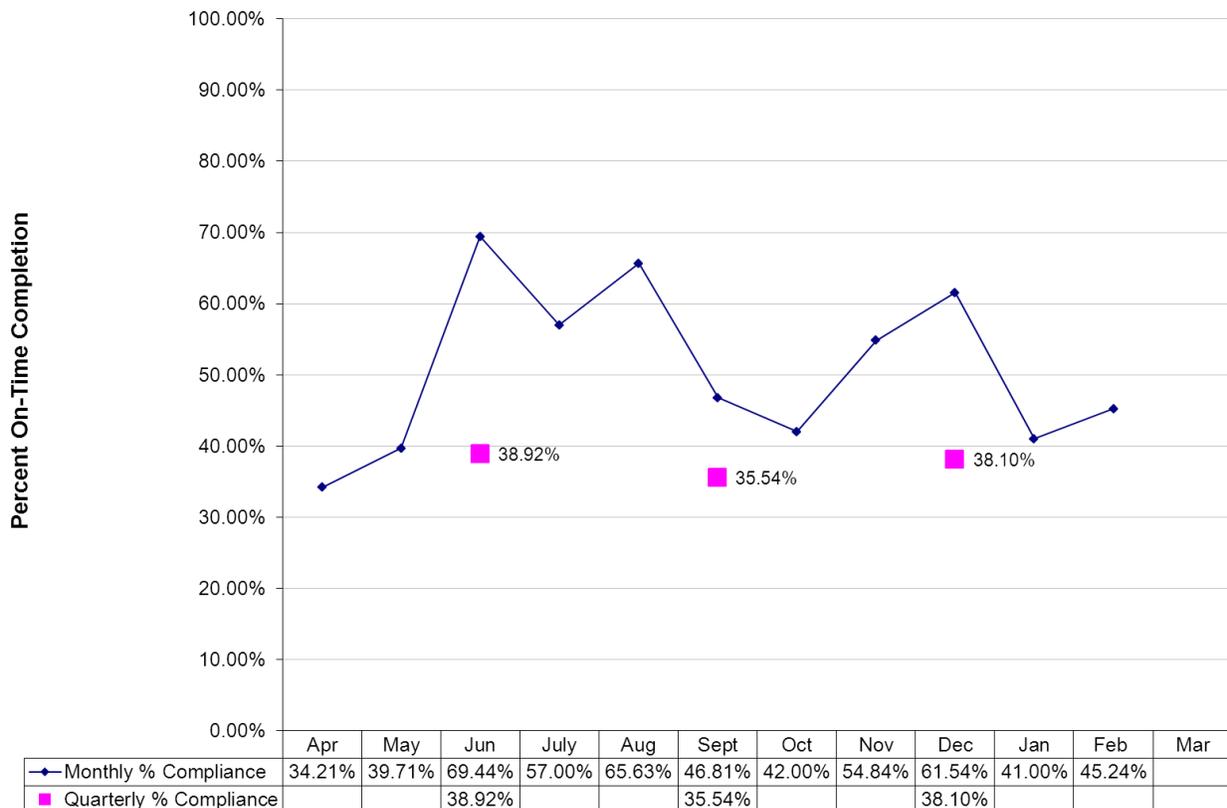
Improve

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

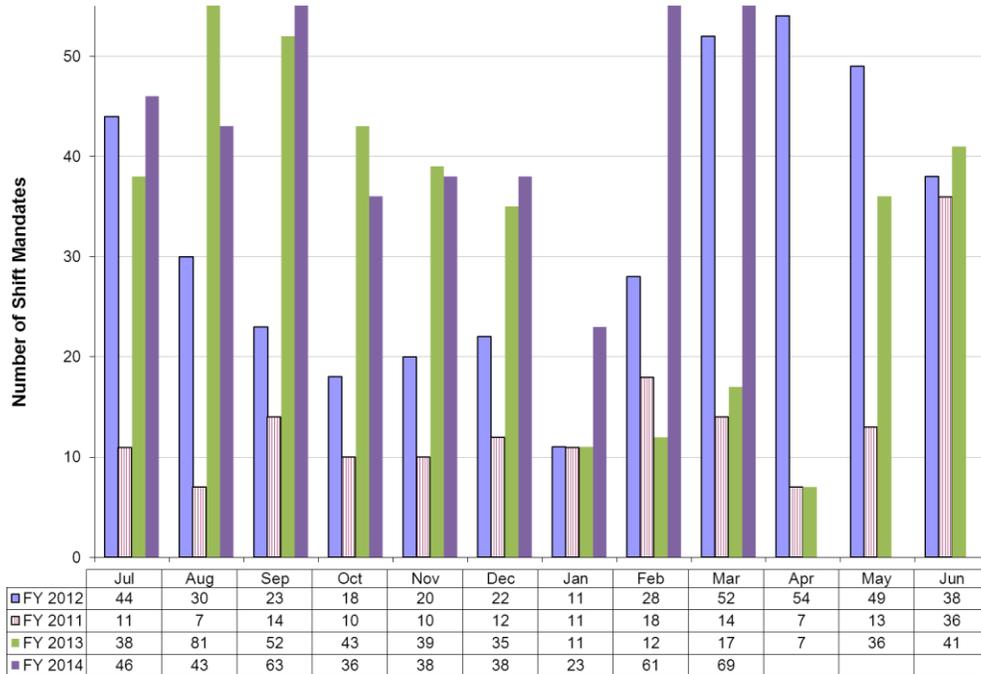
Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.

Performance Evaluation Compliance

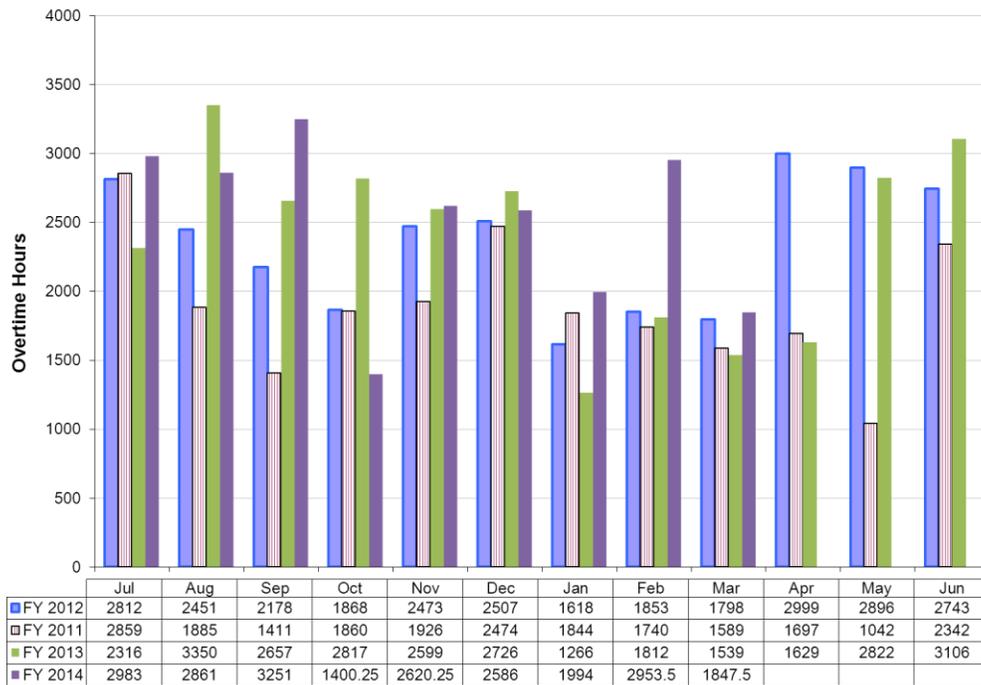


STRATEGIC PERFORMANCE EXCELLENCE

Monthly Mandated Shifts

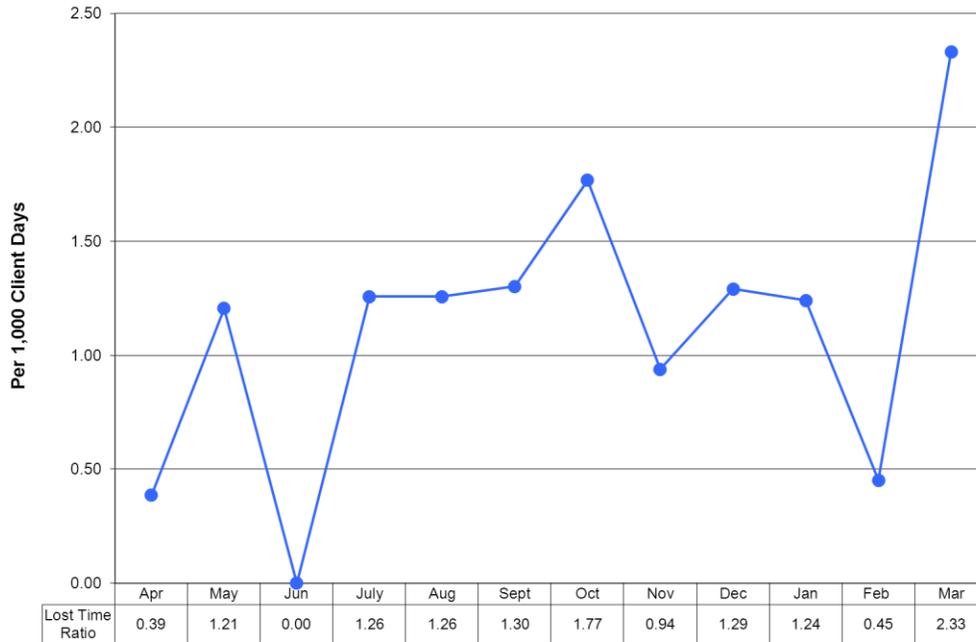


Monthly Overtime

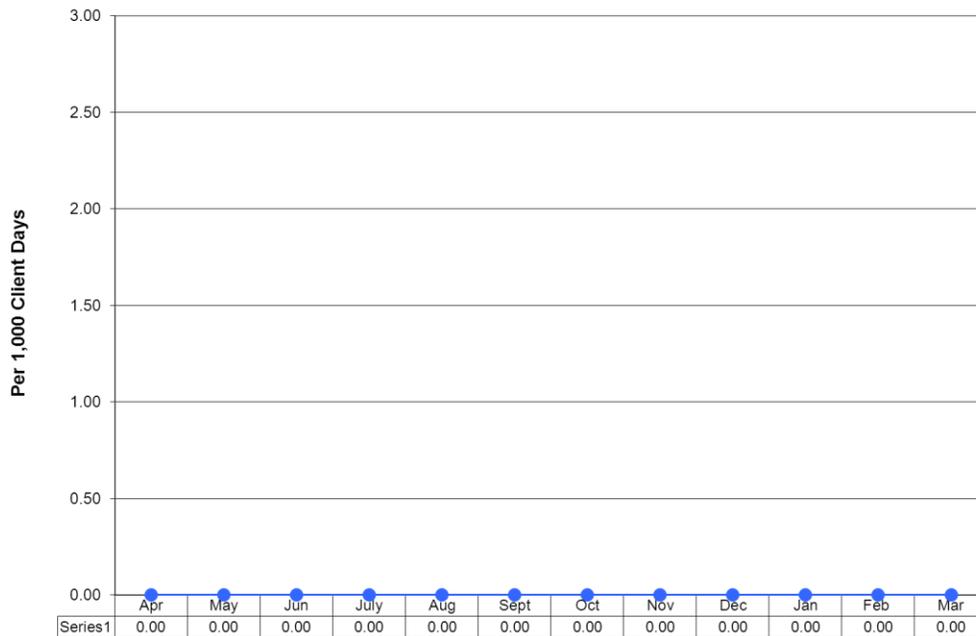


STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



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



STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff

April 15, 2014

PROGRESS AND EVOLVING PROCESS WITH REGARD TO MEDICAL STAFF PERFORMANCE IMPROVEMENT:

Since taking over as clinical director at Riverview Psychiatric Center on January 1, 2014, an area of particular interest has been the medical staff performance improvement process. This is not surprising given that medical staff performance improvement had been severely in abeyance early in 2013 when CMS evaluated the hospital. Attempting to have a functional, effective, and eventually excellent medical staff performance improvement plan is a primary target of my clinical directorship. This report will focus on, not only specific aspects of the plan, but also the evolving process and progress relating to medical staff performance improvement.

Specific aspects of medical staff performance improvement include:

1. The antibiotic monitoring indicator.
2. The multiple antipsychotics while hospitalized indicator.
3. The metabolic monitoring indicator.
4. The timeliness of psychological testing indicator.
5. The introduction of the COTREI rating scale indicator.
6. Medical staff engagement in case reports and detailed case discussions.
7. Discussion of implementation of patient satisfaction surveys in the hospital setting.
8. The status of monthly record reviews.
9. Reporting items including – cognitive impairment throughout hospitalization, two or more antipsychotics at the time of discharge, creatinine clearance of patient's older than 60 who are diabetic or who are on lithium, medication side effect reports, six monthly AIMS testing on inpatients.

NOTE ON PROCESS: On initially taking over the clinical director position, the peer review and performance committee met on a monthly basis for a period of 1 hour. Although this continues, I have identified that the committee needs to be augmented by more specific meetings between those sessions and, to this end, I have set up a meeting with Dr. Miranda Cole, Pharmacist, on a monthly basis to focus specifically on the three current pharmacy-related indicators, but also to use this time evaluating those indicators, viewing the potential future for those indicators, and making consideration as to where those indicators may lead in terms of further performance improvement measures.

In a similar way, I meet with Dr. DiRocco, the director of psychology and in twice-monthly, 1-hour meetings we, among other things, ensure that we follow what is currently the two psychology department indicators, their implementation, results, etc.

Further, it is noted that the Director of Psychology already attends the peer review and performance improvement committee meetings, but that Dr. Cole, Pharmacist, has begun attending these in addition. The value of the extra meetings is also evidenced by an ability to mutually assign homework and update on the indicators and process. This is in addition to any assignments that may be given to other medical staff members during the peer review and performance improvement committee meeting itself.

The following will be an outline of each individual indicator to give some idea of the discussion and direction that it is felt each indicator is moving.

1. Appropriate antibiotic prescribing. We are currently in the process of monitoring to ensure that the antibiotic order sheet is being used at least at a 90 percent frequency over a 4-month period. In addition, we are monitoring for the presence of corresponding progress note with each prescription. It is envisaged that the future of this monitor will develop into appropriate choice of antibiotics and this will require further meeting between Dr. Cole, Pharmacist, and the internists at the hospital.

STRATEGIC PERFORMANCE EXCELLENCE

2. Poly-antipsychotic prescribing during hospitalization. Work on this indicator has shown that reduction in prescription of multiple antipsychotics during hospitalization has reduced considerably. In particular, use of four and three antipsychotics for a given individual has reduced markedly. Instances of prescribing two antipsychotics have reduced and further, closer evaluation of appropriateness of combination prescribing has been undertaken. That is, if two antipsychotics used, using two distinct chemical classes is viewed as more appropriate than two medications from within one class. The future of this indicator includes transitioning to an electronic process where physician is automatically contacted either at the point of admission or at the point of adding a second antipsychotic medication. Given that there is a national indicator for appropriateness of using two antipsychotic medications at the time of discharge, it is hoped the future this indicator may well involve an appropriate meshing with this indicator. The possibility of reviewing overall poly-pharmacy as an indicator is a suggestion which has emerged from following this indicator itself. This is an example of how an active performance improvement process leads the discussing physicians in the direction of thinking of further performance improvement ideas.
3. The metabolic monitoring indicator. A baseline evaluation of a vast majority of the inpatients has been completed. Documenting patient refusal for this indicator would be appropriate, as this will clearly indicate if our baseline efforts are completed or if lacking information is present for another reason. The next step with this monitor will be to ensure that appropriate laboratory work is being ordered and, in turn, that the appropriate work is being ordered at the APA/ADA-recommended appropriate interval. The future of this monitor will then be designed to identify individuals with diabetes or metabolic syndrome secondary to prescription of new generation antipsychotics. Clarification of treatment recommendations and how to monitor these responses will be a further step. Making a connection between performance improvement indicator and education of medical staff, it is noted that there are available CME modules focusing on this issue in particular. For example, metabolic monitoring for patients on antipsychotic medications CME Magazine, December 20, 2013. Implementation of this CME module for medical staff is being strongly considered.
4. Timeliness of psychological testing. I am not convinced that this indicator is producing value, but as this is a time of transition in the psychology department, it is appropriate to continue monitoring to ensure that a wait for psychological services does not increase. It is noted that monitoring the absolute amount of psychological testing may be appropriate at present as the psychology department enhances its availability, both through revision of services provided and actual availability of psychologists.
5. Introduction of COTREI. The community outpatient treatment readiness inventory is to be used for the NCR, or not criminally responsible, population in the hospital. Initial target is to obtain a COTREI evaluation of each patient in the hospital setting from both a psychologist and psychiatrist. It is expected that this will reach a 90-percent threshold over the next 4 months and I continue to discuss, both at committee and individually with Dr. DiRocco, Director Of Psychology, the progress of this monitor. The monitor itself is at a stage of introducing the material to clinical staff, but it is envisaged that this tool will provide a set language for evaluating the clinical progress of individuals within that program and hopefully eventually, the indicator will guide treatment planning in the lengthy 6 to 9 month intervals between Superior Court attendance that occurs during the NCR recovery process. Further usefulness of this monitor will relate to researching the population and predicting likelihood of relapse or other difficulties that may be experienced based on specific aspects of the indicator. In turn, this may help focus treatment for resistant or likely difficult areas for given individuals.
6. Case reports. During peer review and performance improvement committee meetings, a number of detailed case presentations have now occurred with follow-up occurring in subsequent months, looking at the discussed recommendations and ensuring follow-through with such recommendations. A future in this regard will include review of a number of the case studies in an effort to evaluate whether specific recommendations are made more frequently than in an individual case.

STRATEGIC PERFORMANCE EXCELLENCE

7. Satisfaction surveys. One of the medical staff suggested looking at use of a satisfaction survey for the patients within the hospital. Satisfaction surveys of customers in any area have been used as a quality improvement tool across multiple organizations and businesses. As evidenced by Quint Studer's work in improving hospital performance, patient satisfaction surveys can be an integral part of driving quality in healthcare. Discussion of the feasibility of implementing such a program within the hospital will be presented by Dr. Davis at the April peer review and performance improvement committee meeting.
8. Medical record reviews. Medical staff has engaged in basic review of admission notes, progress notes, and discharge notes. It has previously been noted that this material, though gathered, has not been integrated into a systematic performance improvement process. Dr. Kirby will be meeting in future with Joseph Reddick, Director Of Quality Services for the hospital, to discuss improving use of medical staff time in documentation review to ensure that the valuable physician time is used in a helpful, quality driven way.
9. Reporting items. It is noted above that there are a number of quality items, which continue to be reported on by medical staff. Ensuring that this information is appropriately delivered, particularly at pharmacy and therapeutics and other committees, has been a focus of the performance improvement efforts.

CHALLENGE: An immediate challenge in med staff PI is to have immediate and detailed access to each monitor's actual figures, graphs, tables, etc. and I will be working to ensure this in the near future.

CONCLUSION: Engagement in the medical staff performance improvement process, setting up appropriate meetings between committee, and working through these issues at committee level, has improved my ability to monitor how medical staff performance improvement will best work within Riverview Psychiatric Center, its medical and allied staffs. Rather than simply attempting to find a valid indicator and dismissing those that appear less valid, working through each indicator in detail and constantly evaluating it for its current situation, possible productivity, and possible future as an indicator, as well as making connections to necessary education and watching for opportunities for further indicators appears to be a much more productive way of engaging in performance improvement. The commitment to changing from a now functional performance improvement system to a highly reliable performance improvement system which strives for and continues to pursue excellence now becomes the target.

Brendan Kirby, MD
Clinical Director

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STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff Timeliness of Psychological Testing

Data Collection: All requests for psychological testing or evaluation were reviewed during the time period of January, February, and March 2014. The date of the request, the medical staff member requesting the information, the date of initiation of testing and date of completion of testing were determined for comparison to target norms.

Findings: During the period in question, there were a total of 23 requests for psychological services.

The table below shows the breakdown of services provided for the 3rd quarter of 2014:

Service	Referrals	Avg. Days to Complete	Max Days	% w/in 30 days
Therapeutic intervention	3	4	6	100.0%
Individual Counseling	6	2.8	6	100.0%
Psych Consults	5	3.8	6	100.0%
Assessments	9	8.2	18	100.0%
Referral total	23	5.3	% completed	100.0%
Incomplete	0			

Analysis: The Psychology department has set a goal of improving the value of psychological services provided to clients and the staff of Riverview. The delivery of diagnostic and psychotherapeutic services in a timely and efficient manner has been made a priority for the department as a whole. At present, as the chart above shows, the department is able to document improvement in the delivery of psychological services in a timely manner. All psychological service referrals were addressed within the acceptable time line of 30 days. In other areas, data is being collected on individuals identified as NCR clients to aid in the success of outpatient placement. Current progress towards the goal of 90 percent or better data collection on NCR clients who will be moving into the community is at 37 percent. The target goal date for this performance improvement effort is July 1st 2014. This is up from 12 percent as of early March 2014.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff Timeliness of Psychological Testing

Plans: Activities supporting in-service training and psychological research have been initiated to improve the quality of services and to gain useful information related to the efficacy of treatment for our clients. Recovery oriented treatment groups led by peer facilitators have been undertaken as of this date. Measures of quality of services provided are being collected each session.

The psychology department continues providing interns and practicum students with the opportunity to study and learn at Riverview over the course of a calendar year. There are currently two interns completing a one year rotation and two more who have already been selected for the new academic year beginning in July 2014. The goal of the internship program is to provide a well-rounded and focused learning opportunity for graduate students in psychology. We are also attempting to expand the program to four interns for the 2014 – 15 internship rotation. The department has also been contacted by a foreign student from Germany who has heard about the Riverview Psychiatric Center and is interested in a practicum experience from July to mid-September.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff Metabolic Monitoring of Atypical Antipsychotics

	January	February	March
Census (Beginning + Admissions)	113	110	112
Antipsychotic Orders for Clients			
No Antipsychotics	31 (27%)	29 (26%)	30 (27%)
Mono-antipsychotic therapy	53 (47%)	49 (45%)	50 (45%)
Two Antipsychotics	22 (19%)	25 (23%)	25 (22%)
Three Antipsychotics	6 (5%)	7 (6%)	6 (5%)
Four Antipsychotics	1 (<1%)	0	1 (<1%)
At least 1 antipsychotic	82 (73%)	81 (74%)	82 (73%)
Total on Poly-antipsychotic therapy	29 (26%)	32 (29%)	32 (29%)
Percentage of poly-antipsychotic therapy amongst those with orders for antipsychotics	35% (29/82)	40% (32/81)	39% (32/82)
More than 2 antipsychotics	7 (6%)	7 (6%)	7 (6%)
Poly-Antipsychotic therapy breakdown			
SGA + FGA	12 (41%)	17 (53%)	18 (56%)
2 SGAs (“Pine” + “Done”)	5 (17%)	3 (9%)	4 (13%)
Other (2 antipsychotic regimens)	5 (17%)	5 (16%)	3 (9%)
Other 2 Antipsychotic Regimen Details	1) Quetiapine + Aripiprazole 2) Clozapine + Quetiapine 3) Chlorpromazine + Fluphenazine 4) Chlorpromazine + Loxapine 5) Paliperidone + Risperidone	1) Chlorpromazine + Fluphenazine 2) Chlorpromazine + Loxapine 3) Chlorpromazine + Haloperidol 4) Paliperidone + Risperidone 5) Olanzapine + Quetiapine	1) Clozapine + Olanzapine 2) Chlorpromazine + Loxapine 3) Paliperidone + Risperidone
3+ Antipsychotic Regimens	7 (24%) 1) Quetiapine + Haloperidol + Risperidone 2) Aripiprazole + Olanzapine + Ziprasidone 3) Chlorpromazine + Olanzapine + Lurasidone 4) Ziprasidone + Haloperidol + Aripiprazole 5) Olanzapine + Haloperidol + Quetiapine 6) Chlorpromazine + Olanzapine + Risperidone 7) Haloperidol + Olanzapine + Clozapine + Ziprasidone	7 (22%) 1) Haloperidol + Chlorpromazine + Olanzapine 2) Quetiapine + haloperidol + Risperidone 3) Aripiprazole + Olanzapine + Ziprasidone 4) Chlorpromazine + Perphenazine + Loxapine 5) Clozapine + Quetiapine + Ziprasidone 6) Haloperidol + Olanzapine + Clozapine 7) Olanzapine + Haloperidol + Quetiapine	7 (22%) 1) Aripiprazole + Olanzapine + Ziprasidone 2) Olanzapine + quetiapine + Ziprasidone 3) Clozapine + Quetiapine + Ziprasidone 4) Clozapine + Haloperidol + Olanzapine 5) Quetiapine + Olanzapine + Loxapine 6) Quetiapine + Chlorpromazine + Loxapine 7) Quetiapine + Risperidone + Ziprasidone + Haloperidol
Justifiable Poly-Antipsychotic Therapy	24/29 (83%) [below goal of 90%]	29/32 (91%) [above goal of 90%]	30/32 (94%) [above goal of 90%]

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

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff Metabolic Monitoring of Atypical Antipsychotics

Data Collection

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

Findings

Over the quarter we found that about 73% of clients were receiving at least one antipsychotic medication. Of these clients, about 28% were receiving more than one such agent, and by definition was a case of polypharmacy. Within this overall percentage we noted that in January the percentage was 26, in February it was 29, and in March it was 29. This is a seemingly decrease in poly-antipsychotic therapy from the previous quarter (82% total, 34% October, 40% December, and 38% December). However, some discrepancies were identified in data collection and were resolved. We discovered that prospective data collection yields more accurate information and will continue with this going forward.

Analysis

We are just below our target of 90% justified for the quarter at 89%. The trend line showed improvement over the quarter and was above threshold in February and March at 91%. The overall number of clients receiving poly-antipsychotic therapy increased from last quarter but remained relatively constant within quarter. There were 2 instances of clients receiving ultrahigh numbers of medications (greater than 3 antipsychotics) in January and March. This is an increase from last quarter and both instances have been addressed resulting in no current instances of clients receiving more than 3 antipsychotics.

Plan

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

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff Antibiotic Use Monitoring

Data Collection

During the quarter the antibiotic monitoring form consisting of a special doctor's order sheet with details of the antibiotic indication, drug, and strength, and giving agreed upon prescribing guidelines was fully implemented. Adherence to utilization of the form and the clinical appropriateness of indications for the antibiotic orders are gathered at the end of each month and the summary is provided at the following months' Pharmacy and Therapeutics (P&T) Committee. The Peer Review Team has been identified.

Findings

During the monitoring period there were 43 orders for antibiotics. In five instances the antibiotic order form was not utilized. Three of the five were in February and twice in March. This a 88% adherence rate for the quarter. This is a decline from the last quarter which had a 92% adherence rate. The orders for January and February have been presented at the Pharmacy and Therapeutic Committee. January had a total of 11 antibiotic orders and a 100% adherence rate to the form, February had 12 antibiotic orders and a 75% adherence rate to the form and March had 20 antibiotic orders with a 90% adherence rate to the form. Since all of the orders not on an antibiotic order form for the month of February were written by after hour prescribers, it was suspected that they needed additional education provided by the Clinical Director. The result was an increase in the utilization of the appropriate antibiotic form in March. The after hour prescriber that did not utilize the form is a new employee and will be provided with additional education.

Plan

The Peer Review team will evaluate the appropriateness of each antibiotic order. The team will also, on an ongoing basis, review the clinical guidelines and make recommendations for changes. Other trends identified by the team will be reported as necessary. A summary will be presented at each P&T Committee Meeting. Our threshold for this monitor is that 90% of all antibiotic orders will meet clinical guidelines as developed by the Medical Executive Committee.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff Metabolic Monitoring of Atypical Antipsychotics

Data Collection

The pharmacy completed data collection of metabolic monitoring parameters for all clients in the hospital who were receiving atypical antipsychotics during the quarter. Data elements collected on all clients included BMI (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 client was receiving. This information is posted on the physician's shared drive and presented monthly at the Pharmacy and Therapeutics (P&T) Committee Meeting

Findings

During the monitoring period there were 93 clients receiving at least one atypical antipsychotic agent. Data was completely recorded for all desired data elements for 60 of 93 (or 54%) clients. Twenty-three percent of clients were missing enough data elements that their metabolic status was unable to be determined. About 79% of the elements were available for evaluation of metabolic syndrome. Missing data elements were primarily related to lab studies, mostly due to refusal of clients to obtain blood work. Cholesterol labs were the most frequently missing (39%) and then glucose labs (27%)

Analysis

At 54% we were below our target of 95% of clients on atypical antipsychotics having a complete metabolic profile available to the pharmacist and to the medical staff. This was primarily due to missing laboratory values in the data base due to refusals.

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. 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.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing

INDICATOR

Mandate Occurrences

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

Monitoring would be performed by;

- Staffing Office Database Tracking System

METHODS OF REPORTING

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

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

UNIT

Mandate shift occurrences

BASELINE

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

MONTHLY TARGETS

Baseline –10% each month

STRATEGIC PERFORMANCE EXCELLENCE

Nursing Department Mandates Staffing Improvement Task Force

Safety in Culture and Actions	Unit	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Goal
Mandate Occurrences – Nurses	# of shifts	5	3	20	4	8	9	3	12	15	13
When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.											
Mandate Occurrences – Mental Health Workers	# of shifts	51	30	98	32	30	29	20	49	54	49
When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.											

Comments

Nursing mandates were up this quarter from 21 last quarter to 30 this quarter. MHW mandates were also up from 91 last quarter to 123 this quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

INDICATOR

Client Satisfaction Survey Return Rate

DEFINITION

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

OBJECTIVE

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

THOSE RESPONSIBLE FOR MONITORING

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

METHODS OF MONITORING

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

METHODS OF REPORTING

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

UNIT

All client care/residential units

BASELINE

Determined from previous year's data.

QUARTERLY TARGETS

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

STRATEGIC PERFORMANCE EXCELLENCE

Peer Support

Inpatient Client Survey – Improving the Rate of Return

Department: Peer Support Responsible Party: Chris Monahan

Strategic Objectives								
Client Recovery	Unit	Baseline	FY14 Q1	FY14 Q2	FY14 Q3	FY14 Q4	Goal	Comments
CSS Return Rate								
<i>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.</i>	LK	15%	5%	18%	10%		50%	<i>Percentages are calculated based on number of people eligible to receive a survey vs. the number of people who completed the surveys.</i>
	LS	5%	4%	8%	10%	50%	50%	
	UK	45%	39%	47%	30%		50%	
	US	30%	100%	33%			50%	

Summary: 60 (51 discharges / 9 annuals) surveys were offered to clients. The number of refusals and surveys not returned, brought the completed total to only 14 surveys.

STRATEGIC PERFORMANCE EXCELLENCE

Summary of Inpatient Client Survey Results

#	Indicators	1Q2014	2Q2014	3Q2014	Average
		Findings	Findings	Findings	Score
1	I am better able to deal with crisis.	70%	69%	73%	71%
2	My symptoms are not bothering me as much.	78%	71%	63%	71%
3	The medications I am taking help me control symptoms that used to bother me.	65%	75%	83%	74%
4	I do better in social situations.	69%	73%	65%	69%
5	I deal more effectively with daily problems.	70%	69%	68%	69%
6	I was treated with dignity and respect.	70%	75%	73%	73%
7	Staff here believed that I could grow, change and recover.	73%	69%	80%	74%
8	I felt comfortable asking questions about my treatment and medications.	63%	69%	70%	67%
9	I was encouraged to use self-help/support groups.	65%	77%	70%	71%
10	I was given information about how to manage my medication side effects.	65%	63%	65%	64%
11	My other medical conditions were treated.	63%	71%	75%	70%
12	I felt this hospital stay was necessary.	63%	63%	65%	64%
13	I felt free to complain without fear of retaliation.	60%	53%	50%	54%
14	I felt safe to refuse medication or treatment during my hospital stay.	39%	63%	55%	52%
15	My complaints and grievances were addressed.	58%	65%	68%	64%
16	I participated in planning my discharge.	67%	73%	65%	68%
17	Both I and my doctor or therapists from the community were actively involved in my hospital treatment plan.	58%	73%	65%	65%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	72%	71%	63%	69%
19	The surroundings and atmosphere at the hospital helped me get better.	68%	69%	65%	67%
20	I felt I had enough privacy in the hospital.	68%	71%	63%	67%
21	I felt safe while I was in the hospital.	65%	75%	75%	72%
22	The hospital environment was clean and comfortable.	73%	75%	78%	75%
23	Staff was sensitive to my cultural background.	63%	83%	55%	67%
24	My family and/or friends were able to visit me.	78%	77%	78%	78%
25	I had a choice of treatment options.	58%	73%	60%	64%
26	My contact with my doctor was helpful.	70%	77%	68%	72%
27	My contact with nurses and therapists was helpful.	60%	79%	78%	72%
28	If I had a choice of hospitals, I would still choose this one.	58%	69%	48%	58%
29	Did anyone tell you about your rights?	58%	71%	63%	64%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	60%	67%	45%	57%
31	Do you know someone who can help you get what you want or stand up for your rights?	58%	71%	70%	66%
32	My pain was managed.	64%	65%	65%	65%
	Overall Score	64%	71%	66%	67%

Summary: Overall satisfaction dropped by 5% in this quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

Safety in Culture and Actions

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

Fiscal Accountability

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

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline 2013	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Pyxis CII Safe Comparison</u>								10 discrepancies between Pyxis and CII Safe transactions during Q3
<i>Daily and monthly comparison of Pyxis vs CII Safe transactions</i>	Rx		0%	0%	0%	0%		
Quarterly Results			0.3%	0%	2.5%			
<u>Veriform Medication Room Audits</u>								Overall compliance is 98% for Q1, Q2 and Q3
<i>Monthly comprehensive audits of criteria</i>	All	97%	100%	100%	100%	100%	90%	
Quarterly Results			98%	98%	98%			
<u>Pyxis Discrepancies</u>								Trending of monthly data was significantly increased for Q2 and Q3 vs Q1
<i>Monthly monitoring and trending of Pxyis discrepancies.</i>	All	63/mo	50	50	50	50	50/mo	
Quarterly Results			226 (75/mo)	403 (134/mo)	389 (130/mo)			
<u>Pyxis Overrides – Controlled Drugs</u>								Target goal is 10/month
<i>Monthly monitoring and trending of Pyxis overrides for Controlled Drugs</i>	All	15/month	10	10	10	10	10	
Quarterly Results			65	53	114			
Fiscal Accountability	Unit	2013 Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Discharge Prescriptions</u>								Significant costs are incurred in providing discharge drugs.
<i>Monitoring and Tracking of dispensed Discharge Prescriptions</i>	Rx	\$8440 334 drugs	\$5262 418 drugs	\$4184 252 drugs	\$2679 359 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 →	Days 7 Evenings 7	100%	14 weekly
2. Number of clients attending day groups on unit or facilitated by day staff (approx.)	3	60%	5/group
3. Number of clients attending evening groups on unit or facilitated by evening staff (approx.)	4	80%	5/group
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	9/10	90%	100%
5. The client can identify distress tolerance tools on the unit	9/10	90%	100%
7. The client is able to state who his primary staff is	8/10	80%	100%

EVALUATION OF EFFECTIVENESS

On unit groups continue each day of the week on the day and evening shifts. There has been an increase in the number of clients that can identify coping tools on the unit. This may be a result of promotion of these items in this quarter. There is a slight decrease in the number of clients who identified their primary worker. The percentage of on unit groups on the treatment plans has improved this quarter from 50% to 90%. This is attributed to the QA checks that nursing leadership is performing on the treatment plans.

ISSUES

Participation in on unit groups is not meeting the threshold. Attendance varies with census, client movement through admission, discharge and transfers on the acute lower Kennebec unit.

ACTIONS

An emphasis on personal medicine and recovery education as well as implementation will continue through the next quarter

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	Days 7 Evenings 7	100%	14weekly
2. Number of clients attending day groups on unit or facilitated by day staff (approx.)	3/5	60%	5/group
3. Number of clients attending evening groups on unit or facilitated by evening staff (approx.)	4/5	80%	5/group
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	4/10	40%	100%
5. The client can identify distress tolerance tools on the unit	9/10	90%	100%
7. The client is able to state who his primary staff is	9/10	90%	100%

EVALUATION OF EFFECTIVENESS On unit groups are offered daily on the day and evening shifts. The percentage of on unit groups on the treatment plan has decreased this quarter from 90% to 40%. The unit acuity and census has increased. Regular assigned unit nursing staff has had a slight decrease.

ISSUES Participation in on unit groups is not meeting the threshold. The team will continue to evaluate feedback from clients on group satisfaction.

ACTIONS Measures to in cooperate on unit groups on all client treatment plans have been put in place. An emphasis on personal medicine and recovery education as well as implementation will continue through the next quarter.

STRATEGIC PERFORMANCE EXCELLENCE

Program Services Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. How many on unit groups were offered each week Day shift → Evenings →	Main/SCU 36 / 12 27 / 10	100% 100%	7 / 7 = 14 7 / 7 = 14
2. Number of clients attending day groups on unit or facilitated by day staff (# of clients in all of day groups divided by # of day groups provided)	4.5 / 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)	3.5 / 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%
7. 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. Documentation in the Meditech has improved. This treatment effort continues to be reflected in the treatment plans. 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. Recreational Therapy staff members are more consistent in documenting participation and nursing staff have improved documentation over the past quarter. Only an occasional new client may need to be reminded about available tools/activities to help relieve distress.

ACTIONS

RT staff members are very important in providing diversion and therapy groups to Lower Saco clients, which needs to be maintained. The unit is offering many more groups weekly than the threshold; We have added new staff acuity specialist positions, which have helped address acuity situations and further improved 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 9	 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)	1.5avg./14grps		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)	4avg./9grps		N/A
4. Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended	3	30%	100%
5. The client can identify distress tolerance tools on the unit	30/30	100%	100%
7. The client is able to state who his primary staff is	30/30	100%	100%

EVALUATION OF EFFECTIVENESS

ISSUES

There continues to be a need to better reflect this on-unit treatment effort in the treatment plans. Nearly all of the clients 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 clients not regularly attending the hospital treatment mall.

ACTIONS

Newly admitted clients quickly become familiar with distress tolerance tools (MP3 players, cards, exercise machines, etc.) and how to access them. They also know their assigned primary staff. Additional efforts need to be made to get all on-unit offered groups in individual treatment plans. Continued efforts are being made to offer groups to those clients that have less activity at the hospital treatment mall. Treatment planning on-unit groups and follow-up documentation issues are being identified with the new nursing leader.

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Vocational Incentive Program Treatment Plans</u>	55%	92%	95%	98%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	All charts reviewed but 1 had current plans in the chart. The plan was completed by the employment specialist but was missing in the chart. New one printed and placed in the chart. 2 charts missing bi weekly documentation
<i>The objective of this improvement project is to ensure vocational treatment plans are initiated on all clients within 5 days of beginning work and will be reviewed and updated if necessary every 30 days. Documentation on interventions in the treatment plans will reflect progress towards interventions and will be documented on weekly.</i>							
<u>Quarterly Results</u>		95%	88%	93%			

Client Recovery	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<u>Recreational Therapy Assessments & Treatment Plans</u>	75%					The treatment plans will be reviewed more regularly and updated at each client treatment team meeting or if there is any change in client status	All plans updated and documentation in the chart for this quarter.
<i>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.</i>		85%	90%	95%	100%		
<u>Quarterly Results</u>		85%	91%	100%			

STRATEGIC PERFORMANCE EXCELLENCE

Rehabilitation Services

Department: Rehabilitation Services Responsible Party: Janet Barrett

Strategic Objectives							
Client Recovery & Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
<p><u>Occupational Therapy referrals and doctors orders.</u></p> <p><i>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.</i></p>	33%	50%	75%	100%	100%	To increase the percentage of referrals and doctor's orders by 25 % each quarter until we attain 100% compliance.	Only 1 client which the Dr.'s order was written the day services started but the referral was not received until 3 days later.
<u>Quarterly Results</u>		91%	81%	96%			

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: 10/01/2013 To 12/31/2013

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Non-hospitalized member** - MaineCare member who is not in an inpatient psychiatric facility at the time of application for services. This is indicated by the member not having an open authorization for inpatient psychiatric services on the day a CFSN is completed or on the day the member is referred for CI services.
- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **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 time 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: 1,974

Total assigned within 3 working days: 1,371

% assigned within 3 working days: 69%

Total assigned in 4 - 7 working days: 203

% assigned in 4 - 7 working days: 10%

Total assigned within 7 working days: 1,574

% assigned within 7 working days: 80%

Total assigned after 8 or more working days: 400

% assigned after 8 or more working days: 20%

	<u>Waited 3 working days or less</u>	<u>Waited 4 to 7 working days</u>	<u>Waited 8 or more working days</u>	<u>Total</u>
Gender				
Female	861	135	271	1,267
Male	510	68	129	707
Total	1,371	203	400	1,974
Adult Age Groups				
18-20	92	14	33	139
21-24	98	19	26	143
25-64	1,125	160	319	1,604
65-74	43	9	18	70
Over 75 Years Old	13	1	4	18
Total	1,371	203	400	1,974

AMHI Class	<u>Waited 3 working days or less</u>	<u>Waited 4 to 7 working days</u>	<u>Waited 8 or more working days</u>	<u>Total</u>
AMHI Class N	1,299	197	385	1,881
AMHI Class Y	72	6	15	93
Total	1,371	203	400	1,974

District	<u>Waited 3 working days or less</u>	<u>Waited 4 to 7 working days</u>	<u>Waited 8 or more working days</u>	<u>Total</u>
District 1/ York County	87	21	63	171
District 2/ Cumberland County	191	47	104	342
District 3/ Androscoggin, Franklin, and Oxford Counties	360	36	57	453
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	161	20	33	214
District 5/ Somerset and Kennebec Counties	249	27	59	335
District 6/ Piscataquis and Penobscot Counties	198	31	55	284
District 7/ Washington and Hancock Counties	55	10	14	79
District 8/ Aroostook County	58	9	12	79
Unknown	12	2	3	17
Total	1,371	203	400	1,974

Providers	<u>Waited 3 working days or less</u>	<u>Waited 4 to 7 working days</u>	<u>Waited 8 or more working days</u>	<u>Total</u>
Acadia Healthcare	9	0	0	9
Allies	13	4	10	27
Alternative Services	14	0	1	15
Alternative Wellness Services	2	0	0	2
Aroostook Mental Health Services	41	3	2	46
Assistance Plus	48	1	7	56
Behavior Health Solutions for Me	10	1	0	11
Break of Day, Inc	12	10	15	37
Broadreach Family & Community Services	20	4	0	24
Catholic Charities Maine	23	28	37	88
Charlotte White Center	12	3	8	23
Choices	13	0	0	13
Common Ties	52	10	22	84
Community Care	21	0	1	22
Community Counseling Center	47	10	24	81
Community Health & Counseling Services	94	17	19	130
Connections for Kids	1	0	3	4
Cornerstone Behavioral Healthcare - CM	31	3	5	39
Counseling Services Inc.	77	16	46	139
Direct Community Care	48	4	3	55
Dirigo Counseling Clinic	14	4	1	19
Employment Specialist of Maine	4	1	2	7
Evergreen Behavioral Services	18	1	1	20
Fullcircle Supports Inc	44	2	1	47
Graham Behavioral Services	24	1	0	25
Harbor Family Services	3	2	3	8
Healing Hearts LLC	5	0	0	5
Health Affiliates Maine	139	1	4	144
Higher Ground Services	5	1	1	7
Kennebec Behavioral Health	90	3	10	103
Life by Design	14	3	5	22
Lutheran Social Services	11	0	0	11
Maine Behavioral Health Organization	39	0	1	40
Maine Vocational & Rehabilitation Assoc.	3	1	2	6
Manna Inc	10	0	1	11

Providers	<u>Waited 3 working days or less</u>	<u>Waited 4 to 7 working days</u>	<u>Waited 8 or more working days</u>	<u>Total</u>
Merrymeeting Behavioral Health Associates-Adult Case Mgmt	20	0	0	20
Mid Coast Mental Health	16	3	8	27
Motivational Services	7	0	0	7
Northeast Occupational Exchange	11	11	37	59
Northern Maine General - Community Support	1	0	0	1
Ocean Way Mental Health Agency	3	0	0	3
OHI	4	2	5	11
Oxford County Mental Health Services	11	8	3	22
Port Resources-Sec 17	1	0	0	1
Rumford Group Homes	13	0	1	14
Sequel Care of Maine	27	0	0	27
Shalom House	15	1	2	18
Smart Child & Family Services	10	2	6	18
Somali Bantu Youth Association of Maine	15	2	0	17
St. Andre Homes	6	1	1	8
Stepping Stones	14	1	0	15
Sunrise Opportunities	5	0	0	5
Sweetser	69	10	48	127
The Opportunity Alliance	29	16	20	65
Tri-County Mental Health	74	11	33	118
UCP VI	1	1	1	3
York County Shelter Program	8	0	0	8
Total	1,371	203	400	1,974

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: 10/01/2013 To 12/31/2013

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Hospitalized member** - MaineCare member who is in an inpatient psychiatric facility at the time of application for services. This is indicated by the member having an open authorization for inpatient psychiatric services at the time a CFSN authorization is entered into CareConnection 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 time of admission, but is expected to be served using either MaineCare and/or state funds.

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 to 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: 47

Total assigned within 2 working days: 36

% assigned within 2 working days: 77%

Total assigned in 3 - 7 working days: 4

% assigned in 3 -7 working days:9 %

Total assigned within 7 working days: 40

% assigned within 7 working days: 85%

Total assigned after 8 or more working days: 7

% assigned after 8 or more working days: 15%

	<u>Waited 2 working days or less</u>	<u>Waited 3 to 7 working days</u>	<u>Waited 8 or more working days</u>	<u>Total</u>
Gender				
Female	15	2	3	20
Male	21	2	4	27
Total	36	4	7	47
	<u>Waited 2 working days or less</u>	<u>Waited 3 to 7 working days</u>	<u>Waited 8 or more working days</u>	<u>Total</u>
AMHI Class				
AMHI Class N	29	3	6	38
AMHI Class Y	7	1	1	9
Total	36	4	7	47

District	<u>Waited 2 working days or less</u>	<u>Waited 3 to 7 working days</u>	<u>Waited 8 or more working days</u>	<u>Total</u>
District 1/ York County	3	0	2	5
District 2/ Cumberland County	4	0	1	5
District 3/ Androscoggin, Franklin, and Oxford Counties	6	0	1	7
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	0	0	1	1
District 5/ Somerset and Kennebec Counties	10	2	2	14
District 6/ Piscataquis and Penobscot Counties	7	1	0	8
District 7/ Washington and Hancock Counties	3	1	0	4
District 8/ Aroostook County	2	0	0	2
Unknown	1	0	0	1
Total	36	4	7	47

Providers	<u>Waited 2 working days or less</u>	<u>Waited 3 to 7 working days</u>	<u>Waited 8 or more working days</u>	<u>Total</u>
Acadia Healthcare	4	0	0	4
Alternative Services	4	0	0	4
Aroostook Mental Health Services	1	0	0	1
Assistance Plus	2	0	0	2
Catholic Charities Maine	2	0	0	2
Common Ties	3	0	0	3
Community Health & Counseling Services	2	1	0	3
Cornerstone Behavioral Healthcare - CM	1	0	0	1
Counseling Services Inc.	1	0	2	3
Direct Community Care	0	0	1	1
Employment Specialist of Maine	0	1	1	2
Graham Behavioral Services	2	0	0	2
Healing Hearts LLC	1	0	0	1
Kennebec Behavioral Health	6	1	0	7
Maine Behavioral Health Organization	1	0	0	1
Northeast Occupational Exchange	0	1	0	1
Oxford County Mental Health Services	1	0	0	1
Shalom House	2	0	0	2
Sweetser	0	0	1	1
The Opportunity Alliance	2	0	0	2
Tri-County Mental Health	0	0	2	2
UCP VI	1	0	0	1
Total	36	4	7	47

Quarterly Report 60a for Members on MaineCare Waitlist for CI

Report Dates: 10/01/2013 To 12/31/2013

Report Run Date: 4/11/2014

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 768

For those who received the service: Average number of days waiting: 11 days
Percent waiting 30 days or less: 88% Percent waiting 90 days or less: 99%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
AMHI Class N	726	707	19	635	87	4	11
AMHI Class Y	42	42	0	39	3	0	8
Totals	768	749	19	674	90	4	11

District	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
District 1	91	87	4	80	11	0	12
District 2	221	217	4	195	25	1	11
District 3	110	108	2	100	9	1	10
District 4	66	66	0	55	11	0	13
District 5	141	135	6	132	9	0	7
District 6	77	76	1	66	9	2	12
District 7	32	32	0	24	8	0	18
District 8	20	19	1	13	7	0	23
Unknown	10	9	1	9	1	0	8
Totals	768	749	19	674	90	4	11

Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
Assistance Plus	62	61	1	57	5	0	5
Break of Day, Inc	2	2	0	2	0	0	6
Catholic Charities Maine	82	82	0	82	0	0	8
Charlotte White Center	3	3	0	2	0	1	47
Common Ties	42	40	2	41	0	1	11
Community Care	22	21	1	17	5	0	15
Community Counseling Center	59	57	2	44	14	1	19
Community Health & Counseling Services	69	69	0	57	11	1	13
Counseling Services Inc.	95	93	2	93	2	0	5
Direct Community Care	37	37	0	37	0	0	1
Fullcircle Supports Inc	2	2	0	2	0	0	0
Graham Behavioral Services	2	2	0	2	0	0	0
Healing Hearts LLC	2	2	0	2	0	0	3
Health Affiliates Maine	2	2	0	1	1	0	32
Higher Ground Services	8	8	0	8	0	0	3
Kennebec Behavioral Health	66	61	5	60	6	0	8
Life by Design	12	11	1	6	6	0	32
Lutheran Social Services	1	1	0	1	0	0	2
Maine Behavioral Health Organization	1	1	0	1	0	0	0
Mid Coast Mental Health	23	23	0	17	6	0	18
Shalom House	6	6	0	6	0	0	4
Sweetser	60	57	3	41	19	0	24
The Opportunity Alliance	78	77	1	72	6	0	9
Tri-County Mental Health	29	28	1	21	8	0	19
UCP VI	3	3	0	2	1	0	12
Totals	768	749	19	674	90	4	11

Quarterly Report 60b for People on State-funded Waitlist for CI

Report Dates: 10/01/2013 To 12/31/2013

Report Run Date: 4/11/2014

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **Contact for Service Notification (CFSN)** is a form submitted by a Provider into CareConnection whenever a member is put on a wait list for service. The CFSN is used in conjunction with the authorization start date of the service to determine the number of days the member waited.
- **Courtesy Review** - APS completes courtesy reviews when a member is not MaineCare eligible at the time of admission, but is expected to be served using either MaineCare and/or state funds.
- **State-funded** is funding through State of Maine for individuals who are not eligible to receive a particular service using MaineCare funds.

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: 187

For those who received the service: Average number of days waiting: 17 days
Percent waiting 30 days or less: 79% Percent waiting 90 days or less: 99%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
AMHI Class N	178	30	148	139	37	2	17
AMHI Class Y	9	2	7	9	0	0	7
Totals	187	32	155	148	37	2	17

District	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
District 1	26	5	21	18	7	1	25
District 2	66	7	59	55	11	0	14
District 3	21	9	12	16	5	0	18
District 4	14	2	12	8	6	0	29
District 5	30	4	26	25	4	1	17
District 6	27	5	22	24	3	0	8
District 7	1	0	1	1	0	0	0
District 8	2	0	2	1	1	0	30
Totals	187	32	155	148	37	2	17

Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90	# auth in > 91	Average # days waiting
Assistance Plus	20	5	15	18	2	0	12
Break of Day, Inc	1	0	1	0	1	0	40
Catholic Charities Maine	3	0	3	3	0	0	6
Common Ties	3	3	0	3	0	0	10
Community Care	15	1	14	13	2	0	9
Community Counseling Center	22	0	22	20	2	0	10
Community Health & Counseling Services	9	3	6	8	1	0	8
Counseling Services Inc.	23	8	15	17	6	0	22
Direct Community Care	2	0	2	2	0	0	2
Kennebec Behavioral Health	13	3	10	11	1	1	20
Life by Design	3	0	3	2	1	0	22
Mid Coast Mental Health	7	0	7	3	4	0	38
Shalom House	2	1	1	1	1	0	19
Smart Child & Family Services	2	0	2	2	0	0	24
Sweetser	11	1	10	6	4	1	31
The Opportunity Alliance	38	3	35	31	7	0	14
Tri-County Mental Health	12	3	9	7	5	0	26
UCP VI	1	1	0	1	0	0	7
Totals	187	32	155	148	37	2	17

MaineCare Data FY 2013

Mental Health Treatment Services Received	Total Number	*Total Number of Class Members	Percent of Class Members	Total Payments	Total Payments For Class Members
Assertive Community Treatment	863	285	33.02%	\$8,453,943.36	\$2,723,585.99
Community Integration	14,670	1,170	7.98%	\$44,609,318.53	\$4,666,184.54
Community Rehabilitation	185	64	34.59%	\$3,172,922.80	\$1,182,776.97
**Crisis Services	5,186	543	10.47%	\$8,154,721.88	\$1,515,824.18
Crisis Residential (CSU)	2,049	479	23.38%	\$32,371,953.57	\$16,212,106.59
Day Support/Day Treatment	1,138	126	11.07%	\$6,725,344.33	\$577,345.00
Medication Management	12,608	588	4.66%	\$8,662,069.52	\$491,652.31
Outpatient (Comp Assess &Therapy)	23,716	538	2.27%	\$24,020,714.95	\$530,114.63
***Residential	785	310	39.49%	\$25,760,678.52	\$12,538,893.31
Skills Development	502	49	9.76%	\$2,127,858.20	\$234,225.48
Daily Living Supports	1,924	229	11.90%	\$18,314,799.17	\$3,457,804.25
****Total Unduplicated Count	36,553	1,758	4.81%	\$182,374,324.83	\$44,130,513.25

MaineCare Data FY 2012

Mental Health Treatment Services Received	Total Number	Total Number of Class Members	Percent of Class Members
Assertive Community Treatment	891	306	34.30%
Community Integration	13,647	1,219	8.90%
Community Rehabilitation	164	64	39.00%
Crisis Services	5,612	567	10.10%
Crisis Residential (CSU)	1,425	194	13.60%
Day Support/Day Treatment	957	117	12.20%
Medication Management	13,337	622	4.70%
Outpatient (Comp Assess &Therapy)	25,067	575	2.30%
Residential	821	366	44.60%
Skills Development	350	39	11.10%
Daily Living Supports	1,596	207	13.00%
*Total Unduplicated Count	37,933	1,826	4.80%

Note: Data is based on MaineCare incurred claims from DSS. Age: 18 and above.

* Class Members' SSNs are used to match MedicaidIDs in DSS.

** Crisis Residential (CSU) includes procedure codes H0018, H0018-HA, H0019 and H0019-HA.

*** Residential includes procedure codes: S9485, H0019-CG, H0019-HE, H0019-HU and T1020-HE.

** Residential patients with procedure codes H0019 and H0019-HA are excluded in this category. The dollars are the sum of the 785 patients' expenditure.

**** Patient counts for individual procedures are unduplicated and the total is unduplicated across all procedures; summing of patient counts in each service category will produce a duplicated count since patients often use multiple services.