

STATE OF MAINE  
KENNEBEC, ss.

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

PAUL BATES, et al.,

Plaintiffs

v.

ORDER ADOPTING  
COMPLIANCE STANDARDS

BRENDA HARVEY, COMMISSIONER,  
DEPARTMENT OF HEALTH AND  
HUMAN SERVICES, et al,

Defendants

In accordance with Paragraph 291 of the Settlement Agreement, and having consulted with counsel for the parties, I do hereby adopt the attached Standards for evaluating and measuring the Department's compliance with the terms and principles of the Settlement Agreement. In large part the Standards are the product of agreement between the parties and counsel, and they are commended for their joint effort. The Standards may be applied to the conduct of the Department from October, 2006 forward, and shall remain in effect until amended.

DATED: October 29, 2007

/s/Daniel E. Wathen  
Daniel E. Wathen  
Court Master

## STANDARDS FOR DEFINING SUBSTANTIAL COMPLIANCE

### I. **Implementation of Comprehensive Plan for Adult Community Mental Health System (§38)**

Key Question: Has the Department of Health and Human Services (“the Department”) implemented all the system development steps outlined in the October 2006 Consent Decree Plan?

- this part of the compliance review focuses entirely on demonstrating that the Department has met the terms of §38 of the Settlement Agreement by implementing all aspects of the Consent Decree Plan approved in October 2006
- the effectiveness of the system as developed (including the effectiveness of the new system developments outlined in the Consent Decree Plan) will be measured as described in Part IV of this proposal

Evaluation process and determination of substantial compliance:

• in addition to checking off the specific action steps on the work plan grid, **[I.1]** the Department would certify that each of the following major system developments has been put in place, in accordance with the terms of the approved Consent Decree Plan:

- system for identifying unmet needs **[I.2]**
  - Community Service Networks (“CSNs”) and related mechanisms (contract provisions, memoranda of understanding, etc.) to improve continuity of care **[I.3]**
  - Consumer Councils **[I.4]**
  - new vocational services **[I.5]**
  - realignment of housing and support services **[I.6]**
  - Quality Management system **[I.7]**
- the Department would submit each of these certifications (separately, or combined) to the court master and plaintiffs when the Department is ready to do so
- each certification would include the Department’s explanation of its basis for claiming completion of that particular system development, together with supporting documentation
- the plaintiffs would have 21 days in which to respond to each certification, by submitting any comments or objections to the court master and to defendants

- the Department would be given 21 days to respond to plaintiffs’ comments or objections before the court master acted on the certification
- if the court master disagrees with the certification (i.e., concludes based on his review or an expert’s review that certain steps required by the Consent Decree Plan have not been implemented), he would issue written findings, as described in ¶299 of the Settlement Agreement, and recommendations for further steps, which would become final and binding unless the Department invoked the dispute resolution procedures in ¶¶294- 297of the Settlement Agreement; if the court master agreed with the certification, over plaintiffs’ objections, the plaintiffs would likewise have the opportunity to invoke the dispute resolution procedures in ¶¶294-297.
- whenever the court master accepts the certification (or does so with conditions the Department is willing to accept), the system component addressed by the certification would be deemed compliant with the Settlement Agreement and the Consent Decree Plan. At any point after the court master accepts certification and before defendants are found in substantial compliance with the Settlement Agreement, if the plaintiffs produce evidence that the system component certified by the Department no longer conforms to the Plan, the court master will determine, after defendants have an opportunity to respond, whether the certification remains valid. Whether the system (once all components listed above are in place) is operating in substantial compliance would be assessed pursuant to Parts II, III and IV below.

*Note:* meeting the applicable terms and timetables of the Consent Decree Plan is also the primary means by which the Department would demonstrate compliance with ¶¶ 101-102 (vocational opportunities and training); ¶¶105-106 (rec/social/avocational opportunities); ¶¶107-108 (transportation); and ¶¶ 109-111 (family support).

## **II. Unmet Needs Identification, Planning, Budgeting and Resource Development (¶¶ 63, 263, 268)**

Key Question: Does the Department have in place a reliable system for determining ISP-identified unmet needs, and are those needs appropriately addressed in budgeting and resource development?

Subsidiary questions:

- is unmet needs data captured from Riverview Psychiatric Center and Dorothea Dix Psychiatric Center as well as from class members not in service pursuant to ¶74 (i.e., class members who do not have Individualized Support Plans (“ISPs”)) and other consumers who are enrolled in community support?

- does the Department utilize input from Consumer Councils in resource planning and development?
- does the Department also collect input from public forums and other relevant data sources (see below) in resource planning and development?
- does the adult mental health budget submitted by the Department's Office of Adult Mental Health Services ("OAMHS") to the Governor's office reflect use of this information in preparing budget requests for resources to address unmet needs?

Data sources:

- aggregate unmet needs reports from the Enterprise Information System ("EIS"), showing information on all consumers enrolled in community support and as well as class members without ISPs who contact Consent Decree Coordinators ("CDCs") to request services (§74 data)
- monthly tally of resource needs gleaned from weekly discharge meetings for civil patients remaining at Riverview for 30 days or more after a maximum benefit determination and for forensic patients who have court orders for release, who have been adjudged non-restorable, or who are working with Maine Pre-Trial for a conditional release pending a discharge placement
- matrix of resource needs for core services (as defined in the Consent Decree Plan) updated annually by OAMHS for each Community Service Network ("CSN") region, based on data showing actual consumer needs
- information collected from consumers, family members and others at CSN meetings across the state [*note: each CSN meeting includes the opportunity for public comment, but at least one meeting per year would be advertised to the public to encourage such input*]
- input provided by the Statewide Consumer Council on unmet resource needs and the annual updates of the OAMHS matrix of resource needs for core services

Evaluation process and determination of substantial compliance:

- the Department would provide documentation to demonstrate that it is using unmet needs data and information listed above in planning for resource development and in preparing budget requests [II.1]

- the Department also would demonstrate reliability of the unmet needs data based on an evaluation performed as part of its Quality Management system [II.2]
- compliance with the Department’s ¶268 obligations would be demonstrated by:
  - submission of the budget proposals for adult mental health services given to the Governor, with pertinent supporting documentation showing requests for funding to address unmet needs; [II.3] and
  - submission of quarterly reports to the Joint Standing Committee on Health and Human Services, as required by ¶280 [II.4]
- in addition, the Department will produce an annual report of MaineCare expenditures and grant funds expended on adult mental health services, broken down by service area. [II.5] Current service areas for reporting purposes are shown on Attachment A.
- If the documentation provides an affirmative answer to the questions noted above, that constitutes substantial compliance.

### III. Quality Management System (¶¶ 274 – 279)

Key question: Does the Department collect and regularly review quality management data for the community adult mental health system, including licensing reviews and contract reviews; analyze it to explore causes of problems indicated; and make policy and budget decisions based on that data?

*Note:* As part of system development and plan implementation under Part I of this proposal, the Department would have to certify that the Quality Management system described in the Consent Decree Plan has been implemented. This would require showing that the Quality Management system includes at least the following components [See I.7]:

- an annual, random, statistically significant survey of class members, both at Riverview and in the community, as required by ¶279
- a periodic review of the Department’s unmet needs data to test its reliability – e.g., by examining a representative sample of ISPs against Resource Data Summary (“RDS”) forms, to see if unmet needs are being reported correctly
- ISP document reviews (currently conducted by the CDCs)

- use of licensing data from regular licensing reviews as well as complaint investigations
- use of contract reviews
- use of some performance measures (e.g., consumer survey data) to trigger further review to determine if corrective action is necessary (see references in Part IV below)
- opportunities for meaningful consumer input into the quality management process – i.e., not just by using consumer survey data but also by reviewing data with Consumer Councils
- a description of what data is reported to whom -- both within the Department and also externally to providers such as mental health agencies and hospitals, CSNs, the statewide Quality Improvement Council (“QIC”), Consumer Councils, the Joint Standing Committee on Health and Human Services, plaintiffs and the court master
- a description of what types of reports will be generated and how frequently (e.g., only certain data would be generated quarterly, but a more detailed report would be produced annually)

Evaluation process and determination of substantial compliance:

- compliance with the obligation to implement a Quality Management system would be established under the certification process described in Part I above [*See I.7*]; after that, the Department would need to demonstrate that it is utilizing the Quality Management system [**III.1**]
- for example, the Department would document, through quarterly or annual reports, the data (including the ¶279 survey) that is being collected and the activities undertaken to assure the reliability of the data [**III.1.a**]
- the Department also would document how quality management data (including consumer input) is being used to develop policy and system improvements [**III.1.b**]
- if that documentation provides an affirmative answer to the key questions noted above, that constitutes substantial compliance with ¶¶ 274-279 of the Settlement Agreement

*Note:* Part IV of these standards for determining substantial compliance identifies the Quality Management data from the system that will be used in part to evaluate substantial compliance with particular Settlement Agreement requirements. Other data on performance standards outlined in

Chapter VI of the Consent Decree Plan will continue to be utilized as a regular part of the Quality Management system and will be available to plaintiffs and the court master if they wish to review it.

**IV. Compliance with obligations set forth in each topic area of the Settlement Agreement relating to the community mental health system**

Key Question: Has the Department substantially complied with its obligations in each of the topic areas covered by the Settlement Agreement, as set forth below?

Evaluation process and determination of substantial compliance: the Department must demonstrate that it has met the definitions of substantial compliance set forth below for each topic area.

For many subject areas, the standards set forth below require that a particular % be achieved in 3 out of 4 consecutive quarters. Substantial compliance may be found as long as:

- the data for 3 quarters meets or exceeds the standard, or is below the standard by an amount that is de minimis when considered in light of such factors as the sample size, whether the standard relates to a specific or general Settlement Agreement requirement, and the extent to which the standard relates to, or is significantly interrelated with, a critical component of the comprehensive mental health system;
- data for the substandard quarter out of the 4 consecutive quarters is no more than 10% below the standard, or is out of compliance due to extenuating circumstances (e.g. computer failures, catastrophic storm events, or a provider agency suddenly going out of business) that are not reflective of a failure in the community mental health system; and
- although data shows the standard is not met for 3 out of 4 consecutive quarters, the Department demonstrates to the satisfaction of the court master that the standard can be met through corrective action, the Department implements that corrective action, and meets the standard within an additional number of quarters as determined by the court master.

**Rights, Dignity, and Respect**

¶ 57 (Performance Standard #4): Demonstrate that upon application for services, consumers/class members are informed of their rights as recipients of mental health services.

Substantial compliance means:

- the Department has certified, based on contract and licensing reviews, that 100% of the provider agencies licensed or funded by the Department have a protocol and procedures in place to notify all clients of their rights, or have corrected any deficiency in this area within 30 days of notice from the Department; **[IV.1]**
- Quality Management system documentation shows that, if results from the annual consumer survey fall below the levels identified in Performance Standard 4, measurement methods 1, 1a, 1b and 2, the Department (i) consults with the Consumer Council; (ii) takes corrective action if determined necessary by the Consumer Council; and (iii) develops that corrective action in consultation with the Consumer Council; **[IV.2]**
- Grievance tracking data shows that the Department responds to 90% of Level II grievances within five working days of the date of receipt or within an agreed upon five-day extension; **[IV.3]** and
- Grievance tracking data shows that for 90% of Level III grievances the Department sends a written reply within five working days or within an additional five days if a hearing is to be held or if the parties concur. **[IV.4]**

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

**¶¶ 49, 55, 56, 58** (Performance Standard #5): Demonstrate that Community Integration /Intensive Case Managers are assigned to hospitalized and non-hospitalized class members and that initial ISPs and ISP updates are completed, all within Settlement Agreement timeframes.

Substantial compliance means:

- quarterly performance data shows that, for 3 out of 4 consecutive quarters:
  - 90% of hospitalized class members were assigned a community support worker within 2 working days of requesting one; **[IV.5]**
  - 90% of non-hospitalized class members who were assigned a worker within 3 days of date of application; **[IV.6]**
  - 95% of those class members in the hospital or in the community who were not assigned a community support worker within the specified 2 or 3 day period were assigned one within an additional 7 days; **[IV.7]**
  - 90% of class members enrolled in community support services had an initial ISP completed within 30 days of program enrollment; **[IV.8]** and
  - 90% of class members had their 90-day ISP review(s) completed within that period. **[IV.9]**

- the Quality Management system includes documentation showing that the Department follows up to require corrective action by the provider agency when ISPs are more than 30 days overdue. [IV.10]

- data collected once a year shows that no more than 5% of class members enrolled in community support did not have their ISP reviewed before the next annual review. [IV.11]

¶ 53 (quarterly mailings to class members to offer services):

Substantial compliance means:

- the Department certifies in its quarterly ¶280 reports that it is meeting this obligation [Note: plaintiffs' counsel is on the list to receive the quarterly mailings.] [IV.12]

¶ 61 (Performance Standard #7): Demonstrate that ISP's are based upon consideration of the class members' housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional, and psychiatric or psychological strengths and needs as well as their potential need for crisis intervention and resolution services.

Substantial compliance means:

- quarterly performance data shows that, for 3 out of 4 consecutive quarters:

- 90% of ISPs reviewed revealed that all domains were assessed with the consumer in treatment planning; [IV.13] [Note: this data is captured in ISP document reviews which will be included in quality management reports.]

- 90% of ISPs reviewed showed that the treatment plan goals reflect the strengths of the consumer; [IV.14] and

- 90% of ISPs reviewed showed existence of a crisis plan or documentation re: why a crisis plan was not developed. [IV.15]

- the Quality Management system includes documentation showing that the Department follows up to require corrective action by the provider agency when document reviews reveal that all domains have not been assessed with the consumer. [IV.16]

¶ 63 (Performance Standard #8): Demonstrate that services are based upon the actual needs of the class member rather than on what services are currently available.

Substantial compliance means:

- quarterly performance data shows that, for 3 out of 4 consecutive quarters, 90% of the ISPs reviewed where resources were not available within the expected response times (see p. 17 of the Consent Decree Plan) revealed that interim plans were developed for the consumer [IV.17]

¶ 69 (Performance Standard #9): Demonstrate that when a service is to be delivered by an agency funded or licensed by the State, the community support worker executes a written service agreement with the provider (or a signed treatment plan attached to the ISP).

Substantial compliance means:

- quarterly performance data shows that, for 3 out of 4 consecutive quarters, 90% of ISPs reviewed included a signed service agreement or signed treatment plan with each provider of mental health services. [IV.18]

¶¶ 71 & 257 (Performance Standard #10): Demonstrate that the ratio of community support workers to class members, and the ratio of DHHS caseworkers to class member public wards, meet Settlement Agreement requirements.

Substantial compliance means:

- quarterly performance data shows that, for 3 out of 4 consecutive quarters:
  - 90 % of ACT providers statewide meet 1:10 caseload ratio (based on filled direct care staff positions excluding psychiatrist or advanced nurse practitioner and peer specialist); [IV.19]
  - 90 % of CSW providers statewide meet 1:40 caseload ratio; [IV.19]
  - 90 % of ICI providers statewide meet 1:16 caseload ratio; [IV.19]
  - 90 % of ICMs with class member caseloads meet 1:16 caseload ratio; [IV.19] and
  - 90% of DHHS caseworkers with class member public wards have caseloads of no more than 25 class member public wards. [IV.20]

To demonstrate substantial compliance with ¶¶49-74 of the Settlement Agreement, the Department also would have to show that an independent review of the Individual Support Planning process, performed in accordance with **Attachment B** to these standards found the ISPs met a reasonable level of compliance as defined in **Attachment B. [IV.21]**

## Community Resources and Treatment Services

### Housing and Residential Support Services

¶ 97, 98 (Performance Standard #12): Demonstrate that the array of residential support services is flexible and is adequate to meet ISP-identified residential support needs of class members and the needs of hospitalized class members ready for discharge.

Substantial compliance means:

- quarterly unmet needs data shows that, for 3 out of 4 consecutive quarters, 5% or fewer class members have ISP-identified unmet needs for residential support services; [IV.22] and
- EITHER quarterly unmet needs data about residential support services for one year shows that the percentage of qualified non-class members with unmet needs does not exceed by 15 percentage points or more the percentage of class members with unmet needs; [IV.23]
- OR, if the quarterly data for one or more quarters in that year shows that the percentage of qualified non-class members with unmet needs for residential support services exceeds by 15 percentage points or more the percentage of class members with unmet needs for residential support services, the Department produces information sufficient to explain the cause of that disparity and to show that the cause of the disparity is something other than the defendants having deprived non-class members of services because they are not members of the class; [IV.23] and:

*Note: the term “qualified” modifying “non-class member” in this context means qualified for state financial support.*

*Note: for purposes of this standard, residential support services includes support services provided not only in independent living situations, but also in settings such as nursing homes or residential treatment facilities.*

- meeting the Riverview discharge standards (see Part V below, Goal 2 Objective 2), or, if not met, the Department documents the reasons for not meeting the standards, and the documentation demonstrates that the failure to meet those standards is not attributable to a lack of residential support services in the community. [IV.24]

¶¶ 94, 95 (Performance Standard #14): Demonstrate that an array of housing alternatives is available and sufficient to meet the ISP-identified needs of class members and the needs of hospitalized class members ready for discharge.

Substantial compliance means:

- quarterly unmet needs data shows that, for 3 out of 4 consecutive quarters, 10% or fewer class members have ISP-identified unmet needs for housing resources; **[IV.25]** and
- meeting the Riverview discharge standards (see Part V below, Goal 2 Objective 2), or, if not met, the Department documents the reasons for not meeting the standards, and the documentation demonstrates that the failure to meet those standards is not attributable to a lack of housing alternatives in the community. **[IV.26]**

¶ **96** (Performance Standard #15): Demonstrate that clients in homes with more than 8 beds have given informed consent to reside there.

Substantial compliance means:

- the Department has certified that class members residing in homes with more than 8 beds (see list of facilities, dated July 2007) have given informed consent to reside there, in accordance with the approved protocol (updated July 2007). **[IV.27]**

### **Acute Inpatient Psychiatric Services**

¶ **88** (Performance Standard #16): Demonstrate that the Department has made reasonable efforts to provide acute inpatient psychiatric hospitalization options for class members that allow for hospitalization reasonably near an individual's local community.

Substantial compliance means:

- 90% of class member admissions to community involuntary inpatient units are determined to be within the class member's community service network or other county listed in the table attached hereto as Attachment C. **[IV.28]**

¶ **89** (Performance Standard #17): Demonstrate that class member admissions to community hospitals funded by the Department are in accordance with law and meet medical necessity criteria.

AND

¶¶ **83, 90** (Performance Standard #18): Demonstrate that the Department is funding only hospitals that assure continuity of treatment during hospitalization.

Substantial compliance for both of the above means:

- the Department has demonstrated that:

- its contracts with hospitals require compliance with all legal requirements for involuntary patients and with obligations to obtain ISPs and to involve CSWs in treatment and discharge planning; [IV.29]
- it evaluates compliance during contract reviews and imposes sanctions for noncompliance through contract reviews and licensing; [IV.30] and
- the ongoing monitoring (Quality Management) system involves the Utilization Review nurses reviewing all involuntary admissions funded by the Department, taking corrective action (i.e., notifying appropriate personnel in the hospital) when they identify deficiencies and sending notices of any violations to the licensing division and to the hospital [See existing protocol] [IV.31]
- licensing reviews of hospitals include an evaluation of compliance with patient rights, in accordance with the second sentence of ¶83, and require a plan of correction to address any deficiencies [IV.32]
- based on review of all involuntary admissions at contracted hospitals or that are paid for by MaineCare or state grant funds, the Department took corrective action in 90% of those instances in which any of the following occurred: [IV.33]
  - the blue paper was not completed in accordance with its terms; [IV.33]
  - the 24-hour recertification was not completed or filed; [IV.33] or
  - documentation revealed that patient rights were not maintained; [IV.33] and
- Quality Management system documentation shows that if hospitals have fallen below the performance standard for any one of the following: (i) obtaining ISPs, (ii) creating a treatment and discharge plan consistent with ISP goals and objectives, or (iii) involving CSWs in treatment and discharge planning, the Department made that information public through distribution to the CSNs, addressed it in contract reviews with the hospitals and community support providers, and took appropriate corrective action to enforce the hospitals' and community support providers' responsibilities under the terms of their contracts or provider agreements with the Department. [IV.34]

### **Crisis Intervention Services**

¶¶ 99, 100 (Performance Standard #19): Demonstrate that crisis intervention/resolution services are effective and meet settlement agreement standards, including 24 hours per

day/ 7 days per week availability, personnel trained in crisis intervention, timely access to psychological/psychiatric consultation services; availability of short-term housing with focus on avoidance of un-necessary hospitalizations.

Substantial compliance means:

- quarterly performance data shows that, for 3 out of 4 consecutive quarters:
  - no more than 20-25% of face-to-face crisis contacts result in hospitalization; **[IV.35]**
  - 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; **[IV.36]**
  - 90% of all face-to-face assessments result in resolution for the consumer within 8 hours of initiation of the face-to-face assessment; **[IV.37]** and
  - 90% of face-to-face crisis contacts occurred in which client has a community integration worker and the worker was notified of the crisis. **[IV.38]**
- Quality Management system documentation shows that the Department conducts a further review, and takes appropriate corrective action if results from the annual consumer survey fall below the levels identified in Performance Standard 20, measurement method 1 (whether class members know how to get help in a crisis). **[IV.39]**

### **Vocational and Employment Services**

¶ **101, 102:** Demonstrate that the Department has made reasonable efforts to provide an array of vocational/employment opportunities and supports to meet the ISP-identified needs of class members.

Substantial compliance means:

- the Department has certified that it has implemented the components of the Consent Decree Plan relating to vocational services; **[IV.40]** and
- Quality Management system documentation shows that the Department conducts a further review, and takes appropriate corrective action if quarterly performance measure data shows that the numbers of class members under age 62 and employed in supportive or competitive employment fall below 13%, or fall below the baselines shown in the performance measure data for Performance Standard 26, measurement methods 2 and 3. **[IV.41]**

## **Treatment Services**

¶ **103** (Performance Standard #21): Demonstrate that an array of mental health treatment services is available and sufficient to meet the ISP-identified needs of class members and the needs of hospitalized class members ready for discharge.

Substantial compliance means:

- quarterly unmet needs data shows that, for 3 out of 4 consecutive quarters, 5% or fewer class members have ISP-identified unmet needs for mental health treatment services; [IV.42] and
- EITHER quarterly unmet needs data about mental health treatment for one year shows that the percentage of qualified non-class members with unmet needs does not exceed by 15 percentage points or more the percentage of class members with unmet needs; [IV.43]
- OR, if the quarterly data for one or more quarters in that year shows that the percentage of qualified non-class members with unmet needs for mental health treatment exceeds by 15 percentage points or more the percentage of class members with unmet needs for mental health treatment, the Department produces information sufficient to explain the cause of that disparity and to show that the cause of the disparity is something other than the defendants having deprived non-class members of services because they are not members of the class; [IV.43]

*Note: the term “qualified” modifying “non-class member” in this context means qualified for state financial support.*

- Quality Management system documentation shows that the Department conducts a further review, and takes appropriate corrective action if results from the annual consumer survey fall below the levels identified in Performance Standard 22, measurement method 1 (whether class members are able to get the mental health services and supports they need). [IV.44]
- meeting the Riverview discharge standards (see Part V below, Goal 2 Objective 2), or, if not met, the Department documents the reasons for not meeting the standards, and the documentation demonstrates that the failure to meet those standards is not attributable to a lack of mental health treatment services in the community. [IV.45]

## **Recreation/Social/Avocational/Spiritual Opportunities**

¶ **105, 106:** Demonstrate that the Department has assisted class members in the development of leisure skills and has sponsored programs that allow class members to utilize, improve or gain recognition for their avocational talents.

Substantial compliance means:

- the Department lists in quarterly reports the programs it has sponsored that are designed to improve quality of life and community inclusion for class members, including support of peer centers, social clubs, community connections training, wellness programs, and leadership and advocacy training programs. [IV.46]
- if the programs listed cover the prescribed topics, and audiences described fit the parameters of ¶105, substantial compliance is achieved.

### **Transportation**

¶ 107 (Performance Standard #28): Demonstrate that the Department has made reasonable efforts to identify and resolve transportation problems that limit access to services identified as needed to meet class members' ISP-identified needs.

Substantial compliance means:

- quarterly unmet needs data shows that, for 3 out of 4 consecutive quarters, 10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services. [IV.47]

### **Family Support Services**

¶ 109 (Performance Standard #23): Demonstrate provision of an array of family support services that meet Settlement Agreement requirements including:

- a. Education on the terms of the Settlement Agreement;
- b. Education on available services, and on mental illness from the perspectives of professionals, other families, and mental health service recipients;
- c. Direct support of family groups through the provision of a facilitator at meetings, if requested;
- d. Education on treatment, medications, diagnoses, prognoses, and how to care for persons with mental illness;
- e. Group counseling;
- f. Psycho-educational programs; and
- g. Respite services for families who provide class members with intense supervision and assistance. These services shall be made available on a planned basis and shall be delivered according to models that cause the least disruption to plaintiffs and their families.

Substantial compliance means:

- the Department provides documentation in quarterly reports to show that it has funded, developed, recruited and supported an array of family support services that include those listed in paragraphs (a) through (g) above. [IV.48]

¶ 110 (Performance Standard #25): Demonstrate that provider agencies are referring family members to family support groups.

Substantial compliance means:

- the Department certifies that all contracts with agency providers include a requirement to refer family members to family support services, and produces documentation that contract reviews include evaluation of compliance with this requirement. [IV.49]

### **Public Education**

¶ 252 (Performance Standard #34): Demonstrate provision of a variety of public education programs on mental health and illness topics, including: myths and stigma associated with mental illness and rights of consumers of mental health services and their families.

Substantial compliance means:

- the Department lists in quarterly reports the number and types of mental health informational workshops, forums, and presentations geared toward the general public that are designed to reduce myths and stigma of mental illness and to foster community integration of persons with mental illness. [IV.50]
- if the programs listed cover the prescribed topics, and audiences described fit the parameters of ¶252, substantial compliance is achieved.

## **V. Compliance with obligations set forth in the Riverview-related portions of the Settlement Agreement**

Key Questions: Has the Department implemented the changes outlined in Chapter VIII of the Consent Decree Plan at Riverview and has the Department substantially complied with its obligations with regard to the operation of Riverview Psychiatric Center, in accordance with the standards set forth below?

Evaluation process/determination of substantial compliance: the Department would demonstrate substantial compliance by:

- a) documenting that it has implemented the changes described in the action steps with targeted completion dates set forth in Chapter VIII of the Consent Decree Plan; [V.1] and
- b) showing results that meet the definitions of substantial compliance for particular topic areas, as set forth below.

**Client rights** (Goal 1, Objective 5)

Substantial compliance means:

- Riverview produces documentation that clients are routinely informed of their rights upon admission in accordance with ¶ 150 of the Settlement Agreement; [V.2] and
- 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. [V.3]

**Admissions** (Goal 2, Objective 1):

Substantial compliance means:

- quarterly performance data shows that in 4 consecutive quarters, 95% of admissions to Riverview meet legal criteria; [V.4]
- 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; [V.5]
- 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; [V.6] and
- 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. [V.7]

**Peer Supports** (Goal 1, Objective 2)

Substantial compliance means:

- quarterly performance data shows that in 3 out of 4 consecutive quarters:
  - 80% of all clients have documented contact with a peer specialist during hospitalization; [V.8] and
  - 80% of all treatment meetings involve a peer specialist. [V.9]

## **Treatment planning** (Goal 1 Objective 1)

Substantial compliance means:

- quarterly performance data shows that in 3 out of 4 consecutive quarters,
  - 95% of clients have a preliminary treatment and transition plan developed within 3 working days of admission; [V.10]
  - 95% of clients also have individualized treatment plans in their records within 7 days thereafter; [V.11] and
  - Riverview certifies that all treatment modalities required by ¶155 are available. [V.12]
- an evaluation of treatment planning and implementation, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:
  - the treatment plans reflect [V.13]
    - 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;
  - the treatment provided is consistent with the individual treatment plans; [V.14] and
  - 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 [V.15]

## Medications

Substantial compliance means:

- 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. [V.16]

## Discharges (Goal 2, Objective 2)

Substantial compliance means:

- quarterly performance data shows that in 4 consecutive quarters:
  - 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; [V.17]
  - 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; [V.18] and
  - 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). [V.19]
- an evaluation of treatment and discharge planning, performed in accordance with **Attachment D**, demonstrates that, for 90% of the cases reviewed:
  - treatment and discharge plans reflect interventions appropriate to address discharge and transition goals; [V.20]
    - 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; [V.20.a] and
  - interventions to address discharge and transition planning goals are in fact being implemented; [V.21]
    - 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. [V.21.a]

- the Department demonstrates that 95% of the annual reports for forensic patients are submitted to the Commissioner and forwarded to the court on time. [V.22]

### **Staffing and Staff Training**

Substantial compliance means:

- Riverview performance data shows that 95% of all new direct care staff have received 90% of their orientation training before having been assigned to duties requiring unsupervised direct care of patients; [V.23]
- 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; [V.24]
- Riverview certifies that staffing ratios required by ¶202 are met, and makes available documentation that shows actual staffing for up to one recent month; [V.25]
- 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. [V.26]

### **Use of Seclusion and Restraints** (Goal 1, Objective 3)

Substantial compliance means:

- 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; [V.27]
- 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; [V.28]
- 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; [V.29] and

- 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. [V.30]**

**Client elopements** (Goal 3, Objective 1, measure b)

Substantial compliance means:

- quarterly performance data shows that, in 5 out of 6 quarters, the number of client elopements do not exceed one standard deviation from the national mean as reported by NASMHPD. **[V.31]**

**Client injuries** (Goal 3, Objective 1, measure c)

Substantial compliance means:

- quarterly performance data shows that, in 5 out of 6 quarters, the number of client injuries do not exceed one standard deviation from the national mean as reported by NASMHPD. **[V.32]**

**Patient Abuse, Neglect, Exploitation, Injury or Death**

Substantial compliance means:

- 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. **[V.33]**

**Performance Improvement and Quality Assurance**

Substantial compliance means:

- Riverview maintains JCAHO accreditation; **[V.34]**
- Riverview maintains its hospital license; **[V.35]**
- 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; **[V.36]** and
- Riverview conducts quarterly monitoring of performance indicators in key areas of hospital administration, in accordance with the Consent Decree Plan, and demonstrates through quarterly reports that management uses that data to improve

institutional performance, prioritize resources and evaluate strategic operations.  
[V.37]

### **Attachment A to Substantial Compliance Standards**

The categories of MaineCare and grant fund expenditures on adult mental health services for purposes of annual reporting currently include the following:

- Assertive Community Treatment
- Intensive Community Integration
- Community Integration
- Crisis Services
- Crisis Stabilization Units
- Daily Living Supports (*a residential support service*)
- Skills Development
- Specialized Groups (*mental health treatment*)
- Medication Management
- Outpatient
- Residential (PNMI) (*including Skilled Nursing Homes*)
- Vocational Long Term Supports
- Vocational Employment Specialists
- Vocational – Other (including Benefit Specialists)
- Peers in the Emergency Rooms
- Peer Services Other (inc. Recreation, Social and Avocational)
- Flexible Funds (*wrap around*)
- Housing Subsidies (BRAP and Shelter Plus Care)
- Transportation
- Inpatient
- Information and Referral, Family Support and Community Education/Training Services
- Family Respite

### **Attachment B to Compliance Standards Protocol for Evaluation of Individualized Support Planning Process**

Purpose of evaluation:

To determine whether the Individualized Support Plans and Planning Process meet a reasonable level of quality to show substantial compliance with Settlement Agreement requirements

## Scope of evaluation:

The evaluation would consist of two major parts:

### 1) ISP Record Review

- the Record Review component is designed to assess one-year's worth of ISP records for a random sampling of approximately 300 class members served by all types of community support provider agencies (CI, ICI, ICM and ACT, including the Riverview ACT). This sample size was determined using a 95 percent confidence level and a confidence interval of 5 points, based on a population of approximately 1,300 class members enrolled in community support services as of July 2007. The sample will be stratified by Community Service Network ("CSN") to ensure a representative statewide distribution of class members.
- documents to be reviewed within each client's record include, at a minimum, psychosocial assessments, treatment plans, progress notes, resource data summary ("RDS") forms and authorizations for release of client information
- the questions to be considered in the record review are those outlined in the attached "*Draft Evaluation Tool for ISP Records*," subject to refinement by the independent consultant in consultation with the parties.
- reviews will be conducted using a structured review protocol for extracting information from the record, to be developed by the independent evaluator in consultation with the parties. All reviewers will receive training on the use of the document review protocol, and the methodology will include an assessment of inter-rater reliability on, at a minimum, a 20% sample of the reviews.

### 2) Key Informant Interviews

- Key Informant Interviews will be conducted with all class members who agree to be interviewed and whose records are reviewed under part 1 above, as well as with their community support workers. Interviews will address consumer and community support worker experiences and perceptions of the quality and effectiveness of the ISP planning process.
- the key ISP quality and outcome domains and sample questions to be considered in the interviews are outlined in the attached "*Draft Interview Domains for Consumers and Community Support Workers*." The actual questions will be developed by the independent consultant in consultation with the parties.

### Conduct of Evaluation:

- the ISP record reviews and Key Informant Interviews will be conducted by a team of reviewers, trained by and operating under the direction of, an independent consultant who would manage the entire evaluation process
- the independent consultant will be selected jointly by DHHS/OAMHS and Plaintiffs' counsel, based on review of proposals solicited from a minimum of 3 qualified candidates, using a process that meets requirements of the State Division of Purchases
  - the list of candidates to be invited to submit proposals would be developed and agreed upon by both parties
- the consultant's role will be to:
  - refine and finalize the evaluation tools (e.g., the structured record review document and the key informant interview questions) and data collection methods, in conjunction with the parties
  - select and train the team of reviewers/project evaluators on record review and interview protocols
  - test data collection tools and protocols and revise accordingly
  - develop data system and data preparation methods for recording the results of the record reviews and key informant interviews
  - perform all data analysis and summarize results
  - devise a method of scoring the results, designed to focus on the key areas listed below (under "defining a reasonable level of compliance") and subject to agreement of both parties (DHHS/OAMHS and Plaintiffs' counsel)
  - provide quality assurance throughout the evaluation process
  - produce a final report to the parties and the court master summarizing the results

### Timing of Evaluation:

- DHHS/OAMHS will decide when to call for the evaluation, as part of the process of claiming substantial compliance

- the parties expect to select an independent consultant sometime in 2008, with the goal of being prepared to conduct the evaluation in the fall of 2008 or spring of 2009

Defining a reasonable level of compliance:

- the methodology for determining whether the results of this evaluation satisfy a reasonable level of compliance under the Consent Decree Compliance Standards will be developed by the independent consultant in consultation with the parties, as noted above.

- the scoring methodology will be designed to focus on the following key aspects of the ISP planning process:

1) consumer participation, involvement and choice in the ISP planning process

e.g., did the client participate in the planning process, including in choice of services and supports?

2) development and implementation of appropriate goals and objectives

e.g., were the client's strengths and needs considered in all domain areas and were the plans updated regularly and in response to significant changes in the client's circumstances?

e.g., were services identified for each area of need that the client wanted to address and were treatment plans or service agreements in existence for each of those services?

e.g., were goals clearly identified for each area of need and were measurable objectives defined that were reasonably related to attainment of those goals?

3) CSW role

e.g., did the CSW maintain contact with the client consistent with the client's wishes and needs and work with the client to keep their ISP up to date and to help coordinate delivery of the needed services?

*Draft Evaluation Tool for ISP Records  
Sept. 28, 2007*

Client Name: \_\_\_\_\_ Client DOB:  
\_\_\_\_\_

Agency: \_\_\_\_\_ Date of Review:  
\_\_\_\_\_

Program Type: Community Integration \_\_\_\_\_ Intensive Case Management  
\_\_\_\_\_ Intensive Community Integration \_\_\_\_ Assertive Community Treatment  
\_\_\_\_\_

**1. Client participation**

1. A. Did the client participate in the development of the ISP?

Yes \_\_\_\_\_ No \_\_\_\_\_

Evidence:  
\_\_\_\_\_

1. B. If 'no', was the rationale for non-participation documented in the record?

Yes \_\_\_\_\_ No \_\_\_\_\_

Evidence:  
\_\_\_\_\_

**2. Assessments**

2. A. Was a comprehensive psychosocial assessment conducted prior to development of the original ISP? Yes \_\_\_\_\_ No \_\_\_\_\_

Evidence:  
\_\_\_\_\_

2. B. Was the comprehensive psychosocial assessment updated when needed to reflect significant events or changes in the client's life? Yes \_\_\_\_\_ No \_\_\_\_\_

Evidence:  
\_\_\_\_\_

**3. Consideration of strengths and needs.**

3. A. Were the client's strengths considered in each of the following domains during ISP development and review?

Housing Yes \_\_\_\_\_ No \_\_\_\_\_

Financial Yes \_\_\_\_\_ No \_\_\_\_\_

Social Yes \_\_\_\_\_ No \_\_\_\_\_

Recreational	Yes _____	No _____
Transportation	Yes _____	No _____
Vocational	Yes _____	No _____
Educational	Yes _____	No _____
General Health	Yes _____	No _____
Dental	Yes _____	No _____
Emotional/Psychological	Yes _____	No _____
Psychiatric	Yes _____	No _____
Crisis intervention	Yes _____	No _____

Evidence:

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3. B. Were the client's needs considered in each of the following domains?

Housing	Yes _____	No _____
Financial	Yes _____	No _____
Social	Yes _____	No _____
Recreational	Yes _____	No _____
Transportation	Yes _____	No _____
Vocational	Yes _____	No _____
Educational	Yes _____	No _____
General Health	Yes _____	No _____
Dental	Yes _____	No _____
Emotional/Psychological	Yes _____	No _____
Psychiatric	Yes _____	No _____
Crisis intervention	Yes _____	No _____

Evidence:

---

**4. Identification of services:**

4. A. In how many domain areas were there identified needs which the client wanted to address in their ISP?

Number: \_\_\_\_\_

4. B. Are there services identified on the ISP to assist the client in meeting needs for each area in which a need is identified and which client wishes to address?

Number identified \_\_\_\_\_

Number not identified \_\_\_\_\_

4. C. Does the ISP identify who will be providing each service?

Number identified \_\_\_\_\_

Number not identified \_\_\_\_\_

4. D. Does the ISP identify how each service will be provided?

Number identified \_\_\_\_\_

Number not identified \_\_\_\_\_

4. E. Will the service be provided in a way that maximizes the consumer's strengths, independence and integration into the community?

Yes \_\_\_\_\_ No \_\_\_\_\_

Evidence:

---

*[NOTE: If unclear from the record, this may be used as an interview question]*

4. F. Does it appear that the services to be provided are based on consumer need, not service availability? Yes \_\_\_\_\_ No \_\_\_\_\_

Evidence:

---

*[NOTE: If unclear from the record, this may be used as an interview question]*

## **5. Services Unavailable to Meet Needs**

5. A. If services were unavailable for a need area, was this identified in the ISP?

Yes \_\_\_\_\_ No \_\_\_\_\_

Evidence:

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5. B. If there were services unavailable for a need area, was an interim plan developed? Yes \_\_\_\_\_ No \_\_\_\_\_

Evidence:

---

**6. Community Integration**

6. A. Does the record reflect that generic resources were considered as part of planning? Yes \_\_\_\_\_ No \_\_\_\_\_  
Evidence:

---

6. B. Does the record reflect efforts by the community support worker to help the client become more integrated into his or her community?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
Evidence:

---

**7. Service Plans**

7. A. For each state funded or contracted service that the client receives from another agency, is there a treatment plan or service plan reflecting that provider's agreement to the terms of paragraph 69?  
Number needing one \_\_\_\_\_  
Number attached \_\_\_\_\_

**8. Goals and objectives**

8. A. For each area in which a service is to be provided, including CSW services, does the ISP include goals and objectives? Yes \_\_\_\_\_ No \_\_\_\_\_  
Evidence:

---

8. B. Are the objectives/actions steps connected to achievement of the goal?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
Evidence:

---

8. C. Can the objectives/action steps be objectively measured? Yes \_\_\_\_\_  
No \_\_\_\_\_  
Evidence:

---

8. D. Do the goals and objectives/action steps utilize the client's strengths in addressing his/her goals? Yes \_\_\_\_\_ No \_\_\_\_\_  
Evidence:

---

8. E. Over time, did the objectives/action steps change to support the client in moving closer to his/her goal? Yes \_\_\_\_\_ No \_\_\_\_\_  
Evidence:
- 

**9. Review and update**

9. A. Were the ISP and any attached treatment plans reviewed every 90 days?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
Evidence:
- 

9. B. If there were any major events during a 90 review period (such as hospitalization, crisis intervention, eviction, increased substance abusing, contact with criminal justice system, or other significant event [victim of crime, divorce, separation, death of significant friend or relative, for example], does the record document that the event was discussed with the client and action taken as appropriate? Yes \_\_\_\_\_ No \_\_\_\_\_  
Evidence:
- 

**Comments:**

*Draft Interview Domains for Consumers and Community Support Workers  
September 28, 2007*

The goal of the key informant interviews is to evaluate the quality of the ISP planning process from the perspective of the consumer and the community support worker assigned to that consumer. The interviews would focus on the following topic areas, with key subtopics listed below. The independent consultant would create the actual interview questions within these topic areas, in consultation with the Department and Plaintiffs' counsel.

**Consumer Participation, Involvement and Choice in the ISP planning process**

- involvement of others selected by the consumer
- degree of choice of services offered to consumer to meet needs
- consumer's involvement in choosing services and supports
- whether the consumer's views, opinions and wishes were respected in the process

**ISP and Service Delivery Process Builds on Consumer Strengths and Addresses Individual Consumer Needs**

- degree to which CSW worked with consumer to identify their strengths and tried to build on those in developing the plan
- consideration of consumer needs in all domains of ISP

- updating of ISP over time, to respond to changing circumstances

**ISP and Service Delivery Process Fosters Increased Community Connections, Integration and Independence**

- CSW efforts to get consumer connected (or to help them stay connected) to others in the community, including family and friends
- CSW efforts to monitor and coordinate services for consumer
- CSW performance of all job responsibilities under ¶70

**Perceptions of Progress on Reaching ISP Goals and Effectiveness of ISP Process**

- overall sense of progress in meeting ISP goals
- whether services and supports seem to be helping consumer meet goals

**Attachment C to Substantial Compliance Standards**

**Designation of counties for purposes of involuntary inpatient hospitalization under the compliance standard for ¶88**

<b>County where individual resides</b>	<b>Community Support Network</b>	<b>County deemed to be reasonably near county of residence for purposes of inpatient hospitalization under ¶88</b>  (Note: the counties listed below all currently have involuntary beds)
Aroostook	CSN 1	Penobscot
Kennebec	CSN 3	Androscoggin
Sagadahoc	CSN 4	Kennebec, Androscoggin, Cumberland
Lincoln	CSN 4	Kennebec, Cumberland
Knox	CSN 4	Kennebec
Waldo	CSN 4	Penobscot, Kennebec
Androscoggin	CSN 5	Kennebec, Cumberland
Oxford	CSN 5	York, Cumberland
Franklin	CSN 5	Kennebec
Cumberland	CSN 6	York, Androscoggin
York	CSN 7	Cumberland

## **Attachment D to Compliance Standards**

### **Protocol for Point in Time Review of Treatment at Riverview Psychiatric Center**

#### **Purpose of review:**

To evaluate substantial compliance with treatment planning, provision of treatment, and discharge planning at Riverview Psychiatric Center.

#### **Conduct of review:**

- Review will be conducted by a team of five or six people who are or have been Department heads in a public hospital in medical, nursing, rehabilitation, social work, or psychology, or qualified individuals with experience in reviewing state hospital treatment plans in contexts such as licensing or accreditation; review of forensic discharges will be conducted by one of those experts who has a background in state forensic services.
- The parties will select the experts by each putting forth the names of at least seven people who satisfy the criteria described above. Each party may reject out of hand two names offered by the other party. From the remaining pool, the parties will attempt to agree upon a team. If the parties cannot agree on a team, they will submit to the court master the names that have not been rejected and ask him to select the team. In the alternative, the parties may agree to redesign the process for selecting experts.
- The defendants will notify the plaintiffs and the court master when they are ready for the review.
- The review will include an examination of the medical records of 28 people currently being treated by Riverview staff, with seven records randomly selected from each of the four inpatient units. (Clients served by the Riverview ACT team will be included in the pool from which the community ISP review sample is drawn. See Attachment B.) For each patient, the reviewers will examine records from the six-month period leading up to the date of the review or from the beginning of the patient's current admission, whichever is shorter. Record review will be supplemented as necessary (e.g., if the record is unclear) by interviews with those patients or clients whose records are reviewed, and with the staff who provide services to those patients or clients.

## Scope of review:

### 1. Treatment and discharge planning and implementation

For 90% of the cases reviewed (25 of 28)

A. the treatment plans for civil patients and for those patients found not criminally responsible or incompetent to stand trial reflect

i. screening of the patient's needs in the following domains [¶ 61]:

- housing,
- financial,
- social,
- recreational,
- transportation,
- vocational,
- educational,
- general health,
- dental,
- emotional,
- psychiatric or psychological, and
- crisis intervention;

(Evidence to be considered in the record will include all screening tools, professional assessments, treatment plans, and treatment plan reviews. The patient's legal status will also be considered. If an individual case review indicates that a patient exhibits or exhibited no signs, symptoms or other indications of need that would lead a prudent clinician to request an assessment in that domain, then that domain will be deemed to have been appropriately screened.)

For patients who are transferred to Riverview from prison or jail and for whom the discharge plan is a return to incarceration, housing, financial, recreational, transportation, vocational and educational needs will be deemed to have been screened.

ii. consideration of the patient's need for [¶155]:

- group and individual psychotherapy,
- psychopharmacological therapy,
- social services,
- physical therapy,
- occupational therapy,
- activities of daily living skills training,
- recreational therapy,
- vocational/educational programs,
- family support services and education,
- substance abuse services,

- sexual/physical abuse counseling, or
- instruction in basic health care, hygiene, and nutrition;

(Evidence to be considered in the record will include all screening tools, professional assessments, treatment plans, and treatment plan reviews. The patient's legal status will also be considered. If an individual case review indicates that a patient exhibits or exhibited no signs, symptoms or other indications of a need for the type of services listed above that would lead a prudent clinician to consider it, then that service will be deemed to have been appropriately considered.)

For patients who are committed for forensic evaluation and observation, these services must be considered only if the court order requires treatment.

iii. treatment goals for each area of need identified, unless the patient chooses not, or is not yet ready, to address that treatment goal;  
(Evidence: treatment plan shows a goal that covers identified need for each active treatment issue.)

iv. appropriate services or interventions to address treatment goals;  
(Evidence: treatment plans, treatment plan reviews, and progress notes.)

v. treatment goals necessary to meet discharge criteria are noted as such in the treatment plan; and  
(Evidence: assessments, treatment plans and treatment plan reviews.)

vi. assessments of whether the patient is clinically safe for discharge;  
(Evidence: treatment plans, treatment plan reviews, and progress notes.)

B. the treatment provided is consistent with the individual treatment plans and patient's assessed needs; and  
(Evidence: recent progress notes identifying that interventions identified in treatment plan were offered.)

C. if the record reflects limitations on a patient's rights listed below [¶159], those limitations were imposed consistent with the Rights of Recipients of Mental Health Services:

- receive individualized treatment;
- have access to activities necessary to achievement of their individualized treatment goals;
- receive visitors;
- communicate by telephone and mail;
- exercise daily;
- recreate outdoors; and
- exercise their religion

D. treatment and discharge plans reflect interventions appropriate to address discharge and transition goals;

- 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; and

E. interventions to address discharge and transition planning goals are in fact being implemented;

(Evidence: progress notes, treatment plan, treatment plan reviews, continuity of care manager notes.)

- 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.

(Evidence: progress notes, treatment plan, treatment plan reviews, continuity of care manager notes.)

## **2. Staffing**

The record review of the 28 people reflects that staffing has been sufficient

- to provide patients access to activities necessary to achieve the patients' treatment plan goals,
- to enable patients to exercise daily and to recreate outdoors consistent with their treatment plans, as those plans may be limited by appropriately documented restrictions and safety level status, and
- to keep medical appointments, provided that, if staff is unavailable to transport patients to non-urgent medical appointments, staffing will not be deemed insufficient if the non-urgent appointments can be rescheduled within a reasonable period of time.

(Evidence: staffing reports, grievance documentation and incident reports. Staffing will be deemed sufficient if, collectively the 28 files reflect on average not more than 2 staffing exception per week within the study period of the sample.)

**Attachment E-1 to Compliance Standards  
Review of Seclusion Events at Riverview Psychiatric Center**

Each seclusion event and each renewal of a seclusion order will be reviewed against the following requirements.

1. 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.

Rate of compliance (must meet 95%) \_\_\_\_\_

2. The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.

Rate of compliance (must meet 90%) \_\_\_\_\_

3. The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.

Rate of compliance (must meet 90%) \_\_\_\_\_

4. The decision to place the patient in seclusion was entered in the patient's records as a medical order.

Rate of compliance (must meet 90%) \_\_\_\_\_

5. 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.

Rate of compliance (must meet 90%) \_\_\_\_\_

6. 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.

Rate of compliance (must meet 90%) \_\_\_\_\_

7. The record reflects that the patient was monitored every 15 minutes.

Rate of compliance (must meet 90%) \_\_\_\_\_

Compliance will be deemed if the patient was monitored at least 3 times per hour.

8. Individuals implementing seclusion have been trained in techniques and alternatives.

Rate of compliance (must meet 90%) \_\_\_\_\_

9. The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.

Rate of compliance (must meet 75%) \_\_\_\_\_

10. The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.

Rate of compliance (must meet 85%) \_\_\_\_\_

11. The medical order states the conditions under which the patient may be sooner released.

Rate of compliance (must meet 85%) \_\_\_\_\_

12. The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.

Rate of compliance (must meet 90%) \_\_\_\_\_

Compliance will be deemed if the delay is no more than 15 minutes.

13. The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.

Rate of compliance (must meet 70%) \_\_\_\_\_

14. 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.

Rate of compliance (must meet 85%) \_\_\_\_\_

15. 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.

Rate of compliance (must meet 85%) \_\_\_\_\_

16. Reports of seclusion events were forwarded to medical director and advocate.

Rate of compliance (must meet 90%) \_\_\_\_\_

17. The record reflects that, for persons with mental retardation, the regulations governing seclusion of clients with mental retardation were met.

Rate of compliance (must meet 85%) \_\_\_\_\_

18. The medical order for seclusion was not entered as a PRN order.

Rate of compliance (must meet 90%) \_\_\_\_\_

19. Where there was a PRN order, there is evidence that physician was counseled.

Rate of compliance (must meet 95%) \_\_\_\_\_

**Attachment E-2 to Compliance Standards  
Review of Restraint Events at Riverview Psychiatric Center**

A. Each restraint event (“restraint” is the immobilization of a patient’s arms, legs or entire body through the use of an apparatus which is not a protective device) and each renewal of a restraint order will be reviewed against the following twenty requirements.

1. The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.

Rate of compliance (must meet 95%) \_\_\_\_\_

2. The record reflects that lesser restrictive alternatives were inappropriate or ineffective.

Rate of compliance (must meet 90%) \_\_\_\_\_

3. The record reflects that the decision to place the patient in restraint was made by a physician or physician extender

Rate of compliance (must meet 90%) \_\_\_\_\_

4. The decision to place the patient in restraint was entered in the patient’s records as a medical order.

Rate of compliance (must meet 90%) \_\_\_\_\_

5. 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.

Rate of compliance (must meet 90%) \_\_\_\_\_

6. 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.

Rate of compliance (must meet 90%) \_\_\_\_\_

7. The record reflects that the patient was kept under constant observation during restraint.

Rate of compliance (must meet 95%) \_\_\_\_\_

8. Individuals implementing restraint have been trained in techniques and alternatives.

Rate of compliance (must meet 90%) \_\_\_\_\_

9. The record reflects that reasonable efforts taken to notify guardian or designated representative as soon as possible that patient was placed in restraint.

Rate of compliance (must meet 75%) \_\_\_\_\_

10. The medical order states time of entry of order and that number of hours shall not exceed four.

Rate of compliance (must meet 90%) \_\_\_\_\_

11. The medical order shall state the conditions under which the patient may be sooner released.

Rate of compliance (must meet 85%) \_\_\_\_\_

12. The record reflects that the need for restraint was re-evaluated every 2 hours by a nurse.

Rate of compliance (must meet 90%) \_\_\_\_\_

Compliance will be deemed if the delay is no more than 15 minutes.

13. The record reflects that re-evaluation was conducted while the patient was free of restraints unless clinically contraindicated.

Rate of compliance (must meet 70%) \_\_\_\_\_

14. 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.

Rate of compliance (must meet 85%) \_\_\_\_\_

15. The record reflects that the patient was released as necessary for eating, drinking, bathing, toileting or special medical orders.

Rate of compliance (must meet 90%) \_\_\_\_\_

16. The record reflects that the patient's extremities were released sequentially, with one released at least every fifteen minutes.

Rate of compliance (must meet 90%) \_\_\_\_\_

Compliance will be deemed if extremities were released at least 3 times per hour.

17. Copies of events were forwarded to medical director and advocate.

Rate of compliance (must meet 90%) \_\_\_\_\_

18. For persons with mental retardation, the applicable regulations were met.

Rate of compliance (must meet 85%) \_\_\_\_\_

19. The record reflects that the order was not entered as a PRN order.

Rate of compliance (must meet 90%) \_\_\_\_\_

20. Where there was a PRN order, there is evidence that physician was counseled.

Rate of compliance (must meet 95%) \_\_\_\_\_

B. 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.

Rate of compliance (must meet 90%) \_\_\_\_\_