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

Department of Health and Human Services
Substance Abuse and Mental Health Services
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May 1, 2013

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 30, 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

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 & Human Services, Office of Adult Mental Health Services
Bates v. DHHS Consent Decree
January, February, March : 3rd Quarter, SFY 2013
CONSENT DECREE REPORT

SUMMARY

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 2013, covering the period from January through March 2013. Each document title is linked to the PDF version of the document on the OAMHS website. Links to the Word (or Excel) versions are also listed.

	DOCUMENT	DESCRIPTION
1	**Cover Letter, Quarterly Report** Section 1 & 1A *May 1, 2013* 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 30, 2012
2	**Second Quarter Fiscal Year 2013 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	Lists and describes all of the data sources used for measuring and reporting the Department's compliance on the Performance and Quality Improvement Standards.
6	**Cover: Unmet Needs and Quality Improvement Initiative** Section 6	Provides a brief introduction to the unmet needs report as well as some definitions of the data, initial findings and next steps. Also includes information on the quality improvement initiatives undertaken by SAMHS.

	DOCUMENT	DESCRIPTION
	Microsoft Word or Adobe PDF	
7	**Unmet Needs by CSN for FY13 Q2** Section 7 Adobe PDF & 7A 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 and ICM) concerning consumers (class members and non-class members) who indicate a need for a resource that is not immediately available. Providers are required to enter the information electronically upon enrollment of a client in Community Support Services and update the information from their clients' Individual Service Plans (ISPs) every 90 days via an RDS (Resource Data Summary) entered as a component of prior authorization and continuing stay requests made to APS Healthcare via their online system, CareConnections.
8	**BRAP Waitlist Monitoring Report,** Section 8 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 for the 3rd Quarter of Fiscal Year 2013** Section 9 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 for the 2nd Quarter of Fiscal Year 2012: Class Members** Section 10 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 Members for the 2nd Quarter Fiscal Year 2012** Section 11 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: 2nd Quarter, Fiscal Year 2013** Section 12 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**	Reports on Riverview's compliance with specific indicators re: performance and quality; recording findings, problem, status, and

	DOCUMENT	DESCRIPTION
	Report Section 13 Microsoft Word or Adobe PDF	actions for the specified quarter.
14	**APS Healthcare Reports** Section 14 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	**Utilization and Expense Report** Section 15 Microsoft Word or Adobe PDF	Report on Mental Health Utilization and Expense Summary for FY11 and FY12.

Department of Health and Human Service
Office of Substance Abuse and Mental Health Services Third Quarter State Fiscal Year 2013 (January-March)
Report on Compliance Plan Standards: Community
May 1, 2013

	Compliance Standard	Report/Update
I.1	Implementation of all the system development steps in October 2006 Plan	As of March 2010, all 119 original components of the system development portion of the Consent Decree Plan of October 2006 have been accomplished or deleted per amendment.
I.2	Certify that a system is in place for identifying unmet needs	See attached *Cover: Unmet Needs May 2013* and *Unmet Needs by CSN for FY13 Q2*
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 *Cover: Unmet Needs and Quality Improvement Initiatives May 2013* and the *Performance and Quality Improvement Standards: FY13 Quarter 3* for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data.

II.3	Submission of budget proposals for adult mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs *(Amended language 9/29/09)*	The Director of SAMHS provides the Court Master 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 … *(Amended language 9/29/09)*	See above.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	MaineCare and Grant Expenditure Report for FY11 and FY12 is attached.
III.1	Demonstrate utilizing QM System	See attached *Cover: Unmet Needs May 2013* and the *Performance and Quality Improvement Standards: May 2013* for examples of the Department Utilizing the QM system.
III.1a	Document through quarterly or annual reports the data collected and activities to assure reliability (including ability of EIS to produce accurate data)	This quarterly report documents significant data collection and review activities of the OAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	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 included.
IV.2	If results from the DIG Survey fall below levels established for Performance and Quality Improvement Standard 4.2, 90% of consumers report they were given information about their rights, the Department: (i) consults with the Consumer Council System of Maine (CCSM); (ii) takes corrective action a determined necessary by CCSM; and (iii) develops that corrective action in consultation with CCSM. *(Amended language 1/19/11)*	The percentage for standard 4.2 from the 2012 DIG Survey was 89.9% (up from 88.6%in 2010). These data are posted on the SAMHS website and provided to the CCSM.
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 grievance filed; it was responded to within the 5 day

		period (100% compliance).
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if hearing is to be held or if parties concur.	Reporting began in the 1st quarter of calendar year 2008. Standard has been consistently addressed. There have been no Level III grievances filed in FY13.
IV.5	90% hospitalized class members assigned worker within 2 days of request - *must be met for 3 out of 4* quarters	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 5-2. This standard was not met in FY3Q3.
IV.6	90% non-hospitalized class members assigned worker within 3 days of request - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 5-3. This standard has not met for the prior 4 quarters.
IV.7	95% of class members in hospital or community not assigned within 2 or 3 days, assigned within an additional 7 days - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 5-4. This standard has not been met for the prior 4 quarters.
IV.8	90% of class members enrolled in CSS with initial ISP completed within 30 days of enrollment - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 5-5. The standard consistently met since FY08.
IV.9	90% of class members had their 90 day ISP review(s) completed within that time period - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 5-6. This standard has not been met for the past 4 quarters.
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. As the data has been consistent over time and the feedback and interaction with providers had lessened greatly, reports are now created quarterly and available to providers upon request. Providers were notified of this change on May 18, 2011. Providers 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	Data being collected in January 2013 and will be reported out next quarter.
IV.12	Certify in quarterly reports that DHHS is meeting its obligation re: quarterly mailings	On May 14, 2010, the court approved a Stipulated Order that requires mailings to be done only semi-annually in 2010, moving to annually in 2011 and thereafter, as long as the number of unverified addresses remains at or below 15%. The most recent mailing was sent in early December 2012. Percentage of unverified addresses remains below 15%.
IV.13	In 90% of ISPs reviewed, all domains were	See Section 9 *Class Member Treatment Planning*

	assessed in treatment planning - *must be met for 3 out of 4 quarters*	*Review,* Question 2A. This standard has been met in 3 of the past 4 quarters. The current percentage is 98.2%.
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 7-1a and *Class Member Treatment Planning Review,* Question 2B Standard has been met continuously since the first quarter of FY08.
IV.15	90% of ISPs reviewed have a crisis plan or documentation as to why one wasn't developed - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 7-1c (does the consumer have a crisis plan) and *Class Member Treatment Planning Review,* Question 2F Standard met since the beginning of FY09
IV.16	QM system documents that SAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	See Section 9 *Class Member Treatment Planning Review,* Question 6.a.1 that addresses plans of correction.
IV.17	In 90% of ISPs reviewed, interim plans developed when resource needs not available within expected response times - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 8-2 and *Class Member Treatment Plan Review,* Question 3F. This standard has been met in 3 out of the 4 quarters.
IV.18	90% of ISPs review included service agreement/treatment plan - *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 9-1 and *Class Member Treatment Plan Review,* Questions 4B & C. This standard has not met in 3 of the past 4 quarters.
IV.19	90% of ACT/ICI/CI providers statewide meet prescribed case load ratios - *must be met for 3 out of 4 quarters* Note: As of 7/1/08, ICI is no longer a service provided by DHHS.	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 10.1 and 10-2 Community Integration -- standard met since the 2nd quarter FY08. ACT – standard met for the 2nd, 3rd and 4th quarters FY10; the 1st, 2nd and 4th quarters FY11; all 4 quarters of FY12, and the first 3 quarters of FY13.
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - *must be met for 3 out of 4 quarters*	ICMs' work is focused on community forensic and outreach services. Individual ICMs no longer carry caseloads. Should this change in the future, SAMHS will resume reporting on caseload ratios.
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 10-5. This standard has not been met in the last 4 quarters.

IV.21	Independent review of the ISP process finds that ISPs met a reasonable level of compliance as defined in Attachment B of the Compliance Plan	
IV.22	5% or fewer class members have ISP-identified unmet residential support - *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 12-1 Standard met for the 4th quarter FY08; the 1st, 3rd and 4th quarters of FY09; all quarters of FY10 and FY11; all 4 quarters of FY12 and quarters 1 and 2 in FY13.
IV.23	**EITHER** quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members **OR** if exceeded for one or more quarters, SAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status **and**	Unmet residential supports do not exceed 15 percentage points of Class Members. Data are normally reported in July. This report was produced in October this year but, in order to ensure data continuity, it uses only data that would have been reported in July. Reporting for this standard will be done again in July 2013. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.24	Meet RPC discharge standards (below); **or** if not met document reasons and demonstrate that failure not due to lack of residential support services • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: May 2013,* Standards 12-2, 12-3 and 12-4 Standard met since the beginning of FY08.
IV.25	10% or fewer class members have ISP-identified unmet needs for housing resources - *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: February 2013,* Standard 14-1 Standard met for first three quarters in FY13 and 20 out of the last 26 quarters.
IV.26	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of housing resources. • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 14-4, 14-5 & 14-6 Standard 14-4 met since the beginning of FY09, except for Q3 FY10. Standard 14-5 met for the 2nd, 3rd and 4th quarters FY09; the 2nd and 4th quarters of FY10; all quarters of FY11; all 4 quarters of FY12; and first 3quarters of FY13. Standard 14-6 met for the 2nd and 4th quarters FY09; the 2nd and 4th quarters FY10; all of FY11; 4 quarters of FY12, and first 3 quarters of FY13.
IV.27	Certify that class members residing in homes > 8 beds have given informed	Results reported in *Performance and Quality Improvement Standards: July 2010 Report,* Standard

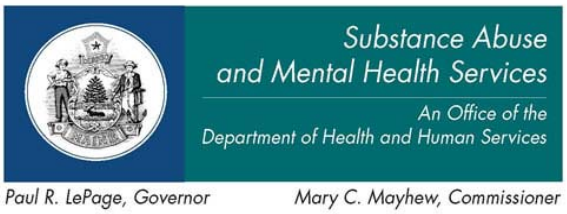
	consent in accordance with approved protocol	15-1 This standard has been met since 2007. SAMHS submitted an amendment request to the court master to modify this requirement on November 23, 2011. The court master approved SAMHS' request to hold the 2011 annual review in abeyance pending a decision on the amendment request.
IV.28	90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in attachment C to the Compliance Plan	See attached *Performance and Quality Improvement Standards: May 2013*, Standard 16-1 and *Community Hospital Utilization Review – Class Members 1th Quarter of Fiscal Year 2013.* In FY10: 1st quarter 88.2% (15 of 17); 2nd quarter 81.8% (9 of 11); 3rd quarter 82.4% (14 of 17); and 4th quarter 90.9% (20 of 22). In FY11: 88% (22 of 25) in the 1st quarter; 75% (9 of 12) in the 2nd quarter; 78.9% (15 of 19) in the 3rd quarter and 80% (12 of 15) in the 4th quarter. In FY12: 76.2% (16 of 21) in the 1st quarter 63.6% (14 of 22) in the 2nd quarter 77.8% (7 of 9) in the 3rd quarter 73.7% (14 of 19) in the 4th quarter IN FY13: 100% (19 of 19) in the 1st quarter 92% (13 of 14) in the 2nd quarter
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	See IV.30 below
IV.30	Evaluates compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	All involuntary hospital contracts are in place.
IV.31	UR Nurses review all involuntary admissions funded by DHHS, take corrective action when they identify deficiencies and send notices of any violations to the licensing division and to	SAMHS reviews emergency involuntary admissions at the following hospitals: MaineGeneral Medical Center, Spring Harbor, St. Mary's, Mid-Coast Hospital, Southern Maine Medical Center, PenBay Medical Center, Maine Medical Center/P6 and Acadia.

	the hospital	See Standard IV.33 below regarding corrective actions.
IV.32	Licensing reviews of hospitals include an evaluation of compliance with patient rights and require a plan of correction to address any deficiencies.	7 Complaints Received 5 Complaints investigated 1 substantiated 0 Plan of correction sought 0 Rights of Recipients Violations
IV.33	• 90% of the time corrective action was taken when blue papers were not completed in accordance with terms • 90% of the time corrective action was taken when 24 hour certifications were not completed in accordance with terms • 90% of the time corrective action was taken when patient rights were not maintained	See attached *Performance and Quality Improvement Standards: May 2013*, Standards 17-2a, 17-3a and 17-4a and *Community Hospital Utilization Review – Class Members 3rd Quarter of Fiscal Year 2013.* Standards met for FY08, FY09, FY10 and FY11; FY12 Standards met for the first 3 quarters of FY13
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 corrective action to enforce responsibilities • obtaining ISPs (90%) • creating treatment and discharge plan consistent with ISPs (90%) • involving CIWs in treatment and discharge planning (90%)	See attached report *Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members 1st Quarter of Fiscal Year 2013.* The report displaying data by hospital for community hospitals accepting emergency involuntary clients is shared quarterly by posting reports on the CSN section of the Office's website. Standard 18.2 met for the past 4 quarters. Standard met for obtaining ISPs and creating treatment and discharge plans consistent with ISP; involving CWs in treatment and discharge planning was at 100% in FY13.
IV.35	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>	See attached *Performance and Quality Improvement Standards: May 2013*, Standard 19-1 and *Adult Mental Health Quarterly Crisis Report Second Quarter, State Fiscal Year 2013 Summary Report.* In FY10, standard met for the 1st quarter: slightly above for the 2nd (25.7%), 3rd (25.7%) and 4th (26.1%) quarters. 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 for the all 4 quarters. In FY 13, standard met first 3 quarters.
IV.36	90% of crisis phone calls requiring face-to-face assessments are responded to within an average of 30 minutes from the end of the phone call – <u>*must be met for 3 out of 4 quarters*</u>	See attached *Adult Mental Health Quarterly Crisis Report Second Quarter, State Fiscal Year 2013 Summary Report*. Starting with July 2008 reporting from providers, SAMHS collects data on the total number of minutes for the response time (calculated from the determination of need for face to face contact or when the individual is ready and able to be seen to when the individual is

		actually seen) and figures an average. Average statewide calls requiring face to face assessments are responded to within an average of 30 minutes from the end of the phone call was met for all 4 Quarters in FY12 and first 3 quarters in FY13.
IV.37	90% of all face-to-face assessments result in resolution for the consumer within 8 hours of initiation of the face-to-face assessment – *must be met for 3 out of 4 quarters*	See attached *Adult Mental Health Quarterly Crisis Report Second Quarter, State Fiscal Year 2013 Summary Report*. Standard has been met since the 2nd quarter of FY08.
IV.38	90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 19-4 and *Adult Mental Health Quarterly Crisis Report Second Quarter, State Fiscal Year 2013 Summary Report.* Standard has been met since the 1st quarter of FY08.
IV.39	Compliance Standard deleted 1/19/2011.	
IV.40	Department has implemented the components of the CD plan related to vocational services	As of quarter 3 FY10, the Department has implemented all components of the CD Plan related to Vocational Services.
IV.41	QM system shows that the Department conducts further review and takes appropriate corrective action if PS 26.3 data shows that the number of consumers under age 62 and employed in supportive or competitive employment falls below 10%. *(Amended language 1/19/11)*	2011 Adult Health and Well-Being Survey: 13.8% of consumers in supported and competitive employment (full or part time). The Director of the Office of Quality Improvement and staff from Office of Adult Mental Health quality management presented results from the 2011 Health and Wellness Survey to the Consumer Counsel of Maine August 17, 2012. The Department has requested feedback on recommendations from the Consumer Council on how they would like to see the data utilized.
IV.42	5% or fewer class members have unmet needs for mental health treatment services – *must be met for 3 out of 4 quarters* **and**	See attached *Performance and Quality Improvement Standards: May 2013,* 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	Unmet mental health treatment needs do not exceed 15 percentage points of Class Members.

	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	Data are normally reported in July. This report was produced in October this year but, in order to ensure data continuity, it uses only data that would have been reported in July. Reporting for this standard will be done again in July 2013. See attached report Consent Decree Compliance Standards IV.23 and IV.43
IV.44	QM documentation shows that the Department conducts further review and takes appropriate corrective action if results from the DIG survey fall below the levels identified in Standard # 22-1 (the domain average of positive responses to the statements in the Perception of Access Domain is at or above 85%) *(Amended language 1/19/11)* **and**	2011 Adult Health and Well-Being Survey: 77% domain average of positive responses. The Director of the Office of Quality Improvement and staff from Office of Substance Abuse and Mental Health Services quality management presented results from the 2011 Health and Wellness Survey to the Consumer Council of Maine on August 17, 2012. The Department has requested feedback on recommendations from the Consumer Counsel on how they would like to see the data utilized.
IV.45	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of mental health treatment services in the community • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master)	See attached *Performance and Quality Improvement Standards: May 2013,* Standards 21-2, 21-3 and 21-4 Standard met since the beginning of FY08
IV.46	SAMHS lists in quarterly reports the programs sponsored that are designed to improve quality of life and community inclusion, including support of peer centers, social clubs, community connections training, wellness programs and leadership and advocacy training programs – list must cover prescribed topics and audiences that fit parameters of ¶105.	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 30
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – *must be met for 3 out of 4 quarters*	See attached *Performance and Quality Improvement Standards: May 2013,* 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 *Performance and Quality Improvement Standards: May 2013,* Standard 23-1 and 23-2
IV.49	Certify that all contracts with providers include a requirement to refer family members to family support services, and produce documentation that contract reviews include evaluation of compliance with this requirement.	100% of contracts include this requirement. Documentation is maintained by the regional offices.

IV.50	Lists in quarterly reports the number and types of mental health informational workshops, forums and presentations geared to general public that are designed to reduce myths/stigma and foster community integration (cover prescribed list and fit audience parameters)	See attached *Performance and Quality Improvement Standards: May 2013,* Standard 34.1 and attached *Public Education Report October – December 2012.*



Consent Decree Performance and Quality Improvement Standards: May 2013

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 5.2, 5.3 and 5.4 will now be calculated by APS Healthcare. Standard 5.1 will be calculated by APS Healthcare and reported on the next quarterly report, FY 12 Q4.

All standards utilizing RDS/enrollment data, inclusive of unmet need data, are reported one quarter behind (for example, reporting 3rd quarter data in the 4th quarter).

Reporting includes, where pertinent, discussion of the data and recommendations.

Definitions:

Standard Title:	What the standard is intending to measure.
Measure Method:	How the standard is being measured.
Standard has been me	The most recent data available for the Standard.
Performance Standard:	Standard set as a component of the Department's approved Adult Mental Health Services Plan dated October 13, 2006.
Compliance Standard:	Standard set as a component of the Department's approved standards for defining substantial compliance approved October 29, 2007.

Calendar and Fiscal Year Definitions:

CY: Calendar Year - January 1 - December 31.

FY: Fiscal Year - State Fiscal Year July 1 - June 30.

Compliance and Performance Standards: Summary Sheet
January - March 2013

Standard 1. Rights Dignity and Respect

Average of positive responses in the DIG 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.
Standard has been met every quarter since 2007
3. Non-hospitalized class members assigned a worker in 3 days.
4. Class members not assigned on time, but within 1-7 extra days.
5. ISP completed within 30 days of service request.
6. 90 day ISP review completed within specified time frame
7. Initial ISPs not developed w/in 30 days, but within 60 days.
8. ISPs not reviewed within 90 days, but within 120 days.

Standard 7. CI/CSS/ Individualized Support Planning

1a. ISPs reflect the strengths of the consumer?
1b. ISPs consider need for crisis intervention and resolution services?
1c. Does the consumer have a crisis plan?
1d. Has the crisis plan been reviewed every 3 months?

Standard 8. CI/CSS Individualized Support Planning

1. ISP team reconvened after an unmet need was identified
2. ISPs reviewed with unmet needs with established interim plans.

Standard 9. ISP Service Agreements

ISPs that require Service Agreements that have current Service Agreements

Compliance and Performance Standards: Summary Sheet
January - March 2013

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 DIG 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 2013

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 DIG Survey Perception of Access domain
2. Average of positive responses in the DIG survey General Satisfaction domain

Standard 23. Family Support Services

1. An array of family support services as per settlement agreement
2. Number and distribution of family support services provided

Compliance and Performance Standards: Summary Sheet
January - March 2013

Standard 24. Family Support Services

1. Counseling group participants reporting satisfaction with services
2. Program participants reporting satisfaction with education programs
3. Deleted: Family participants reporting satisfaction with respite services in the community - NAMI closed its respite programs as of January 2010

Standard 25. Family Support Services

1. Agency contracts with referral mechanism to family support
2. Families reporting satisfaction with referral process.

Standard 26. Vocational Employment Services

1. Class members with ISPs - Unmet vocational/employment Needs.
2. Class Members in competitive employment in the community.
3. Consumers in supported or competitive employment in the community.

Standard 27. Vocational Employment Services

1. Deleted: Amendment request to delete approved 01/19/2011
2. Deleted: Amendment request to delete approved 01/19/2011

Standard 28. Transportation

Class Members with ISPs - Unmet transportation needs.

Standard 29. Transportation

1. Deleted: Amendment request to delete approved 01/19/2011
2. Deleted: Amendment request to delete approved 01/19/2011

Standard 30. Rec/Soc/Avocational/Spiritual Opportunities

1. Number of Social Clubs/peer center participants.
2. Number of other peer support programs

Standard 31. Rec/Soc/Avoc/Spirtual

1. ISP identified class member unmet needs in recreational/social/avocational/spiritual areas
2. Average of positive responses in the DIG Survey 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 2013

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 DIG Survey
5. Consumers reporting providers stressed natural supports/friendships
6. Consumers reporting providers offered peer recovery groups.

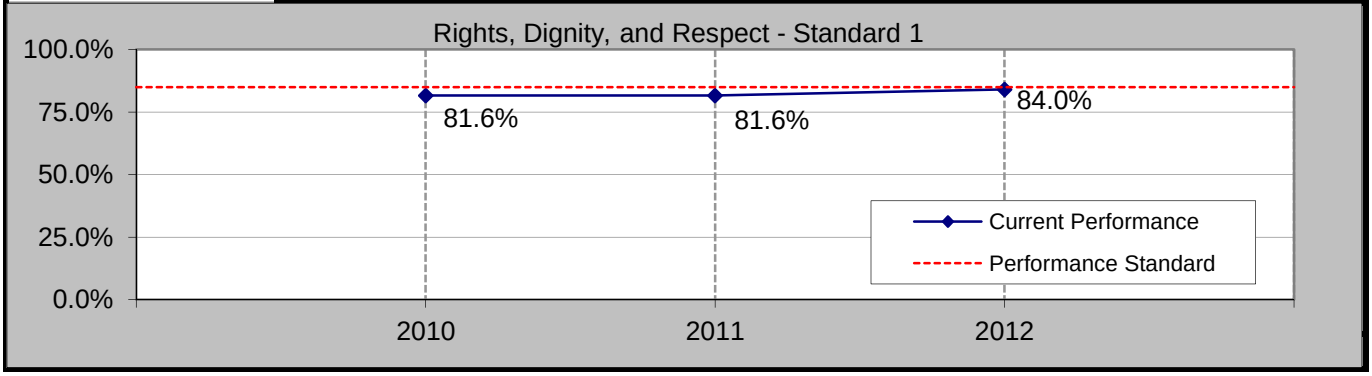
Standard 34. Public Education

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

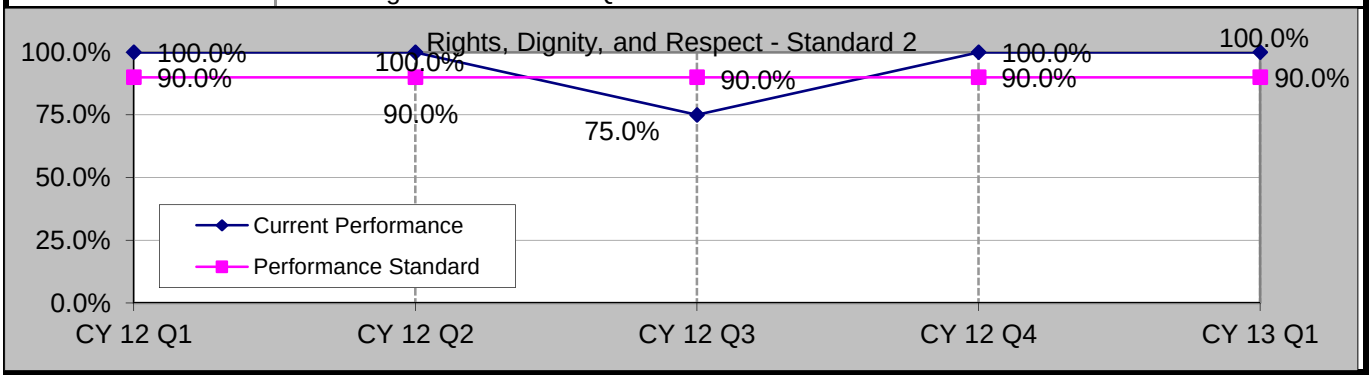
Rights, Dignity, and Respect

Standard 1 - Treated with respect for their individuality

Standard 1	
Measurement	Domain average of positive responses to the statements in the quality and appropriateness domain
Standard	Performance: at or above 85%
Data Source	DIG Survey
Current Level	84.0% (N=1337)



Standard 2 - Grievances are addressed in a timely manner Standard has been met every quarter since 2007	
Standard 2	
Measurement	Response to Level II Grievances within 5 days or agreed upon extension
Standard	Performance: 90% Within 5 days or during extension
Data Source	DHHS Grievance Tracking System
Current Level	1 level II grievances CY13 Q1



Discussion:

Standard 1: SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

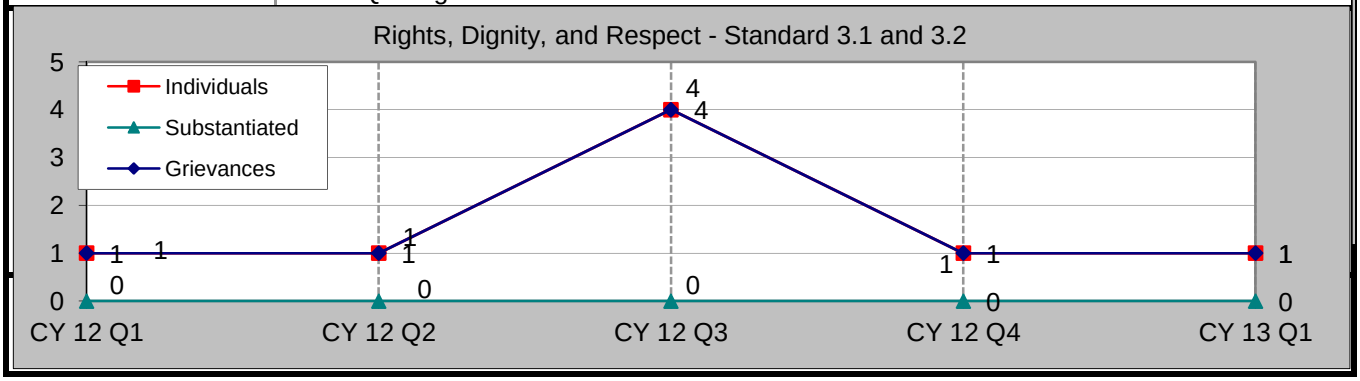
Standard 2: Standard met 23 out of 29 quarters since 2009.

Rights, Dignity, and Respect

Standard 3 - Demonstrate rights are respected and maintained

Standard 3.1	
Measurement	Number of Level II grievances filed and number unduplicated people
Standard	No numerical standards necessary, ongoing monitoring of grievance trends.
Data Source	DHHS Grievance Tracking System
Current Level	CY 12 Q3 1 grievance filed. 1 individuals

Standard 3.2	
Measurement	Number of Level II grievances filed where violation is substantiated
Standard	No numerical standards necessary, ongoing monitoring of grievance trends.
Data Source	DHHS Grievance Tracking System
Current Level	CY 13 Q1 1 grievance filed. 0 substantiated



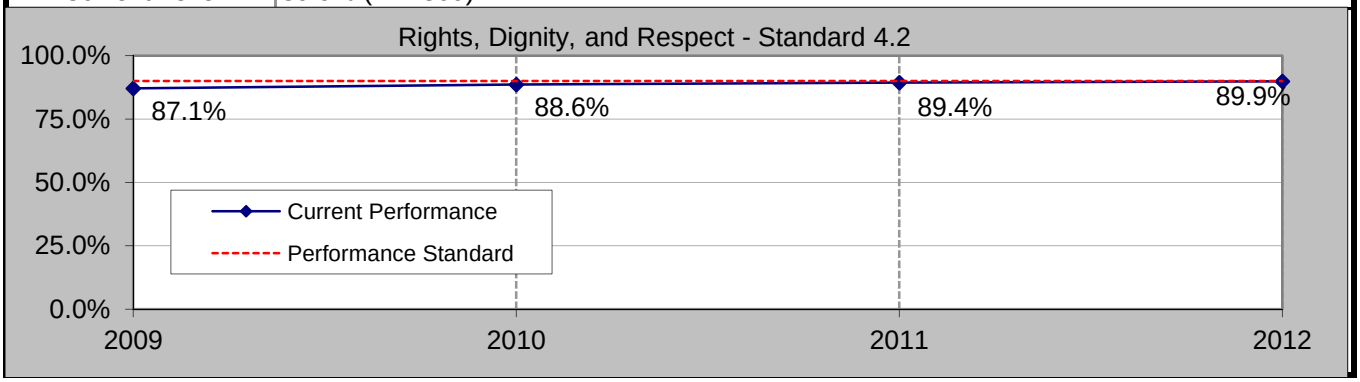
Comment:

Standard 3.1 and 3.2: No grievances have been substantiated since 2006. The number of grievances is not statist

Rights, Dignity, and Respect

Standard 4 - Class Members are informed of their rights

Standard 4.2	
Measurement	Percent of consumers reporting they were given information about their rights.
Standard	Performance: 90%
	Compliance: See explanation below.
Data Source	Data Infrastructure Grant Survey, Q22
Current Level	89.9% (N=1309)



* Compliance standard for 4.2

If results fall below the performance standard level, the Department:

- •Consults with the Consumer Council of Maine (CCSM)
- •Takes corrective action if deemed necessary by the CCSM and
- •Develops that corrective action in collaboration with the CCSM

Discussion:

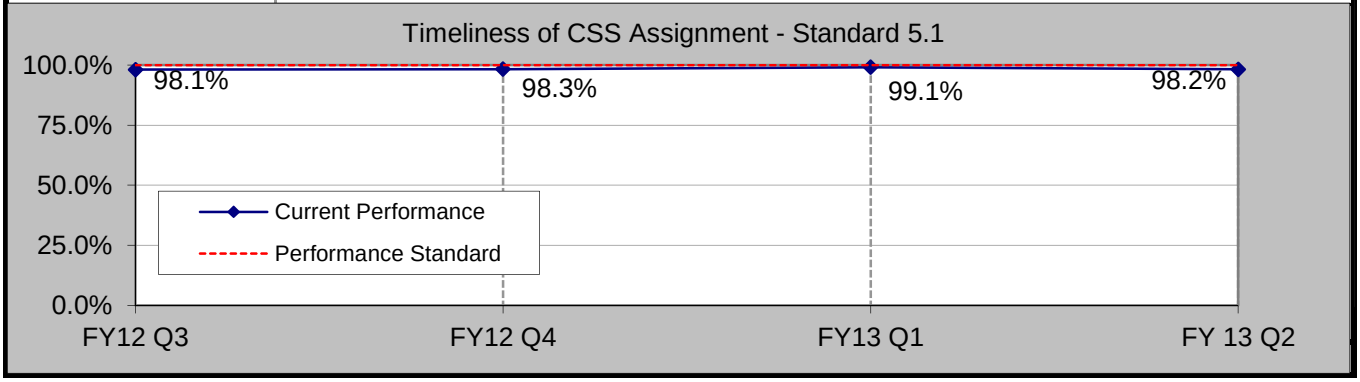
Percentage has increased from 87.9% to 89.9%. Data from the 2012 DIG survey were posted on the website and shared with the CCSM.

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

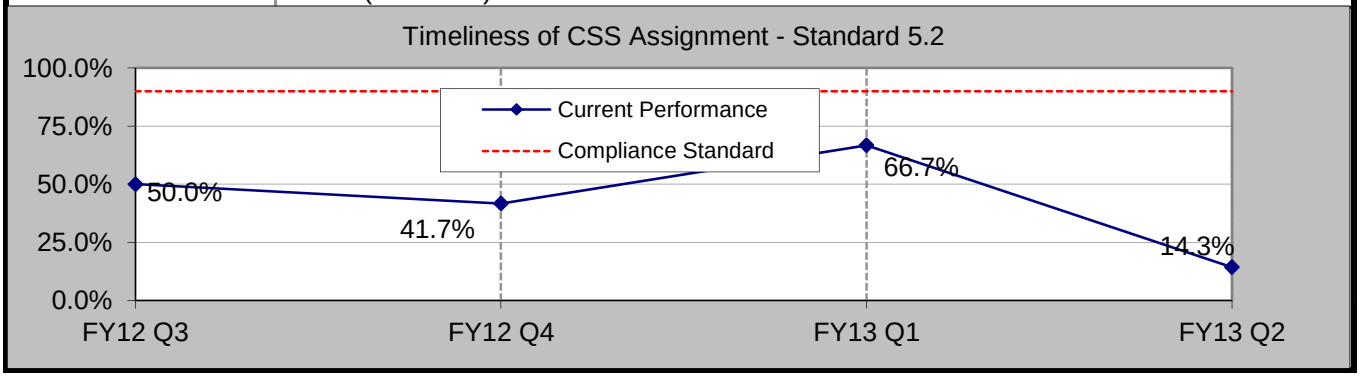
Community Integration / Community Support Services / Individualized Support Planning

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

Standard 5.1	
Measurement	Percentage of class members requesting a worker who were assigned one.
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	98.2% (108 out of 110)



Standard 5.2	
been met every quart	Percentage of hospitalized class members who were a assigned a worker within 2 working days.
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	14.3% (1 out of 7)

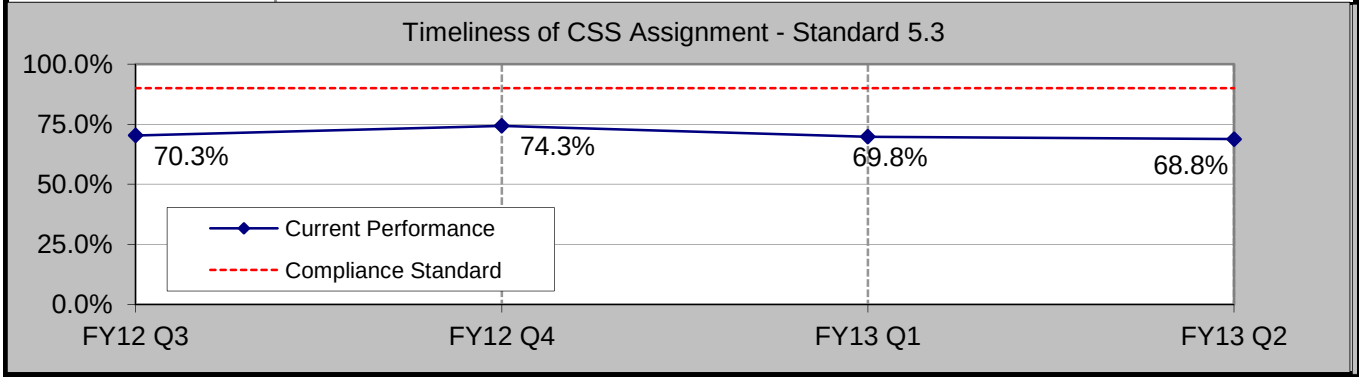


Discussion:

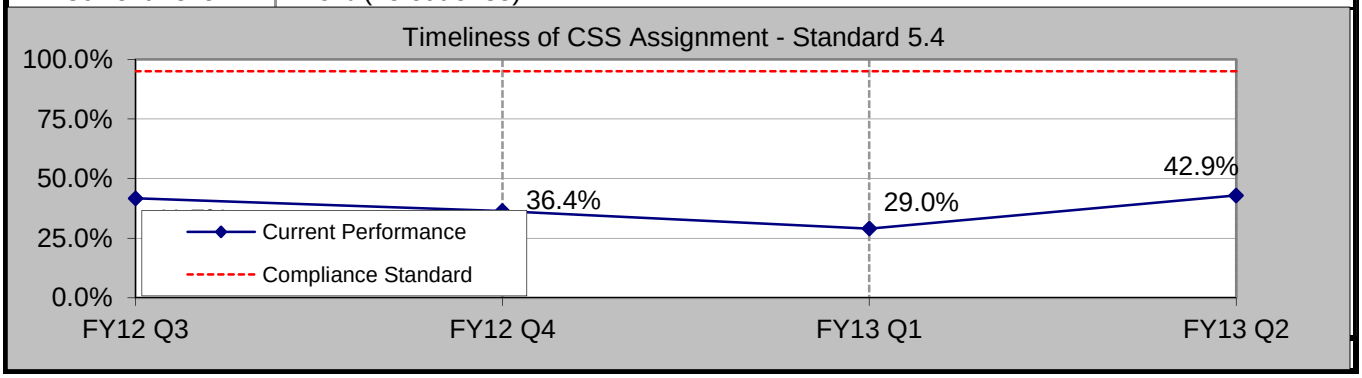
Standard 5.1 and 5.2: The department has begun to improve its process for monitoring agencies' performance through the Niatx project.

Community Integration / Community Support Services / Individualized Support Planning

Standard 5.3	
Measurement	Percent of non-hospitalized class members assigned a worker within 3 working days.
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	68.8% (64 out of 93)



Standard 5.4	
Measurement	Percent of class members in hospital or community not assigned on time but were assigned within an additional 7 working days.
Standard	Performance: 100% Compliance: 95%
Data Source	ISP RDS Data
Current Level	42.9% (15 out of 35)

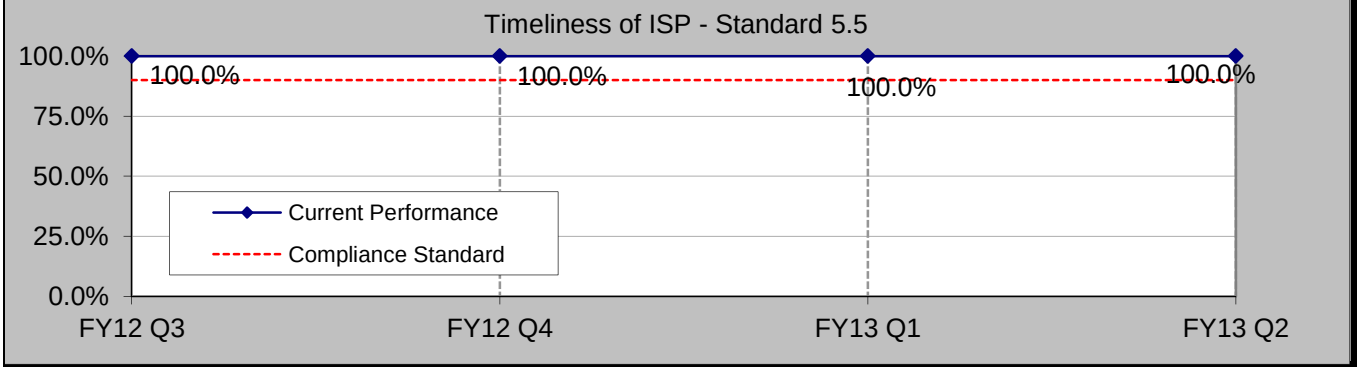


Discussion:

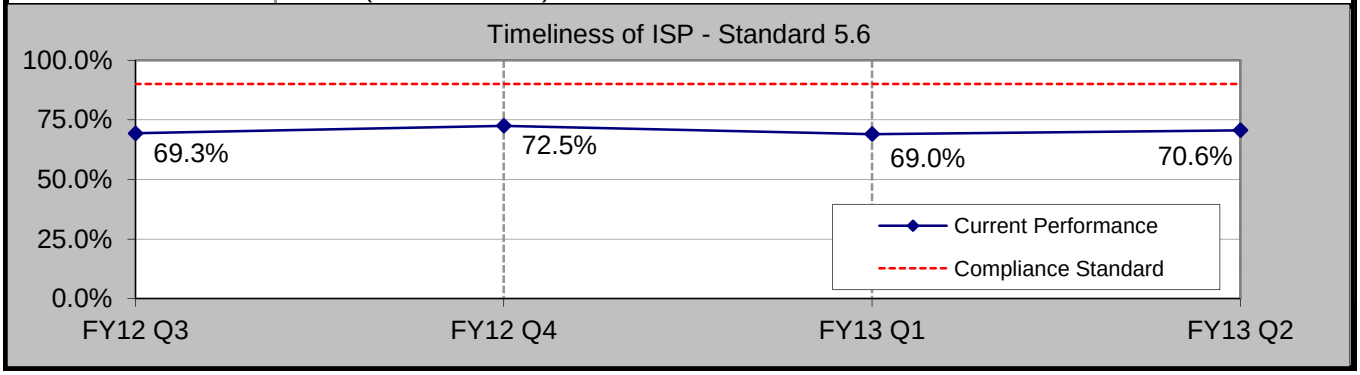
Standard 5.3 and 5.4: See discussion for standard 5.1 and 5.2

Community Integration / Community Support Services / Individualized Support Planning

Standard 5.5	
Measurement	Class member ISPs completed within 30 days of service request
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	100.0% (84 out of 84)



Standard 5.6	
Measurement	90 day class member ISP reviews completed within specified timeframe.
Standard	Performance: 90% Compliance: 90% (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	70.6% (698 out of 989)

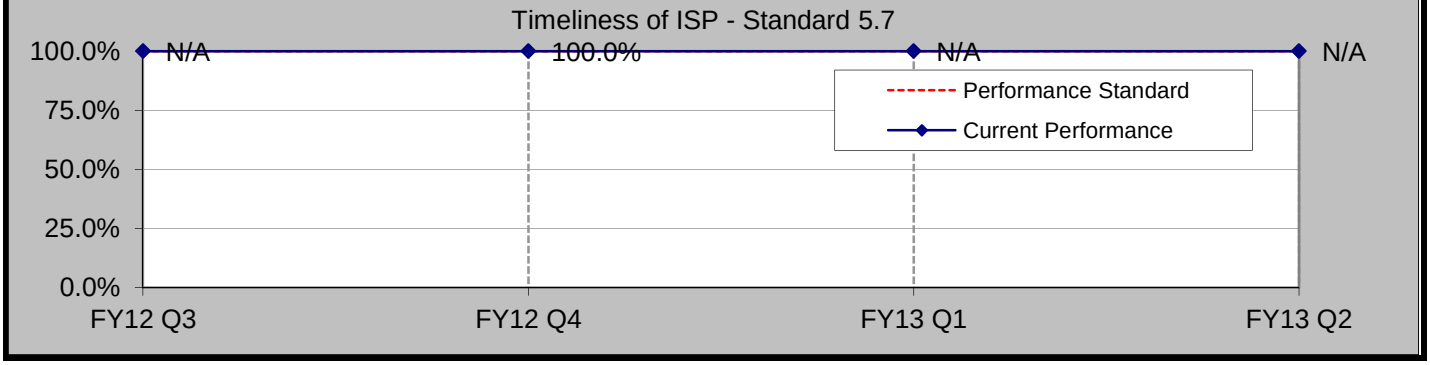


Comment:

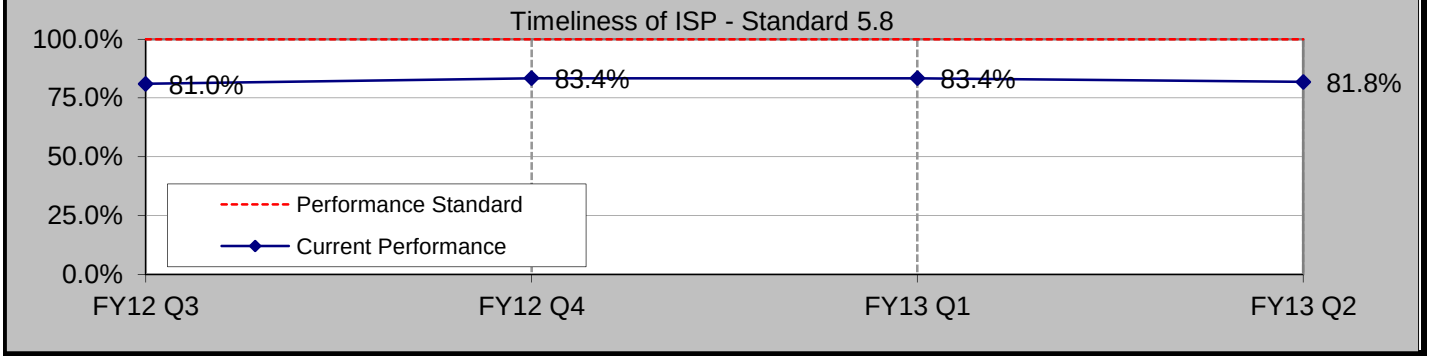
Standard 5.5: This standard has been consistently met since 2008.

Community Integration / Community Support Services / Individualized Support Planning

Standard 5.7	
Measurement	Initial class member ISPs not developed within 30 days, but were developed within 60 working
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	N/A (0 out of 0)



Standard 5.8	
Measurement	Class member ISPs that were not reviewed within 90 days but were reviewed within 120 working
Standard	Performance: 100%
Data Source	ISP RDS Data
Current Level	81.8%(238 out of 291)



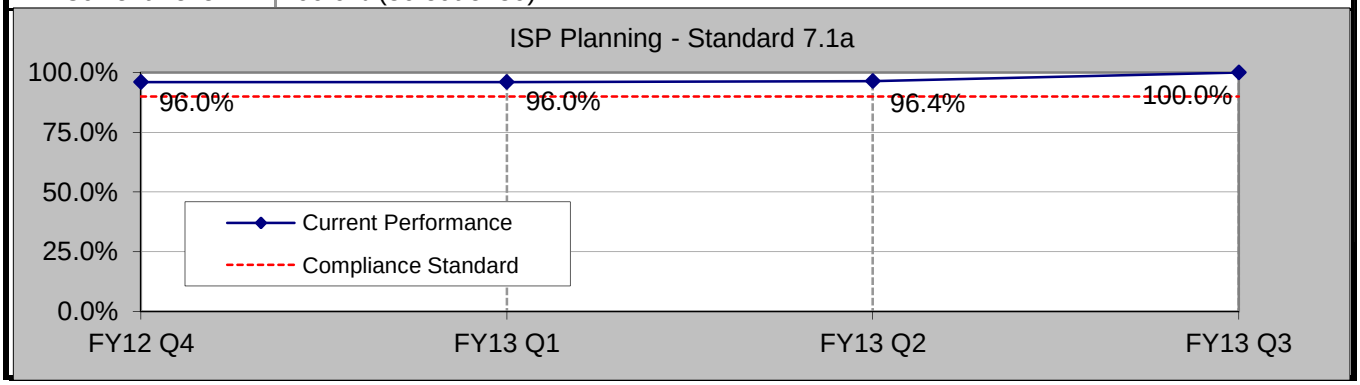
Comment:

Standard 5.8: This area is being addressed by Quality Management Specialists during site visits.

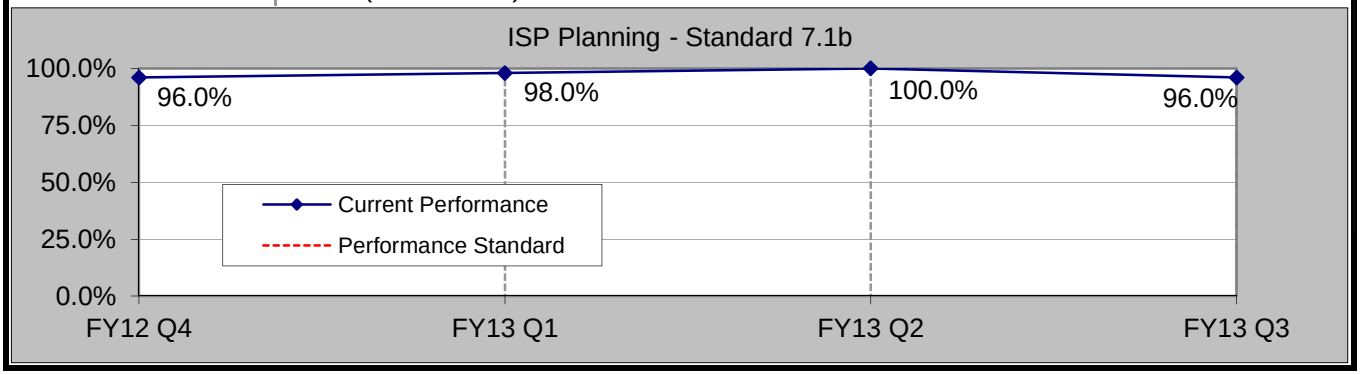
Community Integration / Community Support Services / Individualized Support Planning

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

Standard 7.1a	
Measurement	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?
Standard	Performance: 95%
	Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	100.0% (50 out of 50)



Standard 7.1b	
Measurement	Does record document the individual's potential need for crisis intervention and resolution services was considered during treatment planning?
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	96.0% (48 out of 50)



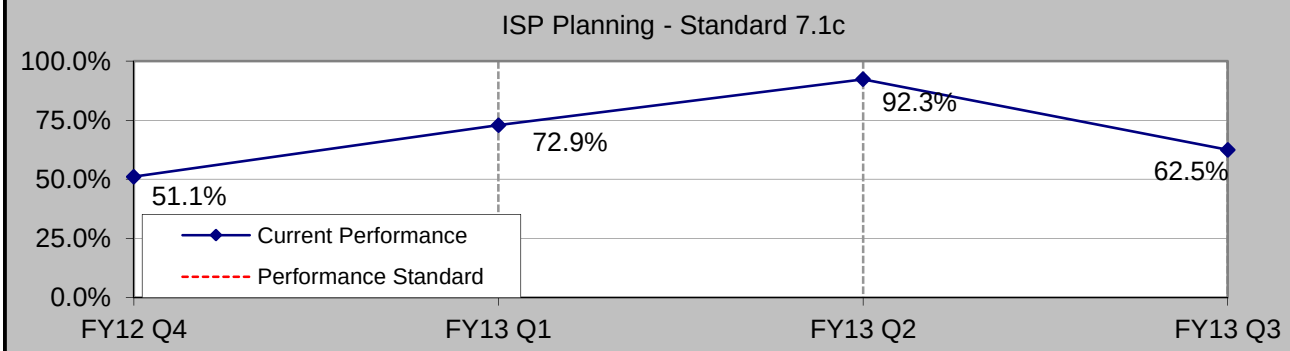
Discussion:

Standard 7.1a: This standard has been met for the past 22 quarters.

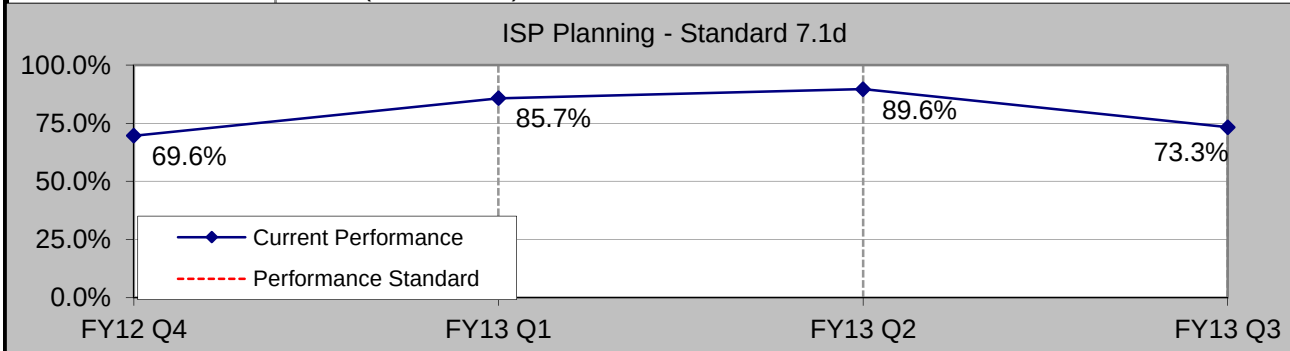
Standard 7.1b: Treatment plans document that crisis planning discussions are consistently occurring.

Community Integration / Community Support Services / Individualized Support Planning

Standard 7.1c	
Measurement	Does the record document that the consumer has a crisis plan?
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	62.5% (30 out of 48)



Standard 7.1d	
Measurement	If the consumer has a crisis plan, "has the crisis plan been reviewed as required, every 3 months?"
Standard	Performance: No Numerical Standard
Data Source	Class Member Treatment Planning Review
Current Level	73.3% (22 out of 30)



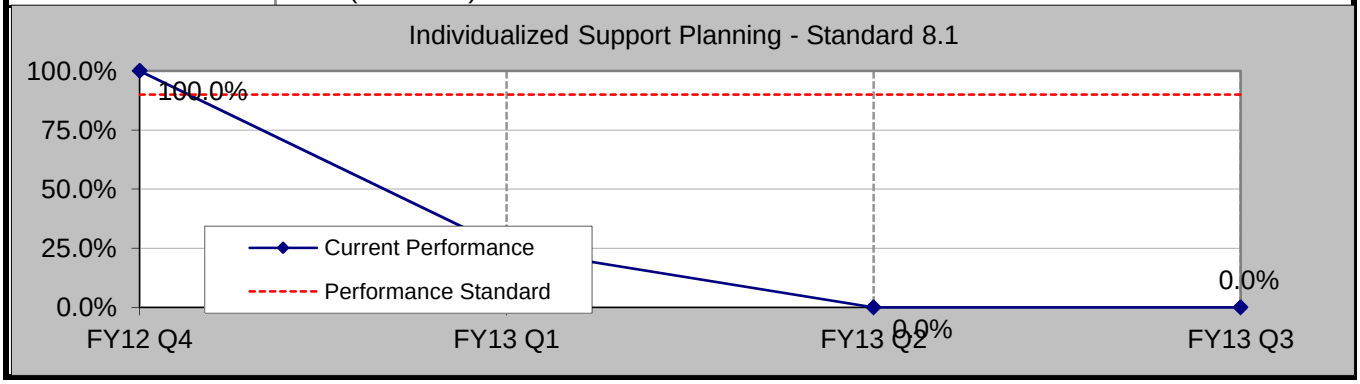
Comment:

Section 7.1c , and 7.1d: Field Service Specialists continue to review standards with agencies and provide technica

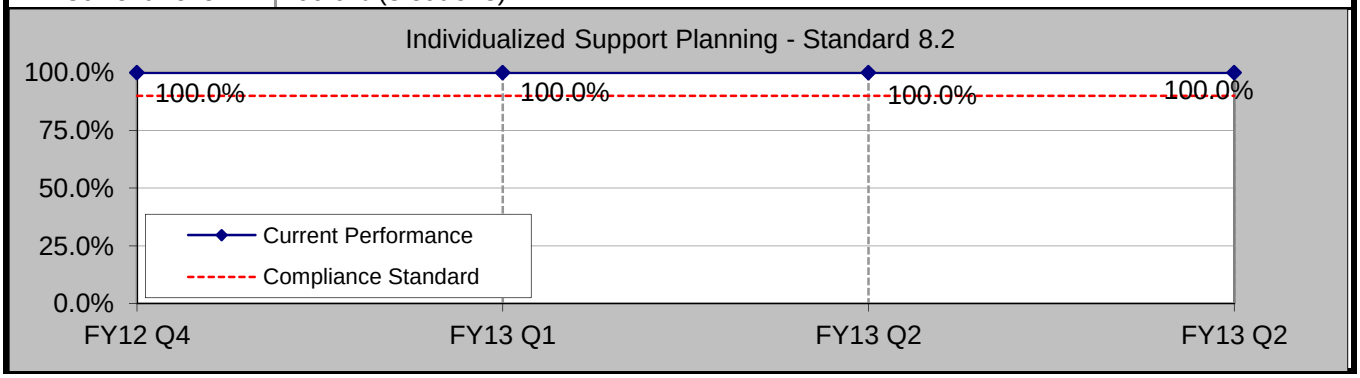
Community Integration / Community Support Services / Individualized Support Planning

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

Standard 8.1	
Measurement	ISPs reviewed in which there is evidence that the ISP team reconvened after an unmet need was identified.
Standard	Performance: 90%
Data Source	Class Member Treatment Planning Review
Current Level	0.0% (0 out of 3)



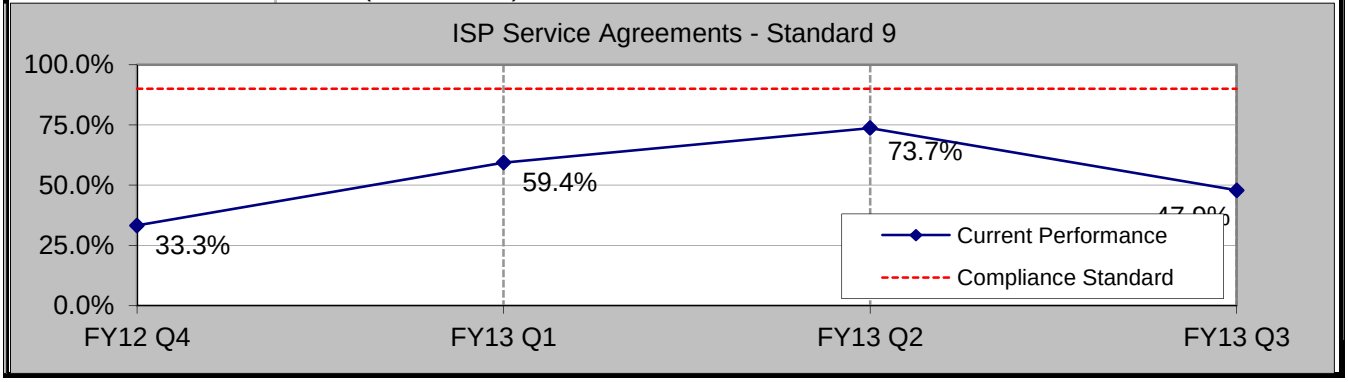
Standard 8.2	
Measurement	ISPs reviewed with identified unmet needs in which interim plans are established.
Standard	Performance: 95% Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	100.0% (3 out of 3)



Community Integration / Community Support Services / Individualized Support Planning

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

Standard 9	
Measurement	ISPs with services identified and with a treatment plan signed by each provider.**
Standard	Performance: 90%
	Compliance: 90% (3 out of 4 quarters)
Data Source	Class Member Treatment Planning Review
Current Level	47.9% (23 out of 48)



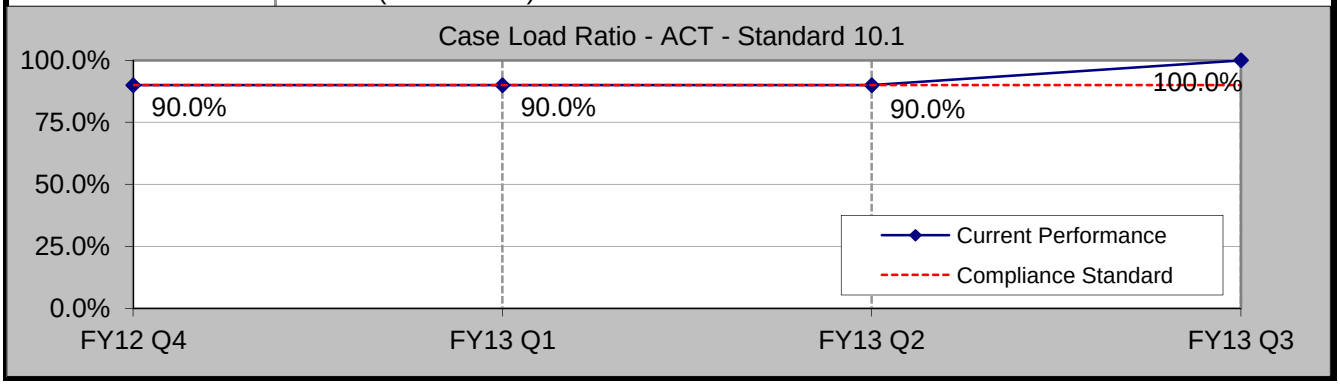
Comment:

Standard 9: Field Service Managers continue to review with providers and provide training.

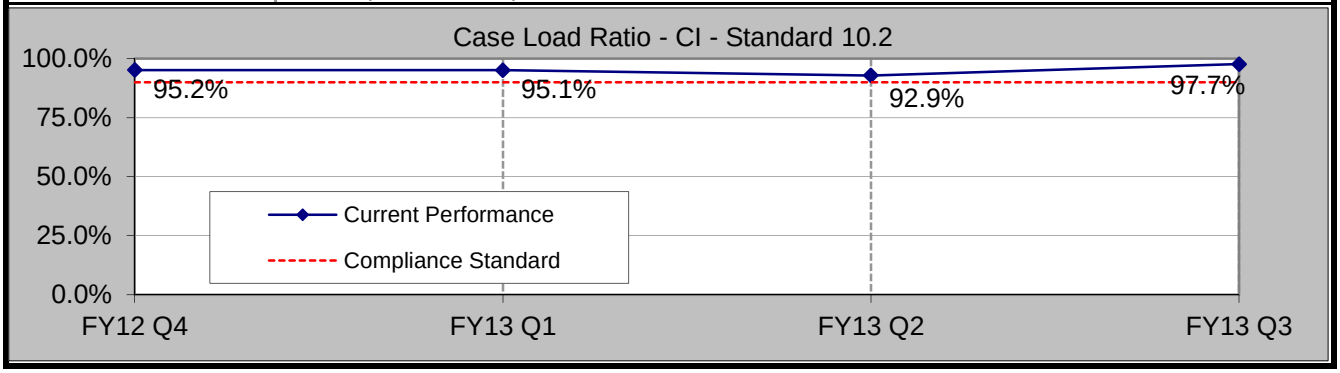
Community Integration / Community Support Services / Individualized Support Planning

Standard 10 - Case Load Ratio

Standard 10.1 - ACT	
Measurement	ACT Providers with average caseloads of 10 or fewer.
Standard	Compliance: 90% of all ACT Teams
Data Source	Agency Community Support Census/Staffing Ratio Database
Current Level	100.0% (10 out of 10)



Standard 10.2 - CI	
Measurement	Community Integration Providers with average caseloads of 40 or fewer.
Standard	Compliance: 90% of all CIW Providers
Data Source	Agency Community Support Census/Staffing Ratio Database
Current Level	97.7% (43 out of 44)



Discussion:

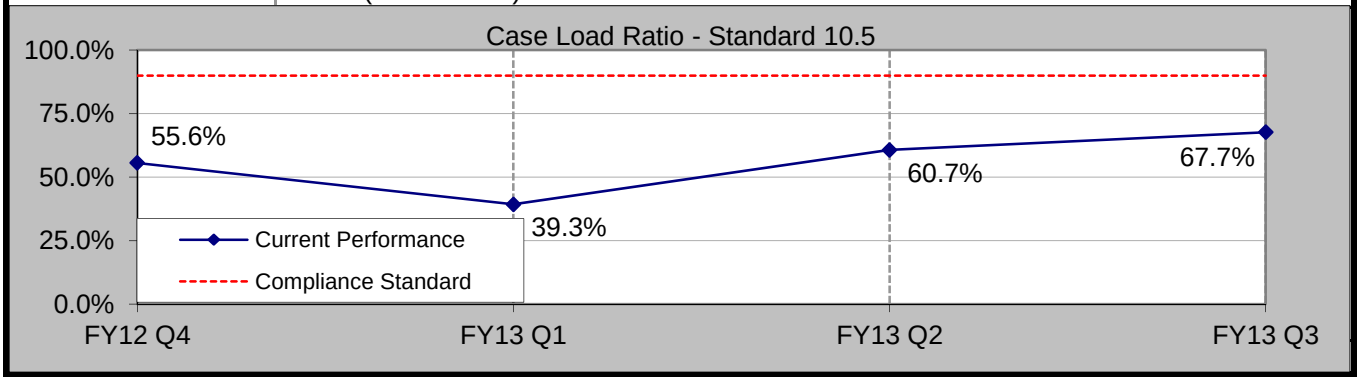
Standard 10.1: The 10/01/2009 revision of MaineCare Section 17 clearly specified staff to be included in calculating staffing ratios; ratio has been met in 24 of the past 29 quarters.

Standard 10.2: Community Integration caseload ratios have been met since the 2nd quarter FY 08

Community Integration / Community Support Services / Individualized Support Planning

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

Standard 10.5 - OADS	
Measurement	Office of Aging and Disability Services Case Managers with average caseload of 25 or fewer.
Standard	Compliance: 90% of all OADS Case Managers with Class Member Public Wards
Data Source	MAPSIS Case Counts for Workers with Class Members Public Wards
Current Level	67.7% (21 out of 31)



Discussion:

Standard 10.5: OADS continues not to meet staff/client 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, 2012				
	Region 1	Region 2	Region 3	Total
Unique Individuals:	0	0	0	0
Unmet Needs:	0	0	0	0

Unmet Needs by Domain Oct 1 ~ Dec 31, 2012	
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

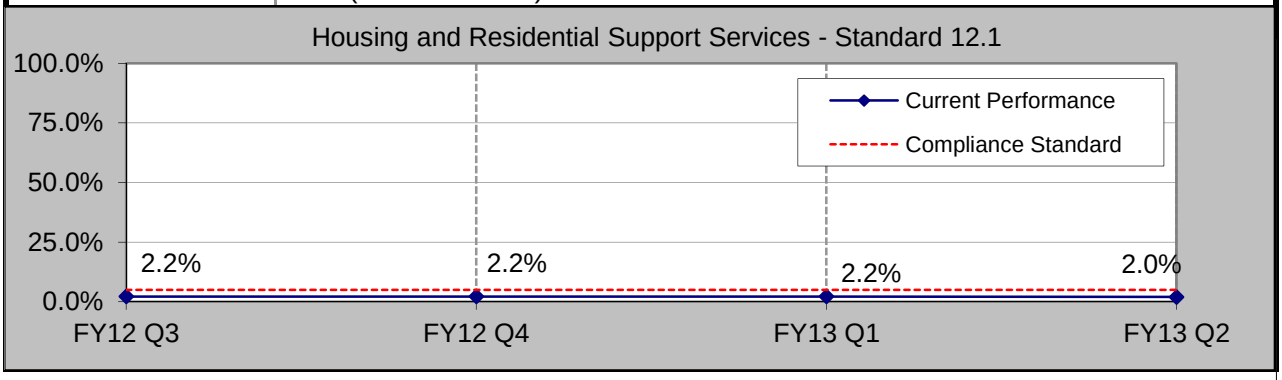
Comment:

Standard 11.1 and 11.2: Low number of documented consumer calls has been reviewed with supervisors.

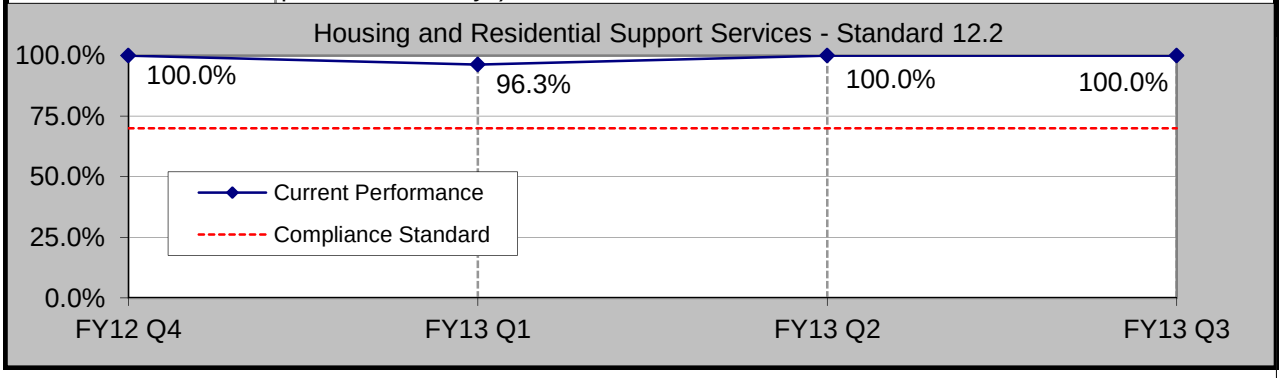
Community Resources and Treatment Services
Housing and Residential

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

Standard 12.1	
Measurement	Class members in community with ISPs with unmet residential support needs.
Standard	Compliance: 5% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	2.0% (23 out of 1135)

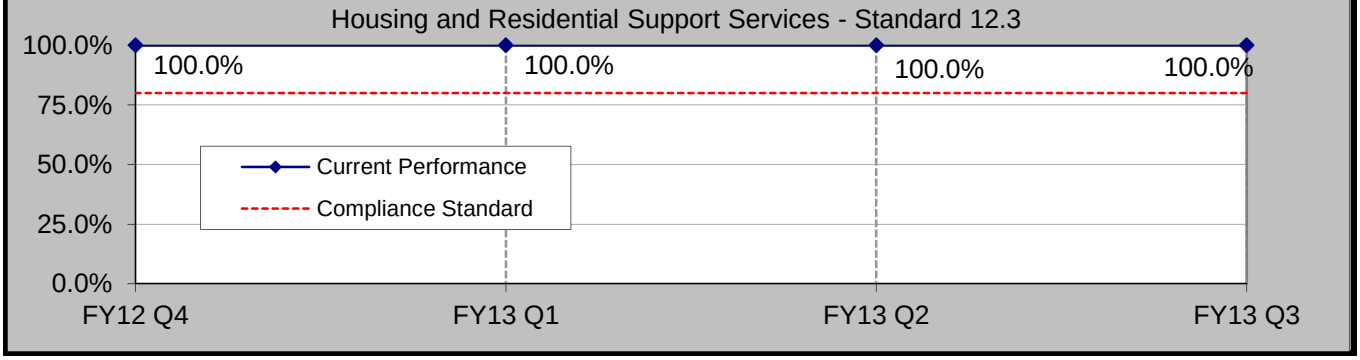


Standard 12.2	
s been met every quart	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY13 Q3 (Lack of residential supports did not impede discharge for any patient with 7 days)

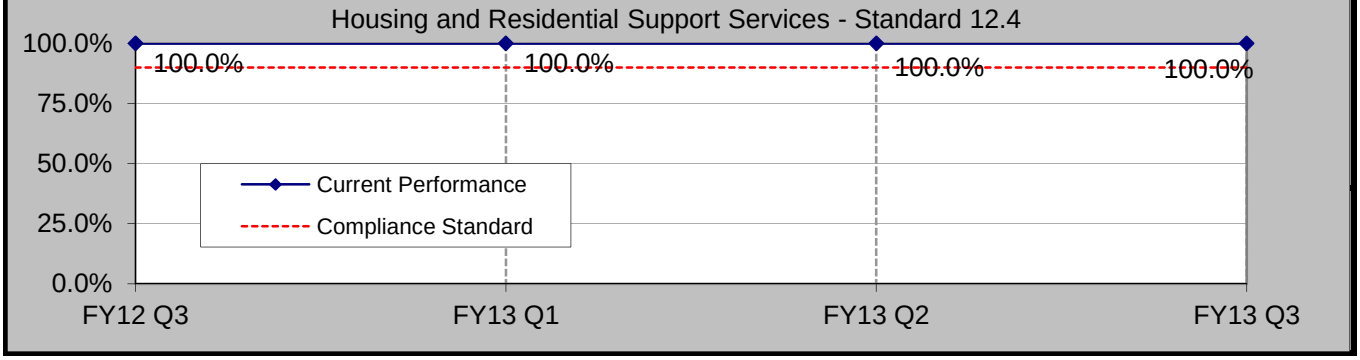


Community Resources and Treatment Services
Housing and Residential

Standard 12.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY13 Q3 (Lack of residential supports did not impede discharge for any patients within 30 days)



Standard 12.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge is not impeded due to lack of residential support services)
Standard	Perfomance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY13 Q3 (Lack of residential supports did not impede discharge for any patients within 45 days)



Discussion:

Standard 12.1: Met consistently since 2010.

Standards 12.2, 12.3, 12.4: Met in all but 2 quarters since 2007.

Riverview Psychiatric Center Discharge Detail to amplify data presented in Standards 12.2, 12.3, 12.4

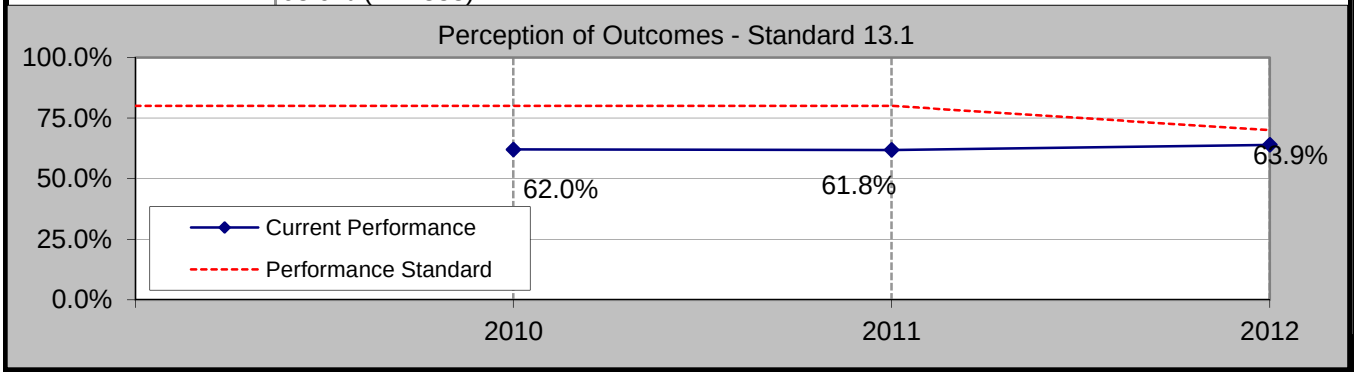
22 Civil Patients discharged in quarter

- 17 discharged at 7 days (77.3%)
- 2 discharged 8-30 days (9.1%)
- 1 discharged 31-45 days (4.5%)
- 2 discharged post 45 days (9.1%)

Residential Support Services did not impede discharge for any patient post clinical readiness for discharge.

Community Resources and Treatment Services
Housing and Residential

Standard 13.1	
Measurement	Domain average of positive responses to the questions in the Perception of Outcomes domain
Standard	Performance: at or above 70%
Data Source	DIG Survey
Current Level	63.9% (N=1338)



Discussion:

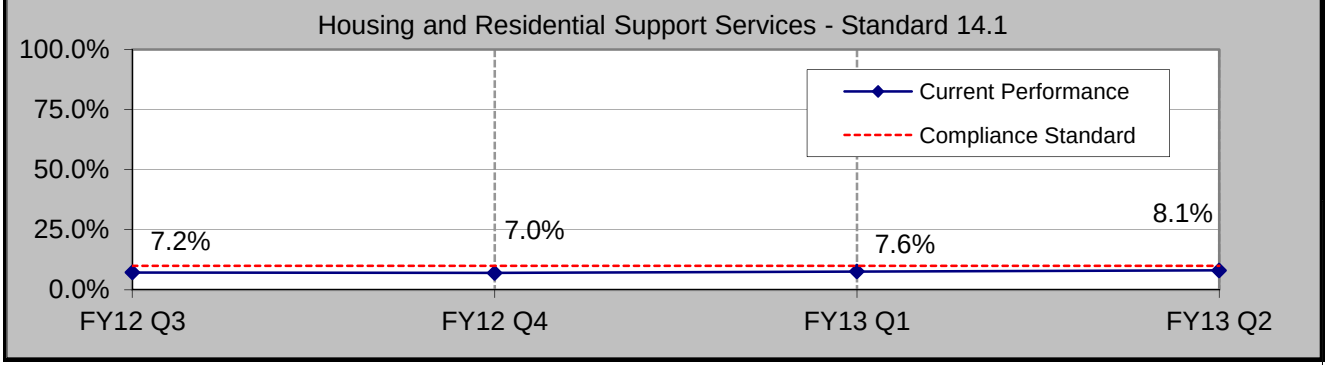
Standard 13.1: There has been an increase in the past three years through we continue to fall short of meeting the standard.

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

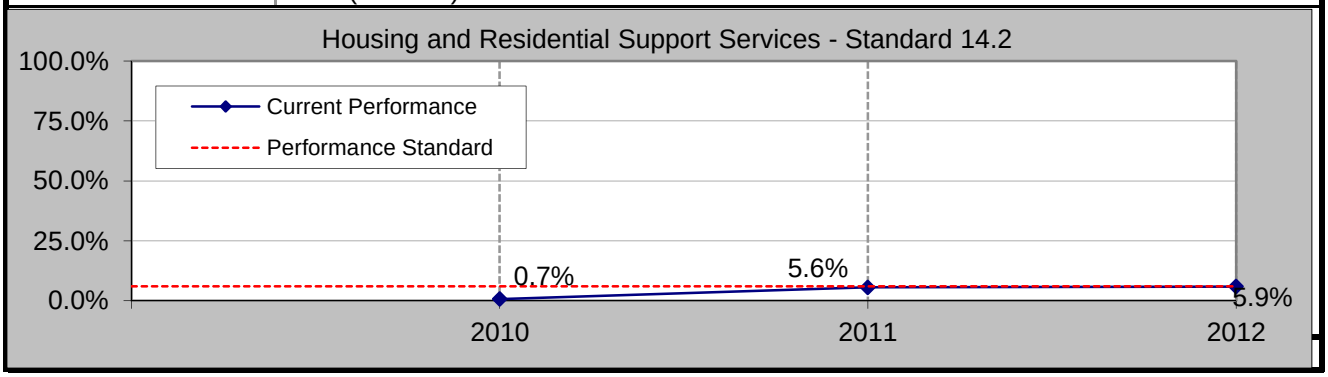
Community Resources and Treatment Services
Housing and Residential

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

Standard 14.1	
Measurement	Class members with ISPs with unmet housing needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	8.1% (92 out of 1135)



Standard 14.2	
Measurement	Percentage of respondents who experienced homelessness over 12-month period.
Standard	Performance: 6% or fewer
Data Source	DIG Survey, living situation data
Current Level	5.9% (N=1275)



Discussion:

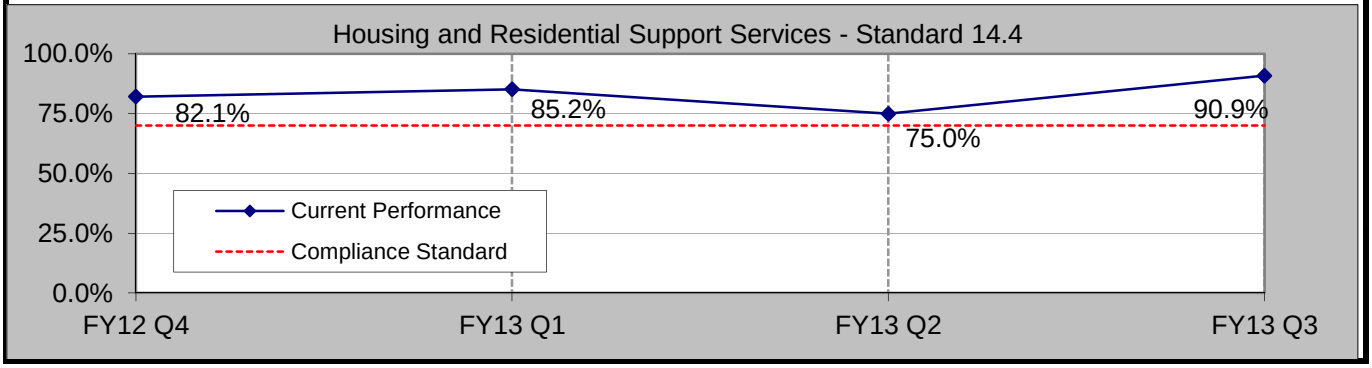
Standard 14.1: Met in 20 of the past 26 quarters.

Standard 14.2: Starting in 2010, % of 'currently homeless' was reported instead of 'experienced homelessness over 12 month period'. This standard has been met for the past two years.

Standard 14.3: Request to delete approved 01/19/2011

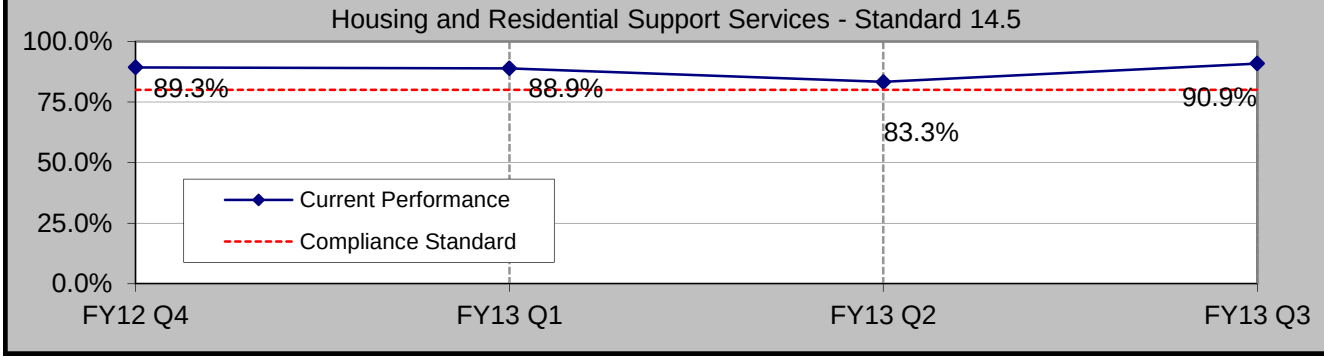
Community Resources and Treatment Services
Housing and Residential

Standard 14.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	90.9% FY13 Q3. (Lack of housing alternatives did not impede discharge for 20 out of 22 patients within 7 days)

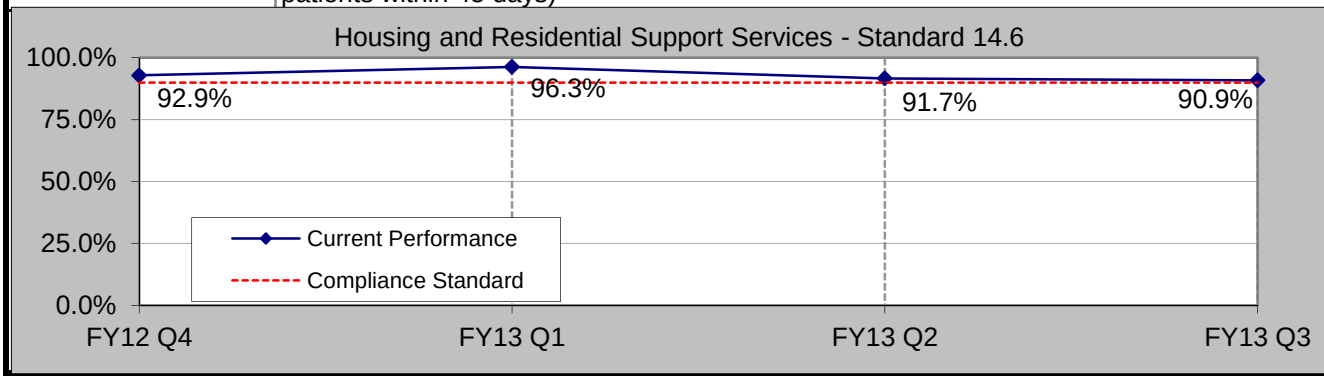


Community Resources and Treatment Services
Housing and Residential

Standard 14.5	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 96% (within 30 days of that determination)
	Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	90.9% FY13 Q3 (Lack of housing alternatives did not impede discharge for 20 out of 24 patients within 30 days)



Standard 14.6	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination. (discharge not impeded due to lack of housing alternatives)
Standard	Performance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	90.9% FY13 Q3 (Lack of housing alternatives did not impede discharge for 22 out of 24 patients within 45 days)



Discussion:

Standard 14.4: This standard has been met 25 of the past 27 quarters.

Standard 14.5: Met the 3rd and 4th quarters FY 09; the 2nd and 4th quarters FY 10; all quarters FY 11; all quarters of FY 12 and first three quarters of FY 13

Standard 14.6: Met 2nd and 4th quarters FY 09; 2nd and 4th quarters FY 10; all quarters FY 11; all quarters of FY 12 and first three quarters of FY 13

Riverview Psychiatric Center Discharge Detail to amplify data presented in Standards 14.4, 14.5, 14.6:

22 Civil Patients discharged in quarter

17 discharged at 7 days (77.3%)
2 discharged 8-30 days (9.1%)
1 discharged 31-45 days (4.5%)
2 discharged post 45 days (9.1%)

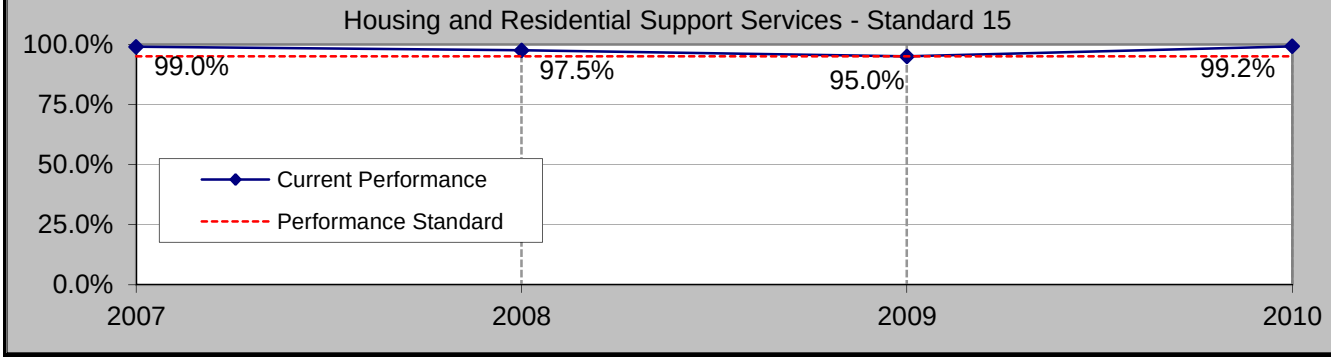
Housing Alternatives impeded discharge for 2 patients (9.1%)

2 patients 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

Standard 15	
Measurement	Class members residing in homes with more than 8 beds in which the class member chooses to reside in that facility is documented.
Standard	Performance: 95%
Data Source	Paragraph 96 Annual Review
Current Level	99.2% (120 of 121)



Discussion:

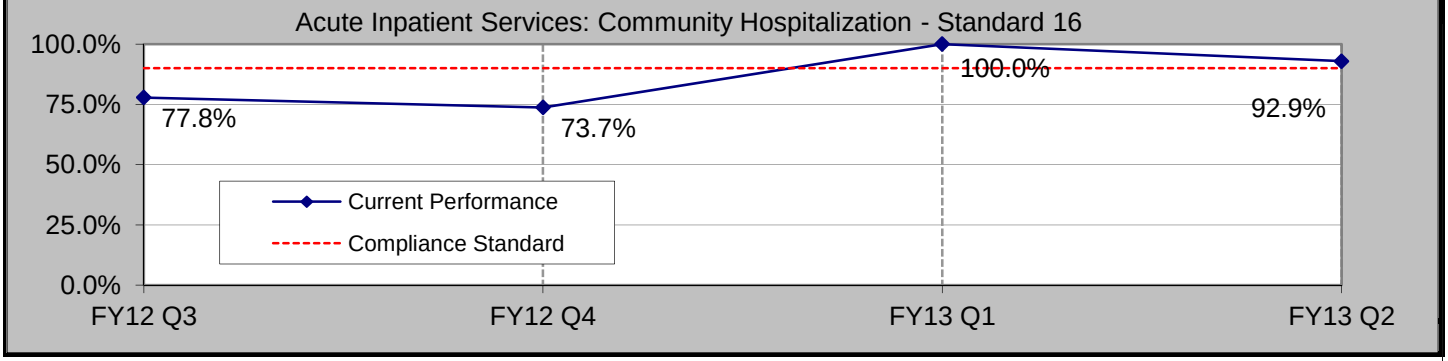
Standard met since 2007.

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

Standard 16	
Measurement	Class Member admissions determined to be reasonably near an individual's local community of residence.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	UR Database/EIS
Current Level	92.9% (13 out of 14)



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

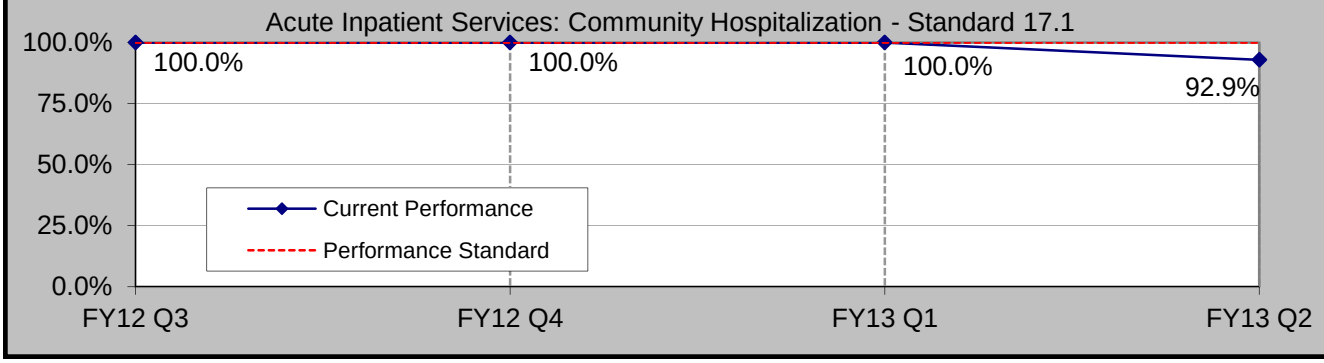
Standard has been met every quarter since 2007

This standard has been met over the past two quarters. The number of class member reviews is small making it difficult to draw conclusions systemically.

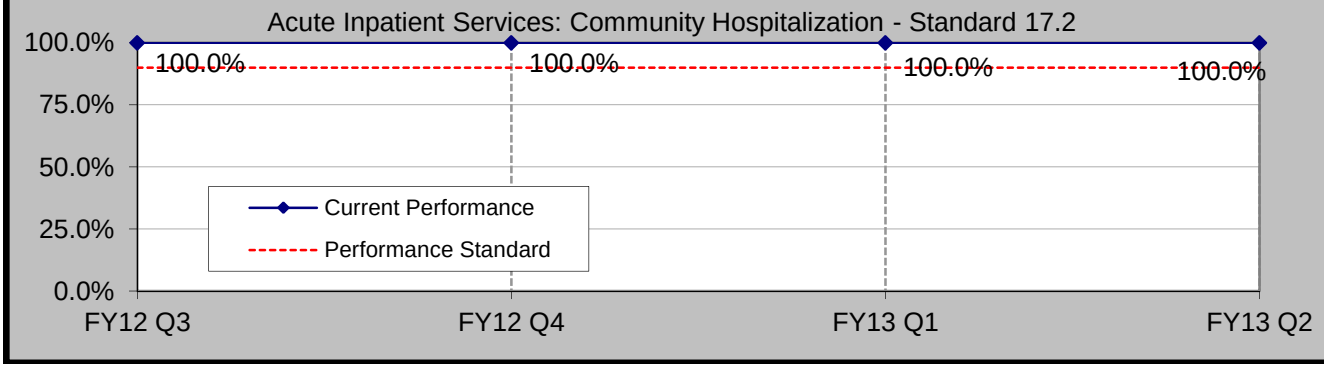
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

Standard 17.1	
Measurement	Class member involuntary admissions to community inpatient units have blue paper on file.
Standard	Performance: 100%
Data Source	UR Database/EIS
Current Level	92.9% (13 out of 14)

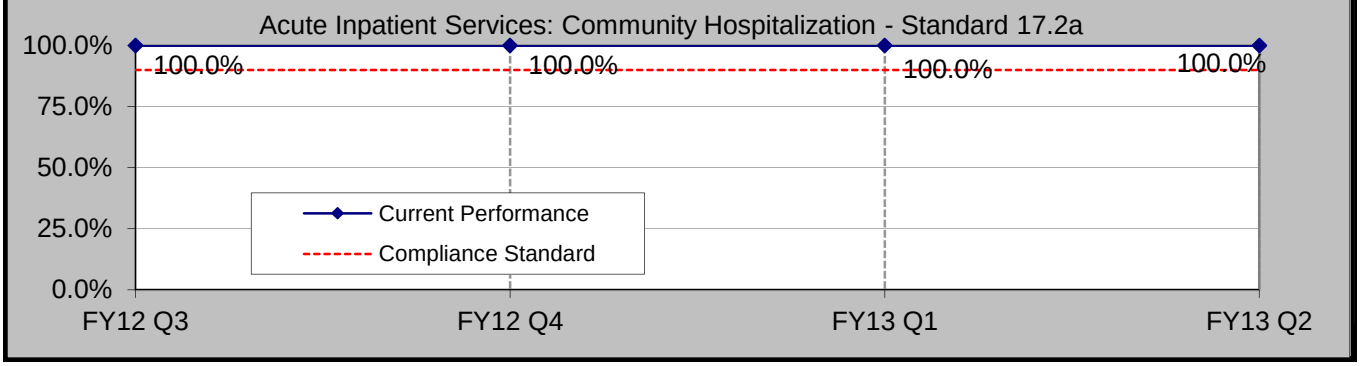


Standard 17.2	
Measurement	Blue paper was completed and in accordance with terms.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (13 out of 13)

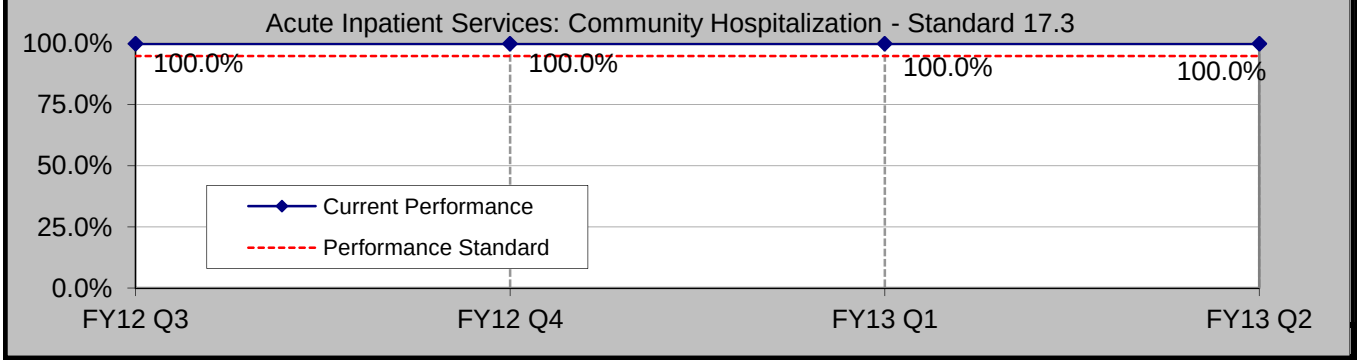


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

Standard 17.2a	
Measurement	Corrective action taken by UR nurse where blue paper not completed in accordance with terms.
Standard	Performance: 95% Compliance:90%
Data Source	UR Database/EIS
Current Level	100.0% (All blue papers reported as completed and in accordance with terms)

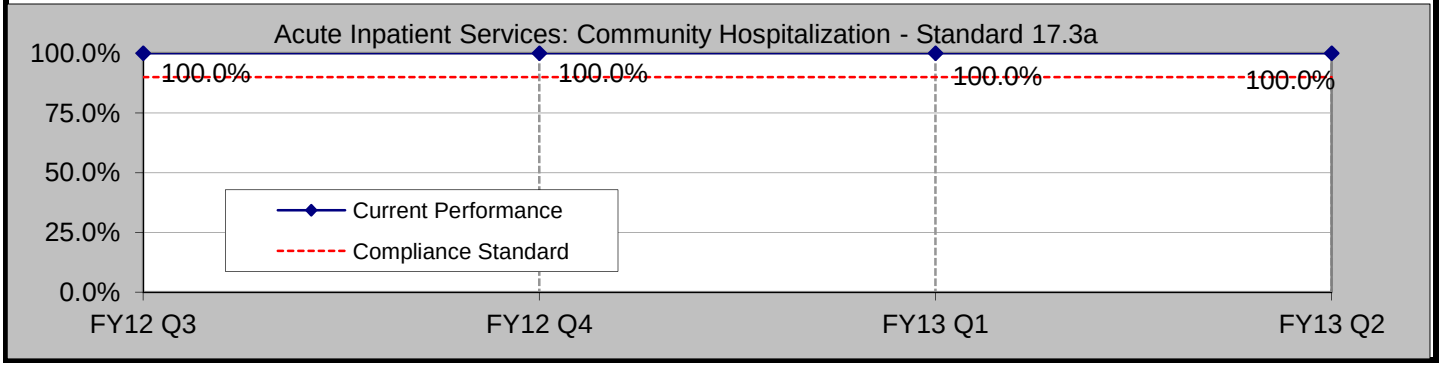


Standard 17.3	
Measurement	Class member involuntary admissions to community inpatient units in which 24 hour certification was completed.
Standard	Performance: 95%
Data Source	UR Database/EIS
Current Level	100.0% (13 out of 13)

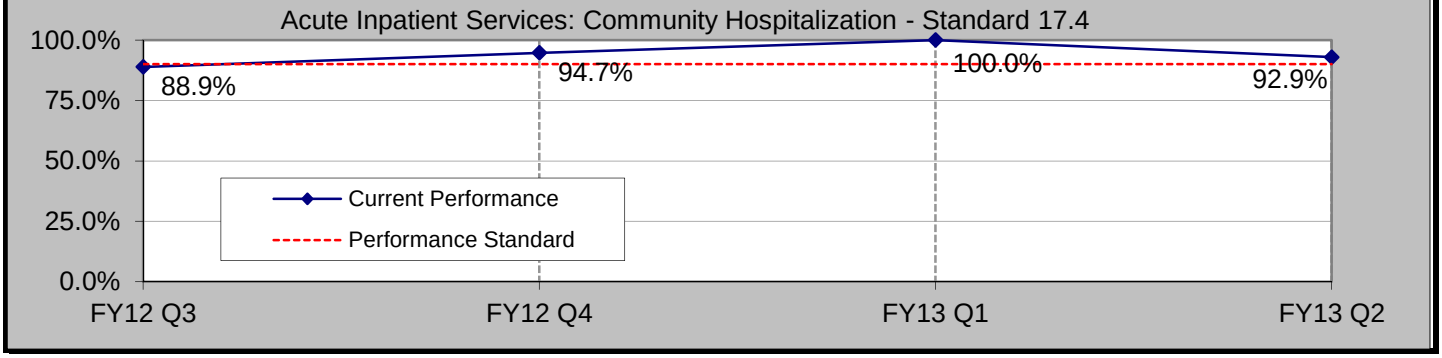


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

Standard 17.3a	
Measurement	Corrective action taken by UR nurse where 24 hour certification was not completed.
Standard	Performance: 100% Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (All 24 hr certifications reported as completed)

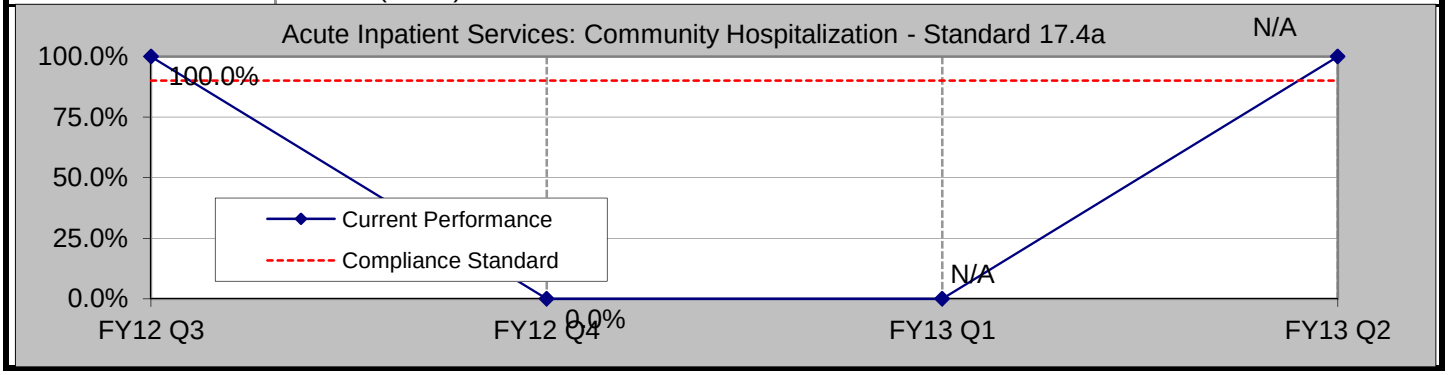


Standard 17.4	
Measurement	Class member involuntary admissions to community inpatient units in which patients' rights were maintained.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	92.9% (13 out of 13)

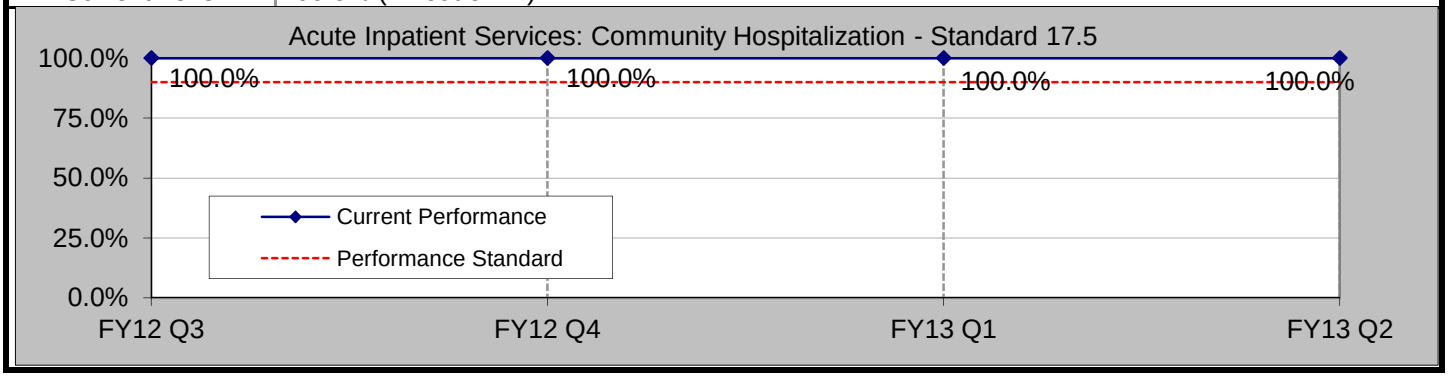


Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

Standard 17.4a	
Measurement	Corrective action taken by UR nurse where documentation showed patients' rights not maintained.
Standard	Performance: 90% Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (1 of 1)



Standard 17.5	
Measurement	Class member involuntary admissions for which medical necessity has been established.
Standard	Performance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (14 out of 14)



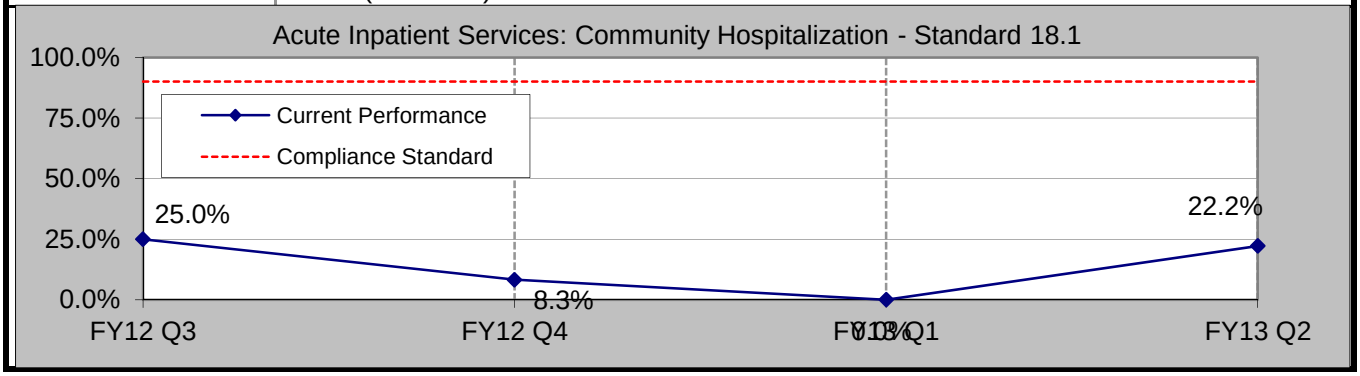
Discussion:

Standards 17.1, 17.2, 17.3, 17.4, 17.4a, and 17.5: Consistently met since the 1st quarter of FY 08

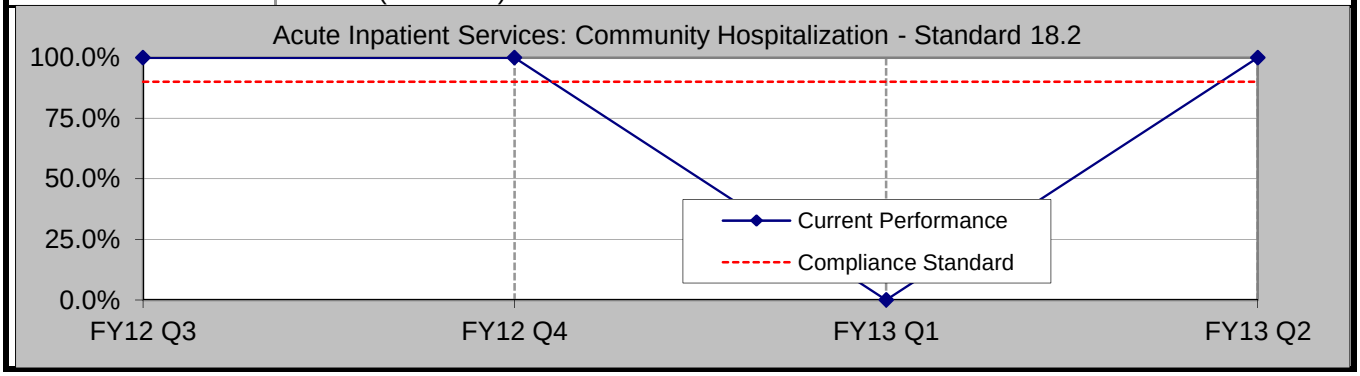
Community Resources and Treatment Services
Acute Inpatient Services: Involuntary Community Hospitalization

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

Standard 18.1	
Measurement	Class members admitted with ISPs for whom hospital obtained ISP.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	22.2% (2 out of 9)

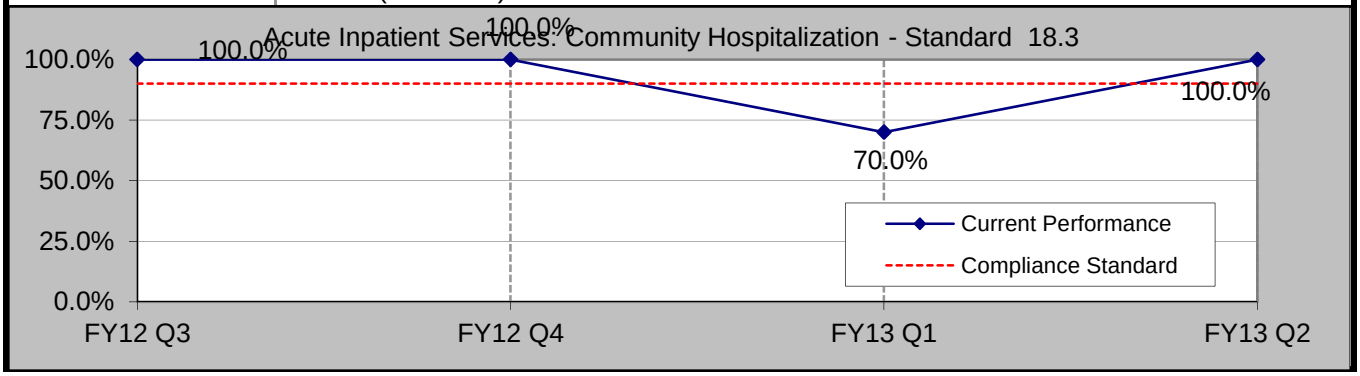


Standard 18.2	
Measurement	Treatment and discharge plan were determined to be consistent with ISP goals and objectives.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (2 out of 2)



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

Standard 18.3	
Measurement	CI/ICI/ICM/ACT worker participated in hospital treatment and discharge planning.
Standard	Compliance: 90%
Data Source	UR Database/EIS
Current Level	100.0% (9 out of 9)



Discussion

OAMHS staff have met with Quality Improvement Director Jay Yoe.

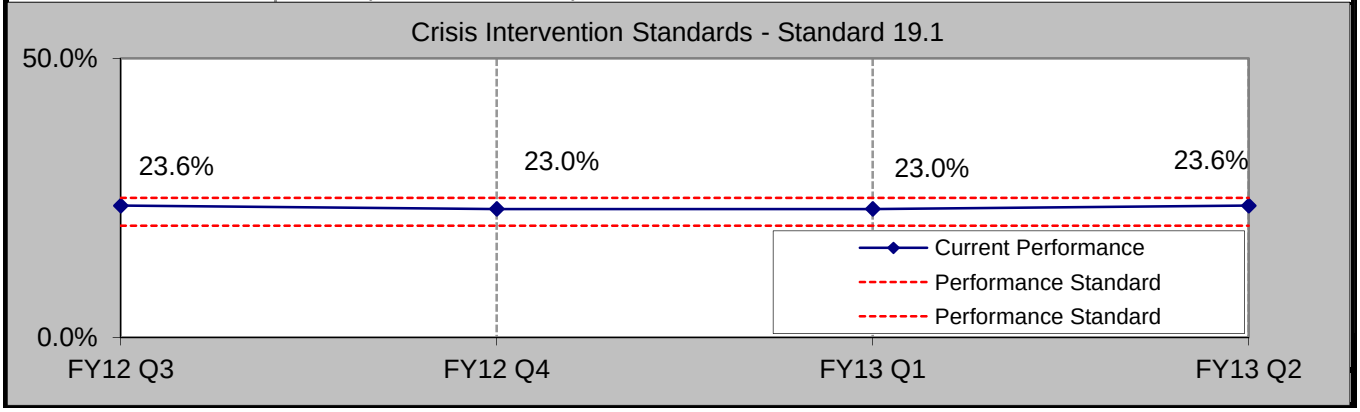
standards 17.1, 17.2, 17.2a, 17.3, 17.3a, 17.4, 17.4a, 17.5, 19.1, 18.2, and 18.3 do not have statistically significant data

Standards 18.1, 18.2, and 18.3: Each quarter, hospital specific data regarding these standards is posted online and CSNs notified of their availability. Numbers for each standard are very small making it difficult to draw definitive conclusions. Worker participation has been higher than the hospital actually receiving the ISP.

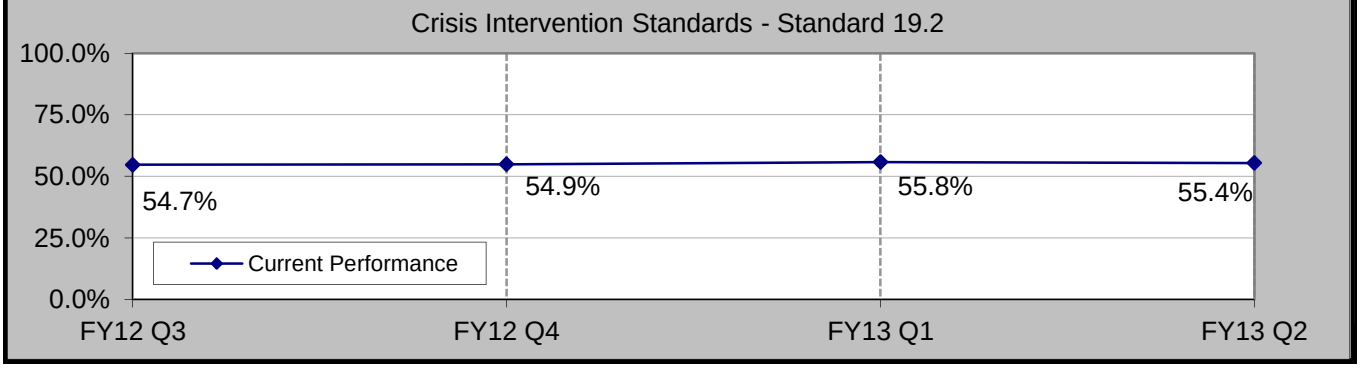
Community Resources and Treatment Services
Crisis Intervention Services

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

Standard 19.1	
Measurement	Face to face crisis contacts that result in hospitalizations.
Standard	Performance: No more than 20 - 25% are hospitalized as result of crisis intervention.
Data Source	Quarterly Contract Performance Data
Current Level	23.6% (1033 out of 4689)



Standard 19.2	
Measurement	Face to face crisis contacts that result in follow-up and/or referral to community based services.
Standard	To Be Established
Data Source	Quarterly Contract Performance Data
Current Level	55.4% (2615 out of 4689)



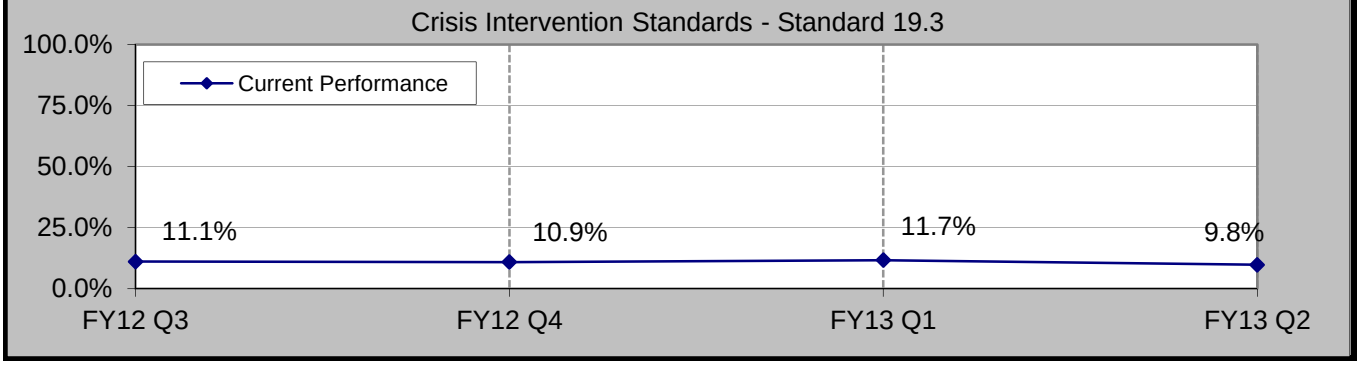
Comment:

Standard 19.1: This is a performance measure in the FY 13 contracts

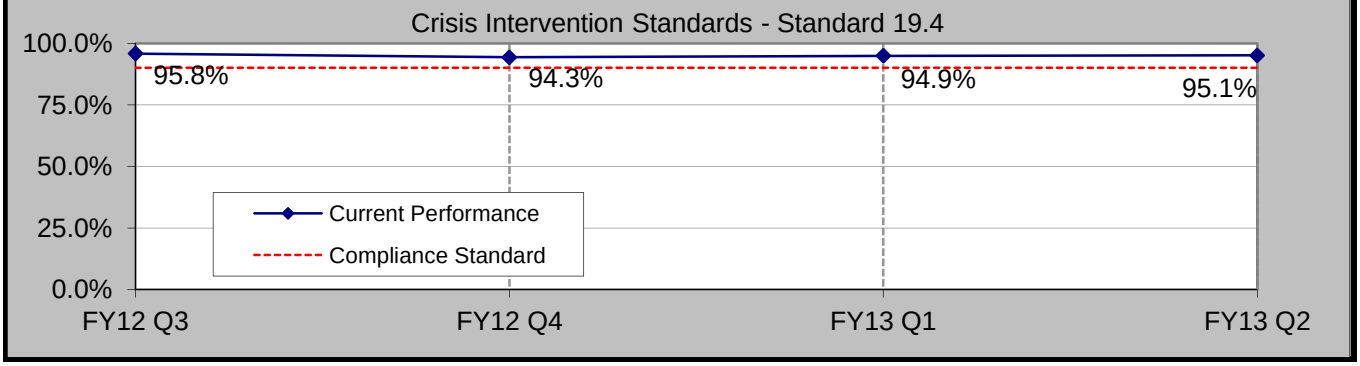
Standard 19.2: Continue to monitor.

Community Resources and Treatment Services
Crisis Intervention Services

Standard 19.3	
Measurement	Face to face crisis contacts in which a previously developed crisis plan was available and used.
Standard	To Be Established
Data Source	Quarterly Contract Performance Data
Current Level	9.8% (432 out of 4386)



Standard 19.4	
Measurement	Face to face crisis contacts in which client has a CI worker and worker was notified about the crisis.
Standard	Compliance: 90% (3 out of 4 quarters)
Data Source	Quarterly Contract Performance Data
Current Level	95.1% (1096 out of 1152)



Discussion:

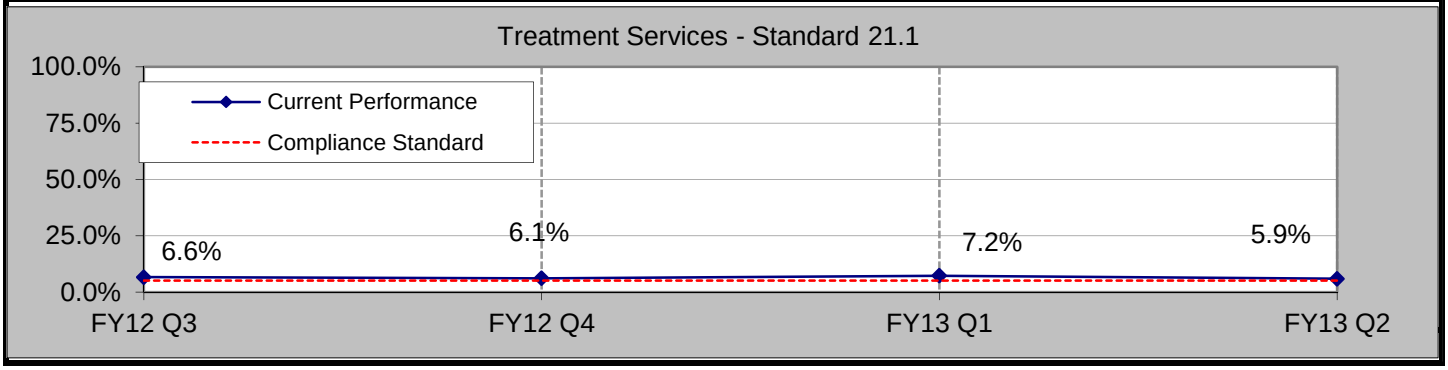
Standard 19.3: Continue to monitor.

Standard 19.4: Met since for FY' 09.

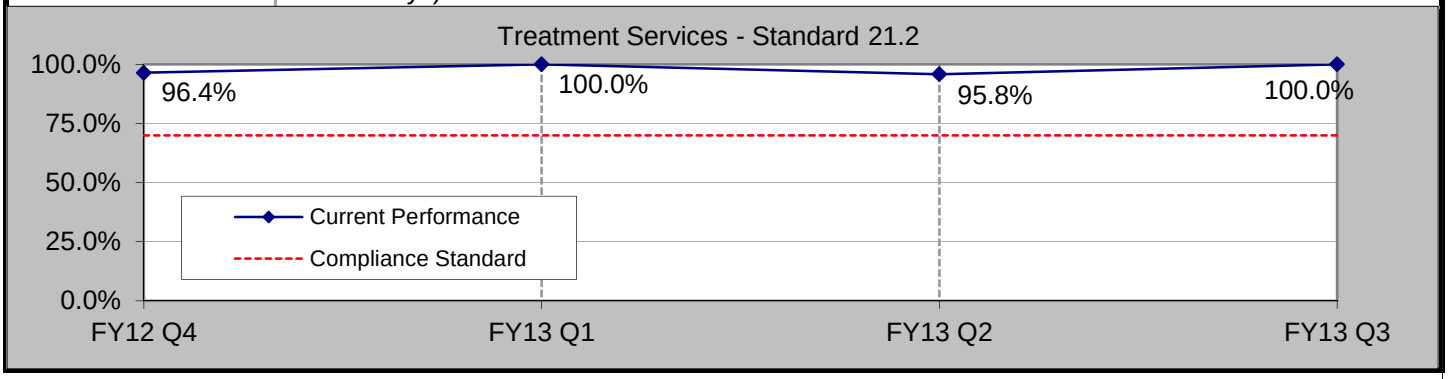
Community Resources and Treatment Services
Treatment Services

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

Standard 21.1	
Measurement	Class members with ISPs with unmet mental health treatment needs
Standard	Compliance: 5% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	5.9% (67 out of 1135)

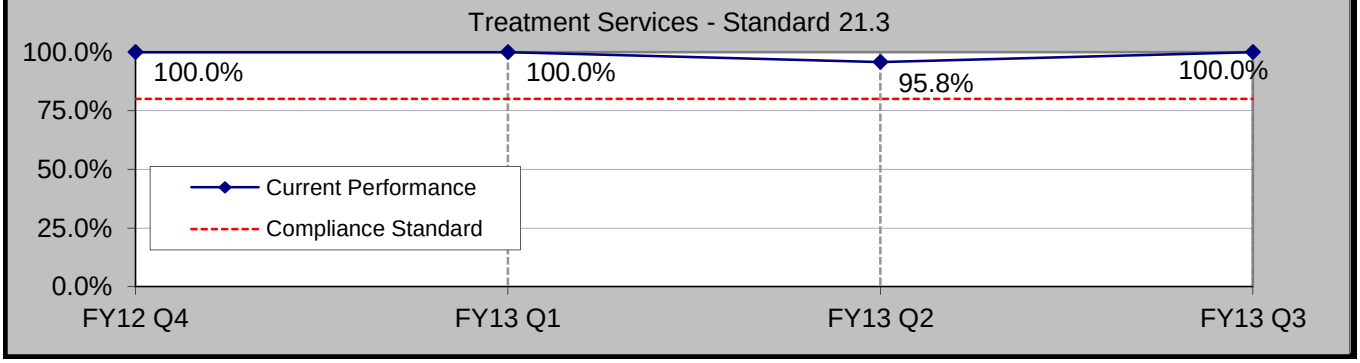


Standard 21.2	
been met every quart	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 7 days of that determination
Standard	Performance: 75% (within 7 days of that determination)
	Compliance: 70% (within 7 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY13 Q3 (Lack of mental health treatment did not impede discharge for any patients within 7 days)

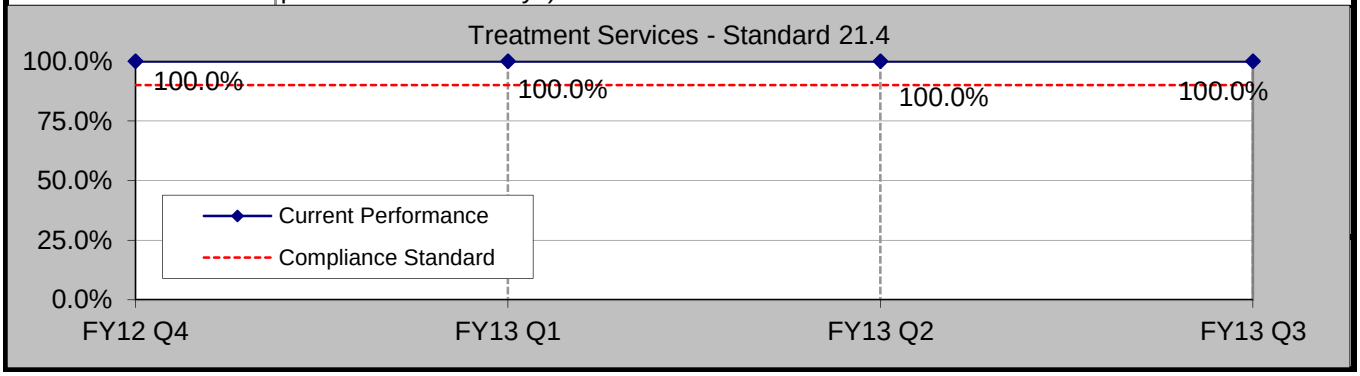


Community Resources and Treatment Services
Treatment Services

Standard 21.3	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 30 days of that determination
Standard	Performance: 96% (within 30 days of that determination) Compliance: 80% (within 30 days of that determination)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY13 Q3 (Lack of mental health treatment did not impede discharge for any patients within 30 days)



Standard 21.4	
Measurement	Percentage of patients at Riverview determined to be ready for discharge who are discharged within 45 days of that determination
Standard	Performance: 100% (within 45 days of that determination) Compliance: 90% (within 45 days of that determination with certain clients excepted by agreement of the parties and the Court Master)
Data Source	Riverview Psychiatric Center Discharge Data
Current Level	100.0% FY13 Q3 (Lack of mental health treatment did not impede discharge for any patients within 45 days)



Discussion:

Standard 21.1: Standard has been met since 2007.

Standards 21.2, 21.3, 21.4: Standard has been met since 2008.

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

22 Civil Patients discharged in quarter

17 discharged at 7 days (77.3%)
2 discharged 8-30 days (9.1%)
1 discharged 31-45 days (4.5%)
2 discharged post 45 days (9.1%)

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

Community Resources and Treatment Services
Treatment Services

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

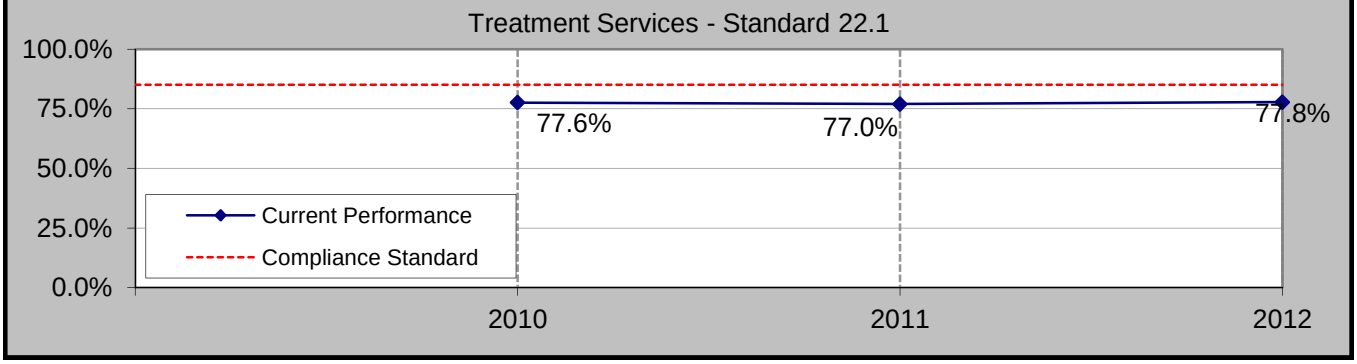
MaineCare Data FY 2012			
Mental Health Treatment Services Received	**Total Number**	**Total Number of Class Members**	**Percent of Class Members**
Assertive Community Treatment	891	306	34.3%
Community Integration	13,647	1,219	8.9%
Communty Rehabilitation	164	64	39.0%
Crisis Services	5,612	567	10.1%
Crisis Residential (CSU)	1,425	194	13.6%
Day Support/Day Treatment	957	117	12.2%
Medication Management	13,337	622	4.7%
Outpatient (Comp Assess&Therapy)	25,067	575	2.3%
Residential	821	366	44.6%
Skills Development	350	39	11.1%
Daily Living Supports	1,596	207	13.0%
***Total Unduplicated Count**	**37,933**	**1,826**	**4.8%**

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

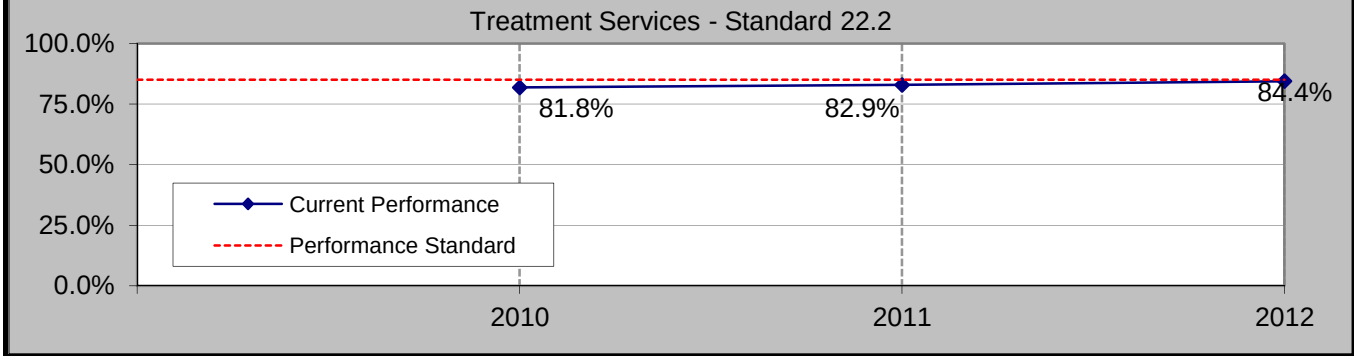
Community Resources and Treatment Services
Treatment Services

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

Standard 22.1	
Measurement	Domain average of positive responses in the Perception of access domain
Standard	Performance: At or above 85%
	Compliance: OAMHS conducts review, takes action if results fall below defined levels.
Data Source	DIG Survey
Current Level	77.8% (N=1320)



Standard 22.2	
Measurement	Domain average of positive responses in the General Satisfaction domain
Standard	Performance: at or above 85%
Data Source	DIG Survey
Current Level	84.4% (N=1344)



Comment:

Standard 22.1 and 22.2: SAMHS has reached out to the Consumer Counsel of Maine for feedback and discussion on ways we can work with providers to improve.

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 class: Q2 FY 13

Standard 23.2	
Measurement	Number and distribution of family support services provided
Standard	No standard necessary
Data Source	NAMI
Current Level	15 family support groups, 16 sites: Q2 FY 13

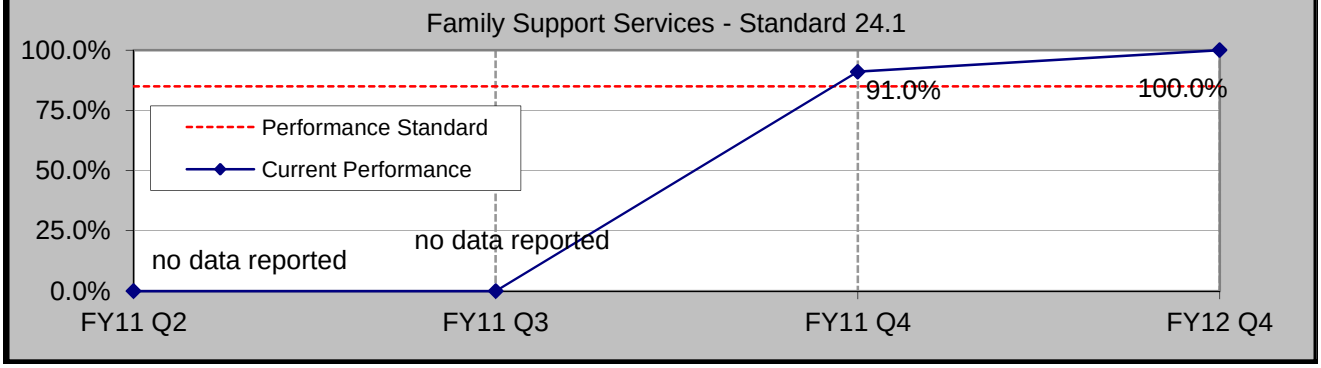
Note: Contracted agencies are allowed one month after the end of the quarter to submit performance indicator data.

Standard has been met every quarter since 2007

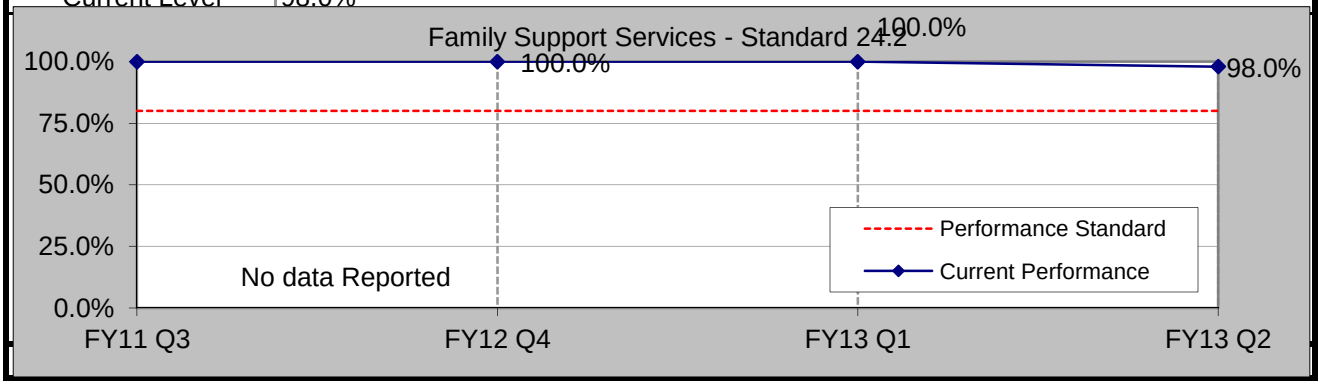
Community Resources and Treatment Services
Family Support Services

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

Standard 24.1	
Measurement	Percentage of support group and group counseling participants reporting satisfaction with services.
Standard	Performance: 85%
Data Source	NAMI
Current Level	100.0%



Standard 24.2	
Measurement	Percentage of program participants reporting satisfaction with education programs.
Standard	Performance: 80%
Data Source	NAMI
Current Level	98.0%



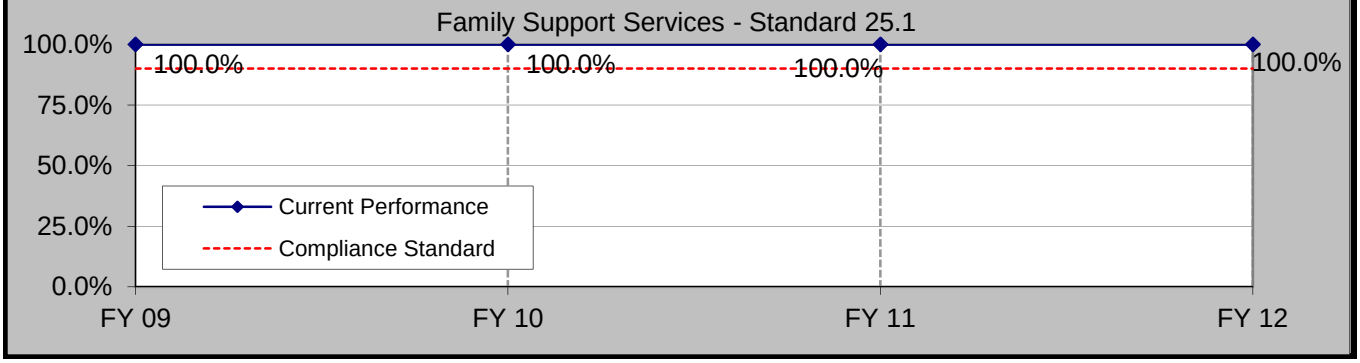
Discussion:

Standards 24.1 and 24.2: Data is now collected annually.

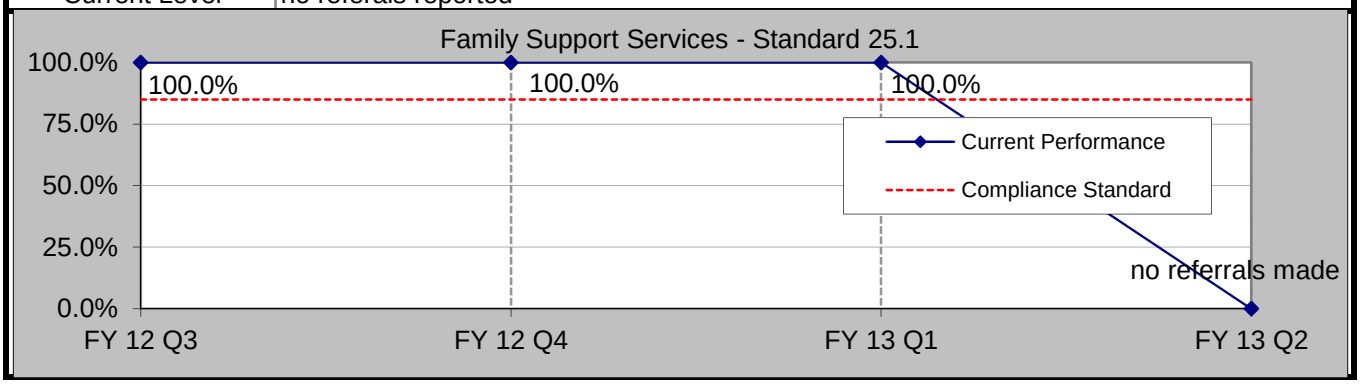
Community Resources and Treatment Services
Family Support Services

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

Standard 25.1	
Measurement	Agency contracts reviewed with documented evidence of referral mechanism to family support services.
Standard	Compliance: 90%
Data Source	Contract Reviews
Current Level	100.0%



Standard 25.2	
Measurement	Families receiving referrals for family support services reporting satisfaction with referral process.
Standard	Performance: 85%
Data Source	NAMI
Current Level	no referals reported



Comment:

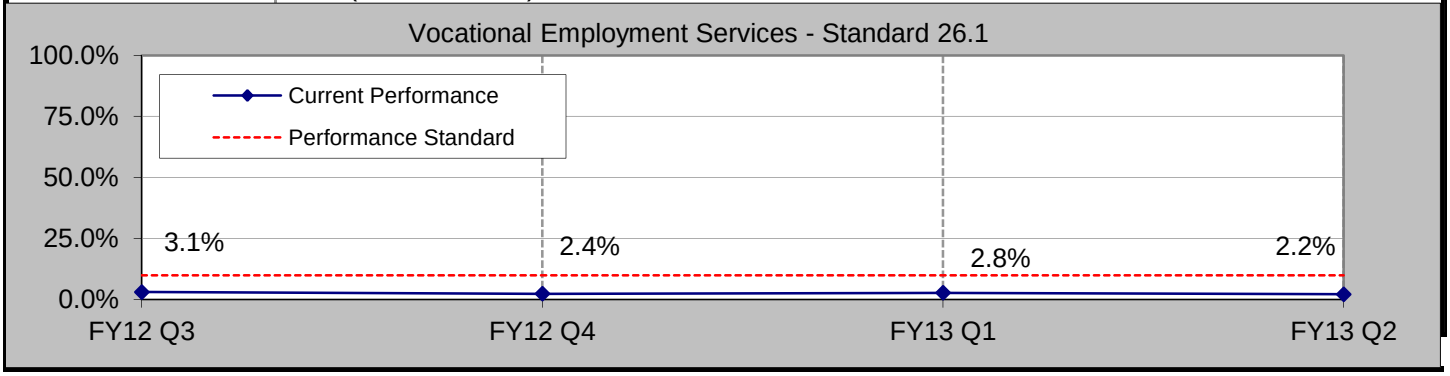
Standard 25.1: Standard met since 2007.

Standard 5.2: Consistently met when referrals have been made.

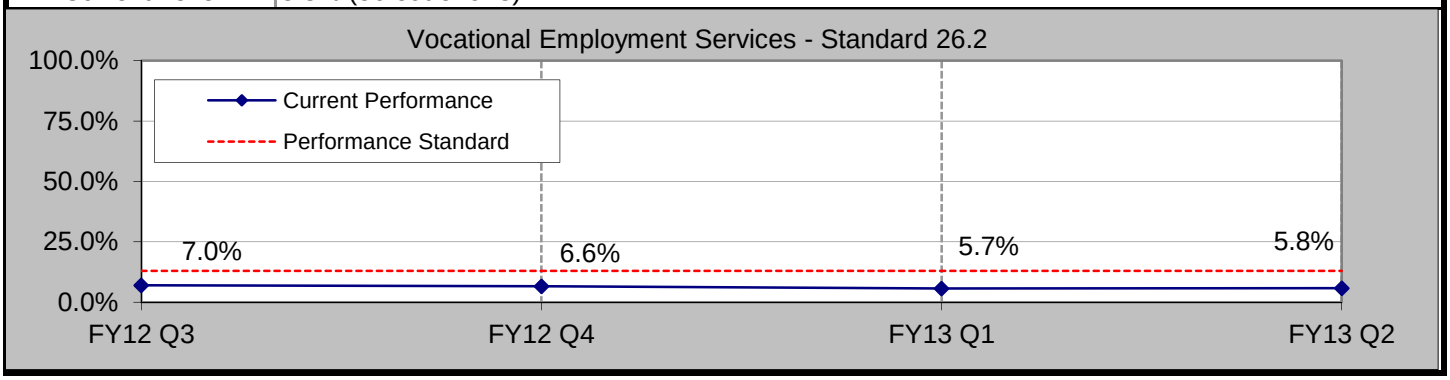
Community Resources and Treatment Services
Vocational Employment Services

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

Standard 26.1	
Measurement	Class members with ISP identified unmet vocational/employment support needs.
Standard	Performance: 10% or fewer
Data Source	ISP RDS Data
Current Level	2.2% (26 out of 1135)



Standard 26.2	
been met every quart	Class members younger than age 62 in competitive employment in the community.
Standard	Performance: 15% of class members employed in competitive employment. Compliance: 13% or Baseline (10.8%).
Data Source	ISP RDS Data
Current Level	5.8% (56 out of 973)

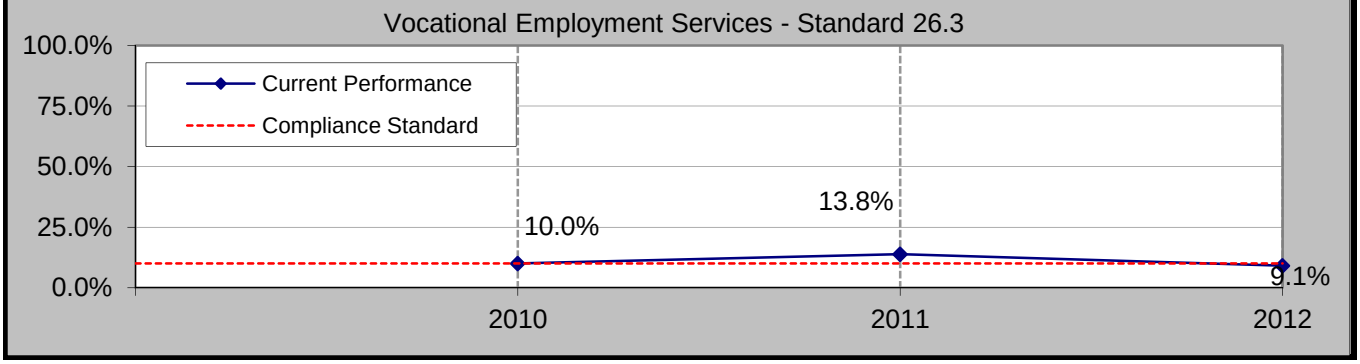


Discussion:

Standard 26.1: Standard continues to be met.

Community Resources and Treatment Services
Vocational Employment Services

Standard 26.3	
Measurement	Consumers under age 62 in supported and competitive employment (part or full time)
Standard	Performance: 15% in either competitive or supported employment Compliance: If number falls below 10%, Department conducts further review and takes appropriate action.
Data Source	DIG Survey
Current Level	9.1% (110 of 1205)



Discussion:

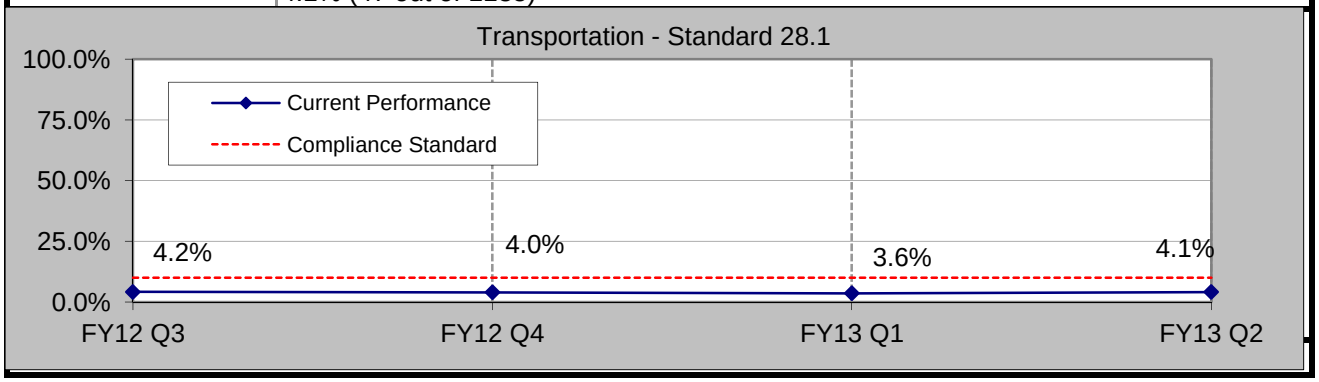
This standard factored out those persons responding to the DIG employment questions who are 62 and older, indicated they were retired or indicated they were not looking for work

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

Community Resources and Treatment Services
Transportation

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

Standard 28.1	
Measurement	Percentage of class members with ISP identified unmet transportation needs.
Standard	Compliance: 10% or fewer (3 out of 4 quarters)
Data Source	ISP RDS Data
Current Level	4.1% (47 out of 1135)



Discussion:

Standard has been met every quarter since 2007.

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	Division of Community Partnerships Data
Current Level	22,412 total visits, 1359unduplicated clients (11 of 13 social clubs/peer centers reporting for FY 13 Q2.)

Standard 30.2	
Measurement	Number of other peer support programs and participation.
Standard	Qualitative evaluation; no numerical standard required.
Data Source	Division of Community Partnerships Data
Current Level	29 Peer Support programs statewide during FY 2013 Q2. (includes social clubs/peer centers): Participation data is not collected for the Statewide Initiatives noted below.

Peer Support Groups funded by DHHS 2013 Q2:

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
Standard I Unlimited Solutions Clubhouse -- Bangor

Statewide:

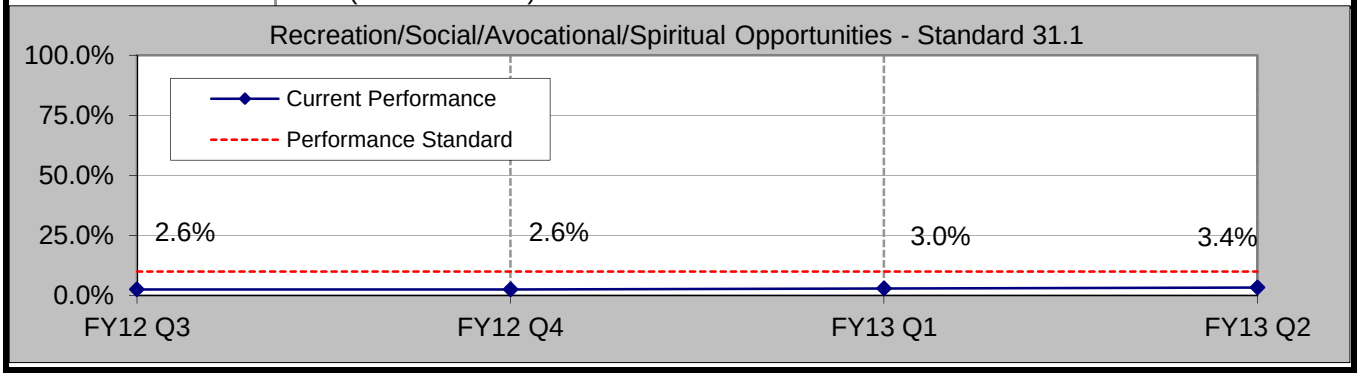
Community Connections: Community based recreational opportunities and leisure planning
MAPSRC (Maine Association of Psychosocial Rehabilitation Centers)

NAMI Support Groups primarily attended by consumers:

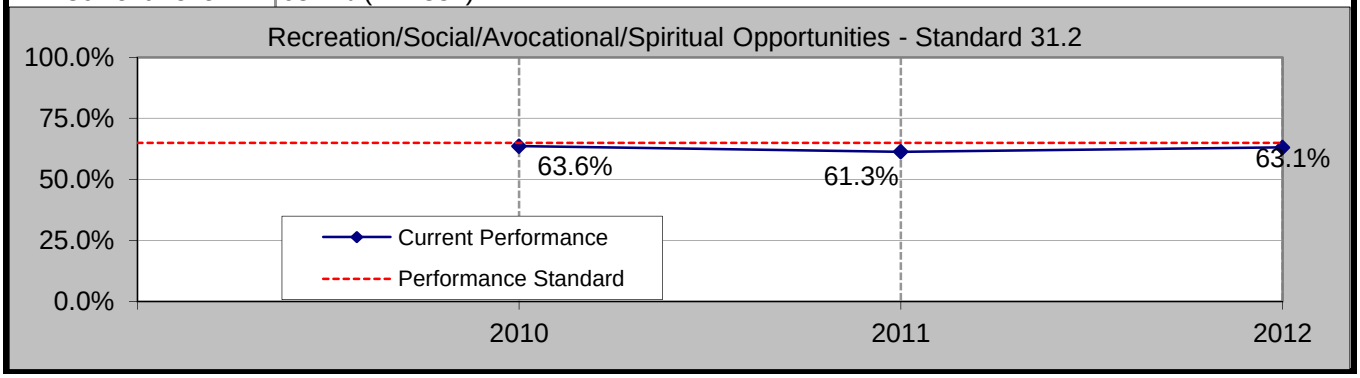
Augusta, Bangor, Biddeford, Damariscotta, Lewiston, Farmington, Rockland, Sanford, Waterville.

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

Standard 31.1	
Measurement	ISP identified class member unmet needs in recreational, social, avocational and spiritual areas.
Standard	Performance: 10% or fewer
Data Source	ISP RDS Data
Current Level	3.4% (39 out of 1135)



Standard 31.2	
Measurement	Domain average of positive responses in the Social Connectedness domain
Standard	Performance: At or above 65%
Data Source	DIG Survey
Current Level	63.1% (N=1332)



Comments:

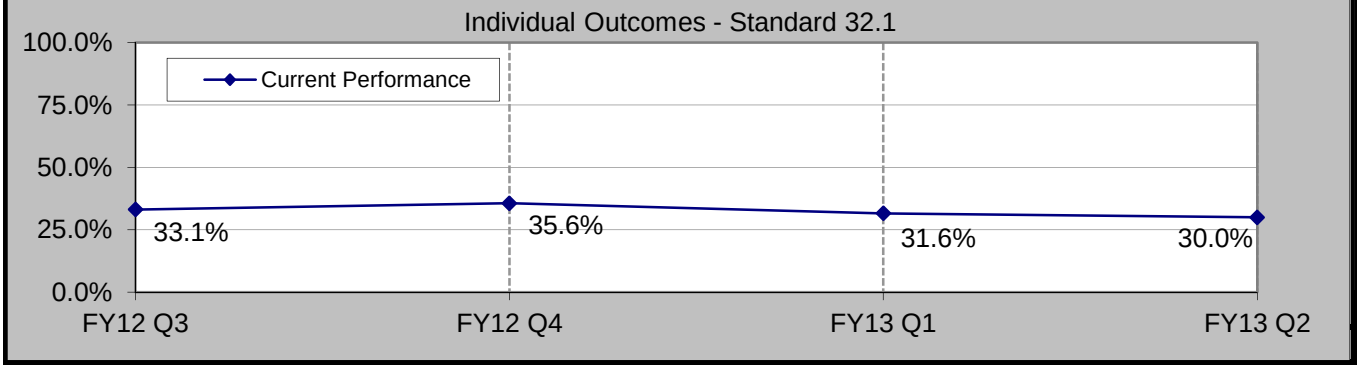
Standard 31.1: Continues to be met.

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

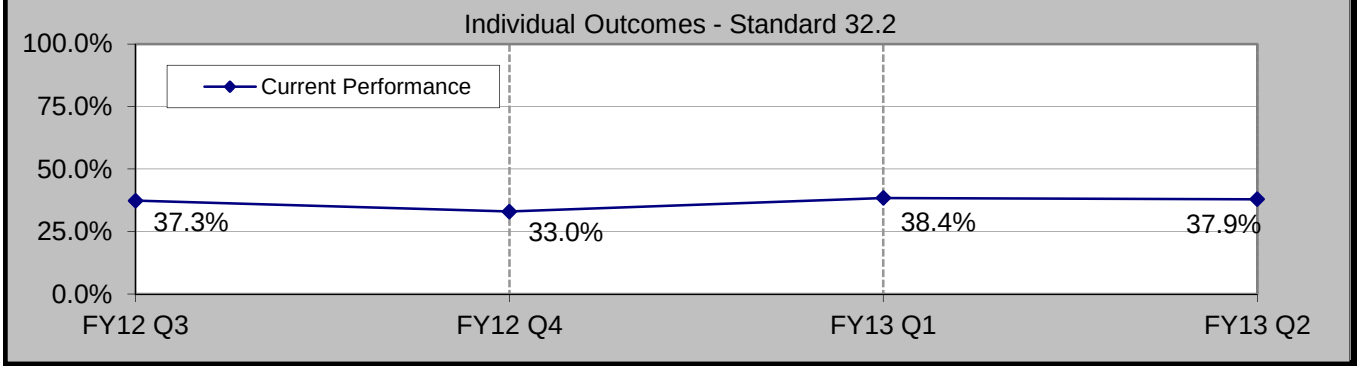
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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

Standard 32.1	
Measurement	Class Members demonstrating functional improvement on LOCUS between baseline and 12 month re-certification
Standard	Standard to be established.
Data Source	Enrollment data (Based on overall composite score.)
Current Level	30.0% (110 out of 367)



Standard 32.2	
s been met every quart	Class Members who have maintained level of functioning between baseline and 12 month re-certification.
Standard	Standard to be established.
Data Source	Enrollment data (Based on overall composite score.)
Current Level	37.9% (139 out of 367)

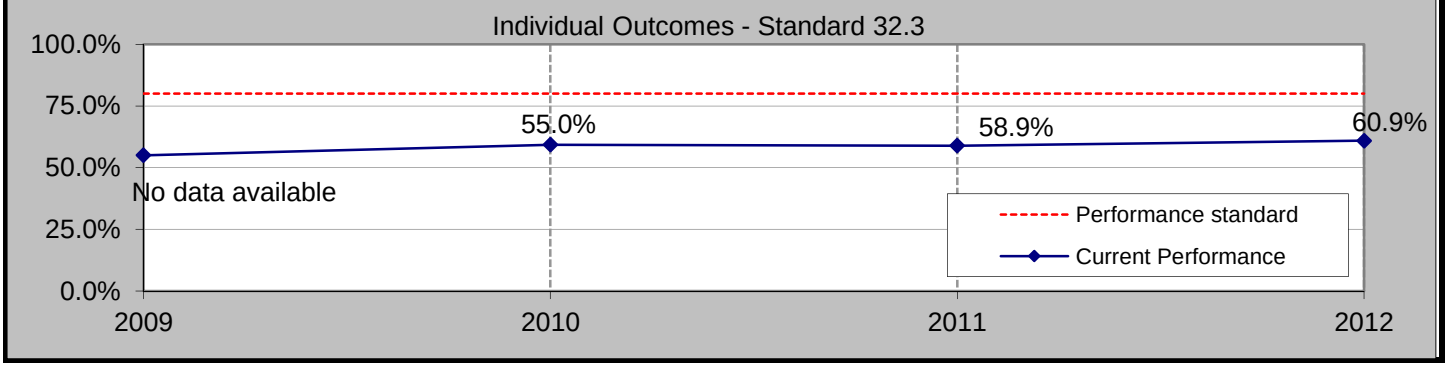


Comment

Standard 32.2: continue to monitor until standard is established.

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

Standard 32.3	
Measurement	Consumers reporting positively on functional outcomes on Data Infrastructure Survey outcome items.
Standard	Performance: 80%
Data Source	Data Infrastructure Grant Survey
Current Level	60.9% (N=1349)



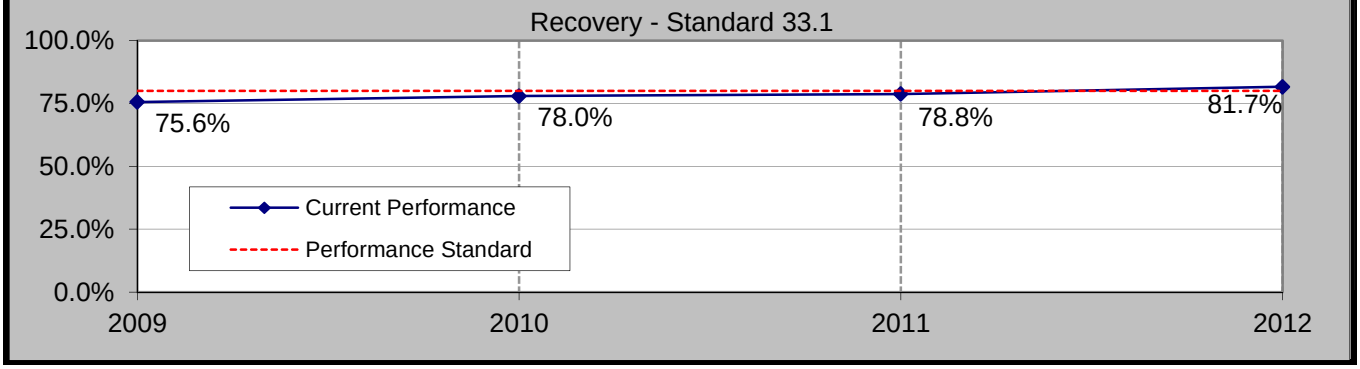
Discussion:

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

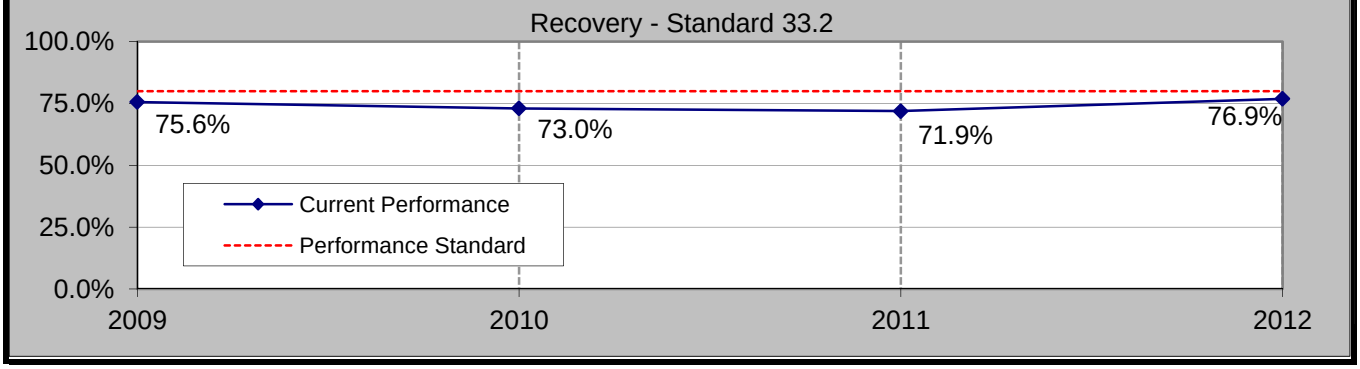
System Outcomes: Supporting the Recovery of Adults with Mental Illness Recovery

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

Standard 33.1	
Measurement	Consumer reporting that agency staff helped them obtain information needed to take charge of managing illness.
Standard	Performance: 80%
Data Source	Data Infrastructure Grant Survey, Q20
Current Level	81.7% (N=1180)



Standard 33.2	
Measurement	Consumers reporting that agency staff believe that they can grow, change and recover
Standard	Performance: 80%
Data Source	Data Infrastructure Grant Survey, Q13
Current Level	76.9% (N=1271)

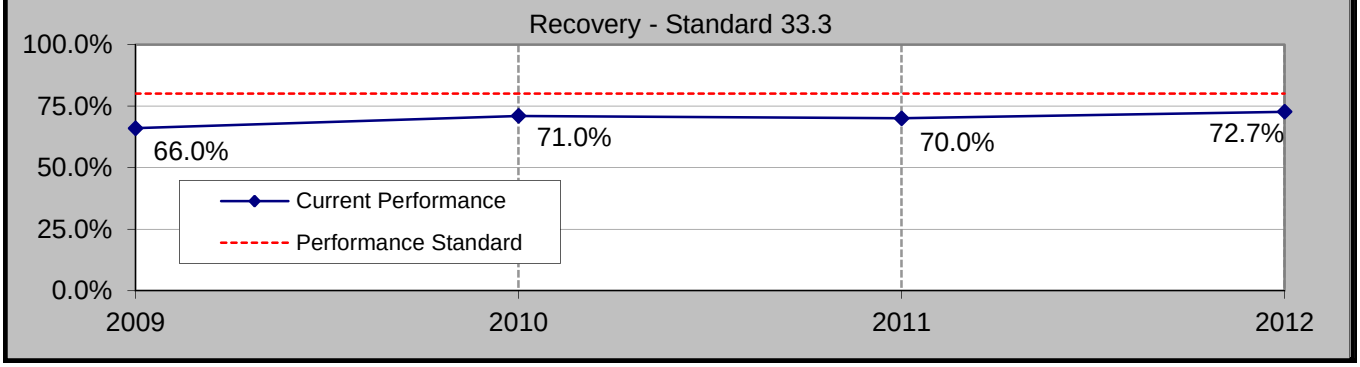


Comment:

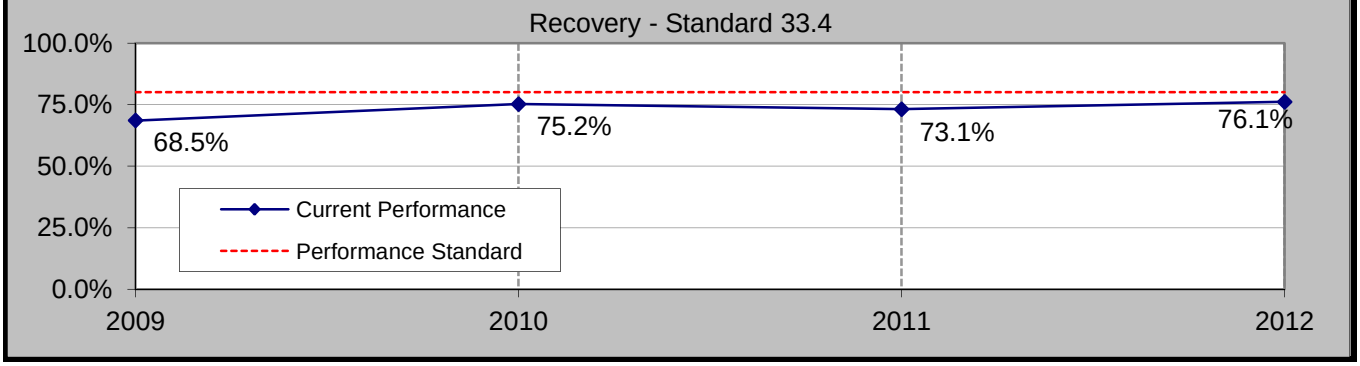
SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

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

Standard 33.3	
Measurement	Consumers reporting that agency services and staff supported their recovery and wellness efforts and beliefs.
Standard	Performance: 80%
Data Source	Data Infrastructure Grant Survey, Q15
Current Level	72.7% (N=1307)



Standard 33.4	
Measurement	Consumers reporting that providers offered opportunities to learn skills to strengthen and maintain wellness.
Standard	Performance: 80%
Data Source	Data Infrastructure Grant Survey, Q16
Current Level	76.1% (N=1292)

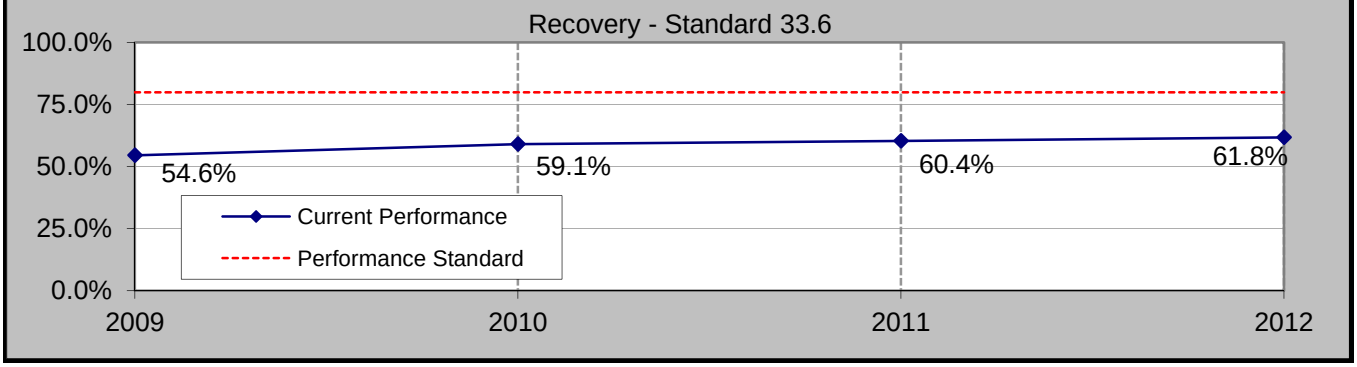


Comment:

Standard 33.3 and 33.4: SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

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

Standard 33.6	
Measurement	Consumers reporting that service providers offered mutual support or recovery-oriented groups run by peers.
Standard	Performance: 80%
Source	Data Infrastructure Grant Survey, Q17
Current Level	61.8% (N=1134)



Comments:

SAMHS has contacted the Executive Director of the Consumer Council of Maine for feedback and discussion on ways we can work with providers to improve services.

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

Standard 34 - Variety of public education programs on mental health and illness topics.

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	
Current Level	24 FY 13 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	
Current Level	191 FY 13 Q2

Standard has been met every quarter since 2007

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

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

Consent Decree Performance and Quality Improvement Standard 5

Report for: 2013 Q2
(October, November, December 2012)
(Class Members)

Measurement			
Method 1	Percent of class members requesting a worker who were assigned one.		
	2012 Q3	98.1%	(109 of 111)
	2012 Q4	98.3%	(113 of 115)
	2013 Q1	99.1%	(115 of 116)
	2013 Q2	98.2%	(108 of 110)
Method 2	Percent of hospitalized class members who were assigned a worker within 2 days.		
	2012 Q3	50.0%	(9 of 18)
	2012 Q4	41.7%	(5 of 12)
	2013 Q1	66.7%	(4 of 6)
	2013 Q2	14.3%	(1 of 7)
Method 3	Percent of non-hospitalized class members assigned a worker within 3 days.		
	2012 Q3	70.3%	(64 of 91)
	2012 Q4	74.3%	(75 of 101)
	2013 Q1	69.8%	(67 of 96)
	2013 Q2	68.8%	(64 of 93)
Method 4	Percent of class members in hospital or community not assigned on time but were assigned within 1-7 additional days.		
	2012 Q3	41.7%	(15 of 36)
	2012 Q4	36.4%	(12 of 33)
	2013 Q1	29.0%	(9 of 31)
	2013 Q2	42.9%	(15 of 35)
Method 5	ISP completed within 30 days of service request.		
	2012 Q3	100.0%	(75 of 75)
	2012 Q4	100.0%	(82 of 82)
	2013 Q1	100.0%	(73 of 73)
	2013 Q2	100.0%	(84 of 84)
Method 6	90 Day ISP review completed within specified timeframe.		
	2012 Q3	69.3%	(749 of 1,081)
	2012 Q4	72.5%	(780 of 1,076)
	2013 Q1	69.0%	(725 of 1,050)
	2013 Q2	70.6%	(698 of 989)
Method 7	Initial ISPs not developed within 30 days, but were developed within 60 days.		
	2012 Q3	N/A	(0 of 0)
	2012 Q4	N/A	(0 of 0)
	2013 Q1	N/A	(0 of 0)
	2013 Q2	N/A	(0 of 0)
Method 8	ISPs that were not reviewed within 90 days, but were reviewed within 120 days.		
	2012 Q3	81.0%	(269 of 332)
	2012 Q4	83.4%	(247 of 296)
	2013 Q1	84.3%	(274 of 326)
	2013 Q2	81.8%	(238 of 291)

As of: Apr 16, 2013 Run By:
Brandi.Giguere
Starting with Fiscal Year 2008, Quarter 1 (July, August, September 2008) all calculations are based on 'working days' to time of assignment.
Method 4 percentages were updated FY12 Q4 to reflect a calculation error in the previous quarter

Public Education- Standard 34

Jan - March 2013 (See Note Below)

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 Oct - Dec 2012

**Psychiatric & Forensic Grand Rounds, and Lunch and Learn, are open to the public and advertised by use of stakeholder email distribution lists.

Measure Method One:

Date & Location of Public Education Program	Audience: Public Service Agency	Audience: RPC and/or DDPC staff	Audience: Community Members	Audience: Other (Please Specify)	Total # of Participants	Topic: Addressing Myths & Stigma	Topic: Promoting Community Integration	Topic: Rights of MH Consumers and/or their Families	Topic: Other (Please Specify)	Total # Presentations/ # Participants This Quarter
02/22/13-Acadia Bangor	x		x		24	x	x	x	Eating Disorders: An Update	**24/ 380**
03/08/13-Acadia Bangor	x		x		28	x	x	x	Invisible Wounds of War	
03/22/13-Acadia Bangor	x		x		40	x	x	x	Trauma Informed CBT	
1/8/13-RPC Augusta		x	x		11				PGR: Neuroscience of Major Depressive Disorder: Focus on Anhedonia	
1/15/13- RPC Augusta		x	x		13				PGR: The Risk of Menopausal Depression Based on Estrogen Exposure	
1/22/13 - RPC Augusta		x	x		5				PGR: Spirituality and Mental Health Research	
1/29/13- RPC Augusta		x	x		12				PGR: Effects of Collision Sports on the Brain	

2/12/13- RPC Augusta		x	x		11				PGR:Improving Integrated Care for Complex Patients with Physical and Mental Illness	
3/12/13 - RPC Augusta		x	x		9				PGR: Using a Tele-health Device to Improve Psychiatric Illness Management: Results of a Pilot Study Project	
3/26/13-RPC Augusta		x	x		10				PGR: Using Mobile Technologies in the Assessment and Treatment of Serious Mental Illness	
1/14/13 Lewiston	x		x	Consumers	16	x	x	x	Peer Support 101	
1/23/13 Biddeford	x		x	Consumers	12	x	x	x	Peer Support 101	
1/25/13 Augusta	x		x	Consumers	4	x	x	x	Peer Support 101	
1/29/13 Augusta			x	Consumers	11	x		x	Crisis & Intentional Peer Support	
2/4/13 Portland	x		x	Consumers	17	x	x	x	Peer Support 101	
2/11/13 Augusta	x		x	Consumers	5	x	x	x	Peer Support 101	
2/22/13 Bangor	x		x	Consumers	10	x	x	x	Peer Support 101	
3/4/13 Augusta			x	Consumers	16		x	x	Self-Care	
3/13/13 Augusta			x	Consumers	12	x	x	x	Peer Support Fidelity	
3/28/13 Augusta			x	Consumers	17	x	x	x	CIPSS Training	
10/22/12-10/26/12 Kennebec County Sheriff's Office	x			Law Enforcement	10	x	x	x	40 hour CIT training	
11/5/12 - 11/9/12 Warren Maine State Prison	x			Law Enforcement	15	x	x	x	40 hour CIT training	

11/15/12 Vassalboro Me Crim Just Acad	x			Law Enforcement	60	x	x	x	8 hour CIT training	
12/3/12 - 12/7/12 Sanford PD	x			Law Enforcement	12	x	x	x	40 hour CIT training	

Public Education- Standard 34
Jan - March 2013 (See note below)
Measure Method Two:

Note: Contracted agencies are allowed 1 month after the quarter to submit performance indicator data.
As a result, NAMI Maine is submitting performance indicator data for Oct - Dec 2012

TOPIC of Info Packet,etc. Distributed to Public Audiences	TYPE of Info Packet, Publication, Press Release, etc. (Please Specify) Distributed to Public Audiences	TOTAL # Info Packets, Publications,etc Distributed This Quarter
		191
Peer Support	Brochures, Articles	
PGR: The Neuroscience of Major Depressive Disorder: Focus on Anhedonia	Attendance & Eval form	
PGR: The Risk of Menopausal Depression Based on Estrogen Exposure During the Reproductive Years	Attendance & Eval form	
PGR: Spirituality and Mental Health Research: Implications for Patient Care	Attendance & Eval form	
PGR: Effects of Collision Sports on the Brain: Should Everyone Worry?	Attendance & Eval form	
PGR:Improving Integrated Care for Complex Patients with Physical and Mental Illness	Attendance & Eval form	
PGR: Using a Tele-health Device to Improve Psychiatric Illness Management: Results of a Pilot Study Project	Attendance & Eval form	
PGR: Using Mobile Technologies in the Assessment and Treatment of Serious Mental Illness	Attendance & Eval form	

Family Support Services- Standard 23-25

Jan - March 2013 (see note below)

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 Oct - Dec 2012

Total # Presentations/ #Participants This Quarter	*% Families Referred to FSS from MH Agencies w/Referral Process This Quarter*	*Educ on terms of Settlement Agreement*	*Educ on services, MI from varying perspectives*	*Educ on tx, meds, dx, prog, care*	*Family Group Meeting Facilitator*	*Group Counseling*	*Psycho-educational Programs*	*Respite Services (# of days)*	*Other (Please Specify)*
Three Family to Family classes with 27 participants. Fifteen Family and Combined Support Groups with 704 people attending. Seven veterans groups with 67 people attending. All group locations: Augusta, Bangor, Dover-Foxcroft, Ellsworth, Machias, Norway, Old Orchard Beach, Portland, Raymond, Rockport, Rumford, Sanford, South Paris, Skowhegan, Waterville, York	n/a-no referrals reported	x	x	x	x	x	x	2946 hours to 363 families	

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.

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 2013

Attached Report:

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Quarter 2 (October, November, December 2012)

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 algorithm of needs:

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

New Quality Improvement Initiatives This Quarter

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 team is meeting weekly to review information, receive feedback from team members and refine the work with staff within each of the four pillars of SAMHS services. 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. Anticipated completion date for the draft is September 2013.
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 CY2006 to the present to determine patterns of compliance with the standards. After the data are analyzed, the workgroup will make recommendations to Commissioner Mayhew and Director Cousins on levels of compliance and strategies to address unmet needs.
Identified Need: A,B,C,D,E,F,G,H,I,J,K,L,M

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

Ongoing Quality Improvement Initiatives

NIATx Quality Improvement Initiative. NIATx has been deployed in six provider agencies to address wait list and time to assignment issues in provider agencies. SAMHS has contracted with a NIATx trainer who is providing provide 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. It is anticipated that in FY14, the number of agencies using NIATx will be expanded.
Identified Need: A,B

Wait List Graphs. On a weekly basis, the Data/Management staff update 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. This report is sent to management and field service staff to monitor trends in services over the past six months.
Identified Need: A

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 are being tested in FY13. A review of the process will occur in early FY14 to determine which data to include for expansion of this initiative to all SAMHS contractors.

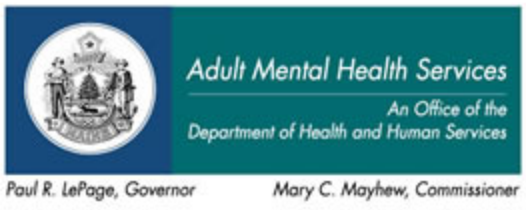
Identified Need: A, B, D, E, I, J, L

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 is overseeing and organizing the review process and will collect our data to generate a summary report. This review has been pushed back to FY14.
Identified Need: B

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

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

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 annually.
Identified Need: E, H, K

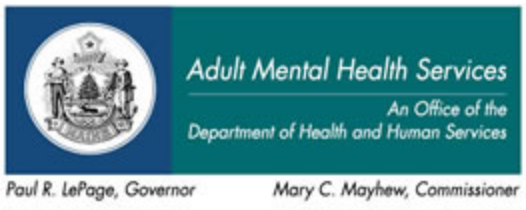


'Other' Unmet Resource Needs

Other Resources

For RDS Between Oct 1, 2012 and Dec 31, 2012

Peo_ID	RDS Date	Description	Date IDed	Days Unmet
ALLIES INC				
200910	11/10/2012	FOOD PANTRY	2/29/2012	255
247209	11/20/2012	HANDICAP ACCESSIBLE HOUSING	7/7/2012	136
191254	10/11/2012	APPROPRIATE SIGN LANGUAGE CLASS	7/14/2011	455
ALTERNATIVE SERVICES NE INC				
166279	12/8/2012	TRANSPORTATION TO NON MAINE CARE APPOINTMENTS	4/10/2012	242
213344	11/15/2012	IN HOME SUPPORTS	4/16/2010	944
167539	11/2/2012	NATURAL SUPPORTS WITHIN CURRENT COMMUNITY/HOME	4/20/2012	196
171301	12/20/2012	HOME REPAIR/ CLEANING	7/15/2012	158
AROOSTOOK MENTAL HEALTH SERVICES, INC.				
198275	12/15/2012	NURSING CARE	10/4/2011	438
341302	12/11/2012	ASSERTIVENESS TRAINING	1/25/2012	321
132809	11/30/2012	MR SERVICES	7/1/2012	152
329796	10/24/2012	HOME REPAIR	5/8/2012	162
244094	12/18/2012	IN-HOME HELP	7/1/2011	536
219481	12/1/2012	LINKAGE TO COMMUNITY - SUPPORT WITH CONNECTING W/OTHERS	7/5/2012	149
ASSISTANCE PLUS				
225260	12/4/2012	MAINE CARE HEALTH INSURANCE	3/8/2012	271
223018	12/24/2012	COORDINATION OF SERVICES	3/26/2012	273
131855	10/7/2012	AGENCY FOR THE BLIND	1/12/2012	269
166398	11/2/2012	MAKING A WILL	4/4/2012	212
BROADREACH FAMILY AND COMMUNITY SERVICES				
358125	11/8/2012	PSYCHOLOGICAL EVALUATION	6/28/2012	133
236579	12/5/2012	NEUROPSY EVALUATION	4/12/2012	237
CATHOLIC CHARITIES				
145766	11/8/2012	APARTEMENT THAT ACCEPTS BRAP	7/18/2012	113
355285	10/18/2012	PERSONAL CARE SERVICES	6/29/2012	111
341343	11/8/2012	CHILD CARE	1/13/2012	300
273888	11/13/2012	FURNITURE	8/27/2010	809
257417	10/23/2012	CHILD CARE FOR YOUNGEST CHLILD TO MAINTAIN MENTAL HEALTH APPOINTMENTS	10/27/2010	727
247861	10/15/2012	AQUIRED BRAIN INJURY SERVICES	10/21/2011	360
219410	11/26/2012	LEGAL	2/25/2011	640



'Other' Unmet Resource Needs

Other Resources

For RDS Between Oct 1, 2012 and Dec 31, 2012

Peo_ID	RDS Date	Description	Date IDed	Days Unmet
214936	10/17/2012	SKILLS TO COPE W/ HEIGHTEND ANXIETY AND PANIC ON HER OWN OR WITH OTHER SUPPORTS BESIDES CASE MGMT.	10/14/2011	369
207313	12/11/2012	HOMEMAKER SERVICES	8/27/2012	106
200480	10/27/2012	LIVING SKILLS RES	10/12/2007	1,842
158704	12/5/2012	FURNITURE, APPLIANCES	3/6/2012	274
151073	10/17/2012	SKILLS TO CONSISTENTLY SET APPROPRIATE BOUNDRIES W/ OTHERS.	10/14/2011	357
146409	12/19/2012	MOTORIZXED SCOOTER	6/1/2012	130

CHARLOTTE WHITE CENTER

257551	12/21/2012	ANGER MANAGMENT GROUP	9/21/2012	91

COMMON TIES MENTAL HEALTH COALITION

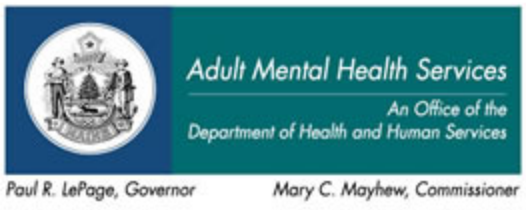
337494	12/5/2012	COMMUNITY RESOURCES FOR NEW BABY	12/27/2011	344
229755	10/24/2012	RENTAL DEPOSIT RETURNED	5/8/2012	169
198721	10/9/2012	SUPPORTS FOR ELDERLY MOTHER BEYOND CLIENTS ABILITIES	11/13/2009	1,061
332119	12/15/2012	GET DRIVERS LICENSE	10/4/2011	372
167227	10/17/2012	DRIVING PERMIT	2/9/2012	251
124671	11/15/2012	DRIVERS LICENSE	10/18/2011	394
233712	12/31/2012	PRIMARY RESIDENCE OF SON, MOVING TO SOUTH PORTLAND	2/1/2012	334
312617	10/22/2012	VOLUNTEER	2/7/2012	258
354718	11/28/2012	BUGETING FOOD STAMPS FOR HEALTHY FOOD PURCHASES AND MEAL PLANNING	6/12/2012	169
256135	10/31/2012	HOMEMAKING SERVICES	6/19/2009	1,230
253830	12/5/2012	FIND APARTMENT	12/27/2011	344
336590	10/17/2012	VOLUNTEER OPPORTUNITIES	12/7/2011	315

COMMUNITY CARE

202017	11/28/2012	LONG-TERM MAINECARE FOR ASSISTED LIVING FACILITY	4/2/2012	240

COMMUNITY COUNSELING CENTER

227837	10/26/2012	INDEPENDENT APARTMENT	7/27/2012	91
213354	12/3/2012	PROBATION	11/15/2010	749
205219	12/14/2012	INDEPENENT HOUSING	8/16/2012	120
202204	11/6/2012	HEAD INJURY TREATMENT AND RESIDENCE THAT ADRESSES HIS LEVEL ON NEED	8/27/2009	1,167
316411	11/21/2012	ACCESSING SERVICES FROM LOCAL GA	5/25/2011	611
326066	12/3/2012	MEALS ON WHEELS	8/2/2012	123
283338	10/17/2012	FOOD RESOURCES	5/5/2011	531
264504	10/9/2012	SSI BENEFITS	4/23/2010	900
262099	11/25/2012	FOOD PANTRY	11/17/2010	739



'Other' Unmet Resource Needs

Other Resources

For RDS Between Oct 1, 2012 and Dec 31, 2012

Peo_ID	RDS Date	Description	Date IDed	Days Unmet
COMMUNITY HEALTH AND COUNSELING SERVICES				
246526	11/18/2012	OBTAIN A VEHICLE	5/22/2012	180
231598	10/1/2012	DOMESTIC VIOLENCE SUPPORT	6/8/2012	115
248464	10/31/2012	ASSISTANCE WITH SECURITY DEPOSIT	4/9/2009	1,301
218961	11/2/2012	DENTURES	4/3/2012	213
216410	11/30/2012	ASSISTANCE WITH SETTING UP TRAILER.	7/30/2012	123
160960	12/14/2012	DHHS CUSTODY ISSUES	8/16/2012	109
206268	12/16/2012	CLEANING SERVICE	10/3/2011	440
358110	12/30/2012	OBTAIN A VEHICLE	7/3/2012	180
354600	11/28/2012	CHILD CARE SERVICES	4/2/2012	213
261687	12/15/2012	RENEWAL OF DRIVERS LICENSE	1/18/2012	332
231869	11/14/2012	ALTERNATE SUBSIDY NON RELIANT ON CIS	1/4/2010	1,045
154943	11/2/2012	GETTING BIRTH CERTIFICATE, STATE ID	9/15/2011	414
257355	11/26/2012	SAFE AND AFFORDABLE HOUSING	3/1/2011	636
COUNSELING SERVICES, INC.				
202199	10/5/2012	WOMANS SUPPORT GROUP	10/5/2011	366
169905	10/26/2012	ASSISTED LIVING FACILITY FOR INDIVIDUALS WITH MENTAL HEALTH ISSUES OTHER THAN ELDERLY	11/3/2011	358
170851	11/1/2012	NEEDS FURNITURE	7/23/2012	101
332167	10/16/2012	DENTURES/IMPLANTS	9/30/2011	397
209092	11/12/2012	COMPLIMENTARY THERAPIES	3/2/2012	255
314656	10/12/2012	FURNITURE FOR APARTMENT	10/31/2011	347
212856	12/6/2012	GREEN CARD	10/8/2009	1,155
331997	10/5/2012	GROUP HOME	10/5/2011	366
332525	11/6/2012	CLIENT WANTS A DOG TO INCREASE STABILITY	8/7/2012	91
215054	10/8/2012	HOARDING SUPPORT GROUP	11/11/2011	466
HEALTH AFFILIATES MAINE				
129803	11/20/2012	WANTS DRIVERS LICENSE	8/8/2011	470
133213	12/18/2012	DRIVERS LICENSE	9/14/2011	461
169168	10/30/2012	PORTABLE OXYGEN	7/31/2012	91
173405	12/19/2012	DRIVERS LICENSE, CPR CERTIFICATION.	5/7/2012	192
192777	10/18/2012	ASSISTANCE WITH DV CHARGE	8/4/2011	441
204761	12/2/2012	MANAGING ANXIETY IN THE COMMUNITY AND ADVOCACY SERVICES FOR CONFLICT IN THE HOUSING BUILDING.	8/31/2011	459
205553	12/29/2012	HOUSING	5/21/2012	222

'Other' Unmet Resource Needs

Other Resources

For RDS Between Oct 1, 2012 and Dec 31, 2012

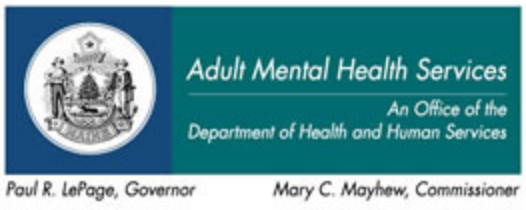
Peo_ID	RDS Date	Description	Date IDed	Days Unmet
212652	12/3/2012	OBTAIN DRIVERS LICENSE, LEARN TO SPEAK ENGLISH, SUPPORT WITH HOUSING REVEIWS	12/3/2011	366
228798	11/1/2012	VOLUNTEER IN COMPASSIONATE CARE ACTIVITY	10/20/2011	365
232934	10/30/2012	MOVING SUPPORT TO NEW TOWN; VEHICLE	10/19/2011	377
237820	10/27/2012	LEARNING DISABILITY TESTING;	7/16/2011	469
247127	10/13/2012	FIRST FLOOR APARTMENT	10/7/2011	372
247233	11/1/2012	LEGAL RESOURCES: CRIMINAL LAWYER TO ASSIST WITH IRS/HR BLOCK ISSUES	10/20/2011	378
250927	10/16/2012	IMMIGRATION	10/26/2011	366
256654	10/3/2012	VEHICLE REPAIR	1/17/2012	260
257335	10/16/2012	VEHICLE REPAIR ASSISTANCE	5/23/2011	512
258553	12/19/2012	HEAP ASSISTANCE, GOULD ASSESSMENT	5/7/2012	226
260689	10/16/2012	GROUP FOR AMPUTEES, PROSTHETIC LEG	8/12/2011	431
260906	10/22/2012	LOOKING FOR HOUSE TO EITHER RENT OR BUY	2/7/2012	254
264474	12/2/2012	TCM FOR CHILDREN	3/1/2012	276
267406	10/16/2012	DRIVING LESSONS THRU THE WISP	10/28/2011	354
277400	10/18/2012	CHILDCARE	7/27/2011	449
298315	12/19/2012	VEHICLE REPAIR	4/20/2011	609
298379	12/3/2012	HEAP	3/21/2012	257
305019	10/15/2012	MOVE TO ANOTHER APARTMENT IN SAME HOUSING COMPLEX	4/19/2012	179
305453	12/19/2012	HEAP ASSISTANCE	4/20/2011	544
322120	11/20/2012	NEEDS A CAR, WOULD LIKE LEGAL CONSULT TO DETERMINE IF ENTITLED TO MONEY, POSSIBLE EMERGENCY SHELTER	8/8/2011	430
323547	12/3/2012	IMMIGRATION	12/3/2011	366
336505	12/1/2012	HOME OWNERSHIP; IMMIGRATION	12/30/2011	337
341388	11/2/2012	OTHER VOCATIONAL/EMPLOYMENT RESOURCES -EMDC	2/19/2012	257
344187	12/11/2012	REPAIRS FOR TRANSPORTATION/CAR	3/28/2012	258
345823	12/7/2012	LEGAL SUPPORT WITH HOUSING ISSUE	3/27/2012	255
348165	12/5/2012	IMMIGRATION RELATED TO NATURALIZATION OF CHILDREN	4/12/2012	204
353131	11/28/2012	IMMIGRATION	5/28/2012	184
354614	10/16/2012	TO OWN A HOME	5/1/2012	168
355281	12/4/2012	IMMIGRATION	7/2/2012	115
361697	10/28/2012	IMMIGRATION NEEDS	7/28/2012	92

KENNEBEC BEHAVIORAL HEALTH

169387	11/12/2012		5/14/2012	182

LIFE BY DESIGN

342929	12/13/2012	OBTAINING NEUROPSYCH	3/13/2012	275

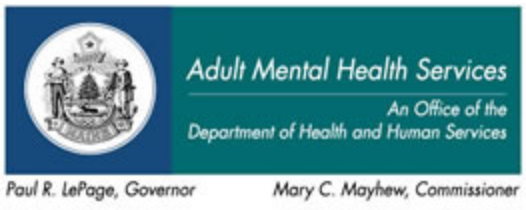


'Other' Unmet Resource Needs

Other Resources

For RDS Between Oct 1, 2012 and Dec 31, 2012

Peo_ID	RDS Date	Description	Date IDed	Days Unmet
268802	11/27/2012	HOME REPAIRS	9/26/2011	428
204815	12/3/2012	CIWC	3/21/2012	254
205497	12/20/2012	LEGAL REPRESENTATION	7/13/2012	160
203981	12/18/2012	HOUSE REPAIRED	3/23/2012	270
152409	11/30/2012	VOLUNTEERING	7/17/2012	136
LUTHERAN COMMUNITY SERVICES OF MAINE, INC.				
214089	12/4/2012	SUPERVISED VISITS WITH CHILDREN	7/2/2012	153
MAINE VOCATIONAL AND REHABILITATION ASSOCIATES, INC.				
256147	11/16/2012	EATING DISORDER CENTER	6/27/2012	142
249570	12/19/2012	LEGAL SUPPORT AROUND CUSTODY ISSUES FOR CHILDREN	6/1/2012	201
OXFORD COUNTY MENTAL HEALTH SERVICES				
332003	10/15/2012	NEUROPSYCH EVALUATION	4/19/2012	169
SUNRISE OPPORTUNITIES				
266899	10/10/2012	USE PORTABLE SECTION 8 VOUCHER FOR MOVE TO PENOBSCOT COUNTY	2/13/2012	240
SWEETSER				
248504	10/4/2012	LEGAL ASSISTANCE	2/10/2012	237
226464	10/4/2012	OTHER HOUSING-LANDLORD IS NOT RENEWING LEASE	5/30/2012	152
224867	12/21/2012	MEDICAL SPECIALISTS RELATED TO ONGOING DEBILITATING CONDITION	6/20/2012	184
222564	12/26/2012	ASSISTANCE WITH CHILD SUPPORT PAYMENTS	9/20/2011	463
202791	11/5/2012	SENIOR COLLEGE CLASSES	2/15/2012	264
201544	11/18/2012	P.R.O.P. (LINK TO WEATHERIZATION, ELP, AND HOUSING SUPPORTS)	10/17/2011	398
201090	11/9/2012	PRODUCTIVITY INCREASING ACTIVITIES	12/9/2009	1,066
171222	11/30/2012	HOMEMAKER SERVICES	4/1/2011	609
166412	12/5/2012	12-STEP	4/6/2012	243
359763	10/25/2012	GUARDIAN ASSESSMENT	6/25/2012	122
103858	10/12/2012	DRIVERS LICENSE	12/12/2011	305
146474	12/7/2012	CULTURAL ACTIVITIES	9/9/2011	455
358136	12/30/2012	HOUSING	7/3/2012	136
355234	11/30/2012	PSYCH TESTING	7/30/2012	91
353094	12/4/2012	VISITING NURSES	7/2/2012	155
345840	12/3/2012	HOUSING	3/12/2012	224
314725	11/9/2012	PARENTING CLASSES	12/20/2011	325
302090	12/21/2012	ALTERNATIVE RESPONSE PROGRAM	2/18/2011	672



'Other' Unmet Resource Needs

Other Resources

For RDS Between Oct 1, 2012 and Dec 31, 2012

Peo_ID	RDS Date	Description	Date IDed	Days Unmet
THE OPPORTUNITY ALLIANCE				
200464	11/12/2012	NEEDS A WALKER OR REPAIR FOR CURRENT WALKER	11/16/2011	362
166640	12/12/2012	WANTS TO PURCHASE HOME THROUGH SEC 8 HOME BUY PROGRAM	4/24/2012	232
251037	11/29/2012	CHILDCARE	2/17/2009	1,381
TRI COUNTY MENTAL HEALTH SERVICES				
337488	10/24/2012	DRIVERS LICENSE	5/8/2012	156
UMBRELLA MENTAL HEALTH SERVICES				
204164	12/26/2012	SMOKING CECSATION	7/9/2012	170
YORK COUNTY SHELTERS INC				
345776	12/3/2012	COMMUNITY REHABILITATION SERVICES	3/12/2012	266
Total Unmet Resource Needs				**151**

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

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Quarter 2

(Oct, Nov, Dec 2012)

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 18, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q2

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

CSN	Counties	Distinct People
CSN 1	Aroostook	361
CSN 2	Hancock, Penobscot, Piscataquis & Washington	1,665
CSN 3	Kennebec & Somerset	1,950
CSN 4	Knox, Lincoln, Sagadahoc & Waldo	805
CSN 5	Androscoggin, Franklin & Oxford	1,885
CSN 6	Cumberland	1,951
CSN 7	York	517
Not Assigned	No legal address	328
Statewide		9,462

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

	2012 Q3			2012 Q4			2013 Q1			2013 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	100	348	28.7%	93	335	27.8%	99	345	28.7%	109	361	30.2%
CSN 2	466	1,770	26.3%	490	1,792	27.3%	480	1,759	27.3%	456	1,665	27.4%
CSN 3	331	1,876	17.6%	326	1,967	16.6%	323	1,957	16.5%	355	1,950	18.2%
CSN 4	228	757	30.1%	220	775	28.4%	233	817	28.5%	237	805	29.4%
CSN 5	542	1,756	30.9%	607	1,812	33.5%	657	1,866	35.2%	618	1,885	32.8%
CSN 6	575	1,888	30.5%	566	1,909	29.6%	560	1,953	28.7%	593	1,951	30.4%
CSN 7	164	488	33.6%	162	477	34.0%	148	458	32.3%	166	517	32.1%
N/A	104	391	26.6%	102	378	27.0%	90	368	24.5%	83	328	25.3%
Total	2,510	9,274	27.1%	2,566	9,445	27.2%	2,590	9,523	27.2%	2,617	9,462	27.7%

Report Run: Apr 18, 2013

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

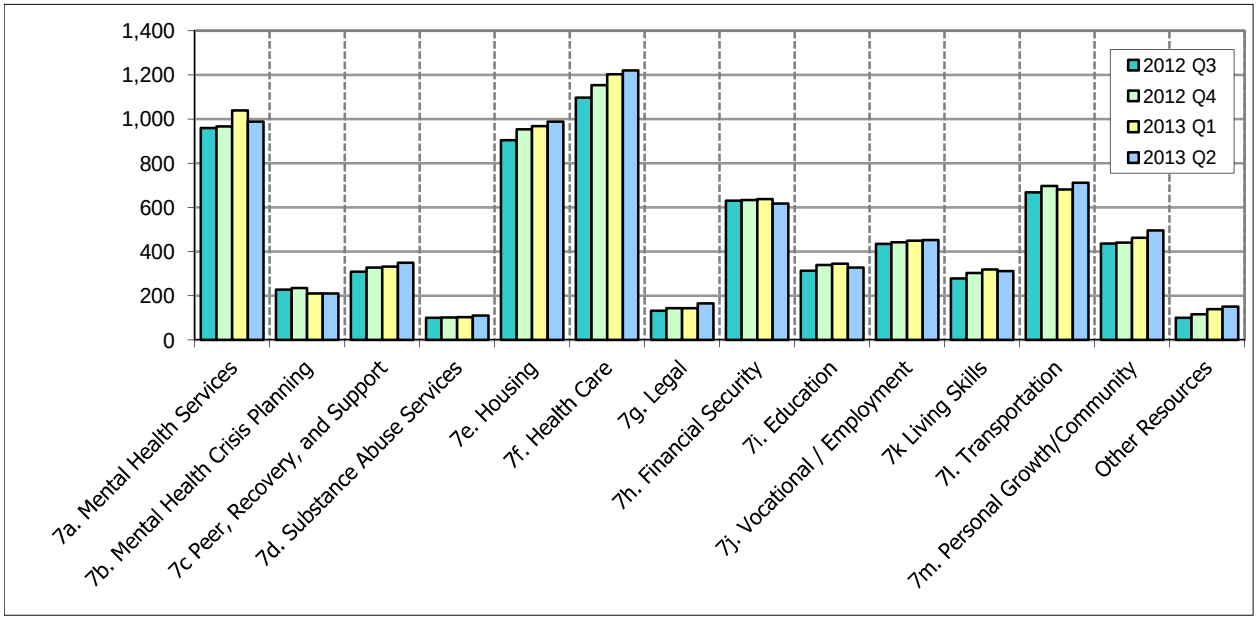


Table 3: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q3	2012 Q4	2013 Q1	2013 Q2
7a. Mental Health Services	959	967	1,039	988
7b. Mental Health Crisis Planning	228	235	210	211
7c Peer, Recovery, and Support	309	328	332	349
7d. Substance Abuse Services	101	102	103	110
7e. Housing	904	954	969	988
7f. Health Care	1,097	1,154	1,203	1,220
7g. Legal	133	144	144	165
7h. Financial Security	631	633	638	618
7i. Education	313	340	345	328
7j. Vocational / Employment	435	442	450	453
7k Living Skills	278	304	319	312
7l. Transportation	669	697	681	712
7m. Personal Growth/Community	437	441	463	496
Other Resources	100	117	139	151
Total Statewide Unmet Needs	2,510	2,566	2,590	2,617

Report Run: Apr 18, 2013

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

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

Report of Unmet Resource Needs

Statewide

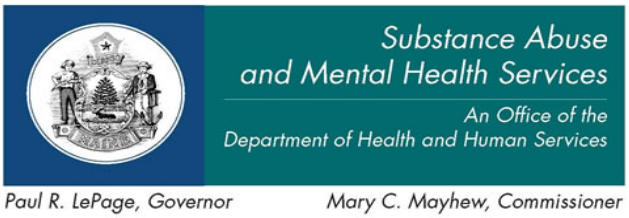
(All CSNs)

Fiscal Year 2013 Quarter 2

(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	9,274	9,445	9,523	9,462
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	29	26	36	32
7a-iii Dialectical Behavioral Therapy	32	33	34	32
7a-iv Family Psycho-Educational Treatment	14	14	8	8
7a-v Group Counseling	36	37	36	32
7a-vi Individual Counseling	387	398	452	423
7a-vii Inpatient Psychiatric Facility	3	2	5	2
7a-viii Intensive Case Management	10	11	20	18
7a-x Psychiatric Medication Management	477	472	484	473
Total Unmet Resource Needs	959	967	1,039	988
Distinct Clients with Unmet Resource Needs	781	777	829	784
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	167	174	159	158
7b-ii Mental Health Advance Directives	61	61	51	53
Total Unmet Resource Needs	228	235	210	211
Distinct Clients with Unmet Resource Needs	201	214	192	190
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	35	46	51	43
7c-ii Recovery Workbook Group	3	2	1	3
7c-iii Social Club	120	115	115	122
7c-iv Peer-Run Trauma Recovery Group	36	39	36	36
7c-v Wellness Recovery and Action Planning	17	16	18	21
7c-vi Family Support	98	110	111	124
Total Unmet Resource Needs	309	328	332	349
Distinct Clients with Unmet Resource Needs	261	280	277	293
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	83	85	86	94
7d-ii Residential Treatment Substance Abuse Services	18	17	17	16
Total Unmet Resource Needs	101	102	103	110
Distinct Clients with Unmet Resource Needs	95	97	97	106
7e. Housing				

Report Run: Apr 18, 2013



Report of Unmet Resource Needs

Statewide

(All CSNs)

Fiscal Year 2013 Quarter 2

(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	9,274	9,445	9,523	9,462
7e-i Supported Apartment	98	100	117	109
7e-ii Community Residential Facility	35	40	37	30
7e-iii Residential Treatment Facility (group home)	16	16	17	15
7e-iv Assisted Living Facility	33	42	39	45
7e-v Nursing Home	3	6	4	5
7e-vi Residential Crisis Unit	2	2	1	2
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	717	748	754	782
Total Unmet Resource Needs	904	954	969	988
Distinct Clients with Unmet Resource Needs	840	884	895	916
7f. Health Care				
7f-i Dental Services	581	604	619	631
7f-ii Eye Care Services	230	244	253	251
7f-iii Hearing Services	59	63	64	57
7f-iv Physical Therapy	29	31	35	38
7f-v Physician/Medical Services	198	212	232	243
Total Unmet Resource Needs	1,097	1,154	1,203	1,220
Distinct Clients with Unmet Resource Needs	820	856	874	902
7g. Legal				
7g-i Advocate	82	85	83	98
7g-ii Guardian (private)	41	45	47	51
7g-iii Guardian (public)	10	14	14	16
Total Unmet Resource Needs	133	144	144	165
Distinct Clients with Unmet Resource Needs	122	134	132	152
7h. Financial Security				
7h-i Assistance with Managing Money	367	373	379	361
7h-ii Assistance with Securing Public Benefits	223	227	221	216
7h-iii Representative Payee	41	33	38	41
Total Unmet Resource Needs	631	633	638	618
Distinct Clients with Unmet Resource Needs	557	555	569	559
7i. Education				

Report Run: Apr 18, 2013

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

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

Report of Unmet Resource Needs

Statewide

(All CSNs)

Fiscal Year 2013 Quarter 2

(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	9,274	9,445	9,523	9,462
7i-i Adult Education (other than GED)	79	76	64	74
7i-ii GED	70	79	82	85
7i-iii Literacy Assistance	25	28	29	33
7i-iv Post High School Education	116	134	141	110
7i-v Tuition Reimbursement	23	23	29	26
Total Unmet Resource Needs	313	340	345	328
Distinct Clients with Unmet Resource Needs	287	313	318	302
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	34	32	49	45
7j-ii Club House and/or Peer Vocational Support	16	21	27	25
7j-iii Competitive Employment (no supports)	65	70	65	68
7j-iv Supported Employment	38	42	42	37
7j-v Vocational Rehabilitation	282	277	267	278
Total Unmet Resource Needs	435	442	450	453
Distinct Clients with Unmet Resource Needs	392	391	399	401
7k. Living Skills				
7k-i Daily Living Support Services	177	206	207	217
7k-ii Day Support Services	19	21	32	26
7k-iii Occupational Therapy	8	11	10	13
7k-iv Skills Development Services	74	66	70	56
Total Unmet Resource Needs	278	304	319	312
Distinct Clients with Unmet Resource Needs	253	282	291	289
7l. Transportation				
7l-i Transportation to ISP-Identified Services	350	336	340	359
7-ii Transportation to Other ISP Activities	164	187	183	194
7-iii After Hours Transportation	155	174	158	159
Total Unmet Resource Needs	669	697	681	712
Distinct Clients with Unmet Resource Needs	499	502	493	501
7m. Personal Growth/Community				
7m-i Avocational Activities	19	23	25	20
7m. Personal Growth/Community				

Report Run: Apr 18, 2013

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

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

Report of Unmet Resource Needs

Statewide

(All CSNs)

Fiscal Year 2013 Quarter 2

(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	9,274	9,445	9,523	9,462
7m-ii Recreation Activities	115	128	128	135
7m-iii Social Activities	261	249	257	282
7m-iv Spiritual Activities	42	41	53	59
Total Unmet Resource Needs	437	441	463	496
Distinct Clients with Unmet Resource Needs	332	328	343	359
Other Resources				
Other Resources	100	117	139	151
Total Unmet Resource Needs	100	117	139	151
Distinct Clients with Unmet Resource Needs	100	117	139	151
Statewide Totals				
Total Unmet Resource Needs	6,594	6,858	7,035	7,101
Distinct Clients With any Unmet Resource Need	2,510	2,566	2,590	2,617
Distinct Clients with a RDS	9,274	9,445	9,523	9,462

Report Run: Apr 18, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q2

CSN 1 - Aroostook

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

2012 Q3			2012 Q4			2013 Q1			2013 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
100	348	28.7%	93	335	27.8%	99	345	28.7%	109	361	30.2%

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

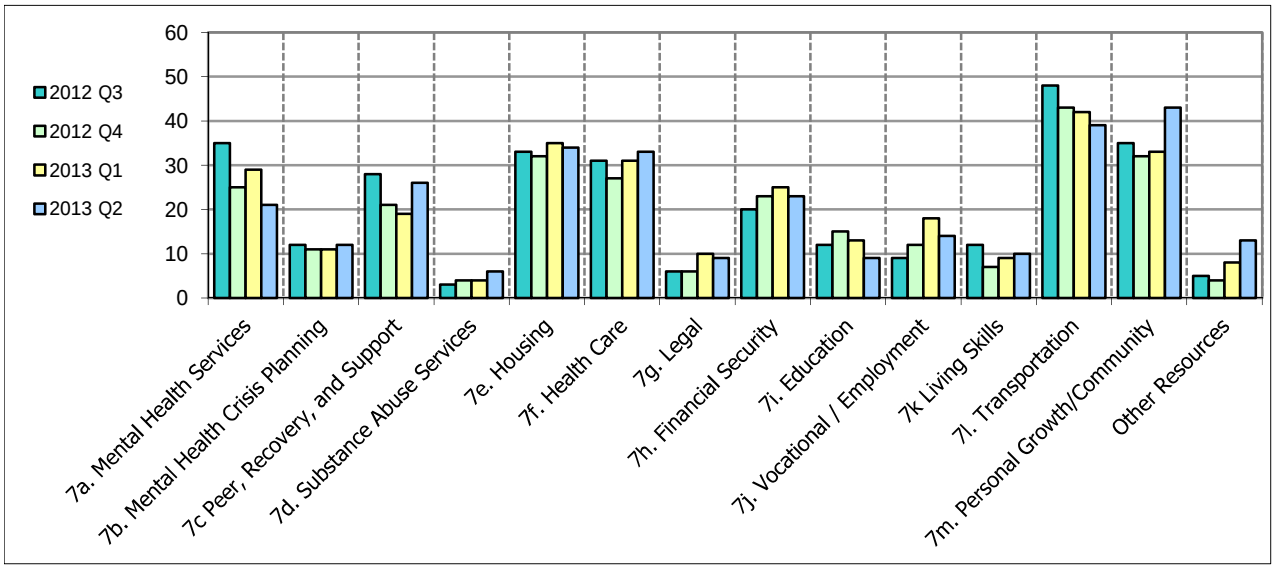


Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q3	2012 Q4	2013 Q1	2013 Q2
7a. Mental Health Services	35	25	29	21
7b. Mental Health Crisis Planning	12	11	11	12
7c Peer, Recovery, and Support	28	21	19	26
7d. Substance Abuse Services	3	4	4	6
7e. Housing	33	32	35	34
7f. Health Care	31	27	31	33
7g. Legal	6	6	10	9
7h. Financial Security	20	23	25	23
7i. Education	12	15	13	9
7j. Vocational / Employment	9	12	18	14
7k Living Skills	12	7	9	10
7l. Transportation	48	43	42	39
7m. Personal Growth/Community	35	32	33	43
Other Resources	5	4	8	13
Total CSN 1 Unmet Needs	289	262	287	292

Report Run: Apr 18, 2013

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	348	335	345	361
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	1	0	0	0
7a-iii Dialectical Behavioral Therapy	4	3	3	4
7a-iv Family Psycho-Educational Treatment	1	1	0	0
7a-v Group Counseling	0	2	1	0
7a-vi Individual Counseling	12	8	9	4
7a-vii Inpatient Psychiatric Facility	2	0	1	1
7a-viii Intensive Case Management	0	0	0	0
7a-x Psychiatric Medication Management	15	11	15	12
Total Unmet Resource Needs	35	25	29	21
Distinct Clients with Unmet Resource Needs	27	21	24	17
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	8	8	7	9
7b-ii Mental Health Advance Directives	4	3	4	3
Total Unmet Resource Needs	12	11	11	12
Distinct Clients with Unmet Resource Needs	10	10	9	11
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	1	0	0
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	21	17	13	18
7c-iv Peer-Run Trauma Recovery Group	1	0	0	2
7c-v Wellness Recovery and Action Planning	2	1	2	1
7c-vi Family Support	3	2	4	5
Total Unmet Resource Needs	28	21	19	26
Distinct Clients with Unmet Resource Needs	24	20	18	23
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	3	3	3	5
7d-ii Residential Treatment Substance Abuse Services	0	1	1	1
Total Unmet Resource Needs	3	4	4	6
Distinct Clients with Unmet Resource Needs	3	4	4	6
7e. Housing				

Report Run: Apr 18, 2013

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

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

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	348	335	345	361
7e-i Supported Apartment	8	7	8	6
7e-ii Community Residential Facility	0	1	0	0
7e-iii Residential Treatment Facility (group home)	3	2	4	3
7e-iv Assisted Living Facility	3	1	2	2
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)	19	21	21	23
Total Unmet Resource Needs	33	32	35	34
Distinct Clients with Unmet Resource Needs	26	26	29	32
7f. Health Care				
7f-i Dental Services	15	13	9	8
7f-ii Eye Care Services	3	1	4	7
7f-iii Hearing Services	1	0	3	2
7f-iv Physical Therapy	1	2	2	1
7f-v Physician/Medical Services	11	11	13	15
Total Unmet Resource Needs	31	27	31	33
Distinct Clients with Unmet Resource Needs	27	23	26	29
7g. Legal				
7g-i Advocate	5	6	8	8
7g-ii Guardian (private)	1	0	1	0
7g-iii Guardian (public)	0	0	1	1
Total Unmet Resource Needs	6	6	10	9
Distinct Clients with Unmet Resource Needs	6	6	10	8
7h. Financial Security				
7h-i Assistance with Managing Money	10	11	15	13
7h-ii Assistance with Securing Public Benefits	10	12	10	10
7h-iii Representative Payee	0	0	0	0
Total Unmet Resource Needs	20	23	25	23
Distinct Clients with Unmet Resource Needs	18	19	22	22
7i. Education				

Report Run: Apr 18, 2013

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	348	335	345	361
7i-i Adult Education (other than GED)	5	5	2	1
7i-ii GED	4	4	5	5
7i-iii Literacy Assistance	0	1	2	2
7i-iv Post High School Education	2	4	3	1
7i-v Tuition Reimbursement	1	1	1	0
Total Unmet Resource Needs	12	15	13	9
Distinct Clients with Unmet Resource Needs	12	14	13	9
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	0	0	4	1
7j-ii Club House and/or Peer Vocational Support	1	0	1	1
7j-iii Competitive Employment (no supports)	1	1	0	1
7j-iv Supported Employment	2	4	5	3
7j-v Vocational Rehabilitation	5	7	8	8
Total Unmet Resource Needs	9	12	18	14
Distinct Clients with Unmet Resource Needs	9	11	15	12
7k. Living Skills				
7k-i Daily Living Support Services	5	2	4	5
7k-ii Day Support Services	0	1	2	1
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	7	4	3	4
Total Unmet Resource Needs	12	7	9	10
Distinct Clients with Unmet Resource Needs	9	6	9	9
7l. Transportation				
7l-i Transportation to ISP-Identified Services	25	20	20	18
7-ii Transportation to Other ISP Activities	8	8	7	7
7-iii After Hours Transportation	15	15	15	14
Total Unmet Resource Needs	48	43	42	39
Distinct Clients with Unmet Resource Needs	38	31	33	28
7m. Personal Growth/Community				
7m-i Avocational Activities	0	1	2	0
7m. Personal Growth/Community				

Report Run: Apr 18, 2013

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 1
(Aroostook)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	348	335	345	361
7m-ii Recreation Activities	7	10	8	13
7m-iii Social Activities	26	20	20	26
7m-iv Spiritual Activities	2	1	3	4
Total Unmet Resource Needs	35	32	33	43
Distinct Clients with Unmet Resource Needs	29	25	25	32
Other Resources				
Other Resources	5	4	8	13
Total Unmet Resource Needs	5	4	8	13
Distinct Clients with Unmet Resource Needs	5	4	8	13
CSN 1 Totals				
Total Unmet Resource Needs	289	262	287	292
Distinct Clients With any Unmet Resource Need	100	93	99	109
Distinct Clients with a RDS	348	335	345	361

Report Run: Apr 18, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q2

CSN 2 - Hancock, Washington, Penobscot, Piscataquis

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

2012 Q3			2012 Q4			2013 Q1			2013 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
466	1,770	26.3%	490	1,792	27.3%	480	1,759	27.3%	456	1,665	27.4%

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

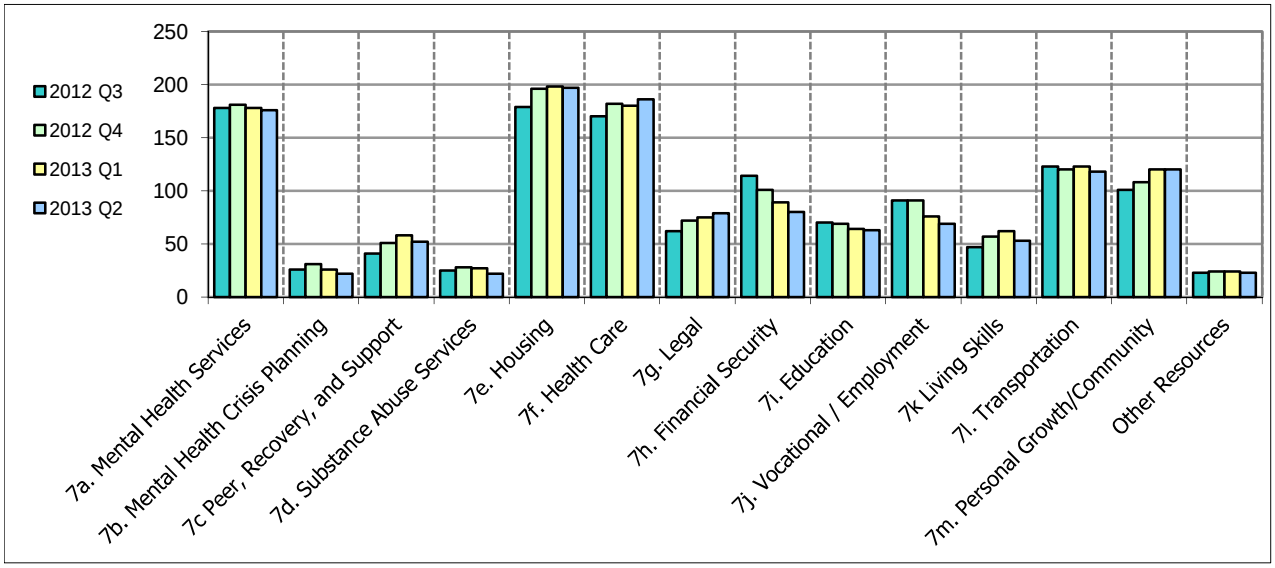

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q3	2012 Q4	2013 Q1	2013 Q2
7a. Mental Health Services	178	181	178	176
7b. Mental Health Crisis Planning	26	31	26	22
7c Peer, Recovery, and Support	41	51	58	52
7d. Substance Abuse Services	25	28	27	22
7e. Housing	179	196	198	197
7f. Health Care	170	182	180	186
7g. Legal	62	72	75	79
7h. Financial Security	114	101	89	80
7i. Education	70	69	64	63
7j. Vocational / Employment	91	91	76	69
7k Living Skills	47	57	62	53
7l. Transportation	123	120	123	118
7m. Personal Growth/Community	101	108	120	120
Other Resources	23	24	24	23
Total CSN 2 Unmet Needs	1,250	1,311	1,300	1,260

Report Run: Apr 18, 2013

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

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,770	1,792	1,759	1,665
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	1	2	2	2
7a-iii Dialectical Behavioral Therapy	3	3	3	2
7a-iv Family Psycho-Educational Treatment	2	3	2	4
7a-v Group Counseling	7	7	8	9
7a-vi Individual Counseling	83	84	88	86
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	1	2	1	1
7a-x Psychiatric Medication Management	81	80	74	72
Total Unmet Resource Needs	178	181	178	176
Distinct Clients with Unmet Resource Needs	139	136	136	134
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	22	27	24	20
7b-ii Mental Health Advance Directives	4	4	2	2
Total Unmet Resource Needs	26	31	26	22
Distinct Clients with Unmet Resource Needs	25	29	26	21
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	4	9	6	6
7c-ii Recovery Workbook Group	0	0	0	1
7c-iii Social Club	15	17	22	15
7c-iv Peer-Run Trauma Recovery Group	6	9	8	10
7c-v Wellness Recovery and Action Planning	3	7	8	7
7c-vi Family Support	13	9	14	13
Total Unmet Resource Needs	41	51	58	52
Distinct Clients with Unmet Resource Needs	33	39	44	37
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	22	25	25	19
7d-ii Residential Treatment Substance Abuse Services	3	3	2	3
Total Unmet Resource Needs	25	28	27	22
Distinct Clients with Unmet Resource Needs	24	27	26	20
7e. Housing				

Report Run: Apr 18, 2013

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,770	1,792	1,759	1,665
7e-i Supported Apartment	17	17	22	23
7e-ii Community Residential Facility	5	8	6	4
7e-iii Residential Treatment Facility (group home)	2	1	1	1
7e-iv Assisted Living Facility	5	6	6	9
7e-v Nursing Home	0	1	1	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	150	163	162	160
Total Unmet Resource Needs	179	196	198	197
Distinct Clients with Unmet Resource Needs	166	184	182	184
7f. Health Care				
7f-i Dental Services	72	78	77	88
7f-ii Eye Care Services	51	52	54	45
7f-iii Hearing Services	7	8	5	4
7f-iv Physical Therapy	5	5	7	7
7f-v Physician/Medical Services	35	39	37	42
Total Unmet Resource Needs	170	182	180	186
Distinct Clients with Unmet Resource Needs	125	136	124	133
7g. Legal				
7g-i Advocate	25	30	32	31
7g-ii Guardian (private)	33	38	39	44
7g-iii Guardian (public)	4	4	4	4
Total Unmet Resource Needs	62	72	75	79
Distinct Clients with Unmet Resource Needs	52	63	64	70
7h. Financial Security				
7h-i Assistance with Managing Money	65	58	55	47
7h-ii Assistance with Securing Public Benefits	45	39	31	33
7h-iii Representative Payee	4	4	3	0
Total Unmet Resource Needs	114	101	89	80
Distinct Clients with Unmet Resource Needs	98	88	84	75
7i. Education				

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

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

Report of Unmet Resource Needs

CSN 2
(Hancock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,770	1,792	1,759	1,665
7i-i Adult Education (other than GED)	10	9	10	9
7i-ii GED	14	13	10	7
7i-iii Literacy Assistance	4	3	4	5
7i-iv Post High School Education	32	35	33	30
7i-v Tuition Reimbursement	10	9	7	12
Total Unmet Resource Needs	70	69	64	63
Distinct Clients with Unmet Resource Needs	64	60	60	55
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	11	10	10	8
7j-ii Club House and/or Peer Vocational Support	0	2	3	2
7j-iii Competitive Employment (no supports)	22	20	17	17
7j-iv Supported Employment	7	10	7	7
7j-v Vocational Rehabilitation	51	49	39	35
Total Unmet Resource Needs	91	91	76	69
Distinct Clients with Unmet Resource Needs	76	72	66	59
7k. Living Skills				
7k-i Daily Living Support Services	32	44	43	36
7k-ii Day Support Services	1	2	5	2
7k-iii Occupational Therapy	0	1	2	2
7k-iv Skills Development Services	14	10	12	13
Total Unmet Resource Needs	47	57	62	53
Distinct Clients with Unmet Resource Needs	44	51	52	45
7l. Transportation				
7l-i Transportation to ISP-Identified Services	60	57	65	58
7-ii Transportation to Other ISP Activities	26	23	21	21
7-iii After Hours Transportation	37	40	37	39
Total Unmet Resource Needs	123	120	123	118
Distinct Clients with Unmet Resource Needs	95	96	96	91
7m. Personal Growth/Community				
7m-i Avocational Activities	3	4	7	7
7m. Personal Growth/Community				

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Report of Unmet Resource Needs

CSN 2

ıcock, Washington, Penobscot, Piscataquis)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,770	1,792	1,759	1,665
7m-ii Recreation Activities	35	35	39	41
7m-iii Social Activities	58	63	67	65
7m-iv Spiritual Activities	5	6	7	7
Total Unmet Resource Needs	101	108	120	120
Distinct Clients with Unmet Resource Needs	75	77	84	80
Other Resources				
Other Resources	23	24	24	23
Total Unmet Resource Needs	23	24	24	23
Distinct Clients with Unmet Resource Needs	23	24	24	23
CSN 2 Totals				
Total Unmet Resource Needs	1,250	1,311	1,300	1,260
Distinct Clients With any Unmet Resource Need	466	490	480	456
Distinct Clients with a RDS	1,770	1,792	1,759	1,665

Report Run: Apr 18, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q2

CSN 3 - Kennebec and Somerset

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

2012 Q3			2012 Q4			2013 Q1			2013 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
331	1,876	17.6%	326	1,967	16.6%	323	1,957	16.5%	355	1,950	18.2%

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

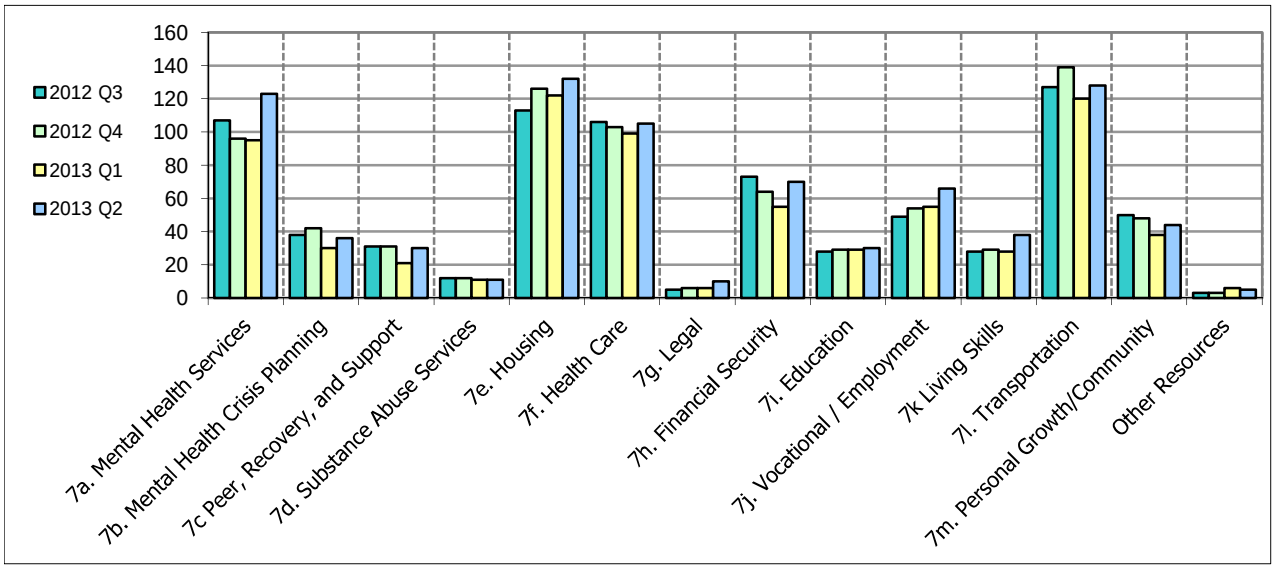

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q3	2012 Q4	2013 Q1	2013 Q2
7a. Mental Health Services	107	96	95	123
7b. Mental Health Crisis Planning	38	42	30	36
7c Peer, Recovery, and Support	31	31	21	30
7d. Substance Abuse Services	12	12	11	11
7e. Housing	113	126	122	132
7f. Health Care	106	103	99	105
7g. Legal	5	6	6	10
7h. Financial Security	73	64	55	70
7i. Education	28	29	29	30
7j. Vocational / Employment	49	54	55	66
7k Living Skills	28	29	28	38
7l. Transportation	127	139	120	128
7m. Personal Growth/Community	50	48	38	44
Other Resources	3	3	6	5
Total CSN 3 Unmet Needs	770	782	715	828

Report Run: Apr 18, 2013

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

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

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,876	1,967	1,957	1,950
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	4	3	5
7a-iii Dialectical Behavioral Therapy	2	0	0	0
7a-iv Family Psycho-Educational Treatment	1	2	2	1
7a-v Group Counseling	1	4	3	3
7a-vi Individual Counseling	40	39	37	49
7a-vii Inpatient Psychiatric Facility	0	0	1	1
7a-viii Intensive Case Management	2	1	1	0
7a-x Psychiatric Medication Management	59	46	48	64
Total Unmet Resource Needs	107	96	95	123
Distinct Clients with Unmet Resource Needs	90	76	72	93
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	26	29	23	26
7b-ii Mental Health Advance Directives	12	13	7	10
Total Unmet Resource Needs	38	42	30	36
Distinct Clients with Unmet Resource Needs	29	34	26	29
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	1	0	3
7c-ii Recovery Workbook Group	0	0	0	1
7c-iii Social Club	12	13	7	12
7c-iv Peer-Run Trauma Recovery Group	3	4	3	0
7c-v Wellness Recovery and Action Planning	0	0	0	1
7c-vi Family Support	15	13	11	13
Total Unmet Resource Needs	31	31	21	30
Distinct Clients with Unmet Resource Needs	29	30	20	28
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	9	8	7	9
7d-ii Residential Treatment Substance Abuse Services	3	4	4	2
Total Unmet Resource Needs	12	12	11	11
Distinct Clients with Unmet Resource Needs	12	12	11	11
7e. Housing				

Report Run: Apr 18, 2013

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,876	1,967	1,957	1,950
7e-i Supported Apartment	3	4	7	9
7e-ii Community Residential Facility	6	7	6	4
7e-iii Residential Treatment Facility (group home)	0	0	1	2
7e-iv Assisted Living Facility	3	6	4	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)	101	109	104	114
Total Unmet Resource Needs	113	126	122	132
Distinct Clients with Unmet Resource Needs	109	121	113	123
7f. Health Care				
7f-i Dental Services	50	51	51	53
7f-ii Eye Care Services	20	14	13	19
7f-iii Hearing Services	9	10	10	7
7f-iv Physical Therapy	2	2	1	1
7f-v Physician/Medical Services	25	26	24	25
Total Unmet Resource Needs	106	103	99	105
Distinct Clients with Unmet Resource Needs	81	84	85	88
7g. Legal				
7g-i Advocate	3	4	3	5
7g-ii Guardian (private)	0	0	1	2
7g-iii Guardian (public)	2	2	2	3
Total Unmet Resource Needs	5	6	6	10
Distinct Clients with Unmet Resource Needs	5	6	6	8
7h. Financial Security				
7h-i Assistance with Managing Money	43	35	31	39
7h-ii Assistance with Securing Public Benefits	27	25	21	28
7h-iii Representative Payee	3	4	3	3
Total Unmet Resource Needs	73	64	55	70
Distinct Clients with Unmet Resource Needs	65	55	49	64
7i. Education				

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Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,876	1,967	1,957	1,950
7i-i Adult Education (other than GED)	4	4	4	4
7i-ii GED	11	11	10	12
7i-iii Literacy Assistance	5	6	6	5
7i-iv Post High School Education	4	6	7	7
7i-v Tuition Reimbursement	4	2	2	2
Total Unmet Resource Needs	28	29	29	30
Distinct Clients with Unmet Resource Needs	26	27	27	27
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	3	3	4	7
7j-ii Club House and/or Peer Vocational Support	7	9	8	8
7j-iii Competitive Employment (no supports)	5	6	5	4
7j-iv Supported Employment	2	3	2	5
7j-v Vocational Rehabilitation	32	33	36	42
Total Unmet Resource Needs	49	54	55	66
Distinct Clients with Unmet Resource Needs	44	47	49	56
7k. Living Skills				
7k-i Daily Living Support Services	19	20	23	30
7k-ii Day Support Services	0	0	0	1
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	9	9	5	7
Total Unmet Resource Needs	28	29	28	38
Distinct Clients with Unmet Resource Needs	26	28	28	37
7l. Transportation				
7l-i Transportation to ISP-Identified Services	82	78	70	85
7-ii Transportation to Other ISP Activities	26	36	31	28
7-iii After Hours Transportation	19	25	19	15
Total Unmet Resource Needs	127	139	120	128
Distinct Clients with Unmet Resource Needs	102	99	86	98
7m. Personal Growth/Community				
7m-i Avocational Activities	0	1	0	1
7m. Personal Growth/Community				

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Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 3
(Kennebec, Somerset)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,876	1,967	1,957	1,950
7m-ii Recreation Activities	11	12	9	8
7m-iii Social Activities	36	32	26	33
7m-iv Spiritual Activities	3	3	3	2
Total Unmet Resource Needs	50	48	38	44
Distinct Clients with Unmet Resource Needs	40	38	30	37
Other Resources				
Other Resources	3	3	6	5
Total Unmet Resource Needs	3	3	6	5
Distinct Clients with Unmet Resource Needs	3	3	6	5
CSN 3 Totals				
Total Unmet Resource Needs	770	782	715	828
Distinct Clients With any Unmet Resource Need	331	326	323	355
Distinct Clients with a RDS	1,876	1,967	1,957	1,950

Report Run: Apr 18, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q2

CSN 4 - Knox, Lincoln, Sagadahoc, Waldo

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

2012 Q3			2012 Q4			2013 Q1			2013 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
228	757	30.1%	220	775	28.4%	233	817	28.5%	237	805	29.4%

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

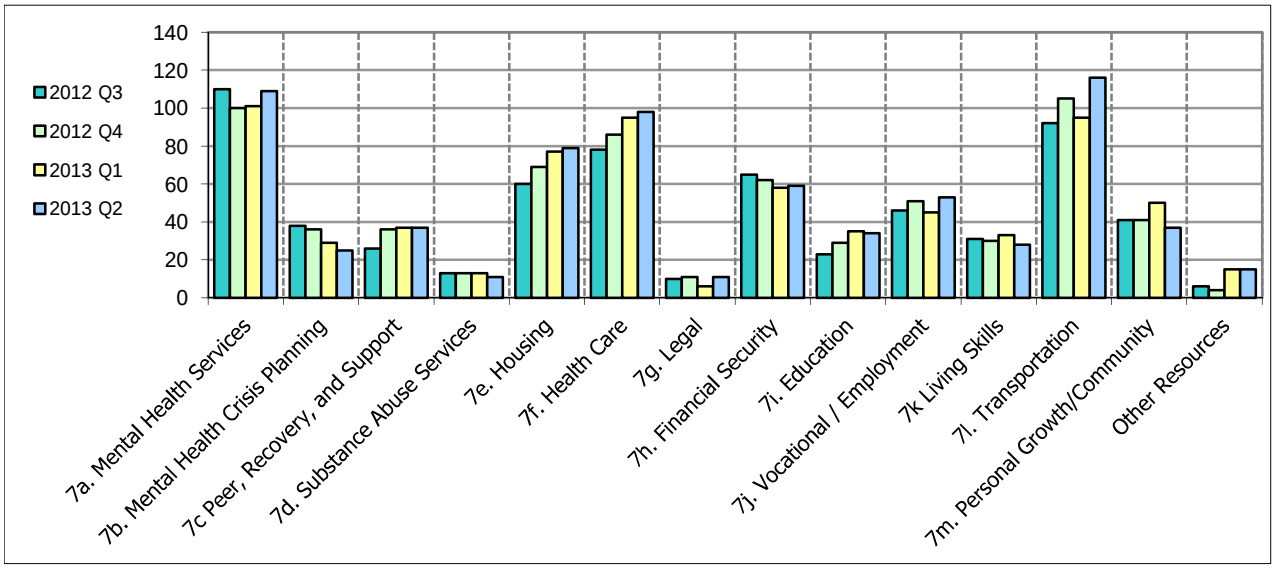

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q3	2012 Q4	2013 Q1	2013 Q2
7a. Mental Health Services	110	100	101	109
7b. Mental Health Crisis Planning	38	36	29	25
7c Peer, Recovery, and Support	26	36	37	37
7d. Substance Abuse Services	13	13	13	11
7e. Housing	60	69	77	79
7f. Health Care	78	86	95	98
7g. Legal	10	11	6	11
7h. Financial Security	65	62	58	59
7i. Education	23	29	35	34
7j. Vocational / Employment	46	51	45	53
7k Living Skills	31	30	33	28
7l. Transportation	92	105	95	116
7m. Personal Growth/Community	41	41	50	37
Other Resources	6	4	15	15
Total CSN 4 Unmet Needs	639	673	689	712

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An Office of the Department of Health and Human Services

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

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	757	775	817	805
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	2	2	4	4
7a-iii Dialectical Behavioral Therapy	1	2	1	2
7a-iv Family Psycho-Educational Treatment	1	1	0	0
7a-v Group Counseling	1	1	3	2
7a-vi Individual Counseling	45	39	44	50
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	1	0	1	0
7a-x Psychiatric Medication Management	59	55	48	51
Total Unmet Resource Needs	110	100	101	109
Distinct Clients with Unmet Resource Needs	81	77	78	79
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	32	31	24	21
7b-ii Mental Health Advance Directives	6	5	5	4
Total Unmet Resource Needs	38	36	29	25
Distinct Clients with Unmet Resource Needs	34	33	26	23
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	7	9	12	7
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	7	8	9	8
7c-iv Peer-Run Trauma Recovery Group	3	4	5	4
7c-v Wellness Recovery and Action Planning	0	0	0	0
7c-vi Family Support	9	15	11	18
Total Unmet Resource Needs	26	36	37	37
Distinct Clients with Unmet Resource Needs	25	32	33	34
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	12	11	11	9
7d-ii Residential Treatment Substance Abuse Services	1	2	2	2
Total Unmet Resource Needs	13	13	13	11
Distinct Clients with Unmet Resource Needs	13	12	12	10
7e. Housing				

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Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	757	775	817	805
7e-i Supported Apartment	9	11	13	8
7e-ii Community Residential Facility	1	1	1	1
7e-iii Residential Treatment Facility (group home)	2	4	4	4
7e-iv Assisted Living Facility	3	4	4	5
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	45	49	55	61
Total Unmet Resource Needs	60	69	77	79
Distinct Clients with Unmet Resource Needs	58	64	72	76
7f. Health Care				
7f-i Dental Services	40	51	58	53
7f-ii Eye Care Services	15	16	14	17
7f-iii Hearing Services	3	3	4	5
7f-iv Physical Therapy	4	3	4	4
7f-v Physician/Medical Services	16	13	15	19
Total Unmet Resource Needs	78	86	95	98
Distinct Clients with Unmet Resource Needs	62	70	78	77
7g. Legal				
7g-i Advocate	7	9	4	8
7g-ii Guardian (private)	3	2	2	3
7g-iii Guardian (public)	0	0	0	0
Total Unmet Resource Needs	10	11	6	11
Distinct Clients with Unmet Resource Needs	10	11	6	11
7h. Financial Security				
7h-i Assistance with Managing Money	40	40	36	36
7h-ii Assistance with Securing Public Benefits	21	19	16	16
7h-iii Representative Payee	4	3	6	7
Total Unmet Resource Needs	65	62	58	59
Distinct Clients with Unmet Resource Needs	57	53	51	52
7i. Education				

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Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	757	775	817	805
7i-i Adult Education (other than GED)	6	5	4	7
7i-ii GED	6	6	10	9
7i-iii Literacy Assistance	1	0	0	0
7i-iv Post High School Education	10	14	16	12
7i-v Tuition Reimbursement	0	4	5	6
Total Unmet Resource Needs	23	29	35	34
Distinct Clients with Unmet Resource Needs	22	28	34	32
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	4	4	4	6
7j-ii Club House and/or Peer Vocational Support	2	2	1	1
7j-iii Competitive Employment (no supports)	8	15	9	9
7j-iv Supported Employment	4	2	3	3
7j-v Vocational Rehabilitation	28	28	28	34
Total Unmet Resource Needs	46	51	45	53
Distinct Clients with Unmet Resource Needs	42	46	41	49
7k. Living Skills				
7k-i Daily Living Support Services	26	26	26	22
7k-ii Day Support Services	1	0	2	3
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	4	4	5	3
Total Unmet Resource Needs	31	30	33	28
Distinct Clients with Unmet Resource Needs	30	30	31	28
7l. Transportation				
7l-i Transportation to ISP-Identified Services	53	52	53	61
7-ii Transportation to Other ISP Activities	29	39	32	40
7-iii After Hours Transportation	10	14	10	15
Total Unmet Resource Needs	92	105	95	116
Distinct Clients with Unmet Resource Needs	57	58	60	68
7m. Personal Growth/Community				
7m-i Avocational Activities	2	3	2	1
7m. Personal Growth/Community				

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Report of Unmet Resource Needs

CSN 4
(Knox, Lincoln, Sagadahoc, Waldo)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	757	775	817	805
7m-ii Recreation Activities	9	10	12	8
7m-iii Social Activities	28	23	29	24
7m-iv Spiritual Activities	2	5	7	4
Total Unmet Resource Needs	41	41	50	37
Distinct Clients with Unmet Resource Needs	33	31	37	29
Other Resources				
Other Resources	6	4	15	15
Total Unmet Resource Needs	6	4	15	15
Distinct Clients with Unmet Resource Needs	6	4	15	15
CSN 4 Totals				
Total Unmet Resource Needs	639	673	689	712
Distinct Clients With any Unmet Resource Need	228	220	233	237
Distinct Clients with a RDS	757	775	817	805

Report Run: Apr 18, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q2

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

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

2012 Q3			2012 Q4			2013 Q1			2013 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
542	1,756	30.9%	607	1,812	33.5%	657	1,866	35.2%	618	1,885	32.8%

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

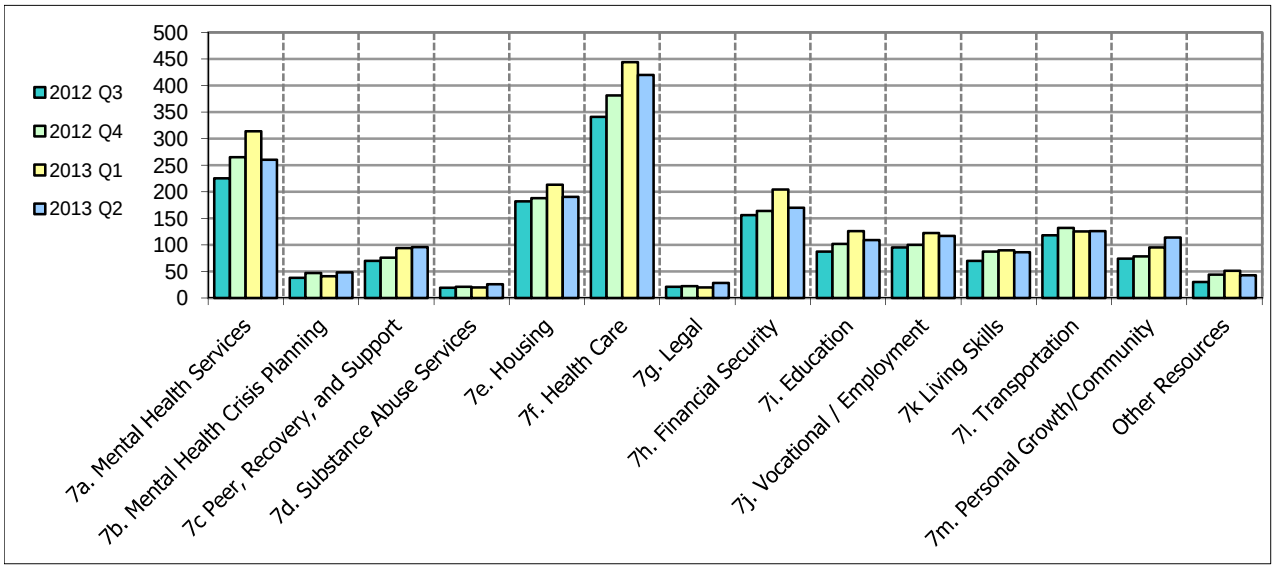

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q3	2012 Q4	2013 Q1	2013 Q2
7a. Mental Health Services	225	265	314	260
7b. Mental Health Crisis Planning	38	47	41	48
7c Peer, Recovery, and Support	70	76	94	96
7d. Substance Abuse Services	19	21	20	26
7e. Housing	182	188	213	190
7f. Health Care	341	381	444	420
7g. Legal	21	22	20	28
7h. Financial Security	156	164	204	170
7i. Education	87	102	126	109
7j. Vocational / Employment	95	100	122	117
7k Living Skills	70	87	90	86
7l. Transportation	118	132	125	126
7m. Personal Growth/Community	74	78	95	114
Other Resources	30	44	51	43
Total CSN 5 Unmet Needs	1,526	1,707	1,959	1,833

Report Run: Apr 18, 2013

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

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

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,756	1,812	1,866	1,885
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	7	7	10	3
7a-iii Dialectical Behavioral Therapy	12	10	18	11
7a-iv Family Psycho-Educational Treatment	1	2	2	1
7a-v Group Counseling	10	11	9	2
7a-vi Individual Counseling	76	92	122	110
7a-vii Inpatient Psychiatric Facility	1	0	1	0
7a-viii Intensive Case Management	2	1	2	1
7a-x Psychiatric Medication Management	116	142	150	132
Total Unmet Resource Needs	225	265	314	260
Distinct Clients with Unmet Resource Needs	189	226	256	212
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	18	22	20	26
7b-ii Mental Health Advance Directives	20	25	21	22
Total Unmet Resource Needs	38	47	41	48
Distinct Clients with Unmet Resource Needs	33	43	37	43
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	4	6	13	10
7c-ii Recovery Workbook Group	2	1	0	0
7c-iii Social Club	19	16	20	25
7c-iv Peer-Run Trauma Recovery Group	13	15	14	8
7c-v Wellness Recovery and Action Planning	1	2	1	2
7c-vi Family Support	31	36	46	51
Total Unmet Resource Needs	70	76	94	96
Distinct Clients with Unmet Resource Needs	57	65	80	86
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	16	18	17	24
7d-ii Residential Treatment Substance Abuse Services	3	3	3	2
Total Unmet Resource Needs	19	21	20	26
Distinct Clients with Unmet Resource Needs	18	20	19	26
7e. Housing				

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Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,756	1,812	1,866	1,885
7e-i Supported Apartment	12	13	12	11
7e-ii Community Residential Facility	9	6	6	4
7e-iii Residential Treatment Facility (group home)	3	2	2	1
7e-iv Assisted Living Facility	3	6	5	6
7e-v Nursing Home	0	0	0	0
7e-vi Residential Crisis Unit	1	1	1	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	154	160	187	167
Total Unmet Resource Needs	182	188	213	190
Distinct Clients with Unmet Resource Needs	173	182	206	182
7f. Health Care				
7f-i Dental Services	199	204	241	231
7f-ii Eye Care Services	73	94	95	85
7f-iii Hearing Services	19	21	28	23
7f-iv Physical Therapy	8	7	10	12
7f-v Physician/Medical Services	42	55	70	69
Total Unmet Resource Needs	341	381	444	420
Distinct Clients with Unmet Resource Needs	244	255	296	290
7g. Legal				
7g-i Advocate	20	18	17	27
7g-ii Guardian (private)	0	2	1	0
7g-iii Guardian (public)	1	2	2	1
Total Unmet Resource Needs	21	22	20	28
Distinct Clients with Unmet Resource Needs	20	21	19	28
7h. Financial Security				
7h-i Assistance with Managing Money	91	94	117	108
7h-ii Assistance with Securing Public Benefits	56	61	77	52
7h-iii Representative Payee	9	9	10	10
Total Unmet Resource Needs	156	164	204	170
Distinct Clients with Unmet Resource Needs	141	148	183	157
7i. Education				

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Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,756	1,812	1,866	1,885
7i-i Adult Education (other than GED)	24	20	24	27
7i-ii GED	11	24	27	30
7i-iii Literacy Assistance	9	10	9	11
7i-iv Post High School Education	37	44	55	36
7i-v Tuition Reimbursement	6	4	11	5
Total Unmet Resource Needs	87	102	126	109
Distinct Clients with Unmet Resource Needs	78	96	112	102
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	5	3	9	6
7j-ii Club House and/or Peer Vocational Support	3	4	10	9
7j-iii Competitive Employment (no supports)	8	9	13	11
7j-iv Supported Employment	6	7	11	10
7j-v Vocational Rehabilitation	73	77	79	81
Total Unmet Resource Needs	95	100	122	117
Distinct Clients with Unmet Resource Needs	90	95	110	107
7k. Living Skills				
7k-i Daily Living Support Services	48	63	62	62
7k-ii Day Support Services	8	8	10	9
7k-iii Occupational Therapy	4	6	5	8
7k-iv Skills Development Services	10	10	13	7
Total Unmet Resource Needs	70	87	90	86
Distinct Clients with Unmet Resource Needs	64	80	83	79
7l. Transportation				
7l-i Transportation to ISP-Identified Services	47	52	49	47
7-ii Transportation to Other ISP Activities	35	37	37	40
7-iii After Hours Transportation	36	43	39	39
Total Unmet Resource Needs	118	132	125	126
Distinct Clients with Unmet Resource Needs	89	98	95	87
7m. Personal Growth/Community				
7m-i Avocational Activities	5	4	4	3
7m. Personal Growth/Community				

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Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 5
(Androscoggin, Franklin, Oxford)
(Includes: Bridgton, Harrison, Naples, Casco)
Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,756	1,812	1,866	1,885
7m-ii Recreation Activities	22	28	26	28
7m-iii Social Activities	35	33	45	57
7m-iv Spiritual Activities	12	13	20	26
Total Unmet Resource Needs	74	78	95	114
Distinct Clients with Unmet Resource Needs	48	53	68	74
Other Resources				
Other Resources	30	44	51	43
Total Unmet Resource Needs	30	44	51	43
Distinct Clients with Unmet Resource Needs	30	44	51	43
CSN 5 Totals				
Total Unmet Resource Needs	1,526	1,707	1,959	1,833
Distinct Clients With any Unmet Resource Need	542	607	657	618
Distinct Clients with a RDS	1,756	1,812	1,866	1,885

Report Run: Apr 18, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q2

CSN 6 - Cumberland

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

2012 Q3			2012 Q4			2013 Q1			2013 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
575	1,888	30.5%	566	1,909	29.6%	560	1,953	28.7%	593	1,951	30.4%

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

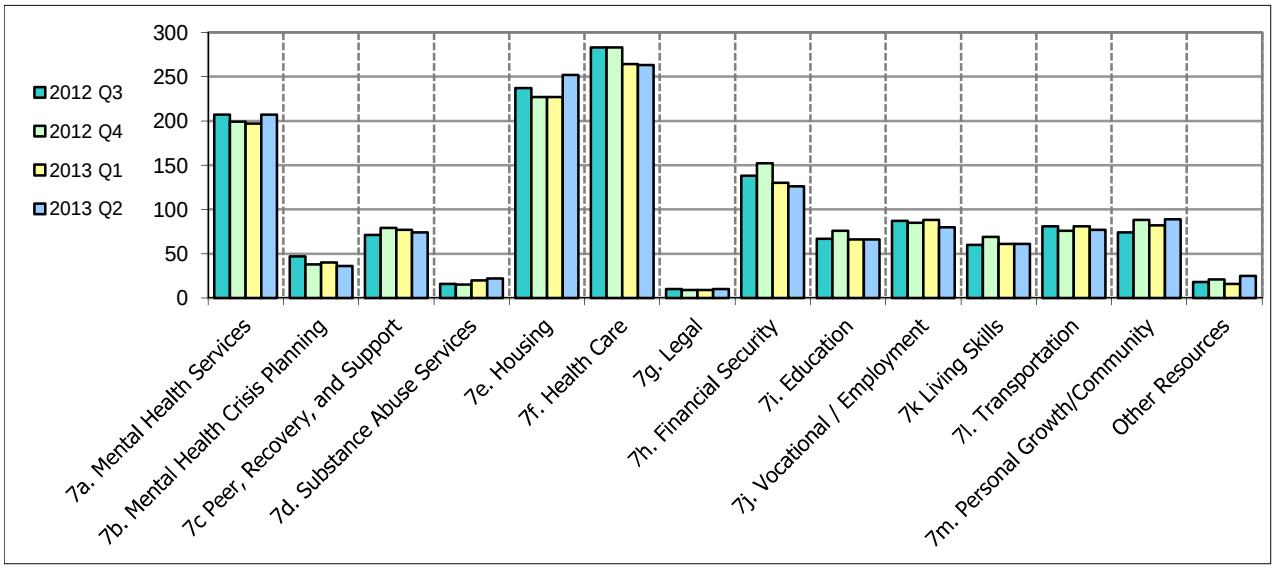

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q3	2012 Q4	2013 Q1	2013 Q2
7a. Mental Health Services	207	199	197	207
7b. Mental Health Crisis Planning	47	38	40	36
7c Peer, Recovery, and Support	71	79	77	74
7d. Substance Abuse Services	16	15	20	22
7e. Housing	237	227	227	252
7f. Health Care	283	283	264	263
7g. Legal	10	9	9	10
7h. Financial Security	138	152	130	126
7i. Education	67	76	66	66
7j. Vocational / Employment	87	85	88	80
7k Living Skills	60	69	61	61
7l. Transportation	81	76	81	77
7m. Personal Growth/Community	74	88	82	89
Other Resources	18	21	16	25
Total CSN 6 Unmet Needs	1,396	1,417	1,358	1,388

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

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

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,888	1,909	1,953	1,951
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	11	8	13	12
7a-iii Dialectical Behavioral Therapy	4	7	3	7
7a-iv Family Psycho-Educational Treatment	6	4	0	1
7a-v Group Counseling	11	10	9	11
7a-vi Individual Counseling	84	87	77	76
7a-vii Inpatient Psychiatric Facility	0	2	2	0
7a-viii Intensive Case Management	3	7	13	13
7a-x Psychiatric Medication Management	88	74	80	87
Total Unmet Resource Needs	207	199	197	207
Distinct Clients with Unmet Resource Needs	156	144	144	156
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	39	33	34	30
7b-ii Mental Health Advance Directives	8	5	6	6
Total Unmet Resource Needs	47	38	40	36
Distinct Clients with Unmet Resource Needs	44	37	37	33
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	15	18	18	14
7c-ii Recovery Workbook Group	1	1	1	1
7c-iii Social Club	28	32	34	32
7c-iv Peer-Run Trauma Recovery Group	2	3	3	5
7c-v Wellness Recovery and Action Planning	6	5	7	8
7c-vi Family Support	19	20	14	14
Total Unmet Resource Needs	71	79	77	74
Distinct Clients with Unmet Resource Needs	57	66	59	57
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	10	12	16	18
7d-ii Residential Treatment Substance Abuse Services	6	3	4	4
Total Unmet Resource Needs	16	15	20	22
Distinct Clients with Unmet Resource Needs	13	14	18	22
7e. Housing				

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Substance Abuse and Mental Health Services
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Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,888	1,909	1,953	1,951
7e-i Supported Apartment	38	36	42	45
7e-ii Community Residential Facility	10	12	13	13
7e-iii Residential Treatment Facility (group home)	6	7	4	3
7e-iv Assisted Living Facility	12	14	16	17
7e-v Nursing Home	2	4	2	2
7e-vi Residential Crisis Unit	1	1	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	168	153	150	172
Total Unmet Resource Needs	237	227	227	252
Distinct Clients with Unmet Resource Needs	213	200	204	224
7f. Health Care				
7f-i Dental Services	156	156	144	143
7f-ii Eye Care Services	50	50	52	52
7f-iii Hearing Services	19	16	10	11
7f-iv Physical Therapy	6	9	7	6
7f-v Physician/Medical Services	52	52	51	51
Total Unmet Resource Needs	283	283	264	263
Distinct Clients with Unmet Resource Needs	210	215	199	202
7g. Legal				
7g-i Advocate	9	5	6	6
7g-ii Guardian (private)	1	1	1	1
7g-iii Guardian (public)	0	3	2	3
Total Unmet Resource Needs	10	9	9	10
Distinct Clients with Unmet Resource Needs	10	9	9	10
7h. Financial Security				
7h-i Assistance with Managing Money	82	91	77	72
7h-ii Assistance with Securing Public Benefits	40	48	40	40
7h-iii Representative Payee	16	13	13	14
Total Unmet Resource Needs	138	152	130	126
Distinct Clients with Unmet Resource Needs	122	135	117	116
7i. Education				

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Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,888	1,909	1,953	1,951
7i-i Adult Education (other than GED)	25	27	19	21
7i-ii GED	16	15	14	15
7i-iii Literacy Assistance	3	7	7	7
7i-iv Post High School Education	23	24	23	22
7i-v Tuition Reimbursement	0	3	3	1
Total Unmet Resource Needs	67	76	66	66
Distinct Clients with Unmet Resource Needs	62	69	60	61
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	6	7	10	8
7j-ii Club House and/or Peer Vocational Support	2	3	3	2
7j-iii Competitive Employment (no supports)	13	14	17	17
7j-iv Supported Employment	8	11	8	5
7j-v Vocational Rehabilitation	58	50	50	48
Total Unmet Resource Needs	87	85	88	80
Distinct Clients with Unmet Resource Needs	81	75	79	74
7k. Living Skills				
7k-i Daily Living Support Services	31	37	31	35
7k-ii Day Support Services	5	6	7	7
7k-iii Occupational Therapy	3	3	3	3
7k-iv Skills Development Services	21	23	20	16
Total Unmet Resource Needs	60	69	61	61
Distinct Clients with Unmet Resource Needs	56	64	57	58
7l. Transportation				
7l-i Transportation to ISP-Identified Services	46	44	40	40
7-ii Transportation to Other ISP Activities	18	16	23	20
7-iii After Hours Transportation	17	16	18	17
Total Unmet Resource Needs	81	76	81	77
Distinct Clients with Unmet Resource Needs	65	64	62	63
7m. Personal Growth/Community				
7m-i Avocational Activities	4	6	5	4
7m. Personal Growth/Community				

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Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 6
(Cumberland)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	1,888	1,909	1,953	1,951
7m-ii Recreation Activities	18	21	21	23
7m-iii Social Activities	39	49	45	48
7m-iv Spiritual Activities	13	12	11	14
Total Unmet Resource Needs	74	88	82	89
Distinct Clients with Unmet Resource Needs	57	65	64	69
Other Resources				
Other Resources	18	21	16	25
Total Unmet Resource Needs	18	21	16	25
Distinct Clients with Unmet Resource Needs	18	21	16	25
CSN 6 Totals				
Total Unmet Resource Needs	1,396	1,417	1,358	1,388
Distinct Clients With any Unmet Resource Need	575	566	560	593
Distinct Clients with a RDS	1,888	1,909	1,953	1,951

Report Run: Apr 18, 2013

Statewide Report of Unmet Resource Needs for Fiscal Year 2013 Q2

CSN 7 - York

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

2012 Q3			2012 Q4			2013 Q1			2013 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
164	488	33.6%	162	477	34.0%	148	458	32.3%	166	517	32.1%

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

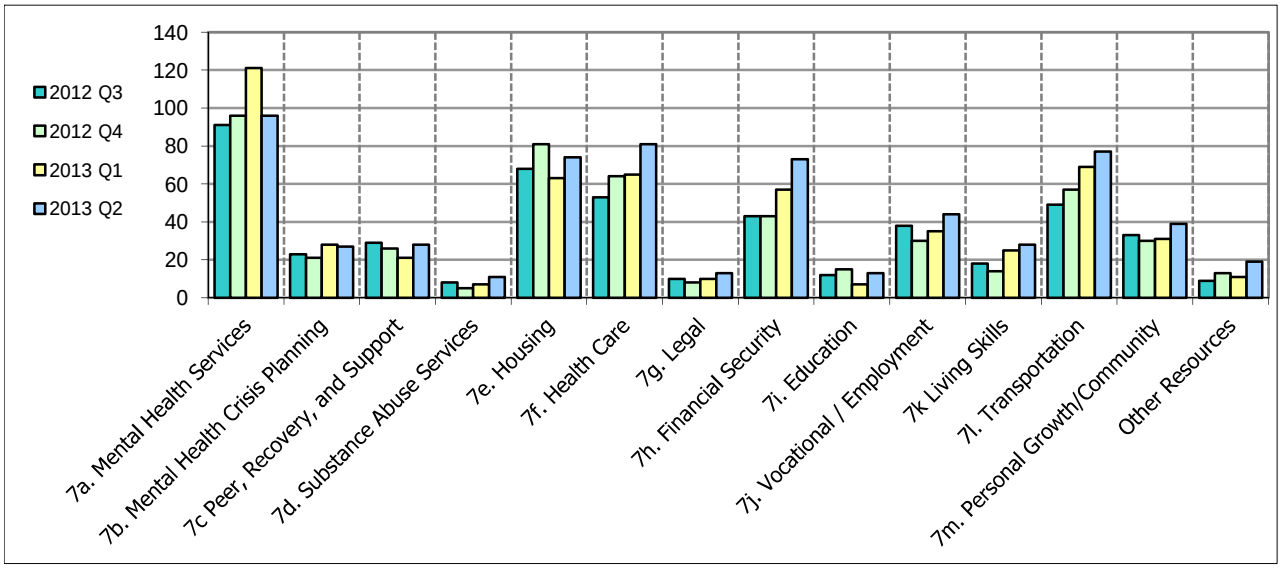

Table 2: Total Number of Unmet Resource Needs Reported

Reported Unmet Resource Needs	2012 Q3	2012 Q4	2013 Q1	2013 Q2
7a. Mental Health Services	91	96	121	96
7b. Mental Health Crisis Planning	23	21	28	27
7c Peer, Recovery, and Support	29	26	21	28
7d. Substance Abuse Services	8	5	7	11
7e. Housing	68	81	63	74
7f. Health Care	53	64	65	81
7g. Legal	10	8	10	13
7h. Financial Security	43	43	57	73
7i. Education	12	15	7	13
7j. Vocational / Employment	38	30	35	44
7k Living Skills	18	14	25	28
7l. Transportation	49	57	69	77
7m. Personal Growth/Community	33	30	31	39
Other Resources	9	13	11	19
Total CSN 7 Unmet Needs	484	503	550	623

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

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	488	477	458	517
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	4	3	4	6
7a-iii Dialectical Behavioral Therapy	3	6	2	4
7a-iv Family Psycho-Educational Treatment	1	1	2	1
7a-v Group Counseling	3	1	1	4
7a-vi Individual Counseling	35	40	58	39
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	1	0	1	0
7a-x Psychiatric Medication Management	44	45	53	42
Total Unmet Resource Needs	91	96	121	96
Distinct Clients with Unmet Resource Needs	67	69	84	68
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	19	19	25	24
7b-ii Mental Health Advance Directives	4	2	3	3
Total Unmet Resource Needs	23	21	28	27
Distinct Clients with Unmet Resource Needs	20	19	26	25
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	2	1	1	1
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	10	9	9	10
7c-iv Peer-Run Trauma Recovery Group	5	2	1	6
7c-v Wellness Recovery and Action Planning	5	1	0	2
7c-vi Family Support	7	13	10	9
Total Unmet Resource Needs	29	26	21	28
Distinct Clients with Unmet Resource Needs	25	21	18	22
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	7	5	6	9
7d-ii Residential Treatment Substance Abuse Services	1	0	1	2
Total Unmet Resource Needs	8	5	7	11
Distinct Clients with Unmet Resource Needs	8	5	6	10
7e. Housing				

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Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	488	477	458	517
7e-i Supported Apartment	9	11	10	5
7e-ii Community Residential Facility	0	2	3	3
7e-iii Residential Treatment Facility (group home)	0	0	0	1
7e-iv Assisted Living Facility	4	4	2	3
7e-v Nursing Home	1	0	0	2
7e-vi Residential Crisis Unit	0	0	0	1
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	54	64	48	59
Total Unmet Resource Needs	68	81	63	74
Distinct Clients with Unmet Resource Needs	63	72	57	66
7f. Health Care				
7f-i Dental Services	29	36	27	37
7f-ii Eye Care Services	11	13	16	17
7f-iii Hearing Services	0	3	2	2
7f-iv Physical Therapy	1	2	4	6
7f-v Physician/Medical Services	12	10	16	19
Total Unmet Resource Needs	53	64	65	81
Distinct Clients with Unmet Resource Needs	42	49	45	58
7g. Legal				
7g-i Advocate	8	8	9	11
7g-ii Guardian (private)	0	0	0	0
7g-iii Guardian (public)	2	0	1	2
Total Unmet Resource Needs	10	8	10	13
Distinct Clients with Unmet Resource Needs	10	8	10	13
7h. Financial Security				
7h-i Assistance with Managing Money	25	28	34	36
7h-ii Assistance with Securing Public Benefits	15	15	20	30
7h-iii Representative Payee	3	0	3	7
Total Unmet Resource Needs	43	43	57	73
Distinct Clients with Unmet Resource Needs	37	37	45	56
7i. Education				

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Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	488	477	458	517
7i-i Adult Education (other than GED)	2	5	1	4
7i-ii GED	3	5	3	5
7i-iii Literacy Assistance	3	1	1	3
7i-iv Post High School Education	3	4	2	1
7i-v Tuition Reimbursement	1	0	0	0
Total Unmet Resource Needs	12	15	7	13
Distinct Clients with Unmet Resource Needs	10	14	7	12
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	4	3	5	8
7j-ii Club House and/or Peer Vocational Support	0	0	1	2
7j-iii Competitive Employment (no supports)	6	2	3	8
7j-iv Supported Employment	6	3	4	2
7j-v Vocational Rehabilitation	22	22	22	24
Total Unmet Resource Needs	38	30	35	44
Distinct Clients with Unmet Resource Needs	31	26	28	35
7k. Living Skills				
7k-i Daily Living Support Services	10	9	14	22
7k-ii Day Support Services	1	1	1	1
7k-iii Occupational Therapy	0	0	0	0
7k-iv Skills Development Services	7	4	10	5
Total Unmet Resource Needs	18	14	25	28
Distinct Clients with Unmet Resource Needs	15	14	23	26
7l. Transportation				
7l-i Transportation to ISP-Identified Services	24	23	31	37
7-ii Transportation to Other ISP Activities	12	19	24	26
7-iii After Hours Transportation	13	15	14	14
Total Unmet Resource Needs	49	57	69	77
Distinct Clients with Unmet Resource Needs	32	40	41	46
7m. Personal Growth/Community				
7m-i Avocational Activities	4	3	4	3
7m. Personal Growth/Community				

Report Run: Apr 18, 2013

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

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

Report of Unmet Resource Needs

CSN 7
(York)

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	488	477	458	517
7m-ii Recreation Activities	6	8	9	12
7m-iii Social Activities	21	18	16	22
7m-iv Spiritual Activities	2	1	2	2
Total Unmet Resource Needs	33	30	31	39
Distinct Clients with Unmet Resource Needs	29	24	22	29
Other Resources				
Other Resources	9	13	11	19
Total Unmet Resource Needs	9	13	11	19
Distinct Clients with Unmet Resource Needs	9	13	11	19
CSN 7 Totals				
Total Unmet Resource Needs	484	503	550	623
Distinct Clients With any Unmet Resource Need	164	162	148	166
Distinct Clients with a RDS	488	477	458	517

Report Run: Apr 18, 2013

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	391	378	368	328
7a. Mental Health Services				
7a-i Assertive Community Treatment (ACT)	1	0	0	0
7a-iii Dialectical Behavioral Therapy	3	2	4	2
7a-iv Family Psycho-Educational Treatment	1	0	0	0
7a-v Group Counseling	3	1	2	1
7a-vi Individual Counseling	12	9	17	9
7a-vii Inpatient Psychiatric Facility	0	0	0	0
7a-viii Intensive Case Management	0	0	1	3
7a-x Psychiatric Medication Management	15	19	16	13
Total Unmet Resource Needs	35	31	40	28
Distinct Clients with Unmet Resource Needs	32	28	35	25
7b. Mental Health Crisis Planning				
7b-i Development of Mental Health Crisis Plan	3	5	2	2
7b-ii Mental Health Advance Directives	3	4	3	3
Total Unmet Resource Needs	6	9	5	5
Distinct Clients with Unmet Resource Needs	6	9	5	5
7c Peer, Recovery, and Support				
7c-i Peer Recovery Center	1	1	1	2
7c-ii Recovery Workbook Group	0	0	0	0
7c-iii Social Club	8	3	1	2
7c-iv Peer-Run Trauma Recovery Group	3	2	2	1
7c-v Wellness Recovery and Action Planning	0	0	0	0
7c-vi Family Support	1	2	1	1
Total Unmet Resource Needs	13	8	5	6
Distinct Clients with Unmet Resource Needs	11	7	5	6
7d Substance Abuse Services				
7d-i Outpatient Substance Abuse Services	4	3	1	1
7d-ii Residential Treatment Substance Abuse Services	1	1	0	0
Total Unmet Resource Needs	5	4	1	1
Distinct Clients with Unmet Resource Needs	4	3	1	1
7e. Housing				

Report Run: Apr 18, 2013

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	391	378	368	328
7e-i Supported Apartment	2	1	3	2
7e-ii Community Residential Facility	4	3	2	1
7e-iii Residential Treatment Facility (group home)	0	0	1	0
7e-iv Assisted Living Facility	0	1	0	0
7e-v Nursing Home	0	1	1	1
7e-vi Residential Crisis Unit	0	0	0	0
7e-vii Rent Subsidy (Section 8, BRAP, Shelter Plus)	26	29	27	26
Total Unmet Resource Needs	32	35	34	30
Distinct Clients with Unmet Resource Needs	32	35	32	29
7f. Health Care				
7f-i Dental Services	20	15	12	18
7f-ii Eye Care Services	7	4	5	9
7f-iii Hearing Services	1	2	2	3
7f-iv Physical Therapy	2	1	0	1
7f-v Physician/Medical Services	5	6	6	3
Total Unmet Resource Needs	35	28	25	34
Distinct Clients with Unmet Resource Needs	29	24	21	25
7g. Legal				
7g-i Advocate	5	5	4	2
7g-ii Guardian (private)	3	2	2	1
7g-iii Guardian (public)	1	3	2	2
Total Unmet Resource Needs	9	10	8	5
Distinct Clients with Unmet Resource Needs	9	10	8	4
7h. Financial Security				
7h-i Assistance with Managing Money	11	16	14	10
7h-ii Assistance with Securing Public Benefits	9	8	6	7
7h-iii Representative Payee	2	0	0	0
Total Unmet Resource Needs	22	24	20	17
Distinct Clients with Unmet Resource Needs	19	20	18	17
7i. Education				

Report Run: Apr 18, 2013

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	391	378	368	328
7i-i Adult Education (other than GED)	3	1	0	1
7i-ii GED	5	1	3	2
7i-iii Literacy Assistance	0	0	0	0
7i-iv Post High School Education	5	3	2	1
7i-v Tuition Reimbursement	1	0	0	0
Total Unmet Resource Needs	14	5	5	4
Distinct Clients with Unmet Resource Needs	13	5	5	4
7j. Vocational / Employment				
7j-i Benefits Counseling Related to Employment	1	2	3	1
7j-ii Club House and/or Peer Vocational Support	1	1	0	0
7j-iii Competitive Employment (no supports)	2	3	1	1
7j-iv Supported Employment	3	2	2	2
7j-v Vocational Rehabilitation	13	11	5	6
Total Unmet Resource Needs	20	19	11	10
Distinct Clients with Unmet Resource Needs	19	19	11	9
7k. Living Skills				
7k-i Daily Living Support Services	6	5	4	5
7k-ii Day Support Services	3	3	5	2
7k-iii Occupational Therapy	1	1	0	0
7k-iv Skills Development Services	2	2	2	1
Total Unmet Resource Needs	12	11	11	8
Distinct Clients with Unmet Resource Needs	9	9	8	7
7l. Transportation				
7l-i Transportation to ISP-Identified Services	13	10	12	13
7-ii Transportation to Other ISP Activities	10	9	8	12
7-iii After Hours Transportation	8	6	6	6
Total Unmet Resource Needs	31	25	26	31
Distinct Clients with Unmet Resource Needs	21	16	20	20
7m. Personal Growth/Community				
7m-i Avocational Activities	1	1	1	1
7m. Personal Growth/Community				

Report Run: Apr 18, 2013

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Report of Unmet Resource Needs

CSN Not Assigned

Fiscal Year 2013 Quarter 2
(Oct, Nov, Dec 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Distinct Clients with a RDS	391	378	368	328
7m-ii Recreation Activities	7	4	4	2
7m-iii Social Activities	18	11	9	7
7m-iv Spiritual Activities	3	0	0	0
Total Unmet Resource Needs	29	16	14	10
Distinct Clients with Unmet Resource Needs	21	15	13	9
Other Resources				
Other Resources	6	4	8	8
Total Unmet Resource Needs	6	4	8	8
Distinct Clients with Unmet Resource Needs	6	4	8	8
CSN Not Assigned Totals				
Total Unmet Resource Needs	269	229	213	197
Distinct Clients With any Unmet Resource Need	104	102	90	83
Distinct Clients with a RDS	391	378	368	328

Report Run: Apr 18, 2013

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

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Bridging Rental Assistance Program (BRAP)
Monitoring Report
Quarter 3 FY2013 (January, February, March 2013)

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, and homeless shelters. 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 2010*, in Maine, 98% 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 104% and Sagadahoc 106%. In the City of Portland 126% 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) 125%.

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.

On July 13, 2007, because the number of persons with BRAP vouchers was 41 over the maximum, the BRAP Wait List Protocol was fully activated. The following report details the census activity over the most recent four quarters. Trending information from the previous reports is provided so ongoing activity can be readily measured against longitudinal trends.

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, the formula is ((Current Report Number – Previous Report Number) / Current Report Number).

- Priority #1 applicants (Discharge from a psychiatric hospital within the last 6 months). Riverview and Dorothea Dix consumers are typically not waiting more than 5 days from the date of a completed application. Priority 1 applicants waiting for a BRAP voucher have decreased from 23 to 22 persons, down 4%.
- Priority #2 applicants (Homeless) have increased from 342 to 369 up 8%

- Priority #3 applicants (Substandard Housing) no change, remains at 3 persons.
- Priority #4 applicants (Community Residential Facility) have also decreased 44 to 40 persons, down 9%.
- Persons on the waitlist greater than 90 days have increased from 242 to 350 persons, up 45%.

Since inception of the wait list, there has been a total of 2,071 BRAP vouchers awarded broken down as follows: Priority #1, 976; Priority #2, 844; Priority #3, 27; Priority #4, 212. Note that 12 vouchers have been awarded to persons with no priority. In the last quarter 33 vouchers were awarded and 24 people were added to the waitlist.

The current BRAP census as of March 31, 2013 is 768 vouchers. Given the fiscal climate, it is unlikely there will be any carry-over dollars via the no-lapse in funds clause this year. We anticipate requesting $100,000 of AG Funds for Quarter 4, that were part of the Supplemental Budget passed earlier this year. This should allow us to provide up to 100 additional vouchers, or approximately 25% of the documented waitlist in Q4. Additional dollars using AG Funds budgeted for FY14 should allow us to carry forward these vouchers into the next Fiscal Year.

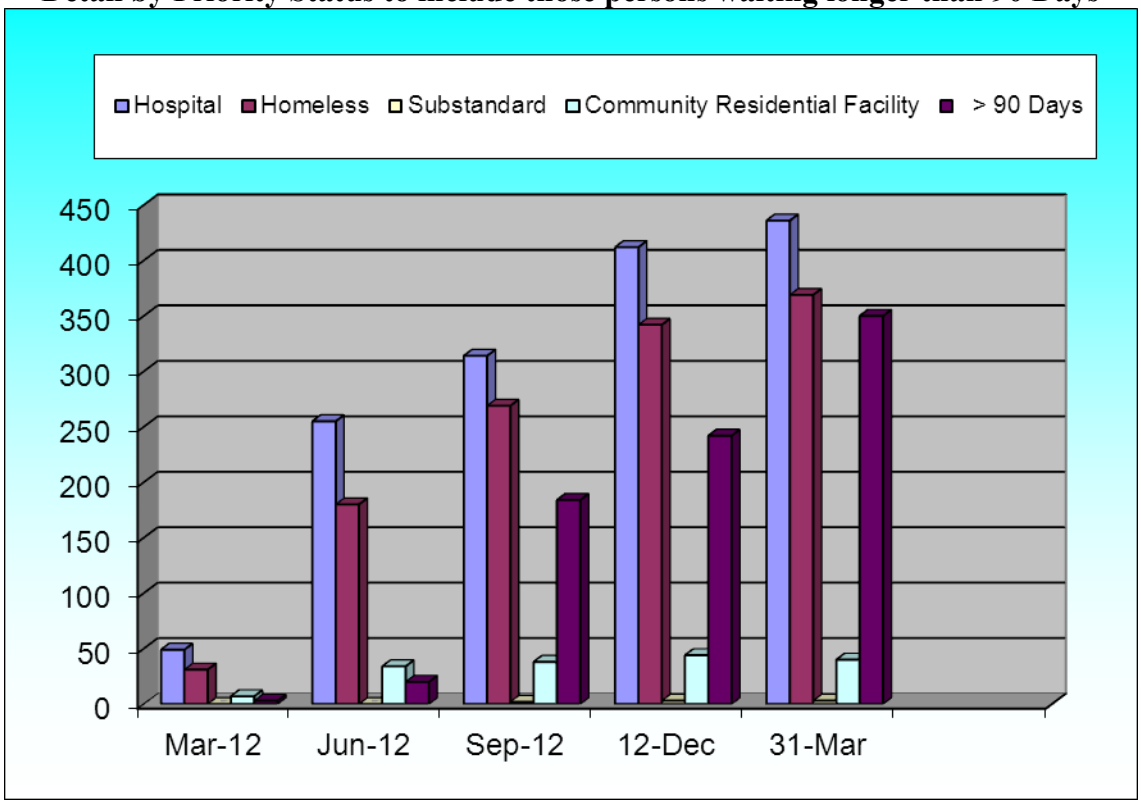
The number of persons on the program for greater than 24 months remains steady at 25% of the entire program. This is principally a result of decades of federal and state cuts to low-income and supportive housing programs, including persons who will not qualify for Section 8 due criminal activity. The lack of availability of these resources, particularly Section 8 at the federal level, has translated to increased pressures on state programs such as BRAP.

HUD has recently issued a second definition of homelessness which has a direct impact on the Shelter Plus Care program. We are awaiting further clarification from HUD on the new definitions before implementing them into the BRAP program. HUDs new homeless definition is broader than the existing one and includes 'at-risk' categories. It is likely we will have to narrow BRAP to the 'literally homeless' category in order to stay within limits of funding and manage waitlists.

Other potential impacts to the program surround General Assistance and TANF as BRAP currently has an income requirement, and is not desgined to support 100% of the rental assistance. Depending on legislative initiatives and outcomes this Legislative session (126th) we may need to modify BRAP program guidelines regarding income and longevity.

SAMHS administered a substantial number of Shelter Plus Care vouchers, 794 as of March 31, 2013. 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. The FY2013 annual budget for Shelter Plus Care is $7.1 million. The total dollars for all SPC grants (one year renewals to 5 year new contracts) administered by SAMHS is $13,434,250. Shelter Plus Care (SPC) is designed to provide 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%).

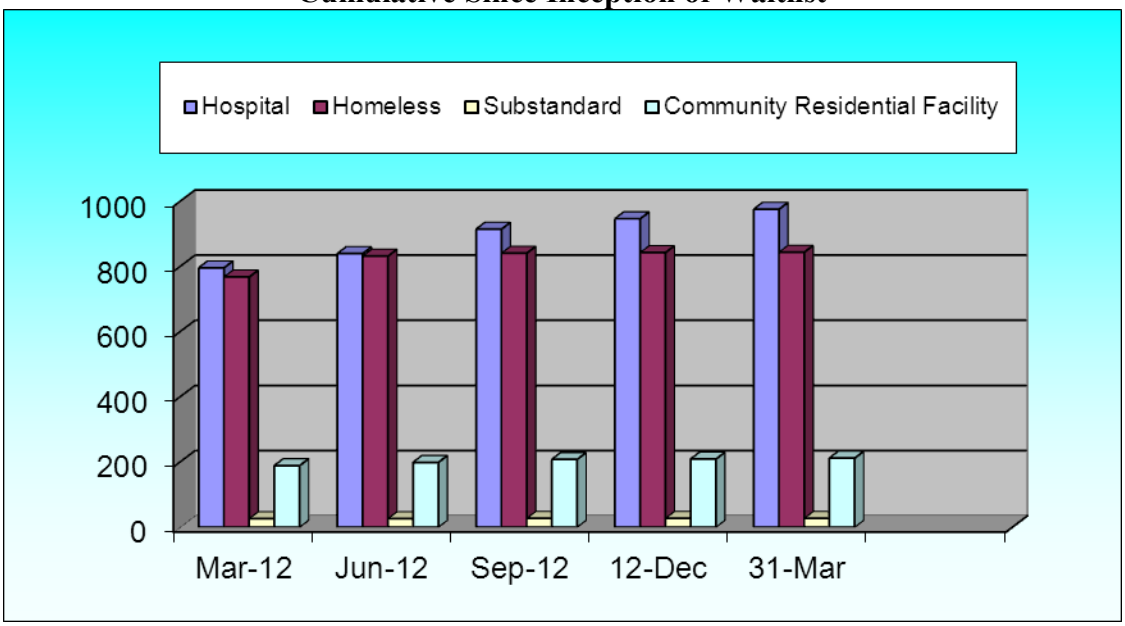
BRAP Waitlist Status--Graph:
Detail by Priority Status to include those persons waiting longer than 90 Days



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

Reporting Period	Mar-12	Jun-12	Sep-12	12-Dec	31-Mar	% Change relative to Last Report
Total number of persons waiting for BRAP	49	255	314	412	436	6%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	11	41	5	23	22	-4%
Priority 2—Homeless (HUD Transitional Definition)	31	180	269	342	369	8%
Priority 3—Sub-standard Housing	0	0	2	3	3	0%
Priority 4—Leaving a Community Residential living facility	7	34	38	44	40	-9%
Total number of persons on wait list more than 90 days awaiting voucher	3	20	184	242	350	45%

BRAP Awards—Graph
Cumulative Since Inception of Waitlist



BRAP Awards—Table
Cumulative Since Inception of Waitlist

Reporting Periods	Mar-12	Jun-12	Sep-12	12-Dec	31-Mar	% Change relative to Last Report
Cumulative number of persons awarded BRAP	1790	1908	2003	2038	2071	2%
Priority 1—Discharge from state or private psychiatric hospital within last 6 months	796	840	915	947	976	3%
Priority 2—Homeless (HUD Transitional Definition)	768	832	841	843	844	0%
Priority 3—Sub-standard Housing	26	26	27	27	27	0%
Priority 4—Leaving a DHHS funded living facility	189	199	208	209	212	1%

Note: 12 persons awarded with no priority

Substance Abuse and Mental Health Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Class Member Treatment Planning Review

For the 2nd Quarter of Fiscal Year 2013

(January, February, March 2013)

		2012 Q4	2013 Q1	2013 Q2	2013 Q3
Total Plans Reviewed		50	50	55	50
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?	100.0% 17 of 17	100.0% 13 of 13	100.0% 18 of 18	100.0% 18 of 18
1B	Does the record document that the agency has planned with and educated the consumer regarding releases of information during each treatment plan review?	77.8% 35 of 45	77.6% 38 of 49	96.2% 51 of 53	85.4% 41 of 48
1C	Does the record document that the consumer has a primary care physician (PCP)?	94.0% 47 of 50	95.8% 46 of 48	88.7% 47 of 53	92.0% 46 of 50
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?	85.1% 40 of 47	82.6% 38 of 46	85.1% 40 of 47	91.3% 42 of 46
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?	90.0% 45 of 50	95.8% 46 of 48	98.2% 54 of 55	98.0% 49 of 50

2B	Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?	96.0%	48 of 50	96.0%	48 of 50	96.4%	53 of 55	100.0%	50 of 50
2C	Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?	95.7%	45 of 47	95.9%	47 of 49	98.2%	54 of 55	98.0%	49 of 50
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?	96.0%	48 of 50	98.0%	48 of 49	100.0%	55 of 55	96.0%	48 of 50
2E	Does the record document that the consumer has a crisis plan?	51.1%	23 of 45	72.9%	35 of 48	92.3%	48 of 52	62.5%	30 of 48
2F	If 2E. is no, is the reason documented?	100.0%	22 of 22	100.0%	13 of 13	100.0%	4 of 4	100.0%	18 of 18
2G	If 2E. is yes, has the crisis plan been reviewed as required every three months?	69.6%	16 of 23	85.7%	30 of 35	89.6%	43 of 48	73.3%	22 of 30
2H	If 2E. is yes, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?	N/A	4 of 0	54.5%	6 of 11	100.0%	4 of 4	50.0%	3 of 6
2I	Does the record document that the consumer has a mental health advance directive?	7.7%	3 of 39	12.2%	6 of 49	12.7%	7 of 55	4.1%	2 of 49
2J	If 2I. is yes, has the advance directive been reviewed at least annually by the CSW and consumer?	33.3%	1 of 3	50.0%	3 of 6	0.0%	0 of 7	0.0%	0 of 2
2K	If 2I. is no, is the reason why documented?	100.0%	36 of 36	100.0%	43 of 43	100.0%	48 of 48	100.0%	47 of 47
III Needed Resources									
3A	Does the record document that natural supports (family/friends) are being accessed as a resource?	92.0%	46 of 50	100.0%	11 of 11	N/A	0 of 0	N/A	0 of 0
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	N/A	0 of 0	N/A	0 of 0	N/A	0 of 0
3C	Does the record document that generic resources (those resources that anyone can access) are being accessed?	100.0%	50 of 50	91.7%	11 of 12	100.0%	2 of 2	66.7%	2 of 3

3D	If 3C. is no, has the worker discussed with the consumer the consideration of generic resources as a resource?	N/A	0 of 0	0.0%	0 of 1	N/A	0 of 0	0.0%	0 of 1
3E	Does the record document a resource need that has not been provided according to/within the expected response time?	15.4%	6 of 39	26.7%	4 of 15	80.0%	8 of 10	50.0%	3 of 6
3F	Does the treatment plan reflect interim planning?	100.0%	6 of 6	100.0%	4 of 4	100.0%	8 of 8	100.0%	3 of 3
3G	Does the record document that the treatment team reconvened after the unmet need was identified?	100.0%	6 of 6	25.0%	1 of 4	0.0%	0 of 8	0.0%	0 of 3
IV Service Agreements									
4A	Does the record document that service agreements are required for this plan? (see paragraph 69 protocol for definitions)	34.9%	15 of 43	65.3%	32 of 49	34.5%	19 of 55	47.9%	23 of 48
4B	If 4A. is yes, have service agreements been acquired?	40.0%	6 of 15	65.6%	21 of 32	73.7%	14 of 19	73.9%	17 of 23
4C	If 4A. is yes, are the service agreements current?	33.3%	5 of 15	59.4%	19 of 32	73.7%	14 of 19	65.2%	15 of 23
V Vocational Services									
5A	Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?	90.0%	45 of 50	100.0%	50 of 50	98.2%	54 of 55	98.0%	49 of 50
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	94.0%	47 of 50	98.2%	54 of 55	93.8%	45 of 48
VI Comments									
6A	Plan of correction requested?	42.0%	21 of 50	32.0%	16 of 50	27.3%	15 of 55	30.0%	15 of 50
6A.1.	Plan of correction for section 2A. (required when not all domains assessed) included?	100.0%	5 of 5	0.0%	0 of 2	0.0%	0 of 1	0.0%	0 of 1
6C	Plan of correction received?	95.2%	20 of 21	68.8%	11 of 16	66.7%	10 of 15	13.3%	2 of 15
6D	Were corrections made to the satisfaction of the CDC?	100.0%	20 of 20	100.0%	11 of 11	100.0%	10 of 10	100.0%	2 of 2

Report Run by: Brandi.Giguere Report Run on: Apr 16 2013 at 9:00:51 AM

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

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

Community Hospital Utilization Review for Involuntary Admissions

Class Members

For the 2nd Quarter of Fiscal Year 2013

(October, November, December 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Total Admissions	9	19	19	14
Hospital				
Hospitalized in Local Area	77.8% (7 of 9)	73.7% (14 of 19)	100.0% (19 of 19)	92.9% (13 of 14)
Hospitalization Made Voluntary	77.8% (7 of 9)	57.9% (11 of 19)	78.9% (15 of 19)	50.0% (7 of 14)
Legal Status				
Blue Paper on File	100.0% (9 of 9)	100.0% (19 of 19)	100.0% (19 of 19)	92.9% (13 of 14)
Blue Paper Complete/Accurate	100.0% (9 of 9)	100.0% (19 of 19)	100.0% (19 of 19)	100.0% (13 of 13)
If not complete, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
24 Hr. Certification Required	88.9% (8 of 9)	94.7% (18 of 19)	94.7% (18 of 19)	100.0% (14 of 14)
24 Hr. Certification on file	100.0% (8 of 8)	100.0% (18 of 18)	100.0% (18 of 18)	92.9% (13 of 14)
24 Hr. Certification Complete/Accurate	100.0% (8 of 8)	100.0% (18 of 18)	100.0% (18 of 18)	100.0% (13 of 13)
If not, Follow up per policy	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Quality Care				
Medical Necessity Established	100.0% (9 of 9)	100.0% (19 of 19)	100.0% (19 of 19)	100.0% (14 of 14)
Active Treatment Within Guidelines	100.0% (9 of 9)	94.7% (18 of 19)	100.0% (19 of 19)	100.0% (14 of 14)
Patient's Rights Maintained	88.9% (8 of 9)	94.7% (18 of 19)	100.0% (19 of 19)	92.9% (13 of 14)
If not maintained, follow up per policy	100.0% (1 of 1)	N/A (0 of 0)	N/A (0 of 0)	100.0% (1 of 1)
Inappropriate Use of Blue Paper	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Individual Service Plans				
Receiving Case Management Services	55.6% (5 of 9)	68.4% (13 of 19)	52.6% (10 of 19)	64.3% (9 of 14)
Case Manager Involved with Discharge Planning	100.0% (5 of 5)	100.0% (13 of 13)	70.0% (7 of 10)	100.0% (9 of 9)
Total Clients who Authorized Hospital to Obtain ISP	80.0% (4 of 5)	92.3% (12 of 13)	100.0% (10 of 10)	100.0% (9 of 9)
Hospital Obtained ISP when authorized	25.0% (1 of 4)	8.3% (1 of 12)	0.0% (0 of 10)	22.2% (2 of 9)
Treatment and Discharge Plan Consistant with ISP	100.0% (1 of 1)	100.0% (1 of 1)	N/A (0 of 0)	100.0% (2 of 2)

Report Run: Apr 18, 2013

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

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

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

Community Hospital Utilization Review for Involuntary Admissions

All Clients

For the 2nd Quarter of Fiscal Year 2013

(October, November, December 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Total Admissions	115	128	98	132
Hospital				
Hospitalized in Local Area	83.5% (96 of 115)	84.4% (108 of 128)	83.7% (82 of 98)	87.1% (115 of 132)
Hospitalization Made Voluntary	85.2% (98 of 115)	81.2% (104 of 128)	86.7% (85 of 98)	75.8% (100 of 132)
Legal Status				
Blue Paper on File	100.0% (115 of 115)	95.3% (122 of 128)	100.0% (98 of 98)	99.2% (131 of 132)
Blue Paper Complete/Accurate	99.1% (114 of 115)	98.4% (120 of 122)	100.0% (98 of 98)	100.0% (131 of 131)
If not complete, Follow up per policy	100.0% (1 of 1)	100.0% (2 of 2)	N/A (0 of 0)	N/A (0 of 0)
24 Hr. Certification Required	89.6% (103 of 115)	90.6% (116 of 128)	87.8% (86 of 98)	90.9% (120 of 132)
24 Hr. Certification on file	99.0% (102 of 103)	99.1% (115 of 116)	98.8% (85 of 86)	99.2% (119 of 120)
24 Hr. Certification Complete/Accurate	99.0% (101 of 102)	100.0% (115 of 115)	100.0% (85 of 85)	100.0% (119 of 119)
If not, Follow up per policy	100.0% (1 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Quality Care				
Medical Necessity Established	100.0% (115 of 115)	100.0% (128 of 128)	100.0% (98 of 98)	100.0% (132 of 132)
Active Treatment Within Guidelines	100.0% (115 of 115)	99.2% (127 of 128)	100.0% (98 of 98)	100.0% (132 of 132)
Patient's Rights Maintained	96.5% (111 of 115)	95.3% (122 of 128)	99.0% (97 of 98)	97.7% (129 of 132)
If not maintained, follow up per policy	100.0% (3 of 3)	100.0% (4 of 4)	100.0% (1 of 1)	100.0% (2 of 2)
Inappropriate Use of Blue Paper	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
Individual Service Plans				
Receiving Case Management Services	28.7% (33 of 115)	23.4% (30 of 128)	19.4% (19 of 98)	28.8% (38 of 132)
Case Manager Involved with Discharge Planning	90.9% (30 of 33)	86.7% (26 of 30)	78.9% (15 of 19)	94.7% (36 of 38)
Total Clients who Authorized Hospital to Obtain ISP	97.0% (32 of 33)	90.0% (27 of 30)	84.2% (16 of 19)	97.4% (37 of 38)
Hospital Obtained ISP when authorized	3.1% (1 of 32)	11.1% (3 of 27)	0.0% (0 of 16)	8.1% (3 of 37)
Treatment and Discharge Plan Consistant with ISP	100.0% (1 of 1)	100.0% (3 of 3)	N/A (0 of 0)	100.0% (3 of 3)

Report Run: Apr 18, 2013

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

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

Community Hospital Utilization Review for Involuntary Admissions

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

For the 2nd Quarter of Fiscal Year 2013

(October, November and December, 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Number of Admissions	10	19	19	14
Involuntarily Admitted Clients who were Receiving CSS Services	5	13	10	9
Number of ISPs Hospitals were Authorized to Obtain	4	12	10	9
Number of ISPs Hospitals Obtained	1	1	0	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
2012 Q3	**Acadia**	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Maine General - Waterville	1	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)	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)
	Spring Harbor	4	50.0% (2 of 4)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	St. Mary's	2	50.0% (1 of 2)	N/A (0 of 0)	N/A (0 of 0)	100.0% (1 of 1)
2012 Q4	**Acadia**	5	80.0% (4 of 5)	25.0% (1 of 4)	100.0% (1 of 1)	100.0% (4 of 4)
	Mid-coast Hospital	2	50.0% (1 of 2)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	5	60.0% (3 of 5)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Spring Harbor	6	66.7% (4 of 6)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (4 of 4)
	St. Mary's	1	100.0% (1 of 1)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
2013 Q1	**PenBay Medical Center**	4	0.0% (0 of 4)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	4	75.0% (3 of 4)	0.0% (0 of 3)	N/A (0 of 0)	0.0% (0 of 3)
	Spring Harbor	9	77.8% (7 of 9)	0.0% (0 of 7)	N/A (0 of 0)	100.0% (7 of 7)
	St. Mary's	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
2013 Q2	**Acadia**	2	100.0% (2 of 2)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Maine General - Waterville	2	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)	100.0% (2 of 2)
	PenBay Medical Center	4	75.0% (3 of 4)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Southern Maine Medical Center	3	33.3% (1 of 3)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Spring Harbor	2	50.0% (1 of 2)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	St. Mary's	1	0.0% (0 of 1)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)

Report Run: Apr 18, 2013

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Community Hospital Utilization Review for Involuntary Admissions

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

For the 2nd Quarter of Fiscal Year 2013

(October, November, and Decemeber, 2012)

	2012 Q3	2012 Q4	2013 Q1	2013 Q2
Number of Admissions	115	128	98	132
Involuntarily Admitted Clients who were Receiving CSS Services	33	30	19	38
Number of ISPs Hospitals were Authorized to Obtain	32	27	16	37
Number of ISPs Hospitals Obtained	1	3	0	3

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
2012 Q3	Acadia	21	14.3% (3 of 21)	0.0% (0 of 3)	N/A (0 of 0)	100.0% (3 of 3)
	Maine General - Waterville	6	16.7% (1 of 6)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Maine Medical Center	3	66.7% (2 of 3)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	Mid-coast Hospital	6	33.3% (2 of 6)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	PenBay Medical Center	5	20.0% (1 of 5)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	12	16.7% (2 of 12)	0.0% (0 of 2)	N/A (0 of 0)	50.0% (1 of 2)
	Spring Harbor	54	31.5% (17 of 54)	0.0% (0 of 17)	N/A (0 of 0)	100.0% (17 of 17)
	St. Mary's	8	62.5% (5 of 8)	0.0% (0 of 4)	N/A (0 of 0)	60.0% (3 of 5)
2012 Q4	Acadia	28	17.9% (5 of 28)	20.0% (1 of 5)	100.0% (1 of 1)	100.0% (5 of 5)
	Maine General - Waterville	7	14.3% (1 of 7)	100.0% (1 of 1)	100.0% (1 of 1)	100.0% (1 of 1)
	Maine Medical Center	1	100.0% (1 of 1)	N/A (0 of 0)	N/A (0 of 0)	100.0% (1 of 1)
	Mid-coast Hospital	6	16.7% (1 of 6)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	PenBay Medical Center	8	12.5% (1 of 8)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
	Southern Maine Medical Center	18	33.3% (6 of 18)	0.0% (0 of 6)	N/A (0 of 0)	66.7% (4 of 6)
	Spring Harbor	47	29.8% (14 of 47)	8.3% (1 of 12)	100.0% (1 of 1)	85.7% (12 of 14)
	St. Mary's	13	7.7% (1 of 13)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)
2012 Q1	Acadia	10	0.0% (0 of 10)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Maine General - Waterville	5	0.0% (0 of 5)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	PenBay Medical Center	8	0.0% (0 of 8)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Southern Maine Medical Center	13	23.1% (3 of 13)	0.0% (0 of 3)	N/A (0 of 0)	0.0% (0 of 3)
	Spring Harbor	51	27.5% (14 of 51)	0.0% (0 of 11)	N/A (0 of 0)	92.9% (13 of 14)
	St. Mary's	11	18.2% (2 of 11)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
2013 Q2	Acadia	23	21.7% (5 of 23)	0.0% (0 of 5)	N/A (0 of 0)	100.0% (5 of 5)
	Maine General - Waterville	7	42.9% (3 of 7)	66.7% (2 of 3)	100.0% (2 of 2)	100.0% (3 of 3)
	Maine Medical Center	2	0.0% (0 of 2)	N/A (0 of 0)	N/A (0 of 0)	N/A (0 of 0)
	Mid-coast Hospital	11	18.2% (2 of 11)	0.0% (0 of 2)	N/A (0 of 0)	100.0% (2 of 2)
	PenBay Medical Center	16	50.0% (8 of 16)	0.0% (0 of 8)	N/A (0 of 0)	100.0% (8 of 8)
	Select (unknown)	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	20	20.0% (4 of 20)	0.0% (0 of 4)	N/A (0 of 0)	75.0% (3 of 4)
	Spring Harbor	39	38.5% (15 of 39)	7.1% (1 of 14)	100.0% (1 of 1)	93.3% (14 of 15)
	St. Mary's	13	7.7% (1 of 13)	0.0% (0 of 1)	N/A (0 of 0)	100.0% (1 of 1)

Report Run: Apr 18, 2013

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

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

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

Department of Health and Human Services
Licensing and Regulatory Services
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-9300; Fax: (207) 287-9307
Toll Free (800) 791-4080; TTY Users: Dial 711 (Maine Relay)

Division of Licensing and Regulatory Services/Hospitals
Quarterly Consent Decree Reporting
Psychiatric Hospitals and Hospitals with Psychiatric Units

This report covers:
2013 Fiscal Year
__ First Quarter (July, August, September)
__ Second Quarter (October, November, December)
X Third Quarter (January, February, March)
__ Fourth Quarter (April, May, June)

0 Number of Surveys Completed
0 Number of non-accredited hospitals (specify): _____
_____
0 Number accredited hospitals (specify): _____
_____
0 Number in which Office of Adult Mental Health Service UR Nurse participated
0 Number of SODs (statements of deficiencies) forwarded to the Office of Adult Mental Health Services

7 Number of Complaints Received 5 Number of Complaints Investigated
1 Number substantiated
0 Number of Rights of Recipients of Mental Health Services violations
0 Number of Plans of Correction sought

Summary of Rights violations by Hospital:
_____
_____
_____
_____

Other: _____
_____
_____
_____
_____

Completed by: Bethany Laflin Date: March 15, 2013

Maine Department of Health and Human Services

Integrated Quarterly Crisis Report

STATEWIDE with GRAPHS

Quarter 2 (October, November, December) SFY 2013

I. Consumer Demographics (Unduplicated Counts - Face to Face)

Gender	Children	Males	644	Females	639				
	Adults	Males	2096	Females	2049				
Age Range	Children	<5y.o.	11	5-9	156	10-14	576	15-17	540
	Adults	18-21	443	22-35	1320	36-60	1965	61 & Older	390
Payment Source	Children	MaineCare	909	Private Ins.	309	Uninsured	80	Medicare	3
	Adults	MaineCare	2249	Private Ins.	727	Uninsured	790	Medicare	466

II. Summary of All Crisis Contacts

	CHILDREN	ADULT
a. Total number of telephone contacts.	9353	43394
b. Total number of all *INITIAL* face to face contacts.	1324	4386
c. Number in II.b. who are children/youth with MENTAL RETARDATION/AUTISM/PERVASIVE DEVELOPMENTAL DISORDER	85	
d. Number of face to face contacts that are ongoing support for crisis resolution/stabilization.	280	1557

III. Initial Crisis Contact Information

	CHILDREN		ADULT	
a. Total number of **INITIAL** face to face contacts in which wellness plan, crisis plan, ISP or advanced directive plan previously developed with the individual was used.	173	13.1%	432	9.8%
b. Number of **INITIAL** face to face contacts who have a Community Support Worker (CI, CRS, ICM, ACT,TCM).	457	34.5%	1152	26.3%
c. Number of **INITIAL** face to face contacts who have a Community Support Worker and whose worker was notified of the crisis.	442	96.7%	1096	95.1%
d. **SUM TOTAL** 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.			109755	25.0
e. Number of **INITIAL** face to face contacts in Emergency Department with final disposition made within 8 hours of that contact.			2404	91.4%
f. Number of **INITIAL** face to face contacts ***NOT*** in Emergency Department with final disposition made within 8 hours of that contact.			1731	98.6%

CHILDREN ONLY: Time from determination of need for face to face contact or when individual was ready and able to be seen to initial face to face contact

Less than 1 hour	731	1 to 2 hours	300	2 to 4 hours	206	More than 4 hours	66	
	55%		23%		16%		5%	

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

Less than 3 hours	930	3 to 6 hours	255	6 to 8 hours	25	8 to 14 hours	30	More than 14 hours	50
	70%		19%		2%		2%		4%

IV. Site of Initial Face to Face Contacts

Number of face to face contacts seen in :	CHILDREN		ADULT	
a. Primary Residence (Home)	251	19.0%	361	8.2%
b. Family/Relative/Other Residence	21	1.6%	24	0.5%
c. Other Community Setting (Work, School, Police Dept., Public Place)	137	10.3%	154	3.5%
d. SNF, Nursing Home, Boarding Home	0	0.0%	40	0.9%
e. Residential Program (Congregate Community Residence, Apartment Program)	4	0.3%	45	1.0%
f. Homeless Shelter	4	0.3%	31	0.7%
g. Provider Office	12	0.9%	96	2.2%
h. Crisis Office	218	16.5%	764	17.4%
i. Emergency Department	659	49.8%	2630	60.0%
j. Other Hospital Location	13	1.0%	143	3.3%
k. Incarcerated (Local Jail, State Prison, Juvenile Correction Facility)	5	0.4%	98	2.2%
NOTE: Sum of Crisis Resolutions must equal II.b.= Total no. of all INITIAL face-to-face contacts — **Sec. IV Total**	1324	100%	4386	100%

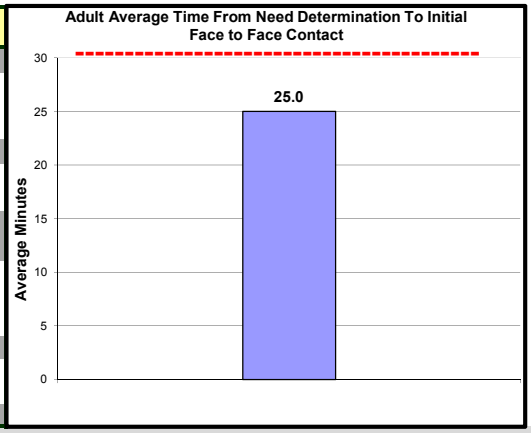
V. Initial Crisis Resolution (Mutually Exclusive & Exhaustive)

Number of face to face contacts that resulted in:	CHILDREN		ADULT	
a. Crisis stabilization with no referral for mental health/substance abuse follow-up	45	3.4%	247	5.6%
b. Crisis stabilization with *referral to new provider* for mental health/substance abuse follow-up	275	20.8%	800	18.2%
c. Crisis stabilization with *referral back to current provider* for mental health/substance abuse follow-up	517	39.0%	1630	37.2%
d. Admission to Crisis Stabilization Unit	224	16.9%	480	10.9%
e. Inpatient Hospitalization-Medical	12	0.9%	114	2.6%
f. Voluntary Psychiatric Hospitalization	247	18.7%	852	19.4%
g. Involuntary Psychiatric Hospitalization	4	0.3%	181	4.1%
h. Admission to Detox Unit	0	0.0%	82	1.9%
NOTE: Sum of Crisis Resolutions must equal II.b.= Total no. of all INITIAL face-to-face contacts — **Sec. V Total**	1324	100%	4386	100%

RJ Melville MSW MPA 1.25.2013

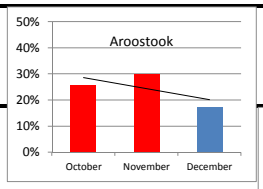
ADULTS ONLY

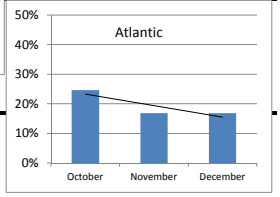
Adult AMHI CONSENT DECREE FEEDBACK REPORT		
No.	Result	STANDARD
IV.35	23.6%	No more than 20-25% of face to face contacts result in Psychiatric Hospitalization.
IV.36	25.0 Average Minutes	90% of Crisis Phone Calls Requiring Face to Face Assessments are responded to within an average of 30 minutes from the end of the phone call.
IV. 37	94.3%	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.38	95.1%	90% of all Face to Face Contacts in which the client has a Community Support Worker, the Worker is notified of the crisis.

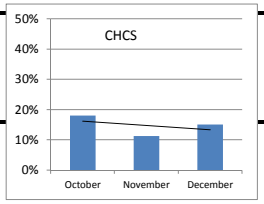


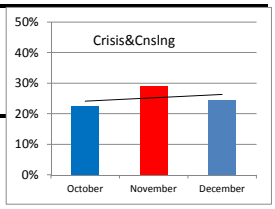
Adult AMHI Consent Decree Standard: No More Than 20-25% of face to face contacts result in Psychiatric hospitalization.
Actual Percent face to face contacts resulting in Psychiatric Hospitalization.

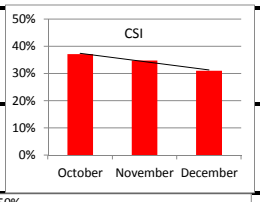
AGENCY	MONTH		
	October	November	December
AMHC Aroostook	26%	30%	17%
AMHC Atlantic	25%	17%	17%
CHCS	18%	11%	15%
Crisis & Counseling	22%	29%	25%
CSI	37%	35%	31%
EVERGREEN	8%	18%	9%
MCMH	41%	36%	34%
Opportunity Alliance	5%	10%	8%
OCMH	11%	17%	15%
Sweetser Region 2	34%	28%	27%
Tri County MH	39%	25%	21%

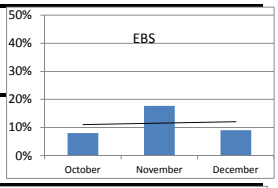


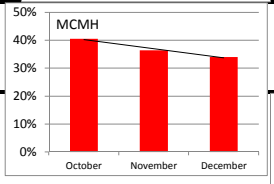


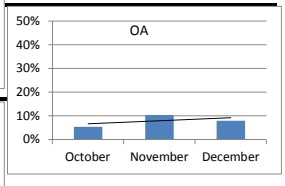


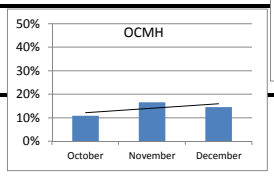


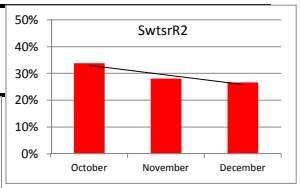


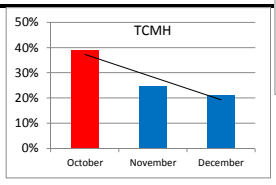






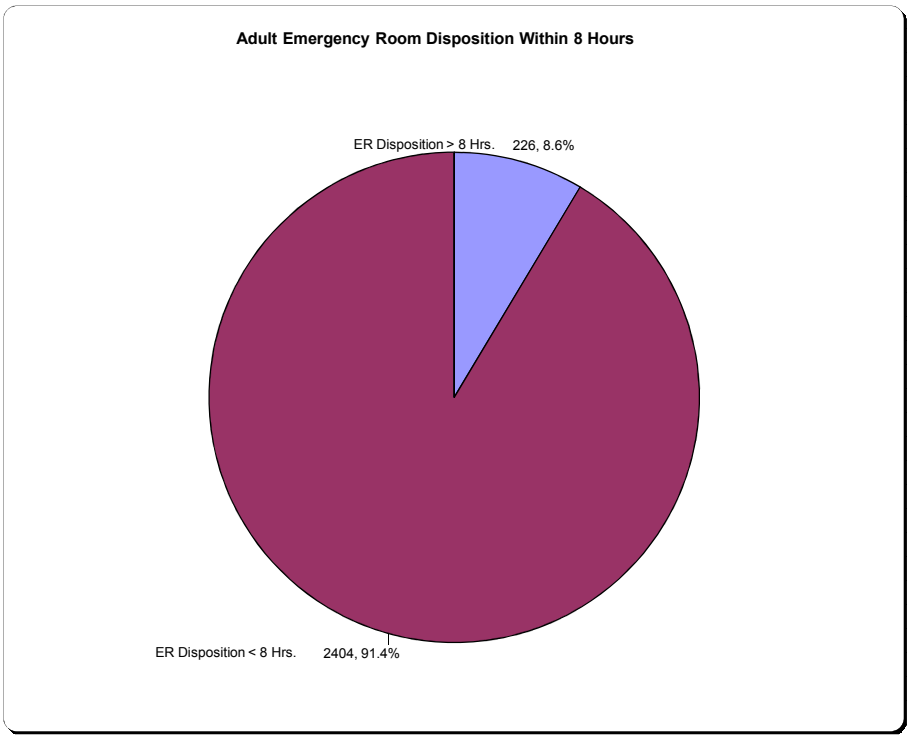


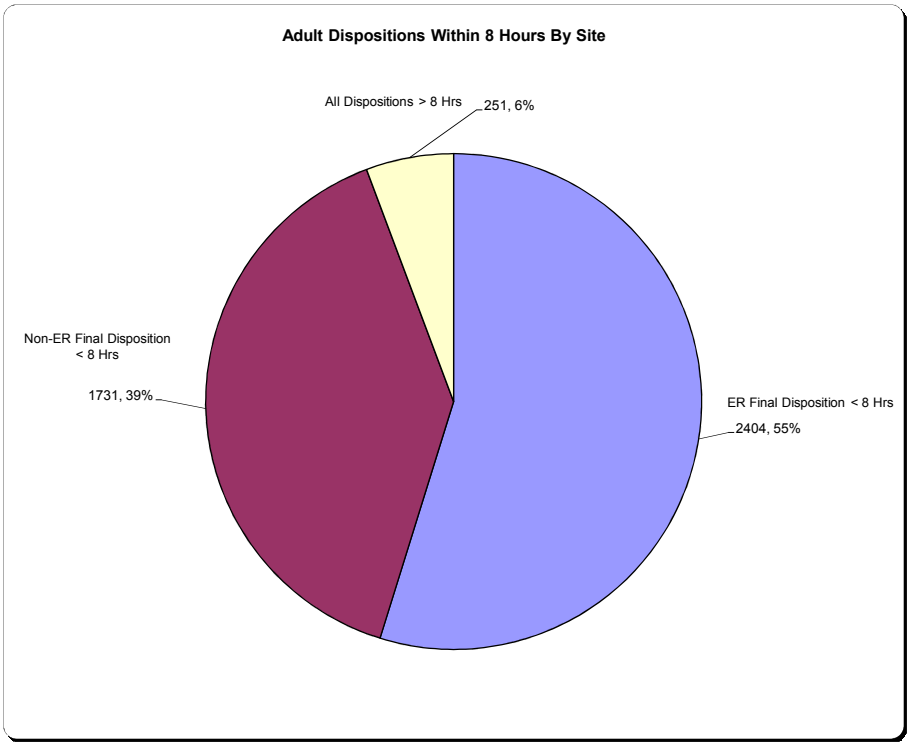




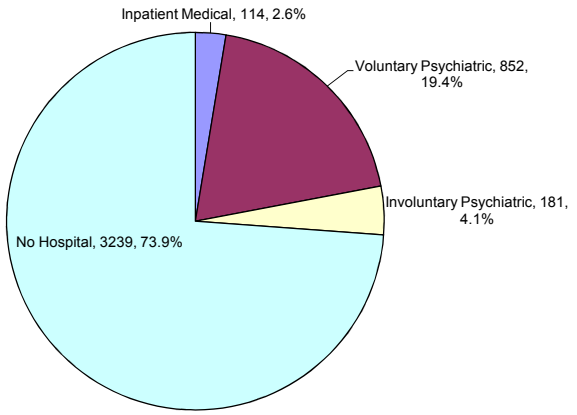
NOTES
1) Red Bars > 25%
2) Black lines are trend lines

ADULTS ONLY

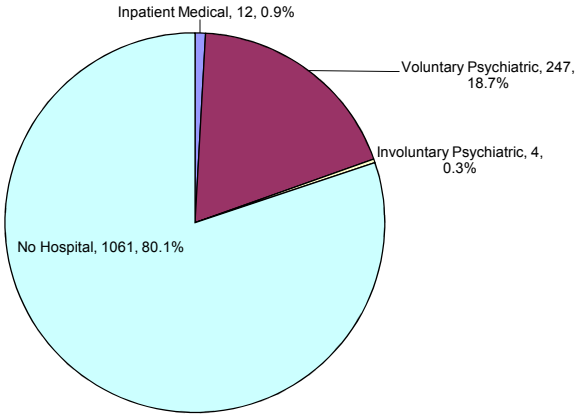

Adult Emergency Room Disposition Within 8 Hours
ER Disposition > 8 Hrs. 226, 8.6%
ER Disposition < 8 Hrs. 2404, 91.4%


Adult Dispositions Within 8 Hours By Site
All Dispositions > 8 Hrs
251, 6%
Non-ER Final Disposition
< 8 Hrs
1731, 39%
ER Final Disposition < 8 Hrs
2404, 55%

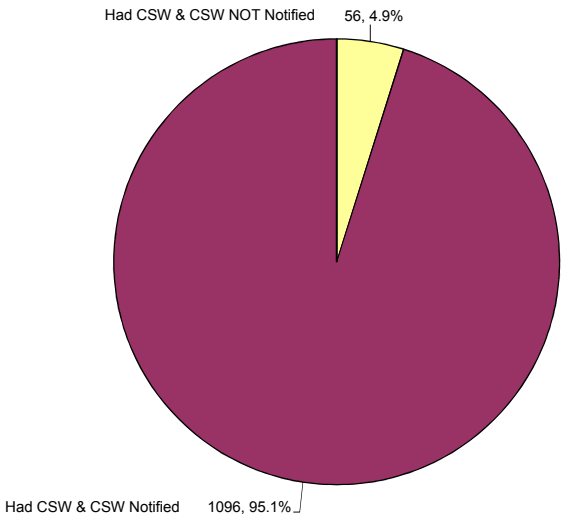
Adult Initial Contacts Hospitalized



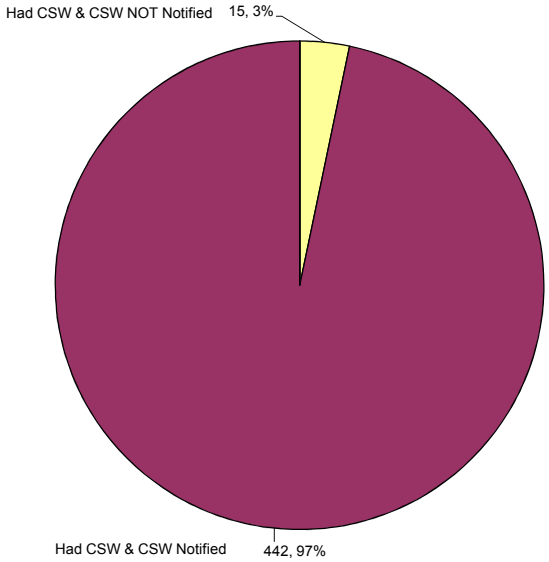
Children Initial Contacts Hospitalized

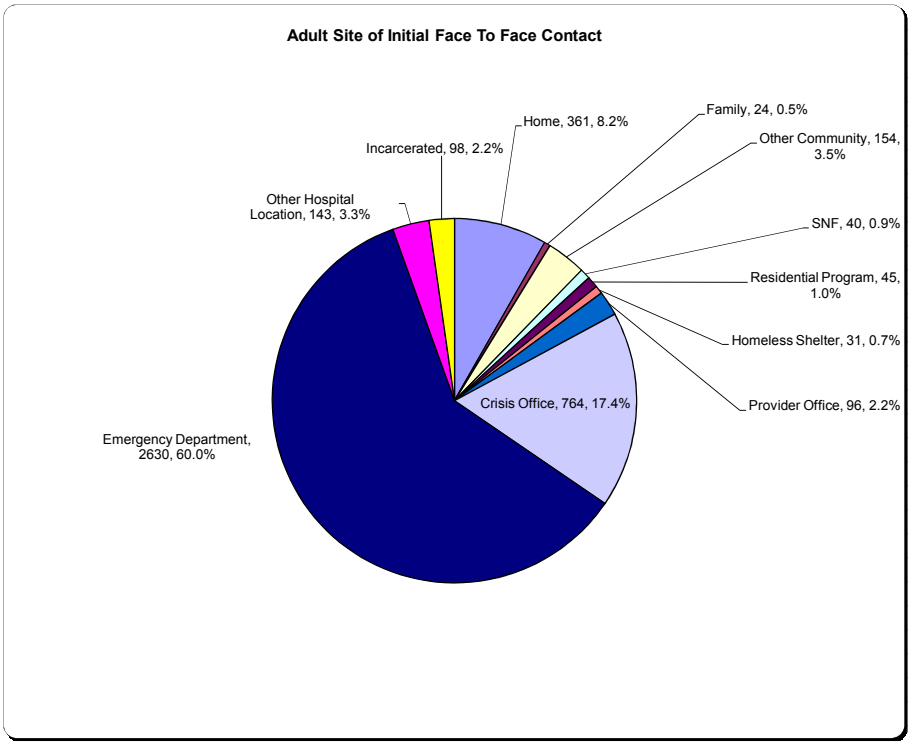


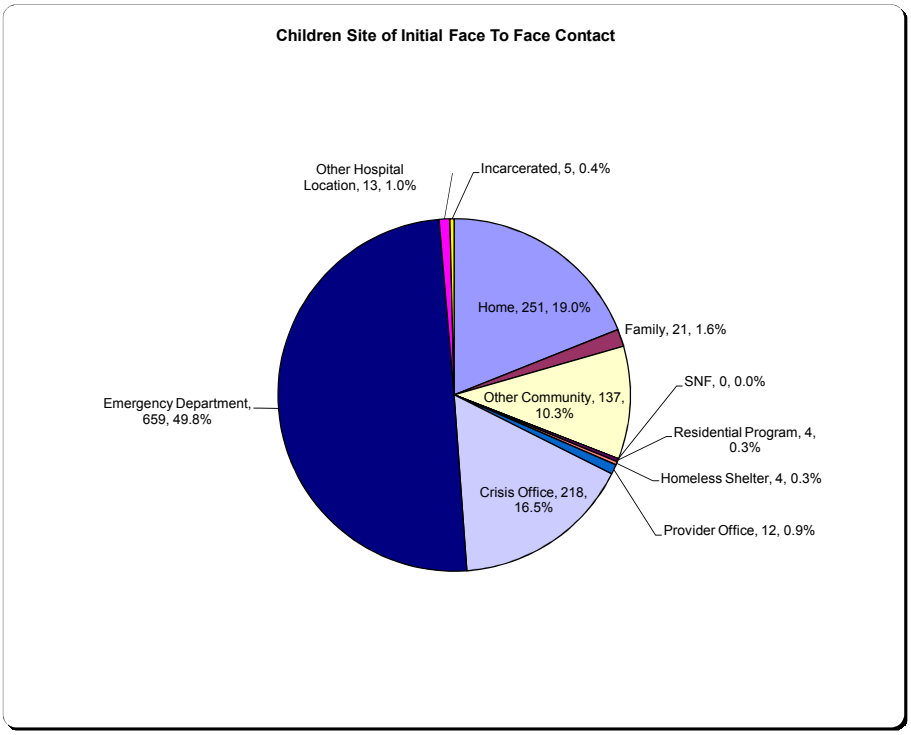
Adult Initial Face to Face Contacts in Which the Client has a CI Worker & The Worker is Notified of the Crisis



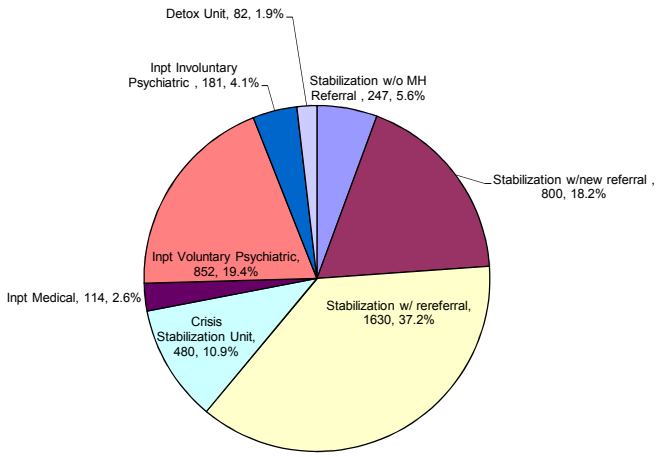
Children Initial Face to Face Contacts in Which the Client has a CI Worker & The Worker is Notified of the Crisis



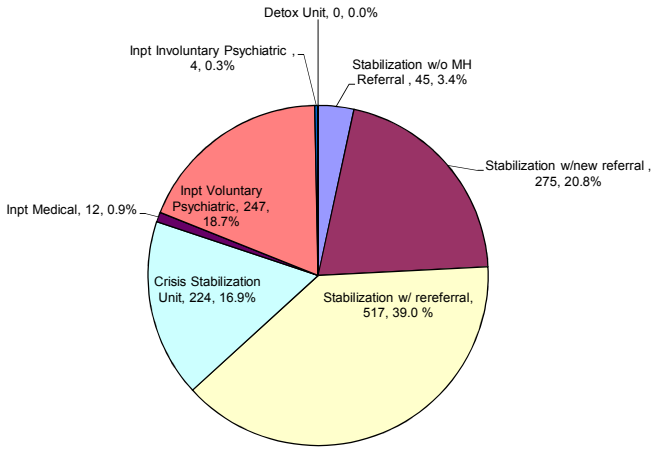

Adult Site of Initial Face To Face Contact
Home, 361, 8.2%
Family, 24, 0.5%
Other Community, 154, 3.5%
Incarcerated, 98, 2.2%
Other Hospital Location, 143, 3.3%
SNF, 40, 0.9%
Residential Program, 45, 1.0%
Homeless Shelter, 31, 0.7%
Provider Office, 96, 2.2%
Crisis Office, 764, 17.4%
Emergency Department, 2630, 60.0%


Children Site of Initial Face To Face Contact
Other Hospital Location, 13, 1.0%
Incarcerated, 5, 0.4%
Home, 251, 19.0%
Family, 21, 1.6%
SNF, 0, 0.0%
Other Community, 137, 10.3%
Residential Program, 4, 0.3%
Emergency Department, 659, 49.8%
Homeless Shelter, 4, 0.3%
Crisis Office, 218, 16.5%
Provider Office, 12, 0.9%

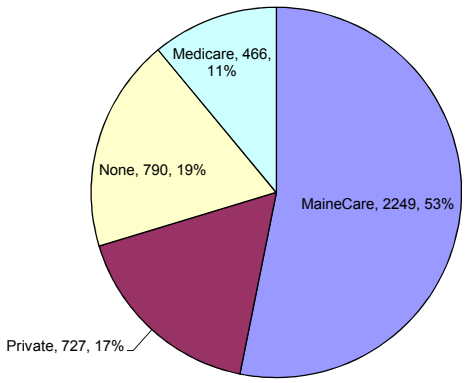
Adult Initial Crisis Resolution



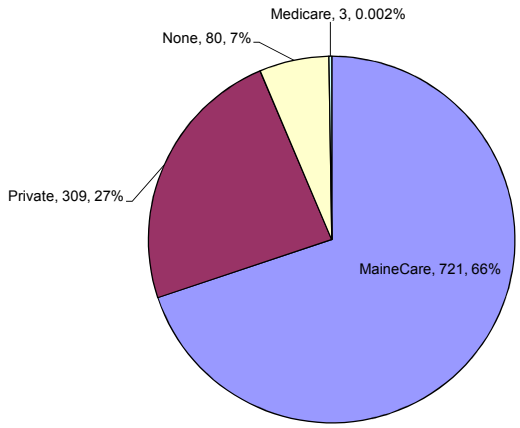
Children Initial Crisis Resolution

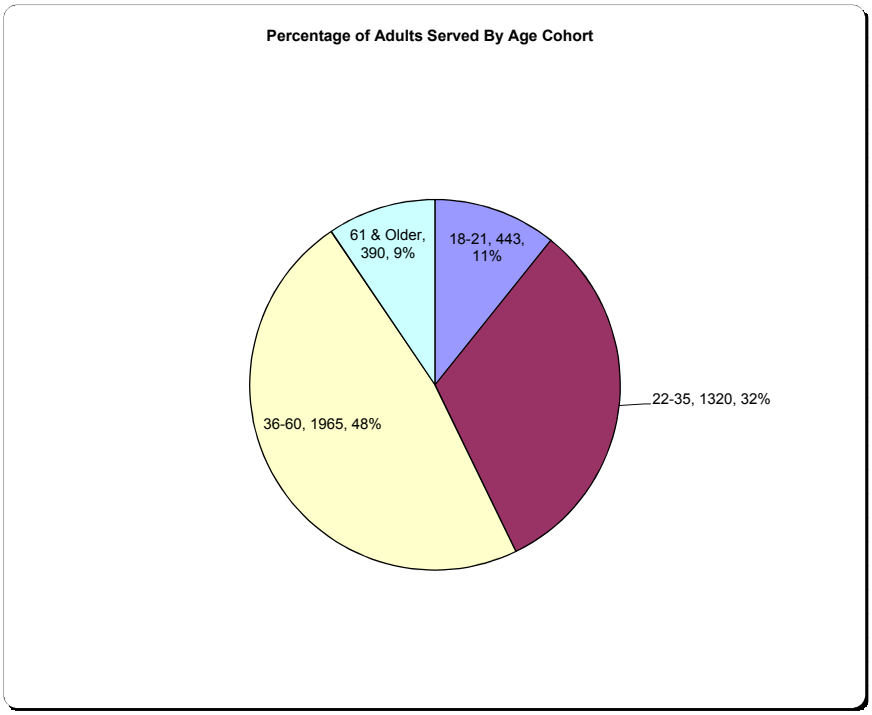


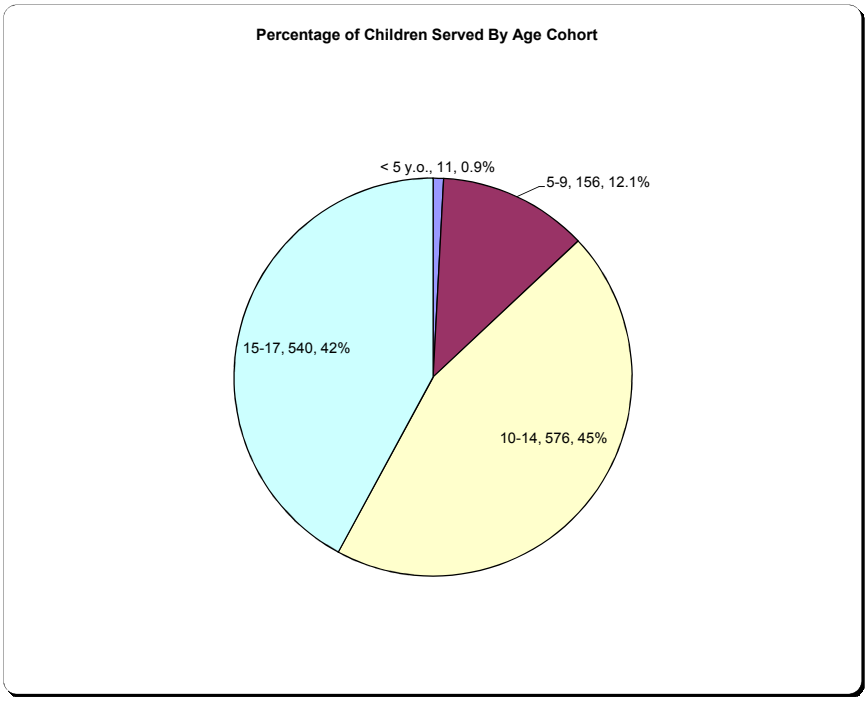
Percentage of Adults Served By Payment Source

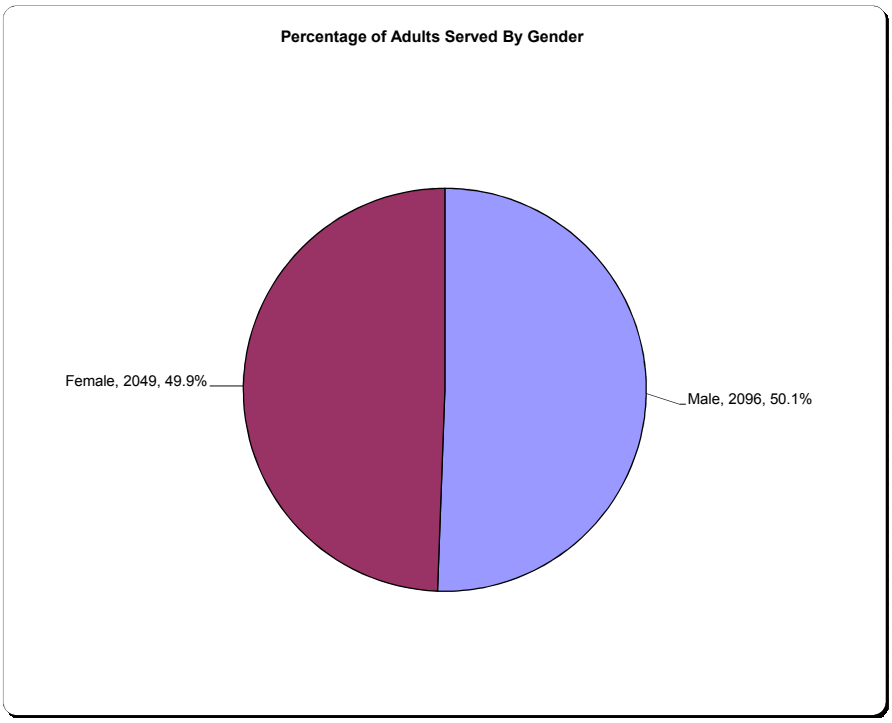


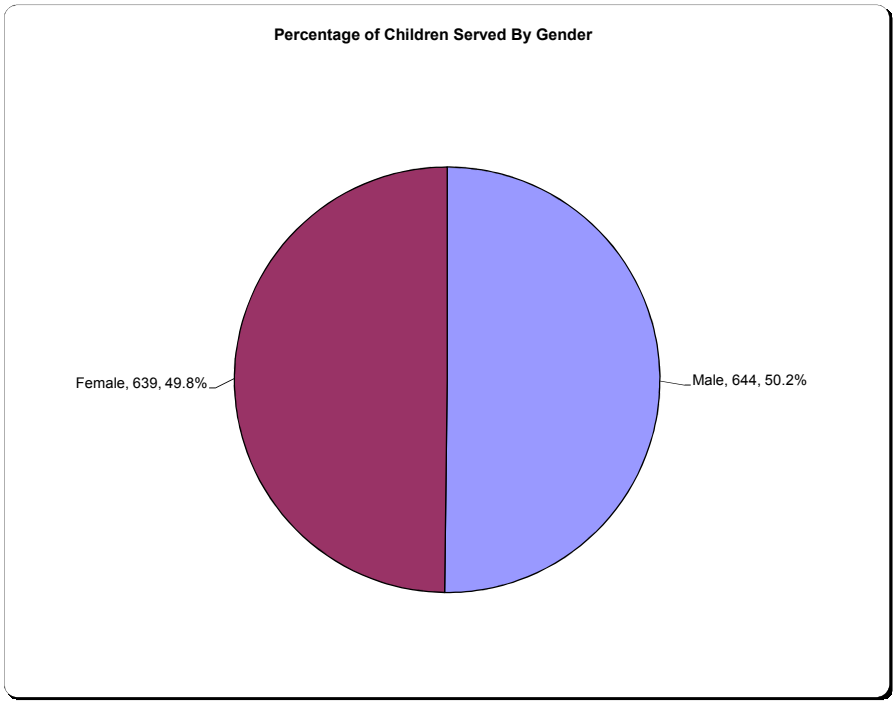
Percentage of Children Served By Payment Source

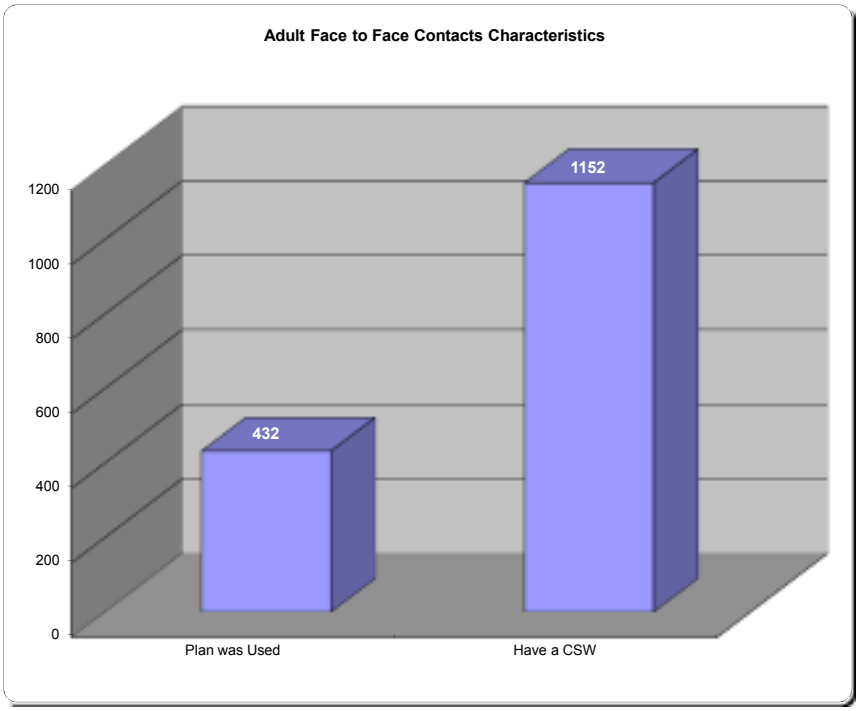


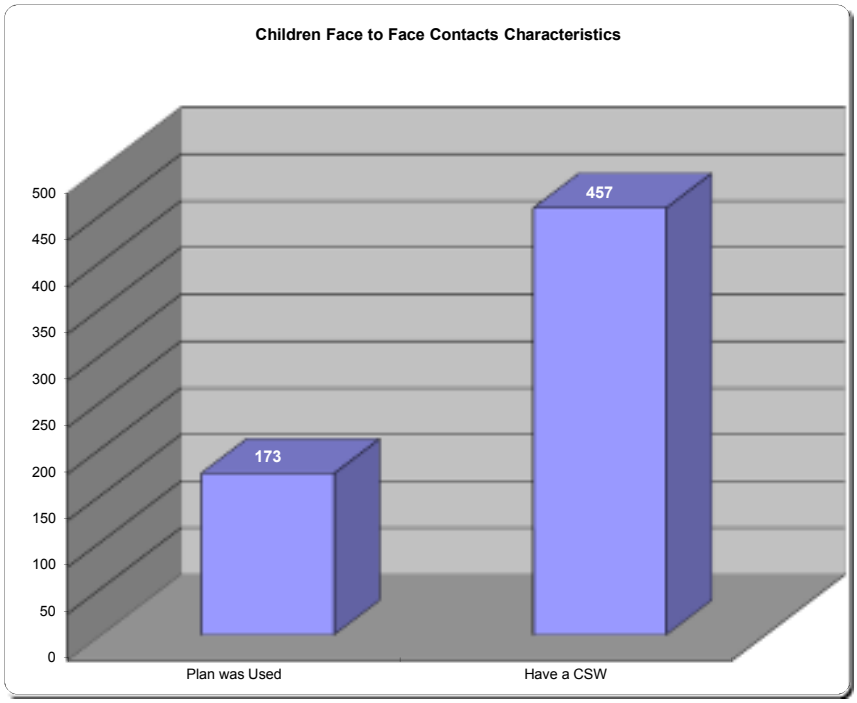

Percentage of Adults Served By Age Cohort
61 & Older, 390, 9%
18-21, 443, 11%
22-35, 1320, 32%
36-60, 1965, 48%


Percentage of Children Served By Age Cohort
< 5 y.o., 11, 0.9%
5-9, 156, 12.1%
15-17, 540, 42%
10-14, 576, 45%


Percentage of Adults Served By Gender
Female, 2049, 49.9%
Male, 2096, 50.1%


Percentage of Children Served By Gender
Female, 639, 49.8%
Male, 644, 50.2%


Adult Face to Face Contacts Characteristics
1200
1000
800
600
400
200
0
1152
432
Plan was Used
Have a CSW


Children Face to Face Contacts Characteristics
500
450
400
350
300
250
200
150
100
50
0
457
173
Plan was Used
Have a CSW

Riverview
PSYCHIATRIC CENTER

QUARTERLY REPORT ON
ORGANIZATIONAL PERFORMANCE EXCELLENCE

THIRD STATE FISCAL QUARTER 2013
January, February, March 2013

Mary Louise McEwen, RN, MBA
Superintendent

April 15, 2013

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Table of Contents

Table of Contents

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.

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	4Q2012	1Q2013	2Q2013	3Q2013
1. Clients are routinely informed of their rights upon admission	--	74% 37/50	91% 42/46	91% 42/46

This measure has recently been established. The practice of informing clients of their rights is often delayed as a result of admission acuity. While this process is usually completed after the initial assessment and stabilization, documentation of the act may not be readily available for abstraction. Further refinement of the process is warranted.

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	4Q2012	1Q2013	2Q2013	3Q2013
1. Level II grievances responded to by RPC on time.	100% 4/4	100% 1/1	100% 5/5	100% 1/1
2. Level I grievances responded to by RPC on time.	56% 63/112	73% 27/37	60% 64/106	95% 96/101

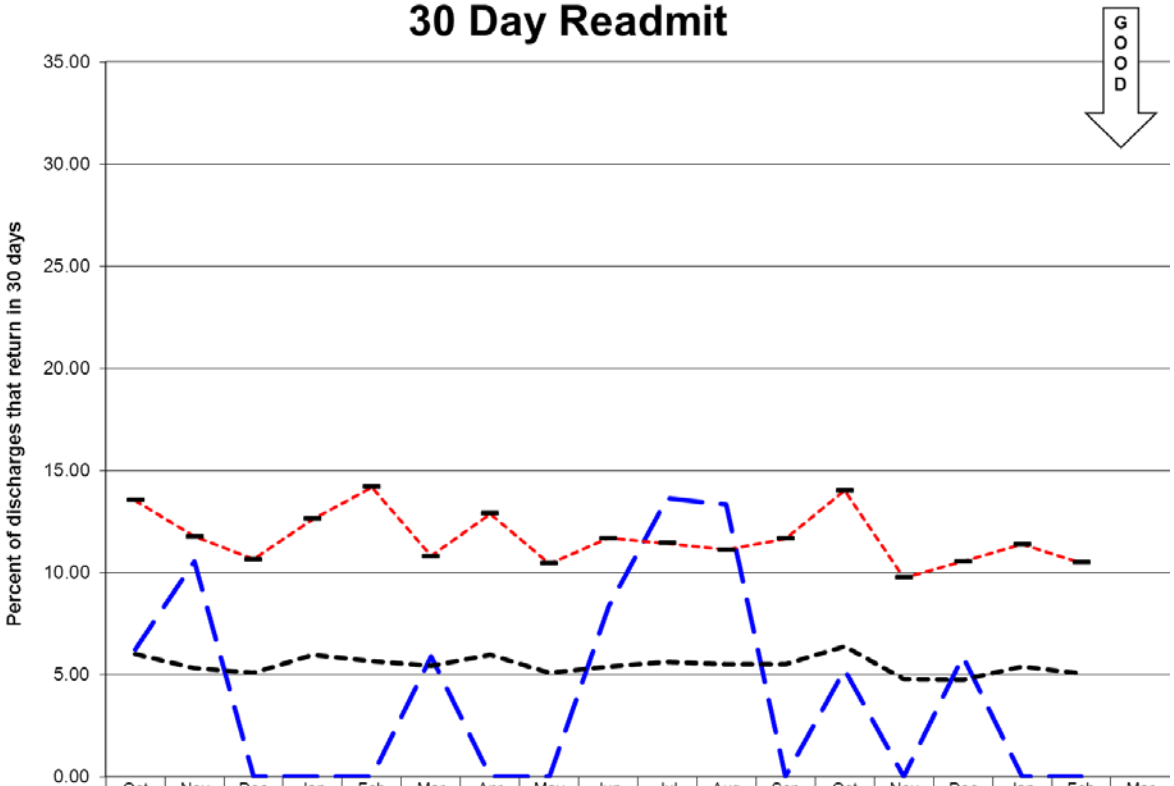
Admissions

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

Legal Status on Admission	4Q2012	1Q2013	2Q2013	3Q2013
ICDCC	19	17	9	20
ICDCC-M				
ICDCC-PTP				
IC-PTP+M				
ICRDCC		3		
INVOL CRIM	39	19	34	21
INVOL-CIV				1
PCHDCC		1		
PCHDCC+M	1		1	1
VOL	4	6		7
VOL-OTHER				

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;



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	6.25	10.53	0.00	0.00	0.00	5.88	0.00	0.00	8.33	13.64	13.33	0.00	5.26	0.00	5.88	0.00	0.00	
Ntl Mean	6.00	5.31	5.08	5.96	5.65	5.42	5.97	5.11	5.39	5.62	5.51	5.50	6.37	4.78	4.75	5.40	5.06	
+1 StDev	13.53	11.76	10.65	12.61	14.18	10.8	12.89	10.45	11.69	11.43	11.11	11.66	14	9.75	10.53	11.38	10.48	

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

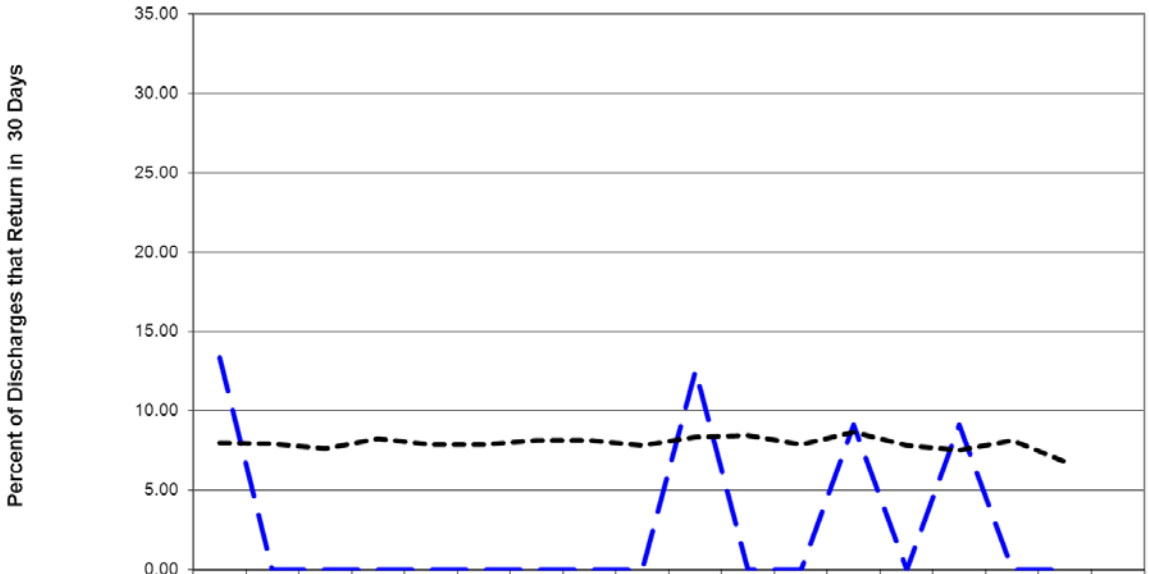
The graphs shown on the next page depict the percent of discharges from the facility that returned within 30 days of a discharge of the same client from the same facility stratified by forensic or civil classifications. For example, a rate of 10.0 means that 10% of all discharges were readmitted within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

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

CONSENT DECREE

30 Day Readmit

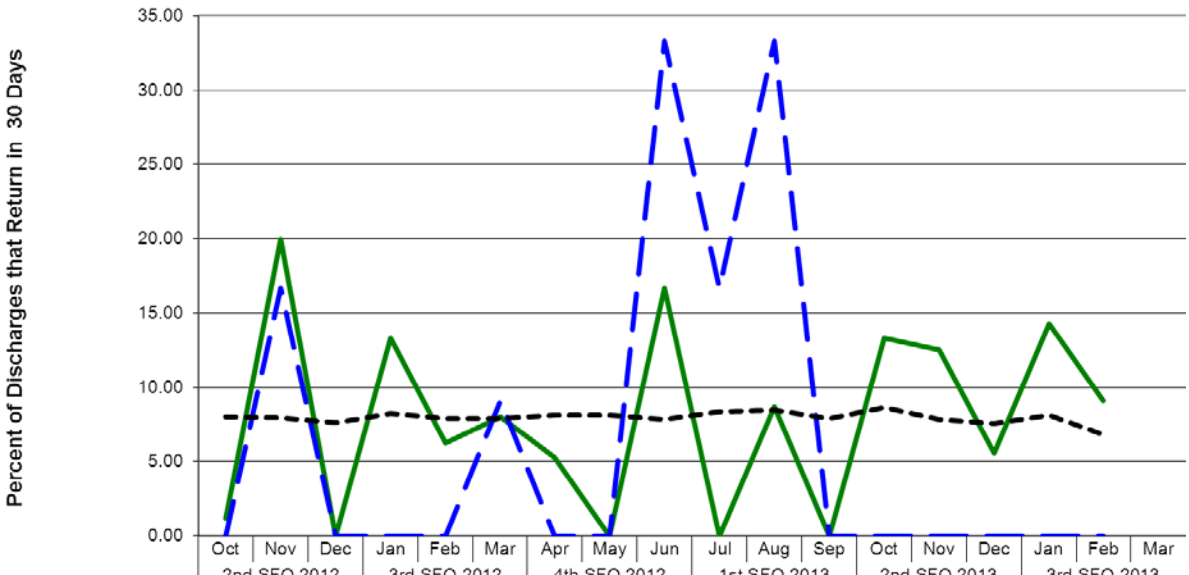
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	13.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	12.50	0.00	0.00	9.09	0.00	9.09	0.00	0.00	
National Mean	8.00	7.95	7.63	8.25	7.90	7.88	8.11	8.15	7.84	8.34	8.45	7.88	8.65	7.83	7.54	8.11	6.79	

30 Day Readmit

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Dorothea Dix	1.17	20.00	0.00	13.33	6.25	8.00	5.26	0.00	16.67	0.00	8.70	0.00	13.33	12.50	5.56	14.29	9.09	
Riverview	0.00	16.67	0.00	0.00	0.00	9.09	0.00	0.00	33.33	16.67	33.33	0.00	0.00	0.00	0.00	0.00	0.00	
National Mean	8.00	7.95	7.63	8.25	7.90	7.88	8.11	8.15	7.84	8.34	8.45	7.88	8.65	7.83	7.54	8.11	6.79	

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	4Q2012	1Q2013	2Q2013	3Q2013
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% 3/3	n/a 0/0	100% 2/2

REDUCTION OF RE-HOSPITALIZATION FOR ACT TEAM CLIENTS

Indicators	4Q2012	1Q2013	2Q2013	3Q2013
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: 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	100% 4 NCR clients were re-admitted to RPC; 1 for violation of court order, 1 who was readmitted due to elopement and 2 for increased psychiatric symptoms	100% 8 readmissions to RPC, 2 medical admissions to MMC	100% 3 clients were re-admitted to RPC;all were NCR, two due to increased psychiatric symptoms, one for using illicit substance in the forensic group home.	100% 3 clients were returned to RPC; two for substance use and 1 for psychiatric decompensating.
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.	100%	100%		100%

Current Quarter Summary

1. All readmissions were male, two under the care of the DHHS Commissioner (NCR), one PTP; both NCR clients were living in independent apartments in the Augusta area for over one year, neither had developed community support networks, both appeared to be medication adherent

and one had attended all sessions as scheduled, the other NCR client had sporadic attendance; the PTP client was living in a 24/7 group home within three miles of the office/hospital. Two clients are between 50 and 65, and the third in his mid thirties. The PTP client was a psychiatric readmission and both NCR clients were re-admitted due to using illicit or illegal substances which violated their court orders. The first re-admission remains at Riverview, with an expected discharge within a few weeks. The second (also NCR) was discharged back to his independent apartment after two weeks. The third (PTP) remains in Riverview and may be able to return to his group home although he may be charged for damages he caused by throwing a lamp and table out of a window. The direct care staff of the group home where the PTP client resided were in immediate contact with ACT Staff the evening of the decompensation; the first NCR client was discovered to be using through a drug urinalysis and the second NCR client reported to his case manager he was using and requested to be returned to RPC.

2. The ACT Team and the inpatient unit of RPC (Lower Saco, Lower Kennebec) worked collaboratively to minimize the time spent in Riverview while maximizing the opportunity for success upon their return to the community placements. For the remaining clients on Lower Saco and on Lower Kennebec, the ACT Team case managers and inpatient teams have and will continue to work closely together to develop discharge plans as the last two clients prepare to return to the community.

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	4Q12	1Q13	2Q13	3Q13	TOT
ADJUSTMENT DIS W MIXED DISTURBANCE OF EMOTIONS & CONDUCT		1			1
ADJUSTMENT DISORDER WITH DEPRESSED MOOD		1	1		2
ADJUSTMENT DISORDER WITH ANXIETY				1	
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD	1		3	1	5
ADJUSTMENT REACTION NOS	1	2	1	1	5
ALCOHOL ABUSE-IN REMISS			1		1
ALCOH DEP NEC/NOS-REMISS	1				1
ANXIETY STATE NOS				1	1
ATTN DEFICIT W HYPERACT				1	1
BIPOL I DIS, MOST RECENT EPIS (OR CURRENT) MANIC, UNSPEC		1			1
BIPOLAR DISORDER, UNSPECIFIED	5	6	5	5	21
DELUSIONAL DISORDER	3		1	2	6
DEPRESS DISORDER-UNSPEC	1				1
DEPRESSIVE DISORDER NEC			2	2	4
DRUG ABUSE NEC-IN REMISS	3		1		4
IMPULSE CONTROL DIS NOS		1	1	2	4
INTERMITT EXPLOSIVE DIS			1	1	2
MOOD DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE		1	1		2
OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER		1			1
OTH PERSISTENT MENTAL DIS DUE TO COND CLASSIFIED ELSEWHERE			1		1
PARANOID SCHIZO-CHRONIC	1	7	5	8	21
PARANOID SCHIZO-UNSPEC				1	1
PERSON FEIGNING ILLNESS	1		1		2
POSTTRAUMATIC STRESS DISORDER	4	2	3	3	11
PSYCHOSIS NOS	6	6	4	4	20
REC DEPR DISOR-PSYCHOTIC	1				1
RECUR DEPR DISOR-SEVERE	2				2
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	10	9	6	9	34
SCHIZOPHRENIA NOS-CHR	3	1		1	5
SCHIZOPHRENIA NOS-UNSPEC				2	2
SCHIZOPHRENIFORM DISORDER, UNSPECIFIED				1	1
UNSPEC PERSISTENT MENTAL DIS DUE TO COND CLASS ELSEWHERE	3				3
UNSPECIFIED EPISODIC MOOD DISORDER	9	7	6	4	26
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER	2				2
Total Admissions	57	46	44	50	197
Admitted with primary diagnosis of mental retardation, traumatic brain injury, dementia, substance abuse or dependence.	7.0%	0.0%	4.5%	0%	3.0%

Peer Supports

Quarterly performance data shows that in 3 out of 4 consecutive quarters:

V8) 80% of all clients have documented contact with a peer specialist during hospitalization;

V9) 80% of all treatment meetings involve a peer specialist.

Indicators	4Q2012	1Q2013	2Q2013	3Q2013
1. Attendance at Comprehensive Treatment Team meetings. (v9)	91% 387/427	90% 410/458	87% 342/395	87% 354/406
2. Attendance at Service Integration meetings. (v8)	93% 52/56	100% 42/42	100% 31/31	98% 48/49
3. Contact during admission. (v8)	100% 63/63	100% 46/46	100% 44/44	100% 50/50

Treatment Planning

Quarterly performance data shows that in 3 out of 4 consecutive quarters,

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

Indicators	4Q2012	1Q2013	2Q2013	3Q2013
1. Preliminary Continuity of Care meeting completed by end of 3rd day	96% 29/30	93% 28/30	100% 30/30	100% 30/30
2. Service Integration form completed by the end of the 3rd day	100% 30/30	93% 28/30	100% 30/30	100% 30/30
3a. Client Participation in Preliminary Continuity of Care meeting.	96% 29/30	93% 28/30	96% 29/30	96% 29/30
3b. CCM Participation in Preliminary Continuity of Care meeting.	100% 30/30	93% 28/30	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.	93% 28/30	93% 28/30	100% 30/30	100% 30/30
4a. Initial Comprehensive Psychosocial Assessments completed within 7 days of admission.	96% 29/30	96% 29/30	93% 28/30	93% 28/30
4b. Annual Psychosocial Assessment completed and current in chart	100% 30/30	100% 30/30	100% 30/30	100% 30/30

Medical Staff, Nursing, and Rehabilitation Services are all engaged in the initial review process. Evidence of fulfilling the standard can be found through a review of individual charts.

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

Indicators	4Q2012	1Q2013	2Q2013	3Q2013
1. Progress notes in GAP/Incidental/Contact format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload.	95% 43/45	95% 43/45	97% 44/45	93% 43/45
2. On Upper Saco progress notes in GAP/Incidental format will indicate at minimum weekly 1:1 meeting with all clients on assigned **CCM** caseload	100% 15/15	93% 14/15	93% 14/15	95% 14/15
3. 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.	96% 58/60	98% 59/60	96% 58/60	96% 58/60

Medical Staff, Nursing, and Rehabilitation Services are all engaged in the treatment planning process. Evidence of fulfilling the standard can be found through a review of individual charts.

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;

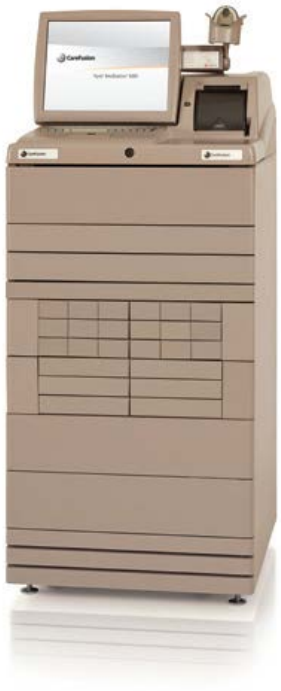
V15) If the record reflects limitations on a patient's rights listed in ¶159, those limitations were imposed consistent with the Rights of Recipients of Mental Health Services

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.

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

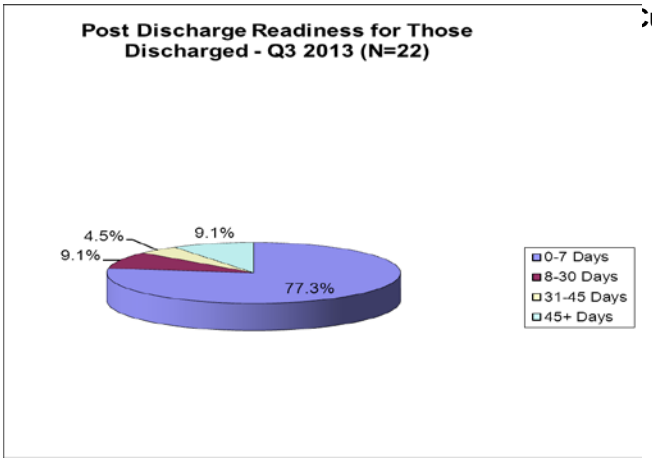
Discharges

Quarterly performance data shows that in 4 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 = (17) 77.3% (target 70%)
Within 30 days = (2) 86.4% (target 80%)
Within 45 days = (1) 90.9% (target 90%)
Post 45 days = (2) 9.1% (target 0%)

Barriers to Discharge Following Clinical Readiness

Residential Supports (0)

Housing (7)

1 client discharged 64 days post clinical readiness
1 client discharged 335 days post clinical readiness

Treatment Services (0)

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%
2Q2013	N-24	54.2%	70.9%	87.6%	12.5%
1Q2013	N=27	66.7%	85.2%	96.3%	3.7%
4Q2012	N=28	53.6%	89.2%	92.9%	7.1%
3Q2012	N=42	69.0%	85.7%	92.9%	7.1%
2Q2012	N=42	69.0%	85.7%	92.9%	7.1%

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	4Q2012	1Q2013	2Q2013	3Q2013
1. The Client Discharge Plan Report will be updated/reviewed by each **Social Worker minimally one time per week.**	100% 13/13	100% 13/13	100% 12/12	100% 12/12
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% 13/13	100% 12/12	100% 12/12
2a. The Client Discharge Plan Report will be sent out weekly as indicated in the approved court plan.	100% 13/13	100% 13/13	100% 12/12	100% 12/12
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	100% 13/13	100% 12/12	100% 12/12

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	4Q2012	1Q2013	2Q2013	3Q2013
1. Institutional Reports will be completed, reviewed internally, and delivered to the court within 10 business days of request.	100% 7/7	60% 3/5	100% 3/3	87% 7/8
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% 5/5	100% 9/9	100% 5/5	100$ 9/9
3. Annual Reports (due Dec) to the commissioner for all inpatient NCR clients are submitted annually				

Staffing and Staff Training

V23) 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;

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. New employees will complete new employee orientation within 60 days of hire.	100% 25/25	100% 21/21	100% 20/20	
2. New employees will complete CPR training within 30 days of hire.	100% 25/25	100% 21/21	100% 20/20	
3. New employees will complete NAPPI training within 60 days of hire.	100% 25/25	100% 21/21	100% 20/20	
4. Riverview and Contract staff will attend CPR training bi-annually.	100% 50/51*	100% 29/31	98% 47/48*	
5. Riverview and Contract staff will attend NAPPI training annually.	100% 118/118	100% 112/134*	100% 99/125	
6. Riverview and Contract staff will attend Annual training.	100% 27/27	100% 238/244*	98% 297/311*	

The indicators are based on the requirements for all new/current staff to complete mandatory training and maintain current certifications.

***** One Riverview employee is out of compliance due to being out of work on a medical leave one employee is out of compliance on light duty.

*Two Riverview employees on Leave of Absence Status, will complete this requirement upon return to regular duty.

*Twenty Riverview employees are scheduled to attend training. Six Riverview employees are still on leave of absence or light duty during this quarter will complete this mandatory training prior to returning to regular employ.

**Fourteen employees on leave of absence during this quarter will not return to work until their Annual Training is complete.

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	Jan- March 2012	Winter Semester (see1Q13 Quarterly Report)
4Q2012	11	Apr – June 2012	Spring Semester (see1Q13 Quarterly Report)
1Q2013	3	Jul – Sep 2012	Summer Hiatus (see1Q13 Quarterly Report)
2Q2013	9	Oct – Dec 2012	Winter Semester (see2Q13 Quarterly Report)
1/3/13	1	Pam Miller, PMNHP	Mirror Neurons
1/10/13	1	Paula Jursa, LCPC LADC CCS Patrick Steele, Psy Intern	"I Don't Have a Problem"
1/17/13	1	George Davis, MD	Six Recent Cases Demonstrating Significant Medical Comorbidity in Psychiatric/Forensic Admissions
1/24/13	1	Deborah Wear-Finkle, MD, MPA	Clinicians and Guns: Duties, Dilemmas, Data, Decisions and Opportunities
1/31/13	1	Elise Freeman, MD, MPH	Diabetes Prevention for Persons with Serious Mental Illness: What can we do?
2/7/13	1	Randy Beal, PMHNP	A Case Study: The Dilemma of Chronic Mental Illness and Diabetes
2/14/13	1	James Weathersby	Sacred Cow Cheeseburgers: spiritual assumptions with clients in a mental health facility
2/28/13	1	Alex Raev, MD	Bethlem Royal Hospital: NHS and Management of Treatment-resistant psychosis in UK
3/7/13	1	Ken Beattie, PhD	Delusion or Displacement: Is it psychosis or is it trauma?
3/21/13	1	John Kootz, MD	Physical findings and underlying illness: what the eye can see
3/28/13	1	Miranda Cole, PharmD	Long Acting Injectable Antipsychotics

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

Staffing levels are most often determined by an analysis of unity 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.

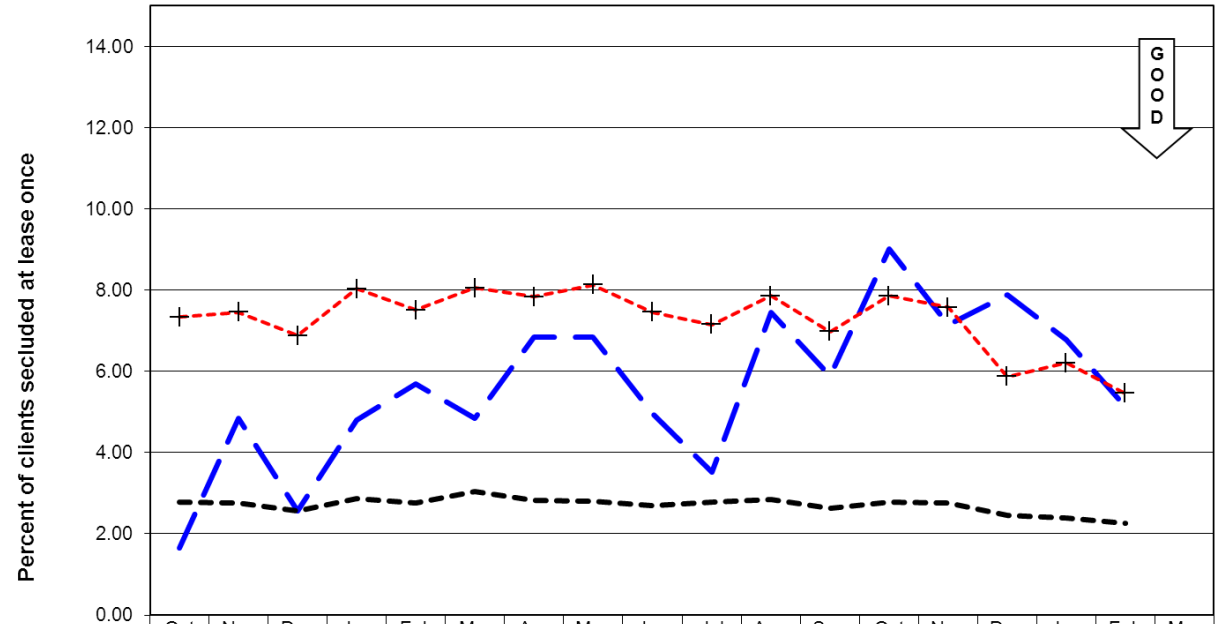
Treatment teams regularly monitor the needs of individual clients and make recommendations for ongoing treatment modalities. Staffing levels are carefully monitored to ensure that all treatment goals, exercise needs, and outdoor activities are achievable. Staffing does not present a barrier to the fulfillment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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	1.65	4.84	2.56	4.80	5.69	4.84	6.84	6.84	4.96	3.51	7.44	5.88	9.01	7.14	7.89	6.78	5.13	
Ntl Mean	2.79	2.77	2.56	2.86	2.77	3.04	2.82	2.81	2.69	2.78	2.85	2.64	2.78	2.76	2.46	2.38	2.27	
+1 StDev	7.34	7.46	6.88	8.03	7.51	8.05	7.84	8.13	7.45	7.15	7.86	6.98	7.86	7.58	5.87	6.21	5.46	

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

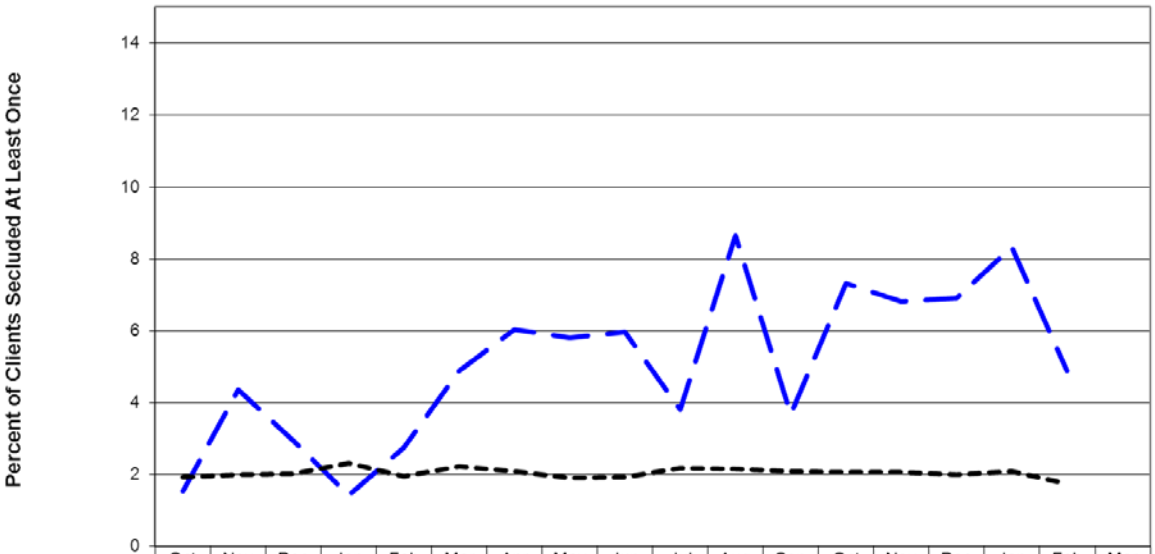
The following graphs depict the percent of unique clients who were secluded at least once stratified by forensic or civil classifications. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

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

CONSENT DECREE

Percent of Clients Secluded

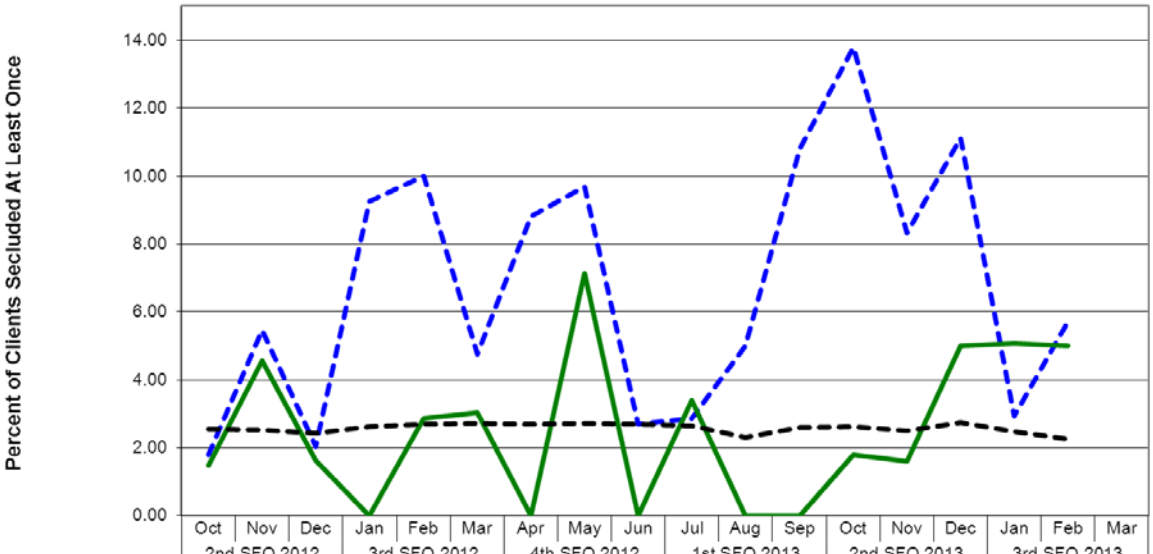
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	1.54	4.35	2.94	1.41	2.74	4.88	6.02	5.81	5.95	3.8	8.64	3.66	7.32	6.82	6.9	8.33	4.88	
Ntl Mean	1.92	1.99	2.02	2.32	1.95	2.21	2.08	1.9	1.92	2.18	2.16	2.08	2.05	2.05	1.99	2.09	1.73	

Percent of Clients Secluded

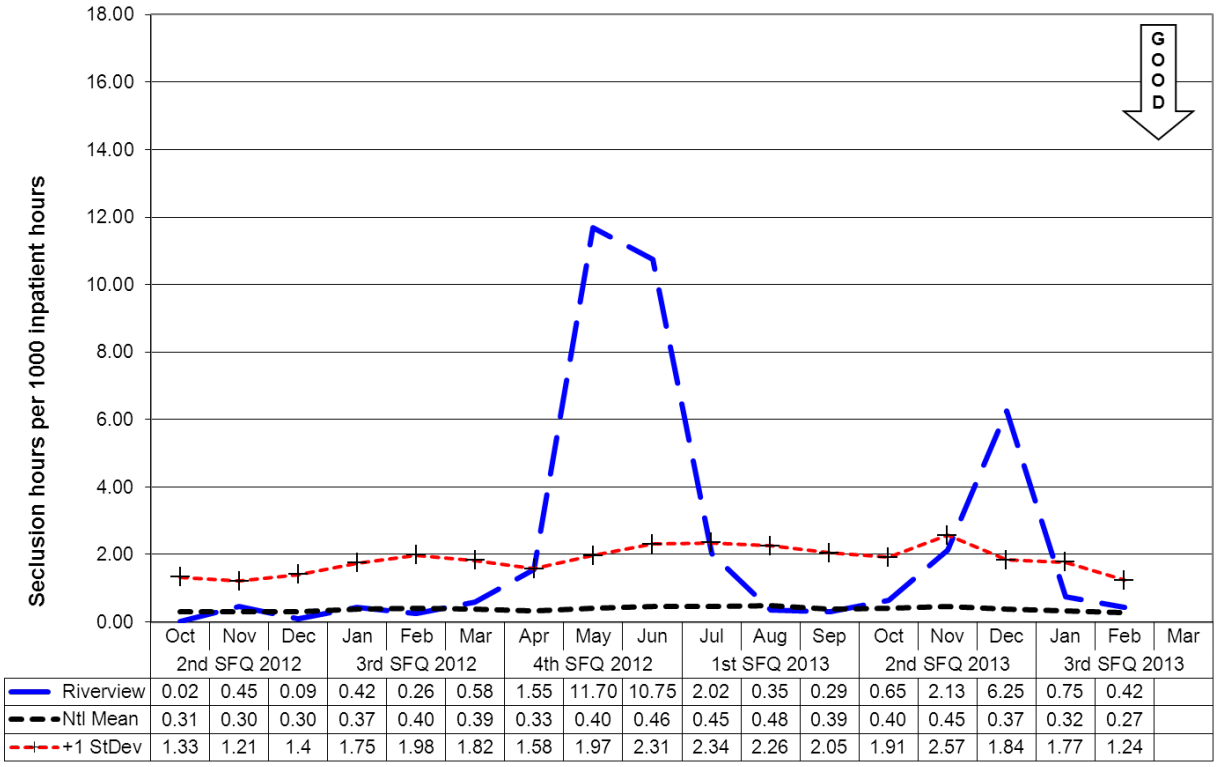
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	1.79	5.45	2.04	9.26	10	4.76	8.82	9.68	2.7	2.86	5	10.81	13.79	8.33	11.11	2.94	5.71	
Dorothea Dix	1.47	4.55	1.61	0.00	2.86	3.03	0.00	7.14	0.00	3.39	0.00	0.00	1.79	1.59	5.00	5.08	5.00	
Ntl Mean	2.55	2.53	2.43	2.61	2.68	2.71	2.69	2.72	2.69	2.63	2.29	2.58	2.62	2.5	2.74	2.46	2.26	

CONSENT DECREE

Seclusion Hours



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.02	0.45	0.09	0.42	0.26	0.58	1.55	11.70	10.75	2.02	0.35	0.29	0.65	2.13	6.25	0.75	0.42	
Ntl Mean	0.31	0.30	0.30	0.37	0.40	0.39	0.33	0.40	0.46	0.45	0.48	0.39	0.40	0.45	0.37	0.32	0.27	
+1 StDev	1.33	1.21	1.4	1.75	1.98	1.82	1.58	1.97	2.31	2.34	2.26	2.05	1.91	2.57	1.84	1.77	1.24	

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.

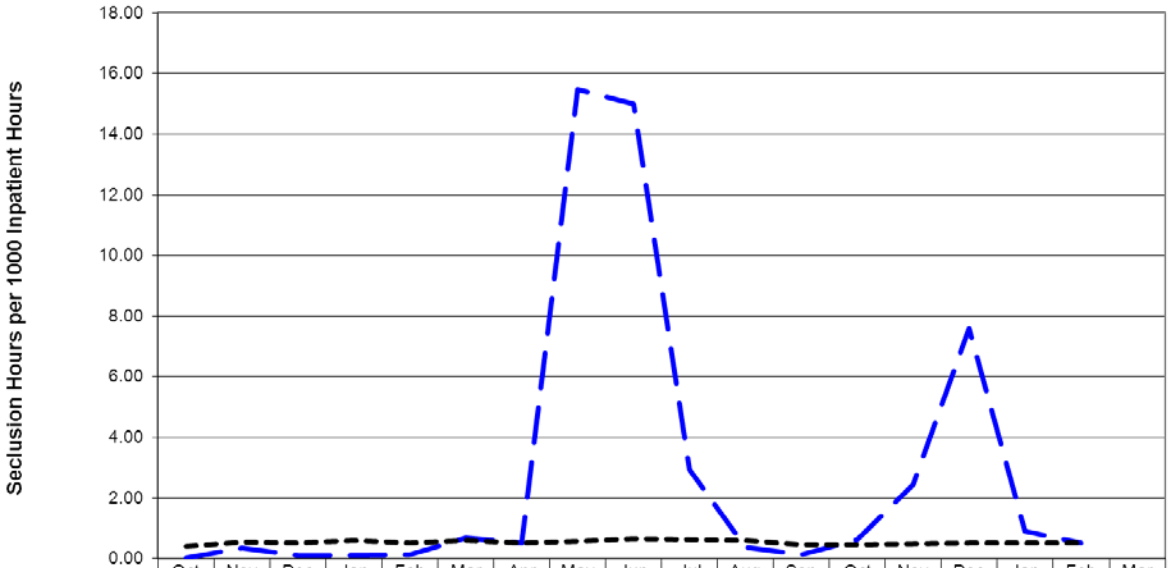
The following graphs depict the number of hours clients spent in seclusion for every 1000 inpatient hours stratified by forensic or civil classifications. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

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

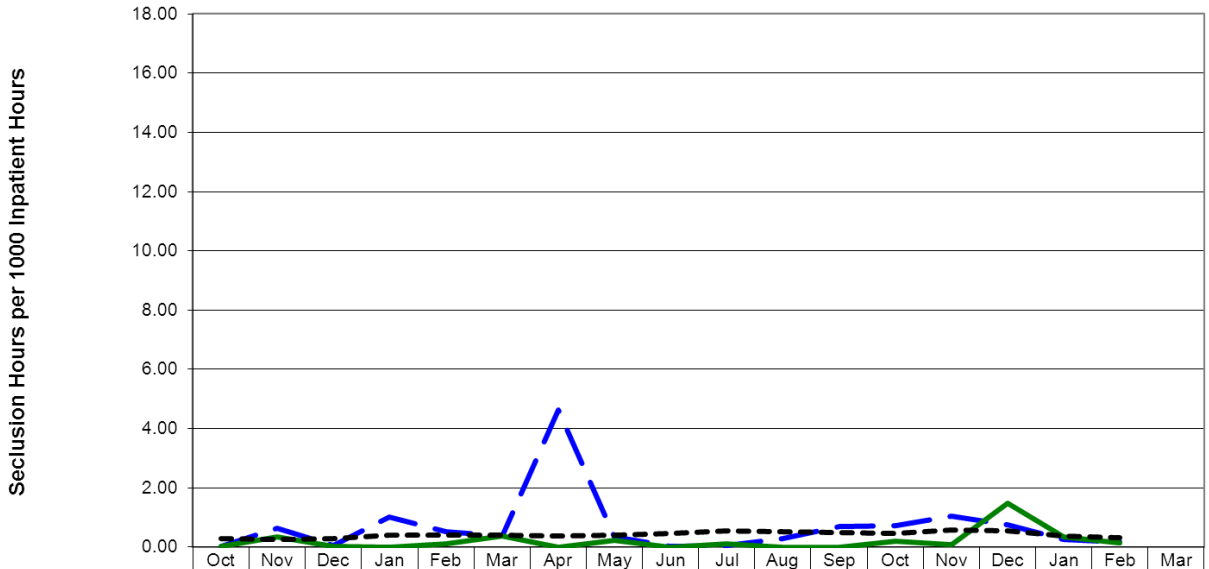
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.02	0.34	0.11	0.1	0.12	0.69	0.5	15.47	15.01	2.94	0.37	0.12	0.63	2.43	7.6	0.9	0.52	
Ntl Mean	0.41	0.55	0.51	0.59	0.52	0.59	0.52	0.57	0.64	0.62	0.59	0.46	0.47	0.48	0.51	0.5	0.5	

Seclusion Hours

Civil Stratification



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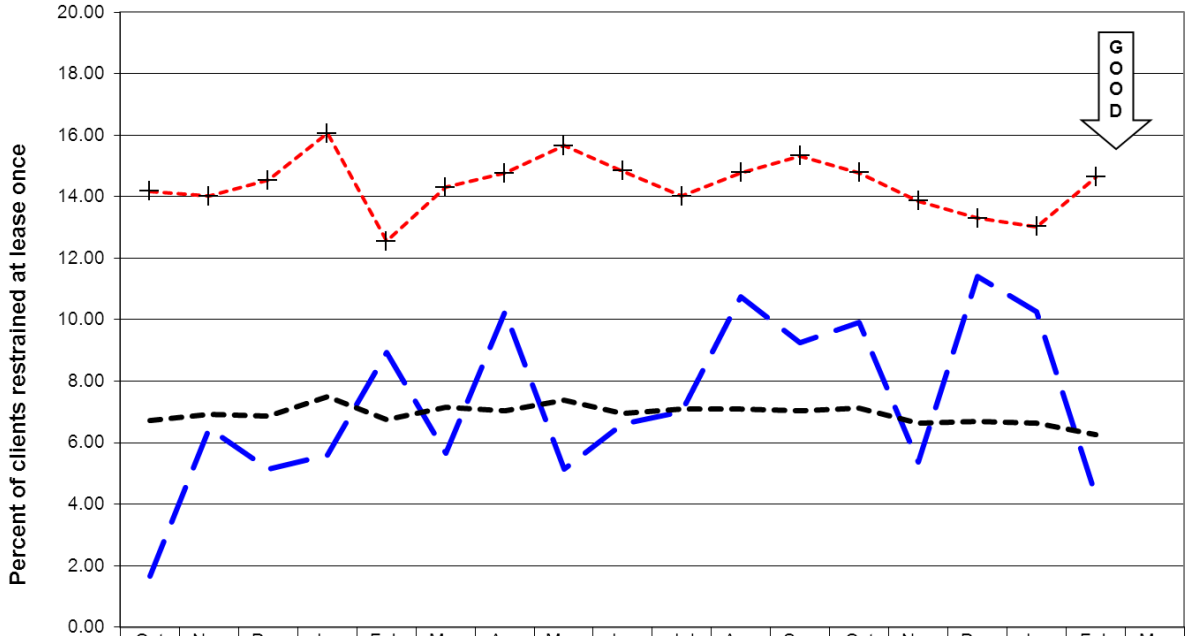
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.02	0.62	0.06	1	0.51	0.37	4.64	0.35	0.03	0.04	0.29	0.68	0.71	1.04	0.74	0.26	0.16	
Dorothea Dix	0.02	0.33	0.02	0.00	0.10	0.38	0.00	0.22	0.00	0.10	0.00	0.00	0.20	0.09	1.47	0.35	0.13	
Ntl Mean	0.28	0.26	0.27	0.4	0.41	0.4	0.37	0.4	0.47	0.54	0.51	0.49	0.46	0.57	0.54	0.36	0.3	

CONSENT DECREE

Percent of Clients Restrained



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	1.65	6.45	5.13	5.60	8.94	5.65	10.26	5.13	6.61	7.02	10.74	9.24	9.91	5.36	11.40	10.26	4.27	
Ntl Mean	6.73	6.92	6.85	7.50	6.74	7.15	7.04	7.39	6.95	7.10	7.08	7.04	7.12	6.62	6.69	6.62	6.27	
+1 StDev	14.18	14.01	14.53	16.06	12.55	14.31	14.76	15.66	14.84	14.01	14.78	15.32	14.78	13.86	13.29	13.02	14.63	

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

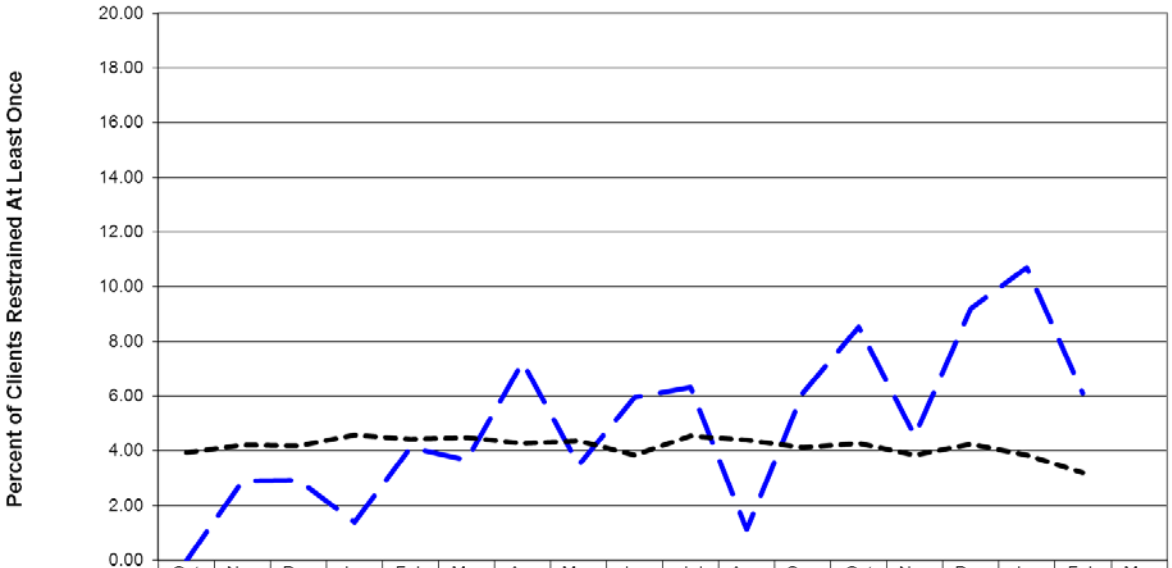
The following graphs depict the percent of unique clients who were restrained at least once stratified by forensic or civil classifications – includes all forms of restraint of any duration. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

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

CONSENT DECREE

Percent of Clients Restrained

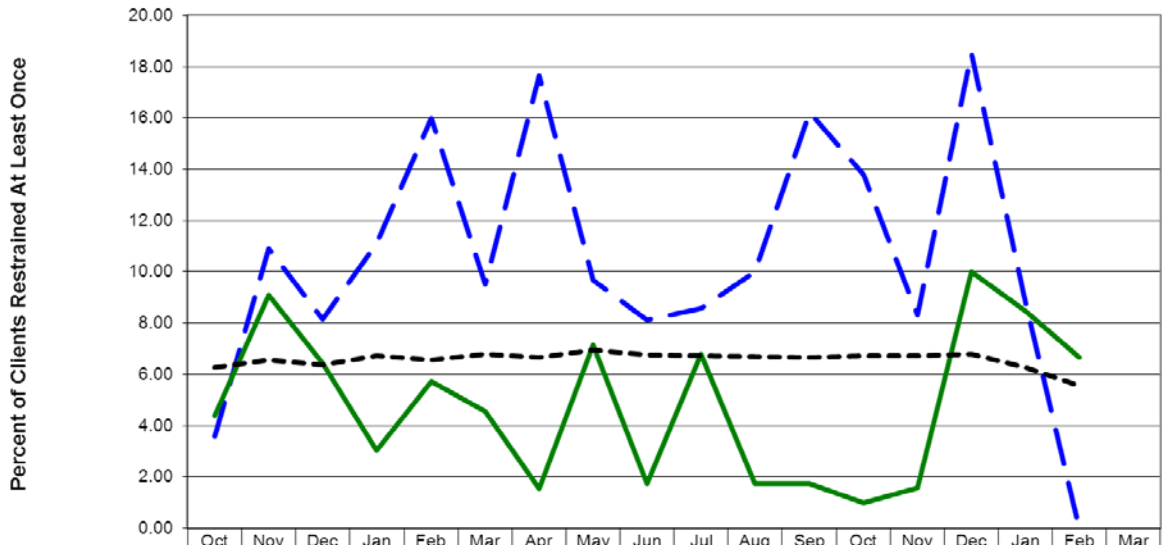
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0	2.9	2.94	1.41	4.11	3.66	7.23	3.49	5.95	6.33	1.11	6.1	8.54	4.55	9.2	10.71	6.1	
Ntl Mean	3.94	4.22	4.18	4.57	4.44	4.49	4.27	4.37	3.86	4.56	4.41	4.11	4.27	3.86	4.23	3.85	3.19	

Percent of Clients Restrained

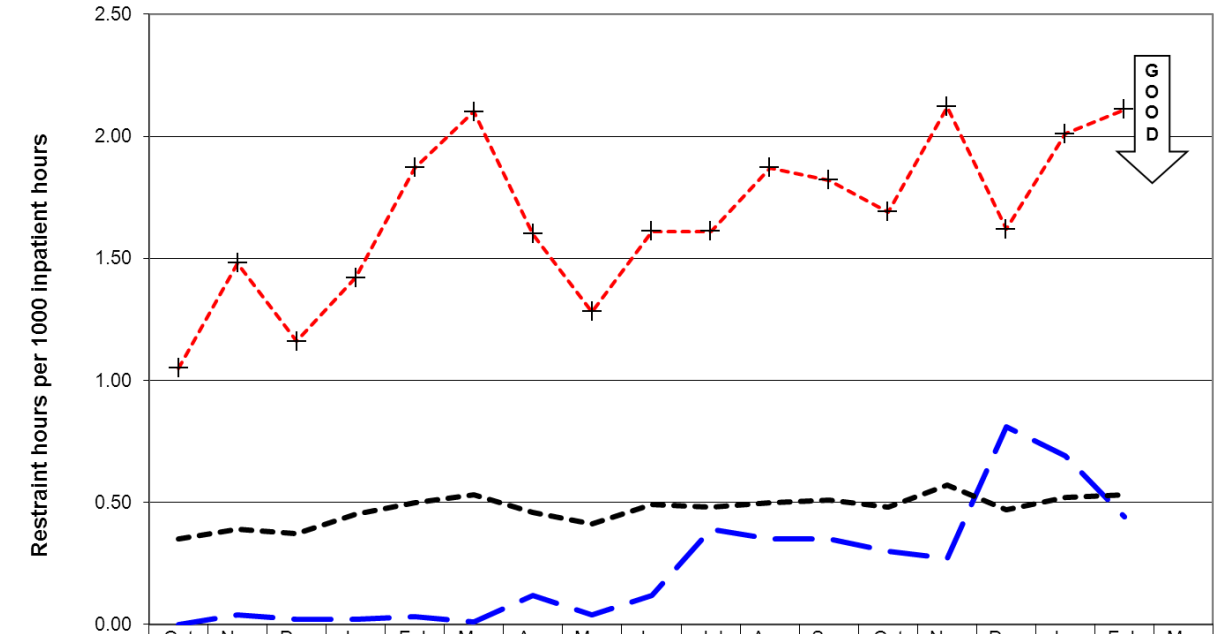
Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	3.57	10.91	8.16	11.11	16	9.52	17.65	9.68	8.11	8.57	10	16.22	13.79	8.33	18.52	8.82	0	
Dorothea Dix	4.41	9.09	6.45	3.03	5.71	4.55	1.54	7.14	1.75	6.78	1.75	1.75	1.00	1.59	10.00	8.47	6.67	
Ntl Mean	6.28	6.56	6.36	6.74	6.57	6.79	6.67	6.95	6.75	6.72	6.7	6.66	6.72	6.72	6.78	6.27	5.55	

CONSENT DECREE

Restraint Hours



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.04	0.02	0.02	0.03	0.01	0.12	0.04	0.12	0.39	0.35	0.35	0.30	0.27	0.81	0.69	0.44	
Ntl Mean	0.35	0.39	0.37	0.45	0.50	0.53	0.46	0.41	0.49	0.48	0.50	0.51	0.48	0.57	0.47	0.52	0.53	
+1 StDev	1.05	1.48	1.16	1.42	1.87	2.1	1.6	1.28	1.61	1.61	1.87	1.82	1.69	2.12	1.62	2.01	2.11	

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.

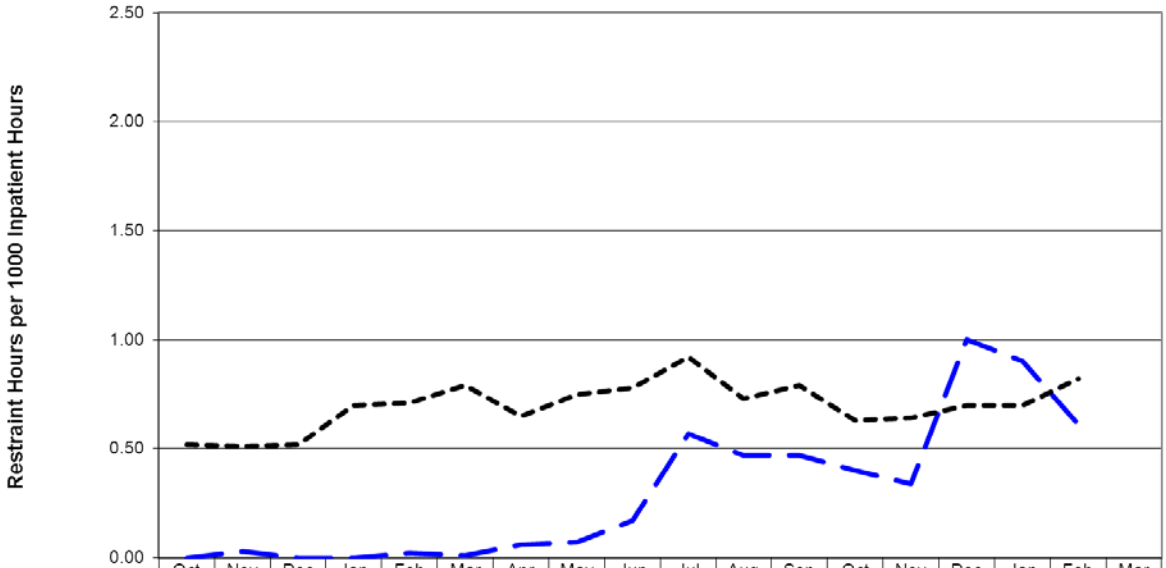
The following graphs depict the number of hours clients spent in restraint for every 1000 inpatient hours stratified by forensic or civil classifications - includes all forms of restraint of any duration. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

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

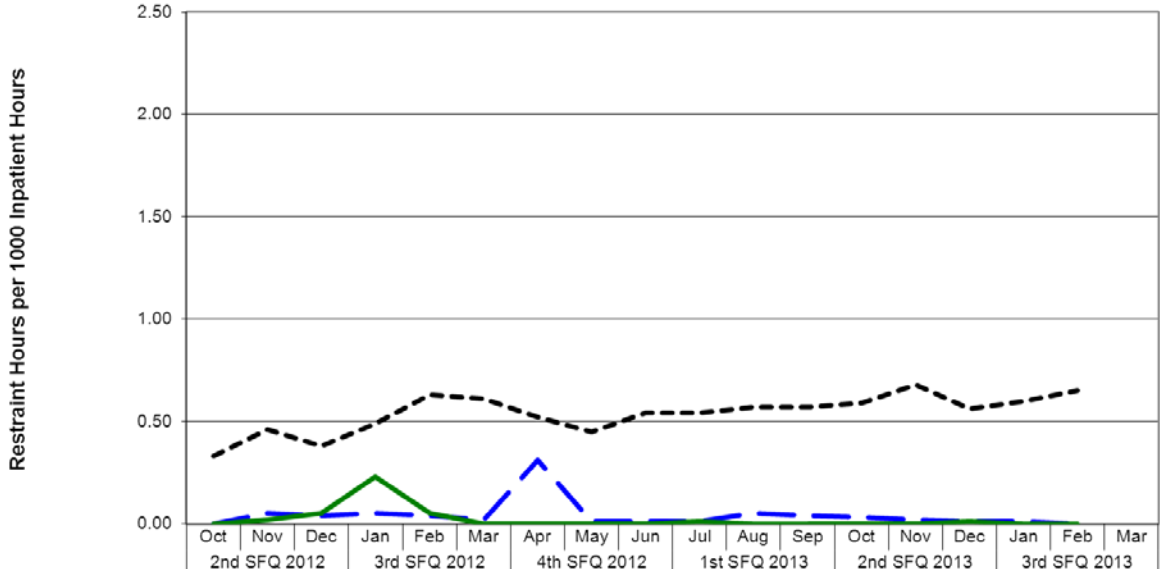
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.03	0.00	0.00	0.02	0.01	0.06	0.07	0.17	0.57	0.47	0.47	0.40	0.34	1.00	0.90	0.61	
Ntl Mean	0.52	0.51	0.52	0.70	0.71	0.79	0.65	0.75	0.78	0.92	0.73	0.79	0.63	0.64	0.70	0.70	0.82	

Restraint Hours

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.05	0.04	0.05	0.04	0.02	0.31	0.01	0.01	0.01	0.05	0.04	0.03	0.02	0.01	0.01	0	
Dorothea Dix	0.00	0.02	0.05	0.23	0.05	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.01	0.00	0.00	
Ntl Mean	0.33	0.46	0.38	0.49	0.63	0.61	0.52	0.45	0.54	0.54	0.57	0.57	0.59	0.68	0.56	0.60	0.65	

CONSENT DECREE

Confinement Event Detail

3rd Quarter 2013

	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MR00000657	17	27	11	55	38%	38%
MR00003374	14		17	31	21%	59%
MR00000029	2	8	2	12	8%	67%
MR00004974	4	3	3	10	7%	74%
MR00006940	4		2	6	4%	78%
MR00005327	2		2	4	3%	81%
MR00004898			3	3	2%	83%
MR00007121			2	2	1%	84%
MR00006630	1		1	2	1%	86%
MR00000189	1		1	2	1%	87%
MR00004271		1	1	2	1%	88%
MR00000668	2			2	1%	90%
MR00004808	2			2	1%	91%
MR00007148		1	1	2	1%	92%
MR00000477	2			2	1%	94%
MR00000115	1		1	2	1%	95%
MR00005267			1	1	1%	96%
MR00007129			1	1	1%	97%
MR00003726			1	1	1%	97%
MR00006962			1	1	1%	98%
MR00000581	1			1	1%	99%
MR00006993	1			1	1%	99%
MR00007015	1			1	1%	100%
Grand Total	55	40	51	146		

29% (23/80) of average hospital population experienced some form of confinement event during the 3rd fiscal quarter 2013. Eight of these clients (10% of the average hospital population) accounted for 84% 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.

For example, 68% of mechanical restraint events can be attributed to one client. This individual is also attributable to the greatest number of manual hold events, however, it is common to have an accompanying manual hold during the initiation and termination of a mechanical restraint event or a seclusion event

CONSENT DECREE

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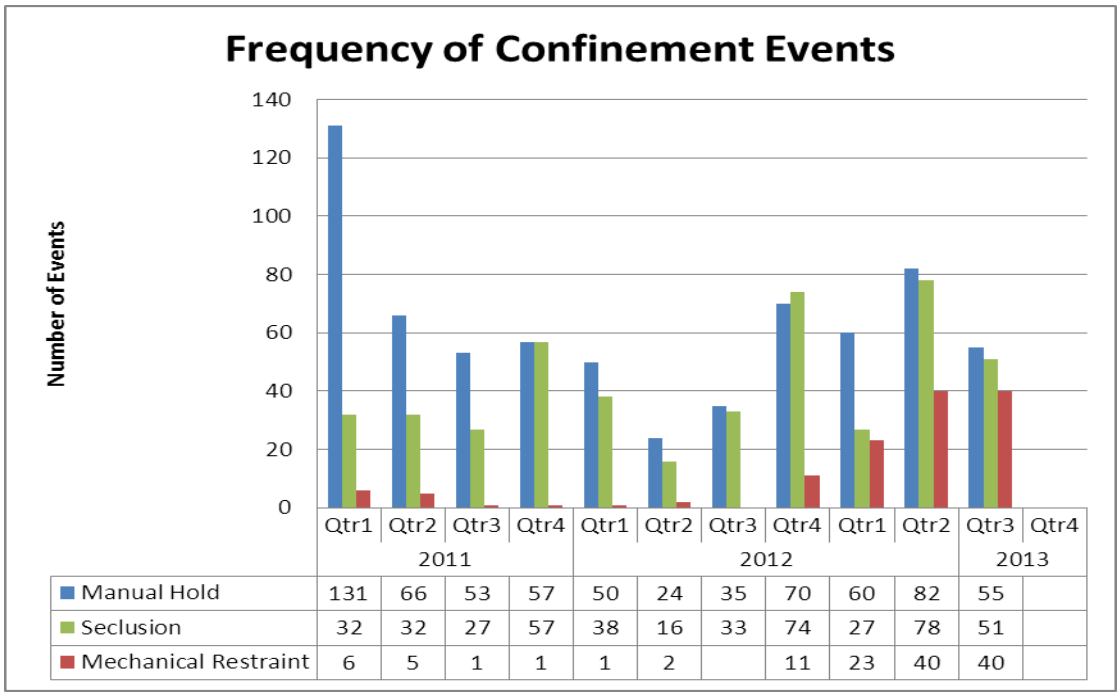


	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
	2011				2012						2013	
Manual Hold	131	66	53	57	50	24	35	70	60	82	55	
Seclusion	32	32	27	57	38	16	33	74	27	78	51	
Mechanical Restraint	6	5	1	1	1	2		11	23	40	40	

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

	3Q12	4Q12	1Q13	2Q13	3Q13
Danger to Others/Self	31	73	23	78	50
Danger to Others	2		4		
Danger to Self		1			1
% Dangerous Precipitation	100%	100%	100%	100%	100%
Total Events	33	74	27	78	51

V29) Riverview demonstrates that, based on a review of two quarters of data, for 95% of restraint events involving mechanical restraints, the restraint was used only when absolutely necessary to protect the patient from serious physical injury to self or others;

Factors of Causation Related to Mechanical Restraint Events

	3Q12	4Q12	1Q13	2Q13	3Q13
Danger to Others/Self		11	22	40	40
Danger to Others			1		
Danger to Self					
% Dangerous Precipitation	--	100%	100%	100%	100%
Total Events	0	11	23	40	40

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 26 & 27

CONSENT DECREE

Confinement Events Management

Seclusion Events (51) Events

Standard	Threshold	Compliance
The record reflects that seclusion was absolutely necessary to protect the patient from causing physical harm to self or others, or if the patient was examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption that significantly interferes with other patients' treatment.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective. This can be reflected anywhere in record.	90%	100%
The record reflects that the decision to place the patient in seclusion was made by a physician or physician extender.	90%	100%
The decision to place the patient in seclusion was entered in the patient's records as a medical order.	90%	100%
The record reflects that, if the physician or physician extender was not immediately available to examine the patient, the patient was placed in seclusion following an examination by a nurse.	90%	100%
The record reflects that the physician or physician extender personally evaluated the patient within 30 minutes after the patient has been placed in seclusion, and if there is a delay, the reasons for the delay.	90%	100%
The record reflects that the patient was monitored every 15 minutes. (Compliance will be deemed if the patient was monitored at least 3 times per hour.)	90%	100%
Individuals implementing seclusion have been trained in techniques and alternatives.	90%	100%
The record reflects that reasonable efforts were taken to notify guardian or designated representative as soon as possible that patient was placed in seclusion.	75%	100%

Standard	Threshold	Compliance
The medical order states time of entry of order and that number of hours in seclusion shall not exceed 4.	85%	100%
The medical order states the conditions under which the patient may be sooner released.	85%	100%
The record reflects that the need for seclusion is re-evaluated at least every 2 hours by a nurse.	90%	100%
The record reflects that the 2 hour re-evaluation was conducted while the patient was out of seclusion room unless clinically contraindicated.	70%	100%
The record includes a special check sheet that has been filled out to document reason for seclusion, description of behavior and the lesser restrictive alternatives considered.	85%	100%
The record reflects that the patient was released, unless clinically contraindicated, at least every 2 hours or as necessary for eating, drinking, bathing, toileting or special medical orders.	85%	100%
Reports of seclusion events were forwarded to medical director and advocate.	90%	100%
The record reflects that, for persons with mental retardation, the regulations governing seclusion of clients with mental retardation were met.	85%	100%
The medical order for seclusion was not entered as a PRN order.	90%	100%
Where there was a PRN order, there is evidence that physician was counseled.	95%	N/A

CONSENT DECREE

Confinement Events Management

Mechanical Restraint Events (40) Events

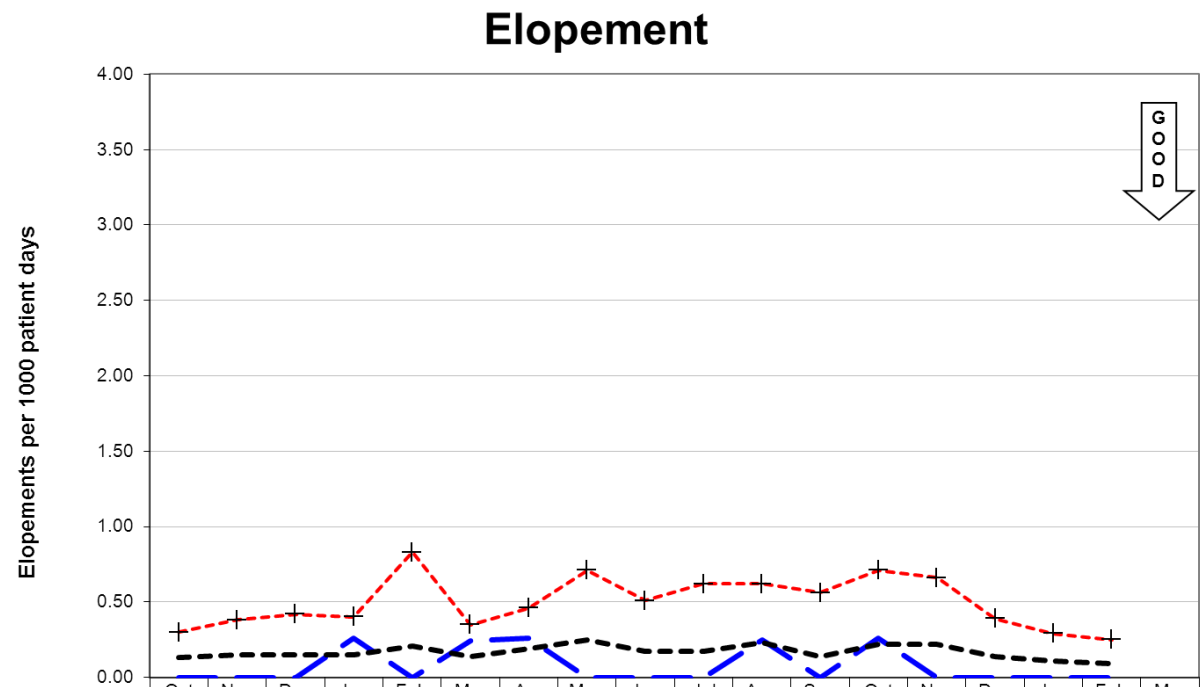
Standard	Threshold	Compliance
The record reflects that restraint was absolutely necessary to protect the patient from causing serious physical injury to self or others.	95%	100%
The record reflects that lesser restrictive alternatives were inappropriate or ineffective.	90%	100%
The record reflects that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

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

CONSENT DECREE

Client Elopements

V31) 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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.00	0.00	0.26	0.00	0.24	0.26	0.00	0.00	0.00	0.25	0.00	0.26	0.00	0.00	0.00	0.00	
Ntl Mean	0.13	0.15	0.15	0.15	0.21	0.14	0.19	0.25	0.17	0.17	0.23	0.14	0.22	0.22	0.14	0.11	0.09	
StDev	0.3	0.38	0.42	0.4	0.83	0.35	0.46	0.71	0.51	0.62	0.62	0.56	0.71	0.66	0.39	0.29	0.25	

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This graph depicts the number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

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

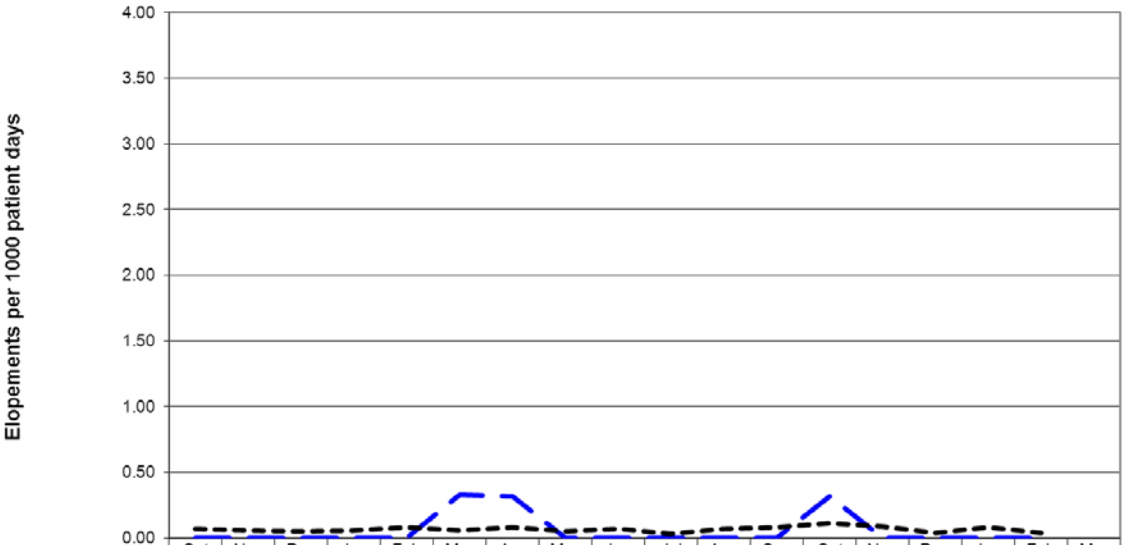
The following graphs depict the number of elopements stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

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

CONSENT DECREE

Elopement

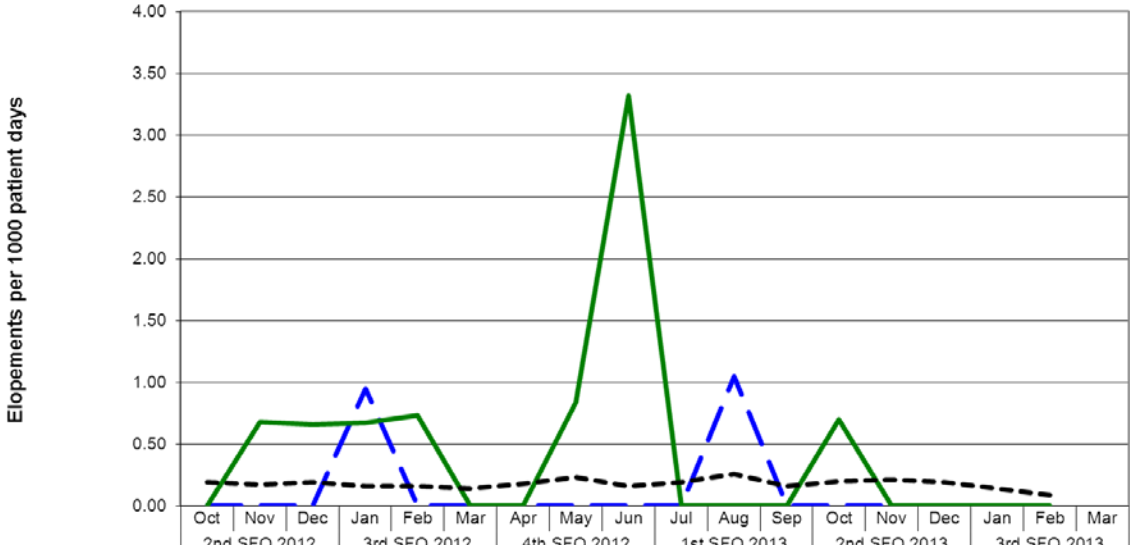
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.00	0.00	0.00	0.00	0.33	0.32	0.00	0.00	0.00	0.00	0.00	0.32	0.00	0.00	0.00	0.00	
Ntl Mean	0.07	0.06	0.05	0.06	0.08	0.06	0.08	0.05	0.07	0.03	0.07	0.08	0.11	0.09	0.04	0.08	0.04	

Elopement

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.00	0.00	0.95	0.00	0.00	0.00	0.00	0.00	0.00	1.05	0.00	0.00	0.00	0.00	0.00	0.00	
Dorothea Dix	0.00	0.68	0.66	0.67	0.73	0.00	0.00	0.84	3.32	0.00	0.00	0.00	0.70	0.00	0.00	0.00	0.00	
Ntl Mean	0.19	0.17	0.19	0.16	0.16	0.14	0.18	0.23	0.16	0.19	0.26	0.16	0.20	0.21	0.19	0.14	0.09	

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

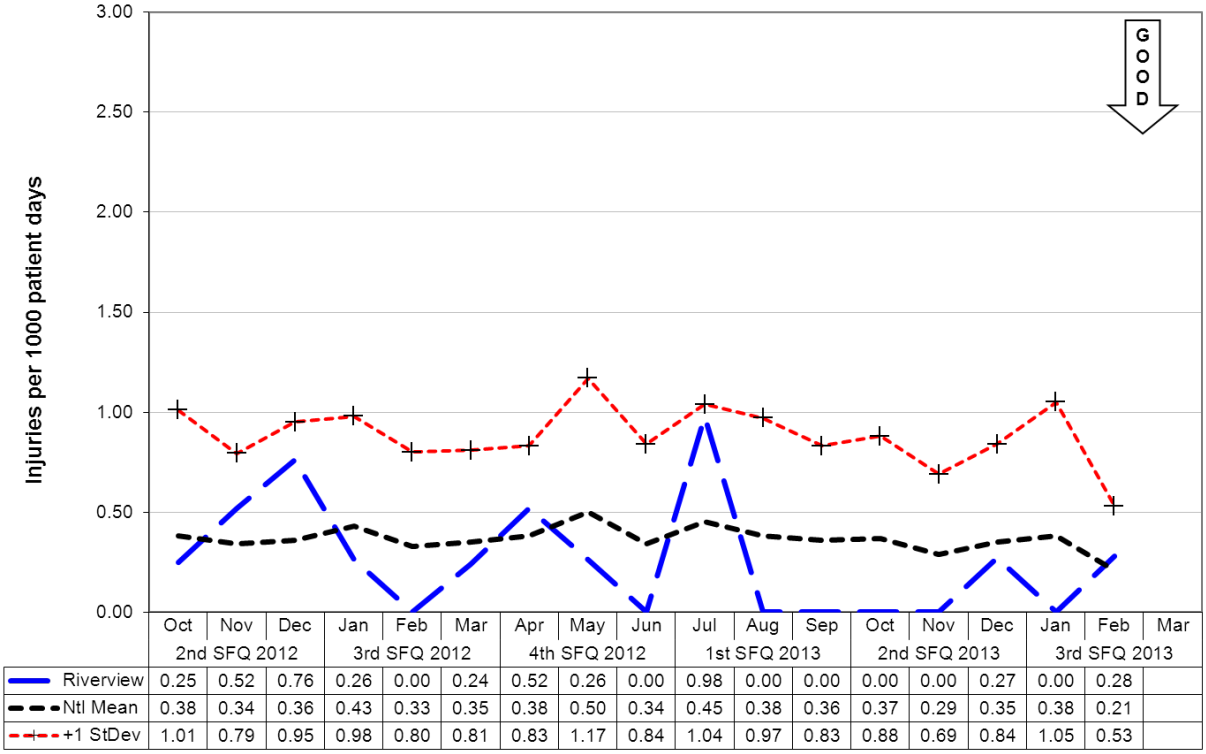
Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

- 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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.25	0.52	0.76	0.26	0.00	0.24	0.52	0.26	0.00	0.98	0.00	0.00	0.00	0.00	0.27	0.00	0.28	
Ntl Mean	0.38	0.34	0.36	0.43	0.33	0.35	0.38	0.50	0.34	0.45	0.38	0.36	0.37	0.29	0.35	0.38	0.21	
+1 StDev	1.01	0.79	0.95	0.98	0.80	0.81	0.83	1.17	0.84	1.04	0.97	0.83	0.88	0.69	0.84	1.05	0.53	

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.

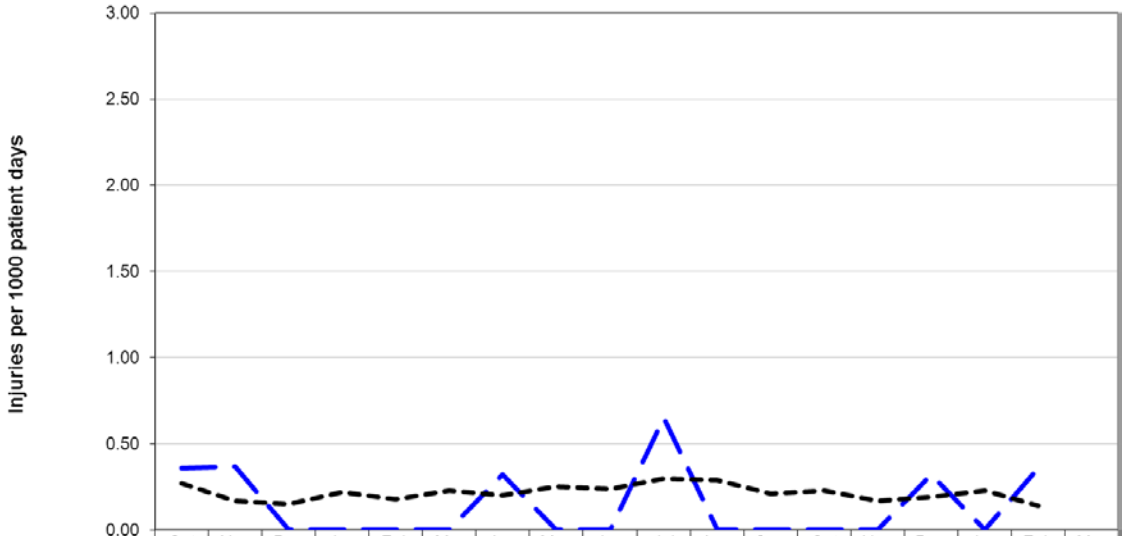
The following graphs depict the number of client injury events stratified by forensic or civil classifications that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

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

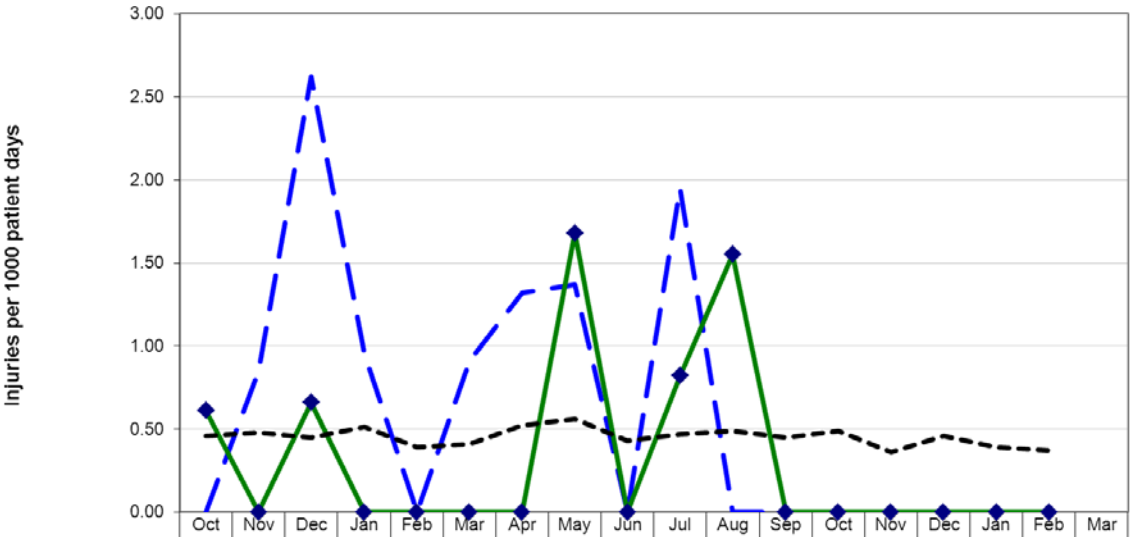
Forensic Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.36	0.37	0.00	0.00	0.00	0.00	0.32	0.00	0.00	0.65	0.00	0.00	0.00	0.00	0.32	0.00	0.36	
Ntl Mean	0.27	0.17	0.15	0.22	0.18	0.23	0.20	0.25	0.24	0.30	0.29	0.21	0.23	0.17	0.19	0.23	0.14	

Client Injury Rate

Civil Stratification



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	0.00	0.85	2.62	0.95	0.00	0.91	1.32	1.37	0.00	1.95	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Dorothea Dix	0.61	0.00	0.66	0.00	0.00	0.00	0.00	1.68	0.00	0.82	1.55	0.00	0.00	0.00	0.00	0.00	0.00	
Ntl Mean	0.46	0.48	0.45	0.51	0.39	0.41	0.52	0.56	0.43	0.47	0.49	0.45	0.49	0.36	0.46	0.39	0.37	

CONSENT DECREE

Severity of injury by Month

Severity	JAN	FEB	MAR	3Q2013
No Treatment	10	14	15	39
Minor First Aid	4			4
Medical Intervention Required		1		1
Hospitalization Required				
Death Occurred				
Total	14	15	15	44

The event that required medical intervention involved a client to client assault. The four events that required minor first aid also involved client to client assaults.

Type and Cause of Injury by Month

Type - Cause	JAN	FEB	MAR	3Q2013
Accident - Equipment Use	1	2		3
Accident – Fall Unwitnessed	1	1	1	3
Accident – Fall Witnessed	3	1	2	6
Accident – Other			1	1
Assault – Client to Client	9	9	11	29
Assault – Other		1		1
Self-Injurious Behavior		1		1

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.

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	4Q2012	1Q2013	2Q2013	3Q2013
Abuse Physical	2	3	5	2
Abuse Sexual	10	6	2	2
Abuse Verbal			1	
Coercion	2			
Neglect				

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 receives a report on the incidence of alleged abuse, neglect, and exploitation monthly.

Performance Improvement and Quality Assurance

V34) Riverview maintains Joint Commission accreditation;

Riverview successfully completed an accreditation survey with the Joint Commission on November 15-19, 2010.

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

The surveyors identified nine areas of indirect impact that required a review and revision of hospital processes within 60 days.

Riverview received notification of full accreditation status on October 3, 2011 with an effective date of November 20, 2010.

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;

Centers for Medicare and Medicaid Services certification is ongoing and applicable for all units, including the Lower Saco SCU. Lower Saco SCU received CMS Certification in January 2011. This certification is required to ensure reimbursement under Medicare, Medicaid, and through the Disproportionate Share Process.

V37) 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.

Riverview complies with this element of substantial compliance as evidenced by this document and a transition to an improvement orientated methodology that is support by the Joint Commission and is consistent with modern principles of process management and strategic methods of promoting organizational performance excellence.

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

JOINT COMMISSION

Admissions Screening (HBIPS 1)

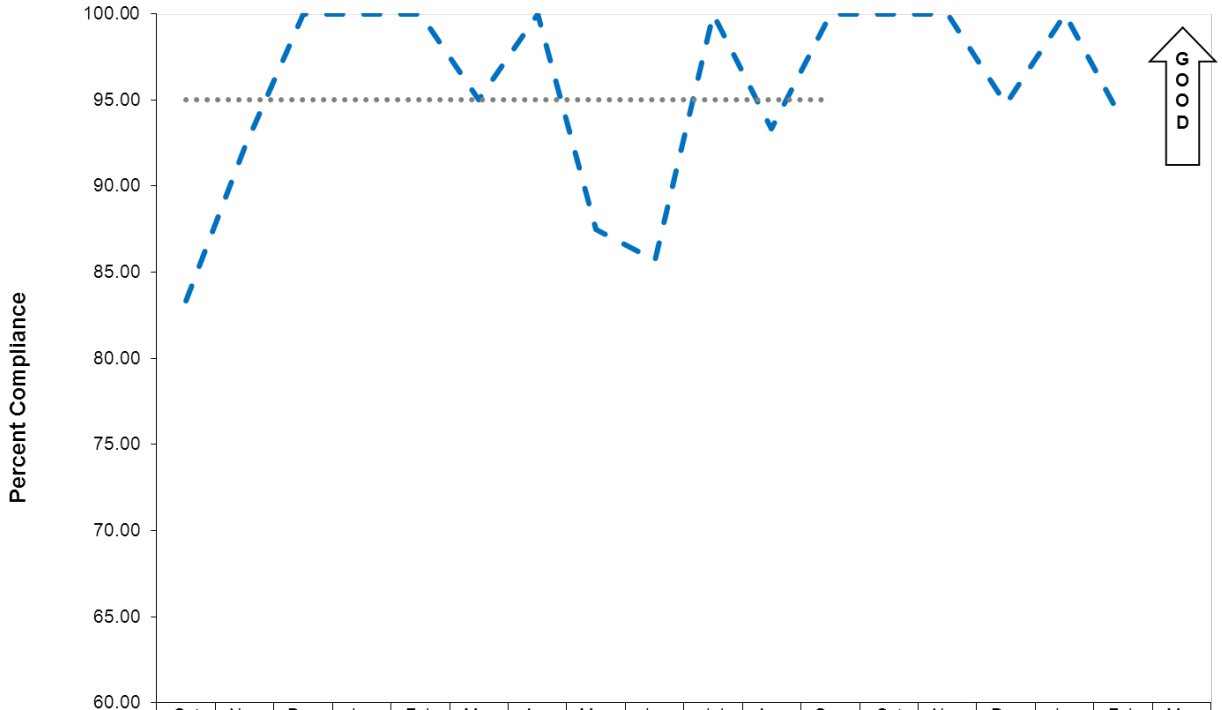
For Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths

Description

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

Rationale

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



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	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	83.33	92.31	100.00	100.00	100.00	95.00	100.00	87.50	85.71	100.00	93.33	100.00	100.00	100.00	94.74	100.00	93.75	
TJC Target	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00						

JOINT COMMISSION

Physical Restraint (HBIPS 2)

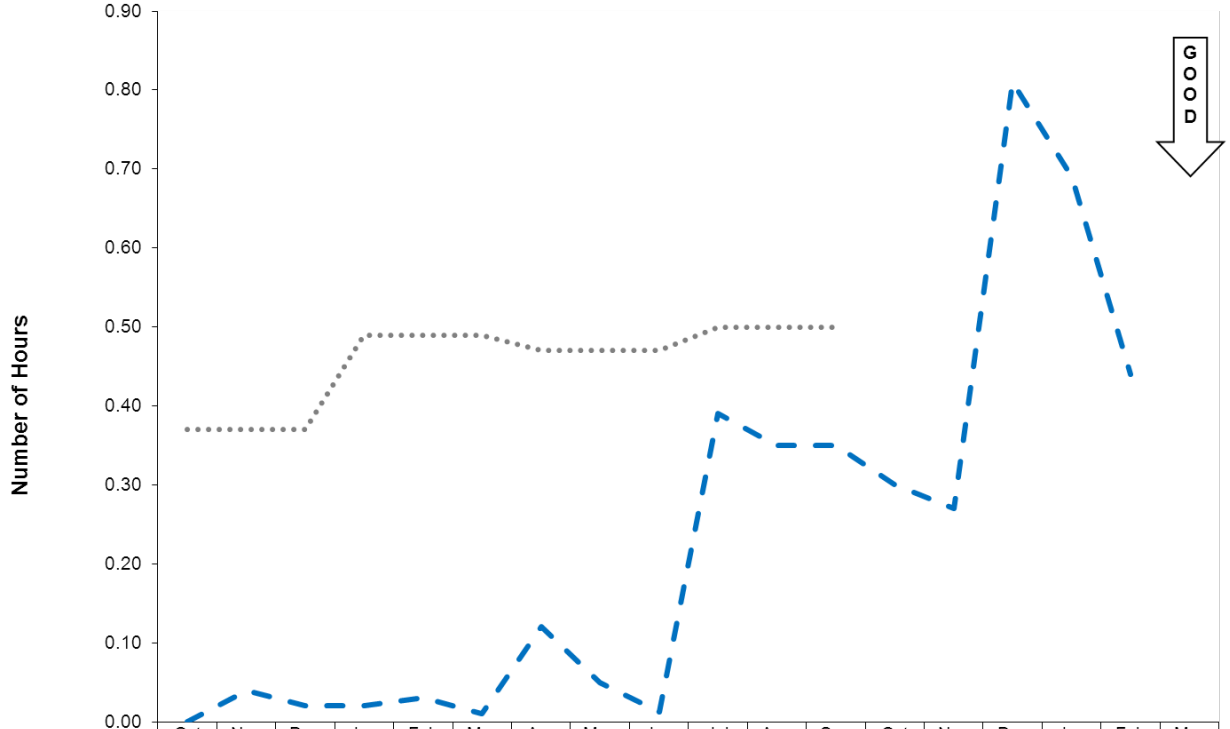
Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were 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).



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	0.00	0.04	0.02	0.02	0.03	0.01	0.12	0.05	0.01	0.39	0.35	0.35	0.30	0.27	0.81	0.69	0.44	
TJC Target	0.37	0.37	0.37	0.49	0.49	0.49	0.47	0.47	0.47	0.50	0.50	0.50						

JOINT COMMISSION

Seclusion (HBIPS 3)

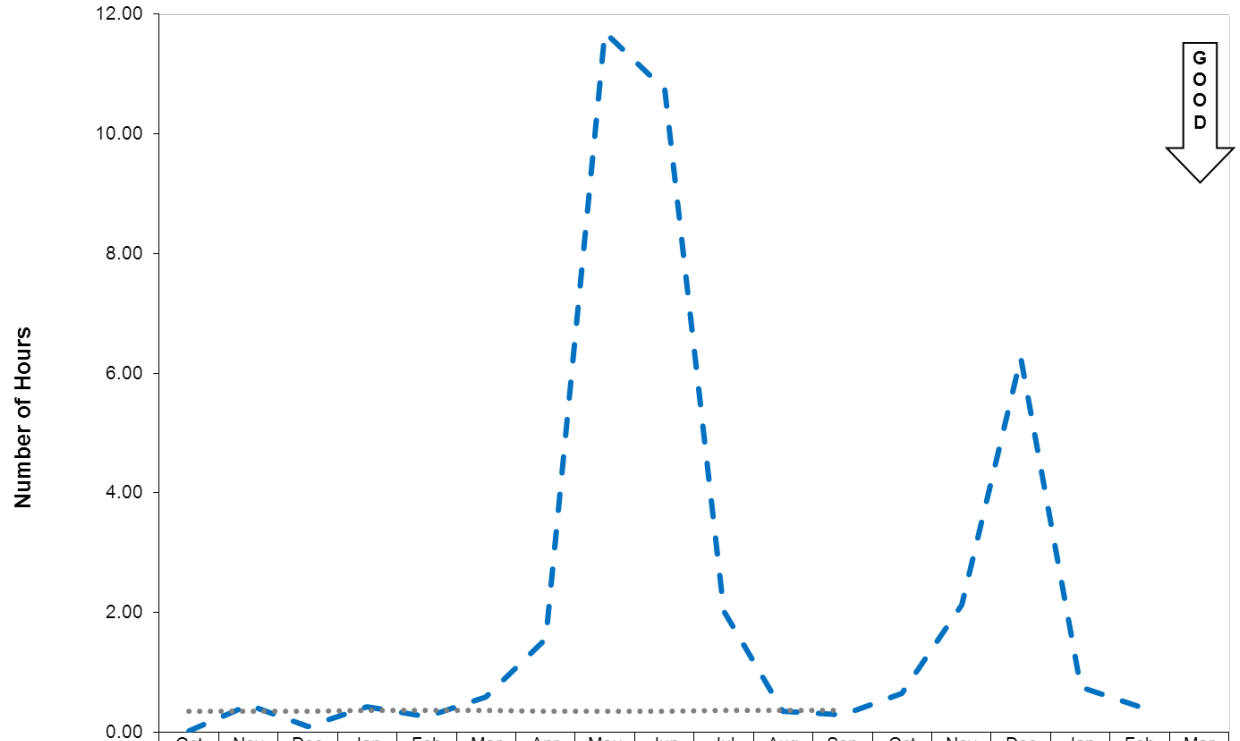
Hours of Use

Description

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were 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).



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	0.02	0.45	0.09	0.42	0.26	0.58	1.55	11.70	10.75	2.02	0.35	0.29	0.65	2.13	6.25	0.75	0.42	
TJC Target	0.34	0.34	0.34	0.36	0.36	0.36	0.35	0.35	0.35	0.36	0.36	0.36						

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)

Description

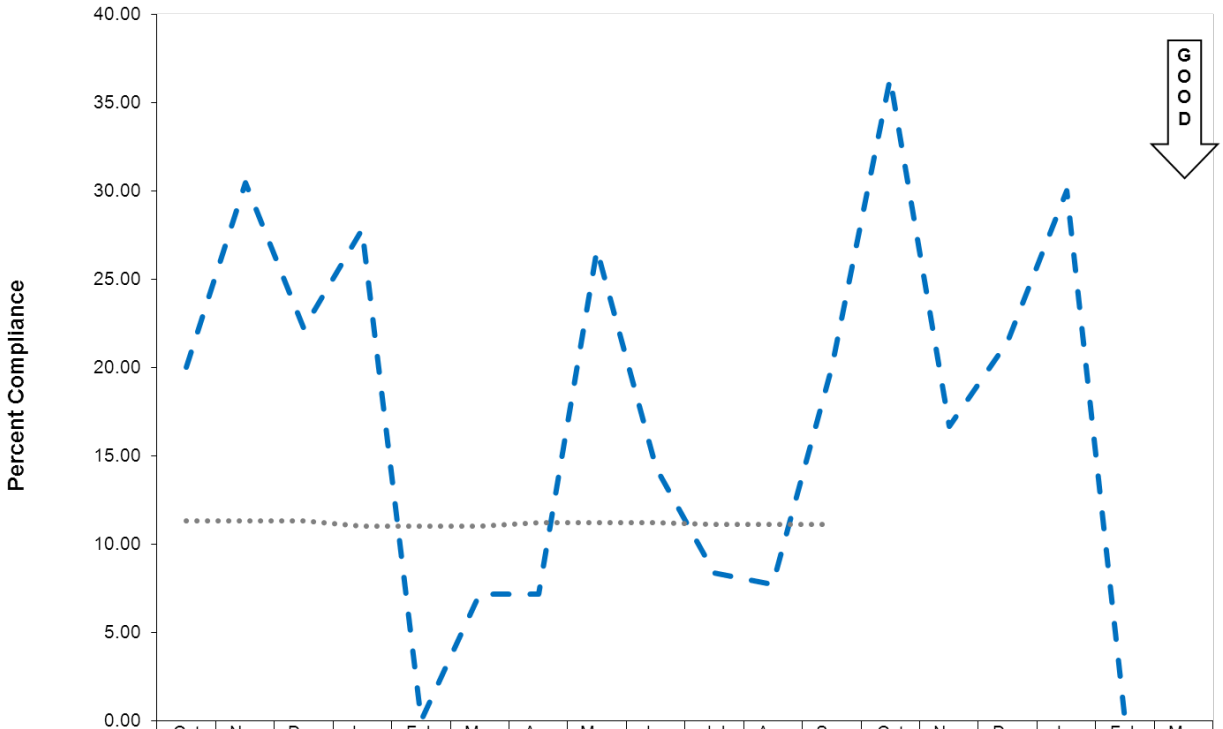
Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications

Rationale

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

JOINT COMMISSION

Multiple Antipsychotic Medications on Discharge (HBIPS 4)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	20.00	30.43	22.22	27.78	0.00	7.14	7.14	26.67	14.29	8.33	7.69	20.00	36.36	16.67	21.43	30.00	0.00	
TJC Target	11.30	11.30	11.30	11.00	11.00	11.00	11.20	11.20	11.20	11.10	11.10	11.10						

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)

Description

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

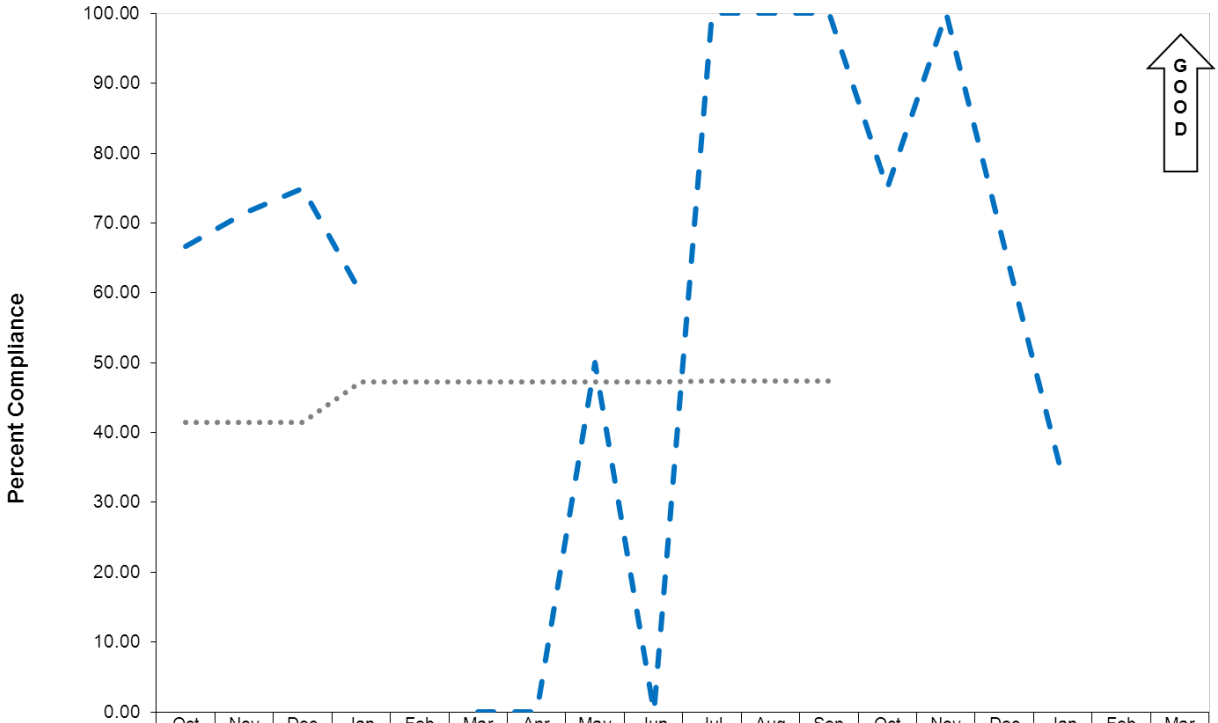
Rationale

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006).

Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in *treatment resistant* patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients *without* a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

JOINT COMMISSION

Multiple Antipsychotic Medications at Discharge with Justification (HBIPS 5)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	66.67	71.43	75.00	60.00		0.00	0.00	50.00	0.00	100.00	100.00	100.00	75.00	100.00	66.67	33.33		
TJC Target	41.50	41.50	41.50	47.30	47.30	47.30	47.20	47.20	47.20	47.40	47.40	47.40						

JOINT COMMISSION

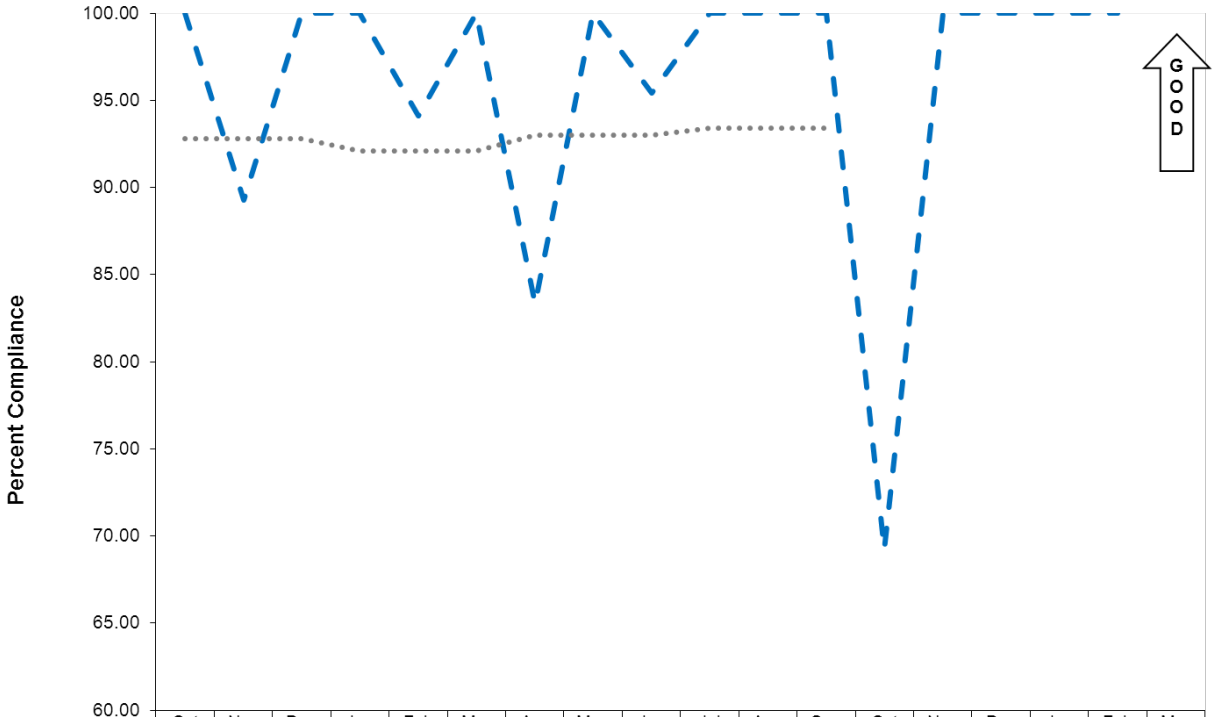
Post Discharge Continuing Care Plan (HBIPS 6)

Description

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

Rationale

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	100.00	89.29	100.00	100.00	94.12	100.00	83.33	100.00	95.45	100.00	100.00	100.00	69.23	100.00	100.00	100.00	100.00	
TJC Target	92.80	92.80	92.80	92.10	92.10	92.10	93.00	93.00	93.00	93.40	93.40	93.40						

JOINT COMMISSION

Post Discharge Continuing Care Plan Transmitted (HBIPS 7)

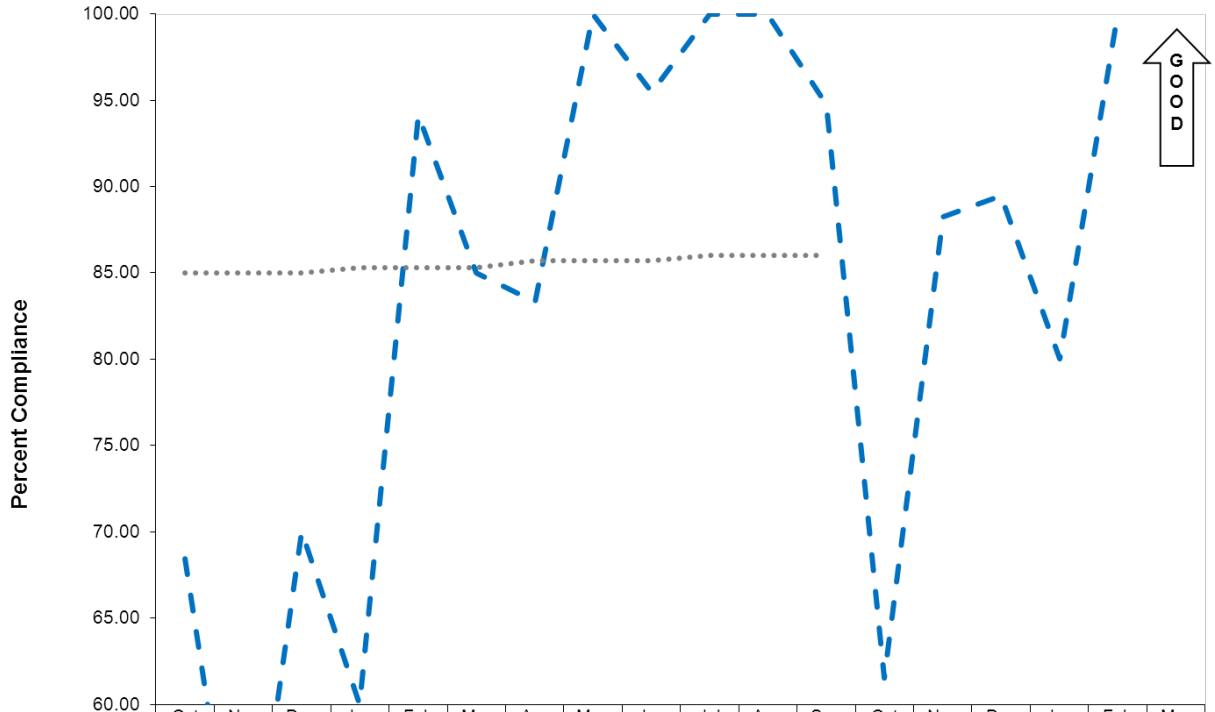
To Next Level of Care Provider on Discharge

Description

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

Rationale

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
RPC Rate	68.42	46.43	70.00	60.00	94.12	85.00	83.33	100.00	95.45	100.00	100.00	94.74	61.54	88.24	89.47	80.00	100.00	
TJC Target	85.00	85.00	85.00	85.30	85.30	85.30	85.70	85.70	85.70	86.00	86.00	86.00						

JOINT COMMISSION

Joint Commission Priority Focus Areas

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	1Q2013	2Q2013	3Q2013	4Q2013
National Patent Safety Goals Goal 1: Improve the accuracy of Client Identification. Capital Community Dental Clinic assures accurate client identification by: asking the client to state his/her name and date of birth. A time out will be taken before the procedure to verify location and numbered tooth. The time out section is in the progress notes of the patient chart. This page will be signed by the Dentist as well as the dental assistant.	**July** 100% 14/14 **August** 100% 4/4 **September** 100% 5/5 **Total** 100% 23/23	**October** 100% 5/5 **November** 100% 3/3 **December** 100% 4/4 **Total** 100% 12/12	**January** 100% 7/7 **February** 100% 3/3 **March** 100% 9/9 **Total** 100% 19/19	**April** **May** **June** **Total**

Dental Clinic Post Extraction Prevention of Complications and Follow-up

Indicators	1Q2013	2Q2013	3Q2013	4Q2013
1. All clients with tooth extractions, will be assessed and have teaching post procedure, on the following topics, as provided by the Dentist or Dental Assistant • Bleeding • Swelling • Pain • Muscle soreness • Mouth care • Diet • Signs/symptoms of infection 2. The client, post procedure tooth extraction, will verbalize understanding of the above by repeating instructions given by Dental Assistant/Hygienist. 3. Post dental extractions, the clients will receive a follow-up phone call from the clinic within 24hrs of procedure to assess for post procedure complications	**July** 100% 14/14 **August** 100% 4/4 **September** 100% 5/5 **Total** 100% 23/23	**October** 100% 5/5 **November** 100% 3/3 **December** 100% 4/4 **Total** 100% 12/12	**January** 100% 7/7 **February** 100% 3/3 **March** 100% 9/9 **Total** 100% 19/19	**April** **May** **June** **Total**

JOINT COMMISSION

Healthcare Acquired Infections Monitoring and Management

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

Indicators	Findings	Compliance	Threshold Percentile
Total number of infections for the third quarter of the fiscal year, per 1000 patient days	5.1	100 % within standard	1 SD within the mean
Hospital Acquired (healthcare associated) infection rate, infections per 1000 patient days	0.94	100% within standard	1 SD within the mean

Data:

Upper Respiratoy Infection (URI): 5
Lower Respiratory Infection (LRI): 1
Gastrointestinal (GI): 2
Reproductive: 4
Dental: 4
Skin: 18
Ear: 1
UTI: 2
Eye: 1
Wound: 0

Hospital Associated Infections (HAI): 7

*Sinusitis-2
*Viral Gastitis-1
*Cellulitis- 2
*Pneumonia-1
*Asymptomatic UTI - 1

Community Acquired Infections (CAI): 31
One client on LOK diagnosed with latent TB.
Infestation: Lice - 1

Lower Saco: 18 CAI and 2 HAI
Lower Saco Scu (LOSSCU): 1CAI
Upper Saco (UPS): 3 HAI and 4 CAI
Lower Kennebec (LOK): 2 HAI and 3 CAI
Lower Kennebec Scu (LOKSC): 1 CAI
Upper Kennebec (UPK): 4 CAI

Summary

Hospital associated infection rates remain low and within one standard deviation of the mean. The type and number of infections is scattered throughout the hospital. Upper and lower respiratory infections are typical for this time of year; as is gastrointestinal infections. One client infestation with lice was treated and quickly contained. One client was diagnosed with latent TB.

Action Plan

Continue total house surveillance (client and employee). Encourage hand hygiene and respiratory hygiene.

JOINT COMMISSION

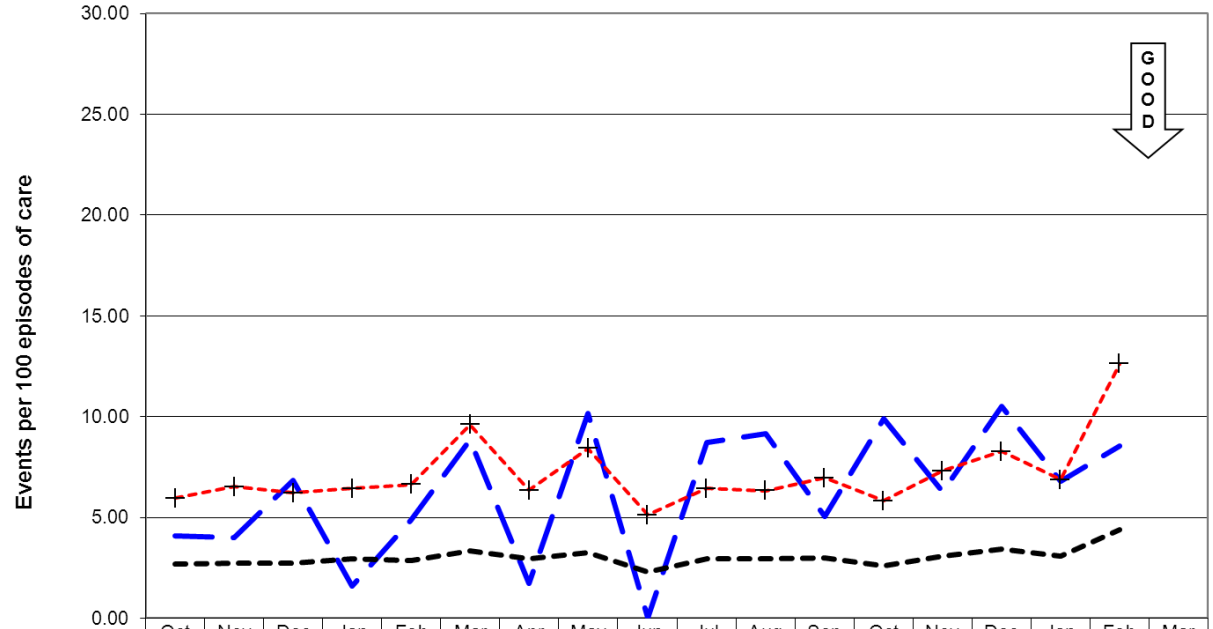
Medication Management

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



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	4.10	4.00	6.84	1.60	4.88	8.87	1.71	10.17	0.00	8.70	9.17	5.04	9.91	6.25	10.53	6.78	8.55	
Ntl Mean	2.68	2.71	2.71	2.95	2.85	3.36	2.93	3.26	2.30	2.94	2.94	2.99	2.60	3.06	3.45	3.08	4.39	
+1 StDev	5.95	6.52	6.22	6.43	6.63	9.6	6.34	8.43	5.13	6.44	6.33	6.96	5.83	7.31	8.28	6.87	12.62	

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

JOINT COMMISSION

MEDICATION ERRORS RELATED TO STAFFING EFFECTIVENESS

Date	OMIT	Co-mission	Float	New	O/T	Unit Acuity	Staff Mix
1/1/13	N	Klonopin 1 mg given 0.5 mg ordered	Y	Y	N	LS	5 RN, 0 LPN, 8 MHW
1/3/13	Y	Seroquil 300 PRN extra dose	Y	N	N	LK	3 RN, 1 LPN, 7 MHW
1/5/13	N	Extra dose – Chloral Hydrate @ 0300	Y	N	Y	UK	1 RN, 0 LPN, 3 MHW
1/9/13	N	Minipress – extra dose	N	Y	N	LS	4 RN, 1 LPN, 7 MHW
1/9/13	N	Wrong time	N	N	N	UK	3 RN, 4 MHW
1/10/13	Y	Vistaril 50 mg missed x2; Vistaril 25 mg missed x1	N	N	N	LS	3 RN, 1 LPN, 8 MHW
1/11/13	N	Wrong time x1	Y	Y	N	LK	3 RN, 1 LPN, 8 MHW
1/14/13	Y	Debrox ear gtts 6 doses	N	N	N	LK	2 RN, 1 LPN, 7 MHW
2/4/13	N	Fazaclo – wrong dose	N	Y	N	LS	3 RN, 8 MHW
2/4/13	N	Biotin Alpha – wrong dose	N	N	N	UK	3-4 RN, 1 LPN, 4 MHW
2/5/13	Y	2 meds omitted x 1 Abilify / Vitamin D	N	Y	N	LS	4 RN, 1 LPN, 8 MHW
2/5/13	Y	Geodon omitted x1	N	Y	N	LS	4 RN, 1 LPN, 8 MHW
2/11/13	Y	Scheduled Doxepin 100 mg omitted, PRN Doxepin 25 mg given	N	Y	Y	UK	2 RN, 4 MHW
2/14/13	N	Zydis – wrong dose given	N	N	N	LS	3 RN, 8 MHW
2/16/13	N	Topamax wrong dose x 6	N	Y	N	LS	4 RN, 1 LPN, 8 MHW
2/18/13	N	Septra given without current order x2	N	Y	N	US	2 RN, 1 LPN, 4 MHW
2/19/13	N	Tramadol wrong dose given	N	N	N	US	2 RN, 1 LPN, 3 MHW
2/25/13	N	Keppra wrong dose given	N	N	N	LS	4 RN, 1 LPN, 7 MHW
Totals	6	12	4	50%	2	LS-9 US-2 LK-3 UK-4	
Percent	33%	67%	22%	70%	11%		

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

Medication errors 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

Joint Commission Measures of Success

Medication Management		Baseline (July-Sept)	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Controlled Substances Loss Data *Daily Pyxis-CII Safe Compare Report*	All	0%	0%	0%			0%	Goal of "0" discrepancies between Pyxis and CII Safe transactions
Quarterly Results								
Monthly CII Safe Vendor Receipt Report	Rx	0	0	0			0	*No discrepancies between CII Safe and vendor transactions for December.
Quarterly Results				0*				
Monthly Pyxis Controlled Drug discrepancies	All	9	0	0			0	Goal of "0" discrepancies involving controlled drugs dispensed from Pxyis
Quarterly Results			9	13				
Medication Management Monitoring								
Measures of drug reactions, adverse drug events and other management data	Rx	17/year	0	0				4 ADR's reported in Q1 and Q2
Quarterly Results			3	1				
Resource Documentation Reports of Clinical Interventions	Rx	134 reports in 2012						100% of all clinical interventions are documented
Quarterly Results			16	36				

JOINT COMMISSION

Inpatient Consumer Survey

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

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

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

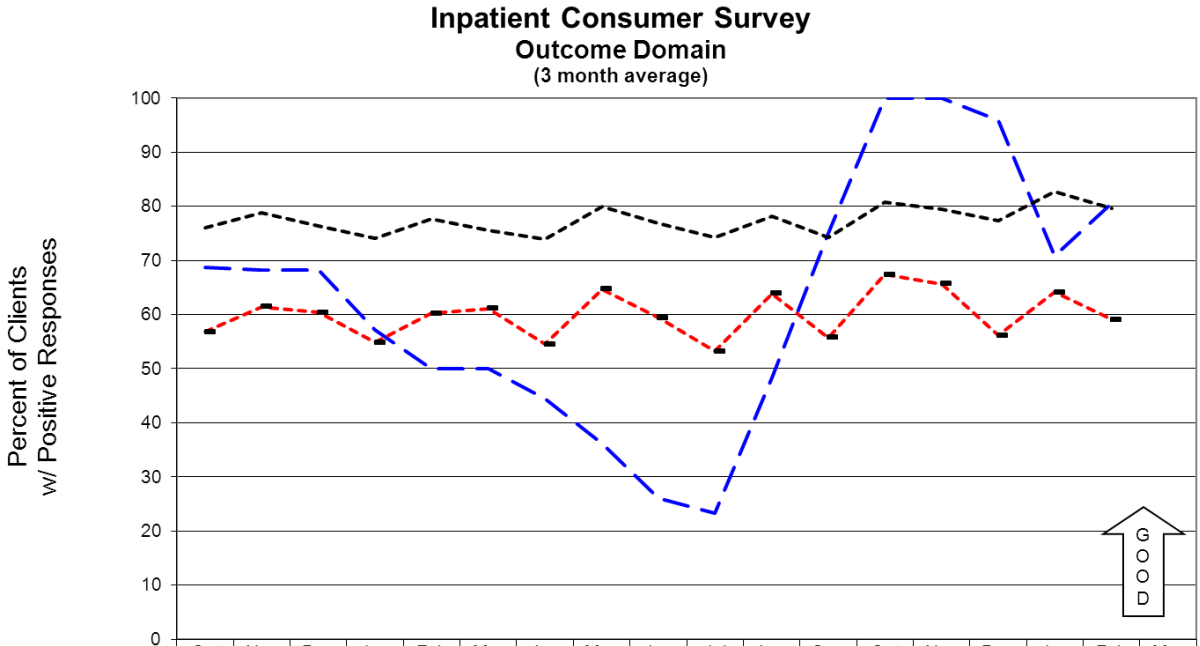
Rate of Response for the Inpatient Consumer Survey

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

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

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

JOINT COMMISSION

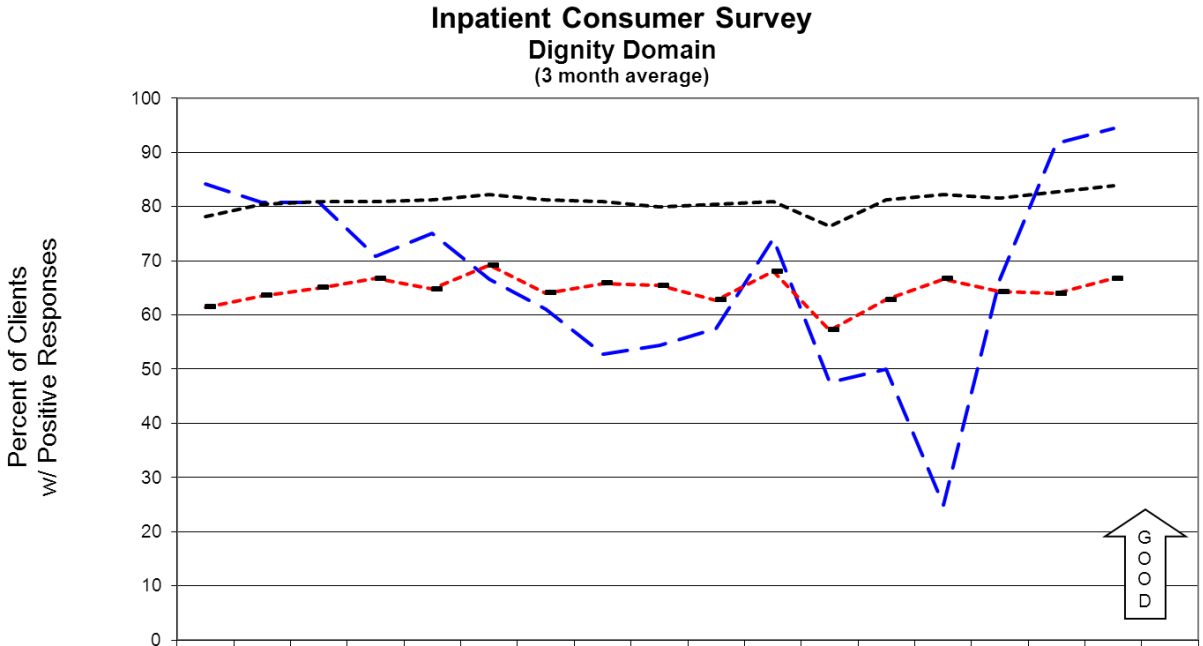


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	68.69	68.25	68.25	57.14	50.00	50.00	44.44	36.11	26.11	23.33	48.33	75.00	100.0	100.0	95.84	70.84	80.56	
Ntl Mean	76.06	78.76	76.42	74.02	77.68	75.51	73.94	80.01	76.92	74.26	78.08	74.22	80.77	79.52	77.33	82.67	79.69	
1 StDev	56.79	61.43	60.35	54.81	60.24	61.09	54.51	64.66	59.39	53.19	63.85	55.72	67.40	65.68	56.11	64.16	59.11	

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

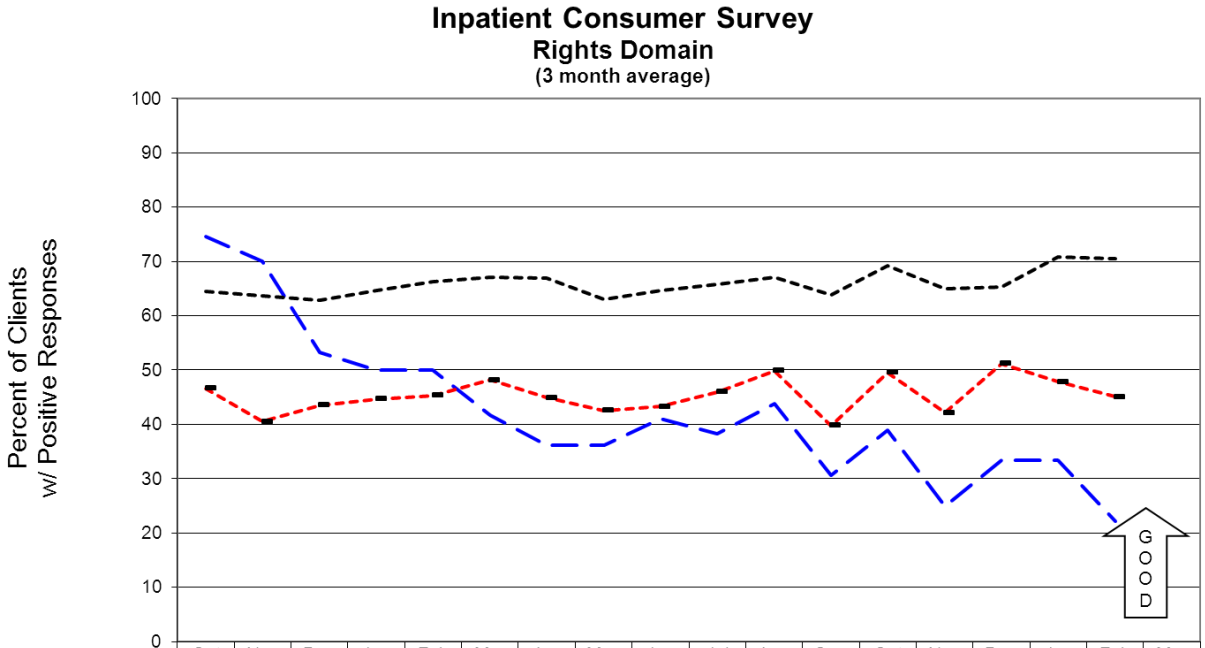


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	84.24	80.83	80.83	70.83	75.00	66.67	61.11	52.78	54.44	57.50	74.17	47.50	50.00	25.00	66.67	91.67	94.44	
Ntl Mean	78.16	80.42	80.87	80.98	81.24	82.20	81.29	80.96	79.96	80.49	80.99	76.45	81.22	82.16	81.61	82.70	83.84	
- 1 StDev	61.46	63.54	65.00	66.73	64.78	69.18	64.01	65.80	65.44	62.76	68.01	57.23	62.82	66.61	64.32	63.98	66.70	

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



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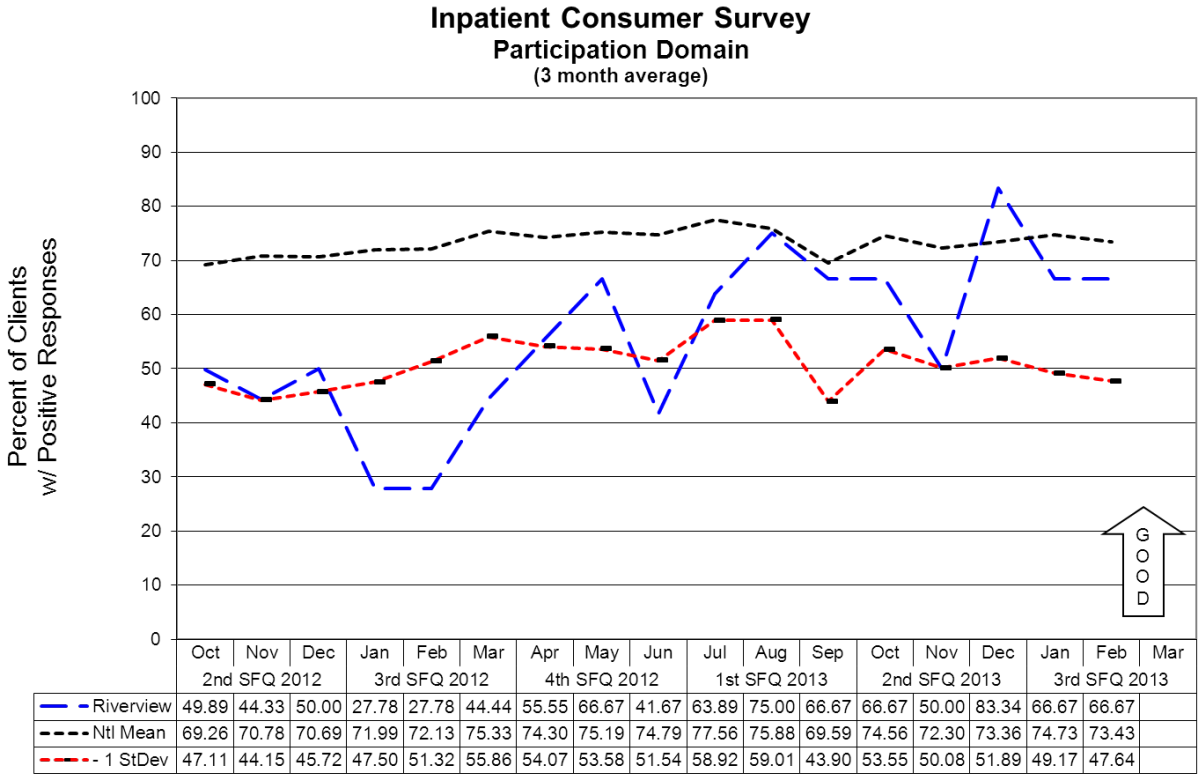
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	74.55	70.00	53.33	50.00	50.00	41.67	36.11	36.11	41.11	38.33	43.89	30.56	38.89	25.00	33.34	33.34	22.22	
Ntl Mean	64.42	63.65	62.80	64.70	66.20	67.12	66.94	63.08	64.62	65.81	67.05	63.77	69.19	64.95	65.36	70.76	70.45	
1 StDev	46.65	40.51	43.50	44.66	45.35	48.14	44.91	42.51	43.25	45.95	49.85	39.74	49.54	42.12	51.20	47.82	45.04	

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



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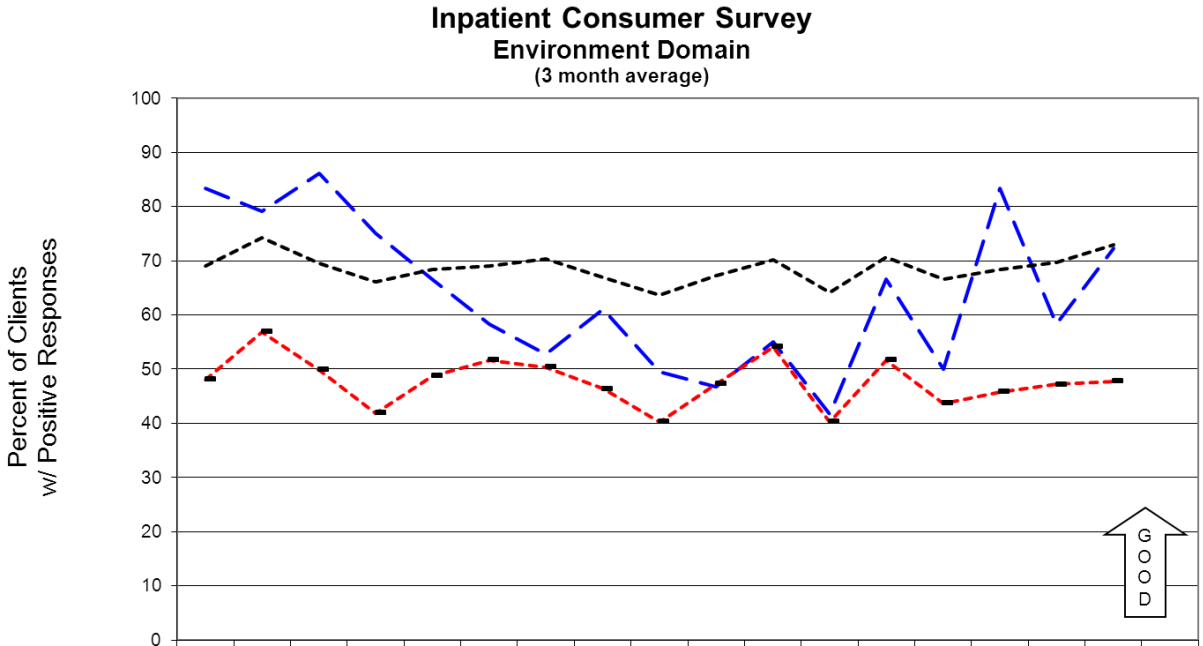
	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	49.89	44.33	50.00	27.78	27.78	44.44	55.55	66.67	41.67	63.89	75.00	66.67	66.67	50.00	83.34	66.67	66.67	
Ntl Mean	69.26	70.78	70.69	71.99	72.13	75.33	74.30	75.19	74.79	77.56	75.88	69.59	74.56	72.30	73.36	74.73	73.43	
1 StDev	47.11	44.15	45.72	47.50	51.32	55.86	54.07	53.58	51.54	58.92	59.01	43.90	53.55	50.08	51.89	49.17	47.64	

Participation Domain Questions

1. I participated in planning my discharge.
2. Both I and my doctor or therapist 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



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	2nd SFQ 2012			3rd SFQ 2012			4th SFQ 2012			1st SFQ 2013			2nd SFQ 2013			3rd SFQ 2013		
Riverview	83.33	79.17	86.11	75.00	66.67	58.33	52.78	61.11	49.44	46.67	55.00	41.67	66.67	50.00	83.34	58.34	72.22	
Ntl Mean	68.99	74.31	69.59	66.19	68.46	69.02	70.34	66.92	63.60	67.32	70.11	64.13	70.65	66.54	68.42	69.74	72.98	
- 1 StDev	48.11	56.84	49.86	41.90	48.73	51.64	50.37	46.41	40.28	47.25	54.11	40.30	51.68	43.72	45.78	47.16	47.76	

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

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	3Q2013
Un-witnessed	MR00005121	1			1
	MR00006695		1		1
	MR00007157			1	1
Witnessed	MR00004212		1		1
	MR00006963	2		2	4
	MR00007015	1			1

* Clients have experienced both witnessed and un-witnessed falls during the reporting quarter.

Review, Reporting and Follow-up Process

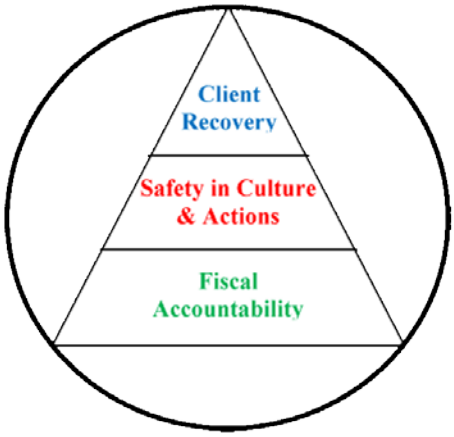
The Falls Assessment and Prevention Process Review Team (PRT) meets monthly to evaluate the causation factors related to the falls reported on the units and makes recommendations, through its multi-disciplinary membership, for changes to workflow, environmental factor, and client care practices.

The activities and recommendations of the Falls PRT are reported monthly to the Integrated Performance Excellence Committee.

STRATEGIC PERFORMANCE EXCELLENCE

Priority Focus Areas
for Strategic Performance Excellence

In an effort to ensure that quality management methods used within the Maine Psychiatric Hospitals System are consistent with modern approaches of systems engineering, culture transformation, and process focused improvement strategies and in response to the evolution of Joint Commission methods to a more modern systems-based approach instead of compliance-based approach



Building a framework for client recovery by ensuring fiscal accountability and a culture of organizational safety through the promotion of…

- The conviction that staffs are concerned with doing the right thing in support of client rights and recovery;
- A philosophy that promotes an understanding that errors most often occur as a result of deficiencies in system design or deployment;
- Systems and processes that strive to evaluate and mitigate risks and identify the root cause of operational deficits or deficiencies without erroneously assigning blame to system stakeholders;
- The practice of engaging staffs and clients in the planning and implementing of organizational policy and protocol as a critical step in the development of a system that fulfills ethical and regulatory requirements while maintaining a practicable workflow;
- A cycle of improvement that aligns organizational performance objectives with key success factors determined by stakeholder defined strategic imperatives.
- Enhanced communications and collaborative relationships within and between cross-functional work teams to support organizational change and effective process improvement;
- Transitions of care practices where knowledge is freely shared to improve the safety of clients before, during, and after care;
- A just culture that supports the emotional and physical needs of staffs, clients, and family members that are impacted by serious, acute, and cumulative events.

STRATEGIC PERFORMANCE EXCELLENCE

Strategic Performance Excellence Model Reporting Process

Department of Health and Human Services Goals

Protect and enhance the health and well-being of Maine people
Promote independence and self sufficiency
Protect and care for those who are unable to care for themselves
Provide effective stewardship for the resources entrusted to the department

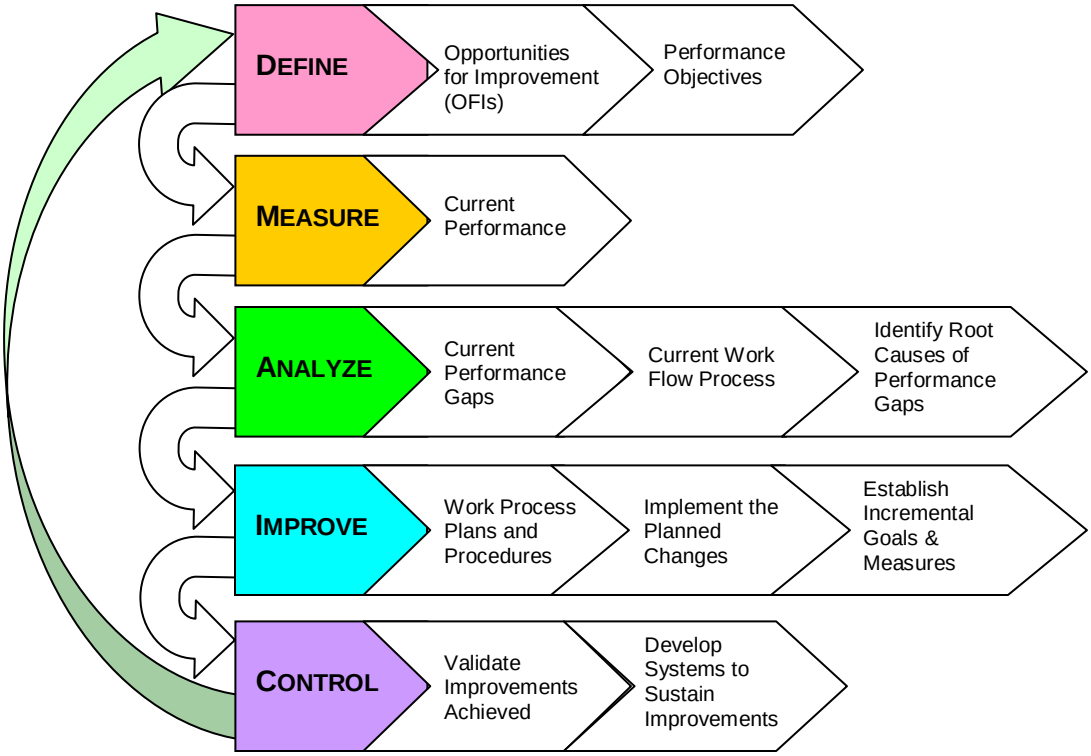
Dorothea Dix and Riverview Psychiatric Centers
Priority Focus Areas

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

Promote a Safety Culture by…
Improving Communication
Improving Staffing Capacity and Capability
Evaluating and Mitigating Errors and Risk Factors
Promoting Critical Thinking
Supporting the Engagement and Empowerment of Staffs

Enhance Client Recovery by…
Develop Active Treatment Programs and Options for Clients
Supporting clients in their discovery of personal coping and improvement activities.

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



STRATEGIC PERFORMANCE EXCELLENCE

Admissions

DEFINE

OPPORTUNITIES FOR IMPROVEMENT (OFI'S)

- Streamline Pre-Admission Face Sheet (PAFS) and remove obsolete items.

PERFORMANCE OBJECTIVES

- Decrease paperwork redundancy due to repetitive information on current worksheet.
- Increase provider satisfaction with information gathered and accessibility of information.

MEASURE

Based on a survey:

- How happy are the employees with the new PASF forms?
- Does it contain the proper/needed information?
- Is it easy to find the information needed?
- Is it well organized?
- Is it legible?
- Is it easier/faster to complete than the previous forms?
- Overall improvement of the forms?

ANALYZE

CURRENT PERFORMANCE GAPS:

- Duplication of the same information required.
- Wasted space on the PSAF.
- Time consuming to complete multiple forms.
- Disorganized, hard to read and find information.
- Lacking important information needed.

CURRENT WORK FLOW PROCESS:

- Based on the amount of history faxed from the referral source, at times, 50-100 pages or more of information is sent per client. This may come in several packets over a period of time, which needs to be reviewed to determine if the client is appropriate for admission.
- The average wait period is 24 days for an admission (based on figures of Sept, 2012 Forensic Referral List) and many clients decompensate further and have to be medically cleared an additional time.

IDENTIFY ROOT CAUSES OF PERFORMANCE GAPS:

- Time and duplication of client information.
- Lacking important information needed.

STRATEGIC PERFORMANCE EXCELLENCE

IMPROVE:

WORK PROCESS PLANS AND PROCEDURES:

- Talk to the Nurse IV and other direct care staff to gather opinions on Admission form revision.
- Hand out survey's to be completed and get feedback regarding the new forms.

IMPLEMENT THE PLANNED PROCEDURES:

- Rearrange the needed information.
- Remove non-applicable items from the PAFS.
- Attend the scheduled meeting with Medical Records staff and obtain approval for 1st draft of changes.
- Add additional information needed by the units upon admission.

CONTROL:

VALIDATE IMPROVEMENTS ACHIEVED

- Based on interviews and surveys completed by staff: Is it working?

DEVELOP SYSTEMS TO SUSTAIN IMPROVEMENTS:

- A new form will be used to support the previous Admission forms.
- It will be reviewed each year to determine if it continues to support the admission process adequately.
- Any feedback from direct staff will be discussed and implemented as necessary for improvements.

Admissions Pilot PSFA Form

Please rate the new forms .
1. The new admission pilot forms contain the information needed upon admission. Strongly Disagree Disagree Agree Strongly Agree
2. It is easy to find the information needed on the new admission pilot forms. Strongly Disagree Disagree Agree Strongly Agree
3. The new admission pilot forms are well organized. Strongly Disagree Disagree Agree Strongly Agree
4. The information is legible on the new admission pilot forms. Strongly Disagree Disagree Agree Strongly Agree
5. For those of you who have to complete the new form: It now takes less time to complete the new PASF form than it did to complete the old PASF form. Strongly Disagree Disagree Agree Strongly Agree
6. I would not make any changes to the new admission pilot forms. Strongly Disagree Disagree Agree Strongly Agree

STRATEGIC PERFORMANCE EXCELLENCE

Admissions Process Improvement Activities
3Q2013

- Over the past few months the admissions department has been working on making some changes to the PASF forms.
- A third information sheet was added based on an identified need for more specific information prior to admission of a new client. The form was created and adjustments were made to accommodate these needs.
- Staff were surveyed regarding the changes and feedback was taken. The form was once again revised based on staff input.
- The final draft of the new PASF form is now being piloted and staff will once again be surveyed on their satisfaction with the new forms.
- Admissions has also collaborated with medical records to streamline the admission process for the units.
- Old forms were archived and duplication was eliminated.
- Patient packets have been added to the admission process to ensure that the clients are receiving the information they need upon arrival.
- Feedback has been positive from the staff regarding these changes.
- We are once again open to accepting civil admissions and we have managed to keep our waiting lists down for both forensic and civil referrals.
- We are continuing to build relationships with the jails, keeping open communication so information is passed on in a timely manner.
- I have also created a step by step check sheet for our NOD's. They are now able to reference this document to help them navigate through meditech from an admissions standpoint. This has helped facilitate smoother transitioning of clients returning from CS to the hospital and ensured that data is being entered in correctly.

STRATEGIC PERFORMANCE EXCELLENCE

Dietary Services

Responsible Party: Kristen Piela DSM

Strategic Objective: Safety in Culture and Actions												
Hand Hygiene Compliance: In an effort to monitor, sustain and improve hand hygiene compliance, the Dietary department measures its results through observations of Dietary staff when returning from a scheduled break.												
1st Quarter			2nd Quarter			3rd Quarter			4th Quarter			Goal
Baseline Established	Findings	Compliance	Target – Q1 + 12%	Findings	Compliance	Target – Q2 + 10%	Findings	Compliance	Target – Q3 + 10%	Findings	Compliance	
58%	22/43	N/A	70%	18/34	53%	63%	41/49	84%				80-90%

Data

41 compliant observations / 49 hand hygiene observations = 84% hand hygiene compliance rate

Summary

- Review of the importance of data collection occurred with the Food Service Manager and Clinical Dietitian.
- A hand hygiene in-service was provided in January. All employees attended the training.
- Dietary employees completed ServSafe training (national food safety course)
- Hand hygiene compliance increased by 31%

Action Plan

- Continue discussion with Food Service Manager and Dietitian regarding the importance of consistency and quantities of data collection.
- Encourage employees to adhere hand hygiene via verbal interaction.
- Present quarterly report at departmental staff 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 on August/12 to September/12.

Q2-Q4 TARGETS

Baseline – 5% each Q

STRATEGIC PERFORMANCE EXCELLENCE

Department: Safety & Security Responsible Party: Rick Levesque
Environment of Care Committee

Strategic Objectives								
Safety in Culture and Actions	Unit	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Grounds Safety & Security Incidents Safety/Security incidents occurring on the grounds at Riverview, which include "*Acts of thefts, vandalism, injuries, mischief, contraband found, and safety / security breaches*	# of Incidents	* Baseline of 10 was determined in the months of Aug. & Sept. of 2012	*	(10) -5% (13)	(13) -5% (6)			

SUMMARY OF EVENTS

The Q3 Target was (13)-5%. Our actual number was (6); a reduction of 55%. 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 additional cameras and improved exterior lighting has positively impacted our surveillance capabilities.

EVENT	DATE	TIME	LOCATION	DISPOSTION	COMMENTS
1. Safety Threat (keys found in lot)	01/04/13	1536	Staff Lot	Turned into Operations	1. Set of Ford keys found in snow bank 2. Turned into Operations 3. Facility-wide email sent out
2. Safety Threat (items in back of truck)	02/23/13	0945	Staff Lot	Owner responded and moved vehicle to another lot off site	1. Security notified Operations 2. Operations notified staff/owner 3. Moved to another lot 4. IR completed 5. Supervisor called
3. Safety Threat (items in back of truck)	03/02/13	0913	Staff Lot	Owner responded and secured	1. System-wide email sent to claim. 2. Reminded owner of risks 3. Supervisor notified 4. Safety notified by IR
4. Safety Threat (Loose dog)	03/13/13	1025	Staff Lot	Taken to animal shelter	1. Staff took animal to shelter
5. Safety Threat (Loose dog)	03/21/13	0956	Staff Lot	Augusta PD responded and took to shelter	1. Augusta PD called, investigated, and took dog to shelter
6. Security Concern (discarded empty beer can on lawn by Kennebec Wing)	03/28/13	0650	Lawn off Kennebec Wing	Placed in redemption container	1. Security found during patrol 2. IR completed 3. Can properly disposed of 4. Communicated to Security team

STRATEGIC PERFORMANCE EXCELLENCE

Harbor Treatment Mall

Objectives	*2Q2013*	*3Q2013*	*4Q2013*	*1Q2014*
1. Hand-off communication sheet was received at the Harbor Mall within the designated time frame.	*45% 19 of 42*	*67% 28 of 42*		
2. SBAR information completed from the units to the Harbor Mall.	*67% 28 of 42*	*76% 32 of 42*		

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 45% last quarter to 67% for this quarter. Indicator number two has increased from 67% last quarter to 76% this quarter.

ANALYZE

Overall compliance has increased. For indicator one the time frames for being late was between one and fifteen minutes. This is an overall improvement in the range of specific times the sheets were late. Continue to concentrate on both indicators to improve current performance gaps.

IMPROVE

On January 23rd I attended a meeting with the Kennebec PSD, all four Nurse IV's, three Treatment Team Coordinators, one floor nurse and one milieu manager. This meeting was scheduled to educate the Treatment Team Coordinators on the Hand-off Communication sheets since this is one of their responsibilities. We reviewed policy, protocol, forms, performance improvement data collected and current results and the reasons why we have this policy.

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 system that works for them to meet the objectives. I will meet with the Nurse IV from one unit that has shown improvement but continues to have difficulties meeting the objectives.

Department: Harbor Mall Responsible Party: Lisa Manwaring, PSD

Strategic Objectives							
Hand of Communication	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
95% of HOC sheets were received at the Harbor Mall within the designated time frame.	55	60	70	80	90	95%	
95% of SBAR information completed from the units to the Harbor Mall	64	60	70	80	90	95%	

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Technology (Medical Records)

Documentation of Client Encounters in Support of Superbills Submitted

Define

The opportunity for improvement in the Health Information Department is auditing the charges submitted, along with documentation of those charges.

Measure

26 providers submitted superbills to the Health Information department for quarter 3.

Analyze

One provider (NH) submitted superbills for the month of January with no documentation found. The provider had been providing hand written documentation instead of documenting in the EMR. There were 8 superbills with no documentation for one provider (RK). There were 18 superbills with an incorrect date of service. There were 2 duplicate superbills.

Improve

Spoke with the Medical Director regarding the written documentation issue. In regards to the incorrect dating issue, superbills are all being returned to the providers for correction. Continue to work with providers on appropriate/consistent documentation.

Control

Continue auditing 10 (at minimum) superbills & documentation per provider. For quarter 3, 100% of superbills were audited.

Process Deficiencies Identified	2Q2013	3Q2013	4Q2013	1Q2014
Superbill Submission without supporting documentation	18/25 72%	9/26 35%		
Superbills with incorrect information		18/26 69%		
Duplicate Superbills	19/25 76%	2/26 8%		

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

Measure

To evaluate the validity of the perceived delays a process was established to measure the date the application was signed by the application and the date the application was received for processing by the hospital. This measure produces data on the number of days the application is in the hands of the issuing agency before being referred to the hospitals for review. In addition, the date that application was returned to the issuing agency is also recorded to measure the delay in processing by the hospital.

Analyze

Baseline data on delays in receipt and processing was collected beginning March 13, 2013.

- Maine State Police forwarded a total of 526 applications for the month with an average processing delay prior to receipt by the hospital of 72 days. The maximum delay for any application was 124 days
- The greatest delay in receipt of an application was 381 days from the Bridgton PD.
- The average number of days for hospital processing of applications was 11 days. The maximum number of days was 13.

Improve

Several improvements have been implemented to facilitate the workflow within the department including the immediate sorting of the applications as they arrive so the alphabetic records can be reviewed more efficiently.

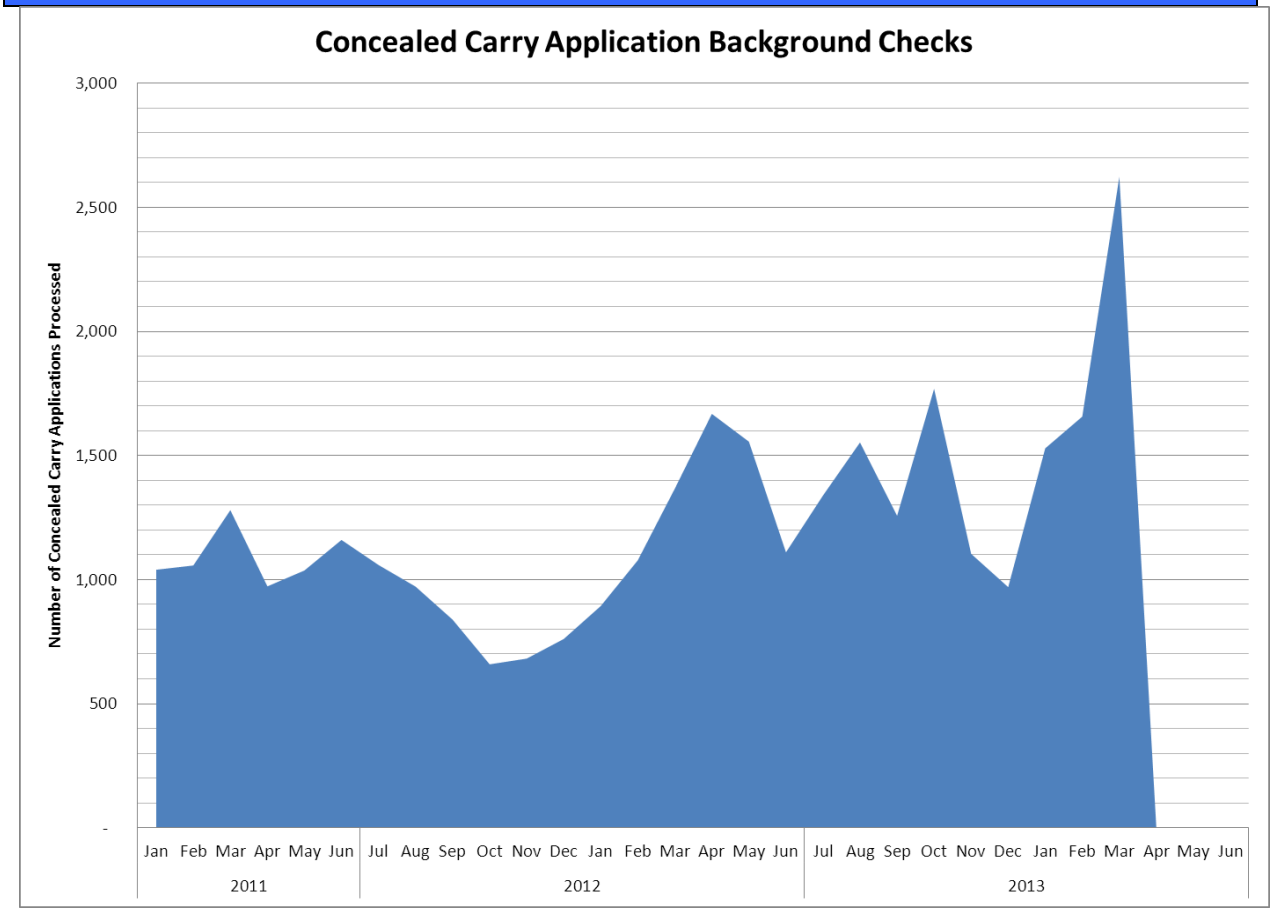
Other improvements being considered include transforming the existing archival records to a digital format. Barriers to be considered in this change include the significant time and fiscal impact required.

Control

While not always the case, many of the significant delays in processing the concealed carry applications originate with the workflow of the issuing agency. Ongoing monitoring of the process will be conducted and staff input on improvements will be solicited for the purpose of enhancing the timeliness of applications processes by hospital staff.

FY 2013	Jul	Aug	Sep	Oct	Nov	Dec	Jan`	Feb	Mar	Apr	May	Jun
# Applications Received	1339	1553	1257	1757	1104	970	1529	1657	2623			
Avg Receipt Delay	--	--	--	--	--	--	--	--	35			
Max Receipt Delay	--	--	--	--	--	--	--	--	381			
Avg Processing Time	--	--	--	--	--	--	--	--	11			
Max Processing Time	--	--	--	--	--	--	--	--	13			

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

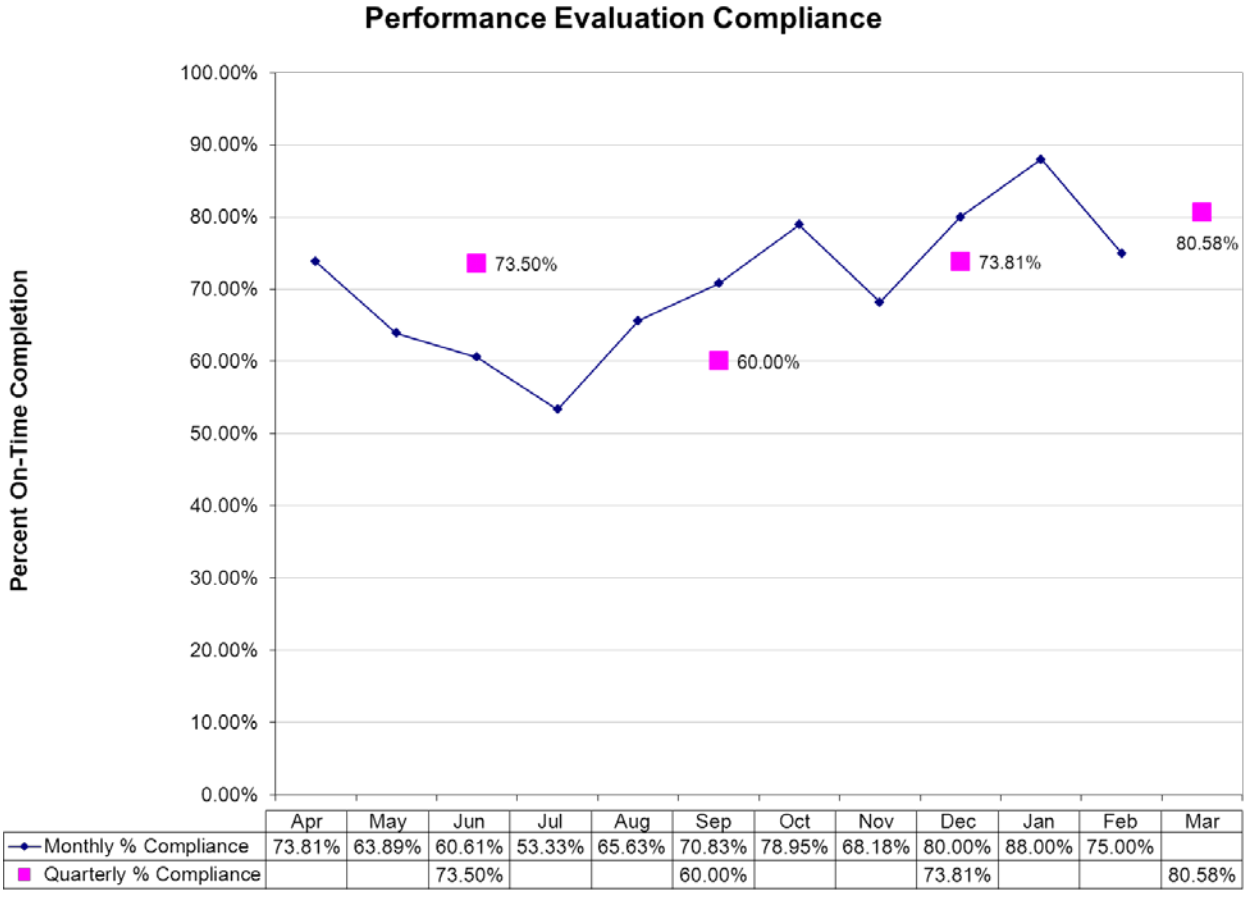
A thorough analysis of the root causes for lack of compliance with this performance standard is indicated. This analysis

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

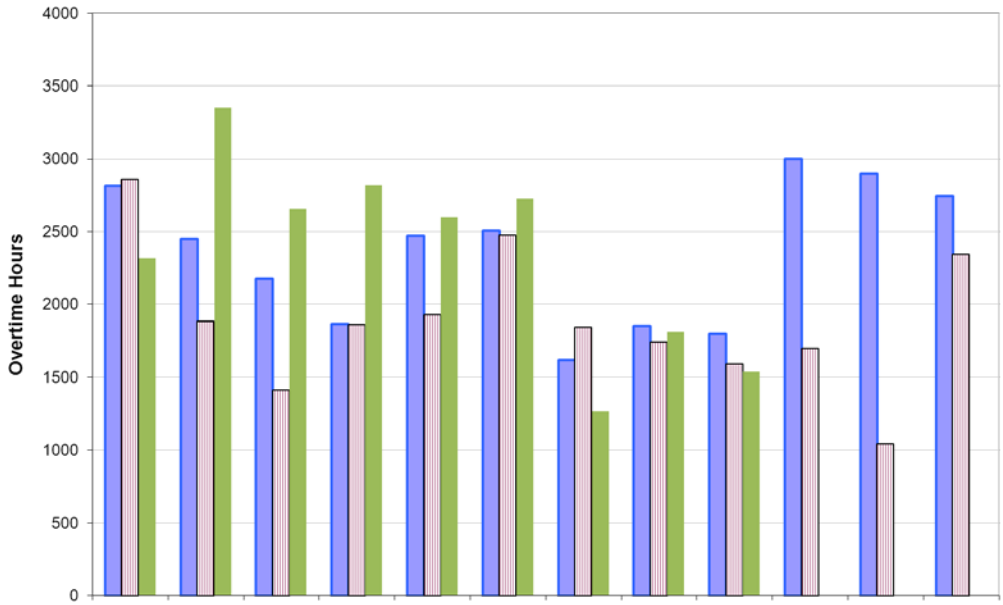
Plans to modify hospital performance evaluation goals for supervisory personnel will include the completion of subordinate performance evaluations in a timely manner as a critical supervisory function.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly % Compliance	73.81%	63.89%	60.61%	53.33%	65.63%	70.83%	78.95%	68.18%	80.00%	88.00%	75.00%	
Quarterly % Compliance			73.50%			60.00%			73.81%			80.58%

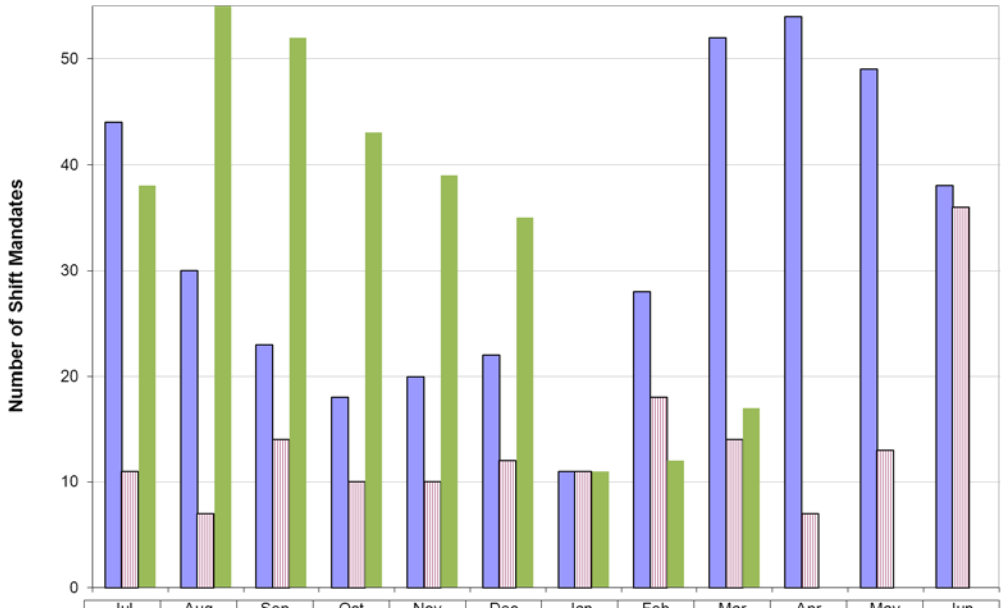
STRATEGIC PERFORMANCE EXCELLENCE

Monthly Overtime



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	2812	2451	2178	1868	2473	2507	1618	1853	1798	2999	2896	2743
FY 2011	2859	1885	1411	1860	1926	2474	1844	1740	1589	1697	1042	2342
FY 2013	2316	3350	2657	2817	2599	2726	1266	1812	1539			

Monthly Mandated Shifts

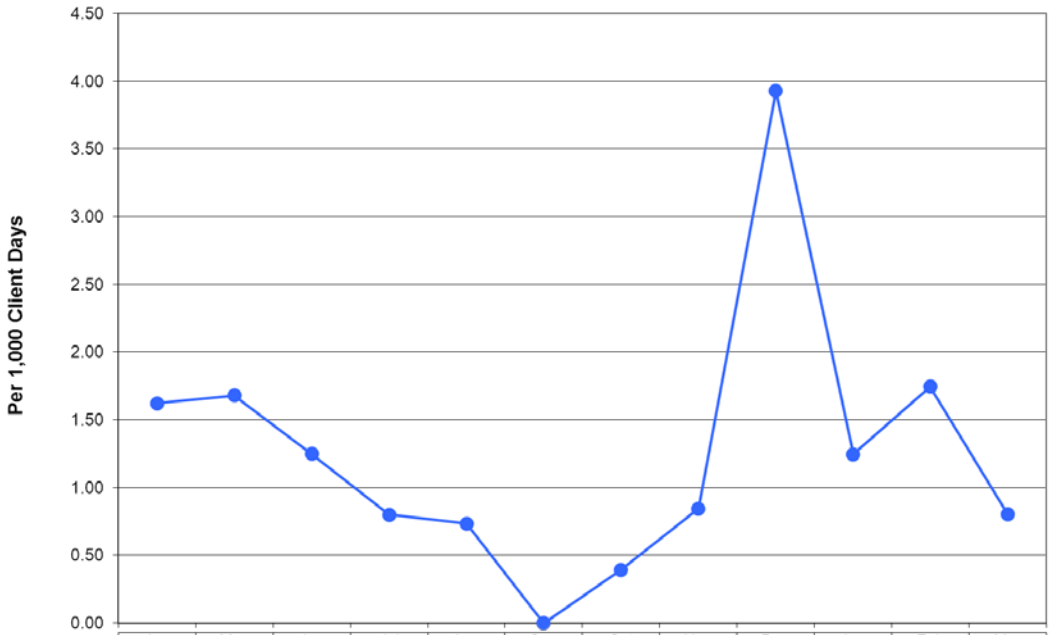


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2012	44	30	23	18	20	22	11	28	52	54	49	38
FY2011	11	7	14	10	10	12	11	18	14	7	13	36
FY 2013	38	81	52	43	39	35	11	12	17			

The nursing department has implemented a staffing patterns study in an attempt to minimize the incidence of mandates. Further information on this study can be viewed on page 75 of this report.

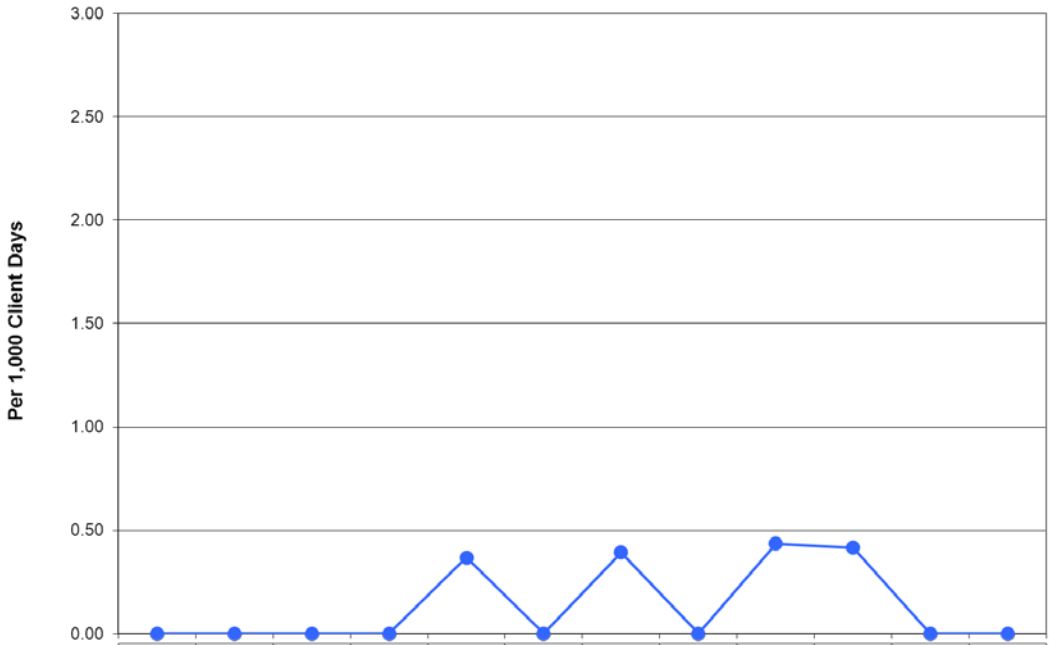
STRATEGIC PERFORMANCE EXCELLENCE

Reportable (Lost Time & Medical) Direct Care Staff Injuries



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lost Time Ratio	1.62	1.68	1.25	0.80	0.74	0.00	0.39	0.85	3.93	1.25	1.75	0.81

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lost Time Ratio	0.00	0.00	0.00	0.00	0.37	0.00	0.39	0.00	0.44	0.42	0.00	0.00

STRATEGIC PERFORMANCE EXCELLENCE

Infection Prevention and Control

Responsible Party: Kathleen Mitton RN

Strategic Objective: Safety in Culture and Actions		
Hand Hygiene Measurement: To gain an accurate and consistent perspective on employee hand hygiene practice, an effective measurement process needs to be in place. Current experience has demonstrated that the collection of observations of employee hand hygiene practice is inconsistent and incomplete. The measure will strive to improve the process of data collection and measurement.		
	Hand Hygiene Compliance	Date Collection Compliance
Indicator:	Each unit will do 80 hand hygiene observations per month	To improve the process of data collection
Goal:	Increase hand hygiene compliance rate to 80%	95% data collection
January 2013		
Number of Observations:	256	320 Observations per Month
Compliance	171	256 Observations done
% Compliance	68% hand hygiene compliance rate	80% Compliance with Data Collection
February 2013		
Number of Observations	486	320 Observations per Month
Compliance	262	486 Observations done
% Compliance	54% hand hygiene compliance rate	>100% Compliance with Data Collection
March 2013		
Number of Obvservations	242	320 observations per Month
Compliance	145	242
% Compliance	60% hand hygiene compliance rate	77% compliance with Data Collection
3rd Quarter Mean Compliance	61%	81%

Summary

The hospital mean hand hygiene rate is consistently 60 – 65%. This is based on an average of 86% data collection for the last three quarters. As previously expressed in quarterly reports, collecting data to measure hand hygiene practice is not as easy a task as one may think. Data collection is based on observations of hand hygiene before and after client care. Staff/client interactions are typically verbal with very little physical hands on care. The manager of Central Supply reports that hand sanitizer is "flying off the shelves". I frequently observe staff using hand sanitizer at the nursing station, in the chart room, and in the conference rooms. I question how valid this process is.

Plan of Action

Continue to collect and measure hand hygiene practice; and consider changing the focus of observation to medication passes at the beginning of the fiscal year.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff

1. Identification of Opportunities for Improvement:

   Some members of the medical staff have long complained about lack of timeliness and difficulty in obtaining certain psychological services. For example there is an nuclear process for requesting or ordering such services as individual psychotherapy, psychological testing, and related activities for individual clients. Furthermore there continued to be anecdotal complaints of the quality and responsiveness of some services. A review of the process did determine that there was a "Request Form for Psychological Services" in existence but it was not widely disseminated amongst all units and providers. There was also a "Psychological Services Satisfaction Survey" in existence, but again, it was neither widely known nor utilized. Initial work by the Medical Executive Committee was done to improve both forms and to mandate their use by all medical and nursing staff when requesting any psychological service.

2. The Measurement Process:

   The Medical Executive Committee is in the process of revising both the Referral Form and the Satisfaction Survey to better articulate the ordering clinician's specific need for a service, the clinical question to be addressed, and the time acuity of the need. It was agreed that the ordering clinicians would always utilize this form and no procedure would be conducted without one. It was further agreed that there would be a central point of contact in the Psychology Section Office for the review of the requests for service, a triage function, and the assignment of requested tasks (therapy or testing or consultation) to individual psychologists for completion. The Chief of Section, Dr. DiRocco, will oversee the process and track the time from assignment to completion (or in the case of psychotherapy until the first session has been completed). He will also make certain ordering medical staff complete a Satisfaction Questionnaire upon completion of the requested task, and he will track the outcome of this rating scale. We will therefore be tracking two data sets: one of timeliness of completion of requested service and one on the quality and usefulness of the completed work product.

3. Baseline Measures:

   Dr. DiRocco is in the process of obtaining additional baseline data on the averages and range of time to completion of a given service, and on the averages and range of ratings on the Satisfaction Survey. An initial accounting found that over the period of mid-June to mid-August the average time to completion of requested psychological testing was 9.6 working days, with a range of 2 to 31 working days. Additional baseline data, incorporating all requested services (not just testing), is necessary. Once these are obtained we will determine our goals of improvement for the next 4 quarters.

4. Goal of Improvement and Measures of Success:

   We will monitor on a monthly basis the average waiting time for completion of the requested service, and the ratings of satisfaction with the service. Our goal obviously is to improve both timeliness and quality of the reports and interventions. We will make further process improvements as needed based on the data obtained over the next 4 quarters.

Quarterly Update

2nd Quarter 2013	Due to a significant loss of Psychology providers during the past few months this study has been delayed until replacements can be recruited.

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

Department:	Nursing	**Responsible Party:**	Coleen Cutler, Acting DON; Staffing Improvement Task Force

Strategic Objectives

Safety in Culture and Actions	Unit	Baseline Aug 2012	Mth 1: Sep 2012	Mth 2: Oct 2012	Mth 3: Nov 2012	Mth 4: Dec 2012	Goal	Comments
Mandate Occurrences - Nurses When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	# of shifts	24	10	5	0	6	16 (10% reduction monthly x4 from baseline)	Goal exceeded.
Mandate Occurrences – Mental Health Workers When no volunteers are found to cover a required staffing need, an employee is mandated to cover the staffing need according to policy.	# of shifts	53	38	36	34	28	35 (10% reduction monthly x4 from baseline)	Goal exceeded
Safety in Culture and Actions	# of shifts	Mth 5 Jan 2013	Mth 6 Feb 2013	Mth 7 Mar 2013				
Mandate Occurrences - Nurses		1	2	1				Goal Exceeded
Mandate Occurrences – Mental Health Workers	# of shifts	8	8	15				Goal Exceeded

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%.

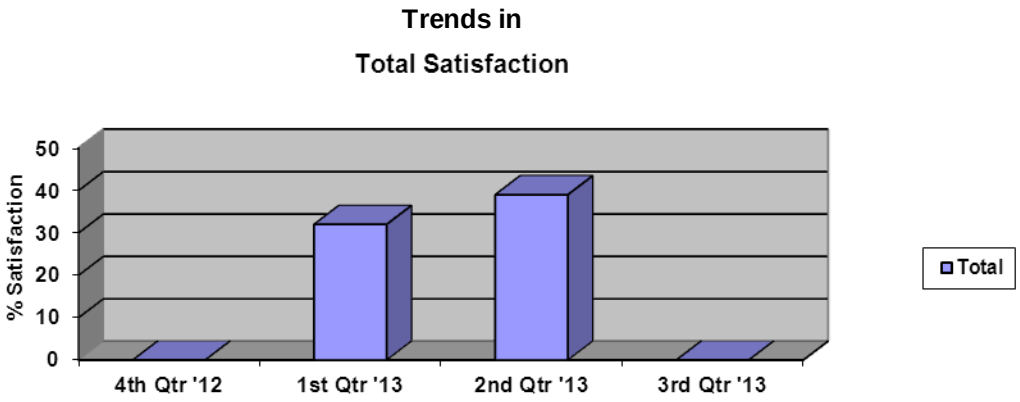
STRATEGIC PERFORMANCE EXCELLENCE

Department: Peer Support Responsible Party: Holly Dixon

Strategic Objectives								
Client Recovery	Unit	Baseline	Q1	Q2	Q3	Q4 Target	Goal	Comments
CSS Return Rate	LK	15%	ND	9%	8%	25%	50%	
The client satisfaction survey is the primary tool for collecting data on how clients feel about the services they are provided at the hospital. Data collection has been low on all units and the way in which the surveys are administered has challenges based on the unit operations and performance of the peer support worker.	LS	5%	ND	0%	0%	25%	50%	*Percentages are calculated based on number of people eligible to receive a survey vs. the number of people who completed the surveys.*
	UK	45%	ND	44%	27%	50%	50%	
	US	30%	ND	78%	60%	50%	50%	

Summary

Compliance on LK remained relatively the same this quarter. Although a number of surveys were offered to clients, the number of refusals brought the potential compliance from 17% to 8%, which would have been closer to the 3rd quarter target of 25%. LS continues to have a 0% return rate. This is primarily due to the nature of the unit population and the lack of staff administration of the surveys, despite reminders. Protocols are being put into place for 4th quarter to ensure that surveys are offered on a regular basis. The return rate on UK dropped significantly, as the number of refusals to complete surveys increased. There was also a drop in compliance on US as well due to the same reason.



STRATEGIC PERFORMANCE EXCELLENCE

Summary of Inpatient Client Survey Results

#	Indicators	Findings Total	
1	I am better able to deal with crisis.	29%	-31%
2	My symptoms are not bothering me as much.	57%	-6%
3	The medications I am taking help me control symptoms that used to bother me.	36%	-4%
4	I do better in social situations.	14%	-36%
5	I deal more effectively with daily problems.	36%	-14%
6	I was treated with dignity and respect.	79%	+26%
7	Staff here believed that I could grow, change and recover.	64%	-3%
8	I felt comfortable asking questions about my treatment and medications.	50%	+7%
9	I was encouraged to use self-help/support groups.	57%	+4%
10	I was given information about how to manage my medication side effects.	29%	-24%
11	My other medical conditions were treated.	50%	+10%
12	I felt this hospital stay was necessary.	7%	-50%
13	I felt free to complain without fear of retaliation.	7%	-6%
14	I felt safe to refuse medication or treatment during my hospital stay.	-7%	-7%
15	My complaints and grievances were addressed.	14%	-6%
16	I participated in planning my discharge.	29%	-8%
17	Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	0%	-23%
18	I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	-7%	-30%
19	The surroundings and atmosphere at the hospital helped me get better.	36%	-7%
20	I felt I had enough privacy in the hospital.	57%	+34%
21	I felt safe while I was in the hospital.	36%	-11%
22	The hospital environment was clean and comfortable.	50%	-3%
23	Staff were sensitive to my cultural background.	14%	-16%
24	My family and/or friends were able to visit me.	50%	+10%
25	I had a choice of treatment options.	21%	-6%
26	My contact with my doctor was helpful.	50%	+3%
27	My contact with nurses and therapists was helpful.	64%	+14%
28	If I had a choice of hospitals, I would still choose this one.	21%	-19%
29	Did anyone tell you about your rights?	25%	-8%
30	Are you told ahead of time of changes in your privileges, appointments, or daily routine?	19%	+9%
31	Do you know someone who can help you get what you want or stand up for your rights?	44%	+11%
32	My pain was managed.	25%	+5%

Summary

Overall satisfaction dropped by 45%. Positive scores indicate satisfaction, while negative scores indicate dissatisfaction. Percentages are calculated using actual weighted scores and highest possible score for each indicator. The total number of respondents was 7. The first column indicates the score for 3rd quarter and the second column shows increases/decreases from 2nd quarter. Of the 32 indicators, 21 went down this quarter. The most significant decreases in satisfaction were with indicators 1, 4, 12, and 18. The most significant increases were in indicators 6 and 20. Indicators 13 and 14 continue to have low satisfaction. Two indicators indicated dissatisfaction this quarter, indicators number 14 and 18.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services

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

Strategic Objectives

Safety in Culture and Actions		Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Pyxis CII Safe Comparison	Rx							
Daily and monthly comparison of Pyxis vs CII Safe transactions								
Quarterly Results								
Veriform Medication Room Audits	All	Apr-June 100%	100%	100%	100%		90%	
Monthly comprehensive audits of 14 criteria								
Quarterly Results			92%	99%				
Pyxis Discrepancies	All	Aug-Nov 107/mth	107	107	50	50	50/mo	
Monthly monitoring and trending of Pxyis discrepancies.								
Quarterly Results			128	96				
Pyxis Overrides – Controlled Drugs	All	Aug-Nov 25/mth	25	25	10	10	10	
Monthly monitoring and trending of Pyxis overrides for Controlled Drugs								
Quarterly Results			32	17				
Fiscal Accountability		Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Discharge Prescriptions	Rx	$12412 361drugs	$5809 345 drugs	$19015 377 drugs				Significant costs are incurred in providing discharge drugs.
Monitoring and Tracking of dispensed Discharge Prescriptions								

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%**
7. **The client is able to can identify his or her primary staff.**			**100%**

STRATEGIC PERFORMANCE EXCELLENCE

Lower Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	12/14	84%	**14 weekly**
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	80%	5/group
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**)**	5	100%	5/group
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	7/10	70%	**100%**
5. **The client can identify distress tolerance tools on the unit**	5/10	50%	**100%**
7. **The client is able to state who his primary staff is**	8/10	80%	**100%**

EVALUATION OF EFFECTIVENESS

There are on unit groups seven days a week on Lower Kennebec. There is one on the day shift and one on the evening shift daily. These groups are open to all Clients on the unit. Clients who do not have a level to attend the Treatment Mall are strongly encouraged to attend the on unit groups. Participation in on unit groups is a consideration in advancing to a higher level. 8/10 Clients could identify their primary worker for the shift. One client was unable to process the question. The other knew where the assignment board was posted.

ISSUES

Daily on unit groups have been scheduled. Each group has an assigned group leader. When the primary group leader was absent or floated to another unit, the group was sometimes not conducted. The RV 4 on LK assigned an alternate leader to each group. In addition the PSD has promoted the importance of the groups and assisted in unit coverage to ensure that the groups are taking place. The on unit Focus group was being conducted by the Psychology Department. Due to a reduction in staff of that department, the group is now conducted by the unit staff and not the Psychology Department. 7/10 treatment plans listed on unit groups. A team effort has been established to capture on unit groups at the seven day treatment plan review. 50% of the Clients could not identify the distress tolerance tools on the unit. Awareness, visibility and availability are a factor, as well as promotion.

ACTIONS

Unit leadership will continue to promote the on unit groups. An up to date listing of each group schedule and focus will be posted for staff and clients. Documentation will be monitored for compliance. Attendance will continue to be encouraged On unit groups will be addressed at each treatment team meeting. Inventory of distress tolerance tools will be conducted and needed items will be obtained. Staff will be encouraged and expected to introduce themselves to their assigned clients at the beginning of each shift.

STRATEGIC PERFORMANCE EXCELLENCE

Upper Kennebec

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	14/14	100%	14weekly
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	80%	5/group
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**)**	5/5	100%	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**	8/10	80%	100%
7. **The client is able to state who his primary staff is**	10/10	100%	100%

EVALUATION OF EFFECTIVENESS

Upper Kennebec has implemented much organization to the on unit groups. With the addition of an RN Treatment Team Coordinator, a formalized group listing and focus has been posted on the unit for reference. UK typically has more of a treatment mall attending milieu. Evenings groups remain more of leisure in nature. Most clients on UK have a level to leave the unit and attend the treatment mall during the day.

Many of the Clients on UK have a preference for the computer lab and the gym. Others have expressed a need to unwind in the evening due to a busy treatment mall schedule during the day. Evening participation in on unit groups averages 5/group which is the threshold.

ISSUES

Consistency in on unit groups has improved. Unexpected changes in unit acuity cause a challenge to conduct groups when the unit is staffed at core staffing levels.

ACTIONS

Continue to promote on unit groups. Continue to monitor documentation for compliance. Explore client interests in on unit groups. Request suggestions from the direct care staff.

STRATEGIC PERFORMANCE EXCELLENCE

Lower Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	Main/SCU 5 / 5 5 / 5	 71% 71%	 **7 / 7 = 14** **7 / 7 = 14**
2. **Number of clients attending day groups on unit or facilitated by day staff** (# of clients in all of day groups divided by # of day groups provided**)**	3 / 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**	5	50%	**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**	27/30	90%	**100%**

EVALUATION OF EFFECTIVENESS

ISSUES

The Lower Saco unit has made a start at offering on-unit groups by MHWS, although the documentation in the Electronic Medical Record is sporadic. There is evidence that this treatment effort is being reflected in the treatment plans but the RT staff is much more consistent in documenting participation than nursing staff.

ACTIONS

I will meet with the unit Nursing leadership and the Treatment Team Coordinator to make sure these groups get prescribed in the treatment plans (including on-unit groups by MHWs and nursing) and bring documentation shortfalls to the staff meeting agendas through the RN4.

STRATEGIC PERFORMANCE EXCELLENCE

Upper Saco

INDICATOR	FINDINGS	%	THRESHOLD
1. **How many on unit groups were offered each week** **Day shift →** **Evenings →**	 5 8	 71% 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**)**	2 Avg.		N/A
3. **Number of clients attending evening groups on unit or facilitated by evening staff** (# of clients in all of evenings groups divided by # of evening groups provided**)**	4 Avg.		N/A
4. **Of the 10 charts reviewed, how many treatment plans reflected the on unit groups attended**	2	20%	**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 Upper Saco unit has made a good start at offering on-unit groups, although the documentation in the Electronic Medical Record is sporadic. There is no evidence that this treatment effort is being reflected in the treatment plans.

ACTIONS

I am meeting with the unit nursing leadership, MHWs and the Treatment Team Coordinator to make sure these groups get prescribed in the treatment plans and bring documentation shortfalls to the staff meeting agendas.

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
Vocational Incentive Program Treatment Plans *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.*	55%	70%	85%	100%	100%	The treatment plans will be reviewed more regularly and updated at each client 30 day treatment team meeting.	Treatment plans were completed in a timely fashion but the review and updates were not consistent. Documentation is not always done on a weekly basis. Goal for next quarter is to increase by 19%.
Quarterly Results		77%	81%				

Safety in Culture and Actions	Baseline	Q1 Target	Q2 Target	Q3 Target	Q4 Target	Goal	Comments
Client/Staff Injuries in the Gym (to start in the second quarter) *The objective of this improvement project is to reduce/eliminate staff/client injury in the gym by increasing education on the proper techniques for equipment use as well as proper techniques for other activities in done in the gym. This will also include education on performing environmental checks of the area to ensure there are no safety issues.*							It was discovered that the reporting of incidents in the gym are not identified as happening in that area on the incident report sheets. This has been remedied and more accurate data will be available next quarter.
Quarterly Results		No injuries during the quarter	No injuries during the quarter				

APS Healthcare

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

Quarterly Report 60a for Members on MaineCare Waitlist for CI

Report Dates: 10/01/2012 To 12/31/2012 **Report Run Date: 4/11/2013**

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.

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 364

For those who received the service: Average number of days waiting: 21 days

Percent waiting 30 days or less: 77% Percent waiting 90 days or less: 97%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
AMHI Class N	346	341	5	263	71	12	21
AMHI Class Y	18	18	0	18	0	0	8
Totals	**364**	**359**	**5**	**281**	**71**	**12**	**21**

CSN	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
CSN 1 Aroostook	12	12	0	10	1	1	25
CSN 2 Hancock, Washington, Penobscot, and Piscataquis	58	58	0	40	11	7	32
CSN 3 Kennebec and Somerset	27	27	0	25	2	0	12
CSN 4 Knox, Lincoln, Sagadahoc, and Waldo	18	18	0	16	2	0	13
CSN 5 Androscoggin, Franklin, and Oxford	20	18	2	16	3	1	20
CSN 6 Cumberland	140	137	3	125	14	1	12
CSN 7 York	86	86	0	47	37	2	31
Unknown	3	3	0	2	1	0	29
Totals	**364**	**359**	**5**	**281**	**71**	**12**	**21**

APS Healthcare

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

Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
Acadia Healthcare	13	13	0	12	1	0	14
Alternative Services	4	4	0	4	0	0	9
Assistance Plus	37	37	0	31	5	1	17
Break of Day, Inc	10	10	0	9	1	0	10
Catholic Charities Maine	44	43	1	42	2	0	8
Charlotte White Center	2	2	0	2	0	0	0
Community Care	21	21	0	6	8	7	66
Community Health & Counseling Services	2	2	0	2	0	0	19
Counseling Services Inc.	87	87	0	44	41	2	31
Graham Behavioral Services	2	2	0	2	0	0	7
Health Affiliates Maine	1	1	0	1	0	0	0
Higher Ground Services	17	17	0	16	1	0	8
Life by Design	13	13	0	11	1	1	24
Mid Coast Mental Health	7	7	0	6	1	0	17
Shalom House	7	7	0	7	0	0	13
Sweetser	13	13	0	6	7	0	38
The Opportunity Alliance	78	77	1	75	3	0	9
Tri-County Mental Health	3	0	3	2	0	1	49
York County Shelter Program	3	3	0	3	0	0	21
Totals	**364**	**359**	**5**	**281**	**71**	**12**	**21**

APS Healthcare

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

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

Report Dates: 10/01/2012 To 12/31/2012 **Report Run Date: 4/11/2013**

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.

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: 49

For those who received the service: Average number of days waiting: 58 days

Percent waiting 30 days or less: 47% Percent waiting 90 days or less: 65%

AMHI Class	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
AMHI Class N	47	14	33	23	7	17	58
AMHI Class Y	2	0	2	0	2	0	55
Totals	**49**	**14**	**35**	**23**	**9**	**17**	**58**

CSN	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
CSN 1 Aroostook	1	0	1	0	0	1	126
CSN 2 Hancock, Washington, Penobscot, and Piscataquis	7	3	4	3	1	3	54
CSN 3 Kennebec and Somerset	6	2	4	1	4	1	47
CSN 4 Knox, Lincoln, Sagadahoc, and Waldo	3	0	3	2	0	1	47
CSN 5 Androscoggin, Franklin, and Oxford	5	0	5	3	2	0	21
CSN 6 Cumberland	17	6	11	12	1	4	43
CSN 7 York	9	3	6	1	1	7	115
Unknown	1	0	1	1	0	0	26
Totals	**49**	**14**	**35**	**23**	**9**	**17**	**58**

APS Healthcare

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

Providers	# auth for CI service	# with MaineCare auth	# with State funded auth	# auth in < 30 days	# auth in 31 - 90 days	# auth in > 91 days	Average # days waiting
Assistance Plus	11	2	9	5	5	1	33
Catholic Charities Maine	5	4	1	5	0	0	6
Charlotte White Center	2	1	1	1	1	0	29
Community Care	5	2	3	2	0	3	64
Community Counseling Center	3	0	3	3	0	0	17
Counseling Services Inc.	10	2	8	1	1	8	124
Life by Design	1	0	1	0	0	1	126
Sweetser	4	2	2	1	0	3	77
The Opportunity Alliance	4	0	4	2	1	1	61
Tri-County Mental Health	4	1	3	3	1	0	22
Totals	**49**	**14**	**35**	**23**	**9**	**17**	**58**

APS Healthcare

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

Report Number: 27 and 28

Non-Hospitalized Members Assigned to Community Integration Service (CI) within 3 and 7 Working Days

(Includes MaineCare members and Courtesy Reviews done by APS)

Report Dates: 10/01/2012 To 12/31/2012

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.
- **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 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 tme of admission, but is expected to be served using either MaineCare and/or state funds.
- **SMI - Serious Mental Illness.** A proxy for serious mental illness (SMI) is the use of specific services. All active adult members who used Section 17 (Community Support) or resided in a PNMI setting within 12 months of the date of this report. Section 17 services include: Community Integration (CI), Intensive Case Management (ICM), Assertive Community Treatment (ACT), Community Rehabilitation Services (CRS) as well as Daily Living Support Services, Day Supports-Day Treatment, Skills Development-Group Therapy, Skills Development-Ongoing Support to Maintain Employment, and the Specialized Group Services of WRAP, Recovery Wkbk, TREM, or DBT.

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: 1,808
Total assigned within 3 working days: 1,034
Total assigned in 4 - 7 working days: 243
Total assigned within 7 working days: 1,277
Total assigned after 8 or more working days: 531

% assigned within 3 working days: 57%
% assigned in 4 -7 working days: 13%
% assigned within 7 working days: 71%
% assigned after 8 or more working days: 29%

All Members	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Total MaineCare	1,034	243	531	1,808
Total	**1,034**	**243**	**531**	**1,808**

Gender	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Female	631	166	327	1,124
Male	403	77	204	684
Total	**1,034**	**243**	**531**	**1,808**

Adult Age Groups	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
18-20	72	25	34	131
21-24	83	21	51	155
25-64	827	187	430	1,444
65-74	34	7	13	54
Over 75 Years Old	18	3	3	24
Total	**1,034**	**243**	**531**	**1,808**

SMI	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
SMI	1,034	243	531	1,808
Total	**1,034**	**243**	**531**	**1,808**

AMHI Class	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	970	232	513	1,715
AMHI Class Y	64	11	18	93
Total	**1,034**	**243**	**531**	**1,808**

District	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	67	18	83	168
District 2/ Cumberland County	178	56	113	347
District 3/ Androscoggin, Franklin, and Oxford Counties	234	39	104	377
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	133	29	44	206
District 5/ Somerset and Kennebec Counties	185	46	53	284
District 6/ Piscataquis and Penobscot Counties	160	32	90	282
District 7/ Washington and Hancock Counties	34	12	22	68
District 8/ Aroostook County	35	9	16	60
Unknown	8	2	6	16
Total	**1,034**	**243**	**531**	**1,808**

APS Healthcare

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

Providers	Waited 3 working days or less	Waited 4 to 7 working days	Waited 8 or more working days	Total
Acadia Healthcare	2	1	9	12
Allies	12	10	17	39
Alternative Services	19	1	1	21
Aroostook Mental Health Services	21	4	3	28
Assistance Plus	28	9	25	62
Break of Day, Inc	20	2	7	29
Broadreach Family & Community Services	14	4	2	20
Catholic Charities Maine	57	30	22	109
Charlotte White Center	3	1	17	21
Choices	13	0	0	13
Common Ties	29	16	41	86
Community Care	2	0	7	9
Community Counseling Center	58	12	20	90
Community Health & Counseling Services	89	16	20	125
Constellations, Inc.	11	1	0	12
Cornerstone Behavioral Healthcare -CM	7	0	2	9
Counseling Services Inc.	32	18	87	137
Dirigo Counseling Clinic	27	0	1	28
Employment Specialist of Maine	1	2	11	14
Fullcircle Supports Inc	22	0	0	22
Graham Behavioral Services	26	2	1	29
Health Affiliates Maine	119	0	0	119
Higher Ground Services	7	4	2	13
Kennebec Behavioral Health	45	7	17	69
Life by Design	5	3	8	16
Lutheran Social Services	8	0	0	8
Maine Behavioral Health Organization	10	8	9	27
Maine Vocational & Rehabilitation Assoc.	10	0	0	10
Manna Inc	10	3	1	14
Mid Coast Mental Health	3	1	3	7
Motivational Services	6	0	3	9
Northeast Occupational Exchange	8	15	68	91
Northern Maine General - Community Support	1	0	1	2
Ocean Way Mental Health Agency	16	0	0	16
OHI	9	0	1	10
Oxford County Mental Health Services	3	3	4	10
Rumford Group Homes	6	3	4	13
Shalom House	8	0	10	18
Spurwink	1	0	0	1
Stepping Stones	4	0	0	4
Sunrise Opportunities	4	0	0	4
Sweetser	104	19	36	159
The Opportunity Alliance	29	29	18	76
Tri-County Mental Health	88	11	45	144
Umbrella Mental Health Services	33	8	5	46
York County Shelter Program	4	0	3	7
Total	**1,034**	**243**	**531**	**1,808**

APS Healthcare

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

Report Number: 29 and 30

Hospitalized Members Assigned to Community Integration Service (CI) within 2 and 7 Working Days

(Includes MaineCare members and Courtesy Reviews done by APS)

Report Dates: 10/01/2012 To 12/31/2012

Report Source: Authorization data from APS CareConnection®

Definitions:

- **Hospitalized member -** MaineCare member who is in an inpatient psychiatric facility at the time of application for services. This is indicated by the member having an open authorization for inpatient psychiatric services at the time a CFSN authorization is entered into CareConection or on the day that the member is referred for CI services.
- **Community Integration (CI)** was formerly known as "case management" or "community support". It is a service available to adults with serious mental illness.
- **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 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 tme of admission, but is expected to be served using either MaineCare and/or state funds.
- **SMI - Serious Mental Illness.** A proxy for serious mental illness (SMI) is the use of specific services. All active adult members who used Section 17 (Community Support) or resided in a PNMI setting within 12 months of the date of this report. Section 17 services include: Community Integration (CI), Intensive Case Management (ICM), Assertive Community Treatment (ACT), Community Rehabilitation Services (CRS) as well as Daily Living Support Services, Day Supports-Day Treatment, Skills Development-Group Therapy, Skills Development-Ongoing Support to Maintain Employment, and the Specialized Group Services of WRAP, Recovery Wkbk, TREM, or DBT.

What This Report Measures: The number of hospitalized members authorized for Community Integration (CI) and whether they a.) were assigned to a case manager in the CI service within 2 working days, b.) Waited 3-7 working days be assigned a CI worker, or c.) waited longer than 8 days but were eventually assigned to the service

Total number of hospitalized members applying for CI: 24

Total assigned within 2 working days: 9	% assigned within 2 working days: 38%
Total assigned in 3 - 7 working days: 8	% assigned in 3 -7 working days:33 %
Total assigned within 7 working days: 17	% assigned within 7 working days: 71%
Total assigned after 8 or more working days: 7	% assigned after 8 or more working days: 29%

All Members	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Total MaineCare	9	8	7	24
Total	**9**	**8**	**7**	**24**

Gender	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Female	5	4	4	13
Male	4	4	3	11
Total	**9**	**8**	**7**	**24**

SMI	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
SMI	9	8	7	24
Total	**9**	**8**	**7**	**24**

AMHI Class	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
AMHI Class N	8	4	5	17
AMHI Class Y	1	4	2	7
Total	**9**	**8**	**7**	**24**

District	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
District 1/ York County	0	1	1	2
District 2/ Cumberland County	2	1	0	3
District 3/ Androscoggin, Franklin, and Oxford Counties	1	3	2	6
District 4/ Knox, Lincoln, Sagadahoc, and Waldo Counties	5	0	0	5
District 5/ Somerset and Kennebec Counties	0	3	1	4
District 6/ Piscataquis and Penobscot Counties	0	0	1	1
District 7/ Washington and Hancock Counties	0	0	1	1
District 8/ Aroostook County	1	0	0	1
Unknown	0	0	1	1
Total	**9**	**8**	**7**	**24**

Providers	Waited 2 working days or less	Waited 3 to 7 working days	Waited 8 or more working days	Total
Assistance Plus	1	2	1	4
Break of Day, Inc	1	0	0	1
Catholic Charities Maine	1	1	0	2
Common Ties	0	1	1	2
Community Health & Counseling Services	0	0	1	1
Counseling Services Inc.	0	0	1	1
Employment Specialist of Maine	0	0	1	1
Kennebec Behavioral Health	0	1	0	1
Manna Inc	1	0	0	1
Motivational Services	0	2	0	2
Ocean Way Mental Health Agency	1	0	0	1
OHI	0	0	1	1
Shalom House	1	0	0	1
Sweetser	1	0	0	1
Tri-County Mental Health	0	1	0	1
Umbrella Mental Health Services	2	0	1	3
Total	**9**	**8**	**7**	**24**

DIG Childrens Services - SFY2011 & SFY2012 Summary - Revised

March 21, 2013

		MEMBERS		TOTAL PYMTS	
Service Class	**SERVICE AREA**	**sfy2011**	**sfy2012**	**sfy2011**	**sfy2012**
CBHS-01	Sec 65 HCT	3,117	3,425	$19,650,112	$24,603,152
CBHS-02	Sec 65 Child ACT	133	78	$416,096	$299,515
CBHS-04	Sec 28 Rehab and Community Support Svcs	833	1,299	$10,025,729	$17,081,580
CBHS-05	Crisis Stabilization (Crisis Residential)	715	686	$3,872,542	$4,288,694
CBHS-06	Sec 65 Crisis Intervention/ Resolution	2,182	2,240	$2,818,967	$2,900,059
CBHS-10	Day Treatment	732	1,033	$8,819,090	$20,422,740
CBHS-13	M&N	14	27	$1,844	$0
CBHS-14	M&N-Both M&N	-	1		$0
CBHS-15	Sec 65 Multi-Systemic Therapy (MST)	442	482	$2,368,627	$2,840,649
CBHS-18	Sec 65 Medication Management	2,669	3,941	$2,177,473	$3,521,320
CBHS-19	Sec 65 Outpatient Tx Services	14,609	15,224	$16,891,735	$18,552,287
CBHS-20	Sec 97 Residential PNMI	825	765	$39,146,106	$36,290,615
CBHS-22	Sec 65I-Psychoeducation	21	-	$0	
CBHS-25	Sec 13 Targeted Case Management	6,366	6,953	$17,513,065	$19,372,334
CBHS-99x	Listed Adult Svc-Age 18 and Under	2,119	259	$1,780,940	$121,909
CBHSOther-02	Other Identified Services	1	-	$100	
CBHSOther-03	Psychiatric/Psychological Services	2,672	4,452	$1,405,802	$485,578
CBHSOther-04	Psycho/Neuro Testing	2,123	2,741	$1,261,928	$1,588,324
TOTALS	**GRAND TOTALS**	**20,030**	**21,964**	**$128,155,265**	**$152,387,316**

Based on extract of MaineCare Paid Claims Data for SFY 2011 and 2012

Claims were extracted based on service or incurred date or the date the service was provided.

Includes child and adolescent mental health service users between birth and 17 years old as defined by Data Infrastructure Grant critera.

CBHS-13 and CBHS-14 are old codes for In-Home services that are no longer used (See HCT services (CBHS-01)

CBHS-99x includes children/adolescents under 18 years who are receiving and adult services.

Notes:
Adjustments made in sfy2011 for :
CBHS-05 (H0018 and H0018-HA)
CBHS-06 (H2011 and H2011-HA)
Policy changes in sfy2012 added 'HA' suffix to identify services to children. Our service category groupings are based on current policy. Subsequently, sfy2011 codes did not have "HA' suffixes. Since they are currently categorized as adult codes without the 'HA' suffix, they fell into the CBHS-99x catch-all category.
We have taken steps to remove them from CBHS-99x and properly report them in CBHS-05 and CBHS-06. This conforms with where those codes appear in sfy2012.

DIG Adult Services - SFY2011 & SFY2012 Summary

March 19, 2013

		MEMBERS		TOTAL PYMTS		CLASS Members	
Service Class	SERVICE AREA	sfy2011	sfy2012	sfy2011	sfy2012	sfy2011	sfy2012
Adlt-01	ACT	997	891	$8,987,212	$8,835,755	316	306
Adlt-02	Community Integration	12,214	13,727	$35,075,675	$39,830,181	1,222	1,221
Adlt-17c	Community Rehab Services	123	164	$2,290,801	$2,475,394	50	64
Adlt-04	Crisis Resolution/Intervention	5,527	5,612	$7,491,828	$8,104,380	516	567
Adlt-05	Crisis Residential	1,593	1,425	$5,130,899	$5,383,628	196	194
Adlt-07	Day Treatment	772	957	$2,881,145	$3,522,401	101	117
Adlt-10	Medication Management	13,501	13,337	$7,488,866	$8,301,632	868	622
Adlt-12&13	Outpatient	25,395	24,973	$21,707,895	$23,926,111	607	570
Adlt-15	Residential-PNMI	828	821	$31,155,826	$35,512,443	370	366
Adlt-17	Skills Development	242	350	$813,879	$1,284,818	27	39
Adlt-17b	Daily Living Supports	1,234	1,596	$11,332,130	$14,912,022	193	207
Adlt-11	Other Identified Services	18	19	$42,103	$83,683	-	2
Adlt-18	Target Case Mgmt	526	550	$1,298,450	$1,444,423	2	1
Adlt-99x	Listed CBHS Svc-Age 18 and Over	670	893	$6,124,609	$8,337,220	3	17
AdltOther-02	Other Identified Services	5	7	$2,435	$13,167	-	-
AdltOther-03	Psychiatric/Psychological Services	11,002	17,202	$4,938,631	$2,807,620	475	766
AdltOther-04	Psycho/Neuro Testing	1,126	1,182	$621,375	$613,872	14	24
TOTALS	**GRAND TOTALS**	**43,056**	**46,712**	**$147,383,757**	**$165,388,749**	**1,960**	**1,951**

Based on extract of MaineCare Paid Claims Data for SFY 2011 and 2012
Claims were extracted based on service or incurred date or the date the service was provided.
Includes adult mental health service users 18 years and older as defined by Data Infrastructure Grant critera.
Adult 99x include child/adolescent services provided to members 18 years and older. These are mostly transition age youth who 18 to 22 years that were placed in the adult services due to the age cut-offs.