Department of Health and Human Services
Adult Mental Health Services Plan

Consent Decree Plan

Pursuant to paragraphs 36, 37, 38 and 279
of the Settlement Agreement
in Bates v. DHHS

October 13, 2006

Contents

This Consent Decree Plan builds on the Department of Health and Human Services (DHHS) Consent Decree Plan submission of June 30, 2005. Subsequent revisions were made on:

- July 7, 2005, revisions to Chapter VIII, Riverview Psychiatric Center;
- July 29, 2005, revisions by the Court Master to Chapters III, VI, and VIII, approval of Chapters I, II, and V, and disapproval of Chapters IV and VII;
- December 9, 2005, revisions to Chapter VIII, approved by the Court Master;
- August 16 and October 2, 2006, revisions to Chapters IV and VII.

Final revisions to Chapter IV, submitted on October 13, 2006, have been incorporated with the previous revisions, and this document is, then, the complete current plan.

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I. Plan Goal and Core Principles

Goal

The Department of Health and Human Services (DHHS) recognizes that the Adult Mental Health System is fragmented and can be difficult to navigate. Major change in the way the state, providers, and consumer organizations do business is required to move to a system that truly promotes recovery, provides good continuity of care, and gives consumers assurance that the mental health system is delivering on its commitments. The overarching goal of this plan for adult mental health services is to deliver in a coordinated way the individualized services that are needed to support recovery of adults with mental illness. DHHS seeks to achieve its goal through:

- Providing defined roles and financial support for consumer voice as an integral part of the mental health system;
- Implementing a system of managing behavioral health care; and
- Creating a reliable information system that can provide accurate, timely data to guide decision-making.

Highlights of the Plan

This plan describes the development and monitoring that DHHS must undertake in its adult mental health services system to enable DHHS to demonstrate substantial compliance with Settlement Agreement in *Bates v. DHHS*, the so-called AMHI Consent Decree case. The plan focuses on three major themes: providing flexibility, ensuring continuity, and managing care. The plan incorporates activities and ongoing initiatives described in the work plan previously submitted to the Superior Court on September 17, 2004 and approved by the court on December 8, 2004. This revised plan also includes changes and additions to the work plan to assure that the current plan is consistent with the requirements of paragraphs 36-38 and 279 of the Settlement Agreement and with the Law Court decision issued on December 17, 2004, in the AMHI Consent Decree case.[1] It also addresses changes at the Riverview Psychiatric Center, following the work of the court-appointed receiver in 2004.

The components of the comprehensive community mental health system will continue to be funded and operated in accordance with current practice and models except as changes in funding and operation are specifically addressed in this plan.

[1] Although many of the initiatives promised in the work plan have begun, this plan continues to use the future tense to describe some initiatives in order to maintain clarity about the starting point and ongoing nature of several of the initiatives. A status report to be issued following approval of this plan will provide an update of activities begun since the September 2004 submission of the work plan. The revised plan further reflects DHHS' response to circumstances that have changed since the work plan was approved.

Consumer Voice

Informed consumer voice is an integral part of the mental health system proposed in this plan. To provide more opportunities for consumer input, DHHS will provide financial support for the creation of eight regional councils and one statewide council. These councils will receive financial support from DHHS, but will operate as independent bodies with their own staff. The councils will participate in the assessment of the quality, accessibility, and adequacy of services within their regions. Quality assurance and quality improvement reports will be a key focus. Additionally, the councils will provide peers for participation in licensing reviews. The State of Maine has applied for a federal Mental Health Transformation State Incentive Grant seeking funding for these consumer initiatives. Announcement of grant awards will be made in the summer or early fall 2005 for an October start date. If the State is not awarded this grant, DHHS include the costs of these initiatives in the budget put forward to the Governor for the legislative session starting January 2006.

The plan also acknowledges the importance of consumer voice by building recognized roles for peers into the provision of warm lines, services in Emergency Departments, and services at Riverview Psychiatric Center. DHHS has received federal funding to create a training program for peer recovery specialists as part of workforce development. The next step will be a certification process that will make peer recovery specialists reimbursable by MaineCare.

Improved Continuity of Care

DHHS believes that improving continuity of care requires a redesign of the funding mechanism for mental health services in the state. In developing this plan, DHHS has explored several models for doing so. The common factor in each model has been providing an economic incentive that encourages providers to address efficiently the precise needs that will support consumers working toward recovery.

DHHS is now under a legislative mandate "to establish a system of managed behavioral health care services" including adult mental health, children's behavioral health, and substance abuse services, through a contract with an experienced outside agency (L.D. 1691, part PP). This service change is to take effect as of July 2006. DHHS believes that it can use this mandate to create economic incentives for better continuity of care. This plan approaches managing care in the context of this recent legislation and the principles of choice, flexibility, and recovery that are reflected in the Settlement Agreement.

In conjunction with the shift to managing care, DHHS is embedding a team approach to community support services. A team approach helps maintain important relationships, increases the ability to have consistent and up-to-date information, and provides better continuity of care. The Department believes that the financing changes that will accompany managed care will make the team approach possible.

Inclusion of Non-Class Members

The consumers covered by this plan are those people with serious and persistent mental illness who are thereby eligible for Community Support Services, and all class members. This approach is consistent with the terms of the Law Court's decision of December 17, 2004, and the Americans with Disabilities Act. The Department has developed criteria, as discussed in Chapter III, to measure whether different types of services are accessible to all within an appropriate period of time, regardless of class status.

While the system is designed to serve class and non-class members alike, the Settlement Agreement does contain certain requirements that apply solely to class members, and these will continue to be applied only to class members under this plan. For example, class members are entitled to receive an ISP and be assigned a community support worker regardless of need, pursuant to paragraphs 49, 55 and 56. Non-class members may access those same services, but only based upon need. Other Settlement Agreement requirements that are unique to class members and will be continued under this plan include: 1) the obligations in paragraphs 55 and 56 to assign a community support worker to class members within 3 working days of application if in the community, or within 2 working days of application if in the hospital; 2) the protocol under paragraph 96 for obtaining informed consent from class members to reside in group homes with more than 8 beds; and 3) the ratio of DHHS caseworkers to class member public wards under paragraph 257.

In addition, the Department has instituted a number of monitoring and evaluation procedures that involve gathering data about class members, rather than the entire population of adult Maine residents with serious mental illness. For example, paragraphs 74 and 279 describe monitoring processes that are, by the terms of those paragraphs, specific to class members. The data from these monitoring processes will also be used as a sample to evaluate the performance of the entire adult community mental health system. A number of other monitoring tools developed or described in this plan, however, such as enrollment data, the Data Infrastructure Grant survey, grievance reports, utilization review of hospital data, the ISP survey, and contract performance indicator data, encompass non-class as well as class members and will also be used to evaluate system performance.

A Successful Mental Health System

Three key components to any successful system are clear responsibility for service delivery and decisions, good information on which to base decisions, and clear standards for system performance in concert with good mechanisms to assure quality assurance and quality improvement.

DHHS views the Community Support Worker or case manager as the hub of the service delivery system for the consumer. Regardless of the variety of services, the case manager is responsible under this plan for assuring coordination and for continuing to follow consumers who are hospitalized or who become part of the correctional system. This approach will continue to be reinforced throughout FY 06. When the move to managed care occurs, the managed care entity will be responsible for assuring clear responsibilities among service providers and for the team structure to provide continuity of care.

The second component of a successful mental health system is a reliable information system. Only by carefully analyzing data will the system be able to shift or increase resources, demonstrate success in the recovery process, and assure consumers that the system is meeting its own standards. This plan relies on the new enrollment process, and several existing data sources to provide reliable information. This plan also notes DHHS' continuing work on EIS to ensure that it becomes a reliable information source for adult mental health information.

The third component of an effective, efficient system is a set of standards used to measure system performance and for quality improvement, and processes for meaningful internal and external review. This plan includes clear standards for system measurement. Additionally, the contract to be negotiated with the managed care entity will include clear performance measures and data requirements. This plan adds consumers as a component of meaningful review of system performance by creating independent consumer councils that will have a major role in quality assurance and quality improvement. Consumers will participate in licensing reviews, reviewing service data, and will be invited to recommend system changes based on data and advances in the field of mental health.

Core Principles

The plan is based on a set of principles, as articulated in the Settlement Agreement and addressed in the plan. They are as follows:

Settlement Agreement Principle[2]	Plan Response
Class members are at all times entitled to respect for their individuality and to recognition that their personalities, abilities, needs, and aspirations are not determinable on the basis of a psychiatric label.	**Individualized Support Planning**
Class members have individualized needs which may change or vary in intensity over time and according to the individual's circumstances. Needs may span those for housing, financial security, health and dental care, socialization and companionship, spiritual growth, recreation, transportation, education, vocational opportunity and training, emotional support, psychiatric treatment and crisis intervention and resolution services. The services shall be flexible so that support and supervision may be increased or decreased as the class consumer's needs change and, to the extent possible, without requiring the class consumer to move to another setting.	**No Wrong Door** **Comprehensive Service Array**
All services within the comprehensive mental health system shall be oriented to supporting class members to continue to live in the community and to avoid hospitalization. When class consumers require psychiatric hospitalization due to medical necessity, services shall be oriented to hospitalizing them in facilities nearest their homes and thereafter discharging them to the community with all necessary supports as soon as is medically possible.	**Comprehensive Service Array (including Crisis Services)**
Patients have the right to receive treatment in the least restrictive available setting according to the least restrictive means appropriate to their needs.	**Comprehensive Service Array**
The comprehensive mental health system shall be designed and services shall be delivered based on identified individual needs.	**Comprehensive Service Array** **Individualized Support Planning**
Class members have the same rights as do all other citizens of Maine, including the right to live in the community of their choice without constraints upon their independence, except those constraints to which all citizens are subject.	**Individualized Support Planning**
Non-class members shall not be deprived of services solely because they are not members of the plaintiff class.	**No Wrong Door**
Class members have the right to refuse all or some of the services offered, subject to the exceptions noted below. A person's refusal of a particular mode or course of treatment shall not per se be grounds for refusing a class member's access to other services which the person accepts.	**Individualized Support Planning**

[2]Settlement Agreement, Section IV, paragraph 32

This plan is intended to combine the mandates of the Settlement Agreement with contemporary thinking on the necessary ingredients for reforming mental health services, including above all else, orientation of the mental health system to the hope of recovery. The following chapters of the plan explain each of the principles identified above, including one that is implied throughout the Settlement Agreement, that of quality assurance.

No Wrong Door: Service Pathway – This chapter defines how a person navigates the system. It emphasizes the point that there is "no wrong door." A person can enter in various ways, receive a common assessment and have that information shared with all appropriate individuals and providers both now and in the future when new service needs arise. With the new plan people will not be shuttled from one provider to another or have to repeat basic information.

Consumer Driven: Individualized Support Planning – This chapter describes the approach used for planning and delivering individual services. The approach is managed and driven by the individual receiving the services. With the new approach, individuals will develop one comprehensive plan that many can access as they provide services or supports to the plan.

Continuity of Care: Comprehensive Service Array – This chapter defines the essential components of the comprehensive system of services, including emergency and crisis services, hospitalization services, and residential and community support services.

Assuring Quality Services – This chapter describes how the system remains accountable on an ongoing basis through the continuous collection of consumer-specific information including data on unmet service needs. This information can and will be used to articulate in concrete terms how resources need to be increased, marshaled or shifted to meet the needs of individuals with serious and persistent mental illness over the long term in Maine.

The plan includes other chapters that explain how the changes will be managed and that provide specific information on implementation of the plan. These chapters include a chapter on ***Managing the Change***, which discusses how the principles will be implemented in concrete terms; a chapter on the ***Cost of Plan Implementation,*** which discusses requests for new funding, re-allocation of existing funds and methods for identifying future funding needs; and a chapter on the ***Operational Plan and Timeline,*** which defines the major constellation of activities that will be undertaken to implement the plan. There is also a chapter on the ***Riverview Psychiatric Center***, which describes planning initiatives there intended to lead the hospital to compliance with the portion of the Settlement Agreement related to care and treatment at the hospital, and to improved integration of the hospital as a component of the overall spectrum of services for people with mental illness in Maine.

The next section provides definitions on key terms that are used throughout the plan.

Definitions

AMHS Needs Assessment – The Adult Mental Health Services (AMHS) Needs Assessment, formerly known as the BDS Needs Assessment, is an assessment based on a standardized form that covers life domains such as housing, financial and spiritual needs. The assessment, jointly completed by a Community Support Worker (CSW) and consumer, informs the development of the Individualized Support Plan.

Class Member – A Class Member is an individual who was a patient at Augusta Mental Health Institute or Riverview Psychiatric Center on or after January 1, 1988.

Community Services – Community Services include both community support services, defined below, and residential (PNMI) services.

Community Support Services (CSS) – Community Support Services are Community Integration, Intensive Community Integration, Intensive Case Management, and Assertive Community Treatment, as defined in the MaineCare Manual, Chapter II, Section 17. Community Support Services vary in intensity and are provided in the community based on assessed level of need.

Community Support Worker (CSW) – A Community Support Worker is an individual who performs case management functions in any of the four levels of case management included in Community Support Services.

Diagnostic Assessment – The Diagnostic Assessment is an assessment performed by a clinician, using an assessment tool chosen by the clinician, and required to enroll the consumer with DHHS for CSS and Residential Services prior to the initiation of CSS services It is reviewed at least once annually.

Enrollment – Enrollment is the point at which a provider submits data to DHHS about a consumer who is receiving Community Support Services or Residential Services following a Diagnostic Assessment.

Level of Care Utilization – The Level of Care Utilization System (LOCUS), developed by the American Association of Community Psychiatrists (AACP), is a tool to provide mental health clinicians and service providers with a systematic approach to the assessment and determination of the mental health and substance abuse service and support needs of adults with serious mental health challenges. The LOCUS tool contains two primary components: 1) an assessment that is based on a dimensional rating system, and 2) a structured decision framework that is used by the assessor to arrive at a recommended level of care or resource

intensity to best meet the consumer's needs prior to the initiation of Community Support and Residential Services.

Private Non-medical Institution (PNMI) – PNMI is defined in the MaineCare Manual, Chapter II, Section 97, Appendix E as an agency or facility that provides food, shelter, and treatment services to four or more residents in single or multiple facilities.

Residential Services – For purposes of this plan, Residential Services are those provided in a PNMI-funded setting.

Service Review – For purposes of this plan, Service Review is the process described in Chapter V, Managing the Change, by which clinical information is evaluated against level of care criteria to assure that individuals are receiving what they need.

II. No Wrong Door: Service Pathway

Consumers report frustration with having to go to many different locations not only to obtain services but also to obtain information about services. The concept of No Wrong Door means that people seeking mental health services will not be shuttled from one place to another or required to go through repetitive processes of providing personal and sensitive information. Instead, they can go for services to any of several starting points, including the community support agency itself, and have the assessment process completed there. No Wrong Door also means that service plans will be comprehensive, and accessible to the various parties involved in carrying out the plans.

DHHS will develop uniform service information so consumers can have a description of available services in their area in order to make a more informed choice. DHHS encourages provider agencies to have peer services available to consumers to assist with service descriptions, understanding options, and understanding rights. DHHS will create a training program for peer recovery specialists and a certification process, which will open the option for reimbursement by MaineCare as a means to create peer services.

Consumer Pathway

An individual can seek help at a regional office of Adult Mental Health Services, Department of Health and Human Services, at the office of a private therapist, from an agency under contract to DHHS Adult Mental Health Services, or at the community support agency of the consumer's choosing. The individual may even have his or her first contact with the crisis system and be referred to a community support or residential services provider. Under the concept of No Wrong Door, it does not matter which of these it is. In addition, a family member of a consumer or an advocate may help an individual to access services by contacting a licensed independent provider, agency clinician or community support service agency. When the individual arrives at the door to apply for services, he or she will be given a menu of service options before a LOCUS or needs assessment is completed.

Whatever the setting, the individual receives a diagnostic assessment to identify and assess issues and to determine eligibility for Community Services. Any person living in Maine who meets clinical criteria for Community Services is eligible for those services, regardless of insurance status. A diagnostic assessment will be considered valid if conducted within the past twelve months and performed by a licensed clinician. If DHHS is the first point of contact, the staff will provide the consumer with information about options and can locate a licensed clinician to perform the diagnostic assessment, or connect the consumer directly with the community support agency of their choosing.

If the person performing the diagnostic assessment determines that a consumer could benefit from community support or residential services, the assessor may

perform a LOCUS at the same time to determine the level of care that is appropriate.[3] The LOCUS is a tool to assist in directing consumers to the level of intensity of services that is appropriate to their needs. If the diagnostic assessment results confirm the need for Community Support Services, the provider will make a referral to a CSW or Residential Service provider, guided by the preference of the individual and the level of care needed. The community support agency, before conducting a LOCUS or needs assessment, must inform the consumer of the menu of the mental health services available within the geographic area and a description of agencies providing such services. The provider may also contact DHHS for assistance in completing the referral.[4] Once a provider of Community Support Services or Residential Services is selected, that provider must assure that the LOCUS has been conducted and that the individual is enrolled. (See Chapter IV, Continuity of Care, for more discussion of the intake process.)

Community Support Service agencies may provide peer specialists to perform intake functions. Peer specialists who are CSWs must meet the criteria for MHRT/C Certification. DHHS has received a Center for Medicare and Medicaid Services, Real Choice Systems Change Grant to develop a peer recovery specialist program, including the development of a training curriculum. A training and certification process must be first established to provide a trained workforce and reimbursement by MaineCare.

The CSW will perform an AMHS Needs Assessment in preparation for the Individualized Support Plan, which must be developed within 30 days of the initial application for Community Support Services. Working with the consumer, CSWs will be expected to use the results from the diagnostic assessment, LOCUS and the AMHS Needs Assessment to inform the development of the ISP. A consumer may grieve the results of the needs assessment under paragraph 65 of the Settlement Agreement.

As described in greater detail in Chapter III, the Individualized Support Plan is comprehensive. It contains components addressing many areas of need such as mental health treatment, transportation and employment. ISPs will evolve based on the consumer's progress toward recovery, taking into account additional considerations such as the person's social supports, housing circumstances and general well-being.
The various components of the ISP are unified within one plan and are supported by different individuals and agencies in the community, in large measure at the consumer's discretion.

[3] The LOCUS is not utilized to determine eligibility. The LOCUS measures, among other things, potential complications in the course of illness related to co-existing medical illness, substance use disorder, and the psychiatric disorder. It directs consumers to appropriate level of intensity of services.
[4] PNMI referrals must be submitted to the DHHS regional Mental Health Team Leader for prior authorization.

Provider Pathway

The providers' functions are more clearly coordinated under this plan than in the current system. When the provider (individual therapist or agency under contract) determines from the Diagnostic Assessment that Community Services are needed, the provider will make a referral for a Community Support Worker or Residential Services at the appropriate level of care.[5] The Community Support Services or Residential Services provider will send enrollment information to DHHS, by paper or electronically, either through the web portal or through a batch submission. It is at this point that the demographic and other information will be recorded in the data management system known as EIS, to be updated as necessary.

Paragraph 61 of the Settlement Agreement requires that, where formal assessment procedures are available to examine class member strengths and needs, the assessments should occur with appropriately credentialed professionals. DHHS provides training so that not only licensed clinicians but also trained CSWs can administer the LOCUS assessment tool. (Consumers have reported that this system flexibility would increase their comfort level and help reduce multiple interactions and inconvenience.)

After the consumer and CSW develop the ISP, the identified resource needs will be recorded in the EIS. As described in the Chapter V, Managing the Change, EIS is an essential component in identifying needed resources throughout the state.

Providers will use the assessment tools that they currently use to perform diagnostic assessments. The professional standards and DHHS requirements already assure that clinical information is current. When clinicians anticipate the need for Community Support Services or Residential Services, they may also conduct a LOCUS to assist in determining the level of service required.

The Community Support Services or Residential Services provider must submit enrollment information to DHHS within 5 days of having accepted a consumer into service. The provider must also complete the LOCUS within those first 5 days if the clinician who conducted the diagnostic assessment did not complete one. Once a person's enrollment information has been received, DHHS will verify that a diagnostic assessment has been completed within the last twelve months and that a LOCUS has been administered. Additionally, the DHHS staff will collect information about the individual's reimbursement source, such as MaineCare, any other third party carrier or grant fee-for-service. This information will be entered into EIS.

[5] Both DHHS and crisis services will refer clients to a provider who will conduct an eligibility assessment or review.

When a person is enrolled, the party submitting the information will be informed of any known services already being provided to the consumer. This will minimize redundant services.

Class members who are not in service and who contact the CDC office will continue to be referred as appropriate for Community Support Services. In addition, class members who choose not to have an ISP but who request other services will continue to be referred to requested services by the Consent Decree Coordinators. For class members who choose to get access to services that way, the Consent Decree Coordinators will assure that the necessary enrollment data is entered into EIS.

The enrollment process began in July of 2004 with a ninety- day period in which DHHS required providers to submit to DHHS available enrollment data for all consumers who were then receiving Community Support Services or Residential Services. For those consumers, the LOCUS will be administered at the time of the annual clinical reassessment, and updated enrollment information will be submitted to DHHS within 5 days of that clinical reassessment. Following the ninety-day mass enrollment period, providers have continued and will continue to provide enrollment data about consumers newly accepted for services.

DHHS Outreach

DHHS will continue the process of contacting class members to offer services through quarterly mailings and other mechanisms as described in the February 1997 Stipulated Order. DHHS and providers that are funded to perform outreach services will also continue to approach individuals with mental illness who are homeless or are in jail. Intensive case managers assigned to jails and shelters will continue efforts to engage people with mental illness for referral to appropriate community providers. DHHS is currently working with various groups, including the Task Force on Homelessness, the Maine State Housing Authority and the Association of Jail Administrators to develop strategies for the engagement and support of individuals on the streets and in temporary shelters.

DHHS has conducted a review of the mental health concerns in Maine's jail system. This review identifies both mental health practices and assistance needed. DHHS, the Department of Corrections, and county jail representatives have established regular meetings in order to address mental health treatment and planning needs within the correctional system collaboratively. DHHS has also created a Community Corrections Manager (previously referred to as the Director of Forensic Services) position on the Adult Mental Health Team to provide leadership and further focus on mental health issues in the correctional and jail systems.

III. Consumer Driven: Individualized Support Planning

The process of developing the Individualized Support Plan (ISP) provides an opportunity for the consumer and the Community Support Worker to come together with an agreed-upon roadmap to recovery. The ISP holds the consumer, the provider and DHHS accountable for certain actions. It also provides DHHS with information it needs to monitor both the timeliness of services to individuals and the adequacy of system resources.

Using input from consumers, providers, consultants, and family members, DHHS redesigned the ISP process, with a goal of developing a consumer-friendly, consumer-driven process that satisfies Settlement Agreement requirements.

Consumer Perspective

Individualized Support Planning is the process by which the consumer selects and receives supports and services that he or she needs to reach self-determined goals. The consumer may choose whether or not to participate in the ISP process.

The ISP planning process results in a global plan developed by the consumer and his or her CSW. The ISP builds on the resourcefulness of the consumer and his or her natural supports, and adds those system supports that lead to a meaningful life for the consumer in the community. The ISP is comprehensive and may address any life domains that the consumer identifies that may require support or change. The ISP helps the consumer to avoid redundant, duplicative or disconnected planning.

If the consumer is working with a team for planning purposes or wishes to do so, those team members can be involved in the plan's development as well. If the consumer wishes others in addition to the CSW to participate in the ISP process, the CSW will provide notice to the others. Additionally, the inclusion of natural supports such as friends or family members is strongly encouraged. DHHS supports the concept of having peers available to participate in this process and encourages agencies to provide peer services. DHHS has received federal funding to develop a program for peer recovery specialists. Workforce development is necessary for these resources to exist as well as a certification program to allow for MaineCare reimbursement. The CSW will, in any event, provide notice to any guardian of ISP planning meetings.

Within the context of the consumer's self-determined goals, the CSW assists the consumer to identify needs and to locate and get access to services. CSWs play an active role in engaging and involving consumers in developing the ISP, preparing for and carrying out linkage to appropriate resources, and discussing problems impeding the consumer's attainment of her or his goals. The planning process and plan implementation are opportunities for the consumer to define flexible levels of involvement for his or her CSW, ranging from advocacy in

navigating the system to serving as a safety net. Additional roles for the CSW in assuring that the mental health system is best serving the consumer are described in Chapter IV, Continuity of Care: Comprehensive Service Array. Additional information about a move to a system that encourages a team approach appears in Chapter IV also.

Provider Perspective: ISP Development, Monitoring and Revisions

It is the responsibility of DHHS to involve all persons eligible for Community Support Services in the development and implementation of an ISP. MaineCare regulations in Section 17 refer to this as a comprehensive plan. All class members are eligible for services, as are other persons who meet criteria for age, diagnosis, and functioning. If a consumer has urgent needs upon initial application for Community Support Services, these needs will be addressed even if he or she has not yet been enrolled or assigned a CSW.

Providers must assign a CSW within two days to class members who are hospitalized at the time of application for CSW services. Providers must assign a CSW within three days for class members who are not hospitalized at the time of application. Non-class members must be assigned a CSW within seven days. Application means the date on which the request for a CSW was made by the consumer or person acting on behalf of the consumer. The application date could be the date of the phone call to the community support service provider or receipt of the written application, whichever first occurs.

The Settlement Agreement does not apply to consumers who are in jails or prison. However, in order to facilitate transition to the community for incarcerated consumers who do not have a CSW, DHHS provides an opportunity for those consumers to connect seamlessly with Community Support Services upon discharge. Specifically, DHHS has assigned Intensive Case Managers to assist consumers who are in jail to begin reentry planning. One job of those ICMs is to help consumers apply for Community Support Services if they wish to do so.

DHHS will track the timeliness of CSW assignment through enrollment data and by continuing CDC monitoring of agency wait lists for community support services. It is the provider's responsibility to assure that the consumer's goals and needed services reflected in the ISP planning process are documented. Thus, the process should record the person's desired goal(s); a description of the resources needed or wanted to attain those goals; identification of providers selected; identification of needs for which no resource is available or accessible; and interim plans and revisions as necessary. Encouraging consumers to develop crisis plans is a part of the ISP process. It is also the responsibility of the provider to assure that the ISP documentation follows the consumer, should the consumer choose to change community support providers.

The ISP will incorporate specific treatment or service plans from providers selected as a result of identifying resources needed to achieve goals. Those plans,

including the specific CSW plan, are part of the ISP and are unified as one document by the CSW. At a minimum, the treatment or service plans must include the following elements:

Goal – A statement describing in measurable terms the solution to an unsatisfactory situation in the person's life or for a next step in improving the quality of life (must be the ISP goal).

Strengths – Personal and external assets relative to reaching the ISP goal

Barriers – Personal and external challenges relative to reaching the ISP goal

Objectives – Measurable statements of outcome that describe the desired result of service participation designed to resolve barriers or promote recovery (the objective cannot simply be service participation)

Interventions – Description of the service to reach the objective (should include type of service, frequency, duration, and responsibility)

Incorporated treatment and service plans with each provider constitute a service agreement with that provider under paragraph 69 and will include the required notice provisions related to termination of services.

The ISP will be developed within 30 days of application for Community Support Services. The ISP process is intended to be dynamic, with ISPs changing in response to the consumer's needs and progress towards recovery, instead of according to arbitrary time-lines or not at all. The CSW must review the ISP at a minimum of every 90 days to determine the efficacy of the services and supports and to assist the consumer in formulating changes in the plan as necessary. The CSW should also be prepared to review the plan more frequently if substantial changes, such as hospitalization, occur. A CSW who is assigned as a result of a referral while the class member is in the hospital must meet with the class member within four days of discharge to assure that the ISP-identified services are being received.

In those instances in which resource needs are not met, CSWs have the responsibility to involve the consumer in developing and implementing interim plans, which describe CSW actions to compensate for and develop the needed resource, if necessary. Interim plans do not negate the need to advocate for and facilitate access to the services initially identified in the ISP. The needs listed on the interim plan will be tracked just as the needs of the regular plan are tracked.

Response Times and Unmet Needs

This plan makes a distinction between expected response times for services to individual consumers and how unmet needs are determined for resource development. Table 1, below, delineates each service, the expected time within which the consumer should have the service, and the period during which the management information system will track the service before labeling it as an unmet need for resource development purposes.

When providers send in the ISPs for all individuals enrolled in community support or residential services, information from the ISP cover page about resources needed will be entered into EIS. The expected response times, as set forth in the middle column of Table 1, establish expectations for provider performance and serve as the trigger for determining whether an interim plan should be developed. When a service needed to help the consumer meet a goal is not available, the CSW has the responsibility to do interim planning with the consumer as soon as possible and within the time frames listed in the middle column of Table 1. If a service is not available within the time frames listed in the last column of Table 1, this signifies a lack of capacity in the system and triggers the need for development of additional resources.

Table 1. Response Times and Unmet Resource Needs

Service	Expected Response Time / Interim Planning	Unmet Need For Resource Development
Emergent	Immediately	
Urgent	Within 24 Hours	
Daily Living Support Services	Within 5 Days	30 Days
Community Integration	Within 7 Days (3 for class members)	60 Days
Intensive Community Integration	Within 7 Days (3 for class members)	60Days
Assertive Community Treatment	Within 7 Days (3 for class members)	60 Days
Psychiatric Medication and Monitoring for Consumers in the Community	Within 10 Days[6]	
Skills Development	Within 30 Days	90 Days
Day Supports	Within 30 Days	90 Days
Specialized Groups	Within 30 Days	90 Days
PNMI	Varies with consumer's current situation	90 Days
All Other Services to address ISP-identified needs	Within 30 Days	90 Days

This system thus obviates the need for CSWs to make determinations of what constitutes an unmet need, and relies instead on the objective time frames set forth in the above table. The time frames will be tracked in the Enterprise Information System, which will generate reports of services deemed unavailable as unmet needs under paragraph 63 of the Settlement Agreement, based on the time periods in the third column in Table 1.. DHHS will aggregate and analyze this unmet needs information to determine whether there is a need to develop further resources. Based on those determinations, DHHS will prepare budget requests to the Governor and the Legislature for necessary additional resources. Those requests will consider the cost of funding services through Section 17, Section 97, Section 65 of the MaineCare regulations and through grant funds.

Consent Decree Coordinators will continue to gather information on unmet needs of class members who are not in service and who contact the CDC office. The CDCs will continue to report this information for purposes of budgeting and resource development pursuant to Paragraph 74.

[6] The ten-day expected response time for psychiatric medication and monitoring services does not apply to persons being discharged from a hospital or crisis residential unit. The hospital or crisis residential unit discharge plan will include making the connection between the consumer and a provider of medication monitoring services within a time that does not put the person in jeopardy. The needs of patients discharged without such a plan would be deemed urgent.

DHHS will continue to perform periodic case reviews of class members with brain injury residing out of state. A DHHS Intensive Case Manager will continue go to Lakeview every month to assure that individual needs have been assessed and to determine whether additional housing and in-state support services are necessary.

Riverview shall send weekly discharge reports, which identify individuals needing assistance from either Adult Mental Health Services or a provider agency. These reports shall be sent to Central Office and then distributed to the Mental Health Team Leaders for report and follow-up within 7 days.
The Team Leaders shall be responsible for delivering the supports needed for reentry within the timeframe mandated by the Riverview Performance Standards. The mental health team will use this information from Riverview to determine whether there is a further need for system development, as well as planning for individual consumers. Based on review of the Riverview reports, this plan includes a budget component for development of specialized supported housing for eight consumers.

ISP Documents

To implement the revised ISP process, DHHS will do the following:

1. Implement a simplified ISP form;
2. Develop an ISP Manual that clearly identifies the key components of ISP development and implementation; and
3. Train consumers, community support services and other service providers in the use of the revised ISP process and form. These trainings will be co-facilitated by consumers.
4. Modify its regulations for licensing mental health agencies to incorporate the changes to the ISP process.

Public Wards

Not all consumers have the legal capacity to make their own life decisions. As public guardians, DHHS caseworkers and their supervisors are charged, consistent with common law obligations, to make decisions in the best interest of their wards. The Settlement Agreement provides specific additional administrative safeguards to class members who have been adjudged in need of a public guardian. The Department of Health and Human Services, through its Office of Elder Services (OES), formerly the Bureau of Elder and Adult Services, works to assure that all of its public wards receive appropriate services, and that its class member public wards are afforded specific additional protections described in the Settlement Agreement.

As outlined in its policy and procedure manual, OES provides casework services to all of its public wards. A case plan for each public ward documents case management services being provided. Services include monitoring ISPs or

hospital treatment and discharge plans and attending all planning meetings. In the event that a caseworker is unable to attend an ISP or planning meeting, the casework supervisor or another caseworker attends in the caseworker's place.

Additionally, before medical treatment for any public ward is authorized, caseworkers and their supervisors seek the counsel or opinion of an independent professional when the risks associated with the proposed medical order or procedure are great or when the proposed medical order or procedure limits the ward's independence and the prognosis for improvement as a result of implementing a proposed medical order or procedure is poor or guarded.

Caseworkers visit all wards in accordance with the assessed needs of ward. During a crisis, this assessment of need may result in visits as frequently as daily. In no event is any public ward visited less frequently quarterly. As required in the Settlement Agreement, caseworkers visit class member public wards at least twice monthly, except that visits may be reduced to monthly in accordance with a protocol approved by the court master. Caseworkers report the frequency of visits in the case plan and, for class member public wards, provide this information to the court master in annual reports.

Caseworkers refer any public ward who would benefit from a community support worker and an ISP for those services, and participate on behalf of the ward in development of an ISP. As required in the Settlement Agreement, they undertake these activities for all class member public wards, except that, on occasion, the caseworker, in consultation with the class member public ward and casework supervisor, may determine that an ISP is not necessary or desirable. For example, the ward may be unable or unwilling to participate in the ISP process and may have no unmet needs. In that case, the decision making process is documented in the case plan and in the class member public ward report.

In the absence of a community support worker, caseworkers provide the advocacy services that community support workers provide. For example, caseworkers advocate for wards to receive generic resources and services to the maximum extent possible. Caseworker advocacy may include referring a matter to the Disability Rights Center, or filing a grievance in accordance with the Rights of Recipients of Mental Health Services. Caseworkers advise class member public wards of the right to name a designated representative or representatives and the availability of advocacy and peer advocacy assistance, and provide the same information as needed for non-class members. Caseworkers also advise class member public wards orally and in writing at least annually of their right to petition the Probate Court for termination of guardianship, including information about the hearing process and about the availability of legal assistance, and provide the same information as needed for non-class members.

Caseworkers make placement decisions for all of their public wards consistent with the scope of the guardianship granted by the Probate Court. When making placement decisions on behalf of any public ward, caseworkers consider the

wishes of the ward. For any class member public ward, caseworkers first seek placements in facilities (other than hospices, shelters, or nursing homes) of 8 beds or less, considering the wishes of the ward and any limitations on the guardianship imposed by the Probate Court. Under a protocol for class member public wards approved by the court master in July of 2004, the caseworker must determine the ward's wishes regarding placement; advise the ward of the provisions of paragraph 96 of the Settlement Agreement; determine if the placement is the least restrictive and most appropriate for the class member public ward; and make an informed decision about the appropriateness of the placement. The caseworker must document the decision making process in the case record and on the annual class member public ward report.

To assure that caseworkers are knowledgeable about the job obligations described above, DHS requires that caseworkers be trained annually. Adult Protective Program administrators document attendance at training. In addition, new caseworkers assigned to work with class member public wards receive orientation training on the terms of the Settlement Agreement and specific performance obligations. These new caseworkers must complete ninety percent of the training before being assigned to work with a class member public ward. Casework supervisors and Adult Protective Program administrators are responsible to ensure that this orientation training occurs.

DHHS reviews the caseload size of caseworkers monthly. Caseloads of workers with class member public wards are assessed to assure that case loads do not exceed a ratio of 25 wards to 1 case worker. Caseloads of workers without class member public wards are generally larger. They are reviewed to assure that they are consistent with current standards, the nature of services being provided (i. e. protective investigation services or case management services), and the specific needs of individuals on the caseload.

Revised October 13, 2006

IV. Continuity of Care and Services

While Maine has a comprehensive array of adult mental health services, quality of care for consumers depends in large part upon how easily they can access those services and make transitions from one level of care to another without being disconnected. Coordination among service providers, with appropriate sharing of information, and a primary focus by each provider on their contribution to the whole community mental health system, is what makes an effective and responsive system.

This plan is based on the premise that local planning, local problem solving, and a mutual understanding of the roles and expectations of each service provider are effective ways to support continuity of care. Continuity cannot simply be mandated by the Department of Health and Human Services (DHHS) nor can it be achieved entirely at a local level. The DHHS Office of Adult Mental Health Services (OAMHS), other DHHS offices, consumers, service providers, hospitals, and the community at large all have a part to play in a comprehensive, successful mental health system.

The implementation of managed care for behavioral health services was the main strategy by which OAMHS expected to accomplish the improvements in the continuity of care, as described in the previous June 2005 plan. DHHS had planned to use managed care to provide contractual coordination among service providers, thereby knitting together the diverse services available to consumers. However, in order to incorporate more input from consumers and service providers in the design and implementation of managed care, its implementation was extended beyond the date originally anticipated in June 2005. In the absence of a managed care system, OAMHS has developed and described in this plan strategies that, standing by themselves, improve continuity of care. Specifically, DHHS has incorporated into this plan the community service network approach that underlies managed care. OAMHS will be providing leadership to and oversight for these networks. The network structure is such that it can be folded into managed care once a vendor for managed care is selected.

This chapter describes:

- The four areas of system redesign to improve continuity of care:
  - Community Service Networks;
  - Performance Requirements;
  - Flexible Services and Housing; and
  - Consumer Councils and Peer Services.
- Action steps related to:
  - Persons experiencing psychiatric crises;
  - Riverview ACT team;
  - Vocational services; and
  - Managed care.

System Design Changes: The Four Components

OAMHS is revising four components of system design to assure continuity of care for adult mental health consumers. OAMHS is:

- Dividing Maine into seven Community Service Networks comprised of the mental health providers, including hospitals, in each region, with all core services and functions coordinated to reflect a collective responsibility to all consumers in the network area;

- Delineating and enforcing performance requirements through contract and provider agreements for hospitals and mental health service providers;

- Providing housing (with the exception of residential treatment) that is permanent with flexible services added or reduced based on consumer needs, and service coordination by the community support worker;

- Supporting an independent consumer council system and requiring the inclusion of peer services as part of core mental health services.

Community Service Networks

Creation of Local Community Service Networks

The development of Community Service Networks (CSNs) involves a major shift in how DHHS and mental health service providers currently do business. The networks will be created and will function consistent with contract amendments and statutes, and their activities will be monitored consistent with the processes outlined in Chapter VI of this plan. The local consumer councils will have representation at each local network. Immediate network actions will focus on the coordination of mental health services. Over time, the networks will have greater involvement with other behavioral health services, such as substance abuse treatment, and with health centers and primary care physicians in the area.

Actions to be undertaken by OAMHS:

- Within one week of approval of this portion of the plan, issue amendments to provider contracts to create the following seven local community service networks, charged with the responsibility to provide comprehensive services to all adult mental health consumers in the network area:
    1. Aroostook
    2. Hancock, Washington, Penobscot, Piscataquis
    3. Kennebec, Somerset
    4. Knox, Lincoln, Sagadahoc, Waldo
    5. Androscoggin, Franklin, Oxford
    6. Cumberland
    7. York

  For purposes of this plan, Dorothea Dix Psychiatric Center and Acadia Hospital will be considered part of networks 1 and 2, above, and Riverview

Psychiatric Center and Spring Harbor Hospital will be considered part of networks 3 through 7.

- Assure that each of the seven networks provides the following services:
    1. Peer Services
    2. Crisis Services, including Crisis Stabilization Units
    3. Community Support Services (which currently include Community Integration, Intensive Community Integration, Assertive Community Treatment, Daily Living Skills, Skills Development, and Day Support Services)
    4. Outpatient Services
    5. Medication Management
    6. Residential Services
    7. Vocational Services
    8. Inpatient Services (including hospitals that do and hospitals that do not provide inpatient psychiatric services)

While providers of these services form the core membership of the CSN, this list does not limit the array of services that must be available to consumers.

- Within one week of approval of this portion of the plan, issue contract amendments that will require each participant in the network to participate in formulating operational protocols and to enter into a memorandum of agreement with other network participants outlining the following responsibilities to ensure that the collective obligations of the network are satisfied:

    - Delivery of services to all adult mental health consumers in the network area;
    - Compliance with all provisions of the Consent Decree, especially where coordination among service providers is required;
    - Assurance of 24-hour access to a consumer's community support records for better continuity of care during a psychiatric crisis;
    - Planning based on data and consumer outcomes;
    - Identification and provision of services to consumers at risk while maintaining a "no reject" policy so that no consumer is refused service within the network's area, other than in accordance with provisions of this plan and the Settlement Agreement;
    - Engaging in network problem solving to ensure that consumers with complex needs are appropriately served;
    - Implementation of the Rapid Response protocol;
    - Coordination among the community support program, the crisis program and hospitals to ensure that ISPs and crisis plans are available to those involved in treatment and that community support workers are participants in hospital treatment and discharge planning;
    - Assuring continuity of treatment during hospitalization and the full protection of a client's right to due process.

- The contract amendments must be executed within thirty days of issuance. The operational protocols and the memoranda of agreement must be finalized by the networks and approved by OAMHS within 45 days thereafter. If any network does not submit approvable documents within that 45 days, OAMHS will provide the protocols and memorandum of agreement that must be implemented by the network.

- By the end of October 2006, assess the service offerings in each network to determine whether they provide adequate geographic coverage to serve the entire network area, and by January 15, 2007, identify any resource gaps and establish remedial measures and fixed time frames for implementation.

- Request additional funding to cover gaps in network services..

- Propose an amendment to 22 MRSA § 3608 (Attachment 1) in the first session of the 123rd Legislature to define community service networks. This will assure continued momentum and will be consistent with the implementation of managed care, regardless of implementation date;

- Revise the quality management structure described in the May 2006 progress report to:
  - Replace monthly provider meeting with monthly network member meetings;
  - Provide data on system performance by agency and by network and structure problem solving to be the responsibility of the network, together with participation from the local consumer council.

Cost: Within existing resources.

Realignment of Services

This plan for continuity of care and access to services is based on a commitment to providing services in local communities and to promoting flexible and appropriate service options. The following describes roles for existing service providers and their relationships under this plan:

A. Community Support Services

The community support providers coordinate the array of consumer services, with the crisis agencies providing coordination during a psychiatric crisis. In circumstances where a class member is not enrolled in community support services but is requesting assistance, the coordination is done by a Consent Decree Coordinator (CDC). The crisis provider is responsible for linking back to the community support provider or the CDC.

For each consumer who has a community support worker (CSW), that worker is clearly responsible for coordinating an active Individualized Support Plan (ISP) and a crisis plan, and for locating, obtaining, facilitating, coordinating, and monitoring services. The CSW

is responsible for resolving problems related to the implementation of services. The CSW coordinates team meetings for ISP development and review. The consumer may elect to meet solely with the community support worker, in which case the CSW is responsible for relaying the consumer's wishes to the other providers of service. The agency that employs the CSW must ensure that this CSW function is covered when the community support worker is unavailable as well as when the position is vacant. The CSW's employer serves as the lead agency for the CSW's client. The client shall retain the right to request a change in CSW and a change in the lead agency.

Each contracted community support provider must assure that consumers will be well served in psychiatric crises. To that end, the providers must assure round the clock coverage to allow access to pertinent consumer information, including the ISP, the crisis plan, health care advance directives, medical information as available, and basic demographic and service information that might be needed during a crisis. The community support worker is responsible for maintaining the name of the prescriber of psychiatric medications and up-to-date contact information for that prescriber. The CSW must participate in hospital treatment and discharge planning when their clients are admitted to the hospital, and must ensure that the hospital receives a copy of the consumer's ISP. Additionally, the CSW is responsible for communicating with the crisis provider or the hospital to assure appropriate follow-up services, and for reviewing the ISP and the crisis plan with the consumer whenever there is a major psychiatric event, updating the plans as needed.

B. Crisis Services

Crisis services are delivered by providers who operate under licensing rules promulgated to reflect the requirements of the Settlement Agreement. The crisis providers facilitate local network efforts to provide services in the network area during the psychiatric crisis. Crisis services are mobile and are provided in a variety of settings, including a consumer's home, mental health agency, social service agency, public locations, and emergency departments of hospitals. Crisis services are to be provided at locations other than an emergency department of a hospital unless the consumer chooses to receive services in an emergency department, requires treatment for a medical condition, or is in protective custody. The primary purpose of crisis services is to avoid hospitalization through community based alternatives.

During regular business hours, the first line responsibility for crisis resolution is the consumer's CSW. During non-business hours, responsibility moves to the crisis service, unless the consumer is enrolled in ACT, in which case the responsibility stays with the ACT team. When the consumer is in a hospital emergency department, it is the responsibility of the crisis provider to assess for the appropriateness and availability of less restrictive alternatives to hospitalization, to locate and arrange for these services, and to review crisis plans and advance directives. The determination regarding hospitalization is the responsibility of the physician, licensed clinical psychologist, physician's assistant, nurse practitioner or certified psychiatric clinical nurse specialist who has examined the patient in the emergency department. If the qualified professional

determines that hospitalization is required, the crisis worker is responsible for assisting the emergency department in locating a bed.

Cost: Within existing resources.

C. Hospital Services

The plan recognizes the varying missions of the community general hospitals, the specialty hospitals, and the state hospitals. It also recognizes the preference to hospitalize consumers reasonably near their home communities. It also recognizes the undesirability of admissions and discharges from multiple hospitals within the same hospitalization period. In order to balance these considerations and to manage inpatient services effectively, this plan creates single gateways to the state hospitals, with recognition of special circumstances under which the gateways may be bypassed.

1. Community Hospitals

Given the goal of ensuring that consumers are hospitalized as close to their home community as possible, community hospitals with psychiatric units are the first level of hospitalization response. The community hospitals are for short-term admissions, generally 30 days or less. OAMHS, through the Community Services Network memorandum of agreement and the amendment to the MaineCare provider agreement, described below, will ensure that hospitals have a no-reject policy for providing coverage to consumers in their community service network areas.

The crisis provider must document data on consumers who are denied admission to a hospital or crisis stabilization unit that has available beds. The data must include reasons for rejection. This data will be provided to the Community Service Networks for review and action in accordance with their quality improvement functions. This data also must be submitted to OAMHS for contract performance reviews. The crisis provider must also convene a meeting of the rapid response team to assist consumers who are expected to be in the emergency department for more than eight hours. The rapid response protocol that is currently being used describes the responsibilities for the crisis provider in more detail (Attachment 2).

2. Specialty Hospitals

Maine's two specialty hospitals, Acadia and Spring Harbor, are the next line of treatment and will take admissions from the community hospitals. These free standing psychiatric hospitals are designed to safely treat consumers who present with greater acuity and clinical complexity than community hospitals are able to effectively and safely serve. Additionally, Acadia and Spring Harbor serve as community hospitals for their local areas. Consumers who need specialty hospitalization will transfer to the specialty hospital closest to their home community.

3. Public Hospitals

Riverview Psychiatric Center and Dorothea Dix Psychiatric Center are the tertiary hospitals and will take referrals from Spring Harbor and Acadia, forensic admissions, and other admissions based on unique clinical needs, within the statutory authority of the

hospitals or based on unusual circumstances as described below. Riverview Psychiatric Center will be paired with Spring Harbor and Dorothea Dix Psychiatric Center will be paired with Acadia Hospital.

4. Unusual Circumstances

Consumers who are hospitalized in a community hospital and who need specialty hospitalization will transfer to the specialty hospital closest to the consumer's home community. Consumers in community hospitals may bypass hospitalization in a specialty hospital when:

- A consumer's history and current presentation indicate that a longer term of stay is likely;
- A consumer's documented clinical history makes a particular hospital inappropriate;
- A consumer has serious objections based on a documented serious incident or experience that would make a particular facility inappropriate.

If the community hospital finds that unusual circumstances, as described above, apply, then it must confer with the closest specialty hospital. The specialty hospital retains authority to decide whether to refer the patient directly to one of the state facilities, provided, however, that if there is a disagreement between the specialty and community hospital about a proposed referral, that disagreement will be resolved by OAMHS. OAMHS will require the community hospitals to report promptly to OAMHS any requests to bypass the specialty hospitals, and the responses to the requests. OAMHS informed the Hospital and Crisis Initiative Group in September 2006 about the design for the realignment of these services.

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Action to be undertaken by OAMHS:

- Within one week of approval of this portion of the plan, issue amendments to Contract Rider A to require community support services providers to give round the clock access to pertinent consumer information in a psychiatric crisis, as described above. These contract amendments must be executed within thirty days of issuance. Monitor compliance with this requirement and take corrective action according to the process described in the contract amendment;

- Complete a contract with each community hospital with involuntary psychiatric inpatient beds, as well as with Spring Harbor Hospital, by the end of November 2006, and continue to encourage Acadia Hospital to enter into a contract as well;

- Within one week of approval of this portion of the plan, issue contract amendments regarding implementation of changes with each crisis provider;

- By the end of December, 2006, amend the MaineCare provider agreements with all community hospitals and with Spring Harbor Hospital and Acadia

Hospital to require compliance with the functions described in the community service network memorandum of agreement.

Performance Requirements for Providers

Contract Requirements and Monitoring
Establishing clear performance requirements for providers and enforcing those obligations is a critical step to accomplishing continuity of care. To that end, OAMHS will take the following actions:

- Within one week of approval of this portion of the plan, issue amendments to contracts with community service providers to clarify expectations and establish compliance criteria. These amendments will include progressive steps OAMHS will take for non-compliance with contract requirements, up to and including termination, and issuance of a RFP for the services in question. The amendments must be executed within thirty days of issuance;

- Review data regarding contract performance and consent decree requirements at monthly Community Service Network meetings, beginning in the month following approval of this portion of the plan, for corrective action;

- Issue quarterly updates to the Statewide Quality Improvement Council, the Consumer Advisory Group, the Maine Association of Peer Support and Recovery Centers, and the Consumer Council system once established detailing performance, corrective actions, and seeking ideas for further improvement.

Cost: Within existing resources

Education about Releases of Information
There is some disagreement among service providers about how current confidentiality laws affect their ability to exchange information about consumers in times of crisis and to support continuity of care.

Action to be undertaken by OAMHS:

- Issue a policy directive by November 2006 to providers outlining Department expectations under current law about sharing consumer-specific information with consumers directly, with other providers, with family caretakers, and with the Department;

- Amend contracts to require that agencies request appropriate releases of information at intake and with every service plan update;

- Beginning with the Consent Decree Coordinators' October 2006 Document Review, monitor the extent to which agencies plan with consumers for

appropriate release of information and educate consumers about the benefits of shared information to continuity of care. Where CDCs find deficiencies in this area, they will provide training to providers.

Cost: Within existing resources.

Crisis Program Standards

Crisis program standards were revised through the Hospital and Crisis Initiative Group, but the Department was awaiting approval of the Consent Decree Plan before finalizing them, in order to ensure that they included all relevant requirements. OAMHS will move ahead with the implementation of these standards as follows.

Action to be undertaken by OAMHS:

- Present crisis program standards at the Hospital and Crisis Initiative meeting, the October QIC, the Consumer Advisory Group, and the MAPSRC meetings;

- Issue final standards by November 2006, including protocols for measuring adherence and assessment of any need for further resources;

- Conduct review of each crisis program for adherence to the standards beginning in 2007, and every two years thereafter;

- Create a protocol for standardizing the elements of the hospitalization process by January 2007 which includes but is not limited to such elements as face to face assessments, involvement of family members and others familiar with the consumer as well as others with information regarding the precipitating circumstances of the crisis, and advance directives.

Cost: Within existing resources.

Assure Appropriate Use of Blue Papers

OAMHS has communicated and will continue to communicate a clear message to all hospitals and crisis providers that the use of so-called procedural blue papers violates the Rights of Recipients of Mental Health Services and is an unacceptable practice. Crisis providers and hospitals have both been directed to report to the DHHS utilization review nurses in their respective regions any instances of the use of applications for involuntary hospitalization for people who would otherwise consent to voluntary admission. Upon receipt of a complaint, the utilization review nurses follow up with the crisis provider and hospital involved to assess the circumstances surrounding the use of the blue paper and, if it appears that a blue paper was used inappropriately, to report that information to DHHS licensing for further review and appropriate corrective action. These findings will also be reported to the Hospital and Crisis Initiative Group for the development of additional strategies to assure that this practice does not occur.

Action to be undertaken by OAMHS:

- Amend MaineCare provider agreements with hospitals by the end of December 2006 to require the hospitals to allow access by the Utilization Review Nurses to monitor involuntary admissions;

- Report the findings from the ongoing work of the Utilization Review Nurses in monitoring involuntary admissions and responding to complaints about the inappropriate use of blue papers to the monthly network meetings for any corrective action and to the Maine Hospital Association Mental Health Council beginning in September 2006;

- Update as necessary the web-based information on blue paper rules, procedures and forms that is currently on the OAMHS website and publicize that information to consumers and providers;

- Propose an amendment to Title 34-B of the Maine Revised Statutes to authorize DHHS to promulgate rules for monitoring emergency involuntary commitment procedures.

Cost: Within existing resources.

Assure Coordination with Psychologists in Private Practice
A consistent set of expectations for service coordination during a psychiatric crisis for persons seeing a private psychologist is a part of continuity of care.

Action to be undertaken by OAMHS:

- Amend the MaineCare provider agreement for private practitioners to delineate psychologists' responsibilities concerning communication about the ISP and coverage and access to information after office hours.

Cost: Within existing resources.

Flexible Services and Housing

Currently residential services are provided under one MaineCare category, referred to as Private Non-Medical Institutions (PNMIs) and funded under MaineCare Chapter 97. OAMHS currently offers three levels of service under PNMI funding: residential treatment (a treatment option under paragraph 103 of the Settlement Agreement), community residential, and supported housing (residential support services under paragraphs 97 and 98 of the Settlement Agreement). As consumers improve their functioning and psychiatric condition, they may be required to move from one facility type to the next until they are living on their own, possibly with a variety of supports financed under MaineCare Chapter 17. The current PNMI model "bundles" services to those living in these particular residences, in that treatment, support, and housing are combined in one rate which is then applied to all of the residents. Moreover, today, consumers who are currently living in their own home and who may require a temporary increase in support to 24/7 may have to give up their own home to move into the PNMI

residence to receive the necessary increase in support. Services under Chapter 17 are of less intensity and duration than is currently available in a PNMI. Much of the current model is based on the notion that recovery is a linear process, moving from intensive support and rehabilitation to increasingly less intensive support and rehabilitation.

Realignment of Housing and Support Services

Recognizing that recovery from mental illness is not linear, OAMHS will realign its service system to focus on providing services to consumers in their chosen, permanent home at the level of intensity, duration and type necessary to meet the individual consumer's need. Services will be flexible and "wrapped around" the consumer. Services will be provided on a very intermittent basis, or up to twenty-four hours per day seven days per week, depending on consumer need. The current link between services and housing will be broken.

With the realignment as noted above, only residential treatment will remain as a group home model or a bundled service. This service is available through MaineCare and is defined in OAMHS (formerly BDS) service definitions for contracts as follows:

> This service includes providing or arranging for comprehensive treatment to include psychiatric and other specialized services, training and support (including housekeeping/home maintenance and meal planning/preparation); transportation; interpersonal relationships, self advocacy and assertiveness training; health maintenance and safety practices; financial, personal and legal affairs management, contingency planning and decision making; basic academic, work and recreational skills; and utilization of community services and resources. Services are provided by specific levels of credentialed staff. Service is typically provided in a group home living arrangement.

To accomplish this realignment, changes in licensing and MaineCare regulations will be necessary as the level and intensity of services which are needed are not allowed in certain regulations and licensing. Currently, two chapters of MaineCare cover the services to be changed – Chapter 17 and Chapter 97. Chapter 17 only allows services for a maximum of16 hours per day and expects that they will be rapidly reduced. Chapter 97, which allows for 24/7 service, is for only residential services (PNMI).

This realignment will result in the re-structuring and re-financing of the categories of residential services that are currently called supported housing and community residential, thus yielding more flexibility and individual choice in the community array of living arrangements, and leaving only residential treatment as a structured transitional treatment service, funded under PNMI.

Residential treatment will continue to operate under the Utilization Policy for Residential Facilities revised 7/13/2000. Under this policy, length of stay in a residential treatment facility is determined through the team-based ISP planning process. The policy acknowledges that the determination of length of stay is contingent upon the availability of other appropriate housing and housing support services. Moreover, when appropriate, consumers will be transitioned into other arrangements with necessary supports. The

transition may include a period during which residential treatment services are reduced while community residential supports are increased.

Since so many of the residential support services currently provided to consumers are bundled with housing, these changes need to be implemented with full participation of the consumer and provider communities in order to minimize the impact on current services. This transformation is such a fundamental change that all parties need to be involved in helping shape the changes.

Community support services are also structured such that when a consumer experiences a significant change in the intensity of level of support needed, the consumer may be assigned to a different community support worker who can provide the changed level of support. Because not all providers offer all levels of community support services, this may also entail a transfer to another service provider. The three levels of community support services that are offered by community providers are also currently billed at different rates under MaineCare. These are current realities that constitute barriers to allowing the consumer and the CSW to continue to maintain a working relationship as the consumer experiences the need for significant changes in levels of community support.

In the June 2005 Consent Decree Plan, the Department had proposed a team approach, supported by a change in the reimbursement structure, to address these barriers to continuity of care. In the period since disapproval of that portion of the plan, however, the Department has determined that the proposed financial approach is not a feasible. OAMHS has therefore sought other ways to ensure flexibility and continuity in support services to individual consumers. The Community Service Networks that are being established in each region under this plan offer an alternative to providing the degree of integration and coordination that the team approach sought. OAMHS anticipates that the closely coordinated work among community support services agencies and others in each CSN will foster increased teamwork among services providers and offer the appropriately continuous care that a comprehensive mental health system demands.

Nonetheless, OAMHS remains committed to trying to restructure services so that consumers can maintain the same core team of providers (e.g., the case manager, psychiatrist, or therapist) even as the intensity of their needs for support increases and decreases. (This restructuring will most likely recognize that consumers who need ACT team services, like consumers who need residential treatment care, may need to change to a different team of service providers if ACT services become necessary.) As with the unbundling of housing and residential support services noted above, figuring out the best way to structure service delivery and reimbursement rates to foster the team approach for all levels of community support services will require the involvement of providers and consumers, as well as DHHS licensing and OAMHS staff.

Action undertaken by OAMHS:

- By October 2006 establish a work group led by OAMHS and including consumers, providers, MaineCare and licensing representatives to identify and develop solutions to resolve the practical issues faced by the community support worker in implementing the system of flexible services and provider

coordination, as well as the necessary funding changes to assure that a consumer's core team of providers can be maintained;

- By February 2007 have an implementation plan for the realigned system, including both the unbundling of housing and residential support services and the team approach to community support services, that includes changes to contracts for SFY 08 and revision of licensing and MaineCare regulations;

- For SFY 08, realign contracts to reflect the realigned system.

Housing and Housing Database

Given the changes outlined above, especially with the emphasis on unbundling of residential support services and housing, the housing side of the equation, and resources available for that become a focus of major attention. However, this is an arena in which OAMHS has a sure footing.

OAMHS continues to expand the array of housing options available to consumers. In 1996 there were less than 50 units developed with the support of the Department, today there are more than 900. Rental assistance vouchers have witnessed similar growth. In 1995, the Bridging Rental Assistance Program started with less than 40 vouchers, today more than 4,250 cumulative vouchers have been issued. Shelter Plus Care, a federally funded rental assistance program targeting homeless persons with mental illness, has grown from an initial grant of $300,000 in 1998 to more than $25,000,000 today.

OAMHS applied to the U. S. Department of Housing and Urban Development (HUD) in March 2006 for new Tenant Based Shelter Plus Care rental assistance vouchers and for continuing Sponsor Based Shelter Plus Care vouchers, totaling $900,000. These vouchers can be utilized at the discretion of the sponsor (the non-profit agency that owns or leases the property) in any unit or building that is owned or sub-leased by the sponsor. These vouchers are unique in that they represent a hybrid between the traditional project based voucher programs and tenant based vouchers. These vouchers will reduce the potential financial risk for sponsors and will likely result in increasing the availability of housing stock.

OAMHS has been very active in building collaborative partnerships with a myriad of stakeholders. Maine was one of the first states in the nation to develop an Action Plan to End Homelessness. Maine's Shelter Plus Care program is used as a model in New Hampshire, and our manuals are being used as foundational documents in Arizona, as well as a component of a HUD initiative to create a national Shelter Plus Care desk reference and program guide.

The demands for rental assistance continue to grow in the Bridging Rental Assistance Program (BRAP) as well. The overall housing market has tightened dramatically over the last five years. This program will continue, using current eligibility requirements and priorities. Based on the growth in usage of BRAP funding, OAMHS currently projects a demand for an additional $180,000 in the second year of the next biennium.

OAMHS also will develop a housing database that will identify all programs, capacity and current vacancies. This will be vital, not only in the conversion process, but also for purposes of future planning within the Community Services Networks.

Action undertaken by OAMHS:

- By November 2006 Beacon Health Strategies will have their initial web-based PNMI database system operational, and OAMHS will utilize this as a template for the development of its own housing database;

- By May 2007 introduce a pilot data base for one of the Community Service Networks with all fields populated. The OAMHS Regional Housing Coordinators will take the lead on provider education and utilization of this system to ensure occupancy levels are documented accurately in a timely fashion. Regional Housing Coordinators will continue to utilize the existing OAMHS electronic reporting system as a fail safe until such time as the new database is operational without problems, errors, or system breakdowns;
- By July 2007 a useable database will be in place;

- Continue to monitor BRAP waiting lists, and request additional resources when the data demonstrates the need;

- Provide ongoing training for OAMHS housing coordinators concerning eligibility criteria for various housing programs;

- Post eligibility requirements for the various housing programs and information regarding who is accepting applications for Section 8 housing, as well as contact information for the housing coordinators, on the OAMHS website. Encourage community providers to use this website and the expertise of the housing coordinators.

Cost: OAMHS will submit a budget request for SFY 09 for $180,000.

Peer Services

Consumer Councils

The Consumer Advisory Group created the Transition Planning Group (TPG) to develop the basic elements and structure of the independent local and Statewide Consumer Councils, referenced in Chapter VI of the June 2005 plan and further articulated in the Action Steps of November 2005. This process is consumer led, and the TPG has already developed timelines and tasks to accomplish its goals. OAMHS continues to participate in the process and to provide support requested by the TPG. However, it would be inconsistent with the very purpose of creating an independent consumer body if OAMHS were to dictate a detailed plan for the formation of the councils.

Action to be undertaken by OAMHS:

- Continue support and participation in the development of the councils. The setting of tasks remains the responsibility of the Consumer Advisory Group and the TPG. Balancing the need for consumer autonomy with the need to implement this plan in a timely fashion, OAMHS will ask the TPG to work within the following timelines:
  - The TPG, at its discretion, appoints one to three consumer representatives to each of the Community Service Networks once they are approved by the court or court master. These are temporary appointments to provide for continuous representation until the Consumer Councils and Community Service Networks are formed;
  - Develop a budget by October 2006;
  - Hold three regional conferences by March 2007;
  - Form at least three temporary regional councils by May 2007;
  - Form the Statewide Consumer Council and hold it first meeting by June 2007;
  - Form seven local Consumer Councils by August 2007.

Cost: The second session of the 122nd Legislature appropriated $323,000 for support of the Consumer Councils and the TPG is preparing a budget for spending these funds.

Licensing

OAMHS is committed to providing for consumer participation in licensing. This is one of the areas that will be addressed by the Consumer Advisory Group. OAMHS will provide outreach, training and financial support to make it possible for consumers to participate in licensing reviews.

Action to be undertaken by OAMHS:

- Present a proposal for consumer participation in licensing reviews by November 2006 to the Consumer Advisory Group for their review;

- Complete the Consumer Advisory Group proposal review process by March 2007 and begin implementation in April 2007;

- Provide training for consumers beginning in the spring of 2007;

- Begin consumer participation in the licensing reviews by June 2007

Cost: The training and financial support for SFY 07 will be absorbed within existing resources.

Warm Lines

OAMHS has already implemented a single, statewide warm line through a contract with Amistad. In addition, there are four local warm lines, developed through local efforts with some OAMHS funding. OAMHS is committed to supporting warm lines but believes it is important to assess their effectiveness through a careful evaluation process, as we are implementing with other services.

Action to be undertaken by OAMHS:

- Increase funding for the Amistad warm line beyond the $214,877 up to an additional $65,000 for SFY 07 only, to fund additional warm line staff from 5 pm to 1:30 am.;

- Complete an evaluation, including the data currently collected by warm lines, of the statewide and local warm lines by April 2007. The evaluation will assess the effectiveness and efficiency of warm lines, the impact of the model on promoting recovery, and a cost effectiveness of the service;

- Unless the evaluation establishes that the service is not effective, efficient, or cost effective, or that it does not promote recovery, expand warm line services in SFY 08 to assure availability throughout the state from 5 p.m. to 8 a.m. with adequate staff to respond to calling levels.

Cost: OAMHS currently funds the Amistad warm line with $214,877 which includes an additional appropriation of $90,000 from the second session of the 122nd Legislature. The additional funding for the expanded staff coverage and the evaluation will be done within existing resources. OAMHS will seek any additional appropriations made necessary by the expansion planned for SFY 08..

Peer Services in Emergency Departments

OAMHS currently funds Peer Services in Emergency Departments through Amistad at Maine Medical Center and through Sweetser at Parkview Medical Center and Mid Coast Hospital. Each program uses a different model for provision of services. OAMHS is expanding the program to all community hospitals with and without psychiatric inpatient beds through existing or newly developed peer programs.

Action to be undertaken by OAMHS:

- Coordinate with Mid Coast Hospital, Parkview Medical Center, Maine Medical Center, Spring Harbor Hospital, and the Maine Hospital Association Mental Health Council for support of the expansion of peer services in the ED by November 2006;

- Develop a phased in approach to peer services in Emergency Departments. For example, there is no peer center in the mid-coast area so this resource would require development, and for those areas with more that one peer service, OAMHS may need to solicit bids through a RFP;

- Complete an assessment of possible locations with the availability of peer programs that could support an ED program by November 2006;

- Complete an evaluation of these current ED peer services to refine the model or models and assess costs by February 2007;

- Provide peer specialist training and technical assistance to peer programs that want to pursue delivery of this service in March-June 2007;

Cost: Funded within existing resources for SFY 07. OAMHS will submit a biennial budget request for $100,000 for SFY 09 to support the expansion, and, assuming that the assessments and evaluations support further expenditures, will submit a supplemental budget request for $250,000 for SFY 09.

Persons Experiencing Psychiatric Crises: Specific Actions

Crisis Hotline

OAMHS has heard from consumers and providers that crisis calls are not always routed to the nearest crisis service. We have discovered that crisis calls made by cell phones and through the internet cannot currently be directed to the local crisis provider. Assignment of cell phone and internet phone numbers are done by a system independent of land lines and are not linked to a specific location.

Action to be undertaken by OAMHS:

- Determine by November 2006 whether technical solutions for this problem exist and, if so, implement a solution. If not, OAMHS may implement other service models such as a central call center, as the use of cell phones and internet usage will continue to grow. The timeline for implementation of a technical solution or transition to another service model must be established by the end of December, 2006.

Cost: unknown at this time

Crisis Stabilization Units

The second session of the 122nd legislature appropriated $230,950 for the MaineCare seed account for crisis stabilization units. DHHS currently funds 45 beds at 11 locations, and they run at about 80% occupancy.

Action to be undertaken by OAMHS:

- Issue contracts by January 2007 to increase the number of crisis beds and to add more qualified crisis program staff to increase the capacity for CSUs to meet the goal of diverting people from unnecessary hospitalization.

Cost: $230,950 available in seed account.

Outpatient Observation Beds

Observation beds in community hospitals, in addition to the crisis stabilization beds, provide the possibility of another resource for diversion from inpatient hospitalization,

particularly in rural areas where there are no inpatient psychiatric facilities. Observation beds are defined under MaineCare hospital regulations, 45.05-9, as follows:

> Observation beds and services are covered services when a patient remains in the hospital for observation or testing. Reimbursement is available only when such services are ordered by a physician. In no case shall outpatient observation covered services exceed 48 hours.

Because observation beds are considered as outpatient services, a stay in an observation bed does not constitute a hospital admission. Admission to observation beds is entirely voluntary. The person admitted to an observation bed cannot be held for evaluation purposes unless in protective custody. OAMHS is developing these beds in community hospitals without psychiatric inpatient units. Any involuntary or voluntary psychiatric admission would require the transfer to another hospital.

Action to be undertaken by OAMHS:

- Determine the feasibility of operating this service at current reimbursement rates;

- Create four observation beds in hospitals in rural areas where there are no psychiatric inpatient units in SFY 07;

- One year after these new observation beds become available, evaluate the service to determine the rate of utilization and its effectiveness as a means of assisting consumers in crisis while avoiding inpatient hospitalization.

Cost: This service is covered under MaineCare, and may provide a net savings to the state because it is reimbursed at a lower rate than inpatient hospitalization.

Increase Access to Psychiatric and Psychological Services

Telemedicine is a growing strategy to address uneven workforce distribution and skills, particularly given the low population density and rural nature of Maine. Spring Harbor and Acadia have both developed the capacity and willingness to provide telemedicine. In addition, the State's Office of Health Policy and Finance is developing a statewide plan for telemedicine to include removing barriers to its usage. Currently, MaineCare will only reimburse for one site, not both the sending and receiving site.

Action to be undertaken by OAMHS:

- Explore with Riverview, Dorothea Dix, Acadia, Spring Harbor, as well as other network members, the cost for providing consultation to Emergency Departments needing these resources, and what may be possible with existing resources;

- By July 2007, establish the cost to use telemedicine in all the emergency departments and crisis programs and methods of reimbursement;

- Through the Community Service Networks, create agreements to assure that all community hospitals have the access to consultation through telemedicine.

Cost: To be determined by July 2007.

Service in Emergency Departments
The Emergency Department is often the first point of contact for a consumer in crisis. While this plan encourages providers to support consumers in the use of individualized crisis plans and sets expectations with crisis providers to provide crisis services in settings other than emergency departments, in fact, consumers often choose to go to Emergency Department, and this setting is often seen by members of the community as where to go in crisis. Therefore, it is important to assure that emergency departments are prepared for consumers in crisis.

Action to be undertaken by OAMHS:

- Monitor the implementation of the Rapid Response protocol and take any necessary corrective action;

- Provide by December 2006 site and web based training and information on available resources, protocols, contacts, blue paper information, and Consent Decree requirements.

Cost: To be done within existing resources.

Promote Non Traumatic Transportation during Psychiatric Crises
Consumers have repeatedly expressed concern about traumatizing methods of transportation that are used for persons in crisis, such as the use of a police vehicle and ambulances for transportation and restraints while in transit when violence is not an issue.

Action to be taken by OAMHS:

- Collaborate with NAMI-ME to assure that law enforcement agencies, the Maine Criminal Justice Academy, and ambulance services have access to training regarding the use of least restrictive, non-traumatizing transportation;
- Complete a contract amendment with NAMI-ME by October 2006 to make this resource available, if further funding is needed;

- Involve consumers in providing training to staff in the emergency departments regarding utilization of family, friends, and other public transportation providers when appropriate;

- OAMHS will work with DOC and NAMI-ME to assess the need and cost for expanding to unserved areas and whether there is a need to increase training at the Maine Criminal Justice Academy.

Cost: The Department of Corrections (DOC) and DHHS jointly fund NAMI-ME for Crisis Intervention Training (CIT) for law enforcement through a contract in SFY 06 and SFY 07 for $20,000. If expansion is necessary, the cost of that will be determined and included in a supplemental budget request for SFY 08-09.

Advance Mental HealthCare Directives and Crisis Plans
Both advance directives and crisis plans are tools that consumers can develop to help guide their treatment wishes and aid in the continuity of care.

Action to be undertaken by OAMHS:

- Monitor through quarterly document reviews and rapid response interventions, contract compliance regarding the requirement that community support workers actively engage consumers in discussions regarding the importance of crisis plans and advance directives and include such plans and directives as part of the ISP unless the client refuses. Impose contract sanctions for failure to adhere to this Consent Decree requirement;

- Consent Decree Coordinators are monitoring the use of crisis plans as part of the document review process as of August 2006. Corrective action will be required of individual agencies, and any changes will be discussed at the monthly network meetings;

- Partner with Disability Rights Center to create a training module on advance health care directives and how they relate to crisis plans, Workbook Recovery Action Plans (WRAP), and the power of attorney, beginning in November 2006;

- Collaborate with the Statewide Quality Improvement Council (QIC), NAMI-ME, the Consumer Advisory Group, Maine Association of Peer Support and Recovery Centers, the Advocacy Initiative Network of Maine, and providers to review and distribute information about crisis planning, Workbook Recovery Action Plans (WRAP) and advance directives, starting in December 2006;

- Complete the training module on advance directives by April 2007;

- In the meantime, post on the OAMHS web site sample crisis plans, advance directive materials, and other related materials as a resource by October 2006 and share at network meetings.

Cost: Within existing resources.

Persons with Complex Needs
OAMHS identified the need to develop additional residential services for persons with mental illness, complex medical needs, and behavioral issues, based on discharge resource needs at Riverview Psychiatric Center and Dorothea Dix Psychiatric Center.

OAMHS requested and received legislative funding in 2006 to develop resources to meet these medical and psychiatric residential needs.

OAMHS contracts with several specialized nursing care facilities that serve consumers with mental health and medical needs; however, these facilities require consumers to be at the nursing level of care and in some instances to be geriatric. Additionally, these facilities have significant difficulty with some behaviors given the layout of their facilities. OAMHS also contracts with specialized residential treatment facilities that serve this population to some degree, and they are consistently at full capacity.

Based on current capacity and demand, eight additional beds at the residential treatment level of care are needed in the short term to meet the existing need. With the realignment of residential services to occur in the next fiscal year an assessment of capacity will occur to determine any additional need.

Action to be undertaken by OAMHS:

- Develop residential treatment level mental health services for persons with complex health needs by February 2007;

- By July 2007, either issue contract amendments or propose changes to regulations to assure that all PNMIs and specialized nursing facilities that are under contract with DHHS through OAMHS notify consumers of all applicable rights of appeal from a discharge decision; and clarify that any transfer of a resident to an acute hospital neither constitutes a transfer nor a discharge for purposes of contracts or regulations. The facilities will be further obligated to obtain OAMHS approval for discharges and to participate in discharge planning.

Cost: The second session of the 122nd Legislature appropriated $360,000 to the MaineCare seed account for mental health/medical residential services. If additional funds are needed, OAMHS will make a supplemental budget request for SFY 08.

Workforce Development

OAMHS contracted with the Advocacy Initiative Network of Maine to hold consumer forums in 2005 to gather input on how to improve care during a psychiatric crisis. Consumers at those forums consistently emphasized that education and training for all providers of crisis services would have the greatest effect in improving delivery of those services.

Action to be undertaken by OAMHS:

- Collaborate with the Maine Hospital Association, Maine Chapter of the American College of Emergency Room Physicians and Maine State Nurses Association to provide training to ED staff about mental health recovery, how

to respond to and treat persons experiencing psychiatric crisis, and how to lessen trauma. Develop training material and deliver training together with consumers on an ongoing basis beginning in 2007, and provide continuing education credits;

- Implement the crisis training curriculum for crisis workers by December 2006.

Cost: Within existing resources.

Riverview ACT Team

Chapter VIII of this plan calls for development of an ACT team at Riverview Psychiatric Facility to support releases of forensic patients who can live safely in the community with appropriate support. Since that portion of the plan was approved, the Legislature enacted chapter 519, Part DDDD, creating a Progressive Treatment Program. Consistent with this plan and the legislation, DHHS will include that program within the Forensic ACT team at Riverview.

The Riverview team will be comprised of state employees and community providers, and operate under the auspices of Riverview. DHHS is making two homes on the Riverview campus available as housing for forensic clients who are ready to be in a setting that is less restrictive than the hospital. The Riverview ACT team will be targeted toward these clients. The current provider of services for those residences is transitioning the consumers who currently live there to other housing in the community in accordance with the current DHHS Utilization Policy for Residential Facilities, rev. 7/13/00. The Riverview ACT team will also serve clients under the progressive treatment program.

Action to be undertaken by OAMHS:

- By October 2006, issue a contract for appropriate staffing of the two residences on the Riverview campus that are being made available to forensic clients eligible for ACT team support;

- By November 2006, begin to transition forensic clients who are assigned to the ACT team to the two residences on the grounds;

- By November 2006, the Riverview ACT Team will be fully staffed, trained and accepting clients. Staff have been identified and are being pulled together as a team during August and early September.

Cost: The Legislature funded this through PL 2005 ch. 519, passed during the second regular session of the 122nd Legislature.

Vocational Opportunities

The Settlement Agreement requires that DHHS make reasonable efforts to fund, develop, recruit and support an array of vocational services to meet class members' needs as identified in their ISPs.

Currently, the array of services includes support through the Department of Labor Bureau of Rehabilitation Services (BRS) vocational program and through the long term vocational supports program funded by OAMHS. The BRS vocational rehabilitation program helps consumers identify job skills and find employment, and it pays for necessary job related expenses. The OAMHS long-term vocational support program pays contracted providers for sustained job coaching and other related support needed by a consumer to maintain successful employment. OAMHS also funds ACT teams that include employment specialists, as well as two clubhouses that provide employment services.

The current concern is that, while DHHS may be meeting ISP-identified vocational needs, few such needs are being identified. This is inconsistent with national data about vocational needs of people with mental illness. Therefore, this plan focuses first on ways to assure that community support workers are effectively engaging consumers in discussions of vocational goals. It should not be the consumer's responsibility to initiate employment as a goal. Instead, CSWs should reference supported employment as an evidence-based practice that is an important means to recovery and should offer encouragement and support to assist the consumer in their transition to work. As CSWs become more skilled in this area, there should be a corresponding increase in the number of vocational goals identified in ISPs. If services prove to be inadequate to meet those needs, that will become evident through resource needs data that is being collected through the EIS. As with other resource needs, these would then be reflected in funding requests as required to meet the needs.

In the meantime, DHHS believes that a necessary preliminary step is adding capacity and resources for consumers and providers through the use of Employment Specialists. National experts disagree as to whether these specialists can be most effective if placed in community mental health centers or in career centers. Based on consultant advice, OAMHS has determined that these specialists will serve the population better if they are based in community mental health agencies, and this plan includes one for each Community Service Network. OAMHS will monitor performance to assure that providers are not diverting Employment Specialists to tasks unrelated to employment support.

This vocational plan:

- Provides training and education to community support staff about the importance of employment to recovery and the engagement of the consumers in discussions about work, and adds the requirement for certification and ongoing education in employment as a required competency module;
- Funds additional Benefit Specialists so that misinformation and lack of information are removed as barriers to pursuing work; and

- Increases both the prominence and possibility of employment by adding Employment Specialists to agencies in each of the seven community service networks. The employment specialists will work directly with consumers, serve as a resource to providers, and coordinate employment support services between OAMHS and BRS.

Action to be undertaken by OAMHS:

- Between now and February 2007 provide training for all community support workers on the importance of employment to recovery and on the engagement of consumers. This will include conferences, written material, web based training and resources. Consumers will be part of the development and presentation of the materials. The Department of Labor Bureau of Rehabilitative Services (BRS) has agreed to work with OAMHS on training development and implementation, and with the use of their newly expanded video-conferencing system;

- By October 2006 update the memorandum of agreement between the Department of Health and Human Services OAMHS and the Department of Labor Bureau of Rehabilitation Services (BRS). The updated memorandum will address how BRS will refer consumers to and receive referrals from the new employment specialists. A major focus is aligning the services of both agencies so that consumers will experience minimal or no barriers or delays in moving from one to the other. Designate an employee of OAMHS and an employee of BRS to oversee and assist in the implementation of the vocational portion of this plan in both OAMHS and BRS for a period of at least one year. Together, the employees must (1) review all employment services offered to mental health clients throughout the state, (2) review qualitative and quantitative data and other sources (including information about ISP-identified needs for vocational services) to determine the array of employment services needed (including job development and coaching), the resources currently available to address the need, and solutions to the obstacles to obtaining employment support or to ongoing employment, (3) stay current with evidence-based practices and promising approaches available to support employment, and disseminate that information to providers and consumers, and (4) provide oversight capacity to ensure that employment supports are provided in a manner that is consistent with evidence-based practices.

- By October 2006 contract with Maine Medical Center to add two benefit specialists to serve parts of the state that are not well covered currently. BRS has committed to their continued annual contribution of $100,000 to this contract with MMC;

- By November 2006 ensure that the role of employment specialists on ACT teams is focused on employment functions and not on providing case management services;

- Continue the Maine Employment Curriculum (MEC) contract with the University of Maine to update the curriculum and to support trainers. Successful completion of the MEC qualifies attendees to work as job coaches or Certified Employment Specialists, depending on which strand of this 14 module curriculum is completed;

- Develop a web based module of the MEC by May 2007. This module will be part of the training for mental health providers;

- By January 2007 contract for four employment specialists to be placed in community support agencies. Contract for an additional three employment specialists by July 1, 2007, so that there will be one for each community service network. The employment specialists will be resources to the community support workers and treatment teams throughout the agency as well as providing consultation for other agencies;

- Set an annual performance target for each employment specialist (including those who serve on ACT teams) for employment of 15% of their caseload, and require reporting as part of the DHHS quality assurance system;

- Ensure that employment opportunities are part of community service network planning;

- Modify the current Mental Health Rehabilitation Technician-Certified (required for community support workers) certification requirements to include a mandatory course on the importance of work to recovery, so incoming community support workers will have this important background. OAMHS will work with academic and nonacademic institutions to implement this change to certification requirements during 2008;

- Continue the funding of the long term vocational support program and evaluate the program on a regular basis to assure compliance with the Supported Employment Fidelity Scale, which is the recognized "best practice" model.

Cost: OAMHS will provide funding for the two benefit specialists, four of the seven employment specialists, the training described above, and the web based development of the MEC within existing resources, using the $200,000 that the second session of the 122nd Legislature appropriated. OAMHS has the existing resources to support the three additional employment specialists starting in July 2007, and will request funding in the SFY 09 biennial budget to continue those positions in 2008.

Managed Care

In a budget bill enacted in the spring of 2005, the Legislature directed DHHS "to establish a system of managed behavioral health care services" including adult mental

health, children's, and substance abuse services, through a contract with an experienced outside vendor. P.L. 2005, c. 457, part PP, effective September 17, 2005. The Consent Decree Plan for adult mental health services submitted by DHHS in June 2005, pursuant to paragraphs 36, 37, 38 and 279 of the Settlement Agreement and in accordance with the remand order of the Superior Court, incorporated managed care as a key strategy to achieve better continuity of care. For that reason, and because the details concerning implementation of managed care had not yet been defined at the time, the court master conditioned approval of the DHHS Consent Decree Plan on submission of the mental health portion of a proposed contract for a managed care vendor for his review and approval by June 30, 2006. *See* Court Master's Supplemental Order Regarding Plan Approval, dated December 9, 2005.

Implementation of managed care will affect how services for adults with mental illness – both class and non-class members -- are managed. However, adults with serious mental illness represent only one portion of the population to be covered under managed care. Accordingly, many other stakeholders, who are not involved in this consent decree have a substantial interest in how managed care is designed and implemented. Indeed, DHHS recognizes that for successful implementation of managed care, it is best if all of the major stakeholders understand it thoroughly and are invested in it.

The initial efforts to solicit input from stakeholders in the winter and early spring of 2006 were deemed inadequate, and DHHS accordingly expanded those efforts. OAMHS contracted in May 2006 with the Advocacy Initiative Network of Maine to facilitate four workshops for consumers addressing the content areas for a request for proposals (RFP) to select a managed care vendor. Additionally, OAMHS participated in 28 consumer forums held at 14 sites throughout Maine in July. OAMHS has since selected a consumer to be part of the group that is developing the RFP development.

Although DHHS originally targeted July 1, 2006 for the implementation of a managed care contract, numerous consumers and consumer groups, including NAMI-Maine, and service providers argued that the process of implementation should be slowed down to allow them to have more input. The Governor ultimately agreed, and the schedule was extended. In addition, it was determined that DHHS would have to go through a competitive bidding process to select a managed care vendor, consistent with state purchasing laws, thereby requiring development of a request for proposals (RFP). Other preliminary steps necessary to implement managed care include obtaining a waiver from the federal Center for Medicare and Medicaid Services (CMS), and retaining an actuarial consultant to prepare the cost neutrality analysis required for submission of the CMS waiver. For all of these reasons, no contract with a managed care vendor existed to submit to the court master in June 2006. [7]

The delay in this process caused OAMHS to consider new approaches to achieving continuity of care that are not dependent upon contracting with a managed care vendor, but also do not conflict with the state's plans to implement managed care. The proposed

[7] DHHS reports regularly on the status of all activities involved in implementation of managed care, and those reports are posted at http://www.maine.gov/dhhs/managed_care/dhhs-updates/index.html.

plan amendments submitted to the court master on August 16, 2006, and this updated revision of Chapter IV incorporate the new approaches adopted by OAMHS.

Any managed care contract will be consistent with the principles and requirements of the Settlement Agreement and with this plan. As soon as it is available, the adult mental health portion of the contract will be submitted to the court master for review and approval. If any adjustments to this plan are required after a managed care contract is negotiated by DHHS, OAMHS will submit those changes to the court master for review and approval.

Action to be undertaken by OAMHS:

- Continue to update and seek input from the Statewide Quality Improvement Council, the Consumer Advisory Group, the Transition Planning Group, the Maine Association of Peer Support and Recovery Centers, the Advocacy Initiative Network of Maine, and NAMI-ME regarding managed care;

- Submit mental health portion of proposed contract for managed care to the court master for review and approval as soon as it is available.

Cost: The steps described above are being done with current resources.

Family Support Services

OAMHS continues to fund an array of community family support services through a contract with one statewide organization (the Maine chapter of the National Association for the Mentally Ill, or NAMI-Maine). In addition, OAMHS requires providers to include among their services the referral of families to area family support services. OAMHS will be monitoring its contract with NAMI-Maine to ensure that NAMI is providing all the services specified in paragraph 109 of the Settlement Agreement.

Public Education

Paragraph 252 of the Consent Decree requires that DHHS develop, fund, and support a variety of public education programs designed to educate the public regarding mental illness, the myths and stigma associated with it, and the rights of consumers and their families. OAMHS will continue contracting for public education services and issuing mini-grants to consumer organizations to support public education activities. These contracts will be more closely monitored to ensure that the providers are offering the required programs and reaching the intended audiences as described in paragraph 252 of the Settlement Agreement. Additionally, OAMHS expects that the local consumer councils will bring forward ideas for increased public education as well as participating in local efforts.

Specialized Services

Paragraphs 86 and 87 discuss development of resources for special populations. As noted above, OAMHS is developing specialized services for people with complex needs. In addition, DHHS currently funds and supports specialized housing and support services for people with traumatic brain injury and dementia. It also funds facilities that are capable of meeting the housing needs people who suffer from both mental illness and mental retardation. DHHS will continue these activities and will monitor the need for any additional resource development through the ISP process.

OAMHS continues to support a trauma-informed mental health system that will enable these consumers to be integrated in the mental health system. Their needs can then be addressed though the ISP process.

Other Community Services

In addition to services already discussed in this plan, OAMHS will continue to fund an array of community services including outpatient treatment and other treatment options, transportation, and social and peer recovery centers where consumers can develop and use leisure and avocational skills. OAMHS will seek additional funding whenever unmet needs data indicates the need to do so. OAMHS also will continue to train and encourage CSWs to assist consumers in locating and using natural supports and generic resources wherever possible.

V. Managing the Change

To bring about system change, DHHS must work from information and monitoring systems that will assure that investments in the mental health system will produce measurable increases in the effectiveness of service outcomes. DHHS must be clear in its expectations that providers fulfill their contractual obligations, and must create a sanctioned, legitimate role for consumer voice. DHHS will work with service providers, the consumer regional councils, and eventually with the managed care entity to assure that all participants in the mental health system are demanding the most seamless and effective services that can lead to recovery, and at the best cost. Aspects of the plan focusing on consumer choice - No Wrong Door, consumer-driven ISP and continuity of care through the broad service array - are all intended to achieve the goal of a mental health system based on recovery from mental illness, that is efficient, effective, and responsive, and provides quality care at the best cost. Critical to the success of this program will be the ability to collect data that relates to the services that individuals are receiving. DHHS will rely in part on the Enterprise Information System (EIS), which can serve as a hub for data collection and reporting and for service management, and on processes described further below.

This chapter describes some basic processes that will be used to help manage the complex system of services.

Administrative Management Changes

To support the changes required by this plan, DHHS is enhancing its management capacity in three ways. First, DHHS is reallocating existing positions in order to expand the capacity of the mental health team. DHHS has filled the positions of Continuity of Care Manager, Interagency Services Coordinator, Information Services QA Coordinator, and Medical Director, and is in the hiring process for a Director of Community Corrections. The Quality Assurance Manager position has been filled but staff is currently reassigned as acting Mental Health Director. Second, DHHS is contracting with Maine Health Strategies (Beacon) to provide consultation, technical assistance, and staff support for enrollment and service review. Third, DHHS has established an Enrollment and Service Review Unit in each regional office. They will serve both to support collection of critical treatment and service information and to perform Service Reviews. Staff in each Unit will consist of at least one Clinical Coordinator, one Consent Decree Coordinator, UR nurses and the Regional Mental Health Team Leader who will provide overall direction.

In addition, DHHS will support consumer councils regionally and statewide, not only to continue to spread the understanding of effective practices leading to recovery, but also in order to assure consumer voice in the quality assurance and quality improvement process. This system change is addressed in Chapter VI, Assuring Quality Services.

Budgeting and System Development

Paragraph 262 requires that DHHS have a centralized system for budgeting and resource development. The Adult Mental Health Services budget is now managed centrally at the program level rather than the regional level. While contracts are still developed regionally, there is now a unified approach to contract and fiscal management within the overall program. This allows for the regular review of expenditures, and reallocation of resources as needed. This management structure allows for a comprehensive view of the system and offers the forum for consideration of either resource reallocation or a request for new resources based on unmet needs data. Information available for the budget and review processes includes all of the currently available information described in Chapter VI, Assuring Quality Services, and will include aggregate ISP information from the EIS when that information is available.

Paragraph 263 requires DHHS to collect information about service needs from family members and other citizens through public forums and to report that information. DHHS undertakes this task indirectly through feedback from the statewide Quality Improvement Council (QIC), which holds regular monthly meetings and annual forums. The forums were held in three sites in FY 04 and in six sites in FY 05. The QIC promotes the event through its membership, through the Advocacy Network of Maine (AIN), the National Alliance for the Mentally Ill (NAMI), and through the peer centers and social clubs. QIC members are responsible for facilitating each site and gathering input about mental health services. DHHS will also rely on information from stakeholder groups such as AIN, NAMI, and the Maine Association of Psycho-Social Rehabilitation Centers. This information is also available for consideration in budget and resource development.

Enrollment and Data Collection

Providers will be required to submit enrollment information electronically to reduce paperwork and to increase accuracy of the data, either through submission of individual forms or by batch submission. The enrollment form is required for all consumers entering Community Support or PNMI Services, and must be submitted within five days of being accepted into service. Additionally, the enrollment form is updated annually and submitted to DHHS within five days of the annual clinical assessment. The enrollment form captures demographics, LOCUS and diagnostic information, as well as the waiting time between application for either Community Support or PNMI and the time of acceptance for the service.

In addition to enrollment information, providers will maintain lists of eligible individuals waiting for services by service type. The waiting list will include the reason for the wait. Individuals will be advised of other service providers that are able to accept a referral immediately, even if the service provider is not the individual's first choice. The choice to accept the alternative provider will remain with the individual.

Using the EIS data warehouse and reporting capabilities, DHHS will generate monthly management reports that provide data on those individuals who are new to treatment or services, as well as those who remain in treatment or continue to receive services.

Service Review

Service review is an ongoing process which will address quality and clinical appropriateness of services, using level of care criteria to assess whether services are focused on recovery outcomes, delivered in the least restrictive setting possible for a clinically appropriate amount of time, and flexibly addressing individuals' changing needs based on progress in achieving treatment or service goals as identified in the ISP. This service review process examines the quality of services and is not being implemented as a gate-keeping function.

Service Review will focus on a number of areas, including the life domains that are on the AMHS Needs Assessment and the LOCUS. DHHS will work with providers to ensure that individuals are getting clinically appropriate services and that resources are available to facilitate progress towards stated goals. In cases where people may not be making progress towards treatment goals, DHHS will work with both the individual and the provider to reevaluate the goals contained in the ISP, revisiting as appropriate the type of treatment and level of service intensity that is being provided.

The Service Review staff will follow up with the provider if more discussion is needed. If the review yields significant concerns about treatment needs, the Service Review unit will contact the regional mental health team leader. The team leader is responsible for bringing together the provider(s) and the consumer for further discussion. While this is viewed as a collegial process, the consumer retains their right to grieve the assessment of their needs.

In cases where DHHS identifies that a more acute level of service is required for the individual to achieve his or her goals, DHHS may suggest that the individual be provided with an alternative service that is more intense in nature. DHHS will make its psychiatric and service review staff available to providers for consultation and clinical dialogue on best practice and evidence based treatment approaches.

In cases where the service review indicates that a person has achieved his or her ISP goals, DHHS will work with the provider to explore less acute levels of service that could be provided to the individual to continue the recovery process.

Where the consumer and the CSW agree that the consumer has achieved his or her ISP goals, the CSW will coordinate with the consumer and DHHS to recommend that treatment and service conclude for the individual. Such a transition out of service will be documented, and CSW services, with agreement

of the consumer, will be placed in a dormant status. The CSW will encourage the consumer, as part of his or her move to dormant status, to participate in developing a plan for reengagement, including contact information, should the consumer later require services.

DHHS will collect information on the following categories to determine whether the service provided matches the needs of the consumer and provides benefit:

- Consumer demographics—Eligibility, risk of harm, co-occurring medical, substance abuse, and psychiatric conditions, trauma, symptom management, diagnosis, and consumer goals;

- Level of care and service elements—Services provided by the agency, recovery environment, community resources, services provided by other providers, referral needs, barriers to care, and crisis plans; benefit to the consumer.

- Benefit—While the degree of recovery and quality of life is defined differently by each consumer, there are commonly agreed upon outcomes which are relevant to a significant number of people. They include housing stability, employment, recreational activities, natural supports, access to health care, and the reduction in need for hospitalization and crisis services.

These questions will be in electronic format with drop down menus and will be collected telephonically by the Enrollment and Service Review Unit and entered in an electronic database.

DHHS believes that the introduction and use of the Service Review process will afford individuals and providers the following:

- Common understanding of level of care criteria
- Service consistency among providers
- Clearly stated standards for performing the service
- Assurance that funding constraints are not driving the service provision

DHHS worked with Maine Health Strategies, providers, and consumers to develop the format for the Service Reviews. Enrollment and Service Review Units in each Region will perform these Service Reviews. The initial service reviews have been completed for 20% of the consumers (approximately 1040) of each community support and residential agency who have been in service for more than one year and who also receive MaineCare. These reviews were completed in June 2005.

DHHS will develop criteria in an Enrollment and Service Review Manual for the frequency of the next review following the initial review. This will include

criteria for immediate referral to the mental health team leader, for a 30, 60, or 90 day review, or an annual review.

DHHS will develop reports to be shared with consumers and providers to inform statewide quality improvement efforts. Reports will provide both aggregate data as well as specific data for individual agencies.

Authorization and Review Process for Residential Services (PNMI)

As is current practice, the DHHS Mental Health Team Leader or designee will continue to be the point of contact for authorization of residential services as listed below:

1. Residential Treatment PNMI
2. Group Home PNMI
3. Scattered Site PNMI

The Enrollment and Service Review Unit will provide a review of the need for service.

Service Review staff will conduct a review of individuals in residential treatment. The provider will be required to contact DHHS with clinical and updated service planning information prior to the review date. During this review, DHHS will review defined treatment and service goals and assessment of progress towards stated goals and make a recommendation for continued residential treatment or services.

DHHS will provide consultation to the provider about alternative treatment recommendations.

VI. Assuring Quality Services

DHHS is responsible for assuring the quality of services required by the Settlement Agreement in *Bates v. Department of Health and Human Services*, and for monitoring and evaluating all mental health services, programs and other systems required to carry out the terms of the Agreement. As required by paragraphs 275 to 279 of the Settlement Agreement, the quality assurance system includes development and enforcement of contracting and licensing standards and the administration of an annual, random statistically valid survey of class members to assess compliance.

Many of the elements of this monitoring, evaluation and quality assurance system have been in place for some time, but were found by the court to be deficient in a number of respects. Much of the information DHHS received was from provider agencies in aggregate form. DHHS could not tell, for example, whether waiting list or service need information was duplicative, that is, if several reports referred to the same people. That issue is addressed under this plan with the advent of the Enterprise Information System, an improved method of collecting data electronically on individual consumers. The system will help not only to track individuals for case-specific quality assurance but also to collect more precise aggregate consumer information. This plan reflects other enhancements to existing QA processes, as well.

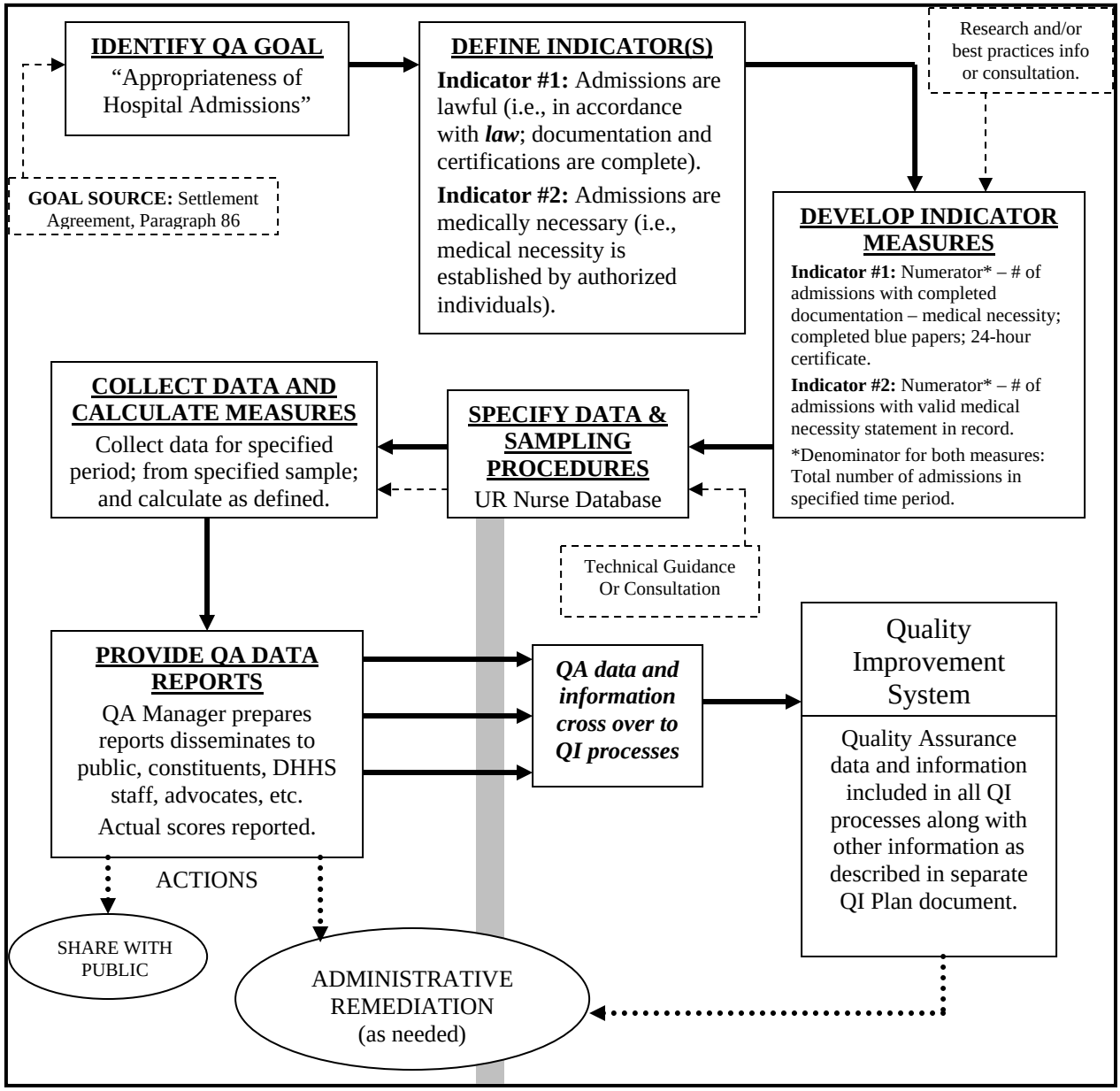
DHHS's mission, "to assist those it serves in achieving good health and meaningful living," asserts a strong focus on improving the quality of lives of its clients. DHHS is expecting individuals who receive services to be in the driver's seat. DHHS has entered into partnerships with individuals, families, and communities to meet this expectation. This quality assurance portion of the plan describes the system for determining whether and to what extent DHHS adult mental health services fulfill the mission of DHHS and comply with the requirements of the Settlement Agreement.

Relationship Between Quality Assurance and Quality Improvement

The Quality Assurance process reviews system requirements, such as an ISP within 30 days, to provide assurance to consumers that they are getting what DHHS and provider organizations have committed to, and to provide DHHS with a way of verifying that services and processes are meeting set requirements.

Quality Improvement looks at the information gathered by the quality assurance process as well as other information and asks the question, "How can we do this better?" For example, the quality improvement process would strive to continue to improve customer's satisfaction with services.

Figure 2. Flow Chart Showing DHHS Quality Assurance Process Settlement Agreement Requirement (¶ 86)



Improving Mental Health Services

DHHS will focus on four major areas to strengthen its own quality improvement performance.

Management Information System

DHHS will demonstrate the ability of the Enterprise Information System (EIS) to produce timely and accurate data. The EIS for mental health services will have program staff assigned whose responsibility is to insure that the appropriate data is being gathered and that it will generate accurate reports. EIS will add resources to format reports, produce reports, and to provide support to the mental health system more quickly as the system moves from a paper to an electronic process. Demonstrating the reliability of data collection and reporting is a crucial part of the work of DHHS to build trust in the Department's ability to meet the terms of the Settlement Agreement.

The Enterprise Information System replaces the Case Management Application (CMA) formerly used to track class members. EIS will afford DHHS with a capacity to track client-specific information for all consumers, which was not possible before. Data from all contracted providers and DHHS will be entered into the system. Client-specific data will be aggregated into monthly reports that will allow DHHS to track the flow of consumers in and out of the system. Reports will be programmed to show service volume and activity. DHHS will be able to track trends over time by region and by state. Perhaps the most critical use of the system from a quality assurance perspective will be to document services that were planned, services that were actually provided and any gaps in service delivery, representing unmet service needs. DHHS will use this unduplicated information to determine whether and how to reallocate contract dollars to particular services or regions and to determine whether and how to expand quantities or types of services.

Information from EIS will also be deployed to monitor the timeliness of service delivery for purposes of evaluating contract performance and for purposes of identifying unmet needs. EIS will also be used to enhance continuity of care, specifically the availability and delivery of services relating to the ISP.

Consumer Input

DHHS will support the creation of meaningful consumer input for the mental health system through:

Regional and statewide councils of consumers. The councils would participate in the assessment of the quality, accessibility and adequacy of services within their areas. The Department would provide funding for start-up of these councils and continued support over a phased in period, but the councils would be independent entities and would be free to raise funds from other sources as well. The councils would hire their own staff instead of having DHHS staff assigned.

The councils will be a key reviewer of the information generated by the quality assurance process and will act as one of the forums for quality improvement reviews. These councils will not only be able to review and contribute to the quality improvement process but they will also learn about data collection and will be able to make recommendations about that process. DHHS sees these groups as partners in developing easy-to-understand information about the quality and quantity of mental health services and in making recommendations for ongoing system improvements.

Inclusion of consumers on licensing review teams. The Department will provide resources for the regional councils to train a pool of consumers for participation on licensing teams. The councils will determine the payment mechanism for participation on the licensing review teams as part of their budgets.

Requirements that providers include consumers as voting members of their boards. DHHS will require through the contracting process that provider agencies maintain consumers as voting members of their boards. The regional councils may play a role in this process, as they may be able to assist in the recruitment, education, and support of consumer board members.

Consumer Survey

DHHS will expand the consumer survey. The response rate of the consumer survey has continued to grow. DHHS will devote resources to expanding the response rate and will work with consumer groups for assistance in doing so.

The survey instrument has been revised to address additional issues specifically identified in the Settlement Agreement. The survey is administered by mail to all class members residing in Maine. The review of class members residing at Riverview continues to be performed by face-to-face interviews and includes forensic patients. Revisions to the survey methodology have resulted in a sample size large enough to draw statistically valid conclusions (from 82 respondents in 2001 to 538 in 2004). DHHS will continue to administer these surveys annually, in accordance with paragraph 279, and the results will continue to be used to inform quality improvement. Use of the survey results to determine compliance with other provisions of the Settlement Agreement will be determined in the course of negotiating paragraph 291 standards.

User-friendly Reports

DHHS will provide resources to produce meaningful, easily-comprehendible reports. DHHS expects that the regional councils will not only be a significant review source for these reports but will also provide valuable feedback on whether the reports are achieving their goal of being easy to understand.

Other Sources of Information about the Mental Health System

MaineCare Billing Data

MaineCare billing data provides a reliable source of information for service utilization. In conjunction with the enrollment process, DHHS will now be able to use the database to compare services received with services requested.

Contracting

DHHS made revisions to its FY '05 contracts with service providers to incorporate the changes called for in this plan. The standards of practice required of contractors are now defined more precisely and, in some instances, at a higher standard. The contracts will be monitored more closely through routine review of specific performance indicators and use of a checklist correlating contract requirements with requirements of the Settlement Agreement. Additionally, contractors who are not performing will be given feedback on how they should improve, and there will be consequences for not adhering to DHHS standards of service delivery and quality. Each provider will be reviewed under this process at least annually. DHHS will further revise the contract performance indicators as necessary to comply with the standards incorporated in the Chapter.

Grievance Procedures

The process for tracking grievances and complaints has been improved as part of this plan and now includes tracking of all timeframes for notices, hearing, and recommended and final decisions on grievances and complaints. DHHS staff will not only compile and distribute the reports summarizing pertinent data on all grievances and complaints, but will also review those reports to determine what corrective action may be required to ensure compliance with regulatory timeframes. These reports will become a regular communication with the regional councils for their review.

In order to assure that grievances are an effective way to gauge compliance with consumer rights, DHHS continues to distribute Rights of Recipients of Mental Health Services widely to providers known to offer services to consumers. DHHS has also developed a curriculum for training providers and staff on the positive use of grievance procedures to protect patient rights and improve the quality of services.

Audits and Utilization Review

Another method of quality assurance occurs through monitoring of hospital practices using utilization review protocols. This process includes reviewing all involuntary admissions to assure compliance with legal requirements and medical necessity criteria; responding to licensing complaints relating to the Rights of Recipients of Mental Health Services; and conducting comprehensive licensing and Inspection of Care reviews. Some protocols for conducting these reviews have been revised as part of development of this plan.

DHHS utilization review nurses use a structured review protocol to assess the appropriateness of each involuntary admission. Using that protocol, the utilization review nurses monitor compliance with active treatment guidelines, whether medical necessity was established, whether the blue paper process was completed appropriately and whether the hospital adhered to patients' rights. Reviews are also performed on a weekly-basis for all continued stays. The data collected as part of the clinical and continued stay reviews is captured regionally and entered into a centralized data system and is utilized for QA and QI purposes. The utilization review nurses discuss problems identified during these reviews directly with hospital staff, and also notify DHHS regional medical directors and the DHHS licensing authority of any problems for appropriate review and corrective action, if needed.

DHHS has redesigned the utilization review form and will review it to assure that the redesign mitigates past problems with consistency of reporting. Additionally, the plaintiffs have recommended establishing standards for the involuntary admissions procedures to include face-to-face interviews and exploration of voluntary admissions. DHHS supports these recommendations and will work to implement them.

CDC Monitoring

The Consent Decree Coordinators (CDCs) are engaged in many quality assurance functions including reviewing Individualized Support Plans, monitoring waiting lists for CSW referrals, and reviewing requests for termination of community support services. In addition, CDCs track class member related tasks such as the Paragraph 96 informed consent process and quarterly mailings to offer services to those class members who are not currently engaged in the system. To date, the CDCs' work has focused specifically on class members. This work will continue, but under this plan, it will be expanded to include participation in the Enrollment and Service Review unit and in the on-going training of staff and providers in ISPs.

A new procedure for monitoring compliance with the timelines for updating ISPs is already in place. In addition, the CDCs have revised the process for reviewing agency requests for termination of community support services to include consultation with the consumer. The CDCs will revise the ISP document review forms and procedures used to evaluate the quality of ISPs in order to conform to the new ISP presented as part of this plan. The document review process will continue to be a training tool for community support workers and their supervisors. Monitoring of wait lists will be enhanced under this plan through enrollment of all clients and tracking in the Enterprise Information System (EIS).

Findings that the CDCs make pursuant to Paragraph 74, ISP document reviews and the other quality assurance activities referenced above will be integrated into the quality assurance system so that the experiences of class members can be

related more systematically to the performance of the mental health system as a whole.

Licensing Process

DHHS has revised its protocol for conducting licensing reviews of facilities and programs to include more in depth review of matters that relate to Settlement Agreement requirements, such as training of agency staff on the perspectives and values of consumers, by consumers. DHHS licensing reviews of adult mental health agencies are current and are being done routinely according to schedule. To enhance licensing oversight, DHHS has developed a checklist for licensing that is keyed to the Settlement Agreement paragraphs. This checklist includes ten sub-categories of licensing monitoring checks, nine of which have items that are keyed directly to the Settlement Agreement. The quality assurance manager will receive reports of licensing reviews and investigations and will follow up to ensure that appropriate corrective actions are taken. As noted previously, the licensing reviews will include consumer participation.

DHHS Report and Case Reviews

DHHS performs case file reviews of selected samples of individuals who are wards of the state. These reviews examine the performance of caseworkers and their accessibility.

DHHS has three primary methods for monitoring and evaluating the quality of services provided by caseworkers to public wards, including class member public wards. All three of these methods are used for assessing the casework services described in Chapter III. First, DHHS monitors services to all public wards through case review to assure that protective services are being provided consistent with mandates and policy. In that process, the supervisor reviews the caseworker's job performance, outcomes for the client, and barriers to achieving client goals, and recommends changes that may help the client achieve goals. Case review entails review of one case for each caseworker each quarter. Caseworkers who serve class member public wards must assure that at least one review each year is of a class member public ward. Second, all caseworkers participate in supervisory conferences at least quarterly. Casework supervisors assess problems in service delivery, provide assistance and direction to caseworkers and develop plans for resolving any problems with staff as needed. Supervisors ensure caseworkers meet all documentation requirements, supervise casework practice through discussion and evaluation, and develop and implement corrective action plans for staff as needed. Third, DHHS submits to the court master and counsel for the plaintiffs reports about each class member public ward annually or more often if requested by the court master, as required by Settlement Agreement paragraph 281. Those reports reflect annual reassessments by caseworkers of the capacity, dependency and danger to class member public wards and case plan review.

If a caseworker with class member public wards has more than 25 cases on his or her caseload, an additional 10% sample of that caseload is reviewed.

These quality assurance activities may also result in any of several actions to improve the quality of services delivered to individual public wards. The quality assurance processes may further result in revisions of policy or procedure; changes in personnel assignments; additional training for staff or providers; additions, deletions or revisions to programs and services; or proposed legislative changes.

Performance and Quality Improvement Standards

Perhaps the most significant change in monitoring, evaluation and quality assurance system lies in the development of numerical standards that are intended to form the foundation upon which compliance with the Settlement Agreement will be assessed. Because national or established industry standards are not well developed in the behavioral health field, DHHS has developed the standards in consultation with expert consultants, providers, consumers, the plaintiffs' counsel, and the court master.

The plaintiffs and DHHS have agreed that the performance standards set forth below 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 therefore rely on both objective and subjective indicators and data to indicate how well the community mental health system is performing in each of those areas. 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 toward compliance. Some performance standards have not been made final in this document, because those standards can only be determined after plan approval and implementation. Those standards are so noted in this document.

The parties agree that these performance standards are not the compliance standards contemplated in paragraph 291 of the Settlement Agreement. In fact, the performance standards include some measures that may not be appropriate for determining substantial compliance ultimately, and exclude some measures that may be necessary for a demonstration of substantial compliance. The parties understand that the paragraph 291 compliance standards may address different issues, and even where the issues are the same as those in the performance standards, the compliance standards may use targets that are greater than or less than the performance targets set forth for monitoring purposes. Thus, the Department's failure to achieve a particular performance standard will not necessarily indicate failure to achieve substantial compliance, and its success in exceeding a particular performance standard will not necessarily indicate that substantial compliance has been attained.

Compliance with the performance standards will be measured using multiple data sources. QI reports will continue to be generated on a quarterly basis. These reports will be reviewed by the Quality Assurance Manager and the Adult Mental Health Services Director to identify the most significant areas of progress and concerns. This data will be

shared with the mental health team for review within the regions. Data, in reader-friendly formats, will also be shared with providers and consumers twice per year. Data will also be shared with statewide consumer, provider and advocacy groups at least twice per year. Strategies to monitor and/or address any concerns will be developed, documented and monitored by the QA Manager.

Rights, Dignity, and Respect

Standard #1: Assess whether class members are at all times treated with respect for their individuality and with recognition that their personalities, abilities, needs and aspirations are not determinable on the basis of a psychiatric label.
Settlement Agreement Paragraph(s): 32a
Measurement Method: Assessed via Class Member Community Survey - Q26.

1. Percent "Yes" to question "Have the service providers you have worked with treated you with courtesy and respect?"

Standard Development: No national or external standard available for mental health services.
Current Baseline(s): 91.78% - Indicator numerator for 2004 survey is 469 out of 511 responses after eliminating non-respondents to question.
Performance Standard: 90%.

Standard #2: Demonstrate that class member grievances are addressed in a timely manner in accordance with reporting timeframes established in the Rights of Recipients of Mental Health Services.
Settlement Agreement Paragraph(s): 19
Measurement Method: Assessed via DHHS Grievance Tracking System with following indicators:

1. Percentage of level II grievances in which reporting timeframes were met (response to grievance within 5 working days or agreed extension of additional 5 working days).

Standard Development: No national or external standard available.
Current Baseline(s): 2003 & 2004 Grievance Tracking data indicates that reporting timeframes were met in 96% of grievances filed in 2003 and in 100% of those filed in 2004. Baseline is established with FY2003 data at 96%.
Performance Standard: 90% of level II grievances addressed within established reporting timeframes.

Standard #3: Demonstrate that consumer/class member rights are respected and maintained.
Settlement Agreement Paragraph(s): 27
Measurement Method: Assessed via DHHS Grievance Tracking System with following indicators:

1. Number of Level II grievances filed and number unduplicated people involved;
2. Number of Level II grievances where violation is substantiated.

Standard Development: No national or external standards available.

Current Baseline(s): 2003 and 2004 Grievance Tracking data indicate that 24 grievances filed in 2003 and 9 filed in 2004.
Performance Standard: No numerical standard necessary. The above indicators are used to monitor grievance trends by specific service areas and DHHS Region and summary reports incorporated in the DHHS Quality Improvement Review Process.

Standard #4: Demonstrate that consumer/class members are informed of their rights as recipients of mental health services.
Settlement Agreement Paragraph(s): 57
Measurement Method: Assessed via Annual Class Member Survey and Maine Data Infrastructure Consumer Survey with following indicators:

1. Percentage of class members reporting that they were informed about their rights in a way that they could understand;

1a. Percentage of class members reporting that they were informed about their rights in a way that they could understand who have a CIW/CSW;

1b. Percentage of class members reporting that they were informed about their right in a way that they could understand who have MaineCare;

2. Percentage of consumers reporting that they were given information about their rights.

Standard Development: Maine Annual Class Member Survey results for 2003 and 2004 indicate that 78% (2003) and 77.3% (2004) of class members reported that they were informed about their rights in a way that they could understand. Maine Data Infrastructure results for 2002 and 2003 indicate that 93.9% (2002) and 90.7% (2003) of consumers reported that they were provided information about their rights.
Current Baseline(s):

1. 77.3%;

1a. 87%;

1b. 81% (using Annual Class Member Survey);

2. 90.7% (using Maine Data Infrastructure Consumer Survey).

Performance Standard:

1. 90% of class members reporting that they were informed about their rights in a way that they could understand;

1a. 95% of class members who have a CIW/CSW reporting that they were informed about their rights in a way that they could understand;

1b. 90% of class members who have MaineCare reporting that they were informed about their rights in a way that they could understand;

2. 90% of consumers reporting that they were given information about their rights.

Community Integration/Community Support Services/Individualized Support Planning

Standard #5: Demonstrate that Community Integration /Intensive Case Managers are assigned promptly to hospitalized and non-hospitalized class members, that initial ISPs and ISP updates are completed within Consent Decree timeframes, and that appropriate personnel attend ISP meetings.
Settlement Agreement Paragraph(s): 49, 55, 56, 58

Measurement Method: Assessed using Community Integration Enrollment and ISP tracking data with three indicators:

1a. Percentage of class members requesting a CSW/CI/ICM/ACT worker who were assigned one;
1b. Percentage of class members requesting an ISP who received one;
2. Percentage of hospitalized class members who were assigned a CSW/CI/ICM/ACT worker within 2 working days of requesting one;
3. Percentage of non-hospitalized class members assessed and found eligible for CSW/CI/ICM/ACT services who were assigned a worker within 3 days of date of application;
4. Percentage of those class members in the hospital or in the community not assigned a CSW/CI/ICM/ACT worker within the specified 2 or 3 day period who were assigned one within an additional 7 days;
5. Percentage of class members enrolled in CSW/CI/ICM/ACT services where an initial ISP was completed within 30 days of program enrollment;
6. Percentage of class members for whom 90 day ISP review(s) were completed within specified timeframe;
7. Percentage of class members whose initial ISPs were not developed within 30 days but were developed within 60 days;
8. Percentage of class members whose ISPs were not reviewed within 90 days but were reviewed within 120 days;

Standard Development: Performance levels established in the Settlement Agreement**.** No national or external standards available.

Current Baseline(s): Not currently available – to be established pending availability of data from revised ISP data systems.

Performance Standards:

1a. 100% of class members requesting a CSW/CI/ICM/ACT worker were assigned one;
1b. 100% of class members requesting an ISP received one;
2. 90% of hospitalized class members who requested a CSW/CI/ICM/ACT worker were assigned one within 2 working days;
3. 90% of non-hospitalized class members who applied for CSW/CI/ICM/ACT services were assigned a worker within 3 days of date of application;
4. 100% of those class members in the hospital or in the community who were not assigned a CSW/CI/ICM/ACT worker within the specified 2 or 3 day period were assigned one within an additional 7 days;
5. 90% of class members enrolled in CSW/CI/ICM/ACT services had their initial ISP completed within 30 days of program enrollment;
6. 90% of class members for whom 90 day ISP review(s) was completed within the specified timeframe;
7. 100% of class members whose initial ISPs were not developed within 30 days had one developed within 60 days;
8. 100% of class members whose ISPs were not reviewed within 90 days received a review within 120 days.

[NOTE: once baseline data is available from the enrollment process, a performance standard will be developed for timeliness of assignment of CSW/CI/ICM/ACT workers for non-class members, as plaintiffs had proposed pursuant to paragraph 32(g)]

[NOTE: There is no Standard #6, and those aspects are now covered in Standards #5 and 18]

Standard #7: Demonstrate that ISP's are based upon consideration of the class members' housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional, and psychiatric and/or psychological strengths and needs as well as their potential need for crisis intervention and resolution services.
Settlement Agreement Paragraph(s): 61
Measurement Method: Assessed via utilization review of ISP's using a statewide random sample of 100 ISPs per quarter (total 400 per year) stratified by region based on statewide distribution of class members with the following indicator:

1. Percentage of ISPs reviewed with documented evidence that housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional, and psychiatric, psychological strengths and needs, and potential need for crisis intervention and resolution services are considered.

Standard Development: No national or external standard available
Current Baseline(s): To be established pending implementation of revised ISP Utilization Review protocol and methods.
Performance Standard: 95%

Standard #8: Demonstrate that services are based upon the actual needs of the class member rather than on what services are currently available.
Settlement Agreement Paragraph(s): 63
Measurement Method: Assessed via utilization review of ISP Process as described previously using the following indicators:

1. Percentage of ISPs reviewed in which there is evidence that the ISP team reconvened after an unmet need was identified;
2. Percentage of ISPs reviewed with identified unmet needs in which interim plans are established.

Standard Development: No national or external standard available.
Current Baseline(s): Baseline to be established pending availability of data from revised ISP utilization review protocol.
Performance Standard:

1. 90% of ISPs reviewed in which there is evidence that the ISP team reconvened after an unmet need was identified;
2. 95% of ISPs reviewed with identified unmet needs in which interim plans are established.

Standard #9: Demonstrate that when a service is to be delivered by an agency funded or licensed by the State, the community integration/community support worker will execute a written service agreement with the provider (signed treatment plan attached to the ISP).
Settlement Agreement Paragraph(s): 69

Measurement Method: Assessed via utilization review of ISPs as described previously using the following indicator:

1. Percentage of ISPs with services identified that are provided by outside agencies that have a signed treatment plan attached to the ISP cover sheet for each provider.

Standard Development: No national or external standard available.
Current Baseline(s): Baseline to be established pending availability of revised ISP utilization review process.
Performance Standard: 90%
Standard #10: Demonstrate that the ratio of community integration/community support workers to clients for community integration services, intensive community integration services and ACT services, and the ratio of DHHS caseworkers to class member public wards meet Settlement Agreement requirements.
Settlement Agreement Paragraph(s): 71 and 257
Measurement Method: Assessed via Mental Health Case Load Ratios and Wait List Data from Community Integration waitlist tracking with the following indicators:

1. Percentage of Community Integration service providers with average caseload ratio of 1:40 or lower;
2. Percentage of Intensive Community Support providers with average caseload ratio of 1:16 or lower;
3. Percentage of ACT providers with average caseload ratio of 1:10 or lower.
4. Percentage of DHHS caseworkers with average class member public ward caseload ratio of 1:25 or lower.

Standard Development: Standards derived from Settlement Agreement. Maximum 1:40; 1:16 for Intensive community support; 1:10 based on ACT fidelity standards.
Current Baseline(s): ACT is 1:9.2; Community integration is 1:17.8; Intensive Community Integration is 1:9.9.
Performance Standard:

1. 100% of Community Integration service providers with average caseload ratio of 1:40 or lower;
2. 100% of Intensive Community Support providers with average caseload ratio of 1:16 or lower;
3. 100% of ACT providers with average caseload ratio of 1:10 or lower;
4. 100% of DHHS caseworkers with average class member public ward caseload ratio of 1:25 or lower.

Standard #11: Demonstrate that the needs of class members who do not receive community support worker assistance are considered in the design and delivery of comprehensive mental health services.
Settlement Agreement Paragraph(s): 74
Measurement Method: Assessed via DHHS Paragraph 74 data system. This data system was designed to collect information on needs of class members who are not receiving community integration/community support services. The following indicators will be used:

1. Percentage of class members without community integration workers reporting needs in ISP identified need areas, such as housing, financial, education, dental,

psychiatric/medication, transportation, crisis services, mental health services, vocational services etc. via Paragraph 74 data.

Standard Development: No standard necessary. Trend data from the Paragraph 74 process performed by consent decree coordinators will be used to guide and inform DHHS service and budget planning.

Performance Standard: No standard necessary

Community Resources and Treatment Services

Housing and Residential Support Services

Standard #12: Demonstrate that the array of residential support services is flexible and is adequate to meet ISP identified residential support needs of class members and the needs of hospitalized class members ready for discharge.

Settlement Agreement Paragraph(s): 97, 98

Measurement Method: Assessed via ISP Unmet Needs data with following indicator(s):

1. Percentage of class members in community with ISPs with unmet residential support needs;
2. Percentage of class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care who are discharged within 7 days of that determination;
3. Percentage of class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care who are discharged within 30 days of that determination.
4. Percentage of class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care who are discharged within 45 days of that determination.

Standard Development: No national or external standards available.

Current Performance/Baseline: Not currently available – to be established pending availability of data from revised ISP data systems.

Performance Standard:

1. 5% or fewer class members have ISP identified unmet residential support needs;
2. Of the class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care , lack of residential support services does not impede discharge of 75% within 7 days of that determination;
3. Of the class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care, lack of residential support services does not impede discharge of 96% within 30 days of that determination.
4. Of the class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care, lack of residential support services does not impede discharge of 100% within 45 days of that determination.

Standard #13: Demonstrate class member satisfaction with access and quality of residential support services.

Settlement Agreement Paragraph(s): 97, 98

Measurement Method: Assessed via Annual Class Member Survey with following indicator (s):

1. Percentage of class members reporting satisfaction with their current living situation;
2. Percentage of class members receiving residential/housing support services who report satisfaction with these services *(New indicator has been added to 2005 Class Member Survey).*

Standard Development: Maine data obtained from the 2003 and 2004 Annual Class Member Survey shows general service satisfaction percentages of 79.8% and 81.2% respectively and percent satisfaction with current living situation of 80.4% and 80.2%.
Current Baseline(s): For indicator 1, 2004 Class Member Survey baseline established at 80.2% satisfied with current living arrangement.
Performance Standard:

1. 80% of class members reporting satisfaction with their current living situation;
2. 85% of class members receiving residential/housing support services who report satisfaction with these services.

Standard #14: Demonstrate that an array of housing alternatives is available and sufficient to meet the ISP identified needs of class members and the needs of hospitalized class members ready for discharge.
Settlement Agreement Paragraph(s): 94, 95
Measurement Method: Assessed via ISP Unmet Needs data, Class Member Provider Survey & Annual Class Member Survey with following indicator (s):

1. Percentage of class members with ISPs with unmet housing resource needs;
2. Percentage of class members who experience homelessness over 12-month period;
3. Percentage of class members who report satisfaction with their current living arrangement;
4. Percentage of class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care who are discharged within 7 days of that determination;
5. Percentage of class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care who are discharged within 30 days of that determination.
6. Percentage of class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care who are discharged within 45 days of that determination.

Standard Development: No national or external standard available regarding unmet needs**.** National studies indicate that 6% to 7% of persons with serious mental illness experience periods of homelessness over 12-month period. Maine data from the Class Member Provider Survey for 2002 and 2003 show homeless percentages of 6.2% (2002) and 6.6% (2003) respectively. Maine Annual Class Member Survey results for 2003 and 2004 indicate homeless percentages of 10.3% (2003) and 8.7% (2004). The percentages differ between the two surveys due to differences in the class member samples surveyed. The focus of the Class Member Provider Survey is on class members who are recipients of Community Integration services, while the Annual Class Member Survey targets all class members, whether they are current recipients of services or not. Maine data

obtained from the 2003 and 2004 Annual Class Member Survey for indicator 3 shows satisfaction percentages for current living situation of 80.4% (2003) and 80.2% (2004).

Current Baseline(s):

1. Baseline data currently unavailable - to be established pending availability of data from revised ISP data systems;
2. Based on results of the 2004 Annual Class Member Provider Survey, the baseline for this indicator is – 6.6% and for the 2004 Annual Class Member Survey 8.7%;
3. Based on results of the 2004 Annual Class Member Survey the baseline for the above indicators is 80.2%;
4. No baseline data available;
5. No baseline data available.

Performance Standard:

1. 10% or fewer class members with ISPs with unmet housing resource needs;
2. 6% or fewer class members receiving community integration services who experience homelessness over 12-month period;
3. 80% or more class members reporting satisfaction with their current living arrangement;
4. Of the class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care, lack of housing does not impede discharge of 75% within 7 days of that determination;
5. Of the class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care, lack of housing does not impede discharge of 96% within 30 days of that determination.
6. Of the class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care, lack of housing does not impede discharge of 100% within 45 days of that determination.

[NOTE: A performance standard will need to be developed for timeliness of discharges of voluntary patients from community hospitals.]

Standard #15: Demonstrate that housing that is developed, recruited, newly funded or supported under this Agreement is located where the other community services are reasonably available and that clients in homes with more than 8 beds have given informed consent to reside there.

Settlement Agreement Paragraph(s): 96

Measurement Method: Assessed via review of files of clients in homes that exceed 8 beds. Indicators include:

1. Percentage of records of class members residing in homes with more than 8 beds, (except for hospices, shelters and nursing homes) in which evidence of client choice is documented.

Standard Development: No national or external standards available.

Current Baseline(s): Baseline to be established pending refinements of paragraph 96 residential utilization review process.

Performance Standard:

1. 95% of records of class members residing in homes with more than 8 beds, (except for hospices, shelters and nursing homes) in which evidence of client choice is documented.

Acute Inpatient Psychiatric Services

Standard #16: Demonstrate that the Department has made reasonable efforts to provide acute inpatient psychiatric hospitalization options for class members that allow for hospitalization reasonably near an individual's local community.
Settlement Agreement Paragraph(s): 88
Measurement Method: Assessed via Utilization Review Hospital data with following indicator:

1. Percentage of class member admissions to community involuntary inpatient units determined to be reasonably near to an individual's local community of residence. (Reasonably near to an individual's local community of residence is defined as within the county of residence or within a county adjacent to the class member's county of residence.)

Standard Development: No national or external standards available.
Current Performance/Baseline: Baseline to be established.
Performance Standard: 90% of class member admissions to community involuntary inpatient units will meet established "nearness" criteria.

Standard #17: Demonstrate that class member admissions to community hospitals are in accordance with law and meet medical necessity criteria.
Settlement Agreement Paragraph(s): 89
Measurement Method: Assessed via Utilization Review Hospital data with following indicators:

1 Percentage of class member involuntary admissions to community inpatient units in which a blue paper is on file;
2. Percentage of class member involuntary admissions to community inpatient units in which the blue paper was completed in accordance with its terms;
2a. Percentage of those instances in which the blue paper was not completed in accordance with its terms where the Department's UR nurse took corrective action;
3. Percentage of class member involuntary admissions to community inpatient units in which 24-hour recertification completed/filed;
3a. Percentage of those instances in which the 24-hour recertification was not completed or filed where the Department's UR nurse took corrective action;
4. Percentage of class member involuntary admissions to community inpatient units in which documentation reveals that patient rights are maintained;
4a. Percentage of those instances in which documentation revealed that patient rights were not maintained where Department's UR nurse took corrective action;
5. Percentage of class member involuntary admissions to community inpatient units for which medical necessity was documented.

Standard Development: No national or external standards available

Current Baseline(s): Based on FY2004 DHHS Utilization Review Hospital data, the following baselines are established:

1a & b. Completed blue paper documented – 86.51%;
2. 24-hour certification completed – 72.8%;
3. Medical Necessity documented – 84.86%;
4. Documentation that patient rights were maintained – 77.1%.

Performance Standard:

1. 100% of class member involuntary admissions to community inpatient units in which a blue paper is on file;
2. 90% of class member involuntary admissions to community inpatient units in which the blue paper was completed in accordance with its terms;

2a. UR nurse took corrective action in 100% of those instances in which the blue paper was not completed in accordance with its terms;

3. 95% of class member involuntary admissions to community inpatient units in which 24-hour recertification was completed/filed;

3a. UR nurse took corrective action in 100% of those instances in which the 24-hour recertification was not completed or filed;

4. 90% of class member involuntary admissions to community inpatient units in which documentation reveals that patient rights are maintained;

4a UR nurse took corrective action in 100% of those instances in which documentation revealed that patient rights were not maintained;

5. 90% of class member involuntary admissions to community inpatient units for which medical necessity was documented.

Standard #18: Demonstrate that continuity of treatment is maintained during hospitalization in community inpatient settings.

Settlement Agreement Paragraph(s): 90

Measurement Method: Assessed via Utilization Review Hospital data with following indicators:

1. Percentage of class members with ISPs admitted to community hospitals for whom hospital obtained ISP;
2. Percentage of class members with ISPs where treatment and discharge plan were determined to be consistent with ISP goals and objectives;
3. Percentage of admissions where class member received community integration/community support services and their worker participated in hospital treatment and discharge planning.

Standard Development: No national or external standards available

Current Baseline(s): Based on FY2002 & FY2003 data, baseline percentages for above indicators are as follows:

1. Hospital obtained ISP - 35.5%;
2. Treatment & discharge plan consistent with ISP - 61.9%;
3. CS/CI worker participation in planning - 57.63 %.

Performance Standard:

1. Corrective action required until performance reaches 90%;
2. Corrective action required until performance reaches 90%;
3. Corrective action required until performance reaches 90%.

Crisis Intervention Services

Standard #19: Demonstrate that crisis intervention/resolution services are effective and meet settlement agreement standards, including 24 hours per day/ 7 days per week availability, personnel trained in crisis intervention, timely access to psychological/psychiatric consultation services; availability of short-term housing with focus on avoidance of un-necessary hospitalizations.

Settlement Agreement Paragraph(s): 99, 100

Measurement Method: Assessed via Quarterly Contract Performance Data with following indicators:

1. Percentage of face-to-face crisis contacts that result in hospitalization;
2. Percentage of face-to-face crisis contacts that result in follow-up and/or referral to community-based services;
3. Percentage of face-to-face crisis contacts in which a previously developed crisis plan/advanced directive was available and used;
4. Percentage of face-to-face crisis contacts in which client has a community integration worker and worker was notified about the crisis.

Standard Development: Research on effectiveness of crisis outreach services reports hospitalization rates of 20% to 25% following crisis intervention. DHHS Quarterly Contract Performance data on the percentage of face-to-face crisis contacts that result in follow-up/referral to community-based services ranges from 53% to 89% across crisis service providers.

Current Baseline(s): FY2004 Quarterly Contract Performance Data baseline data for indicators 1 & 2 are as follows:

1. 21% (average quarterly percentage for first three quarters of FY2004);
2. 47.6% (average quarterly percentage for first three quarters of FY2004);
3. Baseline to be established pending revision to DHHS Quarterly Contract Performance data needed to more accurately capture this indicator;
4. New indicator (FY2005), baseline to be established pending availability of data.

Performance Standard:

1. No more than 20 - 25% of consumers are hospitalized as a result of crisis intervention;
2.

[NOTE: Standards for remaining indicators will be developed after a plan is approved.]

Standard #20: Demonstrate class member satisfaction with the availability and quality of crisis intervention services.

Settlement Agreement Paragraph(s): 99, 100

Measurement Method: Assessed via Annual Class Member Survey with following indicators:

1. Percentage of class members reporting that they know how to get help in crisis when they need it;
2. Percentage of class members reporting that crisis services were available when needed.

Background for Standard Development: Maine data obtained from the 2003 and 2004 Annual Class Member Survey for these items shows satisfaction percentages of 88.9% (2003) and 87.6%(2004) for indicator 1 and 91.2%(2003) and 83.2%(2004) for indicator 2. National consumer satisfaction data from the SAMHSA Data Infrastructure Project consistently report general satisfaction with service percentages of 85% and higher.
Current Baseline(s): Based on 2004 survey results, baseline data for above indicators are as follows:

1. Individual knows how to get help in a crisis - 87.6%;
2. Crisis services available when needed – 83.3%.

Performance Standard:

1. 90% of class members reporting that they know how to get help in crisis when they need it;
2. 85% of class members reporting that crisis services were available when needed.

Treatment Services

Standard #21: Demonstrate that an array of mental health treatment services is available and sufficient to meet the ISP identified needs of class members and the needs of hospitalized class members ready for discharge.
Settlement Agreement Paragraph(s): 103
Measurement Method: Assessed via ISP Unmet Needs data, MaineCare service claims, and Class Member Provider Survey with the following indicators:

1. Percentage of class members with ISPs with unmet mental health treatment needs;
2. Percentage of class members at Riverveiw Psychiatric Center determined to have received maximum benefit from inpatient care who are discharged within 7 days of that determination;
3. Percentage of class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care who are discharged within 30 days of that determination;
4. Percentage of class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care who are discharged within 45 days of that determination;
5. MaineCare data demonstrates by mental health service category that class members use an array of mental health treatment services.

Standard Development: No national or external standard available
Current Baseline(s): Not currently available – to be established pending availability of data from revised ISP data systems.
Performance Standard:

1. 5% or fewer of class members have ISP identified unmet mental health treatment resource needs;
2. Of the class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care, lack of treatment does not impede the discharge of 75% within 7 days of that determination;
3. Of the class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care, lack of housing does not impede discharge of 96% within 30 days of that determination.

4. Of the class members at Riverview Psychiatric Center determined to have received maximum benefit from inpatient care, lack of housing does not impede discharge of 100% within 45 days of that determination.

Standard #22: Demonstrate that class members are satisfied with access and quality of mental health treatment services received.
Settlement Agreement Paragraph(s): 103
Measurement Method: Assessed via Annual Class Member Survey with following indicator(s):

1. Percentage of class members responding "yes" to Q1 on Class Member Community Survey: "Can you get the mental health services and support you feel you need?"
2. Percentage of class members reporting satisfaction with mental health services and supports received in past year Q12 – Class Member Community Survey.

Standard Development: Maine data obtained from the 2003 and 2004 Annual Class Member Survey for indicator 1 shows satisfaction percentages of 79.8% (2003) and 81.2% (2004).
Current Baseline(s): Using 2004 Class Member Survey baselines for the above indicators are as follows:

1. 85.1%;
2. 81.2%.

Performance Standard:

1. 85% of class members responding affirmatively to question asking whether they can get the mental health services and supports they feel they need;
2. 85% of class members reporting satisfaction with mental health services and supports received in past year.

Family Support Services

Standard #23: Demonstrate provision of an array of family support services that meet Settlement Agreement requirements including:

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

Settlement Agreement Paragraph(s): 109

Measurement Method: Assessed via Quarterly Contract Performance Data and utilization review of family support contracts and description and location of trainings developed and implemented, using the following indicators:

1. Number of educational programs developed and delivered that meet Settlement Agreement requirements a, b and d;
2. Number and distribution of family support services provided including: facilitated support group meetings, group counseling, psycho-educational programs, and respite services.

Standard Development: No national or external standard available.
Current Baseline(s): Baseline to be established.
Performance Standard: No standard necessary -- monitor to show that array of services is provided.

Standard #24: Demonstrate consumer/family satisfaction with family support and information and referral services.
Settlement Agreement Paragraph(s): 109
Measurement Method: Assessed via Quarterly Contract Performance Data with following indicators:

1. Percentage of support group and group counseling participants reporting satisfaction with services;
2. Percentage of program participants reporting satisfaction with educational programs;
3. Percentage of family participants reporting satisfaction with respite services.

[NOTE: Satisfaction data is not currently broken down in these categories by NAMI; but changes in reporting requirements will be implemented for the next contract year, beginning July 1, 2005.]
Standard Development: No national or external standard available.
Current Baseline(s): To be established pending data verification for 2004.
Performance Standard:

1. 85% of those participating in support groups or group counseling reporting satisfaction;
2. 80% of program participants reporting satisfaction with educational programs;
3. 80% of participants reporting satisfaction with respite services.

Standard #25: Demonstrate that provider agencies are referring family members to family support groups.
Settlement Agreement Paragraph(s): 110
Measurement Method: Assessed via utilization review of agency provider contracts:

1. Percentage of agency contracts reviewed with documented evidence of referral mechanism to family support services;
2. Percentage of families reporting satisfaction with referrals to family support services.

Standard Development: No national or external standards available.
Current Baseline(s): To be established.
Performance Standard:

1. 90% of agency contracts reviewed showed evidence of mechanism for referrals to family support services;

2. 85% of families receiving referrals for family support services reporting satisfaction with referral process.

Vocational and Employment Services

Standard #26: Demonstrate that the Department has made reasonable efforts to provide an array of vocational/employment opportunities and supports to meet the ISP identified needs of class members.

Settlement Agreement Paragraph(s): 101

Measurement Method: Assessed via ISP Unmet Needs data and the Annual Class Member Provider Survey with the following indicator(s):

1. Percentage of class members with ISP identified unmet vocational/employment support needs;
2. Percentage of class members who are employed in competitive employment in the community.
3. Percentage of class members in either supported or competitive employment.

[NOTE: currently available data for indicators 2 and 3 includes class members receiving community integration services only.]

Standard Development: No national or external standards that specifically address employment support issues for persons with serious mental illness are available. Studies have documented employment rates for individuals with serious mental illness ranging between 13% and 40%. Data from the 2002 and 2003 Class Member Provider Survey show class member employment rates of 10.5% and 9.1% respectively. Employment questions were included in the Annual Class Member Survey in 2004, and the results indicate that 21% of survey respondents reported being employed on either a full-time or part-time basis. The difference in results of the two surveys may be due in part to the difference in populations sampled. The Class Member Provider Survey samples all class members receiving community integration, intensive community integration, intensive case management and ACT Team services. The Annual Class Member Survey samples all class members who receive and who do not receive community services.

Current Baseline(s):

1. Not currently available – to be established pending availability of data from revised ISP data systems;
2. Based on 2004 Class Member Provider data, employment baseline established at 9.1%;
3. Not currently available.

Performance Standard:

1. 10% or fewer class members identified as having ISP identified unmet vocational support needs;
2. 15% of class members employed in competitive employment in the community;
3. 20% of consumers in either supported or competitive employment.

Standard #27: Demonstrate consumer/class member satisfaction with employment situation and with vocational support services.

Settlement Agreement Paragraph(s): 101

Measurement Method: Assessed via Annual Class Member Survey with following items:

1. Percentage of class members who report satisfaction with their employment situation – Q19 on Class Member Community Survey;
2. Percentage of class members who report that vocational supports were available when needed *(New indicator added to Annual Class Member Survey in 2005).*

Standard Development: Consumer satisfaction data from the SAMHSA Data Infrastructure Project consistently report general satisfaction percentages of 85% and higher.

Current Baseline(s): Based on 2004 Annual Class Member Survey results:

1. 78.4%;
2. Baseline to be established pending availability of data.

Performance Standard:

1. 80% of class members reporting satisfaction with their employment situation;
2. 85% of class members reporting that vocational supports were available when needed.

Transportation

Standard #28: Demonstrate that the Department has made reasonable efforts to identify and resolve transportation problems that may limit access to services needed to meet class members' ISP identified needs.

Settlement Agreement Paragraph(s): 107

Measurement Method: Assessed via ISP Unmet Needs Data with following indicator(s):

Percentage of class members with ISP identified unmet transportation needs.

Standard Development: No national or external standards available.

Current Baseline(s): Not currently available – to be established pending availability of data from revised enrollment and ISP data systems.

Performance Standard: 10% or fewer class members have unmet transportation needs.

Standard #29: Demonstrate consumer/class member satisfaction with availability of transportation services.

Settlement Agreement Paragraph(s): 107

Measurement Method: Assessed via Annual Class Member Survey with following indicators:

1. Percentage of class members reporting that they were unable to get to medical/mental health appointments due to lack of transportation *(new question to be added to Annual Class Member Survey for 2005)*;
2. Percentage of class members reporting difficulty participating in recreational/social activities due to lack of transportation.

Standard Development: Maine data obtained from the 2003 and 2004 Annual Class Member Survey for these indicators show percentages for indicator 1 of 83.9% (2003) and 79.7% (2004) and for indicator 2 of 76.7% (2003) and 72.4% (2004).

Current Baseline(s): Baselines established using 2004 results of Class Member Survey are as follows for the two indicators:

1. 79.7%;
2. 72.4%.

Performance Standard:

1. 10% or fewer class members reporting that they were unable to get to medical/mental health appointments due to lack of transportation;
2. 20% of class members reporting difficulty participating in recreational/social activities due to lack of transportation.

Recreation / Social / Avocational / Spiritual Opportunities

Standard #30: Demonstrate that the Department has sponsored programs to assist class members in developing leisure skills and in utilizing, improving, or gaining recognition for their avocational skills.
Settlement Agreement Paragraph(s): 105
Measurement Method: Assessed via Quarterly Contract Performance Indicator Data with following indicators:

1. Number of social clubs/peer center and participants by region;
2. Number of other peer support programs and participation.

Standard Development: No national or external standards available.
Current Baseline(s): 2004 Quarterly Contract Performance Indicator data indicate statewide, on average, 1,907 unduplicated social club/peer center participants per quarter and an average of 28,219 visits per quarter.
Performance Standard: Qualitative evaluation; no numerical standard required.

Standard #31: Demonstrate consumer/class member involvement in personal growth activities and participation in the life of the community.
Settlement Agreement Paragraph(s): 105
Measurement Method: Assessed via ISP Unmet Needs Data and Annual Class Member Survey with following indicators:

1. Percentage of ISP identified class member unmet needs in recreation, social, avocational and spiritual areas;
2. Percentage of class members who report that they participate in regular recreational, social, and avocational and spiritual activities;
3. Percentage of class members reporting satisfaction with the recreational and social opportunities available to them.

Standard Development: Studies with populations of adults with serious mental illness show large variability in reported needs for recreational, social, avocational and spiritual opportunities ranging from 10% to 50%. Maine data obtained from the 2003 & 2004 Annual Class Member Survey show satisfaction percentages of 71% (2003) and 62.2% (2004).
Current Baseline(s):

1. Not currently available – to be established pending availability of data from revised enrollment and ISP data systems;
2. Based on 2004 Class Member Survey Data baseline is established at 44.2%;
3. Based on 2004 Class Member Survey Data baseline is established at 62.2%

Performance Standard:

1. 10% or fewer class member unmet needs in recreation, social, avocational and spiritual areas;
2. 60% of class members reporting that they participate in regular recreational, social, and avocational and spiritual activities;

3. 80% of class members reporting satisfaction with the recreational and social opportunities available to them.

System Outcomes: Supporting the Recovery of Adults with Mental Illness

Recovery

Standard #32: Demonstrate functional improvements in the lives of class members who are receiving services.
Settlement Agreement Paragraph(s):
Measurement Method: Assessed via Data Infrastructure Consumer Survey & Level of Care Utilization System (LOCUS) with following indicators:

1. Percentage of consumers/class members demonstrating functional improvement on LOCUS between baseline and 12 month re-certification;
2. Percentage of consumers/class members who have maintained level of functioning between baseline and 12 month re-certification;
3. Percentage of consumers/class members reporting positively on functional outcomes on Data Infrastructure survey outcome items.

Standard Development: National SAMHSA Data Infrastructure Consumer Survey data for FY2002 and FY2003 indicate percentage of consumers reporting positive treatment outcomes of 81% (2002) and 73% (2003). Maine Data Infrastructure data reflect similar survey percentages for this indicator of 80% (2002) and 78% (2003).
Current Baseline(s):

1. Baseline to be established with availability of LOCUS assessment data;
2. Baseline to be established with availability of LOCUS assessment data;
3. Based on 2003 Maine Data Infrastructure Consumer Survey results, baseline established at 78%.

Performance Standard:

1. Standard to be developed with availability of LOCUS assessment data;
2. Standard to be developed with availability of LOCUS assessment data;
3. 80% of consumers/class members report positive outcomes of treatment.

Standard #33: Demonstrate that consumers are supported in their recovery process.
Settlement Agreement Paragraph(s):
Measurement Method: Assessed via Maine Data Infrastructure Consumer Survey with following indicators:

1. Percentage of consumers reporting that agency staff helped them obtain the information needed to take charge of managing their illness;
2. Percentage of consumers reporting that agency staff believe that they can grow, change and recover;
3. Percentage of consumers reporting that agency services and staff supported their recovery and wellness efforts and beliefs;
4. Percentage of consumers reporting that providers offered opportunities to learn skills that allowed them to strengthen and maintain their wellness;

5. Percentage of consumers reporting that service providers stressed the importance of natural supports and friendships;
6. Percentage of consumers reporting that service providers offered mutual support or recovery-oriented groups facilitated by consumers.

Standard Development: 2003 Maine Data Infrastructure survey results indicate satisfaction with recovery-based practices range from 53.2% (Indicator 6) to 83.5% (Indicator 2). The average percent satisfaction with recovery practices is 70.9%.
Current Baseline(s): Baseline established at 70.9% for combined recovery measure.
Performance Standard:

1. 80% of consumers reporting that agency staff helped them obtain the information needed to take charge of managing their illness;
2. 80% of consumers reporting that agency staff believe that they can grow, change and recover;
3. 80% of consumers reporting that agency services and staff supported their recovery and wellness efforts and beliefs;
4. 80% of consumers reporting that providers offered opportunities to learn skills that allowed them to strengthen and maintain their wellness;
5. 80% of consumers reporting that service providers stressed the importance of natural supports and friendships;
6. 80% of consumers reporting that service providers offered mutual support or recovery-oriented groups facilitated by consumers.

Public Education

Standard #34: Demonstrate provision of a variety of public education programs on mental health and illness topics, including: myths and stigma associated with mental illness and rights of consumers of mental health services and their families.
Settlement Agreement Paragraph(s): 252
Measurement Method: Assessed via Quarterly Contract Performance Data, NAMI Reports, and Adult Mental Health Services, Office of Consumer Affairs public education tracking data with following indicators:

1. Number of mental health informational workshops, forums, and presentations geared toward general public and level of participation;
2. Number and type of informational packets, publications, press releases, etc. distributed to public audiences.

Standard Development: No national or external information available.
Current Baseline(s): Baselines to be established.
Performance Standard: Qualitative evaluation required; no numerical standard.

VII. Cost of Plan Implementation

This section of the plan describes the resources that were added to support OAMHS activities in State Fiscal Year (SFY) 2007, resources that are needed for SFY 08 and SFY 09, and resources that may be needed, except that a determination of need cannot be finally made until further information is available ("To Be Determined" or TBD). This section does not include a description of resources that were added to support OAMHS services in SFY 2006. To the extent that those resources now support ongoing activities, they are part of the Department's ongoing budget for its comprehensive mental health system.

The cost of the potentially largest service component, resources to address unmet needs for both class members and non-class members will be available more data is collected in the Enterprise Information System (EIS) through the Individualized Support Plan Resource Data Summary (ISP RDS). ISP RDS data collection began in the first quarter of calendar year 2006 and analysis will yield useful information beginning in January 2007.

Item	Increased Funding Resources Received for SFY 07	Funding Resources Estimated for SFY 08	Funding Resources Estimated for SFY 09
BRAP Housing			$180,000
Consumer Councils	$323,000 and ongoing		
Warm Line Support	Increase warm line funding by $65,000 in addition to the existing funding of $214,877	TBD	
Peer Services in Emergency Departments			$350,000
Advocacy Initiative Network	$100,000		
Routing of Crisis Calls		TBD	
Increase Access to Psychiatric and Psychological Services		TBD	
Non-traumatic transportation		TBD	
Specialized Residential Development for Persons with Complex Needs	$109,000 state general fund plus $640,000 for the MaineCare seed account and ongoing	TBD	

Expanded Geriatric/Mental Health Residential Services	$360,000 for the MaineCare seed account and ongoing		
Crisis Residential Units	$230,950 for the MaineCare seed account and ongoing		
Three Employment Specialists			$195,000
Vocational Supports	$200,000 and ongoing		
Unmet Resource Needs Identified by the ISP		TBD	TBD
Funding for Noncategorical MaineCare Recipients	$178,000		
ACT Forensic Team	$121,222 state general fund plus $190,000 in new seed plus $270,000 moved from RPC to the MaineCare seed account		

Total new funding for SFY 07

State General Fund……..$1,121,222

MaineCare Seed Account……$1,420,950 plus $270,000 moved from the Riverview General Fund account to the MaineCare seed account.

VIII. Riverview Psychiatric Center

This portion of the Consent Decree Plan is to assure that Riverview Psychiatric Center provides consumer-centered inpatient psychiatric care to Maine citizens with serious mental illness that meets constitutional, statutory, and regulatory standards. It describes in practical and, whenever possible, measurable terms the goals, objectives and strategies that have been collaboratively identified by the Department and its community partners to address critical issues raised by the consent decree and necessary to strengthen Maine's system of mental health care. It builds upon the significant progress that has been made to date by Riverview Psychiatric Center (RPC), and further establishes the hospital as a key component of the mental health service continuum.

The chapter is organized into a set of goals, objectives and strategies which, when successfully achieved, will bring Riverview Psychiatric Center into substantial compliance with the terms of the consent decree within a period of one year. The strategies identified are to be viewed as flexible and may change as circumstances, including successes and failures, are experienced. They are provided here in good faith to communicate how the Department intends to pursue its commitment to achieving the identified outcomes in a responsible manner. All proposed modifications to the strategies in the plan will be communicated through the Quarterly Performance Improvement Reports submitted to the court. Any substantive modifications will be subject to approval by the Court Master. Each of the three overarching goals includes primary objectives and strategies, which are followed by target completion dates and the source of funds required to support each strategy. Finally, performance standards are proposed for each objective, to ensure the achievement of each objective.

The plan is designed to assure that Riverview Psychiatric Center provides a high quality of consumer driven, effective care in a non-coercive, empowering, recovery supportive approach.

Goal 1: Deliver hospital-based psychiatric care at Riverview Psychiatric Center that is consumer-centered, recovery-focused, innovative, and appropriately integrated with community-based care.

Objective #1: To develop and implement a consumer-centered Inpatient Treatment Plan for civil and forensic clients within 7 calendar days of admission that integrates hospital treatment with the attainment of community-based resources and supports necessary for the client to return to his/her community.

Strategies:

1) Develop, implement and train all direct care and clinical staff in a comprehensive treatment and discharge planning process that includes client participation and results in an integrated, competency-based plan consistent with the client's Individualized Support Plan (if any), and including:
   a) active inpatient psychiatric treatment services that are designed to address acute care needs and effectively promote recovery and return to the community by building on needs assessments;
   b) psycho-educational service plans based on appropriate clinical assessment

of knowledge skills and deficits;
c) required dental care and medical treatment;
d) use of the most clinically appropriate medications;
e) for extended care clients who choose to participate, supported employment goals developed through consultation with employment specialists;
f) an "Engagement Plan" in the rehabilitation section of the Inpatient Treatment Plan that addresses, when indicated, a client's refusal to participate in prescribed treatment;
g) an assessment of risks and appropriate safety plans within the hospital;
h) advance directives;
i) role of natural supporters such as family and significant others in the course of hospitalization, with client permission;
j) plans for providing needed supports in/to jails and prisons;
k) plans for accessing desired treatment, entitlements, transportation to/from treatment services, housing, education, employment, and health services in preparation for/upon transition as appropriate and needed.

Target completion date: 95% of current clinical staff will participate in Inpatient Treatment Plan training by 7/1/05.

95% of new hire clinical staff will participate in Inpatient Treatment Planning within 90 days of employment.

Fiscal resources: These strategies will be supported within existing hospital budget.

2) Review and revise forensic treatment plans by:
   a) engaging referring jails and prisons with hospital staff in reviewing treatment plans of forensic clients;
      i. invite participation in service integration meeting.
      ii. monitor participation rates in service integration meeting.
      iii. utilize medical contacts for each jail and prison.
      iv. communicate to each jail and prison RPC Liaison for care resolution/communication issues.
      v. invite jails/prisons to participate in treatment plan reviews.
      vi. monitor jails/prisons participation in treatment plan reviews.
      vii. prior to a transfer to a jail or prison, ensure a dialogue between providers on care issues and delivery of discharge plan/instructions.

   b) Continuously assess appropriateness for petitioning the court for modification to conditions of clients found Not Criminally Responsible. As part of the treatment plan for each client who has been admitted as NCR, establish a safety plan identifying the behavioral criteria to trigger utilization of new conditions of modified release.

      At the time of each treatment plan review, document as part of the review the assessment of adequacy of current court conditions of modification of release and likely course of treatment and potential need for petitioning the court for new conditions. Establish RPC performance measures for NCR court petitions as follows:
      - Report and petition filed with court within 10 days of Treatment Plan

review, if the review indicates current conditions restrict client care delivery.

- Safety Plans indicate behavioral criteria to implement current conditions of modified release.
- An institutional report shall be filed annually for all clients committed to the care of the commissioner.

Target completion date: By June 15, 2005 each NCR client's treatment plan review will (1) include a safety plan identifying the behavioral criteria to trigger utilization of new conditions, and (2) document as part of the review the assessment of adequacy of current court conditions.

Include in Riverview's Quarterly Performance Improvement Report for July, August and September 2005, measurement of the frequency of court petitions filed within 10 days of Treatment Plan review, and Safety Plans that indicate behavioral criteria to implement current conditions of modified release.

A schedule of Annual reports shall be maintained and compliance reflected on the Quarterly Quality Improvement Report.

Fiscal resources: As this involves a change in process only, these strategies will be supported within the existing hospital budget.

3) Expand and intensify treatment and education program options by:
   a) extending services in the evenings and weekends to include 6 hours of structured psycho-educational and rehabilitative services provided until 7:30 pm each evening of the week, in addition to services offered during the day;
   b) transforming Mental Health Worker positions into care delivery agents by implementing a "level of support" protocol for Mental Health Workers to facilitate providing rehabilitation in the area of improvement in primary functional capacity (e.g., personal hygiene, personal space maintenance, self care) and Self Expression Program for all clients assessed with such needs;
   c) providing prescriptive small group activities on the units to address the needs of those unable to participate in the treatment mall;
   d) developing an educational program to address the needs of the Incompetent to Stand Trial population;
   e) providing an educational orientation to the circumstances, process and outcomes of NCR and Stage III clients;
   f) increasing access to vocational rehabilitation services by adding two positions;
   g) defining rehabilitation actions in the treatment plan;
   h) conducting at least two care reviews per year through an existing contract with Dartmouth University to examine risk management practices and advise staff regarding performance standards appropriate to treatment and court-ordered procedures for forensic clients;
   i) implementing a Riverview-facilitated process to connect client family members with the local NAMI Family to Family program and any family psycho-educational services available in the home community;
   j) establishing a Riverview Psychiatric Center Web page with links to local supports.

k) implementing a Riverview-facilitated process to connect clients with local peer supports providing services in or near their home communities.
l) establishing peer support groups at RPC.
m) utilizing Peer Specialists and rehabilitation staff to conduct a minimum of 1 client outing per month to peer social and support groups.

Target completion date: Expanded treatment and education program options identified above shall be implemented by 11/1/05.

Fiscal resources: As this involves delivery processes and deployment of current staff, these strategies will be supported within the existing hospital budget.

4) Conduct multi-disciplinary reviews at least six times a year, using a case conference model and under the supervision of the medical director, of client progress toward achievement of Inpatient Treatment Plan goals and objectives, targeting areas needing additional support and assigning staff responsibility for specific treatment interventions.

Target completion date: Six case conference reviews will be competed by 7/1/06.

Fiscal resources: As this involves delivery processes and deployment of current staff, these strategies will be supported within the existing hospital budget.

5) Reorganize morning rounds to address significant care events since last report, such as the use of PRN medications, restrictive treatments, identification of new problems and any specific interventions that should occur in the next 24-hour period that will further individual treatment.

Target completion date: Completed.

Fiscal resources: As this involves delivery processes, these strategies will be supported within the existing hospital budget.

6) Strengthen hospital-based supported employment services by:
a) hiring two additional employment specialists (for a total of six) over the next 12 months to focus their efforts on obtaining transitional employment placements and community-based employment for extended care clients;
b) providing GED preparation and testing services and monitoring their effectiveness in obtaining diplomas;
c) collaborating with the Department of Education to improve access to GED services in Maine.

Target completion date: Hospital-based employment services will be strengthened by 9/1/05.

Fiscal resources: This involves redeployment of current staff. Two additional MHW (recently redeployed 4 scheduler MHW positions to the units) will

be re-classed to Vocational Specialists. These strategies will be supported within the existing hospital budget.

Goal 1, Objective 1

Performance Indicator:	Develop a preliminary treatment and transition plan within 3 working days of admission
Performance Measure:	Percent of preliminary treatment and transition plans developed within 3 working days of admission
Performance Standard:	95% of clients will have a preliminary treatment and transition plan developed within 3 working days of admission
Performance Indicator:	Develop and implement an individualized Inpatient Treatment Plan within 7 days of admission
Performance Measure:	Percent of plans completed within 7 days of admission
Performance Standard:	100% of clients will have an individualized Inpatient Treatment Plan in the medical record prior to the end of the 7th day of hospitalization.

Objective #2: To engage peer support specialists who provide clients with needed supports and help strengthen client-staff relationships in order to diffuse potential tensions and contribute to a positive treatment environment.

Strategies:

1) Provide fiscal resources to continue the use of peer specialists and identify additional areas of involvement of peer specialists.

Target completion date: Current service contract will be continuously maintained, with the addition of one peer specialist position, by 10/15/05.

Fiscal resources: Funds will be redistributed from all other accounts into existing hospital peer specialists contract budget.

Goal 1, Objective 2

Performance Indicator:	Contacts between clients and peer specialists
Performance Measure:	Percent of clients who have documented contact with a peer specialist during their treatment experience.
Performance Standard:	(a) 80% of clients will have documented contact with a peer specialist during hospitalization. (b) 80% of all treatment meetings shall involve a peer specialist.

Objective #3: To ensure the appropriate and minimal use of seclusion and restraint practices.

Strategies:

1) Continue reporting seclusion and restraint data though NASMHPD Research Institute

protocol.

2) Continue Riverview Psychiatric Hospital's commitment to evaluate and monitor all restraint episodes, including those of less than five minutes that are not reportable through NASMHPD Research Institute protocol.

3) Monitor the use of seclusion and restraint practices through oversight by NAPPI Leadership Committee, Medical Executive Committee, Human Rights Committee and Executive Leadership Committee.

4) Continue to conduct high-intensity education into current uses of and alternatives to seclusion and restraint practices.

5) Monitor the authorization of PRN medication for the management of behavior.

Target completion date: All current efforts and actions will be maintained.

Fiscal resources: To be supported within existing hospital budget.

Goal 1, Objective 3	
Performance Indicator:	Duration of seclusion and restraint incidents
Performance Measure:	Total restraint and seclusion hours do not exceed the national mean as reported by the NASMHPD Research Institute
Performance Standard:	No more than one calendar quarter outside of compliance measure for any six-quarter period

Objective #4: To employ a complement of well-trained, highly supported and supportive staff.

Strategies:

1) Utilize a multi-disciplinary approach to develop and implement an active training plan for all departments and units:
    a) draft a training plan and circulate it for staff review and comment;
    b) conduct staff training and education that includes staff from community programs as participants and/or expert trainers and focuses on issues and topics of special need and interest, such as:
        i. working with clients who have especially challenging or complex needs
        ii. integrating supported employment into client recovery plans
        iii. strengthening active treatment skills for Mental Health Workers and Nurses
        iv. reducing seclusion and restraint practices
        v. understanding the nature of mental illness, the impact of trauma and evidence-based practices;
    c) conduct a minimum of six internal clinical case conferences each year;
    d) conduct a minimum of four external case consultations each year;
    e) maintain a consultant on vocational services through the next six months.

Target completion date: An active training plan will be developed for all departments and units by 7/1/05.

Fiscal resources: To be supported within existing hospital budget.

2) Assess and strengthen staff competencies to ensure fidelity to the principles of psychiatric recovery:
    a) provide regular and supportive supervision and staff development activities to promote demonstrated competencies;
        i. establish unstructured debriefings for staff on each unit with Psychology staff to provide opportunities to discuss and improve understanding of psychiatric recovery principles.
        ii. establish unstructured debriefings for staff on each unit with assigned members of leadership staff to provide opportunities to discuss and improve understanding of psychiatric recovery principles.
        iii. implement a self study program for staff involving psychiatric recovery literature.
    b) conduct annual reviews of individual staff performance and competence;

c) initiate corrective action plans, including progressive disciplinary practices, with staff who do not meet minimum levels of competence;
d) strengthen lines of supervision and accountability with emphasis on local control and accountability at the unit level.
i. implement clinical nursing supervision plan.
ii. implement staff acknowledgement plan to enhance staff morale.

Target completion date: 100% of Nursing and Mental Health Worker staff will have a performance review documenting displayed competencies by 7/1/06.

Fiscal resources: To be supported within existing hospital budget.

3) Strengthen Labor-Management relations:
a) utilize additional support of DHHS to address labor management issues;
b) convene weekly Labor-Management meetings;
c) reduce utilization of mandated shifts;
i. conduct weekly monitoring of mandated shifts use.

Target completion date: A total of 42 Labor-Management Meetings will be conducted by 7/1/06.

Fiscal resources: To be supported within existing hospital budget.

Goal 1, Objective 4

Performance Indicator:	Range of active treatment
Performance Measure:	Percent of clients for whom rehabilitation support is planned, provided and documented for primary functioning skills
Performance Standard:	95% of clients who have assessed needs in the area of primary functional skill rehabilitation will have the needs documented on the treatment plan and treatment or services provided

Objective #5: To assure that client rights are consistently understood, respected and monitored by staff and clients in ways that strengthen the consumer-centered nature of inpatient psychiatric care at Riverview Psychiatric Center.

Strategies:

1) Through a comprehensive critical incident and reporting plan, maintain and regularly review reports of patient incidents, grievances and use of restrictive practices to discern and correct undesirable trends.

Target completion date: A minimum of four Quarterly Performance Improvement Reports will be developed and distributed each year.

Fiscal resources: To be supported within existing hospital budget.

2) Develop and maintain a web page that provides the following, easily-accessible information:
   a) Rights of Recipients;
   b) Client Handbook;
   c) Visitor Guidelines;
   d) How to file a suggestion or complaint, including a description of grievance procedures available to all healthcare recipients;
   e) How to ask for information;
   f) Information about diagnoses;
   g) How to contact NAMI and other advocates or advocacy organizations;
   h) Finding peer supports in the community;
   i) Current and past Quarterly Performance Improvement Reports;
   j) Committee Minutes: Advisory Board, Executive Leadership, Human Rights, Labor Management, Safety, NAPPI Leadership.

   Target completion date: An Internet-based web page will be developed for the hospital with the elements noted above by 7/1/05.

   Fiscal resources: To be supported within existing hospital budget.

3) Establish an independent advocate position.

   Target completion date: A contract for advocacy services will be implemented by 10/15/05.

   Fiscal resources: Funding shall be utilized from savings in all other accounts through improved efficiency and effectiveness, outside medical costs, and reduction in administrative rates on existing contracts. Review existing grievance procedures to ensure reporting from the individual client perspective and appropriateness of the system's response.

   Target completion date: Human Rights Committee will complete review and revision by 8-1-05.

   Fiscal resources: To be supported within existing hospital budget.

4) Continue to have the grievance process monitored by the Human Rights Committee.

   Target completion date: Human Rights Committee will continually monitor grievance process and complete an annual self-evaluation.

   Fiscal resources: To be supported within existing hospital budget.

5) Capacity to consent for treatment shall be assessed by the treating practitioner at each treatment plan review and documented in a medical progress note.

Target completion date: Medical staff will complete a peer review of these assessments twice per year, with the first review by 12/15/05, documenting compliance and initiating quality of care improvement strategies.

Fiscal resources: To be supported within existing hospital budget.

Goal 1, Objective 5

Performance Indicator: Client grievances
Performance Measure: Response to client grievances within 5 days
Performance Standard: 98% of client grievances are responded to within 5 days

Goal 2: Ensure that Riverview Psychiatric Center provides Maine citizens with high-quality mental health inpatient treatment services within the least restrictive and most appropriate treatment setting.

Objective #1: To conduct pre-admission assessment and planning to achieve hospital admissions that are appropriate, timely and necessary to meet acute psychiatric care needs.

Strategies:

1) Riverview Psychiatric Center and other Department representatives, with input from community providers, will develop, implement, assess and revise hospital admission procedures designed to:

a) maintain the hospital's role as a tertiary care facility within the mental health continuum;
b) identify maximum benefit date of hospitalization;
c) coordinate with referral sources and community providers their expectations of hospitalization;
d) anticipate length of stay at time of admission;
e) utilize procedures to request intensive support from community regional team leaders in determining and securing the community service resources needed for especially complex situations;
f) continue referral of people inappropriate for Riverview admission (people with a primary diagnosis of mental retardation or other developmental disabilities, brain injury, dementia or substance abuse) to other treatment settings.

Target completion date: Above realized by 6/15/05.

Fiscal resources: To be supported within existing hospital budget.

2) Hospital staff will offer on-site consultation and training to community providers, including jails and prisons, upon request, to facilitate stabilization of clients in their environment of need.

Target completion date: A procedure will be established and implemented, with jail and prison staff oriented in how to request training by 7/1/05.

Fiscal resources: To be supported within existing hospital budget.

3) A continuity of care meeting will be convened within 2 business days of admission for all clients, including forensic clients who are referred by jails, to clarify expectations and the circumstances leading to hospitalization.

Target completion date: Quarterly Performance Improvement report will monitor implementation of current procedures by 10/15/05.

Fiscal resources: To be supported within existing hospital budget.

Goal 2, Objective 1

Performance Indicator:	Admissions to Riverview Psychiatric Center
Performance Measure:	Percent of admissions that meet all legal admission criteria
Performance Standard:	100% of admissions will meet all legal criteria for admission
Performance Indicator:	Readmissions to Riverview Psychiatric Center
Performance Measure:	Percent of admissions within 30 days of previous discharge that meet all established admission criteria
Performance Standard:	Percent of readmissions not more than the national mean, as reported by the NASMHPD Research Institute

Objective #2: To coordinate with community providers the timely transition into appropriate community placements of civil and forensic clients who no longer need hospitalization.

Strategies:

1) Train key staff in the "Transition Planning Guidelines for People Hospitalized at Riverview Psychiatric Center" policy, including the roles, functions, responsibility and authority of Continuity of Care Managers and Community Support Workers.

Target completion date: 85% of Program Service Directors and Continuity of Care Managers will receive training in the guidelines by 6/15/05.

Fiscal resources: To be supported within existing hospital budget.

2) Review transition-planning guidelines at least annually and make whatever revisions are necessary to improve the timely transition of clients into appropriate community placements.

Target completion date: Guidelines will be assessed and revised as necessary by 7/15/06.

Fiscal resources: To be supported within existing hospital budget.

3) Reduce hospital stays of current civil clients deemed ready to transition from hospital by:
    a) identifying a community services liaison to quickly identify communication issues and strategies that will address any service barriers that are preventing timely transitioning of civil clients into the community and may be leading to rapid hospital readmission of previous clients;
    b) creating a Service Plan of Operation for the Continuity of Care Department, identifying discharge planning, community support, assessment, service planning, active treatment provision and other key functions and orienting all staff to these procedures;
    c) conducting periodic status reviews of civil clients ready for transition to community placement;
    d) conducting a case review for each client readmitted within 30 days to identify specific supports, problematic behaviors, level and type of access to community treatment and other issues that may contribute to re-hospitalization, with results reported through Riverview Psychiatric Hospital's Performance Improvement Program;
    e) increasing participation of community providers in treatment planning and treatment planning reviews and reporting the effectiveness of this activity through the Performance Improvement Program;
    f) implementing a revised access protocol for community providers to increase participation in hospital-based service planning;
    g) maintaining continuity of care with community providers during unit transfers through a clearly defined transfer policy;
    h) convening staff and community provider representatives in a minimum of four Case Resolution Conferences annually to develop unique community care solutions for persons at risk of continued hospitalization.
    i) establish "post- discharge readiness" days as a performance measure for each region.

Target completion date: Average lengths of stay will be monitored through quarterly Performance Improvement reports beginning by 6/15/06. A discharge readiness report will be maintained and updated weekly identifying discharge readiness, needs, and action steps by 6/1/05.

Fiscal resources: To be supported within existing hospital budget.

4) Identify unmet needs requiring resource development through the updating of the ISP cover page by the community support worker, with input from the Riverview treatment team and the client, for those clients who have a community support worker.

5) Identify unmet needs requiring resource development through the Riverview discharge reports for those clients who do not have an ISP or community support worker. The appropriate regional office will be responsible for tracking any unmet needs upon discharge.

6) Reduce hospital stays for forensic NCR clients deemed ready to leave Riverview Psychiatric Center by:
    a) assessing aggressively appropriateness for expanded court conditions for rehabilitation toward community transition.
    b) transferring responsibility for operation and clinical oversight of Homestead to Riverview to provide transitional services for forensic clients.
    c) re-organizing professional services to supplement/coordinate a shared service model where hospital forensic staff provide some of the transitional care services to those in the community.
    d) exploring and assessing electronic monitoring options which may have utility for transitioning forensic clients into the community.

Target completion date: By October 2005, begin ongoing process of transitioning select NCR clients (those assessed to be appropriate, and having the necessary modified release authorizations) into the community on modified release status through use of private and hospital services.

Fiscal resources: Reallocate current RPC funding to isolate $100,000.00 for forensic transitional services by holding over savings from current fiscal year to next.

7) Collaborate with Mental Health Team Leaders to develop discharge plans for forensic clients and provide discharge plans to the placement facility a minimum of 24 hours prior to discharge.

Target completion date: Beginning with the first report produced after 7/15/05, Riverview's Quarterly Performance Improvement Report will address implementation of current procedures to develop and share discharge plans for forensic clients.

Goal 2, Objective 2 Revised 12/9/05

Performance Indicator: Transition of clients from Riverview Psychiatric Center into the community upon determination that maximum benefit has been received from inpatient care

Performance Measure: Percent of individuals transferred into the community post determination that maximum benefit has been received from inpatient care

Performance Standard:

- 75% of clients are transitioned within 7 days of maximum benefit from inpatient care
- 90% of clients are transitioned within 30 days of maximum benefit from inpatient care
- 100% of clients are transitioned within 45 days of maximum benefit from inpatient care, provided that plaintiffs' counsel and the Department may, by agreement, designate certain clients who will not be included in the calculations

for this standard, based on particular circumstances such as the client's refusal to agree to an appropriate discharge plan.

- Whenever a client is not discharged within 45 days of the maximum benefit determination, the Court Master shall, with notice to plaintiffs counsel, conduct an inquiry into the adequacy of the Department's efforts to transition the client into the community. The Court Master may conduct a similar inquiry whenever any of these discharge performance standards are not met.

Objective #3: To develop additional community-based resources necessary to support the placement of all class members who no longer require hospitalization into community settings that are appropriate to their needs.

Strategies:

1) With the support of NASMHPD's National Technical Assistance Center, develop and deliver complementary joint hospital and community education, training and technical assistance designed to increase local program capacity to deliver effective community-based services to complex and challenging individuals who may be self-injurious or present behavioral difficulties.

Target completion date: By 9/1/05, develop and deliver training.

Fiscal resources: Training funds will be provided by the National Technical Assistance Center for State Mental Health at the National Association of State Mental Health Program Directors.

2) Develop and expand appropriate community-based forensic supports by utilizing a jail/hospital liaison to consult with jails and community hospitals to support individuals who are at risk of hospitalization.

Target completion date: A forensic transition support plan will be developed and implemented by 9/15/05.

Fiscal resources: This involves redeployment of current staff. These strategies will be supported within the existing hospital budget.

Goal 2, Objective 3

Performance Indicator:	Training to increase local program capacity to support challenging clients after transition into the community
Performance Measure:	Percent of participants who indicate increase in their capacity to support and maintain challenging clients transitioned from Riverview Psychiatric Center into the community
Performance Standard:	85% of participants indicate that training offers "good" or "excellent" support in maintaining challenging clients in the community

Goal 3: Administer Riverview Psychiatric Center in a professional manner that ensures delivery of appropriate patient care within available fiscal resources.

Objective #1: To monitor, evaluate and improve hospital functions through consistent and timely performance reporting.

Strategies:

1) Implement a Performance Improvement Program that allows RPC to continuously monitor and track improvements in hospital performance in essential areas, including: development and implementation of individualized Inpatient Treatment Plans; PRN medication utilization patterns; frequency of medication errors; delivery and effectiveness of individualized client services; client elopements; client and staff injuries; receipt of appropriate, atypical generation of antipsychotic medications. (A description of the Performance Improvement Plan currently in place is included as Attachment A to this Chapter. The process changes as additional strategies for improvement are identified and incorporated into that plan.) The results of hospital licensing reviews, complaint investigations, inspection of care reports and accreditation reviews will also be utilized for monitoring and evaluation purposes.
2) Identify client needs for services upon discharge from Riverview Psychiatric Center through the development of transition plans which: a) become a component of the Individual Service Plan (ISP); or b) are collected by Continuity of Care Managers, for clients who choose not to have an ISP. (A complete description of the process for collecting and reporting unmet service needs for clients enrolled in the mental health service delivery system is included in Chapter V, Managing the Change.)

3) Conduct administrative morning report twice per week to address cross-discipline and program issues, significant trends in treatment, identification of needed supports or acute organizational challenges.

4) Conduct monthly Superintendent Town Hall Meetings to communicate hospital vision and develop support for continued change and improvements within RPC.

Target completion date: All activities designed to assess and enhance Riverview Psychiatric Center's institutional performance will be continually reviewed and refined throughout the plan period.

Fiscal resources: To be supported within existing hospital budget.

Goal 3, Objective 1

Performance Indicator:	Medication errors
Performance Measure:	Not more than the national mean, as reported by the NASMHPD Research Institute
Performance Standard:	Not more than one calendar quarter above the national mean within any six-quarter period
Performance Indicator:	Client elopements

Performance Measure:	Not more than the national mean, as reported by the NASMHPD Research Institute
Performance Standard:	Not more than one calendar quarter above the national mean within any six-quarter period
Performance Indicator:	Client Injuries
Performance Measure:	Not more than the national mean, as reported by the NASMHPD Research Institute
Performance Standard:	Not more than one calendar quarter above the national mean within any six-quarter period
Performance Indicator:	Clients receiving appropriate, atypical antipsychotic medications
Performance Measure:	Not more than the national mean, as reported by the NASMHPD Research Institute
Performance Standard:	Not more than one calendar quarter the national mean within any six-quarter period