INSTRUCTIONS FOR COMPLETING THE QUARTERLY PROVIDER CAPACITY REPORT

THE PURPOSE OF THE PROVIDER CAPACITY ASSESSMENT REPORT:

The Provider Capacity Assessment Report shall serve as a cover sheet for all Quarterly Documentation submitted to the LME by contract and MOA providers within the ACR catchment area. Contracted providers outside the ACR cathcment area are still required to submit all other required Quarterly Documentation but, are not required to submit the Provider Capacity Assesement Report. Data collected from the Report will be compiled and made available to providers and to the public via Quarterly LME QI Reports and in the LME's Annual Community Needs Assessment. The purpose of the report is to assist the LME in a process of continuous quality improvement in the following ways:

- assess community need and provider capacity to ensure the availability of a continuum of services for individuals with mental health, developmental disability, and substance abuse needs
- identify targeted areas for network development and provide data to support sound fiscal management
- monitor provider compliance with DMH/DD/SAS Rules and contractual requirements
- identify training and/or technical support needs of the provider community so that the LME can assist in meeting these needs

The Provider Capacity Assessment Report is available on the provider website (www.acmhddsa.net) under the Quality Improvement tab. The report must be submitted on a quarterly basis, along with other required quarterly documentation, on the following dates:

- **October 10**
- **January 10**
- **April 10**
- **July 10**

INSTRUCTIONS

Identify individual services (i.e. Community Support Services, Outpatient Therapy, etc…) provided by your agency in the columns at the top of the sheet and specify the population served by circling the appropriate population group.

Please note: Each service and population are to be listed in separate columns. For example, if your agency provides Outpatient Therapy to both adults and consumers, two columns will be required.

If more than 5 columns are needed, please use additional forms.

If any given category is has a zero total or is not applicable, please indicate with 'N/A' or '0', rather than leaving the box empty.

PART 1: ACCESS TO SERVICES

For each service identified at the top of each column, identify the following:

Total # of Consumers served this quarter: Record the total number of consumers receiving a service during the quarter
# of New Consumers enrolled this quarter: Record the total number of NEW consumers enrolled during the quarter
# of Discharges this quarter: Record the number of consumers who were discharged/terminated from each service during the quarter
Of consumers discharged, how many transitioned to a higher level of care: Of the number of consumers discharged, record the number that transitioned to a higher level of care (i.e. living independently/with parents to group care)
Of consumers discharged, how many transitioned to a lower level of care: Of the consumers discharged, record the number that transitioned to a lower level of care (i.e. Community Support Services to Outpatient Therapy, DO NOT INCLUDE THOSE THAT ARE NO LONGER RECEIVING SERVICES).
# of Referrals this quarter: record the total number of referrals received during the quarter
 # Denials this quarter (*): record the number of referrals not accepted/denied for each service
Average wait time from referral to intake: record the average number of days from the date of referral to the date the consumer is enrolled/provided an intake for each service
# of Current Openings: record the current number of openings for each service
(*) Please note reason(s) for any denials noted above: identify the reasons for any referrals that were not accepted/denied (i.e. did not meet target population, no insurance, authorization for services was denied)

PART 2: FIRST RESPONDER INFORMATION (This section must be completed if your agency has first responder responsibilities).

# of calls to First Responder Crisis Hotline: Record the # of calls placed to on-call phone/crisis hotline
# of calls to First Responder Crisis Hotline requiring telephonic intervention: Of the # of calls reported above, identify the # that required only over the phone intervention
# of calls to First Responder Crisis Hotline requiring face-to-face intervention: Of the # of calls reported above, identify the # that required agency staff to conduct a face-to-face intervention
# of calls to First Responder Crisis Hotline requiring external intervention (please specify: police, emergency room, Mobile Crisis, etc…): Of the # of calls reported above, identify the # that required staff to seek additional assistance-specify.

PART 3: REQUIRED ATTACHMENTS

Please attach the following:

- Copies of all External Programmatic Audits (i.e. reports, plans of corrections, etc… from all regulatory agencies)
- Copies of any Internal/Peer Review Audits (i.e. documentation reviews, internal investigations, needs assessments, etc…)
- Quarterly QI Minutes
- Quarterly Human Rights Minutes
- Quarterly Incident Reports

PART 4: OTHER INFORMATION

1. PLEASE DESCRIBE ANY CULTURAL OR LINGUISTIC CAPACITY (OTHER THAN ENGLISH) YOUR AGENCY HAS AVAILABLE FOR EACH SERVICE: SPECIFY LANGUAGES SPOKEN BY VARIOUS STAFF, SIGN LANGUAGE SERVICES, TRANSLATORS, ETC…

2. PLEASE TELL US ABOUT ANY STAFF TRAINING/TECHNICAL ASSISTANCE NEEDS THAT YOU HAVE IDENTIFIED. This information will help us in our on-going effort to provide educational/training opportunities to our providers.