



**New Hampshire Department of Health and Human Services
Division of Community Based Care Services
Bureau of Behavioral Health**

**Performance Audit: Monadnock Family Services
August-September 2010**

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EXECUTIVE SUMMARY

In June and July of this year, the Bureau of Behavioral Health (BBH) received a number of complaints, and expressions of concern regarding the operations of Monadnock Family Services. These concerns were raised by families, consumers and staff of MFS. As a result of these contacts to BBH, Commissioner Nicholas Toumpas of the NH Department of Health and Human Services directed BBH to conduct a performance audit of MFS.

BBH would like to extend sincere appreciation for the candor of each staff interviewed, and their willingness to meet with the audit team members and share their perspective on MFS.

The performance audit focused on the following 3 areas:

1. Whether the health, safety or welfare of consumers and the public is endangered by the continued operation of services by MFS. A positive finding in this area would potentially result in the suspension of MFS's designation to continue operations as a community mental health program pursuant to He-M 403.10(a).
2. An evaluation of the leadership and management of MFS, including oversight by the Board of Directors, and their ability to foster a work environment that supports the delivery of services in an efficient and effective manner as required by He-M 403.05.
3. Whether MFS is providing programs and services in accordance with the contract and applicable state and federal regulation. A positive finding(s) in this area would result in a written notice of the deficiencies and remedial action that is required pursuant to He-M 403.10(b).

The Audit Team made findings that require immediate attention in all 3 areas.

Observations #1 through #5 document concerns about the health, welfare and safety of consumers, families and the public who are provided services at Monadnock Family Services.

Observations #6 through #11 document concerns about the effectiveness of the management and Board leadership of MFS to foster a work environment that supports the ability to deliver services in an efficient and effective manner as required by He-M 403.05

Observations #12 through #14 document areas that MFS is not complying with State and Federal Regulations governing the provision of services. In at least 1 area, the provision of services at Emerald House, these observations reflect concerns about the health and welfare of the consumers residing in that program.

Additional findings are noted in Observations #15 through #17 relating to financial management issues.

Based on these findings, a corrective action plan, approved by the Bureau of Behavioral Health, is due no later than November 14, 2010.

The audit team would strongly encourage MFS to consider outside technical assistance to address these deficiencies, which would include drawing upon outside consultants as well as the internal expertise available from other community mental health centers in NH.

Members of the BBH audit team met with the MFS Board of Directors on September 23 and again on October 14 to review the Draft report and provide an opportunity for comments and suggested revisions. These meetings also provided an important opportunity for the Board to ask questions about the findings, and for the audit team to elaborate on each of the observations and recommendations to assist the Board and management of the organization in beginning the process of formulating and implementing a corrective action plan.

As of the publication of this report, the Board and management of MFS have taken significant steps forward in addressing a number of the observations and recommendations in the report. The audit team would direct the reader to Appendix G of this report for a detailed summary of the actions taken to date by MFS in response to the audit.

The Board and management of the organization have clearly demonstrated a desire to improve and strengthen MFS for the ultimate benefit of the consumers and families served, as well as promoting a positive work environment to support a dedicated staff of employees. The candor and responsiveness of the Board to these issues is sincerely appreciated.

A copy of this report will be available on BBH's website.

Sincerely;

The Bureau of Behavioral Health Audit Team

NEW HAMPSHIRE BUREAU OF BEHAVIORAL HEALTH

The Bureau of Behavioral Health (BBH) is part of the Division of Community Based Care Services within the Department of Health and Human Services. BBH is New Hampshire's designated State Mental Health Authority, and is responsible for providing oversight to New Hampshire's community mental health system, as well as peer and mutual family support services. BBH is also responsible for ensuring the effective and efficient delivery of services to adults with severe mental illness and children and adolescents with serious emotional disturbance. Community mental health services are provided through 10 independent community mental health centers designated by BBH as the regional community mental health program. As the State mental health authority, BBH provides funding and oversight to each of the 10 community mental health programs (CMHP's) through contract and administrative rule.

Performance audits are conducted in the community pursuant to authority granted by law and contract.

RSA 135-C:5, II:

The commissioner or designees may conduct site visits and may otherwise audit and monitor all aspects of the administration, fiscal operations, and services of the program providing the service to determine compliance with the rules authorized in RSA 135-C: 61.

RES 126-A:4, IV:

The department may establish a quality assurance program. Any quality assurance program may consist of a comprehensive ongoing system of mechanisms for monitoring and evaluating the appropriateness of services provided to individuals served by the department or any of its contract service providers so that problems or trends in the delivery of services are identified and steps to correct problems can be taken.

Contract Exhibit A, I. M:

The Contractor agrees that it will perform, or cooperate with the performance of, such quality improvement and/or utilization review activities as are determined to be necessary or appropriate by BBH within timeframes specified by BBH in order to insure the efficient and effective administration of the Medicaid program.

INTRODUCTION

Audit Background

It is a well recognized fact that New Hampshire's non-profit community mental health system has faced a number of significant pressures in the last few years- increased demand for services, an increased level of accountability governing the provision of services, and funding that has had difficulty keeping pace with the increased numbers of individuals and families needing services. Despite these challenges, a number of providers in New Hampshire have diligently planned for and effectively adjusted for these changes. Ultimately, within any non-profit organization, the Board of Directors has the final responsibility to carry out the mission of the agency, and ensure that care is efficiently and effectively provided to the consumers who depend on that agency for critical services. Managing change within an organization such as Monadnock Family Services is a key responsibility of the Board in order to ensure the agency is well positioned for current and future challenges. Failure to carry out these responsibilities not only has consequences for the future viability of the organization, but jeopardizes the services and community supports that those individuals and families so critically rely on.

In June and July of this year, the Bureau of Behavioral Health received a number of complaints, and expressions of concern regarding the operations of Monadnock Family Services. These concerns were raised by families, consumers and staff of MFS. As a result of these contacts to BBH, Commissioner Nicholas Toumpas of the NH Department of Health and Human Services directed BBH to conduct a performance audit on MFS.

The performance audit focused on the following 3 areas:

1. Whether the health, safety or welfare of consumers and the public is endangered by the continued operation of services by MFS. A positive finding in this area would potentially result in the suspension of MFS's designation to continue operations as a community mental health program pursuant to He-M 403.10(a).
2. An evaluation of the leadership and management of MFS, including oversight by the Board of Directors, and their ability to foster a work environment that supports the ability to deliver services in an efficient and effective manner as required by He-M 403.05.
3. Whether MFS is providing services and programs in accordance with the contract and applicable state and federal regulation. A positive finding(s) in this area would result in a written notice of the deficiencies and remedial action that is required pursuant to He-M 403.10(b).

Methodology

In conducting the audit, BBH employed the following approach to address the audit objectives.

1. BBH assembled an internal audit team to be responsible for all field work, conducting interviews with staff, and developing the final report. Please see Appendix A for a listing of the audit team staff.
2. On July 19, 2010, a pre-audit letter was provided to the Executive Director of MFS with a copy sent to the Chair of the Board of Directors informing MFS of BBH's decision to conduct the performance audit.
3. On July 26, 2010 formal written notification was provided to the Executive Director and Board of Directors of the audit, as well as an outline of the scope statement, and an estimated timeline for the audit review period. An initial request for information was also provided.
4. The audit team conducted a detailed review of MFS's most recent reapproval report and recommendations (which was conducted under a prior administration at MFS), the Contract with the State of NH, and the most recent Quality Improvement and Compliance Report (also conducted under a prior administration at MFS).
5. The audit team conducted a detailed review of relevant state and federal regulations specific to the scope and objectives of the audit.
6. Initial requests for information went out to staff designated by the Board of Directors and Executive Director on an ongoing basis throughout the audit process.
7. On August 2, 2010 representatives from BBH met with the Executive Committee of the Board of Directors, as well as the Executive Director to review the following:
 - The purpose and scope of the audit,
 - An outline of the performance audit process,
 - The role of audit team members,
 - The anticipated role of MFS staff and management,
 - A request for a designated point person at MFS for requests for information
 - An opportunity for the Board and the Executive Director to ask questions pertaining to the audit.

The Board provided an assurance to BBH that all staff would be encouraged to have open honest communication with the audit team, without fear of retribution or negative consequences to those individuals.

8. BBH conducted individual interviews with 27 staff. Based upon concerns expressed by staff prior to the commencement of the audit over job security and fear of retribution, BBH arranged for interview space in a neutral location in Keene.

- Interviews were conducted primarily in person, with 2 audit team staff participating in each interview. Based on scheduling issues, staff and consumer preferences, a few interviews were also conducted over the telephone.
 - BBH sent an introductory letter to all staff participating in the interviews. Please see Appendix B for a copy of the introductory interview letter.
 - Interviews were primarily conducted in space provided by Monadnock Developmental Services in Keene.
 - Interviews were conducted during the weeks of August 9th to September 13th.
9. Field work was conducted during the weeks of August 9th to September 13th where clinical records, personnel files, and financial data were reviewed at the agency.
 10. Data compiled from field work and interviews were reviewed with the full audit team on a weekly basis.
 11. A Draft report was prepared and reviewed with the Commissioner of Health and Human Services- Nicholas Toumpas, and Associate Commissioner Nancy Rollins by the audit team.
 12. This report was reviewed with the full Monadnock Family Services Board on September 23, 2010 and on October 14, 2010.
 13. An opportunity to comment on the report was provided before the report was finalized and distributed.
 14. The report will be made available on BBH's website for any interested stakeholder to review.
 15. A corrective action plan was requested with a specific deadline for response within the final report.

Monadnock Family Services Background Information

Monadnock Family Services (MFS) is the designated community mental health program under He-M 403 to serve the following cities and towns in region 5:

Alstead	Greenville	Nelson	Surry
Antrim	Hancock	New Ipswich	Swanzy
Bennington	Harrisville	Peterborough	Temple
Chesterfield	Hinsdale	Richmond	Troy
Dublin	Jaffrey	Rindge	Walpole
Fitzwilliam	Keene	Roxbury	Westmoreland
Francestown	Lyndeborough	Sharon	Wilton
Gilsum	Marlborough	Stoddard	Winchester
Greenfield	Marlow	Sullivan	

MFS has locations in the following communities:

Keene Winchester Jaffrey Peterborough
Walpole

As the designated community mental health program, MFS provides a comprehensive array of services including: Intake; psychiatric diagnostic and medication services; psychiatric emergency services; targeted case management services; individual, group and family psychotherapy, Evidence Based Practices including supported employment and illness management and recovery; residential services; outreach services; education and support to families and consultation services. MFS employs approximately 150 FTE positions.

MFS maintains a website (www.mfs.org) which includes information on treatment programs, consumer and family information, emergency services information, program locations and phone numbers, fundraising, web links and resources.

FINDINGS AND RECOMMENDATIONS

As a result of the audit, the Bureau of Behavioral Health has 15 critical area findings (Observations #1 through #15) which require the immediate attention of the Board of Directors. In addition there are 4 other area findings specific to financial management issues which although requiring a corrective action plan, do not at this point, require immediate attention.

1. There are 5 sets of Observations and Recommendations (Observation #1 through Observation #5) relating specifically to concerns about the health, welfare and safety of consumers, families and the public who are provided services at Monadnock Family Services. Observations and recommendations in this area fall under the title of “**Health and Safety**”.
2. There are 7 sets of Observations and Recommendations (Observation #6 through Observation #11) relating specifically to concerns about the effectiveness of the management and Board leadership of MFS to foster a work environment that supports the ability to deliver services in an efficient and effective manner as required by He-M 403.05. Observations and recommendations in this area fall under the title of “**Management and Leadership**”. This area had the most findings from the audit team.
3. There are 3 sets of Observations and Recommendations (Observation #12 through Observation #14) relating to areas that MFS is not complying with State and Federal Regulations governing the provision of services. In at least 1 area, the provision of services at Emerald House, these observations reflect concerns about the health and welfare of the consumers residing in that program. Observations in this area fall under the title of “**Compliance Issues**”.

Finally, the report details 4 sets of Observations and Recommendations (Observation #15 through Observation #17) relating to the financial management issues, which have been determined non-critical issues, but nevertheless require the attention of the management and Board of Directors to resolve. Observations and recommendations in this area fall under the title of “**Other Findings**”.

Health and Safety
Critical Findings Requiring Immediate Attention

Organization leaders have not effectively planned for the resources needed to provide a safe, accessible, supportive, effective and efficient environment for consumers, families, staff and others.

Observation #1: A review of the Emerald House program has found a number of serious deficiencies and non-compliance with state regulations that unless immediately corrected, pose a threat to the health and welfare of the residents who live and are served in this program.

Staff shortages, particularly in the area of nursing have significantly contributed to these identified problems.

An August 11 and 12, 2010 BBH review of Crisis Bed Documentation at Emerald House had the following findings:

- MFS staff provided a list of five consumers who had used the Crisis Bed between January 1, 2010 and August 11, 2010. Emerald House staff reported it was difficult to generate an accurate list of people who used the crisis bed with admission and discharge information. In addition, the Emerald House Crisis Bed 2010 Admission/Discharges list provided often did not correspond to documentation in the clinical records.
- Staff noted that crisis bed census data did not correspond with actual utilization- clients are admitted and served without any record of an admission.
- Medication logs for one February 2010 admission were not on file in the client record and could not be located at Emerald House.
- No medication logs were on file in the client record for a March 2010 admission, but were subsequently located at Emerald House.
- A third person appears to have had three admissions to Emerald House in April 2010, but medication logs were not on file in the client record. The medication logs were subsequently located at Emerald House.
- A May 2010 admission had no medication logs filed in the client record, but were subsequently found at Emerald House.
- A second May 2010 admission had several changes (Including the prescribing physician) noted on the medication logs and were simply crossed out but not dated or initialed.

The BBH review noted numerous deficiencies in crisis bed documentation and record keeping procedures, the ability to accurately determine utilization of the Emerald House crisis bed, and compliance with clinical record documentation.

An August 17, 2010 annual certification inspection report of Emerald House by the Health Facilities Administration finds the program not in compliance with numerous regulations. A corrective action plan to Health Facilities Administration is due within 21 days of receipt of the report. Areas of noncompliance cited in the report include:

- Emergency and Fire Safety
- Qualifications for Service Provision
- Health and Safety
- Renewal Certification Process
- Medication Administration
- Documentation
- Quality Review

BBH staff met with Health Facilities Administration staff on September 13, 2010 to review our respective findings and coordinate corrective action planning and follow-up visits to insure client safety.

If these issues are not immediately corrected, BBH will need to consider terminating funding for the program.

- ❑ *Recommendation #1.1: MFS leadership shall develop a plan to hire and retain nursing staff to meet the needs of the population served and comply with state and federal regulations.*
- ❑ *Recommendation #1.2: All program deficiencies, including documentation issues, for Emerald House shall be corrected within 30-days. The management and Board of Directors needs to develop and implement a corrective action plan to BBH and provide updates back to BBH on a weekly basis until all issues have been resolved.*

Observation #2: Administrative Rule He-M 403 requires a designated community mental health program to employ a qualified medical director. There have been three Chief Medical Officers since January 2010, the first 2 Chief Medical Officers resigned over disagreements with management. The current Chief Medical Officer (August 2010) is a temporary physician provided by a staffing agency who has been working under contract to MFS since May 2010. The current contract is extended in short, 3-month periods of time. The frequent changes in medical leadership have resulted in unclear roles, responsibilities and accountabilities for medical services staff within the organization. Physician oversight of care planning is severely limited. Access to safe, effective, and efficient care has been, and continues to be, significantly compromised.

- ❑ *Recommendation #2.1: MFS leadership shall develop a plan for the hiring and retention of a permanent Chief Medical Officer with clear roles and responsibilities.*
- ❑ *Recommendation #2.2: When contractual agreements for clinical services are renegotiated or terminated, the organization shall have a plan to maintain the continuity of client care.*

Observation #3: The lack of psychiatry staff has significantly impacted access to care for children and adults. Planned psychiatry staff departures have been terminated early by organization leaders without appropriate transition planning for consumers and families. Planning for the continuity of medical care including notification of changes to staff, consumers and families, rescheduling appointments, urgent/emergent care planning, evaluation and management of current and new applicants for service have not been articulated nor communicated throughout the organization.

Staff report that psychiatry services have been eliminated for clients who are determined not eligible for services but are nevertheless requesting services from MFS as Medicaid recipients.

Staff have reported high distress for family members, parents and consumers who have had multiple changes in physicians over the last year, often without notice, appointments being cancelled with little to no notice and an inability of staff to relay who will be seeing the client or when they will have an appointment available. Several staff interviewed noted that they will not refer clients for psychiatry services internally based on the unavailability of the service.

While management can document continuous and ongoing efforts to recruit permanent qualified psychiatry staff, not having sufficient psychiatry services results in poor care to consumers and families, and violates state and federal regulations requiring physician oversight of care provided.

Adequate psychiatry capacity at MFS is critical in ensuring timely access to these services and the required physician oversight of all services prescribed on the treatment plan.

Recommendation #3.1: MFS leadership shall develop and fully execute a plan to hire and retain psychiatry staff to meet the needs of the population served and comply with state and federal regulations.

Recommendation #3.2: Transition plans shall be developed and implemented for consumers, families and staff to insure access to and continuity of care.

Observation #4: The lack of nursing staff, specifically the Nurse Trainer, seriously jeopardizes safe medication administration for the residents at Emerald House. In addition, the Emerald House program is not in compliance with NH state regulations (He-M 1202).

- *Recommendation #4.1: MFS leadership shall develop a plan to hire and retain appropriate credentialed nursing staff to meet the needs of the population served and comply with state and federal regulations.*

Observation #5: The management has not provided a sufficient number and mix of individuals with the requisite competencies to support safe, quality care, treatment and services. Interviewed staff report inconsistent supervision, limited seasoned, credentialed staff, interns who require licensed supervisors to oversee their work and managers lacking in the competencies to perform their functions.

Recommendation #5.1: The management and leadership shall evaluate the sufficiency of staff to provide services and the effectiveness of those who work in the organization to promote safety and quality. Job descriptions reflective of the recent changes in organizational structure and function need to specify the competencies required for each position.

Management and Leadership
Critical Findings Requiring Immediate Attention

The Board of Directors (Board) has ultimate responsibility for safety and the quality of services based on its legal responsibility and operational authority.

Observation #6: MFS management report that the last comprehensive strategic planning process was conducted in May 2008. The strategic planning process is critical for not only the development of an organizations mission and vision, but also to proactively respond to changes in the overall business climate through a written strategic plan that actively involves the Board, staff, stakeholders and recipients of services from the organization.

Recommendation #6.1: The Board of Directors shall develop and implement a strategic planning process that actively involves all members of the Board, and actively seek input from stakeholders, MFS staff, consumers and families.

Observation #7: Based on interviews of staff, there is little indication MFS evaluates the organization's performance in relation to its mission, vision, and goals. There is Board correspondence acknowledging dramatic changes that MFS has undergone in the past year, including staff turnover and staff response to such change. The Board provided an opportunity for staff to express their concerns in a confidential manner.

Recommendation #7.1: The Board shall identify processes and tools to evaluate the effectiveness and efficiency of the ongoing organizational change at MFS.

Recommendation #7.2: The Board would benefit from additional training and technical assistance to further strengthen the Board and provide an opportunity for continued education.

Observation #8: The organizational leadership is not clear to the MFS staff interviewed. The organizational chart provided to BBH on 8-20-10 reflects senior management staff fulfilling several different functions. Staff interviewed identify the senior management as the CEO, COO and Director of Acute Care and Outpatient Services which is not consistent with the current organizational chart.

The majority of staff interviewed could not identify who is responsible for providing oversight to corporate compliance issues or quality improvement.

Many staff interviewed did not know the name of the medical director or who to report complaints to.

The majority of staff interviewed was unable to describe the roles and responsibilities of senior management in the organization, or who to go to in order to have a question answered specific to agency policy.

Recommendation #8.1: Management and leadership shall clearly communicate MFS organizational changes and changes in individual roles and functions in a consistent manner to all staff.

Observation #9: Management has not sufficiently encouraged teamwork to create structures, processes, and programs to permit a culture of safety and quality to flourish at MFS. Staff interviewed report that functions of departed staff are "picked up" only after gaps in services or programs are noticed. Staff interviewed report that a lack of proactive planning has often resulted in a loss of "key functions". Staff roles often are changed to adapt to needs of consumers and families, caseload changes based on staff vacancies, supervisory changes, and program changes.

Recommendation #9.1: Management and leadership shall establish a team approach among all staff at all levels to manage the organizational change at MFS.

Observation #10: MFS does have a code of conduct policy that defines acceptable, disruptive, and inappropriate staff behaviors. However, staff interviewed report that this policy is consistently ignored. The current culture demonstrated by the leadership is described as one of disrespect, intimidation, fear and retaliation. Many staff interviewed report being in fear of losing their jobs, particularly if they “speak up and raise concerns to management”. Many of the staff interviewed report that some senior management of the organization publicly speaks about staff using derogatory terms.

Staff interviewed report that issues of safety and quality cannot be openly discussed which has negatively impacted morale, staff turnover, and client care. Continuous staff turnover and poor morale contribute to poor care coordination and services to consumers and families.

The majority of staff interviewed noted that they would leave MFS if they had the opportunity to work somewhere else based on the “poor working conditions.” During the course of this review, one long-term staff member from MFS did in fact resign from their position in the agency.

Recommendation #10.1: The MFS Board and MFS management shall implement an effective Human Resources process to ensure all employees, including the management of the organization, model professional behavior in compliance with MFS policy and sound business practice. The organization shall have a process that allows staff, clients and families the opportunity to address ethical issues or complaints in a safe manner. This process shall be inclusive of staff, clients and families in its development.

Recommendation #10.2: The Board and management shall implement and incorporate a staff feedback process into the performance assessment of senior management staff.

Observation #11: Staff interviewed has no clear vision of systematic planning adapted to changes in the care environment, services and programs. Strategies for effectively managing performance improvement to support innovation and meet organizational challenges have not been sufficiently communicated by the leadership.

Recommendation #11.1: Planning shall include the consumers and staff. Leadership needs to communicate all elements of the organizational change process as it relates to improving client safety and behavioral

health care quality. Leadership shall evaluate the effectiveness of communication methods.

Recommendation 11.2: Leadership shall communicate the quality assurance plan to staff at all levels in the organization.

Compliance Findings
Critical Findings Requiring Immediate Attention

Observation #12: The organization must comply with federal and state laws and regulations that support client choice in the receipt of services. Some staff and consumers interviewed report that consumers are required to receive case management services in order to access physician and other services and treatment. This is a violation of state and federal regulations.

Recommendation #12.1: Organizational policies and procedures shall follow federal and state regulations.

Observation #13: All services and programs must be in compliance with BBH/MFS contract provisions and local, state and federal regulations in order to continue operations.

Recommendation #13.1: The organization shall submit a corrective action plan to DHHS Healthcare Facilities and Licensing within the specified timeframes. The organization must continue to be in compliance with federal and state regulations.

Observation #14: A review of documentation, which included progress notes and individual service plans relating to the provision of groups found a number of records which did not have the service prescribed or authorized by the physician. In addition, the practice of holding sign up sessions for therapeutic group participation without the direct participation of the physician does not meet state and federal requirements for the determination of medical necessity.

Recommendation #14.1: All services shall be reviewed and authorized by the physician, including the medical necessity of each clinical service, and documented on the individualized service plan, and contain the physician signature.

Recommendation #14.2: A plan shall be developed and implemented to ensure the active participation of the physician in the treatment plan development and oversight of the care provided.

Other Findings

Observation #15: The Memorandum of Understanding (MOU) between the Bureau and MFS regarding contract performance domains and standards were piloted during the state fiscal year 2005. The ratios of all of the Centers are given to the Agency on a monthly basis.

BBH calculated the financial performance standards using unaudited financial statements for the fiscal year 2005 sent to the Bureau. Subsequent to fiscal year 2005, MFS has been submitting monthly financial information for the continuation of calculating the financial performance standards.

Although the Board routinely receives monthly financial performance information, the monthly ratios calculated by BBH are not being reported to the Board.

Recommendation #15.1: The Agency shall submit the monthly ratio schedule to the Board of Directors.

Observation #16: The reappraisal report indicated that MFS's accounts receivable listing older than 360 days had increased by 87% from 2008 to 2009.

As of June 30, 2010 this amount increased by approximately 29% and an additional increase of 11.5% as of August 19, 2010.

An analysis clearly indicates that 67% of these receivables are for client fees. MFS stated that a new Finance position, Staff Accountant, has been developed and filled, with approximately half of this position being dedicated to improving the monitoring and management of the A/R system.

Although the annual external audit report has not noted any need to adjust the balance sheet for inadequate reserves, there is no indication that there has been any improvement at all with these outstanding receivables.

Recommendation #16.1: All receivables deemed uncollectible shall be written off in accordance with generally acceptable accounting principles.

Recommendation #16.2: A formal plan shall be developed to lower the overall days in receivables with weekly progress reports forwarded to BBH.

Recommendation #16.3: Complete work on current receivables as well as the oldest ones.

Observation #17: Some of the insurances (excluding Medicaid) are recorded to the general ledger without an adjustment for the contractual allowances. These adjustments are posted to the general ledger when MFS receives the statements from the applicable insurance company with the Explanation of Benefits (EOB). If the statements are not received timely the revenues will appear artificially higher than the actual amount of revenues received. MFS is aware of the contractual allowances for most insurance companies.

Recommendation #17.1: MFS should be recording the contractual allowances for these insurance billings in the same manner as they are recording Medicaid and clients fees. This will present the revenue more accurately and be more efficient as they will not have the extra procedure subsequent to the billings be processed.

CORRECTIVE ACTION PLAN REQUIRED

Upon Board receipt of this final report, Monadnock Family Services is hereby required to submit a corrective action plan, **approved by BBH prior to submission**, which addresses all of the observations and recommendations in this report, no later than 5:00 pm on November 14, 2010.

Failure to submit an approved corrective action plan to BBH will result in a notice of suspension of Monadnock Family Services' designation as the region 5 community mental health program.

On Behalf of the Bureau of Behavioral Health



Erik G. Riera
Bureau Administrator

October 19, 2010

Date

APPENDIX A

Listing of Audit Team Members (15)

Erik G. Riera	Bureau Administrator
Kelley Capuchino	Medicaid Policy Analyst
Dr. Mary Brunette	BBH Medical Director
Ann Driscoll	Audit Manager
Joy Cadarette	BBH Quality Improvement Unit
Chip Maltais	BBH Program Unit
Karen Orsini	Director of Quality Improvement
Michele Harlan	Office of Program Improvement
Robin Raycraft Flynn	BBH Program Unit Administrator
Jonathan McCosh	Audit Director, Division of Community Based Care Svcs.
William Howley	Division of Community Based Care Financial Manager
Diane Langley	Deputy Director, Division of Community Based Care Svcs.
Ry Perry	Director, Office of Client and Legal Services
Michael Kelly	BBH Quality Improvement Unit
Peter Reid	Financial Manager

APPENDIX B

Copy of Introductory Letter to Staff

On behalf of the Bureau of Behavioral Health we want to thank-you for taking time out of what we know is a busy and challenging schedule to meet with our review team. As you are aware, the Bureau of Behavioral Health is currently conducting a performance audit of Monadnock Family Services. When we conduct a review within an organization, it is generally part of a regular annual review or a process called "redesignation" which occurs every 5 years. This review is different, however, in that it is being done in response to concerns that we have heard from some of the staff at MFS as well as other stakeholders in the community. We understand that a lot has changed in the past year, and we are here to get your perspective on how things are going within the organization, and to help us learn more about how clients are accessing services, and whether or not there is anything the organization can do to improve services and promote a working environment for the staff that is safe and supportive of the work that you all do on a daily basis.

During our time at MFS, we will be not only meeting with various staff at the agency, but also doing work on site reviewing clinical records, agency policies and procedures and taking a close look at how clients access services, and specific requirements relating to the terms established in our contract as well as state and federal regulations.

We have arranged for interviews with some of the staff, and will be meeting with people in a neutral location- space secured at Monadnock Developmental Services, in order to provide for a setting that will hopefully allow for an open and constructive dialogue.

At the conclusion of this review, our team will develop a report outlining a clear set of observations and recommendations back to the Management and Board of Directors, from which we will require a corrective action plan to be submitted back to the Bureau of Behavioral Health for any areas of deficiencies noted. The Bureau of Behavioral Health places a high value on transparency within our own organization and the work that is done through community providers- we will therefore be making this report available to any interested individual or stakeholder.

The Bureau will be monitoring this plan very closely to ensure that it is carried out in a way that meets our overall goal, and a goal that I believe all of you share with us- to strengthen the organization both in the short term and long term for the future, and ensure that services to NH citizens in the Monadnock area remain available with a commitment to quality, and improved outcomes.

If you have any questions or concerns, please do not hesitate to contact me directly.

Sincerely;

Erik G. Riera
Bureau Administrator
NH Bureau of Behavioral Health
Hugh Gallen Office Park
105 Pleasant Street
Concord, NH 03301

APPENDIX C

Public Notice

THIS REPORT IS AVAILABLE TO THE PUBLIC
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The Bureau of Behavioral Health (BBH) is making this report available to the public in the interest of promoting a greater degree of transparency in state government specific to the oversight of contracted providers, as well as continuing to ensure a high degree of accountability and engagement of stakeholders in continuously improving New Hampshire’s service delivery system.

Questions pertaining to the content of this report can be directed to:

Erik G. Riera
Bureau Administrator
NH Bureau of Behavioral Health
Hugh Gallen Office Park
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Concord, NH 03301

(603) 271-5007
eriera@dhhs.state.nh.us

APPENDIX D

RESULTS OF ANNUAL CERTIFICATION INSPECTION COMMUNITY RESIDENCE

August 17, 2010

EMERALD HOUSE
Certification Number: 3607
32 Emerald Street
Keene, NH 03431

Based on the results of this survey, Health Facilities Administration finds the facility **NOT IN COMPLIANCE** based on the following regulations:

He-P 814.23 EMERGENCY AND FIRE SAFETY

1. Based on interviews with service providers, *the program failed to ensure that each licensee shall submit it's emergency plan to the local emergency management director and/or the local fire chief or his/her designee for review and approval when initially written and whenever the plan is revised*, as required by He-P 814.23(j)(2). Non-compliance as evidenced by:
 - a. The local emergency management director has not approved the Emergency Disaster Plan.

He-M 1002.04 QUALIFICATIONS FOR SERVICE PROVISION

2. Based on record review, *the program failed to ensure that all staff had a TB symptom screen*, as required by He-M 1002.04(a). Non-compliance as evidenced by:
 - a. Staff #1 did not have documentation of a TB symptom screen.

He-M 1002.06 HEALTH AND SAFETY

3. Based on record review, *the program failed to ensure than a health assessment occurred annually*, as required by He-M 1002.06(a). Non-compliance as evidenced by:
 - a. The most recent documented health assessment for Individual #2 was dated "4/14/09".

4. Based on record review, *the program failed to ensure for each individual unable to evacuate his or her residence within 3 minutes, a fire safety plan shall be developed and approved by the individual or guardian, provider, and residential administrator that identifies the cause(s) for such inability; The specific assistance needed by the individual from the provider; and a training approach to reduce the evacuation time to 3 minutes or less, and approved by the individual or guardian, and residential administrator, as required by He-M 1002.06(u).* Non-compliance is evidenced by:
 - a. The fire evacuation drill that occurred on June 10, 2010 required six (6) minutes to evacuate the residence.
 - b. The fire evacuation drill that occurred on July 27, 2010 required four (4) minutes and fifty-five (55) seconds to evacuate the residence.
 - c. The reviewer was unable to determine how many residents exceeded three (3) minutes to evacuate the residence due to a lack of information on the fire evacuation drill form.
 - d. No fire safety plan was completed for any individual in the home.
5. Based on record review, *the program failed to ensure that medication administration for individuals shall be conducted in accordance with He-M 1202, as required by He-M 1002.06(m).* Non-compliance is evidenced by:
 - a. There has not been an approved nurse-trainer supervising the residence since March 2010.
 - b. There are no current authorizations to administer medications for any staff in the home.
 - c. The medication logs for April 2009 through June 2009 were not present in the home.

He-M 1002.11 RENEWAL CERTIFICATION PROCESS

6. Based on record review, *the program failed to ensure that the application for certification was submitted sixty (60) days prior to the expiration of the certificate, as required by He-M 1002.11(b).* Non-compliance as evidenced by:
 - a. The application was not submitted until August 17, 2010.
7. Based on interviews with service providers, *the program failed to obtain a new, signed approval from the local fire official if renovations were completed since the last submission of a life safety code inspection that required a building permit*

pursuant to local building codes, as required by He-M 1002.11(c). Non-compliance as evidenced by:

- a. There were renovations in the residence that required a building permit.
- b. No new, signed approval from the local fire official has been submitted.

He-M 1202.03 MEDICATION ADMINISTRATION

8. Based on record review, *the program failed to ensure that only authorized providers or licensed persons administered medications*, as required by He-M 1202.03(a). Non-compliance is evidenced by:

- a. Eight (8) of eight (8) staff people did not have current authorizations to administer medications.
- b. Due to a lack of documentation, the reviewer was unable to determine if staff in the home were authorized to administer medications.

9. Based on record review, *the program failed to ensure that authorized providers only administered medications for which there was a valid order*, as required by He-M 1201.03(e). Non-compliance as evidenced by:

- a. The reviewer was unable to determine if the following orders are still valid for Individual #1 due to a lack of documentation of the order:
 - Aspirin 81mg 1 tablet daily. Ordered on July 2, 2009 per medication list.
 - Benadryl 25mg. Take 2 tablets as needed daily. Ordered June 25, 2008 per medication list.
 - Gemfibrozil 600mg. Take 1 tablet twice daily. Ordered July 2, 2009 per medication list.
 - Nlaspar 500mg take 2 tablets at bedtime.. Ordered July 2, 2009 per medication list.
- b. The following orders are not valid for Individual #2:
 - Vitamin D. Take 1 capsule daily. Ordered August 8, 2008.
 - Bupropion take 1 tablet daily. Order not signed or dated.
 - Nexium 40mg. Take 1 capsule daily. Ordered on June 10, 2009.

10. Based on interviews with service providers, *the program failed to ensure that all individuals shall be initially assessed by a licensed practitioner, A.R.N.P., physician assistant, or nurse-trainer to determine the level of support needed specific to medication administration*, as required by He-M 1202.03(b). Non-compliance as evidenced by:
- a. Based on interviews with the program manager and the LPN involved in the program, individuals have not been initially assessed to determine the level of support needed specific to medication administration.
 - b. The assessment only occurs after the individuals have been in the program for at least six (6) months.

He-M 1202.06 DOCUMENTATION

11. Based on record review, *the program failed to ensure that authorized providers shall maintain documentation of medication administration that includes the name of the individual, if applicable, the guardians name and contact information, allergies as applicable, and for each medication prescribed the name, dosage, frequency, route, date and time of administration, the name of the prescribing practitioner, the order date and special considerations*, as required by He-M 1202.06(a). Non-compliance is evidenced by:
- a. The medication logs from April 2009 until June 2009 for all individuals could not be located.
12. Based on record review, *the program failed to ensure that when controlled medications are ordered, authorized providers shall maintain documentation of a daily count*, as required by He-M 1202.06(e)(8). Non-compliance is evidenced by:
- a. Individual #2 was prescribed Percoset 5/325mg, but the reviewer was unable to determine the order date due to a lack of documentation.
 - b. No controlled drug count for any month was completed for this medication.
 - c. The reviewer was unable to determine when the Percoset was prescribed, and which months were missing controlled drug counts due to a lack of documentation of the order date.

He-M 1202.08 QUALITY REVIEW

13. Based on record review, *the program failed to ensure that a registered nurse or licensed practical nurse reviewed medication logs monthly*, as required by He-M 1202.08(a). Non-compliance is evidenced by:

- a. The August 2009 medication logs and July 2009 medication logs were not reviewed until October 5, 2009.
- b. The June 2010 logs were reviewed on June 30, 2010, and the January 2010 logs were reviewed on January 31, 2010.
- c. The quality reviews for April 2009, May 2009 and June 2009 could not be located.

Survey Team:

Jay Kurinskas

Peter E. Bacon Date
Community Residence Coordinator
Health Facilities Administration

APPENDIX E

Acronyms and Definitions

Acronyms

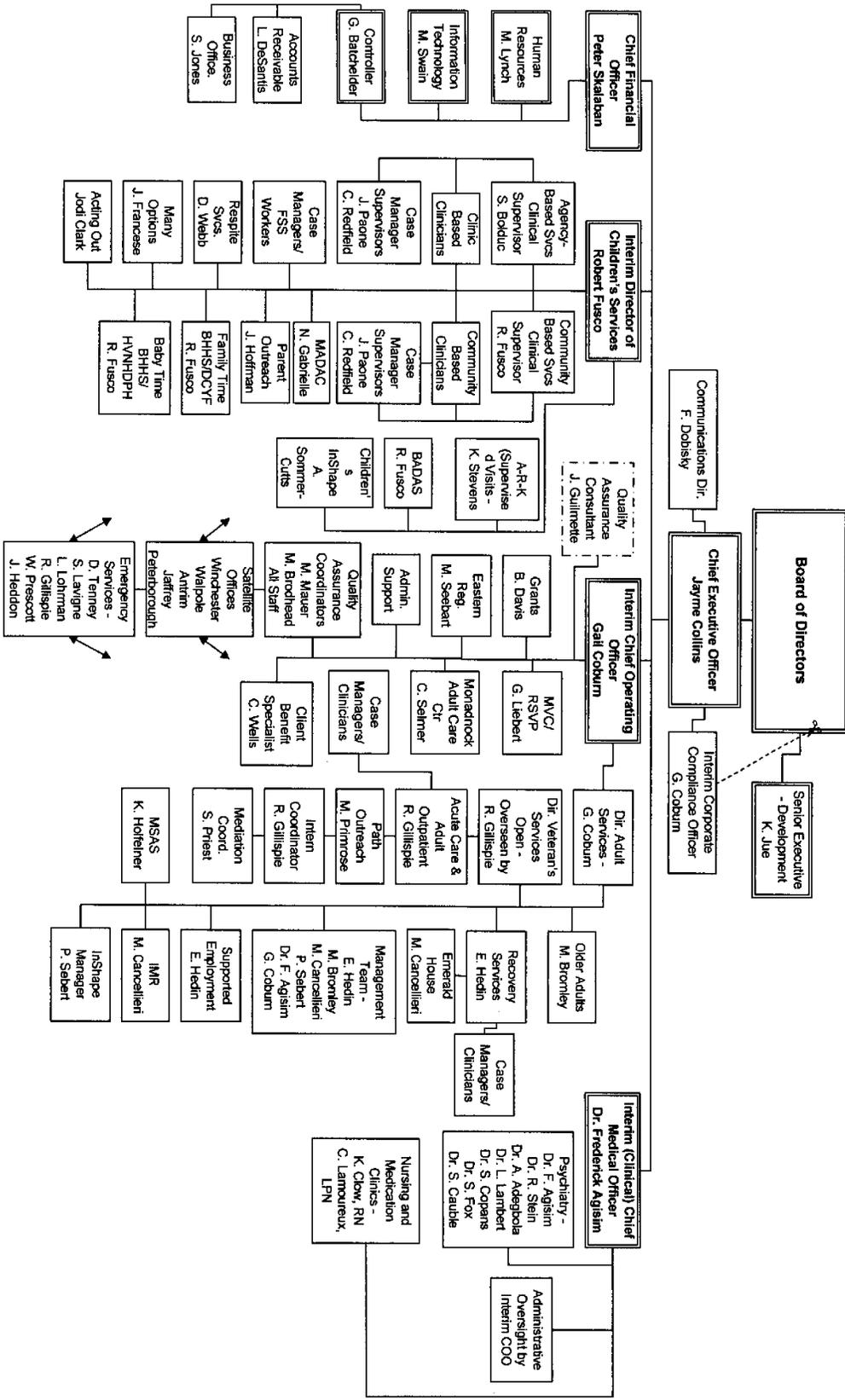
BBH
BOD
CEO
CFO
CMHP
DCBCS
DHHS
EBP
ED
FTE
MFS
MOU
RSA
SFY
SMHA
SURS

Definitions

Bureau of Behavioral Health
Board of Directors
Chief Executive Officer
Chief Financial Officer
Community Mental Health Program
Division of Community Based Care Services
Department of Health and Human Services
Evidence Based Practice
Executive Director
Full-time Employees
Monadnock Family Services
Memorandum of Understanding
Revised Statutes Annotated
State Fiscal Year
State Mental Health Authority
Surveillance Utilization Review Subsystems

APPENDIX F

Monadnock Family Services



APPENDIX G

MFS Response Letter



October 13, 2010

Erik G. Riera
Bureau Administrator
NH Bureau of Behavioral Health
Hugh Gallen Office Park
105 Pleasant Street
Concord, NH 03301

Dear Erik:

This letter is written as an update to the progress that has been accomplished to date with regard to the deficiencies cited in the September 2010 performance audit report. We are grateful for the opportunity to provide some input and observations.

Health and Safety (Observations #1, #2, #3, #4, and #5)

Beginning with **Observation #1**; related to the review of Emerald House on August 17, 2010 during the annual certification inspection by the Health Facilities Administration conducted by Jay Kurinkas; while we acknowledge that there were a number of legitimate deficiencies during the site visit, the health and welfare of the residents was determined by Jay to not be at risk. In fact he commented that because he observed that the clients were “healthy and happy” he did not believe they would be at risk during the time it would take for problem areas to be corrected. Following this visit, we submitted a corrective action plan on September 20, 2010 to Peter Bacon, Community Residence Coordinator, Health Facilities Administration, three days prior to the shorter of two deadlines (September 23, 2010) we were given for responding. By the time the corrective action plan was submitted on September 20, 2010, all of the deficiencies had been corrected with the exception of the nurse training issue.

Currently, medication training for all Emerald House staff as well as case managers has been completed by our former Nurse Trainer, Janet Vandenberg, R.N., and we have a new Nurse Trainer, Chris Selmer, R.N. (also trained by Janet), who is performing the tasks of that role in Emerald House and throughout the agency with regard to the medication training. She received her certification as a Nurse Trainer on October 4, 2010. This was the final piece to bringing Emerald House into complete compliance.

Everything that we did to respond to the site visit report and the deficiencies noted therein has been done in consultation with Jay Kurinskas who has been an enormous resource and provided much technical assistance to our Emerald House Supervisor, Michael Cancielleri. As a matter of fact, Mike has Jay's cell telephone number on speed dial. In spite of completing this successful corrective action, we have yet to receive formal approval of the original corrective action plan submitted on September 20, 2010.

The crisis bed is not being used at this time because when Ry Perry, Director, Office of Compliance and Legal Services, DHHS, declined to authorize the waiver for two additional beds that had been authorized for the past five years, it eliminated the crisis bed. This is unfortunate as it was one alternative to hospitalization that is now closed to our clients. If this waiver for the extra beds is restored to us, we will implement a corrective action plan that will include additional staff training, documenting all significant client activities, clear discharge plans and the appropriate medical orders, etc. It should be noted that, by your own report, the medication logs that were thought to be missing were subsequently found. This indicates one or more procedural problems which again, would be corrected with training and procedural revisions. With the bed being closed; however, it is a moot point. With the hiring of our new C.M.O., the oversight of this critically intense clinical service (the crisis bed) will be more consistently uniformly monitored and supervised.

Observation #2 addresses the community mental health program to employ a qualified medical director. Dr. Frederick Agisim has been working here since May 2010, first as an adult psychiatrist and in August 2010 as our Interim C.M.O. He has now accepted the appointment of C.M.O. and will begin as a full time MFS employee (versus locum tenens) on October 16, 2010. An announcement to staff and board went out this afternoon, October 13, 2010. (See Attachment 1)

Observation #3 addresses lack of psychiatry staff. We have achieved a great deal of progress in this regard. Our last children's psychiatrist, Dr. Cauble, was doing one full day per week seeing children in Keene when our agreement with him was abruptly terminated on September 7, 2010, by the CMO of Dartmouth and at the direction of NHH and his supervisor. He was not able to provide even 24 hours' notice that he would not be in Keene the following day to see a fully scheduled day of clients.

While staff were concerned and frustrated, it was not accurate that clients were left without care or put at risk. We were able to temporarily refer some clients to their PCP who, in Keene, has ready access to psychiatric consults provided by a children's psychiatrist. The following day we were also able to see clients in the children's

department on an emergent basis and we now are seeing them regularly and have been seeing them since the departure of the children's psychiatrist. Throughout these departures, the services for children and adults in Peterborough and our more eastern region were never reduced or interrupted.

Currently, the number of available medication clinic appointments has increased significantly above what MFS has offered for many years. Dr. Joseph, a locum tenens in our recovery department who began in our recovery department September 1, 2010, has now extended her contract to March 2011 and she recently stated that she has "strong leanings toward becoming full time." Between Dr. Agisim and Dr. Joseph, we are currently offering 120 medication clinic appointments each week. Compare this number to the 71 medication clinic appointments offered each week when all four doctors (Dr. Olson, Dr. Marsh, Dr. Wickberg and Dr. Satterfield) were practicing here during January of 2010.

On October 8, 2010 we finalized the hire of a locum tenens psychiatrist with a specialty in children and adolescents who will begin November 15, 2010. Dr. Slenzynsky's contract gives us a one year option for his services. Our search for the permanent doctors that can fill these positions is ongoing, but these extended agreements afford us the time to adequately and more thoughtfully manage the search for filling these permanent positions.

In **Observation #4**, the focus was on lack of nursing staff and we have made significant progress to address the problems that were indicated in the audit report and most particularly those regarding Emerald House. Beginning with the hiring of Chris Selmer, an R.N. with more than 20 years of experience, we have addressed the issues with the nursing problems at Emerald House as well as the issue of nursing leadership and supervision. Additionally, we are advertising and recruiting for another R.N. Finally, we have an employee whose education we have subsidized and who is in her last semester of nursing school. She has expressed an interest in becoming an R.N. here and, with Chris' able assistance, we are hoping to be able to promote this employee so that she can benefit from the wonderful mentoring and training that we know Chris can provide.

Observation #5 describes an insufficient number of competent staff to support providers. Several experienced and qualified staff have been relieved of some direct care responsibilities in order to support and supervise providers at all levels. We have significantly lowered the billable standard for one of our LCSWs and named her Adult Clinical Supervisor. Our new Interim RSS Director is in the process of gathering the documentation for his license in another state and studying for the NH licensing exam (he was previously licensed in Florida, but never pursued his license here). We expect that he will complete this process by the end of this year and will expand his clinical supervision duties for adult clinicians.

The previous Director of Acute Care was licensed in another state and has been replaced by a new Interim Director of Acute Care who is licensed in N.H. He will provide clinical supervision for the acute care (Emergency) staff and clinicians. One of our children's

clinicians who was previously licensed in another State just received October, 2010, her N.H. license and has been named Interim Corporate Compliance Officer and Children's Quality Assurance/Clinical Supervisor. In addition, quality assurance responsibility for adults has been assumed by a former case manager. Both of these staff have trained under Jane Guilmette learning the David Lloyd model for quality assurance. In addition, both of these staff have been identified by us as the next people to be sent to training for complaint investigations.

Management and Leadership (Observation #6, #7, #8, #9, #10, and #11)

In general, **Observations #6 through #11** concern the Board of Directors rolls and responsibilities, staff being uninformed and uninvolved in the management of the agency and communication issues. All of these concerns will be addressed through the proposed hire of a healthcare organizational and management consultant, Ron Morton, of the nationally acclaimed Meyers Group. Please see attached proposal which specifically addresses each of the key areas and is available as soon as we can arrange the board and management schedules. The end product of this in depth consulting will provide a corrective action plan to each of the issues cited in observations 6, 7, 8, 9 and 11. (See Attachment 2)

Observation #10 relates to intimidating conduct by some senior management toward some staff. This serious concern has recently been brought to light through our own confidential opportunity for staff to share concerns known as "Coffee with Audrey". Immediate action was taken the day after the audit team's presentation to the MFS Board. Our Interim Chief of Operations was removed from direct supervision of all staff and announced a transitional plan for her to leave the agency by the end of 2010.

In full acknowledgement of this concern I have decided that all managers and supervisors (including me) will complete Bullying in the Workplace training. I have directed our grant writer, Ben Daviss to investigate cost and availability of presenters. He has contacted the New Hampshire Charitable Foundation regarding possible grant monies to cover the cost of this training. We plan to have this occur by Monday, December 20, 2010.

Compliance Findings (Observation #12, #13, and #14)

While **Observation #12** was a longstanding practice of the agency (requiring consumers to receive case management to access a physician); current leadership discontinued this practice January 1 of 2010. Conversation since receiving the audit, particularly in our children's department revealed both disagreement and confusion about this change. Thanks to the audit, we have now reviewed with all staff that this is not an accepted practice of the agency and is in violation of client rights.

As for **Observation #13** regarding a corrective action for Emerald House, all corrections have been completed and verbally supported by Jay Kurinskas, the Licensing and Evaluation Coordinator of the Health Facilities Administration.

In response to **Observation #14**, we will henceforth request our psychiatrist to attend our registration day for TBS and IMR groups to ensure that all services are reviewed and authorized by the physician who will determine medical necessity of these groups.

Respectfully submitted,

Jayne Collins, C.E.O.

APPENDIX H

TO: New Hampshire Bureau of Behavioral Health
FROM: Monadnock Family Services Board of Directors
DATE: October 4, 2010
SUBJECT: Performance Audit Report

The Board of Directors wishes to express its sincere appreciation for the work of the audit team of the Bureau of Behavioral Health (BBH) and staff of Monadnock Family Services (MFS) for completing this audit report in a timely fashion. The information contained herein represents a significant opportunity for the organization to further understand and act upon the concerns of clients, staff, and the community. The Board has long recognized that the recent leadership transitions within and financial pressures upon MFS are stressful to clients and employees. We are committed to working with management and all members of the organization to address and resolve each of the observations. In the majority of cases, responses to the concerns expressed were already in process based on management's and the Board's knowledge of the issue. We acknowledge that communication of our actions and plans has not always been adequate and we will be attentive to improving this perception as we continue to respond to concerns raised by all constituents.

Our gratitude for the staff of MFS has never been greater than during this time of transition. We have been humbled to hear of the commitment to and concerns for our clients expressed by everyone involved in this evaluation process. We share these commitments and concerns and know that, from that shared set of values, MFS will emerge stronger than ever. We pledge to provide focused attention and guidance to assure that this is the case and to implement a satisfactory resolution to each and every finding contained within this report.

cc. Nancy Rollins, Assistant Commissioner, NH DHHS
Erik Riera, Administrator, BBH
Jayme Collins, CEO, MFS