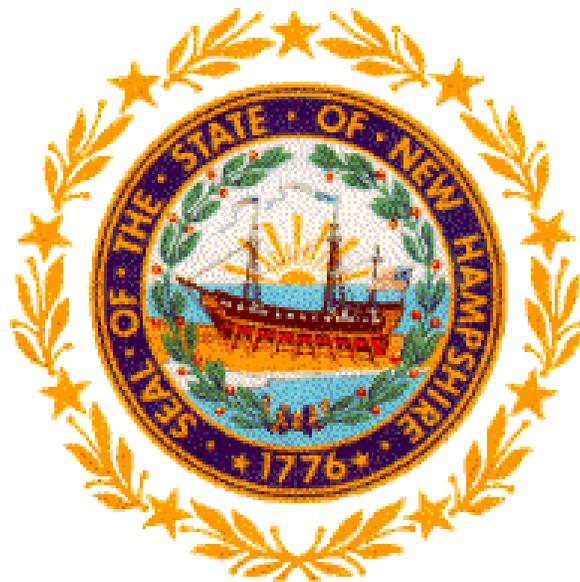


**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF BEHAVIORAL HEALTH**

**COMMUNITY MENTAL HEALTH PROGRAM
REAPPROVAL REPORT**



NORTHERN HUMAN SERVICES

MAY 7, 2010

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF BEHAVIORAL HEALTH

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ACRONYMS AND DEFINITIONS

Acronyms

Definitions

BBH	Bureau of Behavioral Health
BOD	Board of Directors
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CMHP	Community Mental Health Program
CSP	Community Support Program
DCBCS	Division of Community Based Care Services
DHHS	Department of Health and Human Services
EBP	Evidence Based Practice
ED	Executive Director
ES	Emergency Service
FSS	Functional Support Services
GOI	General Organizational Index
GSIL	Granite State Independent Living
IOD	Institute on Disability
IMR	Illness Management and Recovery
ISP	Individual Service Plan
IT	Information Technology
MOU	Memorandum of Understanding
NAMI-NH	National Alliance for the Mentally Ill
NHH	New Hampshire Hospital
NHS	Northern Human Services
NHVR	New Hampshire Vocational Rehabilitation
PRC	Dartmouth Psychiatric Research Center
OCFA	Office of Consumer and Family Affairs
OCLS	Office of Client and Legal Services
OIII	Office of Improvement, Integrity and Information
PSA	Peer Support Agency
QI	Quality Improvement
REAP	Referral, Education, Assistance and Prevention
SFY	State Fiscal Year
SURS	Surveillance Utilization Review Subsystems
SE	Supported Employment
TCM	Targeted Case Management Services
UNH	University of New Hampshire

EXECUTIVE SUMMARY

In accordance with State of New Hampshire Administrative Rule He-403 Approval and Reapproval of Community Mental Health Programs, reviews of community mental health programs (CMHP) occur upon application and thereafter every five years. The purpose of He-403 is to define the criteria and procedures for approval and operation of community mental health programs. A reapproval review of Northern Human Services (NHS) in Conway, NH occurred on June 15-16, 2009. The review team included staff from the Department of Health and Human Services (DHHS), the Bureau of Behavioral Health (BBH) and the Office of Improvement, Integrity and Information (OIII).

NHS submitted an application for reapproval as a CMHP that included:

- A letter requesting Reapproval;
- A description of all programs and services operated and their locations;
- The current strategic plan;
- A comprehensive listing of critical unmet service needs within the region;
- Assurances of compliance with applicable federal and state laws and rules;
- The Mission Statement of the organization;
- A current Board of Director list with terms of office and the towns represented;
- The By-Laws;
- The Board of Director (BOD) meeting minutes for Calendar year 2008;
- The current organizational chart;
- Various job descriptions;
- The current Quality Improvement Plan;
- The current Disaster Response Plan.

Additional sources of information prior to the site visit included:

- The New Hampshire Public Mental Health Consumer Survey Project (December 2008);
- Evidence Based Practice (EBP) Fidelity Reviews for Illness Management and Recovery (IMR) and Supported Employment (SE);
- BBH QI and Compliance Reports Five Year Trends;
- BBH Community Mental Health System Annual Report of Financial Condition for Fiscal Year 2008 with Five Year Financial Trend Analysis;
- A Public Notice published in local newspapers soliciting feedback regard the CMHP;
- A letter to constituents identified on the NHS mailing list soliciting feedback regard the CMHP;
- Staff surveys soliciting information from NHS staff regarding training, supervision, services and CMHP operations.

The site visit to NHS included:

- Review of additional documentation including: orientation materials for new BOD members; the Policy and Procedure Manual; Interagency Agreements and Memoranda of Understanding (MOU); a sample of personnel files;
- Interviews with the BOD, the CMHP Management Team, the Chief Financial Officer (CFO), Human Resources Director.

The findings from the review are detailed in the following focus areas: Governance; Services and Programs, Human Resources; Policy; Financial; Quality Improvement and Compliance; Consumer and Family Satisfaction. The structure of the reports includes the Administrative Rule Requirement, team observations, team recommendations and a text area for the CMHP response.

The following is a summary of the recommendations included in the report:

- The BOD needs to become more involved in the development and approval of the budget;
- Consider having a consumer presentation to BOD that might focus on peer support, Wellness Recovery Action Planning (WRAP) or Intentional Peer Support (IPS) as a way of reinforcing recovery philosophy to BOD;
- The BOD and Finance Committee minutes should document more discussion of the agency's overall financial health;
- It is recommended that the disaster response plan be reviewed and approved by the BOD;
- Strategies be utilized to increase IMR penetration rates;
- A structured IMR training occur within 2 months of hiring for new practitioners and be documented in personnel files;
- Adequate time be allocated in Berlin to accommodate IMR-specific supervision for all practitioners delivering IMR in either individual or group format;
- An outcome measure that is satisfactory to NHS be developed or acquired for the purpose of providing the agency with feedback on the impact of IMR;
- Outcome data should be collected, analyzed and shared with IMR practitioners;
- Invite the IMR Program Leader from Wolfeboro to be an active participant in the monthly Steering Committee meetings;
- Ensure that group sizes remain small enough (8 or less) so that consumers are able to fully participate in the sessions;
- Develop documentation that fosters consumer centered goals and objectives including the individual recovery goals developed in IMR Module 1;
- Provide training in Wolfeboro regarding the principles of behavioral tailoring for medication;
- Actively market the SE program to the eligible population in an effort to increase the penetration rate;
- Leadership make a commitment to fully implementing the SE model;
- Ensure that the employment specialist roles and responsibilities emphasize strategies that will increase competitive employment and de-emphasize agency-based employment;
- Work to enhance integration of employment specialists with the mental health treatment teams;
- Establish a working relationship with the local NHVR counselors in all locations;
- Explore ways to establish a SE team/unit;
- Continue to explore ways to serve ethnic, cultural, sexual and other minority populations in the region;
- Develop policies regarding the provision of or the referral to child and adolescent sexual offender assessment and treatment;
- Complete annual substance use screens for all adults and children over 12 years of age;
- All case management descriptions be limited to the core case management activities of assessment, referral and monitoring;
- Explore opportunities to collaborate with the PSA;
- Revise the Children's Services Coordinator job description to include service system planning for children and adolescents and all inpatient admissions and discharges, including the Anna Philbrook Center;
- Develop an Elder Service Coordinator's job description that includes oversight of program

development, training, and interagency collaboration, and participates in regional and statewide planning activities with other elder serving agencies;

- Personnel files be monitored for completeness at least annually at the time of the performance review;
- A check off sheet be created for the inside cover of each personnel file to facilitate tracking of required elements;
- All policies (including financial) be consolidated in one policy manual;
- NHS should submit the monthly ratio schedule to the BOD;
- NHS should submit the required reports to DHHS on a monthly basis;
- NHS should establish a line of credit with any banking institution;
- NHS should strengthen its information technology controls;
- Explore ways to include consumer and family input into quality improvement and planning activities;
- Devise a corrective action plan to ensure that all services are documented in the clinical record prior to billing;
- Share the BBH QI and Compliance Reports with the BOD and utilize in planning activities;
- Continue to conduct and document internal quality improvement and compliance activities;
- Share the NH Public Mental Health Consumer Survey Project with the BOD and utilize in planning activities.

PURPOSE, SCOPE AND METHODOLOGY

Staff from the NH DHHS, BBH and OIII, conducted an on-site review of NHS on February 2-6, 2009. Members of the review team included Karen Orsini, Michael Kelly, Joy Cadarette, Chip Maltais, Ann Driscoll and Alan Harris. The review was conducted as part of a comprehensive reapproval process that occurs every five years in accordance with Administrative Rule He-M 403.

A brief meeting was held to introduce the team members and discuss the scope and purpose of the review. In an effort to reduce the administrative demands on agencies, the annual QI and Compliance review was conducted during the reapproval visit. Please note that the results of the eligibility determination review are not fully included in this document and have been sent as a separate report. Two structured interviews were conducted as part of the site visit, one with the Management Team and another with the BOD.

A brief exit meeting was conducted on February 6, 2009 and was open to all staff. Preliminary findings were reviewed and discussed at that time.

Prior to the visit, members of the team reviewed the following documents: (Available at BBH)

- Letter of application from NHS requesting reapproval as a community mental health center;
- Critical unmet service needs within the region;
- Assurances of compliance with applicable federal and state laws and rules;
- Description of all programs and services operated and their locations;
- Current strategic plan;
- Mission Statement of the organization;
- Current Board of Director list with terms of office and the towns represented;
- Board of Director By-Laws;
- Board of Director meeting minutes for calendar year 2008;
- Current organizational chart;
- Job descriptions for Chief Executive Officer, Medical Director, Children's Coordinator, Older Adults Coordinator, and Case Manager;
- Current Quality Improvement Plan;
- Current Disaster Response Plan;
- The NHS contract with BBH;
- Results of SFY 2007 Adult and Child Eligibility Review;
- The findings of the previous reapproval report;
- Fiscal Manual;
- Billing Manual;
- Detailed aged accounts receivable listings for SFY 2007 and SFY 2008;
- Job Descriptions for all accounting and billing staff.

The onsite review at NHS included an examination of the following:

- Board of Director policies;
- Orientation materials for new Board of Director members;
- Board of Director approved Policy and Procedure Manual;
- MOUs or Interagency Agreements including those with but not limited to:
 - Peer Support Agencies;
 - Housing Authorities;

- Homeless Shelters;
- Substance Use Disorder Programs;
- Area Agencies;
- Vocational Rehabilitation;
- Division of Children, Youth and Families;
- Other Human Services Agencies;
- Adult and children's Criminal Justice organizations;
- NAMI-NH.
- Policies and procedures for:
 - Clients Rights;
 - Complaint Process/Investigations.
- Management Team Minutes for calendar year 2008;
- Several personnel files including those for:
 - Chief Executive Officer;
 - Medical Director.

A Public Notice of the CMHP's application for Reapproval was published in NH's statewide and local newspapers distributed in the region in an effort to solicit comments from the communities served.

In addition, BBH sent letters soliciting feedback from agencies within the region with which NHS conducts business.

Employee surveys were sent to NHS staff during the review process soliciting anonymous feedback regarding various issues relevant to employee satisfaction. The results are summarized in this report.

Information was gathered from a variety of additional sources from different times within the previous approval period. Observations and recommendations are based on the information published at that time. Sources of information include:

- The New Hampshire Public Mental Health Consumer Survey Project (December 2008);
- EBP Reviews for IMR and SE;
- BBH QI and Compliance Reports Five Year Trends;
- BBH Community Mental Health System Annual Report of Financial Condition for Fiscal Year 2008 with Five Year Financial Trend Analysis.

The findings from the review are detailed in the following focus areas: Governance; Services and Programs; Human Resources; Policy; Financial; Quality Improvement and Compliance; Consumer and Family Satisfaction. The structure of the reports includes the Administrative Rule Requirement, team observations, team recommendations and a text area for the CMHP response.

AGENCY OVERVIEW

Northern Human Services is a nonprofit, community-based, mental health organization serving the needs of individuals and families in New Hampshire's Coos, Carroll and Grafton counties. NHS has primary sites in five locations including: Conway, Wolfeboro, Berlin, Colebrook, and Littleton. In addition, NHS provides developmental disability services and substance abuse treatment and prevention services in this region.

The NHS mission statement is:

“To assist people affected by mental illness, developmental disabilities and related disorders in living meaningful lives.”

NHS provides a comprehensive array of recovery and resiliency oriented community based mental health services for children, adults and older adults. These services include: intake assessment services; psychiatric diagnostic and medication services; psychiatric emergency services; case management services; individual, group and family psychotherapy; evidenced based practices including SE and IMR; services for persons with co-occurring disorders; functional support services; employment services; residential services; respite care; outreach services; education and support to families and consultation services.

NHS has a website (<http://www.northernhs.org/>) which includes information on treatment programs, consumer and family information, emergency services information, program locations and phone numbers, fundraising, web links and resources.

The towns served by NHS include:

Albany	Dummer	Lisbon	Shelburne
Bartlett	Easton	Littleton	Stark
Bath	Eaton	Livermore	Stewartstown
Benton	Effingham	Lyman	Stratford
Berlin	Errol	Madison	Sugar Hill
Bethlehem	Franconia	Milan	Tamworth
Brookfield	Freedom	Monroe	Tuftonboro
Carrol	Gorham	Moultonboro	Wakefield
Chatham	Hart's Location	Northumberland	Warren
Clarksville	Haverhill	Ossipee	Waterville
Colebrook	Jackson	Piermont	Wentworth Location
Columbia	Jefferson	Pittsburg	Whitefield
Conway	Lancaster	Randolph	Wolfeboro
Dalton	Landaff	Sandwich	Woodstock
Dixville	Lincoln		

SECTION I. GOVERNANCE

Administrative Rule He-M 403.06 defines a CMHP as an incorporated nonprofit program operated for the purpose of planning, establishing and administering an array of community-based mental health services.

This administrative rule requires that a CMHP shall have an established plan for governance. The plan for governance shall include a BOD who have responsibility for the entire management and control of the property and affairs of the corporation. The BOD shall have the powers usually vested in a BOD of a nonprofit corporation. The responsibilities and powers shall be stated in a set of by-laws maintained by the BOD.

A CMHP BOD shall establish policies for the governance and administration of the CMHP. Policies shall be developed to ensure efficient and effective operation of the CMHP and adherence to all state and federal requirements.

Each BOD shall establish and document an orientation process for educating new board members. The orientation shall include information regarding the regional and state mental health system, the principles of recovery and family support and the fiduciary responsibilities of board membership.

At the time of the review NHS was in substantial compliance with all the requirements referenced above.

REQUIREMENT: He-M 403.03 (b) (1) A CMHP Board of Directors shall have responsibility for the entire management and control of the property and affairs of the corporation and shall have the powers usually vested in the Board of Directors of a nonprofit corporation, except as regulated herein, and such responsibility and powers shall be stated in a set of by-laws maintained by the CMHP Board;

OBSERVATION I-A:

According to the Chief Finance Officer (CFO) and the management team, the CFO and the Chief Operating Officer (COO) approve the final budget.

RECOMMENDATION I-A:

The BOD needs to become involved in the development and approval of the budget.

CMHP RESPONSE I-A:

REQUIREMENT: He-M 40305 (f) (2) Each BOD shall establish and document an Orientation Process for educating new Board Members including the principles of Recovery and Family Support.

OBSERVATION I-B:

Though the BOD was articulate regarding the role of Evidenced Based Practices (EBP) and other

services for persons with mental illness, it was not evident that any specific recovery oriented training had occurred.

RECOMMENDATIONS I-B:

Consider having a consumer presentation to BOD that might focus on peer support, Wellness Recovery Action Planning (WRAP) or Intentional Peer Support (IPS) as a way of reinforcing recovery philosophy to BOD.

CMHP RESPONSE I-B:

REQUIREMENT: He-M 403.05 (f) (3) Each Board of Directors shall establish and document an Orientation Process for educating new Board Members including the fiduciary responsibilities of Board membership.

OBSERVATION I-C:

A previous review by the NH Division of Community Based Care Services (DCBCS) included an analysis of the NHS BOD and Finance Committee minutes. The minutes provided little written documentation of discussion of the financial situation of the agency at the BOD level. It was not clear how much specific information was provided to the BOD regarding the agency's financial status, activities and decisions. There remained no mention of budget versus actual data subsequent to the issuance of the DCBCS report and the amount of specific financial detail is limited in Board and Finance Committee minutes.

RECOMMENDATION I-C:

The BOD and Finance Committee minutes should document more discussion of the agency's overall financial health including details such as budget versus actual figures.

CMHP RESPONSE I-C:

REQUIREMENT: He-M 403.06 (a) (8) A CMHP shall provide the following, either directly or through a contractual relationship: Planning, coordination, and implementation of a regional mental health Disaster Response Plan.

OBSERVATION I-D:

There was no indication that the disaster response plan is reviewed and approved by the BOD.

RECOMMENDATION I-D:

403.03 (b) (1) states that the BOD is responsible for the entire management and control of the CMHP. It is recommended that the disaster response plan be reviewed and approved by the BOD.

CMHP RESPONSE I-D:

SECTION II: SERVICES AND PROGRAMS

Administrative Rule He-M 403.06 (a) through (f) requires that a CMHP provide a comprehensive array of community based mental health services. The priority populations include children, adults, and older adults meeting BBH eligibility criteria per Administrative Rule He-M 401.

BBH has prioritized EBPs, specifically IMR and SE. CMHPs are also required to offer Targeted Case Management to the BBH eligible population. These requirements are specified in Administrative Rule He-M 426.

Emergency mental health services and intake services are required to be available to the general population. Emergency mental health services are also required to be available 24 hours a day, seven days a week. These requirements are specified in Administrative Rule He-M 403.

The CMHP must provide outreach services to people who are homeless. The CMHP must also collaborate with state and local housing agencies to promote access to housing for persons with mental illness.

Assessment, service planning and monitoring activities are required for all services per Administrative Rules He-M 401 and He-M 408.

Each CMHP is required to have a Disaster Response Plan on file at BBH per Administrative Rule He-M 403.

At the time of the review NHS was in substantial compliance with all the requirements referenced above.

REQUIREMENTS:

He-M 403.05 (d) (3) Enhance the capacity of consumers to manage the symptoms of their mental illness and to foster the process of recovery to the greatest extent possible.

He-M 403.06 (a) (15) A CMHP shall provide the following, either directly or through a contractual relationship: Mental illness self-management and Rehabilitation Services (IROS) pursuant to He-M 426, including those services provided in community settings such as residences and places of employment.

ADDITIONAL INFORMATION SOURCE:

IMR Fidelity Review Reports – The General Organizational Index (GOI) Penetration Review Section. The GOI review is intended to measure the structural components that exist in an agency that will facilitate the delivery of EBPs such as IMR. The anchor points on the GOI scale are defined for each individual item, and can be roughly thought of as ranging from a one (1) corresponding to not implemented in this program at this time, to a five (5) indicating that the item is fully implemented. Only those sections with a score of one (1) or two (2) at the time of the review are referenced below. Recommendations are based on the findings from that review period.

	Littleton Wolfeboro	Berlin			
IMR Penetration	1	2	3	4	5
The maximum number of eligible consumers are served by the EBP, as defined by the ratio: $\frac{\# \text{ consumers receiving EBP}}{\# \text{ consumers eligible for EBP}}$	Ratio $\leq .20$	Ratio between .21 and .40	Ratio between .41 and .60	Ratio between .61 and .80	Ratio $> .80$

OBSERVATION II-A:

Penetration is defined as the percentage of consumers who have access to an EBP as measured against the total number of consumers who could benefit from the EBP. In the case of IMR the percentage of consumers expected to be interested in IMR services is 80%. Numerically, this proportion is defined by:

$$\frac{\# \text{ of consumers receiving an EBP}}{(\# \text{ of consumers eligible for the EBP} * 0.8)}$$

The QI staff provided the appropriate numbers for this rating. These numbers are reflective of the number of adult consumers (age 18-59) with one of four primary diagnoses (i.e., Bipolar Disorder, Major Depression, Schizoaffective Disorder, or Schizophrenic Type Disorder) who either received or are/were receiving IMR/eligible for services between 12/01/07 and 3/31/09. The following calculations were completed for each site:

$$\text{Berlin} \quad \frac{25 \text{ consumers received IMR}}{108 (135 * .80) \text{ consumers eligible for IMR}} = .23 \text{ ratio}$$

$$\text{Littleton} \quad \frac{20 \text{ consumers received IMR}}{99 (124 * .80) \text{ consumers eligible for IMR}} = .20 \text{ ratio}$$

$$\text{Wolfeboro} \quad \frac{8 \text{ consumers received IMR}}{48 (60 * .80) \text{ consumers eligible for IMR}} = .17 \text{ ratio}$$

RECOMMENDATION II-A:

It is recommended that strategies be utilized to increase IMR penetration rates.

CMHP RESPONSE II-A:

	Wolfeboro				
Training	1	2	3	4	5
All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) <i>within 2 months of hiring</i> . Existing practitioners receive annual refresher training (at least 1-day workshop or its equivalent).	$\leq 20\%$ of practitioners receive standardized training annually	21%-40% of practitioners receive standardized training annually	41%-60% of practitioners receive standardized training annually	61%-80% of practitioners receive standardized training annually	$> 80\%$ of practitioners receive standardized training annually

OBSERVATIONS II-B:

At the time of the fidelity review, the CSP Director in Wolfeboro has not received the IMR Trainer Training from other trainers at NHS or through the state sponsored training.

RECOMMENDATIONS II-B:

It is recommended that a structured IMR training occur within 2 months of hiring for new practitioners. The IMR training should be standardized and documented in personnel files. Additionally, it is important for experienced trainers to receive annual refresher trainings.

CMHP RESPONSE II-B:

	Berlin				
Supervision	1	2	3	4	5
EBP practitioners receive structured, weekly supervision (group or individual format) from a practitioner experienced in the particular EBP. The supervision should be client-centered and explicitly address the EBP model and its application to specific client situations.	≤20% of practitioners receive supervision	21% - 40% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision on an informal basis	41%-60% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision monthly	61%-80% of EBP practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision twice a month	>80% of EBP practitioners receive structured weekly supervision, focusing on specific consumers, in sessions that explicitly address the EBP model and its application

OBSERVATION II-C:

At the time of the fidelity review, IMR supervision in Berlin had been reduced to allow increased focus on ACT programming.

RECOMMENDATION II-C:

It is recommended that adequate time be allocated in Berlin to accommodate IMR-specific supervision for all practitioners delivering IMR in either individual or group format.

CMHP RESPONSE II-C:

Outcome Monitoring	1	2	3	4	5
Supervisors/program leaders monitor the outcomes for EBP consumers every 3 months and share the data with EBP practitioners. Monitoring involves a standardized approach to assessing a key outcome related to the EBP, e.g., psychiatric admissions, substance abuse treatment scale, or employment rate.	No outcome monitoring occurs	Outcome monitoring occurs at least once a year, but results are not shared with practitioners	Standardized outcome monitoring occurs at least once a year and results are shared with practitioners	Standardized outcome monitoring occurs at least twice a year and results are shared with practitioners	Standardized outcome monitoring occurs quarterly and results are shared with EBP practitioners

OBSERVATION II-D:

NHS initially utilized the IMR Consumer Scale as part of the quarterly review process and outcome monitoring. Use of this scale was discontinued, except in Littleton, as it was viewed as “too subjective”. Unfortunately, the agency has not developed a process to collect, compile and share this data.

RECOMMENDATION II-D:

An outcome measure that is satisfactory to NHS should be developed or acquired for the purpose of providing the agency with feedback on the impact of IMR. Outcome data should be collected, analyzed and shared with IMR practitioners.

CMHP RESPONSE II-D:

	Wolfeboro				
Quality Assurance	1	2	3	4	5
The agency has a QA Committee or implementation steering committee with an explicit plan to review the EBP, or components of the program, every 6 months.	No review or no committee	QA committee has been formed, but no reviews have been completed	Explicit QA review occurs less than annually OR QA review is superficial	Explicit QA review occurs annually	Explicit review every 6 months by a QA group or steering committee for the EBP

OBSERVATION II-E:

Though there is an active EBP Steering Committee with representation from the Berlin and

Littleton sites, the IMR Program Leader from Wolfeboro has not been invited to attend.

RECOMMENDATION II-E:

Invite the IMR Program Leader from Wolfeboro to be an active participant in the monthly Steering Committee meetings.

CMHP RESPONSE II-E:

IMR Fidelity Review Reports – IMR Fidelity Scale Section. Each of the items from the IMR Fidelity Scale is listed below with an arrow indicating the score for each item as well as a description of the rating and recommendations for improving the IMR practice at NHS. Only those sections with a score of one (1) or two (2) at the time of the review are referenced below. Recommendations are based on the findings from that review period.

	Berlin				
People in a Session or Group:	1	2	3	4	5
IMR is taught individually or in groups of 8 or less consumers.	Some sessions taught with over 15 consumers	Some sessions taught with 13-15 consumers	Some sessions taught with 11 or 12 consumers	Some sessions taught with 9 or 10 consumers	All IMR sessions taught individually or in groups of 8 or less

OBSERVATION II-F:

In Berlin the IMR group is conducted in the RPH program and can include anywhere from 2-13 people.

RECOMMENDATION II-F:

It is important to ensure that group sizes remain small enough (8 or less) to ensure that consumers are able to fully participate in the sessions.

CMHP RESPONSE II-F:

Involvement of Significant Others	1	2	3	4	5
At least one IMR-related contact in the last month <u>OR</u> involvement with the consumer in pursuit of goals (e.g., assisting with homework assignments).	<20% of IMR consumers have significant other(s) involved	20%-29% of IMR consumers have significant other(s) involved	30%-39% of IMR consumers have significant other(s) involved	40-49% of IMR consumers have significant other(s) involved	≥50% of IMR consumers have significant other(s) involved

OBSERVATION II-G:

This is one of the most challenging areas for IMR providers across the country. At NHS,

practitioners and participants described limited contact with natural supports.

RECOMMENDATION II-G:

Outreach and connecting with support networks is an area that could likely be improved with training.

CMHP RESPONSE II-G:

		Berlin Wolfeboro			
IMR Goal Setting	1	2	3	4	5
<ul style="list-style-type: none"> Realistic and measurable Individualized Pertinent to recovery process Linked to IMR plan 	<20% of IMR consumers have at least 1 personal goal in chart	20%-39% of IMR consumers have at least 1 personal goal in chart	40%-69% of IMR consumers have at least 1 personal goal in chart	70%-89% of IMR consumers have at least 1 personal goal in chart	≥90% of IMR consumers have at least 1 personal goal in their chart

	Berlin Wolfeboro				
IMR Goal Follow-up	1	2	3	4	5
Practitioners and consumers collaboratively follow up on goal(s) (See examples in the IMR Practitioner Workbook)	<20% of IMR consumers have follow-up on goal(s) documented in chart	20%-39% of IMR consumers have follow-up on goal(s) documented in chart	40%-69% of IMR consumers have follow-up on goal(s) documented in chart	70%-89% of IMR consumers have follow-up on goal(s) documented in chart	≥90% of IMR consumers have follow-up on the goal(s) documented in their chart

OBSERVATION II-H:

In Berlin and Wolfeboro, IMR goals in charts reviewed seemed agency versus consumer driven for example, “to return to former level of functioning” and “manage symptoms of illness.”

Also, goal-tracking sheets are not used in Berlin and Wolfeboro and there is no evidence of goal follow-up in the charts.

RECOMMENDATION II-H:

NHS develop documentation that fosters the development of consumer centered goals and objectives including the individual recovery goals developed in IMR Module 1.

CMHP RESPONSE II-H:

	Wolfeboro				
Behavioral Tailoring for Meds:	1	2	3	4	5
Developing strategies tailored to the person's needs, motives and resources (e.g., meds that requires less frequent dosing, placing meds next to one's toothbrush).	Few or none of the practitioners are familiar with the principles of behavioral tailoring for medication	Some of the practitioners are familiar with the principles of behavioral tailoring for medication, with a low level of use	Some of the practitioners are familiar with the principles of behavioral tailoring for medication, with a moderate level of use	The majority of the practitioners are familiar with the principles of behavioral tailoring for medication and use it regularly	All practitioners are familiar with the principles of behavioral tailoring for medication and either teach or reinforce it regularly

OBSERVATION II-I:

In Wolfeboro at least two practitioners are not familiar with the principles of behavioral tailoring for medication and had not received training.

RECOMMENDATION II-I:

Provide training in Wolfeboro regarding the principles of behavioral tailoring for medication.

CMHP RESPONSE II-I:

REQUIREMENTS:

He-M 403.06 (a) (5) a. Provide supports and opportunities for consumers to succeed at competitive employment, higher education and community volunteer activities.

He-M 403.06 (a) (5) b. 1-3. Vocational Assessment and Service Planning; competitive employment and supported work placements; and employment counseling and supervision.

ADDITIONAL INFORMATION SOURCE:

SE Fidelity Review Reports - The General Organizational Index (GOI) Penetration Review Section. SE fidelity reviews are conducted in order to determine the level of implementation and adherence to the evidenced based practice model of the CMHPs SE program. A SE fidelity score was determined following the review.

The anchor points on the GOI scale are defined for each individual item, and can be roughly thought of as ranging from a one (1) no implementation, to a five (5) full implementation. Only those sections with a score of one (1) or two (2) at the time of the review are referenced below. Recommendations are based on the findings from that review period.

Penetration.	1	2	3	4	5
The maximum number of eligible consumers are served by the EBP, as defined by the ratio: <u># Consumers receiving EBP</u> <u># Consumers eligible for EBP</u>	Ratio ≤ .20	Ratio between .21 and .40	Ratio between .41 and .60	Ratio between .61 and .80	Ratio > .80

Penetration is defined as the percentage of consumers (age 18-59) who have access to SE as measured against the total number of consumers who could benefit from SE. The number of consumers with severe mental illness who would be eligible and willing to use SE services is shown by research to be 60% of consumers at any given time. Numerically, for the penetration rate for SE is defined by:

$$\frac{\# \text{ Of consumers receiving SE (age 18-59)}}{\# \text{ Of consumers eligible for SE (age 18-59)} * .60}$$

Berlin: $\frac{20 \text{ consumers receiving SE services currently}}{60 = (100 \text{ eligible} \times .60)} = .33 \text{ ratio}$

Littleton: $\frac{20 \text{ consumers receiving SE services currently}}{76 = (127 \text{ eligible} \times .60)} = .26 \text{ ratio}$

Conway: $\frac{26 \text{ consumers receiving SE services currently}}{70 = (117 \text{ eligible} \times .60)} = .37 \text{ ratio}$

OBSERVATION II-J:

Research shows that 60% of consumers voice a desire to work over the course of any given year. At the time of the fidelity review the ratio of # served to # eligible was between .21 and .40 at all three sites. This results in a rating of two out of five.

RECOMMENDATION II-J:

NHS is encouraged to actively market the SE program to the eligible population in an effort to increase the penetration rate.

CMHP RESPONSE II-J:

Please note that the structure of this section of the Reapproval Report varies to reflect the structure of the original SE fidelity report. Specifically, the requirements, ratings and observations are presented as a single section followed by several recommendations.

ORGANIZATION	RATING
Organization: Integration of Employment Services with mental health treatment thru frequent team member contact: Employment specialists actively participate in weekly mental health treatment team meetings (not administrative meetings) that discuss individual consumers and their employment goals with shared decision-making. Employment specialists’ offices are in close proximity with their mental health treatment team members. Documentation of mental health treatment and employment services are integrated in a single chart. Employment specialists help the team think about employment for people who have not yet been referred to employment services.	2

OBSERVATION II-K:

The level of integration of SE with other mental health treatment varied among sites at NHS. Areas of variation included, how active team members were during treatment team meetings, different formats of clinical records, and location of SE staff.

ORGANIZATION	RATING
Organization: Vocational Unit: At least 2 full time employment specialists comprise the employment unit. They have weekly client-based team supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed.	1

OBSERVATION II-L:

At present, each site at NHS has one employment specialist who works with the SE Team Leader. This team structure is not conducive to the suggested group supervision model regarding the nature, scope and location of supervision. At present, NHS has only partially implemented this component of the SE model.

ORGANIZATION	RATING
Organization: Role of employment supervisor: Supported employment unit is led by a supported employment team leader. Employment specialists' skills are developed and improved through outcome-based supervision. All five key roles of the employment supervisor are present. 1. One full-time equivalent (FTE) supervisor is responsible for no more than 10 employment specialists. The supervisor does not have other supervisory responsibilities. (Program leaders supervising fewer than ten employment specialists may spend a percentage of time on other supervisory activities on a prorated basis. For example, an employment supervisor responsible for 4 employment specialists may be devoted to SE supervision half time.) 2. Supervisor conducts weekly supported employment supervision designed to review client situations and identify new strategies and ideas to help consumers in their work lives. 3. Supervisor communicates with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues (such as referral process, or transfer of follow-along to mental health workers) and to be a champion for the value of work. Attends a meeting for each mental health treatment team on a quarterly basis. 4. Supervisor accompanies employment specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development. 5. Supervisor reviews current client outcomes with employment specialists and sets goals to improve program performance at least quarterly.	1

OBSERVATION II-M:

Each of the 3 NHS locations has supervisors who fulfill the SE Team Leader role to varying degrees. However, it does not appear that the SE Team Leaders at NHS are very involved with skills training, field mentoring, integration, promoting the value of work or sharing outcome data. At the time of this review NHS has partially implemented this item.

SERVICES	RATING
Services: Work Incentive Planning: All consumers are offered assistance in obtaining comprehensive, individualized work incentives planning before starting a new job and assistance accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Work incentives' planning includes SSA benefits, medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits and any other source of income. Consumers are provided information and assistance about reporting earnings to SSA, housing programs, VA programs, etc., depending on the person's benefits.	2

OBSERVATION II-N:

At NHS, financial case managers are responsible for providing all consumers with information about the impact of employment on their state and federal benefits and cash assistance. These financial case managers demonstrate a strong understanding of the benefits component of returning to work. The financial case managers reported accessing information related to specific questions or client information through the Social Security Administration District Offices and the NH Division of Family Assistance local office. Additionally, in circumstances where a client may have especially complex benefits, the case manager may consult with Granite State Independent Living (GSIL).

There is a Community Work Incentive Coordinator that serves the Berlin, Littleton, and Conway areas and is available to provide comprehensive benefits counseling at no cost or with assistance through funding from New Hampshire Vocational Rehabilitation (NHVR).

The presence of multiple and complex work incentive programs at both the state and federal level requires that employed consumers have access to comprehensive work incentive planning provided by fully trained community work incentive counselors with an emphasis on client choice.

SERVICES	RATING
Services: Ongoing, work-based vocational assessment: vocational profile/assessment occurs over 2-3 sessions and is updated with information from work experiences in competitive jobs. A vocational profile form that includes information about preferences, experiences, skills, current adjustment, strengths, personal contacts, etc., is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, MH treatment team, clinical records, and with the client's permission, from family members and previous employers.	2

OBSERVATION II-O:

The SE programs at all 3 sites reviewed work in collaboration with NHS's other "work program" that provides work through agency contracted opportunities. This program may be viewed as a

stepwise approach to employment for consumers who may not be prepared for competitive employment. Consumers describe these opportunities as an achievable step in their path toward working in the community. At this point in time, NHS has partially implemented this aspect of the SE model.

SERVICES	RATING
Services: Individualized job search: Employment specialists make employer contacts aimed at making a good job match based on consumers' preferences and needs rather than the job market (i.e. those jobs that are readily available). An individualized job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences.	1

OBSERVATION II-P:

Documentation related to individualized job search activities was limited because of the relatively new implementation of the vocational profile and only partial use of an employment plan.

There was a pervasive sense among both staff and consumers that the job market was a major barrier to people obtaining employment.

At the time of the fidelity review, NHS has not implemented this component of the SE model.

SERVICES	RATING
Services: Job development - Frequent employer contact: Each employment specialist makes at least six (6) face-to-face employer contacts per week on behalf of consumers looking for work. An employer contact is counted even when an employment specialist meets with the same employer more than one time in a week, and when the client is present or not. Client-specific and generic contacts are included. Employment specialists use a weekly tracking form to document employer contacts.	2

OBSERVATION II-Q:

The SE Program at NHS does not have a process in place for tracking employer face-to-face contacts. The lack of active employer contact for job development was consistently cited as the biggest concern regarding the SE program across nearly all stakeholder groups.

NHS has minimally implemented this part of the SE model.

SERVICES	RATING
Services: Job development - Quality of employer contact: Employment specialists build relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer.	2

OBSERVATION II-R:

In general, it appears that employment specialists contact employers to ask about job openings and then share leads with consumers. There were instances where employment specialists had worked to develop materials that generally introduced SE and employment of people with

disabilities. However, it is important to go beyond this informational packet to identify specific aspects of the model and an individual that will work well for a specific employer.

NHS has partially implemented this element of the SE model.

SERVICES	RATING
Services: Diversity of job types and employers: Employment specialists assist consumers in obtaining different types of jobs with different employers.	2

OBSERVATION II-S:

NHS is in the early stages of implementing the SE practice in all of the locations that were reviewed. There was very limited information related to the employer, the type of employment and other important outcomes.

SERVICES	RATING
Services: Competitive jobs: Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status (e.g. transitional employment slots). Competitive jobs pay at least minimum wage, are jobs that anyone can apply for, and are not set aside for people with disabilities.	1

OBSERVATION II-T:

The SE program information is limited as it relates to types of employment. However, a number of consumers are working with employment specialists while participating in the agency’s other “vocational program”. It appears that a large percent of SE consumers are provided with non-competitive employment opportunities. NHS is in the early stages of developing strategies to implement and monitor this component of the SE model.

RECOMMENDATIONS II - K through T:

Leadership make a commitment to fully implementing the SE model.

Ensure that the employment specialist roles and responsibilities emphasize strategies that will increase competitive employment and de-emphasize agency-based employment.

Work to enhance integration of employment specialists with the mental health treatment teams.

NHS leadership and other staff should seek to establish a working relationship with the local NHVR counselors in all locations.

Explore ways to establish a SE team/unit.

CMHP RESPONSE II – K through T:

REQUIREMENT: He-M 403.06 (I) A CMHP shall provide services that are responsive to the particular needs of members of minority communities within the region.

OBSERVATION II-U:

Services to minority populations in the area are somewhat limited to specific events such as health fairs and local multicultural events.

RECOMMENDATION II-U:

It is recommended that NHS continue to explore ways to serve ethnic, cultural, sexual, and other minority populations in the region.

CMHP RESPONSE II-U:

REQUIREMENT: He-M 403.06 (d) (9) Services provided to children shall include Sexual Offender Assessments and Treatment.

OBSERVATION II-V:

NHS does not provide these services.

RECOMMENDATION II-V:

Develop policies regarding the provision of or the referral to child and adolescent sexual offender assessment and treatment.

CMHP RESPONSE II-V:

REQUIREMENT: He-M 403.06 (a) (1) Intake assessment which shall address substance abuse history and at risk behaviors and determination of eligibility pursuant to He-M 401.

OBSERVATION II-W:

FY 2008 BBH QI and Compliance reports reflect that 20% of adult records and 21% of child records contained annual substance use screens. It must be noted that the compliance rating for annual substance use screens for adults has declined in each of the two years since FY 2006.

RECOMMENDATION II-W:

The CMHP must complete annual substance use screens for all adults and children over 12 years of age.

The NHS corrective action plan dated August 12, 2009 indicates the agency's computer system intake and annual assessment templates have been revised to allow for better monitoring and increased compliance with this requirement.

CMHP RESPONSE II-W:

REQUIREMENT: He-M 403.06 (a) A CMHP shall provide the following, either directly or

through a contractual relationship: (2) Case Management pursuant to He-M 426.14

OBSERVATION II-X:

Case management services are listed in the application, policies, agency brochures, case manager job description and on the website. However, the core case management activities were not clearly described and other services were included in the descriptions.

RECOMMENDATION II-X:

It is recommended that all case management descriptions be limited to the core case management activities of assessment, referral and monitoring.

CMHP RESPONSE II-X:

REQUIREMENTS: He-M 403.06 (a) (7) (c) Coordinate with and refer individuals to consumer operated peer support programs such as telephone support lines, where available.

He-M 403.06 (a) (14) A CMHP shall provide the following, either directly or through a contractual relationship: Consultation, as requested, and support to consumer-operated programs to promote the development of consumer self-help/peer support.

OBSERVATION II-Y:

The relationship with the PSA has varied over time.

RECOMMENDATION II-Y:

It is recommended that the CMHP explore opportunities to collaborate with the PSA. This could include shared trainings, public education efforts, general referrals to the PSA and referrals to warmline services.

CMHP RESPONSE II-Y:

SECTION III: HUMAN RESOURCES

The CMHP is responsible for determining the qualifications and competencies for staff based upon its mission, populations served and the treatment and services provided. An organization's personnel policies define what the agency can expect from its employees, and the employees can expect from the agency.

The BOD is responsible to review and approve the CMHP's written personnel policies. The policies should be reviewed on a regular basis to incorporate new legal requirements and organizational needs. Every employee should review a copy of the policies.

The BBH team reviewed a sample of NHS personnel records to assure compliance with Administrative Rule He-M 403.05 (g) through (i) and He-M 403.07 (a) through (e) including current licensure, resumes, training documentation and background checks.

In addition, an anonymous survey was distributed to NHS staff at the time of the review. A total of 210 surveys were distributed and 72 were returned for a response rate of 34%. The focus of the survey were questions regarding training, recovery orientation of the agency, consumer focus, agency responsiveness to consumer, impact of funding restrictions and supervision. A summary of responses in both narrative and aggregate form is included within.

At the time of the review NHS was in partial compliance with all the requirements referenced above.

REQUIREMENT: He-M 403.05 (j) Each program shall employ a Children's Services Coordinator who shall work with the Division in service system planning for children and adolescents and all inpatient admissions and discharges, including the Anna Philbrook Center.

OBSERVATION III-A:

The Children's Services Coordinator job description does not include service system planning for children and adolescents and all inpatient admissions and discharges, including the Anna Philbrook Center.

RECOMMENDATIONS III-A:

Revise the Children's Services Coordinator job description to include service system planning for children and adolescents and all inpatient admissions and discharges, including the Anna Philbrook Center.

CMHP RESPONSE III-A:

REQUIREMENT: He-M 403.05 (k) Each program shall employ an Elder Service Coordinator who oversees program development, training, and interagency collaboration, and participates in regional and statewide planning activities with other elder serving agencies.

OBSERVATION III-B:

There is no Elder Service Coordinator job description that includes oversight of program development, training, and interagency collaboration, and participates in regional and statewide planning activities with other elder serving agencies. These responsibilities are reported to be covered by the Clinical Director.

RECOMMENDATION III-B:

Develop an Elder Service Coordinator's job description that includes oversight of program development, training, and interagency collaboration, and participates in regional and statewide planning activities with other elder serving agencies.

CMHP RESPONSE III-B:

REQUIREMENT: The table below consolidates the findings regarding the requirements in He-M 403.07 (b) through (e) pertaining to documentation found in personnel files.

OBSERVATIONS III-C:

NHS HUMAN RESOURCES TABLE												
He-M	Requirement	Personnel Files										% Compliance
		1	2	3	4	5	6	7	8	9	10	
He-M 403.07 (b)	Annual performance evaluation	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	90%
He-M 403.07 (c)	Staff development plan	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	90%
He-M 403.07 (d)	Documentation of ongoing training	N	Y	N	Y	Y	Y	Y	Y	Y	Y	80%
He-M 403.07 (e)	Documentation of Orientation training	Y	Y	N	N	N	N	N	N	N	N	20%
He-M 403.07 (e) (1)	Does Orientation include the Local and State MH System	N	Y	N	N	N	N	N	N	N	N	10%
He-M 403.07 (e) (2)	Does Orientation include an overview of mental illness and current MH practices	N	N	N	N	N	N	N	N	N	N	0%
He-M 403.07 (e) (3)	Does Orientation include Applicable He-M Administrative Rules	N	N	N	N	N	N	N	N	N	N	0%
He-M 403.07 (e) (4)	Does Orientation include the local service delivery system	Y	N	N	N	N	N	N	N	N	N	10%
He-M 403.07 (e) (5)	Does Orientation include Client Rights training	Y	N	N	N	N	N	N	N	N	N	10%

RECOMMENDATIONS III-C:

It is recommended that personnel files be monitored for completeness at least annually at the time of the performance review. It is also recommended that a check off sheet be created for the inside cover of each personnel file to facilitate tracking of required elements.

CMHP RESPONSE III-C:

PLEASE NOTE: He-M 403 has been revised since the site visit and now includes the following requirement:

He-M 403.07(b) A CMHP shall conduct criminal background checks and a review of the Office of Inspector General's List of Excluded Individuals/Entities for each newly hired and re-hired staff member. In addition, motor vehicle record checks shall be conducted for staff who will be transporting consumers pursuant to employment.

Future reviews will include verification of compliance with this administrative rule.

**REGION I
STAFF SURVEY RESULTS
2009**

As part of the Reapproval process, BBH requested that a CMHP staff survey be distributed. The surveys are completed, returned in a sealed envelope and the results compiled for inclusion in this report. The results of the survey are outlined below for consideration by NHS.

1. Does your agency provide job-related training?

<u>Yes</u>	<u>No</u>	<u>No Answer</u>
104/126	6/126	16/126
83%	5%	13%

a. How would you rate your agency's staff training effects?

<u>Poor</u>	<u>Fair</u>	<u>Good</u>	<u>No Answer</u>
10/126	45/126	63/126	8/126
8%	36%	50%	6%

b. How responsive is your agency to your training requests? (Give examples)

<u>Poor</u>	<u>Fair</u>	<u>Good</u>	<u>No Answer</u>
4/126	40/126	72/126	10/126
3%	32%	57%	8%

1. Minimal and not consistent.
2. Although additional training is offered, it seems to be few and far between.
3. Training in any case is self- driven, but generally supported by supervisor.
4. The effort is made with poor outcome.
5. Requests are granted within reason. (They will not let us go to Hawaii).
6. I have requested training in regard to contagious diseases - and a training is on the agenda with a time and date set.
7. Staff and supervisory meetings are great places to inquire about these. I have never been turned down from one and have attended a few that have been helpful such as wrap around facilitation.
8. My supervisor is on top of all my requests. It's very refreshing.
9. Financial constraints have caused some problems and limitations.
10. All my requests for support with getting training have been met promptly and funded by the agency.
11. There are sometimes agency wide trainings. People needing CEU's go to whatever is needed.
12. We have a large selection of on line training and the agency provides internal training. Recently participated in TF-CBT with Dartmouth and planning to do the disruptive behavioral disorder training and to do supervision.
13. Right now it is between fair and good due to state budget cuts, etc. They are pushing on line training which doesn't really work for a great many people including myself.
14. As of lately any extra trainings, such as just one that is just interesting (autism, bi-polar, etc.) wait. I am thinking of other training conferences. Yes, our agency trains (dealing with difficult

- people was a helpful one).
15. Each individual request for updated trainings is seriously considered and most, if not all come to fruition. I have never been denied access to any trainings.
 16. Most times when a training is available that would benefit the support persons, arrangements can be made for them to go. Cost is becoming a factor with budget cuts on the state level.
 17. Good, if funds are available.
 18. Solicits input with regard to training needs and schedules appropriate training.
 19. Encouraged substance abuse training in support of my LADAC application.
 20. When requests are done for extra training, the reasons given for not being able to have them completed are time restraints, meeting places and costs.
 21. Approves my requests for professional conferences/workshops without hesitation and provides appropriate funding. Provides/welcomes in-service training as needed/available.
 22. Given the financial restraints that we are all under now, there is not much money in the budget for trainings.
 23. Workshops that I need are approved but this position needs a more defined protocol. The state expects me to use an EBP but all components of the EBP don't work with this position.
 24. If I ask for training I get it as soon as possible.
 25. We now have E-learning, which makes it possible to receive web-based training "in demand" with CEU's. This is positive, but agency is at a disadvantage in terms of training based in ___?___. NH, which takes a full day away from productivity even for a 2-hour training.
 26. New employees are offered extensive "one to one" supervision as well as group and specialty focus supervision.
 27. Before I got my license the agency really was supportive in allowing me to take the time to get my CEU's. Since my license, I have been looking at trainings to be certified in areas with support from the agency.
 28. I am member of administrative staff, so don't have a license that needs CEU's. Given that, I try to be mindful of cost factors when I ask to attend training, but have had favorable response when I do. Also, among admin. Staff in the agency, there is good cooperation and openness to sharing information and experience.
 29. A colleague offered to share a training video she had purchased at an outside training – we were told we had to watch it on our own time. The agency does, however, pay our time to attend trainings. So it's a mixed message. We have recently added clinical consultation to our staff meetings and that has been helpful.
 30. Usually will but due to cuts we haven't been able to get much training opportunities.
 31. My position was new and I was not really given any training or supervision. On the other hand, they consider me self-motivated. I would love trainings for employment specialists that really help.
 32. Depends on the current budget. I don't request trainings often and am particular about my requests. This past fall I was denied because of budget issues.
 33. We have been told no to trainings due to not having the money to cover the costs of trainings.
 34. Requests are denied due to lack of funding and decreases in funding from the state. Job related training is often limited to individual supervision.
 35. As a large team, some staff are more proficient in treatment areas than others. Whenever requested, I have been able to find someone interagency to discuss/give training on illnesses/treatment modules, etc. information, it happens.
 36. When hired, I was trained for more than a week. Following my training, I felt comfortable asking anyone my questions.
 37. Good at reviewing and discussing the need for and applicability of particular trainings as relevant to one's current position and involvements. For example, as an ES clinician, I was approved for multiple trainings on crisis assessment, etc.
 38. Ample notice given to us re: trainings to alter schedule if needed.

39. There have been many trainings in needed areas. However, we can always use more education.
40. This agency is very responsive – my supervisor will alert me about different seminars and trainings that are pertinent to my job.
41. Basic computer – physical- paperwork training are always available. Also, someone can request a training and they can usually work something out.
42. At the moment the financial restraints make trainings difficult (agency cannot reimburse), but in past agency had paid for trainings.
43. The agency does allow me to go to trainings that are in relation to my _____(illegible).
44. Poor due to budget restraints.
45. In the past they paid for trainings, they no longer do.
46. I have not been turned down for a training I really needed.
47. Trainings are only available to licensed faculty.
48. Major problem with computer system training in particular. We have very few agency sponsored trainings – they are inconsistent and often are spent trying to figure out what we are supposed to do – interpreting confusing messages.
49. I have been trained in TFCBT, DBT, and crisis intervention. We have ongoing presentations from various staff that greatly impact my work with consumers.
50. I think they do the best they can.
51. Most training opportunities are through outside agencies. Due to limited funds/financial issues we have had some restrictions on our ability to attend.
52. Starting to be better with more improved follow-up to training modules.
53. Monies not available for many offsite seminars. Computer training provided at times.
54. My supervisor has approved all of my requests for educational training.
55. I have worked here many years. Agency has always supported my receiving continuing education as needed to maintain licensures as well as additional training for needs and interests of my job. This has included training costs, mileage, rooms, meals. I know they also support staff through grants for college classes. Difficult economic times may limit this support. I hope not as I believe this is a needed and valued benefit. Also, availability of yearly agency wide training.
56. When I take o r have taken initiative towards bettering my professional performance, trainings have been suggested that are available. Continuous trainings are offered for bettering performance and understanding treatment, and these are shared with all employees year round.
57. It has probably recently become more difficult to schedule trainings. Some meetings have had to be dropped due to budget concerns.
58. Allow you to attend certain trainings that you feel will help you with your job.
59. I am not currently licensed (working on it) and will have more training opportunities once I am.
60. Until recent months, good. Yet, recently budget cuts have cut down requests for trainings.
61. At times, needs are met on agency wide level such as a day-long training on autism. On a more local level we respond to clinician, case managers requests by providing in service with in local areas as needed. Individuals are supported by agency financial support to maintain CEU's.
62. Very. If we find a training that is relevant to our work and someone is able to attend and bring back
63. For licensed staff the agency pays for and gives release time to get training to maintain license. The agency gives release time and supports staff receiving training in state supported practices and pays when needed. In house trainings are presented frequently. The agency has signed up with E-learning and encourages everyone to use it.
64. Give dates ahead of time so we can attend. When I ask about a certain topic, information is given in workshops, etc.

2. Does your agency provide training in recovery philosophy?

<u>Yes</u>	<u>No</u>	<u>No Answer</u>
84/126	16/126	26/126
67%	13%	21%

1. Group and/or individual IMR along with as much support as a client needs.
2. In addition to offering recovery oriented programs like IMR, there is time at staff meetings where discussion of hope, resiliency and the importance of a recovery focus is in helping folks we work with improve the quality of their lives. There are definite opportunities for us to discuss some of the challenges there are in helping consumers who haven't yet grasped this philosophy as well as strategies we can use to help shift their perspective.
3. IMR is great for helping with this as well.
4. I see this often with our clients and their families. Our agency and staff tailor treatment plans to ensure continued success to all our clients and families.
5. We have recovery-oriented trainings at least twice per month as part of weekly team meetings.
6. There has been IMR trainings (sic).
7. IMR
8. I am not trained in IMR, but we do provide it.
9. IMR . Supported employment.
10. Includes IMR training.
11. BBH sponsored training and in-service training.
12. To direct care staff.
13. Do not know what this is – so guess not.
14. Very often-very good.
15. Our director of substance abuse offers in-services to all clinical and case management staff on SA related topics re: "Motivational Interviewing", etc. Our CSP director offers IMR supervision and consultation to all clinical staff re; recovery issues.
16. MI training is talked about in length.
17. Yes, as a member of local management team, I am aware of IMR initiative.
18. It is offered to case managers, but not to use as a therapist. I would very much like to have access to more recovery-oriented training.
19. No, but maybe it's just not offered to case management.
20. Not sure?
21. Supervisors are aware of how to deliver services from this perspective – though it has been a huge and difficult learning curve.
22. IMR is available to consumers and staff, as well as recovery from addictions, DBT training, etc.
23. I have not been with the agency for a year yet, so historically they may have, but I haven't received any yet.
24. Again, I am not aware of trainings that the agency provides. Overall I find very little training provided. If we want it we have to travel to the state taking one half day away from the job.
25. IMR program.
26. I have never received a training in "recovery philosophy" although I do believe in recovery and I work with staff and clients toward supported recovery for all.
27. Throughout the year, we have had trainings and there has been follow-up to address any ongoing questions. Looking at specific treatment goals and implementing strategies, keeping a strength based focus, and developing resource information to address various issues.
28. Unknown if there is a formal training. There are many discussions through supervision, colleague interventions, meetings, etc.

29. Don't know.
30. Our agency will send folks to individual trainings but they also go the extra mile to connect folks with agency-wide trainings focused on evidence-based models of recovery. We do a great deal to train staff in empowering consumers.
31. We continuously receive information on trainings for bettering our performance and understanding throughout the year. Advances in trainings for recovery philosophy are always made available to improve treatment.
32. Up to this year opportunities were excellent. Now the budget is causing us to concentrate on "productive" activities.
33. IMR.
34. I have only been here a short time so may not have seen it yet.
35. Yes, I wish it did more in helping individuals find make and become independent. Yet, some programs are very helpful for clients.
36. Our LADC clinicians provide on-going training at staff meetings on individual basis as needed regarding recovery from substance dependence. IMR is used within our on-going recovery model with multi-service clients. Support/community outreach/group opportunities through the ME Copeland Wellness and Recovery Program offered regularly by our local clinic.
37. IMR and Mary Ellen Copeland Workshops.
38. Not that I am aware of unless you consider the info we got at staff meetings re: IMR and ACT trainings.
39. IMR, wellness, DBT.
40. We have had a lot of IMR training – new staff could use some in this area.
41. They have IMR and BDT programs.
42. IMR.
43. It is hard to grasp the concept that children are to "recover" when I believe they have not yet learned the skills, nor had the experience to learn and practice.
44. Very intensive/informative trainings. Trainings to put into practice with many fine examples. IMR.

3. In helping people with mental illness establish a recovery oriented treatment plan, do you find your agency supportive? (Give examples)

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
90/126	16/126	0/126	20/126
71%	13%	0%	16%

1. Discussion with the consumer is always the first part of any agenda. How else can you assist them?
2. Often treatment plans, goals are worded by consumers
3. We often discuss and create literature about effective treatment planning strategies, emphasizing recovery, being client driven, and being achievable.
4. It is the philosophy of what we do and evident in the plans.
5. We strive to work for the client's recovery, however hard that may be sometimes. We are taught that no one wants to be ill and it's the best they can do at the time.
6. Yes, and everyone on the client's team is supportive and asks for feedback from all members involved.
7. We offer and encourage client participation in all aspects of treatment. We offer IMR group sessions, rehab, etc.
8. By setting attainable goals, with plans on how to meet these goals the person served is able to

- develop coping skills and is given many supports to accomplish their goals.
9. Sometimes wording is a problem in order to include medical necessity with recovery goals.
 10. IMR classes and integration of recovery philosophy throughout CSP services.
 11. Many goals are what the agency wants down on paper and not what the people need or want. We have a tendency of “putting words in their mouths” to make it look good for the auditors.
 12. Focus during treatment team meetings and supervision is on recovery-oriented treatment.
 13. Treatment teams constantly strive to support patient’s growth and engaging new challenges as appropriate and doesn’t settle for the status quo – encouraging more independent living situations, more responsibility for self-care, more social/community engagement and vocational endeavors, all as appropriate to individual needs/abilities/circumstances.
 14. IMR.
 15. All plans are recovery-based and this is the whole philosophy of the agency.
 16. Since NHS considers recovery as the keystone in treatment of mental illness, managers are active in sharing the latest clinical information with staff.
 17. Strength based goals.
 18. I receive a lot of supervision, it’s helpful.
 19. Depends on who writes the treatment plan and who reviews it. Sometimes they are not closely looked at.
 20. Internal chart reviews have increased and are incorporated into supervision.
 21. That is why we work here and one of the biggest parts of our job. Treatment teams are often beneficial with getting other ideas/opinions.
 22. We are guided to use recovery-based language on documentation.
 23. I work in SA and MI – everything I do is about recovery. Everyone I work for and with promotes recovery.
 24. Supervisor and co-workers avail themselves to assist in supervision (both formally and informally).
 25. It always seems like we are trying to catch the train of the moment, trying to figure out what we are supposed to be doing, interpreting the latest interpretation.
 26. We have had some meetings re: language and goal setting on treatment plans and how to incorporate into treatment services.
 27. Difficult to coordinate between CM and MH clinicians.
 28. Plans are specific to recovery needs of clients. Objectives and goals are time specific and concrete. Multi-service clients receive services via case managers, FSS, group and individual therapy to support recovery goals.
 29. Staff are tremendously devoted to helping clients with completing goals towards recovery.
 30. Don’t know.
 31. Case managers in our agency run IMR and wellness recovery groups that get high praise from clients.
 32. I believe our agency is very supportive. However, we are also required to follow mandates, which often seem more focused on filling out a form correctly than on understanding and supporting clients in coping with the realities of their mental illness (sorry I am old – forgive my slip of the tongue – using the word “clients.”)
 33. Absolutely. There has always been an abundance of supports offered and seldom is there limited availability for services. The agency continues to brainstorm new ideas to assist those invested in personal recovery. New needs and interests equal new plans conducive to each person’s treatment.
 34. Always.
 35. We allow the clients to facilitate their annual and make the treatment plan in their own words.
 36. We constantly work as a team to communicate about shared clients and find the best ways possible to help clients utilize their natural supports.
 37. Yes, at times, yet I find the emphasis is getting social services rather than finding ways to

establish independent living. Yet programs like Mary Ellen Copeland Wellness Programs are excellent.

38. We have an active out reach and vocational support staff. We speak in terms of recovery and wellness – strengths based.
39. On the kids side we work with families to support the client, educate the system and work toward long-term goals.
40. This agency offers the clients a variety of programs depending on their needs.
41. I do think we are good at mobilizing the services we offer when developing a client’s treatment plan and this is done with the hope that the client will recover.
42. Listen to the client – which goals/objectives are set accordingly with recovery practices set forth.
43. We do treatment planning with the people we are helping.
44. All treatment plans include goals and objectives which help clients work toward a meaningful productive life.
45. I find that staff are very interested in finding and working through recovery programs.
46. When a consumer comes to the front desk with a problem we assist them in trying to come up with their own solution.
47. Again –when working with children – more support should be given towards parenting, than the child’s “recovery.”
48. Goals are set with recovery in mind – i.e. try to put into practice.

4. Do you find services are on consumer needs and interests?

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
92/126	22/126	0/126	12/126
73%	17%	0%	10%

1. Whenever consumer requests or needs are brought up they are definitely discussed and whenever possible and appropriate they are met. Folks who want support in remembering 45 meds are often, with their consent, given courtesy calls in the evening for a wellness/med check by the ACT/KID on-call system. In cases where those requests can be met (or are not appropriate use of services) creative problem solving strategies are utilized to find other ways for their needs to be met.
2. Generally, they are most always consumer oriented.
3. Just the other day we had an established client who needed her PCP to fill a script that our psychiatrist had recommended during a one time med conflict after learning that the PCP was uncomfortable with this request-it was discussed between client therapist and psychiatrist that our agency would assist. The client was seen within 15 minutes by the psychiatrist and script was offered with follow-up appointment. All involved are pleased with transaction and outcome.
4. We put a lot of effort into providing a variety of services and treatment interventions to meet the needs of the community.
5. But due to the tightness of money it’s becoming more and more about the paperwork, the numbers and the money! Healthcare for people not for profit.
6. For the most part, yes. There are some cases where services are in the best interest of the client but not always what they would like (this I see mostly with our younger teenagers in foster care).
7. Needs around transportation and geography sometimes are not met.
8. Vocational services.
9. Money constraints also play into the services, i.e. how much can we bill, what will it cost, etc.
10. Always striving to create/modify programs to better meet evolving consumer/community needs.
11. Therapists and case managers at NHS believe in client based services and supervision focuses on

- teaching modalities that are client driven.
12. I would like to see more groups.
 13. Again, as a member of local management team, and therefore privy to general programmatic discussions as well as some discussion with regard to individual consumers, I am always impressed with out staff's focus on connecting with and engaging consumers on a very individual basis.
 14. Often, but not every consumer fits our services.
 15. They are all based on consumer needs/interests.
 16. As often as is possible.
 17. Often, but limited by budget constraints.
 18. Needs often, interests not so much.
 19. There is demonstrated need for further integration of MH and substance abuse services. Our agency is a leader in this area, however BBH does not seem to promote or support integration of these services.
 20. The agency tries to be responsive to consumers' needs and interests and there are mixed messages coming from the Bureau about what we should do in light of this. We are always struggling to interpret an interpretation.
 21. Consumers are involved in developing treatment plans and having a say in what services they receive. Consumers are asked for feedback and if they have questions/concerns, they are listened to and strategies are created to address the need.
 22. There could be more groups of interest offered however one difficulty is lack of public transportation in our rural area which makes it difficult for consumers to attend if we were offering more.
 23. Lack of funding for transportation is a problem. Need increased funding for support/treatment groups.
 24. Funding and staffing limit program development.
 25. No anger management therapy for adults – must go elsewhere.
 26. To continue with the dialogue begun under question #3, it is often necessary to base what we do either numbers needed to maintain funding, meeting billable standards or filling out a form correctly under the (funding source) threat of no money, if the source does not see what they want or something is not worded as they want. Do “state level” folks ever talk with the folks who actually interact with consumers?
 27. Absolutely.
 28. Always. In spite of budget difficulties we still put the client's interest first. That is the difference between a professional and nonprofessional “business” and non-profit vs. profit. We dislike the need to push for services that will be “covered” and still try to meet all needs of all clients.
 29. Always – options are always discussed and services offered would always be around client needs – that's who we're here for.
 30. We individualize services to the best of our ability.
 31. It should always be consumer needs based.
 32. It seems to be more of a paper world now. Too much time on paperwork and less time with clients.
 33. Consumers are number one!
 34. Paperwork detracts from client's needs.
 35. Yes, they are helpful and useful to help consumers find more options available to them.
 36. We make goals that are reachable for the client. If a client is struggling extra supports are always offered – aka outreach.
 37. Always – consumers are first – their wants and needs.

5. When you represent consumer requests/needs to your agency staff, are they responsive? (Give examples)

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
89/126	17/126	0/126	20/126
71%	13%	0%	16%

1. Meetings for increase/decrease in services have always been held within a week of request.
2. I have always found my co-workers and supervisors to be helpful when I need information, collaboration or any other type of support regarding a consumer request.
3. Everyone works together as a team to get the consumers needs met.
4. If I have requested increased services or increased case management the client has always received this and benefited by it.
5. If a consumer is having negative effects or no desired effect from their medication, the agency nurse and consumer's doctor are notified. The end result is usually positive for the consumer. If a consumer has no available funds, but is in great need of something (such as winter boots) a way is made to meet this need.
6. Budgetary constraints sometimes impair agency's ability to meet needs. At times, philosophical differences are resolved by hierarchy without understanding by the staff such as whether or not to offer training to a particular client.
7. Local administration easily accessible. Community based programming now common.
8. Usually staff responds in a positive manner. Examples would be increased contacts, better treatment plans, more staff support.
9. Staff always willing to consider consumer requests, evaluate them on the basis of clinical status, personal history, and local resources and creatively accommodate/facilitate them whenever possible and appropriate.
10. Always, as we have an ES person on call 24 hours a day.
11. When a resident has asked to speak to a (their) caseworker, the caseworker some times does not respond.
12. We always get what is needed.
13. We provided extensive service to a very ill person who had no Medicaid, although the agency did not get paid for this outreach. Client requested late evening appointment and clinician came in outside of normal schedule to accommodate.
14. NHS staff nurture and encourage consumer advocacy and independence.
15. Every Wednesday clinical meeting. I openly talk about consumer needs with support from co-workers.
16. If client has more needs, we usually try to find a solution.
17. Our financial case managers are awesome in requests about financial needs. Certain team members are great about wrapping around a consumer and working out problems with them.
18. For the most part, yes, discussing as a team helps.
19. I feel that my consumer needs are heard by the agency and I do feel they make reasonable effort to meet my consumer's needs. They try to reach affordable payment plans for those consumers with insufficient pay sources.
20. I find it difficult to get my request approved. I usually end up looking for outside resources to help my clients.
21. Responsive to fee reductions and payment plans.
22. Resources, referrals(inside and outside of agency).
23. I think that the agency is well intended but the struggles are so steep to figure out the "hows" that it is confusing. I would not describe it as "unresponsive."

24. Yes. We work as a team that includes staff, case managers, outreach, clinician, psychiatrist, clinical director. It creates a supportive environment for the consumers.
25. They try to be.
26. As a team we do the best we can in coming up with creative ways meet and address consumer needs. Having groups meet relative to a community event so transportation is less of an issue.
27. Many problems with accurate up-to-date account summaries for clients. Clients very concerned.
28. I will often ask case managers to assist patients with paperwork, financial concerns, follow-up with medical providers and they are always helpful.
29. One limitation – groups are required to have a certain number of consumers – at a minimum. For example, two staff = minimum of six consumers for one hour – but reality says we may not have numbers needed. I do believe our agency works hard and consistently to meet consumer needs.
30. A wide variety of treatment options are always available, and presented to accommodate client needs and interests.
31. Always. We are still focusing on client needs when creating positions or programs.
32. Yes, when we make referrals to work and outreach.
33. Team meetings are always positive and consumer requests are always respected and met if possible and within reason.
34. Sometimes, at times, yet there is a process which can take time and ideas can take months or even years to translate into a plan.
35. We bring individual needs to supervision and/or staff meetings to plan who/where/when will work to meet consumer needs.
36. In supervision, requests are discussed and worked toward if appropriate. I had a client who wanted their social security card and wanted me to drive them to the nearest office. I validated her need but then offered alternatives as this would have taken 3 plus hours of my time and was not an immediate need.
37. When asking for case management for clients I have received a positive response.
38. A recent client of mine wanted to get into a faith based treatment facility. All the member of her team leaned into providing whatever info and support was needed to try to make it happen, believing this might be very beneficial to her. In the end, the facility itself declined, but, the response and effort at our end was immediate and united.
39. I have always helped consumers with their needs from supporting them in court to housing issues.
40. When a consumer's needs are mentioned at treatment team, case managers, therapist, and other team members are always willing to help.
41. With the new payroll system there have been some glitches to work out as far as over and under payment of clients and staff and we contact payroll department and they take care of it and see that they get the correct check in a timely fashion.
42. Always helpful with consumer requests regarding the payroll.
43. Information is shared including consumer requests during scheduled team/staff meetings as well as one on one contact with treating staff – I have always felt that “we” work well to provide what consumers need/request, problem solving, accessing (new) resources, thinking outside the box – whatever it takes.
44. Especially when someone's situation may turn into crisis – extra support is provided – bulk of time by outreach. Outreach makes themselves available 24 hours 7 days a week. When someone needs help we are there for the consumer.

6. Do you find an individual's services restricted by lack of funds? (Give examples)

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
34/126	60/126	9/126	23/126
27%	48%	7%	18%

1. So what's new! But that is part of human services, there are always ways to assist a person. It just needs a bit of thinking outside the box.
2. DBH only funds Medicaid. Emergency services funding a huge gap.
3. Consumers who either don't have Medicaid or may have significant spend downs sometimes choose to not utilize services that they would otherwise like and would benefit from due to financial constraints. Even though there is a sliding fee scale for those without Medicaid – any fee, no matter how small, is a disincentive for some.
4. If a child does not have Healthy Kids Gold, there is almost no way for them to receive services they need of they fall within the cracks of the "system."
5. We offer programs based on need! With funding restrictions we continue to focus on our main purpose – more funding is needed of course to continue growth.
6. I believe that people are restricted by lack of good health insurance. Our agency does its best to serve everyone who comes to our door. I think there are many people who do not bother to even apply or ask for services.
7. We have become more diligent about collecting co pays and other fees and in some cases, people no-show and cancel more often to avoid the fee.
8. Sometimes it depends on Medicaid funding.
9. When a consumer is eligible for CM but has no Medicaid, it is given to them on a sliding scale – often even that feels like too much for consumers.
10. Seldom, if ever, restricted services to client as traditional services offered by agency. Sometimes often to non-traditional services (therapeutic horseback riding, water therapy not available).
11. We do not spend less time with our clients, but some types of activities have had to cease during outreach due to budget issues.
12. Mileage has been limited which limits the consumer's choices as to where to practice their community skills.
13. A client in a more remote area is less likely to receive intensive services due to budgetary constraints. Impact of low salaries and deferred raises on morale.
14. Because of Medicaid funding.
15. Medicaid/Medicare do not cover SA services. Uninsured people hesitant to generate treatment related debt – despite sliding fee.
16. Funding is still the largest "wall" for mental health professionals and the agencies they work for. The dollar motivates our existence.
17. SA counseling – MCD. MCR limitations (incident-to, etc.) No funding for supported employment program. It's sometimes very difficult to balance staff and transportation costs with revenues.
18. Access to adequate transportation is a huge, chronic issue in the sprawling rural area, and funding limits consumers' ability to achieve social/vocational goals.
19. Transportation of clients by the agency van has been cut back and that impacts services. We have cut back wherever possible to help us stay a viable agency.
20. Emergency service is extremely expensive – we provide this but need to be quite restrictive (hopefully, new video conference will help). Anyone who has high deductible private insurance or no insurance is not funded to receive FSS, CM, etc. We provide if clinically appropriate, but at al loss.

in the ER as the ES clinician attempts to arrange a viable plan. No funds for mental health housing. Paperwork demands increased geometrically in the past year or so cutting into client time.

53. Not aware of any restrictions due to funding.

54. Self-pay may not be able to have as many services as desired due to having to pay each time, but agency will work for payment plan.

7. Are your agency's managers accessible to you?

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
106/126	12/126	0/126	8/126
84%	10%	0%	6%

a. Are your supervisors accessible to you?

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
113/126	8/126	0/126	5/126
90%	6%	0%	4%

b. Do you find managers/supervisors helpful when you have questions, problems, or ideas that you wish to discuss?

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
97/126	18/126	0/126	11/126
77%	14%	0%	9%

1. My managers/supervisors are more than helpful.
2. Always.
3. My supervisors make themselves available by phone, by e-mail and in person. They are often helpful, responsive and respectful.
4. Very open to ideas.
5. It depends on what the question, problem or idea is. The bottom line on the paperwork is already reached and there is no more money.
6. Very accessible.
7. They are all good people; the agency philosophy is to restrict decision making to few individuals, however. They would benefit from annual management and leadership training – both in-house and external.
8. Managers are always available, very supportive and helpful.
9. Always.
10. Would like to see a better job description and protocols in place along with necessary paperwork for the position to be uniform across the state so it meets the EBP outcomes the state is requiring.
11. I have never worked for a more collegial, supportive, accessible agency. As a long-term employee, I have had numerous examples of our staff going “over and above” to assist employees.
12. I feel it is my responsibility to seek out my supervisor and he has always been open to that.
13. Janet Nickerson has been incredible to me, even before she was formally my supervisor.
14. Some supervisors seem rushed and perhaps too quick to make decisions.
15. I have the impression that the managers themselves are struggling to sort out how we are supposed to do things and there are mixed messages all the time. It would be helpful if the Bureau designated documentation format and trained directly to Bureau expectations,

interpretations.

16. Most managers and my supervisor are available, challenge me to do my best and support my efforts.
17. This is a strength to me.
18. Richard Laflamme is an awesome supervisor. He is not judgmental and he is fair. I feel really comfortable to talk to him about anything. Charles Cotton is an awesome boss.
19. This agency supports its staff members and there is reciprocated support among all staff in regard to enabling. Resources for any financial compensation increase, unfortunately this year was not available. Although we might like to all be volunteers, none of us are able to work without pay or very few if any.
20. Always supportive, understanding and knowledgeable.
21. Yes, professional and willing to listen to different ideas, encourage staff to learn and ask questions.
22. Open door policy at our clinic – always someone available if only by phone – but always have access to supervision.
23. My supervisor has always been there whenever I needed help or a question answered.

SECTION IV: POLICY

Policies and procedures ensure that fundamental organizational processes are performed in a consistent way that meets the organization's needs. Policies and procedures can be a control activity used to manage risk and serve as a baseline for compliance and continuous quality improvement. Adherence to policies and procedures can create an effective internal control system as well as help demonstrate compliance with external regulations and standards.

The NHS BOD is ultimately responsible for establishing the policies for the governance and administration of the CMHP. Policies are developed to ensure the efficient and effective operation of the CMHP. The BOD, through a variety of methods, is responsible for demonstrating adherence to the requirements of state and federal funding sources.

At the time of the review NHS was in substantial compliance with all the requirements referenced above.

GENERAL OBSERVATION IV-A:

There are specific written billing procedures that are available for the staff. There are a few financial policies that the agency should consider incorporating in order to strengthen the internal controls of the agency.

RECOMMENDATIONS IV-A:

It is recommended that all policies (including financial) be consolidated in one policy manual. The agency should consider developing the following written policies for:

- Seeking written proposals for services, property or major purchases;
- Differentiating between capital expenditures and repairs;
- Requiring written approval for non-recurring journal entries;
- The use and accountability of credit cards including the supervising of any Executive Director's expense by the Board;
- Requiring two signatures on checks in excess of a certain amount (to be determined by the BOD);
- Consider amending its petty cash policy to include a statement indicating that the funds will be periodically counted on an unannounced basis.

CMHP RESPONSE IV-A:

GENERAL OBSERVATION IV-B:

Case management services are referred to in several NHS policies. However, the core case management activities (assessment, referral and monitoring) are not always clearly described and other services (service planning) were included in the policies.

GENERAL RECOMMENDATION IV-B:

It is recommended that all case management descriptions be limited to the core case management activities of assessment, referral and monitoring.

CMHP RESPONSE IV-B:

SECTION V: FINANCIAL

The purpose of financial oversight and monitoring is to ensure that public funds contracted to the CMHP are managed according to all applicable statutes, rules and regulations. Self-monitoring of a CMHP not only helps ensure the integrity of the single agency but the statewide mental health system. An insolvent CMHP cannot attain its Mission.

An essential role of a BOD is fiduciary oversight. In order for a CMHP BOD to be able to meet its fiduciary responsibilities to the State and the people it serves several things must occur. The BOD often has a Finance Committee that assists with the development of the yearly budget and reviews monthly financial statements, yearly audits and other information. In addition the Finance Committee and the CFO shares information with the rest of the BOD. Discussion of these issues should be well documented in the monthly Board minutes.

It is essential for any CMHP to have a comprehensive Financial Manual with policies and procedures that guide the day-to-day operations of the CMHP. Ongoing monitoring for compliance with internal control policies and by-laws is essential. In addition, there should be ongoing internal monitoring of financial and billing systems in order for an agency to remain solvent. Documentation of these internal controls is also essential.

The purpose of financial oversight and monitoring by the State Mental Health Authority is to review the financial performance of the CMHP. Best practices that serve to enhance the system as a whole through continuous improvement are also identified.

Please note that the format of this section differs from the remainder of the report. This is due in part to He-M 403 not including most financial areas addressed during the reapproval review. Some of the areas below are addressed in BBH contract and others are general comments and best business practices.

At the time of the review NHS was in substantial compliance with all the requirements referenced above.

OBSERVATION V-A:

The Memorandum of Understanding (MOU) between BBH and NHS regarding contract performance domains and standards were piloted during state fiscal year 2005. The ratios of all of the CMHPs are given to NHS on a monthly basis.

BBH calculated the performance standards using unaudited financial statements for state fiscal year 2005. NHS conformed to all of the fiscal benchmarks set by the MOU. Subsequent to state fiscal year 2005, NHS has been submitting monthly financial information for the continuation of calculating these standards. Although NHS conformed to most of the benchmarks for FY08, the Days in Medicaid Accounts Receivable were over the acceptable level.

RECOMMENDATION V-A:

NHS should submit the monthly ratio schedule to the BOD.

CMHP RESPONSE V-A:

OBSERVATION V-B:

A recommendation resulting from the financial review was made that the agency submits monthly revenue and expense reports to DHHS. These reports should be allocated by site, program and cost center based on actual services utilizing DHHS criteria. NHS agreed to the recommendation but has not forwarded this information to the state.

RECOMMENDATION V-B:

NHS should submit the required reports to DHHS on a monthly basis.

CMHP RESPONSE V-B:

OBSERVATION V-C:

During state fiscal year 2009, NHS indicated that the line of credit with Citizens Bank had expired. The bank initially refused to extend the line until such time that NHS showed two consecutive months of surplus. According to the BOD, NHS has still not yet secured a line of credit with any banking institution.

RECOMMENDATION V-C:

NHS should establish a line of credit with any banking institution.

CMHP RESPONSE V-C:

OBSERVATIONS V-D:

According to the CFO, NHS has identified problems within its information technology (IT) system including:

- Incompatible duties that may result in undetected errors in IT procedures;
- Testing of the recovery procedures is not performed annually;
- There is no evidence that computer security logs document unauthorized changes to live data files and are reviewed by IT supervisory personnel.

RECOMMENDATIONS V-D:

NHS should strengthen its information technology controls by:

- Following through on its plan to implement a new monitoring system;
- Perform testing the recovery procedures of data on at least an annual basis and document the results;
- Generating computer security logs by authorized personnel to document all changes to live data files (including any unauthorized changes).

CMHP RESPONSE V-D:

GENERAL OBSERVATIONS V-E:

As a result of a financial review performed by DHHS DCBCS, NHS implemented changes to help reduce costs and better align with revenues. These changes include:

- Initiating a salary freeze for all staff;
- Deferring all performance incentives including bonuses for staff;
- Implementing a 5% reduction in salary for senior management;
- Suspending contributions to the retirement plan.

The review performed by DHHS indicated that a majority of the bad debt expense previously reported on the FY08 audit was inappropriately classified as an expense. The recommendation by the state was to add a footnote in the FY09 audit explaining these mispostings. There was no footnote in the FY09 audit.

RECOMMENDATION V-E: N/A

CMHP RESPONSE V-E: N/A

SECTION VI: QUALITY IMPROVEMENT AND COMPLIANCE

Quality improvement and compliance activities are expected to be conducted on both the state and local level. The BBH conducts annual quality improvement and compliance reviews and CMHP reapproval reviews on a five-year cycle. Other reviews occur as needed and requested.

He-M 403.06 (i) and (j) outlines the minimum requirements for CMHP quality assurance activities. These include a written Quality Assurance Plan which includes outcome indicators and incorporates input from consumers and family members. The annual plan is submitted to BBH. Other activities include utilization peer review; evaluation of clinical services and consumer satisfaction surveys. Please see the findings below regarding internal CMHP quality improvement and compliance activities.

At the time of the review NHS was in substantial compliance with all the requirements referenced above.

REQUIREMENT: He-M 403.06 (i) and (1) A CMHP shall perform active monitoring of services through a comprehensive Quality Assurance Program that is based on a written Quality Assurance Plan that includes outcome indicators and incorporates input from consumers and family members.

OBSERVATION VI-A:

It was difficult to assess the level of consumer and family input into the NHS Quality Assurance Plan. There was no indication of consumer or family input on the QI committee.

RECOMMENDATION VI-A:

It is recommended that NHS explore ways to include consumer and family input into quality improvement and planning activities.

CMHP RESPONSE VI-A:

REQUIREMENT: BBH Contract Exhibit A Scope of Work K. 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 and appropriate by BBH within timeframes specified by BBH.

OBSERVATION VI-B:

The team from the OIII within DHHS participates in the annual quality improvement and compliance conducted by BBH. The focus of the OIII review is to verify supporting documentation in the clinical record for a sample of claims submitted to and paid by Medicaid.

The team reviewed a total of 875 claims and 50 claims had inadequate documentation. These errors account for 5.7% of the total amount of claims that were reviewed by the team. Missing progress notes comprise 46% of these errors. This could indicate a significant weakness in

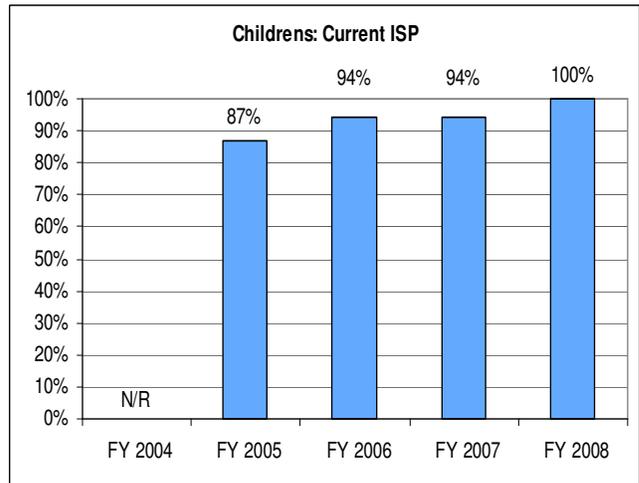
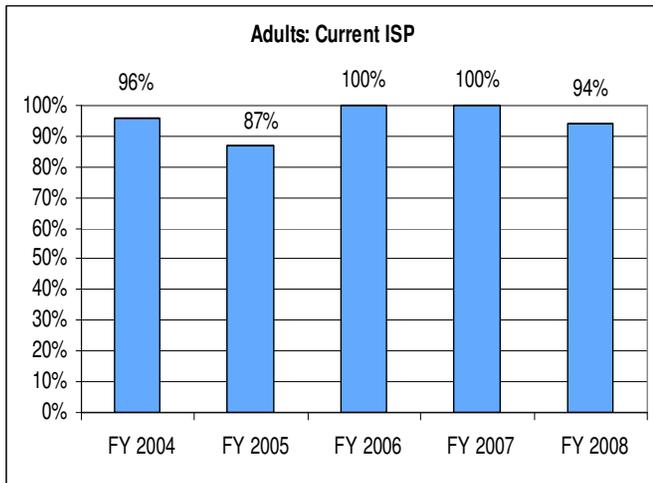
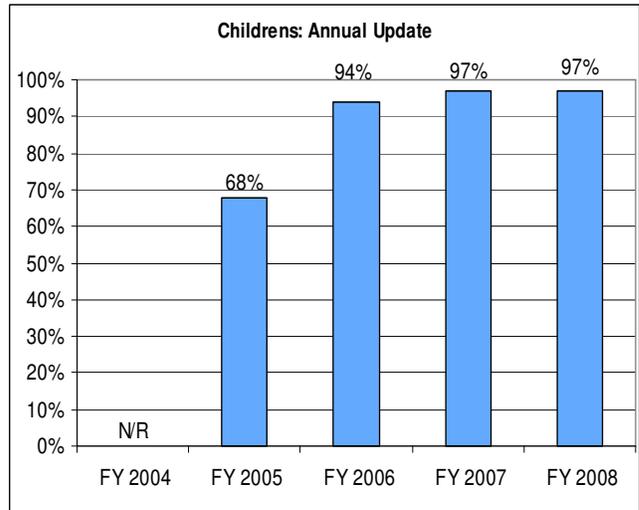
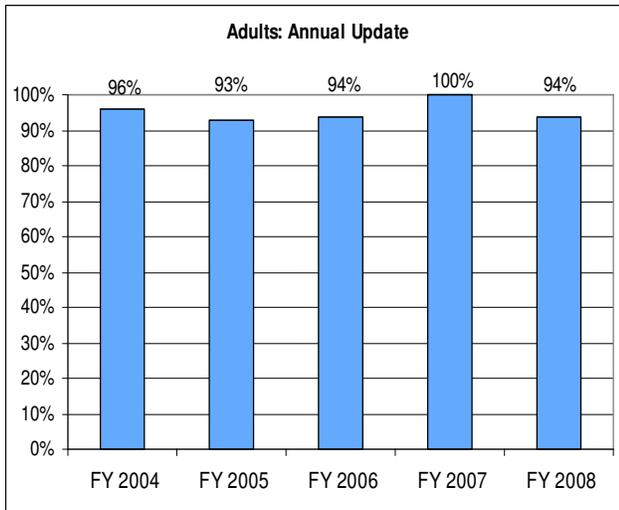
internal controls preventing claims without progress notes from being processed.

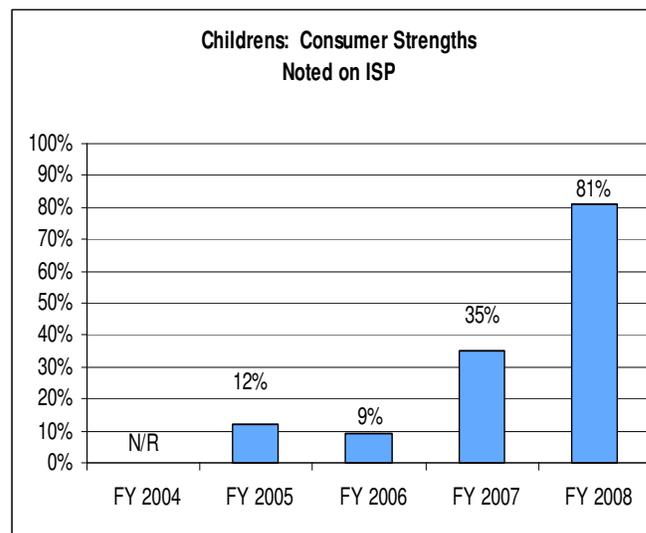
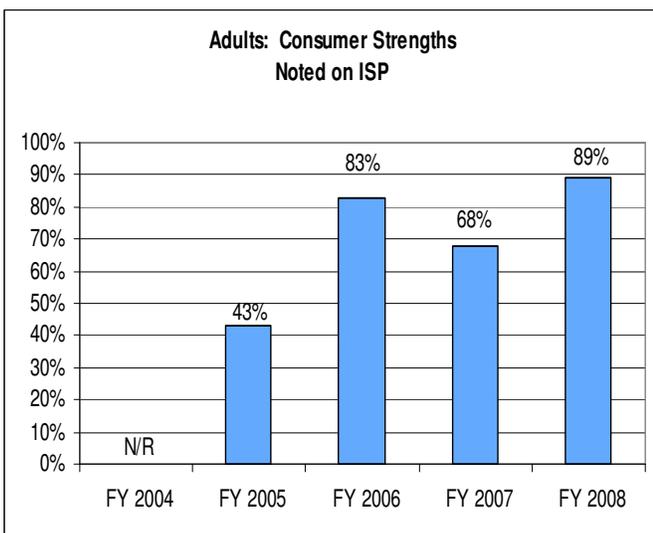
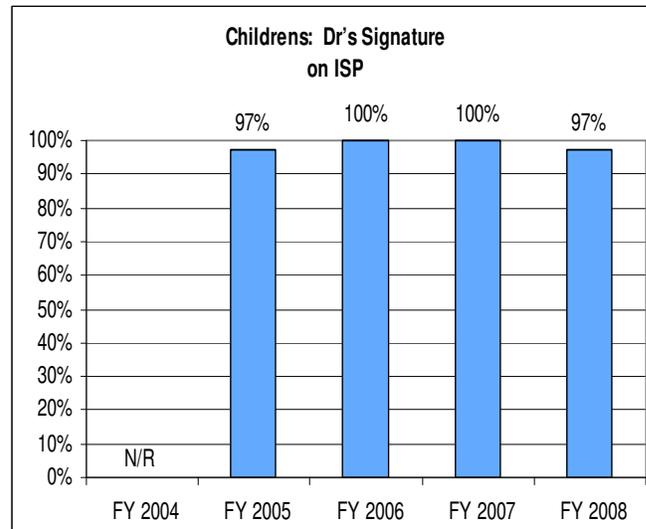
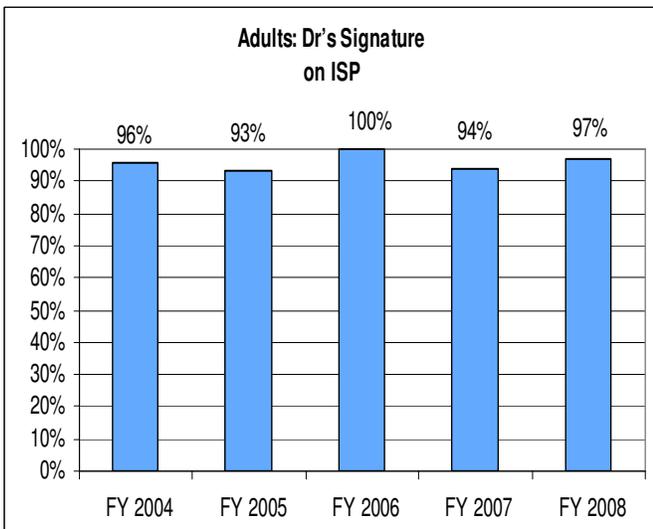
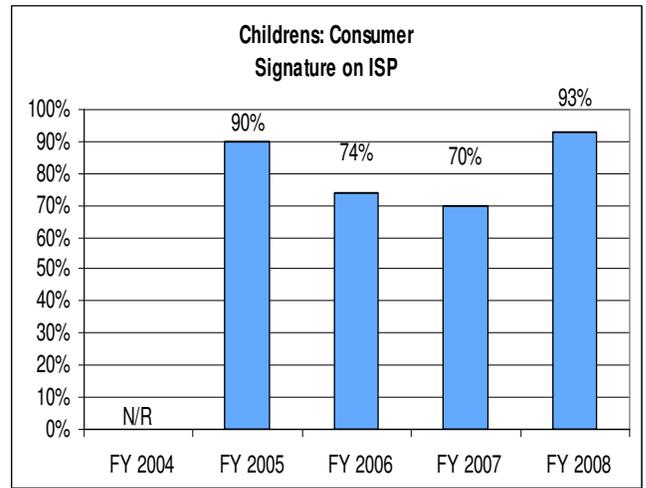
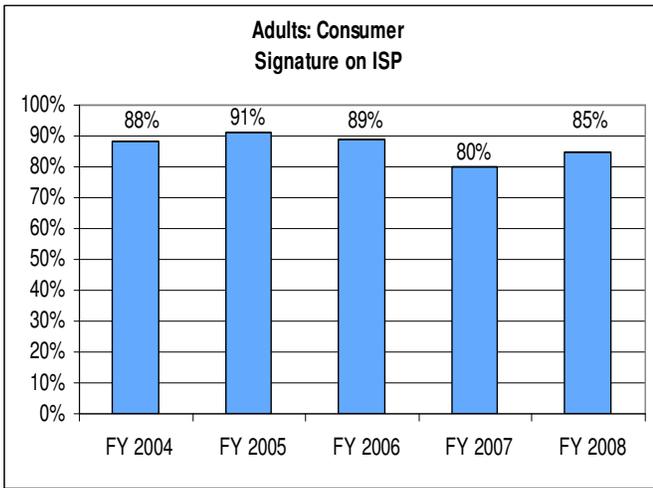
RECOMMENDATION VI-B:

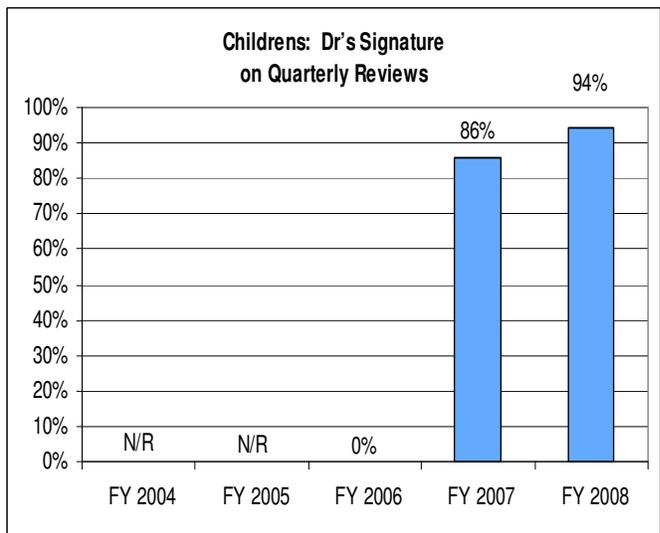
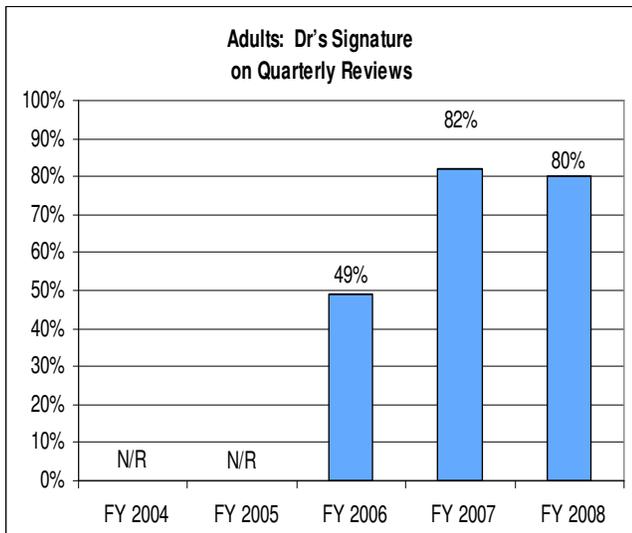
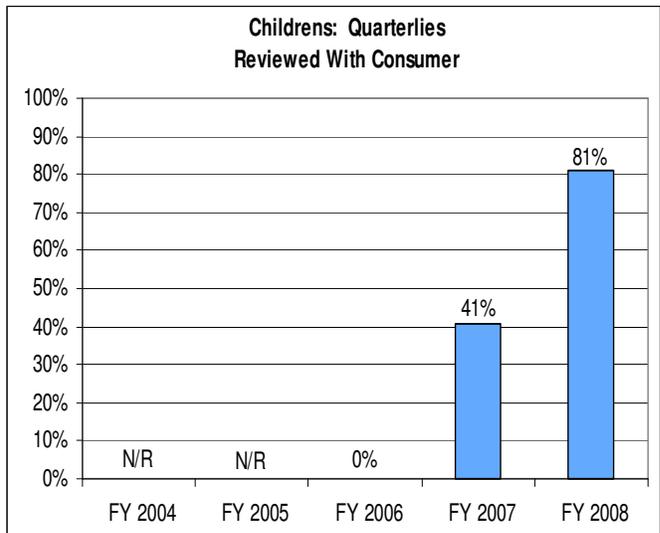
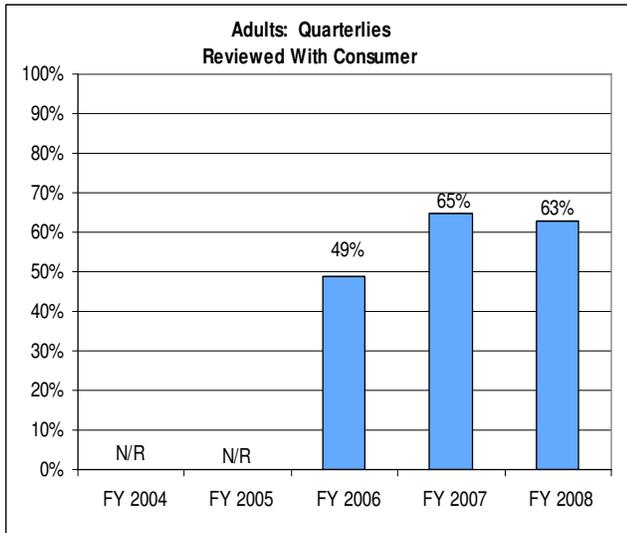
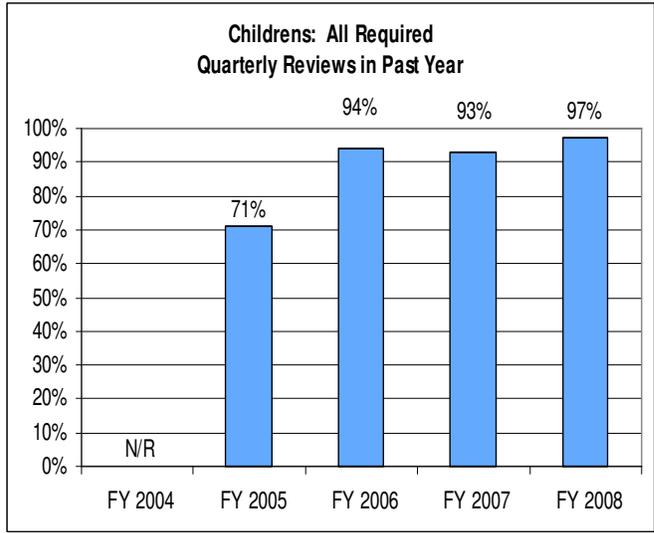
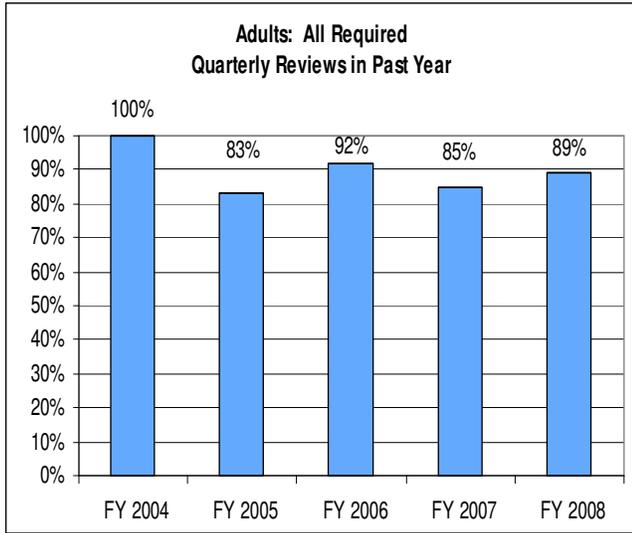
It is recommended that NHS devise a corrective action plan to ensure that all services are documented in the clinical record prior to billing.

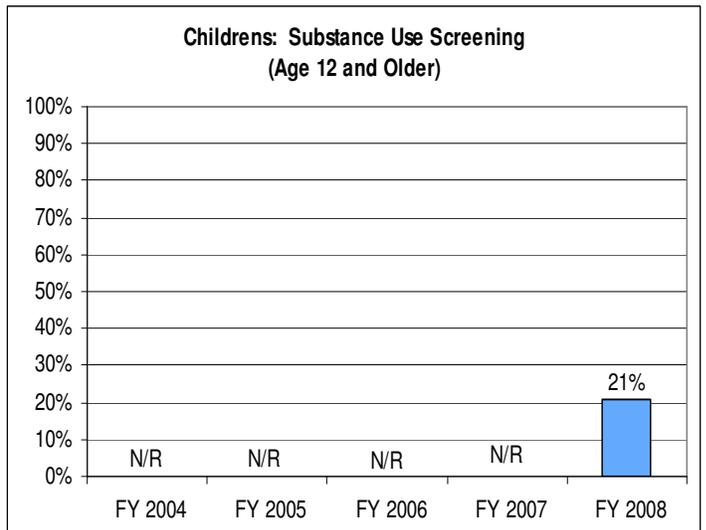
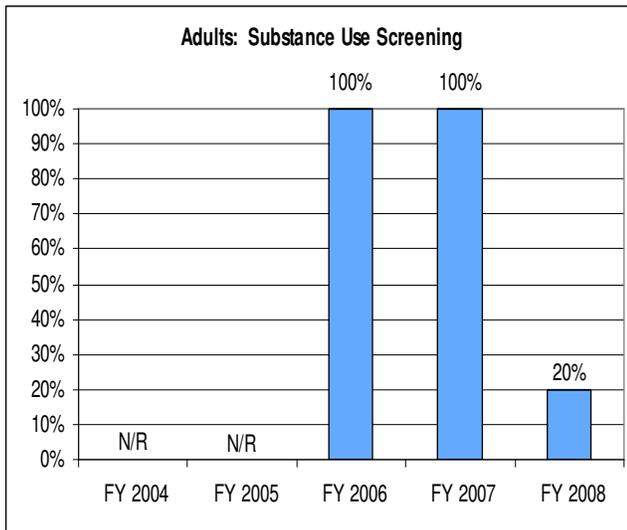
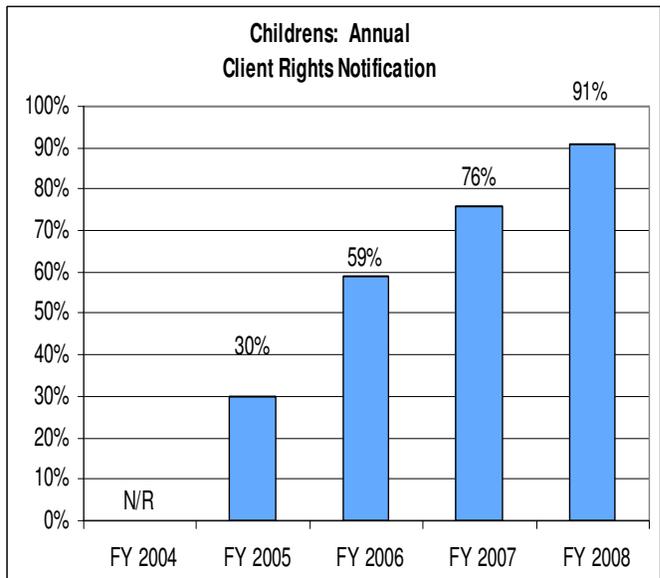
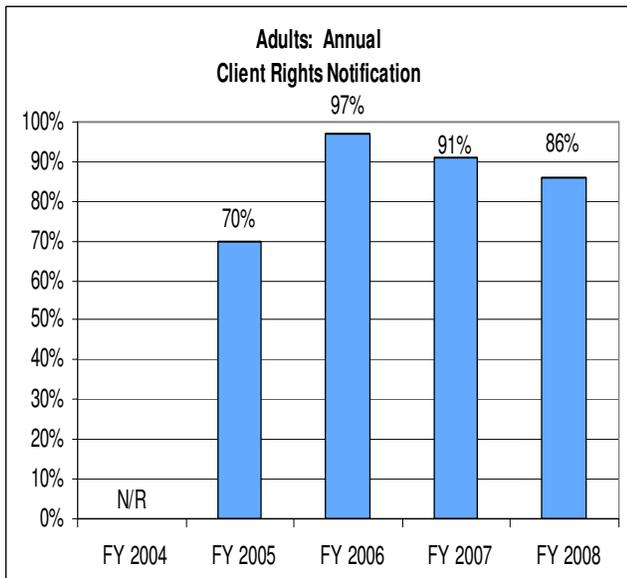
CMHP RESPONSE VI-B:

OBSERVATION VI-C: Five-year trend data from the annual BBH quality improvement and compliance reviews has been included as an overview of the NHS level of compliance with clinical record standards. The charts below reflect some of the clinical record requirements and NHS compliance levels. “N/R” noted in the charts below indicates that this requirement was not reviewed in a given year. In recent years BBH has requested corrective action plans for any area with a compliance rating of 75% or less. These corrective action plans have already been received as part of that annual process.









RECOMMENDATIONS VI-C:

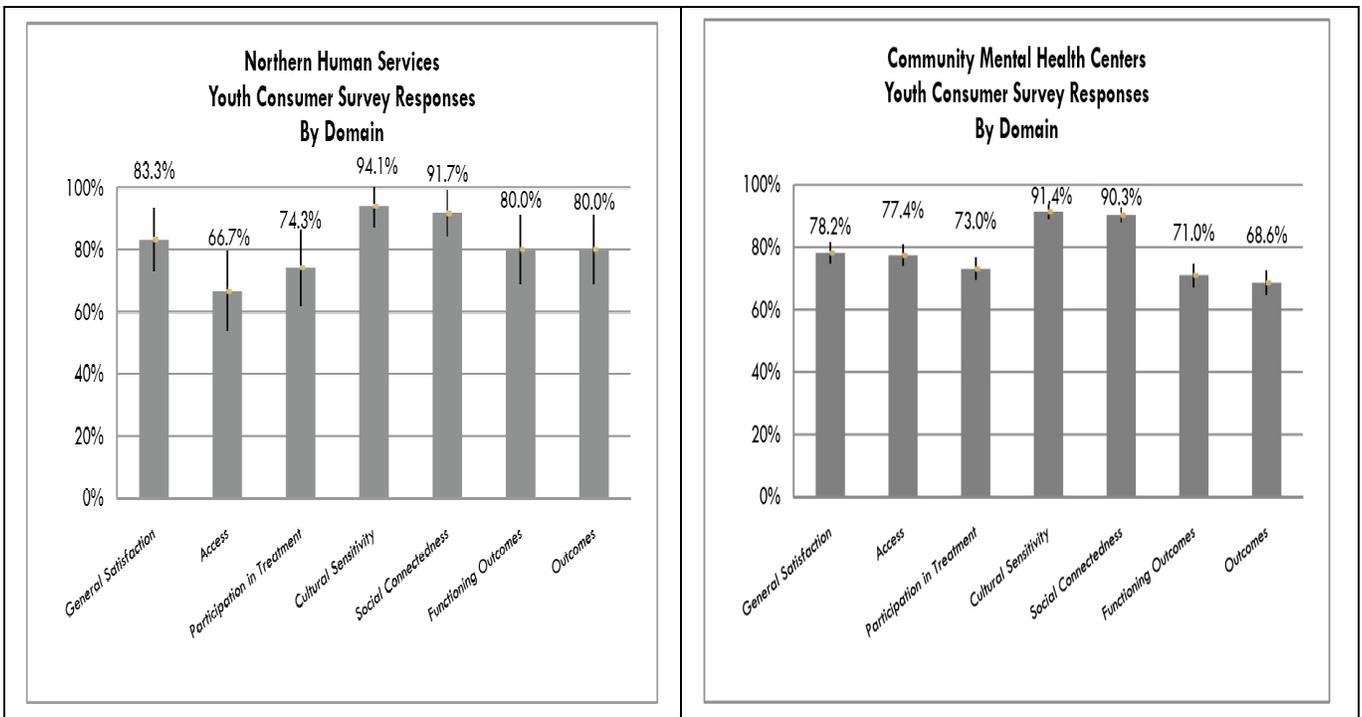
It is recommended that the BBH QI and Compliance Reports be shared with the BOD and utilized in planning activities. It is also recommended that NHS continue to conduct and document internal quality improvement and compliance activities.

CMHP RESPONSE VI-C:

SECTION VII: CONSUMER AND FAMILY SATISFACTION

In the fall of 2007 the NH DHHS, BBH contracted with the Institute on Disability at UNH to conduct the NH Public Mental Health Consumer Survey Project. The project is part of a federally mandated annual survey of the nation’s community mental health centers. The IOD and the UNH Survey Center conducted and analyzed findings for a consumer satisfaction survey of youth (ages 14 through 17), adults (ages 18 years and older), and family members of youth (ages 0 through 17) receiving services from NH’s ten community mental health centers.

Below are summary excerpts from reports for both NHS and the ten CMHPs as a group. Data from the surveys was compiled into seven summary categories including: General Satisfaction, Access, Participation in Treatment, Cultural Sensitivity, Social Connections, Functioning Outcomes and Outcomes. The charts are divided by population into three sections including, youth, adults and family members of youth.



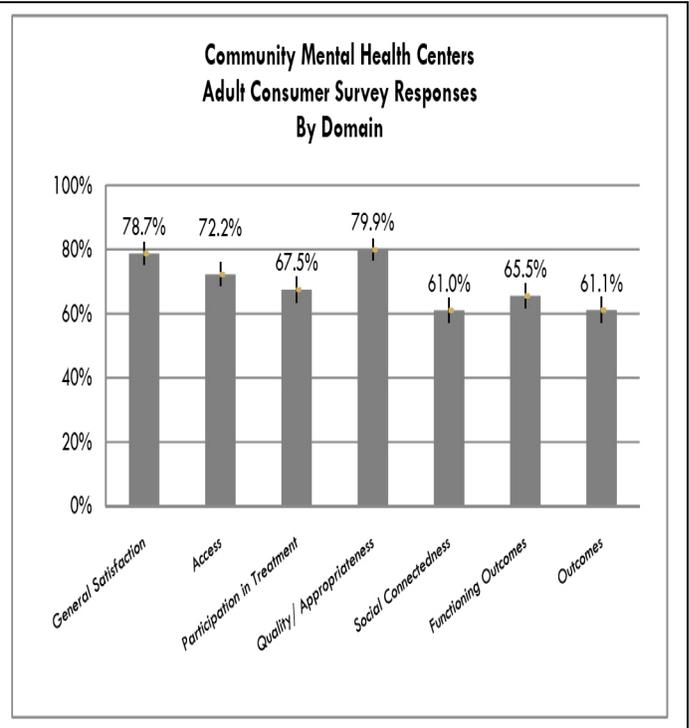
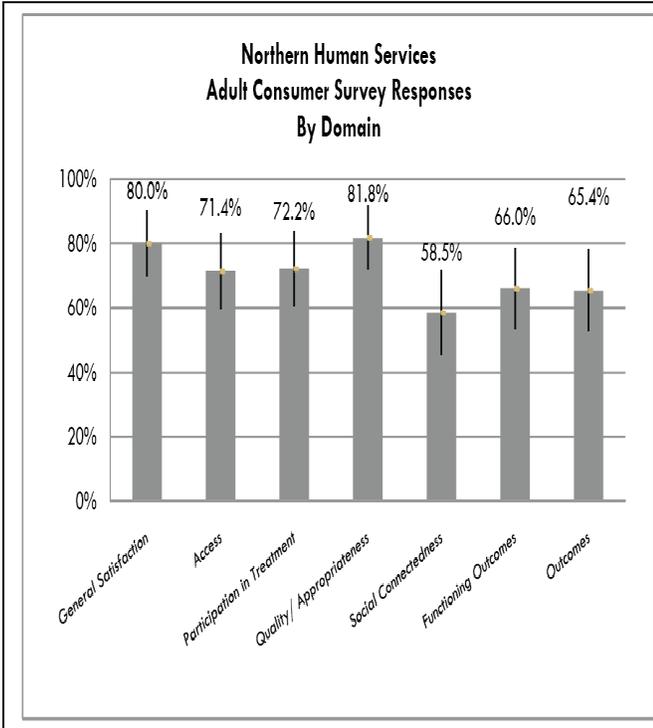
OBSERVATION VII-A:

It is noted that NHS percentages ranked below the statewide average in the following Youth Survey domain: Access.

RECOMMENDATIONS VII-A:

It is recommended that the NH Public Mental Health Consumer Survey Project be shared with the BOD and utilized in planning activities.

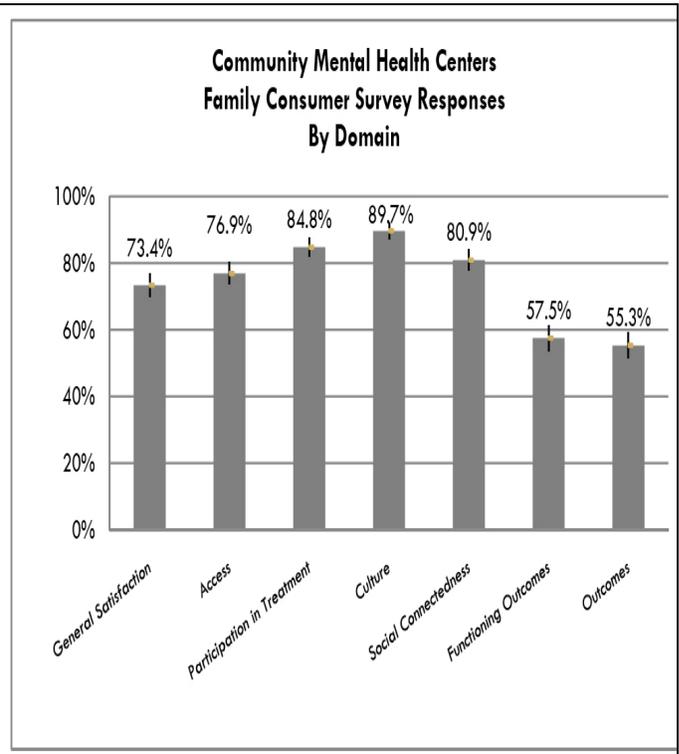
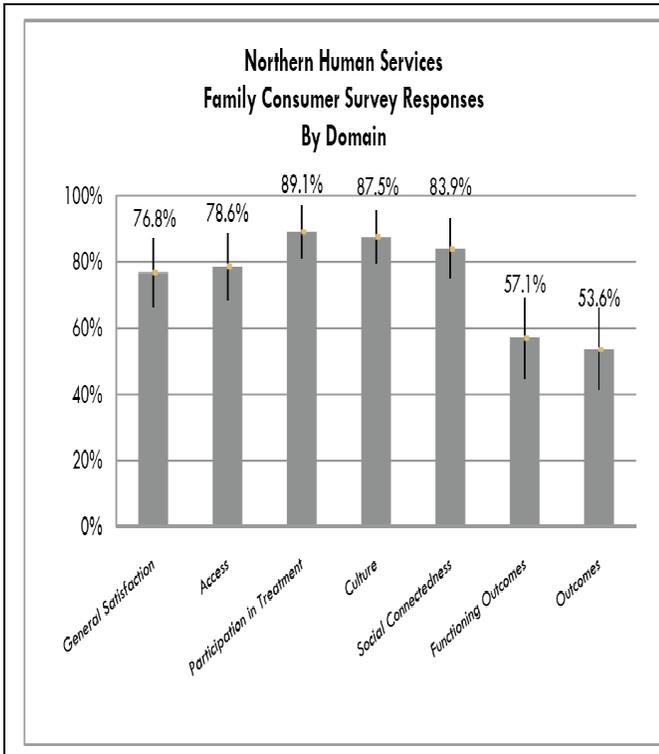
CMHP RESPONSE VII-A:



OBSERVATION VII-B: It is noted that NHS percentages ranked below the statewide average in the following Adult Survey domains: Access and Social Connectedness.

RECOMMENDATIONS VII-B: It is recommended that the NH Public Mental Health Consumer Survey Project be shared with the BOD and utilized in planning activities.

CMHP RESPONSE VII-B:



OBSERVATION VII-C:

It is noted that NHS percentages ranked below the statewide average in the following Family Survey domains: Functioning Outcomes and Outcomes.

RECOMMENDATIONS VII-C:

It is recommended that the NH Public Mental Health Consumer Survey Project be shared with the BOD and utilized in planning activities.

CMHP RESPONSE VII-C:

END OF REPORT