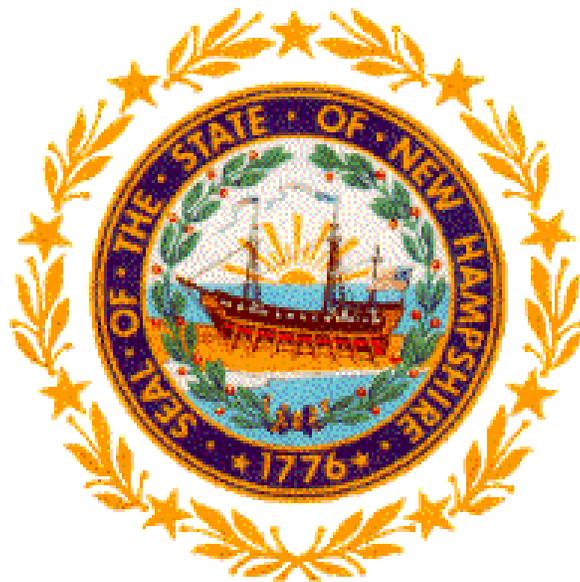


**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF BEHAVIORAL HEALTH**

**COMMUNITY MENTAL HEALTH PROGRAM
REAPPROVAL REPORT**



RIVERBEND COMMUNITY MENTAL HEALTH, INC.

June 15, 2010

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

TABLE OF CONTENTS

ACRONYMS AND DEFINITIONS

EXECUTIVE SUMMARY

PURPOSE, SCOPE AND METHODOLOGY OF REVIEW

AGENCY OVERVIEW

FINDINGS/OBSERVATIONS AND RECOMMENDATIONS

Section I: Governance

Section II: Services And Programs

Section III: Human Resources

Section IV: Policy

Section V: Financial

Section VI: Quality Improvement And Compliance

Section VII: Consumer And Family Satisfaction

STATE OF NEW HAMPSHIRE
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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
CRP	Certified Rehabilitation Provider
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
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
RCMH	Riverbend Community Mental Health
SFY	State Fiscal Year
SURS	Surveillance Utilization Review Subsystems
SE	Supported Employment
TCM	Targeted Case Management Services
UNH	University of New Hampshire
VR	Vocational Rehabilitation

EXECUTIVE SUMMARY

In accordance with State of New Hampshire Administrative Rule He-M 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-M 403 is to define the criteria and procedures for approval and operation of community mental health programs. A reapproval review of Riverbend Community Mental Health (RCMH) in Concord, NH occurred on February 15-19, 2010, that included attending a Board of Directors (BOD) Meeting. The review team included staffs from the Department of Health and Human Services (DHHS); the Bureau of Behavioral Health (BBH); and the Office of Improvement, Integrity and Information (OIII).

RCMH 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 BOD list with terms of office and the towns represented;
- The By-Laws;
- The BOD meeting minutes for Calendar year 2009;
- 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 2009 with Five Year Financial Trend Analysis;
- A Public Notice published in local newspapers soliciting feedback regard the CMHP;
- A letter to RCMH constituents soliciting feedback regarding the CMHP;
- Staff surveys soliciting information from RCMH staff regarding training, supervision, services and CMHP operations.

The site visit to RCMH included:

- Review of additional documentation including: orientation materials for new BOD members; the Policy and Procedure Manual; Interagency Agreements; Memoranda of Understanding (MOU); and a sample of personnel files;
- Interviews with the BOD, the CMHP Management Team, the Chief Financial Officer (CFO), and the 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; and 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 shall document, review, approve, and sign off on all RCMH policies in accordance with He-M 403.05 (e) and RCMH bylaws;
- The BOD shall document, review, approve, and sign off on the RCMH Disaster Response Plan;
- Formal and standardized approaches to offering IMR should be developed and documented;
- Continue to utilize successful strategies to increase IMR penetration rates;
- IMR outcome information should be shared with practitioners;
- IMR outreach to natural support networks is an area that could likely be improved with training;
- Implement IMR goal-tracking sheets;
- Actively market the SE program to the eligible population in an effort to increase penetration rate;
- Refine the Employment Specialist role and responsibilities to emphasize strategies that will increase competitive employment;
- Develop an agency structure that promotes competitive employment;
- Rebuild a relationship with VR;
- Dedicate necessary resources to adequately support the SE Team Leader in the role as a supervisor;
- Enhance the agency focus on competitive employment;
- Develop policies regarding the provision of or the referral to child and adolescent sexual offender assessment and treatment;
- All case management descriptions be limited to the core case management activities of assessment, development of a care plan, referral, and monitoring;
- 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;
- Personnel files be monitored for completeness at least annually at the time of the performance review;
- Develop or amend policies to include: the required elements in a job description; the review of the Office of Inspector General's List of Excluded Individuals/Entities for each newly hired and re-hired staff members; staff grievance procedures; and staff development plans;
- Develop a policy regarding staff orientation that includes, at a minimum, all the requirements outlined in He-M 403.07 (e);
- BBH QI and Compliance Reports be shared with the BOD and utilized in planning activities;
- Continue to conduct and document internal quality improvement and compliance activities;
- The NH Public Mental Health Consumer Survey Project be shared with the BOD and utilized in planning activities.

PURPOSE, SCOPE AND METHODOLOGY

Staff from the NH DHHS, BBH and OIII, conducted an on-site review of RCMH in Concord, NH on February 15-19, 2010, that included attending a Board of Directors (BOD) Meeting. Members of the review team included Karen Orsini, Michael Kelly, Joy Cadarette, Michele Harlan, 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 QI and Compliance 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 19, 2010, 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 RCMH 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 BOD list with terms of office and the towns represented;
- BOD By-Laws;
- BOD meeting minutes for calendar year 2009;
- 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 RCMH contract with BBH;
- Results of SFY 2008 Adult and Child QI and Compliance Review;
- The findings of the previous reapproval report;
- Fiscal manual;
- Billing manual;
- Detailed aged accounts receivable listings for SFY 2008 and SFY 2009;
- Job Descriptions for all accounting and billing staff.

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

- BOD policies;
- Orientation materials for new BOD members;
- BOD approved Policy and Procedure Manual;

- MOUs or Interagency Agreements including those with, but not limited to, the following:
 - 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 2009;
- Several personnel files including those for:
 - Chief Executive Officer
 - Medical Director

A Public Notice of the CMHP’s application for Reapproval was published in 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 RCMH conducts business.

Employee surveys were sent to RCMH 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 2009 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; and 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

In the late 1950s, a group of concerned community members in Concord came together to address a need for mental health services for children and families. Local efforts evolved during this period and The Concord Mental Health Center opened its doors in 1964 with an operating budget of \$20,000. From the start, there was an ever-growing demand for services, so the agency expanded and diversified. During its first decade, the agency added services for adults, couples, and families, in addition to children. Accessibility for the broader geographic community was addressed by opening branch offices in Henniker, New London, and Franklin.

By the end of the 1970s, the Center had become a comprehensive, regional community mental health agency, and the name was changed to Central New Hampshire Community Mental Health Services, Inc. In the 1990s, tremendous change and growth continued in developing comprehensive, community-based supports for people across the lifespan. In 1995, the agency name changed to RCMH.

RCMH became one of the larger employers in Merrimack County, with a workforce of nearly 300 people. The agency has received local and national recognition, and has been the recipient of several awards. RCMH has a strong affiliation with Capital Region Healthcare (Concord Hospital, Concord Regional Visiting Nurse Association, and Monadnock Hospital) and works closely with other providers in the Central New Hampshire area. RCMH also has the most sophisticated and longest operating electronic medical record in the New Hampshire community mental health system.

RCMH 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. Additional services include: at-risk youth prevention programming, counseling for families in transition, and substance abuse programs.

RCMH has a website (<http://www.riverbendcmhc.org/index.php>) that includes information on service programs, consumer and family information, continuing education, mental wellness resources, fundraising, web links, and other resources.

The mission of RCMH is:

“We care for the mental health of our community.”

The towns served by RCMH include:

Allenstown	Canterbury	Dunbarton	Hillsboro	Northfield	Warner
Andover	Chichester	Epsom	Hopkinton	Pembroke	Weare
Boscawen	Concord	Franklin	Loudon	Pittsfield	Webster
Bow	Danbury	Henniker	Newbury	Salisbury	Wilmot
Bradford	Deering	Hill	New Loudon	Sutton	Windsor

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 has 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 bylaws 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 BOD 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 BOD membership.

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

REQUIREMENT: He-M 403.05 (e) A CMHP Board of Directors shall establish policies for the governance and administration of the CMHP and all services through contracts with the CMHP. Policies shall be developed to ensure efficient and effective operation of the CMHP-administered service delivery system and adherence to requirements of federal funding sources and rules and contracts established by the department.

OBSERVATIONS I-A:

There was no indication that the BOD had reviewed and approved RCMH policies. In addition to administrative rule requirements, RCMH bylaws state that the BOD's "primary function shall be to set policy".

RECOMMENDATIONS I-A:

The BOD shall document, review, and approve all of RCMH policies in accordance with He-M 403.05 (e) and RCMH bylaws.

CMHP RESPONSE I-A:

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 bylaws maintained by the CMHP Board.

He-M 403.06 (a) and (a) (7) 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-B:

The Disaster Response Plan included no signatures indicating review and approval by the BOD.

RECOMMENDATION I-B:

The Disaster Response Plan be reviewed and approved by the BOD or their designee.

CMHP RESPONSE I-B:

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, RCMH 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.

Eligibility/Consumer Identification	1	2	3	4	5
All consumers with severe mental illness in the community support program, crisis consumers, and institutionalized consumers are screened to determine whether they qualify for the EBP using standardized tools or admission criteria consistent with the EBP. Also, the agency tracks the number of eligible consumers in a systematic fashion.	≤20% of consumers receive standardized screening and/or agency DOES NOT systematically track eligibility.	21%-40% of consumers receive standardized screening and agency systematically tracks eligibility.	41%-60% of consumers receive standardized screening and agency systematically tracks eligibility.	61%-80% of consumers receive standardized screening and agency systematically tracks eligibility.	>80% of consumers receive standardized screening and agency systematically tracks eligibility.

OBSERVATION II-A:

There was no systematic method to track which eligible consumers had been offered IMR. At the time of the review it appears that within the adult CSP program some consumers were informed about IMR on intake, others may discuss IMR during the annual treatment planning process, and still others may hear about it from their case manager.

RECOMMENDATION II-A:

Formal and standardized approaches to offering IMR should be developed and documented.

CMHP RESPONSE II-A:

IMR 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> # consumers eligible for EBP	Ratio ≤ .20	Ratio between .21 and .40	Ratio between .41 and .60	Ratio between .61 and .80	Ratio > .80

OBSERVATION II-B:

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. Numerically, this proportion is defined by:

$$\frac{\text{\# of consumers receiving an EBP}}{\text{\# of consumers eligible for the EBP}}$$

Efforts to increase the rate of penetration for IMR services at RCMH were successful. The percentage of consumers receiving the service has almost doubled from 10.8% to 19%.

119 consumers receiving IMR = .19 ratio
625 consumers eligible for IMR

RECOMMENDATION II-B:

Continue to utilize successful strategies to increase penetration rates. Additional strategies may include offering more groups to larger numbers of consumers.

CMHP RESPONSE II-B:

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 <i>related to the EBP</i> , 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-C:

Outcome information has been collected, but not shared with the IMR Program Leader and staff.

RECOMMENDATION II-C:

Outcome information should be shared with practitioners.

CMHP RESPONSE II-C:

IMR Fidelity Review Reports – IMR Fidelity Scale Section. Each of the items from the IMR Fidelity Scale is listed below with shading indicating the score for each item as well as a description of the rating and recommendations for improving the IMR practice at RCMH. 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.

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-D:

This is one of the most challenging areas for IMR providers across the country. Practitioners and participants described limited contact with natural supports.

RECOMMENDATION II-D:

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

CMHP RESPONSE II-D:

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 chart.

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-E:

Goals were frequently not individualized or recovery oriented. Goals are not connected to the subject matter in the modules and tracking sheets are not being utilized.

RECOMMENDATION II-E:

The implementation of goal-tracking sheets and goal follow-up should be supported in supervision. The process of practitioners and participants collaborating to establish personally meaningful goals is a critical component to engaging people in IMR.

CMHP RESPONSE II-E:

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: $\frac{\# \text{ Consumers receiving EBP}}{\# \text{ Consumers eligible for EBP}}$	Ratio \leq .20	Ratio between .21 and .40	Ratio between .41 and .60	Ratio between .61 and .80	Ratio $>$.80

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:

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

$$\frac{133 \text{ consumers receiving SE services currently}}{336 = (560 \text{ eligible} * .60)} = .395 \text{ ratio}$$

OBSERVATION II-F:

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 less than .40. This results in a rating of two out of five.

RECOMMENDATION II-F:

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

CMHP RESPONSE II-F:

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
Collaboration between employment specialists and Vocational Rehabilitation counselors: The employment specialists and Vocational Rehabilitation counselors have frequent contact for the purpose of discussing shared consumers and identifying potential referrals.	2

OBSERVATION II-G:

The relationship between RCMH and VR has varied over time. RCMH is a Certified Rehabilitation Provider (CRP) making them eligible to receive VR funding for certain job search and support related activities. At the time of the review, Employment Specialists reported having had limited contact with local VR counselors with irregular frequency of meetings.

ORGANIZATION	RATING
<p>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.</p> <ol style="list-style-type: none"> 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 consumer 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 consumer outcomes with employment specialists and sets goals to improve program performance at least quarterly. 	2

OBSERVATIONS II-H:

At the time of the review, the SE Team Leader had taken on many new responsibilities transitioning into the role as the supervisor. The Team Leader was carrying a large caseload of 24 consumers while attempting to balance responsibilities as a supervisor.

The Team Leader does not currently accompany Employment Specialists in the field, review current client outcomes, or set goals to improve program performance. This is due in large part to the absence of an agency-based system to track employment outcomes. Communication with the treatment teams is accomplished through the EBP coordinator, rather than the Team Leader.

SERVICES	RATING
<p>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 consumer is present or not. Consumer-specific and generic contacts are included. Employment specialists use a weekly tracking form to document employer contacts.</p>	2

OBSERVATION II-I:

The SE Program at RMHC does not track face-to-face contacts with employers. Employment Specialists estimated that they made roughly two employer contacts per week on average, and that it would be beneficial to allocate more time to this activity.

RECOMMENDATIONS II - G through I:

Refine the Employment Specialist role and responsibilities to emphasize strategies that will increase competitive employment.

Develop an agency structure that promotes competitive employment.

Rebuild a relationship with VR.

Dedicate necessary resources to adequately support the SE Team Leader in her role as a supervisor.

Enhance the agency focus on competitive employment.

CMHP RESPONSE II – G through I:

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

OBSERVATION II-J:

RCMH does not provide these services.

RECOMMENDATION II-J:

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

CMHP RESPONSE II – J:

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 426.15

OBSERVATION II-K:

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-K:

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

CMHP RESPONSE II-K:

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

At the time of the review, RCMH 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 Bureau 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.

RECOMMENDATION 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: 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-B:

RCMH HUMAN RESOURCES TABLE												
He-M	Requirement	Personnel Files										% Compliance
		1	2	3	4	5	6	7	8	9	10	
He-M 403.07 (b)	Criminal background checks.	Y	N/A	N	Y	Y	Y	Y	V	Y	Y	88%
He-M 403.07 (b)	OIG sanctioned provider check.	Y	N/A	N	Y	Y	Y	Y	N	Y	Y	77%
He-M 403.07 (b)	DMV check.	Y	N/A	N	N	Y	Y	Y	Y	Y	Y	77%
He-M 403.07 (c)	Annual performance review.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (d)	Staff development plans.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (e)	Orientation training.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (e) (1)	Does Orientation include the Local and State MH System including Peer and Family Support?	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	90%
He-M 403.07 (e) (2)	Does Orientation include an overview of mental illness and current MH practices?	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	90%
He-M 403.07 (e) (3)	Does Orientation include Applicable He-M Administrative Rules?	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	90%
He-M 403.07 (e) (4)	Does Orientation include accessing the local generic service delivery system?	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	90%
He-M 403.07 (e) (5)	Does Orientation include Client Rights training?	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	90%

RECOMMENDATIONS III-B:

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-B:

**RIVERBEND COMMUNITY MENTAL HEALTH
REGION IV**

**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 RCMH.

1. Does your agency provide job-related training?

<u>Yes</u>	<u>No</u>	<u>No Answer</u>
105/107	1/107	1/107
98%	1%	1%

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

<u>Poor</u>	<u>Fair</u>	<u>Good</u>	<u>No Answer</u>
0/107	9/107	98/107	0/107
0%	8%	92%	0%

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>
1/107	12/107	86/107	8/107
1%	11%	80%	7%

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

1. Weekly and regional trainings.

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

1. Good. But – our center consistently fails to offer training in the area of substance abuse diagnosis and treatment! Big problem.
2. The agency is paying me to attend Motivational Interviewing training.
3. Ethics.
4. Monthly calendar of training opportunities, full suite of new hire trainings, email alerts for special trainings with guest trainer/speaker, mandatory annual training hours.
5. Not sure. Haven't made requests.
6. Very good. When I'm interested in a training they pay for it.
7. They always solicit and are open to requests for specific training topics.
8. The agency provides surveys for us to complete to voice the type of training that is needed.
9. Over the past few years suggestions on training have been discussed in meeting and forwarded on to the people coordinating training and in a short time, these have been offered.
10. Emergency services training.
11. The agency polls employees to determine what trainings would be most helpful in their jobs.
12. They try to come up with money even if I ask to go to something that costs money.
13. On every review of training, there is space to put what you want for trainings on. RB is putting

- together a training survey to go out to assess the needs of staff.
14. I.e., Concord’s refugees from Bhutan – training made available in a timely way.
 15. Our team members have gone to specialized trainings relevant to our client group.
 16. My particular training has been on the job training. Which is not the best way to get to know your job. Received 2 days with previous employee whom’s position I filled.
 17. A lot of trainings are offered but the lack of time makes it difficult to set aside time for trainings.
 18. I have not made any training requests, so therefore cannot answer.
 19. Training committee meets regularly to review training options and discusses feedback/requests of staff and works hard to set up trainings that have been requested.
 20. Due to budget cuts, some requested training events that involve fees are not as accessible any more.
 21. I haven’t asked for any training.
 22. Excellent – always supportive of requests for training.
 23. Suicide prevention training offered at least one time per year.
 24. Great in-house offerings, as well as Concord Hospital trainings. I routinely approve outside offerings for my staff and have never been denied.
 25. TIET trainings provided often and in response to changing document needs. Other offerings re: treatment planning, diagnosing, supervising, medications.
 26. If we ask for a specific training on something, they are willing to organize that and provide us with the training.
 27. Staff are periodically surveyed on their training needs and the results of these surveys direct the nature of our trainings.
 28. They seem to take all requests seriously and actively request suggestions.
 29. Training offered almost every Friday. New topics; and active training committee.
 30. There are a variety of trainings, so I would assume requests are granted. I have never requested training, however.
 31. CPI scheduled often and defensive driving as requested.
 32. If something specific comes up they will offer one-on-one training or develop a seminar. They listen to feedback and suggestions.
 33. When I have asked to attend a workshop, the agency has been supportive and often agrees to pay workshop fee.
 34. Ask for a specific area of interest for training and they find someone to do it!!!
 35. I requested a training course and my supervisor looked into resources that I could pursue since our agency was not able to attend conferences relevant to the work I do.
 36. The agency in prior years could afford to send us but since the cuts for mental health came, they have been put on hold. Trainings that are a “have to have” are still paid for.
 37. Trainings are offered in a variety of areas.

2. Does your agency provide training in recovery philosophy?

<u>Yes</u>	<u>No</u>	<u>No Answer</u>
84/107	6/107	17/107
79%	6%	16%

1. IMR, treatment planning, FSS, TBS, other trainings.
2. I work in CHIP – Children’s Intervention Program. This is not a child-focused philosophy/practice.
3. We do not use the term recovery with children.
4. Not a term used in the children’s world.

5. The children’s program does not have a “recovery philosophy.”
6. Recovery not applicable to children’s program.
7. Please – can this be written with more of an understanding that the word “recovery” is not appropriate for children?
8. This is an adult term and is not applicable to my work in the children’s program.
9. We are recovery based both in practice and philosophy.
10. Not as a primary focus.
11. Not applicable to children’s services, but they do for adults.
12. This is geared more toward adults.
13. Not sure what you mean by this.
14. I don’t know.
15. My work is primarily with children whereas recovery philosophy, I believe, is more geared toward adults. When I did work with adults 11 years ago, Riverbend was focused on recovery.
16. I do not know what this is.
17. Recovery is generally an adult oriented term. We work with kids who often develop past their problems.
18. Staff members (several) have been trained in IMR.
19. Strong commitment.
20. Riverbend has a strong focus on recovery and provides training on recovery.
21. Not applicable – recovery philosophy is not a paradigm used for children’s mental health treatment.
22. Ongoing discussion in group setting and more basic trainings as well.
23. Very supportive.
24. Do you mean to say “resiliency” or “growth” since “recovery” is an adult focused term? You, again, are ignoring the children’s world using only adult language.
25. Our agency is VERY recovery orientated. I believe we provide services that enhance the recovery of the clients we serve.

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>
85/107	9/107	1/107	12/107
79%	8%	1%	11%

1. Encourage IMR and community work.
2. This agency works with clients around their goals and we promote change to healthy living.
3. Why can’t DBH take the time to design a survey specific to children’s programs?
4. Yes, we have great training where we work on the treatment plans with consumers.
5. Regular reviews of plans are discussed at team meetings to address all levels of consumer needs.
6. Individual staff – case managers do a superb job at this, however.
7. Peer supervision.
8. “Recovery” is an adult treatment term, which is not applicable to my work in the Children’s Intervention Program.
9. It is the base principle from which we approach every client at Riverbend – monthly, all staff CSP meeting often revolves around this principle and making us comply with state mandates and budget constraints.
10. This language isn’t used as the primary focus but the goals are recovery focused.
11. Again, not applicable to children’s services.

12. Very, we don't view individual with mental illness as less than equal to everyone else.
13. Again, this is geared toward adults.
14. We have served training; discussion lunches to brainstorm strategies to help staff support our consumers establish recovery-focused goal.
15. Treatment plans are 100% client based. Trainings are offered on treatment planning which include clients.
16. Team meetings – staff brainstorm/collaborate on the treatment to meet client needs – support treatment strategies (IMR).
17. Don't know.
18. This agency is very supportive in providing treatment that will help clients become functional, utilize natural supports and be more self-sufficient.
19. Case managers sit down with the clients to discuss goals and objectives and help clients reach them throughout the year.
20. Case managers, our bosses, treatment teams and input, of course, from clients are all used.
21. We have treatment planning sessions so that the client/staff can attend to develop goals/plans.
22. I am admin staff; I do not feel able to evaluate this statement, as I do not work with this.
23. Individual's goals are supported and choices are respected.
24. They offer a specific training on treatment plans which you're able to bring clients to. They are always looking for staff to "meet clients where they are at."
25. Several trainings in motivational interviewing, establishing rapport, IMR.
26. Everyone explains what recovery is and gives examples in terms they can understand. We quote the clients.
27. Our treatment/recovery plans are developed with the client, in client's words. This is a priority of CSP recovery for each individual.
28. Agency is both helpful, supportive. Clients are not always ready to make changes. Have approached 2 clients in past two weeks who have opted to delay engagement.
29. Due to recent budget cuts, staff are forced to take on more responsibility and have less time with clients.
30. The PRC has provided on-site training to help staff develop oriented goals with consumers. IMR is being offered at Intake to all CSP consumers.
31. We must provide every client with a treatment plan. It must state the client's goals and the objectives have to be measurable.
32. We have periodic "refreshers" from our QA department on how to reflect the client's recovery goals in the treatment plan. Also, supervisors and supervisees regularly discuss this in supervision.
33. Not applicable – however, there are trainings and consultations available regarding treatment planning, frequently.
34. Treatment plans a RB appear to be high quality and recovery oriented.
35. Sometimes, depending on the goal it's difficult to explain why the client chose that specific goal – in team for example because sometimes the other providers don't know them as well as the case manager.
36. IMR training held regularly – weekly electronic record system set up to support IMR.
37. Many people (the team) put together the plan with the client. Client centered.
38. Treatment planning trainings. Support in supervision. Again....adult language!
39. IMR groups available, vocational services.
40. The client is encouraged to make their own treatment goals and offer feedback to staff.
41. The treatment plans have changed so much over the years for the better. Clients are more likely to incorporate goals that are focused on the future instead of just maintenance.
42. The case managers meet with each client and help them come up with goals that each client wants to work toward.

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

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
94/107	10/107	2/107	1/107
88%	9%	2%	1%

1. Except the ridiculous FSS requirement for a community location. Who wants to talk about symptoms at the mall?
2. Many times staff are limited to state documentation and billing requirements making it difficult to go one step further.
3. In almost every case, absolutely. There are those on a CD or otherwise compelled into services that may disagree.
4. In my program, we have specific services to offer clients. They are all based on common client needs. But it is frustrating when clients refuse to engage.
5. When I tell team that someone's symptoms are increasing, they try to get them in to see if meds needed to be changed or other form of treatment needs to be done.
6. Input from clients is very important especially at Elders Services. They need to give input or the plan won't work.
7. However, with the state budget cuts the services are more limited.
8. Always based on needs.
9. Initially but current financial setbacks have limited intensive programs.
10. But, also on regulatory requirements, too – consumers find this confusing at times as do providers!
11. Absolutely!
12. Some offerings of different groups has had to be reduced due to budget cuts of the state, but we continue to offer services that promote a recovery focus.
13. The services we provide hinge on the client's goals, which are reflected in the treatment plan.
14. RB does an excellent job at this.
15. Consumers often ask for a consumer group like one that was funded in the 80s and 90s but no funding available for it now.
16. Definitely.
17. Our agency has provided services that are thus far the client's, like the new RPH Programs, to help client with their recovery. It has been a positive addition for our company!

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>
91/107	14/107	1/107	1/107
85%	13%	1%	1%

1. DHHS/Medicaid appears to be overwhelmed – delays requests/questions.
2. In past situations, requests to help parents financially has helped children attend summer (1 week) camp opportunities. Agency also supports children being able to choose low cost, healthy snack from snack shop.
3. Our center bends over backwards to accommodate requests of all kinds from “consumers.”
4. Consumer's requests are timely responded to – supporting services are offered or referred.

- Historical data is reviewed for consistency. All staff levels are consumer need trained.
5. Treatment/recovery plan is consumer driven, based on their requests, strengths and goals.
 6. When clients need something for their apartment – there is a process to get them help in obtaining it.
 7. Individual case consultation. Peer supervision.
 8. Yes, often if a consumer disagrees with a treatment team decision we support them through the QA process.
 9. Client's input regarding safety, stabilization, and hospitalization are presented throughout treatment session.
 10. New groups. Need for advocacy in schools.
 11. We provide services promptly.
 12. Speaking only for my home program, administration is responsive to special needs of consumers.
 13. Educational resources/advocacy. Medical. Financial assistance.
 14. Discussing symptomatic consumers with prescribers usually will cause RN/prescriber to contact consumer for appointment/assessment.
 15. Team meetings 2 times week to discuss consumer needs.
 16. I had a client interested in an anger management group, and after speaking with my supervisor, a group was created.
 17. Our agency is responsive to the voice of clients, and I have found over 17 years here, that clients are well respected and valued.
 18. Bonnie C. and Carrie H. are always available even on their time off at home or away at meetings.
 19. As a nurse often in the role of relaying information from client to their treatment team, I find discussion of issues thoughtful and thorough.
 20. Meet twice weekly as teams to trouble shoot issues, concerns, etc.
 21. Client needs and requests are always discussed in team. If clients are not satisfied they are encouraged to bring their requests to complaint investigators who are always available/accessible and objective.
 22. Client lacks self-discipline to decrease smoking in view of COPD and diet in view of diabetes. Agency allows time for staff to educate and encourage client.
 23. Needs at times are many and sometimes outweigh resources. Immediate needs or critical needs are met in a timely manner.
 24. Changes in meds, crisis stabilization appointments, DBT skills training, relapse prevention skills training, vocational help.
 25. Flexible – listen well.
 26. Smoking Hut – most staff would love to see it removed, but consumers advocated for it to remain.
 27. The agency and my team members are always willing to listen when I am advocating for a client/family need. Often times, there is nothing that can be done because of limited resources.
 28. Riverbend has a culture of dialogue and highly values input from our clients. Our QA department always responds to clients' expression of need.
 29. Staff are very responsive to client need.
 30. Lots of effective ___?___ programs to coordinate care. Client care focus seems to be a common value across programs.
 31. For the most part. If it's the same client over and over, it seems that the request isn't as important as someone else's.
 32. As much as possible. E.g. when a client needs transportation to hospital or therapy/psychiatric appointment we are told we can't provide transportation because it's not covered by Medicaid/Medicare/insurance, and yet there is a great need for transportation for clients in rural New Hampshire.
 33. Team decisions. Team held weekly. You feel very supported.
 34. If we aren't able to help, staff will do anything to find a provider in the area that can.

35. Obtaining waiver. Obtaining participation in partial hospitalization program.
36. Other staff at Riverbend has shown to be very receptive to client's needs and work as a team on client's objectives – including coordinating housing goals, vocational training, and other objectives.
37. I have made many requests to the agency and many have been acted on. I don't always see the outcomes but get the feedback from client that than me for asking for them. Some requests do depend on funds available, client overall wellbeing, etc. So outcomes can be different depending on the request made.
38. The communication between all of each person's team is very good.
39. When consumer request and needs are brought to the program manager's attention she and her team make sure it is resolved.

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>
47/107	45/107	10/107	5/107
44%	42%	9%	5%

1. Time constraints and caseload constraints, which are created by budget issues.
2. Non-Medicaid children could often use services that are not covered by private insurance.
3. Program funding being cut back restricts amounts of services.
4. Not in the recent past. The restrictions on staff income, however, are a serious problem.
5. Private insurance limits appropriate treatment at times.
6. We try to work around spend downs, low utilizer, FSS caps, but it's hard. Consumers are aware of limits and it's not helpful. What other system in HHS has these restrictions?
7. Many aspects of "life skill building" are not reimbursable. Many times we have to choose between a good exercise plan - or picking up meds/groceries.
8. Housing needs – inadequate reimbursement rates for licensed community residences in decreased availability with increased need.
9. Case manager's direct time has been reduced and positions frozen with Medicaid cuts. Caseloads are becoming untenable (30+).
10. Restricted by the State, not by our agency. Putting caps on treatment...asking for more from us while we get less...
11. Clients run out of insurance due to job loss or spouse's job loss.
12. Clients who are privately insured/pay out of pocket often cannot afford and so do not receive the same services that those with Medicaid have – such as FSS or TCM or respite.
13. Very bad economy equals job loss, increase in need for services when services needed rise by 20% and the governor tells you to cut by 20% - that is a 40% gap, we cannot hire to fill positions, case loads rise from 30 – 40 each, quality time with consumers decline – travel times rises – you do the math!
14. Not on my caseload.
15. Case management and medications cannot be afforded by non-Medicaid/care clients when needed – due to state cutbacks.
16. Yes. Inability to provide case management to commercial insurance clients for a reasonable fee.
17. Yes, our clients need much more funding for recovery. Even funding for light therapy would be beneficial and preventative.
18. Insurance limits children who may need additional service not covered by commercial insurance. Amount of trainings available.
19. I have several consumers who, living in a staffed residence, require significant amounts of FSS

support around ADLs, socializing, community integration, due to symptoms. However, due to the daily cap, it has been difficult to support effectively.

20. Yes, with the FSS cut it makes it more challenging to provide services to people who receive a lot on a daily basis.
21. Some clients need more support than can be provided within the 2.5 hour time limit. Not all of the clients require waivers because it is not an every day occurrence.
22. More so since funding cuts – services denied on inability to make payment toward spend-down; Riverbend is responsive to client needs BUT has increasingly limited resources – more strain on case management.
23. Don't know.
24. We often cannot afford to provide needed services to children's families due to insurance/funding issues.
25. Can only see a client for 2 hours a day including most FSS services, some clients need more time. Not being able to hire enough staff so that case managers have more clients and can't give enough time to individual clients.
26. Yes, especially since the funding cap restricted services to 2.5 hours a day.
27. Especially now with less funding our case managers are out straight and client's needs aren't always able to be met – sadly enough.
28. Case managers caseloads are higher as there is a hiring freeze on positions or when people leave which means case managers need to scale back the services despite increased needs of the clients.
29. Unable to answer.
30. Limited office space to meet with clients. Availability of supported housing, non-billable nursing time i.e. to obtain prior auths for meds, communicate with PCPs, educate clients on self-management of mental/physical health.
31. FIT team services often not covered by private insurers.
32. FSS Cap, making visits pressured, clients unable to meet spend downs!!!
33. Many clients need much more support than we are allowed to bill for. Some clients have waivers but the amount of time they are waived for still is not enough.
34. Clients are rushed through medical appointments and can only be supported with one task per day due to a 2.5 hour cap. This is particularly true for clients living outside of Concord.
35. I find it difficult to continue providing excellent care within the restrictions of current budget cuts. It feels that money is being taken away from those we have chosen to help and empower.
36. No group therapy. No sliding scale for working uninsured.
37. Staff availability – restricted by benchmarks which are not open to services which are most helpful to clients – or time limited. FSS limits. Limited vocational rehabilitation.
38. We have a 2-1/2 hour cap with services that we can bill for. If someone is extremely symptomatic, you can't stop providing support after they 2-1/2 hour period is over, however. Due to recent budget cuts and layoffs, reduced staff hours, etc. consumers on medi-planners are now having their independence w/meds taken away and are going to be receiving their meds from the pharmacy in packets now like their less independent peers who require more extensive staff support w/their meds. I thought the goal of the residential programs was to promote independence, however, what little independence they currently have is now being taken away.
39. Clients that may require more intensive support are often overlooked due to minimizing staff presence.
40. I hear consumers say they'd like to see meds management staff more often, we could be offering more groups with more staff, one client has been homeless for months.
41. The entire system is bogged down in regulatory demands so that everything gets fragmented....can't hardly see the forest for all the trees. Peoples' needs get lost in the shuffle and there's no end in sight.... and providers end up taking the heat from both sides!
42. Not at this time, but I am concerned the quality of our services will be affected by proposed

budget cuts.

43. The loss of staff, such as case managers, always affects individual consumers. Loss of programs always affects individuals.
44. The FSS cap has restricted some community-based services.
45. Over the past few months with the state budget crisis, this has led to shrinking staff, which increases burden on current staff and causes some struggles to manage very large caseloads. The services delivered are good quality services.
46. Funding for mental health in NH is severely restrictive of the types and quality of services that can be provided. Lower reimbursement rates lead to pressure for increased practitioner caseloads, which then manifests in less time per client and less thoughtful and lower quality treatment. Increased caseloads decrease collaboration and consultation time – communication among agency staff and between agency staff and outside parties suffers, affecting coordination and continuity of care. Lower reimbursement rates affect staff salary and benefits, which directly causes increased staff turnover. I don't think anyone would disagree with the assertion that increased turnover has a direct and negative effect on client recovery, however, salary also affects job satisfaction which, in turn, leads to burn-out and lower quality services. Additionally, it is difficult to retain experienced, talented practitioners when they could go into another setting and increase their earning and feel a greater sense of value. In the end, lower reimbursement rates end up costing more - - and not just over the long term. When funding is cut, treatment becomes less effective, prolonging or even negating real recovery and offsetting the cost to medical treatment and psychiatric hospitalization.
47. Limits on FSS create problems for high utilizers.
48. This is happening more and more due to statewide Medicaid cuts. I worry about the impact on service availability for clients.
49. Funding is increasingly becoming a concern and is resulting in decreased services.
50. Agency generally does an excellent job serving eligible clients and noneligible clients through ES and crisis services. But, increasingly there are people who don't have resources who don't get in state funded service programs.
51. Those who receive FSS from their CM, and at their residence ____??__ may be restricted if they didn't get a waiver.
52. The 'rules of engagement' with clients are very clearly written, i.e. those services appropriate for billing to Medicaid, but they do not always allow for individual service and client need.
53. Two-and a half hour cap. We are working with elders. They take longer. Only feel like I am pushy to accomplish what they need.
54. With cuts for mental health, a lot of clients cannot be seen as often as they should. We see a lot of clients without insurance that are unable to pay full fee.
55. Many clients who need services but have no insurance or are under-insured, can't afford services they may need.
56. I am often not able to meet with CSP clients for more than 2 billable hours a day, even if the client seems to require more support.
57. Especially, now with the new cuts. I hear a lot of client talk about not being able to meet with their case managers and such! I think the cuts for mental health are awful. It's like telling a cancer patient they can only have every other chemo treatment! Our agency has always been client centered. I'm saddened by the cuts. I understand that we are in a session (sic), but our clients and the clients of all mental health centers are so impacted. If our clients can't get the services they need then our state will be paying more by them going to the ER or NHH or 5 West. How can that be cost effective? These people feel robbed, unheard, and cast away! I know our state needs to do cuts to save money, but are we really saving money by doing the cuts? Could there be a better way? I don't think the state really thought this through and know this cutting process will ultimately cost our state more than just money! I have been working for the agency for 15 years. I have weathered many storms, but this one, I believe, is just wrong!

Our clients are people too!! Thank you for doing this. I believe you will probably hear a lot of the same things. I hope you find it in your hearts to stop cutting our clients/agencies/etc. The impact on our community could be horrific.

- 58. We have a 2-1/2 hour cap and if a case manager also works with a client that takes away from time we can spend with the client. Between meds and helping clients cook, shop or deal with their symptoms, we often cannot bill for necessary services.
- 59. Caps on time when client needing more services.
- 60. Medicaid caps instituted by the state of NH often are to the detriment of individual clients.

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

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
94/107	8/107	1/107	4/107
88%	7%	1%	4%

a. Are your supervisors accessible to you?

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
99/107	2/107	2/107	4/107
93%	2%	2%	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>
94/107	7/107	2/107	4/107
88%	7%	2%	4%

a. Are your supervisors accessible to you?

1. Always. Unless on vacation.

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

- 1. My supervisor provides very strong and consistent support to his staff.
- 2. Carrie and Bonnie are super. Couldn’t ask for better accessibility or assistance.
- 3. We meet regularly with managers, supervisors. Our CEO visits our program bi-monthly and has an open door policy as well.
- 4. Depends which one.
- 5. Always. One is always.
- 6. Very open and accessible culture!
- 7. Attempting to create “integrated care” at a local medical center without much success in 2 years. We need a constant communication source from Riverbend to prioritize!!
- 8. Yes, management/supervision is excellent.
- 9. Open door policy plus scheduled supervision time.

Additional Comments:

1. DBH should take the time to develop a staff survey that is specific to children's programs. DBH should make more of an effort to design a more comprehensive staff survey form with a more sophisticated rating system. DBH should be willing to accept feedback from people about the degree of stress that the audit process places on them – and how much paperwork demands from DBH reduce direct service!
2. The rate cuts and service caps are hurting consumers. BBH is naïve if they think that's not the case. We need more resources, not less. What bad outcome will have to happen to force change? You should look at reapproval in the context of tremendous stress on the system. Where is BBH's leadership and advocacy?
3. I frequently hear clients thank staff for being responsive to their needs and requests.
4. Riverbend is a wonderful place to work. The agency is compiled of warm, caring individuals who always go the extra mile for all facets of work, life and the consumers are always supported to help with all life's challenges – many are more responsive to life through the efforts of our staff.
5. Overall, this agency does phenomenal work with its clientele. I have witnessed recovery in action here. Budget restrictions will affect the consumers and dramatically curtail services that can be offered. Many of our folks may not be able to be maintained in the community without current levels of support. If this and other CMHCs fail – New Hampshire Hospital will be inundated. NHH will need 2500+ beds again, like in the 1980s, prior to deinstitutionalization. All the work of the recovery movement stands to be swept away with Medicaid budget cuts. The dismantling of the Elders Program is tragic.
6. I feel Riverbend is a huge asset to the State of New Hampshire and that all of the rules and regulations and changes that keep coming at us from the State are daunting and unreasonable. Our CEO is a phenomenal advocate for the people we serve and all supervisors/managers and administration at this agency go above and beyond to help us feel that we are doing a good job when what we are doing is close to impossible. Again..the State of New Hampshire is very lucky to have Riverbend!
7. In my humble opinion out legislators live in a bubble. They work less than ½ miles from here and never some see for themselves what is going on unless they are prostituting themselves for votes. All state CMHCs need help not empty rhetoric. DHHS needs funding especially in times like these. Try cutting a few hack jobs, stand up to the unions and pensions, there are other places to cut the budget instead of area agencies that provide direct care with measurable results for the best on the dollar. We do remarkable work with marginal public/state support. Our CEO should run for governor at least he has better sense of priorities and doesn't owe anyone anything.
8. We are limited in our services now due to cut backs. Thanks for your time.
9. Riverbend is a very supportive environment that provides training – best place I've ever worked.
10. Strong leadership; however, feel impact of funding cuts on clinical services and staff morale.
11. Very open to feedback; takes scheduled supervision sessions seriously.
12. Even though my position is “low man on the totem pole” in the hierarchy of Elders – I have never felt that way as the treatment team values input from everyone here at Elders.
13. 1. Growing concern over future cuts to services for this population. 2. There will be a need to update IT, especially in using systems other than paper to order and manage medications, and access medical information rather than have mental health operate in a vacuum disconnected from the rest of medicine. Our systems should dovetail with Concord Hospital for example.
14. I feel very supported by staff at Riverbend. It is a struggle to maintain face to face time with clients, meet their needs while keeping up with the large amount of paperwork.
15. My agency of Riverbend is the greatest mental health organization that I have ever worked for. I have never met an administration and BOD, CEO, etc. who cared so much for the clients and

staff that they represent.

16. The budget cuts and FSS cap have made this job much more stressful and more difficult to coordinate client needs. For example: if a client has a doctor appointment they cannot be supported with grocery shopping on that day instead staff must return the next day to provide support. In order to support client's needs for example with a client out in Webster, staff cannot provide all supports in one day but must break up visits to multiple days driving back and forth to Webster on multiple occasions rather than just once. Also reduction in housing is a problem for our consumers. Some must move into nursing homes due to lack of mental health housing. Riverbend is a very supportive agency but the State funding and budget cuts are impacting the program as well as the clients. Clients that require additional community supports are not getting them at times due to the budget issues. Additionally, many mental health clients have co-morbid medical issues and the CFI (formerly known as the HCBC) has in the past been a resource available to clients which has made an incredible difference in their lives – the cuts in this program are becoming evident as clients are kicked off from HCBC and mental health centers aren't able to pick up the pieces due to lack of funding.
17. The Elders Program is such a wonderful program which is very beneficial to the clients. I love being here.
18. Agency, staff encourages recovery measures. Clients are not always willing, need incentives for them to participate.
19. Riverbend strives to respect and serve clients in spite of an environment that makes this an incredibly discouraging business at the moment.
20. As a part-time employee I receive all information, access and support that full-time employees do.
21. Funding cuts significantly hampering ability to provide services.
22. The Senior Leadership is a very cohesive and supportive team. They provide information on a regular basis to middle management and direct service employees, so I believe that no one feels left in the dark. There is a strong commitment to professional development evidenced by the intern programs, tuition reimbursement and a solid training budget. Staff are encouraged to share their perspectives and have access to all level of leadership.
23. I wish this survey was more geared about the quality and consistency of services we provide. I think morale is good despite significant changes occurring in response to budget cuts. Quality of services is very good, in that the consumer drives the treatment and so far, we are still lucky to provide some good services – RPH, residential services, med monitoring in conjunction with Fellowship, case management, FSS, therapy, DBT I & II, relapse prevention, group, IMR, nursing assessment, psychiatric services groups focusing on gainful employment. But our level of communication and documentation is outstanding. Our electronic record has improved level and consistency of care. We are however, very stretched due to the state cut backs and I worry how this will impact consumer care. I am very concerned that initiatives outlined in the August 2008 report “addressing the critical mental health needs of NH citizens – a strategy for restoration” is being derailed for all of NH mental health and that we continue to erode away critical services. Riverbend does an excellent job of providing services to a challenging population that is ever growing in part due to the state psychiatric hospital in our catchment and SPU at the prison. We have a very acute population as a result and I believe our staff manage this very well.
24. Riverbend provides excellent services to its clients above and beyond what we are allowed to bill for. We give away a tremendous amount of “free service” that is absolutely clinically indicated but state regulations and insurance (private and public) won't reimburse us for. Nonetheless, administration remains supportive of us in doing what we feel is clinically and ethically appropriate even if we do not get paid for it.
25. It is a difficult time for consumers with decreased financial support from the state and decreased encouragement and support from BBH/H &HS.

26. Difficult environment. State to continue to work on decreasing funding for critical and recovery services to the most ill are being decreased during a time when there is increasing demand. The erosion in this area of health care will cost money and lives.
27. I enjoy working for Riverbend and serving the population. I think Riverbend has done a great job despite the budgeting challenges.
28. Mental health affects physical health and society and yet little funding is available for it, with cuts to programs the norm. Every day we witness rage and senseless killing on the news, and people who need help can't afford to get it and are turned away due to lack of resources. Frustrating to work in a field where there is so much need, growing daily with this poor economic climate, and not enough resources to help manage it.
29. I feel very supported by staff especially during emergency situations. Training is readily available during the year for anyone who requires more knowledge in their positions with the agency.
30. I enjoy working for Riverbend and like my co-workers and supervisor. I find people at the agency to be client-focused and compassionate.
31. Riverbend is the best community mental health agency I have worked for in 23 years in the field in NH and VT. Additional comments not regarding RCMH but the state of NH: How can the state of NH receive federal stimulus money earmarked for Medicaid and turn around and put it in general fund while forcing continued cuts in DHHS and CMHCs without violating some federal rule or law that this money must be used for Medicaid? I AM going to refer this to federal authorities via a copy of this, my complaint!

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 RCMH 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, RCMH was in substantial compliance with all the requirements referenced above.

REQUIREMENT: He-M 403.07 (a) A CMHP shall establish and implement written staff development policies applicable to all administrative, management, and direct service staff which shall specifically address the following:

- He-M 403.07 (a) (1) Job descriptions;
- He-M 403.07 (a) (4) Staff grievance procedures;
- He-M 403.07 (a) (6) Individual Staff Development Plans.

OBSERVATIONS IV-A:

There are no policies that have been approved by the BOD, or their designee, as required above for: what is included in a job description; staff grievance procedures; the review of the Office of Inspector General's List of Excluded Individuals/Entities for each newly hired and re-hired staff member; and staff development plans.

RECOMMENDATIONS IV-A:

Develop or amend policies to include: the required elements in a job description; staff grievance procedures; the review of the Office of Inspector General's List of Excluded Individuals/Entities for each newly hired and re-hired staff members; and staff development plans. All policies must be reviewed and approved by the BOD, or their designee.

CMHP RESPONSE IV-A:

REQUIREMENT: He-M 403.07 (e) A CMHP shall provide an Orientation for all new staff providing services to persons with mental illness, which, at a minimum, shall include:

- He-M 403.07 (e) (1) The service delivery system at the state and local level, including family support, and consumer self-help programs;
- He-M 403.07 (e) (2) Mental illness, including the effects of mental illness on persons having such illness, and current practices in treatment and rehabilitation;
- He-M 403.07 (e) (3) All Department rules applicable to community mental health services

provided by the staff member;

- He-M 403.07 (e) (4) Accessing generic services, so that such staff are familiarized with social, medical, and other services available in the local community;
- He-M 403.07 (e) (5) Protection of Consumer Rights pursuant to He-M 202 and He-M 309.

OBSERVATION IV-B:

Though personnel files consistently contained documentation of orientation training, there is no formal policy.

RECOMMENDATIONS IV-B:

Develop a policy regarding staff orientation that includes, at a minimum, all the requirements outlined in He-M 403.07 (e).

CMHP RESPONSE IV-B:

OBSERVATION IV-C:

RCMH has a Fiscal Management Manual updated in November, 2009. Although the content included in this manual is policy oriented, it is written as a procedure manual. There is no indication that the BOD has reviewed or approved these procedures as formal policies.

RECOMMENDATIONS IV-C:

The BOD should review, approve, and sign off on all policies.

CMHP RESPONSE IV-C:

OBSERVATION IV-D:

There are specific written and unwritten 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-D:

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

- 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 ED's expense by the BOD;
- Seeking written proposals for services, property, or major purchases.

CMHP RESPONSE IV-D:

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 BOD 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 bylaws 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, RCMH was in full compliance with all the requirements referenced above.

OBSERVATIONS: None.

SECTION VI: QUALITY IMPROVEMENT AND COMPLIANCE

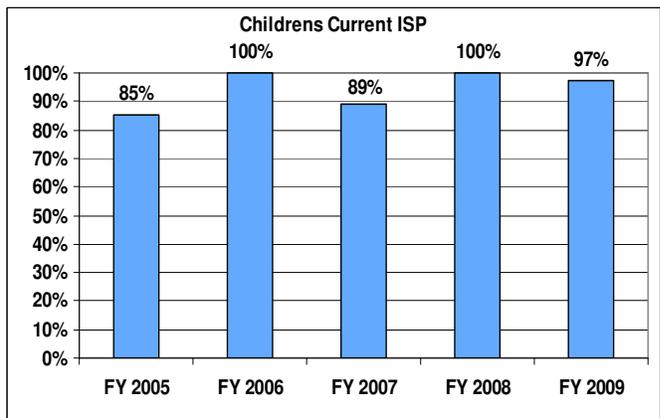
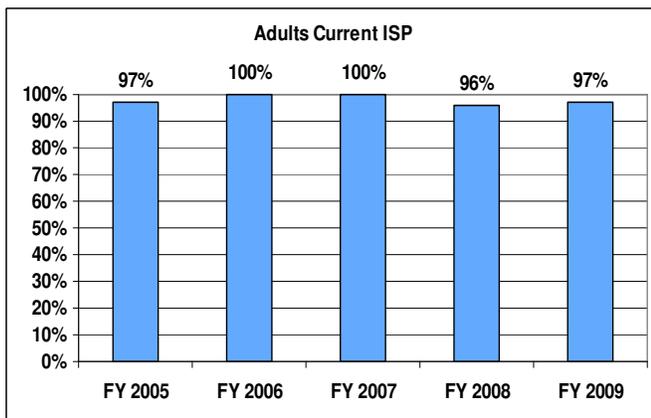
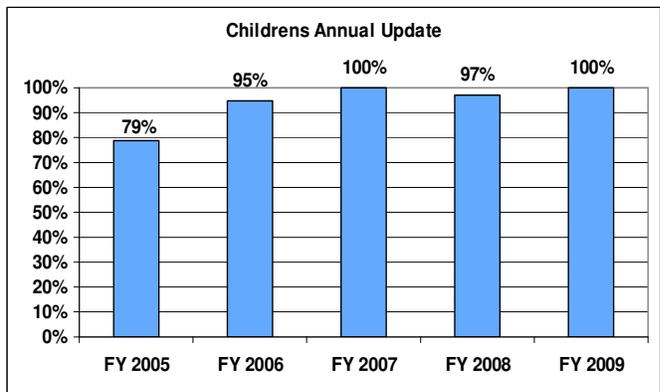
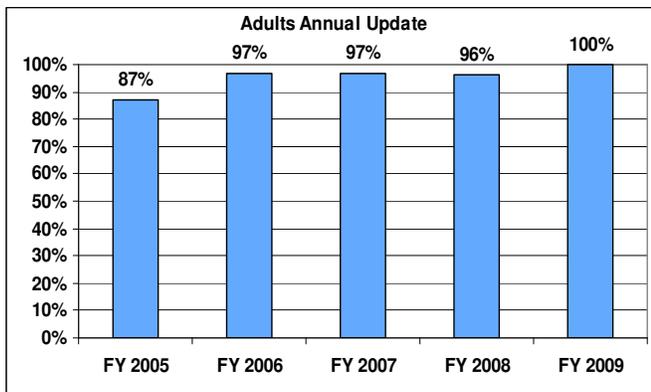
Quality improvement and compliance activities are expected to be conducted on both the state and local level. The BBH conducts annual quality improvement and compliance reviews and CMHP reapproval reviews on a five-year cycle. Other reviews occur as needed and requested.

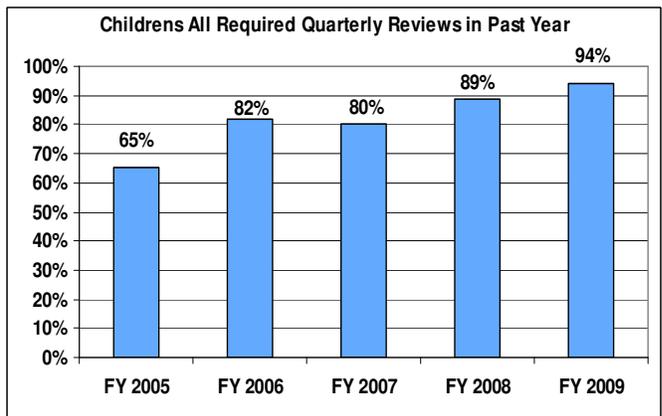
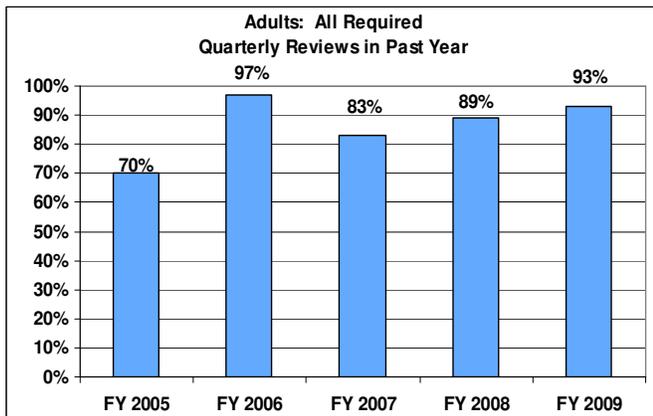
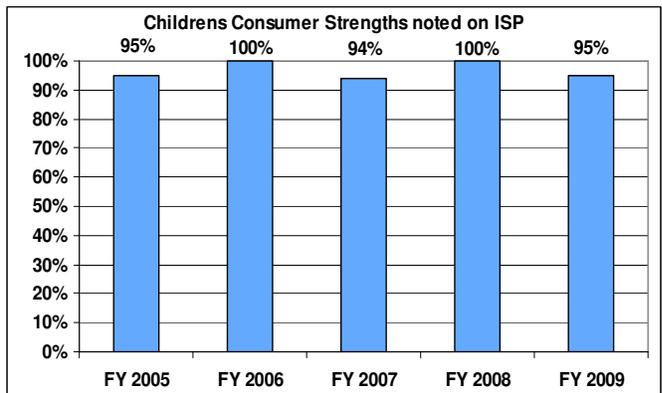
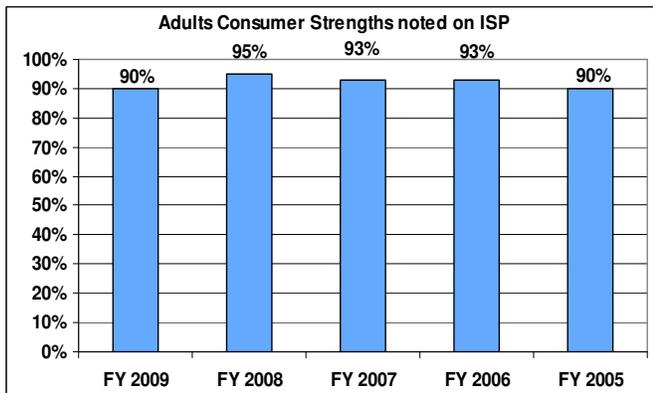
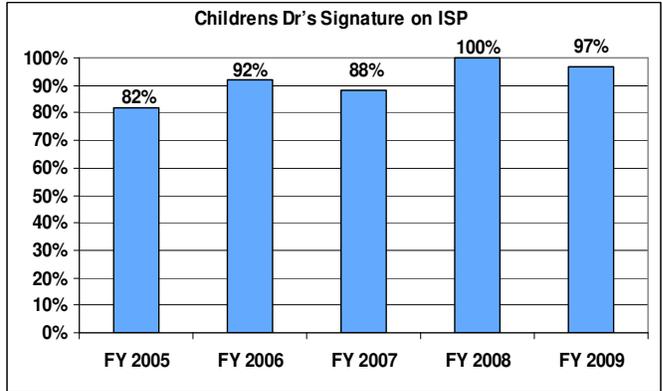
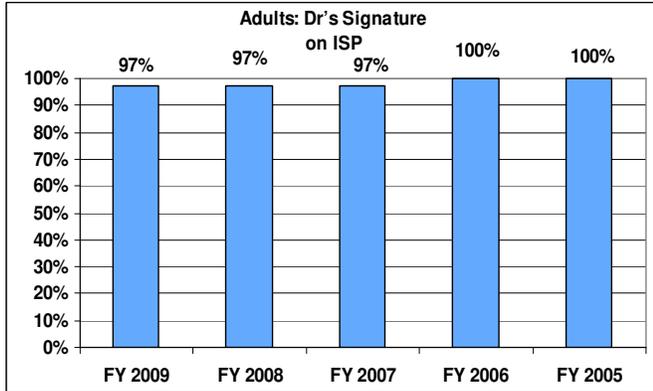
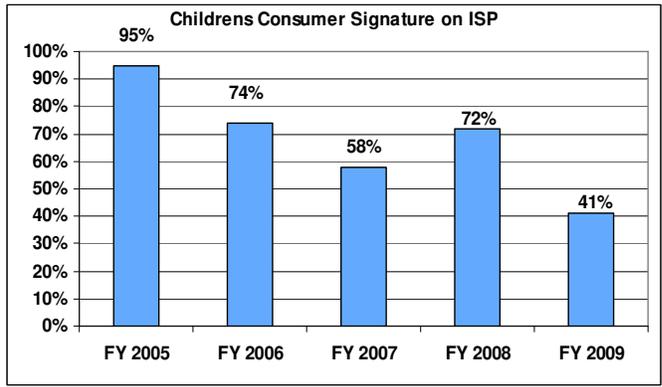
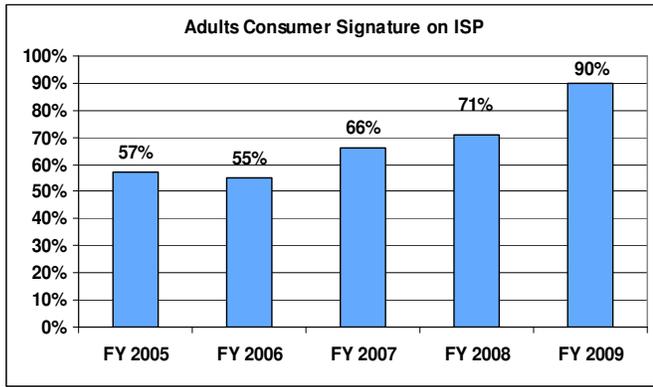
He-M 403.06 (i) and (j) outlines the minimum requirements for CMHP quality assurance activities. These include a written Quality Assurance Plan that includes outcome indicators and incorporates input from consumers and family members. The annual plan is submitted to BBH. Other activities include utilization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

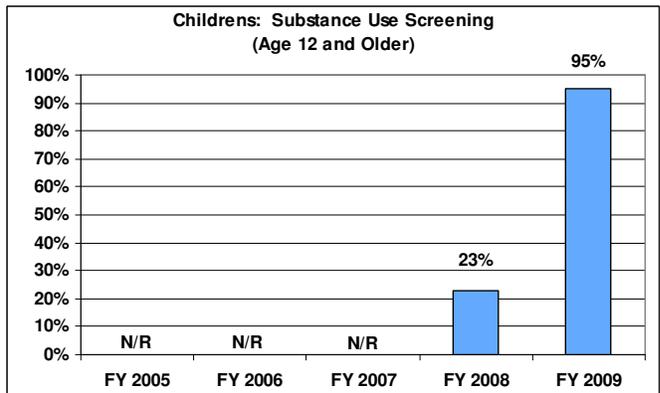
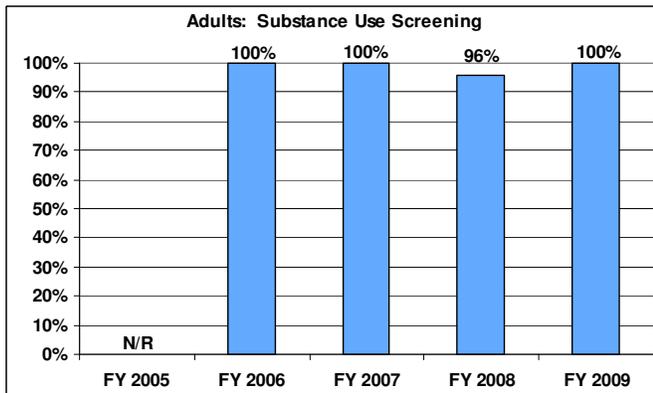
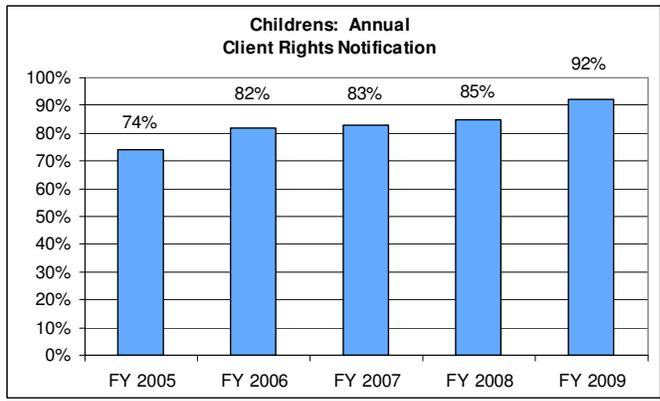
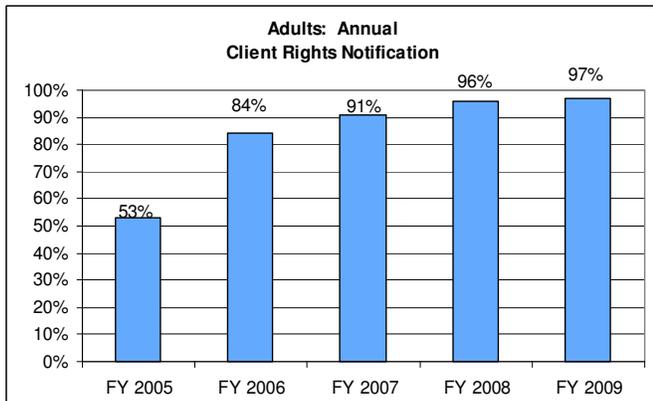
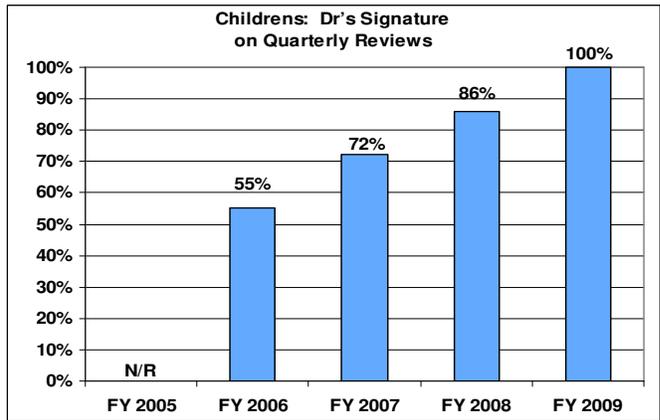
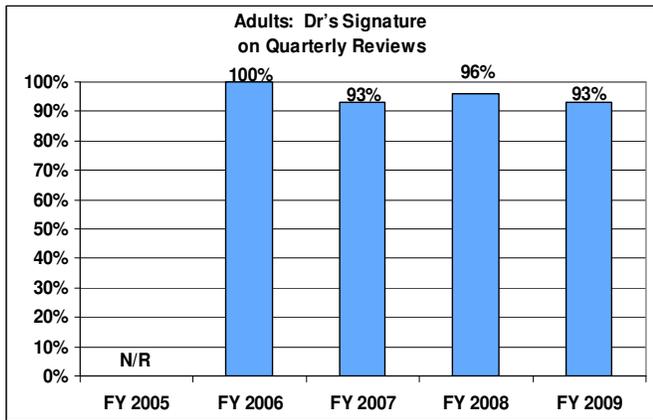
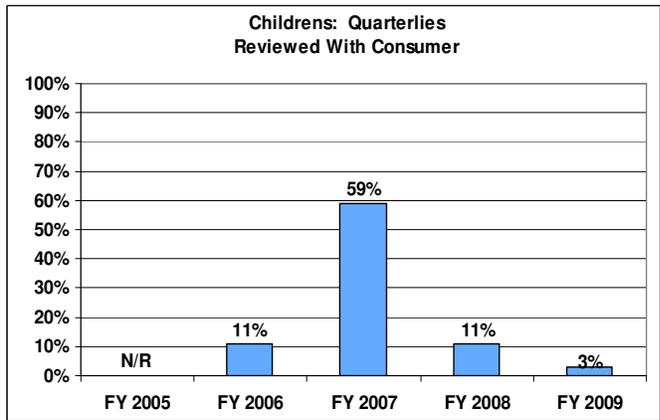
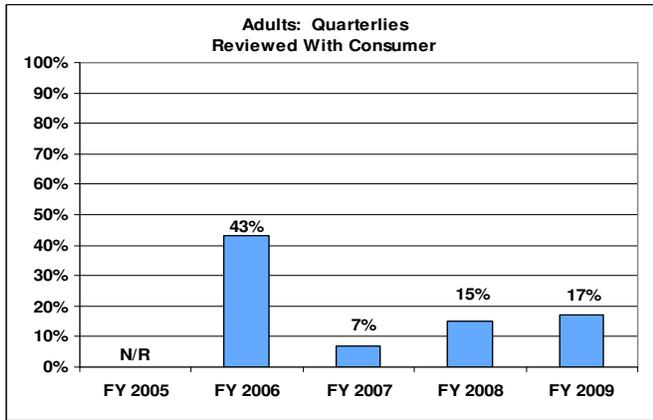
At the time of the review, RCMH was in substantial compliance with all the requirements referenced above.

OBSERVATION VI-A:

Five-year trend data from the annual BBH quality improvement and compliance reviews has been included as an overview of the RCMH level of compliance with clinical record standards. The charts below reflect some of the clinical record requirements and RCMH compliance levels. "N/R" noted in the charts below indicate 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-A:

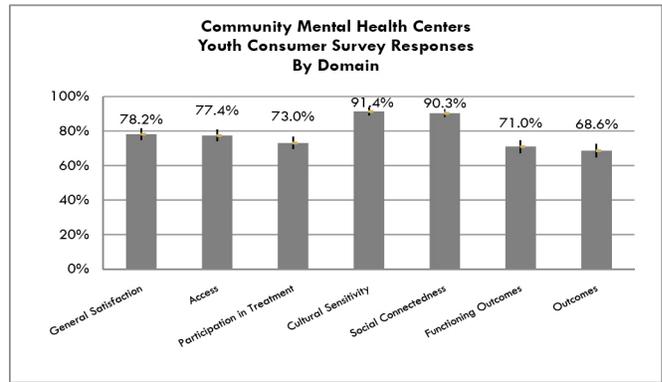
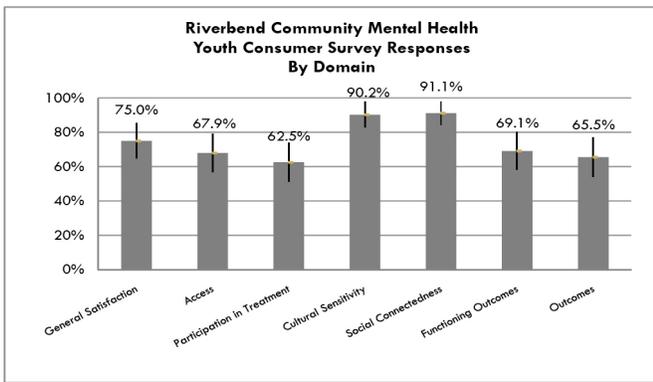
It is recommended that the BBH QI and Compliance Reports be shared with the BOD and utilized in planning activities. It is also recommended that RCMH continue to conduct and document internal quality improvement and compliance activities.

CMHP RESPONSE VI-A:

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 RCMH 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.



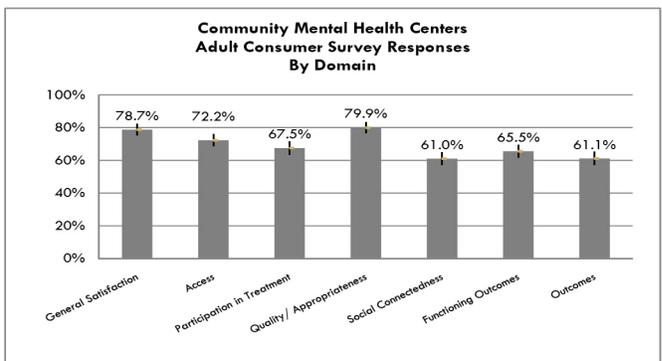
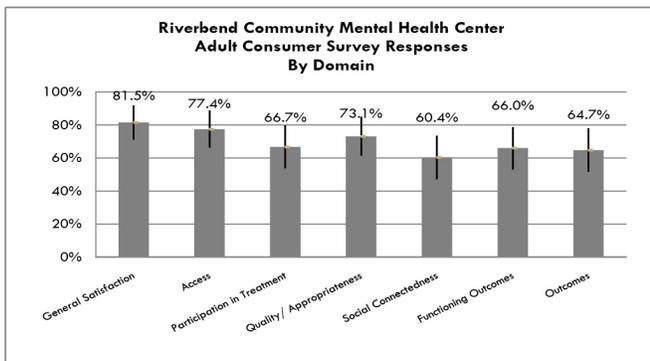
OBSERVATION VII-A:

It is noted that RCMH percentages ranked below the statewide average in the following Youth Survey domains: General Satisfaction; Access; Participation in Treatment; Cultural Sensitivity; Functioning Outcomes; and Outcomes.

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:



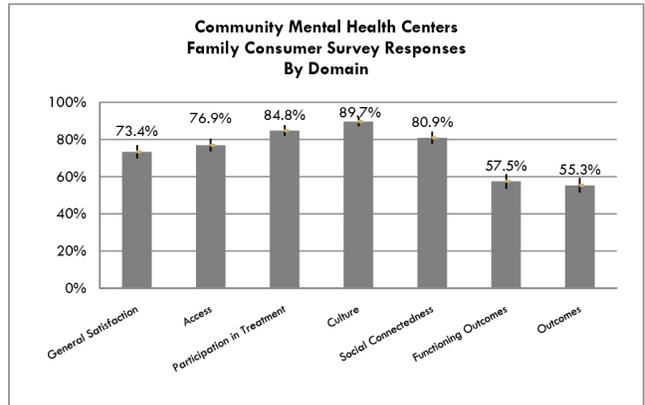
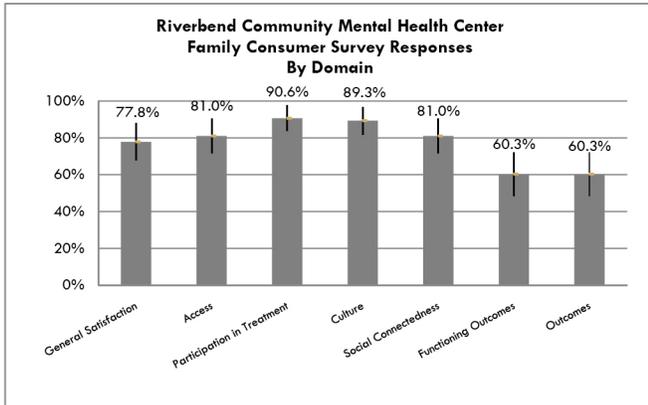
OBSERVATION VII-B:

It is noted that RCMH percentages ranked below the statewide average in the following Adult Survey domains: Participation in Treatment, Quality/Appropriateness, 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 RCMH percentages ranked below the statewide average in the following Family Survey domain: Culture.

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