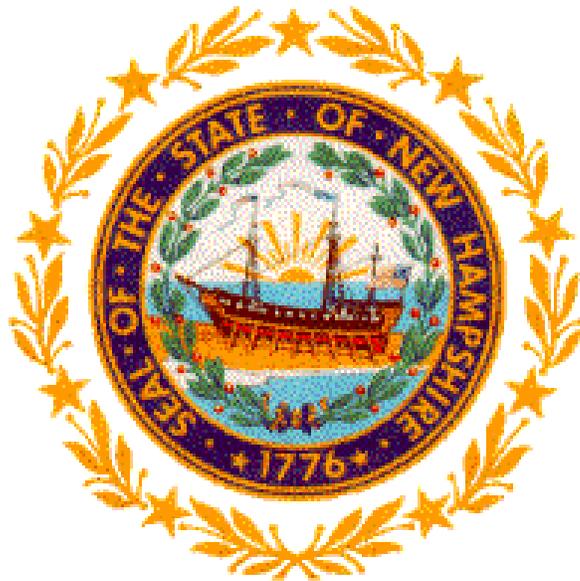


**STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF COMMUNITY BASED CARE SERVICES  
BUREAU OF BEHAVIORAL HEALTH**

**COMMUNITY MENTAL HEALTH PROGRAM  
REAPPROVAL REPORT**



**CLM CENTER FOR LIFE MANAGEMENT**

**March 23, 2012**

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

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**ACRONYMS AND DEFINITIONS**

**Acronyms**

**Definitions**

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

## EXECUTIVE SUMMARY

In accordance with State of New Hampshire Administrative Rule He-403 Approval and Reapproval of Community Mental Health Programs, reviews of community mental health programs (CMHP) occur upon application and thereafter every five years. The purpose of He-403 is to define the criteria and procedures for approval and operation of community mental health programs. A reapproval review of CLM Center for Life Management (CLM) in Derry, NH occurred on March 14 through 18, 2011, and also included a Board of Directors (BOD) Meeting on March 23, 2011. 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).

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

- A letter requesting reapproval;
- A description of all programs and services operated and their locations;
- The current strategic plan;
- A comprehensive listing of critical unmet service needs within the region;
- Assurances of compliance with applicable federal and state laws and rules;
- The Mission Statement of the organization;
- A current Board of Director list with terms of office and the towns represented;
- The By-Laws;
- The BOD meeting minutes for calendar year 2010 through the date of the review;
- 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 (January 2011);
- 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 2010 with Five Year Financial Trend Analysis;
- A Public Notice published in local newspapers soliciting feedback regard the CMHP;
- A letter to CLM constituents soliciting feedback regarding the CMHP;
- Staff surveys soliciting information from CLM staff regarding training, supervision, services, and CMHP operations.

The site visit to CLM included:

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

The findings from the review are detailed in the following focus areas: Governance; Services and Programs; Human Resources; Policy; Financial; Quality Improvement and Compliance; Consumer and Family Satisfaction. The structure of the report 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 agency is to be commended for its continued development of an electronic medical record (EMR).
- The agency is encouraged to continue to explore ways to serve ethnic, cultural, sexual, and other minority populations in the region as demographics change.
- The agency is encouraged to explore ways of collaborating with peer support efforts in the region.
- The agency is encouraged to formalize and document the orientation process for new staff.
- The agency is encouraged to continue policy development where needed, and to adhere to its internal procedures for the development and approval of all policies.

## PURPOSE, SCOPE AND METHODOLOGY

Staff from the NH DHHS, BBH, and OIII conducted an on-site review of CLM on March 14 through 18, 2011, and also included a Board of Directors (BOD) Meeting on March 23, 2011. 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 Board of Directors.

A brief exit meeting was conducted on March 4, 2011, 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 CLM requesting reapproval as a community mental health center;
- Critical unmet service needs within the region;
- Assurances of compliance with applicable federal and state laws and rules;
- Description of all programs and services operated and their locations;
- Current strategic plan;
- Mission Statement of the organization;
- Current Board of Director list with terms of office and the towns represented;
- Board of Director By-Laws;
- Board of Director meeting minutes for calendar year 2010 through the review dates;
- 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 CLM contract with BBH;
- Results of SFY 2010 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 2009 and SFY 2010;
- Job Descriptions for all accounting and billing staff.

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

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

- Homeless Shelters;
- Substance Use Disorder Programs;
- Vocational Rehabilitation;
- Division for Children, Youth and Families;
- Adult and children's Criminal Justice organizations;
- NAMI-NH.
- Policies and procedures for:
  - Clients Rights;
  - Complaint Process/Investigations.
- Management Team Minutes for calendar year 2010;
- 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 CLM conducts business.

Employee surveys were sent to CLM 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 (January 2011);
- 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 2010 with Five Year Financial Trend Analysis;

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

## AGENCY OVERVIEW

The CLM Center for Life Management is a non-profit community mental health organization that has been serving the people and communities of Southern New Hampshire for over 40 years.

The CLM mission statement is:

*“The mission of The Center for Life Management is to promote and advance the mental health and emotional well-being of the individuals, families and organizations within our communities. We accomplish this through professional, individualized, comprehensive services and by partnering with other organizations that share our philosophy.”*

CLM provides a comprehensive array of evidenced based, community 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 that include SE and IMR; services for persons with co-occurring disorders; functional support services; residential services; respite care; outreach services; education and support to families; and consultation services.

CLM has a website (<http://www.centerforlifemanagement.org/>) which includes information on service programs, consumer and family information, continuing education, mental wellness resources, fundraising, web links and other resources.

The towns served by CLM include:

Atkinson  
Chester  
Danville  
Derry

Hampstead  
Newton  
Pelham  
Plaistow

Salem  
Sandown  
Windham

## SECTION I: GOVERNANCE

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

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

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

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

At the time of the review, CLM 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 is a policy on “Policy Development” which states that the BOD has designated the CEO as responsible for approving all policies. Not all policies in the manual were signed.

### **RECOMMENDATIONS I-A:**

It is recommended that all policies be reviewed, approved, and dated.

### **CMHP RESPONSES I-A:**

## 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, CLM 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:**

**Included below are excerpts of summary information from a recent CLM IMR Fidelity Report based upon the review conducted by the Dartmouth Psychiatric Research Center on 8/19/10. Please note that this was an abbreviated review, and the report excerpts below do not include any scores associated with a full review.**

**During the IMR fidelity review in November of 2009, CLM scored exceptionally well in both the Illness & Recovery fidelity scale and the General Organizational Index Fidelity Scale. Given this, decision-makers at CLM chose to receive an abbreviated assessment for this fidelity review, focused solely on the item identified in their FY 11 Quality Improvement Plan for the IMR program.**

In their attempts to engage as many consumers in IMR as possible, the IMR program at CLM has expanded to include an additional IMR practitioner within the past year, whose primary job function is to provide IMR. This expanded capacity for the IMR service appears to have increased consumer access to the service through increased practitioner availability, and an increased number of IMR group offerings including: an all women group; an evening group to accommodate clients' schedules; and a group for younger adults, which couples functional support services with skills learned in IMR. It should also be noted that leaders within the program described future plans to add an additional IMR practitioner to the IMR team, and to run some IMR groups from a separate location in order to address client concerns around transportation issues.

#### **RECOMMENDATION II-A:**

It is recommended that this information be shared with the CLM BOD.

#### **CMHP RESPONSE II-A:**

#### **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:**

Included below are excerpts of summary information from the most recent CLM Supported Employment Fidelity Report based upon the review conducted by the Dartmouth Psychiatric Research Center on 11/29/10 – 12/1/10.

Decision-makers at the Center for Life Management (CLM) chose to participate in a full fidelity review that was focused on all of the items included in the 2008 version of the evidence-based supported employment (EBSE) fidelity scale. The EBSE program at CLM is very strong, and is led by a dedicated EBSE Team Leader who has thoughtfully and persistently worked to strengthen the service. CLM has been engaged in program improvement efforts guided by their quality improvement plan, and helped in part by funding through the Granite State Employment Project (GSEP).

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.

CLM Center for Life Management FY09 & FY11 Fidelity Ratings			Score	
			FY09	FY11
<b>Staffing</b>				
1.	Caseload size		5	5
2.	Employment services staff		3	5
3.	Vocational generalists		4	5
		<b>Subtotal:</b>	12	15
<b>Organization</b>				
1.	Integration of rehabilitation with mental health thru team assignment		2	2
2.	Integration of rehabilitation with mental health thru frequent team contact		3	3
3.	Collaboration between employment specialists and VR		4	5
4.	Vocational unit		5	5
5.	Role of employment supervisor		3	4
6.	Zero exclusion criteria		4	5
7.	Agency focus on employment		3	4
8.	Executive team support for SE		4	5
		<b>Subtotal:</b>	28	33
<b>Services</b>				
1.	Work incentives planning		5	4
2.	Disclosure		5	5
3.	Ongoing, work-based vocational assessment		3	4
4.	Rapid job search for competitive job		4	5
5.	Individualized job search		3	5
6.	Job development — Frequent employer contact		2	5
7.	Job development — Quality of employer contact		2	5
8.	Diversity of job types		3	4
9.	Diversity of employers		5	3
10.	Competitive jobs held		3	5
11.	Individualized follow-along supports		5	4
12.	Time unlimited follow-along supports		3	5
13.	Community-based services		5	5
14.	Assertive engagement and outreach by integrated treatment team		4	5
		<b>Subtotal:</b>	52	64
		<b>Total:</b>	92	112
			Exemplary Fidelity=	115-125
			Good Fidelity=	100-114
			Fair Fidelity=	74-99
			Not Supported Employment=	73 and below

**RECOMMENDATION II-B:**

It is recommended that this information be shared with the CLM BOD.

**CMHP RESPONSE II-B:**

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

**OBSERVATION II-C:**

The BOD and management team report minimal needs and services to minorities in the area.

The agency has translated some agency documentation into other languages and employs some bilingual/bicultural staff.

**RECOMMENDATION II-C:**

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

**CMHP RESPONSE II-C:**

**REQUIREMENT: He-M 403.06 (a) (13) Consultation, as requested, and support to consumer-operated programs to promote the development of consumer self-help/peer support.**

**OBSERVATION II-D:**

The relationship with the local peer support program has varied over time. At the time of the review, the PSA provider had changed and the first meeting between the two agencies was scheduled.

**RECOMMENDATIONS II-D:**

CLM is encouraged to explore opportunities for future collaboration with the local peer support agency.

**CMHP RESPONSE II-D:**

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

**OBSERVATION II-E:**

CLM does not provide these services.

**RECOMMENDATION II-E:**

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

**CMHP RESPONSE II-E:**

### 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 CLM personnel records to assure compliance with Administrative Rule He-M 403.05 (g) through (i) and He-M 403.07 (a) through (e) including: current licensure resumes, training documentation, and background checks.

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

At the time of the review, CLM was in substantial compliance with the requirements referenced in this section.

**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-A:

<b>CLM HUMAN RESOURCES TABLE</b>												
He-M	Requirement	Personnel Files										% Compliance
		1	2	3	4	5	6	7	8	9	10	
<b>He-M 403.07 (b)</b>	Criminal background checks.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
<b>He-M 403.07 (b)</b>	OIG sanctioned provider check.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
<b>He-M 403.07 (b)</b>	DMV check.	N/A	N/A	N/A	N/A	Y	N/A	Y	Y	N/A	N/A	100%
<b>He-M 403.07 (c)</b>	Annual performance review.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
<b>He-M 403.07 (d)</b>	Staff development plans.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
<b>He-M 403.07 (e)</b>	Orientation training.	N	N	N	N	N	N	N	N	N	N	0%
<b>He-M 403.07 (e) (1)</b>	Does Orientation include the Local and State MH System including Peer and Family Support.	N	N	N	N	N	N	N	N	N	N	0%
<b>He-M 403.07 (e) (2)</b>	Does Orientation include an overview of mental illness and current MH practices.	N	N	N	N	N	N	N	N	N	N	0%
<b>He-M 403.07 (e) (3)</b>	Does Orientation include Applicable He-M Administrative Rules.	N	N	N	N	N	N	N	N	N	N	0%
<b>He-M 403.07 (e) (4)</b>	Does Orientation include accessing the local generic service delivery system.	N	N	N	N	N	N	N	N	N	N	0%
<b>He-M 403.07 (e) (5)</b>	Does Orientation include Client Rights training.	N	N	N	N	N	N	N	N	N	N	0%

\* Please note that "N/As" in the table above are due to staff hired before the current requirement became effective or for staff who do not transport consumers".

### **GENERAL OBSERVATIONS:**

An evaluation for the CEO had been completed within one year of the site visit. Some concern was expressed, as the period of review was for calendar year 2009, which was a period of more than a year prior to the review. Care should be taken to reflect annual evaluation of all staff, including the CEO.

### **RECOMMENDATIONS III-A:**

All personnel files be monitored for completeness, including annual evaluations for the CEO per He-M 403.07 (c).

### **CMHP RESPONSE III-A:**

### **RECOMMENDATIONS III-B:**

New staff orientation procedures should be formalized and documented in personnel files.

### **CMHP RESPONSE III-B:**

**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 (NHH).**

### **OBSERVATION III-C:**

The job description for the Child, Adolescent and Family Services Director does not include specific responsibilities regarding system planning for children and adolescents and all inpatient admissions and discharges, including NHH. It is noted that the CLM management team reported that there is a designated children's liaison to NHH.

### **RECOMMENDATION III-C:**

It is recommended that the job description for the Child, Adolescent and Family Services Director be revised to include responsibilities regarding all inpatient admissions and discharges, including NHH. If these responsibilities reside with a separate "NHH Children's Liaison" position, referencing that position and responsibilities in this job description is sufficient.

### **CMHP RESPONSE III-C:**

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 CLM.

**CENTER FOR LIFE MANAGEMENT  
REGION VII STAFF SURVEY RESULTS 2010**

**1. Does your agency provide job-related training?**

<u>Yes</u>	<u>No</u>	<u>No Answer</u>
102/120	9/120	9/120
85%	8%	8%

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

<u>Poor</u>	<u>Fair</u>	<u>Good</u>	<u>No Answer</u>
8/120	51/120	55/120	6/120
7%	43%	46%	5%

**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>
8/120	44/120	57/120	11/120
7%	37%	48%	9%

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

1. Better – they are trying now to implement a “training calendar.”
2. Improving.
3. Only lunch and learn, but no money available for training programs.

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

1. Will hold training, but hard to make or find time to attend.
2. They are willing to sit and go over anything the employee feels they need more training on.
3. Recently clinical group supervision's format changed. Each week a different topic will be discussed. Ex: substance use, play therapy, etc.
4. Some basic brief trainings by medical staff; no training toward license renewal is reimbursed, no training allowance. Attending training reduces productivity and time for documentation. First training 6-2-10.
5. If we have the availability in our schedule, we can participate in 21 hours of related training.
6. When staff ask for specific training requests, supervisors and director follow through and find trainings quickly.
7. Substance abuse consultation and training group. Establishment of lunch-ins. Some reimbursement for trainings outside the agency.
8. If training course is found by employee, and cost or time spent is not more than budget, it is allowed. Multiple requests for training have not occurred due to staff/time constraints.
9. They say, “That's a good idea”, but it is rarely implemented.
10. No funding. Limited days off.
11. Trainings must be requested in order to be received.
12. Have made several requests for specific trainings with little and or slow follow through from the agency.
13. Wide variety offered, approved to attend trainings in a timely manner.
14. Whenever I have questions, I'm always free to go into the office and confront them about what I want to know. I've never once was told to come another time and I have always been able to come out with a reasonable answer.

15. I haven't submitted a request before, so unclear how responsive.
16. CLM has developed a list of training opportunities for us. We have full access to essential learning/training site.
17. In past month, have set up lunch and learn trainings; upcoming behavior plan training.
18. DBT training is offered to staff interested and is required. IMR trainer trains staff as needed. Clinicians are sent to DBT (intensive training).
19. Would like more in-house trainings, would like increased budget for agency to pay for trainings, very expensive out-of-pocket.
20. I've done IMR training with my supervisor and PRC/BBH trainings. I've also done extensive field training, which I requested for FSS.
21. Clinicians offer peer training and request specific topics for training.
22. Never had professional training in my department.
23. Took an Excel class that was paid for by the agency.
24. If we need an in-service, it is planned and scheduled between 1-2 weeks.
25. Whenever I ask for trainings, my supervisors are supportive in finding them. On several occasions, I've asked for trainings on different topics such as autism, self-mutilation, cutting transitional support, and they have never failed to find an appropriate training. I am consistently updated on upcoming training opportunities, as well.
26. Given budget cuts, etc. the agency tries really hard to provide in-house training and is supportive of in-service training and tries to assist with cost of outside training.

**2. Does your agency provide training in recovery philosophy?**

<u>Yes</u>	<u>No</u>	<u>No Answer</u>
82/120	21/120	7/120
68%	18%	6%

1. However, I have had this for many years – nothing new! Again, training reduces time needed for productivity and paperwork.
2. We use an evidenced-based practice called Illness Management and Recovery (IMR), which all staff can be trained in.
3. To new people-but only IMR, not broader recovery philosophy-since the move to larger building in '08, the focus is more medical model compared to when the Windham Inn was separate.
4. Not that I am aware of in the children's department.
5. However, this could be a lot more thorough and professionally handled via trainings.
6. Don't know.
7. Only in some areas.
8. Yearly training would be beneficial to review changes and updates including techniques and resources for all staff including case management.
9. IMR is the model being used. Staff continue to see MI persons as diagnoses vs. people who have an illness. Notes reflect "Client does....." vs. "John does....." – more training needed here.

**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>
85/120	25/120	1/120	9/120
71%	21%	1%	8%

1. But, our computerized system is not user friendly, especially the treatment plan.
2. Family/support centered; encourages independence; offers community support; refer/link people to additional resources offered outside the agency.
3. Clients ages 18-60 have the opportunity to participate in IMR. All treatment plans are goal oriented to help clients achieve recovery success.
4. We are currently re-working the current treatment plan structure to make the treatment plans more user friendly and more person and recovery centered.
5. Has two fulltime staff dedicated to teaching it to clients and staff. This model works well vs. doubling up roles with other roles/providers.
6. Treatment and care plans are updated annually or semiannually with eye on supporting gains, establishing next step goals and objectives and moving forward.
7. Patients provided specific methods to pursue/maintain recovery.
8. Treatment plans are general and often “cut and paste.”
9. Yes, as long as the goals are covered by Medicaid.
10. Person centered, in client’s own words.
11. Yes. When there’s a problem with a resident, we discuss the proper treatment plan for that resident.
12. Our treatment plan is driven off of client’s stated goals.
13. Agency is moving towards client-centered therapy.
14. They provide various types of treatment for those who qualify for such services. ETOH group provided.
15. Don’t know.
16. In some areas.
17. Case management meets with clinicians and doctors when needed along with scheduled treatment team meetings. The children’s team works as a unified team to utilize and find the most affective treatment including outside agencies such as Region 10 and the Upper Room.
18. Treatment plans are all about client recovery and promotion of client goals whatever they may be.
19. There is a real concerted effort to promote IMR and DBT to clients plus anger management courses. Employment and Journey Programs.
20. Yes, we are even this week planning training on person-centered treatment planning.

**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>
93/120	21/120	2/120	4/120
78%	18%	2%	3%

1. Many not on Medicaid must go without services such as case management, etc. Constant turnover of clinicians is problematic for clients.
2. Yes, all the time.
3. I find that services at CLM are consumer driven.
4. Depends on insurance.
5. Yes, if there is a Medicaid billing code.
6. Don’t know.
7. Clinicians will talk with parents and clients about services available initially and once treatment begins will incorporate services including functional support; case management; groups DBT, anger management and socialization skills.

**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>
83/120	31/120	1/120	5/120
69%	26%	1%	4%

1. Flexibility re: client's desires to change providers or therapist. Groups are mostly held during day, so working clients cannot afford.
2. Consumers are encouraged to talk with supervisors and are given contact info.
3. At times there can be communication issues between clinicians and direct care staff when representing client's needs.
4. Increase in groups. Growth of IMR program. Transfers when requested if clinically appropriate.
5. Clients request groups and a gathering place, but agency hasn't been able to provide these, per regs and funding, until recently. Now, especially needed since peer support agency is to close. Lack of or minimal transportation resources (affordable) limits independent gatherings without an agency van.
6. Billing problems/questions – billing response is great! Therapy issues – directors/team leaders response is great!
7. I often receive approval from supervisors to make extra spaces in classes for people who are in distress.
8. Sometimes requests are dismissed.
9. If they can be billed to Medicaid.
10. When I see there's a need or request for a certain resident and I confront my staff with it, they are grateful and happy to listen and come up with options.
11. Requested a phone for consumers use in the building, so they don't use staff phones.
12. If a client needs something – the agency/staff are so helpful and will work together to support the client.
13. Some will respond with adding requested services or changing providers, but many want to hear first hand from the consumer or make the client call for the request.
14. Recently, a mother (client) and her 3 kids (all clients) were infected with bed bugs. CLM offered increased support, vouchers, and some money to alleviate and help remedy their situation.
15. Payment issues.
16. Staff has always been responsive to consumer requests. We always try to accommodate consumer needs especially in emergency situations.
17. A family is in the midst of issues with housing; case manager can utilize staff members such as Barry Quimby who has been working with individuals with these issues for years and his insight and knowledge is valuable.
18. My supervisors respond in a timely manner regarding consumer requests, and more often than not, with beneficial/supportive suggestions.
19. Resources shared among case managers to FSS workers and clients – shopping vouchers.
20. Clinicians are extremely receptive to requests as are case managers and supervisors. It is a good team atmosphere.

**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>
46/120	52/120	17/120	5/120
38%	43%	14%	4%

1. Psychiatry and individual psychotherapy. Case management and functional support services to non-eligible – underinsured.
2. Especially with private insurance.
3. A lot of effort to get extra sessions for Medicaid clients (non-eligible). Documentation requirements are excessive due to management fears of funds being “taken back.”
4. Clients that may have commercial insurance that need case management or clients that need help in obtaining case management.
5. Due to funding restrictions, only a certain amount of services can be provided daily specifically community supports.
6. The cuts to HHS made by the Governor are killing us. The population needing to be served is booming, but many have no insurance or are underinsured and we don’t have enough staff to serve the astronomical increase in people seeking services.
7. Money caps limit individual services (unless certified). Need more skills building groups for clients.
8. Many time clients with tremendous needs for community support or case management services cannot afford these services or do not have appropriate insurance coverage.
9. There are clients that need more support but insurance does not allow for it. Medications are not always covered or affordable.
10. If client does not have insurance, we help by giving resources or often payment plans.
11. Children’s art and play therapy supplies.
12. Residential consumers need more 1:1, due to lack of funding that is not always possible. Residential staff are asked to go way above and beyond with very little pay.
13. Lack of funding.
14. Yes, there are needs of clients that are not Medicaid billable and they are not being met.
15. Clients needing FSS/CM and are not able to afford it based on sliding fee.
16. Short staffed at times, limited sessions/dollar amounts, cuts to necessary programs that have been helpful for consumers.
17. FSS 10-unit cap. Services that client’s want/need, but there is no funding. Not able to bill FSS groups at the agency.
18. Staffing issues. Staff is over loaded with cases. Clients are on waiting lists.
19. For some of our severely impaired consumers with no family support, it can be difficult to help them manage all needs when they have numerous medical problems or need to seek medical specialty outside of local resources.
20. Closing of our only adult 18-59 year old residence.
21. Community support services.
22. Community Health Services provides 7 sessions total.
23. When client lacks insurance needs. When client cannot afford agency’s program referred to outside of CLM.
24. Patient’s can be given a fee reduction form to help afford treatment if they qualify.
25. Don’t know.
26. Uninsured.
27. State budget cuts.
28. A number of clients have lost their insurance coverage.
29. Uninsured clients have few resources – limited resources for extended treatment.
30. Residential staff is spread thin and work hard for their pay. They do over 300 med passes, almost 20 being injections, showers, changing beds, managing meals, etc. They are great!
31. N/A.
32. Youth that have substance abuse issues and need in-patient services is hard to get. Also, children in need of services, such as residential services due to violence perpetrated on family members.

33. When attempting to complete goals, there are times when funding/liability hinder the recovery process.
34. No money seems to be available for training – no real push given even to attend free webinar training opportunities as FSS workers are trying to see as many clients as we can. Training time cuts into our productivity.

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

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
88/120	29/120	3/120	0/120
73%	24%	3%	0%

**a. Are your supervisors accessible to you?**

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
100/120	16/120	2/120	2/120
83%	13%	2%	2%

**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>
92/120	26/120	1/120	1/120
77%	22%	1%	1%

**a. Are your supervisors accessible to you?**

1. Some of us have unusual hours so not always everyone accessible every moment.
2. Absolutely.

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

1. Clinical supervisor sees me once monthly and almost never in her office. Clinical director helps sometimes. No time for discussions due to demands of quota/documentation.
2. At any time, clinical supervisors are available to address questions of concerns.
3. FSS Director-very connected to her large staff and good a building them up. Makes concerted effort to keep communications open. Good resource finder and gets back to us with information.
4. Absolutely.
5. A lot of good ideas are ignored. Often solutions are explored, but never progress. Issues with operating systems and evaluation/assessment information – for example: still needs to be made to pertain to children if it is still geared toward adults.

***ADDITIONAL COMMENTS***

1. CLM is client-centered and a great agency to work for. I do wish there were more training opportunities, both on-site and offsite.
2. High turnover of clinical staff, no doubt due to below market salary rates. Multiple changes of provider inhibit recovery and progress in treatment. Lack of stable housing/residential supported housing interferes with stabilization and management of symptoms. “Targeted case management” makes it more difficult to achieve quotas and discourages certifying clients who may need

increased services. Attending in-house training results in loss of productivity: disincentive. Lack of outpatient services equals increased incarceration, increased inpatient treatment, increased mortality, increased disability and increased homelessness!

3. I have worked in many mental health establishments and never have I felt so appreciated and supported.
4. Kids are in need of programs for after school. Kids with autism need extensive case management that combines OT with behavior strategies.
5. I find CLM to be a great work environment. I feel I am able to continue to grow professionally at this agency. Collaboration is fantastic and client's/consumer's needs are always met with best efforts.
6. Reimbursement to staff is far too low. I cannot support myself on this income.
7. We need increased funding to be able to hire more clinical staff to serve the influx of people seeking services. Burning out the existing staff would not be good for anyone.
8. The agency fully supports IMR and SE but we've a long way to go with seeing/documenting name vs. by client or as a diagnosis (ex-borderline, schizophrenic). Mass. is very far ahead of NH with its understanding and promotion of recovery.
9. Needs and interests are a goal of treatment planning imperatives. Interests are sometimes less of an emphasis in planning. Good motivation and intent, time lag however does occur. For adults the cap limiting number of therapy visits, i.e., cannot even complete anger management sessions, which is due to financial or insurance limitation.
10. I think this agency is well run – has great support and if there isn't a quick answer for something – always researched and answered as quickly as possible for employees and clients.
11. Staff often overrules client's request in an "I know what's best" manner. Lack of person centered planning as treatment plans are generic and goals are often cut and paste. Many staff stigmatize, generalize, and label. Specifically, "borderline" and "Axis II."
12. I have made several requests/suggestions re: safety in the building with no response. I find it inappropriate that there are glass objects (table, vase) in our lobby, in particular. These could be highly dangerous.
13. More funding would help us do our jobs better and this helps our consumers better.
14. CLM really cares about each client we provide services to. I am proud to work at CLM. We have very good case managers and FSS workers.
15. CLM values their staff and is very supportive of training efforts. I would not want to work for any other company. Clients receive excellent care and are offered an array of services to fit their needs.
16. CLM provides several supervision groups – peers, couples/family. DBT group supervision, staff meetings. Supervisors are always available if needed, a peer support is encouraged.
17. I believe that our agency is always striving to improve services to our clients. The supervisors have been very supportive when contacted with issues such as a client not being responsive when I arrived and they follow up to check and see how you are doing after the crisis.
18. Training of administrative assistant staff on an ongoing schedule to update staff.
19. Much of my focus during the day is to complete and maintain paperwork. I find I have little time to prepare for treatment. I wish there was some kind of limit on amount of paperwork required so I could focus on client needs more.
20. The agency as a whole is good; some issues remain which Vic Topo is attempting to rectify with town hall meetings. These meetings are productive and several changes for protocol have improved. Lisa Madden listens and explains issues – she is accessible and approachable. Steve Arnett – quality. Is very good at his job and is willing to talk through issues regarding policy and client's needs, advising staff on most appropriate approach to solve issues.

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

### **REQUIREMENTS:**

**He-M 403. 07 (a) (1) through (6) 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: job descriptions; staffing patterns; conditions of employment; staff grievance procedures; staff performance reviews; and individual staff development plans.**

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

### **OBSERVATIONS IV-A:**

Though there is a comprehensive array of policies, it is recommended that policies continue to be developed, reviewed, signed, and dated by the BOD (or designee) as needed.

### **RECOMMENDATIONS IV-A:**

At a minimum, the policy manual must address the policy requirements outlined in He-M 403 cited above including:

- He-M 403. 07 (a) (1) job descriptions;
- He-M 403. 07 (a) (6) individual staff development plans;
- He-M 403. 07 (b) criminal background checks and motor vehicle record checks.

### **CMHP RESPONSE IV-A:**

### **GENERAL OBSERVATION:**

### **OBSERVATION IV-B:**

While the agency has adopted numerous policies that have strengthened internal controls, there are some procedures in place with no corresponding written policies. These include the following:

- Supervisory review of credit card usage by CEO;
- Seeking written proposals for services, property or major purchases.

**RECOMMENDATION IV-B:**

The agency should consider developing formal written policies for these issues.

**CMHP RESPONSE IV-B:**

## **SECTION V: FINANCIAL**

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

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

It is essential for any CMHP to have a comprehensive Financial Manual with policies and procedures that guide the day-to-day operations of the CMHP. Ongoing monitoring for compliance with internal control policies and 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, CLM was in substantial compliance with all the requirements referenced above.

### **OBSERVATIONS V-A:**

BBH compiles an annual report for the CMHPs that includes a 5-year financial trend analysis. One section of the report addresses the liquidity of the CMHPs. Liquidity refers to the entity's ability to maintain sufficient liquid assets, such as cash and accounts receivable, to meet its short-term obligations.

One ratio used to measure liquidity is Days of Expenses in Cash (year end cash balance divided by average expenses per day). For the Days' of Expenses in Cash ratio in FY10, CLM ranked seventh out of the ten CMHPs, and eighth out of ten when averaging the last five years for this indicator. CLM's indicator of 13 days for FY10 is well below the overall average of 34 days.

The MOU between BBH and CLM was piloted during the state FY05. The MOU included performance domains and standards including financial ratios that are shared with the CMHPs on a monthly basis.

BBH calculated the financial performance standards using unaudited March 2011 financial statements. CLM did not conform to all of the fiscal domain benchmarks established by the MOU.

BBH is concerned about CLM's Days of Cash on Hand Ratio. In June 2010, the ratio indicated 18.71 days. In March 2011, this number decreased to 10.67 days.

It is essential that CLM increase these indicators to assure the short-term viability of the agency.

See schedule below.

REGION/ TREND	Days Expenses In Cash					
	Fiscal Year					
	2006	2007	2008	2009	2010	Avg.
A.	49	56	71	81	92	70
B.	13	27	17	46	64	33
C.	76	83	36	56	64	63
D.	58	62	16	49	61	49
E.	14	31	38	43	32	32
F.	4	7	4	2	24	8
G.	10	15	13	9	16	12
<b>CLM</b>	10	3	13	18	13	11
H.	10	18	13	12	5	12
I.	3	5	9	5	5	6
J.	3	11	4	8	1	6
<b>TOTAL</b>	23	29	21	30	34	27

**RECOMMENDATION V-A:**

It is recommended that CLM develop a corrective action plan designed to improve these outcomes to assure its ability to meet short-term obligations.

**CMHP RESPONSE V-A:**

**OBSERVATION V-B:**

In FY11, CLM's Accounts Receivable balances older than 120 days continued to increase for private consumers. In FY09, this amount was \$240,145. In FY10, it was \$279,601. And as of April 30, 2011, it increased to \$346,991.

**RECOMMENDATIONS V-B:**

CLM is encouraged to monitor any growth in Accounts Receivable older than 120 days. Any receivables that are deemed uncollectible should be written off.

**CMHP RESPONSE V-B:**

**OBSERVATION V-C:**

CLM's consolidated income statement for FY10 showed a deficit of \$287,254 and the unaudited financials for March 2011 also showed a year-to-date deficit of \$163,145.

**RECOMMENDATION V-C:**

It is recommended that CLM examine all cost centers to determine if additional efficiencies can be made to increase the overall surplus of the agency.

**CMHP RESPONSE V-C:**

## SECTION VI: QUALITY IMPROVEMENT AND COMPLIANCE

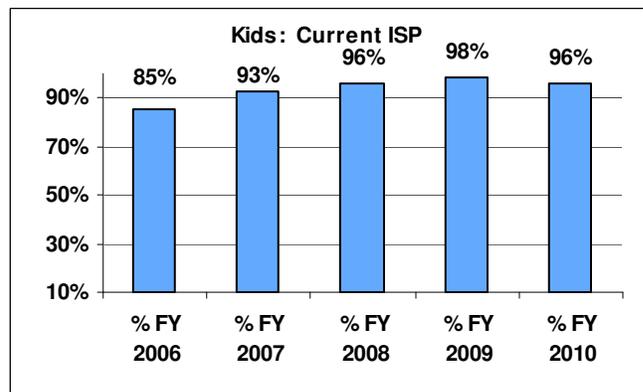
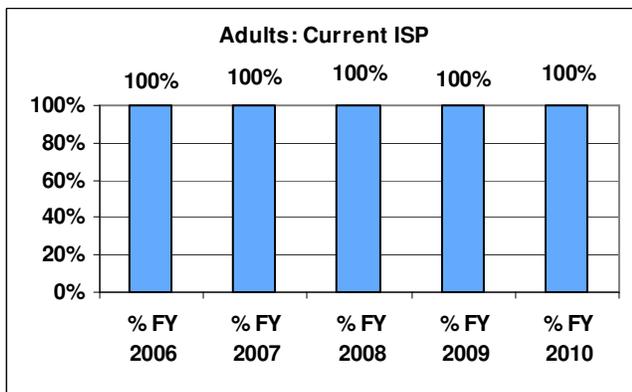
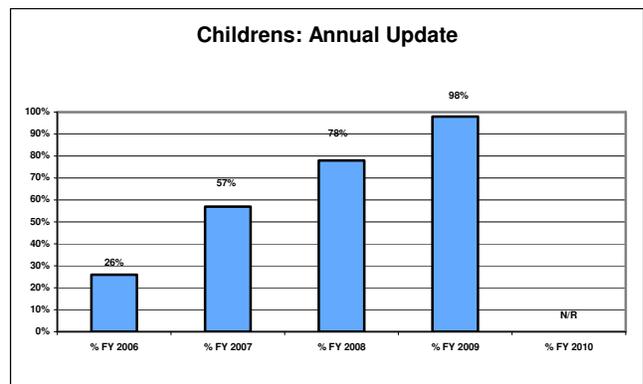
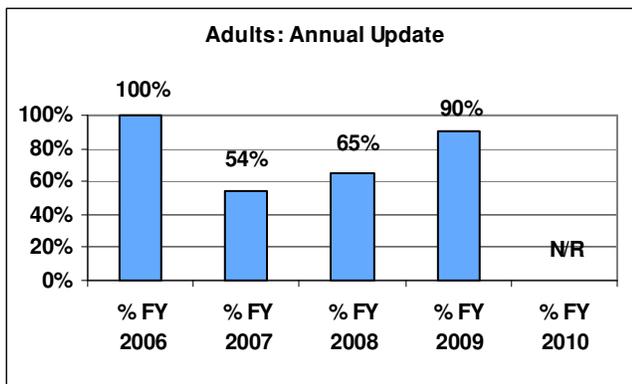
Quality improvement and compliance activities are expected to be conducted on both the state and local level. The BBH conducts annual quality improvement and compliance reviews and CMHP reapproval reviews on a five-year cycle. Other reviews occur as needed and requested.

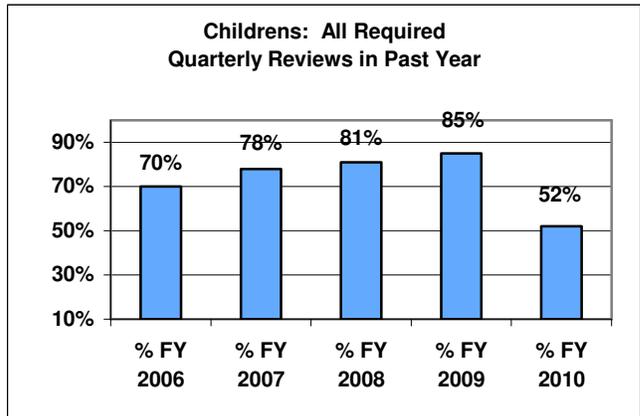
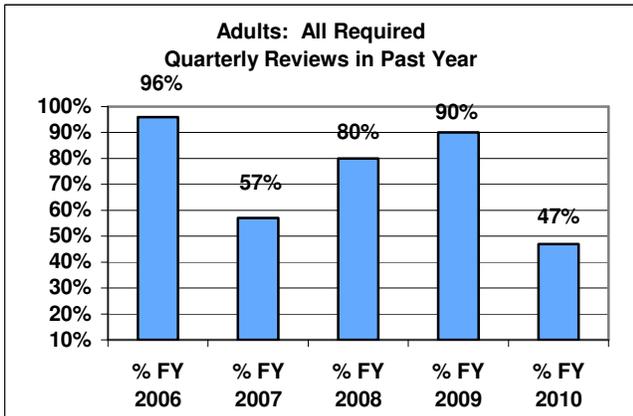
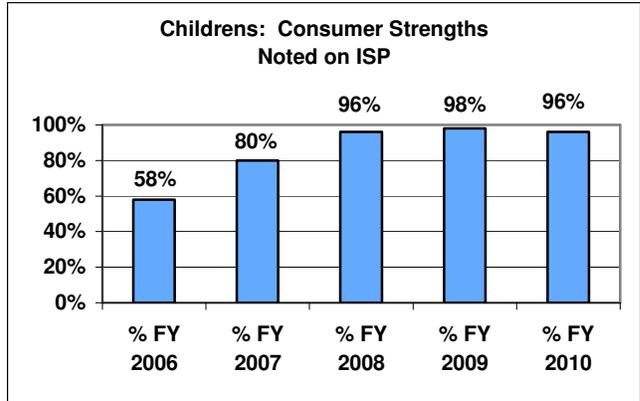
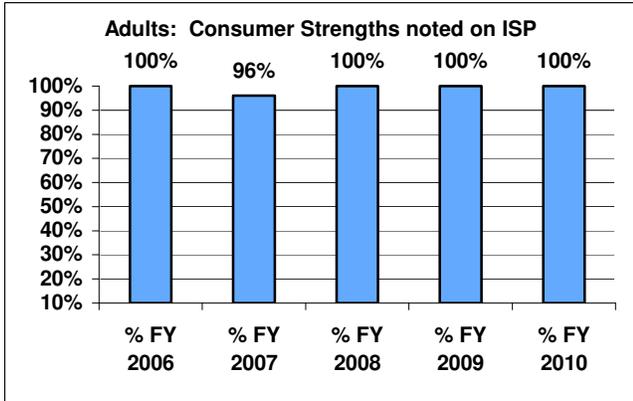
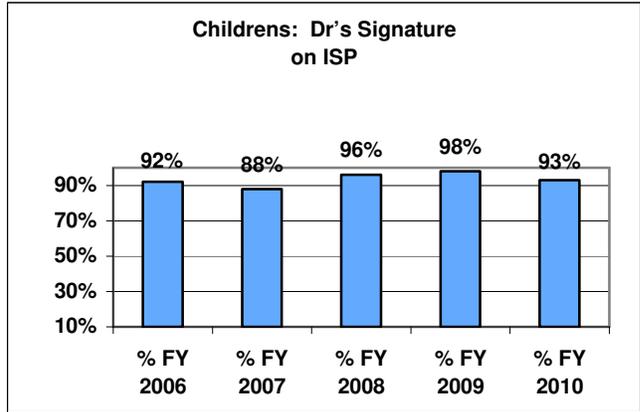
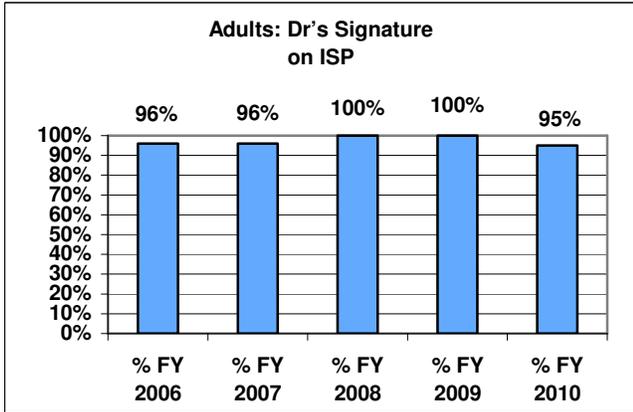
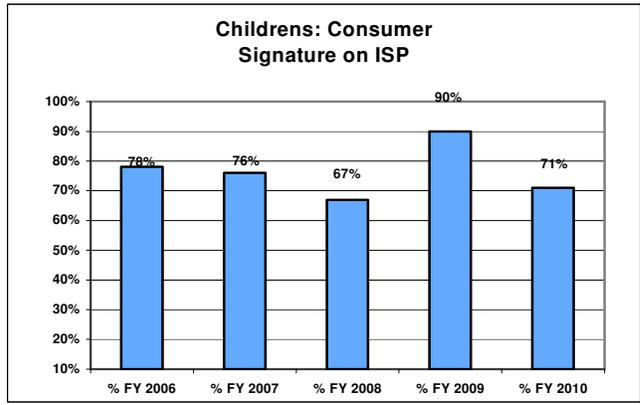
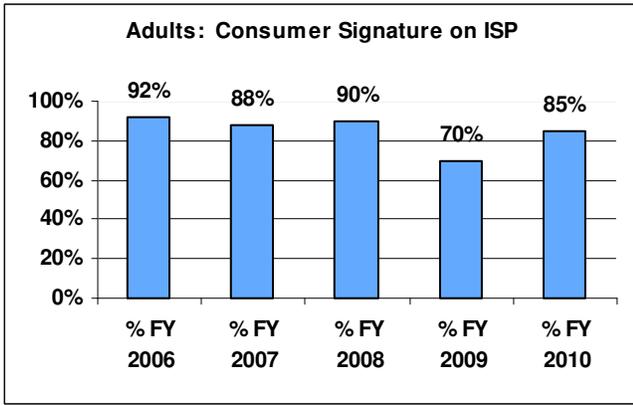
He-M 403.06 (i) and (j) outlines the minimum requirements for CMHP quality assurance activities. These include a written Quality Assurance Plan that includes outcome indicators and incorporates input from consumers and family members. The annual plan is submitted to BBH. Other activities include: utilization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

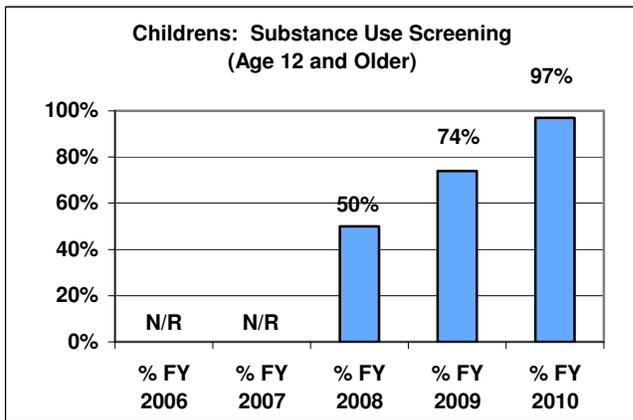
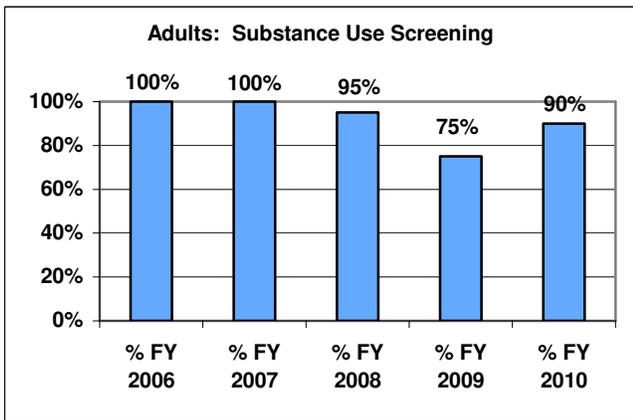
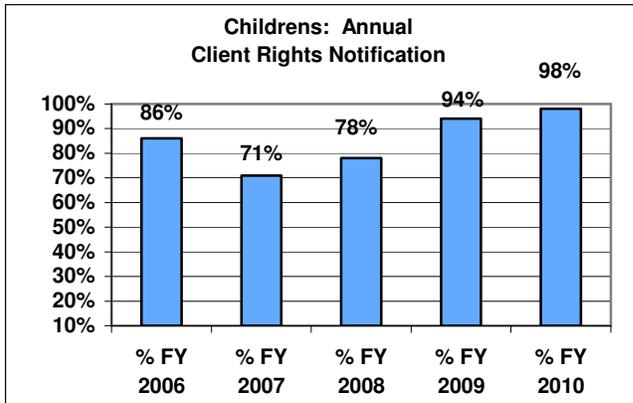
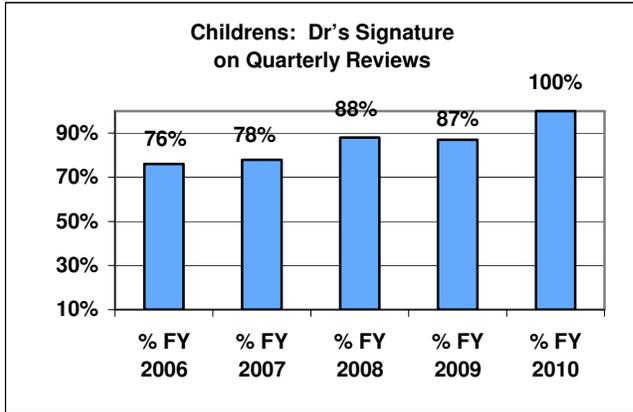
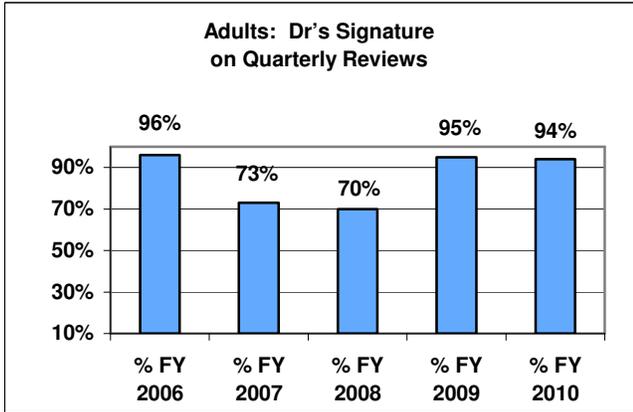
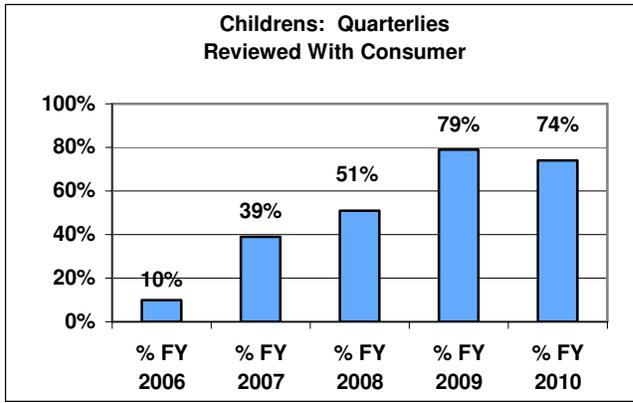
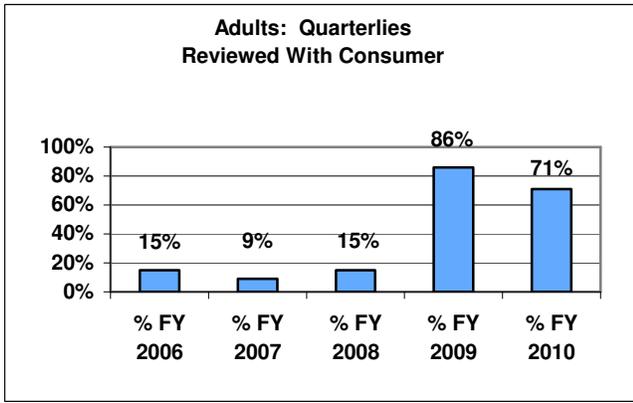
At the time of the review, CLM was in substantial compliance with all the requirements referenced above.

### OBSERVATION VI-A:

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

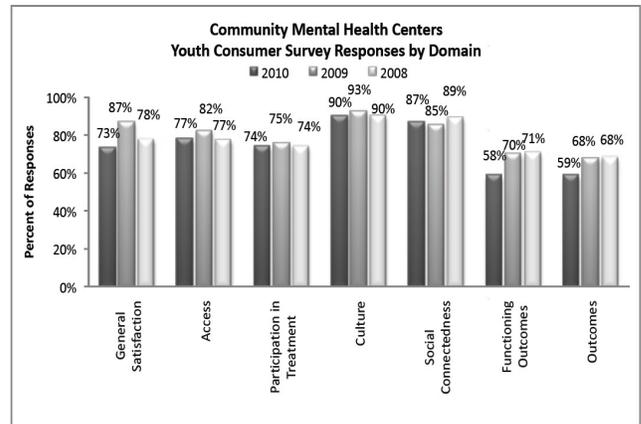
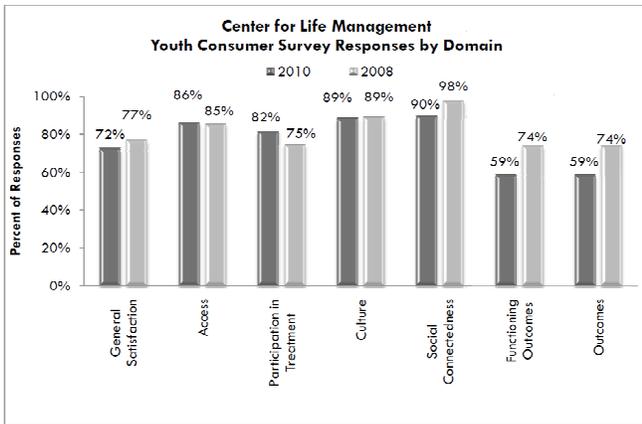
It is also recommended that CLM continue to conduct and document internal quality improvement and compliance activities.

**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 CLM 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.



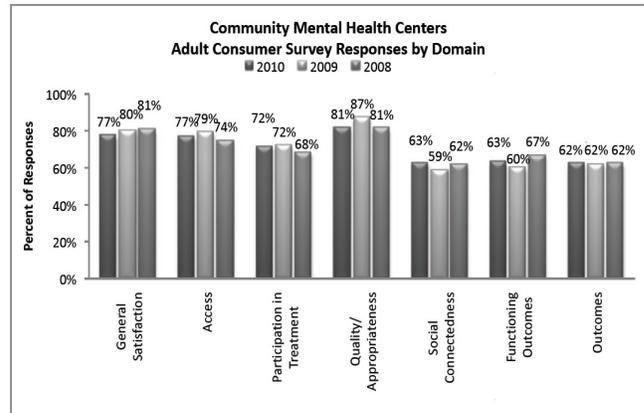
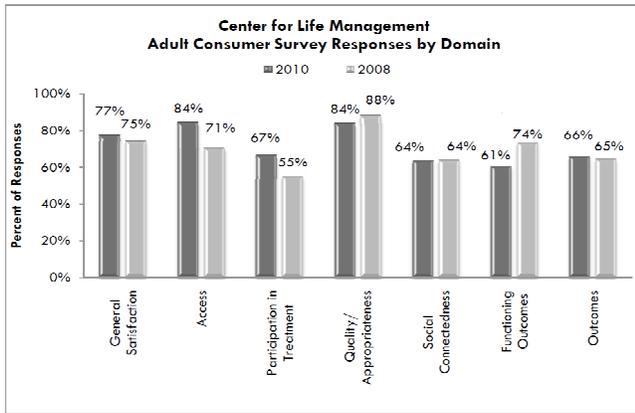
### OBSERVATION VII-A:

It is noted that CLM percentages ranked below the statewide average in the following Youth Survey domains: General Satisfaction and Culture.

### 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:



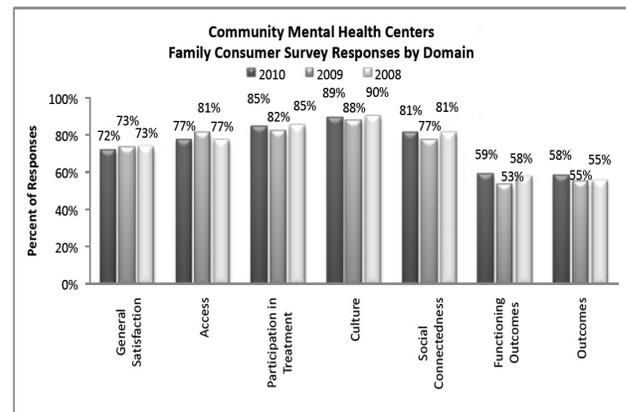
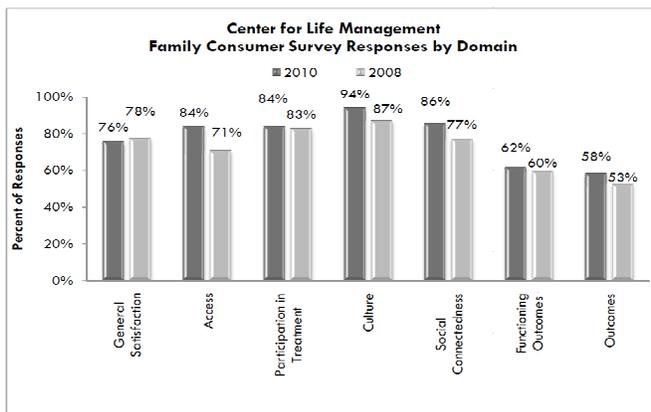
**OBSERVATION VII-B:**

It is noted that CLM percentages ranked below the statewide average in the following Adult Survey domain: Functional Outcomes and Participation in Treatment.

**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 CLM percentages ranked below the statewide average in the following Family Survey domain: None.

**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**