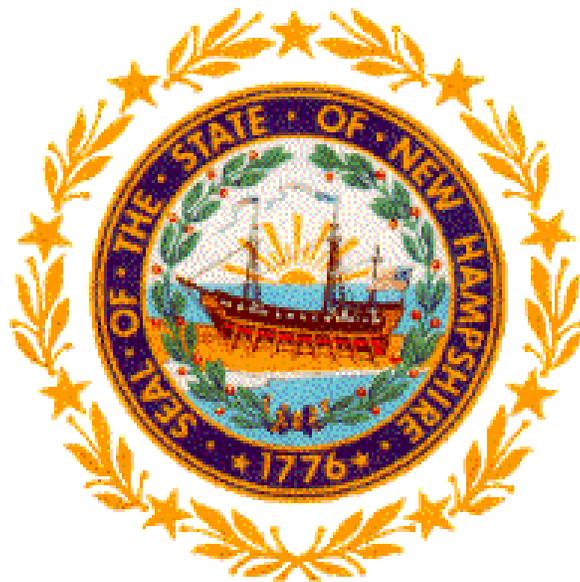


**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF BEHAVIORAL HEALTH**

**COMMUNITY MENTAL HEALTH PROGRAM
REAPPROVAL REPORT**



MONADNOCK FAMILY SERVICES

**MAY 28, 2010
(REVISED)**

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
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
MFS	Monadnock Family Services
MOU	Memorandum of Understanding
NAMI-NH	National Alliance for the Mentally Ill NH
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
VR	Vocational Rehabilitation

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 Monadnock Family Services (MFS) in Keene, NH occurred on December 12-18, 2009. The review team included staff from the Department of Health and Human Services (DHHS), the Bureau of Behavioral Health (BBH) and the Office of Improvement, Integrity and Information (OIII).

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

- A letter requesting Reapproval;
- A description of all programs and services operated and their locations;
- The current strategic plan;
- A comprehensive listing of critical unmet service needs within the region;
- Assurances of compliance with applicable federal and state laws and rules;
- The Mission Statement of the organization;
- A current Board of Director list with terms of office and the towns represented;
- The By-Laws;
- The Board of Director (BOD) meeting minutes for Calendar year 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 constituents identified on the MFS mailing list soliciting feedback regard the CMHP;
- Staff surveys soliciting information from MFS staff regarding training, supervision, services and CMHP operations.

The site visit to MFS included:

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

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

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

- MFS policy states that all policies must be signed by both the CEO and Medical Director. Not all policies were signed. Financial policies were signed by the CFO only. The Disaster Response Plan be reviewed and approved by the BOD or their designee;
- Explore ways of incorporating the principles of recovery and family support into the BOD orientation and ongoing training;
- Both formal and standardized approaches to offering IMR should be developed and documented;
- Strategies be utilized to increase IMR penetration rates;
- MFS utilize documentation that fosters the development of consumer centered goals and objectives;
- All appropriate staff should receive the relevant training in IMR services and supervision;
- The recommended frequency of IMR supervision occur;
- IMR Outcome information should be shared with practitioners;
- Training be provided to increase outreach and connect with support networks;
- The implementation of goal-tracking sheets and goal follow-up should be supported in supervision;
- Training be provided regarding behavioral tailoring for medications;
- Actively market the SE program to the eligible population in an effort to increase the penetration rate;
- Clarify the role of employment specialists;
- Develop an Employment Team that provides only SE services with a maximum caseload of 20 consumers per employment specialist;
- Emphasize the purpose and integration of SE services with the mental health treatment teams;
- Develop an effective working partnership with the local Vocational Rehabilitation (VR);
- It is recommended that a regular monthly meeting occur with staff from the local VR office;
- Enhance SE supervision structure including training and field-based shadowing and monitoring on a regular basis;
- Explore ways to serve ethnic, cultural, sexual and other minority populations in the region;
- All case management descriptions be limited to the core case management activities of assessment, referral and monitoring;
- Develop policies regarding the provision of or the referral to child and adolescent sexual offender assessment and treatment;
- Continue corrective action to improve compliance with the requirement for annual substance use screens for children;
- Explore additional opportunities to collaborate with the local PSA;
- Explore ways to collaborate with the local area agency in the provision of services to persons with both mental illness and developmental disability;
- Include annual staff development plans in all personnel files;
- Revise the Children's Services Coordinator job description to include service system planning including the Anna Philbrook Center;
- It is recommended that personnel files be monitored for completeness at least annually at the time of the performance review;
- Review the staff survey results;

- Develop or amend policies to include the required elements in a job description and the review of the Office of Inspector General's List of Excluded Individuals/Entities for each newly hired and re-hired staff members;
- The agency should consider developing the following written policies for: seeking written proposals for services, property or major purchases and the use and accountability of credit cards including the supervising of any ED's expense by the Board;
- MFS is encouraged to monitor continued growth in Accounts Receivable older than 360 days;
- Any receivables deemed uncollectible should be written off;
- A plan should be developed to lower the overall days in receivables;
- It is recommended that the agency continue to grow its revenue;
- Develop a corrective action plan designed to improve the days of expenses in cash;
- Ensure that all services are documented in the clinical record prior to billing;
- Ensure that all billings reimbursed by Medicaid have a current ISP;
- It is recommended that the BBH QI and Compliance Reports be shared with the BOD and utilized in planning activities;
- It is recommended that 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 MFS on December 14-18, 2009. 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 eligibility determination review are not fully included in this document and have been sent as a separate report. Two structured interviews were conducted as part of the site visit, one with the Management Team and another with the BOD.

A brief exit meeting was conducted on December 18, 2009, and was open to all staff. Preliminary findings were reviewed and discussed at that time.

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

- Letter of application from MFS 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 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 MFS contract with BBH;
- Results of SFY 2009 Adult and Child Eligibility 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 MFS included an examination of the following:

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

- Homeless Shelters;
- Substance Use Disorder Programs;
- Area Agencies;
- Vocational Rehabilitation;
- Division for 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 MFS conducts business.

Employee surveys were sent to MFS 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; 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

MFS is a non-profit community-based, mental health organization serving the needs of individuals and families in southwestern New Hampshire's Monadnock Region. The agency has grown from the small volunteer group in the early 1900s, to hiring social workers in the 1950s, to now employing nearly 300 staff at all levels including counselors, mentors, and psychiatrists.

In 2005 MFS celebrated its centennial birthday and used the opportunity to provide public education about mental health through a film and speaker series. The birthday celebration and public education effort are small illustrations of MFS's strong connection and commitment to the Monadnock community.

The agency has received national and international recognition for its innovative programs such as employment initiatives at the Wyman Way Coop, and physical health initiatives such as the In Shape Program.

MFS Mission Statement:

“Monadnock Family Services fosters mental and emotional health, promotes recovery from mental illness and inspires hope for personal success.”

MFS 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.

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

The towns served by MFS include:

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

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 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, MFS 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” that states that the BOD has designated the CEO and Medical Director as responsible for signing off on policies. Not all policies in the manual were signed.

Financial policies were signed only by the CFO.

RECOMMENDATIONS I-A:

Per MFS policy, all operational policies must be signed by the CEO and all clinical policies signed by both the CEO and Medical Director.

If both the CFO and CEO are to be the responsible parties for signing fiscal policies, the “Policy Development” policy should be revised to reflect this procedure.

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.

RECOMMENDATION I-B:

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

CMHP RESPONSE I-B:

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

OBSERVATION I-C:

There is no evidence of BOD orientation to the principles of recovery and family support.

RECOMMENDATIONS I-C:

Explore ways of incorporating the principles of recovery and family support into the BOD orientation and ongoing training. Documentation of this training should be kept on file at the agency.

CMHP RESPONSE I-C:

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, MFS 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/Client 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. In addition, the times and methods of informing consumers were not consistent.

RECOMMENDATION II-A:

Both 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: $\frac{\# \text{ consumers receiving EBP}}{\# \text{ consumers eligible for EBP}}$	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:

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

The QI Director provided the appropriate numbers for this rating. These numbers are reflective of the number of consumers receiving IMR/eligible for services between 9/1/07 and 1/12/09. This item remains a “2”, however, it is noteworthy that the percentage of consumers receiving the service has risen slightly from .21 to .24.

$$\frac{103 \text{ consumers receiving IMR}}{428 \text{ consumers eligible for IMR}} = .24 \text{ ratio}$$

RECOMMENDATION II-B:

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

CMHP RESPONSE II-B:

Individualized Treatment	1	2	3	4	5
All EBP consumers receive individualized treatment meeting the goals of the EBP.	≤20% of consumers served by EBP receive individualized services meeting the goals of the EBP	21%-40% of consumers served by EBP receive individualized services meeting the goals of the EBP	41%-60% of consumers served by EBP receive individualized services meeting the goals of the EBP	61% - 80% of consumers served by EBP receive individualized services meeting the goals of the EBP	>80% of consumers served by EBP receive individualized services meeting the goals of the EBP

OBSERVATION II-C:

Goals and objectives were not found to be person centered and often repeated from one record to another such as increasing functioning and socialization by meeting with the case manager and taking medication. This item was rated a five on the previous IMR Review.

RECOMMENDATION II-C:

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

CMHP RESPONSE II-C:

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

OBSERVATION II-D:

Significant turnover in staff within the last year has resulted in a lower rating than in the previous review. This item has dropped from a “5” to a “1”. The new program leader has not been fully trained, and has not had the ability to adequately train other staff. The program leader does not have the “Train the Trainers” curriculum developed by the PRC and the BBH to guide in the training of new IMR practitioners.

RECOMMENDATION II-D:

The Program Director should receive the basic IMR and the “Train the Trainers” trainings. All IMR practitioners should receive the equivalent of a 2-day training followed by an annual one-day refresher training. New practitioners should co-facilitate IMR groups with more experienced staff.

CMHP RESPONSE II-D:

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

OBSERVATION II-E:

Some IMR practitioners receive supervision every other week and those in Peterborough did not receive any supervision. The supervision should be client-centered and explicitly address the EBP model and its application to specific client situations.

RECOMMENDATIONS II-E:

The recommended frequency of supervision is weekly and alternates between consumer specific case consultation and skills training.

CMHP RESPONSE II-E:

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-F:

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

RECOMMENDATION II-F:

Outcome information should be shared with practitioners.

CMHP RESPONSE II-F:

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

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-G:

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

CMHP RESPONSE II-G:

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-H:

Documentation of consumer goals and goal tracking is inconsistent. Goals are not connected to the subject matter in the modules and tracking sheets are not being utilized. In the previous fidelity review both of these areas were rated as “5”. There was little evidence of collaborative follow up with consumers.

RECOMMENDATION II-H:

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-H:

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

OBSERVATION II-I:

Documentation of behavioral tailoring for medications varies in quality. Some documentation reflected other types of interventions.

RECOMMENDATION II-I:

Training regarding behavioral tailoring for medications may help to address these issues.

CMHP RESPONSE II-I:

REQUIREMENTS:

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

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

ADDITIONAL INFORMATION SOURCE:

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

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

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

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

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

$$\frac{55 \text{ consumers receiving SE services currently}}{215.4 = (359 \text{ eligible} \times .60)} = .26 \text{ ratio}$$

OBSERVATION II-J:

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

RECOMMENDATION II-J:

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

CMHP RESPONSE II-J:

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

STAFFING	RATING
Staffing: Employment Services staff: Employment specialists provide only employment services	2

OBSERVATION II-K:

Employment specialists provide many services in addition to employment services.

ORGANIZATION	RATING
Organization: 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-L:

There appears to be significant room for improvements in the relationship between VR and the SE team at MFS. Meetings between the two agencies are on an individual consumer basis with no regularly scheduled meetings.

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

OBSERVATION II-M:

Weekly consumer-based team supervision following the supported employment model in which strategies are identified and job leads are shared is not utilized.

ORGANIZATION	RATING
<p>Organization: Role of employment supervisor: Supported employment unit is led by a supported employment team leader. Employment specialists' skills are developed and improved through outcome-based supervision. All five key roles of the employment supervisor are present.</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 client situations and identify new strategies and ideas to help consumers in their work lives. 3. Supervisor communicates with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues (such as referral process, or transfer of follow-along to mental health workers) and to be a champion for the value of work. Attends a meeting for each mental health treatment team on a quarterly basis. 4. Supervisor accompanies employment specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development. 5. Supervisor reviews current client outcomes with employment specialists and sets goals to improve program performance at least quarterly. 	1

OBSERVATION II-N:

Both the SE supervisor and employment specialists identify limited opportunity for supervision. The supervisor does not collect or disseminate outcome data regarding SE services as this function is managed by one of the employment specialists.

SERVICES	RATING
<p>Services: Individualized job search: Employment specialists make employer contacts aimed at making a good job match based on consumers' preferences and needs rather than the job market (i.e. those jobs that are readily available). An individualized job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences.</p>	2

OBSERVATION II-O:

There was limited information in several of the records reviewed about consumer preferences regarding an individualized job search process. Very few consumer records had a job search plan and goals seemed oriented to those jobs that are readily available (First Course).

SERVICES	RATING
Services: Job development: Frequent employer contact: Each employment specialist makes at least six (6) face-to-face employer contacts per week on behalf of consumers looking for work. An employer contact is counted even when an employment specialist meets with the same employer more than one time in a week, and when the client is present or not. Client-specific and generic contacts are included. Employment specialists use a weekly tracking form to document employer contacts.	1

SERVICES	RATING
Services: Job development: Quality of employer contact: Employment specialists build relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer.	1

OBSERVATION II-P:

Employment specialists are not spending time in the community making face-to-face employer contacts.

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

OBSERVATION II-Q:

Diversity of job type seems limited with over 50% of those jobs are in the food service field.

RECOMMENDATIONS II - K through Q:

Consider reviewing all the activities of employment specialists to determine which of these may be carried out by other members of the mental health treatment team. Develop a Supported Employment Team that provides only SE services with a maximum caseload of 20 consumers per employment specialist.

Emphasize the purpose and integration of SE services with the mental health treatment teams.

Develop an effective working partnership with local VR services to assure access to a broad spectrum of vocational services including job development activities. It is also recommended that a regular monthly meeting occur with staff from the local VR office.

Enhance SE supervision structure including training and field-based shadowing and monitoring on a regular basis.

CMHP RESPONSE II – K through Q:

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-R:

Though the strategic plan and some policies address issues related to minority populations such as the use of language interpreters, services to minorities in the area are somewhat limited.

RECOMMENDATION II-R:

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

CMHP RESPONSE II-R:

REQUIREMENT: He-M 403.06 (a) A CMHP shall provide the following, either directly or through a contractual relationship: (2) Case Management pursuant to He-M 426.14

OBSERVATION II-S:

Core targeted case management services are described well in the program description focusing on assessment, referral and monitoring. However, the services identified in job descriptions and on the agency website are more broadly defined and included activities outside the core services of assessment, referral and monitoring.

RECOMMENDATION II-S:

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

CMHP RESPONSE II-S:

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

OBSERVATION II-T:

MFS does not provide these services.

RECOMMENDATION II-T:

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

CMHP RESPONSE II-T:

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

OBSERVATION II-U:

FY 2009 BBH QI and Compliance reports reflect that 74% of child records contained annual substance use screens. The BBH QI and Compliance Reports have typically asked for corrective action responses for any item below 75% compliance.

RECOMMENDATION II-U:

The CMHP should continue corrective action to improve compliance with this requirement.

CMHP RESPONSE II-U:

REQUIREMENTS: He-M 403.06 (a) (13) A CMHP shall provide the following, either directly or through a contractual relationship: Consultation, as requested, and support to consumer-operated programs to promote the development of consumer self-help/peer support.

OBSERVATION II-V:

The relationship with the PSA has reportedly varied over time. The PSA has been involved with the In Shape Program and referrals are made between both agencies.

RECOMMENDATION II-V:

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

CMHP RESPONSE II-V:

REQUIREMENT: He-M 403.06 (f) A CMHP shall make services available to persons who have both a mental illness pursuant to He-M 401 and a developmental disability pursuant to He-M 503.

OBSERVATION II-W:

No description of services for persons who have both mental illness and developmental disability were found in the reapproval application, agency website or program descriptions.

RECOMMENDATION II-W:

Explore ways to collaborate with the local area agency in the provision of services to persons with both mental illness and developmental disability.

CMHP RESPONSE II-W:

SECTION III: HUMAN RESOURCES

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

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

The BBH team reviewed a sample of MFS 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 MFS 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, MFS was in partial compliance with all the requirements referenced above.

REQUIREMENT: He-M 403.07 (c) Each staff person employed by a CMHP shall have an annual performance review based upon that staff person's job description and conducted by his or her supervisor, which shall include an individual staff development plan.

OBSERVATION III-A:

Though personnel files contained staff development plans, some were generic such as "develop skills".

RECOMMENDATIONS III-A:

Include annual staff development plans in all personnel files.

CMHP RESPONSE III-A:

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

OBSERVATION III-B:

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

RECOMMENDATIONS III-B:

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-B:

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

OBSERVATIONS III-C:

MFS 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	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (b)	OIG sanctioned provider check	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (b)	DMV check	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
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	Y	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (e) (2)	Does Orientation include an overview of mental illness and current MH practices	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (e) (3)	Does Orientation include Applicable He-M Administrative Rules	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (e) (4)	Does Orientation include accessing the local generic service delivery system	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (e) (5)	Does Orientation include Client Rights training	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%

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

CMHP RESPONSE III-C:

**MONADNOCK FAMILY SERVICES
REGION V**

**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 MFS.

1. Does your agency provide job-related training?

<u>Yes</u>	<u>No</u>	<u>No Answer</u>
76/89	6/89	7/89
85%	7%	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>
13/89	44/89	28/89	4/89
15%	49%	31%	4 %

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>
13/89	31/89	37/89	8/89
15%	35%	42%	9%

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

1. In-house.
2. We need to push managers to recommend more training opportunities.

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

1. Agency typically has not expended the approval training budget, even before the 07-08 budget crisis.
2. Unsure?
3. Lack of technology-related training.
4. This has improved in the past year.
5. Training is generally off-site, e.g. at a local hospital and therefore, dependent on funding, which is always tight.
6. Administrative training is good. Do not know about other areas.
7. I once needed training on how to deal with clients who become a threat. I requested training and got it right away – unfortunately it was not provided as part of my orientation.
8. Maybe?

9. We have some training provided as well as consultation – for example: TFCBT and HNC programs. People attend other trainings depending upon their needs. I wish the state would provide ethics training free since it's mandated to have 3 CEU yearly.
10. Could provide more financial assistance to attend trainings.
11. We have monthly full team trainings on a variety of subjects and all of my outside trainings have been approved.
12. Cost of training is often out of pocket without reimbursement. Few monetary resources for training - has been offered more long-term training (TF-CBT, HNC, DBT), which seem to be more helpful trainings for staff but are limited to very few who can attend.
13. First position I was hired for – I had one hour with a temp. Current position – computers are not working well-connection issues making training next to impossible for many tasks.
14. Case managers have made numerous requests for trainings on motivational interviewing, but we have not received comprehensive training on this important intervention. Also, DBT trainings have focused more on client experiences of BPD, rather than supportive techniques re: DBT skills.
15. I am a new employee and do not have examples.
16. Some requests have been fulfilled such as training to improve family involvement, however, repeated requests for a goal/ISP planning training have not.
17. Have requested DBT training and have not been allowed to yet.
18. When trainings necessary to job performance are needed, the agency is always supportive of us attending trainings off-site when we need to.
19. Education for personal and professional growth is encouraged, but funding limits the amount and type of training that can be taken. My immediate supervisor has sought out scholarships and grants that have afforded me the opportunity to attend conferences. My program is housed in a clinical setting, and also with prevention. Programs where there is potential for angry or unruly clients – training should be provided to non-clinical and support staff to deal with emergency situations so that we are safe.
20. They provided more training on Social Security benefits and MEAD Program and others as “Inclusion.”
21. Support for yearly training.
22. Typically I have been supported in obtaining the training required to maintain licensure. The state EBP training has been particularly helpful to the children's team and staff involvement is supported.
23. I have not been informed about training opportunities. This could be related to my position (No trainings are available).
24. Gives company time but insufficient to pay expenses for state conference and for educational programs.
25. Some training is provided to some staff, but not for my job role.
26. Permission to attend granted.
27. We were given \$150 per year for training. This covers one workshop when we have to go to about 5 per year to maintain license. In-house training is minimal usually (i.e. confidentiality). Trained in-house staff offered 2 day DBT overview and both staff attendees and leaders were disrespected, many not given approval to attend.
28. The agency has never denied training for myself or staff.
29. Managers seem to respond promptly when the requests are made.

2. Does your agency provide training in recovery philosophy?

<u>Yes</u>	<u>No</u>	<u>No Answer</u>
44/89	15/89	59/89
49%	17%	66%

1. To RSS staff but not enough.
2. Unsure?
3. To clinical staff, not to all staff.
4. I am not sure to be honest.
5. Recovery philosophy is a term that is used in adult services. I don't know what is offered for adults. In children's services every effort is made to keep children functioning in school, family and community.
6. ?
7. Not in my area/department. (If recovery = substance or chronic mental illness).
8. What is this (recovery philosophy)? Does it go by another name?
9. DBT, IMR, TF-CBT
10. We are a prevention program.
11. N/A
12. N/A
13. Don't know.
14. Not recently, and not really focused on how "recovery philosophy" or approach must be implemented in daily practice. Our agency promotes recovery and espouses recovery, but does not clearly convey this philosophy to clients.
15. I work permanently in children's services.
16. N/A
17. Do not know.
18. Did approximately 1-2 years ago (but that was not sufficient as there are other training needs).
19. Not anymore. Been turned down for training I need to do my job because of budgeting funding issues. Been turned down twice in the past 6 months for this.
20. N/A
21. As a children's team clinician we could use some further training on substance abuse and co-occurring disorders.
22. This is not applicable to my job duties. I haven't received training.
23. No applicable in my position.
24. I don't know what is provided to the adult team and this question used the language of adults with severe MI. The philosophy of family directed/involved care is strong in children's along with development of collaborations to support change.
25. N/A to my job.
26. Don't know what this means.
27. Not that I am aware of.
28. N/A
29. N/A for children's services.
30. Yes, the agency has this for adult services, but I don't know much about it.

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>
51/89	16/89	4/89	18/89
57%	18%	4%	20%

1. Dependent on individual staff preference and approach.
2. Don't know. Non-clinical staff responding.
3. Great efforts to keep clients in their homes.
4. This is taken care of at treatment planning meetings, which my department does not attend. But I understand that the agency is supportive in this area.
5. Treatment plans are created by case management staff and clients, working together to create goals, based on dry/therapist recommendations.
6. Recovery plans seem to be there but payment for or to employees to do these services is sparse in comparison to their responsibilities, e.g. case managers.
7. All treatment planning is done in and with client-centered approach.
8. We go beyond traditional therapy to involve children and family in community based activities. We link them up with resources and we have people who donate things through a person-to-person program.
9. We are very client focused.
10. "Recovery" not applicable.
11. Stress reintegration, use of community resources, active client and/or parent involvement in treatment planning.
12. N/A
13. N/A
14. I'm support staff.
15. Case managers are encouraged to use the client's own words to identify goals and objectives on ISPs.
16. Treatment plans are often reviewed in supervision.
17. My work is not in mental health services.
18. I have no basis for judging as my department has limited clinical operation
19. Child service plans are to be strength based, use common language, involve the family and child and have a clear outcome. We tend not to use "recovery" language with kids.
20. Review plan with client – identify areas of need for support.
21. N/A
22. N/A to my job.
23. Too much emphasis on paperwork, treatment plans, etc. – make it look like what State wants, but actually detracts from quality of work/true recovery practices and time for clients.
24. Employees are too overworked to give true quality care.
25. Clinical support – training – mentorship.
26. Working with kids we focus on strengths and on movement towards more functional behaviors at school, home and in community.
27. The agency has always been supportive but during the last year there has been an emphasis on choice, and support of that choice.
28. N/A for children's services.

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>
58/89	26/89	1/89	4/89
65%	29%	1%	4%

1. Don't know.
2. Variety of TBS groups to choose from. A variety of therapists when needed.
3. Seems lately it's all about the money.
4. I think MFS does the best it can with what it has for resources for consumers. MFS always wants to provide more and grow for the consumer.
5. In children's services there are many needed treatment modalities available and every effort is made to work through the child's interests and strengths to help in their overall adaptive functioning.
6. Many more services offered in Keene that clients often don't have transportation to from other areas. Limited staff to expand programming.
7. N/A
8. I think we try, but some consumers prefer to have only psychiatric services and not the entire case management "package." Currently, this request is not honored.
9. I am a new employee and do not have examples
10. Our agency tries to do this but with state funding issues I think mental health care is becoming more about what's a billable service and less about what the needs of the mentally ill. Managed care does not equal quality care.
11. If not then what are we here for?
12. Always.
13. N/A
14. They seem more based on what the payers and the State insist upon (and this is truly problematic at times).
15. Lots of interest in kids anger management program but none for years. Adult anger program disbanded after great work.
16. Over the last year consumers are given many choices to meet their needs and interests.

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>
53/89	25/89	3/89	8/89
60%	28%	3%	9%

1. Consumer complaints and compliments are quickly addressed and acknowledged.
2. This isn't related to my job area, so I don't know.
3. Usually via very strong team effort – getting legal aid involved to prevent eviction.
4. We've been asking for an automatic door (handicap accessible) for years – sometimes the request depends on who it comes from.
5. I have seen some clients become homeless or in abusive situations with family members – I know of one client who was being abused by her sister (both adults) several complaints were filed and it did not get better. One client became homeless due to her symptoms and we did not or could not do anything.

6. The agency has been supportive of staff’s innovative ideas and consumer interest/needs.
7. We are given time during supervision and staff meetings to express.
8. Co-workers responsive – limited response from upper management for past 1-1/2 years. Adult programming and access to resources has been challenging for past 1-1/2 years. Many staff changes.
9. N/A
10. I have often advocated for consumer choice and autonomy, even when other providers seem inclined to be more didactic, shall we say. My requests are usually honored, but I have had to advocate for elders who want to keep driving, for example, or remain in their homes.
11. We are a working team; if I need referrals for services I’m unsure of, I have many options from other staff.
12. Consumer needs are often brought to treatment teams where staff is able to collaborate and respond to needs very effectively.
13. MFS tries hard as an agency to help all families in every way possible – not always possible with funding crisis.
14. Expansion of services to support independent living. Mileage reimbursement for care providers.
15. Consumer/family concerns are taken seriously. If they can’t be addressed by the direct providers, supervisors and managers make themselves available.
16. Whatever it takes to help.
17. N/A
18. N/A
19. Agency inhibited by lack of money, rigid policies set by State and payers, lack of support personnel to assist me in doing what I should/could do for consumers without these “barriers.”
20. Yes, within budgetary/energy/personnel possibilities. Sometimes there’s just not enough of all these resources.
21. My immediate supervisors and coworkers are always responsive to consumer needs. When requests come up there is always a discussion among the team about it.

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>
30/89	42/89	7/89	10/89
34%	47%	8%	11%

1. Don’t know.
2. Less funding = less staff = less services.
3. State agencies and insurance carriers have drastically cut payments. Our management has done a stellar job of responding and adjusting to those cuts while minimizing impact on services or care quality.
4. There is one person to help with an issue such as Medicaid/housing so that person has to be available. There used to be several.
5. Staffing levels have decreased to the point of new clients not being seen for intakes for several weeks. Emergency evals often end with the recommendation to contact another agency or private therapist, as opposed to waiting several weeks to be seen at MFS. The worst part of restrictions of service due to funding is that of psychiatric services. Up until the past few years, all new clients would be assigned a psychiatrist after they were established with a therapist or other MFS provider. Now, only certifiable clients get a psychiatrist, usually weeks after their intake appointment (which itself is weeks out). Local PCPs are

forced to prescribe “psyche” meds due to lack of psychiatric services in this area. Anti-depressants are one thing – bipolar or psychosis-type meds are another, far beyond what most PCPs feel comfortable prescribing.

6. We are understaffed with regards to case management, without whom Questions 3, 4 & 5 would not be nearly as good, and client base is growing.
7. Not enough money = fewer programs and staff to run them.
8. It is impossible to offer all that our consumers need and want under the current budget.
9. We are able to help most children and families, but I understand that services for adults who do not need RSS has been very limited and clients have not been seen in a timely manner due to budget cuts.
10. Parents access to individual counseling.
11. Many clients and their families would benefit from FSS and TCM services – however, their insurance doesn’t cover it.
12. The amount of money that we can spend to assist clients with needs that they can’t meet is limited.
13. Funding challenges has caused numerous staff cuts and changes in roles, which have caused long wait lists for seeing therapist and psychiatrists.
14. N/A
15. An intake clinician recently told me that 2 people who applied for RSS services (“SMI/SPMI”) were denied eligibility because we only have one psychiatrist in the program. I HOPE this isn’t true.....
16. Everyone’s workload has increased due to staff cutbacks – this impacts service. Programs are out, etc.
17. Staff responsibilities are beyond the scope of the staff position (additional hours must be given to accomplish basic work). Less staff = less ability to respond to client needs.
18. Some people with no insurance can’t afford to pay the fees even reduced. People can’t always get to where a service is offered.
19. Referrals and follow-ups are often limited due to need to increase billable face-to-face hours.
20. We are not able to hire more staff in areas that do not always generate fee for service income, even if there is great client need.
21. When MFS began to experience financial hardship, I became aware of individuals who would like to use the services of Onancock Adult Day Program and/or use them more but couldn’t due to lack of resources.
22. Children can get services, but services for their parents is often limited.
23. Many unemployed, no money, etc., but unable to qualify for Medicaid. Trouble paying for services, even at reduced rate.
24. Not all insurance covers all needed services. Medicaid managed care may radically change the availability of the range of services for some so this may be an increasing issue.
25. Lack for natural supports.
26. N/A
27. Bad and getting worse. Inadequate record keeping system (computers and software programs poor). Time wasted for lack of support personnel to do the functions of support personnel. Unable to retain staff. Huge turnover.
28. We eliminated our IOU program 2 years ago – many other program cuts.
29. Conditions.
30. Staff turnover – vacancies because of pay – need for production often causes client needing more with not enough staff.
31. Occasionally, third party insurance caps services and we have to stop seeing clients that legitimately require more. But, honestly not that often.
32. The message to employees has always been to provide services first and secondly how to fund.

- 33. Preventative childcare funds are restricted which are a part of our treatment plans.
- 34. Effects of federal, state and United Way funding is impacted by economy. MFS is making great efforts to offset any impact.
- 35. N/A
- 36. I find in the area of prevention this tends to be more of a problem for consumers. Less so in the area of treatment.

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

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
40/89	35/89	9/89	5/89
45%	39%	10%	6%

a. Are your supervisors accessible to you?

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
67/89	12/89	7/89	3/89
75%	13%	8%	3%

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>
65/89	20/89	2/89	2/89
73%	22%	2%	2%

a. Are your supervisors accessible to you?

- 1. Supervisors also interested in innovative ideas.
- 2. Always.
- 3. Direct supervisors.
- 4. Supervisors – yes. Upper management – less so.
- 5. Direct supervision of lower level managers has been poor. Direct supervision of line staff in children's has continued over the past year with the same frequency and access. That may shift in the future as changes occur in the agency and the focus shifts to greater direct services hours and less training/supervision hours.
- 6. Have for the past year and previous to that, often.

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

- 1. I can access my manager anytime via phone or email.
- 2. Always in meetings – difficult to track down, but sometimes helpful.
- 3. Always. Psychiatrists on children's team are also accessible. The CEO and COO and medical director sometimes attend our team meetings.
- 4. Under newer managers (1-1/2 years) – very seldom accessible. Supervision for middle managers is often cancelled, not consistent.
- 5. I am presently working under the best supervisor I have ever had in many years at this agency and I am EXTREMELY grateful.
- 6. My supervisor is one of my mentors. I have learned a great deal and feel highly valued as an employee due to her efforts.

7. The flow of information has reduced as has opportunity for discussion.
8. Even when available/attentive; they don't have the authority/funding or vision to make changes.
9. I used to have great access to my supervisor. Now that our new incoming CEO is taking over, this has totally dissolved. I don't even see her at work, let alone have any contact with her. I am very concerned about the agency's survival under this new leadership as people are resigning – even our medical director – over this new “leadership.” It's a very sad day for MFS that Ken Jue is leaving and Jayme Collins is “taking over” as she shows very little interest in our consumers, particularly those in our prevention programming, at all!
10. Supportive and listen, but little changes administratively.
11. My immediate supervisor is always helpful with whatever I need.

ADDITIONAL COMMENTS

1. I feel case management staff is understaffed and under paid considering caseloads.
2. Not worth it – the State barely listens to the staff that do the difficult work with clients. It's all about the almighty dollar. MFS needs more medial providers.
3. The biggest problem, as I see it, is under-payment of staff and staff retention so that therapists (case managers) who came here will benefit from their training and stay long enough to benefit the clients. We do not have salaries adequate for individuals to live on their own. The young people live with families and often hold an extra job. The mature people do not receive a salary adequate to manage without a spouse. There needs to be more funding so that mental health professionals are paid as well as teachers, nurses, DCYF, city and county, and state employees. We are well-educated professionals, but we are grossly under paid. With over (LICSW) 20 years in the field, I am paid only \$37,000 a year. This is wrong. New employees have college loans to pay off and we cannot keep them. Clients suffer when there is frequent staff turnover.
4. MFS is made up of a wonderful group of people. In the short time I've had the privilege to be a part of this team, I have witnessed many examples of the compassion, understanding and support shown by the staff here towards, not only the clientele, but to each other as well.
5. I work in administration, not clinical.
6. MFS is very client focused to the extent that they are not employee focused. This is a very challenging environment to work for – as we are constantly getting greater demands without any compensation.
7. Past 2 years very difficult at this agency. Decrease in staff, increase in financial challenges, poor staff moral impacting both quality and availability of services for clients.
8. Clients have many more needs than we have resources to meet them.
9. Intake: Our intake process is way too lengthy, especially with referrals from other community providers. Accessibility: Although our entry has a wheelchair ramp, the main entry door is manually operated and therefore, impossible for wheelchair-bound clients, staff and visitors to open. Staff are rarely available to assist. Another building has an elevator which is too small to accommodate a wheelchair. Offices are on the 2nd and 3rd floors. Parking: Although we have a few handicapped parking spaces, parking is not well managed to promote clients' needs. Not everyone who has a mobility impairment has a handicapped plate or hanging tag.
10. The constant changes in management and leadership at MFS are disruptive to direct service providers and client services. It translates into inconsistent program implementation and staff training/performance.

11. Services are suffering due to under funding! When will NH “get it?” If we do not take care of our families/clients (or partially take care of clients) all of us are affected. Domestic violence, drugs, alcohol are rampant and NH turns a blind eye to all NH residents!
12. For the most part, MFS is a very caring place to work. They try to be fair to all. As with any place, there are things that frustrate people or that you disagree on.
13. Information technology and the inconsistent connectivity to the network needs to be upgraded. As it is, staff cannot do their work, affecting productivity. While responsive, no action has been taken to resolve.
14. MFS doubles and triples people’s jobs in order to save money and this leaves supervisors less accessible, i.e., X supervises and takes care of TCM coordination and is in Concord several times a month. This over extends time, making efforts the best possible, but not truly thorough. Not X’s fault, agency’s for piling on too much.
15. Funding cuts and financial pressures impact ability to be responsive to need of children and their families. Non-reimbursement for no-show clients forces termination of least organized, most-in-need families.
16. It seems to be that everyone is really busy all the time. I feel as though the case managers are in meetings all the time and dealing with family crisis so much they ignore the rest of their caseload. Not all case managers manage their time in this fashion, however, the less experienced ones need more training.
17. I am proud to be part of the team at MFS. I feel we are moving forward to provide the services and supports needed to help individuals with their recovery.
18. It would be useful to know how we compare to other MHCs in NH; and to learn the outcome/purpose to which these inquiries are put! Can you provide US feedback?
19. The amount of work is simply beyond what’s feasible to accomplish in the hours given – unreasonable expectations of employees. Duplicate/unnecessary documentation, ineffective communication and between ‘systems.” Staff health is undermined due to stress – self-defeating and unjust to ask personnel to compromise their well being while “promoting client’s.”
28. Little positive feedback – runs on threats.

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

REQUIREMENT: He-M 403.07 (a) (1) and (b) 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; and a review of the Office of Inspector General's List of Excluded Individuals/Entities for each newly hired and re-hired staff member.

OBSERVATION IV-A:

There are no policies for what is included in a job description and the review of the Office of Inspector General's List of Excluded Individuals/Entities for each newly hired and re-hired staff member that has been approved by the BOD or their designee.

RECOMMENDATIONS IV-A:

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

CMHP RESPONSE IV-A:

OBSERVATION IV-B:

There were many financial policies the agency has adopted which strengthen the internal controls of the agency.

RECOMMENDATIONS IV-B:

All policies, including financial, should be consolidated in one policy manual. The agency should consider developing the following written policies for:

- Seeking written proposals for services, property or major purchases.
- The use and accountability of credit cards including the supervising of any ED's expense by the Board.

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

OBSERVATION V-A:

During FY09, MFS's Accounts Receivable older than 360 days has increased. During FY08 this amount was \$99,000 and at the end of FY09 this amount increased to \$186,000.

The overall days in accounts receivable was 71 in FY09. Since one day equates to \$20,047, lowering the days to 40 would generate approximately \$600,000.

RECOMMENDATIONS V-A:

MFS is encouraged to monitor continued growth in Accounts Receivable older than 360 days.

Any receivables deemed uncollectible should be written off.

A plan should be developed to lower the overall days in receivables.

CMHP RESPONSE V-A:

OBSERVATION V- B:

MFS has shown wide variability in revenues showing remarkable growth in some years and remarkable declines in other years. Surpluses and deficits have been a function of changes in revenues. MFS is aware of this situation and is implementing corrective action.

See table below:

Analysis of CMHC Revenue Trends (Five Year Trends)							
REGION/ CMHC		2005	2006	2007	2008	2009	5YR Totals
V.	Monadnock (Includes Foundation)	\$9,307,209	\$9,653,376	\$11,999,560	\$10,057,388	\$9,495,302	\$50,512,835
	<i>Pct Change</i>	1.4%	3.7%	24.3%	-16.2%	-5.6%	1.5%
A.		\$6,196,366	\$7,134,664	\$7,639,067	\$8,181,486	\$8,899,874	\$38,051,457
	<i>Pct Change</i>	7.1%	15.1%	7.1%	7.1%	8.8%	9.0%
B.		\$10,335,889	\$11,145,564	\$12,210,018	\$13,281,307	\$14,570,245	\$61,543,023
	<i>Pct Change</i>	8.1%	7.8%	9.6%	8.8%	9.7%	8.8%
C.		\$6,612,613	\$7,143,307	\$8,435,057	\$7,657,669	\$7,795,874	\$37,644,520
	<i>Pct Change</i>	-1.6%	8.0%	18.1%	-9.2%	1.8%	3.4%
D.		\$8,308,780	\$8,843,022	\$10,112,852	\$9,675,549	\$9,801,034	\$46,741,237
	<i>Pct Change</i>	0.0%	6.4%	14.4%	-4.3%	1.3%	3.6%
E.		\$20,824,816	\$20,178,146	\$19,100,709	\$19,247,802	\$20,546,354	\$99,897,827
	<i>Pct Change</i>	5.1%	-3.1%	-5.3%	0.8%	6.7%	0.8%
F.		\$9,560,589	\$9,364,833	\$9,611,928	\$10,094,490	\$10,469,539	\$49,101,379
	<i>Pct Change</i>	2.9%	-2.0%	2.6%	5.0%	3.7%	2.4%
G.		\$10,654,052	\$11,193,462	\$11,589,791	\$11,426,909	\$11,520,135	\$56,384,349
	<i>Pct Change</i>	1.3%	5.1%	3.5%	-1.4%	0.8%	1.9%
H.		\$6,858,906	\$7,555,420	\$8,303,781	\$9,234,272	\$10,467,694	\$42,420,073
	<i>Pct Change</i>	1.6%	10.2%	9.9%	11.2%	13.4%	9.2%
I.		\$6,686,143	\$6,446,697	\$7,210,732	\$7,585,832	\$8,142,250	\$36,071,654
	<i>Pct Change</i>	-6.4%	-3.6%	11.9%	5.2%	7.3%	2.9%
J.		\$16,522,366	\$17,823,765	\$18,378,729	\$17,549,333	\$18,082,943	\$88,357,136
	<i>Pct Change</i>	-2.5%	7.9%	3.1%	-4.5%	3.0%	1.4%
TOTALS		\$111,867,729	\$116,482,256	\$124,592,224	\$123,992,037	\$129,791,244	\$606,725,490
	<i>Pct Change</i>	1.7%	4.1%	7.0%	-0.5%	4.7%	3.4%

RECOMMENDATION V- B:

It is recommended that the agency continue to grow its revenue.

CMHP RESPONSE V-B:

OBSERVATION V-C:

BBH compiles an annual report for the CMHPs that include 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' Expenses in Cash ratio in FY09, MFS ranked seventh out of the ten CMHPs and sixth out of ten when averaging the last five years for this indicator.

See table below:

Comparative Analysis of CMHC Liquidity								
Five Year Trends and Highlights								
(2005-2009)								
REGION		Days Expenses In Cash						Avg.
		Fiscal Year						
		2004	2005	2006	2007	2008	2009	
	Agency A	43	57	76	83	36	56	62
	Agency B	24	46	49	56	71	81	61
	Agency C	39	35	58	62	16	49	44
	Agency D	26	18	14	31	38	43	29
	Agency E	19	16	13	27	17	46	24
V.	Monadnock (Includes Foundation)	17	19	10	18	13	12	14
	Agency F	12	14	10	15	13	9	12
	Agency G	19	6	10	3	13	18	10
	Agency H	13	13	3	11	4	8	8
	Agency I	14	10	3	5	9	5	6
	Agency J	25	11	4	7	4	2	5
	TOTAL	23	22	23	29	21	30	25

RECOMMENDATION V-C:

In the event that the budgeted revenues earned are not received in a timely manner, the days of expenses in cash are vital to pay the day-to-day operational expenses. Therefore, it is recommended that MFS develop a corrective action plan designed to improve this outcome.

CMHP RESPONSE VI-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 regard internal CMHP quality improvement and compliance activities.

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

REQUIREMENT: BBH Contract Exhibit A Scope of Work K. The contractor agrees that it will perform, or cooperate with the performance of, such quality improvement and or utilization review activities as are determined to be necessary and appropriate by BBH within timeframes specified by BBH.

OBSERVATIONS VI-A:

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

For FY08 a total of 684 claims were reviewed of which 74 had inadequate documentation resulting in possible payback. These errors constitute 10.8% of the total number of claims reviewed. Services provided without a current ISP comprise 34% of all errors.

For FY09 a total of 642 claims were reviewed of which 92 had inadequate documentation resulting in possible payback. These errors constitute 14.3% of the total amount of claims reviewed. Services provided but not ordered on the ISP or elsewhere by a physician comprise 41% of all errors. This may indicate a significant weakness in internal monitoring.

In addition, payback will be necessary for the seven claims where each service note documents two distinct services. There must be documentation meeting all the requirements of He-M 408 and the NH Medicaid State Plan for each service provided. MFS is responsible for determining which service is appropriately documented in the seven progress notes and repaying the remaining seven claims.

RECOMMENDATION VI-A:

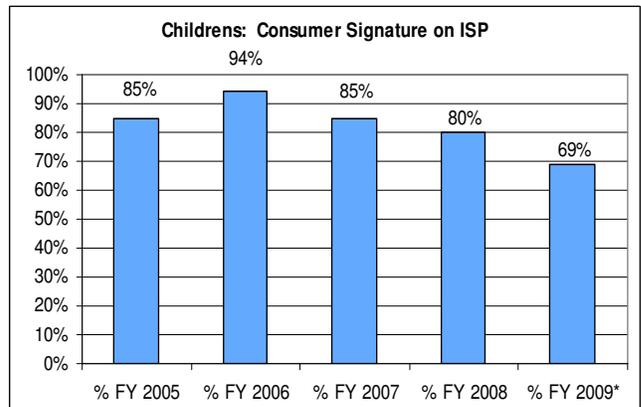
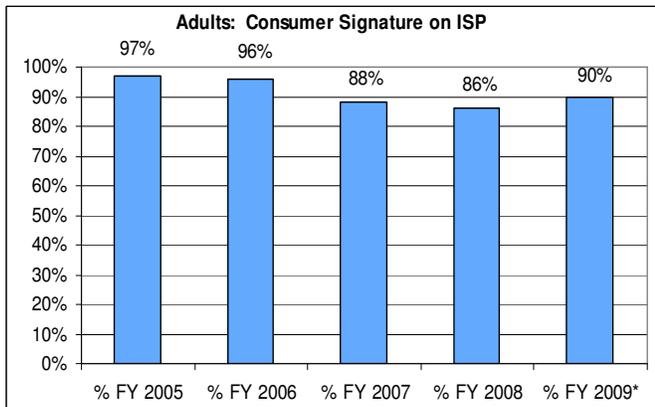
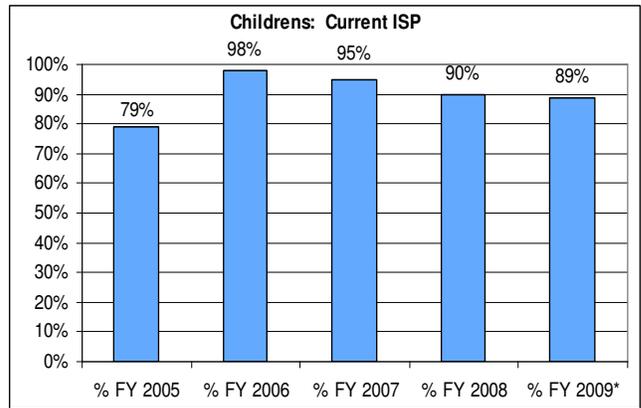
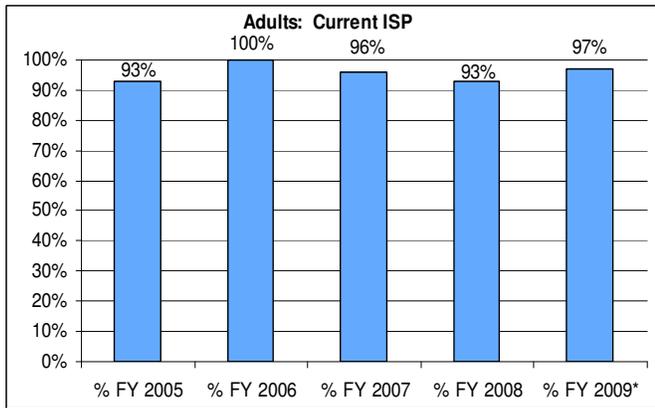
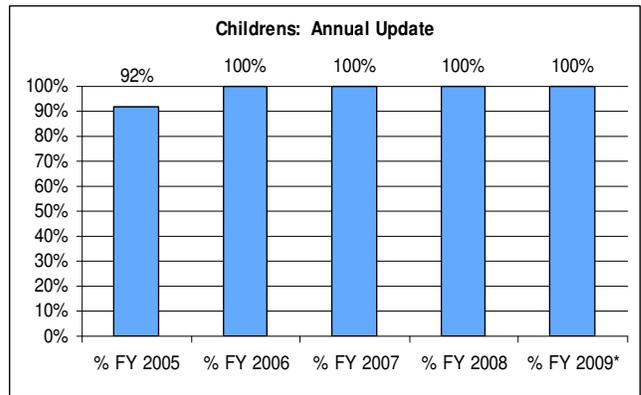
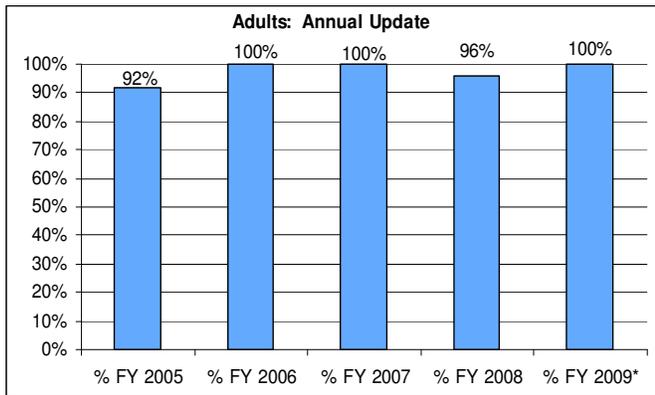
It is recommended that MFS devise a corrective action plan to ensure that all services are documented in the clinical record prior to billing.

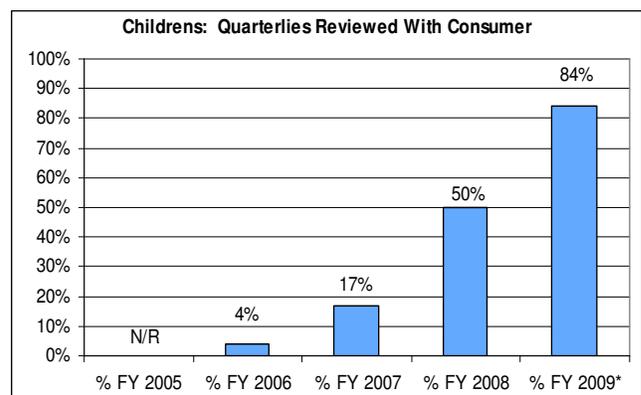
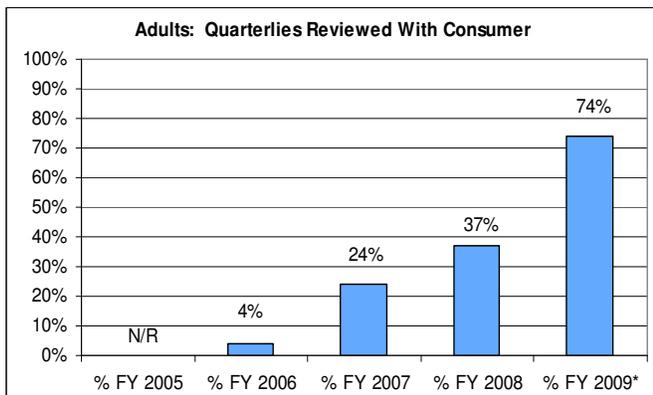
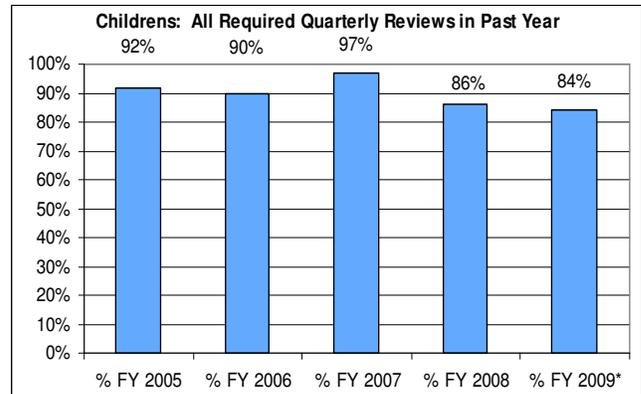
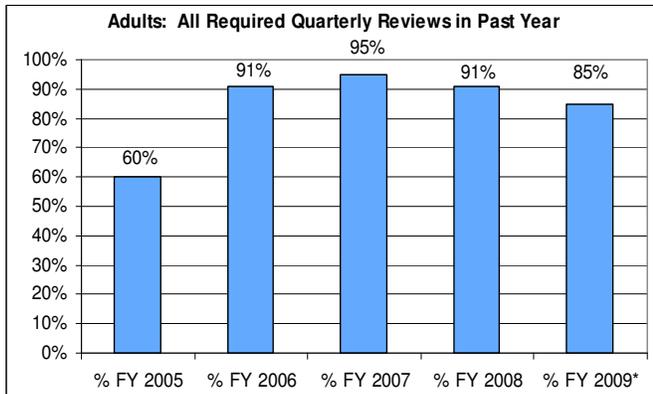
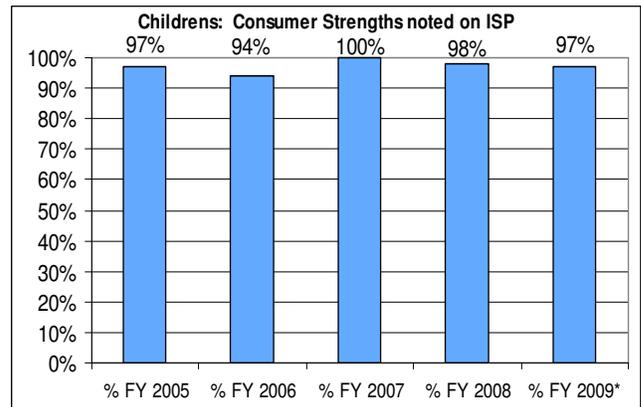
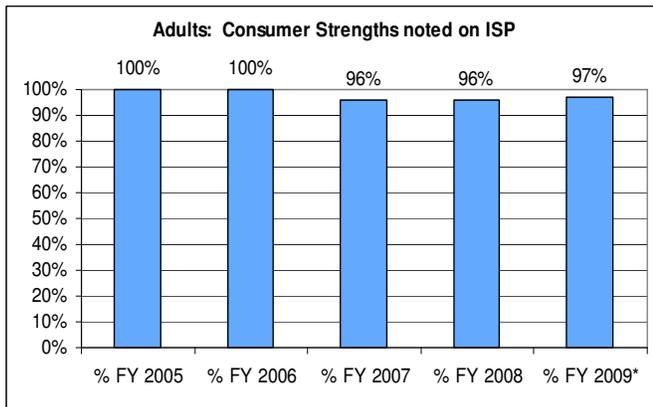
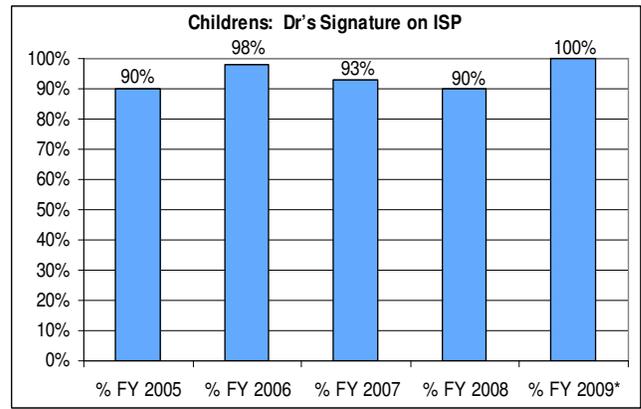
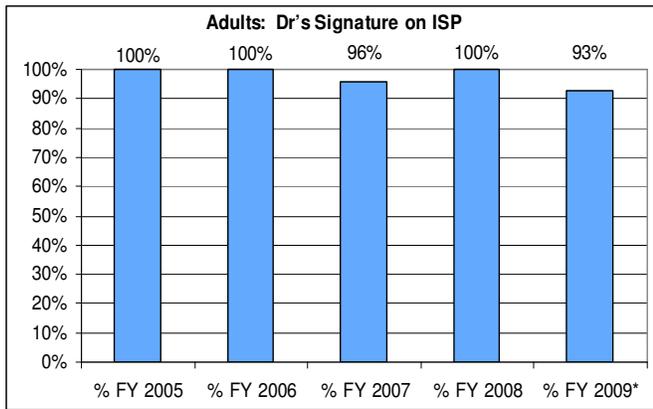
The agency should devise a corrective action plan to ensure that all billings reimbursed by Medicaid have a current ISP.

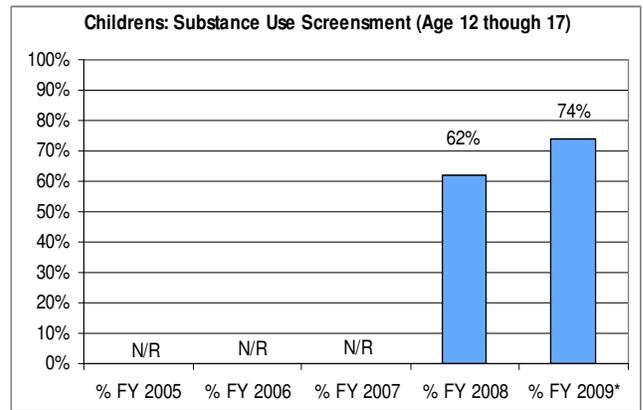
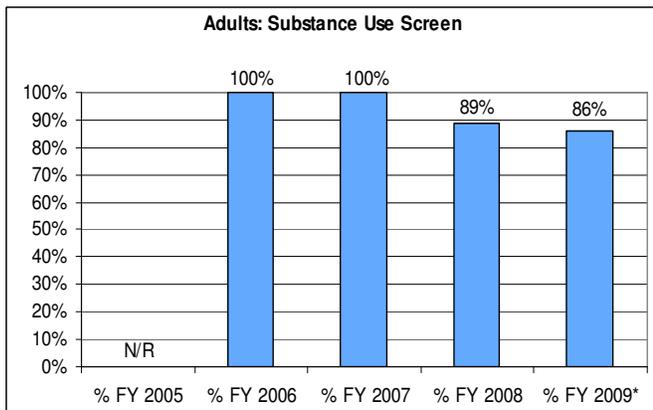
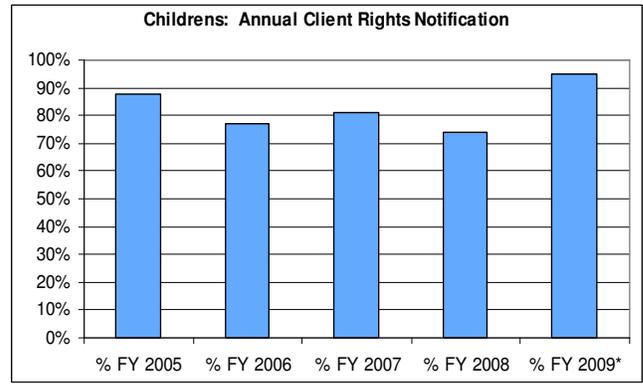
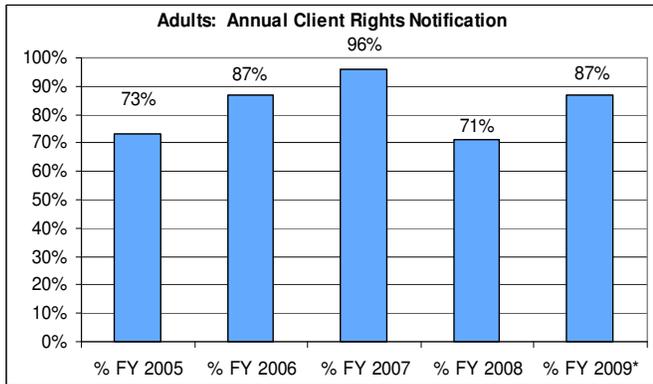
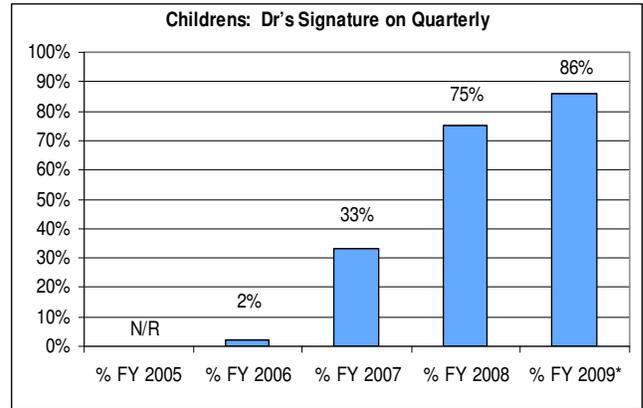
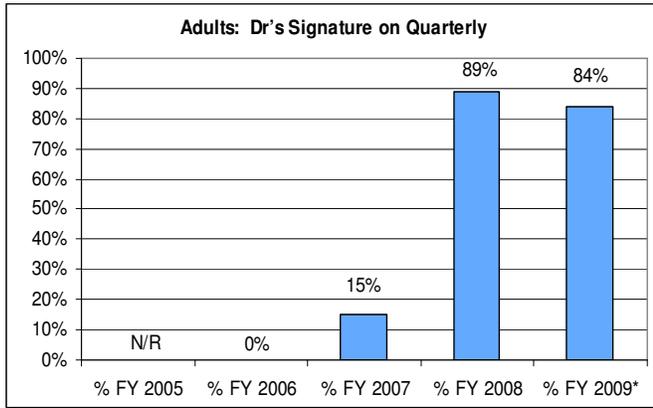
The agency should devise a corrective action plan to ensure that all billings reimbursed by Medicaid are included in the client’s ISP or added on the client’s quarterly review prior to the services being rendered.

CMHP RESPONSE VI-A:

OBSERVATION VI-B: Five-year trend data from the annual BBH quality improvement and compliance reviews has been included as an overview of the MFS level of compliance with clinical record standards. The charts below reflect some of the clinical record requirements and MFS 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-B:

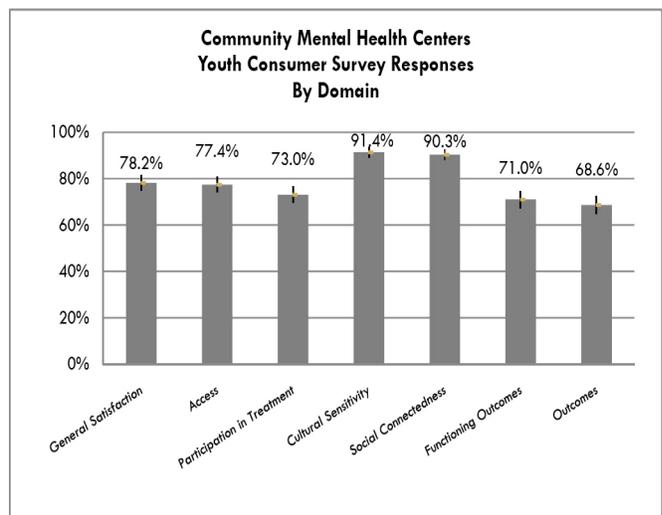
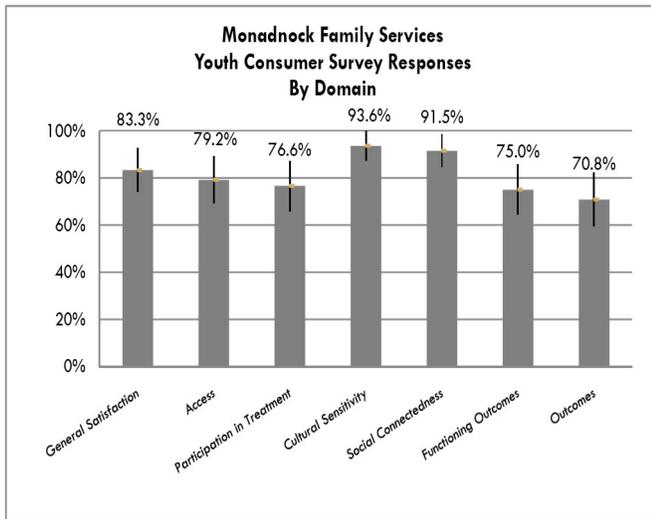
It is recommended that the BBH QI and Compliance Reports be shared with the BOD and utilized in planning activities. It is also recommended that MFS continue to conduct and document internal quality improvement and compliance activities.

CMHP RESPONSE VI-B:

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 MFS 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.



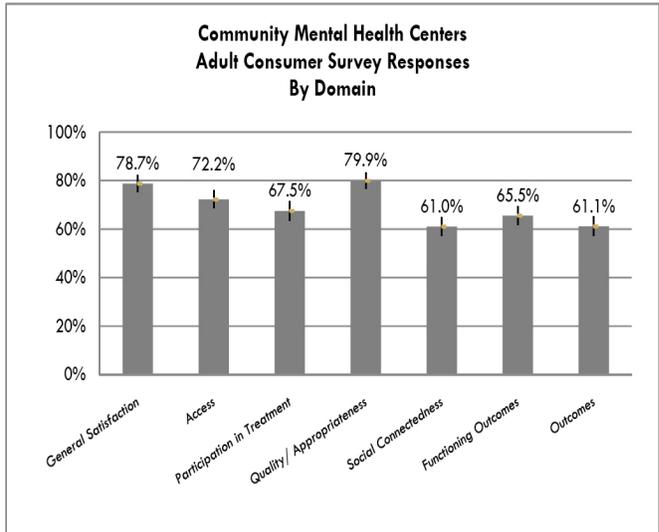
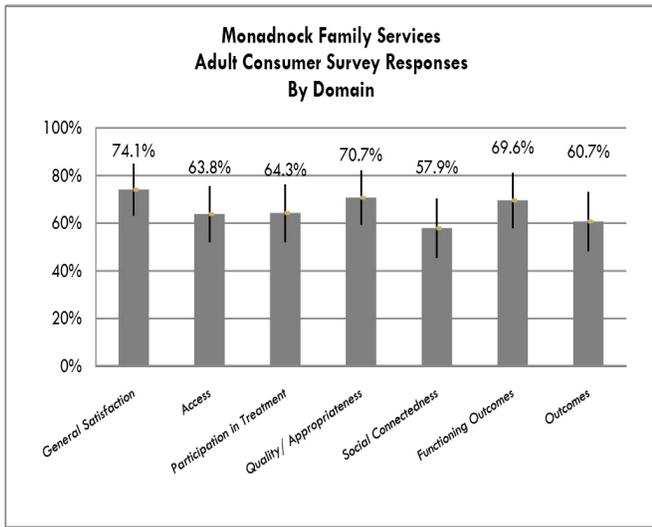
OBSERVATION VII-A:

It is noted that MFS percentages ranked **above** the statewide average in all of the following Youth Survey domains:

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:



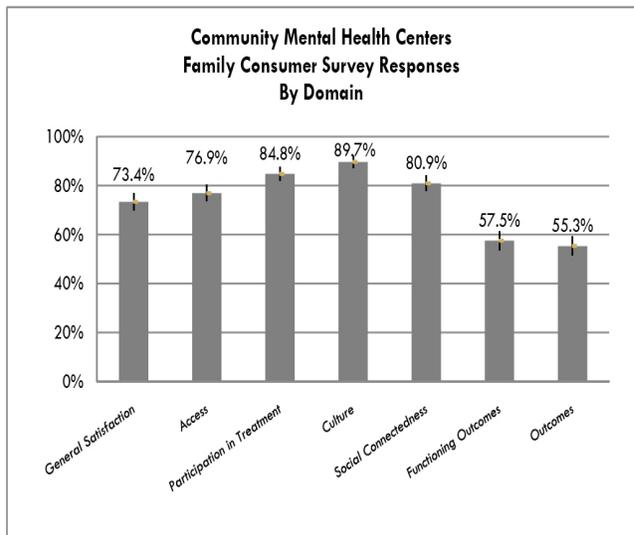
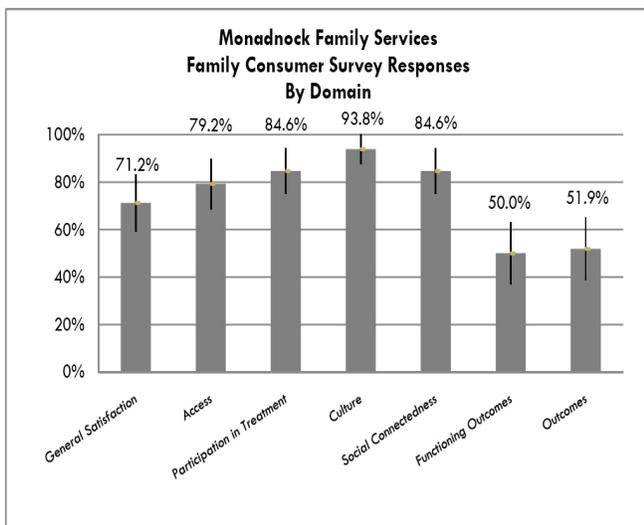
OBSERVATION VII-B:

It is noted that MFS percentages ranked below the statewide average in the following Adult Survey domains: General Satisfaction; Participation in Treatment; Quality/Appropriateness; Access; Social Connectedness; and Outcomes.

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 MFS percentages ranked below the statewide average in the following Family Survey domains: General Satisfaction; Participation in Treatment; Functioning Outcomes; and Outcomes.

RECOMMENDATIONS VII-C:

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

CMHP RESPONSE VII-C:

END OF REPORT