State Health Authority Yardstick
(SHAY)
Report for New Hampshire Bureau of Behavioral Health
Evidence-Based Supported Employment
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Introduction

The State Health Authority Yardstick (SHAY) was designed by a group of mental health researchers and implementers who were interested in assessing the facilitating conditions for the adoption of Evidence-Based Practices (EBPs) created by the state's (mental) health authority.

The reviewers of this report spent two days completing a series of interviews with a variety of stakeholders in the New Hampshire Bureau of Behavioral Health system as well as reading and reviewing relevant documentation that was provided to them. The interviews included the following participants: Erik Riera, Administrator for the Bureau of Behavioral Health (BBH), Mary Brunette, MD, BBH Medical Director, Mike Cohen, NAMI NH Executive Director, Robin Raycraft-Flynn, Administrator for the Community Mental Health Program Unit at BBH, Lisa Hatz, NH Vocational Rehabilitation Field Supervisor, Lee Ustinich, State Planner, Kelley Capuchino, Senior Medicaid Policy Analyst, Heidi Johnson, Program Planning and Review Specialist, Marty Fuller, Director for the Office of Consumer and Family Affairs, ten CEOs from the CMHCs in the state, nine Community Support Program Directors from the CMHCs, a group of SE team leaders from the CMHCs, two former state-wide SE trainers/consultants and two current SE trainer/consultants for the state.

The reviewers are grateful for the courtesy, professionalism and thoughtful responses they received from all participants in the interview process. The reviewers also appreciate the openness demonstrated by the leadership of the NH Bureau of Behavioral Health (NH BBH), both in agreeing to have this assessment completed and in their willingness to distribute and utilize this information to further support the implementation of SE in the NH BBH system.

The SHAY is a tool for assessing the state health authority responsible for mental health policy in a given state. For the purposes of this assessment in New Hampshire, the New Hampshire Bureau of Behavioral Health has been identified as the "State Health Authority." We recognize that BBH is a unit within a larger governmental agency and as such functions within that structure. Therefore, to some degree, identifying BBH as the state health authority is artificial. Nonetheless, we believe that choosing BBH as the focus is the proper choice.

Findings

Based on the information gathered, the reviewers assessed each category of the SHAY as follows.

1. EBP Plan

The SMHA has an EBP plan to address the following: (Use boxes to identify which components are included in the plan) *Note: The plan does not have to be a written document, or if written, does not have to be distinct document, but could be part of the state's overall strategic plan. However if not written the plan must be common knowledge among state employees, e.g. if several different staff are asked, they are able to communicate the plan clearly and consistently.*	
Absent	**1) A defined scope for initial and future implementation efforts,** The New Hampshire Bureau of Behavioral Health (BBH) committed to the implementation of Supported Employment (SE) in February 2006, and a state-wide kick-off was held in Concord in March 2006. It seemed clear that all stakeholders were aware of the planned scope for implementation (across all of the existing Community Mental Health Centers (CMHCs)). However, since there is much less certainty around the current or future implementation plans for SE, it is difficult to say that BBH has a current SE implementation plan in place. Many interviewees identified staff-turnover as one of the biggest barriers to moving SE forward in the state. As one interviewee stated, "employment specialists are seen as entry level positions, lower than case managers," and that ESs often leave their jobs as soon as other opportunities present themselves within the agency. Given this trend, implementation efforts around SE should not be viewed as a "one time" event – ongoing training and technical assistance needs to be provided by BBH to new staff at all levels of CMHC organizations and CMHCs need to take advantage of these trainings in order to sustain SE practices. Currently, it appears that implementation efforts by the state are limited to monitoring SE via fidelity and do not include assisting with it through the utilization of training resources.
Absent	2) **Strategy for outreach, education, and consensus building among providers and other stakeholders**, Perhaps the strongest theme that emerged from interviews was one of ineffective communication around the state's SE initiative both within and between various stakeholder groups. The focus on fidelity reviews is the most

	consistent communication that occurs regarding SE. This has resulted in a great deal of misunderstanding, animosity and lack of consensus on a shared view of the importance of SE for the system, especially between BBH and CMHCs. It was reported that there had been a state-wide Evidence Based Practices (EBP) Steering Committee that was formed primarily around IMR implementation, however it is unclear as to why this steering committee disbanded shortly after the SE implementation began.
Present	**3) Identification of partners and community champions,** Interviewees identified various partners and stakeholders that BBH has developed relationships with to support the implementation of SE around the state, including NH National Alliance on Mental Illness (NAMI), the Dartmouth Psychiatric Research Center (PRC), and the bureau of NH Vocational Rehabilitation (VR). While some initial work was done with these partners, it appears that these relationships are not currently being maximized by BBH in order to move NH's SE initiative forward. Additionally, it is not clear that any new partnerships are being developed or utilized to move SE forward, including partnerships with critical groups such as consumers.
Absent	**4) Sources of funding,** As detailed later in this report, unlike IMR (Illness Management and Recovery) implementation, there has been no additional funding for CMHCs to implement SE. In terms of current funding for the practice, what has been provided by BBH is a definition of where and how to bill for SE under existing Medicaid funds and billing structures, such as Functional Support Services (FSS), as opposed to creating a new billing mechanism or allocating new funding specifically for the practice.
Present	**5) Training resources,** In September 07 BBH drafted a contract with the Dartmouth PRC to provide training and consultation to NH CMHCs for both IMR and SE through 2009. More detail on this agreement will follow in SHAY items #4 and #6.
Absent	6) **Identification of policy and regulatory levers to support EBP**,

	Many respondents pointed to the Memorandum of Understanding (MOU) that is attached to the CMHC contracts with BBH as a mechanism to support SE. Upon further analysis of the MOU, however, the reviewers discovered that there is actually no specific mention of Supported Employment – it merely states, "25% of adult consumers shall be competitively employed at the time of the survey for fiscal year 2008 and a target of 25% for fiscal year 2009". It is noted that fidelity assessments were mandated by BBH to support implementation efforts for all EBPs. However, while reviewers found language regarding performance on IMR fidelity assessments, similar language for performance on SE fidelity did not exist. Though the MOU is a beginning, it neither strengthens nor enhances the implementation of SE. In fact, the MOU seems to cause confusion and resentment as it does not focus on performance, only on fidelity.
Present	7) **Role of other state agencies in supporting and/or implementing the EBP**, BBH has an interagency agreement with the NH Bureau of Vocational Rehabilitation, concerning supported employment. This agreement focuses on the definition of competitive employment and discusses shared responsibilities and decision making around policies related to EBSE. BBH is to be commended for developing a pilot project with VR at one of the CMHCs in the state in order to promote a braided funding stream for SE services.
Absent	**8) Defines how EBP interfaces with other SMHA priorities and supports SMHA mission** Almost all interviewees were asked what they believed the top three priorities of BBH to be. While some individuals within BBH listed the implementation of EBPs as a priority, very few of the stakeholders and partners outside of BBH saw it as such. The priority of "survival" and crisis management around keeping CMHCs up and running was heard over and over again. Several individuals mentioned the DHHS 10 year plan, published in August 2008, as a key BBH priority. Unfortunately, this plan makes no mention of Supported Employment or other EBPs aside from the goal of developing Assertive Community Treatment teams.

	Other respondents felt that BBH has not clearly outlined its goals, let alone the place of EBPs within these priorities. One interviewee stated, "I hear no priorities for BBH—it seems much more like a game of 'whack-a-mole'."
Absent	**9) Evaluation for implementation and outcomes of the EBP** While SE implementation efforts are measured at the CMHC level, via yearly fidelity assessments, there is a startling absence of collection of valid competitive employment outcome data related to SE.
Absent	**10) The plan is a written document, endorsed by the SMHA** As mentioned above, the only written plan related to BBH priorities is the more general DHHS 10 year plan, and that plan makes no mention of supported employment.

Score

	1. No planning activities
X	2. 1 – 3 components of planning
	3. 4 – 6 components of planning
	4. 7 – 9 components
	5. 10 components

2. Financing: Adequacy

Is the funding model for the EBP adequate to cover costs, including direct service, supervision, and reasonable overhead? Are all EBP sites funded at the same level? Do sites have adequate funding so that practice pays for itself?
Note: Consider all sources of funding for the EBP that apply (Medicaid fee-for-service, Medicaid waiver, insurance, special grant

funds, vocational rehabilitation funds, department of education funds, etc.) Adequate funding (score of 4 or 5) would mean that the practice pays for itself; all components of the practice financed adequately, or funding of covered components is sufficient to compensate for non-covered components (e.g. Medicaid reimbursement for covered supported employment services compensates for non-covered on inadequately covered services, e.g. job development in absence of consumer). Sources: state operations and budget, site program managers. If financing is variable among sites, estimate average.

Score:

	1. No components of services are reimbursable
	2. Some costs are covered
	3. Most costs are covered
This Level	**4. Service pays for itself (e.g. all costs covered adequately, or finding of covered components compensates for non-covered components)** It is imperative to assess adequate funding within the overall context of the NH BBH system and associated funding challenges. There were vastly contrasting opinions on the financial viability of providing supported employment in the state. It was explained to reviewers that SE services are currently billed under Medicaid as Functional Support Services (FSS). This rate, when used, funds SE services at $104.00 per hour. Funding from vocational rehabilitation can occur one of two ways – either an upfront reimbursement of $550.00 per consumer for resume building, job development and placement, or a reimbursement of $38.00 per hour for job coaching up to ten hours a month that can be authorized by VR for each individual. Compared to implementation of IMR, there has been little to no additional funding associated with SE, only higher expectations of fidelity and staffing. For some CMHCs, transitioning from traditional step-wise vocational programming to SE can be financially difficult. Additionally, communication, assistance and support regarding financial assistance from BBH could be helpful for providers. There was a great deal of concern raised by providers around the adequacy of funding for SE. While several agency CEOs stated they felt there was basically no funding to provide SE, other community stakeholders focused on the inability of Employment Specialists (ES) to bill for job development activities under the Medicaid FSS code.

	As one SE team leader stated, "The biggest elephant in the room is job development. We can not achieve the SE model without a penny of funding for it." While some providers stated that they eat the cost of conducting job development, others stated that they simply can not allow it to occur. There was also concern about the lost productivity of staff in preparation for and during fidelity assessments that was not adequately taken into consideration by current funding mechanisms. Another SE leader stated, "it's like EBSE gives you the pathway to success for your clients yet you have to cut corners because of the reality of productivity". Based on the experiences of the reviewers with other states, and without adjusting for local economic factors, reimbursement rates seem sufficient to cover the costs of providing SE services and compensate for the cost of those services that are nonbillable – namely job development. This view was supported by providers themselves. As one interviewee stated, "If you are comfortable with cost neutral than SE works." Indeed, CHMC leaders thought that the idea that employment specialists don't pay for themselves is a myth perpetuated by many CEOs. During their interview with the reviewers they stated that they "need CEOs to know the importance of SE and that ES positions are cost neutral." In addition to the experience of the reviewers in other states, and the viewpoint expressed by providers, there appears to be empirical evidence of the financial viability of SE in the state. This is evidenced by the successful implementation and sustaining of SE programs within at least two CMHCs in the state.
	5. Service pays for itself and reimbursement rates attractive relative to competing non-EBP services. As stated above, though the funding levels appear to be solvent, the perception that SE is "nothing special" or "a flash in the pan" is perhaps a more important perceived barrier to implementation than the actual funding amount. Again, comparing to the implementation of IMR which was semi-replete with additional dollars for start-up, SE seems to run a distant second.

*3. Financi*ng: Start-Up & Conversion Costs

Are costs of start up and or conversion covered, including: 1) Lost productivity for staff training, 2) hiring staff before clients enrolled (e.g. ACT), 3) any costs associated with agency planning and meetings, 4) changing medical records if necessary, 5) computer hardware and/or software if necessary, etc. *Note: If overall fiscal model is adequate to cover start-up costs then can rate 5. If*

financing is variable among sites, estimate average. Important to verify with community EBP program leaders/ site program managers.

Score:

	1. No costs of start-up are covered
This Level	**2. Few costs are covered** Many people noted the marked difference between start-up and conversion costs offered for IMR implementation and SE implementation. Cost offsets for IMR implementation were provided through the CMS Real Systems Choice Mental Health Systems Transformation Grant. This grant provided $247,500.00 that was distributed to CMHCs based on proportion of "eligible" Community Support Program clients across the state. The IMR SHAY report from 2007 highlighted the crucial role the receipt of the CMS Real Systems Choice Mental Health Systems Transformation Grant played in financing some of the start-up and conversion costs for CMHCs regarding IMR implementation. There was no comparable funding for SE implementation provided to CMHCs, and it appears that several of the CMHCs are resentful of the state for mandating the adoption of the practice while not securing funding for sites to do this in a financially viable manner. That being said, there were no out of pocket costs to CMHCs for the initial training on Supported Employment, as this was provided by BBH through the Dartmouth PRC. Thus some of the start-up costs are being covered by the state. It is important to note the presence of a consistent and repeated theme from CMHC leadership is that there is significantly insufficient funding to responsibly implement a practice like SE.
	3. Some costs are covered
	4. Majority of costs are covered
	5. Programs are fully compensated for costs of conversion

4. Training: Ongoing consultation and technical support

Is there ongoing training, supervision and consultation for the program leader and clinical staff to support implementation of the EBP and clinical skills: (Use boxes to indicate criteria met.) *Note: If there is variability among sites, then calculate/estimate the average visits per site.*	
Present	**1) Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)** An initial didactic training on SE was provided to CMHC staff in February 2006. A one-day intensive training on SE that covered topics such as the link between employment and recovery, overview on the principles of SE, and research evidence for the practice was provided by employees of the Dartmouth PRC.
Present	**2) Initial agency consultation re. implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training)** Interviewees reported that consultation was provided with agency leadership around the initial implementation of SE. Documentation supported this assertion.
Absent	**3) Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (minimum of 3 months, e.g. monthly x 12 months)** This item is rated based upon what training and consultation is currently being provided to agencies around the state. There was evidence that regular onsite training had been provided to agencies in the past that consisted of consultation with practitioners, SE supervisors and some Program Directors. It appears that while TA was offered to all agencies, not all 10 CMHCs were interested and followed up on the consultation offers being provided through the Dartmouth PRC by the state. There was much confusion over why training had abruptly stopped at the end of last year. Documentation indicates that there had been a reduction in the staffing from Dartmouth PRC and this impacted their ability to honor the commitment to intensive levels of training and TA. Regardless of why these SE training have ended, it was clear from interviews that the result has been great frustration on the part of practitioners and supervisors at the CMHCs.
Absent	**4) On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months).**

	It is important to note that the contract between BBH and the Dartmouth PRC allows for all the kinds of training outlined in the SHAY, with the exception of on-site shadowing/field mentoring and observing of SE practices such as job development and SE team meetings. It is however, not clear that the amount of funding for this part of the contract is sufficient for the PRC to hire enough staff to meet this potential demand. It is worth noting that funding for PRC services has been reduced significantly two times since the beginning of the IMR implementation work.
Absent	**5) Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months)** Program Directors were certainly dismayed that their programs did not have more access to SE trainings, especially given that fidelity assessments are still mandatory. As one Program Director stated, fidelity assessments have come to be viewed "like more of a stick than a carrot" around SE implementation given the lack of guidance around improving services in order to improve fidelity scores.

	Score
	1. 0-1 components
X	2. 2 components
	3. 3 components
	4. 4 components
	5. 5 components

1. .**Training: Quality**

Is high quality training delivered to each site? High quality training should include the following: (Use boxes to indicate which components are in place.) *Note: If there is variation among sites calculate/estimate the average number of components of training across sites.)*	
Present	**1) credible and expert trainer,** Not only are the trainers credible, they include lead researchers for this specific body of work and are

	some of the most requested across the country. State-wide didactic trainings held in Concord utilized the knowledge and skills of SE experts Debbie Becker and David Lynde, and an additional training for SE supervisors was offered by Linda Carlson of the University of Kansas.
Present	**2) active learning strategies (e.g. role play, group work, feedback,** Those individuals involved in initial training efforts described a process of on-site TA provided to CMHCs every two to three weeks by trainers employed by the Dartmouth PRC. Trainers stated that their technical assistance focused on the specific needs and interests of the agency being visited.
Present	**3) good quality manual, e.g. SAMHSA Toolkit,** Materials presented are directly related to the SAMHSA toolkit and are actually more updated versions of that work.
Present	**4) comprehensively addresses all elements of the EBP,** Between the didactic sessions, the 1:1 agency TA and the other trainings outlined in the agreement between BBH and Dartmouth PRC—all elements were covered well with only one exception—field mentoring.
Absent	**5) modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered,** Overall, this was the only gap in all training plans the reviewers reviewed. It would benefit all involved to assist the CMHCs to view each other as resources toward solid implementation and practice—this does not occur at this time.
Present	**6) high quality teaching aides/materials including workbooks/work sheets, slides, videos, handouts, etc, e.g. SAMHSA Toolkit/ West Institute.** All information is the most up-to-date as the PRC generates (nationally) the bulk of the research and supporting materials.

Score:

☐ 1. 0 components

	2. 1 - 2 components
	3. 3 - 4 components
X	4. 5 components
	5. all 6 components of a high quality training

6. Training: Infrastructure / Sustainability

Has the state established a mechanism to allow for continuation and expansion of training activities related to this EBP, for example relationship with a university training and research center, establishing a center for excellence, establishing a learning network or learning collaborative. This mechanism should include the following components: (Use boxes to indicate which components are in place)	
Absent	**1) offers skills training in the EBP,** The reviewers scored this as a "point in time" measure. Though there are reports that skills trainings have been offered, there is no evidence that this is an on-going occurrence.
Absent	**2) offers ongoing supervision and consultation to clinicians to support implementation in new sites,** The reviewers scored this as a "point in time" measure. Though there are reports that skills trainings have been offered, there is no evidence that this is an on-going occurrence.
Absent	**3) offer ongoing consultation and training for program EBP leaders to support their role as clinical supervisors and leaders of the EBP,** The reviewers scored this as a "point in time" measure. Though there are reports that trainings for program leaders have been offered, there is no evidence that this is an on-going occurrence.
Absent	**4) build site capacity to train and supervise their own staff in the EBP,** The reviewers scored this as a "point in time" measure. Though there are reports that efforts have been made towards this in the past, there is no evidence that this is an on-going occurrence.
Absent	**5) offers technical assistance and booster trainings in existing EBP sites as needed,** The reviewers scored this as a "point in time" measure. Though there are reports that booster trainings have been offered, there is no evidence that this is an on-going occurrence.
N/A	**6) expansion plan beyond currently identified EBP sites,** Considering that SE is being implemented in all providers for BBH, this is not an issue.

Absent	**7) one or more identified model programs with documented high fidelity that offer shadowing opportunities for new programs,** Unfortunately, the BBH system is losing a great opportunity to highlight high fidelity SE programs in the state and to provide shadowing opportunities at those sites for staff at other agencies. Nothing formal in this domain is currently happening. One CMHC has established some specific training opportunities as they relate to SE. Word of mouth has created opportunity for some staff from outside CMHCs to access these trainings; however, there is a great deal that can be done to better serve the needs of all CMHCs.
Present	**8) SMHA commitment to sustain mechanism (e.g. center of excellence, university contracts) for foreseeable future, and a method for funding has been identified.** As mentioned earlier in this report, there is a contract between BBH and the Dartmouth PRC for SE training and technical assistance through June 30, 2009. As with SHAY Item #4 on Training, this item was rated by the reviewers in terms of what training was currently being provided to sites, which at this point in time is on hold. Thus no credit was given for any of the other anchors In light of the frequency of staff turnover (which is not unique to NH), it is recommended that NH BBH consider providing initial or "kick-off" trainings again for CMHC staff.

Score:

	1. No mechanism
X	2. 1 - 2 components
	3. 3 - 4 components
	4. 5 - 6 components
	5. 7 - 8 components

7. Training: Penetration

What percent of sites have been provided high quality training (score of 3 or better on question #5, see note below), and ongoing training (score of 3 or better on question #4, see note below). Note: *If both criteria are not met, does not count for penetration. Refers to designated EBP sites only.* *High quality training should include 3 or more of the following components:* *1) credible and expert trainer,* *2) active learning strategies (e.g. role play, group work, feedback,* *3) good quality manual (e.g. SAMHSA toolkit),* *4) comprehensively addresses all elements of the EBP,* *5) modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered,* *6) high quality teaching aids/ materials including workbooks/ work sheets, slides, videos, handouts, etc. e.g. SAMHSA toolkit/ West Institute.* *Ongoing training should include 3 or more of the following components:* *1) Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)* *2) Initial agency consultation re. implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training)* *3) Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (minimum of 3 months, e.g. monthly x 12 months)* *4) On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months).* 5) *Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months)*

Score:

This Level	**1. 0-20%** Clearly the NH BBH leadership is to be commended for their ambitious commitment to implement and provide Supported Employment at all ten CMHCs. Their desire to provide access to an EBP across the system speaks strongly to a commitment to universal quality service delivery. Initial training efforts were of extremely high quality and conducted in an ongoing, systematic fashion. The penetration rate for training during approximately

	the first two years of the SE initiative was nearly at 100% penetration across the state. However, currently, the high quality training available to the state through the Dartmouth PRC is not fully utilized, and recent penetration is at 0%. Ongoing training is essential for both sustaining current levels of implementation and improving the quality of SE services offered to consumers.
	2. 20-40%
	3. 40-60%
	4. 60-80%
	5. 80-100%

8. SMHA Leadership: Commissioner Level (NH BBH Leadership)

Note: For the purposes of this assessment and given the access, personnel and information that were available to the reviewers of this report, the report will concentrate on the NH Bureau of Behavioral Health Administrator as the leadership focal point.

Commissioner (NH BBH Leader) is perceived as a effective leader (influence, authority, persistence, knows how to get things done) concerning EBP implementation who has established EBPs among the top priorities of the SMHA as manifested by: (Use boxes to indicate components in place.) *Note: Rate existing Commissioner, even if new to post.*	
Absent	**1) EBP initiative is incorporated in the state plan, and or other state documents that establish SMHA priorities,** There is consistent concern from stakeholders regarding the status of Behavioral Health as a Bureau as opposed to a Department. The overall sense is that this is an indicator that mental health issues are not a priority for the state of NH and that the Bureau is not in a position of power. There is no evidence that there is any plan that defines SMHA priorities. Many described the "10 year plan" as

	the document which establishes priorities. If that is the case, it is salient to note that the document has no distinguishable reference to supported employment as a priority. There is a publication (Fulfilling the Promise: Transforming New Hampshire's Mental Health System) that clearly focuses on EBPs as a priority, the importance of work in recovery and the role of supported employment. It is not clear why this document was not referenced by any decision makers yet seems to be the most comprehensive environmental scan and solution focused plan available. It is evident by way of verbal communication, that EBPs are an important component to the system of care. The demonstration of this commitment, however, is only evident in the requirement of annual fidelity reviews.
Present	**2) Allocating one or more staff to EBP, including identifying and delegating necessary authority to an EBP leader for the SMHA,** The BBH Administrator clearly defined the role that he plays and the roles of his staff. He described himself as less of a "point-person" and more the "policy-person" while the Community Mental Health Program Unit (CMHP) Administrator is viewed as the "point-person" or the SE leader. While, in one case, this role definition was very clearly stated, outside of the office of the Administrator, it is not clear at all. The majority of those interviewed knew nothing of the CMHP Administrator's (CMHP Administrator) role as leader for EBPs—it is imperative to provide clear communication regarding these roles outside of BBH to strengthen the impact.
Absent	**3) Allocation of non-personnel resources to EBP (e.g. money, IT resources, etc.),** The lack of additional funds to support SE and the lack of a unique billing code (billed under FSS) for SE services are two of the most significant issues with the SE implementation in NH. This is of major concern to nearly all parties with the exception of a few BBH employees. The BBH Administration's view is that the decision to rule out a unique billing code for SE is in the best interest of the centers. The centers do not agree with this interpretation and the lack of clarity and effective communication on these key issues appears to be grounds for mistrust and much frustration. There is a unique opportunity to initiate important communication between BBH and providers to come to a mutually beneficial decision regarding the billing system. It is vital that NH BBH take an active role in providing forums for a thorough discussion and discourse regarding questions about SE billing in NH.

Present	**4) Uses internal and external meetings, including meetings with stakeholders, to express support for, focus attention on, and move EBP agenda,** The BBH Administrator communicates regularly with the CEOs of the CMHCs. It is commendable that BBH leadership remains consistent in requiring fidelity reviews and prioritizing that for all providers. It would be equally beneficial to focus discussion and resources on how providers and BBH can work cooperatively to fully implement SE across the system. This may include conversations regarding requiring reporting of valid competitive employment outcomes, providing incentives for providers for desired outcomes, as well as providing innovative supports for programs working to achieve exemplary fidelity status.
Absent	**5) Can site successful examples of removing policy barriers or establishing new policy supports for EBP.** The previously-mentioned MOU between BBH and the CMHCs is mentioned as a step forward. However, specificity to SE is not noted in this MOU.

How long has the current Commissioner held the post? ___7 years_________
How long has the current Commissioner worked in the agency? __10 years__________

Score:

	1. 0 - 1 component
X	2. 2 components
	3. 3 components
	4. 4 components
	5. all 5 components

9. SMHA Leadership: Central Office (NH BBH) EBP Leader

There is an identified EBP leader (or coordinating team) that is characterized by the following:
(Use boxes to indicate which components in place.)
Note: Rate current EBP leader, even if new to post.

Partially Present	**1) EBP leader has adequate dedicated time for EBP implementation (min 10%), and time is protected from distractions, conflicting priorities, and crises,** It appears that the CMHP Administrator has sufficient time dedicated for SE; however, a profound lack of clarity for community stakeholders over her role as the SE leader minimizes the impact she can have on SE services. At BBH and for many critical players in this EBP's implementation, the CMHP Administrator is viewed as the leader. The exceptions to this leadership included references to "David or David, Robin and Chip, or as far as "I have no idea who is leading this implementation". Though there is some discrepancy regarding the understanding of who the leader is for SE, there is much opportunity to communicate that the CMHP Administrator is that person. There is a great deal of potential to use the CMHP Administrator's time to reconvene a cross-sectional EBP steering committee. Reports of a previously existing group indicated that it was helpful—this would be a very effective way to re-introduce the CMHU Administrator as the leader of the initiative.
Absent	**2) There is evidence that the EBP leader has necessary authority to run the implementation,** It was clearly communicated to the reviewers that this leader would not have the "teeth" in the implementation. The deliberate thought on the part of BBH is that the CMHP Administrator would develop the relationships and that the BBH Administrator would make the "difficult decisions". Though there is merit to the thought of these dual roles, this limits the authority of the CMHP Administrator and also detracts from the position's credibility with providers and other partner organizations as all decisions seemingly need to filter through the BBH Administrator.
Partially Present	**3) There is evidence that EBP leader has good relationships with community programs,** There is little evidence that providers know the CMHP Administrator as a BBH leader for SE at all. Consistently, the providers listed others as leaders for the practice whereas staff of BBH and partner organizations (including NAMI and VR) viewed the CMHP Administrator as the natural leader of the implementation. It is this disparity clearly highlights the need for consistent messaging to all regarding the roles each individual plays in this implementation.

Absent	**4) Is viewed as an effective leader (influence, authority, persistence, knows how to get things done) for the EBP, and can site examples of overcoming implementation barriers or establishing new EBP supports.** Though the position may not be recognized by the providers—other partners view it differently. The CMHP Administrator played a critical, decision-making role in the pilot project with VR and is viewed as an SE leader by both the Dartmouth PRC and NAMI. However, because practitioners did not identify this person as the SE leader, this person has a minimized or marginalized impact on overcoming barriers or establishing supports.

How long has the current EBP leader held the post? __2 years__________

How long has the current EBP leader worked in the agency? _2 years___________

Score:

	1. No EBP leader
X	2. 1 component
	3. 2 components
	4. 3 components
	5. All 4 components

10. Policy and Regulations: Non SMHA State Agencies

The SMHA has developed effective interagency relations (other state agencies, counties, governors office, state legislature) to support and promote the EBP as necessary/appropriate, identifying and removing or mitigating any barriers to EBP implementation, and has introduced new key facilitating regulations as necessary to support the EBP.

Ask SMHA staff and site leadership: What regulations or policies support the EBP implementation? What regulations or policies get in the way? Note: give most weight to policies that impact funding.

Examples of supporting policies:

- Medicaid agency provides reimbursement for the EBP (If Medicaid not under the SMHA)
- The state's vocational rehabilitation agency pays for supported employment programs
- The state's substance abuse agency pays for integrated treatment for dual disorders

- Department of Professional Licensing requires EBP training for MH professionals

Examples of policies that create barriers:

- Medicaid agency excludes EBP, or critical component, e.g. disallows any services delivered in the community (If Medicaid agency not under the SMHA)
- State substance abuse agency prohibits integrated treatment, or will not reimburse for integrated treatment
- State substance abuse agency and state mental health authority are divided, and create obstacles for programs attempting to develop integrated service programs
- State vocational rehabilitation agency does not allow all clients looking for work access to services, or prohibits delivery of other aspects of the supported employment model
- Department of Corrections policies that create barriers to implementation of EBPs

Score:

	1. Virtually all policies and regulations impacting the EBP act as barriers
	2. On balance, policies that create barriers outweigh policies that support/promote the EBP
Balanced Level	**3. Policies that are support/promote the EBP are approximately equally balanced by policies that create barriers** There has been some work done in the last one and one-half years to demonstrate the effectiveness of integrating VR efforts with SE in a pilot project with one CMHC site. Historically, the difficulty with supported employment from a VR perspective is that the practice runs counter to much of perceived VR policy—it was stated that "the model fights VR doctrine". The NH Department of Education/Bureau of Vocational Rehabilitation should be commended on their willingness to match the policy to this practice and come up with working solutions. In the letter of agreement between BBH and VR, each partner in this pilot project committed to specific roles and responsibilities which outline expectations. Though the documentation does not indicate a major shift from traditional VR practice, verbal reports from involved parties paint a different perspective. Those involved in the project report a major concession on the part of VR regarding the need for comprehensive pre-employment assessment. The VR Field Supervisor stated "we need to trust the individual and the employment specialists—our counselors can not be specialists in a population—they need mental health providers to assist with the support". It is clear that this understanding assists in the development of a mutually beneficial partnership.

	Despite their great efforts, the pilot project was consistently reported as "not working well", with "dismal outcomes". Upon evaluating the reasons for the poor performance, the partners agreed that the issues were with staff's (both VR and CMHC) inability to apply the training they received. This pilot is a unique opportunity to demonstrate the impact of effective partnership—quick action to refocus this program should be a priority.
	4. On balance, policies that support/promote the EBP outweigh policies that create barriers
	5. Virtually all policies and regulations impacting the EBP support/promote the EBP

11. Policies and Regulations: (NH BBH) SMHA

The SMHA has reviewed its own regulations, policies and procedures to identify and remove or mitigate any barriers to EBP implementation, and has introduced new key regulations as necessary to support and promote the EBP.
Ask SMHA staff and site leadership: What regulations or policies support the EBP implementation? What regulations or policies get in the way?
Examples of supporting policies:

- *SMHA ties EBP delivery to contracts*
- *SMHA ties EBP to licensing/ certification/ regulation*
- *SMHA develops EBP standards consistent with the EBP model*
- *SMHA develops clinical guidelines or fiscal model designed to support model EBP implementation*

Examples of policies that create barriers:

- *SMHA develops a fiscal model or clinical guidelines that directly conflict with EBP model, e.g. ACT staffing model with 1:20 ratio*
- *SMHA licensing/ certification/ regulations directly interfere with programs ability to implement EBP*

Score:

	1. Virtually all policies and regulations impacting the EBP act as barriers
	2. On balance, policies that create barriers outweigh policies that support/promote the EBP
This Level	**3. Policies that are support/promote the EBP are approximately equally balanced by policies that create barriers**

	As previously outlined, there are differing opinions on the presence of policies which are poised to assist the practice and those that are not. As reported by one BBH staff, "there are no written policies in place to support SE—our biggest barrier is the lack of a unique billing code for SE". Providers and partners agree that this is a major concern. Conversely, it is reported by other BBH staff that the lack of a unique billing code is in the best interest of CMHCs—it is better because is keeps confusion at a minimum. One respondent stated that SE is "written into the BBH Administrative Rules (rule 426)"—where and how SE is written and described is under the control of BBH. A review of the impact of SE's current location within the Administrative Rules and a description related to the rules (possibly by the suggested SE Steering Committee) could lead to necessary adjustments which would highlight BBH's commitment to competitive employment. There is an MOU established between all providers and BBH that references penetration of competitive employment (25%) and mandatory annual fidelity reviews for any EBP. The shortfalls in this document are that there are no references to SE as a means to competitive employment for consumers. With this lack of specificity, SE is not presented as the preferred method of service by BBH. This is further confused for providers by mandatory fidelity—there is seemingly no incentive or assistance to implement EBSE—one CSP Director described this as being offered "a stick instead of a carrot". It is apparent that there is a BBH commitment to SE as the preferred employment practice for providers. It is critical that the policies in place are reviewed and refined to decrease the conflicting messages being delivered.
	4. On balance, policies that support/promote the EBP outweigh policies that create barriers
	5. Virtually all policies and regulations impacting the EBP support/promote the EBP

12. Policies and Regulations: (NH BBH) SMHA EBP Program Standards

The SMHA has developed and implemented EBP standards consistent with the EBP model with the following components: (Use boxes to identify which criteria have been met)	
Absent	**1) Explicit EBP program standards and expectations, consonant with all EBP principles and fidelity components, for delivery of EBP services.** ***(Note: fidelity scale may be considered EBP program standards, e.g. contract requires fidelity assessment with performance expectation)***
Absent	**2) SMHA has incorporated EBP standards into contracts, criteria for grant awards, licensing, certification, accreditation processes and/or other mechanisms**
Absent	**3) Monitors whether EBP standards have been met,**
Absent	**4) Defines explicit consequences if EBP standards not met (e.g. contracts require delivery of model supported employment services, and contract penalties or non-renewal if standards not met; or licensing/accreditation standards if not met result in consequences for program license.)**

Score:

X	1. No components (e.g. no standards and not using available mechanisms at this time)
	2. 1 component
	3. 2 components
	4. 3 components
	5. 4 components

It is very clear that BBH sees fidelity monitoring as setting the program standards. However, though there are requirements to have an annual fidelity review, there are no performance standards attached. MOU language includes the fidelity requirements—it is strongly recommended that performance expectations that explicitly identify desired program standards, such as levels of fidelity, along with desired outcomes, such as competitive employment rates be included in this MOU language. Additionally, it is equally important that clear descriptions of the frequency, intensity and types of training and technical assistance that will be made available to CMHCs to meet those expectations, also be incorporated in this document.

13. Quality Improvement: Fidelity Assessment

There is a system in place for conducting ongoing fidelity reviews by trained reviewers characterized by the following components: (Use boxes to indicate criteria met.) *Note: If fidelity is measured in some but not all sites, answer for the typical site.*	
Present	**1) EBP fidelity (*or functional equivalent designed to assess adherence to all critical components of the EBP model) is measured at defined intervals*** NH BBH is to be commended for its commitment to assuring that SE fidelity reviews are conducted at all sites around the state on a yearly basis. It is also impressive that BBH has decided to use the 2008 revised SE Fidelity Scale which incorporates the most recent evidence about effective SE programs.
Present	**2) GOI fidelity (*or functional equivalent designed to assess adherence to all critical components required to implement and sustain delivery of EBP) is measured at defined intervals.*** All respondents confirmed that GOI fidelity assessments are currently being conducted at all sites around the state in conjunction with IMR fidelity reviewers. It is not clear if the information being gathered for IMR reviews in the GOI assessment is being used at all to improve SE fidelity or outcomes.
Present	**3) Fidelity assessment is measured independent – i.e. not assessed by program itself, *but by SMHA or contracted agency*** As discussed earlier, the NH BBH has allocated funding and resources, within the Dartmouth PRC contract to have fidelity reviews at all SE sites completed with full reports annually.
Present	**4) Fidelity is measured a minimum of annually** All respondents confirmed that SE fidelity reviews are conducted on an annual basis.
Present	**5) Fidelity performance data is given to programs and used for purposes of quality improvement** All respondents confirmed that fidelity review data is given to programs via written reports within a couple weeks of the completion of fidelity visits. All SE sites are given the opportunity to meet with members of the Dartmouth PRC team to discuss ideas for SE fidelity improvement however, it is reported that only one site has taken advantage of this offer. All SE team leaders and Program

	Directors interviewed were aware of the fidelity scores for their respective SE programs.
Present	**6) Fidelity performance data is reviewed by the SMHA +/- local MHA** Key BBH leadership respondents agreed that they had access to SE fidelity reports and had at least a general understanding of the varying levels of quality regarding SE services being offered around the state.
Absent	7) **The SMHA routinely uses fidelity performance data for purposes of quality improvement, to identify and response to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.).** Despite an ongoing commitment to gathering SE fidelity from all agencies across the state, BBH does not use SE fidelity information to develop strategies for improving SE services across the state.
Absent	**8) The fidelity performance data is made public (e.g. website, published in newspaper, etc.)** Interviews with providers confirmed that fidelity performance data is not shared between CMHCs or with the public. Fidelity assessments are a method of quantifying quality of services and publishing these results is critical to transparency in the provision of SE. Consumers should benefit from information regarding the performance of an agency from whom they are requesting services and, in the context of technical assistance and the sharing of best practices, CMHCs could benefit from this level of open data sharing.

Score:

	1. 0 – 1 components
	2. 2 –3 components
	3. 4 – 5 components
X	4. 6 – 7 components
	5. All 8 components

14. Quality Improvement: Client Outcomes

A mechanism is in place for collecting and using client outcome data characterized by the following: (Use boxes to indicate criteria met.) *Note: Client outcomes must be appropriate for the EBP, e.g. Supported employment outcome is persons in competitive employment, and* <u>*excludes*</u> *prevoc work, transitional employment, and shelter workshops. If outcome measurement is variable among sites, consider typical site.*	
Absent	**1) Outcome measures, or indicators are standardized statewide, AND the outcome measures have documented reliability/validity, or indicators are nationally developed/recognized**
Absent	**2) Client outcomes are measured every 6 months at a minimum**
Absent	**3) Client outcome data is used routinely to develop reports on agency performance**
Absent	**4) Client specific outcome data are given to programs and practitioners to support clinical decision making and treatment planning**
Absent	**5) Agency performance data are given to programs and used for purposes of quality improvement**
Absent	**6) Agency performance data are reviewed by the SMHA +/- local MHA**
Absent	**7) The SMHA routinely uses agency performance data for purposes of quality improvement; performance data trigger state action. Client outcome data is used as a mechanism for identification and response to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.).**
Absent	**8) The agency performance data is made public (e.g. website, published in newspaper, etc.)**

Scores:

X	1. 0 components
	2. 1 – 2 components
	3. 3 – 5 components
	4. 6 – 7 components
	5. All 8 components

Rating Rationale

As the IMR SHAY of 2007 states, "It is generally accepted that Evidence Based Practices are implemented to help clients achieve their desired goals and outcomes in an effective way. Therefore, one of the critical tenets of EBPs is the identification, data collection and use of client outcomes to monitor, sustain and improve EBPs." Similar to what reviewers found when conducting the IMR SHAY assessment, the NH BBH system is operating without the collection of any outcomes related to SE services.

Most respondents confirmed that BBH does not collect outcomes related to SE, most notably competitive employment rates. Some individuals at CMHCs believed that competitive employment rates were being collected by BBH based on data being fed into an electronic data collection system developed by the state; however, when the reviewers looked at the specific variables being collected on consumers, they found that general employment status, as opposed to the engagement in competitive employment obtained while enrolled in an SE program, was being tabulated. There also did not appear to be a feedback loop between BBH and CMHCs regarding the data being fed into this system.

Some respondents believed that requirements for SE outcomes were outlined in language found in the MOUs with CMHCs. As stated earlier in this report, however, the MOU speaks of requiring at least 25% of consumers to be enrolled in some vocational program, not necessarily SE. Furthermore, a requirement around consumer access to services is not a client outcome; it is a requirement around service penetration rates.

As found by reviewers conducting the IMR SHAY, there appears to be some confusion over the use of SE fidelity assessment data related to client outcomes. Many stakeholders pointed to agency fidelity assessment scores as an outcome for SE. Fidelity assessments are a method of quantifying quality of services, whereas outcomes are related to consumer functioning in both vocational and nonvocational realms. There also appear to be some confusion over the link between fidelity assessment scores and client outcomes. One informant stated, "We (at BBH) are told that we don't need to measure client outcomes, because if a program has good fidelity that automatically means they must have good outcomes." According to SE research, fidelity accounts for only 40% of client outcomes in an SE program, with the rest related to factors such as the local economy and the skills of individual SE practitioners.

15. Stakeholders

The degree to which consumers, families, and providers are opposed or supportive of EBP implementation.

Note: Ask - Did stakeholders initially have concerns about or oppose EBPs? Why? What steps were taken to reassure/engage/partner with stakeholders. Were these efforts successful? To what extent are stakeholders currently supportive this EBP? Opposed? In what ways are stakeholders currently supporting/ advocating against this EBP? Rate only current opposition/support.

Scores:

1. Active, ongoing opposition to the EBP
2. Opposition outweighs support, or opinion is evenly split, but no active campaigning against EBP
3. Stakeholder is generally indifferent
4. Generally supportive, but no partnerships, or active proponents.
5. Stakeholder advocacy organization leadership/opinion leaders currently offer active, ongoing support for the EBP. Evidence of partnering on initiative.

Three (average score)	**15. Summary Stakeholder Score: (Average of 3 scores below)**
Four	**15.a Consumers Stakeholders Score** BBH has an Office of Consumer and Family Affairs that conducts outreach with consumers around the state. The Director has developed a four part training series that contains one module on the role of employment in recovery. This module, facilitated by David Lynde of the Dartmouth PRC, outlines the principles of supported employment and encourages consumers to ask for SE services at their local CMHC. It was stated from respondents that while most consumers who attend this training are usually not initially aware of SE, they are overwhelmingly supportive of the model once they are given more information. One interviewee stated that, within the context of these trainings, work is one of the top three priorities identified by consumers in the state. While support for SE is voiced by consumers, however, there are currently very few, if any, formal partnerships between BBH and consumer groups to garner support for the implementation and improvement of SE services.
Three	**15.b Family Stakeholders Score** While family stakeholder groups, most notably NAMI, are clearly not opposing SE, there is currently scant public verbal support and advocacy efforts for SE in the state. It was stated by one interviewee that NH NAMI has some awareness of SE but that as an organization it is more in the "contemplation" stage in terms of supporting the practice given NH NAMI's other priorities right now.

One	**15.c Providers Stakeholders Score** First, it should be noted that direct practice and lower level administrative staff from CMHCs interviewed for this review were overwhelmingly supportive of SE. However, this support does not appear to extend to the CEO level, which is imperative if SE implementation is to move forward in New Hampshire. While executive leadership is supportive of and value work for consumers in general, SE was not identified as the preferred vocational model. As one agency leader stated, "We value work but don't want to be told what to do or how to do it." A few executive leaders interviewed discussed alternative, non-competitive employment programs they had in place and preferred to fund as opposed to SE. Supported employment and EBPs in general are viewed by CEOs, as something BBH is holding on to as a proxy for stewardship of the mental health care system. Dismayed over a perceived lack of funding for SE services, combined with minimal leadership from BBH, and the dwindling availability of technical assistance for the practice, it is not surprising that CMHC leaders officially requested that the Division of Health and Human Services Commission impose a moratorium on SE fidelity reviews.

Summary of SHAY Scores

1. EBP Plan — 2
2. Financing: Adequacy — 4
3. Financing: Start-up and Conversion Costs — 2

Item	Score
4. Training: Ongoing Consultation & Technical Support	2
5. Training: Quality	4
6. Training: Infrastructure / Sustainability	2
7. Training: Penetration	1
8. SMHA Leadership: Commissioner Level	2
9. SMHA Leadership: EBP Leader	2
10. Policy and Regulations: Non-SMHA	3
11. Policy and Regulations: SMHA	2
12. Policy and Regulations: SMHA EBP Program Standards	1
13. Quality Improvement: Fidelity Assessment	4
14. Quality Improvement: Client Outcome	1
15. Stakeholders: Aver. Score (Consumer, Family, Provider)	3

OVERALL SHAY SCORE = SUM TOTAL 34 ÷14 = 2.3

*For information on the specific numeric scoring methods for each item, please see the SHAY Rating Scale

<u>Overall Observations and Recommendations</u>

The reviewers are grateful for the time, efforts, resources, energy and commitment of all the people and groups that participated in our two days of interviews and meetings. It is impressive that BBH is committed to assessment and improving state-level supports for the implementation of Supported Employment.

The following are recommendations of the reviewers based on the scores outlined earlier in the report. The reviewers recommend that BBH leadership, in collaboration with other stakeholders, develop an action plan for all of the following items. Failure to address these items will severely diminish the progress of implementing SE throughout the state.

1) EBP Plan

- *Establish priorities that focus on utilization and importance of EBPs, specifically SE.* As stated, most stakeholders referred to the "10 year plan" when asked about BBH priorities. This plan is a broad sweep of the entire DHHS system and has no specific reference to EBPs outside of ACT. It is the recommendation of these reviewers that BBH lead an effort to develop

their own strategic plan which includes evidence based service provision. This document/plan should be designed to set the tone for the re-implementation and on-going continuity of SE provision.

- *Re-introduce the comprehensive training and technical assistance plan with the Dartmouth PRC.* By doing so, SE will be re-established as a priority which will be essential for any movement forward with this service. This will require that NH BBH and Dartmouth PRC review the existing funding and resources allocated to their contract to assure that both funding and resources are available to meet the need for these services for CMHCs, VR and BBH.
- *Revisit relationships with stakeholders.* The relationships with stakeholders are established yet appear passive in nature in that they have not addressed controversies or difficult differences between BBH and stakeholders such as CEOs at CMHCs. By focusing on active relationships, BBH could move further more quickly on goals. Active involvement of stakeholders involves shared-decision-making and planning offers opportunity for buy-in early on, thus establishing mutual interest in the success of BBH's goals. The relationship with VR is a good one and the reviewers suggest that BBH refocus their efforts on the pilot project and make some necessary changes to increase its chances for success. Lastly, it is imperative that BBH establish a relationship with provider agencies based on clear communication and expectations.

2) Financing

- *Implement a unique SE billing code*. Several sources stated that there has been no accurate cost modeling completed for SE services at this point. Some people pointed to the problem that without specific codes for SE services and SE billing there is no current method to undertake SE cost modeling. The reviewers agree that developing an SE billing code should be a top priority of BBH in order to assist CMHCs in developing ways to make SE cost neutral. The presence of a billing code would also allow the BBH system to gather much greater data about the frequency and intensity of SE services being provided by CMHCs. An additional option brought up by some BBH staff is to assist CMHCs in creating a separate cost center under which employment service staff would bill, thus facilitating a way to assess the cost of providing SE services. It is recommended that all options are reviewed and analyzed to determine which would be the most effective and efficient for all parties involved. It is also recommended that SE costs are not reviewed in isolation from other service needs and expectations—BBH will need to clearly identify if there are areas in conflict with SE cost modeling.
- *Promote communication between CMHCs*. BBH is encouraged to create forums, either in person or via teleconference, for CMHCs who have found ways to make SE cost neutral to communicate with those CMHCs who are concerned about its financial viability. Leadership from CMHCs is strongly encouraged to attend these forums in order to develop viable cost models for SE.
- *Ticket to Work*. In many states, leadership from the mental health system, such as NH BBH, in collaboration with state VR systems are working actively to develop additional funding streams for SE from the new Ticket to Work regulations. It is

recommended that NH BBH leadership convene a work group with representatives from NH CMHCs and NH VR to determine how best to utilize the funding opportunities in the new Ticket to Work program for the state.

- *Medicaid Infrastructure Grant***.** While the state is fortunate to have federal funds available from the Medicaid Infrastructure Grant, it would benefit the whole state system if BBH leaders convened a meeting with the leadership of the MIG grant to determine the opportunities and potential barriers in utilizing those funds to more effectively support SE implementation.

3) Training

- *Reinstate training offered under the contract between BBH and the Dartmouth PRC.* As stated previously, it appears that some agency staff members are eager to get more training around SE in order to more fully implement the practice and provide better SE services in the community. Once again, this will require the Dartmouth PRC and NH BBH to assure that their contract reflects this need and provides adequate funding and resources.
- *Add more training that focuses on field mentoring and shadowing of existing SE work being done at sites.* Field mentoring and shadowing is one of the best way for practitioners to learn difficult employment specialist skills, particularly around job development. BBH is encouraged to request that the Dartmouth PRC take an active role in coordinating such activities if needed.
- *Implement and sustain higher levels of funding for the Dartmouth PRC for training and technical assistance with the state*.. The contract between BBH and Dartmouth allocates funding for both IMR and SE training and consultation. For both years under

review in the contract, there was more significantly more funding and personnel resources dedicated to IMR implementation than SE implementation for the state. There is no evidence to show that SE requires less training and consultation to achieve good implementation than IMR. If anything, based on interviews with providers, it would appear that at this point in time more consultation would be required for SE given that implementation is much less advanced than IMR. The reviewers suggest that funding and personnel resources for SE training and consultation be equal to the previous funding allocated towards similar services for IMR. It was also noted that, while the BBH – Dartmouth agreement has a comprehensive plan for training with the exception of on-site shadowing and field mentoring, there was a significant reduction in funding from 08 to 09 for these services. This reduction seems counterintuitive considering the concerns raised by various stakeholders on the challenges to implementation brought about by staff turnover at CMHCs. In addition to reinstating the trainings outlined in the BBH-Dartmouth agreement, we recommend maintaining the higher levels of funding initially allocated for the first years of implementation for the foreseeable future. This funding would hopefully allow for the Dartmouth PRC to recommit to their original staffing levels so the intensive training and consultation needed by CMHCs for SE implementation could be realized.

- *CMHC pursuit of training*. At this point in time it appears that CMHCs are not actively pursuing opportunities for training. We strongly encourage CMHCs to take advantage of the expertise in SE found in their own backyard at Dartmouth in order to improve their programs. Additionally, an increase in communication between the CMHCs and BBH regarding the reasons trainings have not been actively pursued would help to add clarity and understanding and could lead to joint solutions for moving SE training

forward. We also recommend that CMHCs that are further along in the implementation of SE offer up direct practice shadowing opportunities to those CMHCs in early stages of SE development and consultation with leadership around the financial viability of the practice.

4. SMHA Leadership

- *Develop a specific BBH Plan.* As has been stated throughout this review, there is no specificity in the "10 year plan" relating to competitive employment for adults with mental illness, let alone SE. In business, strategic plans (goal setting) are essentially the compass that keeps the company on course—it is the thought of the reviewers that the same applies in the business of recovery. Without clarity of focus, all parties will continue to put out fires, or as one provider stated "just try to stay afloat". Designing a direction and defining the role of each player (BBH, providers, partners and consumers) with the input of all stakeholders could begin the process of moving from a reactionary system to a proactive system.
- *Clarify the roles of BBH Administrator and BBH CMHU Administrator.* Decide who will be the leader of the SE initiative and notify all stakeholders of this decision. Include in this notification the description of the role of both the Administrator and the CMHU Administrator, expectations that providers should have for communication regarding SE and the method with which they can provide feedback. It is imperative that this communication is prioritized and the follow through is transparent.

- *Structure meeting time with Provider CEOs to regularly include SE update.* The BBH Administrator currently joins the Provider CEOs on a regular basis at their monthly meetings. In attempt to establish SE as an on-going priority it is recommended that SE be a standing agenda item for the group to review with the BBH Administrator. To initiate this effort, it may also be beneficial for the CEOs and BBH Administrator to re-visit the data supporting EBSE and data supporting other employment initiatives which are of on-going interest to the CEOs. This review of outcome data could assist in establishing the appropriate amount of support BBH would give to all employment initiatives.
- *Convene an SE (or EBP) State-wide, Multi-stakeholder Steering Committee lead by BBH leadership.* This recommendation is noted in other areas as important; please reference the "stakeholders" section for description.

5. Policy and Regulations

- *Re-focus on the VR/BBH pilot project.* As previously stated, this small pilot project is designed as a learning opportunity. To maximize its benefits to the system, it is highly recommended that involved parties make adjustments to the project to impact the likelihood of positive outcomes. The language in the agreement indicates that 2 CMHCs would be involved and there is currently only one—it may be beneficial to add a second at this point and compare the outcomes at both.

- *Convene an SE (or EBP) Steering Committee with SE as its first priority.* As is stated in other areas of this review, the Steering Committee is an essential component to the success of further SE efforts. (Please see the "Stakeholders" recommendations below for more description)
- *Review MOU language and clarify expectations.* Without clear expectations this project will continue to flounder in NH. There should be no room for misinterpretation regarding expected provider performance levels and regarding BBH support efforts (for example, making training and technical assistance available). BBH has stated that SE is the preferred method of service provision for adults with mental illness; some providers feel that this limits their creative approaches to meeting consumer needs. It is this level of misunderstanding that could be clarified through more concise language in the MOU with consistent follow up communication on the part of BBH. No language change will be effective if it is not followed with on-going support and monitoring from BBH.

6. Quality Improvement

- *Monitor quality improvement at CMHCs.* Periodically monitor quality improvement steps being taken by CMHCs to improve fidelity based on recommendations outlined in fidelity reports. While fidelity is monitored on a yearly basis, we recommend reviewers to follow up with sites within six months of the review to see what movement has been made on implementing changes based on fidelity action plans.

- *Implement quality improvement at BBH based on cumulative fidelity data.* It would be beneficial for providers of training and technical assistance from Dartmouth PRC and BBH leadership to convene a work group, comprised of a subset of members of a statewide steering committee, designed to look at overall trends and themes generated from fidelity assessment scores at all CMHCs in order to develop a TA plan going forward that targets SE practice areas that need the most attention across the state.
- *Implement the collection of client outcome data at CMHCs*. There is not a consistent or valid mechanism currently in place to collect client outcomes regarding competitive employment for adults with mental illness. Establishing a simple, valid and universal method for collecting and reporting client outcome data regarding competitive is in the best interest of BBH, CMHCs VR, consumers and family members for several reasons, among them:

  1) Outcome data is the primary way for providers and BBH to assess whether or not consumers are receiving effective services. All respondents discussed the importance of providing good services to consumers and helping them to achieve their goals around employment. Outcome data will provide all stakeholders with the necessary information to know whether or not consumers are being delivered the quality care so valued by both BBH and the CMHCs. This data will also assist the Dartmouth PRC in targeting their technical assistance to sites that need it the most in a timely fashion.

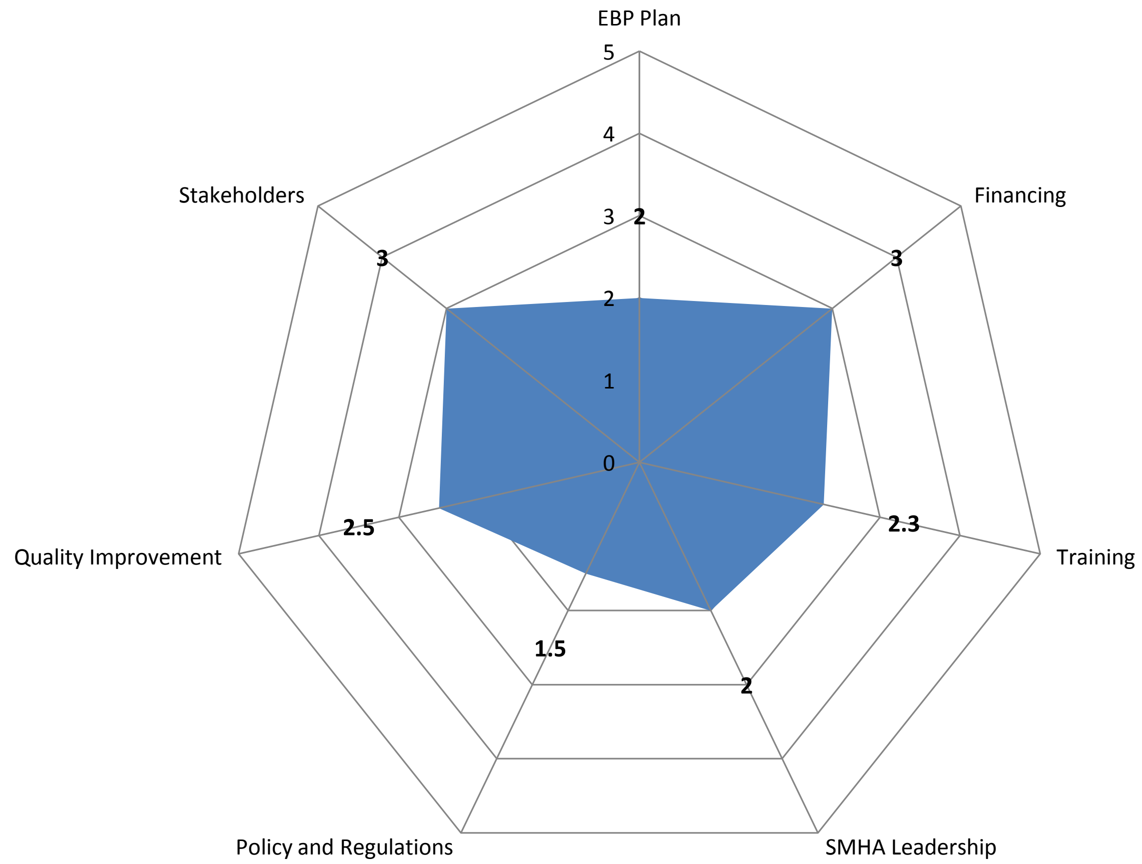
  2) Outcome data can be used by providers and BBH for funding purposes. The reviewers have worked with many SE programs that routinely use outcome data to obtain additional funding – both public and private. Evidence that a program is achieving the desired results is a strong incentive for potential funders looking to quantify the return in their financial

contributions to providers. One BBH interviewee also talked about the potential monetary value of collecting outcome data by stating, “If we had good data we could try to leverage more funding.”

7. Stakeholders

- *Convene an SE (or EBP) Steering Committee.* There has been either a breakdown in, or lack of development of, communication between BBH leadership and all stakeholder groups, ranging from CMHC leaders, direct practitioners/clinical staff at CMHCs, family members, consumers, the Dartmouth PRC and other BBH employees around the implementation and sustainability of supported employment in the state. It is highly recommended that BBH reconvene a statewide steering committee, chaired by the BBH representative who will be recognized by all as the SE leader. This committee should contain members of all the stakeholder groups in order to address the many issues outlined in this report and move forward on implementation efforts. As one person accurately observed, “[stakeholders] won’t be interested in engaging in the [implementation] process if they don’t think they will have some input and influence on it.” Convening a steering committee in which all parties have the opportunity to voice their opinions and have a say in proposed solutions can have an immense positive impact on moving the SE initiative forward. Actively advising BBH on implementation strategies and progress could be a critical first step. This could include, but would not be limited to, advising on MOU language, performance indicators,

fidelity review expectations and training and technical assistance needs. The establishment of this committee as an advisory/influential body would again re-emphasize BBH’s commitment to EBSE.


New Hampshire SE SHAY
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Quality Improvement
Stakeholders
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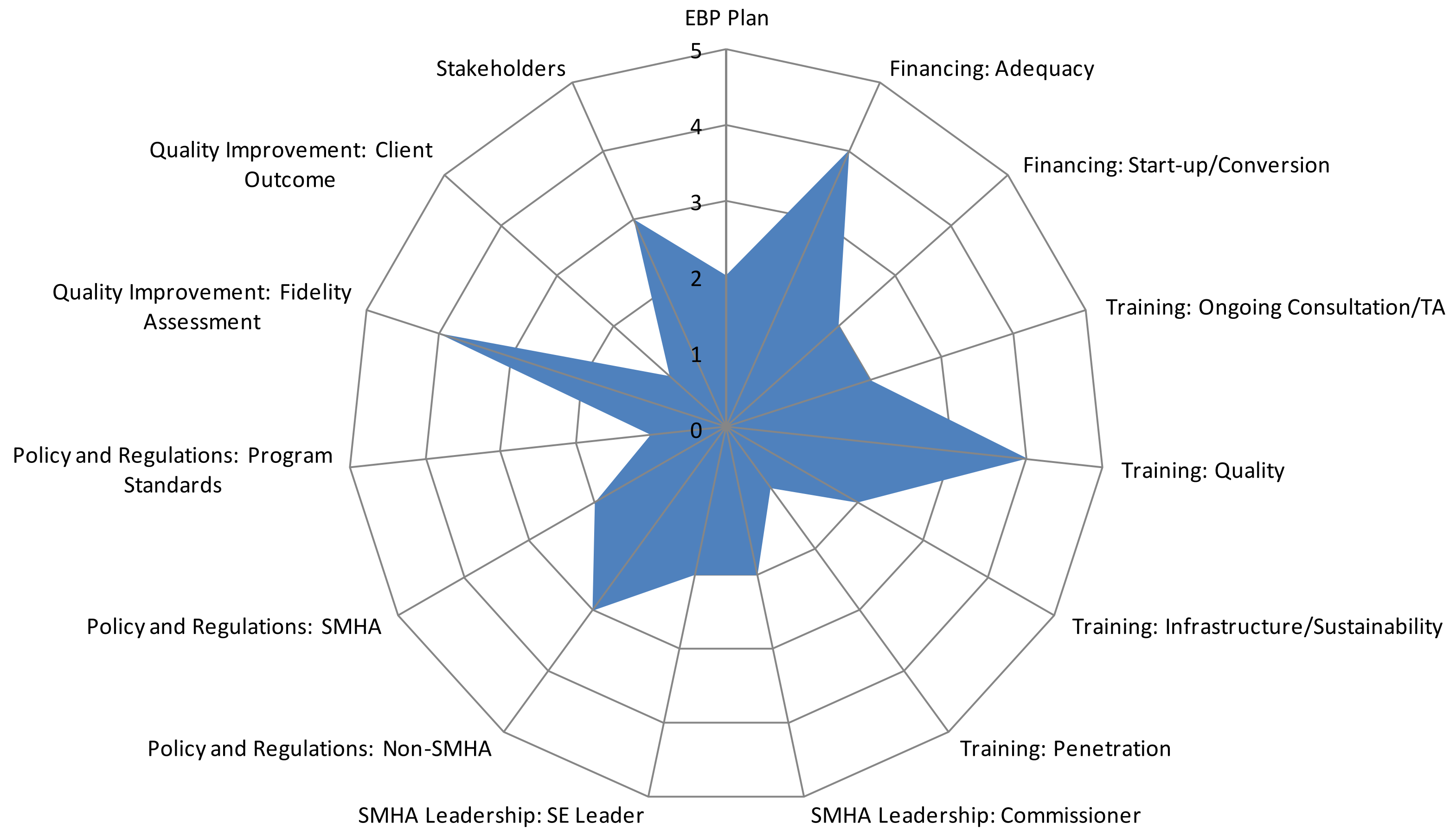
All Scores
EBP Plan
Financing: Adequacy
Financing: Start-up/Conversion
Training: Ongoing Consultation/TA
Training: Quality
Training: Infrastructure/Sustainability
Training: Penetration
SMHA Leadership: Commissioner
SMHA Leadership: SE Leader
Policy and Regulations: Non-SMHA
Policy and Regulations: SMHA
Policy and Regulations: Program Standards
Quality Improvement: Fidelity Assessment
Quality Improvement: Client Outcome
Stakeholders
5
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