New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Seven

January 10, 2017

I. Introduction

This is the seventh semi-annual report of the Expert Reviewer (ER) under the Settlement Agreement in the case of *Amanda D. v. Sununu; United States v. New Hampshire, No. 1:12-cv-53-SM.* For the purpose of this and future reports, the Settlement Agreement will be referred to as the Community Mental Health Agreement (CMHA). Section VIII.K of the CMHA specifies that:

> Twice a year, or more often if deemed appropriate by the Expert Reviewer, the Expert Reviewer will submit to the Parties a public report of the State's implementation efforts and compliance with the provisions of this Settlement Agreement, including, as appropriate, recommendations with regard to steps to be taken to facilitate or sustain compliance with the Settlement Agreement.

In this six-month period (July 1, 2017 through December 31, 2017), the ER has continued to observe the State's work to implement certain key service elements of the CMHA, and has continued to have discussions with relevant parties related to implementation efforts and the documentation of progress and performance consistent with the standards and requirements of the CMHA. During this period, the ER:

- Conducted on site reviews of Assertive Community Treatment (ACT) and Supported Employment (SE) services at Community Partners and Seacoast Mental Health Centers. Non-random samples of ACT and SE records were reviewed at each site.
- Met with senior management and with a clinical team at NHH to review transition planning processes and issues;
- Met with Glencliff leadership, clinical staff, and a resident to discuss transition planning processes and issues;
- Met with the Mobile Crisis Team (MCT) of Harbor Homes, the agency selected to operate the MCT and crisis apartments in the greater Nashua region;
- Observed two five-day Quality Service Review (QSR) reviews; one at Genesis Mental Health Center; and one at the Center for Life Management;
- Met with the DHHS CMHA leadership team to discuss progress in the implementation of CMHA standards and requirements;

- Participated in several meetings with representatives of the Plaintiffs and the United States (hereinafter "Plaintiffs");
- Met twice with DHHS Quality Management/Quality Service Review (QM/QSR) staff to discuss refinements to the QSR process; and
- Convened two all parties meetings to discuss design and implementation issues related to the QSR process and Glencliff transitions to integrated community settings.

Information obtained during these on-site meetings has, to the extent applicable, been incorporated into the discussion of implementation issues and service performance below. The ER will continue to conduct site visits going forward to observe and assess the quality and effectiveness of implementation efforts and whether they achieve positive outcomes for people consistent with CMHA requirements.

Summary of Progress to Date

Eighteen months ago the ER recommended a number of action steps and timelines intended to facilitate movement towards compliance with the CMHA and to increase transparency and accountability related to State actions under the aegis of the CMHA. The State agreed to implement these recommendations, and has made progress in certain areas of compliance and accountability. Specific progress related to these recommendations is summarized below:

1. By August 1, 2016, circulate to all parties a detailed plan with implementation steps and time lines to achieve compliance with the CMHA requirements for ACT services;

   ER Finding: The State has implemented this recommendation by circulating such a plan, and continues to track and report on its implementation of various action steps and limited progress towards compliance with CMHA requirements. However, as will be noted throughout this report, the State remains out of compliance with the ACT requirements of the CMHA. The ER expects the State to propose new and expanded initiatives and implementation strategies to be implemented to move the State closer to compliance in this critical area; and these new initiatives with attendant timelines must be included no later than March 1, 2018 in the ACT section of the monthly progress report. The most recent version of this report (October, 2017) is included as Appendix B to this report.

2. By August 1, 2016, circulate to all parties a detailed plan with implementation steps and timelines to achieve CMHA penetration rates and fidelity standards for SE throughout New Hampshire;

   ER Finding: The State has implemented this recommendation by circulating such a plan, and continues to track and report on its implementation of various action steps and progress towards compliance with CMHA requirements. The State is in compliance with the statewide penetration rate standards for SE, but continues to work

aggressively with the four CMHCs that remain under the standard. Fidelity reviews resulted in Quality Improvement Plans for multiple CMHCs in 2017.

3. By August 1, 2016 circulate to all parties a detailed plan with implementation steps and timelines to achieve CMHA requirements to assist 16 residents of Glencliff with complex medical needs to move into integrated settings as soon as possible;

   ER Finding: The State has implemented this recommendation by circulating such a plan and it continues to track and report on individuals with pending discharge plans. This plan, and the current status of compliance, is discussed in greater detail under the Glencliff Transitions section of this report.

4. Starting September 1, 2016, and each month following, submit to all parties a monthly progress report of the steps taken and completed under these respective plans to assure compliance with CMHA requirements as identified in this report;

   ER Finding: The State has implemented this recommendation and continues to track and report on its progress, which varies depending on the sections of the plan. As noted above, the latest version of the monthly progress report is attached as Appendix B of this report.

5. By October 1, 2016, complete the field tests and technical assistance related to the Quality Service Review (QSR), convene a meeting with Plaintiffs to discuss any recommended design or process changes, and publish a final set of QSR documents governing the process for future QSR activities;

   ER Finding: Working in concert with representatives of the plaintiffs and the ER, DHHS developed revised QSR instrumentation, instructions, and scoring algorithms. The revised QSR has been carried out at three of the Community Mental Health Centers. The ER participated in two of these on-site QSR reviews A more detailed discussion of progress with regard to the QSR is included under the QSR section of this report.

6. Complete at least one QSR site review per month between October 2016 and June 2017, with the exception of the month of December, and circulate to all parties the action items, plans of correction (if applicable), and updates on implementation of needed remedial measures (if applicable) resulting from each of these reviews;

   ER Finding: See #5 above. It should be noted that all 10 of the CMHCs had an onsite QSR review using the previous instruments and protocols during the 2016-2017 period.

7. Starting July 1, 2016, circulate to all parties on a monthly basis the most recent data reports of the Central Team;

ER Finding: The State has implemented this recommendation by circulating monthly reports and it continues to track and report progress towards compliance with CMHA requirements.

8. No later than October 1, 2016, assure that final rules for supportive housing and ACT services are promulgated in accordance with the draft rules developed with input from all parties;

ER Finding: The Supported Housing (SH) and ACT rules have been promulgated, and incorporate positive elements resulting from discussions among DHHS staff and representatives of the Plaintiffs.

9. By October 1, 2016, augment the quarterly data report to include:

- ACT staffing and utilization data for each ACT team, not just for each region.

  ER Finding: The State has implemented this recommendation.

- Discharge destination data and readmission data (at 30, 90, and 180 days) for people discharged from NHH and the other Designated Receiving Facilities (DRFs).

  ER Finding: The State has now complied with this recommendation. The new data is included in the most recent Quarterly Data Report, which is included as Appendix A of this report.

- Reporting from the three Mobile Crisis programs, including hospital and ED diversions.

  ER Finding: Data for the Mobile Crisis Teams and Crisis Apartments is now included in the Quarterly Data Report.

- Supportive housing data on applications, time until eligibility determination, time on waiting list, reason for ineligibility determination, and utilization of supportive services for those receiving supportive housing.

  ER Finding: As of December 2017 DHHS has not produced the requested information. The ER expects the requested information to be provided to the ER and the Plaintiffs no later than March 1, 2018. Once produced, consideration can be given to including these data on a regular basis in the Quarterly Data Report.

10. By October 1, 2016, and then by December 1, 2016, factually demonstrate that significant and substantial progress has been made towards meeting the standards and requirements of the CMHA with regard to ACT, SE and placement of individuals with complex medical conditions from Glencliff into integrated community settings.

ER Finding: The State remains out of compliance with the ACT standards of the CMHA. The State is making progress towards compliance with the Glencliff requirements in the CMHA. See more detailed discussion of these issues under the ACT and Glencliff Transitions sections of this report. The ER notes that the State remains in substantial compliance with the SE penetration rate requirements of the CMHA. The ER will continue to work with the State to document that: (a) that SE services are delivered with adequate intensity and duration to meet individuals' needs; and (b) that SE services are resulting in integrated, competitive employment. As of December, 2017 DHHS has not produced data on the degree to which SE services are resulting in integrated, competitive employment. The ER expects that these data will be produced and delivered to the ER and the Plaintiffs no later than March 1, 2018. Once produced, consideration can be given to including these data on a regular basis in the Quarterly Data Report.

11. By October 1, 2016 demonstrate that aggressive executive action has been taken to address the pace and quality of transition planning from NHH and Glencliff through the development of a specific plan to increase the speed and effectiveness of transitions from these facilities.

ER Finding: The ER believes that both NHH and Glencliff have evidenced, at a leadership and a staff level, increased efforts and commitment to facilitating timely transitions to integrated community settings, albeit with modest result to date. Transitions from Glencliff to integrated community settings appear to be a priority now; nonetheless, only one person was scheduled to be discharged[1] to an integrated community setting in the most recent quarter.

II. Data

The New Hampshire DHHS continues to make progress in developing and delivering data reports addressing performance in some domains of the CMHA. Appendix A contains the most recent DHHS Quarterly Data Report (July to September, 2017), incorporating standardized report formats with clear labeling and date ranges for several important areas of CMHA performance. The ability to conduct and report longitudinal analyses of trends in certain key indicators of CMHA performance continues to improve.

The Quarterly reports now include data from the mobile crisis services in the Concord, Manchester and Nashua Regions; data on discharge destinations from NHH, the DRFs, and Glencliff; admission, discharge and length of stay data for New Hampshire's DRFs; and some data on utilization of the Housing Bridge Subsidy Program.

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[1] This person will actually be discharged in the current quarter, as modifications to the selected apartment were not able to be completed before the end of 2017.

As noted in previous ER reports, there continue to be important categories of data that are needed, but not routinely collected and reported, and which will need to be reported in order to accurately evaluate ongoing implementation of the CMHA. For example, there continues to be no reported or analyzed data on the degree to which participants in SE are engaged in competitive employment in integrated community settings consistent with their individual treatment plans. These data are important in assessing the fidelity with which SE services are provided. DHHS's efforts related to assuring the fidelity of SE services are discussed in the SE section of this report. In addition, revisions to the QSR instruments and protocols are expected to provide more information on the degree to which SE participants are attaining competitive employment.

Another gap in data is related to people receiving Supported Housing (SH) under the Housing Bridge Subsidy Program. These participants are not yet clearly identified in the Phoenix II system, and thus it is difficult to document the degree to which these individuals are: (a) connected to local CMHC services and supports; and (b) actually receiving services and supports to meet their individualized needs on a regular basis in the community. As noted in the January 2016 ER Report, DHHS has identified a strategy to link data from the Bridge Subsidy Program to the Phoenix II system. However, as noted above, these data have not yet been produced. Without the information above, the ER is unable to determine whether or not the State has achieved substantial compliance with the CMHA outcomes and requirements for SH. Other outstanding data requests include SH data on applications, time until eligibility determination, time on waiting list, and the reason for ineligibility determinations,

III. CMHA Services

The following sections of the report address specific service areas and related activities and standards contained in the CMHA.

Mobile/Crisis Services and Crisis Apartments

The CMHA calls for the establishment of a MCT and Crisis Apartments in the Concord Region by June 30, 2015 (Section V.C.3(a)). DHHS conducted a procurement process for this program, and the contract was awarded on June 24, 2015. Riverbend CMHC was selected to implement the MCT and crisis apartments in the Concord Region.

The CMHA specified that a second MCT and Crisis Apartments be established in the Manchester region by June 30, 2016 (V.C.3(b)). The Mental Health Center of Greater Manchester was selected to implement that program. Per CMHA V.C.3(c), a third MCT and Crisis Apartment program became operational in the Nashua region on July1, 2017. The contract for that program was awarded to Harbor Homes in Nashua.

Table I below includes the most recent available information on activities of the three currently operational crisis programs.

Table I

Self-Reported Data on Mobile Crisis Services and Crisis Apartment Programs in the Concord, Manchester and Nashua Regions:

	Concord July – September 2017	Manchester July – September 2017	Nashua July – September 2107
Total unduplicated people served	579	476	55
Services provided in response to immediate crisis:			
• Phone support/triage	721	1,144	33
• Mobile assessments	173	248	14
• Crisis stabilization appointments	37		
• Emergency services medication appointments	110	6	5
• Office based urgent assessments	57	40	3
Services provided after the immediate crisis:			
• Phone support/triage	201		
• Mobile assessments	30		
• Crisis stabilization appointments	36		
• Emergency services medication appointments	60		
• Office based Urgent Assessments	57		
Referral source:			
• Self	292	352	20
• Family	73	107	10
• Guardian	23	5	1
• Mental health provider	19	21	3
• Primary care provider	16	23	0
• Hospital emergency department	46	5	3
• Police	12	135	4
• CMHC Internal	34	79	10
Crisis apartment admissions:	81	9	3
• Bed days	310	29	5
• Average length of stay	3.8	3.2	1.7
Law enforcement involvement	34	135	11
Total hospital diversions*	443	798	49

*Hospital diversions are instances in which services are provided to individuals in crisis resulting in diversion from being assessed at the ED and/or being admitted to a psychiatric hospital.

The Quarterly Data Report in Appendix A contains some historical data for the Concord and Manchester MCTs.

As noted in the previous report, the ER is concerned that the ratio of mobile team responses to the total number of crisis calls seems low. In addition, the number of hospital diversions reported by the MCTs seems to be high, given the number of interventions that do not include a mobile, face to face encounter. The ER will continue to work with the State to document: 1) the number of times a mobile team was requested but not dispatched, and the reason for that decision; 2) the criteria used to determine whether a mobile versus office-based response is appropriate; and 3) the number of times a mobile response was determined to be appropriate, but the team could not be dispatched in a timely way. The ER will also continue to explore with the State the numbers and types of hospital diversions that are reported by the MCTs. The ER notes that overall psychiatric admissions have not been substantially reduced in regions served by the MCTs. There could be a number of reasons for this trend, and at this point it is not clear whether this trend reflects on the existing MCTs.

DHHS has added questions to the QSR interview guides to elicit information about the quality and effectiveness of the MCTs and Crisis Apartments, and to report on that information in the updated QSR instrument. This is one way to determine if individuals who would have benefited from a mobile crisis response received the crisis support their situation required. To date, the CMHC regions for which the revised QSR has been conducted do not have MCT services, and thus it is not possible to report the results of the new QSR questions for those sites.

Assertive Community Treatment (ACT)

ACT is a core element of the CMHA, which specifies, in part:

1. By October 1, 2014, the State will ensure that all of its 11 existing adult ACT teams operate in accordance with the standards set forth in Section V.D.2;
2. By June 30, 2014, the State will ensure that each mental health region has at least one adult ACT team;
3. By June 30, 2016, the State will provide ACT team services consistent with the standards set forth above in Section V.D.2 with the capacity to serve at least 1,500 individuals in the Target Population at any given time; and
4. By June 30, 2017, the State, through its community mental health providers, will identify and maintain a list of all individuals admitted to, or at risk serious risk of being admitted to, NHH and/or Glencliff for whom ACT services are needed but not available, and develop effective regional and statewide plans for providing sufficient ACT services to ensure reasonable access by eligible individuals in the future.

The CMHA requires a robust and effective system of ACT services to be in place throughout the state as of June 30, 2015 (24 months ago). Further, as of June 30, 2016, the State was required to have the capacity to provide ACT to 1,500 priority Target Population individuals.

As displayed in Table II below, the staff capacity of the 12 adult ACT teams in New Hampshire has increased by only 8.03 FTEs (6.91%) since December of 2016. During the same time period, the twelve ACT teams added a total of 153 service participants, an increase of 18.24% (See Table III below).

Table II

Self-Reported ACT Staffing (excluding psychiatry): December 2016 – September 2017

Region	FTE Dec-16	FTE Mar-17	FTE Jun-17	FTE Sep-17	% change Dec-Sept
Northern	11.49	11.89	12.54	12.43	8.18%
West Central	5.5	7.75	7.15	6.95	26.36%
Genesis	11	11	10.6	10.8	-1.82%
Riverbend	9	10	10	10	11.11%
Monadnock	7.25	6.7	8.5	7.9	8.97%
Greater Nashua 1	6.25	6.25	5.25	6	-4.00%
Greater Nashua 2	5.25	5.25	5.25	5	-4.76%
Manchester – CTT	15.53	14.79	16.57	16.27	4.76%
Manchester MCST	21.37	21.86	21.95	22.31	4.40%
Seacoast	9.53	9.53	9.53	10.53	10.49%
Community Partners	6.85	4.08	8.53	6.73	-1.75%
Center for Life Management	7.17	8.3	9.3	9.3	29.71%
Total	116.19	117.4	125.17	124.22	6.91%

Table III

Self-Reported ACT Caseload (Unique Adult Consumers) by Region per Quarter: December 2016 – September 2017

Region	Active Cases Dec-16	Active Cases Mar-17	Active Cases Jun-17	Active Cases Sep-17	% change Dec-Sept
Northern	104	108	111	113	8.65%
West Central	32	53	76	68	112.50%
Genesis	64	70	74	74	15.63%
Riverbend	73	83	97	87	19.18%
Monadnock	63	64	70	69	9.52%
Greater Nashua	74	83	94	98	32.43%
Manchester	248	270	292	287	15.73%
Seacoast	65	64	69	67	3.08%
Community Partners	70	67	69	75	7.14%
Center for Life Management	47	55	55	54	14.89%
Total*	839	913	1,006	992	18.24%

* unduplicated across regions

It is clear from these tables that overall ACT staffing has remained low, and in four regions has decreased over the past four reporting periods. Four of the 12 adult ACT teams have fewer than the 7 - 10 professionals specified for ACT teams in the CMHA, as opposed to the two teams with reported staffing below the defined threshold noted in the previous report. Two teams continue to report having no peer specialist on the ACT Team. Five teams report having at least one FTE peer specialist, but that means that seven of the 12 teams continue to report having less than one FTE peer on the team. Five teams have at least 1.0 FTE supported employment staff, while seven continue to have less than a full time SE specialist on the ACT team. Five teams report having less than .5 FTE combined psychiatry/nurse practitioner time available to their ACT teams[2]; two teams report having less than 0.5 FTE nursing on the team; and seven of the 12 teams report having less than one FTE nurse per team.

The combined ACT teams have a reported September 2017 staff complement of 124.22 FTEs, which is sufficient capacity to serve 1,242 individuals based on the ACT staffing ratios contained in the CMHA. With a current statewide caseload of 992, the existing teams should theoretically be able to accept an additional 250 new ACT clients without adding any more staff. Tapping

[2] The CMHA specifies at least .5 FTE Psychiatrists for teams with at least 70 active service participants. (CMHA V.D.2(e).

into this unused capacity, with appropriate outreach and targeting, should have an impact on alleviating ED boarding and hospital readmission rates across the state. Further, the CMHA requires the State to have capacity to serve 1,500 individuals, but the current ACT capacity of 1,242 is 258 below CMHA criteria.

It is clear from the above tables that State initiatives to expand ACT capacity have had some success, and that overall ACT staffing capacity and active caseloads in most parts of the state have increased in the past year. However, as noted in previous reports, the current pace of staffing increases in combination with client outreach and engagement together are still not sufficient to meet CMHA requirements for ACT team capacity.

Based on the above information, the ER finds that the State remains out of compliance with the foundational service standards described in Section V.D. of the CMHA. The State does not currently provide a robust and effective system of ACT services throughout the state as required by the CMHA.

Additionally, the State has yet to finalize a process for identifying all individuals admitted to, or at risk serious risk of being admitted to, NHH and/or Glencliff for whom ACT services are needed but not available, and to develop effective regional and statewide plans for providing sufficient ACT services.

As noted in recent ER Reports, the New Hampshire DHHS has taken more aggressive action to work with CMHCs in certain Regions to increase their ACT staffing and caseloads. These actions include: (a) monthly ACT monitoring and technical assistance with DHHS leadership and staff; (b) implementation of a firm schedule for ACT self-assessments and DHHS fidelity reviews; (c) incorporating a small increase in ACT funding into the Medicaid rates for CMHCs; (d) active on-site monitoring and technical assistance for CMHCs not yet meeting CMHA ACT standards; and (e) substantial and coordinated efforts to address workforce recruitment and retention.

However, external and self-reported fidelity reviews for the 10 CMHC regions have revealed deficient practices that are not in fidelity with the ACT model. Compliance letters and Performance Improvement Plans (PIPs) have been initiated in several of the Regions. The ER continues to work with the State to assure that these PIPs have been implemented.

Initial QSR reports also revealed that several CMHCs failed to ensure individuals were receiving ACT services using the ACT fidelity model team approach, and with the appropriate frequency to address their individual treatment needs. The ER has emphasized to the State that the QSR process must measure the adequacy and effectiveness of individual ACT service provision, in order to demonstrate that these deficiencies are being corrected. The ER continues to monitor the implementation of quality improvement plans developed by CMHCs in response to these QSR findings.

The ER believes the State, DHHS and many of the CMHCs are making good faith efforts to meet the ACT capacity and fidelity standards of the CMHA. Despite the continued compliance issues noted above, the ER believes there have been improvements in the quality and effectiveness of ACT services provided in most parts of the state. Nonetheless, while these improvements are welcome, it must be noted that the State is still far from compliance with the ACT standards of the CMHA. As with previous reports, the ER expects DHHS and the CMHCs to make use of capacity already available in the system at all deliberate speed, while at the same time addressing additional capacity and fidelity issues.

DHHS and the CMHCs have been attempting to identify individuals at risk of hospitalization, incarceration or homelessness who might benefit from ACT services. Individuals boarding in hospital emergency departments waiting for a psychiatric hospital admission, or who have done so in the recent past, are one important source of potential referrals. DHHS is currently tracking the extent to which identifying and referring these individuals to CMHCS is: (a) reducing ED boarding episodes and lengths of stay; and (b) resulting in enrollment of new qualified individuals in ACT services. As noted in the hospital readmission discussion below, almost one-third of all those discharged out of NHH return for readmission within 180 days. Robust ACT services can help to reduce the number of hospital readmissions throughout the state if affected individuals are promptly screened and referred, and their regional ACT teams have the capacity to deliver needed services. The ER has requested that the State provide a report of the results of these activities. The State has agreed to provide such a report, but at the time of this report such data had not been made available. As a result, the ER can make no findings regarding the scope or efficacy of ongoing outreach and screening procedures for ACT. However, given the over 18 percent increase in ACT utilization noted in Table III, it is possible these initiatives have begun to have some effect on the system.

The State has identified workforce recruitment and retention issues as being a major factor limiting the growth and expansion of the ACT teams. The State has been working collaboratively with the New Hampshire CMHC Association to identify and track workforce gaps and shortages, and to implement a variety of strategies to improve workforce recruitment and retention. The almost seven percent increase in ACT staffing capacity over the past nine months may be some evidence that these strategies are beginning to produce results.

The ER emphasizes, as in past reports, that it must be the first priority of the State and the CMHCs to focus on: 1) assuring required ACT team composition; 2) utilizing existing ACT team capacity; 3) increasing ACT team capacity; and 4) outreach to and enrollment of new ACT clients. As noted earlier in this report, the ER expects the State to propose new and expanded strategies for increasing ACT capacity to meet the requirements of the CMHA. The strategies and related timelines are to be incorporated into the ACT plan and Monthly Progress Report.

Supported Employment

Pursuant to the CMHA's SE requirements, the State must accomplish three things: 1) provide SE services in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings consistent with their individual treatment plans (V.F.1); 2) meet Dartmouth fidelity standards for SE (V.F.1); and 3) meet penetration rate mandates set out in the CMHA. For example, the CMHA states: "By June 30, 2017, the State will increase its penetration rate of individuals with SMI receiving supported employment …to 18.6% of eligible individuals with SMI." (Section V.F.2(e)). In addition, by June 30, 2017 "the State will identify and maintain a list of individuals with SMI who would benefit from supported employment services, but for whom supported employment services are unavailable" and "develop an effective plan for providing sufficient supported employment services to ensure reasonable access to eligible individuals in the future." (V.F.2(f)).

For this reporting period, the State reports that it has achieved a statewide SE penetration rate of 26.4 percent, 42 percent above the 18.6% penetration rate target specified in the CMHA. Table IV below shows the SE penetration rates for each of the 10 Regional CMHCs in New Hampshire.

Table IV

Self-Reported CMHC SE Penetration Rates

	Penetration Dec-16	Penetration Mar-17	Penetration Jun-17	Penetration Sep-17
Northern	27.00%	32.30%	37.20%	40.90%
West Central	21.50%	23.20%	22.50%	22.30%
Genesis	14.50%	12.60%	22.00%	20.70%
Riverbend	13.80%	15.00%	14.80%	14.00%
Monadnock	17.90%	13.50%	14.00%	12.30%
Greater Nashua	12.40%	15.00%	16.10%	17.10%
Manchester	43.10%	39.80%	40.00%	42.00%
Seacoast	12.00%	14.40%	19.30%	23.40%
Community Part.	6.80%	7.20%	10.30%	14.60%
Center for Life Man.	21.10%	19.70%	21.60%	19.20%
CMHA Target	18.10%	18.60%	18.60%	18.60%
Statewide Average	22.90%	23.20%	25.30%	26.40%

As noted in Table IV, the State has exceeded the statewide CMHA penetration rate in recent reporting periods. In the previous ER report, six of the ten regions fell below required CMHA

penetration rates. For this reporting period, four of the ten continue to report penetration rates lower than the CMHA requirement. The New Hampshire DHHS is to be commended for continuing its efforts to: (a) measure the fidelity of SE services on a statewide basis; and (b) work with the Regions with penetration rates below CMHA criteria to increase access to and delivery of SE services to target population members in their Regions. The ER will continue to monitor these issues going forward as the State works with the CMHCs to increase penetration rates to at least 18.6 percent in all regions. As with ACT services, the DHHS has implemented a combination of contract compliance, technical assistance, workforce recruitment and retention, and internal and external fidelity reviews in an attempt to assure sufficient quality and accessibility of SE services statewide. There is currently no mechanism for measuring whether individuals are receiving SE services consistent with their individual treatment plans, or whether SE services are delivered in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings (V.F.1). In addition, as noted earlier in this report, there is no standard reporting of the extent to which SE participants are gaining integrated competitive employment. The ER has recommended that the QSR process measure whether and to what extent SE services are being delivered consistent with these requirements of the CMHA. As noted above, the ER expects the State to produce the requested data on SE integrated competitive employment by March 1, 2018.

Supported Housing

The CMHA requires the State to achieve a target capacity of 450 SH units funded through the Bridge Subsidy Program by June 30, 2016. As of September 2017, DHHS reports having 509 individuals in leased SH apartments, and 58 people approved for a subsidy but not yet leased. The number of people with rents paid has fallen by 36 compared to the prior quarter; the total number of slots has decreased from the prior quarter by 24 – from 591 slots to 567 slots. The State is in compliance with the CMHA numerical standards for SH effective June 30, 2016, but as is discussed below, not yet in compliance with 2017 CMHA criteria.

Table V below summarizes recent data supplied by DHHS related to the Bridge Subsidy Program.

Table V

New Hampshire DHHS Self-Reported Data on the Bridge Subsidy Program:

September 2015 through September 2017

Bridge Subsidy Program Information	March 2016	Sept. 2016	Dec. 2016	March 2017	June 2017	Sept. 2017
Total housing slots (subsidies) available	450	479	513	553	591	567
Total people for whom rents are being subsidized	415	451	481	505	545	509
Individuals accepted but waiting to lease	22	28	32	48	46	58
Individuals currently on the wait list for a bridge subsidy	0	0	0	0	0	0
Total number served since the inception of the Bridge Subsidy Program	518	603	643	675	701	742
Total number receiving a Housing Choice (Section 8) Voucher	71	83	83	85	85	96

The CMHA stipulates that "…all new supported housing …will be scattered-site supported housing, with no more than two units or 10 percent of the units in a multi-unit building with 10 or more units, whichever is greater, and no more than two units in any building with fewer than 10 units known by the State to be occupied by individuals in the Target Population." (V.E.1(b)). Table VI below displays the reported number of units leased at the same address.

Table VI

Self-Reported Housing Bridge Subsidy Concentration (Density)

	Sept. 2015	March 2016	June 2016	Nov. 2016	Feb. 2017	May 2017	Nov. 2017
Number of properties with one leased SH unit at the same address	290	317	325	339	349	367	383
Number of properties with two SH units at the same address	27	22	35	24	23	36	31
Number of properties with three SH units at the same address	2	13	8	13	14	5	6
Number of properties with four SH units at the same address	4	1	1	3	4	4	5
Number of properties with five SH units at the same address	1	2	2	0	0	3	0
Number of properties with six SH units at the same address	1	0	1	1	1	1	0
Number of properties with seven + SH units at same address					0	2	3

These data show that 85% of the leased units are at a unique address or with one additional unit at that address. This supports a conclusion that the Bridge Subsidy Program, to a large degree, is operating as a scattered-site program. For the units shown in Table VI at the same address, it is not known at this time whether the unit density standards included in the CMHA are being met. DHHS is collecting information on the total units in each property where there are two or more Bridge units at the same address, and this data will be reported when it is made available.

It should be noted that these data do not indicate whether any of the leased units are roommate situations, and if so, whether such arrangements meet the requirements of the CMHA (V.E.1(c)). DHHS reports, and anecdotal information seems to support, that there are very few, if any, roommate situations among the currently leased Bridge Subsidy Program units.[3]

As noted in the Data section of this report, current data is not available on the degree to which Bridge Subsidy Program participants access and utilize support services and whether or not the services are effective and meet individualized needs. Receipt of services is not a condition of eligibility for a subsidy under the Bridge Program, but the CMHA does specify that "…supported housing includes support services to enable individuals to attain and maintain integrated affordable housing, and includes support services that are flexible and available as needed and desired…." (V.E.1(a)). As noted in the 2016 and 2017 ER Reports, DHHS has been working on a method to cross-match the Bridge Subsidy Program participant list with the Phoenix II and Medicaid claims data. This will allow documentation of the degree to which Bridge Subsidy Program participants are actually receiving certain mental health or other services and supports. As of the writing of this report, the ER has not received this requested information from the state. The ER expects that such information will be produced and delivered to the ER no later than March 1, 2018. The ER will also work with the State to review and analyze data to determine whether or not individuals have experienced improved outcomes after obtaining supported housing.

In previous reports the ER has identified a number of important and needed data elements associated with the SH eligibility criteria and lack of a waitlist, as well as monitoring implementation of the SH program in the context of the CMHA. These include:

- Total number of Bridge Subsidy Program applicants per quarter;
- Referral sources for Bridge Subsidy Program applicants;
- Number and percent approved for the Bridge Subsidy Program;
- Number and percent rejected for the Bridge Subsidy Program;
    - Reasons for rejection of completed applications, separately documenting those who are rejected because they do not meet federal HCV/Section 8 eligibility requirements;
- Number and disposition of appeals related to rejections of applications;

[3] DHHS reports that currently there is one voluntary roommate situation reflected in the above data.

- Elapsed time between application, approval, and lease-up;
- Number of new individuals leased-up during the quarter;
- Number of terminations from Bridge subsidies per quarter;
- Reasons for termination:
  - Attained permanent subsidized housing (Section 8, public housing, etc.);
  - Chose other living arrangement or housing resource;
  - Moved out of state;
  - Deceased;
  - Long term hospitalization;
  - Incarceration;
  - Landlord termination or eviction; or
  - Other;
- Number of Bridge Subsidy Program participants in a roommate situation; and
- Lease density in properties with multiple Bridge Subsidy Program leases.

This information is important in assessing whether eligibility is properly determined, whether a waitlist is properly maintained, whether or not support services are adequate to enable the individual to "attain and maintain integrated affordable housing," and whether services are "flexible and available as needed and desired." Most rental assistance programs collect and report such information, given its intrinsic value in monitoring program operations. Further, such data enhances DHHS' ability to demonstrate the timeliness and effectiveness of access of the priority target population to this essential CMHA program component. Most importantly, this data is necessary to help the ER determine compliance with CMHA Sections IV.B, IV.C, and VII.A. The ER will continue to work collaboratively with DHHS to identify sources and methods for such data collection and reporting. As noted above, the state has yet to produce or deliver the requested information. And, as noted above, the ER expects production of all requested information pertaining to the SH program to be produced no later than March 1, 2018.

The CMHA also states that: "By June 30, 2017 the State will make all reasonable efforts to apply for and obtain HUD funding for an additional 150 supported housing units for a total of 600 supported housing units." (CMHA V.E.3(e)) In 2015 New Hampshire applied for and was awarded funds to develop a total of 191 units of supported housing under the HUD Section 811 Program. All of these units will be set aside for people with serious mental illness. As of the date of this report, nine of these new units have been developed and are currently occupied by members of the target population and an additional 69 units are in the development pipeline. It should be noted that over the life of the Bridge Subsidy Program the State has accessed 96 HUD Housing Choice Vouchers (HCV – Section 8). These have allowed the State to free up 96 Bridge Subsidy units for new applicants. Nonetheless, the current number of SH slots and units is below the 600 figure set out in the CMHA.

In addition, the CMHA states that "By January 1, 2017, the State will identify and maintain a waitlist of all individuals within the Target Population requiring supported housing services, and whenever there are 25 individuals on the waitlist, each of whom has been on the waitlist for more than two months, the State will add program capacity on an ongoing basis sufficient to ensure that no individual waits longer than six months for supported housing." The ER notes that the State is still not maintaining or reporting on a wait list of people within the target population who are waiting for supported housing services. The State has shared information from October 2017 indicating that 20 individuals who could be discharged from New Hampshire Hospital remain unnecessarily hospitalized because of homelessness, that an additional 10 individuals are similarly stuck at NHH because they are awaiting transitional housing, and that 10 Glencliff residents referred to the Central Team were determined to have residential discharge barriers. Some of these individuals may be ineligible for Bridge housing but nonetheless fall within the Target Population and require supported housing. The ER expects that by March 1, 2018 the State will identify such individuals in a waitlist and maintain that waitlist going forward as required by the CMHA.

Transitions from Institutional to Community Settings

During the past 30 months, the ER has visited both Glencliff and NHH on at least six separate occasions to meet with staff engaged in transition planning under the new policies and procedures adopted by both facilities late last year. Transition planning activities related to specific current residents in both facilities have been observed, and a small non-random sample of resident transition records has been reviewed. Additional discussions have also been held with both line staff and senior clinicians/administrators regarding potential barriers to effective discharge to the most appropriate community settings for residents at both facilities.

The ER has participated in four meetings of the Central Team. The CMHA required the State to create a Central Team to overcome barriers to discharge from institutional settings to community settings. The Central Team has now had about 24 months of operational experience, and has started reporting data on its activities. To date, 34 individuals have been submitted to the Central Team, 21 from Glencliff and 13 from NHH. Of these, the State reports that 13 individual cases have been resolved[4], two individuals are deceased, and 19 individual cases remain under consideration. Table VII below summarizes the discharge barriers that have been identified by the Central Team with regard to these 19 individuals. Note that most individuals encounter multiple discharge barriers, resulting in a total substantially higher than the number of individuals reviewed by the Central Team.

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[4] Two of these individuals were readmitted to NHH after 90 days, and the discharge dispositions for these two individuals are being reviewed.

Table VII

Discharge Barriers for Open Cases Referred from NHH and Glencliff to the Central Team: October 2017[5]

Discharge Barriers	Number for Glencliff	Number for NHH
Legal	3 (10.3%)	4 (21.1%)
Residential	10 (34.5%)	5 (26.3%)
Financial	6 (20.7%)	3 (15.8%)
Clinical	7 (24.1%)	3 (15.8%)
Family/Guardian	1 (3.4%)	2 (10.5%)
Other	2 (6.9%)	2 (10.5%)

Although this Report notes increased efforts and leadership at the State level with regard to the operations of the Central Team, the ER expects that the total number of referrals will grow, and the pace at which individual barriers are resolved will quicken, over the next six month period.

Glencliff

In the time period from April through September, 2017, Glencliff reports that it has admitted 12 individuals, and has had four discharges. The average daily census through this period was 106.5 people. There have been no readmissions during this time frame. The wait list for admission has increased slightly, from 17 people in the previous quarter to 19 people for this quarter. Four discharges have been effectuated during this period; one of which was to an integrated community setting. Two current residents are in active transition planning, and both of whom are expected to be transitioned to integrated community settings within the next several months.

CMHA Section VI requires the State to develop effective transition plans for all appropriate residents of NHH and Glencliff and to implement them to enable these individuals to live in integrated community settings. In addition, Section V.E.3(i) of the CMHA also requires the State by June 30, 2017 to: "…have the capacity to serve in the community [a total of 16][6] individuals with mental illness and complex health care needs residing at Glencliff…." The CMHA defines these as: "individuals with mental illness and complex health care needs who could not be cost-effectively served in supported housing."[7] The ER notes that Glencliff continues to support and effectuate transitions of individuals to integrated community settings under a variety of other funding and living arrangements.

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[5] This is a point in time report for open cases.
[6] Cumulative from CMHA V.E.(g), (h), and (i).
[7] CMHA V.E.2(a)

DHHS reports that the total number of people with complex health conditions transitioned from Glencliff to integrated settings since the inception of the CMHA three years ago increased this quarter from 12 to 14. A fifteenth person is scheduled to transition to an individual apartment as soon as necessary modifications are completed. There are currently 12 individuals undergoing transition planning who could be transitioned to integrated community settings once appropriate living settings and community services become available. Ten of these individuals have been assigned to Choices for Independence (CFI) waiver case management agencies.

DHHS has agreed to provide the ER information about the recent transitions, including clinical summaries, lengths of stay, location and type of community integrated setting, and array of individual services and supports arranged to support them in the integrated community settings. This information is important to monitor the degree to which individuals with complex medical conditions who could not be cost-effectively be served in supported housing continue to experience transitions to integrated community settings.

Of the 14 individuals reported by DHHS to have transitioned to community settings since the onset of the CMHA, the ER agrees five meet the criteria of being medically complex and not able to be cost effectively served in supported housing. Three of these individuals currently reside in a newly developed small scale community residence, and two are living in enhanced family care homes (EFCs) with extensive Medicaid and non-Medicaid services. A sixth person with complex medical needs will be transitioned, as noted above, once apartment modifications are complete.

DHHS has also begun to implement certain action steps to enhance the process of: (a) identifying Glencliff residents wishing to transition to integrated settings; and (b) to increase the capacity, variety and geographic accessibility of integrated community settings and services available to meet the needs of these individuals. Both sets of initiatives should facilitate and speed up such community transitions for additional Glencliff residents.

As noted in the previous report, the ER is at this point reluctant to focus too narrowly on clinical conditions and sets of health, mental health and community services and supports for transitioned and transitioning individuals to monitor the State's progress in assisting Glencliff Home residents to transition to integrated community settings. The ER will monitor the extent to which DHHS, Glencliff, the CMHCs and an array of other community partners collaborate to effectuate as many such transitions as possible over the next two years. The primary thrust and intent of the CMHA is to assure that individuals residing in Glencliff (and their families and guardians) are offered and are willing to accept meaningful opportunities to transition to integrated community settings. It appears likely that the specific requirement in the CMHA for the State to create capacity to serve 16 individuals with complex medical conditions who cannot be cost-effectively served in supported housing will be attained if DHHS and its partners continue to increase the availability of integrated community settings, and provide meaningful in-reach and transition planning for Glencliff residents.

Thus, the ER will continue to monitor the following topics/items going forward:

1. The number of transitions from Glencliff to integrated community settings per quarter. The ER will also monitor information about the clinical and functional level of care needs of these individuals; the integrated settings to which they transition; and the array of Medicaid and non-Medicaid mental health and health-related services and supports put in place to meet their needs to assure successful integrated community living.
2. The number of Glencliff residents newly identified per quarter to engage in transition planning and move towards integrated community settings. The ER will also monitor at a summary level the clinical and functional level of care needs of individuals added to the transition planning list per quarter.
3. New integrated community setting providers with the capacity to facilitate integrated community living for Glencliff residents. These could include EFCs, AFCs, and new small-scale community residential capacity for people with complex medical conditions who cannot be cost-effectively served in supported housing. The ER will monitor DHHS activities and successes relative to identification and engagement of new community providers who express willingness and capacity to provide services in integrated community settings for people transitioning from Glencliff.
4. Within the discharge cohort, the number of transitioned individuals for whom the State special funding mechanism is utilized to effectuate the transition, and the ways in which these funds are used to fill gaps in existing services and supports.
5. Number and types of in-reach visits and communications by CMHCs and other community providers related to identifying and facilitating transitions of Glencliff residents to integrated community settings.
6. Specific documentation of efforts to overcome family and/or guardian resistance to integrated community transitions for Glencliff residents.
7. Number of individuals engaged in transition planning referred to the Central Team; number of these individuals who successfully transition to an integrated community setting; and the elapsed time from referral to resolution.

Preadmission Screening and Resident Review (PASRR)

The State DHHS has provided recent data on PASRR screens for the period August 1, 2017 through October 31, 2017.

Table VIII below provided a high level summary of these data.

Table VIII

PASRR Level I and Level II Screens: 8/1/2017-10/31/2017[8]

[8] Note that reporting of PASRR data is not currently on the same quarterly basis as most of the other data in this report.

Place of Residence at time of screen	PASRR Level I	PASRR Level II
Assisted Living Facility	7	2
Group Home	10	6
Home	56	10
Homeless Shelter	2	1
Inpatient Hospital	35	16
Inpatient Psychiatric Facility	7	2
Nursing Facility	41	21
Other	1	1
Total	159	59

According to the data provided by DHHS, 54 of the Level I screens in the time frame resulted in a referral for a Level II screen.[9] Of these, 35 (65%) were referred because of mental illness; and 7 (13%) were for ID/DD. In this reporting period a total of 59 PASRR Level II screens were completed: 39 (59.7%) received full approval with no special services (SS)[10]; 4 (6.8%) were approved with SS; 14 (23.7%) received provisional approval with no SS; and 2 (3.4%) received provisional approval with SS.

From the data provided it is not possible to determine the disposition results for people referred for Level II screening by reason of mental illness versus those referred for ID/DD or other reasons. Nor is it possible to identify people within either the Level I or Level II categories that were referred to potential integrated community living alternatives. Finally, it is not possible to distinguish which among the Level I and Level II screens might represent a person referred or admitted to Glencliff.

The ER notes that PASRR screens are typically completed before a person is referred to Glencliff, since Glencliff requires that applicants be rejected by at least three nursing facilities before being considered for admission to Glencliff. Thus, a PASRR screen by itself might only indirectly impact admission decisions to Glencliff. Nonetheless, during the up-coming six month period the ER plans to review the individual PASRR screen documents for recent referrals and admissions to Glencliff.

New Hampshire Hospital and the Designated Receiving Facilities (DRFs)

For the time period April through September 2017, DHHS reports that NHH effectuated 497 admissions and 498 discharges. The mean daily census was 153, and the median length of stay for discharges was 13 days in the most recent quarter.

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[9] Referrals for Level II screens could have originated in a previous reporting period, so the number of referrals reported would not necessarily correspond to the number of completed Level II screens completed in the period.

[10] Special services are to be provided over and above the nursing facility services that are included within the facility's regular reimbursement rate.

Table IX below compares NHH discharge destination information for the five most recent reporting periods (9/2015 through 9/2017). The numbers are expressed as percentages because the length of the reporting periods had not previously been consistent, although the type of discharge destination data reported has been consistent throughout.

Table IX

New Hampshire Hospital Self-Reported Data on

Discharge Destination

Discharge Destination	Percent September 2015 through April 2016	Percent October and November 2016	Percent January through March 2017	Percent April through June 2017	Percent July through September 2017
Home – live alone or with others	80.2%	85.1%	84.5%	85.66%	88.3
Glencliff	0.60%	0.36%	1.55%	0,35%	0.49%
Homeless Shelter/motel	2.7%	2.54%	2.71%	3.5%	2.94%
Group home 5+/DDS supported living, etc.	3.2%	1.62%	5.7%	5.59%	3.92%
Jail/corrections	1.4%	2.9%	0.8%	1.05%	0.49%
Nursing home/rehab facility	0.80%	3.6%	1.9%	3.50%	2.45%

The State now consistently reports information on the hospital-based DRFs and The Cypress Center in New Hampshire. It is important to capture the DRF/Cypress Center data and analyze it with NHH and Glencliff data to get a total institutional census across the state for the SMI population. The ER appreciates the State gathering this information. Table X summarizes this data.

Table X

Self-Reported DRF/APRTP Utilization Data: January 2016 through September 2017

	Franklin	Cypress	Portsmouth	Eliot Geriatric	Eliot Pathways	Total
Admissions						
Jan - March 2016	69	257	46	65	121	558
April - June 2016	79	205	378	49	92	803
July - Sept 2016	37	207	375	54	114	787
Oct - Dec 2016	39	217	310	43	72	681
Jan - March 2017	65	204	317	48	138	772
April - June 2017	60	228	363	52	101	804
July - September 2017	NA**	247	363	60	121	NA
Percent involuntary						
Jan - March 2016	53.70%	18.70%	NA	18.50%	30.60%	26.20%*
April - June 2016	55.70%	24.40%	20.40%	4.10%	48.90%	25.50%
July - Sept 2016	43.20%	29.50%	18.90%	13.00%	44.70%	26.20%
Oct - Dec 2016	53.80%	28.60%	17.10%	16.30%	43.10%	25.60%
Jan - March 2017	70.70%	34.30%	21.80%	12.50%	43.50%	32.50%
April - June 2017	58.30%	21.50%	22.00%	11.50%	47.50%	27.10%
July - September 2017	NA**	27.90%	25.60%	10.0%	50.40%	NA
Average Census						
Jan - March 2016	7.9	14.7	NA	19.7	18.1	60.1*
April - June 2016	7.8	13.2	21.4	22.5	16.9	81.8
July - Sept 2016	4.5	13.6	23.2	25.6	14.5	81.4
Oct – Dec 2016	5.6	12.4	23.4	24.8	11.5	77.7
Jan - March 2017	5	14.6	27.2	31.2	24.6	102.6
April - June 2017	4.5	12	30.3	29.3	10	86.1
July - September 2017	NA**	12.9	23.9	29.7	12.2	NA

	Franklin	Cypress	Portsmouth	Eliot Geriatric	Eliot Pathways	Total
Discharges						
Jan - March 2016	76	261	NA	57	122	516*
April - June 2016	78	206	363	51	90	788
July - Sept 2016	35	213	380	64	113	805
Oct - Dec 2016	41	213	309	46	75	684
Jan - March 2017	65	211	305	49	130	760
April - June 2017	59	232	365	54	105	815
July - September 2017	NA**	243	355	63	121	NA
Mean LOS for Discharges						
Jan - March 2016	8.6	4.2	NA	15	7.4	8.8*
April - June 2016	6	4	4	28	7	5
July - Sept 2016	7	5	4	24	8	5
Oct - Dec 2016	5	5	5	24	8	5
Jan - March 2017	5	4	5	27	7	5
April - June 2017	6	4	5	22	8	9
July - September 2017	NA**	4	4	27	7	NA

* Does not include Portsmouth

** Franklin DRF did not report data for the July - September period.

The DRFs should theoretically relieve some of the pressure on NHH for inpatient admissions, and should also reduce the number of people waiting for psychiatric admissions in hospital EDs. As will be discussed in a later section of this report, the State has received funding for additional general hospital DRF beds. The DRF discharge cohort may also be a good source of referrals to CMHCs for ACT or other best practice community services. The ER will continue to work with DHHS to monitor the degree to which DRF functions and activities support the overall objectives of the CMHA.

DHHS has recently begun tracking discharge dispositions for people admitted to the DRFs and Cypress Center. Table XI below provides a summary of these recently reported data.

Table XI

Cumulative Self-Reported Discharge Dispositions for DRFs in New Hampshire

October 2016 through September 2017

Disposition	Franklin **	Cypress	Portsmouth	Eliot Geriatric	Eliot Pathways	Total
Home	136	744	900	43	357	2,180
NHH	5	6	29	1	12	53
Residential Facility/ Assisted Living	6	10	0	134	7	157
Other DRF	1	20	9	2	2	43
Hospital	2	0	0	13	1	16
Death	0	0	0	17	0	17
Other or Unknown	15	54	331	3	52	455

*The Other category for Portsmouth Regional is reported to include shelters, rehab facilities, hotels/motels, friends/families, and unknown.

** Does not include Franklin data for the period July through September 2017.

Based on these self-reported data, 74.8% of the 2,915 discharges from DRFs and the Cypress Center are to home. This compares to the 85% or greater discharges to home reported by NHH. 5.3% of the total DRF discharges are to residential care or assisted living, which is similar to NHH discharges for this category. 1.7% of the DRF discharges are to NHH, 1.5% is to other DRFs. 15.6% of the total discharges are to the other/unknown category, but 73% of these are accounted for by the Portsmouth DRF. This might point to an anomaly in the ways facilities use this category in their reports to the state. The ER will work with the State to clarify what types of discharges are allocated to the other/unknown category for all of the DRFs and the Cypress Center.

Hospital Readmissions

DHHS is now reporting readmission rates for both NHH and the DRFs. Table XII below summarizes these data:

Table XII

Self-Reported Readmission Rates for NHH and the DRFs

October – December 2016

	Number 30 Days	Percent 30 Days	Number 90 Days	Percent 90 Days	Number 180 Days	Percent 180 Days	Total Number
NHH	36	13.0%	78	28.30%	97	35.10%	211
Franklin	1	2.50%	1	2.5%	1	1.50%	3
Cypress	13	6.00%	21	9.70%	24	11.10%	58
Portsmouth	25	8.10%	44	14.20%	56	18.10%	125
Elliot Geriatric	2	4.70%	2	4.70%	4	9.30%	8
Elliot Pathways	8	11.10%	9	12.50%	9	12.50%	26
Total	85		155		191		431

January - March 2017

	Number 30 Days	Percent 30 Days	Number 90 Days	Percent 90 Days	Number 180 Days	Percent 180 Days	Total
NHH	21	8.00%	52	19.80%	73	27.80%	146
Franklin	0	0.00%	0	0.00%	1	1.50%	1
Cypress	14	6.90%	24	11.80%	34	16.70%	72
Portsmouth	23	7.30%	41	12.90%	58	18.30%	122
Elliot Geriatric	4	8.30%	5	10.40%	5	10.40%	14
Elliot Pathways	4	2.90%	6	4.30%	10	7.20%	20
Total	66		128		181		375

April - June 2017

	Number 30 Days	Percent 30 Days	Number 90 Days	Percent 90 Days	Number 180 Days	Percent 180 Days	Total Number
NHH	44	15%	71	24.20%	94	32.1	209
Franklin	0	0.00%	0	0.00%	0	0.00%	0
Cypress	11	4.80%	21	9.20%	30	13.20%	62
Portsmouth	37	10.20%	56	15.40%	75	20.70%	168
Elliot Geriatric	2	3.80%	2	3.80%	3	5.80%	7
Elliot Pathways	7	6.90%	8	7.90%	11	10.90%	26
Total	101		158		213		472

July - September 2017

	Number 30 Days	Percent 30 Days	Number 90 Days	Percent 90 Days	Number 180 Days	Percent 180 Days	Total Number
NHH	20	9.80%	44	21.60%	57	27.90%	121
Franklin	NA	NA	NA	NA	NA	NA	NA
Cypress	12	7.10%	21	12.40%	27	15.90%	60
Portsmouth	33	11.50%	50	17.50%	60	21.00%	143
Elliot Geriatric	0	0.00%	0	0.00%	0	0.00%	0
Elliot Pathways	4	3.30%	8	6.60%	15	12.40%	27
Total	69*		123*		159*		351*

*Totals do not include Franklin readmissions.

In the previous report the ER noted that readmission rates may indicate that people being discharged from inpatient psychiatric facilities are not connecting with necessary and appropriate services and supports in the community. Trends in readmission rates may also be indicators of increased or decreased pressures on the overall system of care. For example, decreased readmission rates could be an indicator that hospitals are not discharging people too quickly because of pressures to admit new patients. Decreases could also indicate that connections to appropriate community services and supports are occurring more effectively. As of the data of

this report, 180-day readmission rates to NHH are substantial, with almost one-third of those discharged returning to NHH within six months.

It is also important to note that the data reported currently include only readmission rates to the same facility, thus potentially understating the extent to which individuals in the target population may be subject to repeated admissions at more than one inpatient facility. In the next reporting period, the ER will work with the State to determine if data that reflects subsequent admission to any institutional facility can be made available – thus providing a more accurate picture of the rate and frequency with which individuals are relying on inpatient facilities statewide.

The data in Table XII above has not been reported for a long enough period to identify trends in readmission rates with confidence. Nonetheless, they do provide some insight into the number of instances in which an appropriate community intervention could have prevented an unnecessary re-hospitalization. For example, if even ten percent of the readmissions between January and March 2017 were diverted through ACT and other community resources, there would have been 38 fewer hospital admissions during that period, with a concurrent lower number of hospital bed days utilized.

The ER will continue to work with DHHS to monitor these data to interpret how they may contribute to overall system improvements consistent with the CMHA.

In the previous three reports, the ER has identified the waiting list (hospital ED boarding) for admission to NHH to be an important indicator of overall system performance. Chart A below displays daily adult admissions delays to NHH for the period July 1, 2016 through October 26, 2017. Chart B shows the average daily ED waiting list for the same time period.)

Chart A

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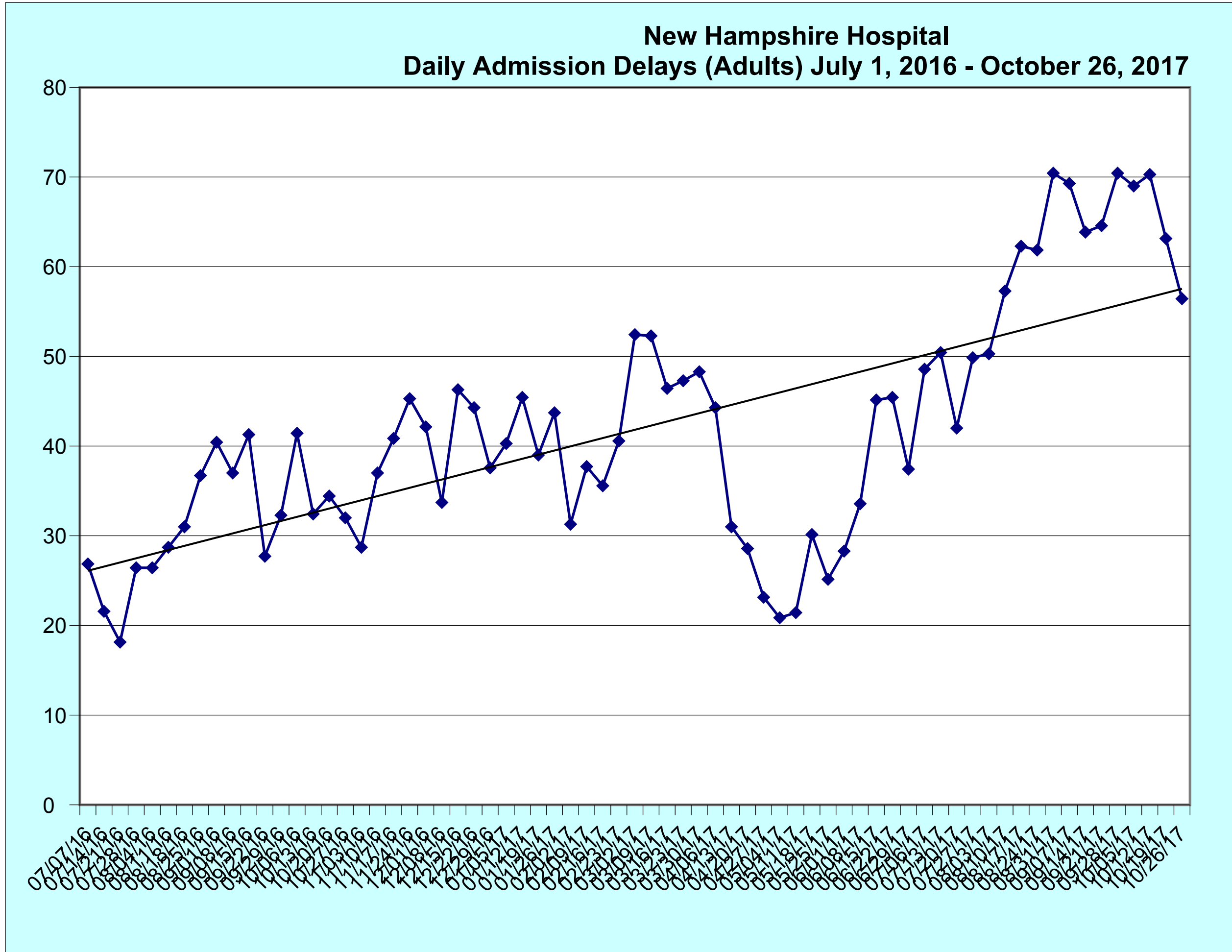
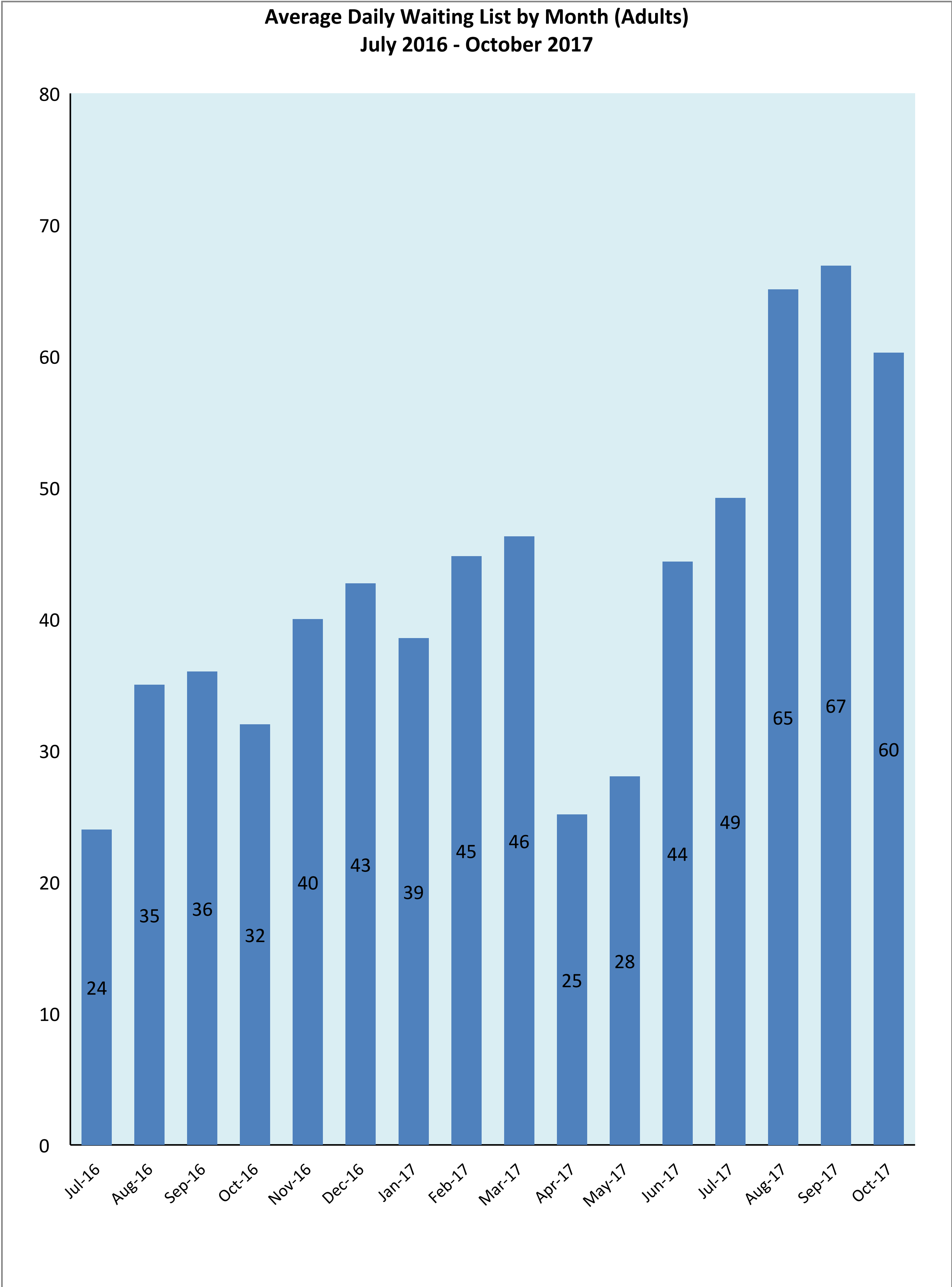


Chart B


Average Daily Waiting List by Month (Adults)
July 2016 - October 2017
80
70
60
50
40
30
20
10
0
24
35
36
32
40
43
39
45
46
25
28
44
49
65
67
60
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17

Based on information reported by DHHS and summarized above, the average number of adults waiting for a NHH inpatient psychiatric bed was 24 per day in FY 2014; 25 per day in FY 2015; and through June of FY 2016 was 28 per day. For the period July 2016 through September 2017, the average monthly wait list for admission to NHH was 42.4 adults. Not surprisingly, as can be seen from Carts A and B together, there appears to be a correlation between the numbers waiting in EDs and the daily admission rate at NHH.

DHHS continues to analyze data related to adults boarding in EDs who may have some connection to the mental health system. DHHS is making these data available to CMHCs on a monthly basis, and expects the CMHCs to use these data to identify potential participants for ACT or related services to reduce the risk of hospitalization and support integrated community living. In future months, DHHS will be receiving information on the degree to which CMHCs have increased ACT (or other services') participation as a result of these analyses. The ER plans to include summaries of this information in future reports. The ER continues to encourage the State, in conjunction with the CMHCs, to conduct targeted outreach to those individuals who may need expanded or enhanced community services so as to minimize or eliminate contact with hospital or institutional settings.

Family and Peer Supports

Family Supports

Per the CMHA, the State has maintained its contract with NAMI New Hampshire for family support services. The ER will arrange for additional NAMI meetings during the next six months.

Peer Support Agencies

As noted in the June 30, 2015 ER report, New Hampshire reported having a total of 16 peer support agency program (PSA) sites, with at least one program site in each of the ten regions. The State now reports having 15 PSAs. The State continues to report that all peer support centers meet the CMHA requirement to be open 44 hours per week. The State reports that those sites have a cumulative total of 2,685 members[11], with an active daily participation rate of 167 people statewide. Membership and active daily participation for the PSAs seems to be relatively unchanged from reporting period to reporting period.

The CMHA requires the peer support programs to be "effective" in helping individuals in managing and coping with the symptoms of their illness, self-advocacy, and identifying and using natural supports. As noted in previous reports, enhanced efforts to increase active daily participation appear to be warranted for the peer support agency programs. Anecdotally, some of the CMHCs report making more concerted efforts to refer service participants to the PSAs in

[11] The State reports that the Peer Support Agencies in the past year have made concerted efforts to verify and correct their membership lists. This activity has resulted in a small reduction in the number of members reported during this time period.

their regions. Increased efforts to communicate and coordinate with PSAs have also been reported. However, as of the most recent report there has not been a consequent increase in active daily participation.

Anecdotally, the ER continues to believe that in some regions of the state, relationships and communications among the CMHCs and the Peer Support Programs have improved. Peer support programs are generally reported by CMHCs to be useful sources of employees for ACT and Mobile Crisis and Crisis Apartment services. In addition, CMHCs report that the peer operated crisis beds available in several regions are a useful intervention for some CMHC clients at risk of hospitalization.

IV. Quality Assurance Systems

In the past 30 months, DHHS has made substantial progress in the design of the QSR process required by the CMHA. Fifteen QSR site visits have been conducted to date, and reports of the findings of most of these site visits have been posted for public review. Based on the experiences of those QSR site visits, plus on-going input from representatives of the Plaintiffs and the ER (in a technical assistance role), the QSR team has continued to make revisions to the QSR protocol, instruments, and scoring algorithm. The most recent round of changes recommended by the Plaintiffs and separately by the ER are currently being implemented. Three on-site QSR visits have been conducted using the new instruments and are currently being scored, analyzed and reported using the revised scoring process. Reports of these QSR site visits have not yet been published. Nor have any quality improvements plans yet been developed by the respective CMHCs in response to the QSR findings. Thus, the ER is not able at this time to comment on the results of the revised QSR instrumentation, protocols and scoring methodologies.

Nonetheless, having participated in two QSR site visits, the ER is confident that: (a) the revised instruments and site interview protocols are working well; and (b) the results and findings of the revised QSR instruments and process reflect, to a large degree, the quality standards of the CMHA.

One key improvement in the revised QSR process has been the addition of several Overall Clinical Review (OCR) questions that provide opportunities for the QSR teams to integrate and summarize service participant-level information collected from a variety of information sources. These new questions include:[12]

1. Is the frequency and intensity of services consistent with the individual's demonstrated need?

[12] Note: detail follow-up questions have not been included in this list.

2. Are there additional services the individual needs that are not identified in the assessment(s) or the treatment plan?
3. Is the individual receiving all the services s/he needs to ensure health, safety, and welfare?
4. Is the individual receiving adequate services that provide reasonable opportunities to support the individual to achieve independence and integration in the community?
5. Is the individual receiving adequate services to obtain and maintain stable housing?
6. Is the individual receiving adequate services to avoid harms and decrease the incidence of unnecessary hospital contacts and/or institutionalization?
7. Is the individual receiving adequate services to live in the most integrated setting?

Questions have also been embedded in the QSR instruments to more accurately document that: (a) the assessment(s) accurately reflect the individual's strengths, needs and goals; and (b) service delivery approaches and patterns reflect best practices, where applicable.

These types of questions reflect the essence of the QSR process: documenting that individual service participants receive the levels and types of services and supports that assist them to achieve their goals and meet their needs in the most integrated community setting possible. These questions also directly respond to target population outcomes and quality expectations of the CMHA. Going forward, responses to these questions are intended to form an important part of the six-month ER reports.

The ER is grateful to both the State and the representatives of the Plaintiffs who have worked long and hard to design and implement a QSR process that will legitimately and accurately reflect the quality and effectiveness of the community mental health system in New Hampshire. This QSR system is a critical element of the CMHA, but in fact it has much broader application and potential long term benefits for the entire mental health system.

As noted above, the State has continued to refine and revise the scoring algorithms within the QSR process. These changes, among many others, reflect the OCR questions as described above. Some issues remain among the State, representatives of the Plaintiffs, and the ER with regard to how the scoring algorithms will be applied across the entire QSR process, and how negative responses to OCR questions will inform required quality improvement plans. Finally, the ER and the parties continue to discuss how to increase expectations for CMHC performance in annual QSR reviews, while also ensuring all CMHCs achieve or exceed the minimum score of 70 percent. Publication of recent QSR site reports using the revised instruments and scoring protocol will assist all parties to reach closure on these issues.

As noted earlier in this report, DHHS has been conducting on-site ACT and SE fidelity reviews to supplement and validate the ACT and SE fidelity self-assessments conducted on an annual basis by the CMHCs. DHHS has engaged the Dartmouth/Hitchcock Center on Evidence Based practices to assist in attaining and assuring fidelity to the evidence based models of ACT and SE.

The Dartmouth/Hitchcock team will also assist on workforce development and training for these and other evidence based practices under the aegis of DHHS and the CMHCs. This partnership with the nationally respected Dartmouth/Hitchcock Center adds valuable expertise and experienced personnel to facilitate further development and operations of fidelity model ACT and SE in conformance with the CMHA. Year-to-year comparisons and the CMHCs Performance Improvement Plan have been included in the publication of recent ACT and SE fidelity reviews. The ER commends DHHS for implementing the comprehensive fidelity review process and its attendant quality improvement and technical assistance activities.

Effective and validated fidelity reviews and consequent training and workforce development activities are essential to DHHS' overall quality management efforts for the community mental health system. As noted in the previous two ER reports, the QSR and the fidelity reviews mutually support but do not supplant or replace each other. The QSR, in particular, examines outcomes from a consumer-centric perspective as opposed to an operational or organizational perspective. It is uniquely positioned to assess the quality, appropriateness and effectiveness of specific ACT and SE services at the individual participant level. The ER continues to believe that implementation of fidelity-based models of delivery does not necessarily mean that specific service interventions are working well or being delivered with the frequency or intensity required by a participant's individual treatment plan The revised QSR instruments and protocols address many of these concerns. In combination, the fidelity reviews and the QSR can mutually support conclusions about the overall quality and effectiveness of the mental health system consistent with the CMHA.

The ER will continue to monitor the degree to which the QSR process produces reliable information on individual outcomes and the quality of CMHA service delivery. In addition, over the next six months, the ER will evaluate the extent to which CMHC Quality Improvement Plans developed as part of the 2017 QSR site visits, are resulting in recommended practice changes and improved outcomes for those in the target population.

V. New State Resources For the CMHA

In New Hampshire the Governor and the Legislature have evidenced increased support for implementation of the CMHA and for making continued improvement in the community mental health system. Table XIII below summarizes new resources appropriated for the current biennium.

Table XIII

New Community Mental Health Resources in New Hampshire for SFY 2018 and 2019

Item	SFY 2018	SFY 2019	Total
Transitional Housing / Community Residence Beds: adds 20 beds in SFY 2018 and up to 20 more in SFY 2019; prioritized to support New Hampshire Hospital discharges.	$2,312,156	$5,424,000	$7,736,156
Mobile Crisis: funds additional crisis response capacity in area with high numbers of New Hampshire Hospital admissions and discharges.	$1,498,551	$3,421,696	$4,920,247
Designated Receiving Facility (DRF) Beds: adds up to 20 additional DRF beds.	$ 484,696	$ 721,440	$1,206,136
Additional Funding: to support workforce development.	$1,500,000	$1,500,000	$3,000,000
		Biennium Total	**$16,862,539**

In addition, a total of $4.3 million has been added to the Mental Health rate cells of the Medicaid capitation rates of the Managed Care Entities (MCEs) for the up-coming biennium in anticipation of increased utilization associated with the CMHA. An additional $2.0 million is available for inclusion in these rates after all CMHA services (excluding fee-for-service services) have been implemented. In addition, an additional $471,186 for general mental health services has been added to the CMHC state contracts. This is exclusive of the separate Mobile/Crisis Team contracts.

It should be noted that the crisis model currently envisioned by the State under this new appropriation is not a replica of the model implemented under the CMHA in the Concord, Manchester and Nashua Regions. The model currently being procured will be called a Behavioral Health Crisis Treatment Center (BHCTC), which is intended to provide center-based (as opposed to mobile) crisis services 24/7. Services will include crisis assessments and treatment, and service participants may include people with substance use disorders. A vendor has not yet been selected for this BHCTC service, and thus a detailed scope of work and

implementation schedule is not yet available. The ER is not able to comment at this time about the implementation of this model.

However, it is notable that this new BHCTC service may operate in a region *in lieu of* the mobile crisis teams and crisis apartments developed under the CMHA. While community-based crisis centers have been effective in some other states, those centers are typically integrated into a larger crisis service system, which includes mobile capacity and apartment settings, and are not operated as stand-alone settings. In New Hampshire, it is the mobile crisis team and crisis apartment model that has a demonstrated record of diverting individuals with mental illness from hospital emergency rooms. The ER is not aware of evidence that requiring individuals in crisis to present themselves for center-based crisis services is unlikely to achieve the same results for members of the target population. The ER is also not aware of evidence that it is easier for individuals in rural areas with limited transportation resources to present at a centralized crisis facility as opposed to having crisis teams go to the location most convenient and natural for individuals in crisis.

VI. Summary of Expert Reviewer Observations and Priorities

The CMHA and ER have now been in place for three and one half years. Within that time frame, the ER has expressed escalating concerns related to noncompliance with CMHA requirements governing ACT and Glencliff community transitions. In addition, the ER has noted long elapsed times and/or delays related to implementation of system improvements or capacities related to the CMHA, including the full and effective functioning of the Central Team. Throughout these reports, the ER has emphasized the need for the State to be more aggressive, assertive, planful, and timely in its implementation and oversight efforts in these areas in order to come into compliance with the CMHA.

More recently the ER has reported that the State is improving its oversight and management of the mental health system. Examples include more comprehensive and accurate data reporting, the revised QSR process, and the growing use of state-validated fidelity reviews for ACT and SE. The State has also substantially strengthened its central management of the mental health system, through improved management structures and increased leadership and operational staffing. The State is making progress towards compliance with several CMHA requirements above, including Glencliff transition and discharge planning. The breadth and content of the final QSR instrument, and the reliability of information it produces, will determine to what extent it is possible to evaluate compliance with other individual outcomes contained within the CMHA, including the adequacy and effectiveness of ACT, SE, SH and MCT.

The one notable exception to this progress relates to ACT services. **For the last two years the ER has stated that the State remains out of compliance with the ACT requirements of the Sections V.D.3(a, b, d, and e), which together require that all ACT teams meet the standards of the CMHA; that each mental health region have at least one adult ACT Team[13]; and that by June 30, 2016, the State provide ACT services that conform to CMHA requirements and have the capacity to serve at least 1,500 people in the Target Population at any given time.**

Despite the many positive initiatives and management efforts undertaken by the State, ACT capacity remains substantially below the required June 30, 2016 capacity to serve 1,500 people at any given time. Moreover, with an active caseload of only 992 people, the state currently is providing 508 fewer people with ACT than could be served if the State had developed the CMHA-specified capacity to serve 1,500 individuals. With the current ACT staff capacity to serve 1,242 people, there are 250 fewer people receiving ACT than the current ACT system could accommodate. This continues to be the single most significant issue in New Hampshire with regard to compliance with the CMHA, and one with negative implications for individuals who remain in NHH, who continue to be readmitted to EDs and inpatient facilities, or who are otherwise at risk of admission, homelessness, or incarceration due to inadequate community supports.

In addition, the ER continues to note that certain elements of information related to SE and SH have yet to be produced by the State, preventing findings of compliance with the CMHA. Finally, while the QSR system is much improved, the ER cannot fully evaluate the degree to which the revised QSR instruments and process is producing accurate and meaningful information related to the CMHA until several reports of site visits have been published, and attendant quality improvement plans have been developed and approved.

Based on the findings presented in this report, the ER expects the following action steps to be taken during the up-coming six month period:

1. By March 1, 2018 the State will update and expand strategies and action steps to accelerate expansion of ACT capacity to attain compliance with the CMHA. New plans and timelines will be added to the Monthly Progress Report as applicable. Data on outreach to, and screening of, potential ACT clients will be made available. In addition, the State will ensure that members of the target population in need of ACT are identified, and that both regional and statewide plans are in place to ensure their reasonable access to services.
2. By March 1, 2018 the State will produce information on SE and SH as specified above in the report.

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[13] The ER notes that each region of the state has had at least one ACT team, or ACT team-in-development, since the inception of the CMHA. However, as documented in the ACT section of this report, four regions continue to have ACT teams that do not meet the minimum staffing requirements for ACT as specified in the CMHA.

3. By March 1, 2018, the State will circulate QSR reports of the first three QSR site visits using the revised instruments and scoring protocols. The ER intends to engage the State and representatives of the Plaintiffs in a final conversation to resolve any remaining issues related to the scoring of QSR responses and generating quality findings. The ER expects these discussions to be accomplished no later than the end of March, 2018.
4. By March 1, 2018, the State and its PASRR contractor will facilitate the ER's review of the individual PASRR screen documents for recent referrals and admissions to Glencliff.
5. The State will continue to provide information requested by the ER for purposes of monitoring transition and discharge planning from Glencliff.
6. The State and its MCT contractors will work with the ER to document requested information on mobile crisis encounters and to explore the number and type of reported hospital diversions.
7. Consistent with the requirements of the CMHA, the State will identify and maintain a waitlist of all individuals within the Target Population requiring supported housing services, regardless of whether those individuals are eligible for a Bridge subsidy.
8. The ER requests the State to work collaboratively with the ER and representatives of the plaintiffs to consider the most effective and efficient model for the 4th crisis program that was funded by the Legislature, before awarding any contract for a facility based crisis center.

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

July through September, 2017

New Hampshire Community Mental Health Agreement

Quarterly Data Report

July to September 2017

New Hampshire Department of Health and Human Services

Office of Quality Assurance and Improvement

November 27, 2017

Community Mental Health Agreement Quarterly Report

New Hampshire Department of Health and Human Services

Publication Date: 11/27/2017

Reporting Period: 7/1/2017 – 9/30/2017

Notes for Quarter

- Harbor Homes Mobile Crisis has been added to the report.
- The Franklin DRF was unable to report data for the quarter. As a result total DRF data is also unavailable. Data for the current quarter will be provided in the next quarterly report.
- Peer Support Agencies were instructed to "purge their member lists" as of July 1, 2017 impacting the Number of Members but not Average Daily Census. The Bureau of Mental Health Services has instructed Peer Support Agencies to purge member lists annually to increase confidence and consistency in this information.

Community Mental Health Agreement Quarterly Report

New Hampshire Department of Health and Human Services

Publication Date: 11/27/2017

Reporting Period: 7/1/2017 – 9/30/2017

1. Community Mental Health Center Services: Unique Count of Adult Assertive Community Treatment Consumers

Center Name	July 2017	August 2017	September 2017	Unique Consumers in Quarter	Unique Consumers in Prior Quarter
01 Northern Human Services	109	107	107	113	111
02 West Central Behavioral Health	48	47	63	68	76
03 Genesis Behavioral Health	74	73	71	74	74
04 Riverbend Community Mental Health Center	78	79	81	87	97
05 Monadnock Family Services	66	61	55	69	70
06 Community Council of Nashua	88	87	90	98	94
07 Mental Health Center of Greater Manchester	269	267	269	287	292
08 Seacoast Mental Health Center	61	60	60	67	69
09 Community Partners	67	70	65	75	69
10 Center for Life Management	52	53	54	54	55
Total	**912**	**904**	**915**	**992**	**1,006**

Revisions to Prior Period: None

Data Source: NH Phoenix 2

Notes: Data extracted 11/14/17; consumers are counted only one time regardless of how many services they receive.

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2a. Community Mental Health Center Services: Assertive Community Treatment Staffing Full Time Equivalents

Center Name	September 2017						June 2017	
	Nurse	Masters Level Clinician/or Equivalent	Functional Support Worker	Peer Specialist	Total (Excluding Psychiatrist)	Psychiatrist/Nurse Practitioner	Total (Excluding Psychiatrist)	Psychiatrist/Nurse Practitioner
01 Northern Human Services	1.09	2.40	8.39	0.55	12.43	0.75	12.54	1.10
02 West Central Behavioral Health	0.60	2.35	3.50	0.50	6.95	0.40	7.15	0.10
03 Genesis Behavioral Health	1.20	2.00	6.60	1.00	10.80	0.75	10.60	0.50
04 Riverbend Community Mental Health Center	0.50	3.00	6.00	0.50	10.00	0.48	10.00	0.30
05 Monadnock Family Services	1.25	3.25	2.70	0.70	7.90	0.65	8.50	0.65
06 Community Council of Nashua 1	0.50	3.00	2.50	0.00	6.00	0.25	5.25	0.25
06 Community Council of Nashua 2	0.50	3.00	1.50	0.00	5.00	0.25	5.25	0.25
07 Mental Health Center of Greater Manchester-CTT	0.98	11.00	3.29	1.00	16.27	0.62	16.57	0.52
07 Mental Health Center of Greater Manchester-MCST	1.05	10.00	10.26	1.00	22.31	0.62	21.95	0.52
08 Seacoast Mental Health Center	0.43	3.10	6.00	1.00	10.53	0.60	9.53	0.60
09 Community Partners	0.00	2.00	4.23	0.50	6.73	0.50	8.53	0.50
10 Center for Life Management	1.00	2.00	5.30	1.00	9.30	0.40	9.30	0.40
Total	**9.10**	**47.10**	**60.27**	**7.75**	**124.22**	**6.27**	**125.17**	**5.69**

2b. Community Mental Health Center Services: Assertive Community Treatment Staffing Competencies, Substance Use Disorder Treatment

Center Name	September 2017	June 2017
01 Northern Human Services	2.05	2.77
02 West Central Behavioral Health	1.20	1.20
03 Genesis Behavioral Health	2.75	2.50
04 Riverbend Community Mental Health Center	1.48	1.30
05 Monadnock Family Services	2.40	3.40
06 Community Council of Nashua 1	4.00	3.00
06 Community Council of Nashua 2	3.00	3.00
07 Mental Health Center of Greater Manchester-CCT	12.00	12.00
07 Mental Health Center of Greater Manchester-MCST	1.00	1.00
08 Seacoast Mental Health Center	1.00	1.00
09 Community Partners	2.00	0.50
10 Center for Life Management	3.00	3.00
Total	**35.88**	**34.67**

2c. Community Mental Health Center Services: Assertive Community Treatment Staffing Competencies, Housing Assistance

Center Name	September 2017	June 2017
01 Northern Human Services	9.95	9.95
02 West Central Behavioral Health	6.35	5.85
03 Genesis Behavioral Health	7.60	8.60
04 Riverbend Community Mental Health	8.50	8.50

Center		
05 Monadnock Family Services	1.00	1.00
06 Community Council of Nashua 1	5.00	4.00
06 Community Council of Nashua 2	4.00	4.00
07 Mental Health Center of Greater Manchester-CCT	12.90	12.36
07 Mental Health Center of Greater Manchester-MCST	18.05	16.28
08 Seacoast Mental Health Center	7.00	6.00
09 Community Partners	3.88	4.50
10 Center for Life Management	7.00	7.00
Total	**91.23**	**88.04**

2d. Community Mental Health Center Services: Assertive Community Treatment Staffing Competencies, Supported Employment

Center Name	September 2017	June 2017
01 Northern Human Services	0.97	1.08
02 West Central Behavioral Health	0.25	0.25
03 Genesis Behavioral Health	4.00	3.00
04 Riverbend Community Mental Health Center	0.50	0.50
05 Monadnock Family Services	1.00	1.00
06 Community Council of Nashua 1	2.50	2.50
06 Community Council of Nashua 2	0.50	1.50
07 Mental Health Center of Greater Manchester-CCT	0.74	0.71

07 Mental Health Center of Greater Manchester-MCST	1.31	1.35
08 Seacoast Mental Health Center	1.00	1.00
09 Community Partners	0.15	0.00
10 Center for Life Management	0.30	0.30
Total	**13.22**	**13.19**

Revisions to Prior Period: None

Data Source: Bureau of Mental Health CMHC ACT Staffing Census Based on CMHC self-report

Notes for 2b-d: Data compiled 11/13/17; the Staff Competency values reflect the sum of FTEs trained to provide each service type. These numbers are not a reflection of the services delivered, rather the quantity of staff available to provide each service. If staff is trained to provide multiple service types, their entire FTE value will be credited to each service type.

3. Community Mental Health Center Services: Annual Adult Supported Employment Penetration Rates for Prior 12 Month Period

	12 Month Period Ending September 2017			Penetration Rate for Period Ending June 2017
Center Name	**Supported Employment Consumers**	**Total Eligible Consumers**	**Penetration Rate**	
01 Northern Human Services	514	1,257	40.9%	37.2%
02 West Central Behavioral Health	162	725	22.3%	22.5%
03 Genesis Behavioral Health	267	1,288	20.7%	22.0%
04 Riverbend Community Mental Health Center	238	1,704	14.0%	14.8%
05 Monadnock Family Services	115	933	12.3%	14.0%
06 Community Council of Nashua	242	1,416	17.1%	16.1%
07 Mental Health Center of Greater Manchester	1,382	3,288	42.0%	40.0%

08 Seacoast Mental Health Center	341	1,456	23.4%	19.3%
09 Community Partners	100	683	14.6%	10.3%
10 Center for Life Management	170	884	19.2%	21.6%
Deduplicated Total	**3,525**	**13,375**	**26.4%**	**25.3%**

Revisions to Prior Period: None

Data Source: NH Phoenix 2

Notes: Data extracted 11/14/17; consumers are counted only one time regardless of how many services they receive.

4a. New Hampshire Hospital: Adult Census Summary

Measure	July – September 2017	April – June 2017
Admissions	204	293
Mean Daily Census	153	153*
Discharges	206	292
Median Length of Stay in Days for Discharges	13	10
Deaths	0	0

*Revisions to Prior Period: *April to June 2017 mean daily census was revised due to improved methodology.*

Data Source: Avatar

Notes 4a: Data extracted 11/16/17; Mean Daily Census includes patients on leave and is rounded to nearest whole number

4b. New Hampshire Hospital: Discharge Location for Adults

Discharge Location	July – September 2017	April – June 2017
Home - Lives with Others	109	138
Home - Lives Alone	73	107

CMHC Group Home	5	9
Private Group Home	3	7
Nursing Home	3	6
Hotel-Motel	3	5
Homeless Shelter/ No Permanent Home	3	5
Discharge/Transfer to IP Rehab Facility	2	4
Secure Psychiatric Unit - SPU	1	3
Peer Support Housing	1	3
Jail or Correctional Facility	1	3
Glencliff Home for the Elderly	1	1
Unknown	1	1

4c. New Hampshire Hospital: Readmission Rates for Adults

Measure	July – September 2017	April – June 2017
30 Days	9.8% (20)	15.0% (44)
90 Days	21.6% (44)	24.2% (71)
180 Days	27.9% (57)	32.1% (94)

Revisions to Prior Period: None.

Data Source: Avatar

Notes 4b-c: Data compiled 11/13/17; readmission rates calculated by looking back in time from admissions in study quarter. 90 and 180 day readmissions lookback period includes readmissions from the shorter period (e.g., 180 day includes the 90 and 30 day readmissions); patients are counted multiple times for each readmission; number in parentheses is the number of readmissions

5a. Designated Receiving Facilities: Admissions for Adults

DRF	July – September 2017

	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	NA	NA	NA
Cypress Center	69	178	247
Portsmouth	93	270	363
Elliot Geriatric Psychiatric Unit	6	54	60
Elliot Pathways	61	60	121
Total	NA	NA	NA

DRF	April – June 2017		
	Involuntary Admissions	**Voluntary Admissions**	**Total Admissions**
Franklin	35	25	60
Cypress Center	49	179	228
Portsmouth	80	283	363
Elliot Geriatric Psychiatric Unit	6	46	52
Elliot Pathways	48	53	101
Total	**218**	**586**	**804**

5b. Designated Receiving Facilities: Mean Daily Census for Adults

DRF	July – September 2017	April – June 2017
Franklin	NA	4.5
Cypress Center	12.9	12.0
Portsmouth	23.9	30.3
Elliot Geriatric Psychiatric Unit	29.7	29.3
Elliot Pathways	12.2	10.0

Total	NA	**17.2**

**Portsmouth Regional Hospital has a total of 12 DRF beds and Elliot Hospital has a total of 14 DRF beds split between Pathways and the Geriatric Psychiatric Unit.*

5c. Designated Receiving Facilities: Discharges for Adults

DRF	July – September 2017	April – June 2017
Franklin	NA	59
Manchester (Cypress Center)	243	232
Portsmouth	355	365
Elliot Geriatric Psychiatric Unit	63	54
Elliot Pathways	121	105
Total	NA	**815**

5d. Designated Receiving Facilities: Median Length of Stay in Days for Discharges for Adults

DRF	July – September 2017	April – June 2017
Franklin	NA	6
Manchester (Cypress Center)	4	4
Portsmouth	4	5
Elliot Geriatric Psychiatric Unit	27	22
Elliot Pathways	7	8
Total	NA	**5**

5e. Designated Receiving Facilities: Discharge Location for Adults

DRF	July – September 2017

	Assisted Living/Group Home	Deceased	DRF	Home	Other Hospital	NH Hospital	Other
Franklin	NA	NA	NA	NA	NA	NA	NA
Manchester (Cypress Center)	1	0	0	166	0	1	10
Portsmouth Regional Hospital	0	0	4	221	0	5	59
Elliot Geriatric Psychiatric Unit	45	4	1	12	0	1	0
Elliot Pathways	4	0	1	101	0	6	9
Total	NA	NA	NA	NA	NA	NA	NA

	April – June 2017						
DRF	**Assisted Living/Group Home**	**Deceased**	**DRF**	**Home**	**Other Hospital**	**NH Hospital**	**Other**
Franklin	2	0	1	44	0	1	11
Manchester (Cypress Center)	4	0	7	204	0	1	16
Portsmouth Regional Hospital	0	0	4	265	0	7	89
Elliot Geriatric Psychiatric Unit	32	6	0	10	6	0	0
Elliot Pathways	1	0	0	82	0	4	18
Total	**39**	**6**	**12**	**605**	**6**	**13**	**134**

**Dispositions to 'DRF' represent a change in legal status from Voluntary to Involuntary within the DRF.*

5f. Designated Receiving Facilities: Readmission Rates for Adults

DRF	July – September 2017		
	30 Days	**90 Days**	**180 Days**
Franklin	NA	NA	NA
Manchester (Cypress Center)	7.1% (12)	12.4% (21)	15.9% (27)
Portsmouth	11.5% (33)	17.5% (50)	21% (60)
Elliot Geriatric Psychiatric Unit	0% (0)	0% (0)	0% (0)
Elliot Pathways	3.3% (4)	6.6% (8)	12.4% (15)
Total	NA	NA	NA
DRF	**April – June 2017**		
	30 Days	**90 Days**	**180 Days**
Franklin	0.0% (0)	0.0% (0)	0.0% (0)
Manchester (Cypress Center)	4.8% (11)	9.2% (21)	13.2% (30)
Portsmouth	10.2% (37)	15.4% (56)	20.7% (75)
Elliot Geriatric Psychiatric Unit	3.8% (2)	3.8% (2)	5.8% (3)
Elliot Pathways	6.9% (7)	7.9% (8)	10.9% (11)
Total	**7.1% (57)**	**10.8% (87)**	**14.8% (119)**

Revisions to Prior Period: None.

Data Source: NH DRF Database

Notes: Franklin DRF was unable to report data for the quarter. As a result total DRF data is also unavailable. Data for the current quarter will be provided in the next quarterly report. Data compiled 11/13/17; discharge location of DRF are patients discharged back to the same DRF for a different level of care within the DRF; readmission rates calculated by looking back in time from admissions in study quarter; patients are counted multiple times for each readmission; number in parentheses is the number of readmissions

6. Glencliff Home: Census Summary

Measure	July – September 2017	April – June 2017

Admissions	3	9
Average Daily Census	107	106
Discharges	2 (1- Dept. of Corrections, 1 – Nursing Facility)	2 (1 private apartment, 1 ABD/ residential care home)
Individual Lengths of Stay in Days for Discharges	115, 366	4507, 399
Deaths	4	3
Readmissions	0	0
Mean Overall Admission Waitlist	19 (12 Active)	17 (9 Active)

Revisions to Prior Period: None.

Data Source: Glencliff Home

Notes: Data Compiled 10/23/17; means rounded to nearest whole number; Active waitlist patients have been reviewed for admission and are awaiting admission pending finalization of paperwork and other steps immediate to admission.

7. NH Mental Health Consumer Peer Support Agencies: Census Summary

Peer Support Agency	July – September 2017		April – June 2017	
	Total Members	**Average Daily Visits**	**Total Members**	**Average Daily Visits**
Alternative Life Center Total	**532**	**46**	**516**	**45**
Conway	*189*	*15*	*183*	*16*
Berlin	*102*	*10*	*108*	*11*
Littleton	*141*	*8*	*139*	*7*
Colebrook	*100*	*13*	*86*	*11*
Stepping Stone Total	**386**	**18**	**592**	**20**
Claremont	*308*	*12*	*493*	*14*

Lebanon	*78*	*6*	*99*	*6*
Cornerbridge Total	**293**	**20**	**390**	**17**
Laconia	*109*	*6*	*171*	*5*
Concord	*127*	*14*	*167*	*12*
Plymouth Outreach	*57*	*NA*	*52*	*NA*
MAPSA Keene Total	**208**	**11**	**190**	**14**
HEARTS Nashua Total	**247**	**37**	**510**	**31**
On the Road to Recovery Total	**516**	**53**	**568**	**41**
Manchester	*382*	*31*	418	34
Derry	*134*	*22*	150	7
Connections Portsmouth Total	**278**	**11**	**278**	**11**
TriCity Coop Rochester Total	**225**	**24**	**382**	**20**
Total	**2,685**	**167**	**3,426**	**158**

Revisions to Prior Period: None

Data Source: Bureau of Mental Health Peer Support Agency Quarterly Statistical Reports

Notes: Data Compiled 11/14/17; Average Daily Visits NA for Outreach Programs; Peer Support Agencies were instructed to "purge their member lists" as of July 1, 2017 impacting the Number of Members but not Average Daily Census. The Bureau of Mental Health Services has instructed Peer Support Agencies to "purge member lists" annually to increase confidence and consistency in this information.

8. Housing Bridge Subsidy Summary to Date

	July – September 2017		
Subsidy	**Total individuals served at start of quarter**	**New individuals added during quarter**	**Total individuals served through end of quarter**

Housing Bridge Subsidy	701	41	742
Section 8 Voucher	85	11	96

	April – June 2017		
Subsidy	**Total individuals served at start of quarter**	**New individuals added during quarter**	**Total individuals served through end of quarter**
Housing Bridge Subsidy	643	58	701
Section 8 Voucher	85	0	85

Revisions to Prior Period: None

Data Source: Bureau of Mental Health

Notes: Data Compiled 11/14/17

9. Housing Bridge Subsidy Current Census Summary

Measure	As of 9/30/2017	As of 6/30/2017
Housing Slots	567	591
Rents currently being paid	509	545
Individuals accepted but waiting to lease	58	46
Waiting list for slots	0	0

Revisions to Prior Period: None

Data Source: Bureau of Mental Health

Notes: Data Compiled 11/14/17; all individuals currently on the Bridge Program are actively transitioning from the program (waiting for their Section 8 housing voucher).

10. Housing Bridge Subsidy Unit Address Density

Number of Unit(s)* at Same Address	Frequency as of 11/9/17	Frequency as of 8/11/17
1	383	391

2	31	37
3	6	6
4	5	6
5	0	3
6	0	0
7	1	2
8 or more	2	1

*All units are individual units

Revisions to Prior Period: None

Data Source: Bureau of Mental Health data compiled by Office of Quality Assurance and Improvement

Notes: Data Compiled 11/14/17

11a. Mobile Crisis Services and Supports for Adults: Riverbend Community Mental Health Center

Measure	July 2017	August 2017	September 2017	July – September 2017	April – June 2017
Unduplicated People Served in Month	165	198	216	579	530
Services Provided by Type					
Mobile Community Assessments	47	61	65	173	124
Crisis Stabilization Appointments	15	13	9	37	64
Office-Based Urgent Assessments	15	11	31	57	96
Emergency Service Medication Appointments	29	40	41	110	47

Phone Support/Triage	200	290	231	721	469
Walk in Assessments	4	4	6	14	11
Services Provided after Immediate Crisis					
Mobile Community Assessments-Post Crisis	4	10	16	30	4
Crisis Stabilization Appointments	15	13	8	36	15
Office-Based Urgent Assessments	15	11	31	57	15
Emergency Service Medication Appointments	16	21	23	60	29
Phone Support/Triage	49	111	41	201	200
Referral Source					
Emergency Department/EMS	14	9	23	46	42
Family	24	34	15	73	96
Friend	1	2	2	5	4
Guardian	0	1	22	23	2
Mental Health Provider	4	13	2	19	32
Police	1	7	4	12	15
Primary Care Provider	5	7	4	16	15
CMHC Internal	17	14	3	34	53
Self	66	100	126	292	223
Other	3	11	15	29	21

Crisis Apartment					
Apartment Admissions	33	25	23	81	84
Apartment Bed Days	124	95	91	310	319
Apartment Average Length of Stay	3.8	3.8	4.0	3.8	3.8*
Law Enforcement Involvement	10	17	7	34	32
Hospital Diversions Total	123	159	161	443	430

*Revisions to Prior Period: *Apartment Average Length of Stay for prior quarter was corrected*

Data Source: Riverbend CMHC submitted reports

Notes: Data Compiled 11/15/17; reported values other than the Unduplicated People Service in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.

11b. Mobile Crisis Services and Supports for Adults: Mental Health Center of Greater Manchester

Measure	July 2017	August 2017	September 2017	July – September 2017	April – June 2017
Unduplicated People Served by Month	186	180	209	476	579
Services Provided by Type					
Phone Support/Triage	380	353	411	1,144	1,127
Mobile Community Assessments	72	72	104	248	270
Office-Based Urgent Assessments	12	11	17	40	53
Emergency Service Medication Appointments	0	1	5	6	2
Crisis Apartment Service	57	108	52	217	0
Referral Source*					
Emergency Department	2	1	2	5	7
Family	29	31	47	107	111
Friend	3	4	2	9	13
Guardian	2	2	1	5	13
Mental Health Provider	6	5	10	21	12
Police	33	32	70	135	89
Primary Care Provider	4	8	11	23	22
CMHC Internal	28	21	30	79	76
Self	111	120	121	352	324
Other	23	17	22	62	87

Crisis Apartment					
Apartment Admissions	3	3	3	9	9
Apartment Bed Days	8	13	8	29	29
Apartment Average Length of Stay	4.0	3.3	2.7	3.2	3.2
Law Enforcement Involvement	33	32	70	135	89
Hospital Diversion Total	241	241	316	798	821

*Revisions to Prior Period: * Prior quarter Referral Source was corrected*

Data Source: New Mobile Crisis Data Reporting System

Notes: Data Compiled 11/14/17; reported values other than the Unduplicated People Service in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.

11c. Mobile Crisis Services and Supports for Adults: Harbor Homes

Measure	July 2017	August 2017	Septembe r 2017	July – Septembe r 2017
Unduplicated People Served by Month	7	24	25	55
Services Provided by Type				
Phone Support/Triage	3	15	15	33
Mobile Community Assessments	3	4	7	14
Office-Based Urgent Assessments	1	1	1	3
Emergency Service Medication Appointments	0	2	3	5
Crisis Apartment Service	2	1	1	4
Referral Source				
Emergency Department	0	3	0	3
Family	7	2	1	10
Friend	0	0	3	3
Guardian	0	0	1	1
Mental Health Provider	0	0	3	3
Police	0	3	1	4
Primary Care Provider	0	0	0	0
CMHC	1	3	6	10
Self	3	8	9	20
Other	4	8	3	15

Crisis Apartment				
Apartment Admissions	1	1	1	3
Apartment Bed Days	3	1	1	5
Apartment Average Length of Stay	3	1	1	1.7
Law Enforcement Involvement	0	6	5	11
Hospital Diversion Total	7	24	18	49

Revisions to Prior Period: NA

Data Source: New Mobile Crisis Data Reporting System

Notes: Data Compiled 11/14/17; reported values other than the Unduplicated People Service in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.

Appendix B

New Hampshire Community Mental Health Agreement

Monthly Progress Reports

July, August, September, 2017

New Hampshire Community Mental Health Agreement Monthly Progress Report

July, August, September 2017

New Hampshire Department of Health and Human Services

December 1, 2017

Acronyms Used in this Report

ACT:	Assertive Community Treatment
BMHS:	Bureau of Mental Health Services
CMHA:	Community Mental Health Agreement
CMHC:	Community Mental Health Center
DHHS:	Department of Health and Human Services
SE:	Supported Employment
SFY:	State Fiscal Year

Background

This Monthly Progress Report is issued in response to the June 29, 2016 Expert Reviewer Report, Number Four, action step 4. It reflects the actions taken in July, August and September 2017, and month-over-month progress made in support of the Community Mental Health Agreement (CMHA) as of September 30, 2017. Three months of data is released in this singular report due to delays experienced in receiving data from the Community Mental Health Centers. Data contained may be subject to change upon further reconciliation with CMHCs. This report is specific to achievement of milestones contained in the agreed upon CMHA Project Plan for Assertive Community Treatment (ACT), Supported Employment (SE) and Glencliff Home Transitions. Where appropriate, the Report includes CMHA lifetime-to-date achievements.

Progress Highlights

Assertive Community Treatment (ACT)

Goal	Status	Recent Actions Taken
CMHC fidelity to ACT evidence-based practice model annually assessed.	2017: 10 of 10 completed 2018: 4 of 10 completed	• 3 fidelity reports issued, improvement plans in place; 4th report in process • 2018 fidelity reports compare progress from 2017 • New improvement plan template developed and implemented
Provide ACT team services, consistent with standards set forth, with the capacity to serve at least 1,500 individuals.	Capacity: July – 1,265 August – 1,256 Sept. – 1,242 Enrollment: July – 912 August – 904 Sept. – 915	• Ongoing technical assistance at CMHC specific level delivered by external DHHS consultant • Launched 6-part training series 6/27/17 for ACT team leaders, substance use specialists, and team members on Co-Occurring Disorders (COD) treatment within ACT. Series capacity permits 4 ACT staff per session; participation is high; one MCO also participates. Series runs through December 2017. Topics include: initial training on addiction and recovery; substance use and affects; screening, assessment and functional analysis; stage-wise psychosocial and medication interventions; motivational strategies for people with COD; and group treatments for people with COD.

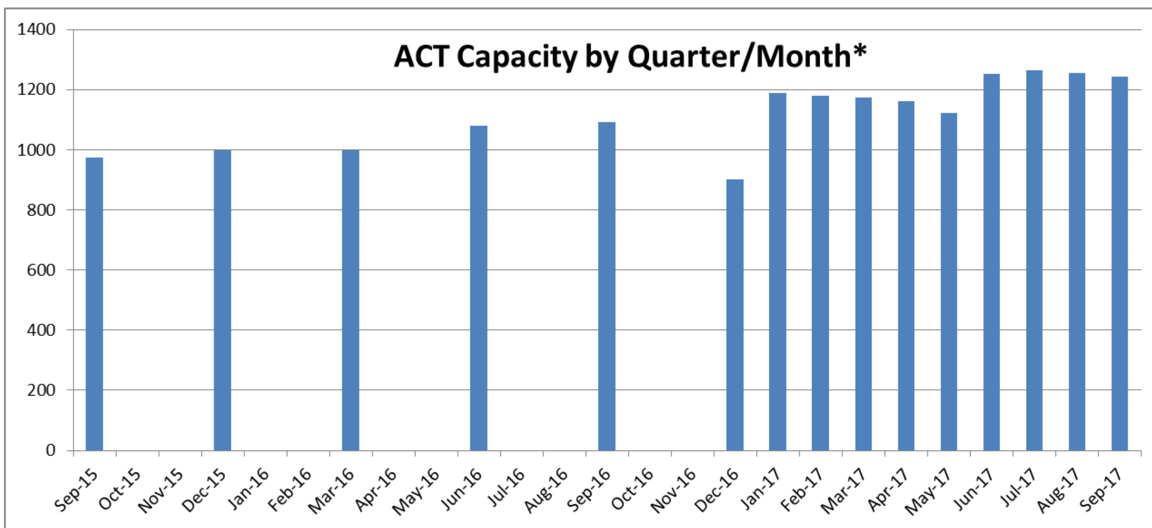
Supported Employment (SE)

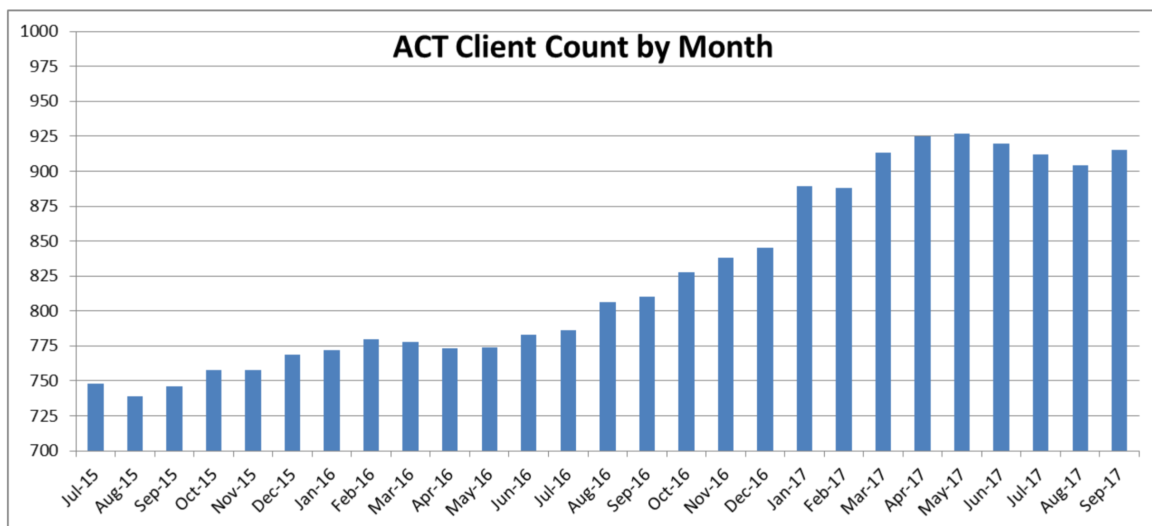
Goal	Status	Recent Actions Taken
CMHC fidelity to SE evidence-based practice model annually assessed.	2017: 10 of 10 completed 2018: 3 of 10 completed	• 3 fidelity reports issued, improvement plans in place • 2018 fidelity reports compare progress from 2017 • New improvement plan template developed and implemented
Increase penetration rate of individuals with a Serious Mental Illness (SMI) receiving SE services to 18.6%.	Statewide penetration rate: July – 25.8% August – 26.4% Sept. – 26.4%	• Ongoing technical assistance at CMHC specific level delivered by external DHHS consultant • Held Supported Employment Basic Training in July 2017; each CMHC was allowed 2 participants. Training designed for new SE specialists.

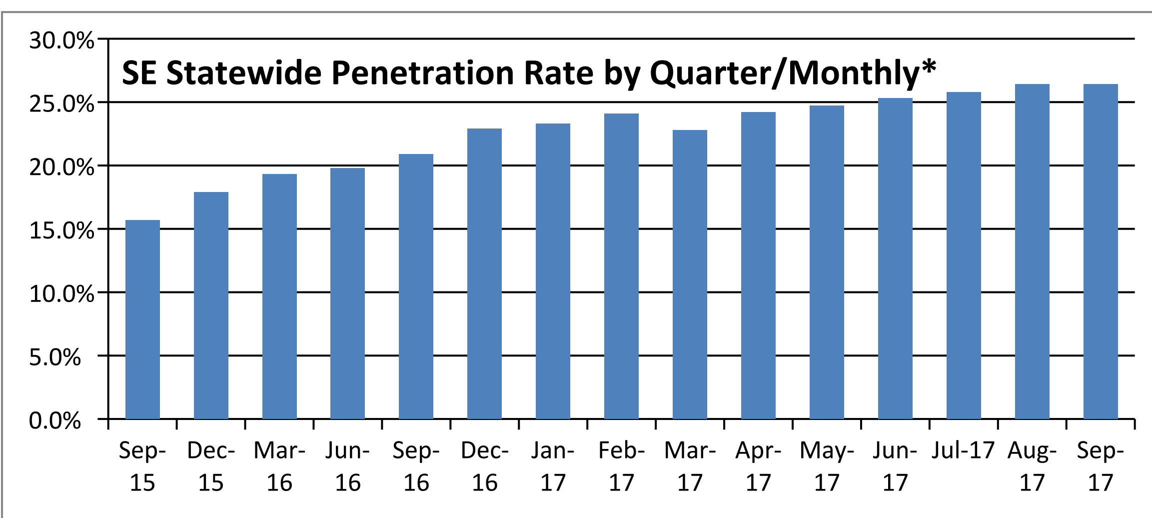
Glencliff Home Transitions into Integrated Community Setting

Goal	Status	Recent Actions Taken
Have capacity to serve in the community 16 (cumulatively) individuals with mental illness and complex health care needs residing at Glencliff who cannot be cost-effectively served in supported housing.	14 of 16 completed[14]	• In July 2017, a former Glencliff resident, discharged originally in 2015, sought readmission to Glencliff as behavioral health issues intensified. Through methods used to effectuate integrated community setting transitions, the individual was transitioned to a 4-person community residence • In November 2017, a resident transitioned to the community residence developed in late 2016. • Coordinating a 15th transition anticipated to be occur in December 2017
By June 30, 2017, identify and maintain a list of all individuals with mental illness and complex health care needs residing at the Glencliff Home who cannot be cost-effectively served in supported housing and develop an effective plan for providing sufficient community-based residential supports for such individuals in the future.	Completed; ongoing	• 12 residents on the list • 11 of the 12 residents have selected their CFI transition case management service provider to actively support transition needs; the 12th is in process

[14] Indicates residents have been transitioned into an integrated community setting; compliance with additional CMHA requirements for such transitions is under review.







* Data is a combination of preliminary monthly and finalized quarterly data from CMHA Quarterly Data Reports.