

New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number One

December 26, 2014

I. Introduction

This is the first semi-annual report of the Expert Reviewer under the Settlement Agreement in the case of *Amanda D. et. al. v. Margaret W. Hassan, Governor, et. al.; United States v. New Hampshire, No. 1:12-cv-53-SM*.¹ For the purpose of this and future reports, the Settlement Agreement will be referred to as the Community Mental Health Agreement. Section VIII.K of the Agreement 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.

The Expert Reviewer was mutually appointed by the Parties effective July 1, 2014.² The first six months of Expert Reviewer activity have been the "orientation phase." That is, during this first period, Expert Reviewer activities have focused on meeting state administrators and visiting inpatient and community based service providers throughout the state to: (a) gain an understanding of the structure and functioning of important elements of the mental health system; (b) to introduce to these entities the functions of the Expert Reviewer vis-à-vis the Community Mental Health Agreement; and (c) to begin to formulate a baseline status assessment of the mental health system as a foundation from which to identify and document progress made in implementation of the Agreement.

As of the submission of this report, the Expert Reviewer has:³

- Met with senior officials and staff of the New Hampshire Department of Health and Human Services (DHHS)
- Met on three occasions with the State Mental Health Coordination Team
- Visited all ten regional Community Mental Health Centers in the state

¹ Class Action Settlement Agreement *Amanda D. et. al. v. Margaret W. Hassan, Governor, et. al.; United States v. New Hampshire, No. 1:12-cv-53-SM*.

² Implementation efforts related to the Community Mental Health Agreement had been underway prior to that date, and to the extent possible these activities are reflected in this report.

³ Schedules of meetings and site visits for the period July 1, 2014 through December 15, 2014, are included in Appendix A of this report.

- Visited five Peer Supports Agency sites
- Visited the Glencliff Home
- Visited New Hampshire Hospital
- Visited the transitional housing operated by NAFI on the grounds of the state hospital complex
- Visited the Yellow Pod at Concord Hospital
- Had a brief tour of the Cypress Center in Manchester
- Met with Ken Norton, Executive Director of NAMI New Hampshire
- Met with the Statewide Mental Health Consumer Council
- Conducted a preliminary de-briefing with state officials to discuss findings and observations from the initial round of site visits
- Conducted a formal debriefing with all Parties to the Agreement to discuss findings and observations from the orientation phase of the Expert Review activity (The agenda for this meeting is included in Appendix B of this report)
- Reviewed voluminous data and documents relevant to the Agreement.

The system orientation activities conducted during the early months of implementation included an assessment of existing data sources that could potentially be used to track progress and performance related to the terms of the Agreement. Several useful sources of data have been identified, as will be discussed further in subsequent sections of this report. However, as would be expected, there is not at this time a unified, comprehensive or validated set of data that can be used to directly report on performance across various components of the Agreement. A major task for the next few months of implementation will be to further explore the various data sets and sources and develop a plan for how these can be best used to inform the Parties and the Expert Reviewer about performance related to the quantitative and qualitative aspects of the Agreement. Pending more detailed data planning and analyses, this Report does not attempt to use existing data to reach concrete conclusions about performance related to specific elements of the Agreement.

Another focus of initial orientation activities was the need for technical assistance designed to assist New Hampshire to effectively implement the Agreement. This assessment of possible technical assistance needs was included in recognition that: (a) the mental health system is in the early stages of implementation; and (b) implementation of modern evidence based and promising practices is difficult and complex, requiring a combination of state-wide and locally based efforts. This report includes some recommendations for technical assistance efforts to support early implementation efforts. In addition, this Report recognizes that technical assistance will be an important element of efforts to attain and sustain compliance with certain elements of the Agreement.

Because the initial phase of activity for the Expert Reviewer was focused on system orientation, an explicit effort was made to remain non-judgmental and non-critical as visits were conducted

and preliminary information collected. Thus, this first Report reflects assessment of the implementation structure and process rather than being a critical assessment of current compliance with specific requirements of the Agreement. The Report identifies areas in which there may be concerns about implementation and for which additional monitoring and technical assistance might be appropriate. However, there is no attempt or basis at this stage to document either compliance or non-compliance with the Agreement.

It is the current impression of the Expert Reviewer that all parties to the implementation of components of the Community Mental Health Agreement are committed to and supportive of efforts to implement the Agreement. This includes the Governor, state officials, state facilities, CMHCs, and other state contractors. Representatives of the Plaintiffs⁴ have also demonstrated commitment to a collaborative and positive process to implement the Agreement.

II. Brief Summary of Observations to Date

The following general observations pertain to: (a) the process for implementing and assuring compliance and quality under the terms of the Agreement over time; and (b) environmental factors that could influence implementation of the agreement.

A. Implementation Structure and Plan

It is the experience of the Expert Reviewer that two preconditions must be met for any implementation process to be successful. These are:

1. There must be an implementation structure. This structure needs to be comprised of officials with sufficient authority over relevant parts of the system to be able to make decisions and assure accountability for the implementation process; and
2. There must be a detailed implementation plan with measurable milestones and assignment of responsibility for each step in the implementation process.

New Hampshire has designated the Mental Health Coordination Team as the implementation oversight entity, or implementation structure, for the Community Mental Health Agreement. The membership of the group includes:

- Katja Fox, Health Care Policy Specialist, Office of the Commissioner (Chair of the Coordination Team and designated single point of contact for the Community Mental Health Agreement)
- Geoff Souther, Interim Administrator, Bureau of Behavioral Health
- Ry Perry, Legal Counsel, Bureau of Behavioral Health

⁴ The term “plaintiffs” throughout this report includes the United States

- Greg Burdwood, Community Integration Specialist, Bureau of Behavioral Health
- Diane Langley, Director, Bureau of Adult and Elderly Services
- Bob McLeod, CEO, New Hampshire Hospital
- Rebecca Woodward, Assistant Attorney General, Department of Justice
- Todd Bickford, Administrator of the Glencliff Home
- Dave Rollins, Project Manager, Project Management Office

The Mental Health Coordination Team has developed a detailed implementation plan with measurable milestones and assignments of responsibility for each key action step. The plan reflects each specific component of the Agreement, and uses the dates and major milestones in the Agreement as its primary performance targets. The implementation plan is, appropriately, very detailed and operational. The plan is also a “living document” in that it continuously undergoes changes, updates and mid-course corrections related to the detailed implementation steps. The implementation plan is essential to the effectiveness of the implementation process, but it is not by itself an Agreement compliance report. Nor does an indication on the plan that a specific action step has been completed indicate per se that an Agreement requirement has been satisfied.

The implementation plan cannot totally reflect activities related to quality and performance under the Community Mental Health Agreement. For example, it does not reflect all data sources, reporting mechanisms and time frames, and analytic frameworks to be developed and used over time to track the movement of priority target groups from institutionalization or risk of institutionalization into stable community living arrangements with evidence based services. Nor does the plan reflect some of the qualitative elements included in the quality management/quality assurance components of the Agreement. These quality components include direct assessment of service participant experiences with housing and services in the community and participant self report of the quality and effectiveness of services. These components are intended to be developed more fully in subsequent months of the planning and development process.

It should be noted that the Mental Health Coordination Team includes representation of New Hampshire Hospital, but does not include representation of other key participants in Agreement implementation and performance. For example, the ten Regional Mental Health Centers in New Hampshire, which are responsible for implementation of most of the community based best practice service elements and are critical to transition from inpatient facilities, are not directly included in Coordination Team activities. Unlike New Hampshire Hospital and Glencliff, the mental health centers are contracted entities, not part of state government, and thus it is appropriate that they not be members of the State Mental Health Coordination Team. However, it is recommended that formal mechanisms be implemented to enhance ongoing communication with the CMHCs regarding Coordination Team activities and plans, and to regularly solicit input

from the CMHCs regarding the work of the Mental Health Coordination Team. As will be noted throughout this Report, it is critical that all parties to the Agreement and all elements of the implementation process be engaged, informed and involved as implementation proceeds.

B. General Systems Issues – Environment for Implementation

In addition to the implementation structure and plan, other important variables affecting the success of any implementation process include environmental factors that could potentially facilitate or constrain implementation of elements of the agreement. These factors constitute the dynamic reality in which the Agreement is to be implemented. Some of these key environmental factors are briefly described below.

1. Limited Resources

In the experience of the Expert Reviewer, there is no state or local jurisdiction in the United States that has sufficient resources to meet all the health and behavioral health needs of its citizens. In addition, because of economic conditions and related factors, most states, including New Hampshire, experienced reductions in mental health resources between 2007 and 2012. An environment of constricted resources may heighten competition for services among disparate priority service populations, and may create incentives for payers to attempt to shift costs to other sectors of the service system. Scarce resources may also affect the staffing levels needed to implement new and enhanced service modalities while also attempting to maintain current service activities. All parties in New Hampshire will need to be respectful of the difficulties of forging ahead with a complex and multi-faceted implementation process in this environment of scarce resources.

However, scarce resources are not a reason to slow down or impede implementation of the Community Mental Health Agreement. Recent New Hampshire system assessments, as well as the findings leading up to the Agreement, have identified disproportional allocations of resources to institutional and congregate facilities at the expense of community alternatives. Shifting the balance towards investments in more cost effective best practice service modalities in concert with more affordable supportive housing resources is an objective of the Agreement. Accomplishing this shift promises better outcomes at reduced per-person costs in terms of investment of state (and federal/state) resources for mental health services.

State and regional system managers will need to assure that new resources are used in concert with existing (base) resources to accomplish the objectives of the Agreement. Nothing in the Agreement specifies that only new resources are to be used for attainment of Agreement objectives and requirements.

2. Community and Service System Culture

System culture issues can influence implementation of the Agreement. These include:

- The relative capacity of components of the mental health system to accept and manage risk in the community; and
- The relative willingness to embark on a system change process that results in substantial changes in traditional ways in which elements of the mental health system function and relate to each other.

In the experience of the Expert Reviewer, every mental health system in the United States has to continuously focus on managing risk throughout the system. In this context, the term “risk” encompasses decisions made at various points of the system when addressing difficult, complex, and sometimes volatile people and situations. The ability to tolerate, accept and manage risk affects:

- Decisions made by police and other first responders about whether to seek hospitalization or jail as opposed to a less intensive interventions;
- Decisions made by emergency room physicians related to whether involuntary commitment is necessary or whether community diversion or voluntary admission could be effectuated;
- Decisions made by CMHC Emergency Services staff related to managing psychiatric crises in non-hospital settings and effectuating community alternatives to hospitalization;
- Decisions made by psychiatric inpatient hospital staff related to how long someone must stay in a facility and what type of settings might be appropriate when returning to the community;
- Decisions made by clinical staff, families and guardians about whether a conditional discharge is necessary for movement into a community setting;
- Decisions by CMHCs related to people who can be successfully served in community settings with ACT and related services; and
- Decisions by housing sponsors and landlords about who can successfully enter into a lease agreement and sustain tenancy in the community.

In every case noted above, and in numerous other day-to-day decisions made throughout the mental health system, the capacity to accept and manage risk influences whether more restrictive or less restrictive interventions are employed. Every time a more restrictive setting is employed, there are consequences related to the individuals involved, and related to discontinuity of services and community supports, wait lists, increased inpatient census, prolonged discharge planning, and necessity to rebuild community supports to assure success in the community.

Implementation of the new transition planning process, new crisis service capacities, and the best practice ACT, supportive employment and supportive housing resources envisioned in the Agreement are specifically designed to increase the capacity of both the hospital and community elements of the mental health system to increase tolerance for and management of risk and to

thereby to reduce the default to more restrictive settings and increase the efforts made to assure successful and long term community living.

At the same time, influencing the degree to which the community and the mental health system can tolerate and manage risk requires changes at all levels in treatment philosophy and approaches, and in the communications and interactions among elements of the system. These types of fundamental system changes are difficult to implement under any circumstances. This is one reason why the implementation structure and plan are so necessary to the implementation process. The difficulty and complexity of implementation also requires that all parties at all levels are mutually engaged information sharing, mutual implementation strategy development, collaboration in implementation action steps, and tracking of implementation successes and mid-course corrections. The state will need to exercise leadership and support to enhance the capacities of CMHC's and facilities to implement and sustain key elements of the agreement.

The Expert Reviewer, in the role of providing technical assistance as well as in the monitoring role, will focus on the environment factors of culture and natural resistance to change as part of the overall Expert Reviewer activity. The Expert Reviewer will also take whatever steps are necessary to make sure that all parties, including the Plaintiffs as well as state and local mental health system participants, are fully informed and engaged in the implementation process.

3. Medicaid Expansion and Medicaid Managed Care

Medicaid is by far the largest source of payment for mental health services relevant to the Community Mental Health Agreement in New Hampshire. And, as Medicaid Expansion adds new enrollees, Medicaid is likely to increase its overall share of payments for mental health services relative to other payer sources. The expansion of Medicaid eligibility is likely to assist previously uninsured individuals to access needed mental health services. In addition, the Medicaid Expansion population will have access to new substance use service benefits, which could improve substance use service access and coordination opportunities for this group.

New Hampshire has implemented fully integrated health and behavioral health managed care for Medicaid beneficiaries via two (and potentially three) statewide managed care organizations (MCOs). These MCOs and the ten regional CMHCs in New Hampshire have been negotiating per member per month (PMPM) reimbursement mechanisms for the portion of the overall mental health benefit delivered to Medicaid beneficiaries by the CMHCs. PMPM contracts have been signed with Well Sense Health Plan/Beacon Health Strategies, and negotiations are continuing with New Hampshire Healthy Families/Cenpatico.

Another Medicaid initiative that could influence implementation of the Agreement is the planned submission of an 1115 Demonstration waiver. Some components of the waiver request are intended to provide additional resources and organizational support to the behavioral health system in general and the Community Mental Health Agreement in particular. In addition, the new 1115 waiver, in concert with the Medicaid coverage expansion and managed care initiatives,

is intended to foster increased integration of physical health and behavioral health services. These integration efforts are intended to benefit many of the same people identified as priority consumers under the Agreement. Assuming the federal Centers for Medicare and Medicaid Services (CMS) approves the final waiver submission, activities under the waiver will be monitored to the extent they directly contribute to attainment of the objectives and quality standards of the Agreement.

The increased influence of Medicaid in the mental health and substance use service arenas, plus the roles of the MCOs vis-à-vis oversight of provider performance and coordination of care for certain beneficiaries is likely to affect the traditional accountability relationship between the CMHCs and the state Department of Health and Human Services (DHHS). As implementation of the Community Mental Health Agreement progresses, it will be important to clarify chains of communication and oversight among state agencies, the MCOs and the CMHCs. It will also be necessary to clearly define the data sets and sources that will be used to track progress and performance related to the Agreement in the context of Medicaid MCOs and PMPM payment mechanisms. For example, the state will need to be able to track and document the various ways in which both existing (base) Medicaid resources and any newly appropriated resources that pass to CMHCs via the MCOs are directly supporting implementation and operations of services consistent with the Agreement. The Expert Reviewer expects that the state will carry out whatever leadership and oversight is necessary and appropriate of both the Medicaid MCO's and the CMHCs to assure compliance with the Agreement. As long as the objectives of the Agreement are met within the defined timeframes and with the desired fidelity and quality, and as long as there is transparency related to the use of funds designated for use in meeting the terms of the Agreement, then it will not be necessary to become more deeply involved in how that oversight and transparency is achieved by the state and its contracted entities.

4. Emergency Department Boarding

As with many other states, emergency department boarding is a critical issue in New Hampshire that is receiving considerable state and local attention and corrective efforts. Emergency department boarding is likely to be symptomatic of issues in the overall mental health system that directly impinge on the objectives and requirements of the Agreement. For example, as New Hampshire Hospital and the CMHCs work to effectuate speedier discharges and lower readmission rates, there should be more beds available at NHH for clinically necessary inpatient admissions. Further, as mobile crisis services and crisis respite services are implemented and expanded, a higher rate of hospital diversion ought to be accomplished before people in psychiatric crisis even reach hospital emergency departments. Finally, effective use of fidelity model best practices such as ACT, SE and supportive housing should substantially increase community tenure, thereby reducing admission rates and demand for inpatient services.

For the above reasons, the Expert Reviewer will continue to review data on ED boarding as one possible indicator of changes in the overall MH system. It will also be important to document

the degree to which strategies to reduce ED boarding, other than those listed above, comport with the objectives and requirements of the Agreement.

5. Variability in the System

As expected during the orientation phase of the Expert Reviewer activity, some variation among CMHCs, and also among services within CMHCs, was observed during the site visits. Some degree of variation is considered to be a positive element of New Hampshire's system of regional CMHCs. However, a high degree of consistency is to be expected of the CMHCs with regard to implementation of components of the Agreement, including attainment of fidelity and quality standards and timely and accurate submission of all required data for tracking progress and performance under the Agreement.

Variations in size, geographic area, service population demographics, staffing and revenues could also result in varying capacities at the CMHC level to implement and manage the required elements of the Agreement. The Expert Reviewer will assist all parties to identify issues related to the capacity to implement and manage components of the Agreement. Technical assistance strategies can be developed and tailored to individual or groups of CMHCs as applicable to their capacities and resources.

III. Observations Related to Agreement Components

The following sections of the Report provide some preliminary observations about specific elements of the Community Mental Health Agreement. Where available, data produced by the state have been summarized to provide some indicators of relative progress or performance related to components of the Agreement. However, the Expert Reviewer and all parties, including the United States and Plaintiffs, are still working to validate data sources and reporting formats, and to develop methods to use data from a variety of sources to track and document the degree to which certain objectives of the Agreement are being attained. It is premature to reach concrete conclusions from the data available and reported at this point. As noted above, for the purposes of his report, no conclusions are reached with regard to either compliance or non-compliance with the Agreement.

a. Assertive Community Treatment (ACT)

As specified in the Agreement, there is now an ACT team at some stage of development in each of the ten CMHC regions. One CMHC has two ACT teams, so there are 11 teams currently at some stage of development/operations in the state. DHHS reports that as of October, 2014 there were a total of 641 individuals enrolled in ACT services in the 11 ACT teams. Because some teams are in the early stages of development, the caseloads are currently lower than would be expected at full implementation. The ACT enrollment target specified in the Agreement is 1,300

enrollees by June 30, 2015. Thus, it will be important to track enrollment rates in ACT over the next few months, and to provide technical assistance if the caseload targets are not being attained.

There is no documentation at this point of the extent to which the current ACT enrollees meet the target population definitions in the Agreement. However, anecdotal reports from the site visits indicate that most of the CMHCs are using clinical criteria for assignment to ACT that are consistent with best practice expectations and the Agreement. For subsequent reporting periods it will be important to identify additional data sources that can be used to verify that the target population guidelines are being met.

DHHS receives monthly data reports from the CMHCs related to progress implementing the ACT services and on the number of consumers enrolled in ACT services. The CMHCs have also recently completed fidelity self assessments for their ACT teams, and have reported this information to DHHS. Some of the results of the fidelity self assessment are reported to be incorporated into the monthly ACT reports. At this point there has been no review or external validation of the results of the self assessments. However, DHHS is reported to be working with CMHCs that have self-reported areas of non-compliance with fidelity standards, with the goal of increasing fidelity to ACT standards throughout the system as soon as possible. For example, DHHS is working with the CMHCs to assist them in the process of recruiting peer specialists to function as members of ACT teams. Independent validation of fidelity self-assessment information will need to be carried out in the future.

Fidelity to ACT staffing models and caseload ratios is a necessary pre-condition to attaining the positive outcomes for consumers that have been demonstrated with the ACT model. However, meeting these basic criteria does not assure that an ACT team is functioning as well as it can. It is also important to assure that: (a) the team is serving the highest risk/highest need consumers in the system; (b) that the team is actually functioning as a team, in that consumers experience and are comfortable with interactions with several members of the team; (c) that the team is realistically capable of responding to enrollee crises on a 24/7 basis, and is not relying on other emergency services capabilities for crisis response; (d) that supported employment and peer supports are provided to ACT enrollees by bona fide members of the ACT team, not staff shared from other service components of an agency; (e) that the team is in reality doing whatever it takes to support each enrollee to be successful in the community and to avoid hospitalization and incarceration; and (f) that over time enrollees in ACT experience positive outcomes such as independent housing, employment, increased community tenure, and reduced emergency department and inpatient hospital episodes of care. Once basic fidelity standards are met, these qualitative and outcome oriented aspects of ACT team functioning will receive greater emphasis from the perspective of both monitoring and technical assistance.

b. Supported Employment

According to information provided by DHHS, each CMHC in New Hampshire has an operational supported employment (SE) program. Consistent with the Agreement and with DHHS policy and funding requirements, these SE programs are intended to meet fidelity standards for the Individual Placement and Supports (IPS) model. DHHS reports that CMHCs have completed fidelity self assessments for these SE programs, but the Expert Reviewer has not yet seen the results of these self assessments. Based on anecdotal information from the site visits, it appears that certain SE staff have been trained in IPS. However, the degree to which IPS fidelity practices are followed within each CMHC is not currently reported or externally validated.

DHHS reports that as of the end of the first quarter of state Fiscal Year 2015⁵, a total of 710 consumers are enrolled in SE throughout the 10 CMHCs. It is not known at this point how many of these individuals are actively engaged in specific job-seeking and actual employment activities. Nor do the data currently document target population membership for consumers enrolled in SE. As with ACT services, anecdotal reports by CMHCs suggest that appropriate clinical criteria are generally used to identify priority consumers for referral to and enrollment in SE. However, additional validation of this from other data sources will be important to future monitoring of SE.

The average penetration rate for SE services across all CMHCs for the first quarter of 2015 was reported by DHHS to be 12.7%. The target penetration rate specified in the Agreement for June 30, 2015 is 16.1%. It is not clear that current calculations of SE penetration rates accurately reflect the number of priority consumers engaged in fidelity model IPS in a consistent manner throughout the state. This will be clarified in the next reporting period. Once the calculation of penetration rates is validated, it will be possible to document progress towards meeting the specified target penetration rate by the end of the next reporting period.

The Agreement specifies that enrollees in ACT teams must receive SE services from employment specialists on their ACT Teams. Several CMHCs stated that trained employment specialists were on their ACT Teams, but others implied that SE staff with broader SE caseloads were participating in providing SE to ACT enrollees. This is an issue for further follow-up in the next six months.

c. Crisis Services – Hospital Diversion

Based on information provided by DHHS, and also on interviews and observations from the CMHC site visits, there are 24/7 crisis services available to people in psychiatric crisis in each region of the state. There do not seem to have been any structural or programmatic changes to the basic crisis service capacity of the CMHCs since the initiation of the Agreement. To date,

⁵ July, August and September, 2014

the Expert Reviewer has not reviewed statewide and comparative data reports specific to the CMHC crisis services programs,⁶ nor has there been a qualitative review of crisis service interventions and dispositions. These will be a priority over the next year of implementation.

DHHS has been preparing an RFP for the first Mobile Crisis Team and Crisis Apartments, to be implemented in Mental Health Region 4 (Concord) by June 30, 2015. The draft RFP is currently being reviewed by the Parties to the Agreement, and is intended to be issued soon. Because the review process for this RFP is not complete, it is premature to comment on progress made to date in moving towards implementation of the mobile crisis and crisis apartment services specified in the Agreement.

Crisis/emergency response services are at the core of community service systems designed to assist people with mental illness to live and work successfully in the community. Such services are also essential to efforts to reduce inpatient hospital admissions and census. Anecdotally, most crisis response services currently provided by CMHCs in New Hampshire are initiated after a person in psychiatric crisis has presented in a hospital emergency department (ED). And, many crisis response services are reported to be physically delivered in hospital EDs. In some cases, crisis staff are anecdotally reported to be assisting ED staff to find an available inpatient psychiatric bed for a person in crisis in the ED.

Frequently, once a person has arrived at the ED it is too late in the process to effectuate a safe and effective diversion back to a person's home and community. This is one reason why the implementation of mobile crisis services is an important component of the Agreement. In addition, there will need to be concerted efforts over the next several months to expand existing crisis response and hospital diversion services beyond the confines of Hospital EDs, with greater focus on up-stream interventions that can assist to stabilize an incipient crisis before hospital admission becomes inevitable.

d. Family and Peer Supports

Information provided by DHHS indicates that there are functioning Peer Supports programs in each of the ten regions, and that these programs are generally open and available to members 44 hours per week.⁷ Documentation is not currently available that would indicate actual member participation during the hours that the Peer Supports Centers are open. The Expert Reviewer was not able to complete visits to Peer Support Agencies within each of the ten regions during the first six months. Thus, it is premature to report on any observations with regard to these programs. These will be addressed in the next semi-annual report.

⁶ For the most part BBH and the CMHCs refer to these programs as "emergency services" rather than "crisis services" programs. Most of the CMHCs did provide some data on emergency services presentations and dispositions as part of the site visits.

⁷ These hours do not necessarily reflect time spent by peer members of the programs providing supports to others via warm lines, crisis respite programs, etc.

The Expert Reviewer was also unable review the Family Supports program during the first six months. DHHS and NAMI New Hampshire confirmed that this program is on-going, but there has been no review of activities, participation, or other information related to the program.

Based on anecdotal information from members of the Statewide Consumer Council, from CMHCs, from DHHS, and from the few Peer Supports programs visited, there are several areas for further information collection and possible technical assistance related to peer supports includes:

- Examine ways in which DHHS and other state agencies could assist Peer Supports programs to participate in supplying peer specialists and other staff with lived experience for ACT teams and other mental health programs;
- Increase/enhance the roles of people with lived experience in facility inreach, transition planning, and effectuating transitions independent community living;
- Encourage increased membership and participation in the Peer Support Programs; and
- Increase the degree of collaboration and communication among the CMHCs and Peer Supports programs, and increase the degree of participation of Peer Supports programs in integrated health and wellness programs on a statewide basis.

e. Supportive Housing

DHHS reports that there are sufficient funds to provide 290 supportive housing units via the state Bridge Subsidy Program by December 31, 2014.

According to tentative information provided by DHHS, as of October 31, 2014 there were 210 people in leased bridge subsidy apartments, with an additional 15 people approved for a bridge rent subsidy who are in the process of finding an apartment and moving in. The above reported occupancy data do not include individuals who have transitioned from the bridge subsidy to mainstream housing choice vouchers or other affordable supportive housing resources, and who may continue to receive community services and supports as well as housing. Thus, it is premature to reach any conclusions about performance related to the provision of supportive housing relative to the Agreement. In addition, the Expert Reviewer has not yet visited Harbor Homes, the state's vendor for the Bridge Subsidy program, and thus has no information or impressions from that agency.⁸ The process of attaining supportive housing, from initial referral and eligibility determination (by defined criteria), to housing search and rent-up, needs to be clarified and documented. Supportive housing will be an important priority for data collection and monitoring over the next few months.

⁸ This visit is scheduled for December 16, 2014, too late for information from that visit to be included in this Report.

From anecdotal information and some preliminary discussions with the Parties, it appears that there are several important questions to be addressed with regard to supportive housing. These include:

- The state supportive housing bridge subsidy is not the only source of affordable scattered site housing for priority target population people as defined in the Agreement. For example, if the federal Department of Housing and Urban Development funds New Hampshire's application for Section 811 PRA funds, there will be a new source of rental subsidies. In addition, some members of the priority target population undoubtedly obtain Housing Choice Vouchers (HCVs – Section 8) or Shelter Plus Care subsidies without first participating in the Bridge Subsidy program. The Bridge Subsidy program is currently the only supportive housing program for which the state reports information on the number of people occupying units.
- There is currently no data source that specifically identifies the exact source of referrals into the Bridge Subsidy program. For example, how many tenants receiving units after the Agreement was signed came to the Bridge Subsidy program via transition planning form NHH and Glencliff? When a subsidy becomes available, who among the target population is awarded the subsidy and on what basis?
- Nor is there currently reported data related to the community services and supports received by supportive housing tenants. For example, how many supportive housing tenants are receiving ACT and SE services? Are all supportive housing tenants receiving services from their cognizant CMHCs? What agencies are accountable at the local level to assure that supportive housing tenants experience continuity of care, adequate crisis response, tenancy supports, eviction prevention, etc.?
- Finally, from anecdotal information from state officials and CMHC site visits, there appears to be some variability regarding the Bridge Subsidy program in the referral and lease-up process, communications and relationships among state facilities doing transition planning, housing acquisition, and service coordination and delivery. As noted above, this process will need to be clarified over the next few months.

f. Community Residences

DHHS is reported to be developing a draft Request for Proposals (RFP) for the four community residence beds identified in the Agreement (Section V.E.3.g) as being available by June 30, 2015. This RFP is not yet available for review, so it is premature to reach any conclusions or recommendations regarding this provision of the Agreement. This will be addressed in the next semi-annual report.

g. Transition Planning

The Community Mental Health Agreement contains detailed specifications for transition planning from New Hampshire Hospital (NHH) and Glencliff, to be in place by June 30, 2014. A version of transition planning had been in place in each facility prior to the Agreement, but new policies and procedures were necessary to meet the standards for transition planning in the Agreement. Glencliff Home issued its new transition planning policy August 14, 2014; NHH issued its revised policy effective October 22, 2014.

The New Hampshire Department of Health and Human Services is also procuring a new Preadmission Screening and Resident Review (PASSR) entity, to assure clinical necessity and appropriateness of admissions to Glencliff. The new vendor has been selected, but implementation is in the very early stages, so it is premature to comment on how that provision of the Agreement is being implemented.

For both NHH and Glencliff, the transition planning policies and practices are too newly issued to be able to comment on their implementation or effectiveness. It is also too early in the implementation process to comment on inreach activities on the part of CMHCs, peer support agencies and other community entities as specified in the Agreement. Transition planning will be another important focus of monitoring and technical assistance over the next six months. Several best practice approaches related to transition planning will be addressed during the next year. These include:

- Including a projected discharge date in the individual person centered transition plans developed by NHH and Glencliff. Without a specific date by which the transition is projected to be accomplished, it is difficult for patients, families, and caregivers to plan. It is also difficult to assure that the necessary community housing, services and supports are in place to effectuate the transition by the projected discharge date. Finally, a projected transition date allows the state, facility managers and other involved parties to track and document the effectiveness of the transition planning process. Monitoring the degree to which discharge dates are incorporated into individual transition plans, as well as the degree to which these dates are met, will become part of the ongoing monitoring of the transition planning process as specified in the Agreement.
- Specifying in the individual person centered transition plan the service and skill building activities that are to be carried out by the facility leading up to a successful discharge. As with the discharge date, specification of pre-discharge services should be included in the individualized transition plans. There is a need to hold CMHCs and other community providers and caregivers accountable for providing the community housing and services to accomplish successful transitions. In the same way, there needs to be a basis in the transition plans for holding facilities accountable for providing the services and skill-building necessary to assure that each individual will be ready for and successful in the community.

DHHS is reported to be developing a data tracking system to identify people at the point of transition from facilities, and to track their service utilization, continuity of care, readmission episodes, etc. after transition. Assuming this data system is implemented, it will fill a current gap in available information related to facility transitions and the linkage of services to these priority consumers in the community. The Expert Reviewer will continue to participate in discussions about the design and implementation of this system over the next few months.

Finally, the Agreement calls for the establishment of a central team to assist and addressing and overcoming barriers to effectuate transitions to the community. Formation and membership of this team is still in development, and thus will be a topic for the next semi-annual report.

Note: Expert Reviewer comments and observations related to other components of the Agreement, including assurance of compliance with the target population definitions, steps to address the needs of people with development disabilities in the target population, measures put in place to prevent placement in nursing homes or other institutional settings, and implementation of quality management services, are reserved for the next semi-annual report, due in June, 2015.

IV. Conclusion

As described in this first Report of the Expert Reviewer, numerous steps have begun to be taken to implement the Community Mental Health Agreement. The parties to the Agreement appear to be committed to meeting the targets and requirements of the Agreement, and also seem committed to a transparent and collaborative implementation process. Progress towards implementing Agreement requirements is evident within most components of the Agreement, and concrete action steps are being developed to keep the process moving forward in the right direction.

Of course, it is very early in the implementation of the Agreement. Most of the implementation process has just begun and, as noted throughout the Report, it is premature to reach any conclusions about meeting the performance and quality requirements of the Agreement. Considerable effort will be necessary within each component of the Agreement to sustain progress already made and to attain the level of quality and results specified by the Agreement.

There are several important priorities both for the implementation process itself and for the monitoring of implementation over the next six months. Perhaps the most important will be to identify the data sets and sources that will be used to inform all parties as to progress and performance related to each discrete component of the Agreement. Several available data sources have been identified, but it is necessary define how these will be used, and how information will be analyzed and interpreted, to document quality and performance under the Agreement going forward. The task of identifying applicable data and designing analytic

frameworks must include all Parties, since all Parties will have to agree that data is timely and reliable and that it accurately responds to the requirements of the Agreement. The supportive housing component of the Agreement is a high priority for data definition and analysis in the next six months.

Other priority items for monitoring in the next six months include:

- Implementation of the Central Team for transition planning and facilitation of discharges for NHH and Glenclyff;
- Results of discharge planning as implemented at NHH and Glenclyff;
- Award of a contract and early implementation of the mobile crisis and crisis apartment services in the Concord region;
- Assurance of service linkage and provision to tenants in supportive housing;
- Full lease up of bridge subsidy and other designated supportive housing resources; and
- Addition of peer specialists to the ACT teams.

The Expert Reviewer has identified several areas in which the state may wish to request technical assistance related to implementation of the Agreement. These include:

- Attainment and sustainability of fidelity for ACT and SE –
- Employment of peers as members of ACT teams, and perhaps also for in-reach services related to transitions from facilities to the community; and
- Workforce development and retention applicable to ACT, SE and other related skill building and community support services within the CMHCs.

The Expert Reviewer is grateful to all the people and agencies that assisted with the six month orientation process. All of the state officials, facilities, CMHCs, Peer Support Agencies and other people and agencies participating in interviews and site visits were cooperative and forthcoming with any information that was requested. The orientation phase is not entirely complete, but a solid foundation of information and exposure to key system components has been established for the ongoing monitoring of quality and performance consistent with the Community Mental Health Agreement.

Appendix A

Schedule of Expert Reviewer Meetings and Site Visits for July through December, 2014

Master Schedule for Expert Reviewer Site Visits

Date	Interview/Site Visit	Comments
Monday, July 14	9:00: Meet with Katja 9:30-10:00: DHHS Senior Management PM: Interim BBH Administrator	
Tuesday, July 15	1:30-3:30: Mental Health Coordination Team	
Wednesday, July 16	10:00-11:30: CMHC Executive Directors Meeting – Concord 1:00-2:00: Ken Norton, NAMI-NH	
Thursday July 17	12:15-12:45: Governor Hassan, DHHS Commissioner Toumpas, Attorney General Foster	
Tuesday July 22	9:00-11:00: Glencliff 1:30 PM: Riverbend - Concord	
Wednesday, July 23	9:00-12:00: Community Partners – Dover 1:30-4:30: Seacoast - Portsmouth	Rescheduled to 9/4, 1:30-4:30
Thursday July 24	9:00-12:00: MHC of Greater Manchester & Cypress Center 2:00-4:00: NH Hospital	
Tuesday August 12	9:00-12:00: Northern Human Services –Berlin 1:30-4:30 PM: Genesis Behavioral Health - Laconia	
Wednesday Aug 13	9:30-12:00: Monadnock Family Services –Keene 1:30-4:30: West Central –Lebanon	Rescheduled to 8/27, 1:00-4:00
Tuesday August 26	9:00-12:00: Greater Nashua MHC 1:00-4:00: Center for Life Management - Derry	
Wednesday, August 27	2:00-5:00: West Central Behavioral Health - Lebanon	
Wednesday, Sept 3	9:30-10:30: Greg Burdwood, Dave Rollins, Katja Fox 1:00-2:00: Michele Harlan-Main Bldg 2:00-3:00: Kelley Capuchino-Main Bldg	DHHS Brown, Room 433 BBH Director’s Office, Main Building BBH Director’s Office, Main Building

	3:00-4:00: Diane Langley-Brown #249	Diane's Office
Thursday, September 4	1:30-4:30: Community Partners – Dover	
Tuesday, Sept 9	10:00-11:00 TH-NFI 3:00-4:30: Debrief with State Team	Howard Rec Center DHHS Brown, Room 468
Tuesday, Sep 16	10:00-1:00: Consumer Council	Fox Chapel, DHHS Main Building (*Time on agenda will be confirmed)
Thursday, Sept 18	2:30-4:30: Meet with all parties in Concord	Debrief on orientation phase Discussion of next steps: DHHS Brown Building, Room 468
November 5, 2014 10:00am	On the Road to Recovery (region 10)	12 Birch Street Derry NH, 03038
November 5, 2014 2:00pm	On the Road to Recovery (region 7)	13 Orange Street Manchester NH, 03105
November 12, 2014 1:00-2:00	Community Mental Health Center Directors	1 Pillsbury Street Concord
November 20, 2014 1:30pm	Seacoast Consumer Alliance	544 Islington Street Portsmouth, NH 03801
December 3, 2014 10:00am	Concord Peer Support Center	55 School Street Concord, NH 03301
December 3, 2014 2:00pm	Cornerbridge of Laconia	328 Union Ave Laconia, NH 03247
December 4, 2014 1:30pm	Tri-City Coop	36 Wakefield Street Rochester, NH 03867
December 9, 2014 10:00-11:00	Meeting with Commissioner, Katja Fox & Jeff Meyers re: integration	Commissioner's Office Brown Bldg, Concord
December 9, 2014 11:00-12:00	Quality Management Meeting- DHHS Staff	Brown Bldg, Room 403
December 10, 2014 1:30pm	Alternative Life Center	6 Main Street Conway, NH 03818
December 11, 2014 10:30am	Monadnock Area Peer Support	64 Beaver Street Keene, NH 03431

December 11, 2014 2:00pm	The Stepping Stone Drop-In Assn.	108 Pleasant Street Claremont, NH 03743
December 16, 2014 9:00-11:00	Harbor Homes	Manchester

Appendix B

Agenda for All Parties Debriefing Meeting – September 18, 2014

Expert Reviewer New Hampshire Meeting of the Parties to the
Community Mental Health Agreement

September 18, 2014

Agenda

1. Purpose of the meeting
2. Summary of system orientation activities to date
 - a. Data and documents
 - b. Site visits
 - c. State staff meetings
3. Brief summary of observations to date
 - a. Implementation planning process
 - b. Structure and resources for implementation and operations
 - i. Mental Health Planning Group
 - c. Service delivery and operations “culture” as it might affect implementation and effectiveness of the mental health agreement
 - d. General systems issues – environment for implementation
 - i. MCO implementation and CMHC payment mechanism
 - ii. Medicaid expansion
 - iii. Medicaid expansion benefit design – MH and SUD
 - iv. Emergency Department boarding
 - v. Capacity of CMHCS
 - vi. Availability of data
4. Observations related to Agreement components
 - a. ACT
 - b. Supported Employment
 - c. Crisis Services – hospital diversion
 - d. Peer supports
 - e. Supportive housing
 - f. Community residences
 - g. Transition planning
 - h. Targeting to priority populations
 - i. Quality Improvement/quality management
5. Issues for future tracking/analysis
 - a. Service access and priority population tracking
 - b. Transition planning – roles/activities of CMHCs
 - c. Fidelity of EBPs – particularly ACT and SE
 - d. Crisis service system evolution
 - i. Mobile crisis

- ii. Crisis respite capacity
 - iii. Up-stream interventions
 - e. State and MCO oversight of contract and financing agreements specifically related to the agreement
 - f. Specification of outcomes/results to be tracked and data sources to be used related to the agreement
- 6. Specific issues related to the agreement
 - a. Need to move towards providing emergency services/crisis response at the site of the crisis, not just in the ED or office
 - i. Track issuance of Mobil Crisis RFP (Planned for November 2014)
 - b. ACT – question if all teams can meet standards by October 1, 2014
- 7. Specific Priorities for Technical Assistance
 - a. TA and training related to ACT and SE – both development and sustainability related to fidelity standards and the philosophy/vision for the EBPs
 - b. TA related to the use of peer support services and re: employment of peers as members of ACT and CSP teams, in-reach services, etc.
 - c. Additional support and TA related to workforce development and retention