New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Five

January 6, 2017

I. Introduction

This is the fifth semi-annual report of the Expert Reviewer (ER) under the Settlement Agreement in the case of *Amanda D. v. Hassan,; 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, 2016 through December 31, 2016), 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) teams/services and Supported Employment (SE) services at West Central Behavioral Health, Greater Nashua Mental Health, and Northern Human Services: a non-random sample of ACT and SE records was reviewed at each of these sites;
- Conducted an on-site visit related to implementation of the Mobile Crisis Program in Manchester;
- Met with the New Hampshire Consumer Council;
- Met with Ken Norton, Executive Director of NAMI New Hampshire;
- Met with the State's Central Team to review progress and discuss barriers to transition from both New Hampshire Hospital (NHH) and Glencliff Home (Glencliff);
- 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 residents to discuss transition planning processes and issues;

- Met with New Hampshire Department of Health and Human Services (DHHS) Commissioner Jeffrey Meyers;
- Met with DHHS staff involved with the PASRR program to discuss the new contract for PASRR services and to identify data reporting issues;
- 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 general progress and implementation issues related to the CMHA.

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.

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 (November 2016), 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. Specific data from the quarterly reports are included in the discussion of individual CMHA services below.

In addition to the standardized reporting of certain types of data, DHHS continues to collect and report on other data necessary to monitor performance related to the CMHA. These include reports from the new mobile crisis services in the Concord and Manchester Regions; data on discharge destinations from NHH and Glencliff; reports of wait list numbers for Emergency Department (ED) boarding; and utilization of the Bridge Housing Subsidy Program.

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 is discussed in the SE section of this report.

Another gap in data is related to people receiving Supported Housing (SH) under the Bridge Housing 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 CMHA services and supports; or (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, such data has not been produced to date, leaving a significant gap in the ER's ability to evaluate compliance with SH provisions of the CMHA. Other gaps in data are referenced later in this report.

Although the soon-to-be-initiated QM/QSR process will provide additional information related to the quality, effectiveness, and (where applicable) the fidelity of the services delivered, the data identified above is an essential complement to those client reviews and necessary in order for the ER and the parties to effectively measure ongoing implementation, and for the State to demonstrate compliance with the terms of the CMHA. The QM/QSR process is discussed later in this report.

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 mobile crisis capacity 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 is the vendor selected to implement the mobile team and crisis apartments in the Concord Region.

Table I below includes the most recent available information on activities of its new crisis program.

Table I

Concord Region Self-Reported Mobile Crisis Services: April-June 2016 and July-September 2016

	April – June 2016	July - September 2016
Total unduplicated people served	532	549
Services provided in response to immediate crisis:		
• Phone support/triage	735	927
• Mobile assessments	142	157
• Crisis stabilization appointments	63	64
• Emergency services medication appointments	33	69
• Office based urgent assessments	36	46
Services provided after the immediate crisis:		
• Phone support/triage	226	427
• Mobile assessments	18	27
• Crisis stabilization appointments	63	64
• Emergency services medication appointments	27	33
• Office based Urgent Assessments	36	46
Referral source:		
• Self	282	310
• Family	111	101
• Guardian	23	0
• Mental health provider	18	28
• Primary care physician	16	18
• Hospital emergency department	24	64
• Police	23	25
• CMHC Internal	94	63
Crisis apartment admissions:		
• Bed days	120	289
• Average length of stay	3.0	3.9
Law enforcement involvement	46	46
Total hospital diversions*	288	263

*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.

These data indicate a growth in the number of people accessing crisis services, and in the number of crisis response services delivered. There has also been substantial growth in utilization of the crisis apartments. These data also suggest that there are hundreds of triage callers each quarter

who receive neither a mobile crisis assessment nor an office-based appointment. In order to measure whether and to what extent class members have appropriate access to community-based MCI, a further examination and analysis of MCI triage and dispatch decisions is needed.

In mid-June 2016, DHHS awarded a contract to the Mental Health Center of Greater Manchester to establish the second Mobile Crisis Team and Crisis Apartments. Given the timing of the contract award, mobile crisis services were not operational in the Manchester Region by June 30, 2016, as specified in the CMHA. However, as of December 2016 the Manchester Mobile Team is staffed and operational; the separate Mobile Crisis telephone system is in place; an interim crisis apartment has been identified and is in use; and outreach has begun to the Manchester police and other first responders in the community. Data from the Manchester Mobile Crisis program will be incorporated in the June 30, 2017 ER report. At that time, the ER hopes to include an analysis of whether the new crisis services are having a positive impact on reducing the number of ED presentations and the number of readmissions to NHH/DRFs in the Concord and Manchester regions.

DHHS reports that it will be incorporating Mobile Crisis and Crisis Apartment data in the Phoenix system, which will support routine collection and reporting of these data in the Quarterly Data Reports. DHHS also reports that the RFP for the new Mobile Team and Crisis Apartments to be developed in the Nashua region by July 1, 2017, was issued on December 19, 2016, and is expected to be approved in March 2017. In order to comply with the terms of the CMHA, and to avoid extended delays in implementation, like those seen in the Concord and Manchester Regions, DHHS must make every effort to ensure this procurement process proceeds rapidly enough to assure the selected vendor is ready to operate the program and begin serving class members by July 1, 2017.

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; and
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.

The CMHA requires a robust and effective system of ACT services to be in place throughout the state as of June 30, 2015 (18 months ago). Further, as of June 30, 2016, the State is 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 two FTEs in the three months between June 2016 and September 2016. During the same time, the total active caseload has increased by only 26 individuals. As of the date of this report, the State is providing ACT services to 865 unique consumers and as a result is delivering only 58 percent of the ACT capacity required by the CMHA, and is out of compliance on this key CMHA service.

Table II

Self-Reported ACT Staffing (excluding psychiatry): May 2015 through September 2016

Region	FTE May-15	FTE Sep-15	FTE Dec-15	FTE March 2016	FTE June	FTE September 2016	% change June – Sept
Northern	14.80	11.29	11.15	11.15	11.15	10.25	-8.78%
West Central	3.00	3.83	2.64	4.37	4.44	5.44	18.38%
Genesis	7.10	7.5	6.4	7.4	7.60	7.00	-8.57%
Riverbend	7.00	7.3	6.7	7	7.50	7.50	0.00%
Monadnock	8.20	8.5	7.75	7.75	7.75	7.25	-6.90%
Nashua 1					5.75	6.25	8.00%
Nashua 2					3.75	5.25	28.57%
Manchester 1					14.61	15.46	5.50%
Manchester 2					18.81	20.24	7.07%
Seacoast	12.80	11.77	11.77	11.53	10.73	8.73	-22.91%
Community Partners	8.20	8.7	7.9	5.9	7.90	8.03	1.62%
Center for Life Man.	7.80	6.36	8.16	8.16	7.91	7.91	0.00%
Total	68.90	65.25	62.47	63.26	107.90	109.31	1.29%

It is clear from this table that overall ACT staffing has remained at best static, and in some regions has decreased over the past four reporting periods. This is true despite previous ER findings that New Hampshire was out of compliance with the standards of the CMHA. Based on staffing shortages alone, more than 500 individuals potentially would not be able to receive such services due to the lack of capacity. This current pace of staff recruitment and capacity development is not sufficient to satisfy the State's outstanding obligations under the CMHA; nor will it allow for a prompt, statewide response to the needs of individuals eligible for ACT and identified through ongoing outreach efforts.

Table III below displays trends in active caseloads for ACT services by Region.

Table III

Self-Reported ACT Caseload (Unique Adult Consumers) by Region per Quarter: May 2015 through September 2016

	Cases May-15	Cases Sep-15	Cases Dec-15	Cases Mar-16	Cases Sep-16	% Change Mar. to Sep
Northern	60	72	74	79	88	10.23%
West Central	16	19	21	26	33	21.21%
Genesis	22	30	34	39	58	32.76%
Riverbend	79	60	56	70	81	13.58%
Monadnock	47	54	61	68	73	6.85%
Greater Nashua	63	74	72	72	76	5.26%
Manchester	254	265	270	293	270	-8.52%
Seacoast	73	65	65	72	70	-2.86%
Community Partners	16	70	76	73	74	1.35%
Center for Life Man.	39	37	40	49	47	-4.26%
Total*	669	746	766	839	865	3.10%

Based on self-reported staffing data, the Regions appear to have made some gains in enhancing staff capacity within certain ACT teams between June and September, 2016. Seven ACT Teams (including the two teams in Manchester and the two teams in Nashua) reported increases in ACT staffing from March through September, 2016, while five teams reported reductions in ACT staffing during that period. All ACT teams continue to report substance use disorder (SUD) staff competency. Four of the teams continue to report less than one FTE SE competency.

Three of the 12 adult ACT teams still have fewer than the 7 - 10 professionals specified for ACT teams in the CMHA, and four teams continue to report having no peer specialist on the ACT Team. As with the previous report, only three teams report having at least one FTE peer specialist. Five teams continue to report having less than .5 FTE combined psychiatry/nurse practitioner time available to their ACT teams. Three teams report having less than 50% FTE Nursing on the Team (Note: this is a substantial improvement from the previous ER report, in which seven ACT Teams were noted to report less than 50% FTE nursing staffing).

Despite the progress noted above, remaining deficiencies in ACT team staffing and composition, leave the State out of compliance with the foundational service standards described in Section V.D.2 of the CMHA, and threaten its ability to provide a robust and effective system of ACT services throughout the State.

As noted in the previous ER Report, the New Hampshire DHHS has begun to take 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) a small increase in ACT funding incorporated 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. Compliance letters and performance improvements plans (PIPs) have been initiated in three of the 10 Regions. Also, as noted in the previous ER report, the new QSR being implemented by DHHS will examine the provision of ACT services, and the QSR findings are expected to prompt additional PIPs where necessary.

DHHS and representatives of the Plaintiffs have been working collaboratively on new regulations defining ACT service eligibility and access standards over the past year. The ER understands that the revised ACT regulations were approved on December 15, 2016. The ER applauds the mutual efforts and spirit of open communication and compromise that have taken place to ensure that these new regulations were developed and promulgated in a positive fashion.

Based on continuing non-compliance with the ACT staffing and capacity standards in the CMHA, in the previous report the ER recommended that DHHS adopt several management initiatives to facilitate and speed up progress towards meeting the CMHA ACT requirements. Progress related to these suggested actions is summarized in the conclusion to this 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, 2016, the State will increase its penetration rate of individuals with SMI receiving supported employment …to 18.1% of eligible individuals with SMI." (Section V.F.2(d)).

For this reporting period, the State reports that it has achieved a statewide SE penetration rate of 20.4%, 2.3 points higher than the 18.1% penetration rate specified for June 30, 2016 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: March 2015 through October 2016

	Penetration Mar-15	Penetration Sep-15	Penetration Dec-15	Penetration Mar-16	Penetration Oct-16	% Change Mar-Oct
Northern	7.10%	8.20%	9.50%	10.60%	14.00%	32.08%
West Central	13.50%	12.90%	14.30%	15.30%	17.50%	14.38%
Genesis	9.40%	9.30%	9.60%	9.60%	14.10%	46.88%
Riverbend	14.90%	14.20%	14.60%	14.10%	13.70%	-2.84%
Monadnock	8.00%	16.40%	19.40%	20.50%	20.40%	-0.49%
Greater Nashua	6.10%	7.70%	8.60%	9.00%	11.90%	32.22%
Manchester	14.60%	26.10%	31.70%	36.70%	37.10%	1.09%
Seacoast	10.50%	13.10%	12.70%	11.00%	12.00%	9.09%
Community Part.	8.10%	11.60%	13.00%	12.60%	10.40%	-17.46%
Center for Life Man.	16.30%	15.70%	13.00%	24.70%	23.00%	-6.88%
CMHA Target	14.10%	16.10%	16.10%	16.10%	18.10%	0.00%
Statewide Average	11.30%	15.70%	17.90%	19.30%	20.40%	5.70%

As noted in Table IV, the State has exceeded the statewide CMHA penetration rate in the last two reporting periods. In addition, the New Hampshire DHHS is commended for continuing its efforts to: (a) measure the fidelity of SE services on a statewide basis; and (b) work with the seven Regions with penetration rates below CMHA criteria to increase access to and delivery of SE services to target population members in their Regions. As can be seen in Table IV, five of the seven Regions with less than 18.1% SE penetration rates have improved their performance in the most recent reporting period. And, 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 to assure the quality and accessibility of SE services statewide. The ER expects the QSR process to measure whether and to what extent 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 consistent with their individual treatment plans and the fidelity requirements of the CMHA. To that end, the ER expects to review employment data from each region during the next reporting period.

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 the September 30, 2016, DHHS reports having 451 individuals in leased SH apartments, and 28 people approved for a subsidy but not yet

leased. The State is in compliance with the CMHA numerical standards for SH effective June 30, 2016.

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 2016

Bridge Subsidy Program Information	September 2015	March 2016	September 2016
Total housing slots (subsidies) available	450	450	479
Total people for whom rents are being subsidized	376	415	451
Individuals accepted but waiting to lease	23	22	28
Individuals currently on the wait list for a bridge subsidy	0	0	0
Total number served since the inception of the Bridge Subsidy Program	466	518	603
Total number receiving a Housing Choice (Section 8) Voucher	70	71	83

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 Bridge Subsidy Housing Concentration (Density)

	September 2015	March 2016	June 2016	November 2016
Number of properties with one leased SH unit at the same address	290	317	325	339
Number of properties with two SH units at the same address	27	22	35	24
Number of properties with three SH units at the same address	2	13	8	13
Number of properties with four SH units at the same address	4	1	1	3
Number of properties with five SH units at the same address	1	2	2	0
Number of properties with six SH units at the same address	1	0	1	1

As noted in the previous report, almost 90% 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 24% of 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 in the next ER report.

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 leased units.[1]

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

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 January and June 2016 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.

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;
- Elapsed time between application, approval, and lease-up;
- Number of new individuals leased-up during the quarter;
- Number of terminations from Bridge subsidies;
- 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 and in assessing 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 described in the previous ER report, DHHS was in the process of drafting Bridge Housing Subsidy Program rules, in consultation with representatives of the Plaintiffs. These revised SH rules have been successfully promulgated, and, as with the ACT rules noted above, represent evidence of positive collaboration among the parties related to CMHA implementation.

Transitions from Institutional to Community Settings

During the past 18 months, the ER has visited both Glencliff and NHH on at least four 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 were observed, and most recently, 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 three meetings of the Central Team. The Central Team has now had about 12 months of operational experience, and has started reporting data on its activities. To date, 21 individuals have been submitted to the Central Team, 14 from Glencliff and seven from NHH. Table VII below summarizes the discharge barriers that have been identified by the Central Team with regard to these 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.

Table VII

Discharge Barriers Identified by the Central Team: September 2015

Through November 2016

Discharge Barriers	NHH	Glencliff
Legal	2	2
Residential	3	7
Financial	1	5
Clinical	3	4
Family/Guardian	1	0
Other	2	0

Glencliff

In the time period from April to September 2016, Glencliff reports that it has admitted nine individuals, and has had only two discharges. There have been no readmissions during this time frame. One of these two discharges is reported to have been to an independent apartment in the community. The wait list for admission has remained relatively constant: averaging 15 people during this time frame. The lengths of stay for the two persons discharged were 481 days and 2,871 days.

Section V.E.3(g) of the CMHA requires the State by June 30, 2015 to: "…have the capacity to serve in the community four individuals with mental illness and complex health care needs residing at Glencliff…." The CMHA defines these as: "individuals …who could not be cost-effectively served in supported housing."[2] This target increases to a total capacity for ten such individuals to be discharged to the community by June 30, 2016. The CMHA includes several options for attaining that goal, including the issuance of an RFP to secure new residential services beds and/or to access existing community capacity in the residential services system. The CMHA also anticipates collaboration with the DHHS Elderly and Adult Services component to assist with implementing transition plans for this population.

[2] CMHA V.E.2(a)

As noted in the June 30, 2015 and January 5, 2016 ER reports, DHHS has been endeavoring to access the Enhanced Family Care service modality included in New Hampshire's Home and Community-Based Services waiver for people who are elderly or have disabilities. DHHS has also been exploring other Medicaid waiver and in-plan service authorities to piece together an array of services for each of the individuals at Glencliff for whom this type of transition planning is being conducted. As of the date of this report, DHHS has: (a) identified a vendor to serve four individuals with complex health care needs in the community; and (b) has developed a funding mechanism through which the vendor can invoice for specialized individualized supports for these individuals. Four individuals have visited the new program site and have accepted transfers to this new program. The first individuals are expected to move to the program in January, and the remaining individual(s) are expected to transition in January. It is hoped that this program model and funding mechanism will provided a template and positive experience to accelerate transitions of individuals with mental illness and complex medical conditions from Glencliff into integrated community settings.

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. DHHS reports that six individuals have transitioned from Glencliff to integrated community settings since the inception of the CMHA. This activity is to be commended, and hopefully will accelerate in parallel with facilitated transitions of individuals with complex health care needs into small program sites as noted above.

The ER continues to find that the State is not in compliance with Section V.E.3(g) and (h) of the CMHA, as well as a number of provisions throughout Section VI. Despite the commendable progress identified above, the ER continues to find that the progress in creating capacity for individuals with mental illness and complex health care needs who cannot be cost-effectively served in supportive housing does not yet meet the requirements of the CMHA.

After this report was drafted, the State provided some information on six individuals that it believes have been discharged from Glencliff consistent with this provision of the CMHA. However, neither the Plaintiffs nor the ER have been able within the time frame of this report to assess the information provided by the State. The ER will request input from the Plaintiffs, and may request additional information from the State. Any changes resulting from these discussions and information analyses will be reflected in future ER reports.

PASRR

In October 2016, the ER met with program staff of DHHS to discuss data reporting related to the State's PASRR Program. At that time the State was engaged in re-procuring the PASRR contract, a new vendor was in the process of being selected, and it was not possible to obtain detailed information about how the new vendor will collect and report data. The ER expects

DHHS will provide the requested data, and will facilitate a meeting between the ER and the new vendor, as soon as possible. The ER needs to be satisfied that PASRR reviews are being conducted as described under VI A.10, and that individuals whose needs could be met in the community are promptly referred to the appropriate area agency or CMHC in order to find that there is compliance with this CMHA requirement.

New Hampshire Hospital

For the time period July through September 2016, DHHS reported that NHH effectuated 373 admissions and 365 discharges. The mean daily census was 134, and the median length of stay for discharges was 8 days.

Table VIII below compares NHH discharge destination information for the three most recent reporting periods. 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 VIII

New Hampshire Hospital Self-Reported Data on Discharge Destination

Discharge Destination	Percent January 2014 through May 2015	Percent July 1 2015 through September 18, 2015	Percent September 19, 2015 through April 20, 2016	Percent October and November 2016
Home – live alone or with others	74.4%	67.3%	80.2%	84.86%
Glencliff	0.4%	0.20%	0.60%	0.54%
Homeless Shelter/motel	3.8%	2.4%	2.7%	0.54%
Group home 5+/DDS supported living, etc.	3.4%	9.02%	3.2%	1.62%
Jail/corrections	1.5%	0.40%	1.4%	3.64%
Nursing home/rehab facility	1.9%	3.0%	0.80%	3.78%
Unknown	12.6%	17.64%	6.8%	1.62%

The most recent Quarterly Data Report contains new, consistently reported information on the hospital-based DRFs/APRTP in New Hampshire. It is important to capture the DRF/APRTP data and combine 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 IX summarizes this data.

Table IX

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

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Total
Admissions						
Jan - March 2016	69	257	NA	65	121	512
April - June 2016	79	205	378	49	92	803
July - Sept 2016	37	207	375	54	114	787
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%
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
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
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

*Totals do not include Portsmouth for Jan – March 2016.

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

Table X

Self-Reported Discharge Dispositions for DRFs in New Hampshire

July 2016 through September 2016

Disposition	Cypress	Elliot GPU	Elliott Pathways	Franklin	Portsmouth Regional	Total
Home	188	16	102	27	245	578
NHH	0	0	0	2	12	14
Nursing Home	0	17	0	0	0	17
Residential Facility	4	16	1	2	0	23
Other DRF	3	2	2	3	0	10
Death	0	2	0	0	0	2
Other or Unknown	18	10	8	0	123*	159

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

It should be noted that the above represents the first DHHS report of discharge disposition data to be included in this report. Thus, there is no reporting or analyses of trends in such discharge dispositions at this point. DHHS is to be commended for producing and sharing this data with the Parties to the CMHA.

In the previous two reports, the ER has identified the waiting list (hospital ED boarding) for admission to NHH to be an important indicator of overall system performance. Based on recent information reported by DHHS, 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 1 through September 30, 2016 the average weekly wait list for admission to NHH was 31.5. The constant and increasing number of adults awaiting inpatient admission to NHH is of concern to DHHS and many other parties in New Hampshire. In most mental health systems, a high number of adults waiting for inpatient admissions is indicative of a need for enhanced crisis response (e.g., mobile crisis) and high intensity community supports (e.g., ACT).

As noted earlier in this report, DHHS is analyzing 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.

Summary of Transition Issues

Over the past three reports, the ER has consistently noted that the transitions process at Glencliff is moving very slowly. This appears to be true both at the individual consumer level, and at the system level. Although information at this point is anecdotal, interviews with both line staff and administrators, plus some selective record reviews, indicate that it is taking substantial amounts of time to overcome the many and varied barriers to discharge to the community. Although the Central Team is now fully operational, it has been concentrating on a small number of cases, and referrals to the Central Team from Glencliff and NHH seems to have declined in the past two months for which data is available (N=1 total referrals to the Central Team in October and November). This centralized resource is expected to play a larger role in addressing, overcoming and reporting on continued barriers to transition planning from both Glencliff and NHH, in keeping with the requirements of the CMHA. (VI.A.6)

The ER will continue to follow up with Glencliff, NHH, and the Central Team to monitor improvements in transitions processes and successes, and to document continued barriers to transitions to the community from these facilities.

Finally, as noted earlier in this report, re-admission data for NHH remains incomplete. A single data point from November 2016 shows 17 readmissions over the previous 90 day period. Readmission rates are one important measure of the quality of discharge planning and community-based service provision. Without more complete information, the ER is unable to fully gauge the adequacy of transition planning for individuals in the target population or measure their resulting stability in the community. The ER renews outstanding requests for regular reporting of this data, as collected at 30/90/180 day intervals, and recommends that this population of individuals be a focus of the State's continued outreach efforts.

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 sites, with at least one program site in each of the ten regions. The State reported that all peer support centers meet the CMHA requirement to be open 44 hours per week. At the time of that report, the State reported that those sites had a cumulative total of 2,924 members, with an active daily participation rate of 169 people statewide. As can be seen from the most recent quarterly data report included in Appendix A, the State currently reports total membership to be 3051, with active daily visits averaging 147 people. In the June 2016 data

report, the total membership was reported to be 2,978 people, with average daily statewide visits of 148.

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, the ER believes that in many 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 18 months, DHHS has made considerable progress in the design of the QSR process required by the CMHA. Three QSR pilot test site visits were conducted in this reporting period. Based on the experiences of those QSR site visits, the QSR team determined that substantial revisions to the protocol and instruments were necessary. These changes have been made and are now under review by the ER (in the role of providing technical assistance on QSR to DHHS). A QSR site visit using the new instruments and process (as may be amended based on input from representatives of the Plaintiffs and the ER) is scheduled for mid-January 2017. Lyn Rucker, who has been providing technical assistance to DHHS under the aegis of the ER, will participate as an observer in that site visit, and offer additional feedback and written recommendations based on her observations.

Given the importance of completing the QSR design process, the ER expects the parties to accomplish the following activities over the next 60 days:

(a) On or before February10, 2017, DHHS will review and respond to Plaintiffs' written comments of December 13, 2016;

(b) On or before February 10, 2017, DHHS will incorporate proposed recommendations from Lyn Rucker, the ER and Plaintiffs into a set of revised QSR documents and recirculate those documents to the ER and Plaintiffs;

(c) On or before February 24, 2017, DHHS will convene a face to face meeting of the QSR leadership and representatives of the Plaintiffs to discuss the findings of the pilot, the Plaintiffs' comments, and further proposed revisions to the QSR instrument; and

(d) Depending on the nature and extent of the revisions, an additional pilot of the revised instrument may be necessary. As soon as practicable thereafter, a final set of QSR documents (protocol and instruments) will be developed.

It is essential that the QSR process produce information that is accurate, verifiable, and actionable. It is similarly essential that all parties, as well as the ER, have confidence in, and are able to rely upon, the QSR as a measure of compliance with the CMHA. Although the QSR process is part of broader DHHS quality management efforts, it must be directly responsive to the quality and performance expectations of the CMHA. This is why all Parties to the agreement have invested so much time and effort into the design and implementation of the QSR process. For the remaining time period covered by the CMHA, the QSR will produce essential core information by which all Parties assess compliance with all quality and performance standards and requirements of the CMHA. Thus, the ER expects that the action steps outlined above will be successfully completed on time, and the final version of the QSR can be implemented in a consistent fashion across the CMHC system.

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. Three DHHS SE fidelity reviews have been completed and published, and two ACT on-site fidelity reviews have been completed, but the reports have not yet been published. DHHS has also 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.

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. The QSR and the fidelity reviews mutually support but do not supplant or replace each other. The QSR, in particular, examines outcomes from a personal as opposed to an organizational perspective. It assesses the quality, appropriateness and effectiveness of specific ACT and SE services at the individual participant level. 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. That is why quality measures for ACT and SE are necessary aspects of the QSR, and essential tools for measuring the effectiveness of services under the CMHA.

V. Summary of Expert Reviewer Observations and Priorities

The CMHA and ER have now been in place for 30 months. At the last three All Parties meetings, the ER has expressed increasing concern related to: (a) continued lack of compliance with at least two major requirements of the CMHA; and (b) long elapsed times and/or delays related to implementation of system improvements or capacities related to the CMHA. The ER has emphasized the need for the State to be more aggressive, assertive, planful, and timely in its implementation and oversight efforts to assure compliance with the CMHA.

DHHS continues to implement more aggressive measures to both remove potential barriers to CMHA implementation, and to assure effective action on the part of the ten CMHAs to achieve compliance. The ER believes these management initiatives are positive and have the potential to improve performance vis-à-vis the CMHA. However, lack of measurable progress to date makes an assessment of the adequacy of these actions, or their ability to remedy ongoing implementation challenges and non-compliance, premature.

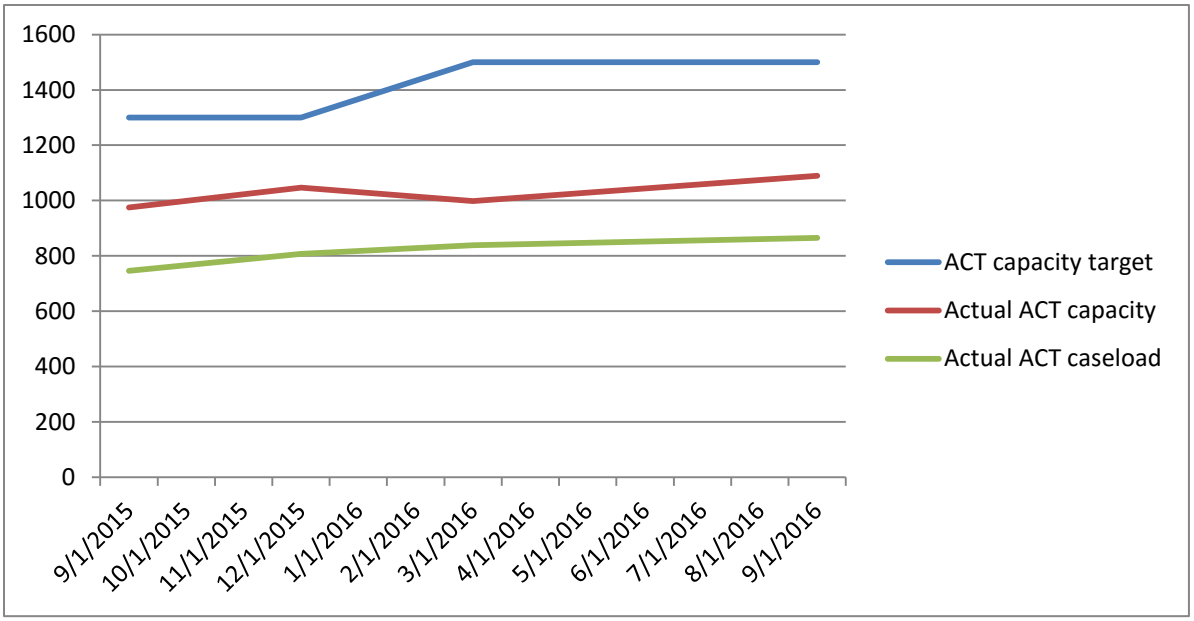
Specifically, the State has been and currently remains out of compliance with the CMHA. Two key examples of the State's non-compliance are:

1. **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; 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; and**
2. **Sections V.E.2(b) and V.E.3(g)(h) which together require that by now the State "have the capacity to serve in the community [ten] individuals with mental illness and complex health care needs residing at Glencliff…."**

With regard to ACT services, aggressive actions by DHHS and the CMHCs have resulted in a net increase in capacity (ACT staffing) of 9.2 staff, thereby increasing capacity by 92 – a 1.3% increase in staff capacity since last June. In the same time period, active ACT caseload has increased by 26 participants - a 3% increase since last March. The direction of change in ACT services continues to be positive, but the pace of change remains exceedingly slow. Chart I below illustrates the relatively slow progress of the CMHC system with regard to ACT capacity and active caseloads.

Chart I

ACT Capacity and Active Caseloads Compared to the CMHA ACT Capacity Target



With regard to placements into integrated community settings of people with complex medical conditions from Glencliff, potential progress has been made. As described earlier in this report, a vendor and program space have been identified, and a payment mechanism has been implemented to support the necessary services and supports to maintain people in the community. However, to date no identified resident of Glencliff with complex medical conditions has moved into the new program or into any other qualifying integrated community setting. It is expected that four such individuals will be living in the new program by the end of January, 2017, but it is not possible for the ER to state for this report that compliance with the CMHA has been attained, as 10 people with complex medical conditions should have been transitioned at this time.

With regard to SE, DHHS is to be commended for exceeding the SE penetration rate target on a statewide basis. DHHS is also to be commended for continuing efforts to increase SE penetration in the seven regions of the state that do not meet the CMHA penetration rate standard.

It should be noted that the State continues to meet the SH capacity standards of the CMHA. This continues to be a positive aspect of the State's overall CMHA implementation efforts.

In the June 30, 2016 report, the ER recommended that the State carry out a number of action steps to increase access to key services for CMHA target population members and thereby to

increase compliance with the CMHA. The State agreed to voluntarily adopt the recommended action steps. The following is a brief summary of the ER's assessment of the degree to which the State has implemented these recommended action steps.

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 and continues to track and report progress on the plan.

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 and continues to track and report progress in the context of on the plan.

3. By August 1, 2016 circulate to all parties a detailed plan with implementation steps and timelines to achieve CMHA requirements to assist 10 residents of Glencliff with complex medical needs to move into integrated settings as soon as possible;

   ER Finding: The State has implemented this recommendation and continues to track and report on four individuals with pending discharge plans. Progress towards fulfillment of the remaining obligations for capacity development and transition remains unclear under the plan.

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.

5. By October 1, 2016, complete the field tests and technical assistance related to the QSR, convene a meeting with Plaintiffs and the United States 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: By agreement with the ER and representatives of the Plaintiffs, this action step has been delayed in order to develop and field test new QSR protocols and instrumentation.

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 visits;

ER Finding: Three QSR site visits were conducted, resulting in QSR team recommendations for substantial changes in the QSR protocols and instruments. The ER and representatives of the Plaintiffs agreed to postpone further site visits until these changes were made. The QSR site visits will begin again in 2017.

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 and continues to track and report progress on the plan.

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 rules have been promulgated, and incorporate positive elements resulting from discussions among DHHS staff and representatives of the Plaintiffs. The ACT rulemaking has been filed, and is reported to have been approved and promulgated as of this date. The State and representatives of the Plaintiffs are to be commended for their collaborative work developing these two regulations.

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 DRFs; ***ER Finding: Readmission data are not yet available for the DRF and readmission data for NHH are currently reported only for the 90 day interval.***
   - Reporting from the two Mobile Crisis programs, including hospital and ED diversions. ***ER Finding: DHHS has determined a method for collecting and reporting Mobile Crisis data through the Phoenix system, and DHHS reports that these data will be incorporated in the next Quarterly Data Report. The most recent past Quarterly Data Report included information submitted by the Riverbend CMHC, but did not include data from the new Mobile Crisis Program in Manchester. The ER understands that Manchester data will be included in the next Quarterly Report***. and;
   - Supportive housing data on applications, time until eligibility determination, reason for ineligibility determination, and utilization of supportive services for those

receiving supportive housing. ***ER Finding: DHHS has not agreed to supply these types of data at this point.***

10. By October 1, 2016, (immediately prior to the next All Parties meeting) and then by December 1, 2016 (the time just before the next ER report), factually demonstrate that significant and substantial progress has been made towards meeting the standards and requirements of the CMHA with regard to the ACT, SE and placement of individuals with complex medical conditions from Glencliff into integrated community settings.

    ER Finding: As noted in the introduction to this section, the State has made limited progress towards compliance with the ACT and Glencliff requirements in the CMHA. Even this limited progress towards compliance remains slow, and the State remains out of compliance on these requirements. The State has achieved compliance with the statewide penetration rate standard for SE, due in part to high penetration rates in one region. The ER encourages ongoing efforts by the State to elevate SE penetration rates in all regions to ensure appropriate access to SE services across all regions of New Hampshire. The ER also encourages continued independent assessments to ensure ACT and SE fidelity to CMHA standards.

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 Central Team has now been functioning for almost a year, and appears to have become more efficient in facilitating transitions from both NHH and Glencliff. 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 dates. As noted above, transitions from Glencliff remain exceedingly slow. It is expected that after the first four transitions of medically complex individuals from Glencliff have been successfully accomplished, the pace of further transitions will be substantially increased.

Conclusion

The ER concludes that the State has increased its level of effort and organizational commitment to achieving compliance with the CMHA. The State has committed additional staffing and leadership resources to CMHA compliance, and has begun to implement management tools and initiatives to facilitate and support compliance efforts. In addition, the State has created a more clear accountability structure that is designed to hold DHHS and the CMHCs to measurable and accountable action steps to attain increased compliance. The ER believes the State is better

positioned today than it has been in the past two years to oversee and effectuate positive steps towards implementing high quality and fidelity model community services to members of the CMHA target population.

Nonetheless, as emphasized above, progress towards compliance over the past six months has been relatively minor and therefore far short of the significant and substantial progress identified as necessary for meeting the standards and requirements of the CMHA. The State remains out of compliance on ACT, and the current pace of change in ACT capacity and active caseloads is not sufficient to attain compliance in the near future. To date, there have been very few transitions from Glencliff, and it remains to be seen whether the pace of transitions to integrated community settings will improve.

The initiatives and administrative actions taken by the State in the past six months have the potential to significantly improve access to CMHA services for CMHA target population members. It is hoped that with the continued effort of DHHS, and the support and commitment of the new Governor, there will begin to be significant and measureable progress towards achieving compliance with the CMHA, as well as evidence of beneficial outcomes for adults with serious mental illness in New Hampshire. To achieve this end, the pace of change must rapidly increase over the next 3-6 months, or non-compliance with the CMHA will become an even more critical issue than it is now.

The ER has stated previously that the time for patience has come and gone, and that the ER continues to be concerned and dissatisfied with the current status of compliance with the CMHA. The State also evidences concern with the current status of compliance with the CMHA. The action steps noted above must produce results, and accountability for attaining necessary service expansions and improvements must be measured and enforced. With a new Administration, there is a significant opportunity for new actions and efforts to reverse this longstanding pattern of noncompliance with several key provisions of the CMHA. If substantial progress is not clearly evident and well documents by the time of the next six month report, the ER will have to consider what other compliance enforcement mechanisms may be necessary, including possible involvement by the Court.

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

July to September 2016

New Hampshire Community Mental Health Agreement Quarterly Data Report

July to September 2016, Revised

New Hampshire Department of Health and Human Services
Office of Quality Assurance and Improvement

December 23, 2016

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence

Community Mental Health Agreement Quarterly Report

New Hampshire Department of Health and Human Services
Publication Date: 11/23/2016
Reporting Period: 7/1/2016 – 9/30/2016

Notes for Quarter

- Prior quarter data was added to the tables for ease of reference. The current quarter is always shown first, followed by the prior quarter (either in the farthest right hand column or below the current quarter).
- Reporting was added on deaths of Glencliff residents.
- Connections Portsmouth Peer Support Agency data for the prior quarter that was previously unavailable has now been included.
- A new reporting mechanism is being implemented that will shift reporting of Mobile Crisis data to the Phoenix system. It is expected that this new mechanism will be used for the next quarterly report. While these future reports are expected to be more accurate and consistent than prior reports, they may not be directly comparable to the current report.

Community Mental Health Agreement Quarterly Report

New Hampshire Department of Health and Human Services
Publication Date: 11/23/2016
Reporting Period: 7/1/2016 – 9/30/2016

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

Center Name	July 2016	August 2016	September 2016	Unique Consumers in Quarter	Unique Consumers in Prior Quarter
01 Northern Human Services	75	80	83	88	82
02 West Central Behavioral Health	26	30	28	33	25
03 Genesis Behavioral Health	50	53	57	58	48
04 Riverbend Community Mental Health Center	63	74	75	81	73
05 Monadnock Family Services	68	72	70	73	70
06 Community Council of Nashua	72	71	69	76	72
07 Mental Health Center of Greater Manchester	259	252	252	270	283
08 Seacoast Mental Health Center	65	68	63	70	71
09 Community Partners	68	68	69	74	70
10 Center for Life Management	40	38	44	47	46
Total	**785**	**803**	**808**	**865**	**839**

Revisions to Prior Period: None
Data Source: NH Phoenix 2
Notes: Data extracted 11/18/16; consumers are counted only one time regardless of how many services they receive.

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

	September 2016						June 2016	
Center Name	Nurse	Masters Level Clinician/or Equivalent	Functional Support Worker	Peer Specialist	Total (Excluding Psychiatry)	Psychiatrist/Nurse Practitioner	Total (Excluding Psychiatry)	Psychiatrist/Nurse Practitioner
01 Northern Human Services	0.53	2.37	7.02	0.33	10.25	0.80	11.15	0.80
02 West Central Behavioral Health	0.40	2.25	2.19	0.60	5.44	0.14	4.44	0.14
03 Genesis Behavioral Health	1.00	2.00	4.00	0.00	7.00	0.50	7.60	0.50
04 Riverbend Community Mental Health Center	0.50	3.00	3.50	0.50	7.50	0.30	7.50	0.40
05 Monadnock Family Services	0.50	3.25	3.00	0.50	7.25	0.65	7.75	0.65
06 Community Council of Nashua 1	0.50	3.00	2.75	0.00	6.25	0.25	5.75	0.25
06 Community Council of Nashua 2	0.50	3.00	1.75	0.00	5.25	0.25	3.75	0.25
07 Mental Health Center of Greater Manchester-CTT	0.99	11.00	2.47	1.00	15.46	0.72	14.61	0.56
07 Mental Health Center of Greater Manchester-MCST	0.96	10.00	8.28	1.00	20.24	0.63	18.81	0.56
08 Seacoast Mental Health Center	0.43	2.30	5.00	1.00	8.73	0.60	10.73	0.60
09 Community Partners	0.40	2.00	5.13	0.50	8.03	0.50	7.90	0.50
10 Center for Life Management	1.00	0.75	6.16	0.00	7.91	0.10	7.91	0.10
Total	**7.71**	**44.92**	**51.25**	**5.43**	**109.31**	**5.44**	**107.90**	**5.31**

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

Center Name	September 2016	June 2016
01 Northern Human Services	2.42	2.55
02 West Central Behavioral Health	1.20	1.20
03 Genesis Behavioral Health	4.50	6.10
04 Riverbend Community Mental Health Center	1.30	1.40
05 Monadnock Family Services	3.40	3.40
06 Community Council of Nashua 1	3.00	2.50
06 Community Council of Nashua 2	3.00	1.50
07 Mental Health Center of Greater Manchester-CCT	11.00	11.00
07 Mental Health Center of Greater Manchester-MCST	2.00	2.00
08 Seacoast Mental Health Center	0.20	0.20
09 Community Partners	1.00	1.00
10 Center for Life Management	2.75	2.75
Total	**35.77**	**35.60**

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

Center Name	September 2016	June 2016
01 Northern Human Services	7.95	9.28
02 West Central Behavioral Health	5.40	5.40
03 Genesis Behavioral Health	6.00	5.80
04 Riverbend Community Mental Health Center	6.00	6.00
05 Monadnock Family Services	1.00	1.00
06 Community Council of Nashua 1	5.00	4.50
06 Community Council of Nashua 2	4.00	2.50
07 Mental Health Center of Greater Manchester-CCT	11.61	11.60
07 Mental Health Center of Greater Manchester-MCST	15.79	15.14
08 Seacoast Mental Health Center	5.00	6.00
09 Community Partners	6.50	6.75
10 Center for Life Management	6.61	6.61
Total	**80.86**	**80.58**

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

Center Name	September 2016	June 2016
01 Northern Human Services	1.27	0.84
02 West Central Behavioral Health	0.19	0.19
03 Genesis Behavioral Health	2.00	2.80
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	3.00
06 Community Council of Nashua 2	1.50	1.00
07 Mental Health Center of Greater Manchester-CCT	0.36	0.41
07 Mental Health Center of Greater Manchester-MCST	1.18	1.19
08 Seacoast Mental Health Center	1.00	1.00
09 Community Partners	1.00	1.25
10 Center for Life Management	0.30	0.30
Total	**12.80**	**13.48**

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 11/18/16; The Staff Competency values reflect the sum of FTE's 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 Supported Employment Penetration Rates for Prior 12 Month Period

Center Name	12 Month Period Ending September 2016			Penetration Rate for Period Ending June 2016
	Supported Employment Consumers	Total Eligible Consumers	Penetration Rate	
01 Northern Human Services	152	1,071	14.2%	10.8%
02 West Central Behavioral Health	103	618	16.7%	16.1%
03 Genesis Behavioral Health	188	1,334	14.1%	12.6%
04 Riverbend Community Mental Health Center	216	1,601	13.5%	12.9%
05 Monadnock Family Services	209	939	22.3%	20.4%
06 Community Council of Nashua	174	1561	11.1%	10.3%
07 Mental Health Center of Greater Manchester	1,238	3,218	38.5%	37.6%
08 Seacoast Mental Health Center	146	1,263	11.6%	9.0%
09 Community Partners	81	744	10.9%	13.1%
10 Center for Life Management	197	821	24.0%	24.1%
Deduplicated Total	**2,698**	**12,917**	**20.9%**	**19.8%**

Revisions to Prior Period: None
Data Source: NH Phoenix 2
Notes: Data extracted 11/18/16; consumers are counted only one time regardless of how many services they receive

4. New Hampshire Hospital: Adult Census Summary

Measure	July – September 2016	April – June 2016
Admissions	373	327
Mean Daily Census	134	132
Discharges	365	330
Median Length of Stay in Days for Discharges	8	12
Deaths	0	0

Revisions to Prior Period: None
Data Source: Avatar
Notes: Data extracted 7/6/16; Average Daily Census includes patients on leave and is rounded to nearest whole number

5a. Designated Receiving Facilities: Admissions

DRF	July – September 2016		
	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	16	21	37
Manchester (Cypress Center)	61	146	207
Portsmouth	71	304	375
Elliot Geriatric Psychiatric Unit	7	47	54
Elliot Pathways	51	63	114
Total	**206**	**581**	**787**
DRF	**April – June 2016**		
	Involuntary Admissions	**Voluntary Admissions**	**Total Admissions**
Franklin	44	35	79
Manchester (Cypress Center)	50	155	205
Portsmouth	64	314	378
Elliot Geriatric Psychiatric Unit	2	47	49
Elliot Pathways	45	47	92
Total	**205**	**598**	**803**

5b. Designated Receiving Facilities: Mean Daily Census

DRF	July – September 2016	April – June 2016
Franklin	4.5	7.8
Manchester (Cypress Center)	13.6	13.2
Portsmouth	23.2	21.4
Elliot Geriatric Psychiatric Unit	25.6	22.5
Elliot Pathways	14.5	16.9
Total	**16.3**	**16.4**

5c. Designated Receiving Facilities: Discharges

DRF	July – September 2016	April – June 2016
Franklin	35	78
Manchester (Cypress Center)	213	206
Portsmouth	380	363
Elliot Geriatric Psychiatric Unit	64	51
Elliot Pathways	113	90
Total	**805**	**788**

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

DRF	July – September 2016	April – June 2016
Franklin	7	6
Manchester (Cypress Center)	5	4
Portsmouth	4	4
Elliot Geriatric Psychiatric Unit	24	28
Elliot Pathways	8	7
Total	**5**	**5**

Revisions to Prior Period: None
Data Source: NH DRF Database
Notes: Data Compiled 11/18/16

6. Glencliff Home: Census Summary

Measure	July – September 2016	April – June 2016
Admissions	3	6
Average Daily Census	114	113
Discharges	1[†]	1
Individual Lengths of Stay in Days for Discharges	481	2,871
Deaths	5	4
Readmissions	0	0
Mean Overall Admission Waitlist	15 (7 Active*)	14 (7 Active)

[†]To independent apartment
Revisions to Prior Period: A discharge reported for the prior quarter actually occurred on 7/25 in the current quarter.
Data Source: Glencliff Home
*Notes: Data Compiled 11/7/16; 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 2016		April – June 2016	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
Alternative Life Center Total	**479**	**42**	**427**	**47**
Conway	*173*	*12*	*98*	*13*
*Wolfeboro Outreach**	*0*	*0*	*18*	*0*
Berlin	*99*	*11*	*115*	*13*
Littleton	*130*	*10*	*125*	*11*
Colebrook	*77*	*9*	*71*	*10*
Stepping Stone Total	**547**	**20**	**534**	**21**
Claremont	*460*	*14*	*448*	*15*
Lebanon	*87*	*6*	*86*	*6*
Cornerbridge Total	**222**	**16**	**326**	**15**
*Laconia***	*149*	*5*	*141*	*5*
Concord	*147*	*11*	*145*	*10*
Plymouth Outreach	*40*	*NA*	*40*	*NA*
MAPSA Keene Total	**179**	**15**	**178**	**14**

Peer Support Agency	July – September 2016		April – June 2016	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
HEARTS Nashua Total	**411**	**24**	**452**	**24**
On the Road to Recovery Total	**489**	**48**	**474**	**49**
Manchester	*332*	*35*	*319*	*40*
Derry	*157*	*13*	*155*	*9*
Connections Portsmouth Total	**271**	**14**	**269**	**13**
TriCity Coop Rochester Total	**339**	**16**	**326**	**14**
Total	**3,051**	**147**	**2,978**	**148**

Revisions to Prior Period: Connections Portsmouth for April – June 2016, not previously available, is now supplied, along with prior quarter totals
Data Source: Bureau of Mental Health Peer Support Agency Quarterly Statistical Reports
*Notes: Data Compiled 11/13/16; Average Daily Visits NA for Outreach Programs; * Wolfeboro Outreach as a distinct program ended operations 7/1/16, Alternative Life Center continues to do some transportation from Wolfeboro and has increased outreach efforts at all four primary sites; **Cornerbridge Laconia estimated based on prior members and new reported members.*

8. Housing Bridge Subsidy Summary to Date

Subsidy	July – September 2016		
	Total individuals served at start of quarter	New individuals added during quarter	Total individuals served through end of quarter
Housing Bridge Subsidy	557	46	603
Section 8 Voucher	80	3	83
Subsidy	**April – June 2016**		
	Total individuals served at start of quarter	**New individuals added during quarter**	**Total individuals served through end of quarter**
Housing Bridge Subsidy	518	39	557
Section 8 Voucher	70	10	80

Revisions to Prior Period: None
Data Source: Bureau of Mental Health
Notes: Data Compiled 11/16/16

9. Housing Bridge Subsidy Current Census Summary

Measure	As of 9/30/2016	As of 6/30/2016
Housing Slots	479	450
Rents currently being paid	451	445
Individuals accepted but waiting to lease	28	16
Waiting list for slots	0	0

Revisions to Prior Period: None
Data Source: Bureau of Mental Health
Notes: Data Compiled 11/16/16; 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 11/16/16	Frequency as of 6/30/16
1	339	325
2	24	35
3	13	8
4	3	1
5	0	2
6	1	1

*All units are individual units
Revisions to Prior Period: None
Data Source: Bureau of Mental Health
Notes: Data Compiled 11/16/16

11. Mobile Crisis Services and Supports: Riverbend Community Mental Health

Measure	July 2016	August 2016	September 2016	July – September 2016	April – June 2016
Unduplicated People Served in Month	194	156	199	549	532
Services Provided by Type					
Mobile Community Assessments	58	54	45	157	142
Crisis Stabilization Appointments	22	17	25	64	63
Office-Based Urgent Assessments	5	19	22	46	36
Emergency Service Medication Appointments	17	28	24	69	33
Phone Support/Triage	292	316	319	927	735
Services Provided after Immediate Crisis					
Mobile Community Assessments-Post Crisis	12	4	11	27	18
Crisis Stabilization Appointments	22	17	25	64	63
Office-Based Urgent Assessments	5	19	22	46	36
Emergency Service Medication Appointments	4	15	14	33	27
Phone Support/Triage	120	162	145	427	226
Referral Source					
Emergency Department/EMS	9	27	28	64	24
Family	49	21	31	101	111

Measure	July 2016	August 2016	September 2016	July – September 2016	April – June 2016
Friend	5	3	8	16	9
Guardian	0	0	0	0	23
Mental Health Provider	8	12	8	28	18
Police	15	7	3	25	23
Primary Care Provider	6	9	3	18	16
CMHC Internal	10	27	26	63	94
School	0	1	6	7	12
Self	92	128	90	310	282
VNA	0	0	1	1	0
Crisis Apartment					
Apartment Admissions	28	23	23	74	40
Apartment Bed Days	103	92	94	289	120
Apartment Average Length of Stay	3.7	3.9	4.1	3.9	3.0
Law Enforcement Involvement	17	17	12	46	46
Hospital Diversions Total	91	90	82	263	288

Revisions to Prior Period: Referrals for April to June 2016 are revised (prior report data were not deduplicated at the client level)
Data Source: Riverbend CMHC submitted reports
Notes: Data Compiled 11/18/16

Appendix B

New Hampshire Community Mental Health Agreement

Monthly Progress Reports

November and December, 2016

New Hampshire Community Mental Health Agreement Monthly Progress Report

November 2016

New Hampshire Department of Health and Human Services

November 3, 2016

Acronyms Used in this Report

ACT:	Assertive Community Treatment
BDAS:	Bureau of Drug and Alcohol Services
BMHS:	Bureau of Mental Health Services
CFI:	Choices for Independence
CMHA:	Community Mental Health Agreement
CMHC:	Community Mental Health Center
DHHS:	Department of Health and Human Services
DPHS:	Division of Public Health Services
EMR:	Electronic Medical Record
IDN:	Integrated Delivery Networks
IPS:	Intentional Peer Support
MCO:	Managed Care Organization
MCSS:	Mobile Crisis Services and Supports
QSR:	Quality Services Review
SE:	Supported Employment
SFY:	State Fiscal Year
WRAP:	Wellness Recovery Action Plan

Introduction

This third 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 October, and month-over-month progress made in support of the Community Mental Health Agreement as of October 31, 2016. This report is specific to achievement of milestones contained in the agreed upon CMHA Project Plan for Assertive Community Treatment, Supported Employment and Glencliff Home Transitions, as updated and attached hereto (Appendix 1). Where appropriate, the Report includes CMHA lifetime-to-date achievements.

Executive Summary

Assertive Community Treatment Progress Achieved in October 2016

- ACT Statewide De-duplicated Enrollment Update (for the period ending September 30, 2016) [1]
  - September 2016 – 808
  - August 2016 – 802
  - One Month Comparison – .7% increase over August 2016
- CMHCs Under ACT Compliance Plans (for the period ending September 30, 2016) 2:
  - September 2016 – 237
  - August 2016 – 234
  - One Month Comparison – 1.3% increase over August 2016
- Project Plan Milestones:
  - By 12/1/2016 DHHS will initiate ACT Fidelity Assessments
    - As of October 31, 2016, six (6) CMHCs completed ACT Self-Fidelity Assessments, DHHS conducted one (1) ACT Fidelity Assessment. DHHS will conduct two (2) additional ACT Fidelity Assessments within 90 days, the tenth CMHC will complete its ACT Self-Fidelity Assessment in November 2016.

Supported Employment

- Supported Employment Statewide Penetration Rate[3] (for the period ending September 30, 2016)
  - September 2016 Penetration Rate – 20.8%
  - August 2016 Penetration Rate – 20.1%
  - One Month Comparison: 3.4% increase over August 2016
- CMHCs Under Compliance Plan September SE Penetration Rates[4]:
  - September 2016 – 12.6%
  - August 2016 – 11.8%
  - One Month Comparison – 6.8% increase over August 2016
- Project Plan Milestones:
  - By 11/1/2016 Resolve barriers to achieving SE penetration goals
    - DHHS exceeded the 3/1/2017 targeted statewide SE Penetration rate in March 2016. In October, DHHS continued providing technical assistance and monitoring of CMHCs not yet meeting the targeted SE penetration goal on a regional level.

[1] Based on preliminary data
[2] Based on preliminary data
[3] Based on preliminary data
[4] Based on preliminary data; average of all four CMHCs under SE compliance plans

Glencliff Home Transitions into Integrated Community Setting

- Discharge Update
  - October Discharges: 2
    - Independent Apartment 1
    - Enhanced Family Care 1
- Project Plan Milestones:
  - By 12/1/2016 transition four (4) individuals to the community
    - October discharges consistent with this milestone – 2
    - DHHS will meet the 12/1/2016 Project Plan Milestone in November when the first two (2) of (4) residents transition into a community residence. Two (2) additional residents will transition into the same residence in December.
      - The community residence provider hired a contractor to complete the renovations required to meet the individual medical needs of these four residents. The work is on schedule for accepting the residents' transition beginning in mid-November.
      - These Glencliff Home residents will transition one per week for four weeks.
- Community Mental Health Agreement Milestones:
  - By 6/30/2016, the capacity to serve six additional individuals (cumulative total of 10) in an integrated community setting.
  - By 6/30/2017, the capacity to serve six additional individuals (cumulative total of 16) in an integrated community setting.
    - As of 10/31/16, DHHS has transitioned seven (7) residents into compliant community residences.
    - By 12/31/16, DHHS will have transitioned eleven (11) residents into compliant residences.
    - By 12/31/16, DHHS will have exceeded the cumulative total required under the 6/30/2016 milestone, and will be on track to meet the 6/30/2017 milestone.

Additional DHHS Efforts to Support CMHA Goals and Strengthen NH's Mental Health System

- New Hampshire Building Capacity for Transformation Medicaid Section 1115a
  - (Distributed $19.5m to Integrated Delivery Networks (IDNs) to support project plan development to integrate primary and behavioral health care statewide
  - Project plans submitted on October 31, 2016 and are under review. Upon approval, additional funds will be released for plan implementation.
- DHHS's proposed SFY 2018-19 budget includes $6.675m/year in additional funding to enhance support for existing twelve (12) ACT teams and to add three additional ACT teams.
- DHHS seeking $350,000/year in additional funding for State Loan Repayment Program, which supports staff employed by certain providers, including CMHCs.
- Community Mental Health Centers and Medicaid managed care plans entered into contracts retroactive to July 1, 2016.

Schedule of State Fiscal Year 2017 Fidelity and Quality Services Review[5]

July 2016	**Center for Life Management** DHHS-conducted QSR **Mental Health Center of Greater Manchester** DHHS-conducted SE Fidelity Assessment **Riverbend Community Mental Health** DHHS-conducted SE Fidelity Assessment
Aug. 2016	**West Central Behavioral Health** DHHS-conducted QSR
Sep. 2016	**Genesis Behavioral Health** DHHS-conducted QSR **Northern Human Services** DHHS-conducted SE Fidelity Assessment
October[6] 2016	**Center for Life Management** Self-conducted ACT Fidelity Assessment Self-conducted SE Fidelity Assessment **Community Partners of Strafford County** Self-conducted ACT Fidelity Assessment **Genesis Behavioral Health** DHHS-conducted ACT Fidelity Assessment Self-conducted SE Fidelity Assessment **Greater Nashua Mental Health Center** DHHS-conducted SE Fidelity Assessment Self-conducted ACT Fidelity Assessment **Mental Health Center of Greater Manchester** Self-conducted ACT Fidelity Assessment **Monadnock Family Services** Self-conducted ACT Fidelity Assessment Self-conducted SE Fidelity Assessment **Riverbend Community Mental Health** DHHS-conducted QSR - **POSTPONED**[7] Self-conducted ACT Fidelity Assessment **Seacoast Mental Health Center** Self-conducted ACT Fidelity Assessment Self-conducted SE Fidelity Assessment **West Central Behavioral Health** Self-conducted SE Fidelity Assessment
November 2016	**Community Partners of Strafford County** DHHS-conducted SE Fidelity Assessment **Monadnock Family Services** DHHS-conducted QSR - **POSTPONED** **Northern Human Services** DHHS-conducted ACT Fidelity Assessment
Dec. 2016	

January 2017	**Mental Health Center of Greater Manchester** DHHS-conducted QSR **West Central Behavioral Health** DHHS-conducted ACT Fidelity Assessment
Feb. 2017	**Seacoast Mental Health Center** DHHS-conducted QSR
March 2017	**Greater Nashua Mental Health Center** DHHS-conducted QSR
April 2017	**Community Partners of Strafford County** DHHS-conducted QSR
May 2017	**Northern Human Services** DHHS-conducted QSR
June 2017	

[5] Schedule incorporated into Monthly Progress Report in response to the Center for Public Representation's 8/24/2016 request for additional information to ensure various tasks and deliverables are occurring at an appropriate pace. Schedule may be subject to change.

[6] The three-month field test of the current QSR process ended in October. DHHS will revise instruments and processes and submit these revisions to the Expert Reviewer to obtain Technical Assistance by October 31, 2016. DHHS will release further-refined instruments and processes to Plaintiffs and stakeholders in November 2016 to receive feedback. DHHS will release finalized process and instruments in December 2016.

[7] The QSRs originally scheduled for October and November 2016 have been postponed to accommodate the revision of QSR tools and processes consistent with CMHA provision (VII.D.2), as discussed in the 9/6/2016 All Parties meeting, and to conduct re-training of QSR teams accordingly. DHHS will reschedule the two impacted QSRs to occur in 2017.

Actions Taken to Enable DHHS to Factually Demonstrate Significant and Substantial Progress

1. Assertive Community Treatment

- October Actions to Increase ACT Enrollment:
  - DHHS implemented enhanced Emergency Department data reporting
    - CMHCs began monthly research of Emergency Department data
      - CMHCs using data to identify consumers for potential ACT enrollment
  - DHHS actions to reduce inpatient behavioral health waitlist for individuals in hospital emergency rooms 10% by July 2017 or 25% by July 2018
    - Initiated redesign of protocols to ensure CMHC daily contact with emergency departments; will address reporting and rapid resolution of barriers to discharge[8]
    - New Hampshire Healthy Families commenced monthly auditing of emergency department admissions; referred eight (8) consumers to CMHCs for potential ACT enrollment. MCO commenced weekly re-evaluation of data to report to DHHS and CMHCs any unresolved consumers to ensure resolution.
    - New Hampshire Healthy Families commenced daily contact with emergency departments and applicable CMHCs for any consumer waiting and to expedite delivery of additional services or supports needed to return consumer to community or discharge to appropriate setting/treatment option.
  - Continuing Actions to increase ACT Enrollment during October include:
    - CMHCs provided ACT training to internal staff
    - CMHCs provided overview of ACT to external stakeholders, such as law enforcement, housing and vocational rehabilitation providers
    - CMHCs improved internal ACT referral processes, such as revising written plans to better align with fidelity, and adjusting EMR to trigger consideration of ACT referral at quarterly evaluations.
- CMHCs Under ACT Compliance Plans (for the period ending September 30, 2016) [9]:
  - Northern Human Services
    - September 2016 – 83
    - August 2016 – 80
    - One Month Comparison – 3.8% increase over August 2016
  - West Central Behavioral Health
    - September 2016 – 28
    - August 2016 – 30
    - One Month Comparison – 7% decrease under August 2016[10]
  - Genesis Behavioral Health
    - September 2016 – 57
    - August 2016 – 53
    - One Month Comparison – 7.5% increase over August 2016

[8] Effort is part of DHHS Innovation Accelerator Program (IAP), Goal #1,

[9] Based on preliminary data

[10] Staffing turnover and consumers moving out of region or graduating from program factor into decrease

- Greater Nashua Mental Health Center
  - September 2016 – 69
  - August 2016 – 71
  - One Month Comparison – 3% decrease under August 2016[11]

- <u>October Efforts to Increase ACT Capacity (Improve CMHC Ability to Recruit and Retain ACT Staff):</u>
  - DHHS and CMHC Executive Directors participated in the four hour kick-off meeting for the New Hampshire Building Capacity for Transformation Medicaid Section 1115a Demonstration Waiver project, "Behavioral Health Workforce Capacity Development.[12]"
  - As required in Item 11 of the approved Project Plan (Appendix 1) DHHS completed research on State Loan Repayment Program (SLRP).
  - To improve CMHC ability to recruit and retain Peer Support Specialists, DHHS hosted five-day nationwide WRAP training. The training brings the number of in-state Peer Support trainers to four (2 IPS trainers, 2 WRAP trainers); three (3) additional individuals are actively concluding IPS trainer requirements.
    - DHHS collaborated with the Peer Support Agency, Stepping Stone, to develop a coordinated approach to ensuring Peer Support Specialist IPS training needs statewide are identified and sufficient opportunities are made available. Stepping Stone agreed to serve as the repository for CMHC Peer Support Specialist IPS training needs and to coordinate with DHHS to meet those needs on an ongoing basis.

- <u>October Actions to Ensure Fidelity</u>
  - Six CMHCs conducted ACT Self-Fidelity Assessments
  - DHHS conducted ACT Fidelity Assessment of Genesis Behavioral Health
  - DHHS granted one CMHC a one month extension to conduct the Center's ACT Self-Fidelity Assessment[13]

- <u>Upcoming Milestones to Ensure Fidelity</u>
  - In November, DHHS will review six ACT Self-Fidelity Assessments and work with applicable CMHCs to finalize reports, and develop compliance plans where appropriate. Final reports will be released in December 2016.
  - In November, the final ACT Self-Fidelity Assessment for SFY2016 will be completed. DHHS will review the ACT Self-Fidelity Assessment and work with the CMHC to finalize the report, and develop a compliance plan if appropriate in December 2016. The final report will be released in January 2017.
  - DHHS will complete the ACT Fidelity Assessment report, review and compliance plan if appropriate, for Genesis Behavioral Health, for release by December 31, 2017.

[11] Staffing turnover and consumers moving out of region factor into decrease
[12] See appendices for the approved project plan.
[13] Extension granted due to multiple auditing/review events occurring in the CMHC during the month of October.

2. Supported Employment

- October Actions Taken to Ensure Fidelity
  - Four CMHCs conducted SE Self-Fidelity Assessments
  - DHHS conducted an SE Fidelity Assessment of Greater Nashua Mental Health Center
  - DHHS granted one CMHC a two-week extension for DHHS to conduct the Center's SE Assessment[14]
- Upcoming Milestones to Ensure Fidelity
  - In November, DHHS will review four SE Self-Fidelity Assessments and work with applicable CMHCs to finalize reports, and develop compliance plans where appropriate. Final reports will be released in December 2016.
  - In November, DHHS will conduct the postponed SE Fidelity Assessment. DHHS will complete the SE Fidelity Assessment report, review and compliance plan, if appropriate, in December 2016. The final report will be released in January 2017.
  - DHHS will complete the SE Fidelity Assessment report, review and compliance plan if appropriate, for Greater Nashua Mental Health Center, for release by December 31, 2017.
  - Continuing Actions to Maintain SE Statewide Penetration Rate and Support all CMHCs to Reach or Exceed 16.8% Penetration Rate During October Include:
    - DHHS discussed monthly SE Penetration Rate data with CMHCs to encourage further collaboration to achieve effective SE programs
    - CMHCs provided SE training to internal staff and worked with regional employers to improve competitive employment opportunities
- CMHCs Under Compliance Plan September SE Penetration Rates[15]
  - Northern Human Services
    - September 2016 – 14.2%
    - August 2016 – 11.1%
    - One Month Comparison – 27.9% increase over August 2016
  - Genesis Behavioral Health
    - September 2016 – 14.1%
    - August 2016 – 13.9%
    - One Month Comparison – 1.4% increase over August 2016
  - Greater Nashua Mental Health Center
    - September 2016 – 11.1%
    - August 2016 – 10.1%
    - One Month Comparison – 9.9% increase over August 2016
  - Community Partners
    - September 2016 – 11.1%
    - August 2016 – 12.1%
    - One Month Comparison – 8.3% decrease under August 201616

[14] Extension granted due to staffing issues and unexpected leave of supervisory staff.
[15] Based on preliminary data
[16] Significant staffing shortage (loss of all SE staff) factor into decrease

3. Glencliff Home Transitions into Integrated Community Setting

- Discharge Barrier Resolution Update
  - Active Pending Discharges – 5
    - Community Residence – 4 (commencing November 2016)
      - Budgets for the four residents were submitted to DHHS in October. DHHS completed its review; DHHS required the provider to resubmit four individual budgets, consistent with the Community Living Plan (Appendix 2).
      - Renovations initiated; provider confirmed residence will be ready for occupancy mid-November 2016
    - Adult Family Home – 1
      - Resident's family agreed to resident's placement in home in October. Glencliff Home staff initiated CFI provider contact and discharge planning is underway.
- Other October Actions Taken to Address Discharge Barriers
  - DHHS approved resident for the ABD waiver; resident added to ABD waitlist.
  - DHHS and Granite State Independent Living Housing Specialist commenced monthly meetings to examine transition/discharge needs for resolution development.
  - DHHS initiated search for additional community residence site development with current provider for other regions in which residents are seeking appropriate housing.
- Project Plan Milestones
  - By 12/1/2016 transition four (4) individuals to the community
    - October discharges consistent with this milestone – 2
    - DHHS will meet the 12/1/2016 Project Plan Milestone in November when the first two (2) of four (4) residents transition into a community residence. Two (2) additional residents will transition into the same residence in December.
      - The community residence provider hired a contractor to complete the renovations required to meet the individual medical needs of these four residents. The work is on schedule for accepting the residents' transition beginning in mid-November.
      - These Glencliff Home residents will transition one per week for four weeks.
- Community Mental Health Agreement Milestones:
  - By 6/30/2016, the capacity to serve six additional individuals (cumulative total of 10) in an integrated community setting.
  - By 6/30/2017, the capacity to serve six additional individuals (cumulative total of 16) in an integrated community setting.
    - As of 10/31/16, DHHS has transitioned seven (7) residents into compliant community residences.
    - By 12/31/16, DHHS will have transitioned eleven (11) residents into compliant residences.
    - By 12/31/16, DHHS will have exceeded the cumulative total required under the 6/30/2016 milestone, and will be on track to meet the 6/30/2017 milestone.

NH Department of Health & Human Services
Community Mental Health Agreement (CMHA)
Project Plan for Assertive Community Treatment, Supported Employment and Glencliff Home Transitions
October 31, 2016

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
				ACT-Expanding capacity/penetration; Staffing array			
1	**Quarterly**	Continue to provide quarterly ACT reports with stakeholder input and distribute to CMHCs and other stakeholders.	M. Brunette	This report focuses on three (3) key quality indicators: staffing array consistent with the Settlement Agreement; capacity/penetration; ACT service intensity, averaging three (3) or more encounters/week. This report is key as it assists CMHC leaders in understanding their performance in relation to quality indicators in the CMHA and past performance.	ACT Quarterly Reports	100% and Ongoing	Use monthly in Implementation Workgroup and Technical Assistance calls; include 4 quarters for trend discussion.
2	**6/30/2016 - letters sent**	Letters sent to CMHCs with low compliance including staffing and/or capacity with a request for improvement plans. The CMHCs will be monitored and follow-up will occur.	M. Brunette	Quality improvement requested by DHHS with detailed quality improvement plans with a focus on increasing the capacity of ACT.	Monthly compliance calls and follow-up	100% - letters, monitoring and follow-up ongoing	Use in Technical Assistance calls with Centers to support continuing progress.
3	**7/20/2016**	DHHS team and CMHC Executive Directors participated in a facilitated session to establish a plan to expand capacity and staffing array.	M.Harlan	This session resulted in a plan with action steps for increased ACT capacity.	The goal was to establish a focused workplan expected to increase new ACT clients.	100%	Workplan is ongoing guide under which the CMHCs and DHHS is operating with focused effort to achieve CMHA goals.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
4	**9/30/2016**	DHHS will continue to provide each CMHC a list of individuals in their region who had emergency department visits for psychiatric reasons, psychiatric hospitalizations, DRF admissions, and NHH admissions in the past quarter to facilitate CMHCs ability to assess people in their region for ACT.	M.Brunette	CMCHs will use these quarterly reports to enhance their screening of people for ACT. CMHCs will provide quarterly reports to DHHS indicating that they have screened each individual and the outcome of the screening.	First report due from CMHCs to DHHS by 7/29/2016. The screening process and reporting will utilize a comprehensive template developed by the ACT and SE community stakeholder group by 9/30/16.	Ongoing	Monthly data distribution began in October. CMHCs monthly reporting to DHHS on research conducted. ACT/SE Implementation Workgroup will use this data for monthly discussion with CMHC ACT coordinators.
5	**10/1/2016**	Address Peer Specialist Challenges-lack of standardized training.	M.Brunette	Behavioral Health Association and DHHS in an effort to expedite increasing peer specialists, will explore the SUD Recovery specialists certification.	Work with BDAS to look at their process.	100%	Research completed. Additional training capacity added. DHHS collaborated with Peer Support Agency to assist with coordination of meeting Peer Support Specialist training needs; ongoing identification of training needs and coordinating delivery of training commenced in October.
6	**10/1/2016**	ACT team data will be reported separately by team.	M.Brunette	The data will be separated starting the month of July 2016 and will be reported in the October 2016 report.	ACT team data will be separated on a quarterly basis moving forward.	100%	Use monthly in Implementation Workgroup and Technical Assistance calls
7	**10/1/2016**	Develop organization strategies to increase capacity.	M.Brunette	Each CMHC will conduct one education session between now and Oct. 1, 2016 to introduce ACT.	Increase community education.	50%	Discussed in monthly ACT/SE Implementation Workgroup calls to identify educational needs. Centers holding additional inservice sessions.
8	**10/1/2016**	Review and make changes as necessary to ACT referral process.	M.Brunette	Each CMHC will review and evaluate their internal referral process and then share with the other CMHCs.	Learning Collaborative to share their processes.	50%	Internal CMHC review of referral process is underway. Some ideas already shared in learning collaborative.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
9	**11/1/2016**	DHHS will require CMHCs to conduct self-fidelity to evaluate their adherence to the ACT treatment model. They will provide a report to DHHS by 11/1/16.	M.Brunette	This report will include their plan for improving their adherence to the model described in the Settlement Agreement.	CMHCs Self-Fidelity Report to DHHS.	85%	DHHS received 6 out of 7 CMHC reports; the 7th was granted extension due to multiple auditing activities underway at CMHC in October.
10	**12/1/2016**	Evaluate potential/structural/systemic issues resulting in high staff turnover/inability to recruit and retain staff.	M. Brunette	Work with TA to develop a report that will communicate the strategies to address ACT staffing issues in collaboration with DHHS.	ACT Staffing Report	80%	NHCBHA released report in September 2016. NH Building Capacity for Transformation, 1115a Medicaid's project on Behavioral Health Workforce Capacity Development, Phase I project completed in October.
11	**12/1/2016**	Increase the number of staff who are eligible for State Loan Repayment Program (SLRP).	M.Brunette	Explore the possibility of increasing the number of staff eligible for this program.	Increase number of staff eligible	50%	Research completed. Will develop presentation to CMHC executive directors and early access plan to apply for SFY2018 funds.
12	**12/1/2016**	DHHS will Initiate ACT fidelity assessments.	M.Brunette	DHHS will conduct ACT fidelity using the ACT toolkit.	Fidelity report	Yearly;75%	Conducted first of three ACT Fidelity Assessments in the month of October. Second scheduled for November. Third for
13	**2/28/2017**	Increase ACT capacity	M. Brunette	Concerted efforts by the CMHCs to assess individuals in Community residences that could be served on ACT. Train direct service providers in coding appropriately for ACT services. Screen 100% eligible individuals for ACT.	By 2/28/16 increase ACT capacity by 25 %.	25%	CMHCs commenced improved process, screening, coding. New capacity (staffing) reports for period July-Sept. 2016 to be released in November.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
14	**3/1/2017**	DHHS will request CMHCs with low compliance to provide DHHS a list of five (5) consumers who are eligible for and who will begin to receive ACT services each month starting August 1, 2016 through February 2017. DHHS will request all other CMHCs to provide DHHS a list of 3 consumers who are eligible for and who will begin to receive ACT services each month starting August 1, 2016 through February 2017.	M.Brunette	Quarterly reports will be provided to each CMHC on their specific list of individuals who had Emergency department visits and psychiatrist hospitalizations to allow CMHCs to assess their center specific clients.	List of (5) consumers from low compliance CMHCs who are eligible for ACT services each month and a list of (3) consumers from other CMHCs who are eligible for ACT services.	25%	DHHS issued reporting tools and reviewed with CMHCs in October. CMHC response reports are being submitted as of October 31, 2016. DHHS actively reviewing reports for consultation with CMHCs. NH Healthy Families (MCO) is also supporting effort by daily monitoring of Emergency Department admissions, referrals to CMHCS, and weekly follow up to address ACT enrollment. 8 such referrals were made in October
15	**6/30/2017**	Increase ACT capacity	M. Brunette	concerted efforts by the CMHCs to assess individuals in Community residences that could be served on ACT. Train direct service providers in coding appropriately for ACT services. Screen 100% eligible individuals for ACT.	By 6/30 2017 increase ACT capacity by an additional 13.5%	0%	
16	**6/30/2017**	After February 2017 DHHS will request that all CMHCs will continue to provide DHHS a list of 2-4 consumers who were hospitalized for psychiatric reasons or are otherwise eligible for ACT and were enrolled each month.	M. Brunette	CMHCs will provided DHHS with a monthly report of newly enrolled clients.	Monthly report with list of consumers to increase ACT capacity.	0%	

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
Supported Employment (SE)							
17	**5/20/16 and ongoing**	Letters sent to CMHCs with low penetration rates including staffing and/or penetration with a request for improvement plans.	M.Brunette	Request for compliance plan with quarterly reports.	Receive and evaluate improvement plans from CMHCs due 6/29/16.	100%	Use in Technical Assistance calls with Centers to support continuing progress. Two out of four reported decreases in September; overall improvement is 6.8% over August for these 4 CMHCs.
18	**6/1/16 and ongoing**	Continue to generate quarterly report with stakeholder input focusing on penetration of SE services distributed to the CMHCs and other stakeholders.	M.Brunette	This report is key as it assists CMHC leaders in understanding their performance in relation to quality indicators in the CMHA and past performance.	Quarterly Report SE Penetration Rate to CMHCs.	Ongoing/Quarterly	Use monthly in Implementation Workgroup and Technical Assistance calls; include 4 quarters for trend discussion.
19	**7/20/2016**	DHHS team and CMHC Executive Directors will participate in a facilitated session to establish a plan to expand penetration and staffing array.	M.Harlan	This session will result in a plan with action steps for increased SE capacity.	The goal is to establish a focused workplan expected to result in a total of 18.6% SE clients by 6/30/17.	100%	Workplan is ongoing guide under which the CMHCs and DHHS is operating with focused effort to achieve CMHA goals.
20	**7/6/2016**	On-site fidelity assessments conducted at CMHCs.	K.Boisvert	The first fidelity assessment took place 7/6-7/8/16 in Manchester.	Report with results of the on-site fidelity assessments.	100%	Tools developed. Assessment conducted. DHHS report issued. Voluntary program improvemeent plan developed by Center.
21	**7/12/2016**	On-site fidelity assessments conducted at CMHCs.	K.Boisvert	The second fidelity assessment took place on 7/12/16 at Riverbend in Concord.	Report with results of the on-site fidelity assessments.	100%	Tools developed. Assessment conducted. DHHS report issued with recommendations.
22	**9/27/2016**	On-site fidelity assessments conducted at CMHCs.	K.Boisvert	The third fidelity assessment will take place on 9/27/16-9/29/16 in Berlin.	Report with results of the on-site fidelity assessments.	50%	DHHS report in draft/review process. Will be sent to CMHC in November.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
23	**10/24/2016**	On-site fidelity assessments conducted at CMHCs.	K.Boisvert	The fourth fidelity assessment will take place on 10/4-5/16 in Nashua.	Report with results of the on-site fidelity assessments.	50%	Assessment conducted. DHHS report in draft/review process. Will be sent to CMHC in December.
24	**10/1/2016**	Monitor monthly ACT staffing for presence of SE.	M.Harlan	Monitor monthly ACT staffing for presence of SE on each team.	A monthly report will be run through the Phoenix system for ACT staffing.	100% and Ongoing	Use monthly in Implementation Workgroup and Technical Assistance calls.
25	**10/15/2016**	All CMHCs will conduct self-fidelity assessments.	K.Boisvert	Self-fidelity assessments	Report to DHHS with self-fidelity assessment results.	100%	4 of 4 CMHCs conducted SE Self-Fidelity Assessments in October. Reports submitted for November 1st deadline.
26	**11/1/2016**	CMHCs will develop and maintain a list of SMI individuals who may benefit from but are not receiving SE services.	M.Harlan	Review individuals that are not on SE for reasons why they are not enrolled.	Quarterly reports of individuals not on SE.	0%	
27	**11/1/2016**	Resolve barriers to achieving SE penetration goals.	M.Harlan	Educate internal CMHC staff on the goals of SE.	Educational plan	50%	Discussed in monthly ACT/SE Implementation Workgroup calls to identify educational needs. Five CMHCs reported holding additional inservice sessions.
28	**12/1/2016**	Explore resources to conduct technical assistance and training. CMHCs and DHHS will explore strategies and barriers DHHS can use to facilitate service delivery.	M.Harlan	CBHA and DHHS will explore the need for technical assistance and training. DHHS will conduct a subgroup of CMHC leaders to explore barriers and administrative burden that prevents service delivery.	Report the barriers and possible solutions. Technical assistance and training if needed.	25%	Initial inventory of training needs underway in October.
29	**12/1/2016**	Increase the number of staff who are eligible for State Loan Repayment Program (SLRP).	M. Harlan	Explore the possibility of increasing the number of staff eligible for this program.	Increase number of staff eligible.	50%	Research completed. Will develop presentation to CMHC executive directors and early access plan to apply for SFY2018 funds.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
30	**6/30/2017**	Increase SE penetration rate to 18.6%	M. Harlan	Learning collaborative meets monthly and has developed a four question script to be used at time of intake as an instrument to introduce SE. If the individual is interested the referral goes to the SE coordinator who will contact the individual within 3 days of the intake to set up an appointment. If the individual is not interested the SE Coordinator will outreach to provide information on SE and will periodically follow up with him/her. This strategy includes working with individual CMHCs that fall below the 18.6% penetration rate.	Monthly meetings of the Learning Collaborative.	100%	Discussed in monthly ACT/SE Implementation Workgroup calls to identify opportunities for improvement at center specific level and in Technical Assistance calls. Ideas discussed in Learning Collaborative. DHHS continues to consult with CMHCs not at 18.6% goal for region.
				Glencliff Home Transitions			
31	**Ongoing at residents every 90 days**	Establish process for identifying individuals interested in transitioning from Glencliff to the community.	Glencliff Staff	Glencliff interviews residents each year to assess if they want to transition back to the community.	Section Q of MDS is a federal requirement. CMHCs have staff go to Glencliff to discuss transition planning with residents.	100% and Ongoing	Monitor referrals to Central Team. Research CMHC inreach activities. Introduce and deliver community living curriculum to increase resident positive engagement.
32	**7/30/2016**	Develop individual transition plans, including a budget.	M.Harlan	Individuals from Glencliff have been identified to transition back to the community. Detailed plans are being developed and DHHS has engaged a community provider who will further develop transition plans.	Individual transition plans/individual budgets.	75%	Individual plans developed. Individual budgets developed (time for completion estimated 9/30/16). Budget received and reviewed in October; provider must resubmit revised budget consistent with Community Living Plan.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
33	**8/31/2016**	Identify community providers to coordinate and support transitional and ongoing community living including but not limited to housing, medical and behavioral service access, budgeting, community integration, socialization, public assistance, transportation, education, employment, recreation, independent living skills, legal/advocacy and faith based services as identified.	M.Harlan	Community providers have been identified and will further develop the transition/community living plans.	Transition/community living plans for individuals to transition to community.	100%	Tools developed, reviewed and approved. Providers identified and engaged. Community Living Plans developed.
34	**8/31/2016**	Implement reimbursement processes for non-Medicaid community transition funds.	M.Harlan	Develop policies and procedures to allow community providers to bill up to $100K in general fund dollars.	Reimbursement procedure documented, tested and approved.	100%	
35	**8/15/2016**	Develop template for Community Living Plan for individuals transitioning from Glencliff to the community.	M.Harlan	Completion of the template to be done as a person centered planning process.	Community Living Plan	100%	
36	**7/25/2016**	Transition three (3) individuals to the community.	M.Harlan	Three individuals have transitioned to the community.	Community placement	100%	
37	**12/1/2016**	Transition four (4) individuals to the community.	M.Harlan	Four individuals to transition into the community.	Community placement	75%	4 residents visited community. Community provider completed assessment. Medicaid eligibility completed. Community Living Plans approved. 4 transitions to begin mid-November upon renovation completion.
38	**3/1/2017**	Transitions four (4) additional individuals to the community.	M.Harlan	Four individuals to transition into the community.	Community placement	0%	
39	**6/30/2017**	Transition five (5) additional individuals to the community.	M.Harlan	Five individuals to transition into the community	Community placement	0%	

Community Transitions Provider Billing Procedure

The following provider billing procedure is to be used by community providers for community transition General Fund reimbursement.

Billing Procedure

1. Glencliff staff identifies residents that meet the target population as defined by Community Mental Health Agreement (CMHA) and have a desire to transition into the community.
2. Glencliff staff identifies providers to coordinate and support transitional and ongoing community living including but not limited to housing, medical and behavioral service access, budgeting, community integration, socialization, public assistance, transportation, education, employment, recreation, independent living skills, legal/advocacy and faith based services.
    a. If identified provider is not enrolled with Xerox, the Medicaid Management Information System (MMIS) as a Medicaid Provider, the provider must complete the enrollment process.
3. The selected community provider works with Glencliff Home to complete their comprehensive assessment, intake and the Department of Health and Human Services (DHHS) Glencliff Transition of Care Community Living Plan[1].
4. The selected community provider must develop an individual budget to support the Community Living Plan.
5. The selected community provider must submit the Individual Service Plan (ISP), the completed Community Living Plan[2], Service Authorization (SA) Request[3], and individual budget to the Director of the Bureau of Mental Health Services for approval; all three documents must be submitted together.
6. Once the request is approved by the Director of the Bureau of Mental Health Services, the Bureau will forward the Service Authorization to the Office of Medicaid Services, Medical Services Unit for data entry into the MMIS system.
7. The Medical Services Unit will fax the SA number to the community provider for billing purposes and to the Bureau of Mental Health Services for its file.
8. The community provider will electronically submit CMS 1500 Form to Xerox for payment.

[1] The Community Living Plan is a personalized set of services that supports CMHA target individuals who have expressed a desire to reside in the community rather than an institutional setting and ensures such individuals living in the community can do so safely without re-entry into an institution. See Appendix 1 for Guidance on completing the Plan.
[2] See Appendix 2 to access the Glencliff Transition of Care Community Living Plan template.
[3] See Appendix 3 to access the Request for Prior Authorization Community Transitional Services form.

Service Authorizations

1. The annual budget will be authorized in equal quarterly increments. Continued authorization will be tied to concurrent review and progress achieved.
2. The community provider may request an upfront payment of the annual approved budget in order to begin work on the transition.

Claims Submission

1. Billing will be done in per diem increments up to the maximum allowed amount approved through the service authorization process.
2. Procedure modifier combination:

   H2016 HWUI

Appendix 1

Guidance for Completing the Glencliff Transition of Care Community Living Plan

Necessity of Person- Centered Plans

The person centered planning process is an ongoing process involving the individual, their family, and other supports. Its intent is to identify and address an individual's strengths, goals, preferences and needs in order to develop a plan for community living.

Sample Questions to Consider:

Strengths questions to ask:

- What am I good at?
- What do I like to do?
- What do other people think I'm good at?
- What skills do I have?

Needs questions to ask:

- What things are difficult for me?
- Are there things I need to get better at in order to live in the community?

Opportunity questions to ask:

- Who can help me with my goal for community living?
- How can they help me?
- What am I doing now that helps me get ready for community living?

Worries question to ask:

- What do I worry about when I think about leaving Glencliff?

Glencliff Transition of Care Community Living Plan	
Goal Category	**Sample Questions to Consider**
Housing/Living Arrangements	Where will they be living? Will they be living at home, in a supervised supported living arrangement, in a group home or in their own apartment? Any safety concerns?
Finances/Money	What about money? What will be their source of income? Will they require assistance with banking? If so, who will help with managing money?
Friendship/Social Life/Social Support	What will their social life look like? Is there a support network in place?
Health Needs	What will their health needs be? Who will manage the health care needs? How will they live a healthy lifestyle i.e. smoking cessation? How will medications be managed? Will they need help making appointments and going to visits?
Goal Category	**Sample Questions to Consider**
Mental Health Needs	What will their mental health needs be? Where will care be obtained? Is peer support available? Is there a crisis/emergency plan in place? Will they need help making appointments and going to visits?
Behavioral Challenges	How much support is needed for the individual to live in the community? Are there non-aggressive inappropriate behaviors? Are there serious behavioral challenges? Does a plan for substance abuse prevention need to be in place? Other behavioral strategies that need to be included?
Transportation	What will their transportation needs look like? Can they navigate public transit or need assistance such as CTS?
Education/Training	Does the individual want education or training and if so what arrangements will be made for this?
Employment	Is there a desire to get a job? Will they go to a day program?
Recreation	What will they do for recreation? Can they go out in the community independently or will activities need to be supervised?
Community Involvement/Participation	What will they do during their spare time? Will they volunteer? What about spiritual and cultural activities?
Independent Living Skills including Activities of Daily Living(ADLs) eating, dressing, bathing grooming, toileting and mobility	Do they have the self-care skills necessary to manage or are supports required? How often will supports be needed?
Instrumental Activities of Daily Living (IADLs) including meal preparation, shopping, housework, use of the telephone	Do they have the skills necessary to carry out the tasks or are supports required? How often will supports be needed?
Communication	What are the person's literacy skills? Can they communicate their needs appropriately? Any cognitive deficits?
Community Resources	What other resources in the community will they need to access to support community living? Who will make the referrals and follow up on the connections?
Legal/Advocacy	What will their legal needs be? Who will assist with this?
Service Coordination	Who is the best person to be the service coordinator and engage the individual?

Glencliff Transition of Care Community Living Plan

Identifying Information:

Name _____

Date of Birth _____

Diagnosis:

Primary _____

Secondary _____

Other _____

Primary Language Spoken _____

Person's Dreams & Vision:

(What is important to this person?) _____

_____

_____

_____

Person Centered Planning Summary:

Strengths _____

_____

_____

Needs _____

_____

_____

Opportunities _____

_____

_____

Worries _____

_____

_____

Health Risk Assessment Summary (what was learned about this person's health status?)

_____

_____

_____

Risk Assessment Summary (including any behaviors that might interfere with community living)

_____

_____

Glencliff Transition of Care Community Living Plan

Goal Category	Plan
Housing/Living arrangements	
Finances/Money	
Friendship/Social Life/Social Support	
Health Needs	
Mental Health Needs	
Behavioral Challenges	
Transportation	
Education/Training	
Employment	
Recreation	
Community Involvement/Participation	
Independent Living Skills	
Instrumental Activities of Daily Living	
Communication	
Community Resources	
Legal/Advocacy	
Service Coordination	

Appendix 2

REQUEST FOR PRIOR AUTHORIZATION
COMMUNITY TRANSITIONAL SERVICES

*****PLEASE PRINT ALL INFORMATION*****

RECIPIENT NAME:_____ **RECIPIENT MEDICAID ID #:** _____

D.O.B.:_____

PROVIDER INFORMATION

DATE OF REQUEST: _____/_____/_____ **CONTACT PERSON:**_____

TELEPHONE:_____ **FAX #:** _____

PROVIDER NAME: _____ **PROVIDER #:** _____

SERVICE(S) REQUESTED: _____

DATE OF SERVICE/DATE RANGE: _____/_____/_____ **TO** _____/_____/_____

PLEASE PROVIDE THE FOLLOWING AS NECESSARY

CPT CODE: H2016 HW U1 **Units Requested:** _____

FOR INTERNAL USE ONLY

BMHS APPROVAL: _____

Signature

AUTHORIZATION COMPLETED BY:

_____

Name

DATE COMPLETED: _____

SERVICE AUTHORIZATION NUMBER:

Return this form along with the initial community living plan and with all quarterly progress notes to

Michele Harlan
Bureau of Mental Health Services
105 Pleasant Street
Concord, NH 03301

Appendix 3

The following pages contain **Preliminary Data** for ACT and SE for the period ending September 30, 2016.

DHHS will publish finalized data reports on a quarterly basis.

Unique Counts of Assertive Community Treatment Consumers

Data Source: Phoenix 2
Date Range: 07/01/2016 through 09/30/2016
Age Range: Adults Only

Center Name	July-2016	August-2016	September-2016	Deduplicated Totals
01 Northern Human Services	75	80	83	88
02 West Central Behavioral Health	26	30	28	33
03 Genesis Behavioral Health	50	53	57	58
04 Riverbend Community Mental Health Center	63	74	75	81
05 Monadnock Family Services	68	72	70	73
06 Community Council of Nashua	72	71	69	76
07 Mental Health Center of Greater Manchester	259	251	252	269
08 Seacoast Mental Health Center	65	68	63	70
09 Community Partners	68	68	69	74
10 Center for Life Management	40	38	44	47
Deduplicated Total	**785**	**802**	**808**	**864**

Consumer counts are determined by taking the unique counts of consumers receiving services in the following Cost Centers:
-Act Team #1
-Act Team #2
-Act Team #3
-Act Team #4
-Act Team #5

Preliminary data

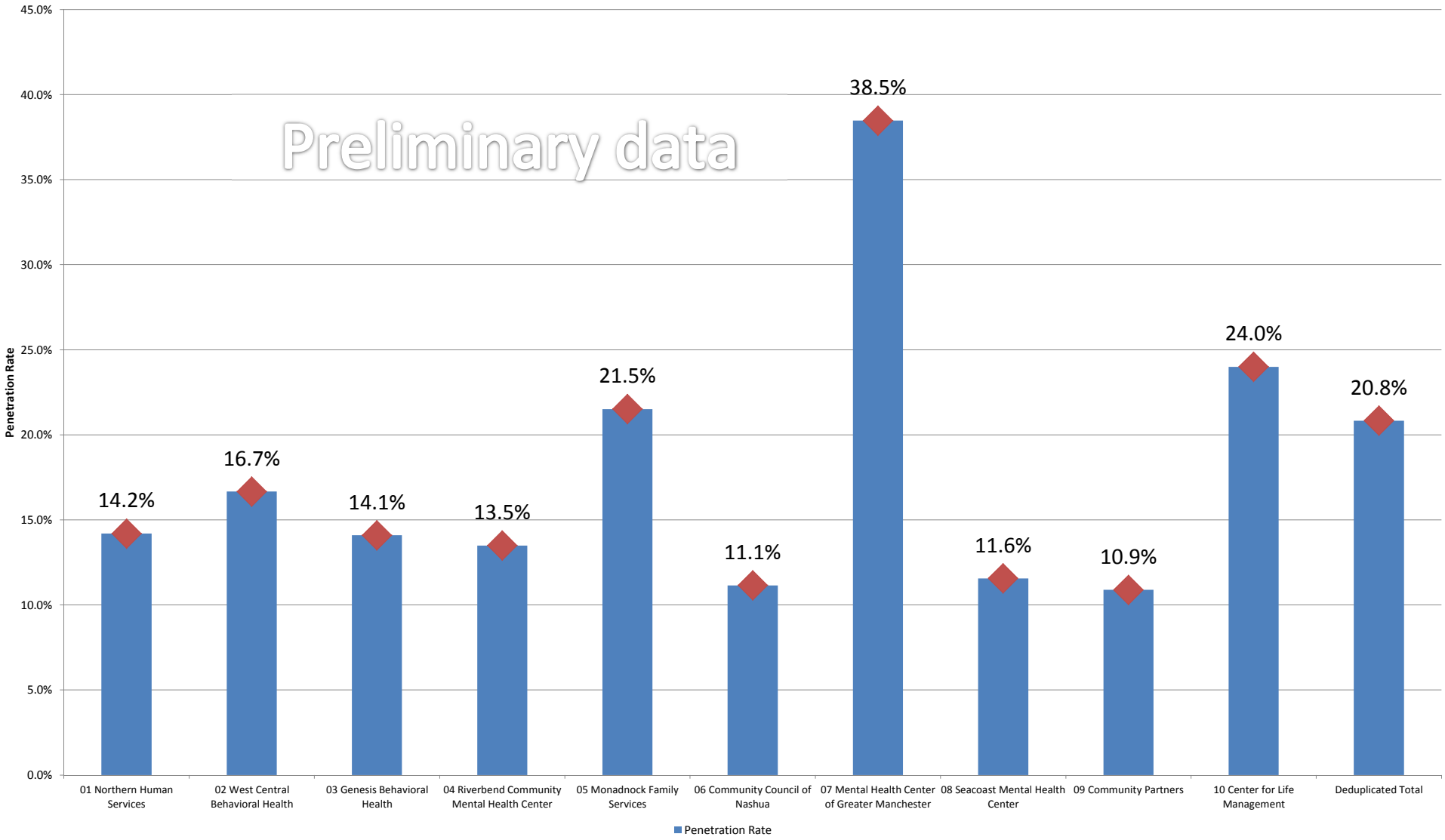
Adults are consumers ages 18 and up.

Consumers are only counted 1 time, regardless of how many services they receive.

Report Produced on 10/26/2016

Supported Employment Penetration Rates for The 12 Month Window Ending on: 09/30/2016

Data Source: Phoenix 2



Produced On: 10/26/2016

Chart User Guide

This chart displays Supported Employment Penetration for Each CMHC & The Weighted Average Penetration Rate across The Centers.

The height of each bar represents the total penetration rate for that center.

Chart Data

Unique Counts of Consumers

CMHC Name	Supported Employment Consumers	Total Eligible Consumers	Penetration Rate
01 Northern Human Services	152	1071	14.2%
02 West Central Behavioral Health	103	618	16.7%
03 Genesis Behavioral Health	188	1334	14.1%
04 Riverbend Community Mental Health Center	216	1601	13.5%
05 Monadnock Family Services	202	939	21.5%
06 Community Council of Nashua	174	1561	11.1%
07 Mental Health Center of Greater Manchester	1238	3218	38.5%
08 Seacoast Mental Health Center	146	1263	11.6%
09 Community Partners	81	744	10.9%
10 Center for Life Management	197	821	24.0%
Deduplicated Total	2691	12917	20.8%

Supported Employment Penetration Rate Definitions

The supported Employment program uses Penetration Rate as the primary KPI (Key Performance Indicator) to track each center's progress.
While the metric is calculated at a CMHC level, the aggregate Penetration Rate for all CMHCs is the KPI for which BBH is accountable.
The Penetration Rate reflects 1 full calendar year of Supported Employment Services.

Penetration Rate consists of a numerator and denominator, the criteria for each is listed below:

Numerator:

The numerator consists of the count of unique consumers whom have received the Supported Employment service, or the Non Billable Supported Employment service during the report period (12 calendar months).
Consumers only need to have received the Supported Employment service 1 time during the report period to be included in the numerator. Consumers will only be counted once regardless of the frequency or quantity of Supported Employment services received.

Denominator:

The denominator consists of the unique count of eligible consumers whom have received any services during the same report period as the numerator (12 calendar months) and have the following characteristics:
Consumers must be 18 years old or older to be eligible.
Consumers must have one of the following BBH eligibilities: Low Utilizer, SMPI or SMI.
Eligible consumers will only be counted once in the denominator regardless of the number of services received during the calendar year.
**If consumers have received services in the past, but not during the report period, they will not be included in the denominator*
The denominator reflects 100% of the eligible population.

New Hampshire Community Mental Health Agreement Monthly Progress Report

December 2016

New Hampshire Department of Health and Human Services

December 5, 2016

Acronyms Used in this Report

ACT:	Assertive Community Treatment
BDAS:	Bureau of Drug and Alcohol Services
BMHS:	Bureau of Mental Health Services
CMHA:	Community Mental Health Agreement
CMHC:	Community Mental Health Center
DHHS:	Department of Health and Human Services
EMR:	Electronic Medical Record
IDN:	Integrated Delivery Networks
QSR:	Quality Services Review
SE:	Supported Employment
SFY:	State Fiscal Year

Introduction

This fourth 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 November, and month-over-month progress made in support of the Community Mental Health Agreement (CMHA) as of November 30, 2016. 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, as updated and attached hereto (Appendix 1). Where appropriate, the Report includes CMHA lifetime-to-date achievements.

Executive Summary

Assertive Community Treatment Progress Achieved in November 2016

- ACT Statewide De-duplicated Enrollment Update (for the period ending October 31, 2016)[1]
  - October 2016 -- 815
  - September 2016 – 808
  - One Month Comparison – 7 more consumers enrolled in ACT than in September 2016
- ACT Statewide Capacity Update (for the period ending October 31, 2016)[2]
  - October 2016 – 1,124
  - September 2016 – 1,093
  - One Month Comparison – 31 more potential consumers than in September 2016
- Community Mental Health Centers (CMHCs) Under ACT Compliance Plans (for the period ending October 31, 2016)[3]:
  - October 2016 – 245
  - September 2016 – 237
  - One Month Comparison – 8 more consumers enrolled in ACT than in September 2016
- Project Plan Milestones:
  - By 12/1/2016 DHHS will initiate ACT Fidelity Assessments
    - As of November 30, 2016, seven (7) CMHCs completed ACT Self-Fidelity Assessments, and DHHS conducted one (1) ACT Fidelity Assessment. November 28-December 1, DHHS conducted a second ACT Fidelity Assessment. In January 2017, DHHS will conduct the third and final ACT Fidelity Assessments for State Fiscal Year (SFY) 2017.
    - As of November 30, 2016, DHHS completed its initial review of the six (6) ACT Self-Fidelity Assessments conducted in October 2016. DHHS anticipates publishing final reports for these assessments in January 2017.

Supported Employment

- Supported Employment Statewide Penetration Rate[4] (for the period ending October 31, 2016)
  - October 2016 Penetration Rate – 20.4%
  - September 2016 Penetration Rate – 20.8%
  - One Month Comparison: .4% lower than in September 2016
- CMHCs Under Compliance Plan – October SE Penetration Rates[5]:
  - October 2016 – 12.8%
  - September 2016 – 12.6%
  - One Month Comparison – .2% higher than in September 2016
- Project Plan Milestones:
  - By 12/1/2016 explore resources to conduct technical assistance and training. CMHCs and DHHS will explore strategies and barriers DHHS can use to facilitate service delivery.

[1] Based on preliminary data contained in Appendix 2
[2] Based on preliminary data contained in Appendix 2
[3] Based on preliminary data contained in Appendix 2
[4] Based on preliminary data contained in Appendix 2
[5] Based on preliminary data contained in Appendix 2; average of all four CMHCs under SE compliance plans

- DHHS exceeded the 3/1/2017 targeted statewide SE Penetration rate in March 2016. In November, DHHS continued providing technical assistance and monitoring of CMHCs not yet meeting the targeted SE penetration goal on a regional level.

Glencliff Home Transitions into Integrated Community Setting

- Discharge Update
  - November Discharges: No residents were discharged in the month of November. Five residents are in active discharge planning status with resolution anticipated in the coming weeks.
- Project Plan Milestones:
  - By 12/1/2016 transition four (4) individuals to the community
    - November discharges consistent with this milestone – None
    - DHHS anticipated meeting the 12/1/2016 Project Plan Milestone in November when the first two (2) of (4) residents were anticipated to transition into a community residence. The community residence provider experienced unanticipated delays in hiring a full staff complement required for safely meeting the residents' needs. At this time, DHHS anticipates the four residents will transition to the community residence beginning in mid-December.
- Community Mental Health Agreement Milestones:
  - By 6/30/2016, the capacity to serve six additional individuals (cumulative total of 10) in an integrated community setting.
  - By 6/30/2017, the capacity to serve six additional individuals (cumulative total of 16) in an integrated community setting.
    - As of 11/30/16, DHHS has transitioned six[6] (6) residents into compliant community residences.
    - By 12/31/16, DHHS will have transitioned ten (10) residents into compliant residences.
    - By 12/31/16, DHHS will have met the cumulative total required under the 6/30/2016 milestone, and will be on track to meet the 6/30/2017 milestone.

Additional DHHS Efforts to Support CMHA Goals and Strengthen NH's Mental Health System

- New Hampshire Building Capacity for Transformation (NHBCT) Medicaid Section 1115a
  - The NHBCT's Health Information Technology (HIT) and Workforce Development Statewide Taskforces continued meeting in November to address cross-Integrated Delivery Network (IDN) planning for: improving information sharing around care for those individuals with Substance Use Disorders (SUD) and Mental Health (MH) complexity; and to consider solutions to effectively mitigate workforce gaps.
  - Integrated Delivery Network (IDN) Project Plans submitted on October 31, 2016 were placed under initial review and assessment in November. On December 12th and 13th, an Independent Panel will conduct an impartial review of all proposed IDN Project Plans. The two review sessions will be open to the public.
  - Upon DHHS approval of IDN Project Plans, additional funds will be released for plan implementation.

[6] In the November Monthly Progress Report, a seventh transition was reported in error. The transition is removed from the cumulative count as it occurred prior to execution of CMHA.

Schedule of State Fiscal Year 2017 Fidelity and Quality Services Review[7]

July 2016	**Center for Life Management** DHHS-conducted QSR **Mental Health Center of Greater Manchester** DHHS-conducted SE Fidelity Assessment **Riverbend Community Mental Health** DHHS-conducted SE Fidelity Assessment
Aug. 2016	**West Central Behavioral Health** DHHS-conducted QSR
Sep. 2016	**Genesis Behavioral Health** DHHS-conducted QSR **Northern Human Services** DHHS-conducted SE Fidelity Assessment
October 2016	**Center for Life Management** Self-conducted ACT Fidelity Assessment Self-conducted SE Fidelity Assessment **Community Partners of Strafford County** Self-conducted ACT Fidelity Assessment **Genesis Behavioral Health** DHHS-conducted ACT Fidelity Assessment Self-conducted SE Fidelity Assessment **Greater Nashua Mental Health Center** DHHS-conducted SE Fidelity Assessment Self-conducted ACT Fidelity Assessment **Mental Health Center of Greater Manchester** Self-conducted ACT Fidelity Assessment **Monadnock Family Services** Self-conducted ACT Fidelity Assessment Self-conducted SE Fidelity Assessment **Riverbend Community Mental Health** DHHS-conducted QSR - **POSTPONED**[8] Self-conducted ACT Fidelity Assessment **Seacoast Mental Health Center** Self-conducted[9] ACT Fidelity Assessment Self-conducted[10] SE Fidelity Assessment **West Central Behavioral Health** Self-conducted SE Fidelity Assessment
November 2016	**Community Partners of Strafford County** DHHS-conducted SE Fidelity Assessment **Monadnock Family Services** DHHS-conducted QSR - **POSTPONED** **Northern Human Services** DHHS-conducted ACT Fidelity Assessment
Dec. 2016	

January 2017	**Mental Health Center of Greater Manchester** DHHS-conducted QSR **West Central Behavioral Health** DHHS-conducted ACT Fidelity Assessment
Feb. 2017	**Seacoast Mental Health Center** DHHS-conducted QSR
March 2017	**Greater Nashua Mental Health Center** DHHS-conducted QSR
April 2017	**Community Partners of Strafford County** DHHS-conducted QSR
May 2017	**Northern Human Services** DHHS-conducted QSR
June 2017	

[7] Schedule incorporated into Monthly Progress Report in response to the Center for Public Representation's 8/24/2016 request for additional information to ensure various tasks and deliverables are occurring at an appropriate pace. Schedule may be subject to change.
[8] The QSRs originally scheduled for October and November 2016 were postponed in October to accommodate the revision of QSR tools and processes consistent with CMHA provision (VII.D.2). DHHS will reschedule the two impacted QSRs to occur in 2017.
[9] At its own discretion, Seacoast Mental Health Center utilized the services of an outside contractor to conduct its Self-Assessment.
[10] At its own discretion, Seacoast Mental Health Center utilized the services of an outside contractor to conduct its Self-Assessment.

Actions Taken to Enable DHHS to Factually Demonstrate Significant and Substantial Progress

1. Assertive Community Treatment

- November Actions to Increase ACT Enrollment:
  - DHHS actions to reduce inpatient behavioral health waitlist for individuals in hospital emergency rooms 10% by July 2017 or 25% by July 2018
    - New protocols to ensure CMHC daily contact with emergency departments are underway; BMHS actively engaged with CMHCs to seek rapid resolution of barriers to discharge.[11]
    - DHHS requested that Well Sense develop aggressive approach to address emergency department admissions, identification and referral of consumers to CMHCs for potential ACT enrollment, and to develop a protocol to daily engage with emergency departments and applicable CMHCs to expedite delivery of additional services or supports needed to return consumer to community or discharge to appropriate setting/treatment option. Well Sense initiated development.
    - New Hampshire Hospital (NHH) representatives provided information to the CMHC Executive Directors to increase understanding of the admission and discharge practices for the Inpatient Stabilization Unit at NHH. Identified areas for improved collaboration with CMHCs to expedite the return of patients to the community.
  - Continuing Actions to increase ACT Enrollment during November include:
    - Enhanced monthly Emergency Department data reporting continues to be implemented
      - DHHS Data Analytics worked with CMHC representatives to develop streamlined reporting tools and reduce reporting redundancy.
      - CMHCs continue to use Emergency Department data to identify consumers for potential ACT enrollment.
      - CMHCs began monthly reporting to DHHS on the identification of consumers screened for ACT and providing explanations for consumers not enrolled.
    - CMHCs provided ACT training to internal staff
    - CMHCs provided overview of ACT to external stakeholders, such as law enforcement, housing and vocational rehabilitation providers
    - CMHCs improved internal ACT referral processes, such as revising written plans to better align with fidelity, and adjusting EMR to trigger consideration of ACT referral at quarterly evaluations.
    - New Hampshire Healthy Families continues monthly auditing of emergency department admissions and referring consumers to CMHCs for potential ACT enrollment. MCO continues weekly re-evaluation of data to report to DHHS and CMHCs any unresolved consumers to ensure resolution.
    - New Hampshire Healthy Families continues daily contact with emergency departments and applicable CMHCs for any consumer waiting and to expedite delivery of additional services or supports needed to return consumer to community or discharge to appropriate setting/treatment option.

[11] Effort is part of DHHS Innovation Accelerator Program (IAP), Goal #1,

- CMHCs Under ACT Compliance Plans (for the period ending October 31, 2016) [12]:
  - Northern Human Services
    - October 2016 -- 88
    - September 2016 – 83
    - One Month Comparison – 5 more consumers enrolled in ACT than in September 2016
  - West Central Behavioral Health
    - October 2016 -- 28
    - September 2016 – 28
    - One Month Comparison – no change from September 2016
  - Genesis Behavioral Health
    - October 2016 -- 59
    - September 2016 – 57
    - One Month Comparison – 2 more consumers enrolled in ACT than in September 2016
  - Greater Nashua Mental Health Center
    - October 2016 -- 70
    - September 2016 – 69
    - One Month Comparison – 1 more consumer enrolled in ACT than in September 2016
- November Efforts to Increase ACT Capacity (Improve CMHC Ability to Recruit and Retain ACT Staff):
  - The DHHS State Loan Repayment Program (SLRP) administrator presented a program overview to the CMHC Executive Directors to promote interest and participation in the program.
  - DHHS Bureau of Drug and Alcohol Services (BDAS) representatives provided an update on the Bureau's efforts to fight the opioid epidemic to the CMHC Executive Directors. Identified potential areas for further collaboration regarding administrative rules and available resources for the State's Substance Use Disorder and Mental Health treatment systems, including: training, certification and streamlined, non-duplicative reporting requirements – all factors that can negatively or positively impact recruitment and retention of ACT staff.
- November Actions to Ensure Fidelity
  - DHHS completed its initial review of six CMHC ACT Self-Fidelity Assessments reports.
  - DHHS conducted an ACT Fidelity Assessment of Northern Human Services[13].
  - The final CMHC required to conduct an ACT Self-Fidelity Assessment completed the assessment in November.
- Upcoming Milestones to Ensure Fidelity
  - In December, DHHS will provide its initial response to seven ACT Self-Fidelity Assessments to the applicable CMHCs. These centers will have two weeks to respond and work with DHHS to finalize the results of the assessments, and to develop and submit improvement plans. DHHS anticipates publishing final reports and improvement plans in January 2017.
  - DHHS will complete the ACT Fidelity Assessment report, review and improvement plan if appropriate, for Genesis Behavioral Health, for release by December 31, 2017.

[12] Based on preliminary data contained in Appendix 2
[13] This assessment began November 28th and concluded December 1st.

2. Supported Employment

- November Actions Taken to Ensure Fidelity
  - DHHS completed its initial review of five CMHC conducted SE Self-Fidelity Assessments.[14]
  - DHHS conducted an SE Fidelity Assessment of Community Partners of Strafford County.
  - On November 14, 2016, DHHS issued its final SE Fidelity Assessment Report for Northern Human Services.
- Upcoming Milestones to Ensure Fidelity
  - In December, DHHS will provide its initial review of five SE Self-Fidelity Assessments to applicable CMHCs. These centers will have two weeks to respond and work with DHHS to finalize the results of the assessments, and to develop and submit improvement plans. DHHS anticipates publishing final reports and improvement plans in January 2017.
  - In December, DHHS will continue completion of SE Fidelity Assessment reports for and work with applicable CMHCS to obtain their responses and improvement plans. Final reports are anticipated for a January 2017 release.
  - Continuing Actions to Maintain SE Statewide Penetration Rate and Support all CMHCs to Reach or Exceed 16.8% Penetration Rate During November Include:
    - DHHS discussed monthly SE Penetration Rate data with CMHCs to encourage further collaboration to achieve effective SE programs
    - CMHCs provided SE training to internal staff and worked with regional employers to improve competitive employment opportunities
- CMHCs Under Compliance Plan September SE Penetration Rates[15]
  - Northern Human Services
    - October 2016 – 14.0%
    - September 2016 – 14.2%
    - One Month Comparison –.2% lower than in September 2016
  - Genesis Behavioral Health
    - October 2016 – 14.1%
    - September 2016 – 14.1%
    - One Month Comparison – no change from September 2016
  - Greater Nashua Mental Health Center
    - October 2016 – 11.9%
    - September 2016 – 11.1%
    - One Month Comparison – .8% higher than in September 2016
  - Community Partners
    - October 2016 – 10.4%
    - September 2016 – 11.1%
    - One Month Comparison –.7% lower than in September 2016[16]

[14] This number is one greater than previously reported; a CMHC originally identified for a DHHS conducted Fidelity Assessment erroneously conducted a Self-Assessment. DHHS agreed to review the Self-Fidelity Assessment.

[15] Based on preliminary data contained in Appendix 2

[16] Significant staffing shortage (loss of all SE staff) factor into decrease

3. Glencliff Home Transitions into Integrated Community Setting

- Discharge Barrier Resolution Update

  Although there were no discharges in the month of November, progress continues to be made towards discharging several residents in the coming weeks:

  - Active Pending Discharges – 5
    - Community Residence – 4 (commencing December 2016)
      - Full staffing complement to ensure residents' needs are safely met.
    - Enhanced Family Home – 1
      - Resident with funded Acquired Brain Disorder (ABD) waiver anticipates meeting in December with potential home provider.

- Other November Actions Taken to Address Discharge Barriers
  - Ongoing identification and reporting of residents interested in transitioning: 24 residents
  - Continued effort to identify services and placement opportunities for residents interested in transitioning.

- Project Plan Milestones:
  - By 12/1/2016 transition four (4) individuals to the community
    - November discharges consistent with this milestone – None.
    - DHHS anticipated meeting the 12/1/2016 Project Plan Milestone in November when the first two (2) of (4) residents were anticipated to transition into a community residence. The community residence provider experienced unanticipated delays in hiring a full staff complement required for safely meeting the residents' needs. At this time, DHHS anticipates the four residents will transition to the community residence beginning in mid-December.

- Community Mental Health Agreement Milestones:
  - By 6/30/2016, the capacity to serve six additional individuals (cumulative total of 10) in an integrated community setting.
  - By 6/30/2017, the capacity to serve six additional individuals (cumulative total of 16) in an integrated community setting.
    - As of 10/31/16, DHHS has transitioned six (6) residents into compliant community residences.
    - By 12/31/16, DHHS will have transitioned ten (10) residents into compliant residences.
    - By 12/31/16, DHHS will have met the cumulative total required under the 6/30/2016 milestone, and will be on track to meet the 6/30/2017 milestone.

NH Department of Health & Human Services
Community Mental Health Agreement (CMHA)
Project Plan for Assertive Community Treatment, Supported Employment and Glencliff Home Transitions
November 30, 2016

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
				ACT-Expanding capacity/penetration; Staffing array			
1	**Quarterly**	Continue to provide quarterly ACT reports with stakeholder input and distribute to CMHCs and other stakeholders.	M. Brunette	This report focuses on three (3) key quality indicators: staffing array consistent with the Settlement Agreement; capacity/penetration; ACT service intensity, averaging three (3) or more encounters/week. This report is key as it assists CMHC leaders in understanding their performance in relation to quality indicators in the CMHA and past performance.	ACT Quarterly Reports	100% and Ongoing	Use monthly in Implementation Workgroup and Technical Assistance calls; include 4 quarters for trend discussion.
2	**6/30/2016 - letters sent**	Letters sent to CMHCs with low compliance including staffing and/or capacity with a request for improvement plans. The CMHCs will be monitored and follow-up will occur.	M. Brunette	Quality improvement requested by DHHS with detailed quality improvement plans with a focus on increasing the capacity of ACT.	Monthly compliance calls and follow-up	100% - letters, monitoring and follow-up ongoing	Use in Technical Assistance calls with Centers to support continuing progress.
3	**7/20/2016**	DHHS team and CMHC Executive Directors participated in a facilitated session to establish a plan to expand capacity and staffing array.	M.Harlan	This session resulted in a plan with action steps for increased ACT capacity.	The goal was to establish a focused workplan expected to increase new ACT clients.	100%	Workplan is ongoing guide under which the CMHCs and DHHS is operating with focused effort to achieve CMHA goals.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
4	**9/30/2016**	DHHS will continue to provide each CMHC a list of individuals in their region who had emergency department visits for psychiatric reasons, psychiatric hospitalizations, DRF admissions, and NHH admissions in the past quarter to facilitate CMHCs ability to assess people in their region for ACT.	M.Brunette	CMCHs will use these quarterly reports to enhance their screening of people for ACT. CMHCs will provide quarterly reports to DHHS indicating that they have screened each individual and the outcome of the screening.	First report due from CMHCs to DHHS by 7/29/2016. The screening process and reporting will utilize a comprehensive template developed by the ACT and SE community stakeholder group by 9/30/16.	Ongoing	Monthly data distribution began in October. CMHCs monthly reporting to DHHS on research conducted. ACT/SE Implementation Workgroup will use this data for monthly discussion with CMHC ACT coordinators.
5	**10/1/2016**	Address Peer Specialist Challenges-lack of standardized training.	M.Brunette	Behavioral Health Association and DHHS in an effort to expedite increasing peer specialists, will explore the SUD Recovery specialists certification.	Work with BDAS to look at their process.	100%	Research completed. Additional training capacity added. DHHS collaborated with Peer Support Agency to assist with coordination of meeting Peer Support Specialist training needs; ongoing identification of training needs and coordinating delivery of training commenced in October.
6	**10/1/2016**	ACT team data will be reported separately by team.	M.Brunette	The data will be separated starting the month of July 2016 and will be reported in the October 2016 report.	ACT team data will be separated on a quarterly basis moving forward.	100%	Use monthly in Implementation Workgroup and Technical Assistance calls
7	**10/1/2016**	Develop organization strategies to increase capacity.	M.Brunette	Each CMHC will conduct one education session between now and Oct. 1, 2016 to introduce ACT.	Increase community education.	80%	Discussed in monthly ACT/SE Implementation Workgroup calls to identify educational needs. Centers holding additional inservice sessions.
8	**10/1/2016**	Review and make changes as necessary to ACT referral process.	M.Brunette	Each CMHC will review and evaluate their internal referral process and then share with the other CMHCs.	Learning Collaborative to share their processes.	50%	Internal CMHC review of referral process is underway. Some ideas already shared in learning collaborative.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
9	**11/1/2016**	DHHS will require CMHCs to conduct self-fidelity to evaluate their adherence to the ACT treatment model. They will provide a report to DHHS by 11/1/16.	M.Brunette	This report will include their plan for improving their adherence to the model described in the Settlement Agreement.	CMHCs Self-Fidelity Report to DHHS.	85%	DHHS received 7out of 7 CMHC reports; final reports and improvement plans anticipated for January 2017 release.
10	**12/1/2016**	Evaluate potential/structural/systemic issues resulting in high staff turnover/inability to recruit and retain staff.	M. Brunette	Work with TA to develop a report that will communicate the strategies to address ACT staffing issues in collaboration with DHHS.	ACT Staffing Report	90%	Collected information from several health care workforce development projects underway that include CMHC staffing (inclusive of ACT staffing).
11	**12/1/2016**	Increase the number of staff who are eligible for State Loan Repayment Program (SLRP).	M.Brunette	Explore the possibility of increasing the number of staff eligible for this program.	Increase number of staff eligible	75%	Presentation to CMHC Executive Directors made to increase understanding of how to access funds; DHHS seeking additional funding for program in 2018-2019 budget.
12	**12/1/2016**	DHHS will Initiate ACT fidelity assessments.	M.Brunette	DHHS will conduct ACT fidelity using the ACT toolkit.	Fidelity report	Yearly; 85%	Conducted second of three ACT Fidelity Assessments (Nov 28-Dec 1). Third and final is scheduled for January 2017.
13	**2/28/2017**	Increase ACT capacity	M. Brunette	Concerted efforts by the CMHCs to assess individuals in Community residences that could be served on ACT. Train direct service providers in coding appropriately for ACT services. Screen 100% eligible individuals for ACT.	By 2/28/16 increase ACT capacity by 25 %.	35%	New monthly capacity (staffing) reports began in November. As of 10/31/16, actual increased capacity is 16.6% toward goal of increase target.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
14	**3/1/2017**	DHHS will request CMHCs with low compliance to provide DHHS a list of five (5) consumers who are eligible for and who will begin to receive ACT services each month starting August 1, 2016 through February 2017. DHHS will request all other CMHCs to provide DHHS a list of 3 consumers who are eligible for and who will begin to receive ACT services each month starting August 1, 2016 through February 2017.	M.Brunette	Quarterly reports will be provided to each CMHC on their specific list of individuals who had Emergency department visits and psychiatrist hospitalizations to allow CMHCs to assess their center specific clients.	List of (5) consumers from low compliance CMHCs who are eligible for ACT services each month and a list of (3) consumers from other CMHCs who are eligible for ACT services.	50%	DHHS issued reporting tools and reviewed with CMHCs in October. CMHC response reports are being submitted as of October 31, 2016. DHHS actively reviewing reports for consultation with CMHCs. NH Healthy Families (MCO) is also supporting effort by daily monitoring of Emergency Department admissions, referrals to CMHCS, and weekly follow up to address ACT enrollment. DHHS requested similar action by WellSense in November; under development now.
15	**6/30/2017**	Increase ACT capacity	M. Brunette	Concerted efforts by the CMHCs to assess individuals in Community residences that could be served on ACT. Train direct service providers in coding appropriately for ACT services. Screen 100% eligible individuals for ACT.	By 6/30 2017 increase ACT capacity by an additional 13.5%	0%	
16	**6/30/2017**	After February 2017 DHHS will request that all CMHCs will continue to provide DHHS a list of 2-4 consumers who were hospitalized for psychiatric reasons or are otherwise eligible for ACT and were enrolled each month.	M. Brunette	CMHCs will provided DHHS with a monthly report of newly enrolled clients.	Monthly report with list of consumers to increase ACT capacity.	0%	

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
Supported Employment (SE)							
17	**5/20/16 and ongoing**	Letters sent to CMHCs with low penetration rates including staffing and/or penetration with a request for improvement plans.	M.Brunette	Request for compliance plan with quarterly reports.	Receive and evaluate improvement plans from CMHCs due 6/29/16.	100%	Use in Technical Assistance calls with Centers to support continuing progress. Two out of four reported decreases in September; overall improvement is 6.8% over August for these 4 CMHCs.
18	**6/1/16 and ongoing**	Continue to generate quarterly report with stakeholder input focusing on penetration of SE services distributed to the CMHCs and other stakeholders.	M.Brunette	This report is key as it assists CMHC leaders in understanding their performance in relation to quality indicators in the CMHA and past performance.	Quarterly Report SE Penetration Rate to CMHCs.	Ongoing/Quarterly	Use monthly in Implementation Workgroup and Technical Assistance calls; include 4 quarters for trend discussion.
19	**7/20/2016**	DHHS team and CMHC Executive Directors will participate in a facilitated session to establish a plan to expand penetration and staffing array.	M.Harlan	This session will result in a plan with action steps for increased SE capacity.	The goal is to establish a focused workplan expected to result in a total of 18.6% SE clients by 6/30/17.	100%	Workplan is ongoing guide under which the CMHCs and DHHS is operating with focused effort to achieve CMHA goals.
20	**7/6/2016**	On-site fidelity assessments conducted at CMHCs.	K.Boisvert	The first fidelity assessment took place 7/6-7/8/16 in Manchester.	Report with results of the on-site fidelity assessments.	100%	Tools developed. Assessment conducted. DHHS report issued. Voluntary program improvemeent plan developed by Center.
21	**7/12/2016**	On-site fidelity assessments conducted at CMHCs.	K.Boisvert	The second fidelity assessment took place on 7/12/16 at Riverbend in Concord.	Report with results of the on-site fidelity assessments.	100%	Tools developed. Assessment conducted. DHHS report issued with recommendations.
22	**9/27/2016**	On-site fidelity assessments conducted at CMHCs.	K.Boisvert	The third fidelity assessment will take place on 9/27/16-9/29/16 in Berlin.	Report with results of the on-site fidelity assessments.	100%	Final report issued 11/14/16.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
23	**10/24/2016**	On-site fidelity assessments conducted at CMHCs.	K.Boisvert	The fourth fidelity assessment will take place on 10/4-5/16 in Nashua.	Report with results of the on-site fidelity assessments.	75%	Assessment conducted. DHHS report in draft/review process. Will be sent to CMHC in December.
24	**10/1/2016**	Monitor monthly ACT staffing for presence of SE.	M.Harlan	Monitor monthly ACT staffing for presence of SE on each team.	A monthly report will be run through the Phoenix system for ACT staffing.	100% and Ongoing	Use monthly in Implementation Workgroup and Technical Assistance calls.
25	**10/15/2016**	All CMHCs will conduct self-fidelity assessments.	K.Boisvert	Self-fidelity assessments	Report to DHHS with self-fidelity assessment results.	100%	DHHS completed its initial review of the assessments received.
26	**11/1/2016**	CMHCs will develop and maintain a list of SMI individuals who may benefit from but are not receiving SE services.	M.Harlan	Review individuals that are not on SE for reasons why they are not enrolled.	Quarterly reports of individuals not on SE.	0%	
27	**11/1/2016**	Resolve barriers to achieving SE penetration goals.	M.Harlan	Educate internal CMHC staff on the goals of SE.	Educational plan	90%	Discussed in monthly ACT/SE Implementation Workgroup calls to identify educational needs. Five CMHCs reported holding additional inservice sessions. Learning Collaborative work has yielded all SE leads meeting with new clients within days of intake; internal staff educated about SE; SE education needs identified, motivational programs for clients explored, etc.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
28	**12/1/2016**	Explore resources to conduct technical assistance and training. CMHCs and DHHS will explore strategies and barriers DHHS can use to facilitate service delivery.	M.Harlan	CBHA and DHHS will explore the need for technical assistance and training. DHHS will conduct a subgroup of CMHC leaders to explore barriers and administrative burden that prevents service delivery.	Report the barriers and possible solutions. Technical assistance (TA) and training if needed.	70%	DHHS began developing plan to resource provision of additional technical assistance to CMHCs. Fidelity Assessment results currently under analysis to identify specific areas of focus for upcoming training and TA needs. Preliminary results suggest need for IMR train the trainer, job development for Supported Employment specialists; schedule to begin in January. Plans for TA underway.
29	**12/1/2016**	Increase the number of staff who are eligible for State Loan Repayment Program (SLRP).	M. Harlan	Explore the possibility of increasing the number of staff eligible for this program.	Increase number of staff eligible.	75%	Presentation to CMHC Executive Directors made to increase understanding of how to access funds; DHHS seeking additional funding for program in 2018-2019 budget.
30	**6/30/2017**	Increase SE penetration rate to 18.6%	M. Harlan	Learning collaborative meets monthly and has developed a four question script to be used at time of intake as an instrument to introduce SE. If the individual is interested the referral goes to the SE coordinator who will contact the individual within 3 days of the intake to set up an appointment. If the individual is not interested the SE Coordinator will outreach to provide information on SE and will periodically follow up with him/her. This strategy includes working with individual CMHCs that fall below the 18.6% penetration rate.	Monthly meetings of the Learning Collaborative.	100%	Discussed in monthly ACT/SE Implementation Workgroup calls to identify opportunities for improvement at center specific level and in Technical Assistance calls. Ideas discussed in Learning Collaborative. DHHS continues to consult with CMHCs not at 18.6% goal for region.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
				Glencliff Home Transitions			
31	**Ongoing at residents every 90 days**	Establish process for identifying individuals interested in transitioning from Glencliff to the community.	Glencliff Staff	Glencliff interviews residents each year to assess if they want to transition back to the community.	Section Q of MDS is a federal requirement. CMHCs have staff go to Glencliff to discuss transition planning with residents.	100% and Ongoing	Monitor referrals to Central Team. Research CMHC inreach activities. Introduce and deliver community living curriculum to increase resident positive engagement.
32	**7/30/2016**	Develop individual transition plans, including a budget.	M.Harlan	Individuals from Glencliff have been identified to transition back to the community. Detailed plans are being developed and DHHS has engaged a community provider who will further develop transition plans.	Individual transition plans/individual budgets.	85%	Individual plans developed. Individual budgets received and reviewed in October. Provider continued budget revisions in November; will resubmit early December.
33	**8/31/2016**	Identify community providers to coordinate and support transitional and ongoing community living including but not limited to housing, medical and behavioral service access, budgeting, community integration, socialization, public assistance, transportation, education, employment, recreation, independent living skills, legal/advocacy and faith based services as identified.	M.Harlan	Community providers have been identified and will further develop the transition/community living plans.	Transition/community living plans for individuals to transition to community.	100%	Tools developed, reviewed and approved. Providers identified and engaged. Community Living Plans developed.
34	**8/31/2016**	Implement reimbursement processes for non-Medicaid community transition funds.	M.Harlan	Develop policies and procedures to allow community providers to bill up to $100K in general fund dollars.	Reimbursement procedure documented, tested and approved.	100%	
35	**8/15/2016**	Develop template for Community Living Plan for individuals transitioning from Glencliff to the community.	M.Harlan	Completion of the template to be done as a person centered planning process.	Community Living Plan	100%	
36	**7/25/2016**	Transition three (3) individuals to the community.	M.Harlan	Three individuals have transitioned to the community.	Community placement	100%	

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
37	**12/1/2016**	Transition four (4) individuals to the community.	M.Harlan	Four individuals to transition into the community.	Community placement	85%	4 residents visited community. Community provider completed assessment. Medicaid eligibility completed. Community Living Plans approved. 4 transitions to delayed; will begin mid-December due to staff recruitment delay.
38	**3/1/2017**	Transitions four (4) additional individuals to the community.	M.Harlan	Four individuals to transition into the community.	Community placement	0%	
39	**6/30/2017**	Transition five (5) additional individuals to the community.	M.Harlan	Five individuals to transition into the community	Community placement	0%	

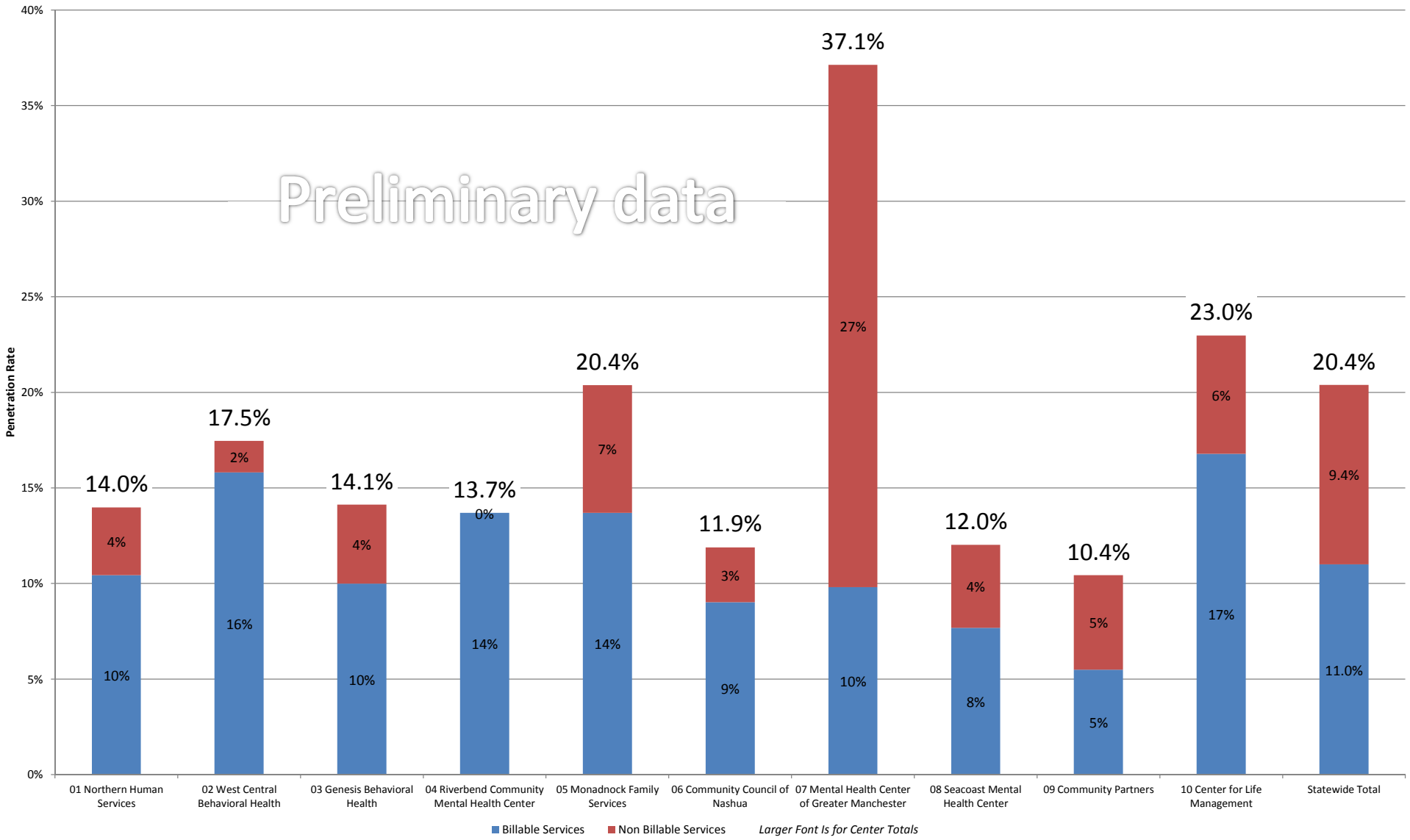
Appendix 2

The following pages contain **Preliminary Data** for ACT and SE for the period ending October 31, 2016.

DHHS will publish finalized data reports on a quarterly basis.

Supported Employment Penetration Rates Split by Billable Vs. Non Billable Services for The 12 Month Window Ending on:
10/31/2016

Data Source: Phoenix 2



Produced On: 11/29/2016

Chart User Guide

This chart displays Supported Employment Penetration Rate Split by Billable and Non Billable services.

The total height of each bar represents the total penetration rate for that center. The smaller sections of each bar reflect the portion of the overall penetration rate that can be attributed to billable Vs. non billable services.

If consumers have received both billable and non billable Supported Employment services, they will only be included in the Billable Services (blue bar) portion of the chart.

If consumers have received only non billable Supported Employment Services, they will only be included in the non billable services (red bar) portion of the chart.

Consumers are only counted 1 time in this report regardless of the frequency of services or if they receive both billable and non billable services.

Chart Data

Unique Counts of Consumers

CMHC Name	Billable Services	Non Billable Services	Total Eligible Consumers
01 Northern Human Services	109	37	1044
02 West Central Behavioral Health	96	10	607
03 Genesis Behavioral Health	133	55	1331
04 Riverbend Community Mental Health Center	221	0	1614
05 Monadnock Family Services	129	63	942
06 Community Council of Nashua	141	45	1564
07 Mental Health Center of Greater Manchester	307	855	3129
08 Seacoast Mental Health Center	99	56	1289
09 Community Partners	40	36	728
10 Center for Life Management	141	52	840
Statewide Total	1413	1206	12846

Penetration Rate by Billable Type

Billable Penetration Rate	Non Billable Penetration Rate	Total Penetration Rate
10%	4%	14.0%
16%	2%	17.5%
10%	4%	14.1%
14%	0%	13.7%
14%	7%	20.4%
9%	3%	11.9%
10%	27%	37.1%
8%	4%	12.0%
5%	5%	10.4%
17%	6%	23.0%
11%	9%	20.4%

Supported Employment Penetration Rate Definitions

The supported Employment program uses Penetration Rate as the primary KPI (Key Performance Indicator) to track each center's progress.
While the metric is calculated at a CMHC level, the aggregate Penetration Rate for all CMHCs is the KPI for which BBH is accountable.
The Penetration Rate reflects 1 full calendar year of Supported Employment Services.

Penetration Rate consists of a numerator and denominator, the criteria for each is listed below:

Numerator:

The numerator consists of the count of unique consumers whom have received the Supported Employment service, or the Non Billable Supported Employment service during the report period (12 calendar months).
Consumers only need to have received the Supported Employment service 1 time during the report period to be included in the numerator. Consumers will only be counted once regardless of the frequency or quantity of Supported Employment services received.

Denominator:

The denominator consists of the unique count of eligible consumers whom have received any services during the same report period as the numerator (12 calendar months) and have the following characteristics:
Consumers must be 18 years old or older to be eligible.
Consumers must have one of the following BBH eligibilities: Low Utilizer, SMPI or SMI.
Eligible consumers will only be counted once in the denominator regardless of the number of services received during the calendar year.
**If consumers have received services in the past, but not during the report period, they will not be included in the denominator*
The denominator reflects 100% of the eligible population.

Unique Counts of Assertive Community Treatment Consumers

Data Source: Phoenix 2
Date Range: 08/01/2016 through 10/31/2016
Age Range: Adults Only

Center Name	August-2016	September-2016	October-2016	Deduplicated Totals
01 Northern Human Services	80	83	88	93
02 West Central Behavioral Health	30	28	28	31
03 Genesis Behavioral Health	53	57	59	60
04 Riverbend Community Mental Health Center	74	75	77	82
05 Monadnock Family Services	72	70	64	73
06 Community Council of Nashua	71	70	70	76
07 Mental Health Center of Greater Manchester	251	252	250	270
08 Seacoast Mental Health Center	68	65	64	71
09 Community Partners	68	69	70	72
10 Center for Life Management	38	44	45	47
Deduplicated Total	**802**	**811**	**815**	**871**

Consumer counts are determined by taking the unique counts of consumers receiving services in the following Cost Centers:
-Act Team #1
-Act Team #2
-Act Team #3
-Act Team #4
-Act Team #5

Preliminary data

Adults are consumers ages 18 and up.

Consumers are only counted 1 time, regardless of how many services they receive.

Report Produced on 12/02/2016

Preliminary Data

Center Name	September 2016 Full Time Equivalents: Nurse	Masters Level Clinician/or Equivalent	Functional Support Worker	Peer Specialist	Total (Excluding Psychiatry)	Psychiatrist/Nurse Practitioner
01 Northern Human Services	0.53	2.37	7.02	0.33	10.25	0.80
02 West Central Behavioral Health	0.40	2.25	2.19	0.60	5.44	0.14
03 Genesis Behavioral Health	1.00	2.00	4.00	0.00	7.00	0.50
04 Riverbend Community Mental Health Center	0.50	3.00	3.50	0.50	7.50	0.40
05 Monadnock Family Services	0.50	3.25	3.00	0.50	7.25	0.65
06 Community Council of Nashua_1	0.50	3.00	2.75	0.00	6.25	0.25
06 Community Council of Nashua_2	0.50	3.00	1.75	0.00	5.25	0.25
07 Mental Health Center of Greater Manchester-CTT	0.99	11.00	2.47	1.00	15.46	0.72
07 Mental Health Center of Greater Manchester-MCST	0.96	10.00	8.28	1.00	20.24	0.63
08 Seacoast Mental Health Center	0.43	2.30	5.00	1.00	8.73	0.60
09 Community Partners	0.40	2.00	5.13	0.50	8.03	0.50
10 Center for Life Management	1.00	0.75	5.16	0.00	6.91	0.10
Total	**7.71**	**44.92**	**50.25**	**5.43**	**108.31**	**5.54**

September 2016 ACT Staff Competencies Substance Use	
Center Name	ACT Staff Count
01 Northern Human Services	2.42
02 West Central Behavioral Health	1.20
03 Genesis Behavioral Health	4.50
04 Riverbend Community Mental Health Center	1.40
05 Monadnock Family Services	3.40
06 Community Council of Nashua_1	3.00
06 Community Council of Nashua_2	3.00
07 Mental Health Center of Greater Manchester-CTT	11.00
07 Mental Health Center of Greater Manchester-MCST	2.00
08 Seacoast Mental Health Center	0.20
09 Community Partners	1.00
10 Center for Life Management	2.75
Total	**35.87**

September 2016 ACT Staff Competencies Housing Assistance	
Center Name	ACT Staff Count
01 Northern Human Services	7.95
02 West Central Behavioral Health	5.40
03 Genesis Behavioral Health	6.00
04 Riverbend Community Mental Health Center	6.00
05 Monadnock Family Services	1.00
06 Community Council of Nashua_1	5.00
06 Community Council of Nashua_2	4.00
07 Mental Health Center of Greater Manchester-CTT	11.61
07 Mental Health Center of Greater Manchester-MCST	15.79
08 Seacoast Mental Health Center	5.00
09 Community Partners	6.50
10 Center for Life Management	5.61
Total	**79.86**

September 2016 ACT Staff Competencies Supported Employment	
Center Name	ACT Staff Count
01 Northern Human Services	1.27
02 West Central Behavioral Health	0.19
03 Genesis Behavioral Health	2.00
04 Riverbend Community Mental Health	0.50
05 Monadnock Family Services	1.00
06 Community Council of Nashua_1	2.50
06 Community Council of Nashua_2	1.50
07 Mental Health Center of Greater	0.36
07 Mental Health Center of Greater	1.18
08 Seacoast Mental Health Center	1.00
09 Community Partners	1.00
10 Center for Life Management	0.30
Total	**12.80**

-The Staff Competency values reflect the sum of FTE's 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.