New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Two

June 30, 2015

I. Introduction

This is the second 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.

The ER was mutually appointed by the parties effective July 1, 2014.[1] The first six months of ER activity was the "orientation phase"; ER activities focused on meeting state administrators and visiting inpatient and community-based service providers throughout the state to: (a) gain an understanding of the structure and functioning of important elements of the mental health system; (b) introduce to these entities the functions of the ER vis-à-vis the CMHA; and (c) begin to formulate a baseline status assessment of the mental health system as a foundation from which to identify and document future progress in implementing the CMHA.

In the second six-month time period, from January 1, 2015 through June 30, 2015, the ER has concentrated on:

1. Working with the parties and state officials to identify data elements and sources to be used to track and document progress and performance related to the CMHA;
2. Beginning to work with state officials on the implementation of Quality Management (QM) and Quality Service Review (QSR) provisions in the CMHA; and
3. Working with the parties to develop collective understandings of how the data tracking and QM/QSR activities will be used to provide the most accurate and timely

[1] Implementation efforts related to the CMHA had been underway prior to the appointment of the ER, and to the extent possible, those activities were reflected in the first ER report.

information to the ER and the parties with regard to attainment of the performance targets, outcomes, and quality requirements of the CMHA.

The ER has continued to make regular visits to New Hampshire, both to observe the implementation of certain key service elements of the CMHA, and to continue discussions with relevant parties related to implementation efforts and the documentation of progress and performance related to the CMHA. Thus far, the ER has:

- Completed visits to peer supports programs in each of New Hampshire's 10 regions. Seven of these were conducted during the first six-month period;
- Conducted on-site reviews of Assertive Community Treatment (ACT) teams/services in Manchester, Nashua, Concord, Laconia, Keene, and Berlin;
- Conducted on-site reviews of Supported Employment (SE) services in Nashua, Concord, Laconia, Keene, and Berlin;
- Met with officials, administrators, and staff at New Hampshire Hospital (NHH) (twice) and Glencliff to discuss and observe transition planning functions;
- Met with the peer supports group at Glencliff;
- Met with NHH staff and the liaisons to the Community Mental Health Centers (CMHCs) to discuss discharge planning issues;
- Met with Ken Norton, Executive Director of NAMI New Hampshire;
- Participated in one CMHC Director's meeting;
- Met with representatives of the Nashua Police Department;
- Met with representatives of the Emergency Department of Androscoggin Valley Hospital in Berlin;
- Participated in three meetings of the Department of Health and Human Services (DHHS) Mental Health Coordination Team;
- Participated in several meetings with representatives of the Plaintiffs and the United States (hereinafter "plaintiffs");
- Conducted numerous meetings with DHHS officials to discuss QM/QSR, data tracking, and data elements and reporting related to the CMHA; and
- Conducted in-person meetings with the parties in Concord on January 26, 2015, March 3, 2015, and June 10, 2015.

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, even outside the context of QSR reviews, to observe and assess the quality and effectiveness of implementation efforts and whether they achieve positive outcomes for people per CMHA requirements.

II. Data

As indicated above, a key priority for the ER during this second six-month period has been working with DHHS to further identify and access data that can be used to routinely track progress related to each element of the CMHA. Data includes participant-level service access and encounter data from CMHCs, NHH, and Glencliff. Updated information derived from this data is included where applicable in the service-specific sections of the report. Consistent with the CMHA, a goal of DHHS is to provide data regularly and in formats that are useful for analysis.

DHHS has been working to produce the requested data, and there have been improvements in the reliability and timeliness of some of the data provided to the ER and the parties. However, some data has still not been supplied at regular intervals, in standardized formats with standardized date ranges. In addition, DHHS is still developing its capacity to match participant-level information across several data bases, including Medicaid claims data, Phoenix 2, and the Avatar system for NHH. Early testing of this data-matching capability has been promising, and when fully developed, will be beneficial to the overall effort to assure performance and quality for the priority target population of the CMHA.

In the course of identifying and testing existing data sources for analyses related to the CMHA, several gaps in current information have been identified. For example, there is no current data on the degree to which participants in Supported Employment (SE) are engaged in competitive employment in integrated community settings consistent with their individual treatment plans as opposed to other SE activities. Competitive employment in integrated community settings consistent with individual treatment plans is a key indicator of the fidelity and success of SE services, and thus another data source will need to be identified to obtain this information. Another gap in data is related to people receiving Supportive Housing (SH) under the Bridge subsidy program. These participants are not clearly identified in the Phoenix 2 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. DHHS has identified a strategy to link data from the Bridge program to the Phoenix 2 system, so a solution to this data gap issue may be forthcoming. A third example is related to the Mobile Crisis program soon to be implemented in the Concord Region. Some data related to Mobile Crisis access and utilization will be captured and reported in the Phoenix 2 system. Other important data elements, such as encounter location, response time and disposition may have to be tabulated and reported separately pursuant to contractual and/or agreements with the prospective Mobile Crisis provider network.

The sporadic and inconsistent reporting of data from various entities has been a source of significant frustration for DHHS, the plaintiffs, and the ER over the past two reporting periods.

Thus, a major priority of the ER for the next two months will be to work with DHHS and the plaintiffs to:

- Define regular reports to be prepared and circulated to the ER and the parties on a routine and predictable basis. Report parameters will specify: the data and data sources; the time frame covered by the data in the report; the date the report is generated; the key contact person/author of the report; and the formulas or related methods used to compile and analyze the reported data;
- Identify methods, time frames and formats for the collection and reporting of some data not currently available in standard data bases and systems; and
- Develop the capacity to collect, cross walk and effectively integrate qualitative data and information collection through the QM and QSR process with service access and utilization data.

Given the importance of this process, and given the need for all parties to continue to have regular input into the data reporting design and development activities, the ER will continue to circulate memoranda and draft reports among the parties for review and comment. It is recognized that data reporting and analysis can always be improved, and that the act of using, questioning, and interpreting data is the best way to assure that it is constantly improved. Nonetheless, this initial data definition process is expected to be completed by October 1, 2015, and regular quarterly reports to be available shortly thereafter.

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

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 a contract is reported to be ready to be awarded on June 24, 2015. The selected vendor and terms of the contract will not be public until the contract has been formally approved by the State.

Given the timing of the contract award, it is unlikely that the Concord mobile crisis program (mobile team and apartments) will be operational by June 30, 2015 as required by the CMHA. At this point, the timetable for implementation is not available for review, so it is difficult to predict what the programmatic impact of this delay will be, and when mobile crisis services will be available to target population members in the Concord region.

The ER will review the contract as soon as it is awarded and becomes public. Key elements of the contract are expected to include parameters set forth in the RFP, as well as: (a) a timetable and action steps for implementation of both the mobile team and the crisis apartments; (b) specification of inter- and intra-agency agreements and protocols to be put into place; and (c) identification of the data elements and reporting timeframes to be provided by the selected vendor to DHHS on a regular basis.

The Concord region mobile crisis program is an essential component of the CMHA for at least two reasons. The first is that it is expected to provide effective mobile crisis services to target population members in the Concord region, with the intended results of reduced hospitalization, reduced Emergency Department (ED) presentations, and increased housing stability and community tenure.

The second reason is that it will be the first of three mobile crisis programs implemented in New Hampshire under the terms of the CMHA, and therefore a model upon which to construct the larger crisis system. It is critical that all parties are in close communication about the roll-out of the Concord Mobile Crisis Program and that there is agreement on key elements of that service including its design, staff training and implementation plans.

For these reasons the ER intends to develop a specific implementation monitoring plan for the Concord mobile crisis program. A draft of this monitoring plan will be circulated to all parties as soon as possible after the contract is made available and after the ER has had one initial visit with the vendor and DHHS officials to discuss the implementation process and expectations. It is expected that the implementation monitoring plan will be circulated by the end of July 2015. It is further expected that full implementation of the mobile crisis program will proceed as quickly as possible, and that mobile crisis services will be available in the Concord region no later than September 30, 2015.

Assertive Community Treatment (ACT)

ACT is a key 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, 2015, 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 1,300 individuals in the Target Population at any given time.

Taken together with the other ACT provisions, the CMHA requires a robust and competent system of ACT services throughout the State as of June 30, 2015.

Table I below summarizes data provided by DHHS as of May 15, 2015.

Table I

ACT Self-Reported Staff Capacity and Active Caseload: May 2015

DHHS Region/ CMHC	FTE ACT Staff May 2015	Staff Capacity	Current Active Caseload – May, 2015	Variance
1. Northern	14.8	148	60	-88
2. West Central	3.0	30	16	-14
3. Genesis	7.1	71	22	-49
4. Riverbend	7.0	70	79	+9
5. Monadnock	8.2	82	47	-35
6. Greater Nashua	8.7	87	63	-24
7. Manchester	24.9	249	254	+5
8. Seacoast	12.8	128	73	-55
9. Community Partners	8.2	82	16	-66
10. Center for Life Management	7.8	78	39	-39
Total	102.5	1,025	669	-356

As can be seen in the table, as of May 15, 2015, there was a statewide total of 102.5 ACT staff. Using the 1:10 staff ratio defined in the ACT standards, the reported staffing results in an overall capacity of 1,025 active ACT participants. This current staff capacity is 275 lower than the 1,300 capacity specified for June 30, 2015 in the CMHA.

The reported statewide active monthly ACT caseload of 669 is 356 people below the current actual staff capacity of 1,025, and 631 people below the number of priority target population members that could be served at the capacity standard of 1,300. The State notes that the CMHA does not specify utilization as opposed to capacity. Strictly speaking, the 275 person gap between actual and required capacity is considered by the State to be the operative concern related to the June 30, 2015 CMHA requirements. However, the ER points out that unused capacity for ACT or any other CMHA service could result in difficulty meeting the overall goals and outcomes for priority target population members identified in the CMHA. It also may indicate that target population members are missing opportunities to enjoy improved and more successful lives in integrated community settings as opposed to encountering crises, potential loss of housing, increased hospitalizations, and potentially longer lengths of stay at hospital or institutional levels of care. This issue will require additional discussions with all Parties.

As can be seen from Table I, there is considerable variation in both capacity and active monthly caseload among the 10 regional CMHCs in New Hampshire. For example, Manchester is

reported to have 24.9 FTE staff, and to have an active monthly caseload of 254, slightly higher than the staff capacity would support. West Central has only three FTE ACT staff, and is also serving 14 fewer people than this capacity would support. Only two of the 11 ACT teams in New Hampshire currently have active monthly caseloads at or slightly above their reported staff capacity.

There also are inconsistencies among ACT teams with regard to their satisfaction of ACT team standards set out in the CMHA. For instance, the CMHA specifies a 1:10 staffing ratio for ACT, and requires certain types of staff competencies to be represented on each ACT team. Additionally, the CMHA requires that each ACT Team have at least one peer member on the team. Based on information provided by the CMHCs to DHHS, five of the 10 regions do not yet have a peer supports/peer counselor member on the teams and two other regions have peer capacity listed as less than one FTE. In addition, there are variations in the amount of staff provided within the competencies specified for each team. For example, some teams have more than one FTE of nursing, while other teams provide only 0.2 or 0.3 FTE of nursing. These numbers reflect important differences in service capacity and expertise among the ACT teams that may compromise the teams' ability to deliver effective ACT services, and warrants further analyses and possible corrective actions by DHHS.

All of the staffing data reported by DHHS for ACT services discussed above had been reported by the CMHCs and has not yet been independently verified by DHHS or the ER. In addition, neither DHHS nor the ER has, to date, reviewed compliance on the part of all ACT teams with the performance and quality standards specified in CMHA Section V.D.2. To help address this issue, the ER expects that the new QM/QSR capacity being developed by DHHS will conduct on-site quality reviews of ACT services and report their findings within the up-coming 12 month period. These reviews are expected to prompt, whenever necessary, implementation of needed remedies to address any compliance concerns.

The ER has visited six CMHCs to receive an overview of seven of the ACT teams in place in the state. These visits were not fidelity or compliance reviews, and did not include any record reviews or separate interviews with team staff or ACT participants. The ER will conduct such reviews in upcoming months. Impressions gleaned from these on-site visits include:

1. As supported by the data summarized above, there appears to be substantial variation among the ACT teams. Some of this variation can be explained by the longevity of ACT service delivery in different areas, and some variation can be explained by differing geographic and socio-demographic conditions in various service areas. For example, several ACT teams had been operating for some years before the CMHA was initiated, while other ACT teams are still in the formation stages. Also, some teams operate in relatively dense urban areas, while others (particularly Northern Human Services) operate in sparse rural areas with large distances to travel. It is expected that DHHS, through its

QM/QSR capacity, will address the high degree of variation among the ACT teams to assure that ACT services meeting the CMHA standards are delivered statewide.

2. There seemed to be a high degree of understanding among ACT supervisors and team members with regard to ACT principles and practices.
3. Most of the teams visited by the ER expressed commitment to the model and enthusiasm for the results that can be obtained for ACT participants. Most teams believe that they are directly facilitating increased community tenure and quality of life for target population members participating in ACT in their regions. Team members for the most part reported commitment to the high intensity service model and team structure that are key to ACT services. However, some variation in the degree of enthusiasm with which these practices were being implemented was observed during the site visits. It will be important that the State implement measures to ensure consistently high performance among all ACT teams statewide.
4. The few ACT teams that employ a peer team member report the importance and positive contribution of the peer staff to the success of the overall team.
5. Many ACT team members reported being trained in and actively utilizing other evidence based service modalities, including Illness Management and Recovery (IMR); Motivational Interviewing (MI); Stages of Change; and Cognitive Behavioral Treatment (CBT) as part of their ACT team service delivery. Use of these evidence based practices in the context of ACT services is considered to be good, pending additional research.
6. All the ACT teams visited had qualified SE staff members assigned to the team, although it appears that most of them also provided SE services to non-ACT participants. The degree to which ACT enrollees participate successfully in SE is an important topic for consideration through the QM/QSR process.
7. Most teams reported having good and cooperative relationships with local primary health care providers, local police/law enforcement, local hospital EDs, local public housing agencies or other sources of affordable housing, and other local resources of importance to ACT participants.
8. Most of the ACT teams visited by the ER reported populating their caseloads with target population members who were already active clients of their CMHC. Teams also reported active outreach to people known to the CMHC who were homeless or otherwise not engaged in services; and also reported receiving referrals from NHH consistent with the NHH transition planning process. An important area for future focus will be to expand the reach of ACT services to target population members currently not connected to NHH or a CMHC, but still utilizing substantial hospital, ED, homeless service, and possible criminal justice resources.

In the coming months, it is expected that DHHS will: 1) develop one set of eligibility and discharge criteria for the provision of ACT services; 2) analyze the high degree of variation among existing ACT teams; 3) take any steps necessary to assure that ACT services are

consistently meeting the CMHA standards statewide, and; 4) expand the capacity of ACT to meet the requirements of the CMHA.

Supported Employment (SE)

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 supported employment (V.F.1); and 3) meet penetration rate mandates set out in the CMHA. For example, the CMHA states: "By June 30, 2015, the state will increase its penetration rate of individuals with SMI receiving supported employment …to 16.1 percent of eligible individuals with SMI." (Section V.F.2(c)).

The baseline SE penetration rate at the beginning of the CMHA was 12.1% (2012). The State reports a current SE penetration rate of 11.3%; this is almost a full percentage point below the 2012 baseline. Moreover, this current rate is 4.8 percentage points below the CMHA target for June 30, 2015. Based on the data provided by DHHS, six CMHCs were below the original SE penetration rate of 12.1% listed in the CMHA for 2012 (Northern (7.1%), Genesis (9.4%), Monadnock (8.0%), Nashua (6.1%), Seacoast (10.5%), and Community Partners (8.1%).

Table II below displays the self-assessed fidelity, current active SE caseload, and current SE penetration rate for each region/CMHC in New Hampshire. Seven of the CMHCs report themselves to be in the "good" fidelity range, and three of the CMHCs report themselves to be in the "fair" fidelity range[2]. Neither DHHS nor the ER has yet independently verified the CMHC fidelity self-assessments. It is expected that QM/QSR validation of CMHC fidelity self assessments will be a priority for the up-coming 12 month period.

As with the ACT services discussed above, there is considerable variation among the CMHCs in the implementation and operations of SE services. Only one CMHC reports a penetration rate that exceeds the June 30, 2015 penetration rate target, while all the others report currently being below the target. Two of the CMHCs with self-reported fidelity scores in the "fair" range also have low penetration rates.

[2] Note: these ranges are defined in the Dartmouth IPS Supported Employment evidence based practice fidelity scoring worksheets.

Table II

SE Participants and Penetration Rates

DHHS Region/CMHC	Self-Reported Fidelity Score	Unique SE Participants (through March 31, 1015)	Penetration Rate (through March 31, 2015)
1. Northern	113	85	7.1%
2. West Central	110	91	13.5
3. Genesis	106	108	9.4
4. Riverbend	98	186	14.9
5. Monadnock	101	57	8.0
6. Greater Nashua	93	78	6.1
7. Manchester	106	445	14.6
8. Seacoast	109	112	10.5
9. Community Partners	92	52	8.1
10. Center for Life Management	109	107	16.3
Statewide Average		1,321	11.3%

The number of active SE participants counted towards the penetration rate calculation currently includes people who have had only one encounter of SE. It is not known whether the "one-encounter" participants become full participants in SE. It will be important for the State to engage in further analyses regarding the "one-encounter" participants as it does not appear that one encounter will satisfy Dartmouth fidelity requirements or lead to actual employment as envisioned in the outcome criteria of the CMHA.

Information supplied by DHHS indicates that all CMHCs have corrective action plans in place to improve the penetration and fidelity of SE. The ER has not yet been able to see these plans or to verify that they are being implemented.

Five SE programs were briefly visited by the ER as adjuncts to the ACT team visits. These were introductory meetings, and did not include record reviews or participant interviews. The ER will conduct more in-depth SE reviews in upcoming months. From the site visits, it would appear that the SE staff of the visited programs are familiar with the Dartmouth Individual Placement and Support (IPS) SE best practices, and with the fidelity requirements. All reported good relationships with the local Vocational Rehabilitation (VR) offices, and several reported good relationships with large local employers.

Information provided by DHHS indicates that job development is a key element of SE for which fidelity has been difficult to attain and maintain. The SE programs visited by the ER reported that they did not believe that the current reimbursement rate for SE adequately covered the costs of job development, and thus, this element received lower priority. This may be a contributing factor to what anecdotally seems to be a smaller than expected number of SE participants participating in competitive employment for wages.

DHHS does not currently receive data from the CMHCs on the number of SE participants who are in competitive employment in integrated community settings consistent with their individual treatment plans, the number of hours they are working, or what they are being paid. DHHS is aware of these gaps in information, and will be working with the CMHCs to develop improved reporting mechanisms related to these factors.

The ER has three concerns about SE that will be a priority for monitoring in the upcoming months. These are:

1. The SE penetration rates have, on a statewide basis, gone down as opposed to up. The current statewide SE penetration rate is substantially below the June 30, 2015 target of 16.1%. Thus, the first priority for DHHS and the CMHCs will be to increase the SE participation rates to specified levels. Penetration rates should include only those who are actively engaged in efforts to gain employment and comply with CMHA outcome criteria, and should not include those who have had only cursory, one-time exposure to SE activities.
2. Most of the CMHCs report doing well on their own fidelity self-assessment. However, a few have reported having difficulty reaching the "good" level of fidelity. The ER recommends that DHHS validate the fidelity self-assessments, and then develop some targeted technical assistance efforts to assist CMHCs to address their specific fidelity issues.
3. SE providers acknowledge limitations in their ability to conduct the kind of job development necessary for the identification and cultivation of competitive, community-based work. DHHS should investigate provider concerns in this area and take steps to offer additional technical assistance or other programmatic resources.
4. Overall, there appears to be a need for greater emphasis on competitive employment for SE participants. DHHS will need to collect competitive employment data as a first step in addressing this issue; this should include the number of people who are working in competitive employment, the number of hours they are working, and what they earn. Clearly, concrete data is necessary to address anecdotal impressions and to develop specific action plans for increasing competitive employment as indicated by the data.

Supportive Housing (SH)

The CMHA requires the State to achieve a target capacity of 340 supportive housing units funded through the Bridge subsidy program by June 30, 2015. At the time of the previous ER report in December of 2014, the State reported that there were 270 individuals under lease in Bridge subsidy funded apartments. As of May of 2015, the State reported an overall net increase in the program of seven people – resulting in a total of 277 participants. However, the actual number of new Bridge subsidy participants living in supportive housing cannot be determined without additional data specific to the dynamics of mental health bridge subsidy programs.

In order to determine the total number of new people added between December and May, the State must also collect data on the following:

1. The number of Bridge subsidy participants who relinquished their Bridge subsidy during that time period because they received a Housing Choice Voucher or other affordable housing subsidy;
2. The number of people who left the Bridge subsidy program during that time period, if any, without receiving a permanent housing subsidy;[3]
3. The number of new people who leased Bridge subsidy apartments during that time period after being given a "turnover" Bridge subsidy made available through (1) or (2) above;
4. The number of new people who leased Bridge subsidy apartments during that time period after being given a new Bridge subsidy.

DHHS reports that an additional 63 individuals have been approved for Bridge subsidies, and are currently in the housing search phase.[4] The 277 current leases, plus the 63 approved but not leased, equals the CMHA target capacity of 340 supportive housing units to be available as of June 30, 2015. The housing search and lease-up process is different for each person, so it is not possible to predict when all 63 people with approved Bridge subsidies will be housed. .

DHHS also reports that an additional 110 Bridge subsidies will be funded in the upcoming year, which would result in the State meeting the CMHA total of 450 SH units by June 30, 2016.

The Bridge program appears to be successful in assisting people in the target population to obtain independent supportive housing in the community. Current concerns about the program at this point are related to: (a) criteria for approval of a Bridge subsidy; (b) transparency of the application and access process for Bridge rental assistance; (c) timely and accurate reporting of data about the Bridge program, including the information noted above; and (d) the amount and sufficiency of services and supports associated with the housing.

[3] All rental subsidy programs experience some normal attrition due to changes in circumstances, such as a move out of state, certain changes in family composition, death, etc.

[4] This information was provided verbally during the All Parties meeting on June 10, 2015. The ER will seek additional information and documentation to support this number.

DHHS reports that currently there is no wait list for Bridge subsidies. This may be due to the DHHS published Bridge program eligibility criteria being narrower than the target population criteria included in the CMHA. There also appears to be a lack of consistent knowledge in the field about the process and criteria for accessing the Bridge program. In combination, these factors seem to create unnecessary barriers for people in the target population to access the program. DHHS has acknowledged that it needs a more transparent set of policies and procedures to govern the program, and will be working with the ER and the parties to establish such policies in the near future. DHHS will also review the criteria for approval for Bridge subsidies and may modify them to be broader and better in conformance with the CMHA target population definition. The State will also establish written notice of acceptance/denial and appeals procedures. The ER will discuss with the parties a time frame for completing these activities. It is expected that drafts of these policies and procedures will begin circulating for review no later than September 1, 2015.

People receiving a Bridge subsidy, whether approved or fully leased, are not automatically entered into the Phoenix 2 system. Many of these individuals are likely clients of the CMHC system, and thus included in Phoenix 2, but whether or not they have a Bridge subsidy is not recorded in Phoenix. Thus, the current Phoenix 2 system is not capable of reporting: (a) the number of unique individuals receiving the Bridge subsidy at any given time; (b) whether the individual receiving the Bridge subsidy is connected to the local CMHC or other service provider in the area; or (c) the numbers and types of services and supports provided by the CMHC to facilitate successful tenancy and community tenure. DHHS has been testing a method for linking the Bridge subsidy participants with the Phoenix 2 system, and it seems to be feasible to accomplish this objective. If that methodology is implemented, then it will be possible to generate more reliable and timely reports on SH access and utilization.

However, even with successful linkage to the Phoenix 2 system, there will be some continuing gaps in information. For example, the number of people leaving the Bridge program, and the reason for departure, will not be available except as special reports for the SH vendor. There also does not at this time seem to be a method for identifying whether any SH tenants are sharing living arrangements with other people in the target population; this information is necessary to help determine whether the State's SH comports with CMHA parameters. DHHS will have to work with the vendor to design and implement revised reporting that will complement the Phoenix 2 reports. The ER expects that the data reporting issues will be addressed and proposed solutions shared with the ER and the parties over the next three months. The ER also expects in upcoming months to conduct more in-depth reviews of SH and associated services and supports to see if they are meeting the needs of individuals, helping them to achieve positive outcomes per CMHA parameters.

Transition Planning

During the past six months the ER has visited both Glencliff and NHH 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 patients in both facilities were observed. In addition, discussions were held with both line staff and senior clinicians/administrators regarding potential barriers to effective discharge to the most appropriate community settings for patients at both facilities. The following is a brief summary of information related to transition planning and effective community discharges for each facility.

1. Glencliff

In the three years from June 2012 through May 2015, Glencliff effectuated only 10 discharges from the facility; two of these were discharged between December 2014 and May 2015. About half of the 10 were placed in institutional settings: four were discharged to other nursing facilities and one was returned to prison. The average length of stay at Glencliff of this discharge cohort was 1,437 days – or almost four years. Only one of the individuals discharged during this time frame stayed for less than a year (167 days); two individuals had lived at Glencliff for more than nine years. As of May 13, 2015, the State reports that there have been no readmissions to Glencliff among this 10-person discharge cohort.

At the same time, Glencliff has had 46 admissions, nine of these since December 2014. Glencliff reports that there are approximately 15 individuals on the wait list for admission as of May 22, 2015.

DHHS is endeavoring to access the Enhanced Family Care service modality included in New Hampshire's Home and Community-Based Services waiver for people who are aged or have disabilities. Currently, there are five individuals at Glencliff for whom this option is being developed. Although this option could be an effective and appropriate alternative to the creation of new intensive group home beds, some barriers to implementation have been encountered. Specifically, respondents have noted that the Enhanced Family Care rates may be too low to attract families to provide this level of care. This factor may be contributing to the overall dearth of providers of this service reported by some participants in the process. Glencliff and DHHS officials are reported to be working towards solutions to these issues. As of May 15, 2015, no individuals have yet been successfully discharged from Glencliff using Enhanced Family Care.

The initial review of transition planning processes at Glencliff did not include a full quality review, review of records, or interviews with patients for whom transition planning was being conducted. These activities will be included in subsequent reviews, after which it will be possible to comment more confidently on the quality and effectiveness of transition planning per CMHA parameters.

It should be noted that staff at Glencliff appear to be taking transition planning very seriously and appear to be committed to effectuating community discharges. Transition planning appears

to be done conscientiously, but also appears to be quite cautious. This could be an indicator that, early in the process, transition planning staff need more exposure to the success of community living alternatives. Absent such experience, there is a temptation be overly concerned about replicating the assumed safety and comprehensiveness of care of the facility before transition plans are effectuated. Based on reports from both Glencliff and several CMHCs, it appears that CMHCs are increasing their efforts to communicate and coordinate with Glencliff, and to take greater responsibility for working towards discharge for residents of Glencliff previously living in their catchment areas. Increased inreach on the part of CMHCs should assist Glencliff transition planners to increase their knowledge of and comfort with community living arrangements available to effectuate discharges. The ER will document inreach activities more clearly within the next six months.

In addition to enhancing transition planning and discharges to the community of existing residents of Glencliff, it is important to also focus on the 15 or so people typically waiting for admission to Glencliff at any given time. It is frequently more feasible and desirable to divert individuals who have not yet been admitted, and have not yet had long lengths of stay away from their home communities.

It is recommended that the State's Central Team, when appointed, make it a priority to address the issues noted above related to the Enhanced Family Care program. The resources set aside under the CMHA for these community settings offer a way to supplement existing waiver rates/state plan services for more complex clients, if that proves to be a barrier to effectively using this program. Over time, the Central Team should also assist DHHS to address the need to enhance and facilitate transition planning and community discharges from Glencliff through increased knowledge and trust of community alternatives in concert with more aggressive inreach from the CMHCs (and potentially the Peer Support Agencies).

PASSR

DHHS has selected the University of Massachusetts Medical School to perform PASSR functions in New Hampshire. Based on information supplied by DHHS, it is believed that PASSR reviews applicable to Glencliff applicants and residents will begin in July 2015. The ER will begin monitoring implementation of PASSR vis-à-vis Glencliff applicants and residents in the next few months.

New Hampshire Hospital

From January 2014 through mid-May 2015, the State reports that NHH effected a total of 2,093 discharges. Of these, 1,580 (75%) were discharged to home, of whom 621 were living alone and 959 were living at home with others. Eight individuals (0.04%) were discharged to Glencliff; 39 (1.9%) were transferred to an inpatient rehabilitation facility or nursing home; 79 (3.8%) were discharged to a shelter or motel; 71 (3.4%) were discharged to a group home, DDS supported living, or peer support housing; and 32 (1.5%) went to a jail or correctional facility. The

discharge destination was recorded as unknown for 264 (12.6%) of the discharges during this time frame.

The State reports that the median length of stay for 2015 (through March 2015) has been 10 days, and the mean has been 32 days. The large difference between the mean and median lengths of stay is explained by the relatively small portion of the inpatient cohort that has stays for long periods of time prior to discharge. A point-in-time snapshot of the NHH census on May 21, 2015, showed that 60% of the patients had been in the hospital for 90 days or less, whereas 40% had been inpatients for 91 days or more. Anecdotal information provided by NHH indicates that about 40 of the longer stay patients are in active transition/discharge planning at any given time.

The discharge data suggest a bifurcated inpatient cohort. The vast majority of discharges are of people who have been admitted and discharged after a median length of stay of 10 days. Transition planning for this short stay group begins on the day of admission, and is almost always focused on restoring functioning so that a person can return to her/his previous living arrangement with ongoing services from the local CMHC.

The second group, patients staying longer than 90 days, typically presents greater challenges to discharge than the shorter-stay cohort of patients. First, people who stay longer are more likely to have some combination of complex psychiatric and medical conditions, and/or criminal justice issues, which make planning for transition to the community somewhat more difficult. In addition, after staying 90 days or more, it is more likely that a person's housing and community support system is no longer in place, thereby increasing the difficulty of arranging for an appropriate living arrangement with needed and chosen supports to effectuate timely discharges. These factors were reinforced as the ER observed transition planning activities and discussed transition planning with staff of the hospital.

The ER identified several specific issues and discussed them with State representatives while reviewing the transition planning process at NHH. One issue is the need to obtain intake assessments before establishing discharge plans for people who are not already connected to the CMHC system. Both NHH and several of the CMHCs verified that there is no current source of reimbursement for CMHCs when CMHC staff travel to NHH to conduct such assessments as part of the transition planning process. This results in a potential delay in accessing and initiating follow-along services and supports following discharge for some individuals, and has been reported to be a factor slowing down the discharge process.

Another barrier is the amount of time needed to effectuate discharges for people for whom Department of Corrections approval is necessary prior to discharge from NHH. It has been reported that several months can elapse between the time a person is clinically ready for discharge and the approval is given by DoC. At the time of one site visit by the ER, it was

reported that there were currently four such individuals awaiting DoC clearance before they could be discharged.

As with the Glencliff review summarized above, the initial review of transition planning processes at NHH did not include a full quality review, review of records, or interviews with patients for whom transition planning was being conducted. These activities will be included in subsequent reviews, after which it will be possible to comment more confidently on the quality and effectiveness of transition planning per CMHA parameters.

NHH and DRF Admissions and Waiting Lists

The Transition Planning requirements of the CMHA are focused on assisting people to move from inpatient and institutional settings into integrated community settings, and thereby to have successful lives in communities of their choice. Thus, the discharge data presented above are a key part of assessing progress and performance related to transition planning.

Admissions, readmission and hospital wait list information and trends are also relevant to transition planning, and more generally speaks to the adequacy of community capacity in the State's mental health system. Any hospital contact or inpatient admission involves a certain degree of disruption to a person's community living arrangements and supports, and the longer a person stays in the hospital or nursing facility the more likely it becomes that these arrangements and supports will have to be re-built to effectuate discharge. Each admission creates a new set of issues and dynamics that both the admitting facility and the CMHC/community supports system must resolve.

In addition, readmissions within 30, 90, and 180 days are considered to be an important indicator of the degree to which transition planning and community follow-through related to facility discharges is being carried out effectively. Moreover, contacts with, and prolonged waits at, hospital emergency departments (ED) reflect a lack of capacity in the community to address mental health crises. For these reasons the ER will be tracking and periodically reporting on NHH and DRF admission and readmission data, and also hospital ED wait list data, as indicators of how the overall system is functioning relative to reduced use of inpatient and nursing facilities and increased use of community alternatives.

According to data supplied by DHHS, in the first 10 months of FY 2015 NHH has had 1,246 admissions. The average daily census during these 10 months has been 129.9, a 97% occupancy rate. Of these 1,246 admissions, a total of 223 were re-admissions within 180 days of discharge (17.9% of admissions for the 10-month period). Of these 223 readmissions total, 128 (57.4%) were readmitted within 30 days of discharge; and an additional 76 (34.1%) were readmitted within 90 days of discharge. Thus, over 90% of the readmission cohort in FY 2015 we readmitted within 90 days of discharge.

The State reports that the two Designated Receiving Facilities (DRFs) at local hospitals (Elliot and Franklin) together have had 606 admissions to date in FY 2015; this projects to 808 admissions for the entire fiscal year. Admissions to DRFs have been steadily increasing in recent years – up 58% since 2013. This warrants close monitoring going forward. In addition, the Cypress Center, which is an Acute Psychiatric Residential Treatment Program (APRTP), had 590 admissions so far in FY 2015; this projects to over 780 admissions for the fiscal year. Current data on the average length of stay in Franklin and Elliot are not available. The average length of stay at Cypress Center has been 4.6 days during SFY 2015.[5]

The State reports that 75 percent of the admissions to the Franklin DRF during FY 2015 have been Involuntary Emergency Admissions (IEAs). At Elliot DRF, 20% of the FY 2015 admissions have been IEAs. At Cypress Center 15% of the admissions in FY have been IEAs. All three facilities have increased the proportion of IEA admissions compared to previous years. This too warrants close monitoring going forward.

Because NHH operates at full occupancy, a wait list has been established throughout New Hampshire of people awaiting admission to the facility, typically at a hospital ED. In FY 2015, the monthly average number of people waiting each day for a bed at NHH has been 22.3. The monthly average of people waiting has fluctuated between a high of 33 people in September 2014 to a low of 10 people in April 2015. Wait list data from January 2013 through the present seem to indicate that the spring months tend to have fewer people waiting on a daily basis, while the late summer and fall months experience spikes in the number of people waiting on a daily basis.

The Central Team

The CMHA requires establishment of a ***"…Central Team to assist in addressing and overcoming any of the barriers to discharge identified during transition planning and/or set forth in the transition plans." (VI.A.6)*** This team is currently in formation, but has not yet been appointed or begun meeting. Implementation of this essential component was to have been substantially completed by June 30, 2014. As will be noted below, the ER believes implementation of this team should be among the highest priorities for the State in the next few months. Several of the issues related to transition planning identified above could be addressed by the Central Team as soon as it is formed. These include, but are not limited to:

- Work towards solutions for accessing Enhanced Family Care services under the aged and disability waiver to facilitate discharges to the community form Glencliff;
- Working with the CMHCs and perhaps the Peer Support Agencies to develop and implement enhanced inreach activities related to the transition planning process; and

[5] One data point for future review is whether, or how many, people are discharged from DRFs to NHH.

Peer and Family Supports

Per the CMHA, the State has maintained its contract with NAMI New Hampshire for family support services.

New Hampshire reports that it has a total of 16 peer support agency program sites, with at least one program site in each of the ten regions. The State reports that these sites have a cumulative total of 2,924 members, and there is an active daily participation rate of 169 people statewide. For a variety of geographic and historical reasons, the membership and daily participation numbers vary considerably among the 16 program sites. All peer support centers report being open eight hours per day, five and one half days per week.

The CMHA does not have specific membership or active daily participation targets. Other than the use of trained peer supports staff to provide services to help individuals in managing and coping with the symptoms of their illness, self advocacy, and identifying and using natural supports, there are no specific requirements as to the functions and activities of the peer supports programs.

Nonetheless, the peer supports programs appear to be a valuable resource for the overall New Hampshire community mental health system. Peer respite services are one good example of this. Utilization of peers as members of ACT teams and in the new mobile crisis services is already included in the CMHA, but peers can also be useful in hospital inreach related to transition planning, and with regard to employment-related activities and objectives.

IV. Quality

The CMHA has specific quality and participant-focused outcomes defined for the interventions and community services. In addition, the CMHA includes a set of overall quality standards applicable to the entirety of the CMHA and its priority target population. The CMHA states:

> The goal of the State's system will be to ensure that ***all mental health and other services/supports*** funded by the State are of good quality and are sufficient to provide ***reasonable opportunities[6] to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harms, and decrease the incidence of hospital contacts and institutionalization***. [***ER emphasis added***] (Section VII.A)

The QM/QSR System

DHHS has hired a team of QM/QSR staff, and has begun working on a QM/QSR system design and process. This work is in the very early development stages and will require a significant

[6] It should be noted that in this context the term "reasonable opportunities" is intended to reflect that not all members of the target population will choose CMHA services and not all will equally benefit from such services,

investment of time and effort over the next six months in order to adequately measure the range of service fidelity, participant outcome and quality assurance issues identified above. The ER will be working with the QM/QSR Team over the next several months to assist in the development of this system, including the use of data as described throughout this report, and including the proposed design, methodology and implementation of a client review process. Early in the design process, there will be opportunities for all parties, particularly the plaintiffs, to participate in this early design phase, and to review and comment on QM/QSR materials as these are drafted.

The ER has been working with all parties to identify certain consumer focused outcome measures, for the most part available from existing data sources, which could be used as indicators of results for people in the target population consistent with the quality parameters included above and in other sections of the CMHA. The State reports some questions and concerns about some of the suggested consumer focused outcome and quality indicators, and thus the ER will continue working over the next three months with all parties to address these concerns and to reach consensus on a set of key indicators that can be employed in concert with qualitative and process related information derived through the QM/QSR process.

V. Summary of Expert Reviewer Observations

The ER has now been in place for 12 months. Much of the first year of activity for the ER has focused on:

1. Developing a comprehensive understanding of the New Hampshire Mental Health system as a foundation for tracking progress and performance related to the CMHA as well as for recommending feasible implementation strategies;
2. Working with state officials to identify data elements and sources to be used to track and document progress and performance related to the CMHA;
3. Beginning to work with state officials on the implementation of QM/QSR activities related to the CMHA; and
4. Working with all parties to the CMHA to develop mutual understandings of how the data tracking and quality/QSR activities will be used to provide the most accurate and timely information to all parties with regard to attainment of the performance targets and quality requirements of the CMHA.

Considerable work will be necessary to complete the development of the data tracking and QM/QSR elements of CMHA implementation. However, there is sufficient information available and experience derived from the first year of ER activity to identify specific priorities for attention and action in the up-coming months. Specifically, there are five major areas of concern that need to be addressed to assure that CMHA implementation and quality objectives can be met over the next six months:

1. The State needs to continue working to implement improvements in data collection, analysis and reporting consistent with the CMHA.
2. The State needs to continue expansion of capacity of ACT services for priority target population members under the CMHA. As of the most recent ACT report, there is functional capacity for 1,025 ACT participants, and the CMHA standard for ACT is capacity for 1,300 as of June 30, 2015. Renewed efforts will be required to meet the CMHA ACT capacity requirements scheduled for June 30, 2015. As noted in the body of the report, the current active ACT census is 669.lightly less than 2/3 of the reported capacity of 1,025. Active census, or ACT utilization, is not a specific compliance measure in the CMHA. However, the ER notes that this unused capacity presents an excellent opportunity for DHHS to expand needed services to the target population. Consistency of operations and attainment of CMHA staffing requirements also remain to be addressed within the ACT program statewide.
3. The State needs to immediately implement the Central Team, an essential component of NHH and Glencliff transition planning under the CMHA. DHHS is still developing a plan for the Central Team; implementation of this essential component was to have been substantially completed by June 30, 2014, yet the membership and processes associated with Central Team activities have not yet been executed.
4. The State needs to continue efforts to increase penetration of evidence-based SE services for members of the priority target population so as to achieve desired outcomes per CMHA criteria. The June 30, 2015 CMHA standard for SE penetration is 16.1%. The most recent statewide penetration rate reported by DHHS is 11.3%. Additional efforts to attain fidelity standards for SE in certain CMHCs will also be required.
5. The State needs to continue the rapid development the DHHS QM/QSR process, with an initial emphasis on assuring the quality and consumer-focused effectiveness of ACT, SE, SH, and facility transition planning. The QM/QSR capacity is essential to DHHS' on-going efforts to use data on outcomes and performance to hold CMHCs and related contractors accountable under the terms of their contracts and the CMHA.

As of this writing, it is assumed that the contract for mobile crisis services in the Concord region will be in place, effective June 30, 2015. It is not known at what point effective capacity of the mobile team will be in place to actually respond to mental health crises in the community. Monitoring of this implementation effort will be one key priority of the ER over the next three months.

Nothing in the above list of concerns should be interpreted to disregard the level of commitment of New Hampshire officials, state agencies, CMHCs and other contractors to faithful implementation of the CMHA. To date, the ER has seen no evidence of diminished commitment or reduced willingness to collaborate on the part of the State. Nonetheless, an increased level of management attention and staff capacity will be required to prevent further slippage in meeting

CMHA standards. As with the previous ER report, DHHS may have to develop statewide strategies to address technical assistance and workforce development strategies to assist CMHCs to meet the CMHA standards. DHHS assistance with finding appropriate reimbursements/financing for certain elements of CMHA services and facility transition services is also likely to be necessary.

Central oversight of the implementation of the CMHA continues to be a critical element of overall CMHA implementation and performance objectives. Clear accountabilities for CMHA implementation and high quality management of services for the CMHA target population need to be reinforced at the state and contractor levels. Equally important, the State will need to increase its efforts to develop and use both quantitative and qualitative data to assure that accountability is maintained and that corrective actions are taken when necessary.