New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Six

June 30, 2017

I. Introduction

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

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

In this six-month period (January 1, 2017 through June 30, 2017), the ER has continued to observe the State's work to implement certain key service elements of the CMHA, and has continued to have discussions with relevant parties related to implementation efforts and the documentation of progress and performance consistent with the standards and requirements of the CMHA. During this period, the ER:

- Conducted an on-site review of Assertive Community Treatment (ACT) teams/services and Supported Employment (SE) services at the Monadnock CMHC. A non-random sample of ACT and SE records was reviewed at that site;
- 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 a resident to discuss transition planning processes and issues;
- Met with DHHS staff involved with the PASRR program to discuss the new contract for PASRR services and to identify data reporting issues;

- Met with the Mobile Crisis Team (MCT) of Riverbend Mental Health Center (Concord NH) and with staff of the Yellow Pod mental health crisis program at Concord Hospital;
- Observed the five-day QSR review at Nashua Community Mental Health Center;
- Met with the DHHS CMHA leadership team to discuss progress in the implementation of CMHA standards and requirements;
- Met with the New Hampshire NAMI Public Policy Committee;
- Participated in several meetings with representatives of the Plaintiffs and the United States (hereinafter "Plaintiffs");
- Met twice with DHHS Quality Management/Quality Service Review (QM/QSR) staff to discuss refinements to the QSR process; and
- Convened two all parties meetings to discuss design and implementation issues related to the QSR process and Glencliff transitions to integrated community settings.

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

Summary of Progress to Date

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

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

   ER Finding: The State has implemented this recommendation by circulating such a plan, and continues to track and report on its implementation of various action steps and limited progress towards compliance with CMHA requirements. Failure to achieve State benchmarks for increased ACT capacity under the plan may require further revision to, and enhancement of, identified action steps. The most recent version of this report (March, 2017) is included as Appendix B to this report.

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

ER Finding: The State has implemented this recommendation by circulating such a plan, and continues to track and report on its implementation of various action steps and progress towards compliance with CMHA requirements.

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

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

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

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

   ER Finding: By agreement with the ER and representatives of the Plaintiffs, this action step has been delayed in order to further negotiate the scope and content of the QSR process. A more detailed discussion of progress with regard to the QSR is included under the QSR section of this report.

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

   ER Finding: Ten QSR site visits have been conducted. Based on the experience of these site visits, and on input from representatives of the Plaintiffs, a revised set of QSR instruments and protocols are currently in development. The revisions are expected to be completed by August 9, 2017. As of the date of this Report, QSR Quality Improvement Plans have not yet been shared with the ER or the Plaintiffs. Six of ten QSR site visit reports have yet to be made public.

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

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

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

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

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

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

     ER Finding: The State has implemented this recommendation.

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

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

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

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

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

     ER Finding: As of June 30, 2017, DHHS is currently developing the system capacity to produce these data.

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

ER Finding: The State remains out of compliance with the ACT standards of the CMHA. The State has begun to make progress towards compliance with the Glencliff requirements in the CMHA. See more detailed discussion of these issues under the ACT and Glencliff Transitions sections of this report. The ER notes that the State remains in substantial compliance with the SE penetration rate requirements of the CMHA. The ER will continue to work with the State to document that: (a) that SE services are delivered with adequate intensity and duration to meet individuals' needs; and (b) that SE services are resulting in integrated, competitive employment.

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

    ER Finding: The ER believes that both NHH and Glencliff have evidenced, at a leadership and a staff level, increased efforts and commitment to facilitating timely transitions to integrated community settings, albeit with modest result to date. Transitions from Glencliff to integrated community settings appear to be accelerating.

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 (March 2017), incorporating standardized report formats with clear labeling and date ranges for several important areas of CMHA performance. The ability to conduct and report longitudinal analyses of trends in certain key indicators of CMHA performance continues to improve.

The Quarterly reports now include data from the new mobile crisis services in the Concord and Manchester Regions; data on discharge destinations from NHH, the DRFs, and Glencliff; admission, discharge and length of stay data for New Hampshire's DRFs; and data on utilization of the Housing Bridge 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 are discussed in the SE section of this report. In addition, needed revisions to the QSR instruments and protocols may

provide more information on the degree to which SE participants are attaining competitive employment.

Another gap in data is related to people receiving Supported Housing (SH) under the Housing Bridge Subsidy Program. These participants are not yet clearly identified in the Phoenix II system, and thus it is difficult to document the degree to which these individuals are: (a) connected to local CMHC services and supports; (b) actually receiving services and supports to meet their individualized needs on a regular basis in the community; or (c) living at addresses with two or fewer SH units.[1] 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. Without the information above, the ER is unable to determine whether or not the State has achieved substantial compliance with the CMHA outcomes and requirements for SH. Other outstanding data requests include SH data on applications, time until eligibility determination, time on waiting list, and the reason for ineligibility determinations,

III. CMHA Services

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

Mobile/Crisis Services and Crisis Apartments

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

The CMHA specified that a second MCT and Crisis Apartments be established in the Manchester region by June 30, 2016 (V.C.3(b)). The Mental Health Center of Greater Manchester was selected to implement that program. A third MCT and Crisis Apartment program is required to be operational in the Nashua region by June 30, 2017. The contract for that program has been awarded to Harbor Homes in Nashua. DHHS reports that Harbor Homes is on track to open the MCT and Crisis Apartments on schedule by June 30, 2017.

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

Table I

[1] ":...no more than two units or 10 percent of the units in a multi-unit building…" CMHA V.E.1(b)

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

	Concord Oct – Dec 2016	Concord Jan – Mar 2017	Manchester Oct – Dec 2016	Manchester Jan –Mar 2017
Total unduplicated people served	535	608	NA	413
Services provided in response to immediate crisis: • Phone support/triage • Mobile assessments • Crisis stabilization appointments • Emergency services medication appointments • Office based urgent assessments	 666 157 61 77 53	 641 157 62 67 82	NA	 1168 154 1 75
Services provided after the immediate crisis: • Phone support/triage • Mobile assessments • Crisis stabilization appointments • Emergency services medication appointments • Office based Urgent Assessments	 197 33 61 49 53	 179 30 62 40 82	NA	NA NA NA NA NA NA
Referral source: • Self • Family • Guardian • Mental health provider • Primary care provider • Hospital emergency department • Police • CMHC Internal	 254 71 19 31 12 33 12 50	 258 110 11 32 16 58 12 41	NA	 275 152 3 17 10 4 45 68
Crisis apartment admissions: • Bed days • Average length of stay	85 316 3.7	95 392 4.1	NA	5 17 3.4
Law enforcement involvement	57	52	NA	45

Total hospital diversions*	327	488	NA	643

*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 in both Regions. The ER is concerned that the ration of mobile team responses to the total number of crisis calls is low. The ER is seeking data from other MCTs throughout the U.S. to see if there are norms or a longer history of implementation to assess the degree to which this ratio may be an issue. The ER plans to work with the State to document: 1) the number of times a mobile team was requested but not dispatched, and the reason for that decision; 2) the criteria used to determine whether a mobile versus office-based response is appropriate; and 3) the number of times a mobile response was determined to be appropriate, but the team could not be dispatched in a timely way.

It has been recommended that DHHS add questions to the QSR interview guides to elicit information about the quality and effectiveness of these programs, and to report on that information in the updated QSR instrument. This is one way to determine if individuals who would have benefited from a mobile crisis response received the crisis support their situation required.

The ER notes that between the two MCT programs a total of 1,131 hospital diversions were reported by the Concord and Manchester MCTs for the three month period ending March, 2017. This is a very positive result from the MCTs in those two regions. However, one would expect this level of reported diversions each quarter to have a more significant impact on the numbers of people presenting to, and boarding in, hospital EDs across the state. And, admissions to NHH and the DRFs have not decreased substantially as the MCTs were implemented. There are many factors that could account for these seemingly contradictory effects. The ER plans to work closely with DHHS over the next six month period to validate the numbers of reported diversions, and to obtain a clearer picture about ways MCTs and Crisis Apartments are impacting members of the CMHA target population.

Assertive Community Treatment (ACT)

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

1. By October 1, 2014, the State will ensure that all of its 11 existing adult ACT teams operate in accordance with the standards set forth in Section V.D.2;
2. By June 30, 2014, the State will ensure that each mental health region has at least one adult ACT team;
3. By June 30, 2016, the State will provide ACT team services consistent with the standards set forth above in Section V.D.2 with the capacity to serve at least 1,500 individuals in the Target Population at any given time; and

4. By June 30, 2017, the State, through its community mental health providers, will identify and maintain a list of all individuals admitted to, or at risk serious risk of being admitted to, NHH and/or Glencliff for whom ACT services are needed but not available, and develop effective regional and statewide plans for providing sufficient ACT services to ensure reasonable access by eligible individuals in the future.

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

As displayed in Table II below, the staff capacity of the 12 adult ACT teams in New Hampshire has increased by only 1.21 FTEs in the first three months of 2017. During the same time, the total active caseload has increased by only 74 individuals. As of the date of this report, the State provided ACT services to 913 unique consumers and as a result is delivering only 61 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 March 2017

Region	FTE May-15	FTE Sep-15	FTE Dec-15	FTE Mar-16	FTE Sep – 16	FTE Dec-16	FTE Mar-17
Northern	14.80	11.29	11.85	11.15	10.25	11.49	11.89
West Central	3.00	3.83	2.78	4.37	5.44	5.5	7.75
Genesis	7.10	7.5	6.9	7.4	7	11	11
Riverbend	7.00	7.3	7.3	7	7.5	9	10
Monadnock	8.20	8.5	8.4	7.75	7.25	7.25	6.7
Greater Nashua 1	8.70	5.98	7.75	6.5	6.25	6.25	6.25
Greater Nashua 2					5.25	5.25	5.25
Manchester – CTT					15.46	15.53	14.79
Manchester – MCST					20.24	21.37	21.86
Seacoast	12.80	11.77	12.37	11.53	8.73	9.53	9.53
Community Partners	8.20	8.7	8.3	5.9	8.03	6.85	4.08
Center for Life Management	7.80	6.36	8.46	8.16	7.91	7.17	8.3
Total	77.60	71.23	74.11	69.76	109.31	116.19	117.4

It is clear from this table that overall ACT staffing has remained at best static, and in some regions has decreased over the past three reporting periods. This is true despite previous ER findings that New Hampshire was out of compliance with the standards of the CMHA. However, it should be emphasized that the combined ACT teams have a reported March 2017 staff complement of 117.4 FTEs, which is sufficient capacity to serve 1,174 individuals. But, in March, all ACT teams served only 913 individuals. At a minimum, the existing teams should be able to accept an additional 261 new ACT clients without adding any more staff. Tapping into this unused capacity could have an impact on alleviating ED boarding and hospital readmission rates across the state.

The current pace of client outreach and engagement is not sufficient to fill current or future required ACT team capacity. Similarly, team composition, staff recruitment and capacity development are not sufficient to satisfy the State's outstanding obligations under the CMHA. Currently, there is a gap of 587 people between the active caseload and the 1,500 ACT capacity required by the CMHA 12 months ago.

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 Month: May 2015 through March 2107

Region	Active Cases May-15	Active Cases Sep-15	Active Cases Dec-15	Active Cases Mar-15	Active Cases Dec-16	Active Cases Mar-17	% change Dec-Mar
Northern	60	72	74	79	104	108	3.85%
West Central	16	19	21	26	32	53	65.63%
Genesis	22	30	34	39	64	70	9.38%
Riverbend	79	60	56	70	73	83	13.70%
Monadnock	47	54	61	68	63	64	1.59%
Greater Nashua	63	74	72	72	74	83	12.16%
Manchester	254	265	270	293	248	270	8.87%
Seacoast	73	65	65	72	65	64	-1.54%
Community Partners	16	70	76	73	70	67	-4.29%
Center for Life Management	39	37	40	49	47	55	17.02%
Total*	669	746	766	839	839	913	8.82%

* *unduplicated across regions*

Four of the 12 adult ACT teams now have fewer than the 7 - 10 professionals specified for ACT teams in the CMHA, as opposed to the three teams with reported staffing below the defined threshold noted in the previous report. Two teams continue to report having no peer specialist on the ACT Team. Five teams now report having at least one FTE peer specialist, but that means that seven of the 12 teams report having less than one FTE peer on the team. Four teams continue to report having less than .5 FTE combined psychiatry/nurse practitioner time available to their ACT teams, and two teams report having less than 0.5 FTE nursing on the team; eight of the 12 teams report having less than one FTE nurse per team.

Ongoing 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) incorporating a small increase in ACT funding into the Medicaid rates for CMHCs; (d) active on-site monitoring and technical assistance for CMHCs not yet

meeting CMHA ACT standards; and (e) substantial and coordinated efforts to address workforce recruitment and retention. However, external and self-reported fidelity reviews for the 10 CMHC regions have revealed deficient practices that are not in fidelity with the ACT model. See Appendix C. Compliance letters and Performance Improvement Plans (PIPs) have been initiated in several of the Regions. Over the next six months, the ER will look for evidence that these plans have been implemented.

Initial QSR field test reports also revealed that several CMHCs failed to ensure individuals were receiving ACT services using the team approach, and with the appropriate frequency to address their individual treatment needs. Quality Improvement Plans for these regions have yet to be shared with the ER or the Plaintiffs. The ER has emphasized to the State that the QSR process must measure the adequacy and effectiveness of individual ACT service provision, in order to demonstrate that these deficiencies are being corrected.

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

DHHS and the CMHCs have been attempting to identify individuals at risk of hospitalization, incarceration or homelessness who might benefit from ACT services. Individuals boarding in hospital emergency departments waiting for a psychiatric hospital admission, or who have done so in the recent past, are one important source of potential referrals. DHHS is currently tracking the extent to which identifying and referring these individuals to CMHCS is: (a) reducing ED boarding episodes and lengths of stay; and (b) resulting in enrollment of new qualified individuals in ACT services. As noted in the hospital readmission discussion below, almost one-third of all those discharged out of NHH return for readmission within 180 days. Robust ACT services can help to reduce the number of hospital readmissions throughout the state if affected individuals are promptly screened and referred, and their regional ACT teams have the capacity to deliver needed services.

At this point it must be the priority of the State and the CMHCs to focus on: 1) ensuring required ACT team composition; 2) utilizing existing ACT team capacity; 3) increasing new ACT team capacity; and 4) outreach to and enrollment of new ACT clients.

Supported Employment

Pursuant to the CMHA's SE requirements, the State must accomplish three things: 1) provide SE services in the amount, duration, and intensity to allow individuals the opportunity to work the

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

For this reporting period, the State reports that it has achieved a statewide SE penetration rate of 23.2 percent, 4.6 percentage points higher than the 18.6% penetration rate specified for June 30, 2017 in the CMHA. Table IV below shows the SE penetration rates for each of the 10 Regional CMHCs in New Hampshire.

Table IV

Self-Reported CMHC SE Penetration Rates*

	Penetration Mar-16	Penetration Oct-16	Penetration Sep-16	Penetration Dec-16	Penetration Mar-17
Northern	10.60%	14.00%	14.20%	27.00%	32.30%
West Central	15.30%	17.50%	16.70%	21.50%	23.20%
Genesis	9.60%	14.10%	14.10%	14.50%	12.60%
Riverbend	14.10%	13.70%	13.50%	13.80%	15.00%
Monadnock	20.50%	20.40%	22.30%	17.90%	13.50%
Greater Nashua	9.00%	11.90%	11.10%	12.40%	15.00%
Manchester	36.70%	37.10%	38.50%	43.10%	39.80%
Seacoast	11.00%	12.00%	11.60%	12.00%	14.40%
Community Part.	12.60%	10.40%	10.90%	6.80%	7.20%
Center for Life Man.	24.70%	23.00%	24.00%	21.10%	19.70%
CMHA Target	18.10%	18.10%	18.10%	18.10%	18.60%
Statewide Average	19.30%	20.40%	20.90%	22.90%	23.20%

*12 month cumulative total

As noted in Table IV, the State has exceeded the statewide CMHA penetration rate in recent reporting periods. However, six of 10 regions fall below required CMHA penetration rates and penetration rates have decreased since December 2016 in four regions. The New Hampshire DHHS is to be commended for continuing its efforts to: (a) measure the fidelity of SE services on a statewide basis; and (b) work with the six Regions with penetration rates below CMHA criteria to increase access to and delivery of SE services to target population members in their

Regions. The ER will continue to monitor these issues going forward as the State works with the CMHCs to increase penetration rates to at least 18.6 percent in all regions. As with ACT services, the DHHS has implemented a combination of contract compliance, technical assistance, workforce recruitment and retention, and internal and external fidelity reviews to try to assure sufficient quality and accessibility of SE services statewide. [See Appendix C for summaries of the SE fidelity reviews for the CMHCs.]

There is currently no mechanism for measuring whether individuals are receiving SE services consistent with their individual treatment plans, or whether SE services are delivered in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings (V.F.1). The ER has recommended that the QSR process measure whether and to what extent SE services are being delivered consistent with these requirements of the CMHA. 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 March, 2017, DHHS reports having 505 individuals in leased SH apartments, and 48 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 March 2017

Bridge Subsidy Program Information	September 2015	March 2016	September 2016	December 2016	March 2017
Total housing slots (subsidies) available	450	450	479	513	553
Total people for whom rents are being subsidized	376	415	451	481	505
Individuals accepted but waiting to lease	23	22	28	32	48
Individuals currently on the wait list for a bridge subsidy	0	0	0	0	0
Total number served since the inception of the Bridge Subsidy Program	466	518	603	643	675
Total number receiving a Housing Choice (Section 8) Voucher	70	71	83	83	85

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

Table VI

Self-Reported Housing Bridge Subsidy Concentration (Density)

	Septem-ber 2015	March 2016	June 2016	Novem-ber 2016	February 2017	May 2017
Number of properties with one leased SH unit at the same address	290	317	325	339	349	367
Number of properties with two SH units at the same address	27	22	35	24	23	36
Number of properties with three SH units at the same address	2	13	8	13	14	5
Number of properties with four SH units at the same address	4	1	1	3	4	4
Number of properties with five SH units at the same address	1	2	2	0	0	3
Number of properties with six SH units at the same address	1	0	1	1	1	1
Number of properties with seven SH units at the same address					0	2

Data reveals that 95% of the leased units are at a unique address or with one additional unit at that address; 87% of the people in SH are living at addresses with two or fewer SH units. This supports a conclusion that the Bridge Subsidy Program, to a large degree, is operating as a scattered-site program. For the units shown in Table VI at the same address, it is not known at this time whether the unit density standards included in the CMHA are being met. DHHS is collecting information on the total units in each property where there are two or more Bridge units at the same address, and this data will be reported 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 units.[2]

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, June, and December 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. The ER will continue to work with the State to document whether is the State is in substantial compliance with CMHA provisions on the availability and provision of support services to persons in SH..

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;

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

- 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, whether or not support services are adequate to enable the individual to "attain and maintain integrated affordable housing," and whether services are "flexible and available as needed and desired." Most rental assistance programs collect and report such information, given its intrinsic value in monitoring program operations. Further, such data enhances DHHS' ability to demonstrate the timeliness and effectiveness of access of the priority target population to this essential CMHA program component. Most importantly, this data is necessary to help the ER determine compliance with CMHA Sections IV.B, IV.C, and VII.A. The ER will continue to work collaboratively with DHHS to identify sources and methods for such data collection and reporting. As noted in the Data section of this report, the State is developing system functionality to produce these data.

The CMHA also states that: "By June 30, 2017 the State will make all reasonable efforts to apply for and obtain HUD funding for an additional 150 supported housing units for a total of 600 supported housing units." (CMHA V.E.3(e)) In 2015 New Hampshire applied for and was awarded funds for 191 units of supported housing under the HUD Section 811 Program. All of these units are intended to be set aside for people with serious mental illness. As of the writing of this report, 57 of these units have been successfully developed and are occupied by members of the target population. It should be noted that over the life of the Bridge Subsidy Program the State has accessed 85 HUD Housing Choice Vouchers (HCV – Section 8). These have allowed the State to free up 85 Bridge Subsidy units for new applicants.

In addition, the CMHA states that "By January 1, 2017, the State will identify and maintain a waitlist of all individuals within the Target Population requiring supported housing services, and whenever there are 25 individuals on the waitlist, each of whom has been on the waitlist for more

than two months, the State will add program capacity on an ongoing basis sufficient that no individual waits longer than six months for supported housing." The ER will monitor the development and implementation of this waiting list closely going forward, and will report on its maintenance in the next ER report.

Transitions from Institutional to Community Settings

During the past 24 months, the ER has visited both Glencliff and NHH on at least five 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 more 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 four meetings of the Central Team. The CMHA required the State to create a Central Team to overcome barriers to discharge from institutional settings to community settings. The Central Team has now had about 18 months of operational experience, and has started reporting data on its activities. To date, 30 individuals have been submitted to the Central Team, 19 from Glencliff and 11 from NHH. Of these, the State reports that 10 individual cases have been resolved, two individuals are deceased, and 18 individual cases remain under consideration. Table VII below summarizes the discharge barriers that have been identified by the Central Team with regard to these 18 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 from NHH and Glencliff Identified by the Central Team: September 2015

Through March 2017

Discharge Barriers	Number	Percent of Cases (N=18)
Legal	8	44.4%
Residential	17	94.4%

Financial	9	50.0%
Clinical	10	55.5%
Family/Guardian	5	27.7%
Other	4	22.2%

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

Glencliff

In the time period from January through March 2017, Glencliff reports that it has admitted five individuals, and has had seven discharges. There have been no readmissions during this time frame. The wait list for admission has remained relatively constant: averaging 15 people during the past two quarters. The lengths of stay for the seven persons discharged were reported to be 1,024, 1,691, 1,680, 629, 952, 486, and 3,207 days, an average of 1,381 days or 3.8 years.

CMHA VI requires the State to develop effective transition plans for all appropriate residents of NHH and Glencliff and to implement them to enable these individuals to live in integrated community settings. In addition, Section V.E.3(i) of the CMHA also requires the State by June 30, 2017 to: "…have the capacity to serve in the community [a total of 16][3] individuals with mental illness and complex health care needs residing at Glencliff…." The CMHA defines these as: "individuals with mental illness and complex health care needs who could not be cost-effectively served in supported housing."[4] 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 the number of people with complex health conditions transitioned from Glencliff to integrated settings since the inception of the CMHA three years ago increased this quarter from 10 to 12. DHHS has agreed to provide the ER information about the recent two transitions that includes a brief clinical summary, length of stay, location and type of community integrated setting, and array of individual services and supports arranged to support them in the integrated community settings. This information is important to monitor the degree to which individuals with complex medical conditions who could not be cost-effectively be served in supported housing continue to experience transitions to integrated community settings.

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

DHHS/Glencliff has developed a list of ten additional individuals currently undergoing transition planning who could be transitioned when appropriate community settings and services are in place.

DHHS has also begun to implement certain action steps to enhance the process of: (a) identifying Glencliff residents wishing to transition to integrated settings; and (b) to increase the capacity,

[3] Cumulative from CMHA V.E.-(g), (h), and (i).
[4] CMHA V.E.2(a)

variety and geographic accessibility of integrated community settings and services available to meet the needs of these individuals. Both sets of initiatives should facilitate and speed up such community transitions for additional Glencliff residents.

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

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

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

7. Number of individuals engaged in transition planning referred to the Central Team; number of these resolved with an integrated community setting; and elapsed time from referral to resolution.

Preadmission Screening and Resident Review (PASRR)

The ER has met with the DHHS PASRR Team and representatives of the PASRR vendor, and has reviewed the most recent PASRR report. The ER needs to be satisfied that PASRR reviews are being conducted as described under CMHA 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 document compliance with this CMHA requirement.

Based on interviews with the PASRR contractor staff and a review of the data, the ER believes that conscientious efforts are being made to refer people to appropriate community alternatives at the time of initial screening. The ER notes that PASRR screens are typically completed before a person is referred to Glencliff, since Glencliff requires that applicants be rejected by at least three nursing facilities before being considered for admission to Glencliff. Thus, PASRR by itself only indirectly impacts admission decisions to Glencliff. For the next report, the ER will assess whether referrals by the PASRR team to Area Agencies or CMHCs are actually resulting in the development of, and individual transition to, integrated community alternatives.

New Hampshire Hospital

For the time period January through March 2017, DHHS reports that NHH effectuated 263 admissions and 258 discharges. The mean daily census was 146, and the median length of stay for discharges was 12 days.

Table VIII below compares NHH discharge destination information for the five 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	Percent January through March 2017
Home – live alone or with others	74.4%	67.3%	80.2%	85.1%	84.5%
Glencliff	0.4%	0.20%	0.60%	0.36%	1.55%
Homeless Shelter/motel	3.8%	2.4%	2.7%	2.54%	2.71%
Group home 5+/DDS supported living, etc.	3.4%	9.02%	3.2%	1.62%	5.7%
Jail/corrections	1.5%	0.40%	1.4%	2.9%	0.8%
Nursing home/rehab facility	1.9%	3.0%	0.80%	3.6%	1.9%

The State's most recent Quarterly Data Report contains new, consistently reported information on the hospital-based DRFs and The Cypress Center in New Hampshire. It is important to capture the DRF/Cypress Center 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 2016 through March 2017

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Total
Admissions						
Jan - March 2016	69	257	46	65	121	558
April - June 2016	79	205	378	49	92	803
July - Sept 2016	37	207	375	54	114	787
Oct - Dec 2016	39	217	310	43	72	681
Jan - March 2017	65	204	317	48	138	772
Percent involuntary						
Jan - March 2016	53.70%	18.70%	NA	18.50%	30.60%	26.20%*
April - June 2016	55.70%	24.40%	20.40%	4.10%	48.90%	25.50%
July - Sept 2016	43.20%	29.50%	18.90%	13.00%	44.70%	26.20%
Oct - Dec 2016	53.80%	28.60%	17.10%	16.30%	43.10%	25.60%
Jan - March 2017	70.70%	34.30%	21.80%	12.50%	43.50%	32.50%
Average Census						
Jan - March 2016	7.9	14.7	NA	19.7	18.1	60.1*
April - June 2016	7.8	13.2	21.4	22.5	16.9	81.8
July - Sept 2016	4.5	13.6	23.2	25.6	14.5	81.4
Oct – Dec	5.6	12.4	23.4	24.8	11.5	77.7
Jan - March 2017	5	14.6	27.2	31.2	24.6	102.6
Discharges						
Jan - March 2016	76	261	NA	57	122	516*
April - June 2016	78	206	363	51	90	788
July - Sept 2016	35	213	380	64	113	805
Oct - Dec 2016	41	213	309	46	75	684
Jan - March 2017	65	211	305	49	130	760
Mean LOS for Discharges						
Jan - March 2016	8.6	4.2	NA	15	7.4	8.8*
April - June 2016	6	4	4	28	7	5
July - Sept 2016	7	5	4	24	8	5
Oct - Dec 2016	5	5	5	24	8	5
Jan - March 2017	5	4	5	27	7	5

* Does not include Portsmouth

These data seem to suggest a small increase in DRF utilization, and a small increase in the proportion of total DRF admissions that are involuntary. Several more quarters of data reporting will be necessary to document whether these trends continue. The DRFs should theoretically relieve some of the pressure on NHH for inpatient admissions, and also should reduce the number of people waiting for psychiatric admissions in hospitals EDs. The DRF discharge cohort may also be a good source of referrals to CMHCs for ACT or other best practice community services. The ER will continue to work with DHHS to monitor the degree to which DRF functions and activities support the overall objectives of the CMHA.

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

Table X

Self-Reported Discharge Dispositions for DRFs in New Hampshire

October 2016 through March 2017

Disposition	Franklin	Cypress	Portsmouth	Eliot Geriatric	Eliot Pathways	Total
Home	92	374	414	21	174	1075
NHH	4	4	16	0	2	26
Residential Facility/ Assisted Living	3	3	0	57	2	65
Other DRF	0	13	1	1	1	16
Hospital	2	0	0	7	1	10
Hospice	0	0	0	3	0	3
Death	0	0	0	7	0	7
Other or Unknown	4	28	183	2	25	242

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

Hospital Readmissions

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

Table XI

Self-Reported Readmission Rates for NHH and the DRFs

October – December 2016

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

January - March 2017

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

Readmission rates sometimes indicate that people being discharged from inpatient psychiatric systems are not connecting with necessary and appropriate services and supports in the community. Trends in readmission rates may also be indicators of increased or decreased pressures on the overall system of care. For example, decreased readmission rates could be an indicator that hospitals are not discharging people too quickly because of pressures to admit new patients. Decreases could also indicate that connections to appropriate community services and

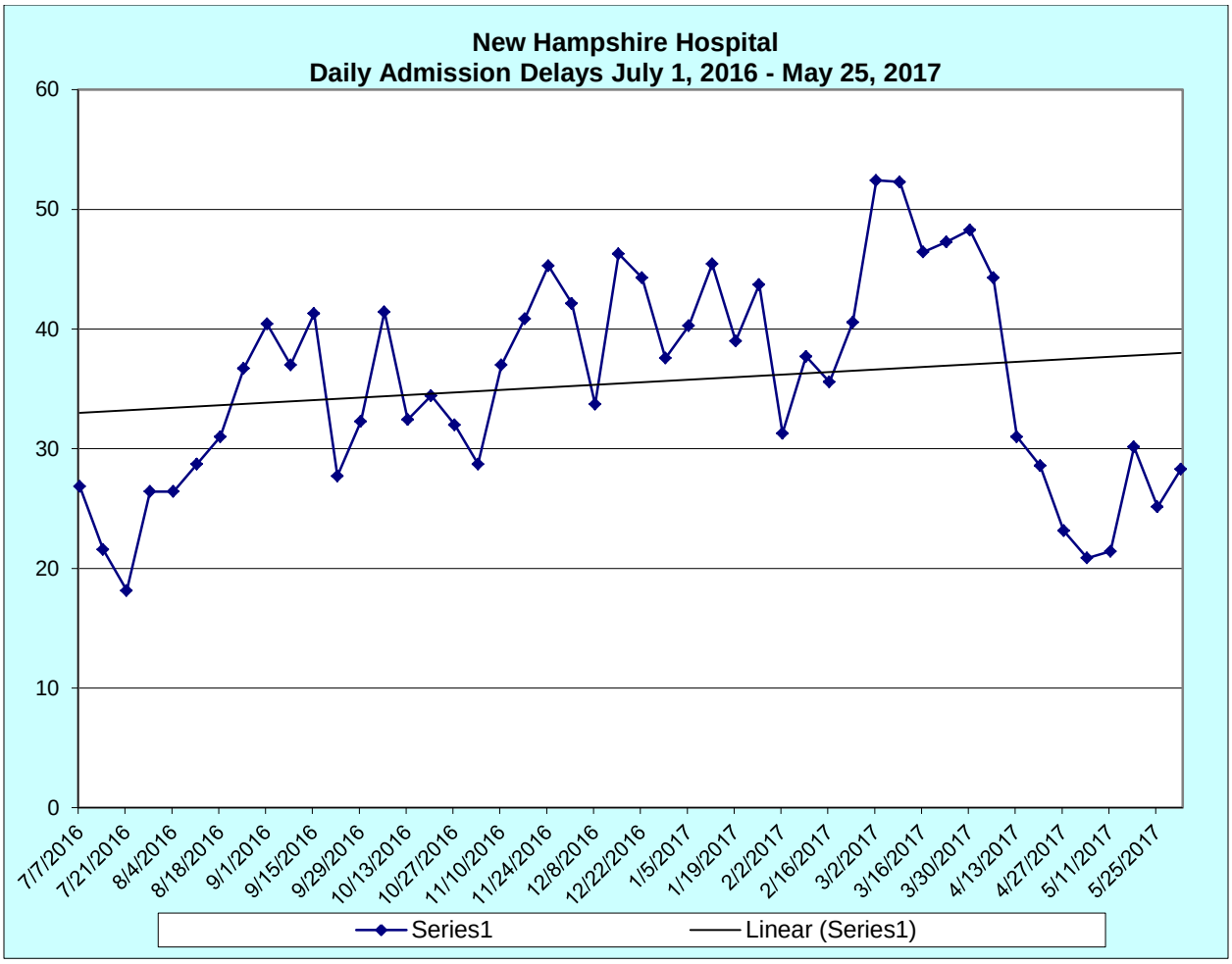
supports are occurring more effectively. Right now, 180-day readmission rates to NHH are substantial, with almost one-third of those discharged returning to NHH within six months.

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

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

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

In the previous 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. As shown in the chart below, there continues to be an average of over 20 people waiting in EDs for admission to NHH on a daily basis. 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).



DHHS continues to analyze data related to adults boarding in EDs who may have some connection to the mental health system. DHHS is making these data available to CMHCs on a monthly basis, and expects the CMHCs to use these data to identify potential participants for ACT or related services to reduce the risk of hospitalization and support integrated community living. In future months, DHHS will be receiving information on the degree to which CMHCs have increased ACT (or other services') participation as a result of these analyses. The ER plans to include summaries of this information in future reports.

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. In the June 2016 data report, the total membership was reported to be 2,978 people, with average daily statewide visits of 148. For the January – March 2017 reporting period, total membership was reported to be 3,265, with an average daily participation of 138 (see Appendix A). It is unclear why daily participation rates at the Peer Support Programs are trending down, while State reports of total membership are increasing over time.

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 24 months, DHHS has made progress in the design of the QSR process required by the CMHA. Ten QSR site visits have been conducted to date, and reports of the findings of these site visits have been (or soon will be) posted for public review. As noted earlier in this report, the ER participated in one of the QSR site visits. Based on the experiences of those QSR site visits, plus on-going input from representatives of the Plaintiffs and the ER (in a technical assistance role), the QSR team continues to make revisions to the QSR protocol and instruments. The most recent round of changes recommended by the Plaintiffs and separately by the ER are currently in development. The revised QSR protocols and instruments are expected to be ready for implementation for the second round of ten CMHA QSR site visits commencing in August, 2017. The ER intends to participate in at least two of the QSR site visits scheduled for the fall of 2017. Participation in the QSR site visits is an important way for the ER to monitor the quality and outcomes of CMHA services at the consumer and point of service level. Such participation also provides opportunities for the ER to monitor the degree to which the QSR process itself is meeting the standards of the CMHA.

Given that the new QSR protocols and instruments are still in development, it is not currently possible for the ER to comment on them. However, the ER and the parties have offered detailed

recommendations intended to inform this final phase of revisions, and to ensure the ability of the QSR to measure the quality and effectiveness of CMHA service delivery at the individual level.

As noted in earlier reports, 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. The QSR will produce essential core information to assist the Parties to assess compliance with all quality and performance standards and requirements of the CMHA, and to document the extent to which CMHA-specified outcomes are attained for members of the target population.

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 (see Appendix C for summaries of the findings of these fidelity reviews). 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. The ER commends DHHS for implementing the comprehensive fidelity review process and its attendant quality improvement and technical assistance activities.

Effective and validated fidelity reviews and consequent training and workforce development activities are essential to DHHS' overall quality management efforts for the community mental health system. As noted in the previous ER report, the QSR and the fidelity reviews mutually support but do not supplant or replace each other. The QSR, in particular, examines outcomes from a consumer-centric perspective as opposed to an operational or organizational perspective. It is uniquely positioned to assess the quality, appropriateness and effectiveness of specific ACT and SE services at the individual participant level. The ER continues to believe that implementation of fidelity-based models of delivery does not necessarily mean that specific service interventions are working well or being delivered with the frequency or intensity required by a participant's individual treatment plan. The ER has advised the parties that without recommend changes to the QSR, it will not be possible to support a conclusion that CMHA's required individual outcomes are being attained for those in the target population.

Amended QSR instruments should be available for review by the ER and the plaintiffs on August 9, 2017. The ER is recommending that the parties confer in person or by phone to

discuss the most recent instrument revisions, as well as the State's revised QSR report format. This discussion should occur on an expedited basis, prior to the end of August, 2017.

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

V. Summary of Expert Reviewer Observations and Priorities

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

The ER now believes that the State is improving its oversight and management of the mental health system, including through the growing use of state-validated fidelity reviews for ACT and SE. It also appears that the State is making progress towards compliance with several of the CMHA requirements above, including Glencliff transition and discharge planning. The breadth and content of the final QSR instrument, and the reliability of information it produces, will determine to what extent it is possible to evaluate compliance with other individual outcomes contained within the CMHA, including the adequacy and effectiveness of ACT, SE, SH and MCT.

The one notable exception to this progress relates to ACT services. **For the last two years the ER has stated that the State remains out of compliance with the ACT requirements of the Sections V.D.3(a, b, d, and e), which together require that all ACT teams meet the standards of the CMHA; that each mental health region have at least one adult ACT Team[5]; and that by June 30, 2016, the State provide ACT services that conform to CMHA requirements and have the capacity to serve at least 1,500 people in the Target Population at any given time.**

Despite the many positive initiatives and management efforts undertaken by the State, ACT capacity remains substantially below the required June 30, 2016 capacity to serve 1,500 people at any given time. Moreover, with an active caseload of only 913 people, the state currently is providing 587 fewer people with ACT than could be served if the State had developed the CMHA-specified capacity. This continues to be the single most significant issue in New Hampshire with regard to compliance with the CMHA, and one with negative implications for

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

individuals who remain stuck in NHH, who continue to be readmitted to EDs and inpatient facilities, or who are otherwise at risk of admission due to inadequate community supports.

DHHS reports working with the Governor's office and the Legislature to develop a number of new program and budget initiatives that should, if enacted and implemented, assist the state to comply with the ACT requirements of the CMHA. Specifically, there is a budget initiative designed to increase funding for workforce recruitment and retention for ACT services in the CMHCs. Lack of adequate workforce has been identified as one barrier to ACT compliance, and it is hoped that this initiative will address that issue. However, even if the budget initiative is enacted, it will be several months into the future before it is likely to have a measurable effect. Although State efforts to date have yet to produce desired outcomes, these important provisions can and must be implemented in order to ensure the needs of the target population are met. If certain action steps identified by the State are failing to produce measurable results, alternative approaches should be considered with feedback from the ER, the parties, and other MH system stakeholders. The ER will continue to closely monitor State and CMHC efforts to meet all the ACT requirements in the CMHA. Substantial, measurable progress must be forthcoming within the next six months. Otherwise, it will be necessary to seek other remedies to move the State into compliance with these requirements.

In addition, the ER will focus on resolving outstanding implementation and compliance issues including the measurement of integrated, competitive employment outcomes for SE participants, ensuring that support services associated with SH are sufficient to meet individual needs, and taking effective steps to reduce readmission rates to NHH (including ACT referrals and more comprehensive transition/discharge planning). Finally, the ER will closely monitor enhanced efforts to transition individuals from Glencliff to integrated, community-based services, and the ongoing conduct of the QSR process.

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

January through March, 2017

New Hampshire Community Mental Health Agreement Quarterly Data Report

January to March 2017

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

May 24, 2017

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: 5/24/2017
Reporting Period: 1/1/2017 – 3/31/2017

Notes for Quarter

- Manchester Mobile Crisis data reporting is now based on our new systematic record reporting process, similar to Phoenix data submission. This allows for routine quality assurance, more consistent reporting, and connection of data to other Phoenix records.

Community Mental Health Agreement Quarterly Report

New Hampshire Department of Health and Human Services
Publication Date: 5/24/2017
Reporting Period: 1/1/2017 – 3/31/2017

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

Center Name	January 2017	February 2017	March 2017	Unique Consumers in Quarter	Unique Consumers in Prior Quarter
01 Northern Human Services	102	102	108	111	107
02 West Central Behavioral Health	47	49	53	60	36
03 Genesis Behavioral Health	68	70	70	74	66
04 Riverbend Community Mental Health Center	77	77	83	88	82
05 Monadnock Family Services	67	66	64	69	67
06 Community Council of Nashua	88	83	83	93	83
07 Mental Health Center of Greater Manchester	256	257	270	281	273
08 Seacoast Mental Health Center	65	67	64	69	68
09 Community Partners	70	68	67	71	73
10 Center for Life Management	50	54	55	56	47
Total	**888**	**890**	**913**	**970**	**901**

Revisions to Prior Period: None
Data Source: NH Phoenix 2
Notes: Data extracted 5/10/17; 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

	March 2017						December 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	0.94	2.57	7.83	0.55	11.89	0.80	11.49	0.80
02 West Central Behavioral Health	0.60	2.55	4.00	0.60	7.75	0.50	5.50	0.14
03 Genesis Behavioral Health	1.00	3.00	6.00	1.00	11.00	0.50	11.00	0.50
04 Riverbend Community Mental Health Center	0.50	3.00	6.00	0.50	10.00	0.30	9.00	0.30
05 Monadnock Family Services	1.25	2.45	2.50	0.50	6.70	0.65	7.25	0.65
06 Community Council of Nashua 1	0.50	3.00	2.75	0.00	6.25	0.25	6.25	0.25
06 Community Council of Nashua 2	0.50	3.00	1.75	0.00	5.25	0.25	5.25	0.25
07 Mental Health Center of Greater Manchester-CTT	1.09	11.00	1.70	1.00	14.79	0.87	15.53	0.62
07 Mental Health Center of Greater Manchester-MCST	0.90	10.00	9.96	1.00	21.86	0.87	21.37	0.53
08 Seacoast Mental Health Center	0.43	2.10	6.00	1.00	9.53	0.60	9.53	0.60
09 Community Partners	0.40	1.00	2.18	0.50	4.08	0.50	6.85	0.50
10 Center for Life Management	1.00	3.00	3.30	1.00	8.30	0.20	7.17	0.20
Total	**9.11**	**46.67**	**53.97**	**7.65**	**117.40**	**6.29**	**116.19**	**5.34**

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

Center Name	March 2017	December 2016
01 Northern Human Services	2.27	2.12
02 West Central Behavioral Health	1.20	1.20
03 Genesis Behavioral Health	2.50	7.50
04 Riverbend Community Mental Health Center	1.30	1.30
05 Monadnock Family Services	2.60	2.40
06 Community Council of Nashua 1	3.00	3.00
06 Community Council of Nashua 2	3.00	3.00
07 Mental Health Center of Greater Manchester-CCT	11.00	11.00
07 Mental Health Center of Greater Manchester-MCST	1.00	1.00
08 Seacoast Mental Health Center	0.00	0.00
09 Community Partners	1.00	1.00
10 Center for Life Management	3.00	2.87
Total	**31.87**	**36.39**

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

Center Name	March 2017	December 2016
01 Northern Human Services	9.07	8.92
02 West Central Behavioral Health	5.85	5.60
03 Genesis Behavioral Health	9.00	9.00
04 Riverbend Community Mental Health Center	8.50	7.50
05 Monadnock Family Services	2.00	2.00
06 Community Council of Nashua 1	5.00	5.00
06 Community Council of Nashua 2	4.00	4.00
07 Mental Health Center of Greater Manchester-CCT	11.72	11.92
07 Mental Health Center of Greater Manchester-MCST	16.64	15.85
08 Seacoast Mental Health Center	6.00	6.00
09 Community Partners	2.43	4.58
10 Center for Life Management	6.00	5.87
Total	**86.21**	**86.24**

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

Center Name	March 2017	December 2016
01 Northern Human Services	1.08	1.08
02 West Central Behavioral Health	0.25	0.25
03 Genesis Behavioral Health	3.00	2.00
04 Riverbend Community Mental Health Center	0.50	0.50
05 Monadnock Family Services	1.00	2.00
06 Community Council of Nashua 1	2.50	2.50
06 Community Council of Nashua 2	1.50	1.50
07 Mental Health Center of Greater Manchester-CCT	0.55	0.56
07 Mental Health Center of Greater Manchester-MCST	0.93	1.29
08 Seacoast Mental Health Center	1.00	1.00
09 Community Partners	0.00	0.00
10 Center for Life Management	0.30	0.30
Total	**12.61**	**12.98**

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 5/10/17; 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 Adult Supported Employment Penetration Rates for Prior 12 Month Period

Center Name	12 Month Period Ending March 2017			Penetration Rate for Period Ending December 2016
	Supported Employment Consumers	Total Eligible Consumers	Penetration Rate	
01 Northern Human Services	419	1,299	32.3%	27.0%
02 West Central Behavioral Health	145	624	23.2%	21.5%
03 Genesis Behavioral Health	166	1,322	12.6%	14.5%
04 Riverbend Community Mental Health Center	249	1,662	15.0%	13.8%
05 Monadnock Family Services	128	945	13.5%	17.9%
06 Community Council of Nashua	229	1,522	15.0%	12.4%
07 Mental Health Center of Greater Manchester	1,295	3,253	39.8%	43.1%
08 Seacoast Mental Health Center	189	1,316	14.4%	12.0%
09 Community Partners	51	711	7.2%	6.8%
10 Center for Life Management	172	872	19.7%	21.1%
Deduplicated Total	**3,040**	**13,108**	**23.2%**	**22.9%**

Revisions to Prior Period: None
Data Source: NH Phoenix 2
Notes: Data extracted 5/10/17; consumers are counted only one time regardless of how many services they receive

4a. New Hampshire Hospital: Adult Census Summary

Measure	January – March 2017	October – December 2016
Admissions	263	275
Mean Daily Census	146	137
Discharges	258	276
Median Length of Stay in Days for Discharges	12	10
Deaths	0	0

Revisions to Prior Period: None
Data Source: Avatar
Notes 4a: Data extracted 1/6/17; Average Daily Census includes patients on leave and is rounded to nearest whole number

4b. New Hampshire Hospital: Discharge Location for Adults

Discharge Location	January – March 2017	October – December 2016
Home - Lives with Others	142	141
Home - Lives Alone	76	94
CMHC Group Home	6	5
Homeless Shelter/ No Permanent Home	6	1
Private Group Home	5	0
DDS Supported Living	4	3
Nursing Home	4	3
Glencliff Home for the Elderly	4	1
Other Residence	3	5
Peer Support Housing	3	1
Jail or Correctional Facility	2	8
Discharge/Transfer to IP Rehab Facility	1	7
Hotel-Motel	1	6
Unknown	1	0
Individualized Service Option-ISO	0	1

4c. New Hampshire Hospital: Readmission Rates for Adults

Measure	January – March 2017	October – December 2016
30 Days	8.0% (21)	13.0% (36)
90 Days	19.8% (52)	28.3% (78)
180 Days	27.8% (73)	35.1% (97)

Revisions to Prior Period: None
Data Source: Avatar
Notes 4b-c: Data compiled 5/10/17; readmission rates calculated by looking back in time from admissions in study quarter. 90 and 180 day readmissions look back period includes readmissions from the shorter period (e.g., 180 day includes the 90 and 30 day readmissions); patients are counted multiple times for each readmission; number in parentheses is the number of readmissions

5a. Designated Receiving Facilities: Admissions for Adults

DRF	January – March 2017		
	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	46	19	65
Manchester (Cypress Center)	70	134	204
Portsmouth	69	248	317
Elliot Geriatric Psychiatric Unit	6	42	48
Elliot Pathways	60	78	138
Total	**251**	**521**	**772**
DRF	**October – December 2016**		
	Involuntary Admissions	**Voluntary Admissions**	**Total Admissions**
Franklin	21	18	39
Manchester (Cypress Center)	62	155	217
Portsmouth	53	257	310
Elliot Geriatric Psychiatric Unit	7	36	43
Elliot Pathways	31	41	72
Total	**174**	**507**	**681**

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

DRF	January – March 2017	October – December 2016
Franklin	5.0	5.6
Manchester (Cypress Center)	14.6	12.4
Portsmouth	27.2	23.4
Elliot Geriatric Psychiatric Unit	31.2	24.8
Elliot Pathways	24.6	11.5
Total	**20.5**	**15.6**

5c. Designated Receiving Facilities: Discharges for Adults

DRF	January – March 2017	October – December 2016
Franklin	65	41
Manchester (Cypress Center)	211	213
Portsmouth	305	309
Elliot Geriatric Psychiatric Unit	49	46
Elliot Pathways	130	75
Total	**760**	**684**

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

DRF	January – March 2017	October – December 2016
Franklin	5	5
Manchester (Cypress Center)	4	5
Portsmouth	5	5
Elliot Geriatric Psychiatric Unit	27	24
Elliot Pathways	7	8
Total	5	**5**

5e. Designated Receiving Facilities: Discharge Location for Adults

	January – March 2017							
DRF	Assisted Living/Group Home	Deceased	DRF	Home	Hospice	Hospital	NHH	Other
Franklin	2	0	0	54	0	2	3	4
Manchester (Cypress Center)	2	0	5	189	0	0	2	13
Portsmouth Regional Hospital	0	0	1	222	0	0	8	74
Elliot Geriatric Psychiatric Unit	27	3	0	14	0	5	0	0
Elliot Pathways	2	0	0	116	0	1	0	11
Total	**33**	**3**	**6**	**595**	**0**	**8**	**13**	**102**
	October – December 2016							
DRF	Assisted Living/Group Home	Deceased	DRF	Home	Hospice	Hospital	NHH	Other
Franklin	1	0	0	38	0	0	1	0
Manchester (Cypress Center)	1	0	8	185	0	0	2	15
Portsmouth Regional Hospital	0	0	0	192	0	0	8	109
Elliot Geriatric Psychiatric Unit	30	4	1	7	3	2	0	2
Elliot Pathways	0	0	1	58	0	0	2	14
Total	**32**	**4**	**10**	**480**	**3**	**2**	**13**	**140**

5f. Designated Receiving Facilities: Readmission Rates for Adults

	January – March 2017		
DRF	30 Days	90 Days	180 Days
Franklin	0.0% (0)	0.0% (0)	1.5% (1)
Manchester (Cypress Center)	6.9% (14)	11.8% (24)	16.7% (34)
Portsmouth	7.3% (23)	12.9% (41)	18.3% (58)
Elliot Geriatric Psychiatric Unit	8.3% (4)	10.4% (5)	10.4% (5)
Elliot Pathways	2.9% (4)	4.3% (6)	7.2% (10)
Total	**5.8% (45)**	**9.8% (76)**	**14.0% (108)**
	October – December 2016		
DRF	30 Days	90 Days	180 Days
Franklin	2.5% (1)	2.5% (1)	2.5% (1)
Manchester (Cypress Center)	6% (13)	9.7% (21)	11.1% (24)
Portsmouth	8.1% (25)	14.2% (44)	18.1% (56)
Elliot Geriatric Psychiatric Unit	4.7% (2)	4.7% (2)	9.3% (4)
Elliot Pathways	11.1% (8)	12.5% (9)	12.5% (9)
Total	**7.2% (49)**	**11.3% (77)**	**13.8% (94)**

Revisions to Prior Period: None
Data Source: NH DRF Database
Notes: Data compiled 5/9/17; discharge location of DRF are patients discharged back to the same DRF for a different level of care within the DRF; readmission rates calculated by looking back in time from admissions in study quarter; patients are counted multiple times for each readmission; number in parentheses is the number of readmissions

6. Glencliff Home: Census Summary

Measure	January – March 2017	October – December 2016
Admissions	5	5
Average Daily Census	104	110
Discharges	7 (3-medical model group home, 1-private apartment, 1-assisted living/ residential care home, 1-NHH, 1-ABD/ enhanced family care home)	3 (supported apartment, enhanced family care home, nursing facility)
Individual Lengths of Stay in Days for Discharges	1024, 1691, 1680, 629, 952, 486, 3207	1027, 2785, 4545
Deaths	3	6
Readmissions	0	0
Mean Overall Admission Waitlist	16 (9 Active*)	14 (6 Active*)

**Active waitlist patients have been reviewed for admission and are awaiting admission pending finalization of paperwork and other steps immediate to admission.*
Revisions to Prior Period: None.
Data Source: Glencliff Home
Notes: Data Compiled 4/28/17; means rounded to nearest whole number.

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

Peer Support Agency	January – March 2017		October – December 2016	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
Alternative Life Center Total	**504**	**38**	**492**	**39**
Conway	*178*	*12*	*179*	*12*
Berlin	*107*	*8*	*102*	*10*
Littleton	*137*	*10*	*134*	*8*
Colebrook	*82*	*8*	*77*	*9*
Stepping Stone Total	**582**	**18**	**571**	**18**
Claremont	*486*	*12*	*479*	*13*
Lebanon	*96*	*6*	*92*	*5*
Cornerbridge Total	**365**	**13**	**348**	**13**
Laconia	*159*	*4*	*152*	*5*
Concord	*157*	*9*	*152*	*8*
Plymouth Outreach	*49*	*NA*	*44*	*NA*
MAPSA Keene Total	**184**	**16**	**180**	**16**
HEARTS Nashua Total	**473**	**26**	**433**	**24**
On the Road to Recovery Total	**524**	**40**	**498**	**36**
Manchester	*386*	*33*	*367*	*31*
Derry	*138*	*7*	*131*	*5*
Connections Portsmouth Total	**275**	**13**	**273**	**14**
TriCity Coop Rochester Total	**358**	**14**	**345**	**16**
Total	**3,265**	**138**	**3,140**	**140**

Revisions to Prior Period: None
Data Source: Bureau of Mental Health Peer Support Agency Quarterly Statistical Reports
Notes: Data Compiled 5/11/17; Average Daily Visits NA for Outreach Programs; Cornerbridge Laconia for October to December 2016 estimated based on prior members and new reported members.

8. Housing Bridge Subsidy Summary to Date

Subsidy	January – March 2017 Total individuals served at start of quarter	New individuals added during quarter	Total individuals served through end of quarter
Housing Bridge Subsidy	643	32	675
Section 8 Voucher	85	2	85
Subsidy	**October – December 2016** **Total individuals served at start of quarter**	**New individuals added during quarter**	**Total individuals served through end of quarter**
Housing Bridge Subsidy	603	40	643
Section 8 Voucher	83	0	83

Revisions to Prior Period: None
Data Source: Bureau of Mental Health
Notes: Data Compiled 2/22/17

9. Housing Bridge Subsidy Current Census Summary

Measure	As of 3/31/2017	As of 12/31/2016
Housing Slots	553	513
Rents currently being paid	505	481
Individuals accepted but waiting to lease	48	32
Waiting list for slots	0	0

Revisions to Prior Period: None
Data Source: Bureau of Mental Health
Notes: Data Compiled 5/2/17; All individuals currently on the Bridge Program are actively transitioning from the program (waiting for their Section 8 housing voucher).

10. Housing Bridge Subsidy Unit Address Density

Number of Unit(s)* at Same Address	Frequency as of 5/12/17	Frequency as of 2/23/17
1	367	349
2	36	23
3	5	14
4	4	4
5	3	0
6	1	1
7	2	0

*All units are individual units
Revisions to Prior Period: None
Data Source: Bureau of Mental Health data compiled by Office of Quality Assurance and Improvement
Notes: Data Compiled 5/12/17

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

Measure	January 2017	February 2017	March 2017	January – March 2017	October – December 2016
Unduplicated People Served in Month	232	194	182	608	535
Services Provided by Type					
Mobile Community Assessments	57	56	44	157	157
Crisis Stabilization Appointments	29	13	20	62	61
Office-Based Urgent Assessments	26	23	33	82	53
Emergency Service Medication Appointments	34	27	6	67	77
Phone Support/Triage	188	288	165	641	666
Walk in Assessments*	5	5	7	17	NA
Services Provided after Immediate Crisis					
Mobile Community Assessments-Post Crisis	13	10	7	30	33
Crisis Stabilization Appointments	29	13	20	62	61
Office-Based Urgent Assessments	26	23	33	82	53
Emergency Service Medication Appointments	17	17	6	40	49
Phone Support/Triage	45	80	54	179	197
Referral Source					
Emergency Department/EMS	30	15	13	58	33
Family	42	47	21	110	71
Friend	4	7	1	12	17
Guardian	1	3	7	11	19
Mental Health Provider	11	16	5	32	31
Police	2	2	8	12	12
Primary Care Provider	3	5	8	16	12
CMHC Internal	13	16	12	41	50
School	5	5	8	18	20
Self	101	70	87	258	254
VNA	0	0	0	0	0
DCYF	0	0	0	0	1
Crisis Apartment					
Apartment Admissions	30	30	35	95	85
Apartment Bed Days	121	126	145	392	316
Apartment Average Length of Stay	4	4.2	4.1	4.1	3.7
Law Enforcement Involvement	20	20	12	52	57
Hospital Diversions Total	167	167	154	488	327

**New category beginning with this report*
Revisions to Prior Period: None
Data Source: Riverbend CMHC submitted reports
Notes: Data Compiled 5/9/17

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

Measure	January 2017	February 2017	March 2017	January – March 2017	October – December 2016
Unduplicated People Served by Month	152	143	201	413	NA
Services Provided by Type					
Phone Support/Triage	399	361	408	1168	NA
Mobile Community Assessments	31	46	77	154	NA
Office-Based Urgent Assessments	30	21	24	75	NA
Emergency Service Medication Appointments	1	0	0	1	NA
Crisis Apartment Service	0	125	23	148	NA
Referral Source					
Emergency Department	0	2	2	4	NA
Family	36	56	60	152	NA
Friend	8	7	7	22	NA
Guardian	1	1	1	3	NA
Mental Health Provider	2	3	12	17	NA
Police	4	8	33	45	NA
Primary Care Provider	1	0	9	10	NA
CMHC Internal	29	16	23	68	NA
Self	64	98	113	275	NA
Other	13	22	24	59	NA
Crisis Apartment					
Apartment Admissions	0	2	3	5	NA
Apartment Bed Days	0	11	6	17	NA
Apartment Average Length of Stay	0	5.5	2	3.4	NA
Law Enforcement Involvement	4	8	33	45	NA
Hospital Diversion Total	151	212	280	643	NA

Revisions to Prior Period: NA
Data Source: New Mobile Crisis Data Reporting System
Notes: Data Compiled 5/19/17

Appendix B

New Hampshire Community Mental Health Agreement

Monthly Progress Reports

March, 2017

New Hampshire Community Mental Health Agreement Monthly Progress Report

March 2017

New Hampshire Department of Health and Human Services

April 24, 2017

Acronyms Used in this Report

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

Background

This Monthly Progress Report is issued in response to the June 29, 2016 Expert Reviewer Report, Number Four, action step 4. It reflects the actions taken in February 2017, and month-over-month progress made in support of the Community Mental Health Agreement (CMHA) as of February 28, 2017. 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.

Progress Highlights

Assertive Community Treatment (ACT)

Goal	Status	February Actions Taken
CMHC fidelity to ACT evidence-based practice model annually assessed.	10 of 10 completed	• CMHC-specific improvement plans implemented • Statewide training program implemented • CMHC-specific technical assistance sessions implemented
Provide ACT team services, consistent with standards set forth, with the capacity to serve at least 1,500 individuals.	Capacity: 1,190 Enrollment: 882	• CMHC-specific technical assistance provided to address ACT Team workforce shortages • Increase public awareness of ACT Team workforce shortages

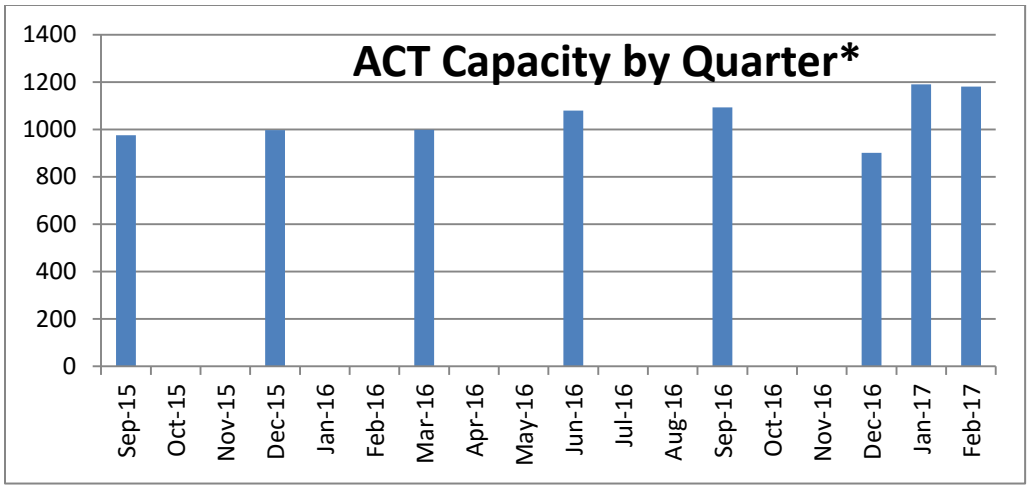
Supported Employment (SE)

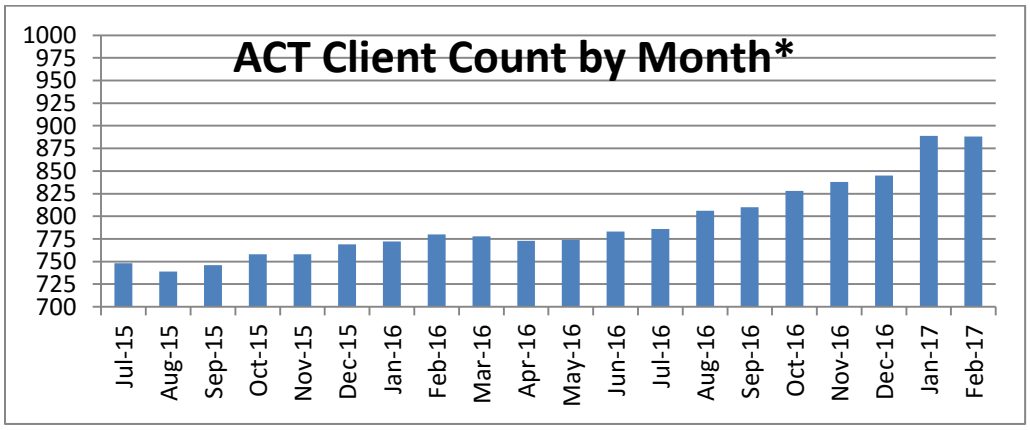
Goal	Status	February Actions Taken
CMHC fidelity to SE evidence-based practice model annually assessed.	10 of 10 completed	• CMHC-specific improvement plans implemented • Statewide training program implemented • CMHC-specific technical assistance sessions implemented
Increase penetration rate of individuals with a Serious Mental Illness (SMI) receiving SE services to 18.6%.	Statewide penetration rate is 23.3%	• BMHS provided technical assistance to CMHCs with penetration rates below 18.6%

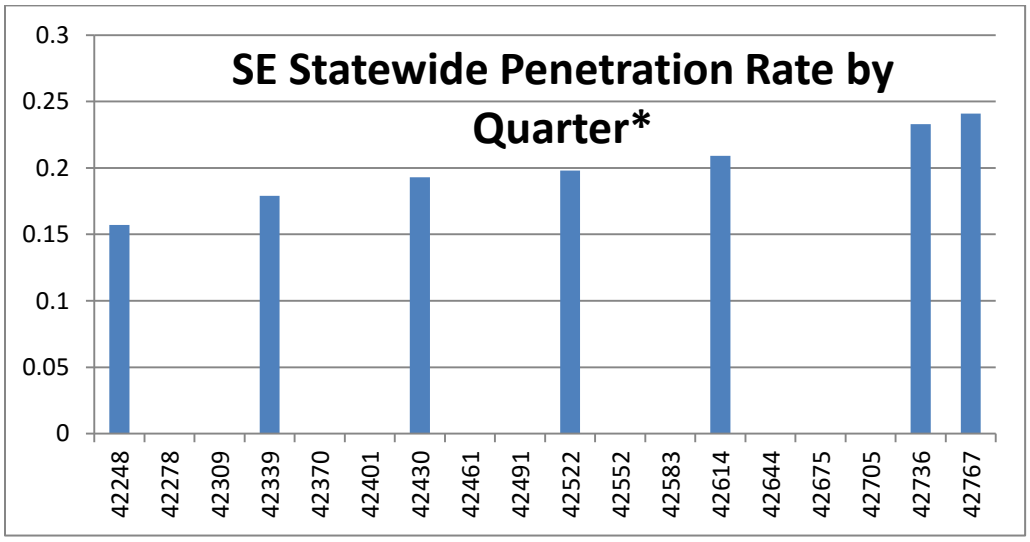
Glencliff Home Transitions into Integrated Community Setting

Goal	Status	February Actions Taken
Have capacity to serve in the community 16 (cumulatively) individuals with mental illness and complex health care needs residing at Glencliff who cannot be cost-effectively served in supported housing.	10 of 16 completed[1]	• Worked with providers to transition 3 residents in coming weeks • Identified community resource challenges to transition additional residents by 6/30/17
By June 30, 2017, identify and maintain a list of all individuals with mental illness and complex health care needs residing at the Glencliff Home who cannot be cost-effectively served in supported housing and develop an effective plan for providing sufficient community-based residential supports for such individuals in the future.	Partially complete	• Plan developed to provide additional resources to support such individuals in enhanced Adult Family Care homes • Multiple individuals identified for future transition to community

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







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

NH Department of Health & Human Services
Community Mental Health Agreement (CMHA)
Project Plan for Assertive Community Treatment, Supported Employment and Glencliff Home Transitions
February 28, 2017

#	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.
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.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
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.	100%	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.	100%	Internal CMHC review of referral process complete. Fidelity assessment process and ED admissions yielded changes.
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.	100%	DHHS received 7out of 7 CMHC reports; final reports and improvement plans have been published on the DHHS website.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
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	100%	Conducted final ACT Fidelity Assessments (Jan 30-31). Final repors and improvement plans will be published in Feb. and Mar. 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 2/28/17 increase ACT capacity by 25 %.	40%	New monthly capacity (staffing) reports began in November. As of 2/28/17, actual increased capacity is 38% toward goal of increase target. Training is underway.
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.	85%	Preliminary reporting steps completed. Reporting is ongoing. Quality of data submitted and achievement of monthly enrollment goal is current objective being monitored.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
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.	100%	Reporting mechanism implemented.

#	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.	100%	Assessment conducted. DHHS final report issued 12/20/2016.
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.	75%	CMHCs began referral screening process incorporated into quarterly treatment plan reviews in Oct. 2016. Process will trigger SE referrals when appropriate. Data reporting to BMHS is in initial phases.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
27	**11/1/2016**	Resolve barriers to achieving SE penetration goals.	M.Harlan	Educate internal CMHC staff on the goals of SE.	Educational plan	100%	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. Voc Rehab actively engaged for inter-agency collaboration. DHHS developed ongoing educational plan.
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.	100%	DHHS began developing plan to resource provision of additional technical assistance to CMHCs. Fidelity Assessment result analysis complete. Identified specific areas of focus for training and TA needs. DHHS developed plan for ongoing training and technical assistance for 2017. Plan is underway.

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
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%	ACT/SE Implementation Workgroup, SE Learning Collaborative, Training program, and CMHC-specific Technial Assistance post SE Fidelity Analysis underway. 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.	100%	Individual plans developed and budgets approved.
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%	1-10/6/14; 1-11/30/15; 1-3/14/16
37	**12/1/2016**	Transition four (4) individuals to the community.	M.Harlan	Four individuals to transition into the community.	Community placement	100%	1-7/25/16; 1-10/11/16; 1-10/31/16; 1-1/12/17

#	Due Date	Task	Assignee	Description	Deliverable	% Done	Related Activities
38	**3/1/2017**	Transitions four (4) additional individuals to the community.	M.Harlan	Four individuals to transition into the community.	Community placement	75%	1-1/13/17; 1/17/17; 1/30/17;
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 C

Assertive Community Treatment & Supported Employment Fidelity Reviews

Summary Report: April 2017

Assertive Community Treatment & Supported Employment Fidelity Reviews 2017 Summary Report

April 2017

New Hampshire Department of Health and Human Services

Division for Behavioral Health

Bureau of Mental Health Services

April 14, 2017

Acronyms Used in this Report

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

Introduction

This Assertive Community Treatment (ACT) and Supported Employment (SE) Fidelity Review Summary Report releases the State Fiscal Year (SFY) 2017 Fidelity Review scores for New Hampshire's ten (10) Community Mental Health Centers (CMHC), and the Bureau of Mental Health Services (BMHS) analysis of statewide and CMHC-specific fidelity to the Evidence-Based Models (EBM) for ACT and SE.

The ACT and SE Fidelity Reviews for SFY 2017 were conducted by either DHHS, through a team of DHHS staff with expertise in the programs or in conducting Quality Service Reviews, or by the CMHC, as a self-assessment utilizing CMHC staff with expertise in the programs. Table 1 indicates which team conducted each Fidelity Review:

Table 1

Community Mental Health Center	ACT	SE
Northern Human Services	DHHS	DHHS
West Central Behavioral Health	DHHS	CMHC
Genesis Behavioral Health	DHHS	CMHC
Riverbend Community Mental Health	CMHC	DHHS
Monadnock Family Services	CMHC	CMHC
Greater Nashua Mental Health Center	CMHC	DHHS
Mental Health Ctr. of Greater Manchester	CMHC	DHHS
Seacoast Mental Health Center	CMHC[1]	CMHC[2]
Community Partners of Strafford County	CMHC	DHHS
Center for Life Management	CMHC	CMHC

The Fidelity Review is a manualized process described in published toolkits. It includes conducting the assessment, a bi-directional review of the assessment scores wherein both DHHS, through BMHS, and the applicable CMHC share feedback, and recommendations for each criterion are developed and agreed upon. Based on the Fidelity Review, improvement plans are developed, setting the path forward for the coming year to improve fidelity at each CMHC. In order to improve areas of the practices, CMHCs may utilize technical assistance, additional training and participation in learning collaboratives. DHHS and CMHCs follow up on progress being made throughout the year.

At the conclusion of the SFY 2017 Fidelity Reviews, BMHS analyzed the results and developed this Summary Report that evaluates quality across the state. Beginning in State Fiscal Year 2018 – once a full cycle (10 CMHCs) of baseline data is available[3] from Quality Service Reviews (QSRs) – the Fidelity Review process will conclude with a summary report that incorporates statewide, system level findings from the QSR cycle –ensuring a fully comprehensive analysis supports program improvement for subsequent years.

[1] Seacoast Mental Health Center chose to have an independent consultant conduct its ACT self-assessment.
[2] Seacoast Mental Health Center chose to have an independent consultant conduct its SE self-assessment.
[3] QSRs were piloted in SFY2017. The pilot QSRs will not be used to create the baseline data necessary for this purpose; only the QSRs that use the finalized QSR process and tools wil contribute to the baseline data.

1. Assertive Community Treatment (ACT)

The EBM for ACT includes the Fidelity Review tool[4] that was utilized for the SFY 2017 Fidelity Review process. The tool assesses ACT Fidelity, including the ACT Team Components described in Section V.D.2. (a) through (g) of the Community Mental Health Agreement, which are briefly described below:

- Availability – 24 hours per day, 7 days per week with on-call availability midnight to 8:00 a.m.;
- Comprehensive and individualized service delivery in consumer homes, natural environments, and community settings, or by telephone where appropriate;
- Appropriate ACT team composition – multidisciplinary team of between 7 and 10 professionals;
- Each ACT team serves appropriate number of consumers – no more than 10 consumers per ACT team member;
- Service delivery able to de-escalate crises without removing consumer from home or community program, consistent with safety concerns; and
- ACT teams work with law enforcement personnel to respond to consumers experiencing a mental health crisis.

The ACT Fidelity Review tool measures ACT Fidelity across three areas:

- Human Resources: Structure and Composition – 11 criterion assess ACT team staffing, caseload size, program size, etc.;
- Organizational Boundaries – 7 criterion assess admission criteria, intake rates, responsibility for treatment services, crisis services, hospitalization and discharge planning, etc.; and
- Nature of Services – 10 criterion assess community-based services, engagement mechanisms, intensity of service, informal support system, Substance Use Disorders, co-occurring disorders, dual disorders, etc.

In whole, 28 criterion are measured against five (5) possible ratings/anchors, for a maximum total score potential of 140. Table 2 (pg 5) provides the SFY 2017 scoring results for every CMHC.

[4] See Appendix 1—ACT Fidelity Review Tool

ACT Fidelity Scale State Fiscal Year 2017 Review	NHS	WCBH	GBH	RCMH	MFS	GNMHC	MHCGM		SMHC	CP	CLM	Mean Score
Region	I	II	III	IV	V	VI	VII		VIII	IX	X	
Type of Review (DHHS or CMHC conducted)	DHHS	DHHS	DHHS	CMHC	CMHC	CMHC	CMHC	CMHC	CMHC	CMHC	CMHC	
Human Resources												
H1 - Small Caseload	4.7	5	5	5	5	5	5	5	5	4	5	**4.88**
H2 - Team Approach	3.3	5	5	5	4	5	4	4	4	5	4	**4.39**
H3 - Program Meeting	3.7	4	3	4	4	5	4	4	4	5	5	**4.15**
H4 - Practicing ACT Leader	4.7	4	4	3	5	5	3	3	3	2	4	**3.70**
H5 - Staff Continuity	4.3	3	4	5	5	4	3	4	3	1	3	**3.57**
H6 - Staff Capacity	4.7	4	4	5	4	3	4	3	3	4	4	**3.88**
H7 - Psychiatry	3.7	3	4	2	4	3	3	3	5	4	2	**3.34**
H8 - Nursing	2.3	4	3	2	2	3	3	2	2	2	5	**2.75**
H9 - Substance Abuse	2.7	2	1	3	5	5	5	5	1	4	5	**3.52**
H10 - Vocational (SE)	3	2	2	2	3	5	4	3	5	4	2	**3.18**
H11 - Program Size	2	3	4	4	3	5	5	5	4	5	4	**4.00**
Organizational Boundaries												
O1 - Admission Criteria	5	5	5	4	4	4	5	5	5	5	5	**4.73**
O2 - Intake Rate	5	5	4	5	5	5	5	5	5	5	5	**4.91**
O3 - Service Responsibility	5	5	4	5	5	4	5	5	4	5	4	**4.64**
O4 - Crisis Responsibility	2	2	4	2	5	5	5	5	4	4	5	**3.91**
O5 - Hospital Admits	5	5	5	4	5	5	5	5	2	4	5	**4.55**
O6 - Hospital Discharges	5	5	5	5	5	5	4	5	5	4	5	**4.82**
O7 - Time Unlimited Svcs	5	5	5	4	5	5	4	4	5	5	4	**4.64**
Nature of Services												
S1 - Community-Based Svcs	4.7	5	5	4	5	5	4	5	4	5	4	**4.61**
S2 - No Dropout Policy	5	4	5	5	5	5	5	5	5	5	4	**4.82**
S3 - Assertive Engagement	5	5	4	5	5	4	5	5	5	5	5	**4.82**
S4 - Intensity of Svcs	2.7	3	5	5	4	5	5	5	2	5	3	**4.06**
S5 - Frequent Contact	2.3	4	4	4	4	5	5	5	2	5	3	**3.94**
S6 - Work with Support Sys	4	3	3	3	4	2	5	5	2	4	2	**3.36**
S7 - Ind Substance Tx	4	4	2	2	4	3	5	4	1	3	4	**3.27**
S8 - Co-Occurring Group	1	3	1	1	1	1	2	1	1	1	2	**1.36**
S9 - Dual Disorder Model	3.7	5	2	3	5	4	5	5	2	5	4	**3.97**
S10 - Consumer on Team	2	2	5	3	3	1	4	1	5	5	4	**3.18**
Total	**105.3**	**109**	**107**	**104**	**118**	**115**	**122**	**116**	**98**	**115**	**111**	**110.94**

Notes:

The Bureau of Mental Health Services hired a contractor to do the ACT Fidelity Review Summary.

Items that were rated low (1 or 2) are highlighted in yellow.

Items that were rated fair (3) are highlighted in blue.

Fidelity items with mean scores in **red text** may be targeted for potential quality improvement activities at the system level.

Score Guide:

28 items, each with a score possible of up to 5, for a total possible score of 140 points.

Total scores result in the following ratings:

84 and below = Not ACT

85 - 112 = Fair Implementation

113 - 140 = Full Implementation

ACT Fidelity Review Summary

Based on scores from the SFY 2017 ACT Fidelity Review, half of New Hampshire's Community Mental Health Centers were rated as "Full Implementation," and half were rated as "Fair Implementation." The provision of integrated treatment of co-occurring substance use disorders was a major area in need of improvement across many centers. The role of the team leader and working with the consumer's support system were two additional significant areas in need of improvement at many centers. Other areas for quality improvement include adequate staffing for the roles of peers, supported employment specialists, psychiatrists and nurses on ACT teams.

<u>BMHS ACT Program Improvement Plan</u>

DHHS will work to improve quality by:

1) Providing bi-monthly technical assistance (or monthly if requested) at centers with Fair Implementation fidelity scores to:

    a. Help teams identify and implement steps towards improvement;
    b. Help teams organize and deliver their co-occurring substance abuse services; and
    c. Help teams organize their team meeting and team activity scheduling.

2) Providing trainings for all CMHCs focused on:

    a. Skills and strategies for substance abuse services – 5 half-day modules for staff who are identified as substance abuse experts, and ongoing supervision for addiction services skills;
    b. Overall ACT skills refresher for ACT specialists; and
    c. ACT Summit – 2-day training to assist CMHCs with the sustaining and improvement of ACT services. Training objectives include:
        i. To increase knowledge of target audiences for ACT services;
        ii. To enhance understanding of the ACT philosophy, values and practice principles;
        iii. To increase knowledge of engagement strategies for ACT;
        iv. To improve knowledge about effective strategies for ACT outreach;
        v. To develop strategies for improving ACT team retention;
        vi. To understand the role of Specialty and Generalist services in ACT; and
        vii. To develop a working understanding of the ACT fidelity scale for quality improvement.

3) Supporting the development of an ACT learning collaborative with:

    a. Data reports; and
    b. Expert technical assistance.

4) Ongoing exploration of additional funding resources and supports for workforce development.

2. Supported Employment (SE)

The EBM for SE includes the Fidelity Review tool[5] that was utilized for the SFY 2017 Fidelity Review process. The tool assesses SE Fidelity, including the SE provisions described in Section V.F.1. of the Community Mental Health Agreement, which are briefly described below:

- Deliver Supported Employment services in accordance with the Dartmouth EBM;
- Provide individualized assistance in identifying, obtaining, and maintaining integrated, paid, competitive employment;
- Provide services in the appropriate amount, duration and intensity;
- Provide services including but not limited to job development, co-worker and peer supports, time management training, benefits counseling, job coaching, etc.

The SE Fidelity Review tool measures ACT Fidelity across three areas:

- Staffing: 3 items assess SE staffing and caseload size;
- Organization: 8 items assess integration of rehabilitation with mental health treatment, vocational rehabilitation, zero exclusion criteria, the SE team leader's role, and agency focus on competitive employment; and
- Services: 14 items assess work incentives, vocational assessment, job search and development, individualized follow-along supports, community-based services, team engagement and outreach, etc.

In whole, 25 items are rated; each item is rated on a 5-point scale ranging from 1 (meaning not implemented) to 5 (meaning fully implemented), for a maximum potential score of 125. Table 3 (pg 8) provides the SFY 2017 scoring results for every CMHC.

[5] See Appendix 2 – SE Fidelity Review Tool

SE Fidelity Scale State Fiscal Year 2017 Review	NHS	WCBH	GBH	RCMH	MFS	GNMHC	MHCGM	SMHC	CP	CLM	Mean Score
Region	**I**	**II**	**III**	**IV**	**V**	**VI**	**VII**	**VIII**	**IX**	**X**	
Type of Review (DHHS or CMHC conducted)	**DHHS**	**DHHS**	**CMHC**	**DHHS**	**CMHC**	**CMHC**	**DHHS**	**CMHC**	**CMHC**	**CMHC**	
Staffing											
1. Caseload	4.5	4	5	4	3	4	4	5	1	4	**3.85**
2. SE Services staff	4.5	5	5	5	5	5	5	5	1	5	**4.55**
3. Voc generalists	5	5	4.5	5	5	5	5	5	1	5	**4.55**
Organization											
1. Integration of rehab w/MH tx	5	2	4.5	3	5	5	5	4	1	5	**3.95**
2. Integration rehab w/freq contact	5	5	4.5	4	4	5	4	4	1	4	**4.05**
3. Collab w/VR	2.5	3	5	3	3	3	4	5	1	5	**3.45**
4. Voc Unit	4.5	3	5	5	5	5	5	5	1	5	**4.35**
5. SE Supervisor	4	3	5	3	4	2	5	4	1	5	**3.60**
6. Zero Exclusion	4.5	4	4	4	5	4	5	3	1	5	**3.95**
7. Competitive Employment	3	4	4	3	4	5	5	3	4	5	**4.00**
8. Exec Team Support	4	5	4	3	4	4	5	5	3	5	**4.20**
Services											
1. Work incentives planning	5	5	5	5	5	4	4	3	1	5	**4.20**
2. Disclosure	5	5	5	5	5	5	5	5	4	5	**4.90**
3. On-going work based assess	4	5	4	4	4	4	5	5	4	5	**4.40**
4. Rapid job search	4	4	4	4	5	5	4	3	3	5	**4.10**
5. Individualized job search	5	4	5	4	5	5	5	5	1	5	**4.40**
6. Job development-employer contact	2.5	2	2	2	2	2	4	2	1	2	**2.15**
7. Job Development-quality contact	5	5	4	4	5	4	4	5	1	4	**4.10**
8. Diversity of jobs	4	5	5	5	5	4	5	4	3	4	**4.40**
9. Diversity of employers	4	5	5	5	5	5	5	4	5	5	**4.80**
10. Competitive jobs	3	5	5	5	5	5	5	5	4	5	**4.70**
11. Individualized follow along supports	5	3	5	5	5	4	5	5	1	5	**4.30**
12. Time unlimited follow-along	5	3	5	5	5	5	5	5	1	5	**4.40**
13. Community based services	4.5	3	2.5	5	5	5	5	5	1	5	**4.10**
14. Assertive engagement	1	4	5	3	5	4	5	5	1	5	**3.80**
Total Score:	**103.50**	**101.00**	**112.00**	**103.00**	**113.00**	**108.00**	**118.00**	**109.00**	**47.00**	**118.00**	**103.25**

Notes:

The Bureau of Mental Health Services hired a contractor to do the SE Fidelity Review Summary.

Items that were rated low (1 or 2) are highlighted in yellow.

Items that were rated fair (3) are highlighted in blue.

Fidelity items with mean scores in **red text** may be targeted for potential quality improvement activities at the system level.

Score Guide:

25 items, each with a score possible of up to 5, for a total possible score of 125 points.

Total scores result in the following ratings:

73 and below = Not Supported Employment

74 - 99 = Fair Fidelity

100 - 114 = Good Fidelity

115 - 125 = Exemplary Fidelity

SE Fidelity Review Summary

Based on scores from the SFY 2017 SE Fidelity reviews, most of New Hampshire's Community Mental Health Centers (9 of 10) were implementing Supported Employment with at least "good fidelity." One center scored poorly because their SE team staff left the agency, and the center had not yet successfully completed recruitment to hire staff to replace the team.

Analysis of individual scores indicated that contact with employers for job development was the single area where most centers needed significant improvement. Other potential areas for improvement, based on at least three centers scoring a 3 or lower, include: collaboration with Vocational Rehabilitation, integration of mental health and SE, variety of competitive employment jobs, community based services and assertive engagement.

<u>BMHS SE Program Improvement Plan</u>

BMHS will work to improve quality by:

1) Providing bi-monthly technical assistance (or monthly if requested) to:

    a. Help the center that is restarting their SE program.
    b. Help all other SE teams address individualized barriers as identified by the fidelity review or the team leader.

2) Providing trainings for all centers focused on:

    a. Skills and strategies for job development – engaging employers and engaging families.
    b. Overall SE skills – basic skills for SE specialists (delivered February 23rd and 28th, 2017).
    c. Illness Management and Recovery (IMR) training that will help SE workers with basic mental health counseling skills.

3) Working with Vocational Rehabilitation leaders at the state level to facilitate SE services in the state by:

    a. Facilitating interagency agreements.
    b. Encouraging regional Vocational Rehabilitation to provide job development services.

4) Supporting the SE learning collaborative with:

    a. Data reports.
    b. Expert technical assistance.

5) Ongoing exploration of additional funding resources and supports for workforce development.

Schedule of State Fiscal Year 2017 Fidelity and Quality Services Review[6]

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** Self-conducted ACT Fidelity Assessment **Seacoast Mental Health Center** Self-conducted[7] ACT Fidelity Assessment Self-conducted[8] 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	**Riverbend Community Mental Health** DHHS-conducted QSR

[6] Schedule may be subject to change.
[7] At its own discretion, Seacoast Mental Health Center utilized the services of an outside contractor to conduct its Self-Assessment.
[8] At its own discretion, Seacoast Mental Health Center utilized the services of an outside contractor to conduct its Self-Assessment.

Appendix 1

The following pages contain the ACT Fidelity Review Tool used for SFY2017.

Community Mental Health Center (CMHC)
Assertive Community Treatment (ACT) Fidelity Report
October 2016

CMHC:	
Report Date:	
Review Date:	
Reviewers: *(list all)*	

Overview:
This report describes Assertive Community Treatment (ACT) services. The fidelity review is considered an integral component to complement and validate self-fidelity measures and is intended to promote and assure fidelity to the model and compliance with the Community Mental Health Agreement (CMHA).

Executive Summary:

(Enter brief summary of review results)

This review resulted in an Implementation rating of:	
Out of a possible 140 points the Center scored:	

Method:

This review consisted of: *(Describe how the Center conducted its review)*

The ACT Fidelity Scale is divided into three sections, including: Human Resources – Structure and Composition; Organizational Boundaries; and Nature of Services. Each item to be scored (criterion) is rated on a 5-point response formation ranging from 1 to 5 with each criterion having a specific anchor assigned to each point within the 5-point range. The following tables (next 3 pages) specify the criterion and the associated ratings/anchors the CMHC must use in conducting its ACT Fidelity Self-Assessment.

Human Resources: Structure and Composition						
		Ratings / Anchors				
Criterion		**1**	**2**	**3**	**4**	**5**
H1	**Small caseload:** Consumer/provider ratio = 10:1	50 consumers/team member or more	35 – 49	21 – 34	11 – 20	10 consumers/team member or fewer
H2	**Team approach:** Provider group functions as team rather than as individual ACT team members; ACT team members know and work with all consumers	Less than 10% consumers with multiple team face-to-face contacts in reporting 2-week period	10 – 36%	37 – 63%	64 – 89%	90% or more consumers have face-to-face contact with >1 staff member in 2 weeks
H3	**Program meeting:** Meets often to plan and review services for each consumer	Service-planning for each consumer usually 1x/month or less	At least 2x/month but less often than 1x/week	At least 1x/week but less than 2x/week	At least 2x/week but less than 4x/week	Meets at least 4 days/week and reviews each consumer each time, even if only briefly
H4	**Practicing ACT leader:** Supervisor of Frontline ACT team members provides direct services	Supervisor provides no services	Supervisor provides services on rare occasions as backup	Supervisor provides services routinely as backup or less than 25% of the time	Supervisor normally provides services between 25% and 50% time	Supervisor provides services at least 50% time
H5	**Continuity of staffing:** Keeps same staffing over time	Greater than 80% turnover in 2 years	60 – 80% turnover in 2 years	40 – 59% turnover in 2 years	20 – 39% turnover in 2 years	Less than 20% turnover in 2 years
H6	**Staff capacity:** Operates at full staffing	Operated at less than 50% staffing in past 12 months	50 – 64%	65 – 79%	80 – 94%	Operated at 95% or more of full staffing in past 12 months
H7	**Psychiatrist on team:** At least 1 full-time psychiatrist for 100 consumers works with program	Less than .10 FTE regular psychiatrist for 100 consumers	.10 – .39 FTE for 100 consumers	.40 – .69 FTE for 100 consumers	.70 – .99 FTE for 100 consumers	At least 1 full-time psychiatrist assigned directly to 100-consumer program
H8	**Nurse on team:** At least 2 full-time nurses assigned for a 100-consumer program	Less than .20 FTE regular nurse for 100 consumers	.20 – .79 FTE for 100 consumers	.80 – 1.39 FTE for 100 consumers	1.40 – 1.99 FTE for 100 consumers	2 full-time nurses or more are members for 100-consumer program
H9	**Substance abuse specialist on team:** A 100-consumer program with at least 2 staff members with 1 year of training or clinical experience in substance abuse treatment	Less than .20 FTE S/A expertise for 100 consumers	.20 – .79 FTE for 100 consumers	.80 – 1.39 FTE for 100 consumers	1.40 – 1.99 FTE for 100 consumers	2 FTEs or more with 1 year S/A training or supervised S/A experience
H10	**Vocational specialist on team:** At least 2 team members with 1 year training/experience in vocational rehabilitation and support	Less than .20 FTE vocational expertise for 100 consumers	.20 – .79 FTE for 100 consumers	.80 – 1.39 FTE for 100 consumers	1.40 – 1.99 FTE for 100 consumers	2 FTEs or more with 1 year voc. rehab. training or supervised VR experience
H11	**Program size:** Of sufficient absolute size to consistently provide necessary staffing diversity and coverage	Less than 2.5 FTE staff	2.5 – 4.9 FTE	5.0 – 7.4 FTE	7.5 – 9.9	At least 10 FTE staff

Organizational Boundaries

		Ratings / Anchors				
Criterion		**1**	**2**	**3**	**4**	**5**
O1	**Explicit admission criteria:** Has clearly identified mission to serve a particular population. Has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	Has no set criteria and takes all types of cases as determined outside the program	Has a generally defined mission but admission process dominated by organizational convenience	Tries to seek and select a defined set of consumers but accepts most referrals	Typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure	Actively recruits a defined population and all cases comply with explicit admission criteria
O2	**Intake rate:** Takes consumers in at a low rate to maintain a stable service environment.	Highest monthly intake rate in the last 6 months = greater than 15 consumers/month	13 – 15	10 – 12	7 – 9	Highest monthly intake rate in the last 6 months no greater than 6 consumers/month
O3	**Full responsibility for treatment services:** In addition to case management, directly provides psychiatric services, counseling/ psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services.	Provides no more than case management services	Provides 1 of 5 additional services and refers externally for others	Provides 2 of 5 additional services and refers externally for others	Provides 3 or 4 of 5 additional services and refers externally for others	Provides all 5 services to consumers
O4	**Responsibility for crisis services:** Has 24-hour responsibility for covering psychiatric crises.	Has no responsibility for handling crises after hours	Emergency service has program-generated protocol for program consumers	Is available by phone, mostly in consulting role	Provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement	Provides 24-hour coverage
O5	**Responsibility for hospital admissions:** Is involved in hospital admissions.	Is involved in fewer than 5% decisions to hospitalize	ACT team is involved in 5% – 34% of admissions	ACT team is involved in 35% – 64% of admissions	ACT team is involved in 65% – 94% of admissions	ACT team is involved in 95% or more admissions
O6	**Responsibility for hospital discharge planning:** Is involved in planning for hospital discharges.	Is involved in fewer than 5% of hospital discharges	5% – 34% of program consumer discharges planned jointly with program	35% – 64% of program consumer discharges planned jointly with program	65 – 94% of program consumer discharges planned jointly with program	95% or more discharges planned jointly with program
O7	**Time-unlimited services (graduation rate):** Rarely closes cases but remains the point of contact for all consumers as needed.	More than 90% of consumers are expected to be discharged within 1 year	From 38 – 90% of consumers expected to be discharged within 1 year	From 18 – 37% of consumers expected to be discharged within 1 year	From 5 – 17% of consumers expected to be discharged within 1 year	All consumers served on a time-unlimited basis, with fewer than 5% expected to graduate annually

Nature of Services

		Ratings / Anchors				
Criterion		**1**	**2**	**3**	**4**	**5**
S1	**Community-based services:** Works to monitor status, develop community living skills in community rather than in office.	Less than 20% of face-to-face contacts in community	20 – 39%	40 – 59%	60 – 79%	80% of total face-to-face contacts in community
S2	**No dropout policy:** Retains high percentage of consumers.	Less than 50% of caseload retained over 12-month period	50 – 64%	65 – 79%	80 – 94%	95% or more of caseload is retained over a 12-month period
S3	**Assertive engagement mechanisms:** As part of ensuring engagement, uses street outreach and legal mechanisms (probation/parole, OP commitment) as indicated and as available.	Passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms	Makes initial attempts to engage but generally focuses on most motivated consumers	Tries outreach and uses legal mechanisms only as convenient	Usually has plan for engagement and uses most mechanisms available	Demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate
S4	**Intensity of service:** High total amount of service time, as needed.	Average 15 minutes/ week or less of face-to-face contact for each consumer	15 – 49 minutes/ week	50 – 84 minutes/week	85 – 119 minutes/week	Average 2 hours/week or more of face-to-face contact for each consumer
S5	**Frequency of contact:** High number of service contacts, as needed.	Average less than 1 face-to-face contact/ week or fewer for each consumer	1 – 2x/week	2 – 3x/week	3 – 4x/week	Average 4 or more face-to-face contacts/week for each consumer
S6	**Work with informal support system:** With or without consumer present, provides support and skills for consumer's support network: family, landlords, employers.	Less than .5 contact/ month for each consumer with support system	.5 – 1 contact/ month for each consumer with support system in the community	1 – 2 contact/month for each consumer with support system in the community	2 – 3 contacts/month for consumer with support system in the community	4 or more contacts/month for each consumer with support system in the community
S7	**Individualized substance abuse treatment:** 1 or more team members provides direct treatment and substance abuse treatment for consumers with substance-use disorders.	No direct, individualized substance abuse treatment provided	Team variably addresses SA concerns with consumers; provides no formal, individualized SA treatment	While team integrates some substance abuse treatment into regular consumer contact, no formal, individualized SA treatment	Some formal individualized SA treatment offered; consumers with substance-use disorders spend less than 24 minutes/week in such treatment	Consumers with substance-use disorders average 24 minutes/week or more in formal substance abuse treatment
S8	**Co-Occurring disorder treatment groups:** Uses group modalities as treatment strategy for consumers with substance-use disorders.	Fewer than 5% of consumers with substance-use disorders attend at least 1 substance abuse treatment group meeting a month	5 – 19%	20 – 34%	35 – 49%	50% or more of consumers with substance-use disorders attend at least 1 substance abuse treatment group meeting/month
S9	**Dual Disorders (DD) Model:** Uses a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence.	Fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	Uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehab; recognizes need to persuade consumers in denial or who don't fit AA	Uses mixed model: e.g., DD principles in treatment plans; refers consumers to persuasion groups; uses hospitalization for rehab.; refers to AA, NA	Uses primarily DD model: e.g., DD principles in treatment plans; persuasion and active treatment groups; rarely hospitalizes for rehab. Or detox except for medical necessity; refers out some SA treatment	Fully based in DD treatment principles, with treatment provided by ACT staff members
S10	**Role of consumers on team:** Consumers involved as team members providing direct services.	Consumers not involved in providing service	Consumers fill consumer-specific service roles (e.g., self-help)	Consumers work part-time in case-management roles with reduced responsibilities	Consumers work full-time in case management roles with reduced responsibilities	Consumers employed full-time as ACT team members (e.g., case managers) with full professional status

Areas of focus:

(Describe the areas of focus the Center wishes to prioritize for improvement in the coming year as a result of this review; include any recommendations for each area)

ACT Fidelity Report:

Human Resources: Structure and Composition

H1 Small caseload: Consumer/provider ratio = 10:1	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

H2 Team approach: Provider group functions as team rather than as individual ACT team members; ACT team members know and work with all consumers	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

H3 Program meeting: Meets often to plan and review services for each consumer	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

H4 Practicing ACT leader: Supervisor of Frontline ACT team members provides direct services	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

H5 Continuity of staffing: Keeps same staffing over time		**Rating = _____ out of 5**
Comments:		
Sources of Information:		
Recommendations:		

H6 Staff capacity: Operates at full staffing		**Rating = _____ out of 5**
Comments:		
Sources of Information:		
Recommendations:		

H7 Psychiatrist on team: At least 1 full-time psychiatrist for 100 consumers works with program		**Rating = _____ out of 5**
Comments:		
Sources of Information:		
Recommendations:		

H8 Nurse on team: At least 2 full-time nurses assigned for a 100-consumer program		**Rating = _____ out of 5**
Comments:		
Sources of Information:		
Recommendations:		

H9 Substance abuse specialist on team: A 100-consumer program with at least 2 staff members with 1 year of training or clinical experience in substance abuse treatment	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

H10 Vocational specialist on team: At least 2 team members with 1 year training/experience in vocational rehabilitation and support	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

H11 Program size: Of sufficient absolute size to consistently provide necessary staffing diversity and coverage	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

Organizational Boundaries

O1 Explicit admission criteria: Has clearly identified mission to serve a particular population. Has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

O2 Intake rate: Takes consumers in at a low rate to maintain a stable service environment.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

O3 Full responsibility for treatment services: In addition to case management, directly provides psychiatric services, counseling/ psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

O4 Responsibility for crisis services: Has 24-hour responsibility for covering psychiatric crises.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

O5 Responsibility for hospital admissions: Is involved in hospital admissions.		**Rating = _____ out of 5**
Comments:		
Sources of Information:		
Recommendations:		

O6 Responsibility for hospital discharge planning: Is involved in planning for hospital discharges.		**Rating = _____ out of 5**
Comments:		
Sources of Information:		
Recommendations:		

O7 Time-unlimited services (graduation rate): Rarely closes cases but remains the point of contact for all consumers as needed.		**Rating = _____ out of 5**
Comments:		
Sources of Information:		
Recommendations:		

Nature of Services

S1 Community-based services: Works to monitor status, develop community living skills in community rather than in office.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

S2 No dropout policy: Retains high percentage of consumers.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

S3 Assertive engagement mechanisms: As part of ensuring engagement, uses street outreach and legal mechanisms (probation/parole, OP commitment) as indicated and as available.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

S4 Intensity of service: High total amount of service time, as needed.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

S5 Frequency of contact: High number of service contacts, as needed.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

S6 Work with informal support system: With or without consumer present, provides support and skills for consumer's support network: family, landlords, employers.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

S7 Individualized substance abuse treatment: 1 or more team members provides direct treatment and substance abuse treatment for consumers with substance-use disorders.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

S8 Co-Occurring disorder treatment groups: Uses group modalities as treatment strategy for consumers with substance-use disorders.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

S9 Dual Disorders (DD) Model: Uses a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

S10 Role of consumers on team: Consumers involved as team members providing direct services.		**Rating = _____ out of 5**
Comments:		
Sources of Information:		
Recommendations:		

Human Resources: Structure and Composition				
#	**Item**	**Assessor 1**	**Assessor 2**	**Consensus**
H1.	Small Caseload			
H2.	Team Approach			
H3.	Program Meeting			
H4.	Practicing ACT Leader			
H5.	Continuity of Staffing			
H6.	Staff Capacity			
H7.	Psychiatrist on Team			
H8.	Nurse on Team			
H9.	Substance Abuse Specialist on Team			
H10.	Vocational Specialist on Team			
H11.	Program Size			
Organizational Boundaries				
#	**Item**	**Assessor 1**	**Assessor 2**	**Consensus**
O1.	Explicit Admission Criteria			
O2.	Intake Rate			
O3.	Full Responsibility for Treatment Services			
O4.	Responsibility for Crisis Services			
O5.	Responsibility for Hospital Admission			
O6.	Responsibility for Hospital Discharge Planning			
O7.	Time-unlimited Services (Graduation Rate)			
Nature of Services				
#	**Item**	**Assessor 1**	**Assessor 2**	**Consensus**
S1.	Community Based Services			
S2.	No Dropout Policy			
S3.	Assertive Engagement Mechanisms			
S4.	Intensity of Services			
S5.	Frequency of Contact			
S6.	Work with Informal Support System			
S7.	Individualized Substance Abuse Treatment			
S8.	Co-occurring Disorder Treatment Group			
S9.	Dual Disorders (DD) Model			
S10.	Role of Consumers on Team			
	Total Mean Score			

Score Range	Implementation Rating
113 – 140	Good Implementation
85 – 112	Fair Implementation
84 and below	Not Assertive Community Treatment

Appendix 2

The following pages contain the SE Fidelity Review Tool used for SFY2017.

Community Mental Health Center (CMHC)
Supported Employment Fidelity Report
October 2016

CMHC:	
Report Date:	
Review Date:	
Reviewers: *(list all)*	

Overview:
This report describes Individual Placement and Support/Supported Employment (IPS/SE) services. The fidelity review is considered an integral component to complement and validate self-fidelity measures and is intended to promote and assure fidelity to the Dartmouth IPS model and compliance with the Community Mental Health Agreement (CMHA).

Executive Summary:

(Enter brief summary of review results)

This review resulted in a Fidelity rating of:	
Out of a possible 125 points the Center scored:	

Method:

This review consisted of: *(Describe how the Center conducted its review)*

The Supported Employment Fidelity Scale is divided into three sections: including staffing, organization and services. Each item is rated on a 5-point response formation ranging from 1= no implementation to 5= full implementation with intermediate numbers representing progressively greater degrees of implementation. The following sections address the three areas based on the review.

Areas of focus:

(Describe the areas of focus the Center wishes to prioritize for improvement in the coming year as a result of this review; include any recommendations for each area)

IPS Supported Employment Fidelity Report:

Staffing

1. Caseload Size

Employment specialists have individual employment caseloads. The maximum caseload for any full-time employment specialist is 20 or fewer clients.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

2. Vocational Services Staff

Employment specialists provide only employment services.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

3. Vocational Generalists

Each employment specialist carries out all phases of employment services, including intake, engagement, assessment, job placement, job coaching, and follow along supports before step down to a less intensive employment support from another MH practitioner.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

Organization

1. Integration of rehabilitation with mental health treatment through team assignment.

Employment specialists are part of up to 2 mental health treatment teams from which at least 90% of the employment specialist's caseload is comprised.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

2. Integration of rehabilitation with mental health treatment through frequent team contact.

Employment specialists actively participate in weekly mental health treatment team meetings (not replaced by administrative meetings) that discuss individual clients and their employment goals with shared decision-making. Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members. Documentation of mental health treatment and employment services are integrated in a single client chart. Employment specialists help the team think about employment for people who haven't yet been referred to supported employment services.	**Rating = _____ out of 5**
✓ *if applicable*	Employment specialist attends weekly mental health treatment team meetings.
✓ *if applicable*	Employment specialist participates actively in treatment team meetings with shared decision-making.
✓ *if applicable*	Employment services documentation (i.e., vocational assessment/profile, employment plan, progress notes) is integrated into client's mental health treatment record.
✓ *if applicable*	Employment specialist's office is in close proximity to (or shared with) his or her mental health treatment team members.
✓ *if applicable*	Employment specialist helps the team think about employment for people who haven't yet been referred to supported employment services.
Comments:	
Sources of Information:	
Recommendations:	

3. Collaboration between employment specialists and Vocational Rehabilitation.

Employment specialists and VR counselors have frequent contact for the purpose of discussing shared clients and identifying potential referrals.	**Rating = _____ out of 3**
Comments:	
Sources of Information:	
Recommendations:	

4. Vocational Unit.

At least 2 full-time employment specialists and a team leader comprise the employment unit. They have weekly client-based group supervision based on the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed.	**Rating = _____ out of 2**
Comments:	
Sources of Information:	
Recommendations:	

5. Role of employment supervisor.

Supported employment unit is led by a supported employment team leader. Employment specialists' skills are developed and improved through outcome-based supervision. All five key roles of the employment supervisor are present.	**Rating = _____ out of 3**
✓ *if applicable*	One full-time supervisor is responsible for no more than 10 employment specialists. The supervisor does not have other supervisory responsibilities. (Program leaders supervising fewer than 10 employment specialists may spend a percentage of time on other supervisor activities on a prorated basis.)
✓ *if applicable*	Supervisor conducts weekly supported employment supervision designed to review client situations and identify new strategies and ideas to help clients in their work lives.
✓ *if applicable*	Supervisor communicates with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues and to be a champion for the value of work. Attends a meeting for each mental health treatment team on a quarterly basis.
✓ *if applicable*	Supervisor accompanies employment specialists who are new or having difficulty

	with job development, in the field monthly to improve skills by observing, modeling and giving feedback on skills, e.g., meeting employers for job development.
✓ *if applicable*	Supervisor reviews current client outcomes with employment specialists and sets goals to improve program performance at least quarterly.

Comments:	
Sources of Information:	
Recommendations:	

6. Zero exclusion criteria

All clients interested in working have access to supported employment services regardless of job readiness factors, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-adherenece, and personal presentation. These apply during supported employment services, too. Employment specialists offer to help with another job when one has ended regardless of the reason that the job ended or the number of jobs held. If VR has screening criteria, the mental health agency does not use them to exclude anybody. Clients are not screened out formally or informally.	**Rating = _____ out of 5**

Comments:	
Sources of Information:	
Recommendations:	

7. Agency focus on competitive employment.

Agency promotes work through multiple strategies. Agency intake includes questions about interest in competitive employment. Agency displays written postings (e.g., brochures, bulletin boards, posters) about employment and supported employment services. The focus should be with the agency programs that provide services to adults with severe mental illness. Agency supports ways for clients to share work stories with other clients and staff. Agency measures rate of competitive employment and shares this information with agency leaders and staff.	**Rating = _____ out of 3**

✓ *if applicable*	Agency intake includes questions about interest in employment
✓ *if applicable*	Agency includes questions about interest in employment on all annual (or semi-annual) assessment or treatment plan reviews..
✓ *if applicable*	Agency displays written postings (e.g., brochures, bulletin boards, posters) about working and supported employment services, in lobby and other waiting areas
✓ *if applicable*	Agency supports ways for clients to share work stories with other clients and staff (e.g., agency-wide employment recognition events, in-service training, peer support groups, agency newsletter articles, invited speakers at client treatment groups, etc.) at least twice a year.
✓ *if applicable*	Agency measures rate of competitive employment on at least a quarterly basis and shares outcomes with agency leadership and staff.
Comments:	
Sources of Information:	
Recommendations:	

8. Executive Team Support for Supported Employment

Agency executive team members (e.g., CEO/Executive Director, Chief Operating Officer, QA Director, Chief Financial Officer, Clinical director, Medical Director, Human Resource Director) assist with supported employment implementation and sustainability. All five key components of executive team are present.	**Rating = _____ out of 3**
✓ *if applicable*	Executive Director and Clinical Director demonstrate knowledge regarding the principles of evidence-based supported employment.
✓ *if applicable*	Agency QA process includes an explicit review of the IPS SE program, or components of the program, at least every 6 months through the use of the Supported Employment Fidelity Scale, or until achieving high fidelity, and at least yearly thereafter. Agency QA process uses the results of the fidelity assessment to improve IPS SE implementation and sustainability.
✓ *if applicable*	At least one member of the executive team actively participates at IPS SE leadership team (steering committee) meetings that occur at least every six months for high fidelity programs and at least quarterly for programs that have not yet achieved high fidelity. Steering committee is defined as a diverse group of stakeholders charged with reviewing fidelity, program implementation, and the service delivery system. Committee develops written action plans aimed at developing or sustaining high fidelity services.
✓ *if applicable*	The agency CEO/Executive Director communicates how IPS SE services support

	the mission of the agency and articulates clear and specific goals for SE and/or competitive employment to all agency staff during the first six months and at least annually (i.e., SE kickoff, all-agency meetings, agency newsletters, etc.). This item is not delegated to another administrator.
✓ *if applicable*	SE program leader shares information about EBP barriers and facilitators with the executive team (including the CEO) at least twice each year. The executive team helps the program leader identify and implement solutions to barriers.

Comments:	
Sources of Information:	
Recommendations:	

Services

1. Work incentives planning

All clients are offered assistance in obtaining comprehensive individualized work incentives planning (benefits planning) before starting a new job and assistance accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Work incentives planning includes SSA benefits, medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits and any other source of income. Clients are provided information and assistance about reporting earnings to SSA, housing programs, VA programs, etc., depending on the person's benefits	**Rating = _____ out of 5**

Comments:	
Sources of Information:	
Recommendations:	

2. Disclosure

Employment specialists provide clients with accurate information and assist with evaluating their choices to make an informed decision regarding what is revealed to the employer about having a disability.	**Rating = _____ out of 3**

✓ *if applicable*	Employment specialists do not require all clients to disclose their psychiatric disability at the work site in order to receive services..
✓ *if applicable*	Employment specialists offer to discuss with clients the possible costs and benefits (pros and cons) of disclosure at the work site in advance of clients disclosing at the work site. Employment specialists describe how disclosure relates to requesting accommodations and the employment specialist's role communicating with the employer.
✓ *if applicable*	Employment specialists discuss specific information to be disclosed (e.g., disclose receiving mental health treatment, or presence of a psychiatric disability, or difficulty with anxiety, etc.) and offers examples of what could be said to employers.
✓ *if applicable*	Employment specialists discuss disclosure on more than one occasion (e.g., if clients have not found employment after 2 months or if clients report difficulties on the job).

Comments:	
Sources of Information:	
Recommendations:	

3. Ongoing, work-based vocational assessment

Initial vocational assessment occurs over 2-3 sessions and is updated with information from work experiences in competitive jobs. A vocational profile form that includes information about preferences, experiences, skills, current adjustment, strengths, personal contacts, etc. is filed in the client's clinical chart and is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include client, treatment team, clinical records, and with the client's permission, from family members and previous employers.	**Rating = _____ out of 2**

Comments:	
Sources of Information:	
Recommendations:	

4. Rapid search for competitive job.

Initial employment assessment and first face-to-face employer contact by the client or the employment specialist about a competitive job occurs within 30 days (one month) after program entry.	**Rating = _____ out of 4**
Comments:	
Sources of Information:	
Recommendations:	

5. Individualized job search

Employment specialists make employer contacts are aimed at making a good job match based on clients' preferences (relating to what each person enjoys and their personal goals) and needs (including experience, ability, symptomatology, health, etc.) rather than the job market (i.e., those jobs that are readily available). An individualized job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences.	**Rating = _____ out of 2**
Comments:	
Sources of Information:	
Recommendations:	

6. Job development-Frequent employer contact

Each employment specialist makes at least 6 face-to-face employer contacts per week on behalf of clients looking for work. (Rate for each then calculate average and use the closest scale point.) An employer contact is counted even when an employment specialist meets an employer twice in one week, and when the client is present or not present. Client specific and generic contacts are included. Employment specialists use a weekly tracking form to document employer contacts and the form is reviewed by the supervisor on a weekly basis.	**Rating = _____ out of 2**
Comments:	
Sources of	

Information:	
Recommendations:	

7. Job development-Quality of employer contact

Employment specialists build relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, and describe client's strengths that are a good match for the employer.	**Rating = _____ out of 3**
Comments:	
Sources of Information:	
Recommendations:	

8. Diversity of jobs developed.

Employment specialists assist clients in obtaining different types of jobs.	**Rating = _____ out of 3**
Comments:	
Sources of Information:	
Recommendations:	

9. Diversity of employers.

Employment specialists assist clients in obtaining jobs with different employers.	**Rating = _____ out of 3**
Comments:	
Sources of Information:	
Recommendations:	

10. Competitive jobs.

Employment specialists provide competitive jobs options that have permanent status rather than temporary or time-limited	**Rating = _____ out of 2**

status, (e.g., transitional employment positions). Competitive jobs pay at least minimum wage, are jobs that anyone can apply for and are not set aside for people with disabilities. (Seasonal jobs and jobs from temporary agencies that other community members use are counted as competitive jobs.)	
Comments:	
Sources of Information:	
Recommendations:	

11. Individualized follow-along supports

Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Supports are provided by a variety of people including treatment team members (i.e., medication changes, social skills training, encouragement), family, friends , co-workers (i.e., natural supports) and employment specialist. Employment specialist also provides employer support (e.g., educational information, job accommodations) at client's request. Employment specialists offer help with career development, i.e., assistance with education, a more desirable job, or more preferred job duties.	**Rating = _____ out of 3**
Comments:	
Sources of Information:	
Recommendations:	

12. Follow-along supports – Time unlimited

Employment Specialists have face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily and desired by clients. Clients are transitioned to step down job supports from a mental health worker following steady employment. Employment specialists contact clients within 3 days of learning about a job loss.	**Rating = _____ out of 3**
Comments:	

Sources of Information:	
Recommendations:	

13. Community-based services

Employment services such as engagement, job finding and follow-along supports are provided in natural community settings by all employment specialists. (Rate each employment specialist based upon their total weekly scheduled work hours then calculate the average and use the closest scale point.).	**Rating = _____ out of 4**
Comments:	
Sources of Information:	
Recommendations:	

14. Assertive engagement and outreach by integrated team.

Service termination is not based on missed appointments or fixed time limits. Systematic documentation of outreach attempts. Engagement and outreach attempts made by integrated team members. Multiple home/community visits. Coordinated visits by employment specialist with integrated team member. Connect with family, when applicable. Once it is clear that the client no longer wants to work or continue in SE services, the team stops outreach.	**Rating = _____ out of 5**
Comments:	
Sources of Information:	
Recommendations:	

Staffing		
#	**Item**	**Score**
1.	Caseload size	
2.	Employment services staff	
3.	Vocational generalists	
Organization		
#	**Item**	**Score**
1.	Integration of rehabilitation with mental health thru team assignment	
2.	Integration of rehabilitation with mental health thru frequent team member contact	
3.	Collaboration between employment specialists and Vocational Rehabilitation	
4.	Vocational unit	
5.	Role of employment supervisor	
6.	Zero exclusion criteria	
7.	Agency focus on employment	
8.	Executive team support for SE	
Services		
#	**Item**	**Score**
1.	Work incentives planning	
2.	Disclosure	
3.	Ongoing, work-based vocational assessment	
4.	Rapid job search for competitive job	
5.	Individualized job search	
6.	Job development—Frequent employer contact	
7.	Job development—Quality of employer contact	
8.	Diversity of job types	
9.	Diversity of employers	
10.	Competitive jobs held	
11.	Individualized follow-along supports	
12.	Time unlimited follow-along supports	
13.	Community-based services	
14.	Assertive engagement and outreach by integrated treatment team	
	Total:	

Score Range	Fidelity Level
115 – 125	Exemplary Fidelity
100 – 114	Good Fidelity
74 – 99	Fair Fidelity
73 and below	Not Supported Employment