# New Hampshire Community Mental Health Agreement

## Expert Reviewer Report Number Nine

## January 21, 2019

# I. Introduction

This is the ninth 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.*[1] 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 (June 1, 2018 through December 31, 2018), 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:

- Met with a clinical team at New Hampshire Hospital (NHH) to review transition planning processes and issues;
- Participated in an individual transition planning meeting, and met with Glencliff clinical staff to discuss transition planning processes and issues;
- Reviewed the Preadmission Screening and Resident Review (PASRR) and Minimum Data Set (MDS) records for the six most recent admissions to Glencliff;
- Met with the DHHS Central Team;
- Met with DHHS and PASRR Contract agency staff to discuss the PASRR process and data reporting;

[1] Due to the lapse in appropriations, the United States was unable to provide input on a draft of this report that was circulated to the parties prior to finalization.

- Observed the Quality Service Review (QSR) conducted at Seacoast Mental Health Center;
- Met with the DHHS CMHA leadership team to discuss data reporting and progress being made in the implementation of CMHA standards and requirements;
- Conducted on-site reviews at the Monadnock and West Central Behavioral Health Centers. These on-site reviews included meetings with the respective Assertive Community Treatment (ACT) teams, reviews of ACT service recipient records, and meetings with senior clinical and administrative leadership;
- Met with DHHS staff to review the process for monitoring progress and performance related to CMHC implementation of Quality Improvement Plan (QIP) action plans. This included participation in telephone calls related to the QSR QIP action plan for Riverbend Mental Health Center and the ACT fidelity QIP for Greater Nashua Mental Health Center;
- Met with senior officials of DHHS and the NH Department of Justice to discuss progress in meeting the requirements of the CMHA;
- Met with DHHS Quality Management/Quality Service Review (QM/QSR) staff to discuss the Seacoast QSR review;
- Participated in a status conference with Judge McAuliffe and representatives of all parties to the CMHA; and
- Convened an All Parties meeting to discuss progress in meeting the requirements of the CMHA.

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

**Summary of Progress to Date**

This report reflects the end of four and one half years of implementation of the CMHA. At this point in the process it is possible to document that some positive steps have been taken to improve the quality and effectiveness of services as envisioned in the CMHA. However, as will be discussed in detail below, implementation issues remain time consuming and frustrating, and there are areas of continued non-compliance with the CMHA. Notwithstanding these on-going concerns, the parties to the CMHA deserve credit for some real and measurable accomplishments.

As noted in the previous ER Report, the State has implemented a comprehensive and reliable QSR process. The QSR has been carried out in ten CMHA regions this fiscal year. The ER considers these QSR reviews to be methodologically correct and reliable, and that the QSR

reviews are producing findings that are accurate and actionable in terms of taking concrete steps to address quality issues in the CMHC system.

Another major accomplishment has been contracting with the Dartmouth-Hitchcock Medical Center to conduct external ACT and Supported Employment (SE) fidelity reviews using nationally validated fidelity review instruments and criteria. In concert with the QSR reviews mentioned above, the fidelity reviews are assisting the state and the CMHCs to develop comprehensive QIPs that address important ACT and SE quality and effectiveness issues at both the consumer and CMHC operational levels.[2]

Statewide data from both the QSR and fidelity reviews are reported later in this report. The ER envisions that these findings will play a central role in any final assessment of compliance with the CMHA, and in demonstrating the sustainability of systemic changes during the one year maintenance of effort period. This data may also provide a framework for the negotiation of terms for joint disengagement from the CMHA.

Much remains to be accomplished to meet all the requirements of the CMHA. The parties originally anticipated that the CMHA could be fully implemented in five years, with a sixth year for maintenance of effort. The CMHA was approved and filed with the Federal Court on February 12, 2014, and the five-year anniversary of that event is less than a month away. The ER was approved by the Parties and the Federal Court effective July 1, 2014, and the five-year anniversary of that event is six months from now. Thus it is critical for this report and for subsequent activities that the focus be on specific strategies and action steps necessary to meet all the requirements of the CMHA, and to plan for total or partial disengagement.

# II. Data

As noted in previous reports, the New Hampshire DHHS continues to make progress in developing and delivering data reports addressing performance in some domains of the CMHA. Appendix A contains the most recent DHHS Quarterly Data Report (July to September, 2018), incorporating standardized report formats with clear labeling and date ranges for several important areas of CMHA performance. The capacity to conduct and report longitudinal analyses of trends in certain key indicators of CMHA performance continues to improve.

However, as will be detailed in subsequent sections of this report, the State has not yet completed its work to produce additional data requested by the ER. Examples include:

1. Complete and comparable data on the extent to which participation in SE results in integrated competitive employment;

[2] The ER also notes, as will be discussed below, that the State remains in compliance with regard to statewide SE penetration rates.

2. Data on the extent to which participants in the Bridge Subsidy program are connected to and receive services from the CMHCs; and
3. Data on the extent to which CMHC outreach, screening and assessment activities result in actual enrollment in ACT services.

The ER continues to be concerned with delays in reporting. DHHS has acquired new staffing, and is providing renewed management attention to the data reporting processes. Report timeliness and contents are improving as of this report. **However , it remains critical that all data and agreed-upon reports are provided on a timely delivery schedule.**

# III. CMHA Services

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

## Mobile/Crisis and Crisis Apartment Programs

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

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

Table I below includes the most recent available information on activities of these three MCT/Crisis Apartment Programs.[3][4]

[3] At this point the three CMHCs hosting MCT and Crisis Apartment programs report data from their programs in different ways and not all programs report the same data elements. Thus, the data in Table I are difficult to correlate and interpret. The ER has requested that these data be made consistent in future reports.
[4] The ER has questions about the reported (or not reported) data in the "after immediate crisis" category. These may be amended and/or expanded after further review.

**Table I**
**Self-Reported Data on Mobile Crisis Services and Crisis Apartment Programs**

| | Concord July - September 2018 | Manchester July -September 2018 | Nashua July - September 2018 |
|---|---|---|---|
| Total unduplicated people served | 519 | 533 | 490 |
| Services provided in response to immediate crisis: | | | |
| • Phone support/triage | 776 | 1693 | 459 |
| • Mobile assessments | 206 | 284 | 501 |
| • Crisis stabilization appointments | 69 | | 0 |
| • Emergency services medication appointments | 4 | 13 | 0 |
| • Crisis apartment serv. | | 465 | |
| • Office based urgent assessments | 53 | 41 | 168 |
| • Case Management | | | 395 |
| • Peer support | | | 371 |
| Services provided after the immediate crisis: | | | |
| • Phone support/triage | 151 | | |
| • Mobile assessments | 32 | Not | Not |
| • Crisis stabilization appointments | 61 | Reported | Reported |
| • Emergency services medication appointments | 4 | | |
| • Office based Urgent Assessments | 53 | | |
| Referral source: | | | |
| • Self | 477 | 433 | 267 |
| • Family | 16 | 97 | 51 |
| • Guardian | 30 | 10 | 1 |
| • Mental health provider | 24 | 19 | 53 |
| • Primary care provider | 7 | 31 | 4 |
| • Hospital emergency department | 6 | 5 | 1 |
| • Police | 18 | 205 | 10 |
| • CMHC Internal | 34 | 44 | 89 |
| • Friend | 5 | 17 | 15 |
| • Other | 7 | 104 | 593 |
| Crisis apartment admissions: | 80 | 29 | 88 |
| • Bed days | 327 | 114 | 436 |
| • Average length of stay | 4.1 | 3.9 | 4.9 |
| Law enforcement involvement | 44 | 205 | 10 |
| Total hospital diversions[5] | 686 | 993 | 1,108 |

[5] 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. DHHS and the MCT providers have developed specific definition of hospital diversions, which will be utilized for future MCT reports.

The Quarterly Data Report in Appendix A contains some historical data for the three regional MCT/Crisis Apartment programs.

As noted in the previous report, the number of hospital diversions reported by the MCTs seems disproportionate, given the continued high admission and readmission rates for NHH and the Designated Receiving Facilities (DRFs), and the high number of people waiting on a daily basis for admission to NHH. The ER plans to visit each of the Mobile Crisis Team programs in the upcoming months to explore in greater depth how these diversions are occurring and being recorded. As part of these visits, the ER will also examine the MCT phone triage process and criteria used determine whether a mobile crisis intervention is delivered in community.

## Assertive Community Treatment

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 (42 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[6] adult ACT teams in New Hampshire actually decreased by .61 FTEs since December of 2016, and has only increased by 2.47 FTE since June of 2018. During the same time period, the 12 ACT teams added only 72 average monthly service participants.[7]

[6] Note: one new ACT team was funded in the Nashua Region, thereby increasing the number of teams from 11 to 12.

[7] Because of service participant turnover, the total number of people served across several months and quarters is somewhat higher than the monthly number of service participants.

## Table II

## Self-Reported ACT Staffing (excluding psychiatry): December 2016 – September 2018

| Region | FTE Dec-16 | FTE Mar-17 | FTE Jun-17 | FTE Sep-17 | FTE Dec-17 | FTE Mar-18 | FTE Jun-18 | FTE Sep-18 |
|---|---|---|---|---|---|---|---|---|
| Northern | 11.49 | 11.89 | 12.54 | 12.43 | 13.04 | 11.64 | 12.73 | 13.07 |
| West Central | 5.5 | 7.75 | 7.15 | 6.95 | 6.2 | 5 | 5.15 | 5.25 |
| Lakes Region | 11 | 11 | 10.6 | 10.8 | 9.4 | 5.7 | 5.55 | 8.35 |
| Riverbend | 9 | 10 | 10 | 10 | 10 | 10.25 | 10.50 | 10.50 |
| Monadnock | 7.25 | 6.7 | 8.5 | 7.9 | 7.9 | 8.7 | 8.50 | 8.70 |
| Greater Nashua 1 | 6.25 | 6.25 | 5.25 | 6 | 5 | 5.75 | 5.75 | 5.50 |
| Greater Nashua 2 | 5.25 | 5.25 | 5.25 | 5 | 5 | 5.75 | 5.75 | 4.50 |
| Manchester – CTT | 15.53 | 14.79 | 16.57 | 16.27 | 12.83 | 17.26 | 15.50 | 14.75 |
| Manchester MCST | 21.37 | 21.86 | 21.95 | 22.31 | 19.04 | 19.51 | 16.25 | 17.75 |
| Seacoast | 9.53 | 9.53 | 9.53 | 10.53 | 10.53 | 11.53 | 9.53 | 10.53 |
| Community Part. | 6.85 | 4.08 | 8.53 | 6.73 | 7.85 | 9.75 | 9.60 | 9.13 |
| CLM | 7.17 | 8.3 | 9.3 | 9.3 | 9.3 | 9.3 | 8.30 | 7.55 |
| Total | 116.19 | 117.4 | 125.17 | 124.22 | 116.09 | 120.14 | 113.11 | 115.58 |

It is clear from the above table that overall ACT staffing has remained low, and for five teams has actually decreased over the past four reporting periods. Three of the 12 adult ACT teams continue to have fewer than the 7 - 10 professionals specified for ACT teams in the CMHA. Four teams now report having no peer specialist on the ACT Team, the same number of teams with no peer support staff in the previous report. Five teams report having at least one FTE peer specialist, but seven of the 12 teams continue to report having less than one FTE peer specialist. Seven teams have at least 1.0 FTE SE staff, while five have less than a full time SE specialist. One team had no SE staff at the time of the most recent report. Six teams report having .5 or less FTE combined psychiatry/nurse practitioner time available to their ACT teams[8]; and six of the 12 teams report having less than one FTE nurse per team. **Staff deficiencies, as noted above, render some of the current ACT teams out of compliance with the ACT service requirements in CMHA V.D.2(d) as of the date of the Quarterly Data Report.**

Table III below displays the active ACT caseloads by CMHC Region for the past 18 months. As noted above, the active monthly caseload has increased by only 72 participants. Since June of 2017 the active monthly caseload has actually decreased by 95 participants. Several ACT teams are reporting caseloads at or near their lowest levels since December 2016.

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

**Table III**

**Self-Reported ACT Caseload (Unique Adult Consumers) by Region in Specified Months: December 2016 – September 2018**

| Region | **Active Cases Dec-16** | Active Cases Mar-17 | Active Cases Jun-17 | Active Cases Sep-17 | Active Cases Dec-17 | Active Cases Mar-18 | **Active Cases Jul-18** | Active Cases Sep-18 |
|---|---|---|---|---|---|---|---|---|
| Northern | 104 | 108 | 111 | 113 | 115 | 114 | 108 | 102 |
| West Central | 32 | 53 | 76 | 68 | 57 | 46 | 45 | 44 |
| Lakes Region | 64 | 70 | 74 | 74 | 65 | 64 | 59 | 53 |
| Riverbend | 73 | 83 | 97 | 87 | 81 | 80 | 78 | 82 |
| Monadnock | 63 | 64 | 70 | 69 | 53 | 55 | 55 | 55 |
| Greater Nashua | 74 | 83 | 94 | 98 | 76 | 74 | 85 | 84 |
| Manchester | 248 | 270 | 292 | 287 | 269 | 277 | 302 | 306 |
| Seacoast | 65 | 64 | 69 | 67 | 54 | 66 | 69 | 69 |
| Community Part. | 70 | 67 | 69 | 75 | 64 | 66 | 59 | 61 |
| CLM | 47 | 55 | 55 | 54 | 55 | 59 | 57 | 55 |
| Total* | 839 | 913 | 1,006 | 992 | 881 | 901 | 917 | 911 |

* unduplicated across regions

The combined ACT teams have a reported September 2018 staff complement of 115.58 FTEs excluding psychiatry, which is sufficient capacity to serve 1,158 individuals based on the ACT non-psychiatry staffing ratios contained in the CMHA.[9] Note that this is a minor (+2.47 FTE) increase in staff-based capacity from the previous ER report. With a statewide caseload of 911 as of September 2018, the existing teams should theoretically be able to accept an additional 247 new ACT clients without additional staff. Tapping into this unused capacity with appropriate outreach and targeting should have an impact on alleviating ED boarding and hospital

[9] The total psychiatry capacity is 6.90 FTE, which is sufficient to serve 966 individuals based on the CMHA's psychiatry staffing ratios.

readmission rates across the state. Further, the CMHA requires the State to have capacity to serve 1,500 individuals, but the current ACT capacity of 1,158 is 342 below CMHA criteria.

**As noted in previous reports, the current level of ACT staffing is not sufficient to meet CMHA requirements for ACT team capacity. Furthermore, current ACT enrollment of 911 individuals is 589 below the number that could be provided ACT services with the capacity required by the CMHA.**

### ACT Screening

As has been documented in previous reports, the State has been implementing a number of strategies to increase ACT enrollment and participation. One of these strategies has been to require the ten CMHCs to conduct and report regular clinical screening for eligibility/appropriateness for ACT services, These clinical screens are conducted:

1. As part of the intake process at the CMHCs; [10]
2. Upon referral to a CMHC following discharge from an inpatient facility; and
3. As part of regular quarterly and annual assessments and plan of care amendments for current CMHC clients (including current active ACT participants) who may qualify for and benefit from ACT.

Table IV below presents data on ACT screens conducted by CMHCs between January and March, 2018 and then September, 2018. This is the third reporting period in which these data are available, and it is too early to interpret or draw conclusions from them. The State continues to work on producing a report of the degree to which ACT screening and assessment activities result in ACT enrollments.

[10] Note that a CMHC intake incorporating the ACT screen is performed when a CMHC emergency services staff or Mobile Crisis Team encounters and refers a person potentially needing CMHC services. In some cases these Emergency Services/ MCT referrals are made on behalf of individuals who have presented in crisis in hospital emergency departments and who may be waiting for a NHH admission. It would be useful to collect data on, and report the outcome of, these crisis screens/referrals, since ACT enrollment at this critical stage would support statewide diversion efforts and help members of the target population avoid unnecessary hospital admissions.

**Table IV**

**Self-Reported Number of Unique Clients Screened for ACT Services**

**Conducted by CMHCs**

| Community Mental Health Center | January 2018 | February 2018 | March 2018 | Sept 2018 |
|---|---|---|---|---|
| 01 Northern Human Services | 157 | 121 | 217 | 314 |
| 02 West Central Behavioral Health | 45 | 41 | 85 | 81 |
| 03 Lakes Region Mental Health Center | 181 | 250 | 244 | 156 |
| 04 Riverbend Community Mental Health Center | 500 | 445 | 598 | 456 |
| 05 Monadnock Family Services | 239 | 159 | 226 | 175 |
| 06 Community Council of Nashua | 416 | 412 | 534 | 281 |
| 07 Mental Health Center of Greater Manchester | 783 | 735 | 690 | 971 |
| 08 Seacoast Mental Health Center | 158 | 652 | 435 | 436 |
| 09 Community Partners | 207 | 170 | 202 | 167 |
| 10 Center for Life Management | 133 | 161 | 151 | 99 |
| **Total** | **2,819** | **3,146** | **3,382** | **3,136** |

Of the 3,136 unique individuals screened for ACT during this period, the State reports that 217 were referred for an ACT assessment. This is a referral rate of less than seven percent. Most of the referrals for ACT screening are internal to the CMHCs. That is, people who have already had a CMHC intake, and who may already be receiving CMHC services, are those most likely to be screened for ACT services. Thus, it is perhaps not surprising that so few of the individuals screened are referred to the next step, which is the assessment for ACT. If this trend continues, it will be even more important to evaluate and expand screening efforts at other points of entry to the service system, including interactions with emergency departments, CMHC emergency services, and MCTs. In the next Quarterly Report the State will begin reporting the number of people enrolled in ACT as a result of this screening and assessment process.

The State has begun collecting and reporting data on the number of individuals waiting for ACT services on a statewide basis. This information is displayed in Table V below. An individual eligible for ACT may have to wait for ACT services because the specific ACT team of the individual's CMHC does not currently have staff capacity to accept new clients. The ER has documented above that there is a statewide gap between ACT staff capacity and ACT participation. However, in some CMHC regions new ACT staff must be hired before new ACT clients can be accepted into the program.

**Table V**

**Self-Reported ACT Wait List: March and September, 2018**

| | | Time on List | | |
|---|---|---|---|---|
| | **Total** | **0-30 days** | **31-60 days** | **61-90 days** |
| March 2018 | 9 | 7 | 2 | 0 |
| June 2018 | 3 | 3 | 0 | 0 |
| September 2018 | 11 | 9 | 2 | 0 |

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

As noted in recent ER Reports, the New Hampshire DHHS has taken deliberate steps to work with CMHCs in certain Regions to increase their ACT staffing and caseloads. These actions include: (a) quarterly ACT monitoring and technical assistance with DHHS leadership and staff; (b) implementation of a firm schedule for ACT fidelity reviews; (c) incorporating a small increase in ACT funding into the Medicaid rates for CMHCs; (d) active on-site and telephonic technical assistance based on CMHC needs related to improving the quality and fidelity of ACT services; and (e) substantial and coordinated efforts to address workforce recruitment and retention.

However, Dartmouth fidelity reviews for the ten CMHC regions have revealed some deficient practices that are not in fidelity with the ACT model. Currently all ten CMHCs meet at least the minimum threshold for "fair" fidelity of ACT services.[11] However, for eight of the ten CMHCs the fidelity scores have gone down by an average of 10 points in a year to year comparison of total ACT fidelity scores.[12] More information is provided on QSR and Fidelity activities in the QSR section of this report.

As of the date of this report the ER has reviewed ten QSR reports using the revised instruments. Nine of the ten CMHCs covered by these QSR reviews had scores below the 70% performance

[11] Note: meeting the minimum threshold for ACT fidelity does not equate to meeting the requirements of the CMHA. ACT staffing requirements in the CMHA are more specific, in some regards, than the ACT Fidelity tool.
[12] Some of this change may have resulted from the states shift to a contracted external organization to conduct ACT and SE fidelity reviews.

threshold on the QSR quality indicator related to the fidelity of ACT services. Quality Improvement Plans (QIPs) have been initiated based on these QSR findings. The State notes, and the ER agrees, that the QSR findings are not a substitute for the ACT fidelity reviews. Nonetheless, as intended in the design of the QSR, the QSR findings add important documentation of the degree to which ACT participants are or are not benefitting from fidelity ACT services. Taken together, the fidelity reviews and the QSR findings present reasonable and actionable information related to the quality and effectiveness of ACT services under the CMHA. The ER continues to review the State's oversight and technical assistance conducted to assure that these QIPs are being properly implemented.

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 (EDs) waiting for a psychiatric hospital admission, or who have done so in the recent past, are one important source of potential referrals. DHHS is attempting to document 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, over a quarter of all those discharged from NHH are readmitted within 180 days. Robust ACT services could help reduce the number of hospital readmissions throughout the state if such individuals are promptly screened and referred, and their regional ACT teams have the capacity to deliver needed services.

The ER has requested that the State provide a report of the results of these activities. To date, the only report available addresses internal CMHC screening for ACT (see Table IV above), but does not report on the extent to which referrals from hospital EDs or other external sources are resulting in new enrollments in ACT services.

The State has identified workforce recruitment and retention issues as factors limiting the growth and expansion of the ACT teams. The State has been working collaboratively with the New Hampshire Community Behavioral Health Association to identify and track workforce gaps and shortages, and to implement a variety of strategies to improve workforce recruitment and retention. However, as noted above, ACT staffing has remained essentially static since December of 2016. Recently, the State has received approval from the federal Centers for Medicare and Medicaid Services (CMS) to use Medicaid waiver funds for directed payments (fee schedule adjustment) to CMHCs for recipients already enrolled in ACT and for each new ACT enrollee. CMS has also approved a fee schedule increase for people discharged from psychiatric inpatient services who receive a same- or next-day appointment at a CMHC. Taken together, these initiatives should provide incentives for CMHCs to sustain and increase their ACT caseloads. Three million dollars has been set aside under this plan to provide fee schedule increased for ACT enrollees. An additional 1.2 million dollars has been budgeted for same or next day CMHC appointments. The impact of this new funding is not likely to be measurable until at least the next ER report in June, 2019.

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

**The ER emphasizes, as in past reports, that it must be the first priority of the State and the CMHCs to focus on: 1) assuring required ACT team composition; 2) utilizing existing ACT team capacity; 3) increasing ACT team capacity; and 4) outreach to and enrollment of new ACT clients. As noted earlier in this report, the ER expects the State to propose new and expanded strategies for increasing ACT capacity to meet the requirements of the CMHA. The strategies and related timelines are to be incorporated into the ACT plan and Monthly Progress Report. In addition, the ER has requested representatives of the State and the Plaintiffs to participate in a short-term working group to focus on strategies to meet the CMHA requirements for ACT services. This working group is expected to deliver recommendations to the parties no later than April 1, 2019.**

## 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 25.9 percent, 39 percent above the 18.6% penetration rate target specified in the CMHA. Table VI below shows the SE penetration rates for each of the 10 Regional CMHCs in New Hampshire.

**Table VI**

**Self-Reported CMHC SE Penetration Rates**

| | Dec-16 | Mar-17 | Jun-17 | Sep-17 | Dec-17 | Mar-18 | Jun-18 | Sep-18 |
|---|---|---|---|---|---|---|---|---|
| Northern | 27.00% | 32.30% | 37.20% | 40.90% | 39.00% | 38.80% | 36.90% | 32.10% |
| West Central | 21.50% | 23.20% | 22.50% | 22.30% | 25.30% | 26.20% | 31.20% | 33.80% |
| Lakes Reg. | 14.50% | 12.60% | 22.00% | 20.70% | 19.10% | 15.40% | 12.10% | 11.80% |
| Riverbend | 13.80% | 15.00% | 14.80% | 14.00% | 13.20% | 12.60% | 11.80% | 16.60% |
| Monadnock | 17.90% | 13.50% | 14.00% | 12.30% | 10.90% | 10.40% | 11.00% | 9.30% |
| Greater Nashua | 12.40% | 15.00% | 16.10% | 17.10% | 16.80% | 14.90% | 14.20% | 12.60% |
| Manchester | 43.10% | 39.80% | 40.00% | 42.00% | 45.30% | 43.50% | 44.10% | 44.10% |
| Seacoast | 12.00% | 14.40% | 19.30% | 23.40% | 28.00% | 30.10% | 29.80% | 29.90% |
| Community Part. | 6.80% | 7.20% | 10.30% | 14.60% | 17.70% | 21.50% | 20.90% | 19.20% |
| CLM | 21.10% | 19.70% | 21.60% | 19.20% | 20.00% | 20.90% | 17.50% | 20.80% |
| CMHA Target | 18.10% | 18.60% | 18.60% | 18.60% | 18.60% | 18.60% | 18.60% | 18.60% |
| Statewide Ave. | 22.90% | 23.20% | 25.30% | 26.40% | 26.70% | 26.40% | 25.90% | 25.90% |

As noted in Table VI, the State has exceeded the statewide CMHA penetration rate in recent reporting periods. In the previous ER report, six of the ten regions fell below required CMHA penetration rates. For this reporting period, four of the ten continue to report penetration rates lower than the CMHA requirement. Three of these four had a slight reduction in penetration from the previous reporting period.

The New Hampshire DHHS is to be commended for continuing its efforts to: (a) assure the fidelity of SE services on a statewide basis; and (b) work with the Regions with penetration rates below CMHA criteria to increase access to and delivery of SE services to target population members in their Regions. The ER will continue to monitor these issues going forward as the State works with the CMHCs to increase penetration rates to at least 18.6 percent in all regions.

As with ACT services, DHHS has implemented a combination of contract compliance, technical assistance, workforce recruitment and retention, and external fidelity reviews in an attempt to assure sufficient quality and accessibility of SE services statewide. The QSR does collect information at the service participant level about the degree to which individuals have been effectively assessed for SE services, are receiving SE services consistent with their individual treatment plans, and/or that 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 QSR process has identified a number of SE performance issues among the CMHCs. For example, for the indicator related to comprehensive employment assessments, eight of the ten CMHCs scored below the 70% performance threshold. In the same manner, nine of the ten CMHCs scored below 70% on the indicator related to the adequacy of employment service delivery. Three of the CMHCs scored below the 70% threshold on the indicator related to employment treatment planning. In each case these findings have resulted in the development of QIPs, and in state technical assistance and monitoring activities designed to improve the quality and effectiveness of SE services. As with ACT services, the QSR findings are not a substitute for SE fidelity reviews, but they do add to the overall documentation of the degree to which SE services are delivered with quality and effectiveness. For example, a SE team can operate at relatively high fidelity, but if individuals are not assessed properly for inclusion in SE services, there could be issues related to matching individual needs with the services available.

System performance in supported employment assessment and service delivery, as documented by the QSR and corresponding provider fidelity reviews, indicates that the State is not yet providing 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, and that eligible individuals may not be properly identified and provided reasonable access to supported employment services.

The State has initiated reporting requirements in which each CMHC will report on the number and percent of SE participants working in integrated competitive settings. These data are not yet fully accurate and comparable, and thus are not included and discussed in this report. The ER expects these data will be ready to be included in subsequent Quarterly Data and ER reports.

## Supported Housing

The CMHA requires the State to achieve a target capacity of 450 SH units funded through the Bridge Program by June 30, 2016. As of September 2018, DHHS reports having 423 individuals leased in Bridge Program subsidized units, and having no people approved for a Bridge Program subsidy but not yet leased (although, as discussed below, there are 35 people on the waitlist for a Bridge subsidy). There has been a precipitous drop in the aggregate number of individuals either leased or approved but not yet leased in the Bridge Program – from 591 in June of 2017 to 423 in September of 2018. In terms of funded capacity of Bridge Program units, the State was in compliance with the CMHA standards for SH effective June 30, 2016. However, as noted above, the number has now dropped below 450, and currently there are no individuals reported to be approved and in the search process for a SH unit.

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

**Table VII**

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

**September 2015 through March 2018**

| Bridge Subsidy Program Information | Sept. 2016 | Dec. 2016 | March 2017 | June 2017 | Sept. 2017 | March 2018 | Sept. 2018 |
|---|---|---|---|---|---|---|---|
| Total individuals receiving a Bridge Program Subsidy | 451 | 481 | 505 | 545 | 509 | 497 | 423 |
| Individuals accepted but waiting to lease | 28 | 32 | 48 | 46 | 58 | 7 | 0 |
| Individuals currently on the wait list for a bridge subsidy[13] | 0 | 0 | 0 | 0 | 0 | 10 | 35 |
| Total number served since the inception of the Bridge Subsidy Program | 603 | 643 | 675 | 701 | 742 | 811 | 812 |
| Total number receiving a HUD Housing Choice Voucher (HCV) | 83 | 83 | 85 | 85 | 96 | 119 | 125 |

In response to previous requests for information, the State, DHHS is now publishing quarterly reports of the number of Bridge Program applications and terminations (Table VIII) and also the wait list for Bridge Program subsidies (see Table VII above).

[13] The State did not maintain a waitlist prior to 2018.

With regard to terminations, Table VII shows that a total of 812 people have been served by the Bridge Program since its inception. It appears that 125 of these 812 individuals have transitioned successfully to HCVs, and thus have moved off the Bridge Program. This includes 29 individuals reported to have transitioned to HCV from September 2017 to September 2018. That leaves a total of 264 Bridge Program exits that are potentially not accounted for in the current data. The State asserts that it intends to provide additional data[14] on the reasons for people who have exited the SH program. Table VIII below is the first step taken by DHHS to report some of these data. The ER expects that expanded reporting on these items will begin with the next Quarterly Data report.

**Table VIII**

**Self-Reported Housing Bridge Subsidy Applications and Terminations**

| Measure | January – March 2018 | April – June 2018 | July – September 2018 |
|---|---|---|---|
| Applications Received | 44 | 28 | 32 |
| Point of Contact<br>CMHCS<br>NHH | 43<br>1 | 24<br>4 | *32*<br>*0* |
| Applications Approved | 10 | 5 | 7 |
| Applications Denied | 0 | 0 | 0 |
| *Denial Reasons* | *NA* | *NA* | *NA* |
| Applications in Process* | 34 | 165 | 197 |
| Terminations | 0 | 0 | 0 |
| *Termination Reasons* | *NA* | *NA* | *NA* |

*These data are currently being audited by BMHS and may be subject to change

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

[14] Prospectively, not retrospectively.

10 units known by the State to be occupied by individuals in the Target Population." (V.E.1(b)). Table IX below displays the reported number of units leased at the same address.

**Table IX**

**Self-Reported Housing Bridge Subsidy Concentration (Density)**

| | Nov. 2016 | Feb. 2017 | May 2017 | Nov. 2017 | Feb 2018 | June 2018 | Sept. 2018 |
|---|---|---|---|---|---|---|---|
| Number of properties with one leased SH unit at the same address | 339 | 349 | 367 | 383 | 372 | 354 | 339 |
| Number of properties with two SH units at the same address | 24 | 23 | 36 | 31 | 35 | 26 | 52 |
| Number of properties with three SH units at the same address | 13 | 14 | 5 | 6 | 13 | 10 | 24 |
| Number of properties with four SH units at the same address | 3 | 4 | 4 | 5 | 4 | 5 | 12 |
| Number of properties with five SH units at the same address | 0 | 0 | 3 | 0 | 1 | 0 | 0 |
| Number of properties with six SH units at the same address | 1 | 1 | 1 | 0 | 0 | 0 | 6 |
| Number of properties with seven + SH units at same address | | 0 | 2 | 3 | 2 | 2 | 17 |

The ER has noted that data in this report does not comport with previous data reports on unit density, or on the number of units under lease. The State is exploring the reasons for these differences, and these data will be verified and corrected in the next ER report. These data

indicate a concerning increase in the unit density of Bridge apartments. The ER expects the State to report information on the number of total SH and non-SH apartment units at each address containing multiple SH units, so that the ER can assess whether the Bridge is operating as a scattered-site program in accordance with the maximum density standards of the CMHA.

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.[15]

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 ER Reports dating back to 2016, 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 who are engaged with a CMHC are actually receiving certain mental health or other services and supports. As noted in the Data section, the ER has not yet received this requested information from the state. The ER expects that such information will be produced and delivered to the ER no later than February 15, 2018.

The CMHA also states that: "By June 30, 2017 the State will make all reasonable efforts to apply for and obtain HUD funding for an additional 150 supported housing units for a total of 600 supported housing units." (CMHA V.E.3(e)) In 2015 New Hampshire applied for and was awarded funds to develop a total of 191 units of supported housing under the HUD Section 811 Program. All of these units will be set aside for people with serious mental illness. As of the date of this report, 28[16] of these new units have been developed and are currently occupied by members of the target population and an additional 89 units are in the development pipeline. It should be noted that over the life of the Bridge Program the State has accessed 125 HUD HCVs. Accessing these HCVs has allowed the State to free up 125 Bridge Program slots for new applicants. The ER plans to work with the state and representatives of the plaintiffs to assure documentation of progress towards the 600 specified units is attained and sustained.

[15] DHHS reports that currently there is one voluntary roommate situation reflected in the above data.
[16] This number likely has increased since the last report. Revised information was not available at the time this report was prepared.

In addition, the CMHA states that "By January 1, 2017, the State will identify and maintain a waitlist of all individuals within the Target Population requiring supported housing services, and whenever there are 25 individuals on the waitlist, each of whom has been on the waitlist for more than two months, the State will add program capacity on an ongoing basis sufficient to ensure that no individual waits longer than six months for supported housing." There are 35 individuals on the wait list for the Bridge program as of September 2018;28 of these individuals have been on the wait list for more than 120 days and 23 of them have been waiting longer than six months for supported housing. The State reports that it has issued an RFP for with an annualized value of $500,000 to add capacity to the Bridge Program. The proposals were to be received by November 29, 2018. To date a vendor has not been selected and the contract for the new Bridge Program capacity has not been awarded. The State has not specified the number of new SH units expected to be added to the Bridge Program as a result of this RFP. The State has asserted that it will notify the ER and representatives of the Plaintiffs as soon as this contract is awarded.

Looking at the above data, it appears that: (1) the number of units under lease for the Bridge Program has fallen below the 450 capacity measure: (2) there are currently no individuals who have been approved for a Bridge subsidy and are actively seeking a unit; and (3) there are at least 28 people on the Bridge Program wait list who have been on the list for more than four months. **The ER is very concerned about these recent data**. In addition, if the information in Table IX is correct, the number of leased units in single occupancy buildings has gone down substantially, while at the same time the number of units in multi-occupancy buildings has increased**. Taken together, it appears that SH is falling further out of compliance with the requirements of the CMHA. The ER intends to review this situation with the State early in the 2019, and will recommend further actions be taken to reverse these trends and to maximize available housing resources.**

## Transitions from Institutional to Community Settings

During the past 48 months, the ER has visited both Glencliff and NHH on at least eight separate occasions to meet with staff engaged in transition planning under the new policies and procedures adopted by both facilities in 2014[17]. Transition planning activities related to specific current residents in both facilities have been observed, and a small non-random sample of resident transition records has been reviewed. Additional discussions have also been held with both line staff and senior clinicians/administrators regarding potential barriers to effective discharge to the most appropriate community settings for residents at both facilities.

The ER has participated in six 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 36 months of operational experience, and has

[17] NHH updated its transition planning policies in 2018.

started reporting data on its activities. As of December, 2018, 50 individuals have been submitted to the Central Team, 31 from Glencliff and 19 from NHH. Of these, the State reports that 24 individual cases have been resolved[18], two individuals are deceased, and 24 individual cases remain under consideration. Table X below summarizes the discharge barriers that have been identified by the Central Team with regard to these 24 individuals. Note that most individuals encounter multiple discharge barriers, resulting in a total higher than the number of individuals reviewed by the Central Team.

**Table X**

**Self-Reported Discharge Barriers for Open Cases Referred from NHH and Glencliff to the Central Team:**

**October, 2018**

| Discharge Barriers | Number for Glencliff | Number for NHH |
|---|---|---|
| **Legal** | **4 (7.7%)** | **3 (15%)** |
| **Residential** | **17 (32.7%)** | **7 (35%)** |
| **Financial** | **5 (9.6%)** | **3 (15%)** |
| **Clinical** | **15 (28.8%)** | **4 (20%)** |
| **Family/Guardian** | **10 (19.2%)** | **2 (10%)** |
| **Other** | **1 (1.9%)** | **1 (5%)** |

**Glencliff**

In the time period from April through September, 2018, Glencliff reports that it has admitted 14 individuals, and has had three discharges and 16 deaths.

The average daily census through this period was 115 people. There has been one readmission during this time frame. The wait list for admission has remained relatively constant at 22 to 23 people for the past six months. Of the three discharges effectuated during this period, none was to an integrated community setting.

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

CMHA Section VI requires the State to develop effective transition planning and a written transition plan for all residents of NHH and Glencliff (VI.A.1), 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][19] 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."[20]

DHHS reports that the total number of people transitioned from Glencliff to integrated settings since the inception of the CMHA three years ago increased since the last ER Report from 16 to 17[21]. There are currently nineteen individuals undergoing transition planning who could be transitioned to integrated community settings once appropriate living settings and community services become available. Twelve of these individuals have been assigned to Choices for Independence (CFI) waiver case management agencies in order to access case management in the community to facilitate transition planning. The remaining seven individuals are in the process of eligibility determination for the Acquired Brain Disorder, Developmentally Disabled, or Choices for Independence waiver programs.

DHHS continues to provide information about Glencliff transitions, including clinical summaries, lengths of stay, location and type of community integrated setting, and array of individual services and supports arranged to support them in the integrated community settings. This information is important to monitor the degree to which individuals with complex medical conditions that could not be cost-effectively be served in SH continue to experience transitions to integrated community settings. To protect the confidentiality of individuals transitioned from Glencliff, this person-specific information is not included in the ER reports.

DHHS has implemented action steps to enhance the process of: (a) identifying Glencliff residents wishing to transition to integrated settings; and (b) increasing the capacity, variety and geographic accessibility of integrated community settings and services available to meet the needs of these individuals. Both sets of initiatives are intended to facilitate such community transitions for additional Glencliff residents. Despite these efforts, the frequency of transitions to integrated community settings from Glencliff has reduced in the past year. DHHS is currently working to revise funding procedures and provider related requirements to facilitate new transitions to integrated setting on a timelier basis. The ER will be closely monitoring whether these initiatives result in increased transitions over the next few months.

[19] Cumulative from CMHA V.E.(g), (h), and (i).
[20] CMHA V.E.2(a)
[21] The ER is working with the State and representatives of the Plaintiffs to verify that the reported settings are in fact integrated community settings.

As noted in the previous report, the ER is at this point reluctant to focus too narrowly on clinical conditions and sets of health, mental health and community services and supports for transitioned and transitioning individuals to monitor the State's progress in assisting Glencliff Home residents to transition to integrated community settings. The ER will monitor the extent to which DHHS, Glencliff, the CMHCs and an array of other community partners collaborate to effectuate as many such transitions as possible over the next year. The primary thrust and intent of the CMHA is to assure that individuals residing in Glencliff (and their families and guardians) are offered meaningful opportunities to consider transition to integrated community settings, and that services necessary to implement those transition are readily available. This includes effective in-reach services, opportunities to explore community alternatives as part of transition planning, and documented efforts to identify and resolve potential barriers to community living.

**The specific requirements in the CMHA for transition and community residential service capacity could still be attained if DHHS and its partners increase the availability of integrated community settings, and provide meaningful in-reach and transition planning for Glencliff residents.**

**However, progress towards effectuating transitions to integrated community settings for current Glencliff residents has been slow over the past 18 months. Unless additional efforts are brought to bear, the 19 individuals in active transition planning could remain at Glencliff indefinitely, and other residents will go without meaningful opportunities to explore potential community alternatives.**

Thus, the ER will continue to monitor the following topics/items to inform his assessment of compliance:

1. The number of transitions from Glencliff to integrated community settings per quarter. The ER will also monitor information about the clinical and functional level of care needs of these individuals; the integrated settings to which they transition; and the array of Medicaid and non-Medicaid mental health and health-related services and supports put in place to meet their needs to assure successful integrated community living.
2. The number of Glencliff residents newly identified per quarter to engage in transition planning and move towards integrated community settings. The ER will also monitor at a summary level the clinical and functional level of care needs of individuals added to the transition planning list per quarter.
3. New integrated community setting providers with the capacity to facilitate integrated community living for Glencliff residents. These could include EFCs, AFCs, and new small-scale community residential capacity for people with complex medical conditions who cannot be cost-effectively served in supported housing. The ER will monitor DHHS activities and successes relative to identification and engagement of community providers who express willingness and capacity to provide services in integrated community settings for people transitioning from Glencliff.

4. Within the discharge cohort, the number of transitioned individuals for whom the State special funding mechanism is utilized to effectuate the transition, and the ways in which these funds are used to fill gaps in existing services and supports.
5. Number and types of in-reach visits and communications by CMHCs and other community providers related to identifying and facilitating transitions of Glencliff residents to integrated community settings.
6. Specific documentation of efforts to overcome family and/or guardian resistance to integrated community transitions for Glencliff residents.
7. Number of individuals engaged in transition planning referred to the Central Team; number of these individuals who successfully transition to an integrated community setting; and the elapsed time from referral to resolution.

**Preadmission Screening and Resident Review (PASRR)**

The State DHHS has provided recent data on PASRR Level II screens for the period May 1, 2018 through August 28, 2018. These data are summarized in Table XI below. A Level II screen is conducted if a PASRR Level I (initial) screen identifies the presence of mental illness, intellectual disability, or related conditions for which a nursing facility placement might not be appropriate. One objective of the Level II screening process is to seek alternatives to nursing facility care by diverting people to appropriate integrated community settings. Another objective is to identify the need for specialized facility based services if individuals are deemed to need nursing facility level of care.

**Table XI**

**PASRR Level II Screens: May through August, 2018**

| | May 2018 | June, July and August. 2018 | Total |
|---|---|---|---|
| Full Approval - No Special Services | 11 | 24 | 35 |
| Full Approval with Special Services | 0 | 4 | 4 |
| Long Term Care Not Recommended | 1 | 1 | 2 |
| Provisional – No Special Services | 3 | 4 | 7 |
| Provisional with Special Services | 0 | 1 | 1 |
| Total | 15 | 34 | 49 |
| Percent with Special Services | 0.00% | 14.7% | 10.2% |

As can be seen in Table XI, a total of 49 Level II screens were conducted in the four months covered by the reports. Two of these screens (4.1%) resulted in a recommendation to not provide care in a nursing facility/long term care setting. It is not known what alternative level of care or community setting was provided for these individuals. Five of the screens (10.2%) resulted in a recommendation for special services. The PASRR data reports do not indicate what specific types of special services have been indicated for the five individuals in this reporting period.

The ER has been seeking comparable data from other states to see if the 10% special services indication rate comports with the experiences of other jurisdictions. So far, information has been received from one state. That particular state has made recent efforts to improve the quality and effectiveness of its PASRR process. This state reports:

> "Of the individuals authorized NF placement, the % of individuals recommended specialized behavioral health services has increased over the years. The percentages by calendar year are listed below:
>
> - 2015 = 47%
> - 2016 = 68%
> - 2017 = 84%
> - 2018 = 88%"

The ER will continue to review comparable PASRR data as it becomes available.

For the period from June 1, 2018 through August 28, 2018, a total of 171 Level I screens are reported to have been completed. 86 of these resulted in "negative screening", meaning that they were not approved for nursing facility level of care or that they were not applicable for the Level II PASRR screening process. 46 of the Level I screens resulted in a referral for Level II screening, and 37 (80.4%) of these were referred because of mental illness. The vendor for the New Hampshire PASRR program reports that the variance between the number of referrals for Level II screens, and the actual number of screens completed, is likely due to the time frame for reporting. That is, the referral for Level II screening came too late in the reporting period for the Level II screen to be completed within the reporting period. It should be noted that the above data represents PASRR activity related to all nursing facility admissions (or re-reviews) in New Hampshire, not just for those being screened for admission to Glencliff.

The ER has also reviewed the PASRR Level II screens and admission assessments for the six most recent admissions to Glencliff. Three of these were not completed: two because of the presence of dementia; and one because there was no diagnosed mental illness or related condition. For the three Level II screens that were completed, no special services were recommended.

For a variety of reasons, virtually all PASRR screens are conducted for people who are already in a nursing facility. For example, for the June to August reporting period, 160 of 171 PASRR Level I screens (93.6%) were conducted in nursing facilities; and for level II screens 33 of 34 (97.1%) were conducted in nursing facilities. A possible consequence of this is that prime opportunities for diversion to integrated community settings may have already been missed by the time the PASRR screen is conducted. In addition, individuals admitted to Glencliff must typically have been turned down by at least three other facilities before being considered for admission. In combination, these facts indicate that interventions to divert individuals from Glencliff or other nursing facilities must typically be used before the PASRR screening process is initiated. PASRR is important to assure that people with mental illness, ID/DD, or related conditions are not inappropriately institutionalized or placed in nursing facilities without access to necessary special services. However, PASRR is not by itself sufficient to divert people from nursing facility care. Up-Stream interventions at NHH, the DRFs, and among the CMHCs are also essential to prevent unnecessary facility placement.

**New Hampshire Hospital and the Designated Receiving Facilities (DRFs)**

For the time period July through September 2018, DHHS reports that NHH effectuated 209 admissions and 212 discharges. The mean daily census was 153, and the median length of stay for discharges was 16 days.

Table XII below compares NHH discharge destination information for the five most recent reporting periods (10/2016 through 9/2018). 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 XII**

**New Hampshire Hospital Self-Reported Data on**

**Discharge Destination**

| Discharge Destination | Percent October and November 2016 | Percent January through March 2017 | Percent April through June 2017 | Percent July through September 2017 | Percent October 2017 through March 2018 | Percent April 2018 through September 2018 |
|---|---|---|---|---|---|---|
| Home – live alone or with others | 85.1% | 84.5% | 85.66% | 88.3% | 81.0% | 81.7% |
| Glencliff | 0.36% | 1.55% | 0,35% | 0.49% | 1.0% | 1.45% |
| Homeless Shelter/motel | 2.54% | 2.71% | 3.5% | 2.94% | 2.5% | 3.13% |
| Group home 5+/DDS supported living, etc. | 1.62% | 5.7% | 5.59% | 3.92% | 7.1% | 4.57% |
| Jail/corrections | 2.9% | 0.8% | 1.05% | 0.49% | 1.7% | 1.45% |
| Nursing home/rehab facility | 3.6% | 1.9% | 3.50% | 2.45% | 2.7% | 5.3% |

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

## Table XIII

## Self-Reported DRF/APRTP Utilization Data: January 2016 through September 2018

| | Franklin | Cypress | Portsmouth | Eliot Geriatric | Eliot Pathways | Total |
|---|---|---|---|---|---|---|
| **Admissions** | | | | | | |
| Jan - March 2016 | 69 | 257 | NA | 65 | 121 | NA |
| April - June 2016 | 79 | 205 | 378 | 49 | 92 | 803 |
| July - Sept 2016 | 37 | 207 | 375 | 54 | 114 | 787 |
| April - June 2017 | 60 | 228 | 363 | 52 | 101 | 804 |
| July - September 2017 | NA** | 178 | 363 | 60 | 121 | 722 |
| Oct. - Dec 2017 | 59 | 209 | 358 | 55 | 102 | 783 |
| Jan. - March 2018 | 52 | 240 | 330 | 66 | 100 | 788 |
| April - June, 2018 | 69 | 244 | 333 | 65 | 104 | 815 |
| July - September 2018 | 67 | 201 | 357 | 54 | 112 | 791 |

| | Franklin | Cypress | Portsmouth | Eliot Geriatric | Eliot Pathways | Total |
|---|---|---|---|---|---|---|
| **Percent involuntary** | | | | | | |
| Jan - March 2016 | 53.70% | 18.70% | NA | 18.50% | 30.60% | NA |
| 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% |
| April - June 2017 | 58.30% | 21.50% | 22.00% | 1.00% | 47.50% | 30.06% |
| July - September 2017 | NA** | 25.60% | 25.60% | 11.50% | 50.40% | NA |
| Oct. - Dec 2017 | 49.20% | 30.10% | 23.70% | 12.70% | 50.00% | 30.00% |
| Jan. - March 2018 | 44.20% | 28.30% | 21.50% | 6.10% | 47.00% | 27.00% |
| April - June, 2018 | 46.73% | 25.82% | 24.62% | 9.23% | 51.92% | 29.08% |
| July - September 2018 | 28.36% | 24.38% | 19.33% | 12.96% | 49.11% | 25.16% |

| | Franklin | Cypress | Portsmouth | Eliot Geriatric | Eliot Pathways | Total |
|---|---|---|---|---|---|---|
| **Average Census** | | | | | | |
| Jan - March 2016 | 7.9 | 14.7 | NA | 19.7 | 18.1 | NA |
| 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 |
| April - June 2017 | 4.5 | 12 | 30.3 | 29.3 | 10 | 86.1 |
| July - September 2017 | NA** | 12.9 | 29.7 | 29.7 | 12.2 | NA |
| Oct. - Dec 2017 | 10.1 | 12.3 | 27.7 | 32.6 | 16.1 | 19.7 |
| Jan. - March 2018 | 6.7 | 11.6 | 32.5 | 34.6 | NA | NA |
| April - June, 2018 | 9.1 | 11.9 | 31.7 | 31.7 | 20.4 | 104.8 |
| July - September 2018 | 11.8 | 8.4 | 39.6 | 33.8 | 18.2 | 111.8 |

| | Franklin | Cypress | Portsmouth | Eliot Geriatric | Eliot Pathways | Total |
|---|---|---|---|---|---|---|
| **Discharges** | | | | | | |
| Jan - March 2016 | 76 | 261 | NA | 57 | 122 | 516* |
| April - June 2016 | 78 | 206 | 363 | 51 | 90 | 788 |
| July - Sept 2016 | 35 | 213 | 380 | 64 | 113 | 805 |
| April - June 2017 | 59 | 232 | 365 | 54 | 105 | 815 |
| July - September 2017 | NA** | 243 | 355 | 63 | 121 | NA |
| Oct. - Dec 2017 | 82 | 212 | 359 | 58 | 102 | 813 |
| Jan. - March 2018 | 53 | 248 | 326 | 67 | 101 | 795 |
| April - June, 2018 | 74 | 244 | 326 | 65 | 107 | 816 |
| July - September 2018 | 66 | 195 | 353 | 54 | 112 | 780 |

| | Franklin | Cypress | Portsmouth | Eliot Geriatric | Eliot Pathways | Total |
|---|---|---|---|---|---|---|
| **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 |
| April - June 2017 | 6 | 4 | 5 | 22 | 8 | 9 |
| July - September 2017 | NA** | 4 | 4 | 27 | 7 | NA |
| Oct. - Dec 2017 | 4 | 4 | 5 | 21 | 7 | 5 |
| Jan. - March 2018 | 5 | 4 | 5 | 23 | 7 | 5 |
| April - June, 2018 | 5 | 4 | 5 | 20 | 8 | 5 |
| July - September 2018 | 4 | 4 | 4 | 21 | 7 | 5 |

* Does not include Portsmouth

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

The DRFs should theoretically relieve some of the pressure on NHH for inpatient admissions, and should also reduce the number of people waiting for psychiatric admissions in hospital EDs. However, at this time there has been no substantial reduction in NHH admissions, NHH re-admissions, or the wait list for NHH admissions of people staying in hospital EDs. This could reflect an increased overall demand for inpatient psychiatric care or be an indicator of limited access to community-based mental health services like ACT.

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

**Table XIV**

**Cumulative Self-Reported Discharge Dispositions for DRFs in New Hampshire**

**October, 2017 through September, 2018**

| Disposition | Franklin ** | Cypress | Portsmouth | Eliot Geriatric | Eliot Pathways | Total |
|---|---|---|---|---|---|---|
| Home | 252 | 825 | 1,144 | 58 | 356 | 2,635 |
| NHH | 3 | 1 | 18 | 1 | 9 | 32 |
| Residential Facility/ Assisted Living | 6 | 23 | 0 | 144 | 9 | 182 |
| Other DRF | 10 | 14 | 6 | 0 | 2 | 32 |
| Hospital | 1 | 0 | 0 | 10 | 0 | 11 |
| Death | 0 | 0 | 0 | 23 | 0 | 23 |
| Other or Unknown | 3 | 36 | 193 | 5 | 43 | 280 |
| Total | 275 | 898 | 1,361 | 241 | 419 | 3,194 |

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

Based on these self-reported data, 82.5% of 3,194 discharges from DRFs and the Cypress Center are to home. This is the same as the 81.7 % or greater discharges to home reported by NHH. 5.9% of the total DRF discharges are to residential care or assisted living, which is similar to NHH discharges for this category. 1.4% of the DRF discharges are to NHH, 0.10% is to other DRFs. 8.77% of the total discharges are to the other/unknown category, but 68.9% of these are accounted for by the Portsmouth DRF. This might point to an anomaly in the ways facilities use this category in their reports to the state. The State reports on-going efforts with the DRFs to improve their data reporting.

### Hospital Readmissions

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

## Table XV

## Self-Reported Readmission Rates for NHH and the DRFs

## July 2017 through September 2018

| | Percent 30 Days | Percent 90 Days | Percent 180 Days |
|---|---|---|---|
| NHH | | | |
| 7 to 9/2017 | 9.80% | 21.60% | 27.90% |
| 10 to 12/2107 | 12.8% | 26.1% | 32.8% |
| 1 to 3/2018 | 13.7% | 22.7% | 29.9% |
| 4/2018 to 6/2018 | 7.6% | 14.7% | 23.4% |
| 7/2018 to 9/2018 | 8.6% | 19.6% | 25.4% |
| | | | |
| Franklin | | | |
| 7 to 9/2017 | NA | NA | NA |
| 10 to 12/2107 | 10.2% | 10.2% | 10.2% |
| 1 to 3/2018 | 0.0% | 0.0% | 1.9% |
| 4/2018 to 6/2018 | 4.3% | 5.8% | 5.8% |
| 7/2018 to 9/2018 | 6.0% | 9.0% | 16.4% |
| | | | |
| Cypress | | | |
| 7 to 9/2017 | 7.10% | 12.40% | 15.90% |
| 10 to 12/2107 | 12.00% | 18.70% | 24.40% |
| 1 to 3/2018 | 4.20% | 9.60% | 15.80% |
| 4/2018 to 6/2018 | 4.50% | 8.20% | 11.90% |
| 7/2018 to 9/2018 | 8.50% | 13.90% | 18.90% |
| | | | |
| Portsmouth | | | |
| 7 to 9/2017 | 11.50% | 17.50% | 21.00% |
| 10 to 12/2107 | 8.70% | 13.70% | 17.60% |
| 1 to 3/2018 | 8.80% | 15.50% | 20.60% |
| 4/2018 to 6/2018 | 10.20% | 15.90% | 21.90% |
| 7/2018 to 9/2018 | 8.40% | 12.90% | 19.00% |
| | | | |
| Elliot Pathways | | | |
| 7 to 9/2017 | 3.30% | 6.60% | 12.40% |
| 10 to 12/2107 | 5.80% | 7.70% | 12.50% |
| 1 to 3/2018 | NA | NA | NA |
| 4/2018 to 6/2018 | 3.80% | 6.70% | 8.60% |
| 7/2018 to 9/2018 | 0.9% | 3.6% | 3.6% |

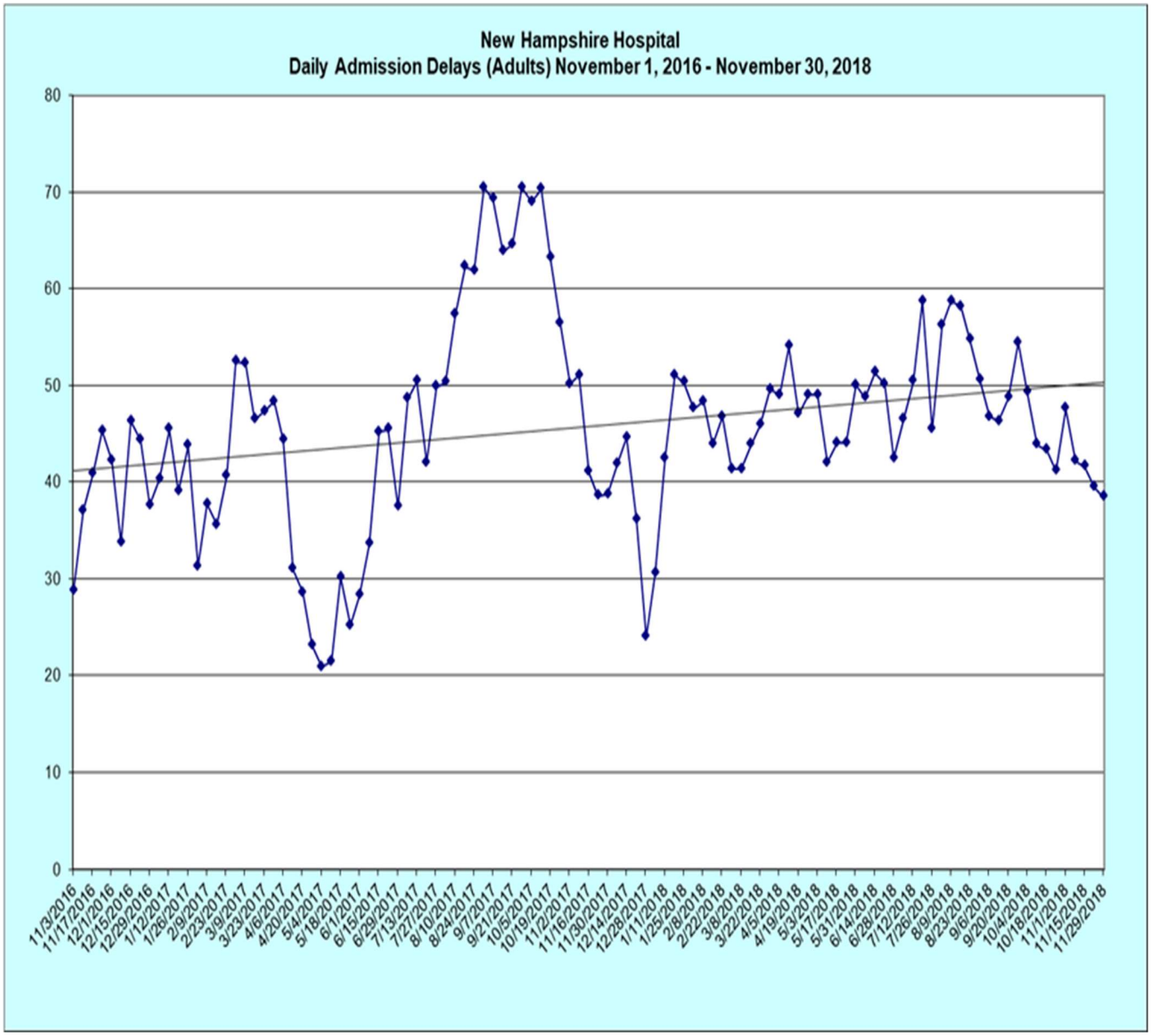
| | | | |
|---|---|---|---|
| Elliott Geriatric | | | |
| 4/2018 to 6/2018 | 6.10% | 6.10% | 6.10% |
| 7/2018 to 9/2018 | 5.60% | 11.10% | 11.10% |

Two facts are documented for the 15 month period in which re-admission rate data has been reported. First, the rates of readmission have changed only slightly: sometimes higher and sometimes lower, but always in the same range. Second, the readmission rates, especially the 180 day readmission rate for NHH, remains very high. At least a quarter of all people discharged form NHH are back in the hospital within 180 days. These data, in concert with the hospital emergency room data presented below, indicate that gaps remain in community services for people with serious mental illness, and that the essential connection between inpatient care and community services is not being effectuated for sizeable numbers of people at risk of re-hospitalization. **These facts need to be understood in light of the States ongoing difficulties increasing ACT capacity and enrollment as documented in Section III of this report.**

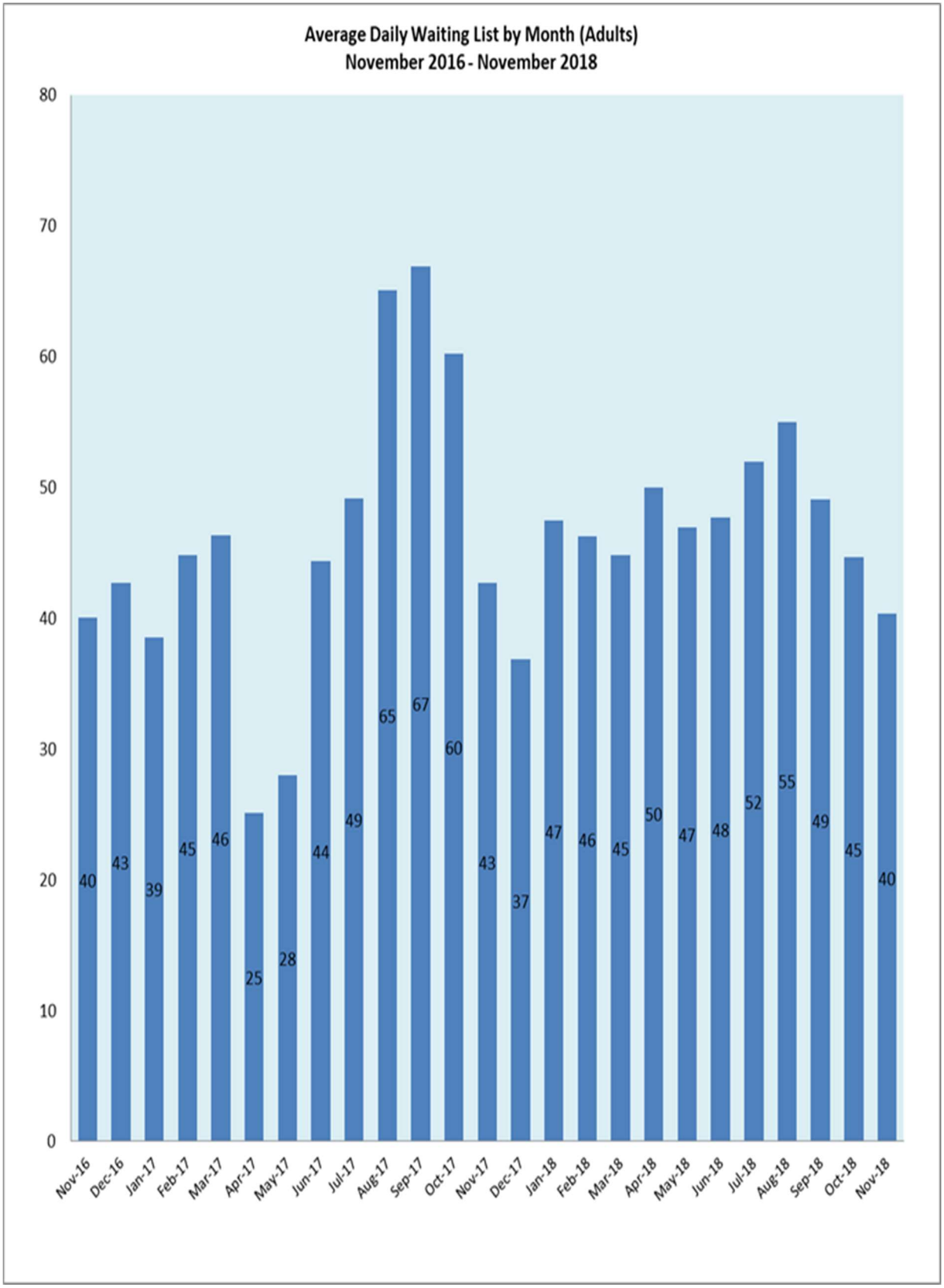
**Hospital ED Waiting List**

In the previous three reports, the ER has identified the waiting list (hospital ED boarding) for admission to NHH to be an important indicator of overall system performance. Chart A below displays daily adult admissions delays to NHH for the period July 1, 2016 through November 20, 2018. Chart B shows the average daily ED waiting list for the same time period.

**Chart A**


New Hampshire Hospital
Daily Admission Delays (Adults) November 1, 2016 - November 30, 2018
80
70
60
50
40
30
20
10
0
11/3/2016
11/17/2016
12/1/2016
12/15/2016
12/29/2016
1/12/2017
1/26/2017
2/9/2017
2/23/2017
3/9/2017
3/23/2017
4/6/2017
4/20/2017
5/4/2017
5/18/2017
6/1/2017
6/15/2017
6/29/2017
7/13/2017
7/27/2017
8/10/2017
8/24/2017
9/7/2017
9/21/2017
10/5/2017
10/19/2017
11/2/2017
11/16/2017
11/30/2017
12/14/2017
12/28/2017
1/11/2018
1/25/2018
2/8/2018
2/22/2018
3/8/2018
3/22/2018
4/5/2018
4/19/2018
5/3/2018
5/17/2018
5/31/2018
6/14/2018
6/28/2018
7/12/2018
7/26/2018
8/9/2018
8/23/2018
9/6/2018
9/20/2018
10/4/2018
10/18/2018
11/1/2018
11/15/2018
11/29/2018

## Chart B


Average Daily Waiting List by Month (Adults)
November 2016 - November 2018
80
70
60
50
40
30
20
10
0
40
43
39
45
46
25
28
44
49
65
67
60
43
37
47
46
45
50
47
48
52
55
49
45
40
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18

Based on information reported by DHHS and illustrated above, a monthly average of 46 adults was waiting for a NHH inpatient psychiatric bed from November of 2016 through November of 2018. As can be seen from Chart A, the average number of adults waiting for admission has trended up during the two year reporting period. As with hospital readmission rate**s**, emergency room boarding should be understood in light of ongoing difficulties increasing ACT capacity.

DHHS continues to analyze data related to adults boarding in EDs who may have some connection to the mental health system. In future months, DHHS will be receiving information on the degree to which CMHCs have increased ACT (or other services') participation as a result of these analyses. The ER plans to include summaries of this information in future reports. The State, in conjunction with the CMHCs, is conducting targeted outreach to those individuals who may need expanded or enhanced community services so as to minimize or eliminate contact with hospital or institutional settings.

## Family and Peer Supports

### Family Supports

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

### Peer Support Agencies

DHHS continues to report having a total of 15 peer support agency program (PSA) sites, with at least one program site in each of the ten regions. The State continues to report that all peer support centers meet the CMHA requirement to be open 44 hours per week. The State reports that those sites have a cumulative total of 945 members, with an active daily participation rate of 132 people statewide. The total membership number has decreased substantially since the last report, from 2,881 members to 945 members. The State reports that all of the PSAs have been auditing and correcting their membership lists, and that the reduction in membership is primarily due to these activities.

The CMHA requires the PSAs 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. There continue to be anecdotal reports that some of the CMHCs are making more concerted efforts to refer service participants to the PSAs in their regions. Increased efforts to communicate and coordinate with PSAs have also been reported. However, as of the most recent report there has been a slight reduction in active daily participation.

In addition, the ER has received anecdotal information that in some regions of the state, relationships and communications among the CMHCs and the Peer Support Agencies have

improved. Peer Support Agencies are generally reported by CMHCs to be useful sources of employees for ACT and Mobile Crisis and Crisis Apartment services. However, it must be noted that in two of the CMHC regions that contract with the local PSAs for staff for the ACT teams, there is currently no peer support reported for ACT services.

Finally, CMHCs have verbally stated 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

As noted in the introduction to this report, the State has made substantial positive progress to implement a comprehensive, reliable and actionable QSR process. The ER has participated in five QSR site visits, and is increasingly confident that: (a) the revised instruments and site interview protocols are working well; and (b) the results and findings of the revised QSR instruments and process reflect, to a large degree, the quality standards of the CMHA.

One key improvement in the revised QSR process has been the addition of several Overall Clinical Review (OCR) questions that provide opportunities for the QSR teams to integrate and summarize service participant-level information collected from a variety of information sources. These new questions include:[22]

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

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

These types of questions reflect the essence of the QSR process: documenting that individual service participants receive the levels and types of services and supports that assist them to

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

achieve their goals and meet their needs in the most integrated community setting possible. These questions also directly respond to target population outcomes and quality expectations of the CMHA. Going forward, responses to these questions are intended to form an important part of the six-month ER reports.

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

DHHS has now completed the QSR process using the revised instruments and protocols for each of the ten CMHCs. Table XVI below summarizes the quality indicator scores for each domain of the QSR. Average scores for the OCR questions (see above) are all above the 70% threshold, so they are not included in this summary table. Highlighted scores are below the 70% performance threshold established for the QSR for the time period covered by this report.

**Table XVI**

**QSR Total Indicator Scores: All CMHCs**

| Indicator Number | Indicator Content | Average |
|---|---|---|
| 1 | Adequacy of Assessment | 80.50% |
| 2 | Approp. Tx Planning | 89.80% |
| 3 | Adequacy of Ind. Serv. Del. | 82.40% |
| 4 | Adequacy of Hsg. Assess. | 99.50% |
| 5 | Approp. Of Hsg. Tx Planning | 90.20% |
| 6 | Adequacy of HSG. Serv. Del. | 84.20% |
| 7 | Effect. Og Hsg. Supports Del. | 76.20% |
| 8 | Adequacy of Emp. Assessment | 57.90% |
| 9 | Approp. Of Emp. Tx Planning | 70.30% |
| 10 | Adequacy of Emp. Serv. Del. | 59.70% |
| 11 | Adequacy of Ass. Of Int. Needs | 94.40% |
| 12 | Integration in Community | 79.50% |
| 13 | Adequacy of Crisis Assess. | 69.00% |
| 14 | Appropriateness of Crisis Plns. | 80.80% |
| 15 | Comp. and Effec. Crisis Del. Syst. | 72.80% |
| 16 | Adequacy of ACT screening | 90.60% |
| 17 | Imp. Of high Fidel. ACT Servs. | 54.30% |
| 18 | Succ. Trans./Dich. From inpat. | 78.10% |

As demonstrated in the table, the CMHC system as a whole scores below the 70% performance threshold on four indicators. Each of these indicators is related to specific standards and requirements of the CMHA. As noted earlier in this report, DHHS requires CMHCs with a score below the performance threshold to develop a QIP, which is then monitored on at least a quarterly basis by DHHS staff. Improvements accomplished as a result of the QIPs should be evidenced in subsequent QSR reports.

DHHS is committed to using the QSR process to continuously improve the quality and effectiveness of CMHA services as the community mental health system matures. For this reason the performance threshold for QSR scoring has been raised to 75% for the current time period. The ER applauds this change, since it moves closer to requiring a level of system and provider performance that the ER considers to be substantial compliance with the CMHA.

As a companion to the QSR process, DHHS has been conducting on-site ACT and SE fidelity reviews**.** DHHS has engaged the Dartmouth/Hitchcock Center on Evidence Based practices to assist in attaining and assuring fidelity to the evidence based models of ACT and SE. The Dartmouth/Hitchcock team will also assist on workforce development and training for these and other evidence based practices under the aegis of DHHS and the CMHCs. This partnership with the nationally respected Dartmouth/Hitchcock Center adds valuable expertise and experienced personnel to facilitate further development of, and increased adherence to, fidelity model ACT and SE in conformance with the CMHA. Year-to-year comparisons and the CMHCs Quality Improvement Plans have been included in the publication of recent ACT and SE fidelity reviews. The ER commends DHHS for implementing the comprehensive fidelity review process and its attendant quality improvement and technical assistance activities.

Table XVII below shows average changes in year-to-year fidelity scores for both ACT and SE. All CMHCs in the state meet the minimum performance threshold for "fair fidelity" both ACT and SE. However, as displayed in the table, the fidelity scores have recently been trending downward, not up-ward. For both ACT and SE, only one of the ten CMHCs showed improvement in the year-to-year comparisons. Fair fidelity scores also tended to correlate with deficits in individual service delivery and performance issues in the QSR. As with the QSR scores, QIPs related to fidelity findings should result in fidelity score improvements over the next round of fidelity reviews.

**Table XVII**

**Trends in ACT and SE Fidelity Scores[23]**

| | Performance Threshold | Average Year-to-Year Fidelity Score Change |
|---|---|---|
| ACT | 84 | -10.3 |
| SE | 74 | -14.3 |

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

The ER will continue to monitor the degree to which the QSR process produces reliable information on individual outcomes and the quality of CMHA service delivery. In addition, over the next six months, the ER will evaluate the extent to which CMHC Quality Improvement Plans developed as part of the 2017-2018 QSR site visits are resulting in recommended practice changes and improved outcomes for those in the target population.

The ER and the Parties to the CMHA have discussed how the QSR and external fidelity reviews can be used to measure compliance with the CMHA, including both the appropriate standards for compliance and the specific provisions of the QSR and fidelity reviews that would be used to assess compliance. These discussions are on-going, and the ER supports the collaborative efforts of both the State and the representatives of the Plaintiffs. The ER intends to employ both the

[23] As noted earlier in this report, the state shifted two years ago from CMHC fidelity self-reports to a contracted organization conducting fidelity reviews, and thus there may be some issues related to the comparability of the year to year scores. In addition, some of the most recent fidelity review scores are not yet reflected in the data as reported above. DHHS will soon release a report of ACT and SE fidelity reviews. The ER hopes that that report will be able to serve as the baseline for future trend analyses of ACT and SE fidelity scores.

QSR and the fidelity reviews as tools to assess individual outcomes, analyze system performance, and ultimately measure compliance with the CMHA.

## V. New State Resources

In New Hampshire the Governor and the Legislature have evidenced increased support for implementation of the CMHA and for making improvement in the community mental health system. These initiatives include:

1. A total of 40 new transitional residential beds prioritized to support NHH discharges;
2. A contract has been awarded to Riverbend Community Mental Health for a Crisis Treatment Center to operate in coordination with the MCT and crisis apartment program in the Concord Region;
3. DHHS has issued an RFP to provide $500,000 to expand the Bridge SH Program;
4. DHHS has issued an RFP to select and fund a new ACT Team; and
5. The newly approved Medicaid waiver includes $3,000,000 for performance payments related to sustaining and increasing ACT enrollments; and $1,500,000 for performance payments related to same or next day appointments at CMHCs for people discharged for psychiatric inpatient care. These funds are in addition to the total of $3,000,000 previously appropriated to ACT rate enhancements and workforce development efforts.

The ER also notes that the transitional housing funding listed above is not intended to be included under the aegis of the CMHA. Twenty of these transitional housing units have been occupied, 14 in the greater Nashua area, and six in central New Hampshire. DHHS reports that all 20 of these units have been occupied by long stay patients from NHH. Twenty new transitional housing beds have now been funded, and are currently in development. These placements, although not directly contributing to the CMHA, nonetheless provide a potentially valuable resource to reduce long stays in NHH. They may also reduce certain barriers that have prevented integrated community placements in supportive housing.

# VI. Summary of Expert Reviewer Observations and Priorities

The CMHA and ER have now been in place for four and one half years. Within that time frame, the ER has expressed escalating concerns related to noncompliance with CMHA requirements governing ACT and Glencliff community transitions.[24] In addition, the ER has noted long

[24] The State reports effectuating 17 placements to integrated community settings since the inception of the CMHA. The ER and the parties remain in discussions with regard to whether these transitions meet all the criteria in the

elapsed times and/or delays related to implementation of system improvements or data reporting. Throughout these reports, the ER has emphasized the need for the State to be more aggressive, assertive, planful, and timely in its implementation and oversight efforts in these areas in order to come into compliance with the CMHA.

More recently the ER has reported that the State is improving its oversight and management of the mental health system. Examples include more comprehensive and accurate data reporting, the revised QSR process, and the growing use of state-validated fidelity reviews for ACT and SE. The QIPs that result from QSR and QIP activities are an improved tool for State-directed technical assistance and monitoring of CMHCs to assure improved quality and effectiveness of services for the CMHA target population.

Despite the management and service delivery improvements noted in this report, the ER remains seriously concerned about compliance with the CMHA standards and requirements related to ACT services. **For the last two and one half years the ER has reported that the State is 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[25]; 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.**

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 911 people, the state currently is providing 589 fewer people with ACT than could be served if the State had developed the CMHA-specified capacity to serve 1,500 individuals. With the current ACT staff capacity to serve 1,156 people, there are 245 fewer people receiving ACT than the current ACT system could accommodate. ***This continues to be the single most significant issue in New Hampshire with regard to compliance with the CMHA. ACT services are specifically designed to serve target population members at risk of hospital admission. Individuals who remain in NHH after being deemed ready for discharge, individuals with high rates of readmission to EDs and inpatient facilities, and individuals awaiting hospitalization in EDs are included in this population. This is a human issue, not just a system issue. The ER remains seriously concerned that individual lives are affected because the ACT service capacity specified in the CMHA has still not been attained.***

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CMHA. Pending resolution of those discussions, the ER intended to keep Glencliff Transitions high on the compliance monitoring priority list.

[25] 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.

In addition to the focus on ACT services for the target population, the ER intends to concentrate on the following priority CMHA compliance issues during the up-coming six month reporting period:

1. More closely monitoring the SH program, including Bridge program and other funding source lease-up rates, and monitoring data on the receipt of services by SH participants;
2. Documenting the receipt, circulation and interpretation of the new data reports as specified in the body of this report;
3. Expanding the analysis and report of recent PASRR data;
4. Monitoring of implementation of QIPs, particularly as they address issues related to ACT and SE;
5. Monitoring of transitions from Glencliff to integrated community settings, particularly with regard to implementation of revised models and financing procedures intended to engage new community provider capacity and facilitate individual transitions;
6. Continuing to assess the quality and effectiveness of CMHA services, including whether ACT and SE services are delivered with the intensity and duration necessary to meet individual's needs; and
7. Continuing discussions with all Parties to the CMHA regarding the use of QSR and fidelity review findings to document compliance with the standards and requirements of the CMHA.

The first priority is the implementation of a short-term ad hoc ACT working group to develop strategies to rapidly increase ACT staff capacity and to meet related CMHA requirements applicable to ACT programs in New Hampshire. Given the overall importance and multiple dimensions of ACT service compliance in the CMHA, this working group is expected to focus solely on ACT.

**ACT Working Group**

DHHS and representatives of the Plaintiffs are expected to appoint a small (≈3 each) number of members to serve on the ACT working group on a time-limited basis. The ER intends to participate in each meeting/conversation of the ACT working group as well. No later than April 1, 2018 the ER expects the ACT working group to produce realistic and measurable action or implementation plans to meet the CMHA ACT requirements.

The expected priority topics the ACT working group include:

1. Strategies to increase and sustain adequate ACT staffing across the system to meet the CMHA requirement of capacity to provide ACT to 1,500 target population members:
    a. The State will notify parties when the projected RFP for a new ACT team is released;

   b. The State will identify its strategies (to date) for improving recruitment and retention of ACT and SE staff, and identify what did and did not work (if any); and
   c. The State will explore concept of statewide contract for ED ACT assessments and/or expedited ACT intake, assessment and enrollment processes
2. Strategies to assure that each ACT team in the state has staffing and staff competencies consistent with the ACT requirements in the CMHA and with the ACT fidelity standards (including the minimum number of non-psychiatry staff per team, sufficient psychiatry hours, adequate peer staff and nursing, as well as competencies in SE and substance use);
3. Strategies to assure the rapid referral, assessment, and enrollment of applicable target population members to ACT, including referrals of target population members in NHH and other DRFs (especially those with a recent readmission), in hospital emergency departments, etc.;
4. Strategies to assure equitable access of target population members to ACT in underserved areas of the state, or areas in which current ACT staffing inhibits rapid enrollment (i.e., the Wolfeboro area and regions with ACT wait lists, etc);
5. Strategies to enhance and sustain the quality of ACT services to address issues documented through the QSR reviews/reports and/or the Fidelity reviews/reports for all current and possible future ACT teams;
6. Strategies to produce more comprehensive data reporting on ACT screening, assessment, enrollment, timeliness of moving through the process, and reasons for non-enrollment; and
7. Strategies to improve ACT team crisis response compliance.

The State may wish to discuss the degree to which there is need for ACT capacity for 1,500 individuals, and if not, provide recommendations that demonstrate that equivalent best practice integrated community based services are delivered to the CMHA target population. Strategies developed under the topics outlined above are, in part, dependent on the outcome of this discussion. Thus, if the State wishes to discuss this issue, it should be the first agenda item for the working group.

For each of the strategies developed for the above topics, the ER expects that there will be a feasible implementation plan that incorporates: (a) measurable milestones and defined products/results; (b) specific assignments of staff accountable for, and resources dedicated to, meeting the defined implementation plans; and (c) concrete measurable indicators of success/completion that will satisfy all parties that the ACT requirements of the CMHA have been met and are capable of being sustained throughout the maintenance of effort year.

The first meeting of the ACT working group is expected to take place in February 2019.

**Other Follow-up Issues**

Participants in the December 5, 2018 All Parties meeting also identified a number of items for follow-up relevant to the CMHA target population and meeting the requirements of the CMHA.

The following is a brief summary of these action items:

**I. Facility transitions**

A. NHH

1. Continue to document barriers to discharge
    a. DHHS will provide to Parties and ER the process for addressing access to ACT services, when appropriate, for individuals near or ready for discharge;
    b. DHHS will research and report back to Parties and ER whether Bridge Program applications are being completed, when appropriate, for individuals near or ready for discharge;
    c. DHHS will document the specific discharge barriers for individuals determined clinically ready for discharge but who remain at NHH (e.g., need for ACT, supported housing, etc.); and
    d. DHHS will work with the parties to identify factors contributing to readmission.

**B. Glencliff Home**

1. DHHS will issue procurement to expand community capacity-date not yet specified;
    a. Address in-reach from CMHCs and other community providers, and discuss a State proposal for system-wide in-reach coordinator for Glencliff
    b. Ensure that there are sufficient and appropriate community services and settings for all individuals at Glencliff who have been identified for transition or who do not oppose transition
2. Medically complex individuals;
    a. DHHS to provide clinical information on two recent discharges from Glencliff
    b. ER and plaintiffs to review new clinical information
    c. Integrated community settings: ER to review info from Plaintiffs' recent survey and record reviews
3. PASRR: The ER will review the percentage of Level II reviews resulting in special services recommendations and then review the availability and provision of such services at Glencliff.

**C. SE**

1. DHHS will work to improve SE penetration in low penetration regions
2. DHHS will work to improve SE staffing levels
3. The State will notify ER and plaintiffs when SE competitive employment data are complete and reliable enough to analyze (anticipated P/E March 2018)

**D. Supported Housing: Bridge Program;**

1. The State will notify ER and plaintiffs when RFP for $500,000 new Bridge subsidies is awarded
2. The State will, as soon as possible, provide ER with draft of report on access to and utilization of support services for Bridge program participants – ER will discuss wider circulation after reviewing draft
3. The State will provide data on elapsed times (beginning P/E December 2018)
4. The State will provide updated information on the development of 811 funded supported housing, including an explanation of any anticipated delays in bringing this capacity on line.
5. The State will review Bridge eligibility criteria and adjust them if necessary to ensure they do not exclude individuals who meet HCV eligibility criteria.
6. The State will expand SH capacity to meet CMHA numerical and waitlist requirements.

## Conclusion

As noted early in this report, the Federal Court approved the CMHA almost five years ago. The expectation at that time was that the terms and requirements of the CMHA could be met within the subsequent five years, and that a maintenance-of-effort year could be initiated once the Parties and the ER agreed that CMHA requirements were met.

In reality, the requirements of the CMHA are far from being met. For example, staff capacity for ACT services has barely changed in the past 30 months; ACT enrollment has grown only slightly in that time frame; transitions from Glencliff to integrated community settings have slowed; four

regions of New Hampshire still do not meet the penetration rate standard for SE in the CMHA[26]; the number of people in SH units has recently decreased and the state does not now meet the CMHA standards for SH; ACT and SE fidelity scores appear to be trending downward instead of upward; and QSR scores show performance deficiencies in ACT, SE and crisis services – each of which is an important element of the CMHA.

In short, the State has made progress in meeting some of the requirements of the CMHA, but much work remains to be done to meet the entirety of the CMHA's expectations for New Hampshire's citizens with serious mental illness. This is why the final section of this report is constructed as an action agenda rather than a series of passive observations. The ER intends to focus considerable attention on the above action agenda over the next six month period, with the expectation that the State will move quickly to meet the terms of the CMHA.

[26] As stated earlier in this report, the SE penetration rate standard is a statewide requirement, and is not specifically applicable to each individual CMHC. However, the ER continues to note that four CMHC regions do not meet the statewide standard, which has the effect of reducing access to SE for individuals residing in those areas.

**Appendix A**

**New Hampshire Community Mental Health Agreement**

***State's Quarterly Data Report***

***July to September 2018***

# New Hampshire Community Mental Health Agreement Quarterly Data Report

***July to September 2018***

New Hampshire Department of Health and Human Services

Office of Quality Assurance and Improvement

November 21, 2018

# Community Mental Health Agreement Quarterly Report

**New Hampshire Department of Health and Human Services**

**Publication Date:**

**Reporting Period: 7/1/2018 – 9/30/2018**

## Notes for Quarter

- Identified all CMHCs having technical difficulties with Employment Screening Status Collection reporting (Table 12c). OQAI and BMHS are working on guidance to encourage reporting compliance in order to improve data quality.

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

| Community Mental Health Center | July 2018 | August 2018 | September 2018 | Unique Consumers in Quarter | Unique Consumers in Prior Quarter |
|---|---|---|---|---|---|
| 01 Northern Human Services | 108 | 110 | 102 | 121 | 121 |
| 02 West Central Behavioral Health | 45 | 44 | 44 | 67 | 67 |
| 03 Lakes Region Mental Health Center | 59 | 55 | 53 | 68 | 68 |
| 04 Riverbend Community Mental Health Center | 79 | 83 | 82 | 83 | 83 |
| 05 Monadnock Family Services | 55 | 55 | 55 | 58 | 58 |
| 06 Community Council of Nashua | 85 | 84 | 79 | 94 | 94 |
| 07 Mental Health Center of Greater Manchester | 302 | 305 | 305 | 289 | 289 |
| 08 Seacoast Mental Health Center | 69 | 68 | 69 | 70 | 70 |
| 09 Community Partners | 59 | 60 | 61 | 68 | 68 |
| 10 Center for Life Management | 57 | 58 | 54 | 58 | 58 |
| **Total** | **918** | **921** | **904** | **980** | **963** |
| **Unique Clients Receiving ACT Services 10/1/2017 to 9/30/2018** | | | | **1,285** | |

*Revisions to Prior Period: None*

*Data Source: NH Phoenix 2*

*Notes: Data extracted 10/17/18; consumers are counted only one time regardless of how many services they receive.*

### 1b. Community Mental Health Center Services: Assertive Community Treatment Screening

| Community Mental Health Center | July 2018 | August 2018 | September 2018 |
|---|---|---|---|

| | Unique Clients Screened | Screening Deemed Appropriate for Further ACT Assessment | Unique Clients Screened | Screening Deemed Appropriate for Further ACT Assessment | Unique Clients Screened | Screening Deemed Appropriate for Further ACT Assessment |
|---|---|---|---|---|---|---|
| 01 Northern Human Services | 434 | 56 | 380 | 42 | 314 | 35 |
| 02 West Central Behavioral Health | 112 | 16 | 113 | 11 | 81 | 0 |
| 03 Lakes Region Mental Health Center | 294 | 19 | 202 | 15 | 156 | 12 |
| 04 Riverbend Community Mental Health Center | 521 | 28 | 424 | 31 | 456 | 32 |
| 05 Monadnock Family Services | 201 | 3 | 186 | 21 | 175 | 3 |
| 06 Community Council of Nashua | 350 | 2 | 328 | 7 | 281 | 2 |
| 07 Mental Health Center of Greater Manchester | 948 | 75 | 1121 | 53 | 971 | 62 |
| 08 Seacoast Mental Health Center | 422 | 32 | 436 | 27 | 436 | 28 |
| 09 Community Partners | 173 | 23 | 50 | 7 | 167 | 12 |
| 10 Center for Life Management | 324 | 41 | 296 | 33 | 99 | 31 |
| **Total ACT Screening** | **3779** | **295** | **3546** | **247** | **3136** | **217** |

*Revisions to Prior Period: None*

*Data Source: NH Phoenix 2 and CMHC self-reported ACT screening records.*

*Notes: Data extracted 10/17/2018; Screening deemed appropriate for further ACT assessment defined as ACT screenings resulting in referral to ACT services assessment.*

### 1c. Community Mental Health Center Services: Assertive Community Treatment Waiting List

| As of 9/30/18 | | | |
|---|---|---|---|
| | Time on List | | |
| Total | 0-30 days | 31-60 days | 61-90 days |
| 11 | 9 | 2 | 0 |
| **As of 6/30/2018** | | | |
| **Total** | **0-30 days** | **31-60 days** | **61-90 days** |
| 3 | 3 | 0 | 0 |

*Revisions to Prior Period: None*

*Data Source: BMHS Report*

*Notes: Data extracted 11/19/18.*

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

| Community Mental Health Center | September 2018 | | | | | | June 2018 | |
|---|---|---|---|---|---|---|---|---|
| | Nurse | Clinician/or Equivalent | Support Worker | Peer Specialist | (Excluding Psychiatry) | Psychiatrist/Nurse Practitioner | (Excluding Psychiatry) | Psychiatrist/Nurse Practitioner |
| 01 Northern Human Services | 1.09 | 1.10 | 10.20 | 0.68 | 13.07 | 0.80 | 12.73 | 0.80 |
| 02 West Central Behavioral Health | 0.60 | 1.70 | 1.65 | 1.30 | 5.25 | 0.25 | 5.15 | 0.45 |
| 03 Lakes Region Mental Health Center | 0.80 | 2.00 | 4.55 | 1.00 | 8.35 | 0.75 | 5.55 | 0.75 |
| 04 Riverbend Community Mental Health Center | 0.50 | 3.00 | 6.00 | 1.00 | 10.50 | 0.50 | 10.50 | 0.50 |
| 05 Monadnock Family Services | 1.25 | 4.25 | 2.70 | 0.50 | 8.70 | 0.65 | 8.50 | 0.65 |
| 06 Community Council of Nashua 1 | 0.50 | 4.00 | 1.00 | 0.00 | 5.50 | 0.25 | 5.75 | 0.25 |
| 06 Community Council of Nashua 2 | 0.50 | 3.00 | 1.00 | 0.00 | 4.50 | 0.25 | 5.75 | 0.25 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 07 Mental Health Center of Greater Manchester-CTT | 1.50 | 11.00 | 2.25 | 0.00 | 14.75 | 1.02 | 15.50 | 0.63 |
| 07 Mental Health Center of Greater Manchester-MCST | 1.50 | 9.00 | 6.25 | 1.00 | 17.75 | 0.93 | 16.25 | 0.63 |
| 08 Seacoast Mental Health Center | 1.43 | 3.10 | 5.00 | 1.00 | 10.53 | 0.60 | 9.53 | 0.60 |
| 09 Community Partners | 0.50 | 2.00 | 6.13 | 0.50 | 9.13 | 0.50 | 9.60 | 0.50 |
| 10 Center for Life Management | 1.25 | 2.00 | 4.30 | 0.00 | 7.55 | 0.40 | 8.30 | 0.40 |
| **Total** | **11.42** | **46.15** | **51.03** | **6.68** | **115.58** | **6.90** | **113.11** | **6.41** |

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

| Community Mental Health Center | September 2018 | June 2018 |
|---|---|---|
| 01 Northern Human Services | 6.00 | 3.70 |
| 02 West Central Behavioral Health | 0.35 | 0.35 |
| 03 Lakes Region Mental Health Center | 2.50 | 2.50 |
| 04 Riverbend Community Mental Health Center | 1.50 | 1.50 |
| 05 Monadnock Family Services | 2.40 | 2.40 |
| 06 Community Council of Nashua 1 | 4.25 | 4.25 |
| 06 Community Council of Nashua 2 | 2.00 | 3.00 |
| 07 Mental Health Center of Greater Manchester-CCT | 11.00 | 13.00 |
| 07 Mental Health Center of Greater Manchester-MCST | 3.00 | 4.00 |
| 08 Seacoast Mental Health Center | 3.00 | 3.00 |
| 09 Community Partners | 1.00 | 2.00 |
| 10 Center for Life Management | 3.00 | 3.00 |
| **Total** | **40.00** | **42.70** |

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

| Community Mental Health Center | September 2018 | June 2018 |
|---|---|---|
| 01 Northern Human Services | 10.15 | 9.85 |
| 02 West Central Behavioral Health | 2.25 | 4.25 |
| 03 Lakes Region Mental Health Center | 4.55 | 4.55 |
| 04 Riverbend Community Mental Health Center | 8.50 | 8.50 |
| 05 Monadnock Family Services | 4.00 | 4.00 |
| 06 Community Council of Nashua 1 | 5.00 | 5.00 |
| 06 Community Council of Nashua 2 | 4.00 | 5.00 |
| 07 Mental Health Center of Greater Manchester-CCT | 11.75 | 12.50 |
| 07 Mental Health Center of Greater Manchester-MCST | 12.75 | 12.50 |
| 08 Seacoast Mental Health Center | 4.00 | 4.00 |
| 09 Community Partners | 3.00 | 4.00 |
| 10 Center for Life Management | 6.00 | 6.00 |
| **Total** | **75.95** | **80.15** |

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

| Community Mental Health Center | September 2018 | June 2018 |
|---|---|---|
| 01 Northern Human Services | 2.00 | 2.00 |
| 02 West Central Behavioral Health | 0.40 | 0.40 |
| 03 Lakes Region Mental Health Center | 3.00 | 3.00 |
| 04 Riverbend Community Mental Health Center | 0.50 | 0.50 |
| 05 Monadnock Family Services | 0.20 | 1.00 |
| 06 Community Council of Nashua 1 | 2.00 | 2.25 |
| 06 Community Council of Nashua 2 | 0.00 | 0.25 |
| 07 Mental Health Center of Greater Manchester-CCT | 1.50 | 1.50 |
| 07 Mental Health Center of Greater Manchester-MCST | 2.50 | 2.00 |
| 08 Seacoast Mental Health Center | 1.00 | 1.00 |
| 09 Community Partners | 1.25 | 0.15 |
| 10 Center for Life Management | 0.30 | 0.30 |
| **Total** | **14.65** | **14.35** |

*Revisions to Prior Period: None*

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

*Notes: Data compiled 10/17/18; for 2b-d: the Staff Competency values reflect the sum of FTEs trained to provide each service type. These numbers are not a reflection of the services delivered, rather the quantity of staff available to provide each service. If staff is trained to provide multiple service types, their entire FTE value will be credited to each service type.*

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

| Community Mental Health Center | 12 Month Period Ending September 2018 | | | Penetration Rate for Period Ending June 2018 |
|---|---|---|---|---|
| | Supported Employment Consumers | Total Eligible Consumers | Penetration Rate | |
| 01 Northern Human Services | 396 | 1,234 | 32.1% | 36.9% |
| 02 West Central Behavioral Health | 223 | 660 | 33.8% | 31.2% |
| 03 Lakes Region Mental Health Center | 152 | 1,292 | 11.8% | 12.1% |
| 04 Riverbend Community Mental Health Center | 303 | 1,827 | 16.6% | 11.8% |
| 05 Monadnock Family Services | 87 | 935 | 9.3% | 11.0% |
| 06 Community Council of Nashua | 226 | 1,787 | 12.6% | 14.2% |
| 07 Mental Health Center of Greater Manchester | 1,444 | 3,271 | 44.1% | 44.1% |
| 08 Seacoast Mental Health Center | 500 | 1,670 | 29.9% | 29.8% |
| 09 Community Partners | 150 | 782 | 19.2% | 20.9% |
| 10 Center for Life Management | 204 | 979 | 20.8% | 17.5% |
| **Deduplicated Total** | **3,672** | **14,182** | **25.9%** | **25.9%** |

*Revisions to Prior Period: None*

*Data Source: NH Phoenix 2*

*Notes: Data extracted 10/25/2018; consumers are counted only one time regardless of how many services they receive. Riverbend non-billable services are currently not available so are not included in this report.*

### 4a. New Hampshire Hospital: Adult Census Summary

| Measure | July - September 2018 | April - June 2018 |
|---|---|---|
| Admissions | 209 | 197 |
| Mean Daily Census | 262 | 178 |

| | | |
|---|---|---|
| Discharges | 212 | 203 |
| Median Length of Stay in Days for Discharges | 16 | 14 |
| Deaths | 0 | 0 |

*Revisions to Prior Period: None.*

*Data Source: Avatar*

*Notes 4a: Data extracted 10/17/18; Mean Daily Census includes patients on leave and is rounded to nearest whole number*

### 4b. New Hampshire Hospital: Discharge Location for Adults

| Discharge Location | July - September 2018 | April - June 2018 |
|---|---|---|
| Home - Lives with Others | 109 | 92 |
| Home - Lives Alone | 67 | 71 |
| CMHC Group Home | 7 | 7 |
| Private Group Home | 2 | 1 |
| Nursing Home | 1 | 2 |
| Hotel-Motel | 3 | 1 |
| Homeless Shelter/ No Permanent Home | 1 | 8 |
| Discharge/Transfer to IP Rehab Facility | 9 | 10 |
| Secure Psychiatric Unit – SPU | 0 | 0 |
| Peer Support Housing | 0 | 2 |
| Jail or Correctional Facility | 4 | 2 |
| Glencliff Home for the Elderly | 4 | 2 |
| Other | 3 | 2 |
| Unknown | 2 | 3 |

### 4c. New Hampshire Hospital: Readmission Rates for Adults

| Measure | July - September 2018 | April - June 2018 |
|---|---|---|
| 30 Days | 8.6% (18) | 7.6% (15) |
| 90 Days | 19.6% (41) | 14.7% (29) |
| 180 Days | 25.4% (53) | 23.4% (46) |

*Revisions to Prior Period: None.*

*Data Source: Avatar*

*Notes 4b-c: Data compiled 10/17/18; readmission rates calculated by looking back in time from admissions in study quarter. 90 and 180 day readmissions lookback period includes readmissions from the shorter period (e.g., 180 day includes the 90 and 30 day readmissions); patients are counted multiple times for each readmission; number in parentheses is the number of readmissions*

## 5a. Designated Receiving Facilities: Admissions for Adults

| Designated Receiving Facility | July - September 2018 | | |
|---|---|---|---|
| | Involuntary Admissions | Voluntary Admissions | Total Admissions |
| Franklin | 19 | 48 | 67 |
| Cypress Center | 49 | 152 | 201 |
| Portsmouth | 69 | 288 | 357 |
| Elliot Geriatric Psychiatric Unit | 7 | 47 | 54 |
| Elliot Pathways | 55 | 57 | 112 |
| **Total** | **199** | **592** | **791** |
| **Designated Receiving Facility** | **April - June 2018** | | |
| | **Involuntary Admissions** | **Voluntary Admissions** | **Total Admissions** |
| Franklin | 32 | 37 | 69 |
| Cypress Center | 63 | 181 | 244 |
| Portsmouth | 82 | 251 | 333 |
| Elliot Geriatric Psychiatric Unit | 6 | 59 | 65 |
| Elliot Pathways | 54 | 50 | 104 |
| **Total** | **237** | **578** | **815** |

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

| Designated Receiving Facility | July - September 2018 | April - June 2018 |
|---|---|---|
| Franklin | 11.8 | 9.1 |
| Cypress Center | 8.4 | 11.9 |
| Portsmouth | 39.6 | 31.7 |

| | | |
|---|---|---|
| Elliot Geriatric Psychiatric Unit | 33.8 | 31.7 |
| Elliot Pathways | 18.2 | 20.4 |
| **Total** | 111.8 | 104.7 |

### 5c. Designated Receiving Facilities: Discharges for Adults

| Designated Receiving Facility | July - September 2018 | April - June 2018 |
|---|---|---|
| Franklin | 66 | 74 |
| Manchester (Cypress Center) | 195 | 244 |
| Portsmouth | 353 | 326 |
| Elliot Geriatric Psychiatric Unit | 54 | 65 |
| Elliot Pathways | 112 | 107 |
| **Total** | **780** | **816** |

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

| Designated Receiving Facility | July - September 2018 | April - June 2018 |
|---|---|---|
| Franklin | 4 | 5 |
| Manchester (Cypress Center) | 4 | 4 |
| Portsmouth | 4 | 5 |
| Elliot Geriatric Psychiatric Unit | 21 | 20 |
| Elliot Pathways | 7 | 8 |
| **Total** | **5** | **5** |

## 5e. Designated Receiving Facilities: Discharge Location for Adults

| Designated Receiving Facility | July - September 2018 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Assisted Living/Group Home | Deceased | DRF | Home | Other Hospital | NH Hospital | Other |
| Franklin | 3 | 0 | 0 | 63 | 0 | 0 | 0 |
| Manchester (Cypress Center) | 4 | 0 | 2 | 186 | 0 | 0 | 3 |
| Portsmouth Regional Hospital | 0 | 0 | 1 | 304 | 0 | 2 | 46 |
| Elliot Geriatric Psychiatric Unit | 38 | 2 | 0 | 11 | 1 | 1 | 1 |
| Elliot Pathways | 4 | 0 | 0 | 97 | 0 | 1 | 10 |
| **Total** | **49** | **2** | **3** | **661** | **1** | **4** | **60** |

| Designated Receiving Facility | April - June 2018 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Assisted Living/Group Home | Deceased | DRF | Home | Other Hospital | NH Hospital | Other |
| Franklin | 1 | 0 | 9 | 63 | 0 | 0 | 1 |
| Manchester (Cypress Center) | 8 | 0 | 5 | 222 | 0 | 0 | 9 |
| Portsmouth Regional Hospital | 0 | 0 | 4 | 294 | 0 | 5 | 23 |
| Elliot Geriatric Psychiatric Unit | 29 | 12 | 0 | 18 | 2 | 0 | 4 |
| Elliot Pathways | 0 | 0 | 2 | 84 | 0 | 2 | 19 |
| **Total** | **38** | **12** | **20** | **681** | **2** | **7** | **56** |

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

### 5f. Designated Receiving Facilities: Readmission Rates for Adults

| Designated Receiving Facility | July - September 2018 | | |
|---|---|---|---|
| | 30 Days | 90 Days | 180 Days |
| Franklin | 6.0% (4) | 9.0% (6) | 16.4% (11) |
| Manchester (Cypress Center) | 8.5% (17) | 13.9% (28) | 18.9% (38) |
| Portsmouth | 8.4% (30) | 12.9% (46) | 19.0% (68) |
| Elliot Geriatric Psychiatric Unit | 5.6% (3) | 11.1% (6) | 11.1% (6) |
| Elliot Pathways | 0.9% (1) | 3.6% (4) | 3.6% (4) |

| **Total** | **7.0% (55)** | **11.5% (90)** | **6.1% (127)** |
|---|---|---|---|
| **Designated Receiving Facility** | **April - June 2018** | | |
| | **30 Days** | **90 Days** | **180 Days** |
| Franklin | 4.3% (3) | 5.8% (4) | 5.8% (4) |
| Manchester (Cypress Center) | 4.5% (11) | 8.2% (20) | 11.9% (29) |
| Portsmouth | 10.2% (34) | 15.9% (53) | 21.9% (73) |
| Elliot Geriatric Psychiatric Unit | 6.1% (4) | 6.1% (4) | 6.1% (4) |
| Elliot Pathways | 3.8% (4) | 6.7% (7) | 8.6% (9) |
| **Total** | **6.9% (56)** | **10.8% (88)** | **4.6% (119)** |

*Revisions to Prior Period: None.*

*Data Source: NH DRF Database*

*Notes: Data compiled 11/5/18.*

*Discharge location of "DRF" are patients discharged back to the same DRF for a different level of care within the DRF; readmission rates calculated by looking back in time from admissions in study quarter; patients are counted multiple times for each readmission; number in parentheses is the number of readmissions*

## 6. Glencliff Home: Census Summary

| Measure | July - September 2018 | April - June 2018 |
|---|---|---|
| Admissions | 6 | 8 |
| Average Daily Census | 114 | 116 |
| Discharges | 2 (1 - NHH, 1 – Assisted Living/Residential Care) | 1 (ABD Residential Care Home – 10 bed) |
| Individual Lengths of Stay in Days for Discharges | 1 and 929 | 1045 |
| Deaths | 9 | 7 |
| Readmissions | 1 | 0 |
| Mean Overall Admission Waitlist | 22 – (13 Active) | 23 (14 Active) |

*Revisions to Prior Period: None.*

*Data Source: Glencliff Home*

*Notes: Data Compiled 10/30/18; means rounded to nearest whole number; Active waitlist patients have been reviewed for admission and are awaiting admission pending finalization of paperwork and other steps immediate to admission.*

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

| Peer Support Agency | July - September 2018 | | April – June 2018 | |
|---|---|---|---|---|
| | Total Members | Average Daily Visits | Total Members | Average Daily Visits |
| **Alternative Life Center Total** | **169** | **46** | **587** | **49** |
| *Conway* | 12 | 13 | 196 | 13 |
| *Berlin* | 62 | 7 | 119 | 11 |
| *Littleton* | 47 | 11 | 158 | 10 |
| *Colebrook* | 48 | 15 | 114 | 15 |
| **Stepping Stone Total** | **240** | **18** | **435** | **18** |
| *Claremont* | 198 | 13 | 342 | 12 |
| *Lebanon* | 42 | 5 | 93 | 6 |
| **Cornerbridge Total** | **217** | **13** | **303** | **14** |
| *Laconia* | 120 | 4 | 130 | 4 |
| *Concord* | 76 | 9 | 153 | 10 |
| *Plymouth Outreach* | 21 | 0 | 20 | 0 |
| **MAPSA Keene Total** | **60** | **14** | **150** | **12** |
| **HEARTS Nashua Total** | **NA** | **NA** | **381** | **31** |
| **On the Road to Recovery Total** | **71** | **7** | **614** | **10** |
| *Manchester* | 34 | 4 | 446 | 4 |
| *Derry* | 37 | 3 | 168 | 6 |
| **Connections Portsmouth Total** | **77** | **14** | **289** | **15** |
| **TriCity Coop Rochester Total** | **111** | **27** | **292** | **27** |

| Peer Support Agency | July - September 2018 | | April – June 2018 | |
|---|---|---|---|---|
| | Total Members | Average Daily Visits | Total Members | Average Daily Visits |
| **Total** | **945** | **132** | **3,051** | **166** |

*Revisions to Prior Period: None*

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

*Notes: Data Compiled 11/20/18; Average Daily Visits NA for Outreach Programs; The Bureau of Mental Health Services (BMHS) annually requires Peer Support Agencies to "purge member lists" to increase confidence and consistency in this information. After a 2018 thorough review, BMHS identified inconsistencies in completing this process. The July-September 2018 data reflects a higher drop in total membership from previous years as a result; Peer Support Agency data not available at publication will be updated in a subsequent report.*

## 8. Housing Bridge Subsidy Summary to Date

| Subsidy | July - September 2018 | | |
|---|---|---|---|
| | Total individuals served at start of quarter | New individuals added during quarter | Total individuals served through end of quarter |
| Housing Bridge Subsidy | 811 | 1 | 812 |
| Section 8 Voucher | 125 | 0 | 125 |
| **Subsidy** | **April - June 2018** | | |
| | Total individuals served at start of quarter | New individuals added during quarter | Total individuals served through end of quarter |
| Housing Bridge Subsidy | 811 | 0 | 811 |
| Section 8 Voucher | 119 | 6 | 125 |

*Revisions to Prior Period: Total served for Section 8 in the prior period was 108, not 102*

*Data Source: Bureau of Mental Health and Housing Bridge Provider*

*Notes: Data Compiled 11/5/18*

### 9a. Housing Bridge Subsidy Applications and Terminations

| Measure | July-Sep 2018 | April - June 2018 |
|---|---|---|
| Applications Received | 32 | 28 |
| *Point of Contact* | *CMHCs: 32* | *CMHCs: 24*<br>*NH Hospital: 4* |
| Applications Approved | 7 | 5 |
| Applications Denied | 0 | 0 |
| *Denial Reasons* | *NA* | *NA* |
| Applications in Process* | 197 | 165 |
| Terminations | 0 | 0 |
| *Termination Reasons* | *NA* | *NA* |
| Program Exits | *Voucher Received: 7*<br>*Deceased: 1*<br>*Over income: 1*<br>*Transitional Housing: 1*<br>*Long-term Nursing Home: 1* | *Vouchers received: 7*<br>*Deceased: 2*<br>*Over income: 1*<br>*Relocated – Not NH: 1* |

**Total number of applications in process at close of reporting period; The Previous quarter data has been corrected based on a recent Bureau of Mental Health Services audit of Housing Bridge files.*

*Data Source: Bureau of Mental Health and Housing Bridge Provider*

*Notes: Data Compiled 11/5/18*

### 9b. Housing Bridge Subsidy Approved Applications on Waitlist

| As of 9/30/2018 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Time on List | | | | | | | |
| Total | 0-30 days | 31-60 days | 61-90 days | 91-120 days | 121-150 days | 151-180 days | 181+ days |
| 35 | 5 | 2 | 0 | 0 | 1 | 4 | 23 |
| As of 6/30/2018 | | | | | | | |

| Total | 0-30 days | 31-60 days | 61-90 days | 91-120 days | 121-150 days | 151-180 days | 181+ days |
|---|---|---|---|---|---|---|---|
| 28 | 0 | 0 | 4 | 1 | 2 | 5 | 15 |

*Data Source: Bureau of Mental Health and Housing Bridge Provider*

*Notes: Data Compiled: 10/25/18*

### 9c. Housing Bridge Subsidy Current Census

| Measure | As of 9/30/2018 | As of 6/30/2018 |
|---|---|---|
| Rents Currently Being Paid | 423 | 479 |
| Individuals Accepted and Working Towards Bridge Lease | 0 | 0 |
| Waiting list for Housing Bridge funding | 35 | 28 |

*Revisions to Prior Period: None*

*Data Source: Bureau of Mental Health and Housing Bridge Provider*

*Notes: Data Compiled 11/5/18; all individuals currently on Bridge Program are intended to transition from the program to other permanent housing).*

### 10. Housing Bridge Subsidy Unit Address Density

| Number of Unit(s)* at Same Address | Frequency as of 9/30/18 | Frequency as of 6/30/18 |
|---|---|---|
| 1 | 339 | 354 |
| 2 | 52 | 26 |
| 3 | 24 | 10 |
| 4 | 12 | 5 |
| 5 | 0 | 0 |
| 6 | 6 | 0 |
| 7 | 7 | 0 |
| 8 or more | 10 | 2 |

*All units are individual units

*Revisions to Prior Period: None*

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

*Notes: Data Compiled 11/14/18*

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

| Measure | July 2018 | August 2018 | September 2018 | July - September 2018 | April - June 2018 |
|---|---|---|---|---|---|
| **Unduplicated People Served in Month** | 157 | 221 | 248 | 519 | 562 |
| | | | | | |
| **Services Provided by Type** | | | | | |
| Phone Support/Triage | 206 | 293 | 277 | 776 | 838 |
| Mobile Community Assessments | 68 | 73 | 65 | 206 | 207 |
| Office-Based Urgent Assessments | 10 | 17 | 26 | 53 | 83 |
| Emergency Service Medication Appointments | 4 | 0 | 0 | 4 | 47 |
| Crisis Stabilization Appointments | 29 | 18 | 22 | 69 | 47 |
| Walk in Assessments | 12 | 9 | 9 | 30 | 25 |
| MHE-4 | NA | NA | 2 | 2 | NA |
| | | | | | |
| **Services Provided after Immediate Crisis** | | | | | |
| Phone Support/Triage | 49 | 73 | 29 | 151 | 235 |
| Mobile Community Assessments-Post Crisis | 9 | 18 | 5 | 32 | 51 |
| Office-Based Urgent Assessments | 10 | 17 | 26 | 53 | 83 |
| Emergency Service Medication Appointments | 4 | 0 | 0 | 4 | 25 |
| Crisis Stabilization Appointments | 29 | 18 | 14 | 61 | 47 |

| Measure | July 2018 | August 2018 | September 2018 | July - September 2018 | April - June 2018 |
|---|---|---|---|---|---|
| | | | | | |
| **Referral Source** | | | | | |
| Emergency Department/EMS | 4 | 1 | 1 | 6 | 35 |
| Family | 5 | 4 | 7 | 16 | 64 |
| Friend | 0 | 1 | 4 | 5 | 9 |
| Guardian | 1 | 10 | 19 | 30 | 74 |
| Mental Health Provider | 1 | 11 | 12 | 24 | 22 |
| Police | 4 | 8 | 6 | 18 | 16 |
| Primary Care Provider | 0 | 4 | 3 | 7 | 16 |
| CMHC Internal | 10 | 10 | 14 | 34 | 42 |
| Self | 131 | 167 | 179 | 477 | 431 |
| Other | 1 | 3 | 3 | 7 | 16 |
| | | | | | |
| **Crisis Apartment** | | | | | |
| Apartment Admissions | 26 | 28 | 26 | 80 | 94 |
| Apartment Bed Days | 104 | 117 | 106 | 327 | 346 |
| Apartment Average Length of Stay | 4.0 | 4.2 | 4.1 | 4.1 | 3.6 |
| | | | | | |
| **Law Enforcement Involvement** | 4 | 17 | 23 | 44 | 67 |
| | | | | | |
| **Hospital Diversions Total** | 250 | 214 | 222 | 686 | 458 |

*Revisions to Prior Period: None*

*Data Source: Riverbend CMHC submitted report, Riverbend MCRT data includes emergency services.*

*Notes: Data Compiled 10/30/18; reported values other than the Unduplicated People Service in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc. MHE-4 is a new initiative at Concord Hospital in an attempt to ease congestion at the emergency department; if a patient is at low risk to self, they rapid triage them out of the emergency department to mobile services within an hour of their arrival at the hospital. Mobile crisis provides the evaluation.*

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

| Measure | July 2018 | August 2018 | September 2018 | July - September 2018 | April - June 2018 |
|---|---|---|---|---|---|
| **Unduplicated People Served by Month** | 222 | 241 | 228 | 533 | 534 |
| | | | | | |
| **Services Provided by Type** | | | | | |
| Phone Support/Triage | 607 | 493 | 593 | 1,693 | 1,503 |
| Mobile Community Assessments | 103 | 77 | 104 | 284 | 268 |
| Office-Based Urgent Assessments | 21 | 14 | 6 | 41 | 45 |
| Emergency Service Medication Appointments | 4 | 2 | 7 | 13 | 5 |
| Crisis Apartment Service | 218 | 80 | 167 | 465 | 109 |
| | | | | | |
| **Referral Source** | | | | | |
| Emergency Department | 4 | 0 | 1 | 5 | 0 |
| Family | 31 | 25 | 41 | 97 | 132 |
| Friend | 4 | 6 | 7 | 17 | 20 |
| Guardian | 3 | 3 | 4 | 10 | 11 |
| Mental Health Provider | 11 | 5 | 3 | 19 | 27 |
| Police | 77 | 75 | 53 | 205 | 185 |
| Primary Care Provider | 9 | 13 | 8 | 31 | 20 |
| CMHC Internal | 23 | 13 | 8 | 44 | 78 |
| Self | 123 | 135 | 175 | 433 | 373 |
| Other | 37 | 21 | 46 | 104 | 100 |

| | | | | | |
|---|---|---|---|---|---|
| **Crisis Apartment** | | | | | |
| Apartment Admissions | 14 | 3 | 12 | 29 | 12 |
| Apartment Bed Days | 46 | 15 | 53 | 114 | 24 |
| Apartment Average Length of Stay | 3.3 | 5.0 | 4.4 | 3.9 | 2.0 |
| | | | | | |
| **Law Enforcement Involvement** | 77 | 75 | 53 | 205 | 132 |
| | | | | | |
| **Hospital Diversion Total** | 336 | 299 | 358 | 993 | 946 |

*Revisions to Prior Period: None.*

*Data Source: Phoenix 2*

*Notes: Data Compiled 10/25/18; reported values other than the Unduplicated People Service in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.*

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

| Measure | July 2018 | August 2018 | September 2018 | July - September 2018 | April - June 2018 |
|---|---|---|---|---|---|
| **Unduplicated People Served by Month** | 213 | 205 | 175 | 490 | 371 |
| | | | | | |
| **Services Provided by Type** | | | | | |
| Case Management | 101 | 162 | 132 | 395 | 84 |
| Crisis Apartment Service | 65 | 66 | 37 | 168 | 70 |
| Crisis Intervention Services | 0 | 0 | 0 | 0 | 0 |
| ED Based Assessment | 0 | 1 | 11 | 12 | 0 |
| Emergency Service Medication Appointments | 0 | 0 | 0 | 0 | 0 |
| Mobile Community Assessments | 173 | 186 | 142 | 501 | 357 |
| Office-Based Urgent Assessments | 2 | 4 | 162 | 168 | 0 |
| Other | 11 | 10 | 29 | 50 | 21 |
| Peer Support | 79 | 158 | 134 | 371 | 0 |
| Phone Support/Triage | 122 | 129 | 208 | 459 | 329 |
| Psychotherapy | 0 | 0 | 0 | 0 | 0 |
| | | | | | |
| **Referral Source** | | | | | |
| Emergency Department | 1 | 0 | 0 | 1 | 1 |
| Family | 19 | 18 | 14 | 51 | 58 |
| Friend | 5 | 7 | 3 | 15 | 13 |

| | | | | | |
|---|---|---|---|---|---|
| Guardian | 1 | 0 | 0 | 1 | 7 |
| MCT Hospitalization | 6 | 0 | 12 | 18 | 0 |
| Mental Health Provider | 19 | 8 | 26 | 53 | 31 |
| Police | 5 | 3 | 2 | 10 | 1 |
| Primary Care Provider | 1 | 0 | 3 | 4 | 0 |
| CMHC | 30 | 31 | 28 | 89 | 29 |
| Self | 94 | 107 | 66 | 267 | 158 |
| Other | 179 | 234 | 180 | 593 | 366 |
| | | | | | |
| **Crisis Apartment** | | | | | |
| Apartment Admissions | 28 | 33 | 27 | 88 | 42 |
| Apartment Bed Days | 172 | 141 | 123 | 436 | 229 |
| Apartment Average Length of Stay | 6.1 | 4.3 | 4.6 | 4.9 | 5.4 |
| | | | | | |
| **Law Enforcement Involvement** | 0 | 0 | 0 | 0 | 0 |
| | | | | | |
| **Hospital Diversion Total** | 365 | 403 | 340 | 1,108 | 563 |

*Revisions to Prior Period: None*

*Data Source: Harbor Homes submitted data*

*Notes: Data Compiled 10/17/18; reported values other than the Unduplicated People Service in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc. Harbor Homes made significant data reporting improvements beginning in May 2018.*

## 12a. Community Mental Health Center Consumers: Adult Employment Status – Total

*Note: Employment Status reporting, while accurately representing the data submitted from the CMHCs to DHHS, does not yet represent true employment status of consumers. Extensive revisions are expected to this data by the CMHCs as their reporting systems become better aligned to reporting requirements*

| | July - September 2018 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Reported Employment Status of Recent Supportive Employment Service Users | | | | | | Reported Employment Status as Percent of Total Adults | | | | Percent Excluding Unknown | |
| Community Mental Health Center | Employed now or in the past 3 months - full time | Employed now or in the past 3 months - part time | Unemployed | Not In the Workforce | Unknown | Total | Employed Full or Part Time | Unemployed | Not in Workforce | Unknown | In Workforce | Employed Full or Part Time of Those in Workforce |
| 01 Northern Human Services | 8 | 19 | 10 | 40 | 818 | 895 | 3.0% | 1.1% | 4.5% | 91.4% | 48.1% | 73.0% |
| 02 West Central Behavioral Health | 16 | 28 | 77 | 74 | 216 | 411 | 10.7% | 18.7% | 18.0% | 52.6% | 62.1% | 36.4% |
| 03 Lakes Region Mental Health Center | 25 | 101 | 47 | 568 | 140 | 881 | 14.3% | 5.3% | 64.5% | 15.9% | 23.3% | 72.8% |
| 04 Riverbend Community Mental Health Center | 99 | 261 | 92 | 869 | 34 | 1,355 | 26.6% | 6.8% | 64.1% | 2.5% | 34.2% | 79.6% |
| 05 Monadnock Family Services | 26 | 129 | 113 | 401 | 20 | 689 | 22.5% | 16.4% | 58.2% | 2.9% | 40.1% | 57.8% |
| 06 Community Council of Nashua | 113 | 201 | 743 | 211 | 114 | 1,382 | 22.7% | 53.8% | 15.3% | 8.2% | 83.4% | 29.7% |
| 07 Mental Health Center of Greater Manchester | 198 | 312 | 916 | 551 | 23 | 2,000 | 25.5% | 45.8% | 27.6% | 1.2% | 72.1% | 35.8% |
| 08 Seacoast Mental Health Center | 143 | 219 | 82 | 681 | 8 | 1,133 | 32.0% | 7.2% | 60.1% | 0.7% | 39.5% | 81.5% |
| 09 Community Partners | 41 | 62 | 173 | 263 | 11 | 550 | 18.7% | 31.5% | 47.8% | 2.0% | 51.2% | 37.3% |
| 10 Center for Life Management | 47 | 136 | 493 | 102 | 22 | 800 | 22.9% | 61.6% | 12.8% | 2.8% | 86.9% | 27.1% |
| **Total** | 716 | 1,468 | 2,746 | 3,760 | 1,406 | 10,096 | 21.6% | 27.2% | 37.2% | 13.9% | 56.7% | 44.3% |

## 12b. Community Mental Health Center Consumers: Adult Employment Status – Recent Users of Supportive Employment Services (One Billable Service in Each of Month of the Quarter)

| | July - September 2018 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Reported Employment Status of Recent Supportive Employment Service Users | | | | | | Reported Employment Status as a Percent of Total Adults | | | | Percent Excluding Unknown | |
| Community Mental Health Center | Employed now or in the past 3 months - full time | Employed now or in the past 3 months - part time | Unemployed | Not In the Workforce | Unknown | Total | Employed Full or Part Time | Unemployed | Not in Workforce | Unknown | Percent in Workforce (Employed or Unemployed) | Employed Full or Part Time of Those in Workforce |
| 01 Northern Human Services | 0 | 0 | 0 | 0 | 34 | 34 | 0.0% | 0.0% | 0.0% | 100.0% | 0.0% | 0.0% |
| 02 West Central Behavioral Health | 0 | 7 | 5 | 1 | 13 | 26 | 26.9% | 19.2% | 3.8% | 50.0% | 92.3% | 58.3% |
| 03 Lakes Region Mental Health Center | 0 | 8 | 3 | 8 | 11 | 30 | 26.7% | 10.0% | 26.7% | 36.7% | 57.9% | 72.7% |
| 04 Riverbend Community Mental Health Center | 3 | 28 | 17 | 4 | 0 | 52 | 59.6% | 32.7% | 7.7% | 0.0% | 92.3% | 64.6% |
| 05 Monadnock Family Services | 1 | 10 | 5 | 1 | 0 | 17 | 64.7% | 29.4% | 5.9% | 0.0% | 94.1% | 68.8% |
| 06 Community Council of Nashua | 5 | 6 | 10 | 5 | 5 | 31 | 35.5% | 32.3% | 16.1% | 16.1% | 80.8% | 52.4% |
| 07 Mental Health Center of Greater Manchester | 5 | 34 | 29 | 4 | 0 | 72 | 54.2% | 40.3% | 5.6% | 0.0% | 94.4% | 57.4% |
| 08 Seacoast Mental Health Center | 0 | 6 | 7 | 11 | 0 | 24 | 25.0% | 29.2% | 45.8% | 0.0% | 54.2% | 46.2% |
| 09 Community Partners | 0 | 6 | 6 | 4 | 0 | 16 | 37.5% | 37.5% | 25.0% | 0.0% | 75.0% | 50.0% |
| 10 Center for Life Management | 1 | 16 | 5 | 0 | 0 | 22 | 77.3% | 22.7% | 0.0% | 0.0% | 100.0% | 77.3% |
| **Total** | 15 | 121 | 87 | 38 | 63 | 324 | 42.0% | 26.9% | 11.7% | 19.4% | 85.4% | 61.0% |

## 12c. Community Mental Health Center Consumers: Employment Screening Status

| Community Mental Health Center | As of 9/30/18 | | | |
|---|---|---|---|---|
| | Current | Overdue*/ Unknown | Total | Percent Overdue |
| 01 Northern Human Services | 213 | 682 | 895 | 76.2% |
| 02 West Central Behavioral Health | NA | NA | NA | NA |
| 03 Lakes Region Mental Health Center | 334 | 547 | 881 | 62.1% |
| 04 Riverbend Community Mental Health Center | 1,218 | 137 | 1,355 | 10.1% |
| 05 Monadnock Family Services | NA | NA | NA | NA |
| 06 Community Council of Nashua | 1,309 | 73 | 1,382 | 5.3% |
| 07 Mental Health Center of Greater Manchester | 1,550 | 450 | 2,000 | 22.5% |
| 08 Seacoast Mental Health Center | 889 | 244 | 1,133 | 21.5% |
| 09 Community Partners | 421 | 129 | 550 | 23.5% |
| 10 Center for Life Management | 800 | 0 | 800 | 0.0% |
| **Total** | **NA** | **NA** | **NA** | **NA** |

**Status More Than 105 Days Old*

*Revisions to Prior Period: None*

*Data Source: Phoenix 2*

*Notes 12a-c: Data extracted 10/17/18.*

- *Employment Status* shown in the tables reflects status data found in DHHS's Phoenix system reported by the CMHCs. Phoenix tracks the individual consumer employment status over time. If more than one status was reported within the Quarterly Report timeframe the most recent update is used.
- *Employed* refers to consumers who are employed in a competitive job. Competitive jobs have these characteristics: exists in the open labor market, pays at least a minimum wage, anyone could have regardless of disability status, not set aside for people with disabilities, and wages (including benefits) not less than for the same work performed by people who do not have a mental illness.
- *Full time* employment is 20 hours and above; *part time* is anything 19 hours and below.
- *Unemployed* refers to consumers who are not employed but are seeking or interested in employment.
- *Not in the Workforce* are consumers who are homemakers, students, retired, disabled, hospital patients or residents of other institutions, in a sheltered/non-competitive employment workshop, otherwise not in the labor force or not employed and not seeking or interested in employment. *Unknown* refers to consumers for with an "unknown" status, no status, or erroneous status code in Phoenix.
- *NA* data not available due to known data submission issue which is undergoing active quality improvement efforts.

**Appendix B**

CMHA Monthly Progress Report

August, 2018

# New Hampshire Community Mental Health Agreement Monthly Progress Report

***August 2018***

New Hampshire Department of Health and Human Services

November 13, 2018

## Acronyms Used in this Report

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

## Background

This Monthly Progress Report is issued in response to the June 29, 2016 Expert Reviewer Report, Number Four, action step 4. It reflects the actions taken in August 2018, and month-over-month progress made in support of the Community Mental Health Agreement (CMHA) as of August 31, 2018. Data contained may be subject to change upon further reconciliation with CMHCs. This report is specific to achievement of milestones contained in the agreed upon CMHA Project Plan for Assertive Community Treatment (ACT), Supported Employment (SE) and Glencliff Home Transitions. Where appropriate, the Report includes CMHA lifetime-to-date achievements.

## Progress Highlights

**Assertive Community Treatment (ACT)**

| Goal | Status | Recent Actions Taken |
|---|---|---|
| CMHC fidelity to ACT evidence-based practice model annually assessed. | SFY 2019:<br>2 of 10 Completed | • 1 report issued, 0 improvement plans in place., 1 improvement plan in development |
| Provide ACT team services, consistent with standards set forth, with the capacity to serve at least 1,500 individuals. | Capacity:<br>August – 1,040<br><br>Enrollment:<br>August – 921 | • 3 post ACT Fidelity Review consultations with participating CMHCs have occurred during State Fiscal Year 2019 thus far.<br>• August newly* enrolled individuals: 25<br>*New is defined as an individual who is new to the ACT program or an individual who has not received an ACT service in more than 90 days. |

**Supported Employment (SE)**

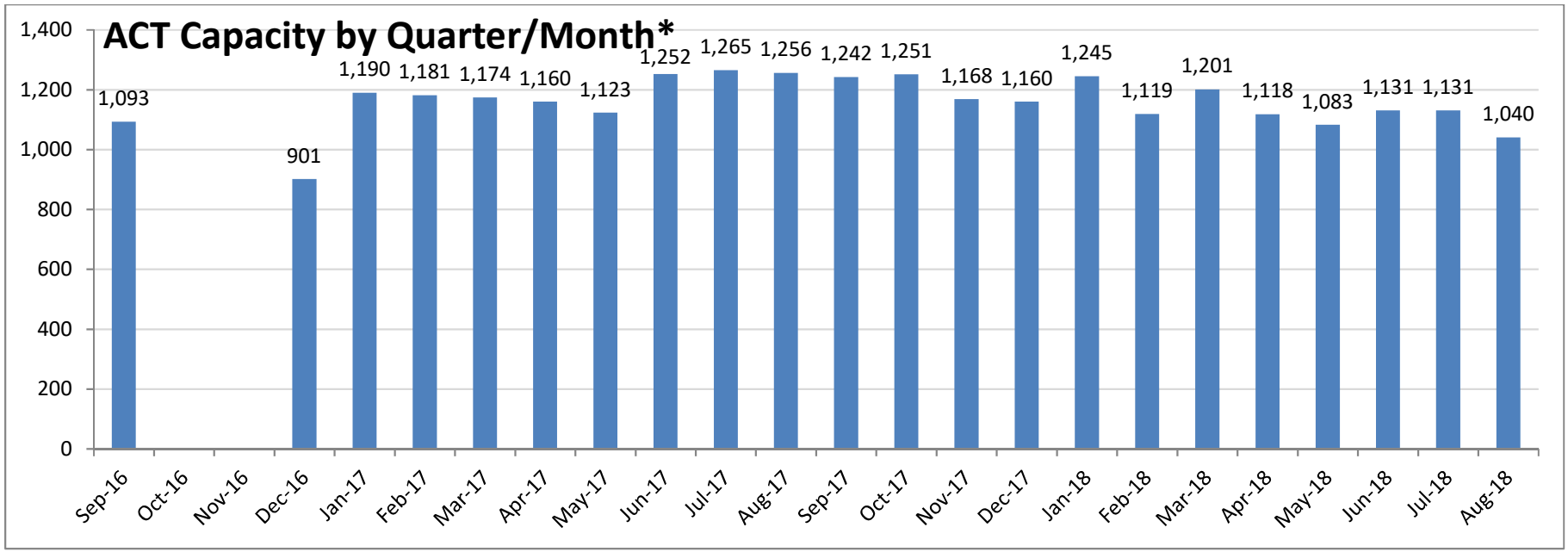
| Goal | Status | Recent Actions Taken |
|---|---|---|
| CMHC fidelity to SE evidence-based practice model annually assessed. | 2019:<br>1 of 10 completed | • 1 fidelity report issued, 1 improvement plan in place. |
| Increase penetration rate of individuals with a Serious Mental Illness (SMI) receiving SE services to 18.6%. | Statewide penetration rate:<br>August – 25.4% | • 0 post SE Fidelity Review consultations with participating CMHCs have occurred during State Fiscal Year 2019 thus far. |

**Glencliff Home Transitions into Integrated Community Setting**

| Goal | Status | Recent Actions Taken |
|---|---|---|
| Have capacity to serve in the community 16 (cumulatively) individuals with mental illness and complex health care needs residing at Glencliff who cannot be cost-effectively served in supported housing. | 16 of 16 completed[27] | • Continued work toward improving the model for small group (4 people or less) residence homes.<br>• 1 individual planning to transition in October to a small group residence in Nashua. |
| 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 | Completed; ongoing | • 18 residents on the list<br>• Bi-weekly meetings between Glencliff Home staff and DHHS Interagency Integration Team representative to review cases of individuals needing multi-system supports to facilitate return to community setting |

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

| | | |
|---|---|---|
| providing sufficient community-based residential supports for such individuals in the future. | | |


ACT Capacity by Quarter/Month*
1,400
1,200
1,000
800
600
400
200
0
1,093
901
1,190
1,181
1,174
1,160
1,123
1,252
1,265
1,256
1,242
1,251
1,168
1,160
1,245
1,119
1,201
1,118
1,083
1,131
1,131
1,040
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
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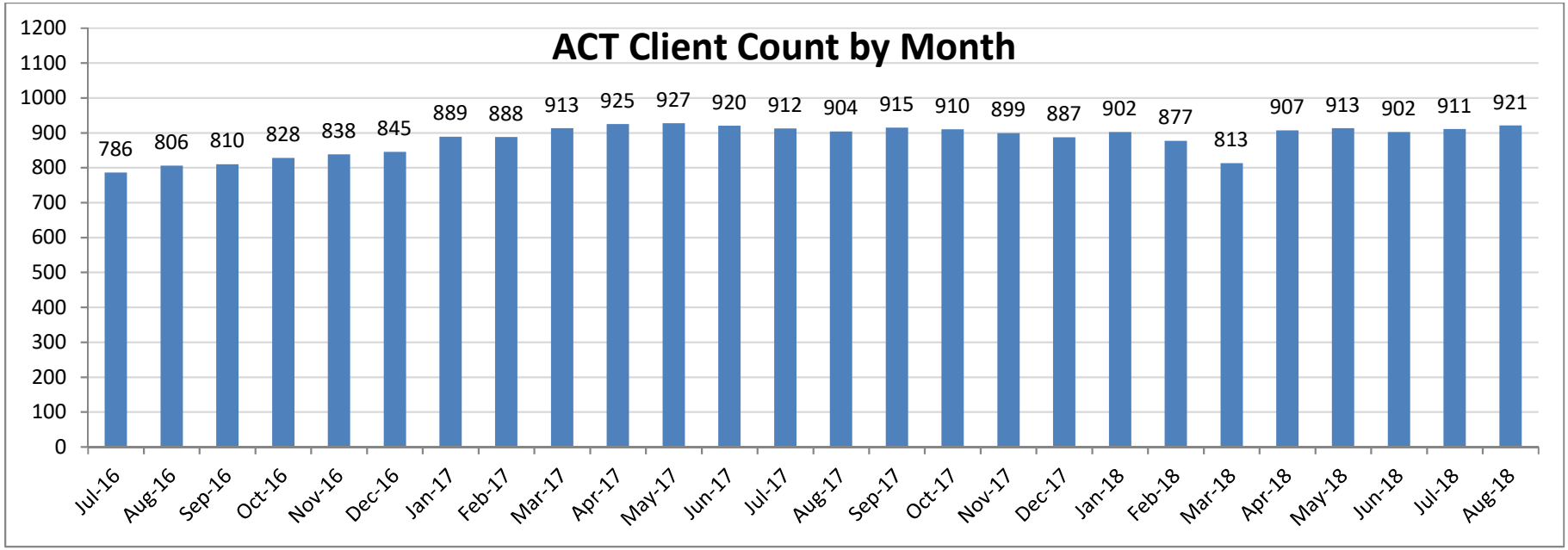
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18


ACT Client Count by Month
1200
1100
1000
900
800
700
600
500
400
300
200
100
0
786
806
810
828
838
845
889
888
913
925
927
920
912
904
915
910
899
887
902
877
813
907
913
902
911
921
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Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
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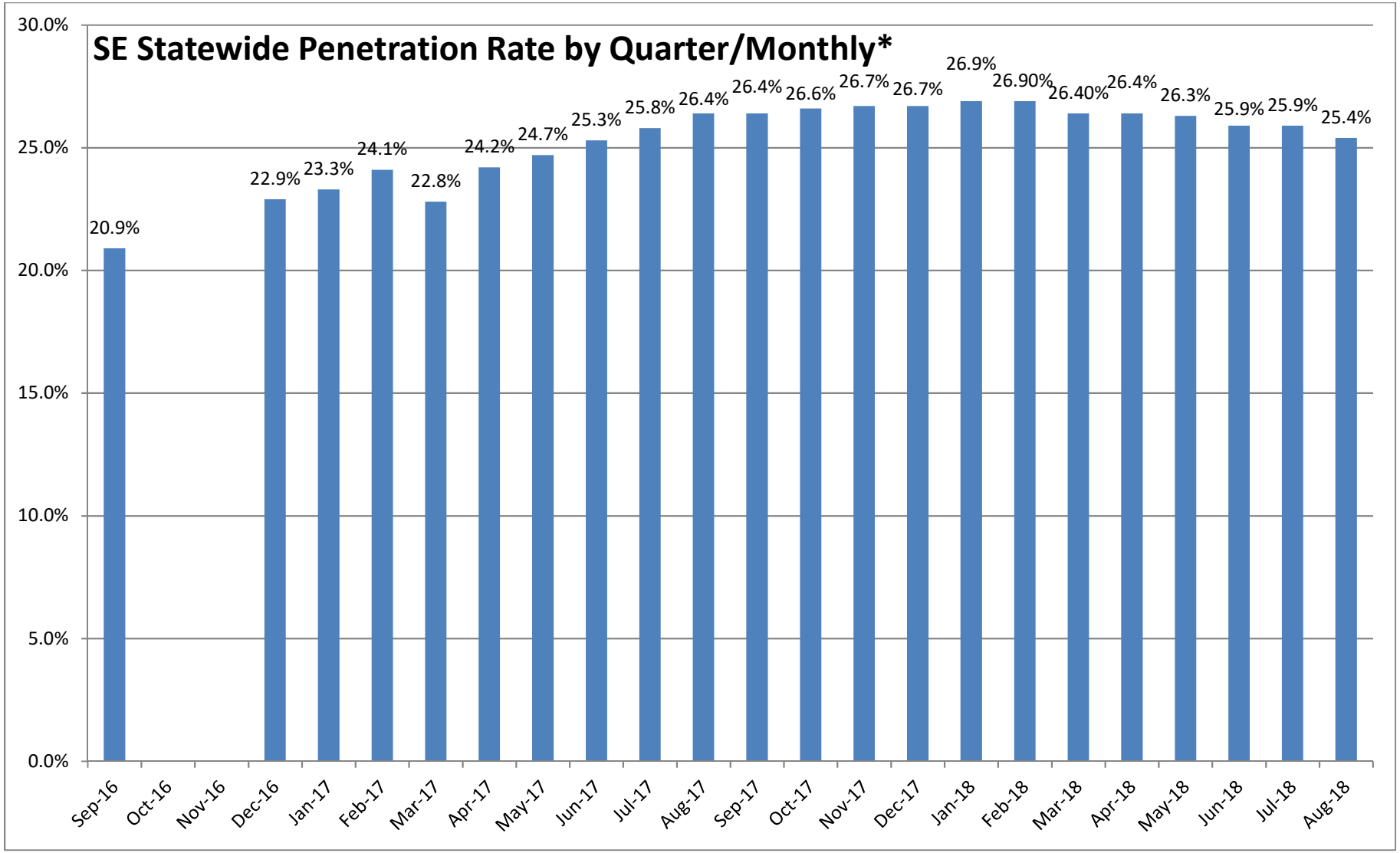
Aug-18




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