New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Fourteen

September 30, 2021

I. Introduction

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

> Twice a year, or more often if deemed appropriate by the Expert Reviewer, the Expert Reviewer will submit to the Parties a public report on 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.

For the past 18 months, the State of New Hampshire has been seriously affected by COVID-19. The State reports that Community Mental Health Centers (CMHCs) have remained functional and open as essential businesses during this period, although a majority of employees have been working remotely. Following Centers for Disease Control and Prevention (CDC) recommendations and NH Division of Public Health Services (DPHS) guidance, in addition to program specific emergency guidance provided by the Bureau of Mental Health Services (BMHS), CMHCs have focused on adjusting service delivery to maintain health and to implement safety protocols while serving participants in a way that met participant needs and preferences. Telehealth services are being provided for participants preferring that method due to COVID-19 concerns, and in-person services remain available for individuals who prefer this method. Mental Health (MH) facilities, including New Hampshire Hospital (NHH), Glencliff, and residential treatment centers, have modified safety protocols to protect residents/patients from COVID-19. The State has implemented numerous strategies, including Medicaid plan changes, eligibility certification improvements, staffing requirements, etc., to insure that, to the extent possible, service response rates and service continuity are maintained.

During the nine-month period since the previous report, the ER has been able to conduct only two on-site reviews, far fewer than would have been conducted in the absence of COVID.

During the past nine months, the ER has participated in a number of conference calls with State officials and representatives of the Plaintiffs, as outlined below. The ER has also continued to monitor the routine monthly and quarterly data reports produced by the State, as well as newly generated data reports related to the response to COVID-19. Nonetheless, by necessity, as with the previous ER Report, this report is constrained by the limited ability to have face-to-face contact with service administrators, service providers and service participants.

During this period, the ER:

- Participated in a conference call with State and Glencliff leadership personnel to discuss the process for documenting and reporting on in-reach activities and results for residents of Glencliff;
- Conducted a two-day on-site review of transition planning and in-reach activities at Glencliff;
- Participated in a Quality Service Review (QSR) pre-site visit planning conference call, and observed a QSR team interview with a service participant;
- Participated in a conference call with State officials to discuss the State's response to information requests in the prior ER Report;
- Participated in a conference call with State officials to receive information regarding hospital admissions and re-admissions, and Assertive Community Treatment (ACT) service utilization;
- Participated in two conference calls with representatives of the Plaintiffs to discuss Glencliff transition planning and in-reach activities, and the new information produced by the State in response to the prior ER report;
- Participated in an on-site visit with State officials and leadership of Greater Nashua Mental Health (GNMH) to observe the status of Mobile Crisis Team (MCT) and Crisis Apartment services in the Nashua Region following the change in program contractor; and
- Participated in two remote all-parties meetings.

Summary of Progress to Date

This report reflects seven years of implementation efforts related to the CMHA. Within that time frame, a number of positive steps have been taken to improve the quality and effectiveness of services as required by the CMHA. However, as will be discussed in detail below, 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 previous ER reports, the State has implemented a comprehensive and reliable QSR process. The ER considers these QSR reviews to be methodologically correct and reliable, 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 (DHMC) to conduct external ACT and Supported Employment (SE) fidelity reviews using nationally validated fidelity review instruments and criteria. In concert with the QSR reviews referenced above, the fidelity reviews have assisted the State and the CMHCs to develop comprehensive Quality Improvement Plans (QIPs) that address important ACT and SE quality and effectiveness issues at both the consumer and CMHC operational levels. The fidelity reviews have not been conducted since the onset of COVID-19. However, the State and the CMHCs have been using Evidence-Based Practice (EBP) checklists DHMC consults and record reviews to monitor and support fidelity to ACT and SE best practice standards during the pandemic. The State has also continued to provide technical assistance and oversight to CMHCs that had active QIPs related to ACT and SE at the time the fidelity reviews were suspended. The State intends to re-start the fidelity review process as early as possible in the coming year.

The parties originally envisioned 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 Court on February 12, 2014, and the five-year anniversary of that event occurred over two- and one-half years ago. The ER was approved by the parties and the Court, effective July 1, 2014, and the five-year anniversary of that occurred 26 months ago.

Most of calendar years 2020 and 2021 have been dominated by the response to the health risks associated with COVID-19 and by the restrictions necessitated by COVID-19. As will be seen in the subsequent sections of this report, most elements of the service system defined by the CMHA have remained relatively stable. Understandably, there has been little measurable progress, but there has also been a relatively consistent level of service delivery and performance. The State is to be congratulated for maintaining services to the CMHA Target Population during these very difficult circumstances. Nonetheless, it is important to emphasize that the pandemic has not altered the terms of the CMHA nor diminished the State's obligations to members of the Target Population. Moreover, the delays and restrictions caused by COVID-19 necessarily require extension of the time periods for the State to complete its responsibilities under the CMHA.

In recent months, the State has undertaken four initiatives related to specific CMHA service components and requirements. These are:

1. Selection of a new vendor (Greater Nashua Mental Health) to operate the MCT and Crisis Apartment program in the Nashua region;
2. Engaging a staffer to focus on transitions and adoption of new transition planning and informed consent protocols at Glencliff;
3. Addition of new funds to the Bridge Program to permit funding of a total of 500 units; and
4. Changing the methods for calculating financial incentives to CMHCs for meeting performance criteria such as ACT enrollments.

These initiatives seem positive, but they were begun too late in this reporting cycle to have yet produced measurable results. The ER will continue to monitor the implementation of these initiatives over the upcoming year.

II. Data

Appendix A contains the most recent DHHS Quarterly Data Report (January 2021 through March 2021) 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. The ER emphasizes that the State must produce the necessary data reports in a timely fashion. The ER is not able to produce the six-month reports on the required schedule as long as the State is late delivering the necessary data and reports.

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)[1] and Crisis Apartments (MCT/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/Crisis Apartment program 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/Crisis Apartment program became operational in the Nashua region on July 1, 2017. The contract for that program was awarded initially to Harbor Homes in Nashua. That contract was transferred in late 2020 to another provider, Greater Nashua Mental Health (GNMH), which is in the process of implementing the program. Full implementation is not expected until later in 2021.

As of the date of this report, the State reports that it has competitively re-procured the existing MCT/Crisis Apartment program contracts in Concord and Manchester. The State reports the new contracts incorporated changes for these programs including: (a) new performance measures related to face-to-face assessments and follow-up engagement with peers; and (b) new data reporting elements related to presenting problems, police involvement, and intervention

[1] Note that the State refers to these programs as Mobile Crisis Response Teams (MCRTs). The ER uses the MCT nomenclature to remain consistent with the term used in the CMHA.

outcomes. The ER will monitor implementation of these new requirements over the next six-month period.

In Nashua, the original vendor (Harbor Homes) opted not to submit a bid for the program and to end its participation in the program. As a result, effective October 1, 2020, the State has contacted with the GNMH to operate the MCT/Crisis Apartment program. The transition between the previous and current vendors concluded November 1, 2020. But, as of the date of this report, the Mobile Team in Nashua is not fully staffed for all shifts, and the crisis apartments are not yet open. At this point GNMH reports it has not yet hired peer support staff for the crisis apartments. The State reported that Mobile Crisis Team/Crisis Apartment data for the Nashua region is "Not Available," and it appears that some reductions in service have occurred now that GNMH has assumed the contract.

The ER visited the site of the Nashua MCT offices and crisis apartments on May 7, 2021. The site was under construction at the time of the visit. Ultimately, the site is expected to house the MCT, two two-person crisis apartments, GNMH's emergency services team, and Nashua's Critical Time Intervention (CTI) program. Construction was delayed for a number of reasons, and a final occupancy permit has not yet been issued. It is anticipated the site will be available for both staff offices and the crisis apartments by late October, 2021

While there may be legitimate reasons for delays in implementation, the fact remains that the Nashua region has been without fully operational MCT/Crisis Apartment services for at least the past eight months. The ER expects the State and GNMH will take all steps necessary to remediate this as soon as possible. The ER will revisit the Nashua site in October/November 2021, to observe and monitor the degree to which GNMH is operating a fully-compliant MCT/crisis apartment program consistent with the CMHA.

The Quarterly Data Report contained in Appendix A includes a detailed table of data from each of the Mobile Team/Crisis Apartment programs. Table I contains a summary of key data trends from the three programs.[2]

[2] Due to a data reporting migration to a new platform, these data may not be reliable. DHHS reports that it is working with the provider to correct and verify the data reporting.

Table I

Self-Reported Data on Mobile Crisis Services and Crisis Apartment Programs October 2020 through March 2021

Region	Variable	Oct -Dec 2020	Jan – Mar 2021
Concord	Total Served	462	429
Manchester	Total Served	658	712
Nashua	Total Served	44	NA
Concord	Phone triage/support	980	963
Manchester	Phone triage/support	1,703	2,041
Nashua	Phone triage/support	37	NA
Concord	Mobile Assess./intervention	110	10
Manchester	Mobile Assess./intervention	312	307
Nashua	Mobile Assess./intervention	3	NA
Concord	Percent Referred by self	51.10%	73.60%
Manchester	Percent Referred by self	36.20%	40.20%
Nashua	Percent Referred by self	55.30%	NA
Concord	Percent referred by police	2.10%	0.35%
Manchester	Percent referred by police	33.20%	18.70%
Nashua	Percent referred by police	0.00%	NA
Concord	Percent Law Enforcement Inv.	3.50%	0.47%
Manchester	Percent Law Enforcement Inv.	35.30%	30.10%
Nashua	Percent Law Enforcement Inv.	0.00%	NA
Concord	Hospital diversions	525	248
Manchester	Hospital diversions	961	1,120
Nashua	Hospital diversions	57	NA
Concord	Apartment Admits	26	18
Manchester	Apartment Admits	0	0
Nashua	Apartment Admits	0	NA
Concord	Apartment bed days	81	78
Manchester	Apartment bed days	0	0
Nashua	Apartment bed days	0	NA

Table I shows evidence of the effects of COVID restrictions on the operations of MCT/Crisis Apartment programs. The absence of Crisis Apartment admissions and bed days reported by Manchester is one example of this. As referenced, as of the date of this report, there are no MCT/Crisis Apartment data reports from the new vendor in the Nashua region (GNMH).

The ER continues to be concerned about some apparent practice and data reporting variations among the existing MCT/Crisis Apartment programs. For example, as can be seen in Table I, there are substantial differences among the programs with regard to police referrals to, and law enforcement involvement in, the various programs. The ER expects additional State oversight of the MCT/Crisis Apartment programs, including increased and improved reporting of program performance in key areas of MCT service delivery, such as phone triage, decisions to deploy mobile crisis teams to community locations, and the efficacy of crisis response. As noted above, the State has added new performance criteria and measures to the contracts for all three of the MCT/Crisis Apartment programs. Both the State and the ER will monitor adherence to these new performance expectations in the coming year, and will request that data on the impact of these new measures be shared with the parties.

The State recently funded a new Behavioral Health Crisis Treatment Center (BHCTC) that has been implemented by the Riverbend CMHC in Concord. The BHCTC is an additional crisis support outside those required by the CMHA. As such, data related to the operations of that program is not included in this report. The State asserts that it is not currently considering this model for expansion to other crisis programs in New Hampshire.

Table II below includes data that reveals some recent changes in both emergency department waiting times for inpatient psychiatric admissions and NHH admissions, and for NHH readmission rates. These data may indicate that the MCT/Crisis Apartment programs could be having a positive effect on system indicators such as hospital recidivism rates. However, there may be numerous other factors influencing these data trends, including the state's expansion of institutional bed capacity.

Table II
DHHS Report of Changes in Waiting Time for Inpatient Psychiatric Admission and NHH Admissions, and NHH Readmission Rates

Comparison 12-mo Period	Average # Adults Waiting per Day for NHH Admission	NHH Admissions	NHH 180-day Readmissions Average
4/1/2019-3/31/2020	31	938	21.9%
4/1/2020-3/31/2021	39	916	17%
Change	Up 25.8%	Down 2.3%	Down 22.4%

Assertive Community Treatment (ACT)

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

1. By October 1, 2014, the State will ensure that all of its 11 existing adult ACT teams operate in accordance with the standards set forth in Section V.D.2;
2. By June 30, 2014, the State will ensure that each mental health region has at least one adult ACT team;
3. By June 30, 2016, the State will provide ACT team services consistent with the standards set forth above in Section V.D.2 with the capacity to serve at least 1,500 individuals in the Target Population at any given time; and
4. By June 30, 2017, the State, through its community mental health providers, will identify and maintain a list of all individuals admitted to, or at 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.

Table III below displays ACT staffing levels for each of the 10 CMHC regions. Three of the regions have multiple ACT teams, and for these the staffing is reported by team.

Table III
Self-Reported ACT Staffing (excluding psychiatry):
December 2019 – March 2021

Region	FTE Dec-19	FTE Mar-20	FTE Jun-20	FTE Sep-20	FTE Dec-20	FTE Mar-21
Northern	16.97	16.37	13.36	15.12	15.75	14.03
Northern Wolfeboro					8.27	6.81
Northern Berlin					4.17	3.94
Northern Littleton					3.31	3.28
West Central	8.75	6.10	6.10	5.00	5.90	5.40
Lakes Region	7.00	7.00	6.50	6.40	7.00	5.00
Riverbend	11.50	10.50	10.50	9.00	10.50	10.40
Monadnock	8.75	8.85	8.85	11.58	10.32	11.17
Greater Nashua 1	8.00	6.50	8.00	8.50	8.50	7.65
Greater Nashua 2	8.00	7.50	8.00	8.50	8.50	8.65
Manchester – CTT	15.75	18.25	18.25	16.25	21.61	19.95
Manchester - MCST	15.75	16.25	17.25	18.25	25.27	19.95
Seacoast	10.10	9.10	9.10	9.00	10.10	10.10
Community Part.	10.80	11.05	9.20	8.95	7.41	7.28
CLM	9.55	8.55	8.30	7.30	6.57	6.71
Total	130.92	127.02	123.41	123.85	137.43	126.29

Six of the 14 teams (or, almost half the teams) report having fewer than the required minimum of seven FTEs to qualify as an ACT team. Four teams report having no peer support specialist. Two report having no SE staff capacity. Three teams report having SUD treatment staff capacity of less than one FTE. Several teams report having 0.5 or less FTE of the required combined psychiatry/nurse practitioner time available to their ACT teams. Five of the 14 teams report having less than one FTE nurse per team, with one team reporting no nursing capacity. Although overall staffing levels have remained relatively stable across all ACT teams, shortages in discrete categories, like nursing and peer support, have worsened since the previous report**. As documented above, a majority of the ACT teams do not meet the CMHA requirements for staffing or team criteria set out in the CMHA.**

Table IV below displays the active ACT caseloads by CMHC Region since June 2017. The active monthly caseload has increased by 23 participants since December 2020, but since June of 2017, the active monthly caseload has dropped by 46 participants.

Table IV

Self-Reported ACT Active Caseload (Unique Adult Consumers) by Region in Specified Months: March 2020 – March 2021

Region	Active Cases Jun-17[3]	Active Cases Mar-20	Active Cases Jun-20	Active Cases Sep-20	Active Cases Dec-20	Active Cases Mar-21
Northern	111	115	117	121	121	124
West Central	76	42	57	43	44	60
Lakes Region	74	57	54	52	55	59
Riverbend	97	94	95	91	97	94
Monadnock	70	51	50	47	45	45
Greater Nashua	94	101	105	107	131	130
Manchester	292	262	254	265	259	254
Seacoast	69	66	69	74	80	80
Community Part.	69	68	70	72	63	73
CLM	55	47	48	49	46	45
Total*	1,006	903	919	920	941	964

[3] Data for June 2017 is included for reference. June 2017 represented the highest ACT active monthly caseload since this reporting commenced.

The CMHA requires the State have the capacity to serve 1,500 individuals on ACT. As of March 2021, the combined ACT teams had a reported staff complement of 126.29 FTEs excluding psychiatry, which is sufficient capacity to serve only 1,263 individuals based on the ACT non-psychiatry staffing ratios contained in the CMHA, which is 237 below the CMHA level. With a statewide caseload of 963, as of March 2021, there is a 300-participant gap between actual reported staff capacity and actual active participants, and a 537-participant gap between the current active caseload and the number of participants that could be served at the required ACT capacity level as set out in the CMHA. There are 11 of 14 teams with unused ACT capacity (exceptions are West Central, Lakes Region, and Community Partners).

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. The clinical screens are conducted:

1. As part of the intake process at the CMHCs;[4]
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[5] who may qualify for and benefit from ACT.

Table V below presents data on ACT screens conducted by CMHCs between October and December 2020. [6]

[4] 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.

[5] Until recently, data on the total number of ACT screenings included current ACT participants. Active ACT clients have now been removed from screening reports.

[6] Note that this is a retrospective table, and thus is always one quarter behind the other State-reported data in this report. This supports the "look forward" component, which documents the extent to which individuals receive services within 90 days of a positive screen.

Table V

Self-Reported Number of Unique Clients Screened for ACT Services by CMHCs October to December 2020 (Retrospective Analysis)

Community Mental Health Center	Total Screened (not already on ACT)	Appropriate for further ACT Assessment	Receiving ACT/ within90 days of Screening	Percent Receiving ACT of those Appropriate for Assessment within 90 days
01 Northern Human Services	1,099	25	4	16%
02 West Central Behavioral Health	113	0	0	0
03 Lakes Region Mental Health Center	194	2	0	0
04 Riverbend Community Mental Health Center	1,398	0	0	0
05 Monadnock Family Services	545	2	0	0
06 Greater Nashua Mental Health	1,128	2	1	50%
07 Mental Health Center of Greater Manchester	1,702	9	3	33.3%
08 Seacoast Mental Health Center	1,381	23	0	0
09 Community Partners	253	2	0	0
10 Center for Life Management	1,122	8	0	0
Total	**8,935**	**73 (0.82% of all screened)**	**8 (10.96% of all assessed after screening- 0.09% of all screened)**	

Of the 8,935 unique individuals screened for ACT during this period, the State reports that 73 were referred for an ACT assessment. This is a referral rate of less than one percent, slightly down from the previous report. Eleven percent (8 individuals) of those referred for ACT assessments was enrolled in ACT services within 90 days of being screened. 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.

The State has reported that about 90 percent of individuals are linked to ACT without having gone through a new ACT screening process. In general, this seems to be confirmed by the fact that 132 new clients were reported to be added, while the screening process only produced 8 new clients. The State asserts that these new ACT clients are determined through CMHC clinical teams due to individual' emerging needs for the more intensive services and supports that ACT provides. Nonetheless, available screening data does not shed light on whether individuals outside of the CMHC system who would benefit from ACT services are being properly identified and referred for assessment. The ER continues to expect that the State implement initiatives to identify and screen/assess individuals outside of the CMHC system, especially those in crisis or decline, such as those having contact with NHH, the DRFs, the MCTs, the ERs, homeless outreach workers and organizations, and/or the criminal justice system.

New ACT Clients

The State has recently begun reporting the number of new ACT clients. Table VI summarizes these data from the four most recent reporting periods.

Table VI

Self-Reported New ACT Clients

CMHC	New Clients April – June 2020	New Clients July to Sept. 2020	New Clients Oct – Dec 2020	New Clients Jan – Mar 2021
Northern Human Services	11	13	10	12
West Central Behavioral Health	21	5	10	22
Lakes Region MHC	5	4	4	6
Riverbend CMHC	9	8	15	13
Monadnock Family Services	0	0	0	2
Greater Nashua Mental Health	5	10	26	38
MHC of Greater Manchester	16	22	18	17
Seacoast MHC	5	7	6	8
Community Partners	6	7	4	12
Center for Life Management	5	4	2	2
Total	**83**	**80**	**95**	**132**

It should be noted that in the past year (April 2020 through March 2021) the combined ACT teams have added an average of 98 new clients per quarter. This indicates that there is substantial turnover in the active ACT caseload over a relatively short time frame; and as a result aggressive efforts to engage new ACT clients are necessary just to maintain steady state[7] operations in the ACT program, much less to grow the program. In light of this data, and to provide further context for this fluctuation in active caseloads, in the previous report, the ER recommended that the State begin capturing and reporting the following information: 1) participants' average length of stay in the service; 2) the number of participants discharged each month; and 3) the reason for their discharge (i.e., withdrawal of consent; achievement of treatment goals; moved out of state, etc.). Such information and analysis have not yet been produced by the State. The ER expects these data will be included in the October through December, 2021 Quarterly Data Report.

The State has been reporting data on the number of individuals waiting for ACT services on a statewide basis for the past 30 months. This information is displayed in Table VII below. The State and the CMHCs assert that 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. As noted above, the gap between staff capacity and active monthly caseload in March 2021 stood at 300 potential participants. State intervention is necessary to reduce delays in accessing ACT services.

[7] The CMHA does not specifically require "steady state" operations. Nor does the CMHA have specific caseload or enrollment requirements for ACT. However, ACT is a core remedial service directly related to meeting the qualitative and quantitative expectations of the CMHA. Thus, the ER intends to continue to monitor and report on ACT enrollment as a key indication of overall compliance with the CMHA.

Table VII

Self-Reported ACT Wait List

		Time on List		
	Total	**0-30 days**	**31-60 days**	**61-180+ days**
December 31, 2018	6	3	0	3
March 31, 2019	2	1	1	0
June 30, 2019	1	1	0	0
September 30, 2019	2	2	0	0
December 31, 2019	5	2	2	1
March 31, 2020	10	0	3	7
June 30, 2020	13	2	2	9
September 30, 2020	11	3	5	3
December 31, 2020	2	0	1	1
March 31, 2021	4	3	1	0

The ER notes that the number of individuals waiting for ACT services has decreased in the most recent two quarters. In addition, the numbers of individuals reported to be waiting for ACT for longer than 60 days has substantially decreased. This may be an indication that State efforts to facilitate entry of already-identified and assessed Target Population individuals into ACT services are being effective.

In recent quarters, those waiting for ACT services all seem to reside in the Manchester region. This is curious as the Manchester CMHC consistently has excess ACT staffing capacity. Combined, the two ACT teams in Manchester could serve 399 individuals as of March 2021, yet the two teams provided ACT services to just 254 people, revealing that there is unused ACT capacity to serve an additional 145 people. In spite of this, people continue to be put on a waitlist for ACT in the Manchester region.

New Hampshire Hospital (NHH) Admissions and Discharge Data Relative to ACT

In concert with other strategies to improve access to ACT services, the State has begun tracking the extent to which individuals on ACT are admitted to NHH; are referred to ACT from NHH; and are accepted into ACT upon discharge from NHH. Table VIII summarizes data from the past six quarters on these issues.

Table VIII

Self-Reported Total ACT-Related Admissions to and Discharges from NHH

October 2019 through March 2021

	On ACT at admission	Percent of all Admissions	Referred to ACT on Discharge[8]	Percent of all Discharges	Accepted into ACT on Discharge	Percent of Those Accepted into ACT on Discharge
Oct.-Dec 2019	64	38.1%	25	24.0%	14	56.0%
Jan.-Mar. 2020	53	35.1%	28	28.6%	11	39.3%
April – June 2020	67	34.1%	33	25.4%	17	51.5%
July to Sept. 2020	37	26.1%	28	26.7%	21	75%
Oct. – Dec. 2020	40	36.0%	20	28.2%	14	70.0%
Jan. – Mar. 2021	37	34.3%	21	29.6%	11	52.4%

Less than 16 percent of those admitted to NHH who were not on ACT, were then accepted into ACT at discharge.

The State has also begun reporting the reasons that individuals are not accepted into ACT upon discharge from NHH. Table VIX summarizes this reported information.

[8] The State reports that this number refers only to individuals who were not enrolled in ACT on admission to NHH.

Table VIX

Self-Reported Reasons Not Accepted into ACT upon Discharge from NHH

October 2019 through March 2020

Reason Not Accepted into ACT on Discharge	October – December 2019	January – March 2020	April – June 2020	July – Sept. 2020	Oct. – Dec 2020	Jan. – March 2021
Not Available in Individual's Town of Residence	0	0	0	0	0	1
Individual Declined	1	0	0	0	0	0
Individual's Insurance does not Cover ACT	0	0	1	0	0	0
Does not Meet ACT Clinical Criteria	2	1	0	0	0	5
Individual Placed on ACT Wait List	0	1	1	0	0	0
Individual Awaiting CMHC Determination for ACT[9]	8	15	14	7	6	4
Total Unique Clients	11	17	16	7	6	10

In the April 2020 through March 2021 time period, about 80 percent of the individuals referred, but not accepted into ACT, were reported to be awaiting CMHC determination of eligibility for ACT. This means that the elapsed time for CMHCs to determine ACT appropriateness has been the most prevalent reason why people referred for ACT have not yet received it post-NHH discharge. Based on State descriptions, it appears that the wait times may extend out several weeks. The State has recently acknowledged that delayed engagement with CMHCs at or near the time of discharge is an area in need of improvement. The ER remains concerned about these reported delays in accessing ACT services at the CMHC level.

The ER understands that the State has been attempting to improve referrals to and acceptance in ACT services, and has implemented directed payments and other incentives to improve performance in this area. However, currently reported data does not support a conclusion that

[9] Some of these individuals may be enrolled in ACT during a subsequent reporting period.

access has in fact been improved. Thus, the ER expects the State to continue to take additional steps to align the reported excess capacity in the ACT system with the needs of individuals for ACT services, both on discharge from NHH and from the ACT waiting list.

ACT Fidelity and Quality

Despite the limitations imposed because of COVID-19, the State has been able to complete QSR reviews for all of the CMHCs during calendar year 2020. The results of the reviews are summarized in the section on Quality later in this report and are tabulated in Appendix B. In previous reports, the ER has noted that one area of concern identified in the QSR reports has been the implementation of ACT services. With regard to QSR indicator number 17, ***implementation of ACT services***, four of the ten CMHCs scored below the State's performance threshold of 80%. It should be noted that, in general, CMHC scores on Indicator 17 have improved somewhat over the past two years. Nonetheless, the ER continues to be concerned about the quality issues identified with regard to ACT services, and the implications for compliance with the CMHA.

The State intends to conduct ACT fidelity reviews for State Fiscal Year 2022. However, the State will temporarily suspend reporting of detailed fidelity scores for reviews conducted under the COVID restrictions. Reporting of detailed fidelity scores will resume after the pandemic. The ER will work with State officials to determine how ACT fidelity review information will be incorporated into future reports.

ACT Summary Findings

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 data makes it clear that the State does not currently provide a robust and effective system of ACT services throughout the state as required by the CMHA.

In addition to the necessity to attain CMHA-specified ACT capacity, the ER continues to emphasize that the State and the CMHCs must focus on: (1) assuring required ACT team composition and staffing; (2) expanding ACT capacity to CMHA levels and fully utilizing existing ACT team capacity; (3) reducing the number of individuals on the ACT wait list and/or awaiting ACT services upon discharge from NHH, as well as reducing the length of time individuals wait for ACT services; and (4) markedly improving outreach to and enrollment of new ACT clients, especially those in decline or in crisis who are outside the system or presenting to the system for the first time.

Supported Employment (SE)

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

maximum number of hours in integrated community settings consistent with their individual treatment plans (V.F.1); 2) meet Dartmouth fidelity standards for 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)).

As noted in Table X below, six of the ten CMHCs now report penetration rates lower than the CMHA requirement. This is consistent with data from the previous reporting period, during which the same six CMHC regions reported being below the state standard of 18.6% penetration.

While the State continues to meet the statewide standard for SE penetration in the CMHA, this is primarily due to strong SE penetration rates in three CMHC Regions (Manchester (40.6%), Seacoast (39.5%), and Lakes Region (39.0%). The ER is increasingly concerned that Target Population members in large portions of New Hampshire are reported to not have adequate or equitable access to this essential best practice service.

Table X

Self-Reported CMHC SE Penetration Rates

March 2020 through March 2021

	Penet. Mar-20	Penet. Jun-20	Penet. Sep-20	Penet. Dec-20	Penet. Mar-21
Northern	14.20%	12.00%	11.80%	12.00%	12.00%
West Central	22.20%	24.30%	25.50%	22.50%	18.60%
Lakes Reg.	15.90%	21.50%	26.90%	32.70%	39.00%
Riverbend	16.20%	16.10%	14.70%	14.10%	13.60%
Monadnock	7.30%	4.80%	4.10%	3.70%	4.20%
Greater Nashua	15.10%	13.40%	13.20%	12.30%	11.30%
Manchester	41.70%	42.80%	41.90%	40.10%	40.60%
Seacoast	39.00%	36.00%	38.70%	37.00%	39.50%
Community Partners	11.70%	11.20%	13.70%	13.20%	13.00%
CLM	16.40%	14.80%	14.80%	14.30%	15.70%
CMHA Target	18.60%	18.60%	18.60%	18.60%	18.60%
Statewide Ave.	23.70%	24.20%	24.50%	23.70%	24.20%

The State reports data on the degree to which CMHC clients are working, either full or part time, in competitive employment.[10] Access to competitive employment is an important indicator of the quality and effectiveness of fidelity model SE services. Table XI summarizes some key findings from these data reporting efforts.

[10] State data defines full time employment as working 20 hours a week or more.

Table XI

Self-Reported Competitive Employment for CMHC Clients Who Recently Used SE Services

CMHC	Percent of SE Active Clients Employed Full or Part Time Oct. Dec 2019	Percent of SE Active Clients Employed Full or Part Time Jan. – Mar. 2020	Percent of SE Active Clients Employed Full or Part Time Mar-June 2020	Percent of SE Active Clients Employed Full or Part Time July – Sept 2020	Percent of SE Active Clients Employed Full or Part Time Oct. – Dec. 2020	Percent of SE Active Clients Employed Full or Part Time Jan. – Mar. 2021
Northern	34.4%	40.5%	27.3%	36.4%	37.5%	20.9%
WCBH	42.1%	45.4%	44.4%	33.3%	33.3%	33.3%
LRMHC	53.0%	40.6%	51.5%	51.3%	57.2%	79.0%
Riverbend	64.3%	54.0%	62.5%	50.0%	50.0%	61.1%
Monadnock	64.7%	36.4%	45.5%	61.9%	83.3%	70.0%
Nashua	37.8%	44.8%	38.6%	42.3%	36.6%	36.6%
MHCGM	54.0%	52.0%	54.4%	60.5%	58.4%	52.7%
Seacoast	32.3%	28.3%	33.3%	31.5%	27.8%	23.9%
Comm. Partners.	50.0%	42.8%	50.1%	47.3%	40.7%	58.9%
CLM	78.1%	63.3%	47.9%	46.0%	51.1%	42.4%
Statewide	51.9%	46.7%	46.7%	47.9%	47.6%	45.9%

For adult CMHC clients not participating in SE, the overall numbers are lower, with only 27.7% currently engaged in full-time or part-time employment statewide. [11]

These data provide a reasonable baseline for future analyses. At this point, there do not appear to be substantial changes in the degree to which SE participants are accessing full or part time competitive employment. The ER will continue to review these competitive employment data in concert with the available SE fidelity and QSR reports.

The State reports that 49 individuals are waiting for SE services. Twenty individuals (or 40.8%) have been waiting for over a month. In the previous quarter (October through December, 2020), 26 individuals were waiting for SE and 23.1% had been waiting for more than a month. Delays

[11] Some individuals in this non-SE cohort could have participated in SE in the past, but are no longer actively enrolled or participating in SE.

in access to SE services must be addressed to "ensure reasonable access to eligible individuals" per CMHA V.F.2(f).

SE Fidelity and Quality

As with ACT services, the limitations created by COVID-19 have prevented SE fidelity reviews from being conducted during much of the time frame covered by this report.

The State has completed QSR reviews for all CMHCs, and continues to report quality and performance concerns related to two SE-related QSR indicators. These are:

1. Indicator 9: Adequacy of employment treatment planning (Statewide average score of 77%; six of ten CMHCs below the performance threshold); and
2. Indicator 10: Adequacy of individual employment service delivery (Statewide average score of 75%; seven of ten CMHCs below the performance threshold).

As with the QSR findings related to ACT services, the ER plans to participate in QSR and SE fidelity reviews, and to monitor performance improvements in SE related to the QSR findings.

Supported Housing (SH)

Overview

The CMHA commits the State to achieve a capacity of 600 units of SH through a combination of: (1) the State-operated and -funded Bridge Subsidy Program; and (2) an array of Federal resources that includes both project-based and tenant-based housing subsidies. This overview section is intended to provide a general context for understanding how each set of resources contributes to meeting the SH requirements of the CMHA.

The Bridge Subsidy Program

The CMHA Commits the State to funding a total of 450 supported housing units, inclusive of those under the Bridge Subsidy Program. In its latest quarterly data report, the State has reported:

- A total of 306 individuals are occupying rental units subsidized by the Bridge Subsidy Program;
- An additional 104 individuals have been approved for a Bridge Subsidy and are currently seeking appropriate housing;
- 41 individuals are reported to be on the wait list for approval for a Bridge Subsidy;
- The State has committed sufficient funds to support a total of 500 Bridge Subsidy Program units, which exceeds the CMHA target by 50 units;
- The State has asserted that it intends to give priority to individuals on the wait list for access to the Bridge Subsidy Program; and

- A cumulative total of 233 individuals are reported to have converted from Bridge subsidies to Federal housing subsidies such as Housing Choice Vouchers and Public Housing units. This is an intended outcome of the Bridge Subsidy Program, in that it provides permanent Federal housing subsidies for these individuals, and allows additional people to be served by the Bridge Program. However, it is not known how many of these 233 individuals are still receiving either a Federal housing subsidy or SH services. In mid-2020, the State estimated that this number was not 233, but only about 75. The CMHA requires the State to provide and maintain current capacity, not merely hit a cumulative total over time.

Additional Federal Subsidies

The CMHA commits the State to obtain 150 additional subsidies over and above the Bridge Subsidy Program, to attain the total required SH capacity of 600 units. As of the end of March 2021, the State reports that:

- The State has successfully applied for and been awarded a total of 191 units of Department of Housing and Urban Development (HUD) Section 811 project-based Permanent Rental Assistance (PRA);
- The State was also successful in being awarded 50 units of Section 811 Mainstream tenant-based vouchers;
- As of the date of this report a combined total of 195 individuals are occupying units funded by these Section 811 programs, leaving a capacity of 46 units yet to be occupied;

Bridge Subsidy Program Information

As of March 2021, the State reports having 306 individuals leased in Bridge Subsidy Program units and 104 people approved for the Bridge Subsidy Program, but not yet leased. This 104 figure is high compared to past totals and may indicate that there are issues related to finding and leasing appropriate apartments in some areas of the state. In spite of some recent progress, it remains true that there has been a substantial drop in the aggregate number of individuals either leased or approved but not yet leased in the Bridge Subsidy Program – from a high of 591 in June of 2017 to the current number of 410 individuals.

There are 41 individuals reported to be on the Bridge Subsidy Program wait list as of the end of March 2021. Of these, 15 individuals have been on the wait list for more than two months. In the prior October to December 2020 quarterly report, the State reported that 28 individuals were on the wait list, of whom 27 had been on the wait list for more than 60 days. If there is Bridge funding for 500 units and only 410 have been approved for utilization thus far, it is unclear why 41 people are on a waitlist.

Table XII below provides data regarding the number of current Bridge Subsidy Program participants in leased units; the number who have received Bridge Subsidies and are seeking

appropriate units to lease; and the number on the Bridge Subsidy Program waiting list. Table XIII provides quarterly data regarding the number of Bridge Subsidy program applications and terminations. Table XIV presents information on the reasons that program participants have exited the program. Table XV provides information on unit density.

Table XII

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

September 2018 through March 2021

Bridge Subsidy Program Information	Sept. 2018	Sept. 2019	Dec. 2019	Mar. 2020	June 2020	Sept. 2020	Dec. 2020	March 2021
Total individuals leased in the Bridge Subsidy Program	423	338	340	327	328	312	300	306
Individuals in process of leasing		35	54	94	79	96	96	104
Individuals on the wait list for a Bridge Subsidy[12]	35	42	25	49	39	85	28	41
Cumulative historical number transitioned to a HUD Housing Choice Voucher (HCV) or other Federal subsidy	125	151	163	179	192	198	212	233[13]

[12] The State did not maintain a waitlist prior to 2018.
[13] Recent State data indicates that only 75 individuals currently have HCV subsidies.

Table XIII

Self-Reported Housing Bridge Subsidy Program Applications and Terminations

Measure	**July-Sept 2019**	**Oct. – Dec. 2019**	**January – March 2020**	**April – June 2020**	**July-Sept. 2020**	**Oct – Dec. 2020**	**Jan. – Mar. 2021**
Applications Received	22	59	74	30	57	25	41
Point of Contact CMHCS NHH Other	13 9 0	51 8 0	63 11 0	29 29 1	50 6 1	22 3	38 2 1
Applications Approved	11	42	104	27	57	25	41
Applications Denied	0	0	0	0	0	0	0
Denial Reasons	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
Applications in Process at end of period	75	79	49	41	0	0	0
Terminations	0	0	2	0	2	0	0
Termination Reasons *Over Income*	*NA*	*NA*	*Not Reported*	*0*	*Failure to pay rent*	*NA*	*NA*

Table XIV

Self-Reported Exits from the Housing Bridge Subsidy Program

April 2020 through March 2021

Type and Reason	April – June 2020	July – September 2020	October – December 2020	January – March 2021
DHHS Initiated Terminations				
Failure to pay rent	0	2	0	0
Client Related Activity				
HUD Voucher Received	16	24	26	24
Deceased	2	1	5	1
Over Income	1	1	0	0
Moved out of State	2	3	1	0
Declined Subsidy at Recertification	2	10	7	5
Higher level of care accessed	2	4	3	0
Other Subsidy provided	1	2	0	0
Moved in with Family	1	0	2	3
Declined to Receive Subsidy			2	0
Total	27	47	46	33

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

Table XV

Self-Reported Bridge Subsidy Program Concentration (Density)

	Sept. 2019	Dec. 2019	Mar. 2020	June 2020	Sept. 2020	Dec. 2020	March 2021
Number of properties with one leased SH unit at the same address	282	276	279	267	255	242	234
Number of properties with two SH units at the same address	18	18	14	15	20	18	22
Number of properties with three SH units at the same address	1	4	2	6	2	3	4
Number of properties with four SH units at the same address	1	2	2	0	0	0	1
Number of properties with five SH units at the same address	1	0	0	0	1	0	1
Number of properties with six SH units at the same address	0	0	0	1	0	1	0
Number of properties with seven+ SH units at same address	1	1	1	1	1	1	1

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 that there is currently only one voluntary roommate occurrence among the currently leased Bridge Subsidy Program units in the above data.

DHHS has developed a method to cross-match the Bridge Subsidy Program participant list with the Phoenix II and Medicaid claims data. Table XVI summarizes the most recent reporting of these data.

Table XVI

Self-Reported Housing Bridge Subsidy Program Tenants Linked to Mental Health Services

	As of 12/31/19	As of 3/31/2020	As of 6/30/20202	As of 9/30/2020	As of 12/31/20	As of 3/31/2021
Housing Bridge Tenants Linked to Mental Health Services	358 of 394 (91%)	348 of 421 (83%)	329 of 406 (81%)	335 of 409 (82%)	356 of 396 (90%)	375 of 410 (91.5%)

These data document the degree to which Bridge Subsidy Program participants are actually receiving certain mental health or other services and supports.[14]

Federal SH Resources

As noted in the overview section above, the CMHA states that: "By June 30, 2017 the State will make all reasonable efforts to apply for and obtain federal Department of Housing and Urban Development (HUD) funding for an additional 150 supported housing units for a total of 600 supported housing units." (CMHA V.E.3(e)).

New Hampshire applied for and was awarded funds to develop a total of 241 SH units under the HUD Section 811 Supportive Housing for Persons with Disabilities Program (191 PRA project-based units, and 50 Mainstream tenant-based vouchers). All of these units are set aside for people with serious mental illness. As of March 2021, the State reports that 195 (combined PRA and Mainstream) of these new units are reported to have been developed and occupied by members of the Target Population. The State has not been able to provide the current number of people in Section 811 housing, only the cumulative total over time. Nor is there clear data at this point about the number of Section 811 Mainstream vouchers (tenant-based rental assistance) versus PRA units (project-based rental assistance) that are currently occupied. As referenced, State data from mid-2020 reveals that the number of current members of the Target Population in these units was much lower than the overall totals. The ER intends to follow-up with the State in the next reporting period to clarify the current implementation and utilization of the HUD 811 Program for Target Population members.

The SH Wait List

[14] Some of these tenants might be receiving services from MH providers other than a CMHC.

The CMHA states that "By January 1, 2017, the State will identify and maintain a waitlist of all individuals within the Target Population requiring SH 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." (V.E.3(f)). As referenced above, there are currently reported to be 41 individuals on the wait list for the Bridge Subsidy Program; 15 of these individuals have been on the wait list for more than two months. The State has recently allocated new funds to the Bridge Subsidy Program. The State asserts that these funds will be sufficient to fund an additional 100 units. Access to these new Bridge Subsidies will be based on priorities established by Bridge Program regulations. The State will continue to manage access of wait list individuals to new Bridge Subsidies in accordance with these priorities.

Because these funds have only recently been released, and individuals continue to wait for SH, it would be premature to conclude that this infusion of resources will fully address the existing unmet need, or result in sufficient additional capacity to ensure no class member waits longer than six months for SH. In the next six months, the ER will closely monitor the impact of the additional Bridge Subsidies on the State's ability to move individuals off the SH wait list.

The State has recently implemented a major change in the administration of the Bridge Subsidy Program. Previously, the program had been administered on a statewide basis by an independent contractor. Under the new model, each of the ten CMHCs is now performing certain participant-level functions, such as: housing search; lease-up and occupancy supports; landlord negotiations; arrangement of housing related services and supports, and eviction prevention. The CMHCs now also directly pay rent subsidies to landlords and are reimbursed for these costs by the State. The State is managing intake and eligibility determination functions and maintaining the statewide waiting list.

These administrative changes could have an impact on the overall effectiveness of the Bridge Subsidy Program; the fact that 104 individuals are enrolled in the Bridge Program, but are still searching for a unit that meets program guidelines for rent and housing quality, supports this conclusion. This is the highest this total has ever been. The 104 total, combined with the 41 individuals on the waitlist, may reveal deficits in the current system that need to be addressed. It is still too early in the implementation process to assess the effects of the State's administrative changes. The ER will continue to monitor the implementation process as well as monitoring data regarding lease-ups, the waiting list, and other related performance data.

Transitions from Institutional to Community Settings

During the past six and one-half years, the ER has visited both Glencliff and NHH on at least 11 separate occasions to meet with staff engaged in transition planning. The ER has also 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 more than five years of operational experience. As of June 2021, 72 individuals have been submitted to the Central Team, 43 from Glencliff and 29 from NHH. Of these, the State reports that 39 individual cases have been resolved, three individuals are deceased, 12 individuals at Glencliff Home are currently inactive and not interested in transitioning to the community due to COVID-19 or increased medical complexity, and two of the individuals have been clinically determined to no longer be members of the CMHA Target Population. There are 23 individual cases that remain under consideration. Table XVII below summarizes the discharge barriers that have been identified by the Central Team with regard to these 23 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 XVII

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

June 2021

Discharge Barriers	Number for Glencliff	Number for NHH
Legal	4 (8.9%)	2 (12.5%)
Residential	12 (26.7%)	5 (31.3%)
Financial	8 (17.8%)	2 (12.5%)
Clinical	11 (24.4%)	4 (25.0%)
Family/Guardian	10 (22.2%)	3 (18.8%)
Other	0 (0%)	0 (0%)

It is notable that residential issues continue to be the leading discharge barriers for both Glencliff and NHH, highlighting the need to address these issues consistent with the CMHA.

Glencliff

For the time period from January to March 2021, Glencliff admitted three individuals (one of which was a readmission), and had had one discharge and four deaths. The average daily census through this period was 111 people. There were reported to be 41 individuals on the wait list for admission to Glencliff.

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][15] 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."[16]

DHHS reports that a total of 23 people have transitioned from Glencliff to integrated settings since the inception of the CMHA seven years ago.

Based on data supplied by the State, there were 29 individuals undergoing transition planning who could be transitioned to integrated community settings once appropriate living settings and community services become available. Nine of these individuals were assigned to Choices for Independence (CFI) waiver case management agencies in order to access case management in the community to facilitate transition planning, and five remained in the application process. Four individuals were found eligible for the Acquired Brain Disorder (ABD) or Developmental Disability (DD) waivers, and two were denied eligibility for these waivers. The remaining six individuals were reported to not meet criteria for referrals to one or more of the waivers.

DHHS continues to provide information about Glencliff transitions at the time of discharge, including clinical summaries, lengths of stay, location and type of setting, and whether or not an array of individual services and supports was arranged to facilitate living in integrated community settings. This information is important to monitor the degree to which individuals with complex medical conditions that could not be cost-effectively 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.

The ER has been concerned about the slow pace and low number of transitions to integrated community settings by residents of the Glencliff Home. Based on this concern, the ER conducted a three-day on-site review at Glencliff during the month of January 2020. This review focused on the following CMHA provisions specifically relevant to transition planning and effectuating transitions to integrated community settings on the part of Glencliff residents:

> Section VI.A.1 and 3: "The State, through its community mental health providers and/or other relevant community providers, will provide *each* individual in NHH and Glencliff with effective transition planning and a written transition plan" setting forth in reasonable detail the particular services and supports needed to "successfully transition to and live in

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

an integrated community setting" and setting forth "any barriers to transition to an integrated community setting and how to overcome them" (Emphasis added);

Section VI.A.2 (a) through (e). Note that Section (e) states: that transition planning will "not exclude any individual from consideration for community living based solely on his or her level of disability";

Section VI.A.4 , which states, in part: "... the State will make all reasonable efforts to avoid placing individuals into nursing homes or other institutional settings";

Section VI.A.7 and 8, which require the State to implement a system of in-reach activities to enable Glencliff residents to meet with CMHPs to "develop relationships of trust" with CMHCs and other providers and to "actively support" residents to transition to the community with proactive efforts to educate residents and family members/guardians about community options; and

Sections V.E.2 (a) and (b) and Sections V.E.3(g) through (j), which require the State to develop integrated community living options for individuals with complex health care needs according to an implementation schedule and wait list provisions.

Based on that January 2020 review, the ER prepared recommendations for State/DHHS-led actions and interventions:

1. *Substantially improve in-reach from the community to Glencliff.*
2. *Improve the success and timeliness of access to Medicaid waivers in support of transitions to integrated community settings.*
3. *Have DHHS Bureau of Mental Health Services (BMHS) staff work more closely and pro-actively with other DHHS officials and the Area Agencies to increase access to community providers.*
4. *Improve access to Bridge subsidies to facilitate transitions from Glencliff.*
5. *Expand access to small scale (3 - 4 person) community residential programs for Glencliff residents with complex medical conditions.*
6. *Make it a very high priority to develop new small scale residential settings for residents with complex medical conditions as soon as possible. This appears to be the most feasible approach to re-starting movement of people to integrated community settings. Some individuals have been waiting for transition for a long time. Others will be encouraged to choose community living by seeing the success and satisfaction of residents that have moved to these programs.*

Over the last 18 months, the State has taken steps in response to the ER's first recommendation on in-reach. Based in part on the findings of the ER Glencliff report, the State developed a new transition planning policy and transition engagement protocols intended to expand and improve transition planning for all Glencliff residents. Representatives of the Plaintiffs provided

substantial recommendations and examples to assist the State to design a more effective transition planning process. This revised process was finalized in October 2020.

The ER conducted a follow-up site visit to Glencliff on May 8 and 9, 2021. There were two primary purposes for the site visit:

1. To observe and monitor the implementation of the in-reach program initiated over a year ago via a contract with Northern Human Services; and
2. To observe and monitor implementation of the Glencliff Home Transition Planning Policy and Informed Choice procedure promulgated on October 1, 2020.

The site visit included the following activities, listed sequentially:

1. Introductory discussion and up-date with Glencliff senior management;
2. Extensive interview and discussion with the in-reach coordinator on contract through Northern Human Services;
3. Observation of a resident transition meeting conducted via ZOOM;
4. Observation of a face-to-face discussion of informed choice/visioning between the in-reach coordinator and a resident;[17]
5. Review of several individual resident records to identify documentation of transition planning and informed consent consistent with the revised policies implemented on 10/1/2020.

Overview

It is important to recognize that COVID has substantially affected operations at the Glencliff Home for the past 19 months. Glencliff has done a good job keeping residents and staff safe from COVID infections, in part by restricting internal face-to-face interactions and eliminating most face-to-face interactions among Glencliff and community providers. This, in turn, has impacted implementation of in-reach and community transition activities. Nonetheless, the in-reach coordinator has recorded interactions with over 40 Glencliff residents.

Glencliff has actively participated in the State's recent initiative to transfer residents of NHH and Glencliff to private nursing facilities as part of an over-all strategy to reduce the number of people who wait for psychiatric admissions in hospital emergency rooms. Glencliff management reported that the receiving nursing facilities receive a payment of $45,000 for each transfer, plus an enhanced per diem rate for as long as the resident remains at the receiving facility. Since May 5, 2021, a total of at least nine Glencliff residents[18] have been transferred to nursing facilities.

[17] Note: this resident has since been transitioned to a 3-bed medical model group home. Extensive transition planning and community service linkages had been in place, but the informed consent/visioning discussion was not conducted until the transition plan was already in place.
[18] One additional Glencliff resident transferred to a nursing facility, but the transfer occurred before the financial incentives were initiated.

This is a larger number of nursing facility transfers than Glencliff believes would have occurred absent the State's financial incentives to nursing facilities.

Glencliff management reported that the daily census on the first day of the site visit was 99, with a goal of achieving an average daily census of 95 going forward. Management reports that insufficient nursing staff is available to serve a Glencliff census greater than 95 at the current time. Thus, the incentive to transfer residents to nursing facilities from Glencliff has not resulted in new admissions capacity, but rather has assisted Glencliff to meet its staffing level shortage-driven census reduction goals.

Due to census reduction and staff shortages, Glencliff management has re-distributed residents among floors/units to make best use of available staffing. As a result, 10 -12 residents needing the least amount of nursing attention and support have moved to the Green Unit. This may create opportunities for internal programming and in-reach designed to facilitate transitions to integrated community settings. As yet though, no such special programming or targeted in-reach is reported to be in place for individuals residing in the Green Unit.

The In-Reach Coordinator

The in-reach coordinator had been in place for over a year as of the date of this report. As noted above, the in-reach coordinator has recorded interactions with over 40 individuals. The coordinator reports that he has conducted the informed consent/visioning process for 17 of these individuals. His office is in the residential building so he reports having many informal interactions/communications with residents as well as those more formal or structured interactions that result in an entry into the monthly log or progress notes for individual resident records.

The in-reach coordinator maintains a monthly activity log[19] in addition to entering transition plan information and progress notes into individual resident records. The ER utilized the most recent monthly report as a basis for detailed discussions with the in-reach coordinator. This allowed for specific discussions about informed consent, visioning, and transition planning activities with individual residents, as well as more general discussions on in-reach activities, issues, and barriers.

The in-reach coordinator reports that most of the residents he has worked with are not seeking integrated community living. He stated that guardians and family members tend to emphasize safety and medical care issues as opposed to independence and community living. He stated that he intends to address certain guardian and family member concerns in the future, but to date reports no proactive strategy or plans to address these issues.

[19] This is intended to form the basis for the quarterly in-reach program data reporting to be included in the Quarterly Data Report.

Of the transitions accomplished since March 2020, three have gone to integrated community settings.[20] Two additional individuals were reported to be transitioning very soon to community settings. The in-reach coordinator reports being actively involved with these transitions to community settings, but also reports being actively involved with many residents transitioned (or transitioning) to nursing facilities or other congregate settings.

Observations

These observations are based on the extensive interview/discussions with the in-reach coordinator, observations of the two face-to-face resident meetings noted above, and record reviews.

Positive Observations

1. A total of five transitions to community settings[21] will have occurred in the past 19 months.
2. Several applications for Bridge subsidies have been submitted on behalf of Glencliff residents, and applications for Housing Choice Vouchers have also been submitted on behalf of Glencliff residents. The in-reach coordinator reports positive experiences with the Bridge Subsidy Program application process. The ER understands that at least two of the recent transitions have been facilitated by access to Housing Choice Vouchers. (The ER believes Bridge Subsidy Program subsidies could have been used for these if the vouchers had not become available.)
3. The in-reach coordinator reports positive interactions with housing staff at several CMHCs related to housing applications and housing search.
4. The in-reach coordinator reported improved relationships and communications with several CMHCs.
5. The in-reach coordinator reported several attempts to assist residents to participate in externally-provided services such as Alcoholics Anonymous and anger management.
6. Improved communications and responsiveness vis-à-vis Area Agencies and CFI applications and case management were also reported by the in-reach coordinator.

Concerns

1. The in-reach coordinator reports completing the informed consent/visioning process with only 17 residents. Plus, in a sample of records, the results of using the informed consent/ visioning script were not well documented. Nor were there any follow-up or next steps specifically described in the records. For one individual, a visioning/transition planning

[20] Two have gone to the Palm Street residence; one has gone to an enhanced family care setting supported by the CFI waiver.
[21] I did not use the term "integrated community settings" because one of the five is moving to an independent apartment that is part of a 24-unit facility specifically for people with disabilities.

session was recorded in January, but no further contact or communication was recorded for that individual.

2. The in-reach coordinator reports having been given written materials regarding the HOPES program by Glencliff management, but stated that no action has been taken to date to re-start the HOPES program. Thus, there are currently no formal or generally available internal services focusing on life skills training and independent living skills for residents of Glencliff.
3. The in-reach coordinator reports spending considerable time and effort assisting to effectuate nursing facility transfers for Glencliff residents. He reports contacting and communicating with numerous nursing facilities, completing facility applications, sending requested medical records, and otherwise seeking to facilitate nursing facility transfers. These efforts are well documented in the sample of individual resident records and also in the monthly activity log. The ER is concerned that the amount of time and effort being spent on nursing facility transfers reduces the amount of time available for priority, integrated community placement functions of the in-reach coordinator.
4. In fact, it appears that the in-reach coordinator has de facto become a "social work staff extender" for Glencliff. That is, he is spending considerable time and effort carrying out functions and activities typically carried out by Glencliff's two social workers. Progress notes entered into the sample of records reviewed mirrored the types and contents of progress notes typically entered by the social workers.[22]
5. At the same time, the ER could find no documentation in the sample of records reviewed that residents transferred to nursing facilities had been offered information on integrated community alternatives or other optional settings. Nor was there detailed documentation of barriers to transition to integrated community settings. And, it was not possible to identify documentation that such information was discussed or shared with individual guardians or family members. Thus, the ER cannot conclude or document that the required informed consent process was completed prior to transfers from Glencliff to other nursing facilities.
6. The in-reach coordinator identified several circumstances in which a resident's guardian or family member was opposed to transition to integrated community settings, and that such opposition caused transition planning to be discontinued. No plans or strategies for engaging these guardians/family members were developed or implemented, and the ER could find no documentation in the record that such strategies were to be attempted. The in-reach coordinator stated that he plans to address some of these issues, particularly with guardians who have multiple clients residing at Glencliff. However, he reported that such activities have not yet been initiated.

Conclusions

[22] One of the two Glencliff social workers has been out on extended medical leave, and the in-reach coordinator reports "filling in" as "part of being on the team" within Glencliff.

The Transition Planning and Informed Consent policies and procedures promulgated in October of 2020 were intended to specifically and pro-actively address non-compliance with the CMHA documented in previous site visits. And, the in-reach contract with Northern Human Services was specifically designed to provide capacity and an independent voice to effectuate the changes envisioned in the new policies to advance compliance with the CMHA.

The ER concludes that neither of these objectives has been accomplished. The ER was unable to find either documentation or anecdotal evidence that comprehensive transition planning and informed consent have been implemented at Glencliff. In fact, in the sample of records reviewed, the ER could find no documentation of informed consent that complies with Glencliff's own policies for individuals transferred to nursing facilities or other placements. Nor could the ER find documentation that other alternatives had been identified or considered by Glencliff staff, including the in-reach coordinator. Barriers to discharge to integrated community settings, and efforts to overcome these barriers, was not clearly documents in the records. Evidence that there had been efforts to intervene with or inform guardians or family members about less restrictive alternatives for the individuals transferred to nursing facilities was also not present in the records. The ER is not able to conclude or document that the purposes and specific requirements of the Glencliff transition planning policies have been carefully or systematically implemented by Glencliff or by the independently-contracted in-reach coordinator.

Glencliff has effectuated the transition of five residents into community settings in the past 19 months. This is a positive result, and credit is due in part to the in-reach coordinator's efforts to facilitate these transitions. However, it should be noted that three of the five transitions are to existing capacity (Palm Street) in Nashua. One of the transitions is to an independent apartment that is part of a highly concentrated disability-only housing complex that does not appear to meet federal DoJ or CMS standards for integrated community living. With the exception of the enhanced family care setting for one resident, no new integrated community capacity has been developed on behalf of Glencliff residents in the past three years. Despite an outstanding RFP for various housing types, there have been no new providers identified for small scale medical model group homes or other qualifying integrated community living settings.

The State is now providing substantial financial incentives to trans-institutionalize residents from NHH and Glencliff to nursing facilities. The State has funded 60 additional transitional housing beds (not integrated community settings) in the past two years, and intends to fund 60 more of these settings. At the same time, there has been virtually no expansion of integrated community alternatives for Glencliff residents. And, even with new resources (the in-reach contract), the State has failed to implement new transition planning and informed consent/visioning policies that could enhance residents' access to integrated community settings as opposed to nursing facilities.

Recent State Information on In-Reach Activities

The State has begun to report certain information related to in-reach services at Glencliff. Table XVIII below provides the information provided to date.

Table XVIII

State Self-Reported Performance Information for Glencliff In-Reach Services

Performance Measure	October to December 2020 Residents	October to December 2020 Activities	January to March 2021 Residents	January to March 2021 Activities
Attend service array and supports group presentations	0	0	0	0
Meet with In-Reach Coordinator regarding individual needs and service arrays	22	27	15	29
Participate in shared learning regarding integrated community living	0	0	0	0
Meet with In-Reach Coordinator regarding community-based living	7	10	12	16
Participate in specific transition discussions with In-Reach Coordinator	10	12	11	21
Participate in meetings with In-Reach Coordinator and others regarding opportunities for community living	13	18	9	28

This is the first set of in-reach information to be included in the Quarterly Data Report. As such, there is not yet sufficient information for trend analysis. As noted above, the In-Reach Coordinator reports conducting activities that are not captured in this report. Thus, the data above does not reflect the totality of In-Reach Coordinator functions and activities. The ER notes that a major function of the In-Reach Coordinator is to communicate with guardians and family members of Glencliff residents to assist them to understand options of integrated community living and community supports. The ER expects that future reports of In-Reach Coordinator activity will incorporate information on these required activities as well as the information displayed above.

The State has also provided a narrative description of In-Reach Coordinator activities. That narrative is provided verbatim below.

> "The In-Reach Liaison role has been actively engaging Glencliff Home residents about transitioning back to a community setting for one year. Based on data supplied by the State, as of June 1, there were 31 Glencliff Home Residents who engaged in transition planning discussions with the In-Reach Liaison about potential and appropriate living settings and community services that are more integrated than Glencliff Home. Of these residents, 43 discussions about goal setting have occurred with residents, 3 discussions regarding barrier resolution, and 4 about the array of available community mental health services have occurred. Additionally, 42 discussions with guardians (residents may be participants in these discussions), 16 discussions with Glencliff Home staff, 15 discussions with other entities involved with residents, such as Ombudsmen, Dept. of Corrections staff, and Service Link staff, 119 discussions with community providers, and 72 discussions with residents and community providers had occurred. Within this same year, 3 Glencliff Home residents transitioned to independent apartments, with Choices for Independence (CFI) and Community Mental Health Center (CMHC) wraparound services and supports, include ACT."

This above narrative covers a time period beyond the time frame of this report for the ER's observation and review of in-reach functions and activities at Glencliff. And, the ER has not reviewed documentation that would verify this narrative information. The ER notes that the State may be characterizing placements to nursing homes and assisted living facilities as "community" settings that are more integrated than Glencliff, when this is not consistent with the letter or spirit of the integrated community settings provisions of the CMHA. The ER intends to conduct additional site visits and record reviews at Glencliff in the up-coming months.

Based on the ER's on-site observations, document and record reviews, and interview information, the ER concludes that the State is not in compliance with CMHA provisions related to Glencliff transition planning and informed consent requirements, and is not in compliance with CMHA requirements related to transitions to integrated community settings.

Preadmission Screening and Resident Review (PASRR)

The State periodically provides data on PASRR Level II screens conducted in New Hampshire. Recent PASRR data are summarized in Table XIX 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 XIX

Self-Reported PASRR Level II Screens [23]

	April through June 2019 Percent	July through Sept 2019 Percent	April – June 2020 Percent	July – October 2020 Percent	April 2020– June 2021 Cumulative Percent
Full Approval - No Specialized Services	28.8%	31.0%	64.4%	61.3%	69.2%
Full Approval with Specialized Services	28.8%	38.0%	0.0%	6.5%	3.1%
Provisional – No Specialized Services	18.8%	19.7%	23.1%	0.0%	3.1%
Provisional with Specialized Services	23.8%	11.3%	11.5%	32.3%	24.6%
Total	100%	100%	100%	100%	100%

In the December 2018 ER report, 10.2% of the Level II screens were approved with a specification for specialized services. At that time, the ER questioned whether this was an unusually low rate for specification of specialized services. In a comparison with one other state, the ER found substantially higher approvals for specialized services than was evidenced in New Hampshire at that time. In the intervening period, the State and the PASRR contractor have been reviewing protocols for specification of specialized services in the Level II process. For the period April through June 2019, 52.6% percent of total Level II screens identified a need for special services. For July through September 2019, the percent was 49.3%. In the July to October 2020, time period, 38.8% of the PASRR Level II approvals included provisions for specialized services. However, in the most recent reporting period, the percent approved with specialized services has fallen to 27.7%. For the 12-month period from July 1, 2020 through June 30, 2021, the State reports that of 178 Level II PASRRs conducted, 28.1% resulted in specification of specialized services.

For a variety of reasons, virtually all PASRR screens in New Hampshire are conducted for people who are already in a nursing facility. Prime opportunities for diversion to integrated community settings may have already been missed by the time the PASRR screen is conducted. The CMHA (IV.A.10) emphasizes efforts to address the needs of those "referred to Glencliff,"

[23] Until recently, the ER has not received PASRR data on a continuous basis. This explains the gaps in reporting periods in Table XIX. The furthest right-hand column contains data that incorporated data from two previous reporting periods.

so as to provide them with alternative services in an integrated community setting, before they are admitted to a congregate setting like Glencliff. In addition, individuals admitted to Glencliff must have been turned down by at least two other facilities before being considered for admission. Clearly, interventions to divert individuals from Glencliff or other nursing facilities must be initiated before the PASRR screening process is conducted. 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 January – March 2021, the State reports that NHH effectuated 165 admissions and 173 discharges. The mean daily census was 173, and the median length of stay for discharges was 35 days. The recent increased daily census reflects the conversion of the children's inpatient unit to an adult acute care unit.

Table XX below compares NHH discharge destination information for the six most recent reporting periods.

Table XX

New Hampshire Hospital Self-Reported Data on

Discharge Destination

Discharge Destination	Percent July through Septem-ber 2019	Percent October through Decem-ber 2019	Percent January through March 2020	Percent April through June 2020	Percent July through Septem-ber 2020	Percent October through Decem-ber 2020	Percent January through March 2021
Home – live alone or with others	70.5%	70.76%	72.77%	80.6%	68.4%	69.1%	61.8%
Glencliff	0.4%	0.42%	2.35%	0	0	0.52%	1.2%
Homeless Shelter/motel	4.38%	7.11%	5.16%	2.3%	2.87%	6.3%	5.2%
Group home 5+/DDS supported living, peer support housing etc.	3.98%	4.24%	3.29%	3.0%	2.46%	5.2%	5.2%
Jail/correc-tion	1.2%	3.0%	1.41%	2.3%	3.28%	2.1%	2.3%
Nursing home/rehab facility	5.98%	5.00%	4.69%	3.3%	6.56%	11.0%	10.4%
Other/un-known[24]		10.17%	10.33%	6.9%	5.33%	9.2%	13.9%

[24] The ER did not include the "Other" category in previous reports.

The State now consistently reports information on the hospital-based Designated Receiving Facilities (DRFs) and the Cypress Center in New Hampshire. It is important to capture the DRF/Cypress Center data and analyze it in concert with NHH and Glencliff data to get a total institutional census across the state for people with serious mental illness. Table XXI summarizes these data.

Table XXI

Self-Reported DRF/APRTP Utilization Data

January 2016 through March 2021

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Parkland	Total
Total Admissions							
Jan - March 2016	69	257	46	65	121		558
April - June 2016	79	205	378	49	92		803
July - Sept 2016	37	207	375	54	114		787
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
October - December 2018	87	198	375	64	72		796
January - March 2019	126	182	349	56	123		836
April to June 2019	108	187	371	89	108		865
July to September 2019	104	194	391	52	95		836
October - December 2010	96	175	350	63	100		784
January - March 2020	114	186	333	52	105		790
April - June 2020	105	129	298	36	119		687
July - September 2020	116	159	348	51	121	54	849
October - December 2020	86	139	332	44	128	51	780
January - March 2021	76	156	324	34	156	202	948

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Parkland	Total
Percent involuntary							
Jan - March 2016	55.70%	24.40%	20.40%	4.10%	48.90%		25.50%
April - June 2016	43.20%	29.50%	18.90%	13.00%	44.70%		26.20%
July - Sept 2016	58.30%	21.50%	22.00%	1.00%	47.50%		30.06%
April - June 2017	NA**	25.60%	25.60%	11.50%	50.40%		NA
July - September 2017	49.20%	30.10%	23.70%	12.70%	50.00%		30.00%
Oct. - Dec 2017	44.20%	28.30%	21.50%	6.10%	47.00%		27.00%
Jan. - March 2018	46.73%	25.82%	24.62%	9.23%	51.92%		29.08%
April - June, 2018	28.36%	24.38%	19.33%	12.96%	49.11%		25.16%
July - September 2018	46.00%	23.20%	22.40%	6.25%	51.40%		26.50%
October - December 2018	45.20%	18.10%	23.20%	12.50%	47.20%		28.20%
January - March 2019	61.10%	20.90%	19.40%	7.90%	47.20%		27.30%
April to June 2019	43.30%	16.50%	25.10%	11.50%	55.80%		28.00%
July to September 2019	63.50%	23.40%	24.00%	7.90%	40.00%		29.50%
October - December 2010	53.50%	24.20%	21.00%	9.60%	40.00%		28.16%
January - March 2020	53.51%	24.19%	21.02%	9.62%	40.00%		28.16%
April - June 2020	44.76%	24.03%	25.84%	13.89%	42.90%		31.59%
July - September 2020	48.28%	39.00%	20.69%	21.56%	42.97%	100.00%	36.16%
October - December 2020	66.30%	28.10%	23.20%	27.30%	46.90%	100.00%	37.90%
January - March 2021	57.90%	23.70%	28.70%	14.70%	55.10%	27.20%	33.80%

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Parkland	Total
Average Census							
Jan - March 2016	7.8	13.2	21.4	22.5	16.9		81.8
April - June 2016	4.5	13.6	23.2	25.6	14.5		81.4
July - Sept 2016	4.5	12	30.3	29.3	10		86.1
April - June 2017	NA**	12.9	29.7	29.7	12.2		NA
July - September 2017	10.1	12.3	27.7	32.6	16.1		19.7
Oct. - Dec 2017	6.7	11.6	32.5	34.6	NA		NA
Jan. - March 2018	9.1	11.9	31.7	31.7	20.4		104.8
April - June, 2018	11.8	8.4	39.6	33.8	18.2		111.8
July - September 2018	10.7	9.2	27.4	33.4	10.7		91.4
October - December 2018	8.5	14.5	30.4	22.6	14.9		90.9
January - March 2019	8.4	11.5	29.7	27	12.1		88.7
April to June 2019	9.4	12.2	24.1	24.1	12		81.8
July to September 2019	10.6	13.4	31.8	23.7	9.5		89
October - December 2010	10.6	13.7	29.2	20.5	12		86
January - March 2020	10.6	13.7	29.2	20.5	12		86
April - June 2020	8.5	11.1	24.8	11.9	11.9		70.9
July - September 2020	9.7	13.4	27.7	14.1	13	3.4	81.3
October - December 2020	9	13.5	28.7	17.4	12.7	4.2	85.5
January - March 2021	7.7	13.7	30.3	18.6	14.1	15.5	99.9

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Parkland	Total
Discharges							
Jan - March 2016	35	213	380	64	113		805
April - June 2016	59	232	365	54	105		815
July - Sept 2016	NA**	243	355	63	121		NA
April - June 2017	82	212	359	58	102		813
July - September 2017	53	248	326	67	101		795
Oct. - Dec 2017	74	244	326	65	107		816
Jan. - March 2018	66	195	353	54	112		780
April - June, 2018	89	204	358	62	79		792
October - December 2018	124	177	348	56	106		811
January - March 2019	108	193	368	55	111		835
April to June 2019	101	192	386	54	97		830
July to September 2019	102	198	353	60	123		836
October - December 2010	110	207	327	71	119		834
January - March 2020	110	207	327	71	119		834
April - June 2020	101	131	294	51	117		694
July - September 2020	117	164	324	41	121	48	815
October - December 2020	92	141	335	48	130	50	796
January - March 2021	76	152	323	28	155	192	926

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Parkland	Median
Median LOS for Discharges							
Jan - March 2016	7	5	4	24	8		5
April - June 2016	6	4	5	22	8		9
July - Sept 2016	NA	4	4	27	7		NA
April - June 2017	4	4	5	21	7		5
July - September 2017	5	4	5	23	7		5
Oct. - Dec 2017	5	4	5	20	8		5
Jan. - March 2018	4	4	4	21	7		5
April - June, 2018	4	3	4	31	7		5
October - December 2018	5	5	6	18	8.5		6
January - March 2019	5	3	5	18	7		5
April to June 2019	6	4	6	26	8		6
July to September 2019	7	5	6	25	7		7
October - December 2010	6	5	6	20	8		6
January - March 2020	6	5	6	20	8		6
April - June 2020	6	6	6	27	8		7
July - September 2020	6	7	6	18	8	5	7
October - December 2020	7	7	6	23	7	6	7
January - March 2021	8	6	6	27	7	5	6

* Does not include Portsmouth

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.

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

Table XXII

Self-Reported Discharge Dispositions for DRFs in New Hampshire

January through March 2021

Disposition	Frank-lin	Cy-press	Ports-mouth	Elliot Geria-tric	Elliot Path-ways	Park-land	Total	Per-cent
Home	70	140	274	5	131	176	796	86.0%
NHH	1	0	6	0	0	1	8	0.86%
Residential Facility/ Assisted Living	0	0	2	9	3	0	14	1.5%
Other DRF[25]	0	6	0	3	0	1	10	1.1%
Hospital	0	0	0	0	0	0	0	0%
Death	0	0	0	4	0	0	0	0.43%
Other or Unknown	5	6	41	7	21	14	94	10.2%

Based on these self-reported data, 86% of recent discharges from DRFs and the Cypress Center are to home. This is similar to the 62% discharges to home reported by NHH. It should be noted that discharges to hotels/motels or shelters are not specifically identified in the reported DRF data. Rather, these are included in the "Other" category. Thus, it is not possible to document whether discharges to hotels/motels and shelters have increased during COVID. For NHH, discharges to hotels/motels and shelters have been variable within a range over the past two years, averaging about five percent.

Hospital Readmissions

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

[25] The State reports that these transfers reflect conversion from involuntary to voluntary status, not transfers among DRF facilities.

Table XXIII

Self-Reported Readmission Rates for NHH and the DRFs

July 2017 through March 2021

	Percent 30 Days	Percent 90 Days	Percent 180 Days
NHH			
7/2017 to 9/2017	9.80%	21.60%	27.90%
10/2017 to 12/2107	12.8%	26.1%	32.8%
1/2018 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%
10/2018 to 12/2018	7.3%	18.1%	25.9%
1/2019 to 3/2019	5.3%	14.8%	21.2%
4/2109 to 6/2019	8.4%	15.0%	20.3%
7/2019 to 9/2019	10.5%	18.6%	23.3%
1/2020 to 3/2020	6.6%	12.4%	21.1%
4/2020 to 6/2020	9.7%	14.7%	20.0%
7/2020 to 9/2020	6.1%	12.7%	16.4%
10/2020 to 12/2020	4.8%	12.3%	18.2%
1/2021 to 3/2021	3.0%	8.5%	13.3%

The latest reported data on readmissions is positive compared with earlier data.

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Franklin			
7/2017 to 9/2017	NA	NA	NA
10/2017 to 12/2107	10.2%	10.2%	10.2%
1/2018 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%
10/2018 to 12/2018	2.3%	4.6%	5.7%
1/2019 to 3/2019	7.9%	10.3%	10.3%
4/2109 to 6/2019	6.5%	9.3%	12.0%
7/2019 to 9/2019	1.9%	6.7%	9.6%
1/2020 to 3/2020	3.5%	6.1%	7.8%
4/2020 to 6/2020	3.8%	4.7%	4.7%
7/2020 to 9/2020	2.5%	5.0%	5.9%
10/2020 to 12/2020	6.7%	11.2%	14.6%
1/2021 to 3/2021	6.6%	6.6%	7.9%

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Manchester (Cypress)			
1/2018 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%
10/2018 to 12/2018	7.10%	11.10%	15.20%
1/2019 to 3/2019	5.50%	14.80%	17.60%
4/2109 to 6/2019	9.90%	15.10%	20.80%
7/2019 to 9/2019	6.60%	9.20%	12.80%
1/2020 to 3/2020	3.50%	5.00%	8.50%
4/2020 to 6/2020	5.20%	11.90%	18.70%
7/2020 to 9/2020	3.10%	6.30%	7.50%
10/2020 to 12/2020	4.3%	7.9%	12.9%
1/2021 to 3/2021	5.8%	7.7%	10.9%

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Portsmouth			
1/2018 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%
10/2018 to 12/2018	7.70%	14.90%	20.30%
1/2019 to 3/2019	12.90%	19.50%	23.50%
4/2109 to 6/2019	10.50%	17.80%	22.40%
7/2019 to 9/2019	8.20%	12.00%	12.00%
1/2020 to 3/2020	9.70%	29.20%	23.00%
4/2020 to 6/2020	7.30%	15.00%	23.60%
7/2020 to 9/2020	14.10%	21.80%	24.70%
10/2020 to 12/2020	9.3%	15.6%	20.7%
1/2021 to 3/2021	8.0%	13.2%	18.5%

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Elliot Geriatric			
1/2018 to 3/2018	NA	NA	NA
4/2018 to 6/2018	3.80%	6.70%	8.60%
7/2018 to 9/2018	7.00%	11.50%	16.10%
10/2018 to 12/2018	2.80%	5.60%	9.70%
1/2019 to 3/2019	4.90%	5.70%	7.30%
4/2109 to 6/2019	5.50%	5.50%	5.50%
7/2019 to 9/2019	2.10%	5.20%	6.30%
1/2020 to 3/2020	9.70%	14.20%	15.90%
4/2020 to 6/2020	3.30%	3.30%	4.20%
7/2020 to 9/2020	6.60%	8.30%	9.10%
10/2020 to 12/2020	9.1%	13.6%	15.9%
1/2021 to 3/2021	2.9%	5.9%	5.9%

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Elliot Pathways			
10/2018 to 12/2018	6.30%	7.80%	9.40%
1/2019 to 3/2019	5.40%	5.40%	5.40%
4/2109 to 6/2019	10.10%	12.40%	14.60%
7/2019 to 9/2019	7.70%	9.60%	13.50%
1/2020 to 3/2020	9.40%	11.30%	18.90%
4/2020 to 6/2020	9.80%	9.80%	9.80%
7/2020 to 9/2020	2.00%	7.80%	7.80%
10/2020 to 12/2020	6.3%	12.5%	14.1%
1/2021 to 3/2021	5.1%	10.9%	13.5%

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Parkland Regional			
10/2020 to 12/2020	7.8%	9.8%	9.8%
1/2021 to 3/2021	5.9%	7.4%	8.4%

The ER notes that re-admission rates to NHH, particularly those within 180 days, have steadily decreased since March of 2018. This may reflect the impact of mobile crisis services and enrollment in ACT services. However, other factors, such as the expansion of transitional housing capacity and the increase in institutional beds at NHH, could also affect readmission rates.

Hospital ED Waiting List

The following two charts display information on the average daily waiting list of adults for inpatient psychiatric beds in New Hampshire.

Chart A

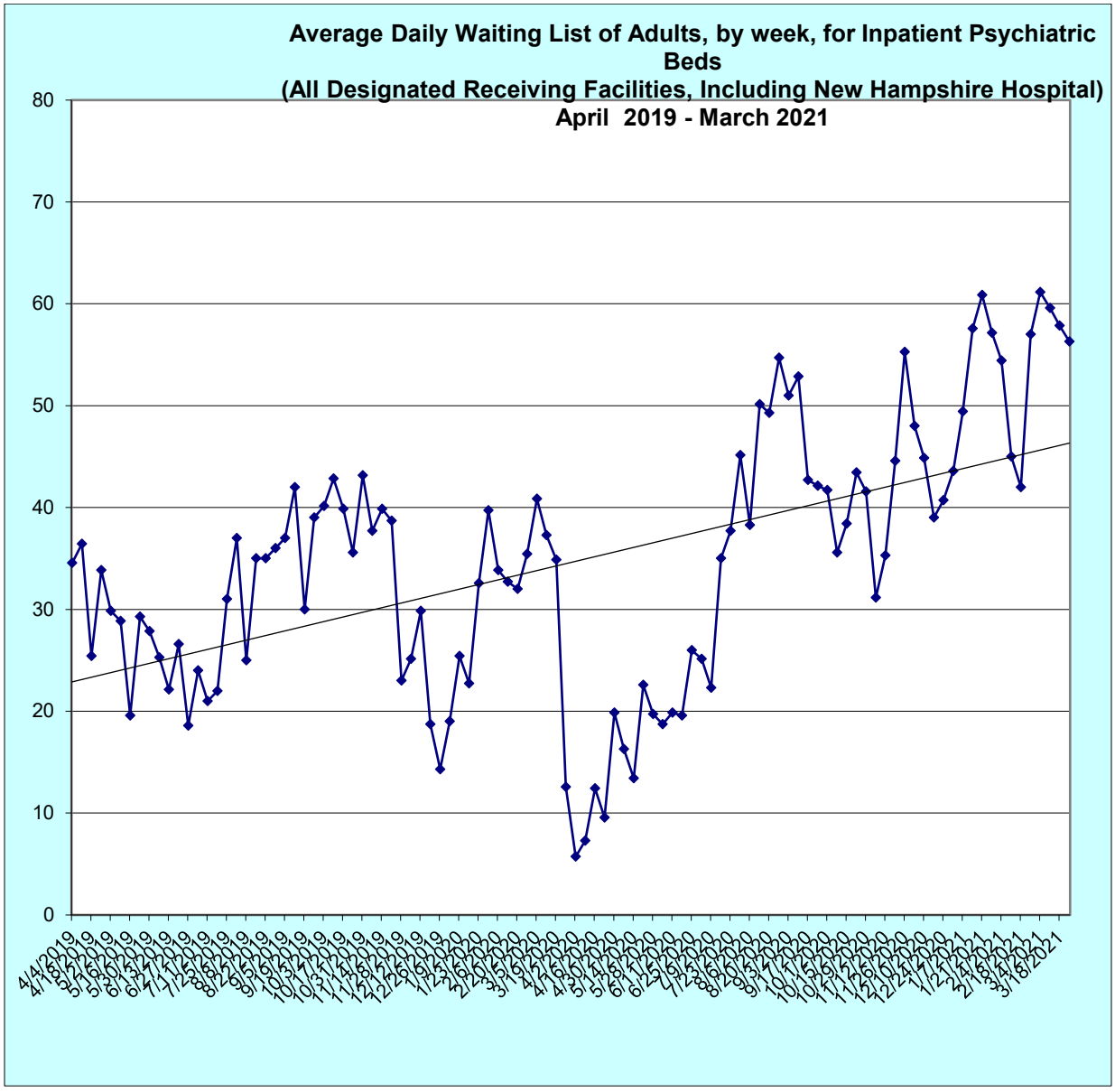
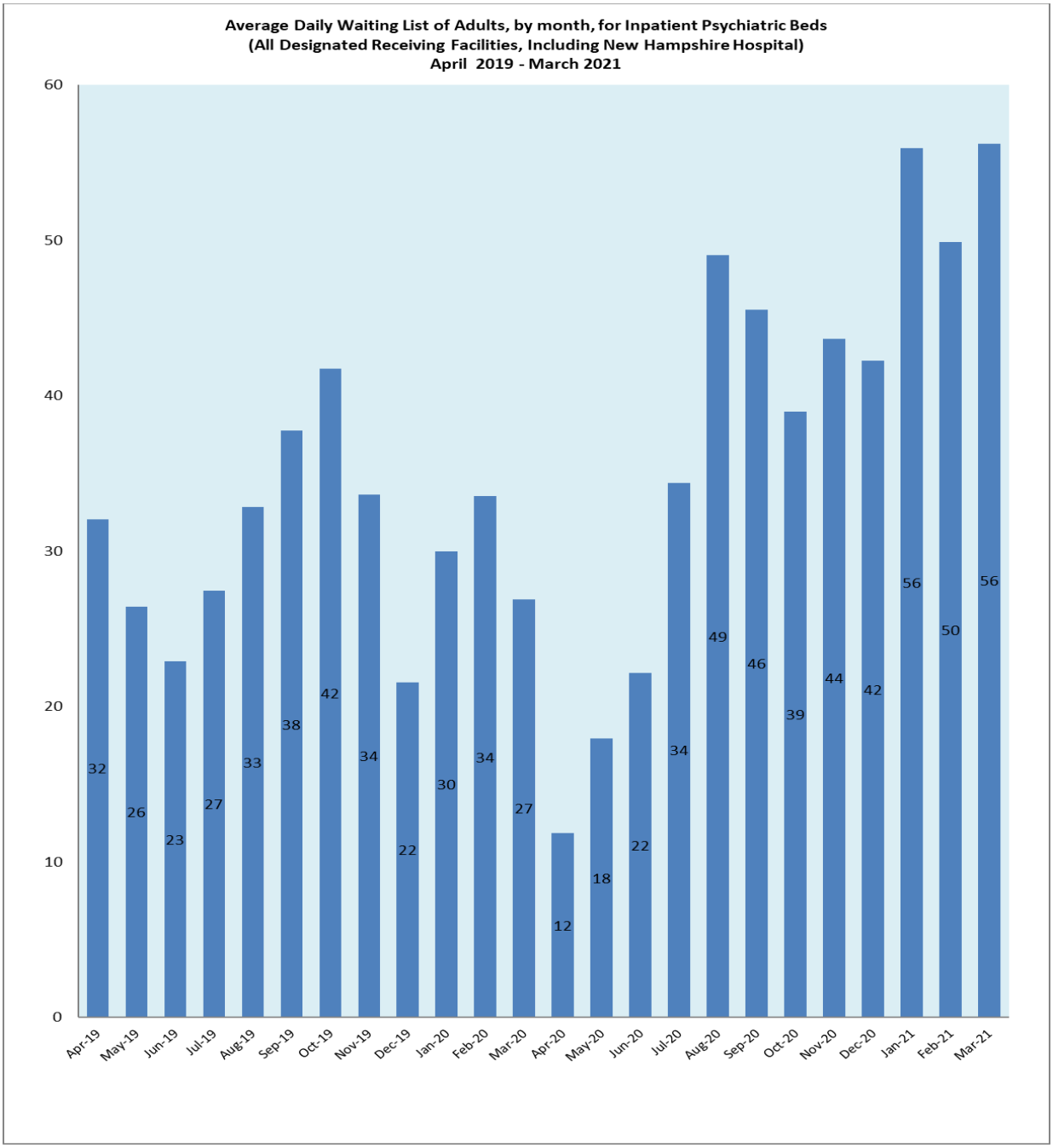


Chart B



Until April of 2020, the overall trend in average daily wait lists for hospital admission was trending downward. However, in the past nine months the average daily wait list has increased substantially. This has occurred despite the addition of 30 beds at NHH, a new 4 bed IEA-DRF

(Parkland), and 13 net new transitional housing beds statewide.[26] In addition, there continues to be excess capacity among several of the State's CMHC-based ACT teams, which can and should reduce reliance on institutional services.

In a recent All-Parties meeting, the State reported that emergency department psychiatric hospital waiting times have been significantly reduced in recent months. That data should be available to be presented in the next ER Report.

Family and Peer Supports

Family Supports

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

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. As of March 2021, the State reports that those sites have a cumulative total of 2,644 members, with an average daily participation rate of 106 people statewide.

IV. Quality Assurance Systems

As noted earlier in this report, COVID restrictions have prevented the State from conducting the contracted ACT and SE fidelity reviews during the past 18 months. However, the State has been successful in conducting QSRs for all ten CMHCs during 2020, and the first half of 2021. A summary tabulation of the results of these QSR activities is included as Appendix B of this report. Due to COVID, the ER has not been able to directly observe QSR CMHC reviews during this period. The ER was able to observe two Zoom/phone interviews during this time period, and has also participated telephone briefings related to QSR site visits.

All QSR reviews have been conducted remotely: that is, the service participant and staff interviews have been conducted by ZOOM or by phone. Nonetheless, participation and completion rates for the interviews have remained high, and quality checks of the interview results have remained positive. The team members report that they believe the QSR review results remain valid, albeit conducted under difficult conditions.

For the most recent set of QSR reviews (State Fiscal Year 2020), the State has increased the performance threshold from 70% to 80% for each indicator and for overall average performance. CMHCs scoring less than 80% on any indicator must submit a quality improvement plan (QIP),

[26] An additional 16 beds of transitional housing are pending.

the implementation of which is monitored by the State. QIPs are also used to prioritize technical assistance and coaching efforts designed to assist CMHCs to improve performance. The ER also monitors implementation of the QIPs via interviews with both State and CMHC staff.

Overall, the CMHC system averages QSR performance scores above the 80% threshold. That is, each CMHC has an aggregate average score above 80%, and the aggregate average for the ten CMHCs together also exceeds 80%. These facts demonstrate that overall CMHC and system-wide performance have been steadily improving since in inception of the QSR review process.

However, there continue to be some areas of lower than desired performance and quality in the CMHC system as documented by the QSR findings. Of the 18 indicators summarized in the QSR reports, the CMHC system as a whole performs below the 80% threshold on four indicators. These are:

1. Indicator 9: adequacy of employment treatment planning (nine of 10 CMHCs below 80%; system wide average 77%);
2. Indicator 10: adequacy of employment service delivery (three of 10 CMHCs below 80%; system-wide average 75%); and
3. Indicator 15: comprehensive crisis services: (one of 10 CMHCs below 80%; system-wide average 79%).

In addition, the CMHC system is very close to the minimum performance threshold on three additional indicators. These are:

1. Indicator 17: implementation of ACT services (four of 10 CMHCs below 80%; state-wide average 80%); and
2. Indicator 18: successful transitions form inpatient to community: (six of 10 CMHCs below 80%; statewide average 81%).

Overall, system performance has improved slightly when compared to last year. Reduced performance levels are documented for indicators 10 (employment service delivery) and 18 (transition from inpatient), but performance levels have slightly improved or stayed even on all other indicators.

The ER notes that performance below the 80% QSR performance threshold is not, by itself, evidence of non-compliance with the CMHA. However, QSR performance scores do provide a clear indication of: 1) whether specific remedial services are being delivered consistent with CMHA requirements; and 2) whether the purpose and objectives of the CMHA are being realized. Currently, the CMHC system continues to demonstrate needs for improvement in domains directly related to the CMHA, including employment, ACT services, crisis services, and transitions to the community from inpatient settings.

As soon as possible after the COVID restrictions are eased, the ER intends to return to active observation of both QSR and Fidelity Review activities.

V. Additional Recent Initiatives

This year, the State has initiated several new activities which may have some impact in the future on the Target Population for the CMHA. These are:

1. Impending roll-out of statewide mobile crisis response services;
2. Impending roll-out of Critical Time Intervention (CTI);
3. Payment of financial incentives to nursing facilities to accept transfer of patients from Glencliff and NHH; and
4. Provision of state funds to each of the 10 CMHCs to support development of six new residential beds per CMHC; the State has acknowledged that these may or may not be in integrated community settings.

With the exception of the financial incentives paid to nursing facilities, which has been underway for the past six months, these initiatives are very early in the implementation process. Until the initiatives are more fully implemented, it will not be possible to document the extent to which members of the Target Population may be affected by one or more of the initiatives.

VI. Summary of Expert Reviewer Observations and Priorities

The ER has emphasized in this report that the State continues to be out of compliance with several key components of the CMHA. These findings are summarized below, along with expectations and recommendations for addressing these issues in the coming months.

ACT

For the last five and one half years, the ER has reported that the State is out of compliance with the ACT requirements of Sections V.D.3, which together require that 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. Moreover, many of the State's ACT teams are failing to meet CMHA requirements for staffing and team composition. In addition, available screening data is limited to individuals already engaged with the CMHCs. It provides no information on whether individuals outside of the CMHC system who would benefit from ACT services are being properly identified and referred for assessment. In addition, there is substantial turnover in the ACT active client caseload over a relatively short time frame, and efforts to engage new ACT clients are necessary just to maintain steady state operations in the ACT program. Finally, many of the State's ACT teams are failing to meet CMHA requirements for staffing and team composition.

In response to these issues, the ER recommends that the State undertake the following actions in advance of the parties next quarterly meeting:

1) Implement and report on initiatives to identify and screen/assess individuals outside of the CMHC system, especially those in crisis or decline, such as those in hospital emergency rooms, NHH, the DRFs, the MCTs, homeless shelters, and the criminal justice system;

2) Collect and report the following information: 1) participants' average length of stay in the service; 2) the number of participants discharged each month; and 3) the reason for their discharge (i.e., withdrawal of consent; achievement of treatment goals; moved out of state, etc.); and

3) Implement and report on quality improvement plans and/or corrective action plans with ACT teams whose staffing and team composition have failed to meet CMHA standards for three consecutive months in 2021.

Mobile Crisis Teams

The Nashua region has been without fully operational MCT/Crisis Apartment services for at least the past eight months. As of the date of this report, the Mobile Team in Nashua is not fully staffed for all shifts, and the crisis apartments are still not open. At this point GNMH reports it has not yet hired peer support staff for the crisis apartments. The State reported that Mobile Crisis Team/Crisis Apartment data for the Nashua region is "Not Available," and it appears that some reductions in service have occurred now that GNMH has assumed the contract.

The ER expects the State and GNMH will take all steps necessary to remediate this as soon as possible. To that end, the ER makes the following recommendations:

1) The ER, and Plaintiff's counsel, revisit the Nashua site in October/November 2021, to observe and monitor the degree to which GNMH is operating a fully compliant MCT/crisis apartment program consistent with the CMHA;

2) The State provide the ER and the parties with a written update on steps being taken to secure full implementation of the Nashua MCT services, as required by the CMHA, no later than October 15, 2021; and

3) The State provide updated data on the delivery of MCT services in the Nashua region, in order to determine to what extent services are being provided to members of the target population.

Transition Planning

With regard to Glencliff, the ER has documented the State's failure to provide effective transition planning and in-reach activities, failure to transition residents of Glencliff into integrated community settings in accordance with the CMHA, and failure to expand community residential and other service capacity to meet the needs of Glencliff residents in alternative community settings. In addition, the ER cannot document or certify that residents of Glencliff have written transition plans in accordance with CMHA requirements, and has been unable to document that residents transitioned to other nursing facilities have exercised informed consent in compliance with the CMHA and with Glencliff informed consent policies. Finally, the ER cannot document that all reasonable efforts were made to explore community alternatives and avoid the transfer of Glencliff residents to other nursing facilities, as required by the CMHA.

In light of these findings, the ER makes the following recommendations:

1) The State review and update the discharge plans for individuals who transitioned from NNH or Glencliff to nursing facilities since 2021, to ensure that any revised plan clearly identifies the barriers to placement in a more integrated setting, and describes steps the State will take to address the barriers (CMHA VI.A.4);

2) Prior to any future nursing facility transfers from either NHH or Glencliff, the State ensures that the following steps have occurred and are documented within the resident's transition plan:

    a) a visioning process that includes exploration of integrated community alternatives;

    b) an updated assessment of actual or perceived barriers to community setting;

    c) documentation of efforts to resolve identified barriers with the resident and guardian, if appropriate, including referral to the Central Team.

3) The State direct CMHCs to prioritize Glencliff and NHH residents for community residential and supported housing initiatives referenced in Section V. above, in keeping with CMHA V.B.2; and

4) The State prioritize the development of new, small, residential settings for residents with complex medical conditions as soon as possible to meet the needs of individuals at Glencliff whose barrier to transition planning is the availability of community residential service capacity required by the CMHA.

Supported Employment

Although the State technically meets the statewide CMHA standard for SE penetration, the ER notes six of the ten CMHC regions of the state have penetration rates lower than the standard. At the very least, the ER considers that this demonstrates that Target Population members do not have equal access to SE services throughout New Hampshire.

In response to these implementation issues, the ER recommends that, prior to the next quarterly meeting, the State:

1) Resume SE fidelity reviews, along with related reporting to the ER and the parties;

2) Provide a written update on efforts to ensure reasonable access to supported employment services for the 49 individuals currently on the statewide waiting list;

3) Continue to report on quality improvement plans for the two SE-related QSR indicators; and

4) Provide technical assistance to, and report on continuing quality improvement efforts with, the six CMHCs reporting SE penetration rates lower than the CMHA requirement.

PASRR

Despite federal Medicaid requirements and the CMHA, the State's PASRR process is not determining if individuals could be diverted from admission to Glencliff, or whether a transfer from either NHH or Glencliff to another nursing facility is necessary and appropriate. Similarly, given the low and declining rate of specialized services recommendations, it is questionable if the PASRR process is accurately determining whether class members admitted to Glencliff or another nursing facility need specialized services, such as behavior or other therapies, beyond those that are part of standard nursing services. As a result, the ER recommends that:

1) The State ensure that all PASRR Level II evaluations consider all appropriate community alternatives and document any determination that such alternatives are not appropriate before a person is admitted to Glencliff or transferred from NHH or Glencliff to another nursing facility; and

2) The State ensure that all PASRR Level II evaluations determine if specialized services, such as behavior and other therapies are needed by the person and document such determination.

As has been noted at several points in this report, the COVID-19 pandemic has influenced the New Hampshire Mental Health System over the past 18 months, although the areas of noncompliance noted in this report all predate the onset of the pandemic. In general, the State is to be congratulated for its efforts to provide basic levels of services for the CMHA Target Population, and also for striving to maintain the quality of services for the Target Population during COVID. The absence of progress towards compliance is not unexpected in light of these challenges, but it does have the practical effect of extending the period of time that is likely to be required before any maintenance of effort year can begin.

COVID has also directly affected the degree to which the ER could directly monitor and document compliance with the terms and requirements of the CMHA. The ER has conducted only two on-site reviews in the past ten months, instead relying on remote conversations and analyses of secondary data. Absent other information, the ER concludes that while service delivery and quality has remained relatively consistent under COVID, there has also been relatively little documented progress made in addressing and making progress on issues related to compliance with the CMHA.

As the ER has stated in previous reports, the State will be unable to disengage from the CMHA until full compliance is reached for all requirements of the CMHA.

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

January through March, 2021

New Hampshire Community Mental Health Agreement Quarterly Data Report

January – March 2021

New Hampshire Department of Health and Human Services

Bureau of Quality Assurance and Improvement

June 30, 2021

Community Mental Health Agreement Quarterly Data Report

New Hampshire Department of Health and Human Services

Publication Date: June 30, 2021

Reporting Period: 01/1/21 – 03/31/2021

Notes for Quarter

- Trends: A new section to the report is introduced. It provides data trends for key CMHA topics, such as the degree to which the target population is able to access services in the least restrictive setting possible (e.g., community-based vs. hospital based).
- On March 13, 2020, Governor Christopher T. Sununu issued Executive Order 2020-04, declaring a State of Emergency due to the Novel Coronavirus (COVID-19). The 2020-04 Order was continually extended and remained in effect throughout the covered reporting period. Service provision during the reporting period continued to be impacted by the emergency.
- Table 5 series, Designated Receiving Facilities. Parkland has begun submitting data regarding voluntary admissions this quarter. In the past, they were only submitting involuntary admissions. All tables in this series are impacted by the change.
- Table 7. NH Mental Health Client Peer Support Agencies: Census Summary – Peer Support Agencies were open with limited on-site capacity due to COVID-19. The Average Daily Visits reported includes the number of individuals participating in groups online and on-site.
- Tables 11a-c. Mobile Crisis Services and Supports for Adults – Several data elements reported as zero (0), or otherwise lower than normal volume, reflect the direct or indirect impact of the COVID-19 pandemic, such as lack of crisis apartment use due to distancing and quarantine protocols.
- Table 11c. Mobile Crisis Services and Supports for Adults – Greater Nashua Mental Health / Harbor Care. The provision of mobile crisis services in Region VI transitioned to Greater Nashua Mental Health (GNMH) on November 1, 2021, however, data reporting is not yet available. The transition of the program includes a phased implementation approach. Mobile Crisis Team services are being provided. Region VI data, for inclusion in the CMHA Quarterly Data Report, is expected to begin for the reporting period of July – September 2021. The crisis apartment services are on a revised scheduled to begin in July 2021, due to complications with construction and local approval processes.

Acronyms Used in this Report

ACT: Assertive Community Treatment

BMHS: Bureau of Mental Health Services

BQAI: Bureau of Quality Assurance and Improvement

CMHA: Community Mental Health Agreement

CMHC: Community Mental Health Center

HUD: US Dept. of Housing and Urban Development

MCT: Mobile Crisis Team

NHH: New Hampshire Hospital

NHHFA: New Hampshire Housing Finance Authority

PRA: Project Rental Assistance

DHHS: Department of Health and Human Services

DRF: Designated Receiving Facility

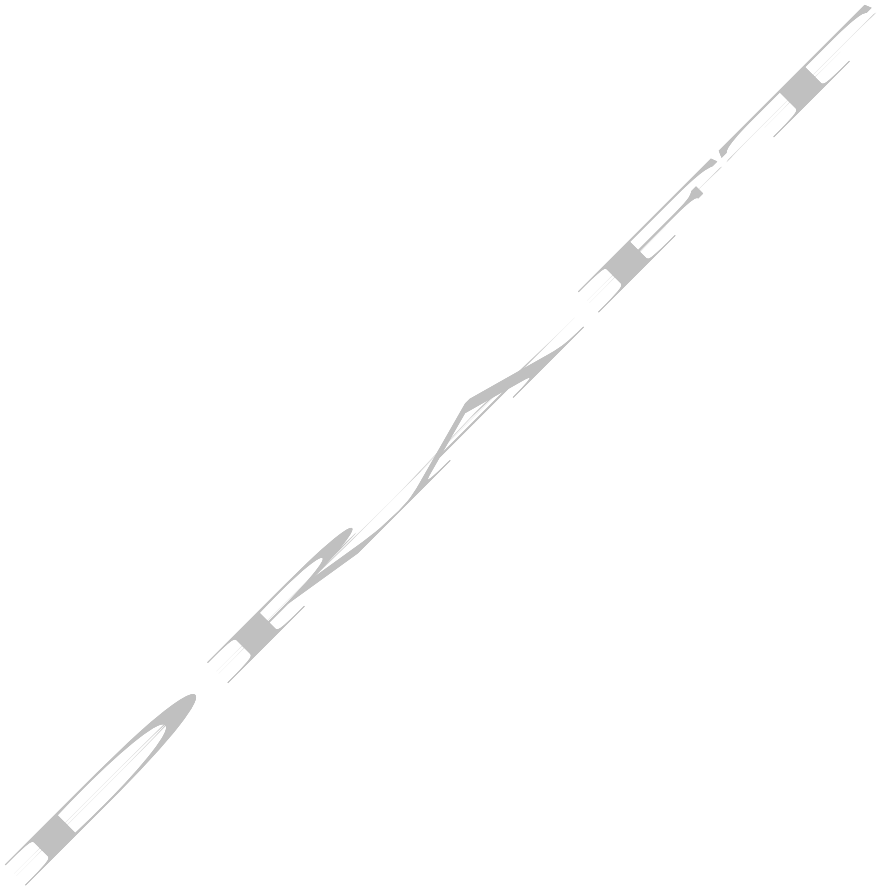
ED: Emergency Department

FTE: Full Time Equivalent

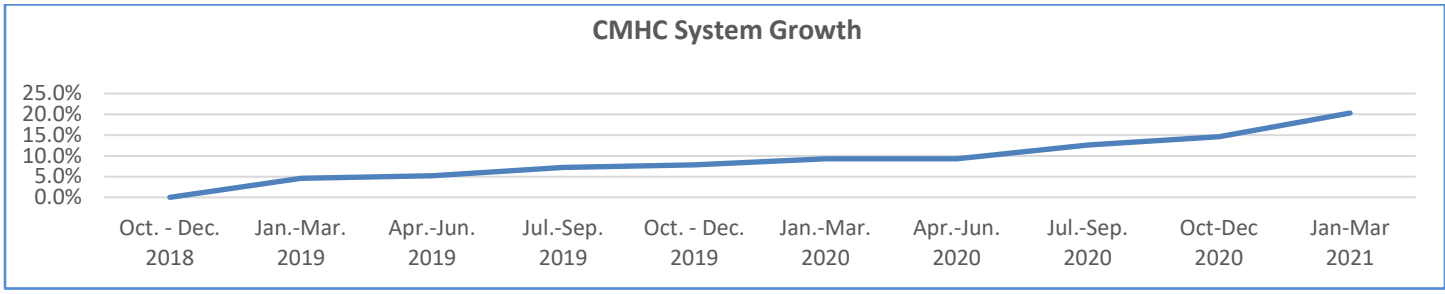
HBSP: Housing Bridge Subsidy Program

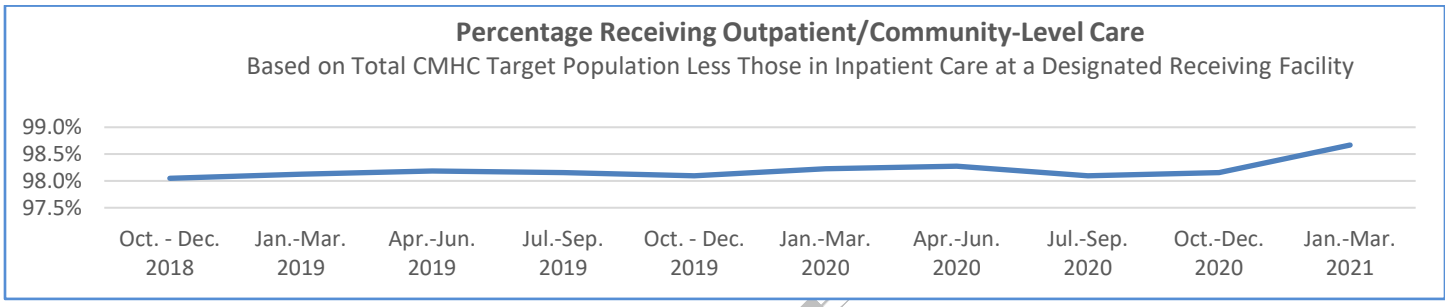
SE: Supported Employment

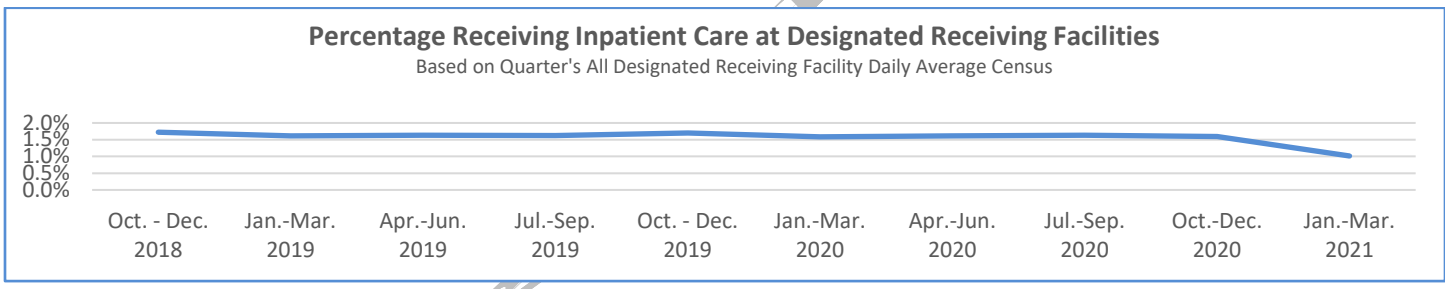
VA: Veterans Benefits Administration

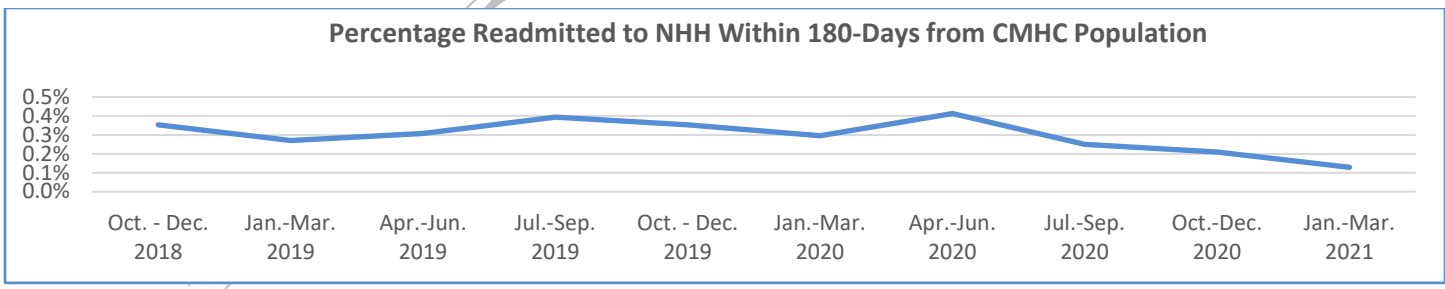


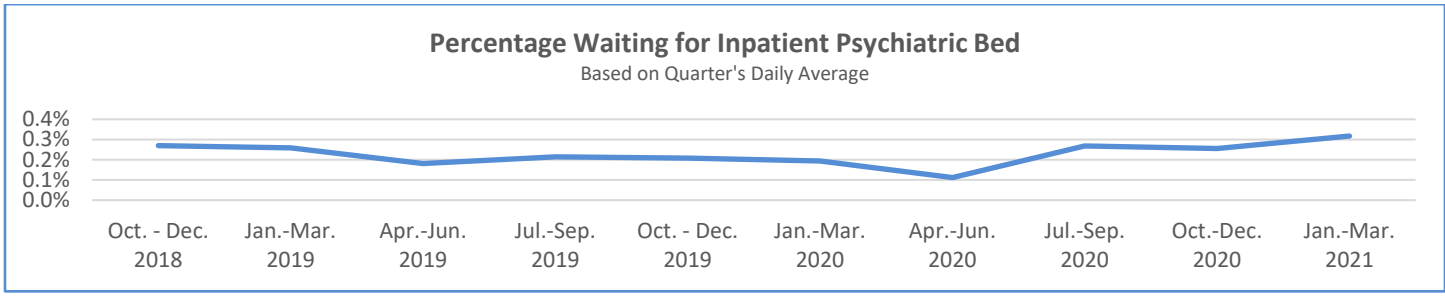
TRENDS: CMHA Target Population System Wide Key Trends

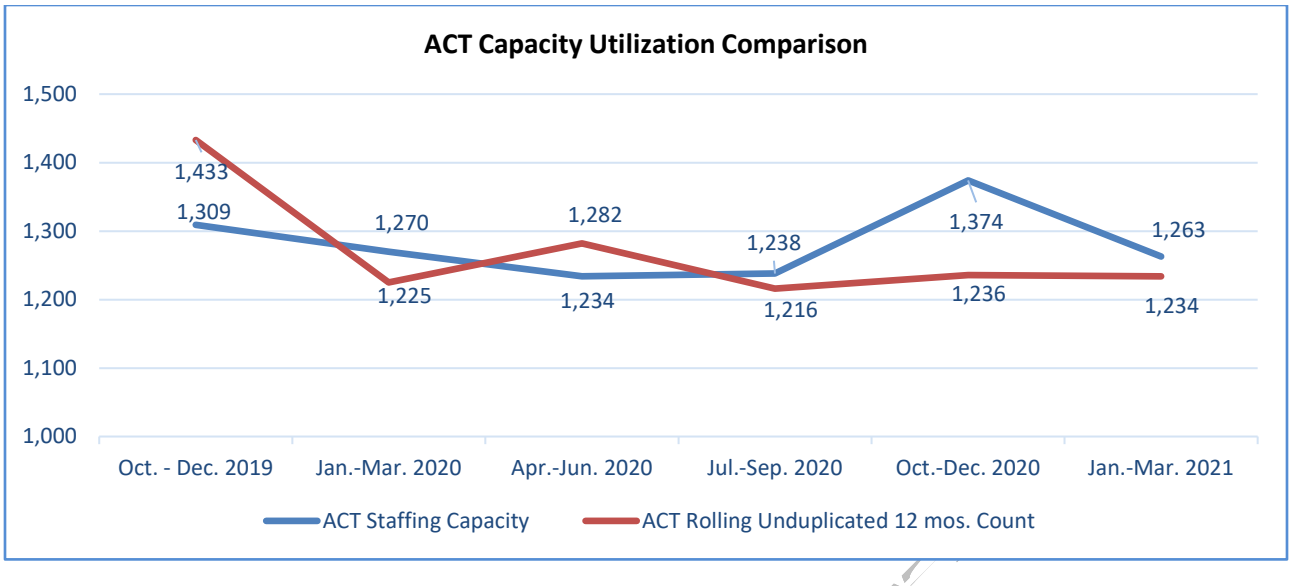











ACT Capacity Utilization Comparison
1,500
1,400
1,300
1,200
1,100
1,000
1,433
1,309
1,270
1,225
1,282
1,234
1,238
1,216
1,374
1,236
1,263
1,234
Oct. - Dec. 2019
Jan.-Mar. 2020
Apr.-Jun. 2020
Jul.-Sep. 2020
Oct.-Dec. 2020
Jan.-Mar. 2021
ACT Staffing Capacity
ACT Rolling Unduplicated 12 mos. Count

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

Community Mental Health Center	January 2021	February 2021	March 2021	Unique Clients in Quarter	Unique Clients in Prior Quarter
01 Northern Human Services	120	121	124	133	133
02 West Central Behavioral Health	43	44	60	66	54
03 Lakes Region Mental Health Center	56	56	59	60	58
04 Riverbend Community Mental Health Center	92	99	94	109	109
05 Monadnock Family Services	46	46	45	47	45
06 Greater Nashua Mental Health	121	126	130	152	133
07 Mental Health Center of Greater Manchester	262	256	254	274	276
08 Seacoast Mental Health Center	80	81	80	86	81
09 Community Partners	65	70	73	79	73
10 Center for Life Management	45	45	45	47	47
Total Unique Clients	**929**	**943**	**963**	**1,051**	**1,007**
Unique Clients Receiving ACT Services 4/1/2020 to 3/31/2021: 1,234					

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 04/26/2021; clients are counted only one time regardless of how many services they receive.

1b. Community Mental Health Center Services: Assertive Community Treatment Screening and Resultant New ACT Clients

	October – December 2020	July – September 2020

Community Mental Health Center	Retrospective Analysis			Retrospective Analysis		
	Unique Clients Screened: Individuals Not Already on ACT*	Screening Deemed Appropriate for Further ACT Assessment:	New Clients receiving ACT Services within 90 days of Screening	Unique Clients Screened: Individuals Not Already on ACT*	Screening Deemed Appropriate for Further ACT Assessment:	New Clients receiving ACT Services within 90 days of Screening
01 Northern Human Services	1,099	25	4	1,180	21	2
02 West Central Behavioral Health	113	0	0	170	2	0
03 Lakes Region Mental Health Center	194	2	0	170	4	0
04 Riverbend Community Mental Health Center	1,398	0	0	1,324	1	1
05 Monadnock Family Services	545	2	0	577	4	0
06 Greater Nashua Mental Health	1,128	2	1	1,020	5	1
07 Mental Health Center of Greater Manchester	1,702	9	3	1,712	9	3
08 Seacoast Mental Health Center	1,381	23	0	1,481	32	1
09 Community Partners	253	2	0	322	2	1
10 Center for Life Management	1,122	8	0	943	4	0
Total ACT Screening	**8,935**	**73**	**8**	**8,899**	**84**	**9**

Data Source: NH Phoenix 2 and CMHC self-reported ACT screening records. ACT screenings submitted through Phoenix capture ACT screenings provided to clients found eligible for state mental health services. Phoenix does not capture data for non-eligible clients; three CMHCs

submit this data through Phoenix. Seven CMHCs self-report. All such screenings, excluding individuals who are already on ACT, are contained in this table.

Notes: Data extracted 05/05/2021. "Unique Clients Screened: Individuals Not Already on ACT" is defined as individuals who were not already on ACT at the time of screening that had a documented ACT screening during the identified reporting period. "Screening Deemed Appropriate for Further ACT Assessment: Individuals Not Already on ACT" is defined as screened individuals not already on ACT that resulted in referral for an ACT assessment. "New Clients Receiving ACT Services within 90 days of ACT Screening" are defined as individuals who were not already on ACT that received an ACT screening in the preceding quarter and then began receiving ACT services. "Unique Clients Screened: Individuals Not Already on ACT": In prior quarter, this field was incorrectly calculated and has been updated to accurately reflect quarter counts. All other category counts were accurate.*

1c. Community Mental Health Center Services: New Assertive Community Treatment Clients

Community Mental Health Center	January – March 2021				October – December 2020			
	January 2021	February	March 2021	Total New ACT Clients	October 2020	November 2020	December	Total New ACT Clients
01 Northern Human Services	1	4	7	**12**	2	4	4	**10**
02 West Central Behavioral Health	3	3	16	**22**	4	4	2	**10**
03 Lakes Region Mental Health Center	3	0	3	**6**	1	3	0	**4**
04 Riverbend Community Mental Health Center	0	9	4	**13**	11	3	1	**15**
05 Monadnock Family Services	1	1	0	**2**	0	0	0	**0**
06 Greater Nashua Mental Health	8	12	18	**38**	2	5	19	**26**
07 Mental Health Center of Greater Manchester	6	5	6	**17**	6	4	8	**18**
08 Seacoast Mental Health Center	3	2	3	**8**	1	1	4	**6**

09 Community Partners	0	5	7	**12**	3	1	0	**4**
10 Center for Life Management	0	1	1	**2**	0	0	2	**2**
Total New ACT Clients	**25**	**42**	**65**	**132**	**30**	**25**	**40**	**95**

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 04/26/2021; New ACT Clients are defined as individuals who were not already on ACT within 90 days prior who then began receiving ACT services. This information is not limited to the individuals that received an ACT screening within the previous 90-day period, and may include individuals transitioning from a higher or lower level of care into ACT.

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

As of 03/31/2021						
	Time on List					
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**
4	3	1	0	0	0	0
As of 12/31/2020						
Time on List						
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**
2	0	1	0	0	1	0

Revisions to Prior Period: None.

Data Source: BMHS Report.

Notes: Data compiled 05/06/2021. All individuals waiting are at MHCGM; increased services for waiting individuals are being provided by the existing treatment team until assigned to an ACT team.

1e. Community Mental Health Center Services: Assertive Community Treatment – New Hampshire Hospital Admission and Discharge Data Relative to ACT

Community Mental Health Center	January – March 2021						October – December 2020					
	On ACT at Admissi		Referred for ACT on		Accepted to ACT at		On ACT at Admissi		Referred for ACT on		Accepted to ACT at	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
01 Northern Human Services	4	7	2	5	2	0	4	12	2	10	2	0
02 West Central Behavioral Health	3	4	1	3	1	0	2	3	1	2	1	0
03 Lakes Region Mental Health Center	2	3	0	3	0	0	2	8	4	4	2	2
04 Riverbend Community Mental Health Center	4	10	3	7	2	1	10	12	4	8	4	0
05 Monadnock Family Services	2	8	1	7	0	1	3	5	0	5	0	0
06 Greater Nashua Mental Health	3	7	5	2	1	4	6	9	6	3	3	3
07 Mental Health Center of Greater Manchester	7	10	6	4	3	3	8	7	1	6	0	1
08 Seacoast Mental Health Center	7	6	1	5	1	0	1	3	0	3	0	0
09 Community Partners	5	10	2	8	1	1	4	8	2	6	2	0
10 Center for Life Management	0	6	0	6	0	0	0	4	0	4	0	0
Total	**37**	**71**	**21**	**50**	**11**	**10**	**40**	**71**	**20**	**51**	**14**	**0**

Revisions to Prior Period: None

Data Source: New Hampshire Hospital.

Notes: Data compiled 06/28/2021.

1f. Community Mental Health Center Services: Assertive Community Treatment – Reasons Not Accepted to ACT at New Hampshire Hospital Discharge Referral

Reason Not Accepted at Discharge	January - March 2021	October - December 2020
Not Available in Individual's Town of Residence	1	0
Individual Declined	0	0
Individual's Insurance Does Not Cover ACT Services	0	0
Individual's Clinical Need Does Not Meet ACT Criteria	5	0
Individual Placed on ACT Waitlist	0	0
Individual Awaiting CMHC Determination for ACT	4	6
Total Unique Clients	**10**	**6**

Revisions to Prior Period: None.

Data Source: New Hampshire Hospital.

Notes: Data compiled 06/28/2021. None of the 4 individuals, who were awaiting CMHC determination at discharge from NHH, were still waiting for determination or were waiting on the ACT Waitlist by the last day of the month of their discharge – indicating the ACT determination and resolution had occurred.

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

Community Mental Health Center	March 2021						December 2020	
	Nurse	Masters Level Clinician/or	Functional Support	Peer Specialist	Total (Excluding	Psychiatrist/Nurse Practitioner	Total (Excluding	Psychiatrist/Nurse Practitioner

01 Northern Human Services - Wolfeboro	1.00	0.00	0.00	0.57	6.81	0.27	8.27	0.25
01 Northern Human Services - Berlin	0.34	0.31	0.00	0.00	3.94	0.14	4.17	0.14
01 Northern Human Services - Littleton	0.00	0.14	0.00	0.00	3.28	0.29	3.31	0.29
02 West Central Behavioral Health	0.60	1.00	0.00	0.00	5.40	0.30	5.90	0.30
03 Lakes Region Mental Health Center	1.00	1.00	0.00	1.00	5.00	0.40	7.00	0.38
04 Riverbend Community Mental Health Center	0.50	1.00	6.90	1.00	10.40	0.50	10.50	0.50
05 Monadnock Family Services	1.91	2.53	0.00	1.12	11.17	0.66	10.32	0.62
06 Greater Nashua Mental Health 1	1.00	1.00	3.00	1.00	7.65	0.15	8.50	0.15
06 Greater Nashua Mental Health 2	1.00	1.00	4.00	1.00	8.65	0.15	8.50	0.15
07 Mental Health Center of Greater Manchester-CTT	1.33	10.64	2.00	0.00	19.95	1.17	21.61	1.21
07 Mental Health Center of Greater Manchester-MCST	1.33	9.31	3.33	1.33	19.95	1.17	25.27	1.21
08 Seacoast Mental Health Center	1.00	1.10	5.00	1.00	10.10	0.60	10.10	0.60
09 Community Partners	0.50	0.00	3.40	0.88	7.28	0.70	7.41	0.70
10 Center for Life Management	1.00	0.00	2.28	1.00	6.71	0.46	6.57	0.46
Total	**12.51**	**29.03**	**29.91**	**9.33**	**126.29**	**6.96**	**137.43**	**6.96**

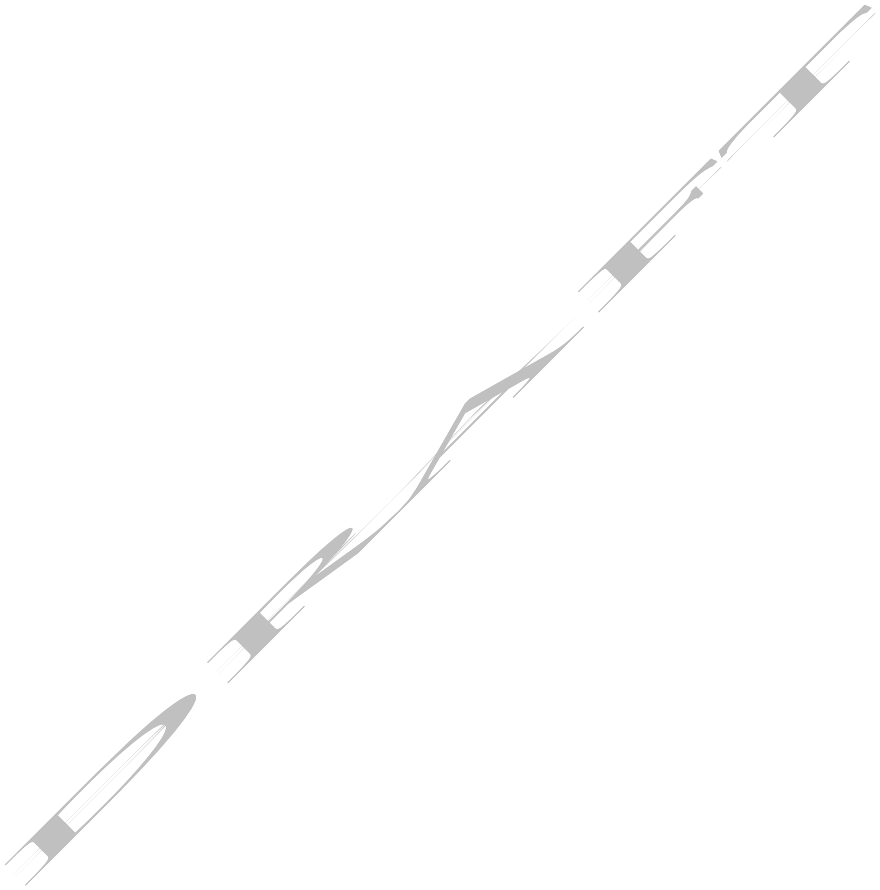
2b. Community Mental Health Center Services: Assertive Community Treatment Staffing Competencies

Community Mental Health Center	Substance Use Disorder Treatment		Housing Assistance		Supported Employment	
	March 2021	December 2020	March 2021	December 2020	March 2021	December 2020
01 Northern Human Services - Wolfeboro	1.27	1.27	5.81	6.30	0.00	0.40
01 Northern Human Services – Berlin	0.74	0.74	3.29	3.29	0.00	0.23
01 Northern Human Services – Littleton	1.43	1.29	2.14	2.14	1.00	1.00
02 West Central Behavioral Health	0.20	0.20	4.00	0.40	0.60	0.60
03 Lakes Region Mental Health Center	1.00	3.00	5.00	7.00	2.00	2.00
04 Riverbend Community Mental Health Center	0.50	0.50	9.40	9.50	0.50	0.50
05 Monadnock Family Services	1.69	1.62	4.56	4.48	0.95	1.18
06 Greater Nashua Mental Health 1	6.15	7.15	5.50	6.50	1.50	1.50
06 Greater Nashua Mental Health 2	5.15	5.15	6.50	6.50	0.50	0.50
07 Mental Health Center of Greater Manchester-CCT	14.47	15.84	13.96	15.62	2.66	2.66
07 Mental Health Center of Greater Manchester-MCST	6.49	7.86	15.29	19.28	1.33	2.66
08 Seacoast Mental Health Center	2.00	2.00	5.00	5.00	1.00	1.00
09 Community Partners	1.20	1.20	4.50	4.50	1.00	1.00
10 Center for Life Management	2.14	2.14	5.42	5.28	0.29	0.29
Total	**44.43**	**49.96**	**90.37**	**99.39**	**13.33**	**15.52**

Revisions to Prior Period: None.

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

Notes: Data compiled 04/26/2021. For 2b: 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, but rather the quantity of staff available to provide each service. If staff are trained to provide multiple service types, their entire FTE value is credited to each service type.



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

Community Mental Health Center	12 Month Period Ending March 2021			Penetration Rate for Period Ending December 2020
	Supported Employment Clients	Total Eligible Clients	Penetration Rate	
01 Northern Human Services	159	1,326	12.0%	12.0%
02 West Central Behavioral Health	100	539	18.6%	22.5%
03 Lakes Region Mental Health Center	624	1,599	39.0%	32.7%
04 Riverbend Community Mental Health Center	259	1,903	13.6%	14.1%
05 Monadnock Family Services	47	1,109	4.2%	3.7%
06 Greater Nashua Mental Health	313	2,777	11.3%	12.3%
07 Mental Health Center of Greater Manchester	1,462	3,605	40.6%	40.1%
08 Seacoast Mental Health Center	844	2,137	39.5%	37.0%
09 Community Partners	109	838	13.0%	13.2%
10 Center for Life Management	232	1,474	15.7%	14.3%
Total Unique Clients	**4,137**	**17,062**	**24.2%**	**23.7%**

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 04/26/2021

3b. Community Mental Health Center Clients: Adult Employment Status – Total

Reported Employment Status Begin Date: 01/01/2021 End Date: 03/31/2021 Employment Status Update Overdue Threshold: 105 days	Northern Human Services	West Central Behavioral Health*	Lakes Region Mental Health Center	Riverbend Community Mental Health	Monadnock Family Services	Greater Nashua Mental Health	Mental Health Center of Greater Manchester	Seacoast Mental Health Center	Community Partners	Center for Life Management	Statewide Total or Mean Percentage	Previous Quarter Statewide Total or Mean Percentage October - December 2020
Updated Employment Status:												
Full time employed now or in past 90 days	61	27	122	118	72	168	290	204	49	136	1,247	**1,120**
Part time employed now or in past 90 days	120	39	396	285	141	283	343	236	77	214	2,134	**2,013**
Unemployed	191	107	50	77	170	887	970	126	237	632	3,447	**3,381**
Not in the Workforce	579	151	492	1060	503	353	633	938	146	166	5,021	**4,863**
Status is not known	4	65	99	31	4	90	23	3	11	49	379	**530**
Total of Eligible Adult CMHC Clients	955	389	1,159	1,571	890	1,781	2,259	1,507	520	1,197	12,228	**11,907**
Previous Quarter: Total of Eligible Adult CMHC Clients	**933**	**385**	**1,097**	**1,552**	**880**	**1,653**	**2,266**	**1,494**	**540**	**1,107**		
Percentage by Updated Employment Status:												
Full time employed now or in past 90 days	6.4%	6.9%	10.5%	7.5%	8.1%	9.4%	12.8%	13.5%	9.4%	11.4%	10.2%	**9.4%**
Part time employed now or in past 90 days	12.6%	10.0%	34.2%	18.1%	15.8%	15.9%	15.2%	15.7%	14.8%	17.9%	17.5%	**16.9%**
Unemployed	20.0%	27.5%	4.3%	4.9%	19.1%	49.8%	42.9%	8.4%	45.6%	52.8%	28.2%	**28.4%**
Not in the Workforce	60.6%	38.8%	42.5%	67.5%	56.5%	19.8%	28.0%	62.2%	28.1%	13.9%	41.1%	**40.8%**
Status is not known	0.4%	16.7%	8.5%	2.0%	0.4%	5.1%	1.0%	0.2%	2.1%	4.1%	3.1%	**4.5%**
Percentage by Timeliness of Employment Status Screening:												
Update is Current	67.3%	0.0%	88.2%	88.4%	71.8%	76.1%	89.5%	92.7%	74.4%	100.0%	82.2%	**83.9%**
Update is Overdue	32.7%	100.0%	11.8%	11.6%	28.2%	23.9%	10.5%	7.3%	25.6%	0.0%	17.8%	**16.1%**
Previous Quarter: Percentage by Timeliness of Employment Status Screening:												
Update is Current	67.8%	22.9%	80.3%	87.4%	63.5%	95.8%	88.8%	91.2%	75.6%	100.0%		
Update is Overdue	32.2%	77.1%	19.7%	12.6%	36.5%	4.2%	11.2%	8.8%	24.4%	0.0%		

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted04/26/2021

**West Central Behavioral Health initiated Electronic Medical Record upgrades and are in the process of working with DHHS to implement a method for the collection of Employment Status data. This explains the high rate of overdue clients under "Timeliness of Employment Status Screening".*

3c. Community Mental Health Center Clients: Adult Employment Status – Recent Users of Supportive Employment Services (At Least One Billable Service in Each of Month of the Quarter)

Supported Employment Cohort Reported Employment Status Begin Date: 01/01/2021 End Date: 03/31/2021	**Northern Human Services**	**West Central Behavioral Health**	**Lakes Region Mental Health Center**	**Riverbend Community Mental Health**	**Monadnock Family Services**	**Greater Nashua Mental Health***	**Mental Health Center of Greater Manchester**	**Seacoast Mental Health Center**	**Community Partners**	**Center for Life Management**	**Statewide Total or Mean Percentage**	**Previous Quarter Statewide Total or Mean Percentage October - December 2020**
Updated Employment Status:												
Full time employed now or in past 90 days	1	2	1	0	0	11	8	0	2	5	30	**28**
Part time employed now or in past 90 days	4	2	14	33	7	22	41	11	8	20	162	**151**
Unemployed	8	7	1	13	1	33	36	8	5	31	143	**112**
Not in the Workforce	11	2	3	8	2	12	8	27	2	3	78	**73**

Status is not known	0	1	0	0	0	5	0	0	0	0	6	**8**
Total of Supported Employment Cohort	24	14	19	54	10	83	93	46	17	59	419	**372**
Previous Quarter: Total of Supported Employment Cohort	**24**	**15**	**28**	**60**	**12**	**-**	**96**	**61**	**27**	**49**		
Percentage by Updated Employment Status:												
Full time employed now or in past 90 days	4.2%	14.3%	5.3%	0.0%	0.0%	13.3%	8.6%	0.0%	11.8%	8.5%	7.2%	**7.5%**
Part time employed now or in past 90 days	16.7%	14.3%	73.7%	61.1%	70.0%	26.5%	44.1%	23.9%	47.1%	33.9%	38.7%	**40.6%**
Unemployed	33.3%	50.0%	5.3%	24.1%	10.0%	39.8%	38.7%	17.4%	29.4%	52.5%	34.1%	**30.1%**
Not in the Workforce	45.8%	14.3%	15.8%	14.8%	20.0%	14.5%	8.6%	58.7%	11.8%	5.1%	18.6%	**19.6%**
Status is not known	0.0%	7.1%	0.0%	0.0%	0.0%	6.0%	0.0%	0.0%	0.0%	0.0%	1.4%	**2.2%**

Revisions to Prior Period: None.

Data Source: Phoenix 2.

Note 3b-c: Data extracted 04/26/2021. Updated Employment Status refers to CMHC-reported status and reflects the most recent update. Update is Current refers to employment status most recently updated within the past 105 days. Update is Overdue refers to employment status most recently updated in excess of 105 days. Actual client employment status may have changed since last updated by CMHC in Phoenix. Employed refers to clients employed in a competitive job that has these characteristics: exists in the open labor market, pays at least a minimum wage, anyone could have this job regardless of disability status, job is not set aside for people with disabilities, and wages (including benefits) are 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 clients not employed but are seeking or interested in employment. Not in the Workforce are clients who are homemakers, students, retired, disabled, hospital patients or residents of other institutions, and includes clients who are in a sheltered/non-competitive employment workshop, are otherwise not in the labor force, and

those not employed and not seeking or interested in employment. Unknown refers to clients with an employment status of "unknown," without a status reported, or with an erroneous status code in Phoenix.

**Greater Nashua Mental Health implemented Electronic Medical Record enhancements that affected the collection of Supported Employment data in the prior quarter; this has since been corrected by their EMR vendor.*

3d. Community Mental Health Center Services: Supported Employment Waiting List

As of 03/31/2021						
	Time on List					
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180+ days**
49	29	6	9	1	2	2
As of 12/21/2021						
Time on List						
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**
26	20	4	2	0	0	0

Data Source: BMHS Report.

Notes: Data compiled 05/06/2021. Individuals waiting are at: LRMHC (46), MFS (1), and CP (2). LRMHC reported loosing multiple SE staff over the last quarter; many clients were receiving SE and had to be added back to the waitlist due to loosing staff. BMHS is working with LRMHC on their staffing challenges.

4a. New Hampshire Hospital: Adult Census Summary

Measure	January – March 2021	October – December 2020
Admissions	165	187
Mean Daily Census	173	173
Discharges	173	191
Median Length of Stay in Days for Discharges	35	32
Deaths	2	0

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4a: 05/05/2021; Mean Daily Census includes patients on leave and is rounded to nearest whole number.

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

Discharge Location	January - March 2021	October - December 2020
CMHC Group Home	5	2
Discharge/Transfer to IP Rehab Facility	15	19
Glencliff Home for the Elderly	2	1
Home - Lives Alone	43	54
Home - Lives with Others	64	78
Homeless Shelter/ No Permanent Home	4	8
Hotel-Motel	5	4
Jail or Correctional Facility	4	4
Nursing Home	3	2
Other	11	6
Peer Support Housing	0	0
Private Group Home	4	1
Secure Psychiatric Unit – SPU	0	0
Unknown	13	12

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

Measure	January – March 2021	October – December 2020
30 Days	3.0% (5)	4.8% (9)
90 Days	8.5% (14)	12.3% (23)
180 Days	13.3% (22)	18.2% (34)

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4b-c: Data compiled 05/05/2021; 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 – once for each readmission; the number in parentheses is the number of readmissions.

5a. Designated Receiving Facilities: Admissions for Adults

Designated Receiving Facility	January – March 2021		
	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	44	32	76
Cypress Center	37	119	156
Portsmouth	93	231	324
Elliot Geriatric Psychiatric Unit	5	29	34
Elliot Pathways	86	70	156
Parkland Regional Hospital	55	147	202
Total	**320**	**628**	**948**
Designated Receiving Facility	**October – December 2020**		
	Involuntary Admissions	**Voluntary Admissions**	**Total Admissions**
Franklin	57	29	86
Cypress Center	39	100	139
Portsmouth	77	255	332
Elliot Geriatric Psychiatric Unit	12	32	44
Elliot Pathways	60	68	128
Parkland Regional Hospital	51	0	51
Total	**296**	**484**	**780**

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

Designated Receiving Facility	January – March 2021	October – December 2020
Franklin	7.7	9.0
Cypress Center	13.7	13.5
Portsmouth	30.3	28.7
Elliot Geriatric Psychiatric Unit	18.6	17.4
Elliot Pathways	14.1	12.7
Parkland Regional Hospital	15.5	4.2
Total	**99.9**	**85.5**

Revisions to Prior Period: None.

5c. Designated Receiving Facilities: Discharges for Adults

Designated Receiving Facility	January – March 2021	October – December 2020
Franklin	76	92
Manchester (Cypress Center)	152	141
Portsmouth	323	335
Elliot Geriatric Psychiatric Unit	28	48
Elliot Pathways	155	130
Parkland Regional Hospital	192	50
Total	**926**	**796**

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

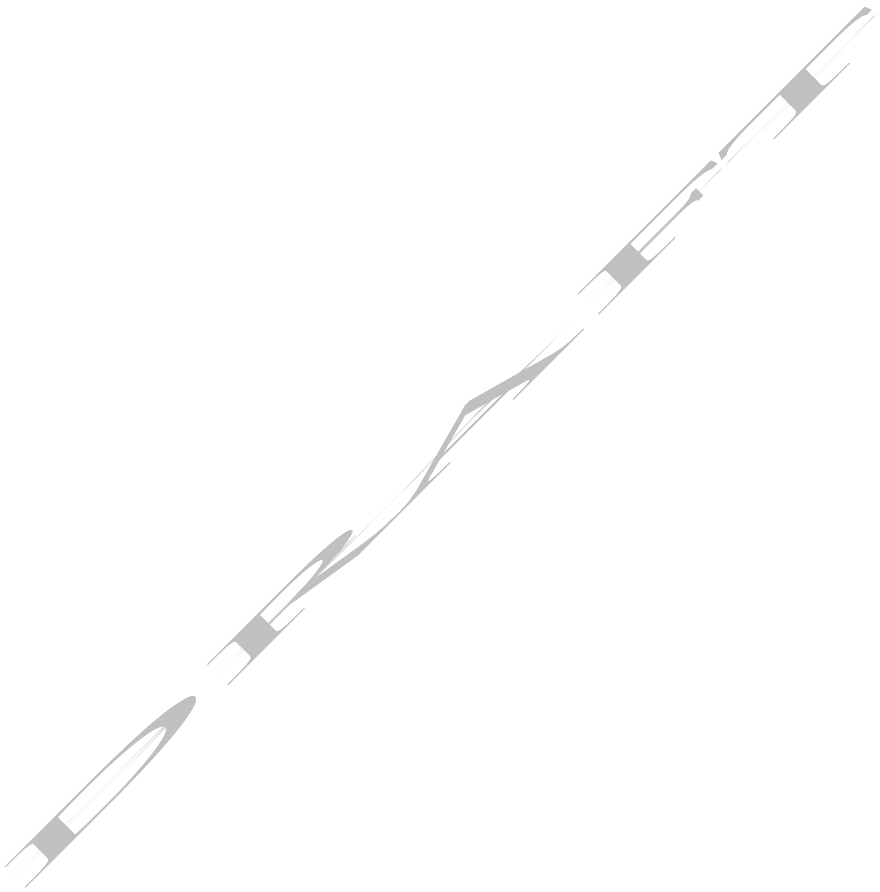
Designated Receiving Facility	January – March 2021	October – December 2020
Franklin	8	7
Manchester (Cypress Center)	6	7
Portsmouth	6	6
Elliot Geriatric Psychiatric Unit	27	23
Elliot Pathways	7	7
Parkland Regional Hospital	5	6
Total	**6**	**7**

5e. Designated Receiving Facilities: Discharge Location for Adults

Designated Receiving Facility	January – March 2021						
	Assisted Living / Group Home	Deceased	DRF*	Home**	Other Hospital	NH Hospital	Other
Franklin	0	0	0	70	0	1	5
Manchester (Cypress Center)	0	0	6	140	0	0	6
Portsmouth Regional Hospital	2	0	0	274	0	6	41
Elliot Geriatric Psychiatric Unit	9	4	3	5	0	0	7
Elliot Pathways	3	0	0	131	0	0	21
Parkland Regional Hospital	0	0	1	176	0	1	14
Total	**14**	**4**	**10**	**796**	**0**	**8**	**94**

Designated Receiving Facility	October – December 2020						
	Assisted Living / Group Home	Deceased	DRF*	Home	Other Hospital	NH Hospital	Other
Franklin	1	0	0	71	0	3	17
Manchester (Cypress Center)	0	0	8	125	0	0	8
Portsmouth Regional Hospital	0	0	0	280	0	0	55
Elliot Geriatric Psychiatric Unit	8	0	0	7	0	0	33
Elliot Pathways	6	0	3	111	0	0	10
Parkland Regional Hospital	0	0	0	47	0	3	0
Total	**15**	**0**	**11**	**641**	**0**	**6**	**123**

**Dispositions to 'DRF' represent a change in legal status from Voluntary to Involuntary within the DRF. **Home includes individuals living with family, living alone, and living with others (non-family).*



5f. Designated Receiving Facilities: Readmission Rates for Adults

Designated Receiving Facility	January – March 2021		
	30 Days	90 Days	180 Days
Franklin	6.6% (5)	6.6% (5)	7.9% (6)
Manchester (Cypress Center)	5.8% (9)	7.7% (12)	10.9% (17)
Portsmouth	8% (26)	13.2% (43)	18.5% (60)
Elliot Geriatric Psychiatric Unit	2.9% (1)	5.9% (2)	5.9% (2)
Elliot Pathways	5.1% (8)	10.9% (17)	13.5% (21)
Parkland Regional Hospital	5.9% (12)	7.4% (15)	8.4% (17)
Total	**6.4% (61)**	**9.9% (94)**	**13.0% (123)**
Designated Receiving Facility	**October – December 2020**		
	30 Days	**90 Days**	**180 Days**
Franklin	6.7% (6)	11.2% (10)	14.6% (13)
Manchester (Cypress Center)	4.3% (6)	7.9% (11)	12.9% (18)
Portsmouth	9.3% (31)	15.6% (52)	20.7% (69)
Elliot Geriatric Psychiatric Unit	9.1% (4)	13.6% (6)	15.9% (7)
Elliot Pathways	6.3% (8)	12.5% (16)	14.1% (18)
Parkland Regional Hospital	7.8% (4)	9.8% (5)	9.8% (5)
Total	**7.5% (59)**	**12.8% (100)**	**16.6% (130)**

Revisions to Prior Period: None.

Data Source: NH DRF Database.

Notes: Data compiled 05/10/2021.

6. Glencliff Home: Census Summary

Measure	January – March 2021	October – December 2020
Admissions	3 (including 1 readmission)	2
Average Daily Census	111	115
Discharges	1	0
Individual Lengths of Stay in Days for Discharges	802	NA
Deaths	4	4
Readmissions	1	0
Mean Overall Admission Waitlist	41	34

Revisions to Prior Period: None.

Data Source: Glencliff Home.

Notes: Data Compiled 05/06/2021; Mean 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.

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6b. Glencliff Home: In-reach Services Performance Outcomes and Measures

Outcomes and Measures:	January – March 2021		October – December 2020	
	Residents	Activities	Residents	Activities
Residents have better awareness of community-based living benefits as evidenced by:				
Residents that attended service array and supports group presentations	0*	0*	0*	0*
Residents that met with In-Reach Liaison regarding resident-specific needs, service array and supports	15	29	22	27
Residents are better prepared to return to community-based living as evidenced by:				
Residents that participated in shared-learning regarding integrated community-based living values	0*	0*	0*	0*
Residents that met with In-Reach Liaison and others regarding community-based living and strategies	12	16	7	10
Community stakeholders and providers are better prepared to participate and collaborate in transition planning activities and to provide needed community-based services to residents seeking to return to community-based living as evidenced by:				
Participated in resident-specific transition discussions with In-Reach Liaison**	11	21	10	12
Participated in meetings with resident, In-Reach Liaison, and others regarding opportunities for community-based living	9	28	13	18

Revisions to Prior Period: None.

Data Source: BMHS.

*Notes: Data Compiled 06/28/2021. Counts of residents are unduplicated per each measure; a resident may be involved in more than one activity during the reporting period. Counts of activities are unduplicated. *Indicates measures that involve activities temporarily suspended due to COVID-19 protocols at Glencliff Home. **The In-Reach Liaison also meets monthly with*

all CMHCs regarding housing needs. In-Reach activities have involved working with 9 of the 10 CMHCs on resident-specific cases thus far.

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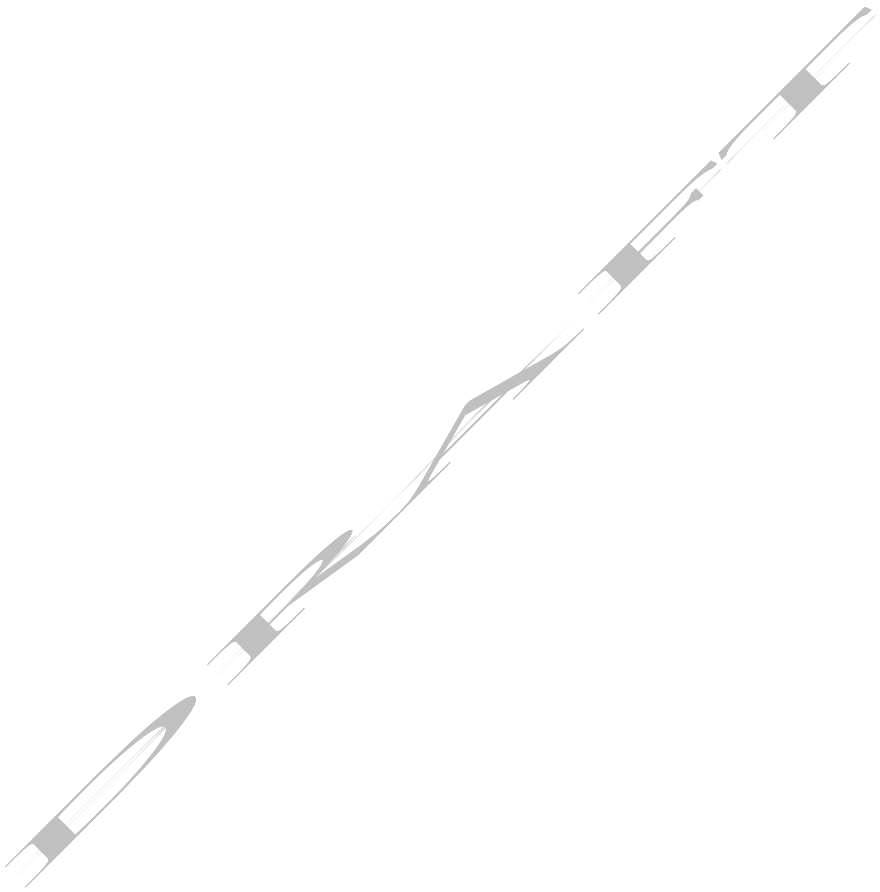
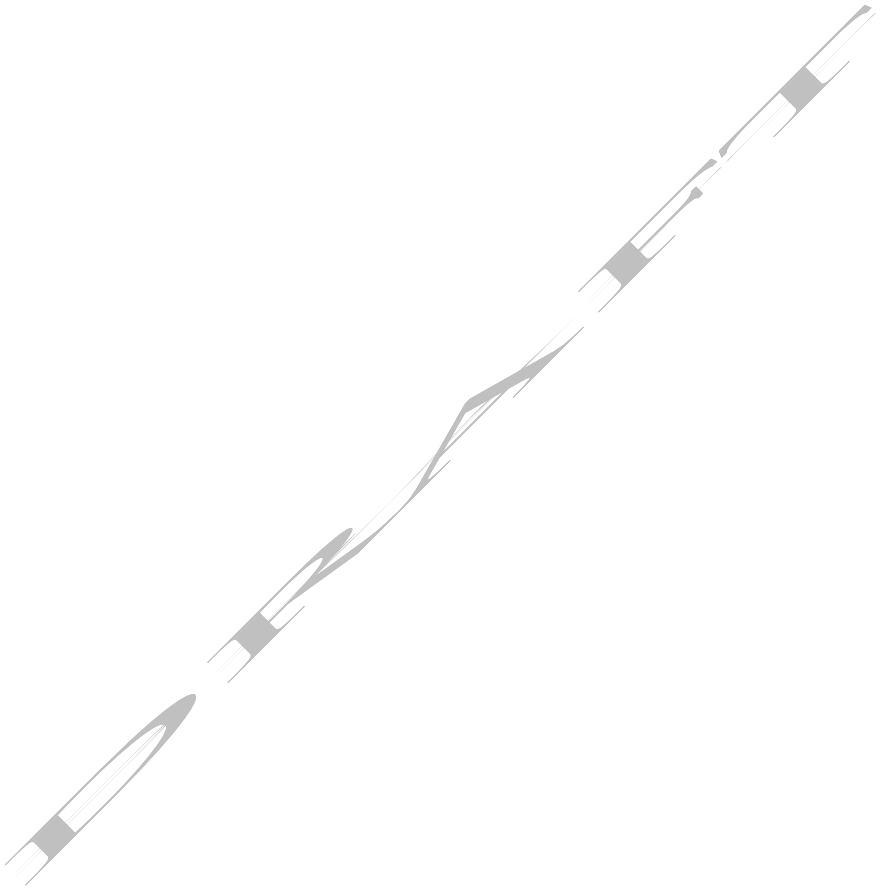


7. NH Mental Health Client Peer Support Agencies: Census Summary



Peer Support Agency	January – March 2021		October – December 2020	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
Alternative Life Center Total	**622**	**25**	**614**	**28**
Conway	271	5	271	6
Berlin	143	6	137	7
Littleton	90	6	89	6
Colebrook	118	8	117	9
Stepping Stone Total	**368**	**6**	**366**	**7**
Claremont	249	5	248	6
Lebanon	119	1	118	1
Cornerbridge Total	**368**	**6**	**141**	**11**
Laconia	249	5	53	5
Concord	119	1	73	3
Plymouth Outreach	15	0	15	3
MAPSA Keene Total	**340**	**19**	**339**	**14**
HEARTS Nashua Total	**391**	**36**	**386**	**50**
On the Road to Recovery Total	**165**	**12**	**149**	**10**

Peer Support Agency	January – March 2021		October – December 2020	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
Manchester	93	5	83	4
Derry	72	7	66	6
Connections Portsmouth Total	**108**	**7**	**101**	**5**
TriCity Coop Rochester Total	**282**	**7**	**277**	**8**
Total	**2,644**	**106**	**2,373**	**123**

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services and Peer Support Agency Quarterly Statistical Reports.

Notes: Data Compiled 05/11/2021. Average Daily Visits are not applicable for Outreach Programs.

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8. Housing Bridge Subsidy Program: Summary of Individuals Served to Date

Subsidy	January – March 2021 Total individuals served at start of quarter	New individuals added during quarter	Total individuals served through end of quarter
Housing Bridge Subsidy	1016	40	1056
Section 8 Voucher (NHHFA/BMHS) - Transitioned from Housing Bridge	212	21	233
Subsidy	**October – December 2020** **Total individuals served at start of quarter**	**New individuals added during quarter**	**Total individuals served through end of quarter**
Housing Bridge Subsidy	979	37	1,016
Section 8 Voucher (NHHFA/BMHS) - Transitioned from Housing Bridge	198	14	212

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

Notes: Data Compiled 4/19/21. Figures at start and end of each quarter are a cumulative total of individuals served since CMHA quarterly reporting began in 2015. Figures for new individuals reflect activity throughout the quarter; these are not a point-in-time count at the end of the reporting period. New individuals added includes individuals newly approved for HBSP funding that have or have not yet secured an HBSP unit, some of whom may have also exited the program in the quarter. These individuals have been on the HBSP waitlist prior to funding approved in the quarter or have newly applied for and been approved for funding in the same quarter.

8a. Housing Bridge Subsidy Program: Current Census of Units/Individuals with Active Funding Status

Measure	As of 03/31/2021	As of 12/31/2020
Rents Currently Being Paid	306	300
Individuals Enrolled and Seeking Unit for Bridge Lease	104	96
Total	**410**	**396**

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

Notes: Data Compiled 4/19/21. All individuals currently on the HBSP are intended to transition from the program to other permanent housing. Individuals seeking a unit include people who have not secured their first unit under HBSP and people who secured a unit previously and are seeking a different unit.

8b. Housing Bridge Subsidy Program: Clients Linked to Mental Health Care Provider Services

Measure	As of 03/31/2021	As of 12/31/2020
Housing Bridge Clients Linked	375/410 (91.5%)	356/396 (90%)

Revisions to Prior Period: None.

Data source: Bureau of Mental Health Services data, Phoenix 2, and Medicaid claims.

Notes: Data compiled 4/19/21; "Housing Bridge Clients Linked" refers to Housing Bridge clients who received one or more mental health services within the previous 3 months, documented as a service or claim data found in Phoenix or the Medicaid Management Information System.

8c. Housing Bridge Subsidy Program: Density of HBSP Funded Units at Same Property Address*

Number of HBSP Funded Unit(s)* at Same Address	Frequency as of 03/31/2021	Frequency as of 12/31/2020
1	234	242
2	22	18
3	4	3
4	1	0
5	1	0
6	0	1
7	1	1
8 or more	0	0

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services and Housing Provider Data.

Notes: Data Compiled 4/19/21. *All units are individual units; property address may include multiple buildings, such as apartment complexes.

8d. Housing Bridge Subsidy Program: Applications

Measure	January – March 2021	October – December 2020*
Applications Received During Period	41	25
Point of Contact for Applications Received	*38 CMHCs; 2 NHH; 1 NFI*	*22 CMHCs; 3 NHH*
Applications Approved	41	25
Applications Denied	0	0
Denial Reasons	*n/a*	*NA*
Applications in Process at End of Period	0	0

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services.

*Notes: Data Compiled 4/19/21. *Data reflects only those applications that were received during the quarter and no longer reflect carryover data from applications received in prior quarters.*

8e. Housing Bridge Subsidy Program: Terminations

Type and Reason	January – March 2021	October – December 2020
Terminations – DHHS Initiated	0	0
Exited Program – Client Related Activity	33	46
Voucher Received	24	26
Deceased	1	5
Over Income	0	0
Moved Out of State	0	1
*Declined Subsidy at Recertification**	5	7
Higher Level of Care Accessed	0	3

Other Subsidy Provided	0	0
Moved in with family	3	2
Declined to receive subsidy	0	2
Total	**33**	**46**

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

*Notes: Data Compiled 4/19/21. This table only includes individuals who were receiving an HBSP subsidy or who had HBSP funding approved and were seeking a unit prior to exiting the program. *Includes all refusals, including refusal to initiate voucher and unable to contact.*

8f. Housing Bridge Subsidy Program: Application Processing Times

Average Elapsed Time of Application Processing (calendar days)	January – March 2021	October – December 2020
Completed Application to Determination	1	1
Approved Determination to Funding Availability*	61	95
Referred to Vendor with Funded HB Slot	1	1
Leased Unit Secured	1	77

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services.

*Notes: Data Compiled 4/19/21. *Based on the 40 individuals who entered the program.*

9. Housing Bridge Subsidy Program Waitlist: Approved Applications

As of 03/31/2021							
Time on List							
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**	**181+ days**
41	24	2	2	1	0	0	12
As of 12/31/2020							
Time on List							

Total	0-30 days	31-60 days	61-90 days	91-120 days	121-150 days	151-180 days	181+ days
28	1	0	4	3	4	4	12

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

Notes: Data Compiled 4/19/21.

9a. Housing Bridge Subsidy Program Waitlist: Reason Administratively Removed from Waitlist

Type and Reason	January – March 2021	October – December 2020
Moved to different state	0	3
Moved in with family	0	2
Received PRA811 voucher	0	3
Received Mainstream 811 voucher	0	2
Received other permanent housing voucher	0	1
Required higher level of care	3	5
Required DOC interventions, not ready for HBSP	3	3
Moved into a sober living facility	2	
Owns own home, not eligible at time of pull	1	
Unable to locate or contact	3	
Total	**12**	**22**

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

Notes: Data Compiled 4/19/21.

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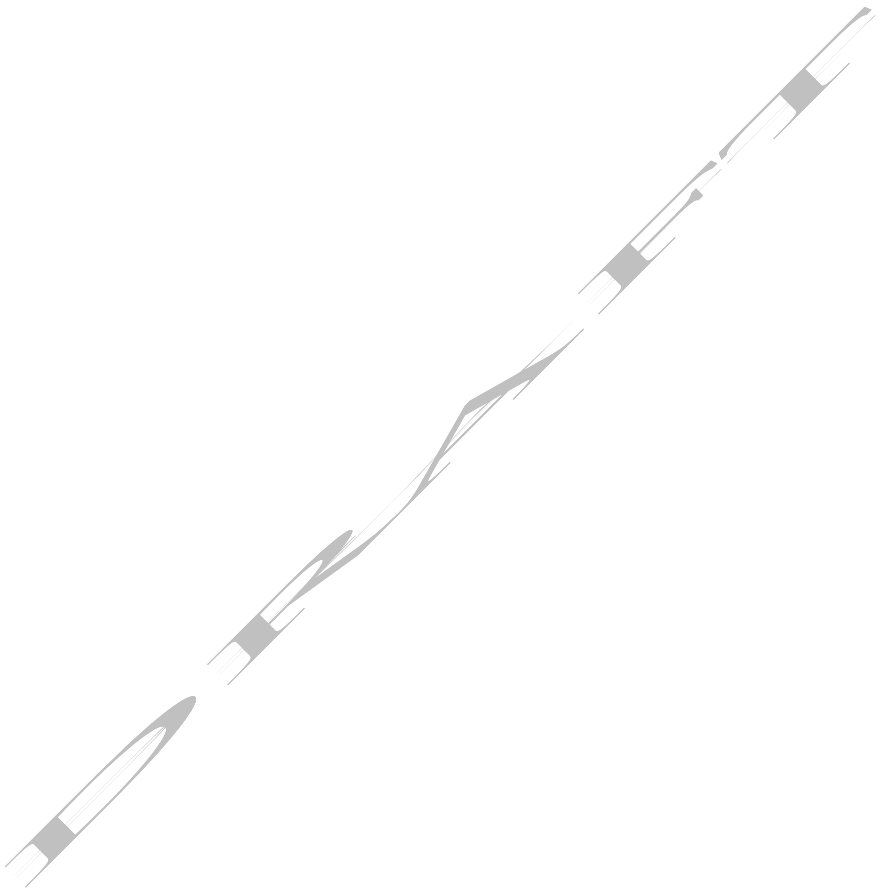

10. Supported Housing Subsidy Summary

Subsidy		January – March 2021 Total subsidies by end of quarter	October – December 2020 Total subsidies by end of quarter
Housing Bridge Subsidy:	Units Currently Active	306	300
	Individuals Enrolled and Seeking Unit for Bridge Lease	104	96
Section 8 Voucher (NHHFA):	Transitioned from Housing Bridge*	233	212
	Not Previously Receiving Housing Bridge	0	0
811 Units:	PRA*	121	114
	Mainstream*	74	74
Other Permanent Housing Vouchers (HUD, Public Housing, VA)*		8	2
Total Supported Housing Subsidies		**846**	**798**

Revisions to Prior Period: Total from previous quarter was calculated wrong. Number should be 802 not 733 listed in report.

Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

Notes: Data Compiled 4/19/21. Section 8 Voucher Not Previously Receiving Housing Bridge are CMHC clients that received a Section 8 Voucher without previously receiving a Housing Bridge subsidy. 811 Units (PRA and Mainstream) are CMHC clients or CMHA target population members that received a PRA or Mainstream 811 funded unit with or without previously receiving a Housing Bridge subsidy. Other Permanent Housing Vouchers (HUD, Public Housing, VA) are CMHC clients that received a unit funded through other HUD or Public Housing sources with or without previously receiving a Housing Bridge subsidy.

**These counts are cumulative; increasing over time since originally reporting this data within the CMHA Quarterly Data Report.*

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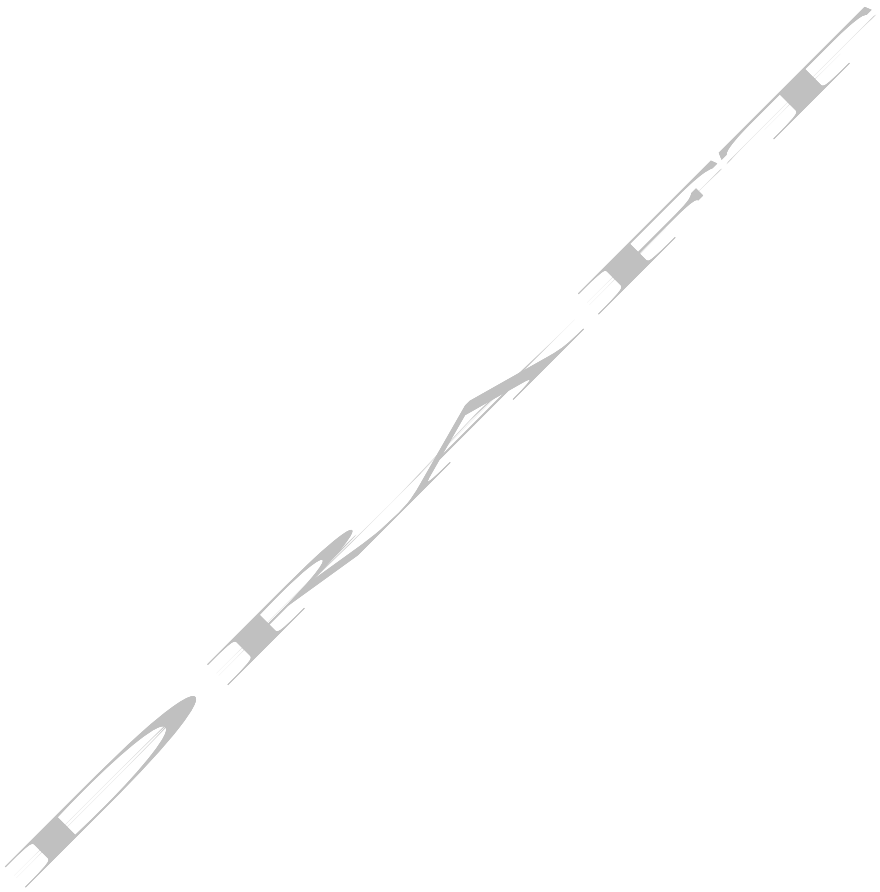


11a. Mobile Crisis Services and Supports for Adults: Riverbend Community Mental Health Center

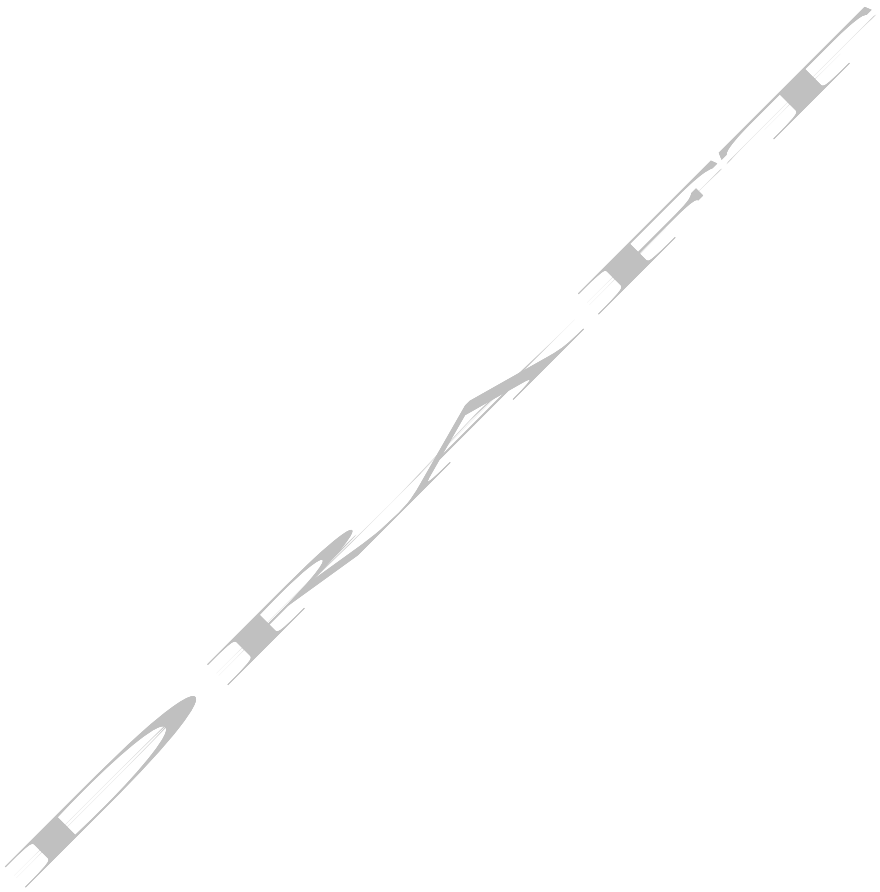
Measure	January 2021	February 2021	March 2021	Jan. – Mar. 2021	Oct. – Dec. 2020
Unique People Served in Month	183	164	192	429	462
Services Provided by Type					
Case Management	0	0	0	0	0
Crisis Apartment Service	54	34	44	132	97
Crisis Intervention Services	0	0	0	0	24
ED Based Assessment	0	0	0	0	0
Medication Appointments or Emergency Medication Appointments	0	0	0	0	0
Mobile Community Assessments*	5	1	4	10	110
Office-Based Urgent Assessments*	55	52	60	167	54
Other	0	0	0	0	0
Peer Support	97	68	103	268	328
Phone Support/Triage	376	306	281	963	980
Psychotherapy	0	0	0	0	0
Referral Source					
CMHC Internal	3	3	1	7	33
Emergency Department	9	2	8	19	40
Family*	12	6	11	29	72

Friend	0	3	1	4	10
Guardian*	0	0	0	0	101
MCT Hospitalization	0	0	0	0	0
Mental Health Provider	16	19	24	59	26
Other	6	4	4	14	29
Police	1	0	1	2	16
Primary Care Provider	3	4	2	9	29
Self	158	112	153	423	394
School	3	1	5	9	21
Crisis Apartment*					
Apartment Admissions	2	7	9	18	26
Apartment Bed Days	6	28	44	78	81
Apartment Average Length of Stay	3.0	4.0	4.0	4.3	3.1
Law Enforcement Involvement	1	0	1	2	16
Hospital Diversions Total*	80	73	95	248	525

Revisions to Prior Period: None.

Notes: Data Compiled 04/26/2021. Reported values, other than Unique People Served in Month, are not de-duplicated at the individual level; individuals can account for multiple instances of service use, hospital diversions, etc.

**In January 2021, the provider began transitioning its mobile crisis data reporting from manual to Phoenix. An "*" indicates areas of active data quality improvement being monitored by DHHS. Counts are anticipated to normalize over the next few quarters.*



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

Measure	January 2021	February 2021	March 2021	Jan. – Mar. 2021	Oct. – Dec. 2020
Unique People Served in Month	284	301	358	712	658
Services Provided by Type					
Case Management	49	30	55	134	176
Crisis Apartment Service	0	0	0	0	0
Crisis Intervention Service	273	233	242	748	760
ED Based Assessment	0	0	0	0	0
Medication Appointments or Emergency Medication Appointments	8	6	5	19	28
Mobile Community Assessments	91	106	110	307	312
Office-Based Urgent Assessments	9	3	16	28	30
Other*	228	239	342	809	643
Peer Support	19	12	9	40	36
Phone Support/Triage	591	670	780	2,041	1,703
Psychotherapy	1	2	3	6	11
Referral Source					
CMHC Internal	2	3	4	9	13
Emergency Department	0	0	0	0	1

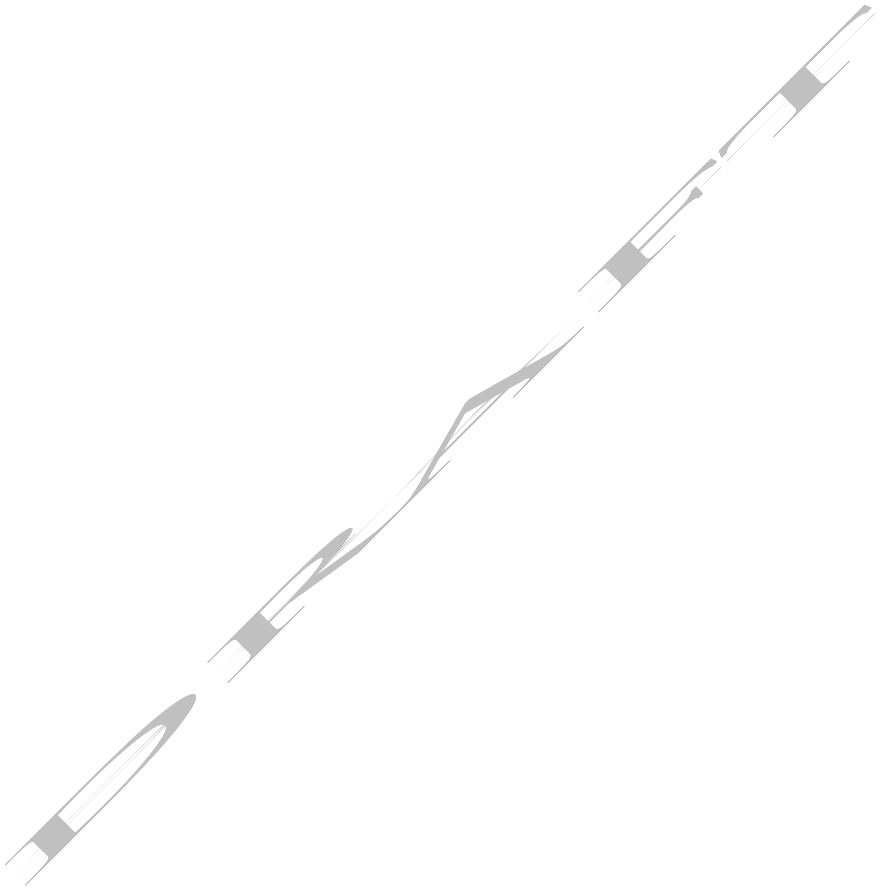
Family	60	58	50	168	149
Friend	11	11	2	24	12
Guardian	19	12	22	53	41
MCT Hospitalization	8	10	14	32	12
Mental Health Provider	15	16	19	50	35
Other	30	17	27	74	71
Police	55	59	100	214	232
Primary Care Provider	12	11	18	41	39
Self	134	154	172	460	353
School	4	4	11	19	16
Crisis Apartment**					
Apartment Admissions	0	0	0	0	0
Apartment Bed Days	0	0	0	0	0
Apartment Average Length of Stay	0.0	0.0	0.0	0.0	0.0
Law Enforcement Involvement	55	59	100	214	232
Hospital Diversion Total	346	357	417	1,120	961

Revisions to Prior Period: None.

Data Source: Phoenix 2.

Notes: Data Compiled 05/05/2021. Reported values, other than Unduplicated People Served in Month, are not de-duplicated at the individual level; individuals can account for multiple instances of service use, hospital diversions, etc.

**Other is an MHCGM closing code and indicates people coming out of the MCRT. **The crisis apartments re-opened April 19, 2021.*



11c. Mobile Crisis Services and Supports for Adults: Greater Nashua Mental Health / Harbor Care

Measure	January 2021	February 2021	March 2021	Jan. – Mar. 2021	Oct. – Dec. 2020*
Unique People Served in Month					44
Services Provided by Type					
Case Management					2
Crisis Apartment Service					13
Crisis Intervention Services					0
ED Based Assessment					5
Medication Appointments or Emergency Medication Appointments					0
Mobile Community Assessments					12
Office-Based Urgent Assessments					3
Other					0
Peer Support					6
Phone Support/Triage					37
Psychotherapy					2
Referral Source					
CMHC Internal					1
Emergency Department					0
Family					9

Not Available**

Friend		1
Guardian		0
MCT Hospitalization		0
Mental Health Provider		0
Other		6
Police		0
Primary Care Provider		0
Self		26
Schools		4
Crisis Apartment		
Apartment Admissions		0
Apartment Bed Days		0
Apartment Average Length of Stay		0.0
Law Enforcement Involvement		0
Hospital Diversion Total		57

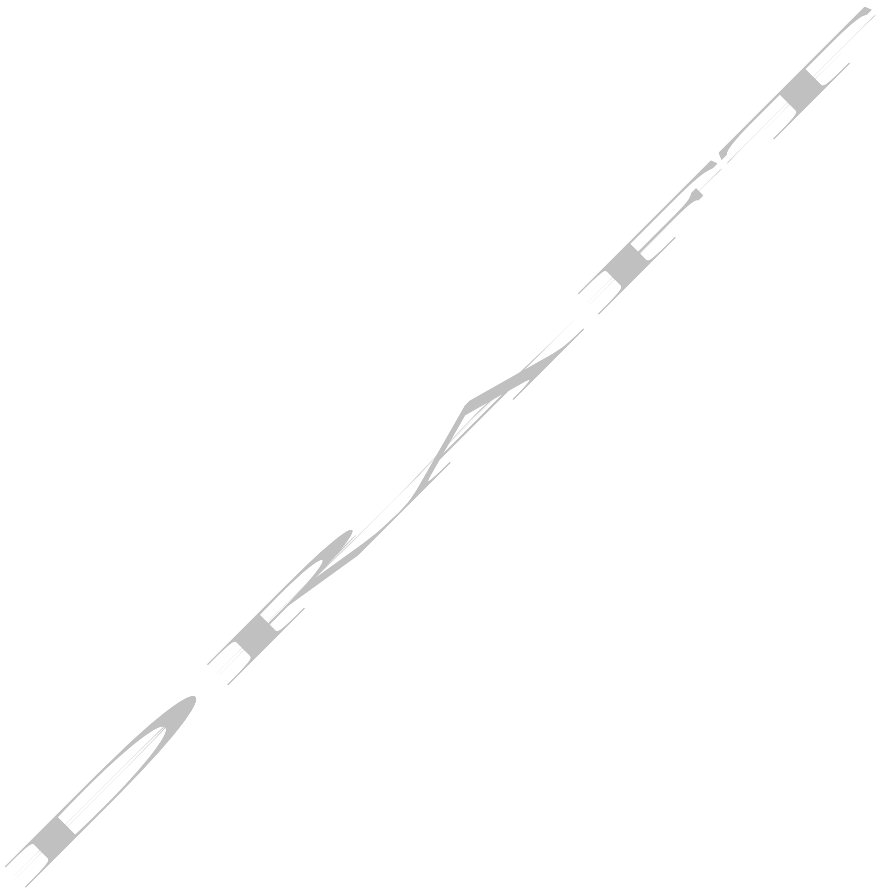
Revisions to Prior Period: None.

Data Source: Harbor Homes submitted data.

Notes: Data Compiled Not Applicable. Reported values other than the Unique People Served in Month value are not de-duplicated at the individual level; individuals can account for multiple instances of service use, hospital diversions, etc.

**Harbor Care Program ended October 31, 2020; therefore, there is no data available for the months of November 2020, December 2020. **Greater Nashua Mental Health became the*

provider November 1, 2020; data reporting for services has not yet been fully implemented, although services are being provided.



Appendix B

QSR Summary Scores:

State Fiscal Year 2021

		Region 1 NHS	Region 2 WCBH	Region 3 LRMHC	Region 4 RMHC	Region 5 MFS	Region 6 GNMHC	Region 7 MHCGH	Region 8 SMHC	Region 9 CP	Region 10 CLM	STATE AVERAGE
1	Adequacy of Assessment	99%	93%	95%	94%	97%	90%	86%	99%	97%	97%	95%
2	Appropriateness of treatment planning	94%	95%	91%	93%	85%	92%	93%	96%	95%	91%	92%
3	Adequacy of individual service delivery	93%	90%	93%	94%	79%	92%	88%	96%	86%	87%	90%
4	Adequacy of Housing Assessment	100%	90%	86%	100%	100%	100%	94%	100%	100%	100%	97%
5	Appropriate of Housing Treatment Plan	94%	95%	82%	100%	88%	80%	94%	84%	95%	94%	91%
6	Adequacy of individual housing service delivery	94%	85%	95%	91%	85%	88%	87%	88%	93%	85%	89%
7	Effectiveness of Housing supports provided	87%	85%	92%	88%	91%	92%	84%	88%	89%	85%	88%
8	Adequacy of employment assessment/screening	100%	76%	74%	94%	94%	98%	75%	100%	92%	78%	88%
9	*Appropriateness of employment treatment planning	75%	62%	73%	83%	71%	60%	75%	100%	88%	83%	77%
10	*Adequacy of individual employment service delivery	72%	73%	81%	71%	78%	78%	61%	86%	71%	82%	75%
11	Adequacy of Assessment of social and community integration needs	100%	97%	100%	100%	100%	100%	94%	100%	100%	100%	99%
12	Individual is integrated into his/her community, has choice, increased independence, and adequate social supports	84%	84%	86%	84%	81%	83%	80%	86%	80%	84%	83%
13	*Adequacy of Crisis Assessment	83%	75%	95%	96%	91%	96%	85%	93%	83%	88%	89%
14	Appropriateness of crisis plans	91%	93%	91%	97%	91%	98%	92%	92%	82%	97%	92%
15	*Comprehensive and effective crisis service delivery	92%	69%	80%	74%	88%	87%	85%	75%	60%	81%	79%
16	Adequacy of ACT Screening	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
17	*Implementation of ACT Services	83%	77%	82%	72%	83%	94%	73%	89%	63%	83%	80%
18	*Successful transition/discharge from the inpatient psychiatric facility	75%	90%	76%	90%	80%	86%	77%	83%	79%	73%	81%
	AVERAGE	**90%**	**85%**	**87%**	**90%**	**88%**	**90%**	**85%**	**92%**	**86%**	**88%**	**88%**

* Indicators that typically have a lower N than the total interviewed sample. This is due to not all individuals having the related need, experience, or service provision as is relevant to the indicator and its measures.