New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Fifteen

January 25, 2021

I. Introduction

This is the fifteenth 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 two years, 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 meets 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, and staffing requirements, to insure that, to the extent possible, service response rates and service continuity are maintained.

During this period, the ER:

- Conducted a one-day on-site review to follow up on transition planning and in-reach activities at Glencliff;
- Conducted a one-day on-site review at NHH to review records of individuals who transitioned to nursing facilities and community residential programs;
- Conducted an on-site visit with leadership at NHH to follow-up on information from the record reviews;
- Participated in an on-site briefing with DHHS staff relative to the Federal 811 program;
- Participated in a ZOOM conference call to discuss the Preadmission Screening and Resident Review (PASRR) process and data reports;
- Observed an Assertive Community Treatment (ACT) Fidelity Review at the Greater Nashua Mental Health (GNMH);
- Observed a Supported Employment (SE) Fidelity Review at the Riverbend Mental Health Center in Concord;
- Participated in an on-site visit with State officials and leadership of 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 a remote all-parties meeting.

Summary of Progress to Date

This report reflects over 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. These include continuing non-compliance related to ACT and facility-based transition planning.

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 accomplishment has been contracting with the Dartmouth-Hitchcock Medical Center (DHMC) to conduct external ACT and 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. On-site fidelity reviews were not conducted for a period of time during the COVID-19 pandemic, commenced again by June 2021. During the pandemic the State and the CMHCs used Evidence-Based Practice (EBP) checklists, DHMC consults, and record reviews to monitor and support fidelity to ACT and SE best practice

standards. The State 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. In recent months, the State and the DHMC fidelity review team have resumed the on-site fidelity reviews.

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 almost three years ago. The ER was approved by the parties and the Court, effective July 1, 2014, and the five-year anniversary of that occurred 30 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.

Data

Appendix A contains the most recent DHHS Quarterly Data Report (April 2021 through June 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.

II. 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 MCT¹ 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/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, GNMH, which is in the process of implementing the program.

As of the date of this report, the State reports that it has established new contracts with the existing MCT/Crisis Apartment programs 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 outcomes. The ER will monitor implementation of these new requirements over the next sixmonth period.

The ER visited the site of the Nashua MCT offices and crisis apartments on May 7, 2021, and again on December 9, 2021. The newly renovated program site is now open, and program staff moved into the space in mid-September of this year. GNMH leadership report that the call center and mobile team staffing is complete for all shifts, and that peer staff are available for both the mobile teams and the crisis apartments. The crisis apartments were ready for occupancy, but as of December 9, 2021 there had been no admissions to the units. As is evident in the most recent Quarterly Data Report where Nashua crisis data is incomplete, the MCT/Crisis Apartment program in Nashua is not yet fully operational and is still in the early stages of growing service volume as compared to Manchester and Concord MCT/Crisis Apartment programs. Therefore, it is not possible to conclude that the State is in compliance with its obligations to provide crisis services, including crisis apartments, in the Nashua region.

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

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.

² Due to data reporting migration to a new platform, the 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 June 2021

Region	Variable	Oct -Dec 2020	Jan - Mar 2021	April-June 2021
Concord	Total Served	462	429	450
Manchester	Total Served	658	712	733
Nashua	Total Served	44	NA	195
Concord	Phone triage/support	980	963	826
Manchester	Phone triage/support	1,703	2,041	1,902
Nashua	Phone triage/support	37	NA	947
Concord	Mobile Assess./intervention Mobile	110	10	57
Manchester	Assess./intervention	312	307	282
Nashua	Mobile Assess./intervention	3	NA	90
		F4 400/	72.600/	64.700/
Concord	Percent Referred by self	51.10%	73.60%	64.70%
Manchester	Percent Referred by self	36.20%	40.20%	44.70%
Nashua	Percent Referred by self	55.30%	NA	15.90%
Concord	Percent referred by police	2.10%	0.35%	1.70%
Manchester	Percent referred by police	33.20%	18.70%	18.4%
Nashua	Percent referred by police	0.00%	NA	12.50%
Concord	Percent Law Enforcement Inv.	3.50%	0.47%	5.60%
Manchester	Percent Law Enforcement Inv.	35.30%	30.10%	28.10%
Nashua	Percent Law Enforcement Inv.	0.00%	NA	5.60%
Concord	Hospital diversions	525	248	312
Manchester	Hospital diversions	961	1,120	1,094
Nashua	Hospital diversions	57	NA	79

Concord	Apartment Admits	26	18	15
Manchester	Apartment Admits	0	0	7
Nashua	Apartment Admits	0	NA	0
Concord	Apartment bed days	81	78	169
Manchester	Apartment bed days	0	0	34
Nashua	Apartment bed days	0	NA	0

Table I shows evidence of the effects of COVID restrictions on the operations of MCT/Crisis Apartment programs. The low number of Crisis Apartment admissions and bed days reported by Manchester is one example of this. As referenced above, as of the date of this report, there have been no MCT/Crisis Apartment admissions 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, and these will be monitored in the next six month period.

The State funded a new Behavioral Health Crisis Treatment Center (BHCTC) 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 are not included in this report and has not been provided to the ER 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 improvements in 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. Indeed, the number of adult beds at NHH, and especially the number of admissions to NHH, have increased in the past year. Quarterly NHH admissions have increased almost 100 percent to 326 in the July-September 2021 period, from 165 in the January-March 2021 period, likely the result of the State converting the NHH children's unit to an adult acute care unit with greater bed capacity.

Table II

DHHS Report on the Number Waiting for Inpatient Psychiatric Admission, 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
10/1/2019-	31	867	27.9%
9/30/2020			
10/1/2020-	35	964	17.4%
9/30/2021			
Change	Up 12.9%	Up 11.2%	Down 37.6%

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 - June 2021

Region	FTE						
	Dec-	Mar-		Sep-			
	19	20	Jun-20	20	Dec-20	Mar-21	Jun-21
Northern							
Wolfeboro					8.27	6.81	7.00
Northern Berlin					4.17	3.94	5.43
Northern Littleton					3.31	3.28	3.44
West Central	8.75	6.10	6.10	5.00	5.90	5.40	5.60
Lakes Region	7.00	7.00	6.50	6.40	7.00	5.00	6.00
Riverbend	11.50	10.50	10.50	9.00	10.50	10.40	10.50
Monadnock	8.75	8.85	8.85	11.58	10.32	11.17	7.70
Greater Nashua 1	8.00	6.50	8.00	8.50	8.50	7.65	8.00
Greater Nashua 2	8.00	7.50	8.00	8.50	8.50	8.65	8.00
Manchester - CTT	15.75	18.25	18.25	16.25	21.61	19.95	20.28
Manchester MCST	15.75	16.25	17.25	18.25	25.27	19.95	19.86
Seacoast	10.10	9.10	9.10	9.00	10.10	10.10	10.10
Community Part.	10.80	11.05	9.20	8.95	7.41	7.28	9.78
CLM	9.55	8.55	8.30	7.30	6.57	6.71	8.28
Total	130.92	127.02	123.41	123.85	137.43	126.29	129.97

Four of the 14 teams report having fewer than the required minimum of seven FTEs to qualify as an ACT team³. Three teams report having no peer support specialist. Three teams report having no SE staff capacity. Four teams report having SUD treatment staff capacity of less than one FTE. Three 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. As documented above, a majority of the ACT teams does not meet one or more of 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 decreased by 55 participants since December 2020, and since June of 2017, the active monthly caseload has dropped by 97 participants. The ER will monitor to see if the decrease in active ACT caseload is related to the increase in admissions to NHH.

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³ Two of these, Northboro Wolfeboro and Northern Littleton, are considered by the State to be "mini-teams" with staffing expectation of 5 FTE rather than 7FTE.

Table IV
Self-Reported ACT Active Caseload (Unique Adult Consumers) by Region in Specified
Months: June 2017 to June 2021

Region	Active						
	Cases						
	Jun-	Mar-					
	17	20	Jun-20	Sep-20	Dec-20	Mar-21	Jun-21
Northern	111	115	117	121	121	124	110
West Central	76	42	57	43	44	60	42
Lakes Region	74	57	54	52	55	59	58
Riverbend	97	94	95	91	97	94	99
Monadnock	70	51	50	47	45	45	43
Greater Nashua	94	101	105	107	131	130	116
Manchester	292	262	254	265	259	254	240
Seacoast	69	66	69	74	80	80	80
Community							
Part.	69	68	70	72	63	73	77
CLM	55	47	48	49	46	45	44
Total*	1,006	903	919	920	941	964	909

The CMHA requires the State have the capacity to serve 1,500 individuals with ACT services "at any given time." As of June 2021, the combined ACT teams had a reported staff complement of 129.97 FTEs excluding psychiatry, which is sufficient capacity to serve only 1,300 individuals based on the ACT non-psychiatry staffing ratios contained in the CMHA, a capacity 200 less than required by the CMHA. With a statewide caseload of 909, as of June 2021, there is a 391-participant gap between actual reported staff capacity and actual active participants, and a 591-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. All 14 teams have unused ACT staff capacity.

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 clients⁵ who may qualify for and benefit from ACT.

Table V below presents data on ACT screens conducted by CMHCs between January and March. 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
January to March 2021
(Retrospective Analysis)

	` 1	ective Analys		
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	1,137	23	3	13%
02 West Central Behavioral Health	112	2	1	50.0%
03 Lakes Region Mental Health Center	808	4	2	50.0%
04 Riverbend Community Mental Health Center	1,451	0	0	0.00%
05 Monadnock Family Services	609	3	0	0.00%
06 Greater Nashua Mental Health	614	4	1	25.0%
07 Mental Health Center of Greater Manchester	1,687	15	2	13.3%
08 Seacoast Mental Health Center	1,495	25	0	0.00%
09 Community Partners	232	2	2	100.%
10 Center for Life Management	1,173	3	1	33.3%
Total	9,318	81 (0.87% of all screened)	12 (14.81% of all assessed after screening- 0.13% of all screened)	

Of the 9,318 unique individuals screened for ACT during this three-month period, the State reports that 81 were referred for an ACT assessment. This is a referral rate of less than one percent, and only very slightly improved from the previous report. Almost 15 percent (12 individuals) of those referred for ACT assessments were 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 80 percent of individuals are linked to ACT without having gone through the CMHC ACT screening process. This seems to be confirmed by the fact that 56 new clients were reported to be added, while the ACT screening process only produced 12 new ACT participants. The State asserts that these new ACT clients were identified through CMHC clinical teams due to each individual's 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, such as those having contact with NHH, the DRFs, the MCTs, the EDs, homeless outreach workers and organizations, and/or the criminal justice system. In addition to the significant increase in adult admissions to NHH, DRF admissions have increased this year to over 900 admissions per quarter. The ER will explore the extent to which these individuals are screened, assessed, and perhaps linked to ACT.

New ACT Clients

Since April of 2020, the State has been 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

СМНС	New Clients April – June 2020	New Clients July to Sept. 2020		New Clients Jan – Mar 2021	New Clients April –June 2021
Northern Human Services	11	13	10	12	8
West Central Behavioral Health	21	5	10	22	8
Lakes Region MHC	5	4	4	6	4
Riverbend CMHC	9	8	15	13	4
Monadnock Family Services	0	0	0	2	2
Greater Nashua Mental Health	5	10	26	87	10
MHC of Greater Manchester	16	22	18	17	7
Seacoast MHC	5	7	6	8	3
Community Partners	6	7	4	12	9
Center for Life Management	5	4	2	2	1
Total	83	80	95	1028	56

⁷ This number was reported to be 38 in the previous report and has been corrected for this report based on improvements to the GNMH's electronic medical record (EMR).

⁸ See Note 7

It should be noted that in the past 15 months (April 2020 through June 2021), the combined ACT teams have added an average of 83 new clients per quarter, while the total number of ACT participants has not increased. This indicates that there is substantial turnover in the active ACT caseload over a relatively short time frame. Indeed, during the April-June 2021 quarter, the State added 56 new clients to ACT, but dropped 98 from ACT – a net loss of 42 clients. As a result, aggressive efforts to engage new ACT participants are necessary just to maintain steady state⁹ 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. Although in the last report, the ER stated an expectation that these data will be included subsequent Quarterly Data Reports, it has not yet been included or provided.

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 June 2021 stood at 391 potential participants. Clients often wait for ACT services from the Manchester CMHC, even though ACT capacity there typically far exceeds its active caseload. In the April-June 2021 quarter, for example, six individuals had to wait for ACT even though Manchester had unused ACT capacity to serve an additional 161 clients. As stated in prior reports, proactive State intervention is necessary to reduce delays in accessing ACT services.

⁹ 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
June 30, 2021	6	1	4	1

The ER notes that the number of individuals waiting for ACT services has increased slightly in the most recent two quarters. This is unexpected, given the reported increases in ACT staffing and system-wide available staff capacity among the ACT teams.

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 seven quarters on these issues.

Table VIII
Self-Reported Total ACT-Related Admissions to and Discharges from NHH
October 2019 through June 2021

	On ACT	Percent of	Referred to	Percent of	Accepted	Percent of
	at	all	ACT on	all	into ACT on	Those
	admission	Admissions	Discharge ¹⁰	Discharges	Discharge	Accepted
		who were				into ACT
		on ACT				on
						Discharge
OctDec	64	38.1%	25	24.0%	14	56.0%
2019						
JanMar.	53	35.1%	28	28.6%	11	39.3%
2020						
April –	67	34.1%	33	25.4%	17	51.5%
June 2020						
July to	37	26.1%	28	26.7%	21	75%
Sept. 2020						
Oct. – Dec.	40	36.0%	20	28.2%	14	70.0%
2020						
Ion Mon	37	24 20/	21	20.69/	11	52 40/
Jan. – Mar.	3/	34.3%	21	29.6%	11	52.4%
2021	5.4	10.00/	2.1	24.60/	1.7	5.4 QQ/
April –	54	18.9%	31	24.6%	17	54.8%
June 2021						

Less than 16 percent of those admitted to NHH, who were not enrolled in ACT upon admission, were then accepted into ACT services at discharge. The ER will explore whether delayed and/or inadequate engagement with CMHCs at or near the time of discharge from NHH – a problem the State reported in recent months – is a cause for concern. It is also notable that the number of adults admitted to NHH and not on ACT has increased significantly in the past quarter – up over 75 percent in the April-June 2021 quarter (126 no-ACT admissions) compared to the prior quarter (71 no-ACT admissions). This combined with the 900+ DRF admissions in the first two

¹⁰ The State reports that this number refers only to individuals who were not enrolled in ACT on admission to NHH.

quarters of 2021, reveals that there may be a need for additional ACT services for at-risk individuals in the community.

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

Table IX
Self-Reported Reasons Not Accepted into ACT upon Discharge from NHH
January 2020 through June 2021

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

As with previous reports, about 80 percent of the individuals referred, but not accepted into ACT in the April 2021 through June 2021 time period 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 acknowledged that delayed engagement with CMHCs at or near the time of discharge is an area in need of improvement, but this has not changed since the last report. 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, assessments and enrollments in ACT services and has implemented directed payments and other incentives to

¹¹ Some of these individuals may be enrolled in ACT during a subsequent reporting period.

improve performance in this area. However, currently reported data does not support a conclusion that 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 the DRFs 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 State Fiscal Year 2021. 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, which have not changed since the last report.

The State has re-started the on-site ACT fidelity reviews as of July 2021. The ER recently observed an on-site ACT fidelity review in the Nashua region. Some participant and staff interviews continue to be conducted by phone or tele-conference, but the review appeared to be complete and thorough.

Because of COVID, the State has followed national EBP guidance to temporarily suspended 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 fails to 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 determination upon discharge from NHH or the DRFs, 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)).

The State has maintained a SE penetration rate between 24% and 25% statewide. However, s noted in Table X below, seven 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 six CMHC regions reported being below the state standard of 18.6% penetration. In fact, the average penetration rate for the seven regions below 18.6% is only 13.3%. One region, Monadnock, has had a penetration rate below 5% since June of 2020.

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 (37.6%), Seacoast (45.3%), and Lakes Region (38.2%). The ER is increasingly concerned that Target Population members in large portions of New Hampshire do not have adequate or equitable access to this essential best practice service.

Table X
Self-Reported CMHC SE Penetration Rates

March 2020 through June 2021

	Penet.	Penet.	Penet.	Penet.	Penet.	Penet.
	Mar-20	Jun-20	Sep-20	Dec-20	Mar-20	Jun-21
Northern	14.20%	12.00%	11.80%	12.00%	12.00%	11.90%
West Central	22.20%	24.30%	25.50%	22.50%	18.60%	17.20%
Lakes Reg.	15.90%	21.50%	26.90%	32.70%	39.00%	38.20%
Riverbend	16.20%	16.10%	14.70%	14.10%	13.60%	13.50%
Monadnock	7.30%	4.80%	4.10%	3.70%	4.20%	4.70%
Greater Nashua	15.10%	13.40%	13.20%	12.30%	11.30%	14.40%
Manchester	41.70%	42.80%	41.90%	40.10%	40.60%	37.60%
Seacoast	39.00%	36.00%	38.70%	37.00%	39.50%	45.30%
Community						
Part.	11.70%	11.20%	13.70%	13.20%	13.00%	13.40%
CLM	16.40%	14.80%	14.80%	14.30%	15.70%	17.80%
CMHA Target	18.60%	18.60%	18.60%	18.60%	18.60%	18.60%
Statewide Ave.	23.70%	24.20%	24.50%	23.70%	24.20%	25.30%

The State reports data on the degree to which CMHC clients are working, either full or part time, in competitive employment. 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.

¹² State data defines full time employment as working 20 hours a week or more.

Table XI
Self-Reported Competitive Employment for CMHC Clients

CMHC	Percent	Percent	Percent of	Percent	Percent
	of SE	of SE	SE Active	of SE	of SE
	Active	Active	Clients	Active	Active
	Clients	Clients	Employed	Clients	Clients
	Employed	Employed	Full or	Employed	Employed
	Full or	Full or	Part Time	Full or	Full or
	Part	Part	Oct. – Dec.	Part	Part
	Time	Time	2020	Time	Time
	Mar-June	July –		Jan. –	April -
	2020	Sept 2020		Mar.	June
				2021	2021
Northern	27.3%	36.4%	37.5%	19.0%	31.6%
WCBH	44.4%	33.3%	33.3%	16.9%	33.3%
LRMHC	51.5%	51.3%	57.2%	44.7%	100%
Riverbend	62.5%	50.0%	50.0%	25.6%	61.2%
Monadnock	45.5%	61.9%	83.3%	23.9%	100%
Nashua	38.6%	42.3%	36.6%	25.3%	35.6%
MHCGM	54.4%	60.5%	58.4%	28.0%	53.8%
Seacoast	33.3%	31.5%	27.8%	29.2%	25.5%
Comm.	50.1%	47.3%	40.7%	24.2%	30.8%
Partners.					
CLM	47.9%	46.0%	51.1%	29.3%	51.8%
Statewide	46.7%	47.9%	47.6%	27.7%	44.9%

For all adult CMHC clients, 28.4%% are also currently engaged in full-time or part-time employment statewide. 13

The State reports that as of June 30, 2021, 68 individuals were waiting for SE services, 55 of which are from the same Region (Lakes). Fifty-six individuals (or 82.4%) have been waiting for over a month. In the previous quarter (January through March, 2021), 49 individuals were waiting for SE and 40.8% had been waiting for more than a month. Increasing delays in attaining access to SE services must be addressed to "ensure reasonable access to eligible individuals" per CMHA V.F.2(f).

SE Fidelity and Quality

¹³ 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.

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 restarted on-site SE fidelity reviews as of July, 2021. The ER recently observed an on-site SE fidelity review and found the process to be complete and thorough.

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 450 SH units, inclusive of those under the Bridge Subsidy Program. In its latest quarterly data report, the State has reported:

- The State has committed sufficient funds to support a total of 500 Bridge Subsidy Program units, which exceeds the CMHA target by 50 units;
- But, a total of only 271 individuals are currently occupying rental units subsidized by the Bridge Subsidy Program;
- An additional 94 individuals have been approved for a Bridge Subsidy: of these 50 (53.2%) are currently seeking appropriate housing; and 44 (46.8%) are not currently seeking housing; so, only 321 individuals are already in or are on an active path to Bridge supported housing;
- 21 individuals are reported to be on the wait list for approval for a Bridge Subsidy;
- The State has asserted that it gives priority to individuals on the wait list for access to and enrollment in the Bridge Subsidy Program; and A cumulative total of 332 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 266 individuals are still receiving either a federal housing subsidy or SH services. In July 2020, the State reported that the *current* federal total was not several hundred people, but only about 75 individuals. It is important to only count *current* supported housing numbers, as the CMHA requires that the State "will have [X] supported housing units" in its system at any given time. Unfortunately, the State's quarterly data report continues to combine apples and oranges – current State Bridge slots with cumulative/historical federal slots.

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 June 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 340¹⁴ units of Section 811 Mainstream tenant-based vouchers, 74 of which are specifically for the target population;
- As of the date of this report, the State reports that 129 individuals have occupied units funded by the Section 811 PRA program, and that 74 have occupied Section 811 Mainstream Voucher units. It is unclear though if this is current data or cumulative data; historically, and until the latest State quarterly report, the State made clear that its data here has been cumulative. Plus, it is unclear if all 74 individuals who have received Mainstream 811 are members of the Target Population with serious mental illness.

Bridge Subsidy Program Information

As of June 2021, the State reports having 271 individuals leased in Bridge Subsidy Program units and 50 people approved for the Bridge Subsidy Program and looking for a lease, but not yet leased. It remains true that there has been a substantial drop in the aggregate number of individuals either leased or approved and looking but not yet leased in the Bridge Subsidy Program – from a high of 591 in June of 2017 to the current number of 321 individuals.

There are 21 individuals reported to be on the Bridge Subsidy Program wait list as of the end of June 2021. Of these, one individual has been on the wait list for more than two months. (In the prior January to April, 2021 Quarterly Data Report the State reported that 41 individuals were on

¹⁴ As of January 1, 2022

the wait list, of whom 15 had been on the wait list for more than 60 days.) If there is Bridge Program funding for 500 units and only 365 have been approved for utilization thus far, it is unclear why 21 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 June 2021

Bridge Subsidy Program Information	Sept. 2018	Sept. 2019	Dec. 2019	Mar. 2020	June 2020	Sept. 2020	Dec. 2020	March 2021	June 2021
Total individuals leased in the Bridge Subsidy Program	423	338	340	327	328	312	300	306	271
Individuals in process of leasing		35	54	94	79	96	96	104	50
Individuals on the wait list for a Bridge Subsidy ¹⁵	35	42	25	49	39	85	28	41	21
Cumulative historical number transitioned to a HUD Housing Choice Voucher (HCV) or other Federal subsidy	125	151	163	179	192	198	212	233 ¹⁶	266

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

Table XIII
Self-Reported Housing Bridge Subsidy Program Applications and Terminations

	July- Sept 2019	Oct. – Dec. 2019	January – March 2020	April – June 2020	July- Sept. 2020	Oct – Dec. 2020	Jan. – Mar. 2021	April –June 2021
Measure								
Applications Received	22	59	74	30	57	25	41	36
Point of Contact CMHCS	13	51	63	29	50	22	38	29
NHH	9 0	8	11 0	29 1	6 1	3	2	4
Other	U	U	0	1	1		1	3
Applications Approved	11	42	104	27	57	25	41	36
Applications Denied	0	0	0	0	0	0	0	0
Denial Reasons	NA	NA	NA	NA	NA	NA	NA	NA
Applications in Process at end of period	75	79	49	41	0	0	0	0

Table XIV
Self-Reported Exits from the Housing Bridge Subsidy Program

April 2020 through June 2021

Type and Reason	April – June 2020	July – September 2020	October – December 2020	January – March 2021	April – June 2021
DHHS Initiated	2020	2020	2020	2021	2021
Terminations					
Failure to pay rent	0	2	0	0	0
Client Related Activity					
HUD Voucher Received	16	24	26	24	33
Deceased	2	1	5	1	2
Over Income	1	1	0	0	4
Moved out of State	2	3	1	0	0
Declined Subsidy at	2	10	7	5	11
Recertification					
Higher level of care	2	4	3	0	11
accessed					
Other Subsidy provided	1	2	0	0	4
Moved in with Family	1	0	2	3	1
Other			2	0	4
Total	27	47	46	33	70

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)

	Mar. 2020	June 2020	Sept. 2020	Dec. 2020	March 2021	June 2021
Number of properties with one leased SH unit at the same address	279	267	255	242	234	206
Number of properties with two SH units at the same address	14	15	20	18	22	15
Number of properties with three SH units at the same address	2	6	2	3	4	6
Number of properties with four SH units at the same address	2	0	0	0	1	0
Number of properties with five SH units at the same address	0	0	1	0	1	1
Number of properties with six SH units at the same address	0	1	0	1	0	2
Number of properties with seven SH units at same address	1	1	1	1	1	0

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. Prior State quarterly data reports noted that all units were individual units, but that note is absent in the current report. The ER will clarify with the State how many members of the Target Population live in each unit.

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 Individuals Approved for Housing Bridge Subsidy Program Linked to
Mental Health Services

	As of	As of	As of	As of	As of
	6/30/20202	9/30/2020	12/31/20	3/31/2021	6/30/2021
Housing Bridge	329 of	335 of	356 of	375 of	326 of
Tenants Linked to	406	409	396	410	365^{17}
Mental Health	(81%)	(82%)	(90%)	(91.5%)	(89.3%)
Services					

These data document the degree to which Bridge Subsidy Program participants are actually receiving certain mental health services and supports. 18

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 265 SH units under the HUD Section 811 Supportive Housing for Persons with Disabilities Program (191 PRA project-based units, and 74 Mainstream tenant-based vouchers). All of these PRA units are set aside for people with serious mental illness. The Mainstream units are available for individuals with disabilities, but are not limited to members of the mental health target population. As of June 2021, the State reports that 191 PRA units and 74 Mainstream units have been occupied by members of the Target Population.

The SH Wait List

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

¹⁷ This number includes some individuals who were in the Bridge Program at the beginning of the quarter but who now have by the end of the quarter transitioned to a Federal subsidy or otherwise left the Bridge Program.

¹⁸ Some of these tenants might be receiving services from MH providers other than a CMHC.

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, as of June 30, 2021 there were currently reported to be 21 individuals on the wait list for the Bridge Subsidy Program; one of these individuals has been on the wait list for more than two months. The State has recently allocated new funds to the Bridge Subsidy Program and 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. The State reports that starting in July 2021 there are no individuals on the wait list for the Bridge Subsidy program.

Some months ago, the State implemented a major change in the administration of the Bridge Subsidy Program. Previously, the program was administered on a statewide basis by an independent contractor. Under the new model, the State continues to administer the Program on a statewide basis, but 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 continues to manage the intake and eligibility determination functions and maintains the statewide waiting list.

These administrative changes could have an impact on the overall effectiveness of the Bridge Subsidy Program; the fact that 94 individuals are enrolled in the Bridge Program, but have not yet leased a unit that meets program guidelines for rent and housing quality, supports this conclusion. The 94 total, combined with the 21 individuals on the waitlist, may reveal deficits in the current system that need to be addressed. It is likely that COVID has made the housing search process more difficult and time consuming. It is also likely that the increasingly tight rental housing market in New Hampshire is making it more difficult to find and access rental units that meet program guidelines. 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 seven and one-half years, the ER has visited both Glencliff and NHH on at least 12 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 six years of operational experience. As of October 2021, 72 individuals have been submitted to the Central Team, 43 from Glencliff and 29 from NHH.

Of these, the State reports that 45 individual cases have been resolved, six 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 17 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 17 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:

Discharge Barriers	Number for Glencliff	Number for NHH		
Legal	3 (12.0%)	1 (4.8%)		
Residential	7 (28.0%)	8 (38.1%)		
Financial	5 (20.0%)	2 (9.5%)		
Clinical	6 (24.0%)	7 (33.3%)		
Family/Guardian	4 (16.0%)	2 (9.5%)		
Other	0 (0%)	1 (5.0%)		

October 2021

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 April to June 2021, Glencliff admitted four individuals and had 14 discharges (12/14 to congregate and segregated nursing facilities) and four deaths. The average daily census as of the date of the State's latest quarterly report was 104 people. There were reported to be 38 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]¹⁹ individuals with mental illness and complex health care needs residing at Glencliff...." The CMHA defines these as: "individuals with mental illness and complex health care needs who could not be cost-effectively served in supported housing." ²⁰

DHHS reports that 26 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. Two individuals were found eligible for the Acquired Brain Disorder (ABD) or Developmental Disability (DD) waivers, one is in the process of applying for the DD waiver, and one was denied eligibility for the ABD waiver.

Glencliff has actively participated in the State's recent initiative to transfer residents of NHH and Glencliff to private nursing and assisted living facilities as part of an over-all strategy to reduce the number of people who wait for psychiatric admissions in hospital emergency rooms. The State 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, 17 Glencliff resident²¹s have been transferred to nursing or assisted living facilities. Of those transitions, 14 residents transitioned to other NH nursing or assisted living facilities under the incentive program. Two transitioned to other nursing or assisted living facilities prior to the implementation of the incentive program and one transitioned to a nursing facility in her hometown in Illinois. This is a larger number of nursing or assisted living facility transfers than Glencliff believes would have occurred absent the State's financial incentives to nursing facilities.

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.

¹⁹ Cumulative from CMHA V.E.3(g), (h), and (i).

²⁰ CMHA V.E.2(a).

²¹ One additional Glencliff resident transferred to a nursing facility, but the transfer occurred before the financial incentives were initiated.

The ER remains 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. The ER then conducted a follow-up review on May 8 and 9, 2021. The findings of these two reviews are incorporated in Appendix C of this report.

Conclusions from the Two Previous Reviews

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.

Nonetheless, based on these two reviews, 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, were not clearly documented in the records. Evidence that there had been efforts to intervene with or inform guardians or family members about integrated community alternatives for the individuals transferred to nursing facilities was also not present in the records. The ER was not able to conclude or document that the purposes and specific requirements of the Glencliff transition planning policies have been systematically implemented by Glencliff or by the independently contracted in-reach coordinator.

Second Follow-up Review

The ER conducted an additional follow-up review on site at Glencliff on October 27, 2021. That visit included:

- Review of detailed in-reach coordinator activity notes;
- Review of a sample of medical records and transition plans;
- Discussions of transition planning issues with senior leadership and social work staff at Glencliff.

The in-reach coordinator left his position during the first week of September, and thus was not included in the discussions. As of the writing of this report, a new in-reach coordinator is not in place.

As of the date of the ER site review, the census at Glencliff was reported to be 81. The Green Unit, which had been established to house individuals deemed to need a lower level of support and potentially ready for transition to integrated community settings, had been closed. The residents of that Unit were transferred into other units at the facility. Both the reduced census and the closing of the Green Unit were reported to be primarily related to staff shortages rather than other considerations.

The HOPES program was reported to have been re-started in September, with six to eight Glencliff residents reported to be participating every other week. In addition, the Peer Support program in Littleton is reported to have re-started its in-reach visits to Glencliff, meeting with six to ten residents two times per month.

Leadership at Glencliff reported that they have accessed all but one of the "slots" available to transition residents to nursing or assisted living facilities under the financial incentive program. It was reported that 14 individuals have been transitioned from Glencliff to nursing or assisted living facilities under this program so far this year.

Findings

The ER found some anecdotal and documentary evidence that Glencliff staff were making efforts to implement the Glencliff Transition Planning and Informed Consent Policy in conformance with the CMHA. For example, there was some limited documentation of discussion of housing and other integrated community settings options with family members and guardians as part of the transition planning process. In at least one record, there was documentation of efforts to inform a guardian about the potential benefits and safety of integrated community settings. Glencliff leadership reports that the in-reach coordinator function and activities were supportive of overall efforts to transition Glencliff residents to integrated community settings. Glencliff management reported being hopeful that a new in-reach coordinator would be in place soon.

Nonetheless, as with the previous on-site visits, the ER was unable to document compliance with the CMHA. For example, the ER found that:

- 1. Documentation of the visioning and informed consent process is still partial or missing in several of the records reviewed;
- 2. Discussion of integrated community setting options with residents, family members, and guardians is partial or missing in several of the records reviewed;
- 3. There is little documentation of specific strategies to overcome family or guardian reluctance to approve transitions to integrated community settings in the records reviewed; and
- 4. Some transitions to nursing facilities seem to have occurred without documentation in the records of informed consent consistent with Glencliff's own Informed Consent policy or the CMHA.

The ER notes that no new specialized small-scale residential capacity designed for people with complex medical conditions has been developed or opened in the past several years. Leadership at Glencliff estimates that two or three new specialized integrated community settings such as the Palm Street residence in Nashua could facilitate additional transitions from Glencliff. Locations mentioned for such new program capacity included Laconia, Berlin, and Concord, but there are no tangible plans or timetables in place at this time.

Informing residents, family members, and guardians about integrated community setting options is a key element of the visioning and informed consent process for Glencliff residents. The absence of new specialized community capacity hinders transitions and may lengthen the time residents spend at Glencliff awaiting an appropriate community setting. At the same time, limitations in available integrated community settings impedes the process of informing residents and assisting them to make choices about community living alternatives.

As noted in the previous ER report, the State has been prioritizing congregate solutions rather than integrated community solutions. The State has been providing substantial financial incentives to trans-institutionalize residents from NHH and Glencliff to nursing facilities. In addition, 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	January to March 2021 Residents	January to March 2021 Activities	April to June 2021 Residents	April to June 2021 Activities
Attend service array and supports group presentations	0	0	0	0
Meet with In-Reach Coordinator regarding individual needs and service arrays	15	29	21	35
Participate in shared learning regarding integrated community living	0	0	0	0
Meet with In-Reach Coordinator regarding community-based living	12	16	23	37
Participate in specific transition discussions with In-Reach Coordinator	11	21	28	76
Participate in meetings with In- Reach Coordinator and others regarding opportunities for community living	9	28	14	28

In spite of this reported activity, records reviewed to date do not suggest that individualized visioning and transition planning discussions are occurring as envisioned by the CMHA or required by Glencliff's revised policies. Nor do recent discharge outcomes comport with increased efforts to inform individuals and guardians about integrated alternatives and address and resolve barriers to community transitions. Rather, only two Glencliff residents transferred to integrated community settings during the latest reported quarter, while 14 individuals transferred to congregate and segregated nursing facilities.

This is the second set of in-reach information to be included in the Quarterly Data Report. As such, there is not yet sufficient information for trend analysis. In addition, as noted above, the previous in-reach coordinator left the position in September of this year, and a replacement has not yet been identified or hired. 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 coordinator is also intended to facilitate meaningful in-reach activities by the CMHCs and other community providers, expose residents to integrated settings and service providers, and work with them to develop and tailor community options to meet their individualized needs. 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 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. Similarly, the narrative reports that 3 transitions to independent apartments occurred during the 12-month period, using existing Medicaid waiver and community mental health services including ACT. However, it is not clear that these transitions satisfy the CMHA's requirement to create community capacity for Glencliff residents with complex medical needs who cannot be cost effectively served in supported housing. The ER intends to conduct additional site visits and record reviews at Glencliff in the up-coming months to evaluate the quality and continuity of transition planning absent a dedicated In-Reach Liaison Coordinator.

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 ²²

	April through June 2019 Percent	July through Sept 2019 Percent	April – June 2020 Percent	July – October 2020 Percent	April 2020– June 2021	July 2021 – October 2021
Full Approval - No	28.8%	31.0%	64.4%	61.3%	69.2%	77.3%
Specialized Services						
Full Approval with	28.8%	38.0%	0.0%	6.5%	3.1%	3.0%
Specialized Services						
Provisional – No	18.8%	19.7%	23.1%	0.0%	3.1%	18.2%
Specialized Services						
Provisional with	23.8%	11.3%	11.5%	32.3%	24.6%	1.5%
Specialized Services						
Total	100%	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.

In 2019 the New Hampshire PASRR evaluation of need for specialized services was reviewed to ensure recommendations would align with increased in-house psychiatric services reported by the State to be provided by nursing homes. If psychiatric standard level services are needed, they are reflected in the report as "recommendations." I psychiatric serves above and beyond what is offered by the nursing home are needed, they are reported as a "specialized service" need.

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. 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,

²² 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.

the State reports that of 178 Level II PASRRs conducted, 28.1% resulted in specification of specialized services.

The CMHA (IV.A.10) emphasizes efforts to address the needs of those "referred to Glencliff," so as to provide them with alternative services in an integrated community setting before they are admitted to a congregate setting like Glencliff. The State asserts that the PASRR contractor will consult with multi-disciplinary teams where appropriate to consider options for lower levels of care, such as engaging occupational therapists, daily living skill support staff, and service options through the CFI waiver. 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 April through June 2021, the State reports that NHH effectuated 286 admissions and 266 discharges. The mean daily census was 180, and the median length of stay for discharges was 19 days. The recent increases in admissions, discharges, and daily census reflect 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

	Percent	Percent	Percent	Percent	Percent
Discharge Destination	April through June 2020	July through Sept. 2020	October through Dec. 2020	January through March 2021	April through June 2021
Home – live alone or with others	80.6%	68.4%	69.1%	61.8%	60.9%
Glencliff	0	0	0.52%	1.2%	0.38%
Homeless Shelter/motel	2.3%	2.87%	6.3%	5.2%	3.76%
Group home 5+/DDS supported living, peer support housing etc.	3.0%	2.46%	5.2%	5.2%	1.88%
Jail/correction	2.3%	3.28%	2.1%	2.3%	1.88%
Nursing home/rehab facility	3.3%	6.56%	11.0%	10.4%	15.4%
Other/un-known ²³	6.9%	5.33%	9.2%	13.9%	15.8%

As referenced above, reliance on nursing facilities has increased significantly in the past year from 3.3 percent of discharges to over 15 percent. The State also reports information on the

 $^{^{\}rm 23}$ The ER did not include the "Other" category in previous reports.

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 them 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 2019 through June 2021

	Franklin	Cypress	Portsmout h	Elliot	Elliot	Parkland	Total
				Geriatric	Pathways		
				Total Admissions			
January - March 2019	126	182	349	56	123		836
April to June 2019	108	187	371	89	108		865
July to September 2019 October - December	104	194	391	52	95		836
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
April - June 2021	77	166	316	44	151	156	910
				Percent involuntary			
	61.10	20.90		•			
January - March 2019	%	%	19.40%	7.90%	47.20%		27.30%
Applitations 2010	43.30	16.50	25.400/	44 500/	FF 000/		20.000/
April to June 2019	% 63.50	% 23.40	25.10%	11.50%	55.80%		28.00%
July to September 2019	%	23.40 %	24.00%	7.90%	40.00%		29.50%
October - December	53.50	24.20					
2010	%	%	21.00%	9.60%	40.00%		28.16%
	53.51	24.19					
January - March 2020	% 44.76	% 24.02	21.02%	9.62%	40.00%		28.16%
April - June 2020	44.76 %	24.03 %	25.84%	13.89%	42.90%		31.59%
April - Julie 2020	48.28	39.00	23.0470	13.8970	42.9070	100.00	31.3370
July - September 2020	%	%	20.69%	21.56%	42.97%	%	36.16%
October - December	66.30	28.10				100.00	
2020	%	%	23.20%	27.30%	46.90%	%	37.90%
	57.90	23.70	20 722/	4.4.700/	FF 400/	27.000/	22.622/
January - March 2021	%	%	28.70%	14.70%	55.10%	27.20%	33.80%

April - June 2021	44.16 %	25.30 %	20.25%	18.18%	43.04%	25.64%	27.80%
				Average Census			
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 October - December	10.6	13.4	31.8	23.7	9.5		89
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 October - December	9.7	13.4	27.7	14.1	13	3.4	81.3
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
April - June 2021	7.5	13.0	27.9	18.4	13.0	12.2	91.9
				Discharges			
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
April - June 2021	77	163	311	44	150	149	894
April Julie 2021	,,	103	311		130	143	054
				Mean LOS for			
				Discharges			
January - March 2019	5	3	5	18	7		5
April to June 2019	6	4	6	26	8		6
July to September 2019 October - December	7	5	6	25	7		7
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 October - December	6	7	6	18	8	5	7
2020	7	7	6	23	7	6	7

January - March 2021	8	6	6	27	7	5	6
April - June 2021	7	6	7	29	7	5	7

As is true in other areas, reliance on DRF institutions has been increasing in the first half of 2021. There were 223 more DRF admissions in the April-June 2021 quarter than in the April-June 2020 quarter – a significant increase of 32 percent. 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
April through June 2021

Disposition	Frank- lin	Cy- press	Ports- mouth	Elliot Geria- tric	Elliot Path- ways	Park- land	Total	Per- cent
Home	64	147	264	6	129	134	744	83.2%
NHH	1	0	5	0	0	1	6	0.67%
Residential Facility/ Assisted Living	2	0	0	24	1	1	28	3.1%
Other DRF ²⁴	1	2	0	6	1	1	10	1.1%
Hospital	0	0	4	4		1	10	1.1%
Death	0	0	0	4	0	0	4	0.45%
Other or Unknown	9	14	38	0	18	13	92	10.3%

Based on these self-reported data, 83.2% of recent discharges from DRFs and the Cypress Center are to home, as opposed to the 60.9% 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 analyze

²⁴ The State reports that these transfers reflect conversion from involuntary to voluntary status, not transfers among DRF facilities.

whether the percentage of discharges to hotels/motels and shelters has increased during COVID. For NHH, discharges to hotels/motels and shelters have been variable 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:

Table XXIII
Self-Reported Readmission Rates for NHH and the DRFs
July 2017 through June 2021

	Percent	Percent	Percent
	30 Days	90 Days	180 Days
NHH			
7 to 9/2017	9.80%	21.60%	27.90%
10 to 12/2107	12.8%	26.1%	32.8%
1 to 3/2018	13.7%	22.7%	29.9%
4/2018 to 6/2018	7.6%	14.7%	23.4%
7/2018 to 9/2018	8.6%	19.6%	25.4%
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%
4/2021 to 6/2021	6.6%	11.9%	16.8%

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Franklin	30 Days	50 Days	100 Days
7 to 9/2017	NA	NA	NA
10 to 12/2107	10.2%	10.2%	10.2%
1 to 3/2018	0.0%	0.0%	1.9%
4/2018 to 6/2018	4.3%	5.8%	5.8%
7/2018 to 9/2018	6.0%	9.0%	16.4%
10/2018 to	0.076	9.076	10.476
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%
4/2021 to 6/2021	2.6%	7.8%	9.1%
	Percent	Percent	Percent
	30 Days	90 Days	180 Days
Manchester (Cypress)		30 Days	100 Days
1 to 3/2018	4.20%	9.60%	15.80%
4/2018 to 6/2018	4.50%	8.20%	11.90%
7/2018 to 9/2018	8.50%	13.90%	18.90%
10/2018 to	0.5070	13.3070	10.5070
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%
4/2021 to 6/2021	9.6%	11.4%	12.7%

	Percent	Percent	Percent
_	30 Days	90 Days	180 Days
Portsmouth			
1 to 3/2018	8.80%	15.50%	20.60%
4/2018 to 6/2018	10.20%	15.90%	21.90%
7/2018 to 9/2018	8.40%	12.90%	19.00%
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%
4/2021 to 6/2021	7.6%	14.9%	18.4%
	Percent	Percent	Percent
	30 Days	90 Days	180 Days
Elliot Geriatric			
1 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%
4/2021 to 6/2021	6.8%	9.1%	13.6%

	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%
4/2021 to 6/2021	6.6%	9.9%	11.9%

	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%
4/2021 to 6/2021	3.2%	6.4%	8.3%

The ER notes that re-admission rates to NHH, particularly those within 90 and 180 days, had generally been declining since March of 2018, but have ticked up again in the latest reported quarter.

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

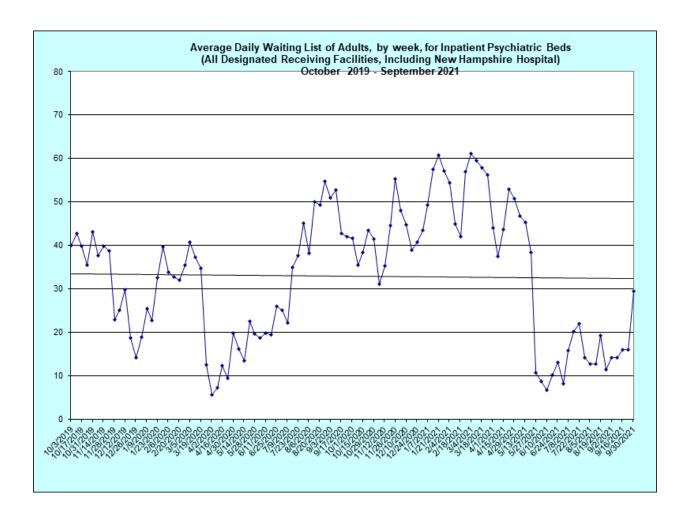
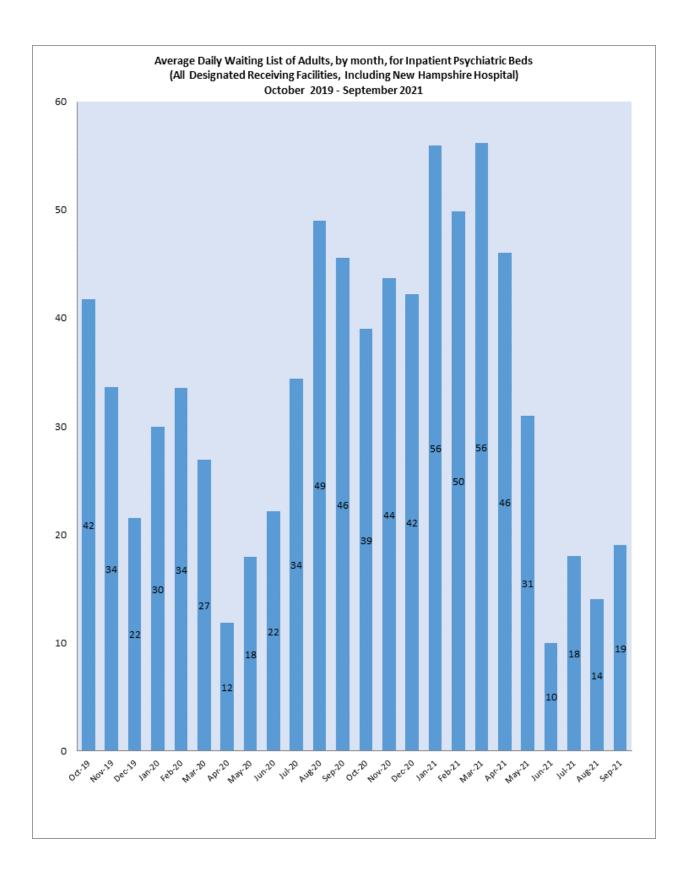


Chart B



DHHS recently implemented a number of institutional initiatives designed to substantially reduce the number of individuals and the elapsed time waiting in hospital emergency departments (EDs) for acute inpatient psychiatric beds. One such initiative was designed to free up admission beds at NHH and Glencliff by making incentive payments to nursing and assisted living facilities to admit patients from NHH and Glencliff to their facilities. The State has reported verbally that a total of 35 – 37 individuals were transitioned to nursing or assisted living facilities from NHH and Glencliff under this program. The State had previously added adult acute beds at NHH, opened new psychiatric beds at Parkland Hospital, and added at least 13 beds to transitional housing facilities with plans to add dozens more. The initial effect of these initiatives has been to reduce the number of individuals waiting in EDs for psychiatric hospital admissions.

However, as can been seen from the above charts, the number of individuals waiting for inpatient psychiatric admission has increased almost back to previous levels, reinforcing the need for permanent integrated community solutions, as outlined in the CMHA. It is not yet clear whether the State's institutional initiatives will have a permanent effect on the number of people awaiting psychiatric hospitalization in hospital EDs.

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 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 June 2021, the State reports that those sites have a cumulative total of 2,554 members, with an average daily participation rate of 113 people statewide.

III. Quality Assurance Systems

As noted earlier in this report, the State and the Dartmouth fidelity team has re-started the on-site comprehensive fidelity review process. The ER was able to observe an ACT fidelity review in Nashua, and an SE fidelity review in Concord during this reporting period. Both reviews appeared to be thorough and effective, even though some interviews with staff and service participants continue to be conducted by phone or ZOOM because of COVID restrictions.

As with the previous reporting period, the State has been successful in conducting QSRs for all ten CMHCs for State Fiscal Year 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 current reporting period.

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 somewhat difficult conditions.

For the most recent set of QSR reviews (State Fiscal Year 2021), 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), 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 through 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 systemwide performance have been steadily improving since in inception of the QSR 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 three indicators. These are:

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

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

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

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 need for improvement in domains directly related to the CMHA, including employment, ACT services, crisis services, and transitions to the community from inpatient settings.

IV. 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. Transforming crisis services to engage people early and divert individuals from entering inpatient settings through development of a statewide call/text/chat center and expansion of statewide mobile crisis response services;
- 2. Roll-out of the evidence-based practice of Critical Time Intervention (CTI) in four regions of the state;
- 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, in an effort to expand the continuum of housing options for the target population. The State has acknowledged that these may or may not be in integrated community settings.

With the exception of payments of 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 benefit from one or more of the initiatives.

V. 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 six years, the ER has reported that the State is out of compliance with the ACT requirements of Sections V.D.3, which 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. Many of the State's ACT teams fail to meet CMHA requirements for staffing and team composition.

It is important to note that 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 as a result current ACT screening and referral activities merely result in steady state operations in the ACT program. To increase active ACT caseload across New Hampshire it appears to be necessary both to reduce turnover and to find new sources of eligible ACT participants.

In response to these issues, the ER expects that, no later than March 1, 2022, the State will carry out the following actions:

- 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 individuals 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 ACT services; 2) the number of ACT 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 with staffing and team composition that have failed to meet CMHA standards for three consecutive months.

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, it appears, based upon the ER's reviews, that residents of Glencliff do not have written transition plans in accordance with CMHA requirements, and that residents transitioned to other nursing facilities have not 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.

On November 22, 2021, representatives of the Plaintiffs issued a notice of noncompliance related to transition planning and related issues at both Glencliff and NHH. The State sent a

response on December 22, 2021. The ER intends to await further developments and discussions among the parties before making specific recommendations on these issues.

Supported Employment

Although the State technically meets the statewide CMHA standard for SE penetration, the ER notes seven 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 June 2022 All Parties meeting, the State:

- 1. Provide a written update on efforts to ensure reasonable access to SE services for the 68 individuals currently on the statewide waiting list;
- 2. Continue to report on quality improvement plans for the two SE-related QSR indicators; and
- 3. Provide technical assistance to, and report on continuing quality improvement efforts with, the seven CMHCs reporting SE penetration rates lower than the CMHA requirement.

PASRR

Despite federal Medicaid and CMHA requirements, 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 whether 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 noted above, representatives of the Plaintiffs issued a notice of noncompliance related to transition planning and related issues at both Glencliff and NHH, and the State sent back a response. The ER intends to await further developments and discussions among the parties before making specific recommendations on these issues.

Conclusion

As has been noted at several points in this report, the COVID-19 pandemic has affected 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 commended for its efforts to provide basic levels of services for the CMHA Target Population, and for striving to maintain the quality of services for the Target Population during COVID. The

absence of progress towards compliance should be understood in the context of these COVID-related 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.

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

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

April through June 2021



New Hampshire Community Mental Health Agreement Quarterly Data Report

April – June 2021

New Hampshire Department of Health and Human Services

Bureau of Quality Assurance and Improvement

December 8, 2021

Community Mental Health Agreement Quarterly Data Report

New Hampshire Department of Health and Human Services

Publication Date: December 8, 2021

Reporting Period: 04/1/21 – 06/30/2021

Notes for Quarter

- Trends: This section 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 in the covered reporting period, terminating in May. 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 8-10 are redesigned tables for Supported Housing programs, services and outcomes. These tables replace the tables 8-10 in prior reports, which addressed Supported Housing programs and services. The tables now include data reorganized to better reflect the degree to which CMHA Supported Housing requirements are met.
- 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.

Acronyms Used in this Report

ACT: Assertive Community Treatment HUD: US Dept. of Housing and Urban Development

BMHS: Bureau of Mental Health Services MCT: Mobile Crisis Team

BQAI: Bureau of Quality Assurance and Improvement

CMHA: Community Mental Health Agreement

CMHC: Community Mental Health Center

DHHS: Department of Health and Human Services

DRF: Designated Receiving Facility

ED: Emergency Department

FTE: Full Time Equivalent

HBSP: Housing Bridge Subsidy Program

NHH: New Hampshire Hospital

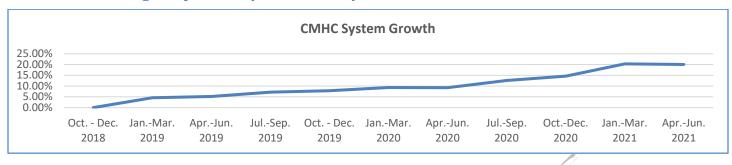
NHHFA: New Hampshire Housing Finance Authority

PRA: Project Rental Assistance

SE: Supported Employment

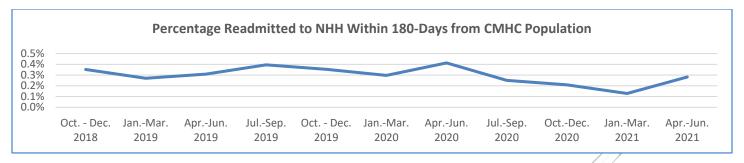
VA: Veterans Benefits Administration

TRENDS: CMHA Target Population System Wide Key Trends

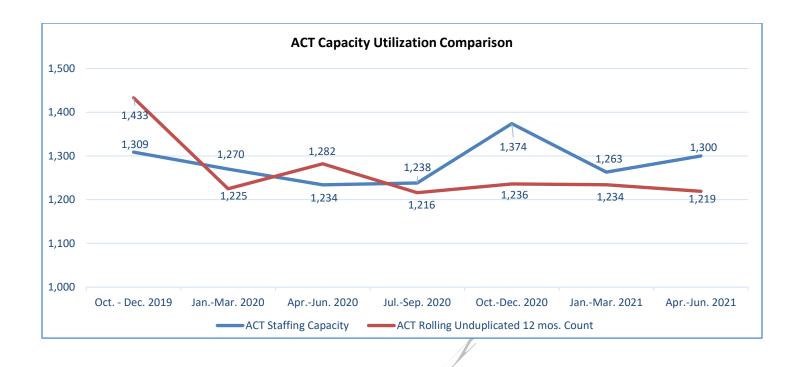












1a. Community Mental Health Center Services: Unique Count of Adult Assertive Community Treatment Clients

Community Mental Health Center	April 2021	May 2021	June 2021	Unique Clients in Quarter	Unique Clients in Prior Quarter
01 Northern Human Services	123	120	110	129	133
02 West Central Behavioral Health	45	44	42	55	66
03 Lakes Region Mental Health Center	59	59	58	61	60
04 Riverbend Community Mental Health Center	96	99	99	103	109
05 Monadnock Family Services	43	45	43	45	47
06 Greater Nashua Mental Health*	115	118	116	124	122*
07 Mental Health Center of Greater Manchester	248	241	240	253	274
08 Seacoast Mental Health Center	81	79	80	84	86
09 Community Partners	75	77	77	82	79
10 Center for Life Management	45	45	44	47	47
Total Unique Clients	929	927	909	982	1,024*

Revisions to Prior Period: Greater Nashua Mental Health (GNMH) data was rerun due to changes in its EMR.

Data Source: NH Phoenix 2. Notes: Data extracted 07/28/2021; clients are counted only one time regardless of how many services they receive. *GNMH identified data discrepancies during validation, resulting in changes to their EMR surrounding eligibility and how ACT/SE clients are reported; this issue has since been corrected. DHHS will continue to monitor their data.

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

		ary – March 2 espective Ana					
Community Mental Health Center	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: Individuals Not Already	New Clients receiving ACT Services within 90 days of Screening	
01 Northern Human Services	1,137	23	3	1,099	25	4	
02 West Central Behavioral Health	112	2	1	113	0	0	
03 Lakes Region Mental Health Center*	808	4	2	194	2	0	
04 Riverbend Community Mental Health Center	1,451	0	0	1,398	0	0	
05 Monadnock Family Services	609	3	0	545	2	0	

Total ACT Screening	9,318	81	12	8,935	73	8
10 Center for Life Management	1,173	3	1/	1,122	8	0
09 Community Partners	232	2	2	253	2	0
08 Seacoast Mental Health Center	1,495	25	0	1,381	23	0
Manchester						
07 Mental Health Center of Greater	1,687	15	2	1,702	9	3
06 Greater Nashua Mental Health**	614	4	1	1,128	2	1

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 08/11/2021. "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.

*Lakes Region Mental Health Center – During monthly validation, additional checks were added to ensure reduction of record discards. Additionally, this CMHC made changes to their reporting for ACT screening/submission process for ACT Screenings, which explains their increase in ACT Screenings when compared to the previous month.

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

		April –	June 20	21	January – March 2021					
Community Mental Health Center	April 2021 New ACT	May 2021 New ACT	June 2021 New ACT	Total New ACT Clients	January 2021 New ACT	February 2021 New	March 2021 New ACT	Total New ACT Clients		
01 Northern Human Services	4/	2	2	8	1	4	7	12		
02 West Central Behavioral Health	4	3	1	8	3	3	16	22		
03 Lakes Region Mental Health Center	2	0	2	4	3	0	3	6		
04 Riverbend Community Mental Health Center	1	2	1	4	0	9	4	13		
05 Monadnock Family Services	0	2	0	2	1	1	0	2		
06 Greater Nashua Mental Health*	2	6	2	10*	1	1	6	8*		
07 Mental Health Center of Greater Manchester	2	4	1	7	6	5	6	17		
08 Seacoast Mental Health Center	2	0	1	3	3	2	3	8		
09 Community Partners	2	4	3	9	0	5	7	12		

^{**}Greater Nashua Mental Health identified discrepancies in their data during validation, resulting in changes to their EMR surrounding eligibility and how ACT/SE clients are reported; this issue has since been corrected with their EMR Vendor and NH DHHS will continue to monitor their data.

10 Center for Life Management	0	1	0	1	0	1	1	2
Total New ACT Clients	19	24	13	56	25	42	65	102*

Revisions to Prior Period: Greater Nashua Mental Health data was rerun for January – March 2021, due to changes in their EMR.

Data Source: NH Phoenix 2.

Notes: Data extracted 08/11/2021; 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.

*Greater Nashua Mental Health identified discrepancies in their data during validation, resulting in changes to their EMR surrounding eligibility and how ACT/SE clients are reported; this issue has since been corrected with their EMR Vendor. The changes also resulted in corrected prior-quarter counts.

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

As of 06/30/2021												
	Time on List											
Total	0-30 days	31-60 days	61-90 days	91-120 days	121-150 days	151-180 days						
6	1 4		1	0	0	0						
			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						

Revisions to Prior Period: None.

Data Source: BMHS Report.

Notes: Data compiled 9/21/2021. All individuals waiting are at MHCGM; 5 have increased services being provided by the existing treatment team until assigned to an ACT team, the other was identified in July as no longer in need of ACT services and was removed from the waitlist. The individual waiting 61-90 days was admitted to ACT on July 7.

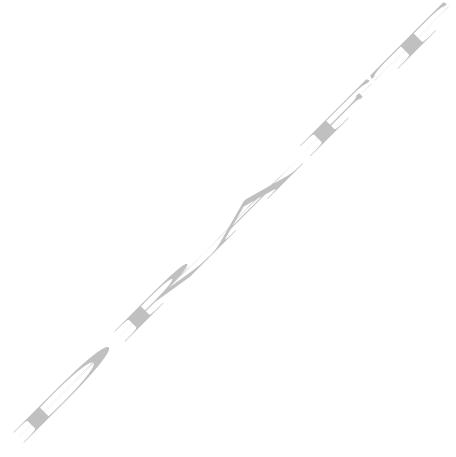
1e. Community Mental Health Center Services: Assertive Community Treatment - New Hampshire Hospital Admission and Discharge Data Relative to ACT

Community Mental Health Center	April – June 2021	January – March 2021

	On ACT at Admissi		Referre	ACT on	Accepte	Accepte d to ACT at		On ACT at Admissi		Referre d for ACT on		d to ACT at
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
01 Northern Human Services	7	16	7	9	4	3	4	7	2	/ 5	2	0
02 West Central Behavioral Health	3	4	1	3	0	1	3	4	1	3	1	0
03 Lakes Region Mental Health Center	4	7	2	5	1	1	2	3	0	3	0	0
04 Riverbend Community Mental Health												
Center	5	14	3	11	2	1	4	10	3	7	2	1
05 Monadnock Family Services	4	13	3	10	1	2	2	8	1	7	0	1
06 Greater Nashua Mental Health	13	21	5	16	4	1	3	7	5	2	1	4
07 Mental Health Center of Greater												
Manchester	8	15	3	12	2	1	7	10	6	4	3	3
08 Seacoast Mental Health Center	6	21	3	18	0	3	7	6	1	5	1	0
09 Community Partners	3	14	4	10	3	1	5	10	2	8	1	1
10 Center for Life Management	1	1	0	1	0	0	0	6	0	6	0	0
Total	54	126	31	95	17	14	37	71	21	50	11	10

Data Source: New Hampshire Hospital.

Notes: Data compiled 08/02/2021.



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	April - June 2021	January - March 2021
Not Available in Individual's Town of	0	1
Residence		
Individual Declined	0	0
Individual's Insurance Does Not Cover ACT	1	0
Services		
Individual's Clinical Need Does Not Meet ACT	2	5
Criteria		
Individual Placed on ACT Waitlist	0	0
Individual Awaiting CMHC Determination for	11	4
ACT		
Total Unique Clients	14	10

Revisions to Prior Period: None.

Data Source: New Hampshire Hospital.

Notes: Data compiled 08/02/2021. None of the 11 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

		June 2021					March	n 2021
Community Mental Health Center	Nurse	Masters Level Clinician/or	Functional Support	Peer Specialist	Total (Excluding	Psychiatrist/Nu rse Practitioner	Total (Excluding	Psychiatrist/Nu rse Practitioner
01 Northern Human Services - Wolfeboro	1.00	0.00	0.00	0.00	7.00	0.27	6.81	0.27
01 Northern Human Services - Berlin	0.34	0.31	1.00	0.00	5.43	0.14	3.94	0.14
01 Northern Human Services - Littleton	0.20	0.10	1.00	0.00	3.44	0.29	3.28	0.29
02 West Central Behavioral Health	0.90	1.00	0.00	1.00	5.60	0.30	5.40	0.30
03 Lakes Region Mental Health Center	1.00	2.00	0.00	1.00	6.00	0.40	5.00	0.40
04 Riverbend Community Mental Health Center	0.50	1.00	6.90	1.00	10.50	0.50	10.40	0.50
05 Monadnock Family Services	1.06	0.98	0.00	1.06	7.70	0.61	11.17	0.66
06 Greater Nashua Mental Health 1	1.00	0.50	4.00	1.00	8.00	0.15	7.65	0.15
06 Greater Nashua Mental Health 2	1.00	0.50	4.00	1.00	8.00	0.15	8.65	0.15
07 Mental Health Center of Greater Manchester-CTT	1.33	9.31	2.00	1.33	20.28	1.17	19.95	1.17

07 Mental Health Center of Greater	1.33	7.98	2.00	1.33	19.86	1.17		
Manchester-MCST							19.95	1.17
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	1.00	5.40	0.88	9.78	0.70	7.28	0.70
10 Center for Life Management	1.00	0.00	3.28	1.00	8.28	0.46	6.71	0.46
Total	12.1	25.78	34.5	11.6	129.9	6.91	126.2	
Total	6		8	0	7		9	6.96

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



	Disc	nce Use order ment		sing tance	Supported Employment		
	June	March	June	March	June	March	
Community Mental Health Center	2021	2021	2021	2021	2021	2021	
01 Northern Human Services - Wolfeboro	1.21	1.27	6.00	5.81	0.00	0.00	
01 Northern Human Services - Berlin	0.74	0.74	3.29	3.29	0.49	0.00	
01 Northern Human Services - Littleton	1.39	1.43	3.14	2.14	0.00	1.00	
02 West Central Behavioral Health	0.30	0.20	3.00	4.00	0.40	0.60	
03 Lakes Region Mental Health Center	1.00	1.00	5.00	5.00	1.00	2.00	
04 Riverbend Community Mental Health	0.50	0.50					
Center			9.50	9.40	0.50	0.50	
05 Monadnock Family Services	0.67	1.69	3.13	4.56	0.00	0.95	
06 Greater Nashua Mental Health 1	5.50	6.15	6.00	5.50	1.00	1.50	
06 Greater Nashua Mental Health 2	6.65	5.15	7.00	6.50	1.00	0.50	
07 Mental Health Center of Greater	14.47	14.47					
Manchester-CCT			14.29	13.96	2.66	2.66	
07 Mental Health Center of Greater	6.49	6.49					
Manchester-MCST			13.87	15.29	2.66	1.33	

08 Seacoast Mental Health Center	2.00	2.00	5.00	5.00	1.00	1.00
09 Community Partners	1.20	1.20	6.00	4.50	2.00	1.00
10 Center for Life Management	2.71	2.14	6.99	5.42	0.29	0.29
Total	44.83	44.43	92.21	90.37	13.00	13.33

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

Notes: Data compiled 07/28/2021. 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



	12 Montl	Penetration Rate for		
	Supported Employment	Total Eligible	Penetration	Period Ending
Community Mental Health Center	Clients	Clients	Rate	March 2021
01 Northern Human Services	156	1,316	11.9%	12.0%
02 West Central Behavioral Health	94	546	17.2%	18.6%
03 Lakes Region Mental Health Center	628	1,645	38.2%	39.0%
04 Riverbend Community Mental Health Center	262	1,936	13.5%	13.6%
05 Monadnock Family Services	54	1,145	4.7%	4.2%
06 Greater Nashua Mental Health	349	2,432	14.4%	11.3%
07 Mental Health Center of Greater Manchester	1,382	3,672	37.6%	40.6%
08 Seacoast Mental Health Center	1,003	2,212	45.3%	39.5%
09 Community Partners	106	789	13.4%	13.0%
10 Center for Life Management	278	1,561	17.8%	15.7%
Total Unique Clients	4,297	17,017	25.3%	24.2%

Data Source: NH Phoenix 2.

Notes: Data extracted 07/28/2021



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

Reported Employment Status Begin Date: 04/01/2021 End Date: 06/30/2021 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
Updated Employment	t Statu 62	s: 27	156	129	72	169	217	216	47	169	1,365	1 247
Full time employed	02	21	130	129	73	109	317	210	4/	109	1,303	1,247
now or in past 90 days	122	44	442	296	130	283	324	245	64	209	2 150	2 124
Part time employed	122	44	442	290	130	283	324	243	04	209	2,159	2,134
now or in past 90 days	105	0.5	25	70	154	996	046	122	221	6.41	2 277	2 447
Unemployed	195	85	35	79	154	889	946	122	231	641	3,377	3,447
Not in the Workforce	570	172	526	1071	509	365	659	983	140	173	5,168	5,021
Status is not known	4	73	34	22		99	9	2	9	73	332	379
Total of Eligible Adult	953	401	1,193	1,597	873	1,805	2,255	1,568	491	1,265	12,40	12,22
CMHC Clients								1,500			12,40	8
Previous Quarter:	955	389	1,159	1,571	890	1,781	2,259	1,507	520	1,197		
Total of Eligible Adult								1,307				
CMHC Clients												
Percentage by Update								10.0				
Full time employed	6.5%	6,7%	13.1%	8.1%	8.4%	9.4%	14.1%	13.8	9.6%	13.4%	11.0 %	10.2
now or in past 90 days												
Part time employed	12.8	11.0%	37.0%	18.5%	14.9%	15.7%	14.4%	15.6	13.0	16.5%	17.4 %	17.5 %
now or in past 90 days												
Unemployed	20.5	21.2%	2.9%	4.9%	17.6%	49.3%	42.0%	7.8%	47.0 %	50.7%	27.2 %	28.2 %

Not in the Workforce	59.8 %	42.9%	44.1%	67.1%	58.3%	20.2%	29.2%	62.7 %	28.5 %	13.7%	41.7 %	41.1
Status is not known		18.2%		10.70	0.070		0.4%	0.1%	1.8%	5.8%	2.7%	3.1%
Percentage by Timeli												
Update is Current	%			85.8%			89.7%	93.8	70.3 %	99.9%	84.9 %	82.2 %
Update is Overdue	%			14.2%			10.3%		%	0.1%	15.1 %	17.8 %
Previous Quarter: Po	ercenta								ng:			
Update is Current	67.3			88.4%				%	74.4 %	100.0		
Update is Overdue	32.7	100.0	11.8%	11.6%	28.2%	23.9%	10.5%	7.3%	25.6 %	0.0%		

Data Source: NH Phoenix 2.

Notes: Data extracted 07/28/2021

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: 04/01/2021 End Date: 06/30/2021	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 January - March 2021
Updated Emp		ont 3	Status 1	s: 0	3	0	6	// 7	0	2	7	26	30
employed			1	U	3	U	- O		U		/	20	30
now or in													
past 90 days													
Part time		6	5	1	38	2	26	36	13	2	22	151	162
employed													
now or in						7							
past 90 days													
Unemployed		7	5	0	/ 17	0	39	29	8	8	21	134	143
Not in the		6	3	0	9	0	10	8	30	1	6	73	78
Workforce				. //									
Status is not		0	1	0	0	0	9	0	0	0	0	10	6
known													
Total of	1	9	15	1	67	2	90	80	51	13	56	394	419
Supported													

Employment Cohort												
	24	14	19	54	10	83	93	16	17	59		
Previous	24	14	19	54	10	63	93	46	1/	39		
Quarter:												
Total of												
Supported												
Employment												
Cohort												
Percentage by	Update	d Emp	loyment	Status	:	-		-	-	5	_	
Full time	0.0%	6.7%	0.0%	4.5%	0.0%	6.7%	8.8%	0.0%	15.4%	12.5%	6.6%	7.2%
employed												
now or in												
past 90 days								/,	,			
Part time	31.6%	33.3%	100.0%	56.7%	100.0%	28.9%	45.0%	25.5%	15.4%	39.3%	38.3%	38.7%
employed												
now or in												
past 90 days							1/					
Unemployed	36.8%	33.3%	0.0%	25.4%	0.0%	43.3%	36.3%	15.7%	61.5%	37.5%	34.0%	34.1%
Not in the	31.6%	20.0%	0.0%	13.4%	0.0%	11.1%	10.0%	58.8%	7.7%	10.7%	18.5%	18.6%
Workforce												
Status is not	0.0%	6.7%	0.0%	0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	0.0%	2.5%	1.4%
known												

Data Source: Phoenix 2.

Note 3b-c: Data extracted 07/28/2021. 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.

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

	As of 06/30/2021										
	Time on List										
Total	0-30 days	0-30 days 31-60 days 61-90 days 91-120 days 121-150 days 151-180+ days									
68	12	12 6 6 25 7 12									
			As of 03/31/	2021							
			Time on L	ist							
Total	0-30 days	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					

Data Source: BMHS Report.

Notes: Data compiled 09/21/2021. 55 individuals waiting are at LRMHC; SE staffing shortages remain a challenge. BMHS is continuing to work with LRMHC on these challenges. Referrals to Vocational Rehabilitation continue to be encouraged and provided where appropriate.

4a. New Hampshire Hospital: Adult Census Summary

Measure	April – June 2021	January – March 2021
Admissions	286	165
Mean Daily Census	180	173
Discharges	266	173
Median Length of Stay in Days for Discharges	19	35
Deaths	0	2

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4a: 08/11/2021; 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	April - June 2021	January - March 2021
CMHC Group Home	3	5
Discharge/Transfer to IP Rehab Facility	20	15
Glencliff Home for the Elderly	1	2
Home - Lives Alone	70	43
Home - Lives with Others	92	64
Homeless Shelter/ No Permanent Home	4	4
Hotel-Motel	6	5
Jail or Correctional Facility	5	4
Nursing Home	21	3
Other	10	11
Peer Support Housing	0	0
Private Group Home	2	4
Secure Psychiatric Unit - SPU	0	0
Unknown	32	13

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

Measure	April – June 2021	January – March 2021
30 Days	6.6% (19)	3.0% (5)
90 Days	11.9% (34)	8.5% (14)
180 Days	16.8% (48)	13.3% (22)

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4b-c: Data compiled 07/28/2021; 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



	April – June 2021					
Designated Receiving Facility	Involuntary Admissions	Voluntary Admissions	Total Admissions			
Franklin	34	43	77			
Cypress Center	42	124	166			
Portsmouth	64	252	316			
Elliot Geriatric Psychiatric Unit	8	36	44			
Elliot Pathways	65	86	151			
Parkland Regional Hospital	40	116	156			
Total	253	657	910			
	Jan	uary – March 2021				
	Involuntary	Voluntary	Total			
Designated Receiving Facility	Admissions	Admissions	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

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

Designated Receiving Facility	April – June 2021	January – March 2021
Franklin	7.5	7.7
Cypress Center	13.0	13.7
Portsmouth	27.9	30.3
Elliot Geriatric Psychiatric Unit	18.4	18.6
Elliot Pathways	13.0	14.1
Parkland Regional Hospital	12.2	15.5
Total	91.9	99.9

Revisions to Prior Period: None.

5c. Designated Receiving Facilities: Discharges for Adults

Designated Receiving Facility	April – June 2021	January – March 2021
Franklin	77	76
Manchester (Cypress Center)	163	152
Portsmouth	311	323
Elliot Geriatric Psychiatric Unit	44	28
Elliot Pathways	150	155
Parkland Regional Hospital	149	192
Total	894	926
Designated Receiving Facility	April – June 2021	January – March 2021
Franklin	7	8
Manchester (Cypress Center)	6	6
Portsmouth	7	6
Elliot Geriatric Psychiatric Unit	29	27
Elliot Pathways	7	7
Parkland Regional Hospital	5	5
Total	7	6

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

5e. Designated Receiving Facilities: Discharge Location for Adults



	April – June 2021						
Designated Receiving Facility	Assisted Living / Group Home	Decease d	DRF*	Hom e**	Other Hospit al	NH Hospita I	Othe r
Franklin	2	0	1	64	0	/// 1	9
Manchester (Cypress Center)	0	0	2	147	0	0	14
Portsmouth Regional Hospital	0	0	0	264	4	5	38
Elliot Geriatric Psychiatric Unit	24	4	6	6	4	0	0
Elliot Pathways	1	0	V	129	1	0	18
Parkland Regional Hospital	1	0	0	134	1	0	13
Total	28	4	10	744	10	6	92
		Ja	anuary -	- March	2021		
	Assisted Living /				Other	NH	
	Group	Decease		Hom	Hospit	Hospita	Othe
Designated Receiving Facility	Home	d	DRF*	е	al	I	r
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

^{*}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).

Data Source: NH DRF Database.

Notes: Data compiled 07/28/2021

5f. Designated Receiving Facilities: Readmission Rates for Adults

	April – June 2021				
Designated Receiving Facility	30 Days	90 Days	180 Days		
Franklin	2.6% (2)	7.8% (6)	9.1% (7)		
Manchester (Cypress Center)	9.6% (16)	11.4% (19)	12.7% (21)		
Portsmouth	7.6% (24)	14.9% (47)	18.4% (58)		
Elliot Geriatric Psychiatric Unit	6.8% (3)	9.1% (4)	13.6% (6)		

Elliot Pathways	6.6% (10)	9.9% (15)	11.9% (18)
Parkland Regional Hospital	3.2% (5)	6.4% (10)	8.3% (13)
Total	6.6% (60)	11.1% (101)	13.5% (123)
	Ja	nuary – March 2021	
Designated Receiving Facility	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)

Data Source: NH DRF Database.

Notes: Data compiled 07/28/2021.

6. Glencliff Home: Census Summary

Measure	April – June 2021	January – March 2021
Admissions	4	3 (including 1 readmission)
Average Daily Census	104	111
Discharges	14 (12 to Nursing Facilities and 2 to Independent Apartments)	1
Individual Lengths of Stay in Days for Discharges	1519, 3307, 987, 938. 2830, 1061, 6367, 2349, 1193, 939, 861, 833, 795, 453	802
Deaths	4	4
Readmissions	0	1
Mean Overall Admission Waitlist	38	41

Revisions to Prior Period: None.

Data Source: Glencliff Home.

Notes: Data Compiled 09/16/2021; 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:	April – June 2021		Janua	ry – March 2021
	Residents	Activities	Residents	Activities
Residents have better awareness of community-based liv	ring benefits	as evidence	d 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	21	35	15	29
Residents are better prepared to return to community-bo	used living a	s 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	23	37	12	16

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**	28	76	11	21
Participated in meetings with resident, In-Reach Liaison, and others regarding opportunities for community-based living	14	28	9	28

Data Source: BMHS.

Notes: Data Compiled 09/01/2021. 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 10 of the 10 CMHCs on resident-specific cases.

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



	April – June 2021		January – March 2021*			
Peer Support Agency	Total Members	Average Daily Visits	Total Members	Average Daily Visits		
Alternative Life Center Total	624	28	622	25		
Conway	271	9	271	5		
Berlin	145	5	143	6		
Littleton	90	6	90	6		
Colebrook	118	8	118	8		
Stepping Stone Total	377	7	368	6		
Claremont	249	5	249	5		
Lebanon	128	2	119	1		
Cornerbridge Total	242	9	142	10		
Laconia	142	5	53	5		
Concord	84	4	74	5		

	April – June 2021		January – March 2021*			
Peer Support Agency	Total Members	Average Daily Visits	Total Members	Average Daily Visits		
Plymouth Outreach	16	0	15	0		
MAPSA Keene Total	349	12	340	19		
HEARTS Nashua Total	421	24	391	36		
On the Road to Recovery						
Total	181	12	165	12		
Manchester	104	6	93	5		
Derry	77	6	72	7		
Connections Portsmouth						
Total	118	8	108	7		
TriCity Coop Rochester						
Total	242	13	282	7		
Total	2,554	113	2,418	122		

Revisions to Prior Period: *Several prior period data points were incorrect, due to human error, and are corrected.

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

Notes: Data Compiled 09/07/2021. Average Daily Visits are not applicable for Outreach Programs.

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8. Supported Housing Outcomes: Quarter-to-Quarter Summary

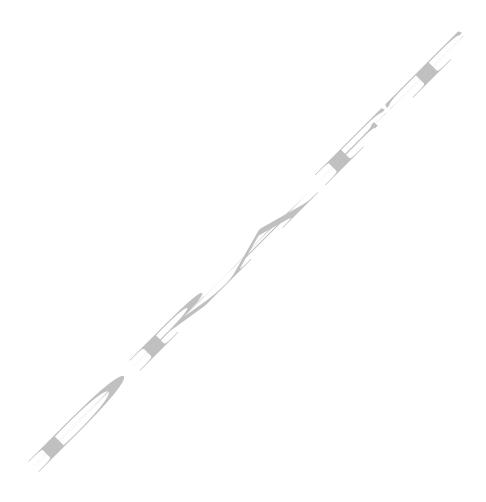
Measure	April - June 2021			JanMarch 2021
All Housing Subsidies Targeted for CMHA Population	Quarterly Count	Quarter's Total	Quarterly Change	Prior Quarter's Total
1. Total Supported Housing Subsidy Funding (1.a. +	- 1.b.)	857	6	851
a. Percentage from Housing Bridge (2.a to 2.c.)	365	42.6%	(5.6%)	48.2%
b. Percentage from Other Subsidies (3.a. to 3.f.)	492	57.4%	5.6%	51.8%
Housing Bridge Program	Quarterly Count	Quarter's Total	Quarterly Change	Prior Quarter's Total
2. Total Housing Bridge Program Participants at Qu End (2.a. to 2.c.)	arter's	365	(45)	410
a. Percentage Housed in Bridge Unit at Quarter's End (Active Status)	271	74.3%	NA	NA
b. Percentage Seeking Bridge Unit Lease at Quarter's End (Active Status)	50	13.7%	NA	NA
c. Percentage Not Actively Seeking Bridge Unit Lease at Quarter's End (Active Status)	44	12.0%	NA	NA
d. Percentage of Participants Linked to Mental Health Care Provider Services (based on 2.a. to 2.c.)	326 out of 365	89.3%	(2.2%)	91.5%

Subsidized Housing Through Other Voucher Programs	Quarterly Count	Quarter's Total	Quarterly Change	Prior Quarter's Total
3. Total Housed Through Other Voucher Program at Quarter's End (3.a. to 3.f.)	t	492	62	430
a. Percentage Housed Through Section 8 Subsidy– Transitioned From Housing Bridge	266	54.1%	(.1%)	54.2%
 b. Percentage Housed Through Section 8 Subsidy Not Previously Receiving Housing Bridge 	0	0.0%	0.00%	0%
c. Percentage Housed Through 811 – PRA Subsidy	129	26,2%	(1.9%)	28.1%
d. Percentage Housed Through 811 – Mainstream Subsidy	74	15.0%	(2.2%)	17.2%
e. Percentage Housed Through Integrative Housing Program	18	3.7%	NA	NA
f. Percentage Housed Through Other Permanent Housing Voucher (e.g., HUD, Local Public Housing, Veterans Administration)	5	1.0%	(.5%)	.5%

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

Notes: Data Compiled 8/17/21. Line 2.d. "Participants Linked" are 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. Line 3.a. count is cumulative, increasing over time since inception within the CMHA Quarterly Data Report; it reflects participants who transitioned to permanent housing that is no longer funded by a Housing Bridge Subsidy. Line 3.b. is a count of CMHC clients who received a Section 8 Voucher during the reporting period but were not previously receiving a Housing Bridge Subsidy. Lines 3.c. and 3.d. counts are CMHC clients who received a PRA or Mainstream 811 funded unit with or without previously receiving a Housing Bridge Subsidy. Line 3.e. counts are criminal justice involved CMHC clients who received an

Integrative Housing Subsidy from DHHS (a Bridge-like subsidy for individuals with an inability to currently qualify for a Section 8 Voucher but are anticipated to be able to qualify after 5 or less years). Line 3.f. counts are CMHC clients who received a unit funded through other HUD or Public Housing sources with or without previously receiving a Housing Bridge Subsidy.



9. Housing Bridge Program Outcomes: Quarter-to-Quarter Summary

Measure	Ap	21	JanMarch 2021	
1. Access to Program Services Statewide: Percentage of Total Active Cases by Referral Source	Quarterly Count	Quarter's Total	Quarterly Change	Prior Quarter's Total
a. Unduplicated Cases		365	NA	NA
i. Community Mental Health Centers	356	97.5%	NA	NA
ii. New Hampshire Hospital	8	2.2%	NA	NA
iii. NFI North	1	0.3%	NA	NA
2. Access to Supported Housing: Housing Bridge Program Waitlist	Quarterly Count	Quarter's Total	Quarterly Change	Prior Quarter's Total
a. Unduplicated Individuals on Waitlist at Quarter' (Point-in-Time Count, 2.b.i. to 2.b.iii.)	s End	21	(20)	41
i. Percentage Waiting 0-60 Days	20	95.2%	(31.8%)	26
ii. Percentage Waiting 61-180 Days	1	4.8%	(2.5%)	3
iii. Percentage Waiting 181+ Days	0	0.00%	(29.3%)	12

3. Access to Scattered Site Housing: Percentage of Units Co-located at Same Address by Frequency	Quarterly Count	Quarter's Total	Quarterly Change	Prior Quarter's Total
a. 1 unit at same address	206	76.0%	(.5%)	76.5%
b. 2 units at same address	15	11.1%	(3.3%)	14.4%
c. 3 units at same address	6	6.7%	2.8%	3.9%
d. 4 units at same address	0	0.0%	(1.3%)	1.3%
e. 5 units at same address	1	1.8%	.2%	1.6%
f. 6 units at same address	2	4.4%	4.4%	0.0%
g. 7 units at same address	0	0.0%	(2.3%)	2.3%
h. 8 or more	0	0.0%	0.0%	0.0%

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

Notes: Data Compiled 8/17/21. Lines 3.a.-3.h counts represent the number of times, during the quarter, at the applicable colocation of units (e.g., 3.b. count of 15 indicates 30 actual units); property address may include multiple buildings, such as apartment complexes.

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10. Housing Bridge Program Activity

Activity Type	April - June 2021	January – March 2021
1. Application Process and Average Elapsed Time in Days	Quarterly Count / Days	Prior Quarterly Count / Days
a. Applications Received During Period	36	41
i. Point of Contact for Applications Received	29 CMHCs; 4 NHH; 3 NFI	38 CMHCs, 2 NHH, 1 NFI
b. Applications Approved	36	41
 i. Completed Application to Determination (in Days) 	1	1
c. Applications Denied	0	0
i. Denial Reasons	NA	NA
d. From Approval to Funding Availability (in Days)	91	61
		Prior Quarterly Count /
2. Lease Up Process and Average Elapsed Time in Days	Quarterly Count / Days	Days
a. Initial Lease Secured	12	1
 i. From Funding Availability to Initial Lease (in Days) 	3	1
b. Other Leases Secured in Quarter (Excludes Initial)	13	7

3. Removals from Waitlist [Prior to Active Status]	Quarterly Count	Prior Quarterly Count
a. Individuals Placed in Funded Status [Moved to Active]	46	25
b. Individuals Administratively Removed (3.b.i. to 3.b.x.)	0	12
Reasons for Removal Moved to different state	0	0
i. Moved to different stateii. Moved in with family	0	0
iii. Received PRA811 voucher	0	0
iv. Received Mainstream 811 voucher	0	0
v. Received other permanent housing voucher	0	0
vi. Required higher level of care	0	3
vii. Required DOC interventions, not ready for HBSP	0	3
viii. Moved into a sober living facility	0	2
ix. Owns own home (no longer eligible)	0	1
x. Unable to locate or contact	0	3
c. Total Individuals Removed from Waitlist (3.a. + 3.b.)	0	37

4. Exits and Terminations [After Active Status]	Quarterly Count	Prior Quarterly Count
a. Client Related Exits (4.a.i. to 4.a.ix.)	70	33
Reasons for Exit:		
i. Permanent Voucher Received	33	24
ii. Deceased	2	1
iii. Over Income	4	0
iv. Moved Out of State	0	0
v. Declined Subsidy at Recertification	11	5
vi. Higher Level of Care Accessed	11	0
vii. Other Subsidy Provided	4	0
viii. Moved in with family	1	3
ix. Became incarcerated	2	0
x. Transferred to Integrative Housing Voucher Program	2	0
b. DHHS Initiated Terminations	0	0
Reason for Termination:	NA	NA
c. Total Program Exits and Terminations (4.a. + 4.b.)	70	33

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

Notes: Data Compiled 8/17/21. Average elapsed time reflects only those applications with the applicable activity occurring during the quarter. Lines 4.a. and 4.a.i. through 4.a.ix. 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 declinations, including declining to initiate voucher and unable to contact.

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

Measure	April 2021	May 2021	June 2021	Apr. – Jun. 2021	Jan. – Mar. 2021
Unique People Served in Month	166	190	191	450	429
Services Provided by Type					
Case Management	0	0	0/	0	0
Crisis Apartment Service	28	35	60	123	132
Crisis Intervention Services	0	0/	0	0	0
ED Based Assessment	0	0	0	0	0
Medication Appointments or Emergency Medication Appointments	0	0	0	0	0
Mobile Community Assessments	14	22	21	57	10
Office-Based Urgent Assessments	37	58	46	141	167
Other	0	0	0	0	0
Peer Support	98	113	138	349	268
Phone Support/Triage	274	276	276	826	963

Measure	April 2021	May 2021	June 2021	Apr. – Jun. 2021	Jan. – Mar. 2021
Psychotherapy	3	0	1	4	0
Referral Source				1	
CMHC Internal	14	17	20	51	7
Emergency Department	9	9	14	32	19
Family	25	37	37	99	29
Friend	1	3/	3	7	4
Guardian*	0	0	0	0	0
MCT Hospitalization	0	0	0	0	0
Mental Health Provider	53	46	70	169	59
Other	31	34	20	85	14
Police	8	7	10	25	2
Primary Care Provider	7	10	8	25	9
Self	294	314	350	958	423

Measure	April 2021	May 2021	June 2021	Apr. – Jun. 2021	Jan. – Mar. 2021
School	5	17	8	30	9
Crisis Apartment*					
Apartment Admissions	4	1	10	15	18
Apartment Bed Days	60	41	68	169	78
Apartment Average Length of Stay	2.0	4.6	6.8	11.3	4.3
Law Enforcement Involvement	8	7	10	25	2
Hospital Diversions Total	85	107	120	312	248

Notes: Data Compiled 08/11/2021. 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 by next quarter.



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

Measure	April 2021	May 2021	June 2021	Apr. – Jun. 2021	Jan. – Mar. 2021
Unique People Served in Month	313	304	333	733	712
Services Provided by Type					
Case Management	41	30	33	104	134
Crisis Apartment Service	2	4	8	14	0
Crisis Intervention Service	313	306	189	808	748
ED Based Assessment	0	0	0	0	0
Medication Appointments or Emergency Medication Appointments	6	2	1	9	19
Mobile Community Assessments	96	81	105	282	307
Office-Based Urgent Assessments	12	15	10	37	28
Other*	254	245	322	821	809
Peer Support	5	4	16	25	40

Phone Support/Triage	697	599	606	1,902	2,041
Psychotherapy	1	7	2	10	6
Referral Source					
CMHC Internal	3	3	9	15	9
Emergency Department	0	0	0	0	0
Family	50	41	47	138	168
Friend	3	1	5	9	24
Guardian	14	18	13	45	53
MCT Hospitalization	8	5	12	25	32
Mental Health Provider	8	12	20	40	50
Other	16	25	22	63	74
Police	69	51	86	206	214
Primary Care Provider	14	9	14	37	41
Self	172	166	164	502	460
School	12	19	11	42	19

Crisis Apartment**					
Apartment Admissions	1	2	4	7	0
Apartment Bed Days	8	14	12	34	0
Apartment Average Length of Stay	8.0	7.0	3.0	4.9	0.0
Law Enforcement Involvement	69	51	86	206	214
			47		
Hospital Diversion Total	362	344	388	1,094	1,120

Data Source: Phoenix 2.

Notes: Data Compiled 08/11/2021. 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" Services represent an MHCGM closing code and indicates people coming out of the MCRT. **The crisis apartments reopened April 19, 2021.

11c. Mobile Crisis Services and Supports for Adults: Greater Nashua Mental Health*

Measure	April 2021*	May 2021*	June 2021	Apr. – Jun. 2021	Jan. – Mar. 2021
Unique People Served in Month	72	83	88	195	NA
Services Provided by Type					
Case Management	17	22	38	77	NA
Crisis Apartment Service	NA	NA			NA
Crisis Intervention Service	NA	NA			NA
ED Based Assessment	NA	NA			NA
Medication Appointments or Emergency Medication Appointments	NA.	NA			NA
Mobile Community Assessments	23	31	36	90	NA
Office-Based Urgent Assessments	NA	NA			NA
Other	58	47	37	142	NA
Peer Support	44	66	85	195	NA

Phone Support/Triage	291	320	336	947	NA
Psychotherapy	NA	NA			NA
Referral Source					
CMHC Internal	1	2	1	4	NA
Emergency Department	1	-	1	1	NA
Family	4	3	6	13	NA
Friend	NA	NA			NA
Guardian	NA	NA			NA
MCT Hospitalization	NA	NA			NA
Mental Health Provider	1	1	3	5	NA
Other	4/	12	11	27	NA
Police	1	4	6	11	NA
Primary Care Provider	NA	1	-	1	NA
Self	6	3	5	14	NA
School	4	5	3	12	NA

Crisis Apartment					
Apartment Admissions	NA	NA			NA
Apartment Bed Days	NA	NA			NA
Apartment Average Length of Stay	NA	NA			NA
Law Enforcement Involvement	1	4	6	11	NA
			47		
Hospital Diversion Total	23	29	27	79	NA

Data Source: Greater Nashua Mental Health submitted data.

Notes: 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. *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. The counts provided for the months of April, May, and June 2021 are manually reported, however reporting and data validation through the Phoenix 2 System will begin with July 1, 2021 data.



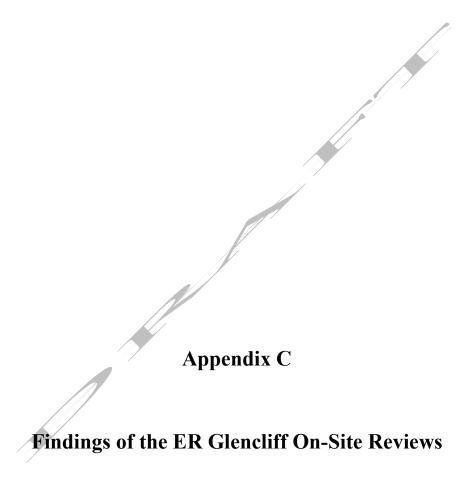


Appendix B

State Fiscal Year 2021 Quality Services Report Summary

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region	STATE
	NHS	WCBH	LRMHC	RMHC	MFS	GNMHC	MHCGH	SMHC	СР	10 CLM	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%
Individual is integrated into his/her community, has choice, 12 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%
*Successful transition/discharge from the inpatient psychiatric											
18 facility AVERAGE	75% 90%	90% 85%		90% 90%	80% 88%	86% 90%		83% 92%	79% 86%	73% 88%	
* Indicators that typically have a lawer Nithan the total interviewed					00/0		03/0	92/0	00/0	00/0	00/0

^{*} 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.



January 15, 16 and 17, 2020 On-Site review (summary)

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 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.

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.

May 8 and 9, 2021 Follow-up Review

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;²⁵
- 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 residents²⁶ have been transferred to nursing facilities. 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

²⁵ 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.

²⁶ One additional Glencliff resident transferred to a nursing facility, but the transfer occurred before the financial incentives were initiated.

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^{27} 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.

Of the transitions accomplished since March 2020, three have gone to integrated community settings. ²⁸ 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

²⁷ This is intended to form the basis for the quarterly in-reach program data reporting to be included in the Quarterly Data Report.

²⁸ Two have gone to the Palm Street residence; one has gone to an enhanced family care setting supported by the CFI waiver.

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 settings²⁹ 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 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.

²⁹ 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.

- 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.³⁰
- 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

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

³⁰ 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.

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.