New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Six

June 30, 2017

(Draft – June 27, 2017)

I. Introduction

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

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

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

- Conducted an on-site review of Assertive Community Treatment (ACT) teams/services and Supported Employment (SE) services at the Monadnock CMHC. A non-random sample of ACT and SE records was reviewed at that site;
- Met with the State's Central Team to review progress and discuss barriers to transition from both New Hampshire Hospital (NHH) and Glencliff Home (Glencliff);
- Met with senior management and with a clinical team at NHH to review transition planning processes and issues;
- Met with Glencliff leadership, clinical staff, and a resident to discuss transition planning processes and issues;
- Met with DHHS staff involved with the PASRR program to discuss the new contract for PASRR services and to identify data reporting issues;

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

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

Summary of Progress to Date

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

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

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

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

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

3. By August 1, 2016 circulate to all parties a detailed plan with implementation steps and timelines to achieve CMHA requirements to assist 10 residents of Glencliff with complex medical needs to move into integrated settings as soon as possible;

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

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

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

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

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

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

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

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

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

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

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

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

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

     ER Finding: The State has implemented this recommendation.

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

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

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

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

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

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

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

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

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

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

II. Data

The New Hampshire DHHS continues to make progress in developing and delivering data reports addressing performance in some domains of the CMHA. Appendix A contains the most recent DHHS Quarterly Data Report (March 2017), incorporating standardized report formats with clear labeling and date ranges for several important areas of CMHA performance. The ability to conduct and report longitudinal analyses of trends in certain key indicators of CMHA performance continues to improve.

The Quarterly reports now include data from the new mobile crisis services in the Concord and Manchester Regions; data on discharge destinations from NHH, the DRFs, and Glencliff; admission, discharge and length of stay data for New Hampshire's DRFs; and data on utilization of the Housing Bridge Subsidy Program.

As noted in previous ER reports, there continue to be important categories of data that are needed, but not routinely collected and reported, and which will need to be reported in order to accurately evaluate ongoing implementation of the CMHA. For example, there continues to be no reported or analyzed data on the degree to which participants in SE are engaged in competitive employment in integrated community settings consistent with their individual treatment plans. These data are important in assessing the fidelity with which SE services are provided. DHHS's efforts related to assuring the fidelity of SE services are discussed in the SE section of this report. In addition, needed revisions to the QSR instruments and protocols may

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

Another gap in data is related to people receiving Supported Housing (SH) under the Housing Bridge Subsidy Program. These participants are not yet clearly identified in the Phoenix II system, and thus it is difficult to document the degree to which these individuals are: (a) connected to local CMHC services and supports; (b) actually receiving services and supports to meet their individualized needs on a regular basis in the community; or (c) living at addresses with two or fewer SH units.[1] As noted in the January 2016 ER Report, DHHS has identified a strategy to link data from the Bridge Subsidy Program to the Phoenix II system. However, such data has not been produced to date. Without the information above, the ER is unable to determine whether or not the State has achieved substantial compliance with the CMHA outcomes and requirements for SH. Other outstanding data requests include SH data on applications, time until eligibility determination, time on waiting list, and the reason for ineligibility determinations,

III. CMHA Services

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

Mobile/Crisis Services and Crisis Apartments

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

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

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

Table I

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

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

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

Total hospital diversions*	327	488	NA	643

*Hospital diversions are instances in which services are provided to individuals in crisis resulting in diversion from being assessed at the ED and/or being admitted to a psychiatric hospital.

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

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

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

Assertive Community Treatment (ACT)

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

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

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

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

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

Table II

Self-Reported ACT Staffing (excluding psychiatry): May 2015 through March 2017

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

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

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

Table III below displays trends in active caseloads for ACT services by Region.

Table III

Self-Reported ACT Caseload (Unique Adult Consumers) by Region per Month: May 2015 through March 2107

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

* *unduplicated across regions*

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

Ongoing deficiencies in ACT team staffing and composition leave the State out of compliance with the foundational service standards described in Section V.D.2 of the CMHA, and threaten its ability to provide a robust and effective system of ACT services throughout the state.

As noted in the previous ER Report, the New Hampshire DHHS has begun to take more aggressive action to work with CMHCs in certain Regions to increase their ACT staffing and caseloads. These actions include: (a) monthly ACT monitoring and technical assistance with DHHS leadership and staff; (b) implementation of a firm schedule for ACT self-assessments and DHHS fidelity reviews ; (c) incorporating a small increase in ACT funding into the Medicaid rates for CMHCs; (d) active on-site monitoring and technical assistance for CMHCs not yet

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

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

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

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

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

Supported Employment

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

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

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

Table IV

Self-Reported CMHC SE Penetration Rates*

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

*12 month cumulative total

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

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

There is currently no mechanism for measuring whether individuals are receiving SE services consistent with their individual treatment plans, or whether SE services are delivered in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings (V.F.1). The ER has recommended that the QSR process measure whether and to what extent SE services are being delivered consistent with these requirements of the CMHA. To that end, the ER expects to review employment data from each region during the next reporting period.

Supported Housing

The CMHA requires the State to achieve a target capacity of 450 SH units funded through the Bridge Subsidy Program by June 30, 2016. As of March, 2017, DHHS reports having 505 individuals in leased SH apartments, and 48 people approved for a subsidy but not yet leased. The State is in compliance with the CMHA numerical standards for SH effective June 30, 2016.

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

Table V

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

September 2015 through March 2017

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

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

Table VI

Self-Reported Housing Bridge Subsidy Concentration (Density)

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

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

It should be noted that these data do not indicate whether any of the leased units are roommate situations, and if so, whether such arrangements meet the requirements of the CMHA (V.E.1(c)). DHHS reports, and anecdotal information seems to support, that there are very few, if any, roommate situations among the currently leased Bridge Subsidy Program units.[2]

As noted in the Data section of this report, current data is not available on the degree to which Bridge Subsidy Program participants access and utilize support services and whether or not the services are effective and meet individualized needs. Receipt of services is not a condition of eligibility for a subsidy under the Bridge Program, but the CMHA does specify that "…supported housing includes support services to enable individuals to attain and maintain integrated affordable housing, and includes support services that are flexible and available as needed and desired…." (V.E.1(a)). As noted in the January, June, and December 2016 ER Reports, DHHS has been working on a method to cross-match the Bridge Subsidy Program participant list with the Phoenix II and Medicaid claims data. This will allow documentation of the degree to which Bridge Subsidy Program participants are actually receiving certain mental health or other services and supports. The ER will continue to work with the State to document whether is the State is in substantial compliance with CMHA provisions on the availability and provision of support services to persons in SH..

In previous reports the ER has identified a number of important and needed data elements associated with the SH eligibility criteria and lack of a waitlist, as well as monitoring implementation of the SH program in the context of the CMHA. These include:

- Total number of Bridge Subsidy Program applicants per quarter;
- Referral sources for Bridge Subsidy Program applicants;
- Number and percent approved for the Bridge Subsidy Program;
- Number and percent rejected for the Bridge Subsidy Program;
    - Reasons for rejection of completed applications, separately documenting those who are rejected because they do not meet federal HCV/Section 8 eligibility requirements;

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

- Number and disposition of appeals related to rejections of applications;
- Elapsed time between application, approval, and lease-up;
- Number of new individuals leased-up during the quarter;
- Number of terminations from Bridge subsidies;
- Reasons for termination:
    - Attained permanent subsidized housing (Section 8, public housing, etc.);
    - Chose other living arrangement or housing resource;
    - Moved out of state;
    - Deceased;
    - Long term hospitalization;
    - Incarceration;
    - Landlord termination or eviction; or
    - Other;
- Number of Bridge Subsidy Program participants in a roommate situation; and
- Lease density in properties with multiple Bridge Subsidy Program leases.

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

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

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

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

Transitions from Institutional to Community Settings

During the past 24 months, the ER has visited both Glencliff and NHH on at least five separate occasions to meet with staff engaged in transition planning under the new policies and procedures adopted by both facilities late last year. Transition planning activities related to specific current residents in both facilities were observed, and more recently, a small non-random sample of resident transition records has been reviewed. Additional discussions have also been held with both line staff and senior clinicians/administrators regarding potential barriers to effective discharge to the most appropriate community settings for residents at both facilities.

The ER has participated in four meetings of the Central Team. The CMHA required the State to create a Central Team to overcome barriers to discharge from institutional settings to community settings. The Central Team has now had about 18 months of operational experience, and has started reporting data on its activities. To date, 30 individuals have been submitted to the Central Team, 19 from Glencliff and 11 from NHH. Of these, the State reports that 10 individual cases have been resolved, two individuals are deceased, and 18 individual cases remain under consideration. Table VII below summarizes the discharge barriers that have been identified by the Central Team with regard to these 18 individuals. Note that most individuals encounter multiple discharge barriers, resulting in a total substantially higher than the number of individuals reviewed by the Central Team.

Table VII

Discharge Barriers from NHH and Glencliff Identified by the Central Team: September 2015

Through March 2017

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

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

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

Glencliff

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

CMHA VI requires the State to develop effective transition plans for all appropriate residents of NHH and Glencliff and to implement them to enable these individuals to live in integrated community settings. In addition, Section V.E.3(i) of the CMHA also requires the State by June 30, 2017 to: "…have the capacity to serve in the community [a total of 16][3] individuals with mental illness and complex health care needs residing at Glencliff…." The CMHA defines these as: "individuals with mental illness and complex health care needs who could not be cost-effectively served in supported housing."[4] The ER notes that Glencliff continues to support and effectuate transitions of individuals to integrated community settings under a variety of other funding and living arrangements.

DHHS reports that the number of people with complex health conditions transitioned from Glencliff to integrated settings since the inception of the CMHA three years ago increased this quarter from 10 to 12. DHHS has agreed to provide the ER information about the recent two transitions that includes a brief clinical summary, length of stay, location and type of community integrated setting, and array of individual services and supports arranged to support them in the integrated community settings. This information is important to monitor the degree to which individuals with complex medical conditions who could not be cost-effectively be served in supported housing continue to experience transitions to integrated community settings.

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

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

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

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

meet the needs of these individuals. Both sets of initiatives should facilitate and speed up such community transitions for additional Glencliff residents.

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

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

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

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

Preadmission Screening and Resident Review (PASRR)

The ER has met with the DHHS PASRR Team and representatives of the PASRR vendor, and has reviewed the most recent PASRR report. The ER needs to be satisfied that PASRR reviews are being conducted as described under CMHA VI.A.10, and that individuals whose needs could be met in the community are promptly referred to the appropriate area agency or CMHC in order to document compliance with this CMHA requirement.

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

New Hampshire Hospital

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

Table VIII below compares NHH discharge destination information for the five most recent reporting periods. The numbers are expressed as percentages because the length of the reporting periods had not previously been consistent, although the type of discharge destination data reported has been consistent throughout.

Table VIII

New Hampshire Hospital Self-Reported Data on

Discharge Destination

Discharge Destination	Percent January 2014 through May 2015	Percent July 1 2015 through September 18, 2015	Percent September 19, 2015 through April 20, 2016	Percent October and November 2016	Percent January through March 2017
Home – live alone or with others	74.4%	67.3%	80.2%	85.1%	84.5%
Glencliff	0.4%	0.20%	0.60%	0.36%	1.55%
Homeless Shelter/motel	3.8%	2.4%	2.7%	2.54%	2.71%
Group home 5+/DDS supported living, etc.	3.4%	9.02%	3.2%	1.62%	5.7%
Jail/corrections	1.5%	0.40%	1.4%	2.9%	0.8%
Nursing home/rehab facility	1.9%	3.0%	0.80%	3.6%	1.9%

The State's most recent Quarterly Data Report contains new, consistently reported information on the hospital-based DRFs and The Cypress Center in New Hampshire. It is important to capture the DRF/Cypress Center data and combine it with NHH and Glencliff data to get a total institutional census across the state for the SMI population. The ER appreciates the State gathering this information. Table IX summarizes this data.

Table IX

Self-Reported DRF/APRTP Utilization Data: January 2016 through March 2017

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

* Does not include Portsmouth

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

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

Table X

Self-Reported Discharge Dispositions for DRFs in New Hampshire

October 2016 through March 2017

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

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

Hospital Readmissions

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

Table XI

Self-Reported Readmission Rates for NHH and the DRFs

October – December 2016

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

January - March 2017

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

Readmission rates sometimes indicate that people being discharged from inpatient psychiatric systems are not connecting with necessary and appropriate services and supports in the community. Trends in readmission rates may also be indicators of increased or decreased pressures on the overall system of care. For example, decreased readmission rates could be an

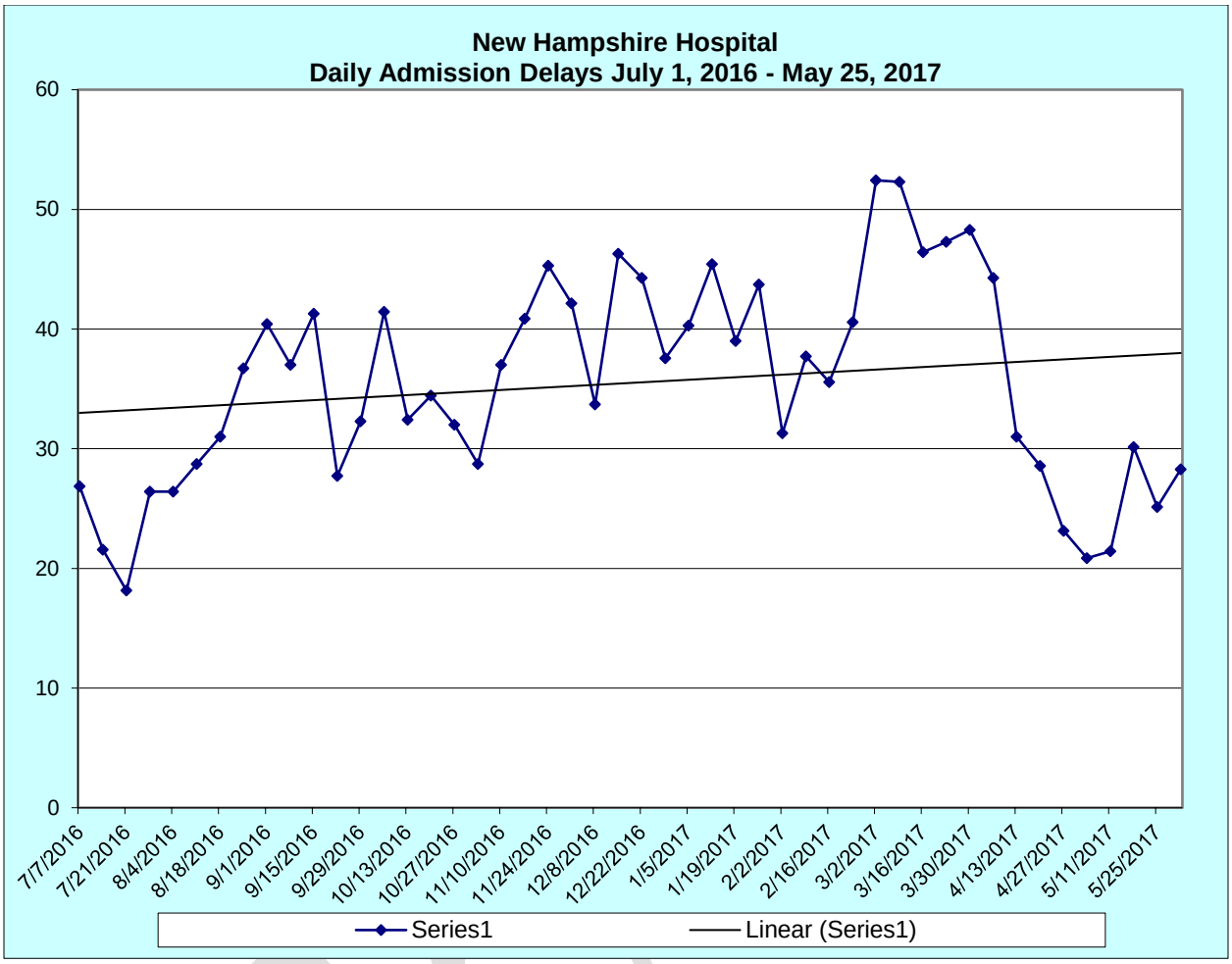
indicator that hospitals are not discharging people too quickly because of pressures to admit new patients. Decreases could also indicate that connections to appropriate community services and supports are occurring more effectively. Right now, 180-day readmission rates to NHH are substantial, with almost one-third of those discharged returning to NHH within six months.

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

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

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

In the previous two reports, the ER has identified the waiting list (hospital ED boarding) for admission to NHH to be an important indicator of overall system performance. Based on recent information reported by DHHS, the average number of adults waiting for a NHH inpatient psychiatric bed was 24 per day in FY 2014; 25 per day in FY 2015; and through June of FY 2016 was 28 per day. For the period July 1 through September 30, 2016 the average weekly wait list for admission to NHH was 31.5. As shown in the chart below, there continues to be an average of over 20 people waiting in EDs for admission to NHH on a daily basis. In most mental health systems, a high number of adults waiting for inpatient admissions is indicative of a need for enhanced crisis response (e.g., mobile crisis) and high intensity community supports (e.g., ACT).



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

Family and Peer Supports

Family Supports

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

Peer Support Agencies

As noted in the June 30, 2015 ER report, New Hampshire reported having a total of 16 peer support agency program sites, with at least one program site in each of the ten regions. The State reported that all peer support centers meet the CMHA requirement to be open 44 hours per week. At the time of that report, the State reported that those sites had a cumulative total of 2,924 members, with an active daily participation rate of 169 people statewide. In the June 2016 data report, the total membership was reported to be 2,978 people, with average daily statewide visits of 148. For the January – March 2017 reporting period, total membership was reported to be 3,265, with an average daily participation of 138 (see Appendix A). It is unclear why daily participation rates at the Peer Support Programs are trending down, while State reports of total membership are increasing over time.

The CMHA requires the peer support programs to be "effective" in helping individuals in managing and coping with the symptoms of their illness, self-advocacy, and identifying and using natural supports. As noted in previous reports, enhanced efforts to increase active daily participation appear to be warranted for the peer support agency programs.

Anecdotally, the ER believes that in many regions of the state, relationships and communications among the CMHCs and the Peer Support Programs have improved. Peer support programs are generally reported by CMHCs to be useful sources of employees for ACT and Mobile Crisis and Crisis Apartment services. In addition, CMHCs report that the peer operated crisis beds available in several regions are a useful intervention for some CMHC clients at risk of hospitalization.

IV. Quality Assurance Systems

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

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

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

As noted in earlier reports, it is essential that the QSR process produce information that is accurate, verifiable, and actionable. It is similarly essential that all parties, as well as the ER, have confidence in, and are able to rely upon, the QSR as a measure of compliance with the CMHA. Although the QSR process is part of broader DHHS quality management efforts, it must be directly responsive to the quality and performance expectations of the CMHA. This is why all Parties to the agreement have invested so much time and effort into the design and implementation of the QSR process. The QSR will produce essential core information to assist the Parties to assess compliance with all quality and performance standards and requirements of the CMHA, and to document the extent to which CMHA-specified outcomes are attained for members of the target population.

As noted earlier in this report, DHHS has been conducting on-site ACT and SE fidelity reviews to supplement and validate the ACT and SE fidelity self-assessments conducted on an annual basis by the CMHCs (see Appendix C for summaries of the findings of these fidelity reviews). DHHS has also engaged the Dartmouth/Hitchcock Center on Evidence Based practices to assist in attaining and assuring fidelity to the evidence based models of ACT and SE. The Dartmouth/Hitchcock team will also assist on workforce development and training for these and other evidence based practices under the aegis of DHHS and the CMHCs. This partnership with the nationally respected Dartmouth/Hitchcock Center adds valuable expertise and experienced personnel to facilitate further development and operations of fidelity model ACT and SE in conformance with the CMHA. The ER commends DHHS for implementing the comprehensive fidelity review process and its attendant quality improvement and technical assistance activities.

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

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

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

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

V. Summary of Expert Reviewer Observations and Priorities

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

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

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

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

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

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

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

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

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

January through March, 2017

Appendix B

New Hampshire Community Mental Health Agreement

Monthly Progress Reports

March, 2017

Appendix C

Assertive Community Treatment & Supported Employment Fidelity Reviews

Summary Report: April 2017