UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

Amanda D., et al., and others similarly situated, Plaintiffs, v. Chris Sununu, Governor, et al., Defendants.	)	Civ. No. 1:12-cv-53-SM
United States of America, Plaintiff-Intervenor, v. State of New Hampshire, Defendant.	)	

JOINT STATUS REPORT ON EXPERT REVIEWER'S THIRTEENTH REPORT

The Plaintiffs, the United States, and the State of New Hampshire file this joint notice to inform the Court that Stephen Day, the Expert Reviewer, has issued his thirteenth public report in this matter:

1. Consistent with the Class Action Settlement Agreement ("Agreement"), the Expert Reviewer issues public reports twice a year, reporting on the State's implementation efforts and compliance with the terms of the Agreement. Agreement, at § VIII.K (ECF No. 105).

2. On January 27, 2021, Mr. Day submitted his thirteenth report to the Parties.

3. The report is attached as Exhibit A for the Court's information.

Dated: February 1, 2021

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that this Status Report has been sent to counsel of record on via the court's Electronic Case Filing system.

/S/ Pamela E. Phelan

New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Thirteen

January 27, 2021

I. Introduction

This is the thirteenth 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 10 months, the State of New Hampshire has been seriously affected by COVID-19. The State reports Community Mental Health Centers (CMHCs) have remained functional and open as essential businesses during this period, although a majority of employees have been working remotely. Following Centers for Disease Control and Prevention (CDC) recommendations and NH Division of Public Health Services (DPHS) guidance, in addition to program specific emergency guidance provided by the Bureau of Mental Health Services (BMHS), CMHCs have focused on adjusting service delivery to maintain health and to implement safety protocols while serving participants in a way that met participant needs and preferences. Telehealth services are being provided for participants preferring that method due to COVID-19 concerns, and in-person services remain available for individuals who prefer this method. Mental Health (MH) facilities, including New Hampshire Hospital (NHH), Glencliff, and residential treatment centers, have modified safety protocols to protect residents/patients from COVID-19. The State has implemented numerous strategies, including Medicaid plan changes, eligibility certification improvements, staffing requirements, etc., to insure that, to the extent possible, service response rates and service continuity are maintained.

During this 10-month period, the ER has been unable to conduct on-site visits or observations. Although Quality Service Reviews have taken place during this period, the ER has not been able to observe any of these activities.

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

During this period, the ER:

- Participated in three conference calls with State officials and representatives of the Plaintiffs to discuss and review transition planning policies and procedures for residents of Glencliff;
- Conducted a telephone interview with leadership and staff of Glencliff and the In-Reach contractor to discuss the implementation of the revised transition planning protocols and the in-reach process and preliminary results;
- Participated in two conference calls with State officials to discuss Mobile Crisis Teams and Crisis Apartment services on a statewide basis and specifically in Nashua;
- Participated in two conference calls with the QSR team to discuss the QSR process during COVID, and also to de-brief on one specific QSR review; and
- Convened an All-Parties conference call meeting to discuss progress in meeting the requirements of the CMHA.

Summary of Progress to Date

This report reflects almost six- and one-half years of implementation efforts related to the CMHA. Within this period, a number of positive steps have been taken to improve the quality and effectiveness of services as envisioned in the CMHA. However, as will be discussed in detail below, there are areas of continued non-compliance with the CMHA. Notwithstanding these on-going concerns, the parties to the CMHA deserve credit for some real and measurable accomplishments.

As noted in previous ER reports, the State has implemented a comprehensive and reliable QSR process. The ER considers these QSR reviews to be methodologically correct and reliable, producing findings that are accurate and actionable in terms of taking concrete steps to address quality issues in the CMHC system.

Another major accomplishment has been contracting with the Dartmouth-Hitchcock Medical Center to conduct external Assertive Community Treatment (ACT) and Supported Employment

(SE) fidelity reviews using nationally validated fidelity review instruments and criteria. In concert with the QSR reviews mentioned above, the fidelity reviews are assisting the State and the CMHCs to develop comprehensive Quality Improvement Plans (QIPs) that address important ACT and SE quality and effectiveness issues at both the consumer and CMHC operational levels. The Fidelity Reviews have not been conducted since the onset of COVID-19. However, the State and the CMHCs have been using evidence Based Practice (EBP) check-lists to monitor fidelity to ACT and SE best practice standards during the pandemic. The State has also continued to provide technical assistance and oversight to CMHCs that had active Quality Improvement Plans (QIPs) related to ACT and SE at the time the fidelity reviews were suspended. The State intends to re-start the Fidelity Review process as early as possible in the coming year.

The parties originally envisioned that the CMHA could be fully implemented in five years, with a sixth year for maintenance of effort. The CMHA was approved and filed with the Federal Court on February 12, 2014, and the five-year anniversary of that event occurred about two years ago. The ER was approved by the Parties and the Federal Court effective July 1, 2014, and the five-year anniversary occurred 18 months ago.

Most of calendar year 2020 has 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 services system defined by the CMHA have remained relatively stable. Understandably, there has been little measurable progress, but there has also been a relatively consistent level of service delivery and performance. **The State is to be congratulated for maintaining services to the CMHA Target Population during these very difficult circumstances. Nonetheless, it is important to emphasize that the pandemic has not altered the terms of the CMHA nor diminished the State's obligations to members of the Target Population. Moreover, the delays and restrictions caused by COVID-19 necessarily require extension of the time periods for the State to complete its responsibilities under the CMHA.**

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

1. Selection of a new vendor (Greater Nashua Mental Health) to operate the Mobile Crisis Team (MCT) and Crisis Apartment program in the Nashua region;
2. Implementation of contracted in-reach services and new transition planning and informed consent protocols at Glencliff; and
3. Addition of new funds to the Bridge Program to permit funding of a total of 500 units.

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

II. Data

As noted in previous reports, the New Hampshire Department of Health and Human Services (DHHS) continues to make progress in developing and delivering data reports addressing performance in some domains of the CMHA. Appendix A contains the most recent DHHS Quarterly Data Report (July 2020 through September 2020) 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 continues to emphasize that the State must produce the necessary data reports in a timely fashion.

III. CMHA Services

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

Mobile/Crisis and Crisis Apartment Programs

The CMHA calls for the establishment of a Mobile Crisis Team (MCT)[1] and Crisis Apartments (MCT/CA) 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/CA 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/CA 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 has recently been transferred to another provider, Greater Nashua Mental Health (GNMH) which is in process of implementing the program. Full implementation is not expected until later in 2021.

As of the date of this report, the State reports that it has competitively reprocured the existing MCT/CA program contracts in Concord and Manchester until June 2022. The State reports the new contracts incorporated changes for these programs including: (a) new performance measures related to face-to-face assessments and follow-up engagement with peers; and (b) new data reporting elements related to presenting problems, police involvement, and intervention

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

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

In Nashua, the original vendor (Harbor Homes) opted not to submit a bid for the program and to end its participation in the program. As a result, effective October 1, 2020, the State has contacted with the GNMH to operate the MCT/Crisis Apartment program. The transition between the previous and current vendors concluded November 1, 2020. Thus, data reported for the Nashua region reflects some reductions in service as the transition was under way.

While the ER is pleased that a new MCT vendor was secured for the Nashua area, diminished service provision during the transition and the limited ability of GNMH to provide key elements of those services in late 2020, including crisis apartment capacity, is concerning and likely to negatively impact class members in this region. The ER will closely monitor ongoing efforts to implement all CMHA required elements of MCT in Nashua in the weeks ahead, and will request that the State provide preliminary data on MCT service delivery in this region, ahead of the standard quarterly reporting period.

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.

Table I

Self-Reported Data on Mobile Crisis Services and Crisis Apartment Programs

Region	Variable	Jan. - Mar. 2020	Apr-June 2020	July – Sept 2020
Concord	Total Served	531	530	557
Manchester	Total Served	618	669	723
Nashua	Total Served	333	245	208
Concord	Phone triage/support	1173	1343	1294
Manchester	Phone triage/support	1565	1552	1699
Nashua	Phone triage/support	385	326	198
Concord	Mobile Assess./intervention	116	211	178
Manchester	Mobile Assess./intervention	290	294	296
Nashua	Mobile Assess./intervention	114	183	74
Concord	Percent Referred by self	64.22%	56.60%	59.90%
Manchester	Percent Referred by self	46.93%	43.00%	40.30%
Nashua	Percent Referred by self	34.23%	56.40%	21.30%
Concord	Percent referred by police	4.33%	5.90%	2.80%
Manchester	Percent referred by police	38.42%	23.20%	26.10%
Nashua	Percent referred by police	3.60%	0.36%	2.70%
Concord	Percent Law Enforcement Inv.	8.70%	14.40%	8.80%
Manchester	Percent Law Enforcement Inv.	36.40%	37.20%	39.80%
Nashua	Percent Law Enforcement Inv.	0.00%	0.04%	0.05%
Concord	Hospital diversions	383	529	523
Manchester	Hospital diversions	1,088	0551055	0751075
Nashua	Hospital diversions	617	511	316
Concord	Apartment Admits	57	39	45
Manchester	Apartment Admits	17	0	0
Nashua	Apartment Admits	56	30	33
Concord	Apartment bed days	245	125	145
Manchester	Apartment bed days	53	0	0
Nashua	Apartment bed days	295	142	172

Table I shows some evidence of the effects of COVID restrictions on the operations of MCT and Crisis Apartment programs. The absence of Crisis Apartment admissions and bed days reported by Manchester is one example of this. Also, as would be expected, there has been a general reduction in levels of service in the Nashua area reflecting the transition to a new vendor.

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

Table II

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

Comparison 12-mo Period	**Average # Adults Waiting per Day for Inpatient Psychiatric Admission**	**NHH Admissions**	**NHH 180-day Readmissions Average**
10/1/2018-9/30/2019	34	812	27.9%
10/1/2019-9/30/2020	31	867	22.7%
Change	Down 9%	Up 6.8%	Down 18.7%

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

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

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.

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

Staffing for the ACT teams has remained stable during the 10 months affected by COVID. However, the combined staffing of the ACT Teams is 5.95 full time equivalents (FTEs) below the levels attained a year ago (September 2019).

Table III

Self-Reported ACT Staffing (excluding psychiatry):

September 2017 – March 2020

Region	FTE Sep-17	FTE Mar-19	FTE Jun-19	FTE Sep-19	FTE Dec-19	FTE Mar-20	FTE Jun-20	FTE Sep-20
Northern	12.4	16.8	16.51	16.37	16.97	16.37	13.36	15.12[2]
West Central	7.0	6.8	7.65	8.25	8.75	6.10	6.10	5.00
Lakes Region	10.8	8.3	8.00	8.00	7.00	7.00	6.50	6.40
Riverbend	10.0	11.5	10.50	11.50	11.50	10.50	10.50	9.00
Monadnock	7.9	9.5	9.00	8.00	8.75	8.85	8.85	11.58
Greater Nashua 1	6.0	6.5	7.00	8.00	8.00	6.50	8.00	8.50
Greater Nashua 2	5.0	4.5	4.00	7.00	8.00	7.50	8.00	8.50
Manchester – CTT	16.3	14.3	15.75	15.75	15.75	18.25	18.25	16.25
Manchester MCST	22.3	15.8	17.25	17.25	15.75	16.25	17.25	18.25
Seacoast	10.5	9.1	9.10	10.10	10.10	9.10	9.10	9.00
Community Part.	6.7	8.8	10.78	11.28	10.80	11.05	9.20	8.95
CLM	9.3	7.9	7.01	8.30	9.55	8.55	8.30	7.30
Total	124.2	119.6	122.55	129.80	130.92	127.02	123.41	123.85

Five teams (West Central and Lakes Region and all three Northern teams) report having fewer than the required minimum of seven FTEs to qualify as an ACT team, an increase from the last report at which time only two teams (Riverbend and Community Partners) had fewer than the required minimum. Five teams (Northern [Berlin and Littleton Teams], Riverbend, Manchester CTT and Community Partners)) report having no peer support specialist. Two teams (Wolfeboro and Nashua 2) report having no SE staff capacity. Northern (Littleton) reports having no SUD treatment staff capacity. Eight teams report having 0.5 or less FTE combined psychiatry/nurse practitioner time available to their ACT teams; and seven of the 14 teams report having less than one FTE nurse per team. Although overall staffing levels have remained relatively stable across all ACT teams, shortages in discrete categories, like nursing and peer support, have worsened

[2] There are now three teams operating in the Northern region. In future reports the ER will document staffing levels for each of these teams, as opposed to the aggregate staffing reflected in this report.

since the previous report. As a result, several teams do not meet the CMHA requirements for staffing or team criteria set out in the CMHA.

Table IV below displays the active ACT caseloads by CMHC Region since June 2017. The active monthly caseload has decreased by 14 participants since December 2019. Since June of 2017 the active monthly caseload has dropped by 86 participants.

Table IV

Self-Reported ACT Active Caseload (Unique Adult Consumers) by Region in Specified Months: June 2017 – March 2020

Region	Active Cases Jun-17	Active Cases Sep-17	Active Cases Jun-19	Active Cases Sep-19	Active Cases Dec-19	Active Cases Mar-20	Active Cases Jun-20	Active Cases Sep-20
Northern	111	113	115	122	118	115	117	121
West Central	76	68	46	47	43	42	57	43
Lakes Region	74	74	57	56	56	57	54	52
Riverbend	97	87	102	86	94	94	95	91
Monadnock	70	69	57	49	50	51	50	47
Greater Nashua	94	98	83	97	99	101	105	107
Manchester	292	287	287	300	286	262	254	265
Seacoast	69	67	66	68	65	66	69	74
Community Part.	69	75	67	71	74	68	70	72
CLM	55	54	47	49	50	47	48	49
Total*	1,006	992	925	942	934	903	919	920

* unduplicated across regions

The combined ACT teams have a reported September 2020 staff complement of 123.85 FTEs excluding psychiatry, which is sufficient capacity to serve 1,238 individuals based on the ACT non-psychiatry staffing ratios contained in the CMHA. However, with a statewide caseload of only 920, as of September 2020, there is a gap between staff capacity and active participants of 318.

As noted above, the CMHA requires the State to have capacity to serve 1,500 individuals. The current ACT staffing levels are 26.15 FTEs (or capacity to serve 262 participants) below the capacity required by the CMHA. This gap between staff capacity and actual service participants

is particularly problematic, given that there are reported to be 11 individuals on the wait list for ACT (see Table VII below).

As noted in previous reports, the current level of ACT staffing on many CMHC teams is not sufficient to meet CMHA requirements for ACT team capacity. Furthermore, the current ACT caseload of 920 individuals is 580 below the number that could be provided ACT services with the staffing capacity required by the CMHA.[3]

ACT Screening

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

1. As part of the intake process at the CMHCs;[4]
2. Upon referral to a CMHC following discharge from an inpatient facility; and
3. As part of regular quarterly and annual assessments and plan of care amendments for current CMHC clients[5] who may qualify for and benefit from ACT.

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

[3] The ER notes that active ACT caseload is a static measure of ACT activity. The ER plans to work with the State and representatives of the Plaintiffs to incorporate other indicators, such as ACT enrollments and unduplicated ACT participants in subsequent reports.
[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: this is a retrospective table, and thus is always one quarter behind most of 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
April to June 2020

Community Mental Health Center	Total Screened (not already on ACT)	Appropriate for further ACT Assessment	Receiving ACT/ w/i 90 days of Screening	Percent Receiving ACT of those Appropriate for Assessment within 90 days	Percent Receiving ACT of those appropriate for assessment in Previous Report within 90 days
01 Northern Human Services	1,037	17	1	5.88%	21.05%
02 West Central Behavioral Health	201	3	0	0.00%	100%
03 Lakes Region Mental Health Center	878	1	0	0.00%	12.5%
04 Riverbend Community Mental Health Center	1,446	2	1	50%	0.0%
05 Monadnock Family Services	690	4	0	0.0%	0.0%
06 Greater Nashua Mental Health	802	7	2	28.6%	0.00%
07 Mental Health Center of Greater Manchester	1,561	14	3	21.4%	17.6%
08 Seacoast Mental Health Center	1,454	23	1	4.3%	2.4%
09 Community Partners	262	0	0	0.0%	100%%
10 Center for Life Management	789	1	0	0.0%	0.0%
Total	**9,120**	**72 (0.79% of all screened)**	**8 (11.1% of all assessed after screening- 0.09% of all screened)**		

Of the 9,120 unique individuals screened for ACT during this period, the State reports that 72 were referred for an ACT assessment. This is a referral rate of less than one percent, slightly

down from the previous report. Eleven percent (8 individuals) of those referred for ACT assessments was enrolled in ACT services within 90 days of being screened. Most of the referrals for ACT screening are internal to the CMHCs. That is, people who have already had a CMHC intake, and who may already be receiving CMHC services, are those most likely to be screened for ACT services. Thus, it is perhaps not surprising that so few of the individuals screened are referred to the next step, which is the assessment for ACT.

The State has reported that about 90 percent of individuals are linked to ACT without having gone through the ACT screening process. In general, this seems to be confirmed by the fact that 80 new clients were reported to be added, while the screening process only produced 8 new clients (10.0%). No specific data have been reported to date about where these referrals originate or how they avoided the CMHC intake and screening process. Because of this limitation, 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 recommends that the State develop and implement an initiative to identify and screen/assess individuals outside of the CMHC system, especially those in crisis or decline, such as those having contact with NHH, the DRFs, the MCTs, the ERs, homeless outreach workers and organizations or the criminal justice system.

New ACT Clients

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

Table VI

Self-Reported New ACT Clients

CMHC	New Clients October 2019 – December 2019	New Clients January 2020 – March 2020	New Clients April – June 2020	New Clients July to Sept. 2020
Northern Human Services	6	10	11	13
West Central Behavioral Health	11	6	21	5
Lakes Region MHC	5	4	5	4
Riverbend CMHC	20	13	9	8
Monadnock Family Services	1	1	0	0
Greater Nashua Mental Health	6	8	5	10
MHC of Greater Manchester	17	19	16	22
Seacoast MHC	3	4	5	7
Community Partners	5	4	6	7
Center for Life Management	3	1	5	4
Total	**77**	**70**	**83**	**80**

It should be noted that in the time period from October to December 2019, the State reported a decrease in active ACT caseload from 958 to 934, while at the same time reporting the addition of 77 new ACT clients. For the period January through March 2020, the State reported that the ACT active caseload decreased from 929 to 903, while at the same time reporting the addition of 70 new ACT clients. For the July to September quarter, the statewide monthly active caseload increased by one participant, whereas 80 new clients were reported to have been added during this time frame. This indicates that: (1) there is substantial turnover in the active ACT caseload over a relatively short time frame; and (2) thus, aggressive efforts to engage new ACT clients are necessary just to maintain steady state[7] operations in the ACT program, much less to grow the program. In light of this data, and to provide further context for this fluctuation in active caseloads, the ER recommends 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).

The State has been reporting data on the number of individuals waiting for ACT services on a statewide basis for the past 27 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. Indeed, other than Riverbend in September 2020 (for the first time at any CMHC), there is excess capacity in each region/team and enough capacity to address the needs of people reported to be on the waitlist, especially in Manchester which has a consistent recent record of causing people to wait for ACT services; both Manchester ACT teams have a combined capacity to serve 345 people, but, as of September 2020, Manchester only served 265 people, leaving unused ACT capacity for 80 people. Nonetheless, the State and the CMHCs note that in some CMHC regions, new ACT staff must be hired before new ACT clients can be accepted into the program.

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

Table VII

Self-Reported ACT Wait List

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

The ER notes that 8 of the 11 individuals reported to be on the wait list for ACT services have been waiting for greater than 30 days: three of the 11 have been waiting for more than 150 days. Given the excess ACT capacity noted above, the ER expects the State will intervene to assure that people in need of, and eligible for, ACT receive ACT services in a timely manner.

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 two quarters on these issues.

Table VIII

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

October 2019 through September 2020

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

In concert with tracking admissions to and discharges from NHH related to ACT, the State has begun reporting the reasons that individuals are not accepted into ACT upon discharge from NHH. Table VIX summarizes this reported information.

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

Table VIX

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

October 2019 through March 2020

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

In the April through June 2020 time period, 87.5% of the individuals referred but not accepted into ACT were reported to be awaiting CMHC determination of eligibility for ACT. In the July to September time period this number was 100%. 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. The ER remains concerned about these reported delays in accessing ACT services at the CMHC level. This concern is in addition to concerns about the number of people reported to be waiting more than 30 days for access to ACT services.

The ER understands that the State has been attempting to improve referrals to and acceptance in ACT services, and has implemented directed payments and other incentives to improve performance in this area. However, currently reported data does not support a conclusion that access has in fact been improved. Thus, the ER expects the State to take additional steps to align the reported excess capacity in the ACT system with the needs of individuals for ACT services, both on discharge from NHH and from the ACT waiting list. By March 1, 2021, the ER expects a written report from the State on: (1) the action steps being taken to address delays in accessing ACT services; and (2) the actual numerical progress being made to assure that individuals eligible for and in need of ACT, including those being discharged from NHH, receive timely access to these services.

ACT Fidelity and Quality

Despite the limitations imposed because of COVID-19, the State has been able to complete QSR reviews for all of the CMHCs during calendar year 2020. The results of the reviews are

summarized in the section on Quality later in the 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***, six of the ten CMHCs scored below the State's performance threshold of 80%. This resulted in a system-wide score on this indicator of 74%, six percentage points below the desired performance threshold. 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.

There have been no ACT Fidelity reviews conducted since March 2020, when restrictions were imposed because of COVID-19. Thus, there is no ACT Fidelity information available for this report. The ER plans to participate in both ACT Fidelity and QSR reviews as soon as possible after COVID restrictions are lifted. The ER will also continue to monitor quality and performance improvements implemented by the State and the CMHCs in response to the QSR findings noted above.

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

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

Supported Employment (SE)

Pursuant to the CMHA's SE requirements, the State must accomplish three things: 1) provide SE services in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings consistent with their individual treatment plans (V.F.1); 2) meet Dartmouth fidelity standards for SE (V.F.1); and 3) meet penetration rate mandates set out in the CMHA. For example, the CMHA states: "By June 30, 2017, the State will increase its penetration rate of individuals with SMI receiving supported employment … to 18.6% of eligible individuals with SMI." (Section V.F.2(e)). In addition, by

June 30, 2017, "the State will identify and maintain a list of individuals with SMI who would benefit from supported employment services, but for whom supported employment services are unavailable" and "develop an effective plan for providing sufficient supported employment services to ensure reasonable access to eligible individuals in the future." (V.F.2(f)).

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

While the State continues to meet the statewide standard for SE penetration in the CMHA, this is primarily due to strong SE penetration rates in two CMHC Regions (Manchester (41.9%) and Seacoast (38.7%). The ER is increasingly concerned that Target Population members in large portions of New Hampshire are reported to not have adequate or equitable access to this essential best practice service.

Table X

Self-Reported CMHC SE Penetration Rates

	Penet. Jun-19	Penet. Sep-19	Penet. Dec-19	Penet. Mar-20	Penet. Jun-20	Penet. Sep-20
Northern	14.90%	15.80%	15.00%	14.20%	12.00%	11.80%
West Central	22.50%	19.70%	20.10%	22.20%	24.30%	25.50%
Lakes Reg.	18.90%	18.90%	19.60%	15.90%	21.50%	26.90%
Riverbend	19.00%	18.40%	17.40%	16.20%	16.10%	14.70%
Monadnock	6.80%	6.20%	6.20%	7.30%	4.80%	4.10%
Greater Nashua	13.10%	13.10%	13.00%	15.10%	13.40%	13.20%
Manchester	39.00%	39.30%	40.50%	41.70%	42.80%	41.90%
Seacoast	33.70%	32.90%	34.20%	39.00%	36.00%	38.70%
Community Part.	8.60%	7.80%	10.10%	11.70%	11.20%	13.70%
CLM	20.80%	20.10%	18.00%	16.40%	14.80%	14.80%
CMHA Target	18.60%	18.60%	18.60%	18.60%	18.60%	18.60%
Statewide Ave.	23.50%	23.20%	23.70%	23.70%	24.20%	24.50%

The State reports data on the degree to which CMHC clients are working, either full or part time, in competitive employment.[9] 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.

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

Table XI

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

CMHC	Percent of SE Active Clients Employed Full or Part Time July – September 2019	Percent of SE Active Clients Employed Full or Part Time Jan – March 2019	Percent of SE Active Clients Employed Full or Part Time Oct. Dec 2019	Percent of SE Active Clients Employed Full or Part Time Jan. – Mar. 2020	Percent of SE Active Clients Employed Full or Part Time Mar-June 2020	Percent of SE Active Clients Employed Full or Part Time July – Sept 2020
Northern	38.9%	44.2%	34.4%	40.5%	27.3%	36.4%
WCBH	28.6%	43.8%	42.1%	45.4%	44.4%	33.3%
LRMHC	34.9%	27.9%	53.0%	40.6%	51.5%	51.3%
Riverbend	60%	61.8%	64.3%	54.0%	62.5%	50.0%
Monadnock	40%	52.0%	64.7%	36.4%	45.5%	61.9%
Nashua	38.9%	31.9%	37.8%	44.8%	38.6%	42.3%
MHCGM	58.3%	54.3%	54.0%	52.0%	54.4%	60.5%
Comm. Partners.	53.9%	57.1%	50.0%	42.8%	33.3%	49.3%
Seacoast	36.3%	31.3%	32.3%	28.3%	50.1%	31.5%
CLM	75%	56.5%	78.1%	63.3%	47.9%	46.0%
Statewide	49.2%	46.7%	51.9%	46.7%	46.7%	47.9%

For adult CMHC clients not participating in SE, the overall numbers are lower, with only 26.49% currently engaged in full-time or part-time employment statewide. [10]

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

The State reports that 38 individuals are waiting for SE services. Twenty-three individuals (or 61 percent) have been waiting for over a month. This is a slight improvement from the previous

[10] 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.

quarter, in which 38 individuals were waiting for SE and 60.5% had been waiting for more than a month. However, delays in access to SE services must be addressed to "ensure reasonable access to eligible individuals" per CMHA V.F.2(f).

SE Fidelity and Quality

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

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

1. Indicator 8: Adequacy of employment assessment/screening (Statewide average score of 69%; nine of ten CMHCs below the performance threshold); and
2. Indicator 10: Adequacy of individual employment service delivery (Statewide average score of 78%; five 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)

The CMHA requires the State to achieve a target capacity of 450 SH units funded through the Bridge Program and HUD-funded subsidies by June 30, 2016. As of September, 2020, the State reports having 312 individuals leased in Bridge Program subsidized units and 96 people approved for a Bridge Program subsidy, but not yet leased. This 96 figure is high compared to past totals and may indicate that there may be issues related to finding and leasing appropriate apartments in some areas of the state. There has been a substantial drop in the aggregate number of individuals either leased or approved but not yet leased in the Bridge Program – from a high of 591 in June of 2017 to the current number of 312 units leased.

There are 85 individuals reported to be on the Bridge Program wait list as of the end of September 2020. Of these, 56 individuals have been on the wait list for more than two months.

Table XII below provides data regarding the number of current Bridge Subsidy participants; the number waiting to lease and the number on the Bridge Subsidy 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 September 2020

Bridge Subsidy Program Information	Sept. 2018	Mar. 2019	June 2019	Sept. 2019	Dec.2 019	Mar. 2020	June, 2020	Sept. 2020
Total individuals leased in the Bridge Subsidy Program	423	389	365	338	340	327	328	312
Individuals in process of leasing	0	11	13	35	54	94	79	96
Individuals on the wait list for a Bridge Subsidy[11]	35	38	44	42	25	49	39	85
Cumulative historical number transitioned to a HUD Housing Choice Voucher (HCV)	125	137	133	151	163	179	192	198[12]

[11] The State did not maintain a waitlist prior to 2018.
[12] As of the date of this report, 75 individuals have HCV subsidies.

Table XIII

Self-Reported Housing Bridge Subsidy Applications and Terminations

Measure	April – June 2019	July-September 2019	October – December 2019	January – March 2020	April – June 2020	July-Sept. 2020
Applications Received	28	22	59	74	30	57
Point of Contact						
CMHCS	11	13	51	63	29	50
NHH	14	9	8	11	29	6
Other	1	0	0	0	1	1
Applications Approved	14	11	42	104	27	57
Applications Denied	1	0	0	0	0	0
Denial Reasons	0	*NA*	*NA*	*NA*	*NA*	*NA*
Applications in Process at end of period	74	75	79	49	41	0
Terminations	0	0	0	2	0	2
Termination Reasons	*NA*	*NA*	*NA*	*Not Reported*	*0*	*Failure to pay rent*
Over Income						

Table XIV

Self-Reported Exits from the Housing Bridge Subsidy Program

April through September 2020

Type and Reason	April – June 2020	July – September 2020
DHHS Initiated Terminations		
Failure to pay rent	0	2
Client Related Activity		
HUD Voucher Received	16	24
Deceased	2	1
Over Income	1	1
Moved out of State	2	3
Declined Subsidy at Recert.	2	10
Higher level of care accessed	2	4
Other Subsidy provided	1	2
Moved in with Family	1	0
Total	27	47

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 Housing Bridge Subsidy Concentration (Density)

	March 2019	June 2019	Sept. 2019	Dec. 2019	Mar. 2020	June 2020	Sept. 2020
Number of properties with one leased SH unit at the same address	315	300	282	276	279	267	255
Number of properties with two SH units at the same address	18	16	18	18	14	15	20
Number of properties with three SH units at the same address	3	4	1	4	2	6	2
Number of properties with four SH units at the same address	2	2	1	2	2	0	0
Number of properties with five SH units at the same address	2	1	1	0	0	0	1
Number of properties with six SH units at the same address	0	0	0	0	0	1	0
Number of properties with seven+ SH units at same address	1	1	1	1	1	1	1

It should be noted that these data do not indicate whether any of the leased units are roommate situations, and if so, whether such arrangements meet the requirements of the CMHA (V.E.1(c)). DHHS reports that there is currently only one voluntary roommate occurrence among the currently leased Bridge Subsidy Program units in the above data.

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

Table XVI

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

	As of 6/30/19	As of 9/30/19	As of 12/31/19	As of 3/31/2020	As of 6/30/20202	As of 9/30/2020
Housing Bridge Tenants Linked to Mental Health Services	360 of 378 (95%)	339 of 373 (91%)	358 of 394 (91%)	348 of 421 (83%)	329 of 406 (81%)	335 of 409 (82%)

These data document the degree to which Bridge Subsidy Program participants are actually receiving certain mental health or other services and supports.[13]

The CMHA also 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)). In 2015, New Hampshire applied for and was awarded funds to develop a total of 241 units of supported housing under the HUD Section 811 Program (191 Program Rental Assistance [PRA] and 50 Mainstream). All of these units are to be set aside for people with serious mental illness. As of the date of this report, 151 (combined PRA and Mainstream) of these new units are reported to have been developed and to have been occupied by members of the Target Population. The State has not been able to provide the current number of people in 811 housing, only the cumulative total over time. Nor is there clear data at this point about the number of Mainstream vouchers (tenant-based rental assistance) versus PRA units (project-based rental assistance) that are currently occupied. The ER intends to follow-up with the State in the next reporting period to clarify the implementation and utilization of the 811 Program for Target Population members.

It should be noted that over the life of the Bridge Program the State has accessed 198 HUD Housing Choice Vouchers (HCVs)[14] and seven HUD public housing or similar subsidized units. But in the notes to the State's data table 10, the State can only confirm that 75 of those who have accessed federal HCV are currently getting it, so that is the figure the ER will use going forward.

[13] Some of these tenants might be receiving services from MH providers other than a CMHC.
[14] This total does not include the number of Section 811 Mainstream vouchers accessed.

The CMHA states that "By January 1, 2017, the State will identify and maintain a waitlist of all individuals within the Target Population requiring supported housing services, and whenever there are 25 individuals on the waitlist, each of whom has been on the waitlist for more than two months, the State will add program capacity on an ongoing basis sufficient to ensure that no individual waits longer than six months for supported housing." (V.E.3(f)). As referenced above, there are currently reported to be 85 individuals on the wait list for the Bridge program; 56 of these individuals have been on the wait list for more than two months. The State has recently allocated new funds to the Housing Bridge Subsidy Program. The State asserts that these funds will be sufficient to fund an additional 100 Bridge Program subsidies. Access to these new units will be based on priorities established by Bridge Program regulations. The State will continue to manage access of wait list individuals to new units in accordance with these priorities.

Because these funds have only recently been released, and individuals continue to wait for supported housing, it would be premature to conclude that this infusion of resources will fully address the existing unmet need, or result in sufficient additional capacity to ensure no class member waits longer than six months for supported housing. In the next 3-6 months, the ER will closely monitor the impact of additional subsidies on the State's ability to move individuals off the supported housing wait list.

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

These administrative changes could be having an impact on the overall effectiveness of the Housing Bridge Subsidy Program; the fact that 96 individuals are enrolled in the Bridge program but are still seeking a unit supports this conclusion. However, it is too early in the implementation process to assess the effects of these changes. The ER will continue to monitor the implementation process as well as monitoring data regarding lease-ups, the waiting list, and other related performance data.

Transitions from Institutional to Community Settings

During the past six and one-half years, the ER has visited both Glencliff and NHH on at least ten 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 had about 64 months of operational experience. As of November 2020, 70 individuals have been submitted to the Central Team, 43 from Glencliff and 23 from NHH. Of these, the State reports that 34 individual cases have been resolved, three individuals are deceased, 12 individuals at Glencliff Home are currently inactive and not interested in transitioning to the community due to COVID-19 or increased medical complexity, and 21 individual cases remain under consideration. Table XVII below summarizes the discharge barriers that have been identified by the Central Team with regard to these 21 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:

November 2020

Discharge Barriers	Number for Glencliff	Number for NHH
Legal	4 (7.1%)	2 (12.5%)
Residential	15 (26.8%)	5 (31.3%)
Financial	8 (14.3%)	2 (12.5%)
Clinical	15 (26.8%)	4 (25.0%)
Family/Guardian	14 (25.0%)	3 (18.8%)
Other	0 (0%)	0 (0%)

It is notable that 20 of the 21 open cases with the Central Team involve residential concerns, which need to be addressed per the CMHA.

Glencliff

In the time period from April through September 2020, Glencliff reports that it has admitted 11 individuals, and has had four discharges and seven deaths. The average daily census through this period was 116 people. There have been no readmissions during this time frame. There are currently 27 individuals on the wait list for admission to Glencliff.

CMHA Section VI requires the State to develop effective transition planning and a written transition plan for all residents of NHH and Glencliff (VI.A.1), and to implement them to enable these individuals to live in integrated community settings. In addition, Section V.E.3(i) of the CMHA also requires the State by June 30, 2017 to: "…have the capacity to serve in the community [a total of 16][15] individuals with mental illness and complex health care needs residing at Glencliff…." The CMHA defines these as: "individuals with mental illness and complex health care needs who could not be cost-effectively served in supported housing."[16]

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

DHHS reports that a total of only 20 people have transitioned from Glencliff to integrated settings since the inception of the CMHA five years ago.

Based on data supplied by the State for the previous report, there are currently 26 individuals undergoing transition planning who could be transitioned to integrated community settings once appropriate living settings and community services become available. Ten of these individuals have been assigned to Choices for Independence (CFI) waiver case management agencies in order to access case management in the community to facilitate transition planning, and seven are currently in the application process. Five individuals have been found eligible for the Acquired Brain Disorder (ABD) or Developmental Disability (DD) waivers, one is in the application process, one has been denied eligibility for these waivers, and prefers to transition to Vermont and is eligible for that state's Choices for care waiver. One individual is reported to not meet criteria for referrals to one or more of the waivers. The remaining three individuals are undergoing transition planning absent CFI or other waiver eligibility.

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

The ER has been concerned about the slow pace 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 during the month of January 2020. This review focused on the following CMHA provisions specifically relevant to transitions planning and effectuating transitions to integrated community settings on the part of Glencliff residents:

> Section VI.A.1 "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 …." (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

Section 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 the above information, the ER prepared recommendations for (State/DHHS-led) actions and interventions:

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

Over the last six months, the State has taken steps in response to the ER's first recommendation on in-reach. Based in part on the findings of the ER Glencliff report, the State has developed a new transition planning policy and transition engagement protocols intended to expand and improve transition planning for all Glencliff residents. Representatives of the Plaintiffs provided substantial recommendations and examples to assist the State to design a more effective transition planning process. This revised process was finalized in October 2020. The results of implementing the improved transition planning process have not yet been documented. The State has executed a contract with Northern Human Services to provide transition support services for residents of Glencliff, and an "in-reach coordinator" has been hired. As of the date of this report, implementation of the in-reach functions and activities is at a very early stage. Implementation has been hindered by the COVID-19 restrictions that have been in effect in New Hampshire since March 2020. The State has not yet shared with the ER or representatives of the Plaintiffs the required monthly data reports from this new program. However, the State has recently provided some preliminary information on activities for the past two months. These include:

- In-reach coordinator 1:1 meetings (in-person or virtually) with approximately 33 residents – some multiple times as work progresses on cases;
- In-reach coordinator meetings (in-person, virtually or by telephone) with others, such as Glencliff Home staff, guardians and family members, approximately 40 times;
- In-reach coordinator meetings (in-person, virtually or by telephone) with providers approximately 40 times;
- In-reach coordinator's work with CMHCs on intake has resulted in some individuals being determined to no longer be in the Target Population (confirmed by DHHS psychiatrists), and to identify a need for specific Registered Sex Offender (RSO) related solutions.

The ER expects that the State will begin sharing the monthly data reports required of the contracted in-reach program with the ER and representatives of the Plaintiffs no later than February 15, 2021.

The activities noted above represent potentially positive improvements of the transition planning and in-reach functions for Glencliff residents as established by the CMHA. However, as of the date of this report, the State has not demonstrated progress with regard to the other specific findings and recommendations enumerated in 2-6 above.

For instance, there has been no expansion of the number or capacity of integrated community settings for Glencliff residents. This failure to develop appropriate, less restrictive alternatives to institutionalization at Glencliff is a major barrier to timely transition and the most common obstacle facing individuals currently waiting for more integrated options in the community. It also reflects an ongoing area of noncompliance with the terms of the CMHA.

The pace of community transitions from Glencliff has also remained stagnant, both before and during the pandemic. With the exception of accessing capacity in one existing program (Palm St. in Nashua), there have been no additional transitions to integrated settings this entire year, despite the fact that there are almost 30 individuals identified as being in active transition planning, and have been for months or years, and many more would benefit from transition to the community if appropriate residential services and supports were available. Nor is there any additional integrated community living capacity in the development pipeline specifically for individual or groups of Glencliff residents. Therefore, the ER will prioritize further action and reporting from the State in the remaining areas of recommendation over the next 3-6 months.

Once COVID restrictions are ended, the ER intends to closely monitor activities related to Glencliff transition planning. This monitoring of in-reach programming will focus on:

1. Implementation of the in-reach program, including written transition plans, individual meetings between Glencliff residents and CMHPs, community visits, CMHC communications, etc.;

2. Implementation of revised policies, procedures, forms, training contents, etc. related to transition planning and informed consent;
3. Tracking and analyzing data reported by the in-reach program to the State;
4. Assessing the degree to which all CMHCs in the state become re-engaged in transition planning and in expanding integrated community settings for Glencliff residents;
5. Tracking progress of individuals on the active discharge planning list towards integration into the community; and
6. Documenting the development of new integrated community settings for Glencliff residents.

The ER recognizes that the State intends to improve transition planning and to facilitate additional community integrated transitions for Glencliff residents. **However, at this point, and based on the lack of progress since the ER's January review, it is still not possible for the ER to document that the State is in compliance with CMHA provisions related to Glencliff transition planning or 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 XVIII 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 XVIII

Self-Reported PASRR Level II Screens

	October 2019 through June 2020 Percent	April through June 2019 Percent	July through Sept 2019 Percent	April – June 2020 Percent	July – October 2020 Percent
Full Approval - No Specialized Services	37.9%	28.8%	31.0%	64.4%	61.3%
Full Approval with Specialized Services	30.3%	28.8%	38.0%	0.0%	6.5%
Provisional – No Specialized Services	16.7%	18.8%	19.7%	23.1%	0.0%
Provisional with Specialized Services	15.2%	23.8%	11.3%	11.5%	32.3%
Total	100%%	100%	100%	100%	100%

In the December 2018 ER report, 10.2% of the Level II screens were approved with a specification for specialized services. At that time, the ER questioned whether this was an unusually low rate for specification of specialized services. In a comparison with one other state, the ER found substantially higher approvals for specialized services than was evidenced in New Hampshire at that time. In the intervening period, the State and the PASRR contractor have been reviewing protocols for specification of specialized services in the Level II process. For the period April through June 2019, 52.6% percent of total Level II screens identified a need for special services. For July through September 2019, the percent was 49.3%. In the July to October 2020, time period, 38.8% of the PASRR Level II approvals included provisions for specialized services.

For a variety of reasons, virtually all PASRR screens in New Hampshire are conducted for people who are already in a nursing facility. For example, for October 2019 through March 2020, 96.7% of Level II screens were conducted in nursing facilities. In the April to June quarter this number was 100%. Prime opportunities for diversion to integrated community settings may have already been missed by the time the PASRR screen is conducted.

In addition, individuals admitted to Glencliff must 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 July through September 2020, the State reports that NHH effectuated 244 admissions and 244 discharges. The mean daily census was 180, and the median length of stay for discharges was 21 days. Note that the average daily census for the January – March 2020 reporting period was 159, with 21 fewer beds being filled on average. This increased daily census reflects the conversion of the children's inpatient unit to an adult acute care unit.

Table XIX below compares NHH discharge destination information for the six 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 XIX

New Hampshire Hospital Self-Reported Data on

Discharge Destination

Discharge Destination	**Percent July through Septem-ber 2019**	**Percent October through Decem-ber 2019**	**Percent January through March 2020**	**Percent April through June 2020**	**Percent July through Septem-ber 2020**
Home – live alone or with others	70.5%	70.76%	72.77%	80.6%	68.4%
Glencliff	0.4%	0.42%	2.35%	0	0
Homeless Shelter/motel	4.38%	7.11%	5.16%	2.3%	2.87%
Group home 5+/DDS supported living, peer support housing etc.	3.98%	4.24%	3.29%	3.0%	2.46%
Jail/correc-tion	1.2%	3.0%	1.41%	2.3%	3.28%
Nursing home/rehab facility	5.98%	5.00%	4.69%	3.3%	6.56%
Other[17]		10.17%	10.33%	6.9%	5.33%

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

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

Table XX

Self-Reported DRF/APRTP Utilization Data

January 2016 through September 2020

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Parkland	Total
Admissions							
Jan - March 2016	69	257	46	65	121		558
April - June 2016	79	205	378	49	92		803
July - Sept 2016	37	207	375	54	114		787
April - June 2017	60	228	363	52	101		804
July - September 2017	NA**	178	363	60	121		722
Oct. - Dec 2017	59	209	358	55	102		783
Jan. - March 2018	52	240	330	66	100		788
April - June, 2018	69	244	333	65	104		815
July - September 2018	67	201	357	54	112		791
October - December 2018	87	198	375	64	72		796
January - March 2019	126	182	349	56	123		836
April to June 2019	108	187	371	89	108		865
July to September 2019	104	194	391	52	95		836
October - December 2019	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

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Parkland	Total
Percent involuntary	53.70%	18.70%	NA	18.50%	30.60%		NA
Jan - March 2016	55.70%	24.40%	20.40%	4.10%	48.90%		25.50%
April - June 2016	43.20%	29.50%	18.90%	13.00%	44.70%		26.20%
July - Sept 2016	58.30%	21.50%	22.00%	1.00%	47.50%		30.06%
April - June 2017	NA**	25.60%	25.60%	11.50%	50.40%		NA
July - September 2017	49.20%	30.10%	23.70%	12.70%	50.00%		30.00%
Oct. - Dec 2017	44.20%	28.30%	21.50%	6.10%	47.00%		27.00%
Jan. - March 2018	46.73%	25.82%	24.62%	9.23%	51.92%		29.08%
April - June, 2018	28.36%	24.38%	19.33%	12.96%	49.11%		25.16%
July - September 2018	46.00%	23.20%	22.40%	6.25%	51.40%		26.50%
October - December 2018	45.20%	18.10%	23.20%	12.50%	47.20%		28.20%
January - March 2019	61.10%	20.90%	19.40%	7.90%	47.20%		27.30%
April to June 2019	43.30%	16.50%	25.10%	11.50%	55.80%		28.00%
July to September 2019	63.50%	23.40%	24.00%	7.90%	40.00%		29.50%
October - December 2019	53.50%	24.20%	21.00%	9.60%	40.00%		28.16%
January - March 2020	53.51%	24.19%	21.02%	9.62%	40.00%		28.16%
April - June 2020	44.76%	24.03%	25.84%	13.89%	42.90%		31.59%
July - September 2020	48.28%	39.00%	20.69%	21.56%	42.97%	100.00%	36.16%

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Parkland	Total
Mean Census	7.9	14.7	NA	19.7	18.1		NA
Jan - March 2016	7.8	13.2	21.4	22.5	16.9		81.8
April - June 2016	4.5	13.6	23.2	25.6	14.5		81.4
July - Sept 2016	4.5	12	30.3	29.3	10		86.1
April - June 2017	NA**	12.9	29.7	29.7	12.2		NA
July - September 2017	10.1	12.3	27.7	32.6	16.1		19.7
Oct. - Dec 2017	6.7	11.6	32.5	34.6	NA		NA
Jan. - March 2018	9.1	11.9	31.7	31.7	20.4		104.8
April - June, 2018	11.8	8.4	39.6	33.8	18.2		111.8
July - September 2018	10.7	9.2	27.4	33.4	10.7		91.4
October - December 2018	8.5	14.5	30.4	22.6	14.9		90.9
January - March 2019	8.4	11.5	29.7	27	12.1		88.7
April to June 2019	9.4	12.2	24.1	24.1	12		81.8
July to September 2019	10.6	13.4	31.8	23.7	9.5		89
October - December 2019	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	11.7		68
July - September 2020	9.7	13.4	27.7	14.1	13	3.4	81.3

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Parkland	Total
	76	261	NA	57	122		516*
Discharges	78	206	363	51	90		788
Jan - March 2016	35	213	380	64	113		805
April - June 2016	59	232	365	54	105		815
July - Sept 2016	NA**	243	355	63	121		NA
April - June 2017	82	212	359	58	102		813
July - September 2017	53	248	326	67	101		795
Oct. - Dec 2017	74	244	326	65	107		816
Jan. - March 2018	66	195	353	54	112		780
April - June, 2018	89	204	358	62	79		792
October - December 2018	124	177	348	56	106		811
January - March 2019	108	193	368	55	111		835
April to June 2019	101	192	386	54	97		830
July to September 2019	102	198	353	60	123		836
October - December 2019	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

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Parkland	Total
	8.6	4.2	NA	15	7.4		8.8*
Mean LOS for Discharges	6	4	4	28	7		5
Jan - March 2016	7	5	4	24	8		5
April - June 2016	6	4	5	22	8		9
July - Sept 2016	NA	4	4	27	7		NA
April - June 2017	4	4	5	21	7		5
July - September 2017	5	4	5	23	7		5
Oct. - Dec 2017	5	4	5	20	8		5
Jan. - March 2018	4	4	4	21	7		5
April - June, 2018	4	3	4	31	7		5
October - December 2018	5	5	6	18	8.5		6
January - March 2019	5	3	5	18	7		5
April to June 2019	6	4	6	26	8		6
July to September 2019	7	5	6	25	7		7
October - December 2019	6	5	6	20	8		6
January - March 2020	6	5	6	20	8		6
April - June 2020	6	6	6	27	8		7
July - September 2020	6	7	6	18	8	5	7

* Does not include Portsmouth

The DRFs should theoretically relieve some of the pressure on NHH for inpatient admissions, and should also reduce the number of people waiting for psychiatric admissions in hospital EDs.

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

Table XXI

Self-Reported Discharge Dispositions for DRFs in New Hampshire

April 2020 through September 2020

Disposition	Frank-lin	Cy-press	Ports-mouth	Elliot Geria-tric	Elliot Path-ways	Park-land	Total	Per-cent
Home	199	264	434	23	198	44	1,162	76.35 %
NHH	6	0	10	0	0	3	23	1.51%
Residential Facility/ Assisted Living	1	0	0	25	0	0	28	1.84%
Other DRF[18]	0	10	5	4	5	0	17	1.12%
Hospital	0	0	0	0	0	0	0	0.00%
Death	0	0	0	0	0	0	0	0.00%
Other or Unknown	14	21	175*	45	36	1	292	19.19
Total	220	295	621	97	241	48	1,522	100%

Based on these self-reported data, 76.35% of recent discharges from DRFs and the Cypress Center are to home. This is similar to the 68.4% discharges to home reported by NHH. It should be noted that discharges to hotels/motels or shelters are not specifically identified in the reported DRF data. Rather, these are included in the "Other" category. Thus, it is not possible to document whether discharges to hotels/motels and shelters have increased during COVID. For NHH, there was only a slight increase in discharges to hotels/motels and shelters during the most recent period, and over the past two years the proportion of such discharges from NHH has been reduced.

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

Hospital Readmissions

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

Table XXII

Self-Reported Readmission Rates for NHH and the DRFs

July 2017 through September 2020

	Percent 30 Days	Percent 90 Days	Percent 180 Days
NHH			
7/2017 to 9/2017	9.80%	21.60%	27.90%
10 to 12/2107	12.8%	26.1%	32.8%
1/2018 to 3/2018	13.7%	22.7%	29.9%
4/2018 to 6/2018	7.6%	14.7%	23.4%
7/2018 to 9/2018	8.6%	19.6%	25.4%
10/2018 to 12/2018	7.3%	18.1%	25.9%
1/2019 to 3/2019	5.3%	14.8%	21.2%
4/2109 to 6/2019	8.4%	15.0%	20.3%
7/2019 to 9/2019	10.5%	18.6%	23.3%
1/2020 to 3/2020	6.6%	12.4%	21.1%
4/2020 to 6/2020	9.7%	14.7%	20.0%
7/2020 to 9/2020	6.1%	12.7%	16.4%
Franklin			
7 to 9/2017	NA	NA	NA
10 to 12/2107	10.2%	10.2%	10.2%
1 to 3/2018	0.0%	0.0%	1.9%
4/2018 to 6/2018	4.3%	5.8%	5.8%
7/2018 to 9/2018	6.0%	9.0%	16.4%
10/2018 to 12/2018	2.3%	4.6%	5.7%
1/2019 to 3/2019	7.9%	10.3%	10.3%
4/2109 to 6/2019	6.5%	9.3%	12.0%
7/2019 to 9/2019	1.9%	6.7%	9.6%
1/2020 to 3/2020	3.5%	6.1%	7.8%
4/2020 to 6/2020	3.8%	4.7%	4.7%
7/2020 to 9/2020	2.5%	5.0%	5.9%

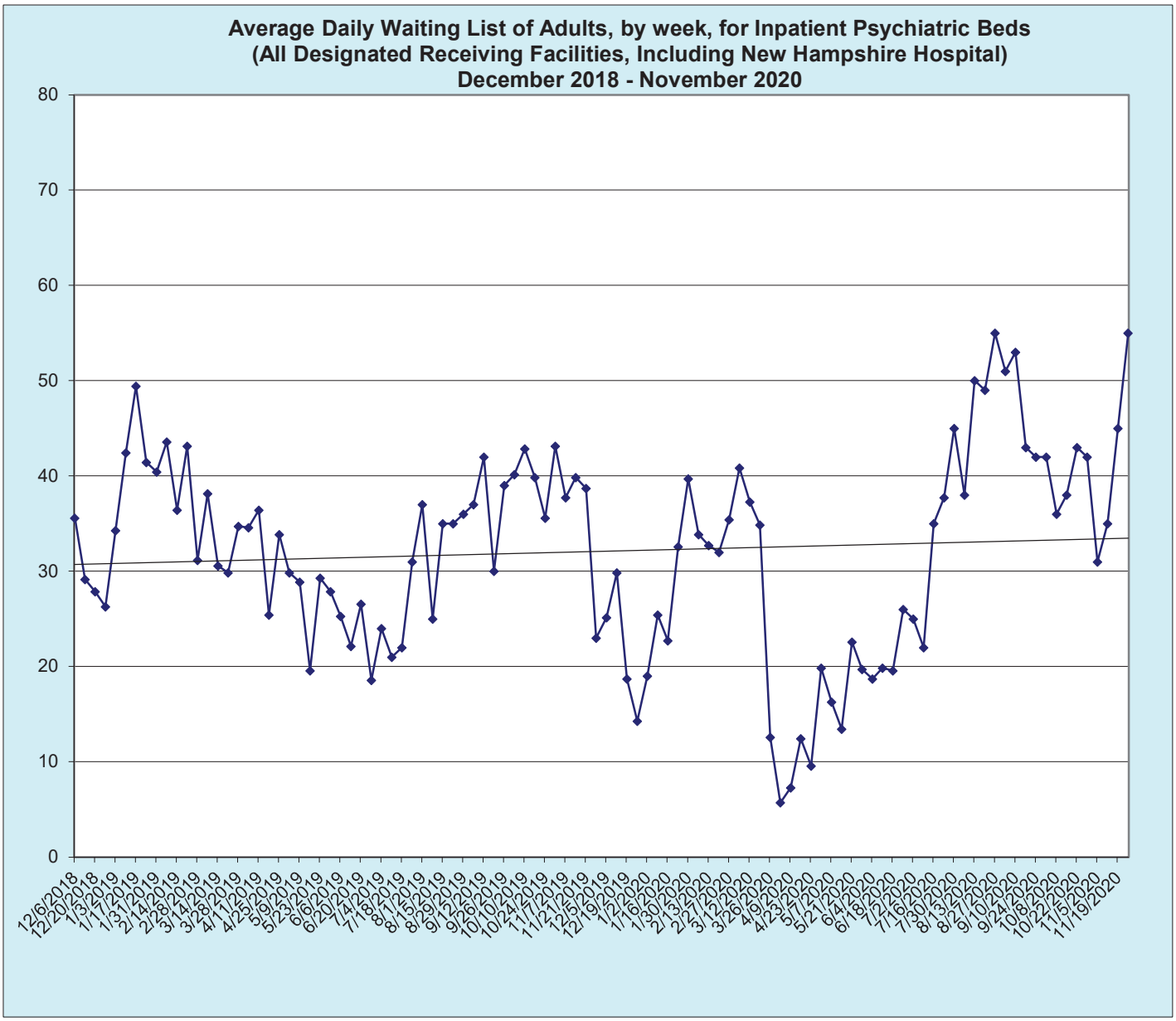
Cypress			
7 to 9/2017	7.10%	12.40%	15.90%
10 to 12/2107	12.00%	18.70%	24.40%
1 to 3/2018	4.20%	9.60%	15.80%
4/2018 to 6/2018	4.50%	8.20%	11.90%
7/2018 to 9/2018	8.50%	13.90%	18.90%
10/2018 to 12/2018	7.10%	11.10%	15.20%
1/2019 to 3/2019	5.50%	14.80%	17.60%
4/2109 to 6/2019	9.90%	15.10%	20.80%
7/2019 to 9/2019	6.60%	9.20%	12.80%
1/2020 to 3/2020	3.50%	5.00%	8.50%
4/2020 to 6/2020	5.20%	11.90%	18.70%
7/2020 to 9/2020	3.10%	6.30%	7.50%
Portsmouth			
7 to 9/2017	11.50%	17.50%	21.00%
10 to 12/2107	8.70%	13.70%	17.60%
1 to 3/2018	8.80%	15.50%	20.60%
4/2018 to 6/2018	10.20%	15.90%	21.90%
7/2018 to 9/2018	8.40%	12.90%	19.00%
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%

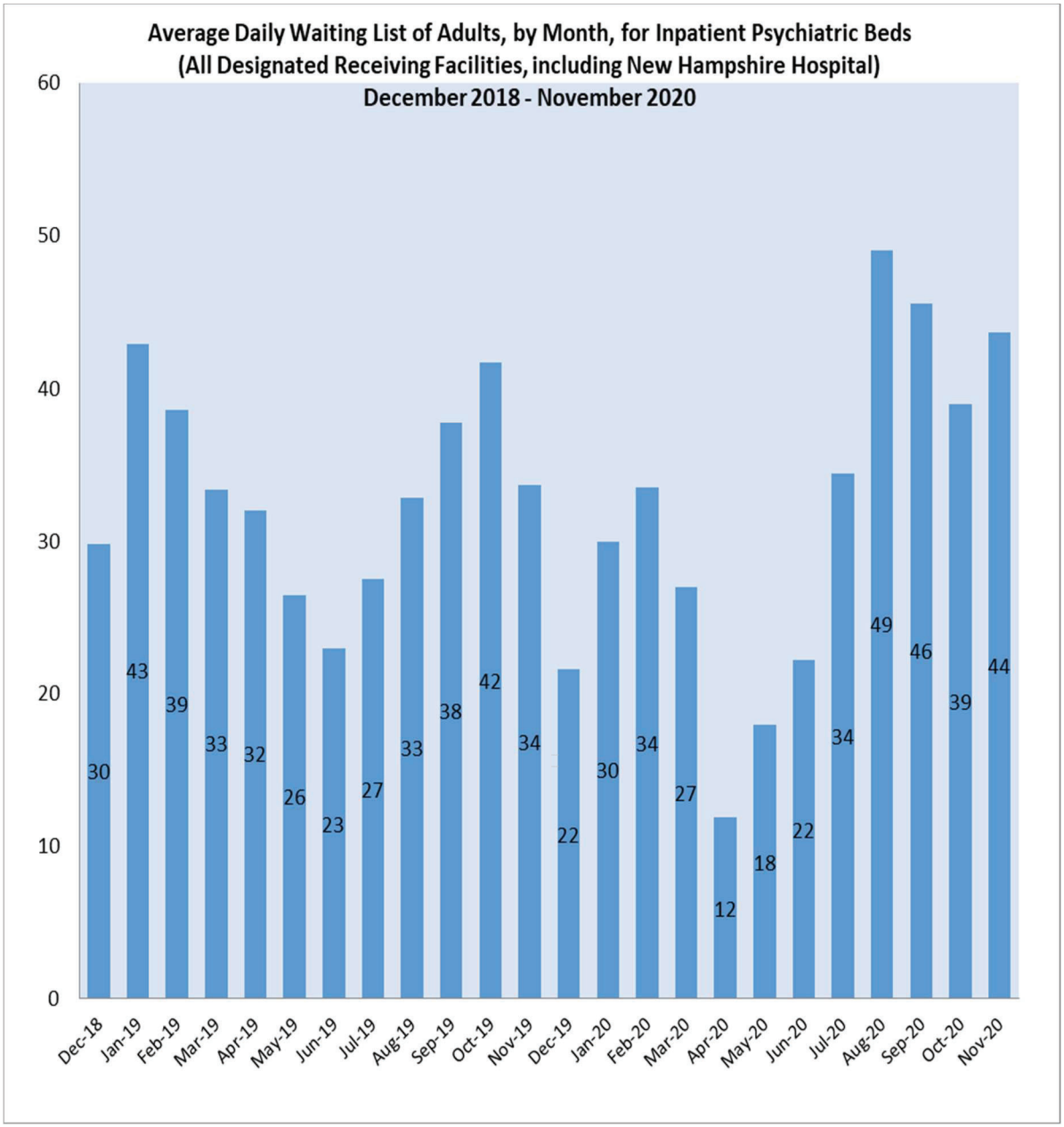
Elliot Pathways			
7 to 9/2017	3.30%	6.60%	12.40%
10 to 12/2107	5.80%	7.70%	12.50%
1 to 3/2018	NA	NA	NA
4/2018 to 6/2018	3.80%	6.70%	8.60%
7/2018 to 9/2018	7.00%	11.50%	16.10%
10/2018 to 12/2018	2.80%	5.60%	9.70%
1/2019 to 3/2019	4.90%	5.70%	7.30%
4/2109 to 6/2019	5.50%	5.50%	5.50%
7/2019 to 9/2019	2.10%	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%
Elliott Geriatric			
4/2018 to 6/2018	6.10%	6.10%	6.10%
7/2018 to 9/2018	5.60%	11.10%	11.10%
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%
Parkland			
7/2020 to 9/2020	1.90%	1.90%	1.90%

Readmission rates, especially the 180-day readmission rate for NHH and Portsmouth, are high. At least a 16% of all people discharged from NHH are readmitted within 180 days. For Portsmouth Hospital, 24.7% of individuals discharged have a readmission within 180 days. These data, in concert with the hospital emergency department data presented below, indicate that gaps remain in community services for people with serious mental illness, and that the essential connection between inpatient care and community services is not being effectuated for sizeable numbers of people at risk of re-hospitalization. **These facts need to be understood in light of the State's ongoing efforts to increase ACT capacity and enrollment as documented earlier in this report. The State must increase the focus on whether or not those readmitted to NHH or a DRF are being screened, assessed, and linked (when appropriate) to ACT and supported housing upon discharge.**

Hospital ED Waiting List

In the previous three reports, the ER has identified the hospital ED boarding wait for admission to NHH to be an important indicator of overall system performance. The following two charts display worsening adult admissions delays to NHH for the period April 2020 through November 2020.





Until April of 2020, the overall trend in average daily wait lists for hospital admission was trending downward. However, in the past six months, the average daily wait list has increased significantly. This has occurred despite the addition of 30 beds at NHH, a new 4 bed IEA-DRF (Parkland) and 13 net new transitional housing beds statewide[19]. In addition, there continues to be excess capacity among several of the state's CMHC-based ACT teams, which can and should reduce reliance on institutional services.

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

In a recent all parties meeting, the State reported that there are 60 people at NHH clinically ready for discharge. The ER also notes that the recent State efforts to increase the number of hospital beds in the system, such that there are now more institutional beds in New Hampshire than at the start of the CMHA. A central purpose of the CMHA is to avoid unnecessary or prolonged institutionalization, and reduce over-reliance on institutional services by increasing community capacity. These two data points suggest that this purpose has not yet achieved, especially when additional investments are needed to ensure individuals have ready access to the remedial services and residential supports required for transitions from NHH and Glencliff. In addition, people awaiting psychiatric hospital admission are potential participants in ACT, MCT, crisis apartments, and other CMHA services. Thus, the ER intends to continue on reporting ED boarding 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.

Peer Support Agencies

DHHS continues to report having a total of 15 peer support agency program (PSA) sites, with at least one program site in each of the ten regions. The State continues to report that all peer support centers meet the CMHA requirement to be open 44 hours per week. As of September 2020, the State reports that those sites have a cumulative total of 2,260 members, with an average daily participation rate of 128 people statewide.

The ER intends to conduct several PSA on-site visits within the next year (by December 30, 2021). Until those visits are complete, there will be no further information to report about these programs.

IV. Quality Assurance Systems

As noted earlier in this report, COVID restrictions have prevented the State from conducting the contracted ACT and SE fidelity reviews during the past 10 months. However, the State has been successful in conducting QSRs for all ten CMHCs during 2020. A summary tabulation of the results of these QSR activities is included as Appendix B of this report. Due to COVID, the ER has not been able to directly observe QSR CMHC reviews during this period, but has conducted two telephone interviews with the QSR leadership and team members.

All QSR reviews have been conducted remotely: that is, the service participant and staff interviews have been conducted by ZOOM or by phone. Nonetheless, participation and completion rates for the interviews have remained high, and quality checks of the interview

results have remained positive. The team members report that they believe the QSR review results remain valid, albeit conducted under difficult conditions.

For the most recent set of QSR reviews (SFY 2020) the State has increased the performance threshold from 70% to 80% for each indicator and for overall average performance. CMHCs scoring less than 70% 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 via interviews with both State and CMHC staff.

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

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

1. Indicator 8: adequacy of employment assessment (nine of 10 CMHCs below 80%; system wide average 69%);
2. Indicator 10: adequacy of employment service delivery (five of 10 CMHCs below 80%; system-wide average 78%);
3. Indicator 12: individual is integrated into the community, has choice, increased independence and social supports (five of 10 CMHCs below 80%; system-wide average 79%); and
4. Indicator 17: implementation of ACT services (six of 10 CMHCs below 80%; state-wide average 74%).

In addition, there are two indicators for which the state-wide average performance is above 80%, but for which five CMHCs are performing below the 80% threshold. These are:

1. Indicator 13: adequacy of crisis assessment; and
2. Indicator 15: crisis service delivery.

The ER notes that performance below the 80% QSR performance threshold is not, by itself, evidence of non-compliance with the CMHA. However, when taken together with data regarding service fidelity and class members' outcomes, including successful community integration, QSR performance scores provide a powerful 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. In addition, scores below the performance threshold indicate a need for improved quality and improved implementation of

services vis-à-vis service participants. These findings trigger increased monitoring and technical assistance activities, which in turn are expected to both result in improved quality and service outcomes for the CMHA Target Population and increase compliance with the requirements of the CMHA.

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

I. Summary of Expert Reviewer Observations and Priorities

The ER has emphasized in this report that the State continues to be far from compliant with the CMHA requirements for ACT. **For the last four and one half years, the ER has reported that the State is out of compliance with the ACT requirements of Sections V.D.3, which together require that the State provide ACT services that conform to CMHA requirements and have the capacity to serve at least 1,500 people in the Target Population at any given time.**

Other areas of non-compliance identified in this report include:

1. **With regard to Glencliff, the ER has documented failure to provide effective transition planning and in-reach activities, failure to transition residents of Glencliff into integrated community settings in accordance with the CMHA, and failure to expand community residential and other service capacity to meet the needs of Glencliff residents in alternative community settings. In addition, the ER cannot document or certify that residents of Glencliff have written transition plans in accordance with CMHA requirements; and**
2. **Although the State technically meets the statewide CMHA standard for SE penetration, the ER notes six of the ten CMHC regions of the state have penetration rates lower than the standard. At the very least, the ER considers that this demonstrates that Target Population members do not have equal access to SE services throughout New Hampshire.**

As has been noted at several points in this report, the COVID-19 pandemic has significantly influenced the New Hampshire mental Health System over the past 10 months, although the areas of noncompliance noted in this report all predate the onset of the pandemic. In general, the State is to be congratulated for its efforts to provide basic levels of services for the CMHA Target Population, and also for striving to maintain the quality of services for the Target Population. The absence of progress towards compliance is not unexpected in light of these challenges, but it does have the practical effect of extending the period of time that is likely to be required before any maintenance of effort year can begin.

COVID has also directly affected the degree to which the ER could directly monitor and document compliance with the terms and requirements of the CMHA. The ER has not been able to conduct any direct on-site reviews or interviews in the past ten months, instead relying on telephonic conversations and analyses of secondary data. Absent other information, the ER concludes that while service delivery and quality has remained relatively consistent under COVID, there has also been relatively little documented progress made in addressing and making progress on issues related to compliance with the CMHA.

With the advent of vaccinations to prevent COVID infection, the ER is hopeful that the State will re-invigorate efforts to comply with the requirements of the CMHA. At the same time, as soon as it is safe to do so, the ER intends to re-engage in on-site and face-to-face monitoring to verify and document the degree to which compliance with the CMHA is being attained and maintained.

As the ER has stated in previous reports, the State will not be able to disengage from the CMHA until full compliance is reached for all requirements of the CMHA.

To facilitate progress towards compliance and disengagement, the ER expects the State to develop and implement measures to address all areas of non-compliance referenced above, and those issues in which further actions or data production is necessary in order to assess compliance, with the following specific actions to take place:

1. No later than March 1, 2021, the State will provide a written update on the following: implementation of specific ACT strategies to expand ACT capacity and enrollment, eliminate the wait list, and reduce the elapsed time for CMHAs to process individuals into ACT services. In addition, the ER expects the State to produce and report preliminary data on participants' length of stay, discharge, and reason for their discharge.

2. No later than February 15, 2021 the State will begin sharing monthly report data, as specified in the contract, from the Glencliff in-reach program with the ER and representatives of the Plaintiffs.

3. No later than March 1, 2021 the State will provide a written report to the ER and representatives of the Plaintiffs documenting the number of new integrated community settings available, or in the development pipeline, specifically for residents of Glencliff.

4. No later than February 1, 2021, a written updated report on the availability of MCT services to class members in the Nashua region, including staffing levels and crisis apartment capacity.

5. No later than March 1, 2021, a written update on the supported housing waiting list, and specifically the utilization of new Housing Bridge subsides to move individuals waiting more than two months into the Bridge program.

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

January through March, 2020

New Hampshire Community Mental Health Agreement Quarterly Data Report

July – September 2020

New Hampshire Department of Health and Human Services

Bureau of Quality Assurance and Improvement

December 28, 2020

Community Mental Health Agreement Quarterly Data Report

New Hampshire Department of Health and Human Services

Publication Date: December 28, 2020

Reporting Period: 7/1/2020 – 9/30/2020

Notes for Quarter

- 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). On March 26, 2020, Governor Sununu issued related Emergency Order #17, implementing a stay-at-home, shelter in place of residence requirement, effective March 27, 2020 at 11:59 PM. Although the stay-at-home order expired June 15, 2020, the State of Emergency declared through Executive Order 2020-04 has been extended (Executive Order 2020-24, dated December 11, 2020, contains the latest extension). The data in this report regards service provision throughout the emergency period.
- Tables 2a-b. Community Mental Health Center Services: Assertive Community Treatment Staffing – Northern Human Services ACT staffing counts are now separated by ACT team. Additionally, some staff counts are lower due to COVID-19 and are not indicative of actual vacancies but individuals on leave related to the pandemic.
- Tables 5a-f. Designated Receiving Facilities (DRF) – In November and December 2019, Portsmouth Regional Hospital and Parkland Memorial Center (respectively) received approval for four (4) new DRF beds, for a total increase of eight (8) DRF beds. Reporting for Portsmouth's new beds was added in the last quarterly report. Parkland's new beds are also now added to the quarterly report.
- Table 5-e. Designated Receiving Facilities: Discharge Location for Adults – Improvement to the data-reporting tool used by the facilities to capture discharges in the "Home" category now includes individuals living with family members, living alone, and living with others (non-family). In the past, some facilities' data did not provide this level of detail and was captured in the "Other" category as a result.
- Table 7. NH Mental Health Client Peer Support Agencies: Census Summary – Peer Support Agencies were open with limited on-site capacity due to COVID-19. The Average Daily Visits reported includes the number of individuals participating in groups online and on-site.
- Tables 11a-c. Mobile Crisis Services and Supports for Adults – several data elements reported as zero (0), or otherwise lower than normal volume, reflects the direct or indirect impact of the State of Emergency declared in response to COVID-19, such as lack of crisis apartment use due to distancing and quarantine protocols.
- Table 11c. Mobile Crisis Services and Supports for Adults – Harbor Care. Data reflects the final months of this program, as operated by Harbor Care. Capacity to provide services gradually decreased due to the loss of staff transitioning to other employment opportunities in anticipation of the closure.

Acronyms Used in this Report

ACT: Assertive Community Treatment

BM S: Bureau of Mental Health Services

inance Authority

N : New Hampshire Hospital

N A: New Hampshire Housing

BQAI: Bureau of Quality Assurance and Improvement

CM A: Community Mental Health Agreement

CM C : Community Mental Health Center Administration

DHHS: Department of Health and u man Services

DRF: Designated Receiving Facility

ED: Emergency Department

TE: ull Time Equivalent

BSP: ou sing Bridge Subsidy Program

UD : US Department of Housing and Urban Development

MCT: Mobile Crisis Team

PRA: Project Rental Assistance

SE: Supported Employment

VA: Veterans Benefits

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

Community Mental Health Center	July 2020	August 2020	September 2020	Unique Clients in Quarter	Unique Clients in Prior Quarter
01 Northern Human Services	117	119	121	127	126
02 West Central Behavioral Health	50	39	43	55	62
03 Lakes Region Mental Health Center	54	54	52	57	60
04 Riverbend Community Mental Health Center	94	94	91	104	111
05 Monadnock Family Services	50	50	47	51	51
06 Greater Nashua Mental Health	106	109	107	115	108
07 Mental Health Center of Greater Manchester	257	266	265	279	269

08 Seacoast Mental Health Center	68	71	74	75	71
09 Community Partners	70	73	72	77	75
10 Center for Life Management	48	48	49	53	51
Total Unique Clients	**913**	**922**	**920**	**990**	**984**
Unique Clients Receiving ACT Services 10/1/2019 to 9/30/2020:			**1,288**		

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 11/2/2020; clients are counted only one time regardless of how many services they receive.

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

Community Mental Health Center	April – June 2020 Retrospective Analysis			January – March 2020 Retrospective Analysis		
	Unique Clients Screened: Individuals Not Already on ACT*	Appropriate for Further ACT Assessment: Individuals Not Already	New Clients receiving ACT Services within 90 days of Screening	Unique Clients Screened: Individuals Not Already on ACT*	Appropriate for Further ACT Assessment: Individuals Not Already	New Clients receiving ACT Services within 90 days of Screening
01 Northern Human Services	1,037	17	1	1,068	19	4
02 West Central Behavioral Health	201	3	0	212	2	2
03 Lakes Region Mental Health Center	878	1	0	733	8	1
04 Riverbend Community Mental Health Center	1,446	2	1	1,449	0	0
05 Monadnock Family	690	4	0	664	6	0

Services						
06 Greater Nashua Mental Health	802	7	2	833	5	0
07 Mental Health Center of Greater Manchester	1,561	14	3	1,610	17	3
08 Seacoast Mental Health Center	1,454	23	1	1,368	42	1
09 Community Partners	262	0	0	254	1	1
10 Center for Life Management	789	1	0	831	1	0
Total ACT Screening	**9,120**	**72**	**8**	**9,022**	**101**	**12**

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 11/5/2020. "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.

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

Community Mental Health Center	July – September 2020				April – June 2020			
	New ACT Clients	New ACT Clients	New 2020 ACT Clients	Total New ACT Clients	New ACT Clients	New ACT Clients	New ACT Clients	Total New ACT Clients

01 Northern Human Services	6	4	3	**13**	4	4	3	**11**
02 West Central Behavioral Health	1	1	3	**5**	8	7	6	**21**
03 Lakes Region Mental Health Center	2	1	1	**4**	1	1	3	**5**
04 Riverbend Community Mental Health Center	1	3	4	**8**	6	2	1	**9**
05 Monadnock Family Services	0	0	0	**0**	0	0	0	**0**
06 Greater Nashua Mental Health	3	5	2	**10**	0	2	3	**5**
07 Mental Health Center of Greater Manchester	6	13	3	**22**	7	5	4	**16**
08 Seacoast Mental Health Center	0	3	4	**7**	0	2	3	**5**
09 Community Partners	1	2	4	**7**	2	1	3	**6**
10 Center for Life Management	1	1	2	**4**	2	2	1	**5**
Total New ACT Clients	**21**	**33**	**26**	**80**	**30**	**26**	**27**	**83**

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 10/27/2020; New ACT Clients are defined as individuals who were not already on ACT within 90 days prior who then began receiving ACT services. This information is not limited to the individuals that received an ACT screening within the previous 90-day period, and may include individuals transitioning from a higher or lower level of care into ACT.

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

As of 9/30/2020						
	Time on List					
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180+*days**
11	3	5	0	0	0	3
As of 6/30/2020						
Time on List						
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**
13	2	2	3	0	1	5

Revisions to Prior Period: None.

Data Source: BMHS Report.

*Notes: Data compiled 10/31/2020. All individuals waiting are at MHCGM with the exception of one individual with CLM whose referral for ACT was received on the last day of the reporting period. Increased services for individuals waiting at MHCGM are being provided by the existing treatment team until assigned to an ACT team. *These individuals were no longer waiting by the end of October.*

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

	July – September 2020						April – June 2020					
	On ACT at Admission		Referred for ACT on Discharge		Referred to ACT at Discharge		On ACT at Admission		Referred for ACT on Discharge		Referred to ACT at Discharge	
Community Mental Health Center	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
01 Northern Human Services	0	11	3	8	2	1	6	10	4	6	2	2
02 West Central Behavioral Health	3	7	3	4	3	0	5	7	3	4	1	2

03 Lakes Region Mental Health Center	6	6	3	3	2	1	5	13	2	11	1	
04 Riverbend Community Mental Health Center	11	15	3	12	3	0	9	18	3	15	3	0
05 Monadnock Family Services	1	16	2	14	2	0	4	13	0	13	0	0
06 Greater Nashua Mental Health	5	14	2	12	1	1	10	25	6	19	2	4
07 Mental Health Center of Greater Manchester	5	15	4	11	2	2	12	15	8	7	3	5
08 Seacoast Mental Health Center	4	5	3	2	3	0	8	9	1	8	0	1
09 Community Partners	1	11	1	10	1	0	8	17	5	12	4	1
10 Center for Life Management	1	5	4	1	2	2	0	3	1	2	1	0
Total	**37**	**105**	**28**	**77**	**21**	**7**	**67**	**130**	**33**	**97**	**17**	**10**

Revisions to Prior Period: None

Data Source: New Hampshire Hospital.

Notes: Data compiled 12/17/20.

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	July - September 2020	April - June 2020
Not Available in Individual's Town of Residence	0	0
Individual Declined	0	0
Individual's Insurance Does Not Cover ACT Services	0	1
Individual's Clinical Need Does Not Meet ACT Criteria	0	0
Individual Placed on ACT Waitlist	0	1
Individual Awaiting CMHC Determination for ACT	7	14
Total Unique Clients	**7**	**16**

Revisions to Prior Period: None.

Data Source: New Hampshire Hospital.

Notes: Data compiled 12/17/2020. Six (6) individuals who were awaiting CMHC determination at discharge from NHH, were no longer waiting for determination and were not on the ACT Waitlist by the last day of the month of discharge – indicating the ACT determination and resolution had occurred. One (1) individual awaiting CMHC determination was placed on the ACT waitlist by the end of the month of discharge and was no longer waiting at the end of the following month. This indicates the individual was assessed for ACT and determined eligible by the end of the month of discharge, and then began receiving ACT in the next month (MHCGM).

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

Community Mental Health Center	September 2020	June 2020

	Nurse	Clinician/or Equivalent	Support Worker	Peer Specialist	(Excluding Psychiatry)	rse Practitioner	(Excluding Psychiatry)	Psychiatrist/Nurse Practitioner
01 Northern Human Services - Wolfeboro	0.00	1.00	4.00	0.57	5.57	0.40	13.36	1.20
01 Northern Human Services - Berlin	0.65	0.80	4.50	0.00	5.95	0.35		
01 Northern Human Services - Littleton	0.60	0.00	3.00	0.00	3.60	0.45		
02 West Central Behavioral Health	0.60	1.20	2.70	0.50	5.00	0.50	6.10	0.50
03 Lakes Region Mental Health Center	0.40	1.00	0.00	1.00	6.40	0.75	6.50	0.75
04 Riverbend Community Mental Health Center	0.50	1.00	7.50	0.00	9.00	0.50	10.50	0.50
05 Monadnock Family Services	2.00	1.25	0.00	1.10	11.58	0.65	8.85	0.65
06 Greater Nashua Mental Health 1	1.00	1.00	5.50	1.00	8.50	0.25	8.00	0.25
06 Greater Nashua Mental Health 2	1.00	1.00	5.50	1.00	8.50	0.25	8.00	0.25
07 Mental Health Center of Greater Manchester-CTT	1.00	10.00	5.25	0.00	16.25	0.91	18.25	0.91
07 Mental Health Center of Greater Manchester-MCST	1.00	9.00	7.25	1.00	18.25	0.91	17.25	0.91
08 Seacoast Mental Health Center	1.00	0.00	4.00	1.00	9.00	0.60	9.10	0.60
09 Community Partners	0.00	2.00	6.95	0.00	8.95	0.7	9.20	0.70

						5		
10 Center for Life Management	1.00	1.00	4.30	1.00	7.30	0.40	8.30	0.40
Total	**10.75**	**30.25**	**60.45**	**8.17**	**123.85**	**7.67**	**123.41**	**7.62**

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

Community Mental Health Center	Substance Use Disorder Treatment		Housing Assistance		Supported Employment	
	September 2020	June 2020	September 2020	June 2020	September 2020	June 2020
01 Northern Human Services - Wolfeboro	1.00	3.55	4.00	8.75	0.00	1.00
01 Northern Human Services - Berlin	1.80		3.00		0.50	
01 Northern Human Services - Littleton	0.00		3.00		1.00	
02 West Central Behavioral Health	0.20	0.20	2.10	4.10	0.60	0.60
03 Lakes Region Mental Health Center	3.00	1.00	6.40	5.50	2.00	2.00
04 Riverbend Community Mental Health Center	0.50	1.50	8.00	9.50	0.50	0.50
05 Monadnock Family Services	1.40	1.40	4.00	2.00	1.00	1.00
06 Greater Nashua Mental Health 1	4.25	4.25	6.25	6.25	1.50	1.00
06 Greater Nashua Mental Health 2	5.25	5.25	7.00	7.00	0.00	0.00
07 Mental Health Center of Greater Manchester-CCT	8.91	10.91	11.75	13.75	2.00	2.00
07 Mental Health Center of Greater Manchester-MCST	5.91	5.91	13.75	12.75	2.00	2.00
08 Seacoast Mental Health Center	2.00	2.00	4.00	5.00	1.00	2.00
09 Community Partners	2.75	2.70	5.05	5.05	1.38	0.38
10 Center for Life Management	2.00	3.00	6.00	7.00	0.30	0.30
Total	**38.97**	**41.67**	**84.30**	**86.65**	**13.78**	**12.78**

Revisions to Prior Period: None.

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

Notes: Data compiled 10/20/2020; for 2b: the Staff Competency values reflect the sum of FTEs trained to provide each service type. These numbers are not a reflection of the services delivered, but rather the quantity of staff available to provide each service. If staff are trained to provide multiple service types, their entire FTE value is credited to each service type.

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

Community Mental Health Center	12 Month Period Ending September 2020			Penetration Rate for Period Ending June 2020
	Supported Employment Clients	Total Eligible Clients	Penetration Rate	
01 Northern Human Services	155	1,317	11.8%	12.0%
02 West Central Behavioral Health	143	561	25.5%	24.3%
03 Lakes Region Mental Health Center	382	1,419	26.9%	21.5%
04 Riverbend Community Mental Health Center	278	1,887	14.7%	16.1%
05 Monadnock Family Services	46	1,112	4.1%	4.8%
06 Greater Nashua Mental Health	275	2,085	13.2%	13.4%
07 Mental Health Center of Greater Manchester	1,542	3,681	41.9%	42.8%
08 Seacoast Mental Health Center	795	2,053	38.7%	36.0%
09 Community Partners	115	841	13.7%	11.2%
10 Center for Life Management	187	1,265	14.8%	14.8%
Total Unique Clients	**3,911**	**15,970**	**24.5%**	**24.2%**

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 10/27/2020

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

Reported Employment Status Begin Date: 7/01/2020 End Date: 9/30/2020 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 April – June 2020
Updated Employment Status:												
Full time employed now or in past 90 days	51	39	33	118	62	137	266	207	43	94	**1,050**	992
Part time employed now or in past 90 days	129	36	268	291	163	279	341	259	62	188	**2,016**	2,013
Unemployed	180	122	33	89	157	811	1036	129	197	558	**3,312**	3,067
Not in the Workforce	569	169	406	1010	487	319	601	880	227	132	**4,800**	4,739
Status is not known	6	27	312	40	3	103	20	3	14	59	**587**	515
Total of Eligible Adult CMHC Clients	**935**	**393**	**1,052**	**1,548**	**872**	**1,649**	**2,264**	**1,478**	**543**	**1,031**	**11,765**	**11,326**
Previous Quarter: Total of Eligible Adult CMHC Clients	**925**	**397**	**1,009**	**1,537**	**833**	**1,451**	**2,215**	**1,464**	**528**	**967**		
Percentage by Updated Employment Status:												
Full time employed now or in past 90 days	5.5%	9.9%	3.1%	7.6%	7.1%	8.3%	11.7%	14.0%	7.9%	9.1%	8.9%	**8.8%**
Part time employed now or in past 90 days	13.8%	9.2%	25.5%	18.8%	18.7%	16.9%	15.1%	17.5%	11.4%	18.2%	17.1%	**17.8%**
Unemployed	19.3%	31.0%	3.1%	5.7%	18.0%	49.2%	45.8%	8.7%	36.3%	54.1%	28.2%	**27.1%**
Not in the Workforce	60.9%	43.0%	38.6%	65.2%	55.8%	19.3%	26.5%	59.5%	41.8%	12.8%	40.8%	**41.8%**
Status is not known	0.6%	6.9%	29.7%	2.6%	0.3%	6.2%	0.9%	0.2%	2.6%	5.7%	5.0%	**4.5%**
Percentage by Timeliness of Employment Status Screening:												
Update is Current	67.8%	36.1%	45.1%	84.8%	65.7%	96.2%	89.5%	96.2%	63.4%	99.9%	81.1%	**76.8%**
Update is Overdue	32.2%	63.9%	54.9%	15.2%	34.3%	3.8%	10.5%	3.8%	36.6%	0.1%	18.9%	**23.2%**
Previous Quarter: Percentage by Timeliness of Employment Status Screening:												
Update is Current	61.6%	41.1%	3.9%	89.4%	64.2%	96.8%	91.5%	94.3%	45.6%	99.7%		
Update is Overdue	38.4%	58.9%	96.1%*	10.6%	35.8%	3.2%	8.5%	5.7%	54.4%	0.3%		

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

*Notes: Data extracted 10/27/2020; *The high rate of overdue employment screening status reported by Lakes Region Mental Health Center for Previous Quarter (4/1/2020 – 6/20/2020) is due to an internal process/reporting change. This has been rectified in the current quarter report.*

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: 7/01/2020 End Date: 9/30/2020	**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 April – June 2020**
Updated Employment Status:												
Full time employed now or in past 90 days	1	1	1	4	0	8	13	1	2	3	**34**	29
Part time employed now or in past 90 days	9	2	19	25	13	22	42	16	7	20	**175**	173
Unemployed	6	5	3	20	3	27	28	13	6	23	**134**	132
Not in the Workforce	13	1	5	9	5	13	8	24	4	4	**86**	77
Status is not	0	0	11	0	0	1	0	0	0	0	**12**	11

known												
Total of Supported Employment Cohort	**29**	**9**	**39**	**58**	**21**	**71**	**91**	**54**	**19**	**50**	**441**	**422**
Previous Quarter: Total of Supported Employment Cohort	**22**	**18**	**33**	**56**	**11**	**70**	**79**	**69**	**16**	**48**		
Percentage by Updated Employment Status:												
Full time employed now or in past 90 days	3.4%	11.1%	2.6%	6.9%	0.0%	11.3%	14.3%	1.9%	10.5%	6.0%	7.7%	6.9%
Part time employed now or in past 90 days	31.0%	22.2%	48.7%	43.1%	61.9%	31.0%	46.2%	29.6%	36.8%	40.0%	39.7%	41.0%
Unemployed	20.7%	55.6%	7.7%	34.5%	14.3%	38.0%	30.8%	24.1%	31.6%	46.0%	30.4%	31.3%
Not in the Workforce	44.8%	11.1%	12.8%	15.5%	23.8%	18.3%	8.8%	44.4%	21.1%	8.0%	19.5%	18.2%
Status is not known	0.0%	0.0%	28.2%	0.0%	0.0%	1.4%	0.0%	0.0%	0.0%	0.0%	2.7%	2.6%

Revisions to Prior Period: None.

Data Source: Phoenix 2.

Note 3b-c: Data extracted 10/27/2020. 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 9/30/2020						
	Time on List					
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180+ days**
38	15	9	3	8	2	1
As of 6/30/2020						
Time on List						
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**
42	20	7	2	3	5	5

Data Source: BMHS Report.

Notes: Data compiled 10/31/2020. Total days waiting are calculated for all individuals waiting when data collection began on January 1, 2020. Individuals waiting are at: LRMHC (29), MFS (3) and CP (6). LRMHC discovered an administrative error in October 2020 that revealed referrals for 6 of the 29 cases had not been submitted to the SE team by 9/30/20; the remaining 23 cases were no longer waiting to receive SE services by October 31, 2020. Five of the 6 individuals waiting at CP were no longer waiting to receive SE services by October 31, 2020; 1 individual has not engaged in services and case closure is anticipated. All 3 of the individuals waiting at MFS were no longer waiting to receive SE services by October 31, 2020.

4a. New Hampshire Hospital: Adult Census Summary

Measure	July – September 2020	April – June 2020
Admissions	244	320
Mean Daily Census	180	172
Discharges	244	304
Median Length of Stay in Days for Discharges	21	13
Deaths	0	0

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4a: 10/29/2020; 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	July - September 2020	April - June 2020
CMHC Group Home	5	5
Discharge/Transfer to IP Rehab Facility	14	5
Glencliff Home for the Elderly	0	0
Home - Lives Alone	64	117
Home - Lives with Others	103	128
Homeless Shelter/ No Permanent Home	3	1
Hotel-Motel	4	6
Jail or Correctional Facility	8	7
Nursing Home	2	5
Other	13	5
Peer Support Housing	0	1
Private Group Home	1	3
Secure Psychiatric Unit - SPU	1	0
Unknown	26	21

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

Measure	July – September 2020	April – June 2020
30 Days	6.1% (15)	9.7% (31)
90 Days	12.7% (31)	14.7% (47)
180 Days	16.4% (40)	20.0% (64)

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4b-c: Data compiled 10/29/2020; readmission rates calculated by looking back in time from admissions in study quarter. 90 and 180 day readmissions lookback period

includes readmissions from the shorter period (e.g., 180 day includes the 90 and 30 day readmissions); patients are counted multiple times – once for each readmission; the number in parentheses is the number of readmissions.

5a. Designated Receiving Facilities: Admissions for Adults

Designated Receiving Facility	July – September 2020		
	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	56	60	116
Cypress Center	62	97	159
Portsmouth	72	276	348
Elliot Geriatric Psychiatric Unit	11	40	51
Elliot Pathways	52	69	121
Parkland Regional Hospital	54	0	54
Total	**307**	**542**	**849**

Designated Receiving Facility	April – June 2020		
	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	47	58	105
Cypress Center	31	98	129
Portsmouth	77	221	298
Elliot Geriatric Psychiatric Unit	5	31	36
Elliot Pathways	57	62	119
Parkland Regional Hospital	NA	NA	NA
Total	**217**	**470**	**687**

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

Designated Receiving Facility	July – September 2020	April – June 2020
Franklin	9.7	8.5*

Cypress Center	13.4	11.1
Portsmouth	27.7	24.8*
Elliot Geriatric Psychiatric Unit	14.1	11.9*
Elliot Pathways	13.0	11.9*
Parkland Regional Hospital	3.4	NA
Total	**81.3**	**70.9***

*Revisions to Prior Period: * indicates corrected counts.*

5c. Designated Receiving Facilities: Discharges for Adults

Designated Receiving Facility	July – September 2020	April – June 2020
Franklin	117	101
Manchester (Cypress Center)	164	131
Portsmouth	324	294
Elliot Geriatric Psychiatric Unit	41	51
Elliot Pathways	121	117
Parkland Regional Hospital	48	NA
Total	**815**	**694**

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

Designated Receiving Facility	July – September 2020	April – June 2020
Franklin	6	6
Manchester (Cypress Center)	7	6
Portsmouth	6	6
Elliot Geriatric Psychiatric Unit	18	27
Elliot Pathways	8	8
Parkland Regional Hospital	5	NA
Total	**7**	**7**

5e. Designated Receiving Facilities: Discharge Location for Adults

Designated Receiving Facility	July – September 2020						
	Assisted Living / Group	Decease		Hom	Other Hospit	NH Hospita	
Franklin	1	0	0	109	0	0	7
Manchester (Cypress Center)	0	0	6	151	0	0	7
Portsmouth Regional Hospital	0	0	0	261	0	8	55
Elliot Geriatric Psychiatric Unit	11	0	4	11	0	0	15
Elliot Pathways	2	0	1	105	0	1	12
Parkland Regional Hospital	0	0	0	44	0	3	1
Total	**14**	**0**	**11**	**681**	**0**	**12**	**97**
	April - June 2020						
							Other
Franklin	0	0	1	89	0	5	6
Manchester (Cypress Center)	0	0	4	113	0	0	14
Portsmouth Regional Hospital	0	0	2	172	0	2	118
Elliot Geriatric Psychiatric Unit	12	0	0	11	0	0	28
Elliot Pathways	0	0	0	92	0	3	22
Parkland Regional Hospital	NA	NA	NA	NA	NA	NA	NA
Total	**12**	**0**	**7**	**477**	**0**	**10**	**188**

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

5f. Designated Receiving Facilities: Readmission Rates for Adults

Designated Receiving Facility	July – September 2020		
	30 Days	90 Days	180 Days
Franklin	2.5% (3)	5.0% (6)	5.9% (7)
Manchester (Cypress Center)	3.1% (5)	6.3% (10)	7.5% (12)
Portsmouth	14.1% (49)	21.8% (76)	24.7% (86)
Elliot Geriatric Psychiatric Unit	2.0% (1)	7.8% (4)	7.8% (4)
Elliot Pathways	6.6% (8)	8.3% (10)	9.1% (11)
Parkland Regional Hospital	1.9% (1)	1.9% (1)	1.9% (1)
Total	**7.9% (67)**	**12.5% (107)**	**14.2% (121)**
Designated Receiving Facility	**April – June 2020**		
	30 Days	**90 Days**	**180 Days**
Franklin	3.8% (4)	4.7% (5)	4.7% (5)
Manchester (Cypress Center)	5.2% (7)	11.9% (16)	18.7% (25)
Portsmouth	7.3% (23)	15.0% (47)	23.6% (74)
Elliot Geriatric Psychiatric Unit	9.8% (4)	9.8% (4)	9.8% (4)
Elliot Pathways	3.3% (4)	3.3% (4)	4.2% (5)
Parkland Regional Hospital	NA	NA	NA
Total	**5.9% (42)**	**10.6% (76)**	**15.8% (113)**

Revisions to Prior Period: None.

Data Source: NH DRF Database.

Notes: Data compiled 11/13/2020.

6. Glencliff Home: Census Summary

Measure	July – September 2020	April – June 2020
Admissions	3	8
Average Daily Census	117	115
Discharges	2 (One resident discharged to a 3 bed Medical Model Group Home and one resident discharged back to the DOC/Concord Prison)	2 (One resident discharged to a 3 bed Medical Model Group Home and one resident discharged to another nursing facility)
Individual Lengths of Stay in Days for Discharges	(1,139 and 870)	(756 and 1,057)
Deaths	1	6
Readmissions	0	0
Mean Overall Admission Waitlist	27	22

Revisions to Prior Period: None.

Data Source: Glencliff Home.

Notes: Data Compiled 11/2/2020; 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.

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

Peer Support Agency	July – September 2020		April – June 2020	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
Alternative Life Center Total	**605**	**36**	**276**	**30**
Conway	271	9	54	7
Berlin	132	7	125	6
Littleton	86	8	51	7
Colebrook	116	12	46	10
Stepping Stone Total	**363**	**11**	**371**	**5**
Claremont	246	9	255	5
Lebanon	117	2	116	0
Cornerbridge Total	**136**	**10**	**166**	**7**
Laconia	49	5	44	4
Concord	72	3	102	3
Plymouth Outreach	15	*2*	20	0
MAPSA Keene Total	**303**	**16**	**85**	**27**
HEARTS Nashua Total	*372*	*41*	**418**	**53**
On the Road to Recovery Total	**137**	**10**		

Peer Support Agency	July – September 2020		April – June 2020	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
			169	**10**
Manchester	*75*	*4*	96	4
Derry	62	6	73	6
Connections Portsmouth Total	**98**	**5**	**100**	**6**
TriCity Coop Rochester Total	**246**	**9**	**265**	**0**
Total	**2260**	**128**	**1,850**	**128**

Revisions to Prior Period: None.

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

Notes: Data Compiled 08/05/2020. Average Daily Visits are not applicable for Outreach Programs.

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

Subsidy	July – September 2020		
	Total individuals served at start of quarter	New individuals added during quarter	Total individuals served through end of quarter
Housing Bridge Subsidy	944	35	979
Section 8 Voucher (NHHFA/BMHS) - Transitioned from Housing Bridge	192	6	198
Subsidy	**April – June 2020**		
	Total individuals served at start of quarter	**New individuals added during quarter**	**Total individuals served through end of quarter**
Housing Bridge Subsidy	922	22	944
Section 8 Voucher (NHHFA/BMHS) - Transitioned from Housing Bridge	179	13	192

Revisions to Prior Period: None.

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

Notes: Data Compiled 09/30/2020. Figures at start and end of each quarter are a cumulative total of individuals served since CMHA quarterly reporting began in 2015. Figures for new individuals reflect activity throughout the quarter; these are not a point-in-time count at the end of the reporting period. New individuals added includes individuals newly approved for HBSP funding that have or have not yet secured an HBSP unit, some of whom may have also exited the program in the quarter. These individuals have been on the HBSP waitlist prior to funding approved in the quarter or have newly applied for and been approved for funding in the same quarter.

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

Measure	As of 9/30/2020	As of 6/30/2020
Rents Currently Being Paid	312	328
Individuals Enrolled and Seeking Unit for Bridge Lease	96	79
Total	**408**	**407**

Revisions to Prior Period: None.

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

Notes: Data Compiled 09/30/2020. All individuals currently on the HBSP are intended to transition from the program to other permanent housing. Individuals seeking a unit include people who have not secured their first unit under HBSP and people who secured a unit previously and are seeking a different unit.

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

Measure	As of 9/30/2020	As of 6/30/2020
Housing Bridge Clients Linked	335/409 (82%)	329/406 (81%)

Revisions to Prior Period: None.

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

Notes: Data compiled 11/10/2020; "Housing Bridge Clients Linked" refers to Housing Bridge clients who received one or more mental health services within the previous 3 months, documented as a service or claim data found in Phoenix or the Medicaid Management Information System.

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

Number of HBSP Funded Unit(s)* at Same Address	Frequency as of 9/30/2020	Frequency as of 6/30/2020
1	255	267
2	20	15
3	2	6
4	0	0
5	1	0
6	0	1
7	1	1
8 or more	0	0

Revisions to Prior Period: None.

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

Notes: Data Compiled 09/30/2020. *All units are individual units; property address may include multiple buildings, such as apartment complexes.

8d. Housing Bridge Subsidy Program: Applications

Measure	July – September 2020*	April - June 2020
Applications Received During Period	57	30
Point of Contact for Applications Received	CMHCs 50; NHH 6; NFI 1	CHMCs 29; NHH 1; NFI 1
Applications Approved	57**	27
Applications Denied	0	0
Denial Reasons	NA	NA
Applications in Process at End of Period	0	41

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services.

*Notes: Data Compiled 09/30/2020. *Data reflects only those applications that were received during the quarter and no longer reflect carryover data from applications received in prior quarters **Includes 15 awarded an HBSP subsidy in the same quarter the application was received, 3 of which also exited the program in the same quarter, and 42 added that remained on the waitlist as of the quarter's close.*

8e. Housing Bridge Subsidy Program: Terminations

Type and Reason	July – September 2020	April - June 2020
Terminations – DHHS Initiated	2	0
He-M 406.08 (a)(5): Failure to pay rent for 3 or more consecutive months	2	0
Exited Program – Client Related Activity	45	27
Voucher Received	24	16
Deceased	1	2
Over Income	1	1
Moved Out of State	3	2

*Declined Subsidy at Recertification**	10	2
*Higher Level of Care Accessed***	4	2
Other Subsidy Provided	2	1
Moved in with family	0	1
Total	**47**	**27**

Revisions to Prior Period: None.

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

*Notes: Data Compiled 09/30/2020. This table only includes individuals who were receiving an HBSP subsidy or who had HBSP funding approved and were seeking a unit prior to exiting the program. *Includes all refusals, including refusal to initiate voucher and unable to contact. **Includes one individual at the Secure Psychiatric Unit (SPU).*

8f. Housing Bridge Subsidy Program: Application Processing Times

Average Elapsed Time of Application Processing (calendar days)*	July – September 2020	April - June 2020
Completed Application to Determination	1	1
Approved Determination to Funding Availability**	75	80
Referred to Vendor with Funded HB Slot	1	1
Leased Unit Secured***	95	80

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services.

Notes: Data Compiled 09/30/2020.

**Elapsed time measure reporting implemented 10/01/18 and applies to any application received on or after that date.*

***Average calculated on 35 applications approved for which funding was made available in the quarter; 15 of these applications were received and approved for funding in the same quarter. ***Average calculated on 14 units leased during the quarter.*

9. Housing Bridge Subsidy Program Waitlist: Approved Applications

As of 9/30/2020*							
Time on List							
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**	**181+ days**
85	12	17	12	7	10	3	24
As of 6/30/2020							
Time on List							
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**	**181+ days**
39	6	9	4	5	6	6	3

Revisions to Prior Period: None.

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

*Notes: Data Compiled 09/30/2020. *Includes some individuals formerly on inactive status returned to waiting status. Additionally, there are four individuals in a higher level of care who were not yet appropriate for discharge as of 9/30/2020 but for whom an HBSP subsidy has been approved, pending discharge. They are in inactive status and are not included in the waitlist count.*

10. Supported Housing Subsidy Summary

	July – September 2020	**April - June 2020**
Subsidy	**Total subsidies by end of quarter**	**Total subsidies by end of quarter**

Housing Bridge Subsidy:	Units Currently Active	312	328
	Individuals Enrolled and Seeking Unit for Bridge Lease	96	79
Section 8 Voucher (NHHFA):	Transitioned from Housing Bridge*	198	192
	Not Previously Receiving Housing Bridge	3	3
811 Units:	PRA	89	81
	Mainstream	62	44
Other Permanent Housing Vouchers (HUD, Public Housing, VA)		7	6
Total Supported Housing Subsidies		**767**	**733**

Revisions to Prior Period:

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

Notes: Data Compiled 09/30/2020. Section 8 Voucher Not Previously Receiving Housing Bridge are CMHC clients that received a Section 8 Voucher without previously receiving a Housing Bridge subsidy. 811 Units (PRA and Mainstream) are CMHC clients or CMHA Target Population members that received a PRA or Mainstream 811 funded unit with or without previously receiving a Housing Bridge subsidy. Other Permanent Housing Vouchers (HUD, Public Housing, VA) are CMHC clients that received a unit funded through other HUD or Public Housing sources with or without previously receiving a Housing Bridge subsidy.

**These counts are cumulative; increasing over time since originally reporting this data within the CMHA Quarterly Data Report. 75 of these units are verified currently occupied units by former program participants; after 6 months of occupancy under the Section 8 Voucher, BMHS routine verification of occupancy discontinues.*

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

Measure	July 2020	August 2020	September 2020	July – Sept. 2020	April – June 2020
Unique People Served in Month	210	197	230	557	530
Services Provided by Type					
Case Management*	0	0	0	0	0
Crisis Apartment Service*	0	0	0	0	0
Crisis Intervention Services	5	5	4	14	1
ED Based Assessment*	0	0	0	0	0
Medication Appointments or Emergency Medication Appointments*	0	0	0	0	0
Mobile Community Assessments	80	43	55	178	211
Office-Based Urgent Assessments	15	10	20	45	28
Other*	0	0	0	0	0
Peer Support*	0	0	0	0	0
Phone Support/Triage	454	425	415	1,294	1,343
Psychotherapy*	0	0	0	0	0
Referral Source					
CMHC Internal	14	17	23	54	34
Emergency Department	1	9	16	26	9

Family	20	31	25	76	70
Friend	7	4	6	17	12
Guardian	22	16	19	57	58
MCT Hospitalization*	0	0	0	0	0
Mental Health Provider	6	7	6	19	23
Other	4	10	17	31	7
Police	12	6	5	23	36
Primary Care Provider	5	5	7	17	14
Self	118	209	168	495	345
School	1	1	9	11	2
Crisis Apartment					
Apartment Admissions	15	10	20	45	39
Apartment Bed Days	40	36	69	145	125
Apartment Average Length of Stay	2.5	3.6	3.5	3.2	3.3
Law Enforcement Involvement	24	6	19	49	76
Hospital Diversions Total	188	160	175	523	529

Revisions to Prior Period: None.

Data Source: Riverbend CMHC submitted report.

*Notes: Data Compiled 10/27/2020. 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. *A data reporting issue resulting in no*

services being captured for reporting purposes in some categories is being addressed with Riverbend.

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

Measure	July 2020	August 2020	September 2020	July – Sept. 2020	April – June 2020
Unique People Served in Month	308	303	305	723	669
Services Provided by Type					
Case Management	27	22	50	99	118
Crisis Apartment Service	0	0	0	0	0
Crisis Intervention Service	198	181	262	641	646
ED Based Assessment	0	0	0	0	0
Medication Appointments or Emergency Medication Appointments	8	5	4	17	14
Mobile Community Assessments	107	92	97	296	294
Office-Based Urgent Assessments	3	10	7	20	23
Other	254	264	249	767	754
Peer Support	16	6	17	39	36
Phone Support/Triage	619	520	560	1,699	1,552
Psychotherapy	2	1	3	6	11
Referral Source					
CMHC Internal	9	3	3	15	14
Emergency Department	1	0	1	2	2

Family	68	43	52	163	171
Friend	3	3	6	12	25
Guardian	3	17	10	30	33
MCT Hospitalization	4	9	5	18	22*
Mental Health Provider	16	13	16	45	18
Other	15	22	19	56	55
Police	92	106	90	288	249
Primary Care Provider	11	9	9	29	21
Self	151	149	145	445	462
School	0	0	0	0	2*
Crisis Apartment					
Apartment Admissions	0	0	0	0	0
Apartment Bed Days	0	0	0	0	0
Apartment Average Length of Stay	0.0	0.0	0.0	0.0	0.0
Law Enforcement Involvement	92	106	90	288	249
Hospital Diversion Total	373	351	351	1,075	1,055

*Revisions to Prior Period: *Indicate corrected counts.*

Data Source: Phoenix 2.

Notes: Data Compiled 10/27/2020. Reported values other than the Unduplicated 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.

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

Measure	July 2020	August 2020	September 2020	July – Sept. 2020	April – June 2020
Unique People Served in Month	79	90	57	208	245
Services Provided by Type					
Case Management	11	20	10	41	59
Crisis Apartment Service	75	47	76	198	168
Crisis Intervention Services	0	0	0	0	0
ED Based Assessment	4	5	3	12	13
Medication Appointments or Emergency Medication Appointments	0	0	0	0	0
Mobile Community Assessments	27	29	18	74	183
Office-Based Urgent Assessments	9	27	21	57	29
Other	0	0	0	0	0
Peer Support	47	26	37	110	227
Phone Support/Triage	79	79	40	198	326
Psychotherapy	2	0	2	4	1
Referral Source					
CMHC Internal	6	10	3	19	13
Emergency Department	1	6	4	11	1
Family	13	15	7	35	32

Friend	4	2	2	8	3
Guardian	0	0	0	0	0
MCT Hospitalization	0	0	0	0	0
Mental Health Provider	7	7	2	16	27
Other	5	16	7	28	217
Police	7	1	0	8	1
Primary Care Provider	0	1	2	3	1
Self	58	68	41	167	80
Schools	0	0	1	1	1
Crisis Apartment					
Apartment Admissions	12	9	12	33	30
Apartment Bed Days	63	39	70	172	142
Apartment Average Length of Stay	5.3	4.3	5.8	5.1	4.8
Law Enforcement Involvement	0	0	1	1	1
Hospital Diversion Total	114	126	76	316	511

Revisions to Prior Period: None.

Data Source: Harbor Homes submitted data.

Notes: Data Compiled 10/27/2020. 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.

Appendix B

QSR Summary Scores: 2020

CMHC QSR Indicator Results: State Fiscal Year 2020

Indicator #	Indicator	Region 1 NHS	Region 2 WCBH	Region 3 LRMHC	Region 4 RMHC	Region 5 MFS	Region 6 GNMHC	Region 7 MHCGH	Region 8 SMHC	Region 9 CP	Region 10 CLM	STATE AVERAGE
1	Adequacy of Assessment	90%	89%	97%	96%	93%	85%	92%	94%	92%	96%	92%
2	Appropriateness of treatment planning	85%	93%	85%	96%	88%	89%	94%	100%	88%	96%	92%
3	Adequacy of individual service delivery	82%	86%	83%	95%	86%	90%	94%	90%	93%	96%	89%
4	Adequacy of Housing Assessment	100%	100%	100%	95%	100%	95%	100%	100%	95%	100%	99%
5	Appropriate of Housing Treatment Plan	95%	90%	86%	95%	100%	86%	100%	90%	86%	68%	90%
6	Adequacy of individual housing service delivery	88%	85%	86%	100%	95%	90%	91%	86%	92%	95%	91%
7	Effectiveness of Housing supports provided	82%	92%	87%	89%	90%	90%	86%	90%	86%	95%	89%
8	Adequacy of employment assessment/screening	70%	68%	55%	71%	68%	64%	78%	81%	64%	68%	69%
9	*Appropriateness of employment treatment planning	88%	82%	63%	100%	82%	64%	90%	67%	100%	100%	83%
10	*Adequacy of individual employment service delivery	69%	63%	59%	95%	90%	90%	63%	82%	91%	78%	78%
11	Adequacy of Assessment of social and community integration needs	100%	100%	100%	97%	100%	100%	100%	100%	98%	100%	100%
12	Individual is integrated into his/her community, has choice, increased independence, and adequate social supports	77%	83%	74%	82%	80%	77%	77%	84%	74%	86%	79%
13	*Adequacy of Crisis Assessment	75%	67%	83%	96%	72%	100%	91%	58%	75%	81%	80%
14	Appropriateness of crisis plans	88%	100%	82%	95%	93%	93%	92%	93%	84%	79%	90%
15	*Comprehensive and effective crisis service delivery	100%	70%	72%	100%	88%	88%	81%	75%	75%	63%	81%
16	Adequacy of ACT Screening	100%	100%	100%	100%	100%	95%	100%	100%	98%	100%	99%
17	*Implementation of ACT Services	36%	77%	73%	85%	81%	88%	80%	79%	71%	67%	74%
18	*Successful transition/discharge from the inpatient psychiatric facility	71%	83%	81%	80%	86%	82%	81%	86%	80%	91%	82%
	AVERAGE	83%	85%	81%	93%	88%	87%	88%	86%	86%	87%	86%