New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Three

January 5, 2016

I. Introduction

This is the third semi-annual report of the Expert Reviewer (ER) under the Settlement Agreement in the case of *Amanda D. v. Hassan,; 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 V.III.K of the CMHA specifies that:

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

In this third six-month period (July 1, 2015 through December 31, 2015), the ER has continued to observe the implementation of certain key service elements of the CMHA, and to have discussions with relevant parties related to implementation efforts and the documentation of progress and performance consistent with the standards and requirements of the CMHA. In this period, the ER:

- Conducted on-site reviews of Assertive Community Treatment (ACT) teams/services and Supported Employment (SE) services at Center for Life Management, Seacoast, West Central, and Community Partners CMHCs. This completes the ER's first round of site visits to each of the ten CMHCs to review ACT and SE services;
- Met again with officials, administrators, and staff at both New Hampshire Hospital (NHH) (twice) and Glencliff to discuss and observe transition planning functions;
- Met with the newly-formed Central Team, established to facilitate transitions from Glencliff and NHH;
- On two occasions, met with leadership and staff of the Riverbend CMHC to assess implementation of the new mobile crisis team and crisis apartments in the Concord region;
- Met with the NAMI New Hampshire family support group in Nashua, NH;
- Met with members of Granite Pathways, a psychosocial clubhouse in Manchester, NH;

- Met with the Chief of the Concord Police Department;
- Met with representatives of the Emergency Department (ED) and the Designated Receiving Facility (DRF) of the Franklin Hospital;
- Participated in several meetings with representatives of the Plaintiffs and the United States (hereinafter "plaintiffs");
- Conducted several meetings with DHHS officials to discuss Quality Service Reviews (QSR), data tracking, and data elements and reporting related to the CMHA; and
- Convened four meetings with the parties -- two meetings to discuss general progress on implementation of the CMHA, and two meetings to provide input on the design and implementation of the QSR process.

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

II. Data

The New Hampshire DHHS has made notable progress in developing and delivering data reports addressing performance in some domains of the CMHA. Appendix A contains the DHHS July to September 2015 Quarterly Data Report, which incorporates standardized report formats with clear labeling and date ranges for several important areas of CMHA performance. The ER appreciates the efforts that have gone into developing these improved data reporting capabilities, and believes that, for those indicators included in the report, a firm foundation has now been laid for on-going tracking of performance related to certain CMHA standards. Specific data from the standard report are included in the discussion of individual CMHA services below.

In addition to the standardized reporting of certain types of data, DHHS continues to collect and report on other data necessary to monitor performance related to the CMHA. These include reports from the new mobile crisis services in the Concord Region; data on discharge destinations from NHH and Glencliff; reports of wait list numbers for ED boarding; and data on utilization of Designated Receiving Facilities (DRFs). Where applicable, these data are incorporated in the discussion of specific CMHA performance standards below.

DHHS has made progress in creating unified data systems that support the improved data reporting identified above. The new database systems also support conducting special analyses and quality reviews which can assist monitoring the performance of the state's mental health system in the context of the CMHA. For example, cohort analyses of people discharged from NHH or people receiving a combination of ACT and SE services can be routinely conducted. Person-specific service access, timeliness, and utilization data can also be generated to support the QSR process discussed below.

As noted in the previous ER report, there continue to be important categories of data that are needed but not routinely collected and reported, and which will need to be developed in order to accurately evaluate ongoing implementation of the CMHA. For example, there continues to be no reported or analyzed data on the degree to which participants in SE are engaged in competitive employment in integrated community settings consistent with their individual treatment plans. Another gap in data is related to people receiving Supported Housing (SH) under the Bridge Subsidy Program. These participants are not yet clearly identified in the Phoenix II system, and thus it is difficult to document the degree to which these individuals are: (a) connected to local CMHA services and supports; or (b) actually receiving services and supports to meet their individualized needs on a regular basis in the community. DHHS has identified a strategy to link data from the Bridge program to the Phoenix II system, so a solution to this data issue may be forthcoming. Data reporting is incomplete in other areas as well. Some missing information is referenced in the substantive sections below. Such data includes, but is not limited to, additional data from NHH, state DRFs/APRTP, and the PASRR system. The ER will continue to work with the State to further augment and refine the data/information reporting process going forward.

In the previous ER report, the sporadic and inconsistent reporting of data was noted to have been a source of significant frustration for DHHS, the plaintiffs, and the ER. Consistent with the above discussion, several of the data reporting issues have been resolved. All parties to the CMHA are looking forward to continuing to receive these reports on a timely basis and to resolving the remaining outstanding issues related to data/information reporting.

III. CMHA Services

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

Mobile Crisis Services and Crisis Apartments

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

Given the timing of the contract award, it was not possible for the mobile team and crisis apartments to be operational by June 30, 2015, as required by the CMHA. Nonetheless, Riverbend has made progress in implementing both the mobile team and the crisis apartments. As of October 2015, Riverbend reports that 135 unduplicated individuals have been served by its

new the mobile crisis program. Table I below provides Riverbend's most recent available information on activities of its new crisis program.

Table I

Concord Region Self-Reported Mobile Crisis Services: July 1, 2015 through October 2015

Total unduplicated people served	135
Services provided in response to immediate crisis: • Phone support/triage • Mobile assessments • Crisis stabilization appointments • Emergency services medication appointments	 179 14 45 18
Services provided after the immediate crisis: • Phone support/triage • Mobile assessments • Crisis stabilization appointments • Emergency services medication appointments	 52 5 29 18
Referral source: • Self • Family • Mental health provider • Personal care physician • Hospital emergency department • Other (school, friend, guardian, VNA, co-worker, etc.)	 66 24 15 4 8 18
Crisis apartment admissions	5
Law enforcement involvement	4
Total hospital diversions	39

The Concord region mobile crisis program is expected to provide effective mobile crisis services to target population members in the Concord region, resulting in reduced institutionalization, hospitalization, ED presentations, and incarceration, and increased housing stability and community tenure. It is too early in the implementation and operations of the program to be able to document that these expected results are being achieved. An essential component of the teams' work, and a key outcome of the CMHA, is the delivery of crisis services in community locations. Given the very low number of mobile encounters reported above (14 out of 179 triaged calls), it will be important to closely monitor the location of service delivery, crisis teams' capacity and willingness to go mobile, and the role of phone triage in determining encounter location. The ER will continue to closely monitor the implementation and operations of this program through the next six-month period and will continue to work with the State to ensure that the new crisis services are truly mobile and not delivered primarily via telephone

interactions. In addition, the ER will work with DHHS to refine some of the data reporting associated with mobile crisis and crisis apartment services. For example, a clear definition of what constitutes a hospital diversion would assist in interpreting the data. Also, data on the utilization of crisis apartments, including the number of days per admission, and disposition following admission, will allow the parties to evaluate the effectiveness of this service component. It will also be important to gather and report on interactions with law enforcement and the outcomes from mobile crisis engagement in these encounters.

The implementation and early operations experience of the new Riverbend mobile crisis program are likely to inform implementation of the next mobile crisis program, scheduled to be operational in the Manchester Region by June 30, 2016. DHHS released the request for proposals (RFP) for that new service on December 7, 2015. Hopefully, this early release of the RFP will facilitate timely selection of a qualified vendor and preparation for initial operations of the Manchester region mobile crisis program by June 30, 2016.

Given that the Mobile Crisis program is still early in the implementation process, this Report does not specifically address the State's progress on each of the required elements and outcomes of the mobile crisis system per the CMH. Within the next six-month period the ER will work with the State to address the State's progress in meeting each of the required elements and outcomes of the crisis system under Section V.C. of the CMHA.

Assertive Community Treatment (ACT)

ACT is a key 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; and
3. By June 30, 2015, 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 1,300 individuals in the Target Population at any given time.

Taken together with the other ACT provisions, the CMHA requires a robust and effective system of ACT services throughout the State as of June 30, 2015.

In the last ER report, it was noted that the reported statewide capacity of 1,025 was 275 less than the 1,300 capacity standard in the CMHA. In June 2015, the ACT system as a whole was serving 356 individuals fewer than the reported capacity of 1,025 would have supported; and 631 individuals fewer than the required capacity of 1,300 could effectively serve.

As displayed in Table II below, the staff capacity of the 11 adult ACT teams in New Hampshire has gone down by almost five percent since the last report. At the same time, the total active

caseload has increased by 77 individuals -- an increase of almost 12% since the previous report. Although the increased active caseload is positive, the reduced staff capacity means that the State remains out of compliance with the June 30, 2015 CMHA standard for ACT.

Table II

ACT Self-Reported Staff Capacity and Active Caseload: May-September 2015

DHHS Region/ CMHC	FTE ACT Staff May 2015	FTE ACT Staff September 2015	Percent Change	Active Caseload – May, 2015	Active Caseload September 2015	Percent Change
1. Northern	14.8	11.29	(23.7%)	60	72	20%
2. West Central	3.0	3.83	27.7%	16	19	18.75%
3. Genesis	7.1	7.5	5.63%	22	30	36.4%
4. Riverbend	7.0	7.3	4.29%	79	60	(24.1%)
5. Monadnock	8.2	8.5	3.66%	47	54	14.89%
6. Greater Nashua	8.7	5.98	(31.3%)	63	74	17.46%
7. Manchester	24.9	26.3	5.62%	254	265	4.33%
8. Seacoast	12.8	11.77	(8.05%)	73	65	(10.96%)
9. Community Partners	8.2	8.7	6.1%	16	70	337.5%
10. Center for Life Management	7.8	6.36	(18.5%)	39	37	(5.13%)
Total	102.5	97.53	(4.85%)	669	746	11.51%

The ER recognizes that staffing levels may fluctuate within a statewide ACT program with 11 ACT teams. And, part of the almost five percent reduction in staffing capacity appears to be related to planned changes in the staffing of the Northern Human Services ACT team. It is also understood that there are challenges throughout the New Hampshire Health and Human Services system with regard to workforce shortages and difficulties in recruiting professional, licensed, and para-professional staff. Nonetheless, the current gap between staff capacity and the requirements of the CMHA cannot be explained or excused by routine staff turnover or workforce development and recruiting issues.

The ER notes that three of the 11 adult ACT teams have fewer than the 7 - 10 professionals specified for ACT teams in the CMHA. In addition, one region currently has no nursing staff and five others have less than one FTE nurse; three regions have no peer specialist staff and five others have less than one FTE peer specialist; and three regions have less psychiatry time than warranted by their active caseloads. From anecdotal information gathered by the ER during ACT team site visits, it also appears that substance abuse competence is not uniformly represented on the ACT teams – data shows less than one FTE in seven regions. In addition, seven of the 10 regions have less than one FTE SE specialist on an ACT team; and six of 10 have

no professional with housing experience. As a result of these and other significant variations in the type and levels of ACT staffing, the State has yet to achieve the level of consistency and fidelity of ACT service delivery required by the CMHA.

The ER recognizes that the CMHA does not specify utilization (active caseload or unduplicated number of persons served) as opposed to staff capacity. The current gap of 325 service recipient gap between the actual and required ACT team capacity is thus the first issue to be addressed. However, in the previous report, the ER noted that unused capacity for ACT or any other CMHA service could result in difficulty meeting the overall goals and outcomes for priority target population members identified in the CMHA. While it is a positive development that the ACT active caseload has increased by almost 12% since June 30, 2015, reports of unmet demand for ACT services are a source of significant concern across the various regions. Moreover, the system is still serving at least 500 fewer people than could be served if the state had attained the required capacity to serve 1,300 people.

ACT team services are critical to the State meeting the many outcome criteria expressly referenced throughout the CMHA, and it will be essential in the coming months for the State to rectify the significant deficiencies in ACT staffing and utilization in various regions throughout the State.

All of the staffing and utilization data reported by DHHS for ACT services discussed above had been reported by the CMHCs and has not yet been independently verified by the ER. In addition, neither DHHS nor the ER has, to date, reviewed compliance of all ACT teams with the performance and quality standards specified in CMHA Section V.D.2. To help address this issue, the ER expects that the new QSR capacity being developed by DHHS will prompt on-site quality reviews of ACT services with findings reports within the up-coming 12-month period. These reviews are expected to prompt, whenever necessary, implementation of needed remedies to address any compliance concerns.

The New Hampshire DHHS recently awarded a contract to the Community Council of Nashua (the designated CMHC for the Nashua region) for a new adult ACT team. That new team is not yet operational, and thus, does not yet contribute to either the capacity measures or the active caseload for ACT services within the state. The Community Council reports that workforce recruitment and retention issues are hindering timely implementation of this new team. At this point, it is not known when the new team will be accepting referrals of new ACT service participants. The ER will continue to monitor this matter going forward.

The ER has visited all ten CMHCs to receive an overview of the ACT teams in place in the state. These visits did not constitute fidelity or compliance reviews, but did provide qualitative impressions of the implementation and operations of the various ACT teams throughout the state. For the most recent four site visits, the ER has also reviewed a small and non-random sample of case records of people receiving ACT services.

Both the reported data and the qualitative impressions formed by the ER during the site visits support a conclusion that there is substantial variation among the ten CMHCs with regard to the implementation and operations of ACT under the CMHA. As noted in the previous ER report, some of this variation can be explained by how long a CMHC has provided ACT services in different areas, and some variation can be explained by differing geographic and socio-demographic conditions in various service areas. The degree of variation in ACT operations must be addressed through the quality management and fidelity review processes to ensure that all regions deliver effective ACT services to individuals in need.

The June 30, 2015 ER report contained the following statement:

"In the coming months, it is expected that DHHS will: 1) develop one set of eligibility and discharge criteria for the provision of ACT services; 2) analyze the high degree of variation among existing ACT teams; 3) take any steps necessary to assure that ACT services are consistently meeting the CMHA standards statewide, and; 4) expand the capacity of ACT to meet the requirements of the CMHA."

DHHS has begun to work on item number one in the above paragraph, but the criteria remain in development. However, more progress is needed on item numbers 2, 3, and 4. The ER recognizes that the state is focusing efforts on mandating that CMHCs comply with their contracts with the State regarding ACT services. These efforts have included increased site visits and program audits, and have resulted in at least one plan of correction. The ER supports the State's emphasis on enforcement as a necessary condition to attain compliance with the CMHA requirements, but recognizes that more assertive actions related to both program expansion and quality will be necessary. The ER expects that DHHS will immediately develop and begin implementation of a concrete and measurable action plan to assure that ACT services comply with CMHA requirements by June 30, 2016.

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, 2015, the state will increase its penetration rate of individuals with SMI receiving supported employment …to 16.1% of eligible individuals with SMI." (Section V.F.2(c)).

The baseline SE penetration rate at the beginning of the CMHA was 12.1% (2012). In the June 2015 ER report, the SE penetration rate was 11.3% -- almost a full percentage point below the 2012 baseline. The June 2015 ER report noted that the penetration rate at that time was 4.8 percentage points below the CMHA target for June 30, 2015.

For this reporting period, it appears that the State and the CMHCs have made progress in moving towards the 16.1% penetration rate specified for June 30, 2015 in the CMHA. As of September 2015, the statewide penetration rate was reported to be 15.7%, only slightly below the 16.1% target.

As shown in Table III below, all but one of the CMHCs report having increased the number of unique individuals reported to have received SE; and seven of the 10 CMHCs report having increased their penetration rates over the previous reporting period.

Table III

CMHC Self-Reported SE Participants and Penetration Rates through September 2015

DHHS Region/CMHC	Unique SE Participants 12 month period ending March 2015	Penetration Rate through March 2015	Unique SE Participants 12 month period ending September 2015	Penetration Rate through September 2015
1. Northern	85	7.1%	106	8.2%
2. West Central	91	13.5%	83	12.9%
3. Genesis	108	9.4%	118	9.3%
4. Riverbend	186	14.9%	194	14.2%
5. Monadnock	57	8.0%	157	16.4%
6. Greater Nashua	78	6.1%	116	7.7%
7. Manchester	445	14.6%	821	26.1%
8. Seacoast	112	10.5%	161	13.1%
9. Community Partners	52	8.1%	98	11.6%
10. Center for Life Management	107	16.3%	153	21.4%
Statewide Average	1,321	11.3%	2,003	15.7%

The CMHA establishes a statewide penetration rate standard, not individual CMHC penetration rate requirements. There are three regions in the state in which priority Target Population members are reported to be receiving SE services at or above the June 30, 2015 penetration rate standard. However, the ER notes that seven of the 10 of CMHCs have penetration rates below the June 2015 standard, and four of these have penetration rates below the 12.1% baseline standard for SE. Wide variation in access to and utilization of SE services on a sub-state level could affect overall attainment of CMHA objectives for the target population. Thus, the ER will continue to monitor and report on individual CMHC penetration rates as well as the statewide total. As with the previous report, the ER will also continue to monitor implementation of

applicable CMHC plans of correction related to improving SE penetration and performance at the regional level.

Several others issues related to the implementation and monitoring of Supported Employment services will need to be resolved in the coming months. First, as noted earlier in this report, there is currently no consistently reported data on the extent to which SE service participants are attaining and sustaining competitive employment. Success in obtaining competitive employment is not a specific numerical standard in the CMHA. However, the CMHA does require the State to operate SE services in conformance with the Dartmouth fidelity standards, and attaining and sustaining competitive employment is an indicator of fidelity to those standards. The ER will be working with the State and the CMHCs to develop a consistent and reliable method for reporting on obtaining and sustaining competitive employment.

Second, there continues to be an issue with regard to the calculation of the penetration rates. Individuals referred for SE and receiving one intake visit, but no other SE services are currently included as SE service participants in the calculation, and thus may inflate the penetration rates. The ER believes that issues related to how SE participants are included in the SE penetration rate calculation occurred before and during the calculation of the baseline 12.1% penetration rate for the CMHA. Thus, it appears that from a methodological perspective the current and original calculations of penetration rates are consistent. Given this limitation in available data, and in order to demonstrate compliance with fidelity standards and corresponding client outcomes in the CMHA, it is necessary to identify the number of target population individuals that actually become engaged in SE and receive SE services in a manner anticipated by the SE fidelity standards. The ER believes that a special query of the Phoenix II database will permit analyses of those actually receiving SE services, excluding those who may have had one contact with the SE system in the past. This, in concert with data on the degree to which SE participants are obtaining competitive employment, should provide a more reliable picture of how well the SE service component is functioning within each CMHC and on a statewide basis.

The June 30, 2015 ER report summarized SE fidelity self-report information from the 10 CMHCs. The ER understands that new fidelity self-assessments have been submitted by the CMHCs to DHHS. However, that information has not yet been reviewed by DHHS, and is not available for this report. The ER expects that the June 30, 2016 report will include a summary of this new SE fidelity self-report analysis, as compared to the information contained in the June 30, 2015 report. The ER plans to provide the parties with updated information and analysis well in advance of the next report date. It should be noted that to date DHHS has not implemented a standardized process for validation of these CMHC fidelity self-reports. DHHS reports that it is exploring options to assure validation of SE fidelity self-reports. The ER expects that a proposal will be circulated for discussion and feedback by the parties in the coming months, and that the process for validation will be operational by June 30, 2016.

Supported Housing (SH)

The CMHA requires the State to achieve a target capacity of 340 SH units funded through the Bridge subsidy program by June 30, 2015. DHHS reports having 376 individuals in leased SH apartments as of September 30, 2015, thereby exceeding the June 30, 2015 CMHA requirement by 36 subsidized people/units. If Bridge program leasing continues at the current pace, it seems likely that the CMHA target of 450 SH units is attainable by June 30, 2016.

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

Table IV

New Hampshire DHHS Self-Reported Data on the Bridge Subsidy Program as of September 30, 2015

Bridge Program Information	Data
Total housing slots (subsidies) available	450
Total people for whom rents are being subsidized as of 9/30/2015	376
Individuals accepted but waiting for lease-up	23
Individuals currently on the wait list for a bridge subsidy	0
Total number served since the inception of the Bridge program	466
Total number receiving a Housing Choice (Section 8) Voucher	70

It should be noted that for this most recent time period, DHHS has made improvements in the ways that SH data is recorded and reported. Comparisons with data reported for previous time periods may not be entirely applicable, and thus previous data has not been included in the data table. However, the ER believes it is accurate to say that the number of people in leased units has increased by 99 individuals, a 36% increase over the previous period. At the same time, the number of people approved, but not yet leased, has been reduced by 40 people, a decrease of over 60% from the previous period. The substantial reduction in the number of people approved, but not yet leased, may indicate that the housing search and lease-up process is working more efficiently. However, there are no current data on the elapsed times between completion of an application, approval, and lease-up. This information is needed before the ER can reach conclusions about the degree to which the system is actually assisting target population members to acquire permanent housing of their choice quickly and effectively.

The Bridge Program is intended to be just that: a short term bridge to a permanent mainstream rental subsidy or other affordable permanent housing program. As shown in Table IV, 70 individuals served under the Bridge Program are reported to have obtained mainstream housing

subsidies via the federal Housing Choice Voucher (Section 8) program. This is a positive accomplishment, both for the people housed, and for the State.

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

Table V

Self-Reported Bridge Subsidy Housing Concentration (Density)

Number of properties with one leased SH unit at the same address	290
Number of properties with two SH units at the same address	27
Number of properties with three SH units at the same address	2
Number of properties with four SH units at the same address	4
Number of properties with five SH units at the same address	1
Number of properties with six SH units at the same address	1

As can be seen in the table, almost 90% of the leased units are at a unique address. This supports a conclusion that the Bridge Program, to a large degree, is operating as a scattered-site program. For the 10% of the units shown in Table V to be at the same address, it is not known at this time whether the unit density standards included in the CMHA are being met. For example, in the one property that is noted to have six units at the same address, the total number of units at that address is not yet reported. If that building has a total of 60 or more units, then having six Bridge program leases in that property would comport with the CMHA. However, if that property has fewer than 60 total units, then the six units leased in that building would exceed the scattered-site definition as quoted above. DHHS is collecting information on the total units in each building where there are two or more Bridge units at the same address, and this data will be reported in the next ER report.

It should be noted that these data do not indicate whether any of the leased units are roommate situations, and if so, whether such arrangements meet the requirements of the CMHA (V.E.1(c)). DHHS reports, and anecdotal information seems to support, that there are very few, if any, roommate situations among the currently leased Bridge program leased units. Data documenting the presence or absence of roommate situations will be included in the overall data reporting specification process outlined below.

Current data is also not available on the degree to which Bridge Program participants access and utilize supportive services and whether or not the services are effective and meet individualized needs. Receipt of services is not a condition of eligibility for a subsidy under the Bridge Program, but the CMHA does specify that "…supported housing included support services to enable individuals to attain and maintain integrated affordable housing…." (V.E.1(a)). DHHS is currently working on a method to cross-match the Bridge Program participant list with the Phoenix II and Medicaid claims data. This will allow documentation of the degree to which Bridge Program participants are actually receiving certain mental health services and supports. The ER expects that this information will be available for discussion by the parties in the coming months, and that an analysis of the data will be included the June 30, 2016 report.

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

- Total number of Bridge Program applicants per quarter;
- Referral sources for Bridge Program applicants;
- Number and percent approved for the Bridge Program;
- Number and percent rejected for the Bridge program;
    - Reasons for rejection of completed applications, separately documenting those who are rejected because they do not meet federal HCV/Section 8 eligibility requirements;
- Number and disposition of appeals related to rejections of applications;
- Elapsed time between application, approval, and lease-up;
- Number of new individuals leased-up during the quarter;
- Number of terminations from Bridge subsidies;
- Reasons for termination:
    - Attained permanent subsidized housing (Section 8, public housing, etc.);
    - Chose other living arrangement or housing resource;
    - Moved out of state;
    - Deceased;
    - Long term hospitalization;
    - Incarceration;
    - Landlord termination or eviction; or
    - Other;
- Number of Bridge Program participants in a roommate situation; and
- Lease density in properties with multiple Bridge Program leases.

The CMHA does not specifically establish requirements or targets related to some of the above data. However, most rental assistance programs collect and report such information, given its intrinsic value in monitoring program operations. Further, such data enhances DHHS' ability to

demonstrate the timeliness and effectiveness of access of the priority target population to this essential CMHA program component. The ER will continue to work collaboratively with DHHS to identify sources and methods for such data collection and reporting.

DHHS and the plaintiffs are currently in discussions related to a draft of new Bridge Program rules. A final draft version is not available at the time of this report. The ER expects DHHS and the representatives of the plaintiffs to complete this review and revision process promptly.

Transition Planning

During the past 12 months the ER has visited both Glencliff and NHH on at least two separate occasions to meet with staff engaged in transition planning under the new policies and procedures adopted by both facilities late last year. Transition planning activities related to specific current residents in both facilities were observed, and most recently, a small non-random sample of resident transition records have been reviewed. Additional discussions have also been held with both line staff and senior clinicians/administrators regarding potential barriers to effective discharge to the most appropriate community settings for residents at both facilities. In the next report the ER plans to identify and discuss barriers to discharge that continue to affect transitions to the community two years after implementation of the CMHA. Finally, the ER participated in one meeting of the Central Team, now that it has been operationalized. As discussed below, it is important that the Central Team expand its capacity to receive and respond to referrals from NHH in order to avoid unnecessary delays in discharge planning for class members in that setting.

Glencliff

In the time period from July to September 2015, Glencliff reported that it has admitted four individuals, and has had no discharges. The wait list for admission has remained relatively constant: averaging 16 people during this time frame. At the same time, the average length of stay has increased from 2,258 days to 2,284 days, or more than six and a quarter years. There is no calculation of length of stay on discharge for this time period, since there have been no reported discharges. The ER is concerned about both the steady state of referrals to Glencliff and the lack of discharges to community settings for the reported quarter.

Section V.E.3(g) of the CMHA requires the State by now to: "…have the capacity to serve in the community four individuals with mental illness and complex health care needs residing at Glencliff…." The CMHA includes several options for attaining that goal, including the issuance of an RFP to secure four new residential services beds, and/or to access existing capacity in the residential services system. The CMHA also anticipates collaboration with the DHHS Elderly and Adult Services component to assist with implementing transition plans for this population.

As noted in the June 30, 2015 ER report, DHHS has been endeavoring to access the Enhanced Family Care service modality included in New Hampshire's Home and Community-Based

Services waiver for people who are elderly or have disabilities. DHHS has also been exploring other Medicaid waiver and in-plan service authorities to piece together an array of services for each of the individuals at Glencliff for whom this type of transition planning is being conducted. Now, six months later, the technical and financial complexities of these mechanisms have not yet been resolved, and no Glencliff resident has yet been discharged to a community setting using one or more of these mechanisms.

The CMHA specifically identifies up to $100,000 per person that can been used, in concert with other applicable Medicaid waiver or similar financing approaches, to develop or acquire the capacity for community transitions for four Glencliff residents by June 30, 2015. None of these funds have been expended to date, and no RFP for enhanced residential capacity has been issued by the State. At the all parties meeting on December 9, 2015, DHHS announced it intended to contract with an agency to function as a "fiscal intermediary" to facilitate blending the $100,000 maximum per person funding availability with other service and financing resources to effectuate the desired transitions to community settings. It is not known at this point which agency might be selected for this role, or what purposes (or limitations) related to the use of these funds might be included in the contract. It is also worth noting that the State is required under the CMHA to serve an additional six individuals with mental illness and complex health care needs residing at Glencliff in the community by June 30, 2016. In working to come into compliance by serving the four individuals that were expected to move by this past June, the State should simultaneously be working to develop the capacity to serve the additional six individuals that must be served by June 30, 2016.

In the June 30, 2015 report, the ER noted that the Central Team specified in the CMHA had not yet been implemented. As of September 2015, the Central Team was constituted and began meeting. To date, DHHS reports that the Central Team has reviewed four potential transition plans for individuals residing at Glencliff, each of whom is in the medically complex category identified above. The ER has the impression that Central Team consideration of these transition plans has been positive and helpful. Nonetheless, as of this date, no actual transitions have resulted from the participation of the Central Team. The ER suggests that the Central Team become more aggressive in both reviewing applicable cases for transition and in effectuating solutions to facilitate such transitions to the community.

The ER finds that the State is not in compliance with Section V.E.3(g) of the CMHA. To date, no capacity has been created or identified to transition individuals meeting the criteria of this section, and no transitions have yet been accomplished. The ER believes that some of the strategies being developed by DHHS and the Central Team to effectuate such transitions have the potential to be effective – both for the individuals to be transitioned, and to facilitate future transitions for similar persons now residing at Glencliff. However, the ER finds that the progress in creating capacity and effectuating transitions has been much too slow, and to date ineffectual, to meet the requirements of the CMHA.

PASRR

As noted in the June 30, 2015 report, DHHS has retained the University of Massachusetts Medical School to perform PASRR functions in New Hampshire. DHHS has reported verbally that the PASRR vendor has been conducting reviews related to applicants to Glencliff. To date no data has been provided relative to the overall number of PASRR reviews conducted; the number of these reviews related to Glencliff; and the number of people reviewed who have been approved for admission to Glencliff. Nor has data been presented to date on the number of people diverted from nursing facility placement, including diversions from Glencliff, resulting from the PASRR process. The ER has recently requested information as summarized above related to PASRR, and has requested that DHHS set up a meeting to discuss PASRR. Monitoring of the PASRR process, particularly for those awaiting placement at Glencliff, will be a priority for the ER early in 2016.

New Hampshire Hospital

For the time period July 1, 2015 through September 30, 2015, the State reported that NHH effected 361 admissions and 373 discharges. The mean daily census was 132, and the median length of stay was 12 days. The NHH data provided during the six-month period covered by this report is more limited than in prior reporting periods. Prior data reports included important information regarding lengths of stay, including both mean and median data, as well as specific information on the percentage of NHH residents that had stayed less 1-10 days, 30-60 days, 60-90 days, over 6 months, etc. The ER will work with DHHS to increase reporting of NHH data available through the Hospital's AVATAR system, to assure that newly reported data is consistent with and comparable to the data provided for the initial ER reports.

Table VI below compares NHH discharge destination information from the previous ER report to the current report time frame. It should be noted that the time frames covered by the data are different, and there may be some variations in the manner in which the data was recorded and reported.

Table VI

New Hampshire Hospital Self-Reported Data on Discharge Destination

Discharge destination	Number January 2014 through May 2015	Percent January 2014 through May 2015	Number July 1 2015 through September 30 2015	Percent July 1 2015 through September 30 2015
Home – live alone	612	29.3%	100	20.0%
Home – live with others	959	45.1%	236	47.3%
Glencliff	8	0.4%	1	0.02%
Shelter/motel	79	3.8%	12	2.4%
Group home/DDS supported living, etc.	71	3.4%	45	9.02%
Jail/corrections	32	1.5%	2	0.04%
Nursing home/rehab facility	39	1.9%	15	3.0%
Unknown	264	12.6%	88	17.64%

Based on the above data, there would appear to be some reductions in discharges to shelters and jails. At the same time, there appears to be increases in discharges to nursing facilities, group homes and related residential facilities. The ER remains concerned that a substantial number and percentage of the discharges have no reported destination. The ER expects that outstanding issues related to recording of discharge destinations will be resolved before the next ER report. In addition, the ER will work with the State and the plaintiffs to identify and monitor implementation of measures to minimize reliance on institutional destinations.

At the time of this report, the ER has not received new data on NHH readmissions. In addition, DHHS is working to improve the collection and reporting of data from DRFs and the APRTP in the state. There is no current information available on discharge destinations or readmission rates from the DRFs/APRTP. Given that there are questions about the available data, comparisons with previous time frames on these issues may not be reliable at this point. This information is critical in evaluating the extent to which transition planning is adequate and remedial services are effective in reducing the risk of institutionalization among the Target Population. The ER requests that this information be produced in the next 60 days so that NHH, DRF, and APRTP readmission rates and discharge destinations can be available for ongoing monitoring and included among the information analyzed in the June 30, 2016 report.

In the previous report, the ER had identified the waiting list (hospital ED boarding) for admission to NHH to be an important indicator of overall system performance. In FY 2015, the reported monthly average number waiting each day for a bed at NHH was 22.3 adults. In the most recent reporting period, July 1, 2015 through September 30, 2015, the average number of adults waiting for admission to NHH was 16.6. This may indicate some improvements in some combination of ED diversions, hospital admission diversions, and/or speedier discharges from NHH that result in improved bed availability for admissions. It could also be the product of increased admissions to other institutional settings like DRFs and the APRTP as an alternative to NHH. The ER will continue to monitor this issue going forward, requesting additional information as needed. This information should also be included by the State in CMHA Quarterly Data Report.

Summary of Transition Issues

The ER has continued to note that the transitions process is moving very slowly. This appears to be true both at the individual consumer level, and at the system level. Although information at this point is anecdotal, interviews with both line staff and administrators, plus some selective record reviews, indicate that it is taking substantial amounts of time to overcome the many and varied barriers to discharge to the community. Although the Central Team is now in place, it has been concentrating on a small number of cases from Glencliff, and has not yet had time to facilitate NHH transition planning. At the all parties meeting on December 9, 2015, the ER emphasized that DHHS needs to take aggressive executive action to increase both the speed and effectiveness of transitions from NHH and Glencliff. This will be a major focus of ER monitoring during the next six-month period.

Family and Peer Supports

Family Supports

Per the CMHA, the State has maintained its contract with NAMI New Hampshire for family support services. The ER met with the NAMI family support group in Nashua during the time frame of this report. This appeared to be a well-established group that was providing effective family support services to NAMI members. During discussions with the group, the ER heard family frustrations with access to and continuity of mental health services that suggest remedial services may not be readily available or provided with the duration and intensity needed by the Target Population. The voices of family members, as represented by NAMI family support groups, can provide important additional input to the overall state quality management process related to the CMHA, and should be included in the parties' ongoing system monitoring discussions.

Peer Support Agencies

As noted in the June 30, 2015 report, New Hampshire reports having a total of 16 peer support agency program sites, with at least one program site in each of the ten regions. At the time of that report, the State reported that those sites had a cumulative total of 2,924 members, with an active daily participation rate of 169 people statewide. As can be seen from the data reports included in Appendix A, the State currently reports total membership to be 2,714, with active daily attendance averaging 171 people. The State reports that all peer support centers meet the requirement to be open eight hours per day, five and one half days per week.

The CMHA does not have specific membership or active daily participation targets. Other than the use of trained peer supports staff to provide services to help individuals in managing and coping with the symptoms of their illness, self advocacy, and identifying and using natural supports, there are no specific requirements as to the functions and activities of the peer supports programs. The ER has seen no change in Peer Support Agency operations since the last report.

Some of the Peer Support agencies have contracted with local CMHCs to supply peer support staff to the CMHC's ACT teams. The ER will review this approach during the next six-month period.

IV. Target Population Outcomes and Quality Assurance Systems

The June 30, 2015 ER report included a lengthy section on Quality Management and Quality Service Reviews (QM/QSR). In the time period since that report, DHHS has begun to develop the QSR process; has assigned senior executive staff to oversee the design and implementation process; and has begun meeting with representatives of the plaintiffs to discuss QSR design and implementation. The ER is facilitating such meetings and is also providing technical assistance to DHHS on QSR design.

Achieving consensus on the design, methodology and implementation of the QSR process is critical to present and future monitoring efforts. Information gathered and analyzed by the annual QSR will play a major role in measuring compliance with the CMHA. If the parties and the ER have confidence in the integrity and reliability of the QSR process, and in its ability to produce actionable information, these findings can support common efforts and reduce disputes regarding the achievement of individual and systemic outcomes. With the continued good faith efforts of both parties, and the addition of technical assistance by the ER's office, it is expected that major progress on QM/QSR will be made between now and March 2016. It is also possible that early information from piloting of the QSR process will be available to incorporate into the June 30, 2016 report.

The ER notes that there are separate but related issues regarding independent verification that ACT and SE services are being provided in a consistent manner by all CMHCs in conformance with the standards of the CMHA. DHHS reports it is working on a process for independent verification for ACT and SE. The ER expects that a concrete plan and action steps for independent verification of ACT and SE will be in place by the time of the next report.

V. Summary of Expert Reviewer Observations and Priorities

The ER has now been in place for 18 months. This has been a time period of learning, of program development and enhancement, and of developing and refining data reporting and other mechanisms to assure that the CMHA is implemented in a timely and effective manner. The ER has thus far avoided specific reference to compliance with the CMHA out of respect for the developmental process and with the expectation of good faith efforts on the part of the State to comply with the CMHA requirements.

However, after 18 months it is necessary for the ER to state specifically that the State is not in compliance with two critical provisions of the CMHA. These are:

1. Sections V.D.3(a, b, and c), which together require that all 11 ACT teams meet the standards of the CMHA; that each mental health region have at least one adult ACT Team; and that by June 30, 2015 (six months ago), the State provide ACT services that conform to CMHA requirements and have the capacity to serve at least 1,300 people in the Target Population at any given time.
2. Sections V.E.2(b) and V.E.3(g) which together require that by now the State "have the capacity to serve in the community four individuals with mental illness and complex health care needs residing at Glencliff…"

These are not the only provisions of the agreement for which the ER finds the State to not have achieved specific targets or dates, or to otherwise be moving too slowly with implementation and/or operations to meet the standards in the CMHA. However, these are the two areas found to be in substantial non-compliance. The ER stated clearly at the all parties meeting of December 9, 2015, that the State will need to develop clear, objective and measurable plans to assure compliance with these provisions as soon as possible. These plans need to be cognizant of the context of the CMHA, which, effective June 30, 2016, has numerical capacity targets for both of these items that are higher than the June 30, 2015 targets referenced here.

Based on the review of the status of implementation related to all components of the CMHA, the ER has determined the following priorities for close monitoring in the up-coming six-month period:

1. Effective implementation of plans to attain compliance with requirements of the CMHA as noted above;
2. Design, field testing, and implementation of the QSR process;
3. Implementation by DHHS of program rules and guidance related to more clearly defining eligibility, access and related program standards for ACT and SH;
4. Design and implementation of mechanisms for independent verification of meeting CMHA requirements for ACT and SE services;
5. Improvements in data related to SE, SH, hospital readmissions, DRF/APRTP utilization, and institution discharge destinations;
6. On-going monitoring of transitions from NHH and Glencliff, with a priority of increasing the speed and effectiveness of transitions from both facilities as well as involvement by the Central Team; and
7. Monitoring of the PASRR process to ensure individuals referred to Glencliff are appropriately assessed for and diverted to community-based services.

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report: July to September 2015

New Hampshire Community Mental Health Agreement Quarterly Data Report

July to September 2015

New Hampshire Department of Health and Human Services
Office of Quality Assurance and Improvement

December 15, 2015

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence

Community Mental Health Agreement Quarterly Report

New Hampshire Department of Health and Human Services
Publication Date: 12/2/2015
Reporting Period: 7/1/2015-9/30/2015

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

Center Name	July 2015	August 2015	September 2015	Unique Consumers in Quarter
01 Northern Human Services	69	68	72	83
02 West Central Behavioral Health	17	16	19	19
03 Genesis Behavioral Health	27	27	30	30
04 Riverbend Community Mental Health Center	57	57	60	64
05 Monadnock Family Services	52	54	54	58
06 Community Council of Nashua	79	72	74	82
07 Mental Health Center of Greater Manchester	271	268	265	289
08 Seacoast Mental Health Center	66	67	65	71
09 Community Partners	72	73	70	75
10 Center for Life Management	38	37	37	42
Deduplicated Total	**747**	**736**	**746**	**810**

Revisions to Prior Period: None
Data Source: NH Phoenix 2
Notes: Data extracted 11/12/15; consumers are counted only one time regardless of how many services they receive.

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

	September 2015 Full Time Equivalents									
Center Name	**Nursing (non-APRN)**	**Masters Level Clinician**	**Functional Support**	**Peer Specialist**	**Substance Abuse Treatment**	**Residential**	**Employment**	**Total**		**Psychiatry and APRN**
01 Northern Human Services	0.53	0.10	7.00	0.53	1.31	1.15	0.68	11.29		0.70
02 West Central Behavioral Health	0.26	3.05	0.00	0.20	0.13	0.00	0.19	3.83		0.14
03 Genesis Behavioral Health	0.20	2.00	3.60	0.70	0.00	0.20	0.80	7.50		0.40
04 Riverbend Community Mental Health Center	0.40	1.20	4.00	0.50	1.00	0.00	0.20	7.30		0.40
05 Monadnock Family Services	0.00	2.00	2.00	0.00	0.50	1.00	3.00	8.50		0.40
06 Community Council of Nashua	1.00	2.48	1.25	0.00	0.00	0.25	1.00	5.98		0.25
07 Mental Health Center of Greater Manchester	1.21	17.50	1.99	0.50	4.50	0.00	0.60	26.30		0.96
08 Seacoast Mental Health Center	1.43	3.00	5.10	1.00	0.24	0.00	1.00	11.77		0.90
09 Community Partners	0.40	1.85	5.90	0.00	0.25	0.00	0.30	8.70		0.60
10 Center for Life Management	1.00	0.10	3.86	1.00	0.10	0.00	0.30	6.36		0.30
Total	**6.43**	**33.28**	**34.70**	**4.43**	**8.03**	**2.60**	**8.07**	**97.53**		**5.05**

Revisions to Prior Period: None
Data Source: Bureau of Behavioral Health CMHC ACT Staffing Census Based on CMHC self-report
Notes: Data extracted 11/20/15

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

	12 Month Period Ending September 2015		
Center Name	**Supported Employment Consumers**	**Total Eligible Consumers**	**Penetration Rate**
01 Northern Human Services	106	1,288	8.2%
02 West Central Behavioral Health	83	641	12.9%
03 Genesis Behavioral Health	118	1,265	9.3%
04 Riverbend Community Mental Health Center	194	1,370	14.2%
05 Monadnock Family Services	157	957	16.4%
06 Community Council of Nashua	116	1,499	7.7%
07 Mental Health Center of Greater Manchester	821	3,151	26.1%
08 Seacoast Mental Health Center	161	1,226	13.1%
09 Community Partners	98	843	11.6%
10 Center for Life Management	153	715	21.4%
Deduplicated Total	**2,003**	**12,748**	**15.7%**

Revisions to Prior Period: None
Data Source: NH Phoenix 2
Notes: Data extracted 11/12/15; consumers are counted only one time regardless of how many services they receive

4. New Hampshire Hospital: Adult Census Summary

Measure	July - September 2015
Admissions	361
Mean Daily Census	132
Discharges	373
Median Length of Stay in Days	12
Deaths	0

Revisions to Prior Period: None
Data Source: Avatar
Notes: Data extracted 11/12/15; Average Daily Census includes patients on leave and is rounded to nearest whole number

5. Glencliff Home: Census Summary

Measure	June 2015	July - September 2015
Admissions	0	4
Average Daily Census	114	115
Discharges	1	0
Mean Length of Stay for Discharges	1,480	NA
Mean Length of Stay in Days	2,258	2,284
Readmissions	0	0
Mean Overall Admission Waitlist	17	16

Revisions to Prior Period: None
Data Source: Glencliff Home
Notes: Data Compiled 11/5/15; means rounded to nearest whole number

6. NH Mental Health Consumer Peer Support Agencies: Census Summary

	April - June 2015		July - September 2015	
Peer Support Agency	**Total Members**	**Average Daily Visits**	**Total Members**	**Average Daily Visits**
Alternative Life Center Total	**440**	**41**	**441**	**40**
Conway	*127*	*11*	*135*	*11*
Wolfeboro Outreach	*17*	*NA*	*18*	*NA*
Berlin	*109*	*10*	*92*	*10*
Littleton	*110*	*10*	*117*	*9*
Colebrook	*77*	*10*	*79*	*10*
Stepping Stone Total	**799**	**23**	**527**	**22**
Claremont	*670*	*18*	*397*	*18*
Lebanon	*129*	*5*	*130*	*4*
Cornerbridge Total	**287**	**11**	**288**	**12**
Laconia	*122*	*4*	*128*	*3*
Concord	*133*	*7*	*126*	*9*
Plymouth Outreach	*32*	*NA*	*34*	*NA*
MAPSA Keene Total	**158**	**13**	**161**	**13**
HEARTS Nashua Total	**461**	**25**	**393**	**24**
On the Road to Recovery Total	**379**	**33**	**356**	**32**
Manchester	*226*	*23*	*215*	*23*
Derry	*153*	*10*	*141*	*9*
SCA Portsmouth Total	**266**	**12**	**263**	**13**
TriCity Coop Rochester Total	**279**	**16**	**285**	**15**
Total	**3,069**	**174**	**2,714**	**171**

Revisions to Prior Period: None
Data Source: Bureau of Behavioral Health Peer Support Agency Quarterly Statistical Reports
Notes: Data Compiled 11/13/15; Average Daily Visits NA for Outreach Programs

7. Housing Bridge Subsidy Summary to Date

	July - September 2015		
Subsidy	**Total individuals served at start of quarter**	**New individuals added during quarter**	**Total individuals served through end of quarter**
Housing Bridge Subsidy	428	38	466
Section 8 Voucher	66	4	70

Revisions to Prior Period: None
Data Source: Bureau of Behavioral Health
Notes: Data Compiled 11/13/15

8. Housing Bridge Subsidy Current Census Summary

Measure	As of 9/30/2015
Housing Slots	450
Rents currently being paid	376
Individuals accepted but waiting to lease	23
Waiting list for slots	0

Revisions to Prior Period: None
Data Source: Bureau of Behavioral Health
Notes: Data Compiled 11/13/15; All individuals currently on the Bridge Program are actively transitioning from the program (waiting for their Section 8 housing voucher).

9. Housing Bridge Subsidy Unit Address Density

Number of Unit(s)* at Same Address	Frequency as of 11/13/15
1	290
2	27
3	2
4	4
5	1
6	1

*All units are individual units

10. Designated Receiving Facility Admissions

	July - September 2015		
DRF	Voluntary Admissions	Involuntary Admissions	Total Admissions
Cypress	180	46	226
Elliot	73	35	108
Franklin	23	40	63
Portsmouth	4	31	35

Revisions to Prior Period: None
Data Source: DRF Self Reports
Notes: Data Compiled 12/15/15