

**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.)
)
<hr style="width: 50%; margin-left: 0;"/>)
United States of America,)
)
Plaintiff-Intervenor,)
)
v.)
)
State of New Hampshire,)
)
Defendant.)
<hr style="width: 50%; margin-left: 0;"/>)

Civ. No. 1:12-cv-53-SM

JOINT STATUS REPORT ON EXPERT REVIEWER’S ELEVENTH 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 eleventh 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 28, 2020, Mr. Day submitted his eleventh report to the Parties.
3. The report is attached as Exhibit A for the Court’s information.

Dated: February 3, 2020

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that this Status Report has been sent to counsel of record on February 3, 2020 via the court's Electronic Case Filing system.

/S/ Pamela E. Phelan (#10089)

EXHIBIT A

New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Eleven

January 28, 2020

I. Introduction

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

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

In this three-month period (September 1, 2019 through December 31, 2019), the ER has continued to observe the State's work to implement key service elements of the CMHA, and has continued to have discussions with relevant parties related to implementation efforts and the documentation of progress and performance consistent with the standards and requirements of the CMHA. During this period, the ER:

- Met with a clinical team and clinical leadership at New Hampshire Hospital (NHH) to review transition planning processes and issues;
- Observed the Quality Service Review (QSR) conducted at Lakes Regional Mental Health Center;
- Conducted site visits at three CMHCs (Monadnock, Community Partners and Center for Life Management). Each site visit consisted of meeting with the ACT and supported employment (SE) teams, and with the senior management of each CMHC;
- Met with the State CMHA Management Oversight Team to discuss new data elements and reports related to ACT, SE, and supported housing (SH);
- Met with State program leadership staff to discuss the management and monitoring of the Bridge supportive housing program and Glencliff transitions to integrated community settings, including the proposed new approach to Glencliff inreach;

- Observed an ACT fidelity review at Greater Nashua Mental Health Center; and
- Convened an All Parties meeting to discuss progress in meeting the requirements of the CMHA.

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

Summary of Progress to Date

This report reflects more than five 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 ACT and 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 Community Mental Health Centers (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.

Recently, following input from representatives of the Plaintiffs and the ER, the State has initiated or enhanced a number of strategies to expand ACT capacity and enrollment. It is too soon to gauge whether these strategies are having the desired effect, although recent data support optimism that ACT staffing and enrollment trends are moving in a positive direction. Nonetheless, the State is to be commended for taking new steps to improve performance with regard to the ACT requirements of the CMHA.

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 11 months ago. The ER was approved by the Parties and the Federal Court effective July 1, 2014, and the five-year anniversary occurred six months ago. Given these elapsed times, it is critical for this report

and for subsequent activities that the focus be on specific strategies and action steps necessary to meet the requirements of the CMHA, and to plan for disengagement.

II. Data

As noted in previous reports, the New Hampshire DHHS continues to make progress in developing and delivering data reports addressing performance in some domains of the CMHA. Appendix A contains the most recent DHHS Quarterly Data Report (July to September 2019), 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 take the steps necessary to 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 in the Concord Region by June 30, 2015 (Section V.C.3(a)). DHHS conducted a procurement process for this program, and the contract was awarded on June 24, 2015. Riverbend CMHC was selected to implement the MCT and Crisis Apartments in the Concord Region.

The CMHA specified that a second MCT and Crisis Apartment program be established in the Manchester region by June 30, 2016 (V.C.3(b)). The Mental Health Center of Greater Manchester was selected to implement that program. Per CMHA V.C.3(c), a third MCT and Crisis Apartment program became operational in the Nashua region on July 1, 2017. The contract for that program was awarded to Harbor Homes in Nashua. All of these contracts will be expiring at the end of the current fiscal year; the State is in the process of issuing a RFP so as to continue the MCTs and crisis apartment services going forward.

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.

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.

Table I

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

Region	Variable	April - June 2019	July - Sept. 2019
Concord	Total Served	517	499
Manchester	Total Served	714	679
Nashua	Total Served	419	377
Concord	Phone triage/support	1,143	1,104
Manchester	Phone triage/support	1,795	1,833
Nashua	Phone triage/support	522	530
Concord	Mobile Assess./intervention	136	211
Manchester	Mobile Assess./intervention	319	280
Nashua	Mobile Assess./intervention	245	231
Concord	Number Referred by self	751	657
Manchester	Number Referred by self	361	395
Nashua	Number Referred by self	200	215
Concord	Number referred by police	20	39
Manchester	Number referred by police	320	273
Nashua	Number referred by police	20	15
Concord	Pct Law Enforcement Inv.	14.2%	12.6%
Manchester	Pct Law Enforcement Inv.	44.8%	40.2%
Nashua	Pc Law Enforcement Inv.	0.0%	0.0%
Concord	Hospital diversions	449	520
Manchester	Hospital diversions	1,185	1,111
Nashua	Hospital diversions	704	710
Concord	Apartment Admits	80	78
Manchester	Apartment Admits	15	9
Nashua	Apartment Admits	51	53
Concord	Apartment bed days	319	397
Manchester	Apartment bed days	46	27
Nashua	Apartment bed days	249	306

The ER conducted site visits at each of the MCT and Crisis Apartment programs in New Hampshire during the past nine months. Each of the programs is fully staffed and, in the opinion of the ER, is generally operating in accordance with best practice approaches to mobile crisis and crisis apartment services. Each program is making good use of peer staff for both mobile crisis response and for staffing of the crisis apartments. To varying degrees, each program is developing more effective relationships with local law enforcement agencies, other first responders, and local hospital emergency departments. To date, crisis apartment average lengths of stay have remained within reasonable ranges. There is some anecdotal evidence suggesting that the mobile team and crisis apartment interventions are beginning to influence pathways into hospital emergency department, inpatient psychiatric services, and local jails.

Table II below includes data that reveal some recent changes in both emergency department waiting times for New Hampshire Hospital (NHH) admissions, and for NHH readmission rates. These data may indicate that the fully implemented MCT and Crisis Apartment programs are beginning to have 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. The ER plans to discuss with the State some analytic approaches that could illuminate the relationships among the MCT programs and the other system indicators

Table II
DHHS Report of Changes in Waiting Time for NHH Admissions and NHH Readmission Rates

State Fiscal Year	Average # Adults Waiting per Day for NHH Admission	NHH Admissions	NHH 180-day Readmissions Average
2018	50	807	28.5%
2019	39	818	23.2%
Change	Down 22%	Up 1.4%	Down 18.6%

The ER continues to be concerned about some apparent practice and data reporting variations among the three MCT/Crisis Apartment 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. Late last year, in concert with representatives of the plaintiffs, the ER requested additional information from the State regarding the functioning of these programs. The State has provided responses to certain information requests, and the ER will follow up with DHHS staff to supplement and clarify these responses early in this calendar year.

While the State reports conducting visits to the MCT program sites, no performance assessments or other contractual reviews/program evaluations have been shared with the ER or the parties. The State's response indicates some need for additional State oversight and/or corrective action on the part of one or more of the programs, including an effort to measure program performance

in key areas of MCT service delivery, like phone triage, decisions to deploy mobile crisis teams to community locations, and the efficacy of crisis response.

The State has issued an RFP and an RFI related to MCT/Crisis Apartment programs, and responses have been received by the State as of the date of this report. The State asserts that the RFP and RFI indicate that it is “actively engaged in a comprehensive effort to explore best practices and model designs for MCT services, and we anticipate this effort also will inform the next contracts for the MCTs required under the CMHA”² Thus, the ER is recommending the parties collectively review the responses to the RFP and RFI and that the ER and representatives of the Plaintiffs to engage in discussions with the State about current program operations and future operations of MCT and similar programs in New Hampshire.

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 that outside those required by the CMHA. As such, data related to the operations of that program is not included in this report. The above-referenced RFI may elicit responses related to the BHCTC model as well as the MCT/Crisis Apartment models implemented under the CMHA. The ER expects that if the State is considering crisis program model variations in the re-procurement of the CMHA-required MCT/Crisis Apartment programs, the State will discuss its potential model with the ER and representatives of the Plaintiffs prior to issuing the re-procurement RFPs.

Assertive Community Treatment (ACT)

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

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

² State response to ER memo re: MCTs, December 12, 2019, page 1

The CMHA requires a robust and effective system of ACT services to be in place throughout the state as of June 30, 2015 (54 months ago). Further, as of June 30, 2016, the State was required to have the capacity to provide ACT to 1,500 priority Target Population individuals.

As displayed in Table III below, the staff capacity of the 12 adult ACT teams in New Hampshire has increased by 7.25 FTE since June of 2019.

Table III**Self-Reported ACT Staffing (excluding psychiatry):****September 2017 – September 2019**

Region	FTE	FTE							
	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Mar-19	Jun-19	Sep-19
Northern	12.4	13.0	11.6	12.7	13.1	17.3	16.8	16.51	16.37
West Central	7.0	6.2	5.0	5.2	5.3	5.8	6.8	7.65	8.25
Lakes Region	10.8	9.4	5.7	5.6	8.4	7.4	8.3	8.00	8.00
Riverbend	10.0	10.0	10.3	10.5	10.5	10.5	11.5	10.50	11.50
Monadnock	7.9	7.9	8.7	8.5	8.7	9.0	9.5	9.00	8.00
Greater Nashua 1	6.0	5.0	5.8	5.8	5.5	5.0	6.5	7.00	8.00
Greater Nashua 2	5.0	5.0	5.8	5.8	4.5	4.0	4.5	4.00	7.00
Manchester – CTT	16.3	12.8	17.3	15.5	14.8	14.3	14.3	15.75	15.75
Manchester MCST	22.3	19.0	19.5	16.3	17.8	15.8	15.8	17.25	17.25
Seacoast	10.5	10.5	11.5	9.5	10.5	11.1	9.1	9.10	10.10
Community Part.	6.7	7.9	9.8	9.6	9.1	7.8	8.8	10.78	11.28
CLM	9.3	9.3	9.3	8.3	7.6	6.6	7.9	7.01	8.30
Total	124.2	116.1	120.1	113.1	115.6	114.3	119.6	122.55	129.80

Overall, ACT team staffing has increased by 10.2 FTEs over the past two reported quarters. Nine teams have at least 1.0 FTE SE staff, while three have less than a full time SE specialist. Five teams report having .5 or less FTE combined psychiatry/nurse practitioner time available to their ACT teams³; and five of the 12 teams report having less than one FTE nurse per team. Six teams have increased the number of FTE substance use specialists, and only one team has less than a full FTE substance use specialist. All ACT teams are now reported to have at least .5 FTE Peer Staff as members of the teams.

Table IV below displays the active ACT caseloads by CMHC Region for the past 27 months. The active monthly caseload increased by 17 participants in the last quarter. Since June of 2017

³ The CMHA specifies at least .5 FTE Psychiatrists for teams with at least 70 active service participants. (CMHA V.D.2(e)).

the active monthly caseload has dropped by 64. Over the past two reported quarters the ACT active caseload has increased by 19 participants.

Table IV

Self-Reported ACT Active Caseload (Unique Adult Consumers) by Region in Specified Months: June 2017 – September 2019

Region	Active Cases Jun-17	Active Cases Sep-17	Active Cases Dec-17	Active Cases Mar-18	Active Cases Jun-18	Active Cases Sep-18	Active Cases Dec-18	Active Cases Mar-19	Active Cases Jun-19	Active Cases Sep-19
Northern	106	107	115	114	108	102	115	120	115	122
West Central	56	63	57	46	48	44	42	43	46	47
Lakes Region	73	71	65	64	59	53	51	56	57	56
Riverbend	92	81	81	80	83	82	87	100	102	86
Monadnock	68	55	53	55	55	55	56	56	57	49
Greater Nashua	85	90	76	74	74	84	77	75	83	97
Manchester	275	269	269	277	290	306	312	303	287	300
Seacoast Community Part.	64	60	54	66	67	69	71	70	66	68
CLM	50	54	55	59	58	55	53	53	47	49
Total*	927	915	887	901	902	911	927	944	925	942

* unduplicated across regions

The combined ACT teams have a reported September 2019 staff complement of 129.8 FTEs excluding psychiatry, which is sufficient capacity to serve 1,298 individuals based on the ACT non-psychiatry staffing ratios contained in the CMHA. This increased staffing represents new capacity to increase active caseload by 102 participants over the capacity reported in the previous ER report. However, with a statewide caseload of only 942 as of September 2019, the gap between staff capacity and active participants has increased by 83 participants since the previous report. As noted above, the CMHA requires the State to have capacity to serve 1,500

individuals. The current ACT FTE staffing level, albeit improved, is still 202 participants below the capacity required by the CMHA. *As noted in previous reports, the current level of ACT staffing is not sufficient to meet CMHA requirements for ACT team capacity. Furthermore, the current ACT caseload of 942 individuals is 558 below the number that could be provided ACT services with the capacity required by the CMHA.*⁴

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;⁵
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 clients⁶ who may qualify for and benefit from ACT.

Table V below presents data on ACT screens conducted by CMHCs between April and June, 2019.

⁴ 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.

⁵ 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.

⁶ Until recently, data on the total number of ACT screenings included current ACT participants. Active ACT clients have now been removed from screening reports.

Table V**Self-Reported Number of Unique Clients Screened for ACT Services Conducted by CMHCs****April - June 2019**

Community Mental Health Center	Total Screened	Appropriate for further ACT Assessment	Receiving ACT/ w/i 90 days of Assessment	Percent Receiving ACT of those Qualified for Assessment
01 Northern Human Services	1,158	37	3	8.1%
02 West Central Behavioral Health	287	5	4	80%
03 Lakes Region Mental Health Center	823	9	0	0.0%
04 Riverbend Community Mental Health Center	1,272	1	0	0.0%
05 Monadnock Family Services	535	4	0	0.0%
06 Greater Nashua Mental Health	633	9	4	44.4%
07 Mental Health Center of Greater Manchester	1571	3	0	0.0%
08 Seacoast Mental Health Center	1286	16	0	0.0%
09 Community Partners	401	1	1	100%
10 Center for Life Management	756	3	1	33.3%
Total	8,722	88 (1.0%) of all screened	13 (14.8%) of all assessed after screening: 0.1% of all screened	

Of the 8,722 unique individuals screened for ACT during this period, the State reports that 88 were referred for an ACT assessment. This is a referral rate of one percent. And, less than 15 percent of those referred for ACT assessments were enrolled in ACT services within 90 days of being screened. Most of the referrals for ACT screening are internal to the CMHCs. That is, people who have already had a CMHC intake, and who may already be receiving CMHC services, are those most likely to be screened for ACT services. Thus, it is perhaps not surprising that so few of the individuals screened are referred to the next step, which is the assessment for ACT. In fact, the State has reported that about 87% of individuals are linked to ACT without having gone through the ACT 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 State has begun collecting and reporting data on the number of individuals waiting for ACT services on a statewide basis. This information is displayed in Table VI below. The State and the CMHCs state 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, there is excess capacity in each region/team and enough capacity to address the needs of people reported to be on the waitlist. However, 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.

Table VI**Self-Reported ACT Wait List:**

	Total	Time on List		
		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

ACT Fidelity and Quality

Only three months have elapsed between this report and the most recent previous ER report. In that interval, only a few ACT fidelity reviews and QSR reports have been published. Thus, the ER will reserve any updates to this section until the June 2020 report.

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.

ACT Working Group

As noted in recent ER Reports, the DHHS has taken deliberate steps to work with CMHCs in certain Regions to increase their ACT staffing and caseloads. These actions include: (a) quarterly ACT monitoring and technical assistance with DHHS leadership and staff; (b) implementation of a firm schedule for ACT fidelity reviews; (c) incorporating a small increase in ACT funding into the Medicaid rates for CMHCs; (d) additional incentive-based payments related to ACT services; (e) active on-site and telephonic technical assistance based on CMHC needs related to improving the quality and fidelity of ACT services; and (f) coordinated efforts to address workforce recruitment and retention. The State has identified workforce recruitment and retention issues as factors limiting the growth and expansion of the ACT teams. The State has

been working collaboratively with the New Hampshire Community Behavioral Health Association to identify and track workforce gaps and shortages, and to initiate a variety of strategies to improve workforce recruitment and retention. However, as noted above, ACT staffing remains substantially below the levels required by the CMHA.

In October 2108 the State has received approval from the federal Centers for Medicare and Medicaid Services (CMS) to use up to \$3.0 Million in Medicaid waiver funds for directed payments (incentive-based rate enhancements) to CMHCs for recipients already enrolled in ACT and for each new ACT enrollee. These incentive payments will be continued for Fiscal Years 2020 and 2021. CMS has also approved up to \$1.2 Million for fee schedule increases for people discharged from psychiatric inpatient services who receive a same - or next-day appointment at a CMHC.

In June 2019 the State increased state funding in its CMHC contracts by \$650,000 to achieve improved ACT and SE fidelity and to positively impact ACT staffing. This incentive-based funding supports recruitment and retention of certain ACT team staffing specialties; after hours crisis coverage training for ACT staff; and technology improvements.

Last year, the ER requested that representatives of the Plaintiffs and the State participate in an ACT working group. The purpose of this working group was to develop a set of feasible, measurable action plans to quickly expand and improve ACT services consistent with the CMHA. The ACT working group met three times, and in the process developed a set of concrete recommendations. These recommendations address the following topic areas:

1. Screening and referral for ACT services;
2. Assessment for ACT eligibility, including reporting on the degree to which ACT assessments result in enrollment in ACT services;
3. Facilitation of referrals from New Hampshire Hospital (NHH) to CMHCs for ACT intake and assessment activities;
4. Analysis of pre- and post- hospitalization data, and hospital readmission data, to identify individuals that could benefit from ACT;
5. Analysis of and reporting on the effectiveness of ACT directed payments as an incentive to increase ACT enrollment;
6. Development of a data dashboard that reports on CMHCs' performance and participant outcomes relevant to ACT services;
7. Enhanced training, technical assistance, and mutual support among CMHCs and ACT teams;
8. Enhanced workforce recruitment and retention activities; and
9. Enhanced management oversight, monitoring, and technical assistance to assure implementation of ACT strategies.

In support of the ACT working group efforts, DHHS has been conducting internal analyses from existing data bases, and also requesting certain new information from the CMHCs. DHHS produced the following new information:⁷

1. ACT referrals from NHH by Region;
2. ACT penetration rates by Region;
3. Tabulation of ACT penetration rates from selected other states, and reported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA);
4. Current diagnoses of active ACT clients by Region; and
5. Tabulation of Managed Care enhanced payments related to ACT initiatives by Region.

The initiatives summarized above have the potential to increase the capacity and quality of ACT services, and also to assure that people in need of ACT services are identified, referred, assessed and served as expeditiously as possible. The ER commends the representatives of the Plaintiffs and the State for their efforts to develop these ACT initiatives. The ER will closely monitor the implementation and management of the ACT strategies to determine if actual improvements are measurable in ACT capacity; enrollment; fidelity; and quality.

The ER emphasizes, as in past reports, that it must be the first priority of the State and the CMHCs to focus on: 1) assuring required ACT team composition; 2) utilizing existing ACT team capacity; 3) increasing ACT team capacity; and 4) outreach to and enrollment of new ACT clients.

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)).

⁷ Recent tabulations of data related to these items were not available at the time of this Report. The ER will incorporate such data in subsequent reports.

As noted in Table VII below, three of the ten CMHCs continue to report penetration rates lower than the CMHA requirement.

Table VII

Self-Reported CMHC SE Penetration Rates

	Penet. Dec-17	Penet. Mar-18	Penet. Jun-18	Penet. Sep-18	Penet. Jun-19	Penet. Sep-19
Northern	39.00%	38.80%	36.90%	32.10%	14.90%	15.80%
West Central	25.30%	26.20%	31.20%	33.80%	22.50%	19.70%
Lakes Reg.	19.10%	15.40%	12.10%	11.80%	18.90%	18.90%
Riverbend	13.20%	12.60%	11.80%	16.60%	19.00%	18.40%
Monadnock	10.90%	10.40%	11.00%	9.30%	6.80%	6.20%
Greater Nashua	16.80%	14.90%	14.20%	12.60%	13.1%	12.7%
Manchester	45.30%	43.50%	44.10%	44.10%	39.30%	39.30%
Seacoast	28.00%	30.10%	29.80%	29.90%	33.70%	32.90%
Comm. Part.	17.70%	21.50%	20.90%	19.20%	8.60%	7.80%
CLM	20.00%	20.90%	17.50%	20.80%	20.80%	20.10%
CMHA Target	18.60%	18.60%	18.60%	18.60%	18.60%	18.60%
Statewide Ave.	26.70%	26.40%	25.90%	25.90%	23.50%	23.20%

The State reports data on the degree to which CMHC clients are working, either full or part time, in competitive employment.⁸ Access to competitive employment is an important indicator of the quality and effectiveness of fidelity model SE services. Table VIII summarizes some key findings from these data reporting efforts.

⁸ State data defines full time employment as working 20 hours a week or more. The statewide percentage of SE users in full-time employment in the quarter ending September 30, 2019 was 6.0%.

Table VIII**Competitive Employment for CMHC Clients**

CMHC	Percent of SE Active Clients Employed Full or Part Time July – September 2019	Percent of SE Active Clients Employed Full or Part Time April – June 2019
Northern	38.9%	44.2%
WCBH	28.6%	43.8%
LRMHC	34.9%	27.9%
Riverbend	60%	61.8%
Monadnock	40%	52.0%
Nashua	38.9%	31.9%
MHCGM	58.3%	54.3%
Comm. Prtnrs.	36.3%	31.3%
Seacoast	53.9%	57.1%
CLM	75%	56.5%
Statewide	49.2%	46.7%

For those eligible adults not involved in SE, the overall numbers are lower – with only 26% currently engaged in full-time or part-time employment statewide.

These data have not yet been collected and reported for a long enough period for reliable trend analyses, but they do provide a reasonable baseline for future analyses. The ER will continue to review these competitive employment data in concert with the available SE fidelity and QSR reports.

SE Fidelity and Quality

As with ACT services, insufficient time has elapsed since the previous ER report to update the SE fidelity and quality reporting. This section will be updated in the next ER report.

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 2019, DHHS reports having 338 individuals leased in Bridge Program subsidized units and having 35 people approved for a Bridge Program subsidy but not yet leased. There are 42 individuals reported to be on the Bridge Program wait list as of the end of September, 2019. Of these, 33 individuals

have been on the wait list for more than two months and 24 of the 33 have been on the waitlist for more than six months; these figures trigger CMHA V.E.3(f), which requires the State to add SH capacity to meet the unmet needs. There has been a precipitous drop in the aggregate number of individuals either leased or approved but not yet leased in the Bridge Program – from 591 in June of 2017 to 373 in September 2019.

Table IX below provides data regarding the number of current Bridge Subsidy participants; the number waiting to lease; the number on the Bridge Subsidy waiting list; the total number leased since the inception of the program; and the total number receiving a HUD Housing Choice Voucher (HCV). Table X provides quarterly data regarding the number of Bridge Subsidy program applications and terminations.

Table IX**New Hampshire DHHS Self-Reported Data on the Bridge Subsidy Program:****December 2016 through September 2019**

Bridge Subsidy Program Information	June 2017	Sept. 2017	March 2018	Sept. 2018	March 2019	June 2019	Sept. 2019
Total individuals leased in the Bridge Subsidy Program	545	509	497	423	389	365	338
Individuals in process of leasing	46	58	7	0	11	13	35
Individuals on the wait list for a Bridge Subsidy ⁹	0	0	10	35	38	44	42
Total number served since the inception of the Bridge Subsidy Program	701	742	811	811	812	812	829
Total number transitioned to a HUD Housing Choice Voucher (HCV)	85	96	119	125	137	133	151

⁹ The State did not maintain a waitlist prior to 2018.

Table X

Self-Reported Housing Bridge Subsidy Applications and Terminations

Measure	July – September 2018	October – December 2018	January – March 2019	April – June 2019	July-September 2019
Applications Received	32	12	29	28	22
Point of Contact					
CMHCS	32	12	22	11	13
NHH	0	0	5		9
Other	0	0	1		0
Applications Approved	7	5	14	14	11
Applications Denied	0	0	0	1	0
<i>Denial Reasons</i>	<i>NA</i>	<i>NA</i>	<i>NA</i>	0	<i>NA</i>
Applications in Process at end of period	197	209	53	74	75
Terminations	0	0	1	0	0
<i>Termination Reasons</i>	<i>NA</i>	<i>NA</i>	1	<i>NA</i>	<i>NA</i>
<i>Over Income</i>					

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 XI below displays the reported number of units leased at the same address.

Table XI**Self-Reported Housing Bridge Subsidy Concentration (Density)**

	June 2018	Sept. 2018	Decem- ber 2018	March 2019	June 2019	Sept. 2019
Number of properties with one leased SH unit at the same address	354	339	329	315	300	282
Number of properties with two SH units at the same address	26	52	27	18	16	18
Number of properties with three SH units at the same address	10	24	4	3	4	1
Number of properties with four SH units at the same address	5	12	3	2	2	1
Number of properties with five SH units at the same address	0	0	1	2	1	1
Number of properties with six SH units at the same address	0	6	0	0	0	0
Number of properties with seven + SH units at same address	2	17	2	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.¹⁰

As noted in the ER Reports dating back to 2016, DHHS was working on a method to cross-match the Bridge Subsidy Program participant list with the Phoenix II and Medicaid claims data. Table XII summarizes the most recent iterations of these data.

Table XII

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

	As of 3/31/19	As of 6/30/19	As of 9/30/19
Housing Bridge Tenants Linked	337 of 400 (84.5%)	360 of 378 (95%)	339 of 373 (91%)

These data document the degree to which Bridge Subsidy Program participants are actually receiving certain mental health or other services and supports.¹¹

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 191 units of supported housing under the HUD Section 811 Program. All of these units will be set aside for people with serious mental illness. As of the date of this report, 72 (combined PRA and Mainstream) of these new units have been developed and are currently occupied by members of the Target Population. It should be noted that over the life of the Bridge Program the State has accessed 151 HUD Housing Choice Vouchers (HCVs) and one HUD public housing unit. Accessing these HCVs allows the State to free up Bridge Program slots for new applicants. The ER plans to work with the State and representatives of the Plaintiffs to assure documentation of progress towards the 600 specified units is attained and sustained.

In addition, the CMHA states that “By January 1, 2017, the State will identify and maintain a waitlist of all individuals within the Target Population requiring supported housing services, and whenever there are 25 individuals on the waitlist, each of whom has been on the waitlist for more than two months, the State will add program capacity on an ongoing basis sufficient to ensure that no individual waits longer than six months for supported housing.” As referenced above, there are currently reported to be 42 individuals on the wait list for the Bridge program; 33 of these individuals have been on the wait list for more than two months and 24 of them have been

¹⁰ DHHS reports that currently there is one voluntary roommate situation reflected in the above data.

¹¹ Note: some of these tenants might be receiving services from MH providers other than a CMHC.

waiting longer than six months for supported housing, in violation of the terms of the CMHA. Based on the above data: (1) The State is reported to have 338 Bridge Program subsidies under lease, and an additional 72 HUD Section 811 units under lease, for a total of 410 supported housing units occupied: (2) there are currently only 35 individuals who have been approved for a Bridge subsidy and are actively seeking a unit; and (3) there are at least 33 people on the Bridge Program wait list who have been on the list for more than six months, and for whom no additional responsive housing capacity has been identified.

Therefore, the ER concludes that the State is not currently in compliance with the CMHA requirements related to SH.

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 will perform 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 will also directly pay rent subsidies to landlords and will be reimbursed for these costs by the State. The State will manage intake and eligibility determination functions and will maintain a statewide waiting list.

These administrative changes could have a substantial impact on the overall effectiveness of the Housing Bridge Subsidy Program. 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. In addition, the ER will work with the State and the parties to ensure these 24 individuals are prioritized by their CMHC housing liaisons, and successfully transitioned to supported housing.

Transitions from Institutional to Community Settings

During the past 64 months, the ER has visited both Glencliff and NHH on at least nine separate occasions to meet with staff engaged in transition planning under the new policies and procedures adopted by both facilities in 2019¹². Transition planning activities related to specific current residents in both facilities have been observed, and a small non-random sample of resident transition records has been reviewed. Additional discussions have also been held with both line staff and senior clinicians/administrators regarding potential barriers to effective discharge to the most appropriate community settings for residents at both facilities.

The ER has participated in 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

¹² NHH updated its transition planning policies in 2018.

settings. The Central Team has now had about 52 months of operational experience. As of October 2019, 61 individuals have been submitted to the Central Team, 39 from Glencliff and 22 from NHH. Of these, the State reports that 28 individual cases have been resolved,¹³ two individuals are deceased, and 31 individual cases remain under consideration. Table XIII below summarizes the discharge barriers that have been identified by the Central Team with regard to these 31 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 XIII

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

October 2019

Discharge Barriers	Number for Glencliff	Number for NHH
Legal	6 (10.7%)	7 (10.1%)
Residential	17 (30.4%)	21 (30.4%)
Financial	7 (12.5%)	8 (11.6%)
Clinical	15 (26.8%)	19 (27.5%)
Family/Guardian	10 (17.9%)	12 (17.4%)
Other	1 (1.8%)	2 (2.9%)

Glencliff

In the time period from April 2019 through September 2019, Glencliff reports that it has admitted five individuals, and has had two discharges and seven deaths. The average daily census through this period was 117 people. There have been no readmissions during this time frame. The wait list for admission has remained relatively constant at 23 to 25 people for the past six months.

¹³ Five of these individuals were readmitted to NHH after 90 days and five of these have returned to community settings as of this report.

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]¹⁴ 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."¹⁵

DHHS reports that a total of 17 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. Nine 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 five are currently in the application process. Four individuals have been found eligible for the Acquired Brain Disorder (ABD) or Developmental Disability (DD) waivers, and two have been denied eligibility for these waivers. The remaining six individuals are reported to not meet criteria for referrals to one or more of the waivers.

DHHS continues to provide information about Glencliff transitions at the time of discharge, including clinical summaries, lengths of stay, location and type of 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.

DHHS has initiated action steps to enhance the process of: (a) identifying Glencliff residents wishing to transition to integrated settings; and (b) increasing the capacity, variety and geographic accessibility of integrated community settings and services available to meet the needs of these individuals. Both sets of initiatives are intended to facilitate such community transitions for additional Glencliff residents. Despite these efforts, transitions to integrated community settings from Glencliff have stalled in the past 30 months.

The ER remains very concerned about the slow pace of transitions to integrated community settings by residents of the Glencliff Home. At this point, the ER does not have sufficient information to understand what factors contribute to the relative slowness of the transition planning process. There is not sufficient information currently available on efforts to engage

¹⁴ Cumulative from CMHA V.E.(g), (h), and (i).

¹⁵ CMHA V.E.2(a)

additional community-based providers, particularly for Glencliff residents with complex conditions. It is also necessary to obtain a better understanding of the blended financing mechanism to support integrated community settings for Glencliff residents with complex conditions. Finally, the State will soon be initiating a new capacity and process for community in-reach to Glencliff, and the ER will need to clarify performance expectations and data reporting related to results to be attained by this new in-reach function. Within the next three months, the ER recommends the parties confer regarding the status and implementation of these in-reach plans.

For all of these reasons, the ER plans to conduct a more intensive and focused review of Glencliff early this year. This review will entail:

1. A review of the clinical records (not just the transition plans) of the 27 individuals reported to be in the transition planning process;
2. Brief face-to-face interviews with individuals within the transition cohort willing to be interviewed;
3. Interviews with the Glencliff transition staff regarding the transition planning priorities and barriers for each of the individuals in the transition cohort;
4. With the assistance of Glencliff staff, identification of an additional cohort of individuals who could potentially transition from Glencliff to integrated community settings, but who have not yet indicated an interest in doing so (Minimum Data Set [MDS] Section Q or other indication);
5. Record reviews and interviews with select individuals in this cohort;
6. Discussions with DHHS and Glencliff staff regarding the efforts to identify and engage providers to serve people transitioning from Glencliff: this may entail interviews with certain community providers, Area Agencies, guardians, etc.;
7. Discussions with DHHS staff and providers about the specific details of the blended funding process for individuals transitioning from Glencliff, including discussion of reasons why providers have not been more enthusiastic about accessing this funding; and
8. Compilation of my findings in a report detailing barriers and solutions to increasing the number of individuals, including those with complex conditions, that transition from Glencliff into integrated community settings.

As noted in previous reports, the ER has been reluctant to focus narrowly on clinical conditions and sets of health, mental health and community services and supports for transitioned and transitioning individuals to monitor the State's progress in assisting Glencliff Home residents to transition to integrated community settings. ***Despite this reluctance, the ER is concerned that the State is not yet in compliance with the CMHA requirements with regard to transitions to integrated community settings, including for residents with complex medical needs.*** This concern is exacerbated by the lack of transitions to integrated community placements over the

past two years. In addition, there has been no additional small-scale community residential capacity developed to serve Glencliff residents with complex medical conditions.

Given the lack of demonstrated progress in these areas, the ER will seek additional, periodic reporting on the status of the 26 individuals currently engaged in transition planning at Glencliff, including any identified barriers to transition and action plans to resolve those barriers. Over the next three months, the ER also will more closely monitor efforts by DHHS, Glencliff, the CMHCs and other community partners to recruit, develop and fund the service capacity needed to transition interested residents in a timely way. .

Progress towards effectuating transitions to integrated community settings for current Glencliff residents has been very slow over the past 30 months. Unless additional efforts are brought to bear, the 26 individuals in active transition planning could remain at Glencliff indefinitely, and other residents will go without meaningful opportunities to explore potential community alternatives.

In addition to the above-described targeted analysis, the ER will continue to monitor the following topics/items to inform assessment of compliance:

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

6. Specific documentation of efforts to overcome family and/or guardian resistance to integrated community transitions for Glencliff residents.
7. Number of individuals engaged in transition planning referred to the Central Team, number of these individuals who successfully transition to an integrated community setting; and the elapsed time from referral to resolution.

Preadmission Screening and Resident Review (PASRR)

The State DHHS has provided recent data on PASRR Level II screens for the period April 1, 2019 through September 30, 2019. These data are summarized in Table XIV 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 XIV

PASRR Level II Screens: April through September 2019

	April through June 2019	Percent	July through September 2019	Percent
Full Approval - No Special Services	23	28.8%	22	31.0%
Full Approval with Special Services	23	28.8	27	38.0%
Provisional – No Special Services	15	18.8	14	19.7%
Provisional with Special Services	19	23.8	8	11.3%
Total	80	100%	71	100%

In the December 2018 ER report, 10.2% of the Level II screens were approved with a specification for special services. At that time, the ER questioned whether this was an unusually low rate for specification of special services. In a comparison with one other state, the ER found substantially higher approvals for special 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 special services in the Level II process. For this current report, the percentage of approvals with special services has increased to 49.3%.

In addition, the State has been reviewing the New Hampshire Medicaid Plan to see if revisions may be appropriate for the section(s) of that Plan identifying what special services may be covered by Medicaid for recipients for whom the Level II screen results in a specification for special services. The State reports that it has not yet completed this review. The ER expects that

the review and any changes to the Medicaid Plan with respect to special services will be completed no later than March 1, 2020.

For a variety of reasons, virtually all PASRR screens are conducted for people who are already in a nursing facility. For example, for July through September 2019, 99% of Level II screens were conducted in nursing facilities. A possible consequence of this is that 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 Glenclyff must typically have been turned down by at least three other facilities before being considered for admission. In combination, these facts indicate that interventions to divert individuals from Glenclyff or other nursing facilities must typically be used before the PASRR screening process is initiated. PASRR is important to assure that people with mental illness, ID/DD, or related conditions are not inappropriately institutionalized or placed in nursing facilities without access to necessary special services. However, PASRR is not by itself sufficient to divert people from nursing facility care. Up-stream interventions at NHH, the DRFs, and among the CMHCs are also essential to prevent unnecessary facility placement.

New Hampshire Hospital and the Designated Receiving Facilities (DRFs)

For the time period April through September 2019, DHHS reports that NHH effectuated 485 admissions and 481 discharges. The mean daily census was 157, and the median length of stay for discharges was 16.3 days.

Table XV below compares NHH discharge destination information for the six most recent reporting periods (4/2017 through 9/2019). 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 XV

**New Hampshire Hospital Self-Reported Data on
Discharge Destination**

Discharge Destination	Percent April through June 2017	Percent July through Septem- ber 2017	Percent October 2017 through March 2018	Percent April 2018 through Septem- ber 2018	Percent Octobe r 2018 through March 2019	Percent July through Septem- ber 2019
Home – live alone or with others	85.66%	88.3%	81.0%	81.7%	73.26%	70.5%
Glenclyff	0.35%	0.49%	1.0%	1.45%	1.6%	.4%
Homeless Shelter/motel	3.5%	2.94%	2.5%	3.13%	6.68%	4.64%
Group home 5+/DDS supported living, peer support housing etc.	5.59%	3.92%	7.1%	4.1%	4.01%	4.38%
Jail/corrections	1.05%	0.49%	2%	1.45%	2.94%	1.2%
Nursing home/rehab facility	3.50%	2.45%	2.7%	5.3%	4.55%	5.98%

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

Table XVI

**Self-Reported DRF/APRTP Utilization Data: January 2016 through
September 2019**

	Franklin	Cypress	Portsmouth	Eliot Geriatric	Eliot Pathways	Total
Admissions						
Jan - March 2016	69	257	46	65	121	558
April - June 2016	79	205	378	49	92	803
July - Sept 2016	37	207	375	54	114	787
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

	Franklin	Cypress	Portsmouth	Eliot Geriatric	Eliot Pathways	Total
Percent involuntary						
Jan - March 2016	53.70%	18.70%	NA	18.50%	30.60%	NA
April - June 2016	55.70%	24.40%	20.40%	4.10%	48.90%	25.50%
July - Sept 2016	43.20%	29.50%	18.90%	13.00%	44.70%	26.20%
April - June 2017	58.30%	21.50%	22.00%	1.00%	47.50%	30.06%
July - September 2017	NA**	25.60%	25.60%	11.50%	50.40%	NA
Oct. - Dec 2017	49.20%	30.10%	23.70%	12.70%	50.00%	30.00%
Jan. - March 2018	44.20%	28.30%	21.50%	6.10%	47.00%	27.00%
April - June, 2018	46.73%	25.82%	24.62%	9.23%	51.92%	29.08%
July - September 2018	28.36%	24.38%	19.33%	12.96%	49.11%	25.16%
October - December 2018	46.00%	23.20%	22.40%	6.25%	51.40%	26.50%
January - March 2019	45.20%	18.10%	23.20%	12.50%	47.20%	28.20%
April to June 2019	61.10%	20.90%	19.40%	7.90%	47.20%	27.30%
July to September 2019	43.30%	16.50%	25.10%	11.50%	55.80%	28.00%

	Franklin	Cypress	Portsmouth	Eliot Geriatric	Eliot Pathways	Total
Average Census						
Jan - March 2016	7.9	14.7	NA	19.7	18.1	NA
April - June 2016	7.8	13.2	21.4	22.5	16.9	81.8
July - Sept 2016	4.5	13.6	23.2	25.6	14.5	81.4
April - June 2017	4.5	12	30.3	29.3	10	86.1
July - September 2017	NA**	12.9	29.7	29.7	12.2	NA
Oct. - Dec 2017	10.1	12.3	27.7	32.6	16.1	19.7
Jan. - March 2018	6.7	11.6	32.5	34.6	NA	NA
April - June, 2018	9.1	11.9	31.7	31.7	20.4	104.8
July - September 2018	11.8	8.4	39.6	33.8	18.2	111.8
October - December 2018	10.7	9.2	27.4	33.4	10.7	91.4
January - March 2019	8.5	14.5	30.4	22.6	14.9	90.9
April to June 2019	8.4	11.5	29.7	27	12.1	88.7
July to September 2019	9.4	12.2	31.7	24.1	12	89.4

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

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

* Does not include Portsmouth

The DRFs should theoretically relieve some of the pressure on NHH for inpatient admissions, and should also reduce the number of people waiting for psychiatric admissions in hospital EDs. At this time there has been no reduction in NHH admissions, but there has been an 18.6% reduction in NHH re-admissions. The wait list for NHH admissions of people staying in hospital EDs has been somewhat reduced, as shown in Charts A and B below.

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

Table XVII**Self-Reported Discharge Dispositions for DRFs in New Hampshire****October 2018 through September 2019**

Disposition	Frank- lin	Cy- press	Ports- mouth	Eliot Geriatric	Eliot Pathways	Total	Per- cent
Home	388	679	1,002	55	337	2,461	75.3%
NHH	1	0	19	0	8	28	.086%
Residential Facility/ Assisted Living	5	23	1	133	7	169	5.1%
Other DRF ¹⁶	3	22	13	8	8	54	65%
Hospital	0	0	0	0	0	0	
Death	0	0	0	6	0	6	0.18%
Other or Unknown	25	42	425	25	33	550	16.8%
Total	422	766	1,460	227	386	3,256	

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

Based on these self-reported data, 75.3% of discharges from DRFs and the Cypress Center are to home. This is essentially the same as the 72.2% discharges to home reported by NHH. In addition:

- 5.2% of the total DRF discharges are to residential care or assisted living, which is similar to NHH discharges for this category.
- 0.86% of the DRF discharges are to NHH, slightly more than the percent discharged to NHH from previous reporting periods.
- 16.8% of the total discharges are to the other/unknown category, but 77% of these are accounted for by the Portsmouth DRF.

Hospital Readmissions

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

¹⁶ The State reports that these transfers reflect conversion from involuntary to voluntary status, not transfers among DRF facilities.

Table XVIII**Self-Reported Readmission Rates for NHH and the DRFs****July 2017 through September 2019**

	Percent 30 Days	Percent 90 Days	Percent 180 Days
NHH			
7 to 9/2017	9.80%	21.60%	27.90%
10 to 12/2107	12.8%	26.1%	32.8%
1 to 3/2018	13.7%	22.7%	29.9%
4/2018 to 6/2018	7.6%	14.7%	23.4%
7/2018 to 9/2018	8.6%	19.6%	25.4%
10/2018 to 12/2018	7.3%	18.1%	25.9%
1/2019 to 3/2019	5.3%	14.8%	21.2%
4/2109 to 6/2019	8.4%	15.0%	20.3%
7/2019 to 9/2019	10.5%	18.6%	23.3%
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%
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%

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%
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%
Elliott Geriatric ¹⁷			
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%

For the 27-month period in which re-admission rate data has been reported, the rates of readmission have trended down somewhat, which is a positive indicator overall. However, readmission rates, especially the 180-day readmission rate for NHH, remain high. At least 23% of all people discharged from NHH are back in the hospital within 180 days. These data, in concert with the hospital emergency room 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

¹⁷ Note that data from July 2017 through March 2018 are not included in this table. The ER will work with the State to clarify these data, and the relevant information will be included in subsequent reports.

people at risk of re-hospitalization. **These facts need to be understood in light of the States ongoing efforts to increase ACT capacity and enrollment as documented earlier in this report.**

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. Chart A below displays external data related to daily adult admissions delays to NHH bi-weekly for the period September 2017 through September 2019. Chart B shows the average daily ED waiting list by month for the same time period.

Chart A

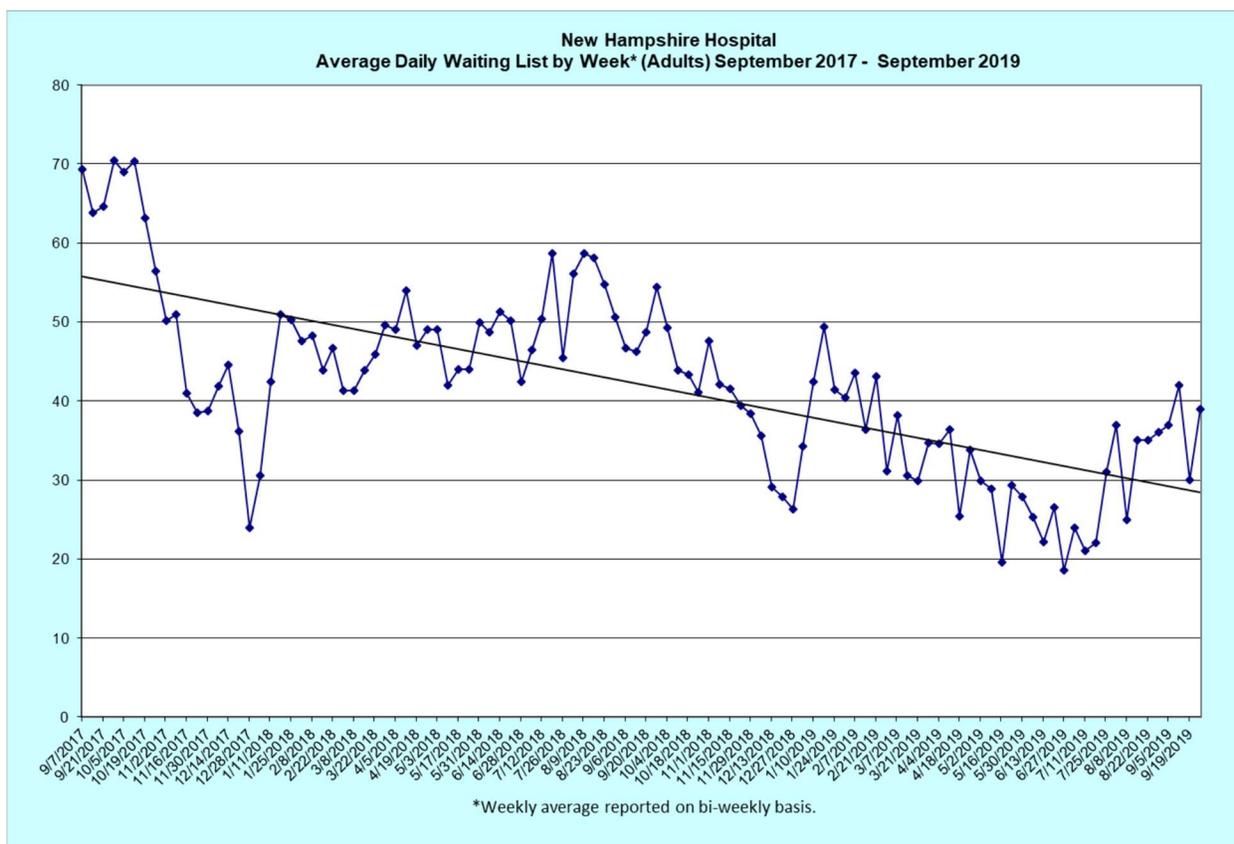
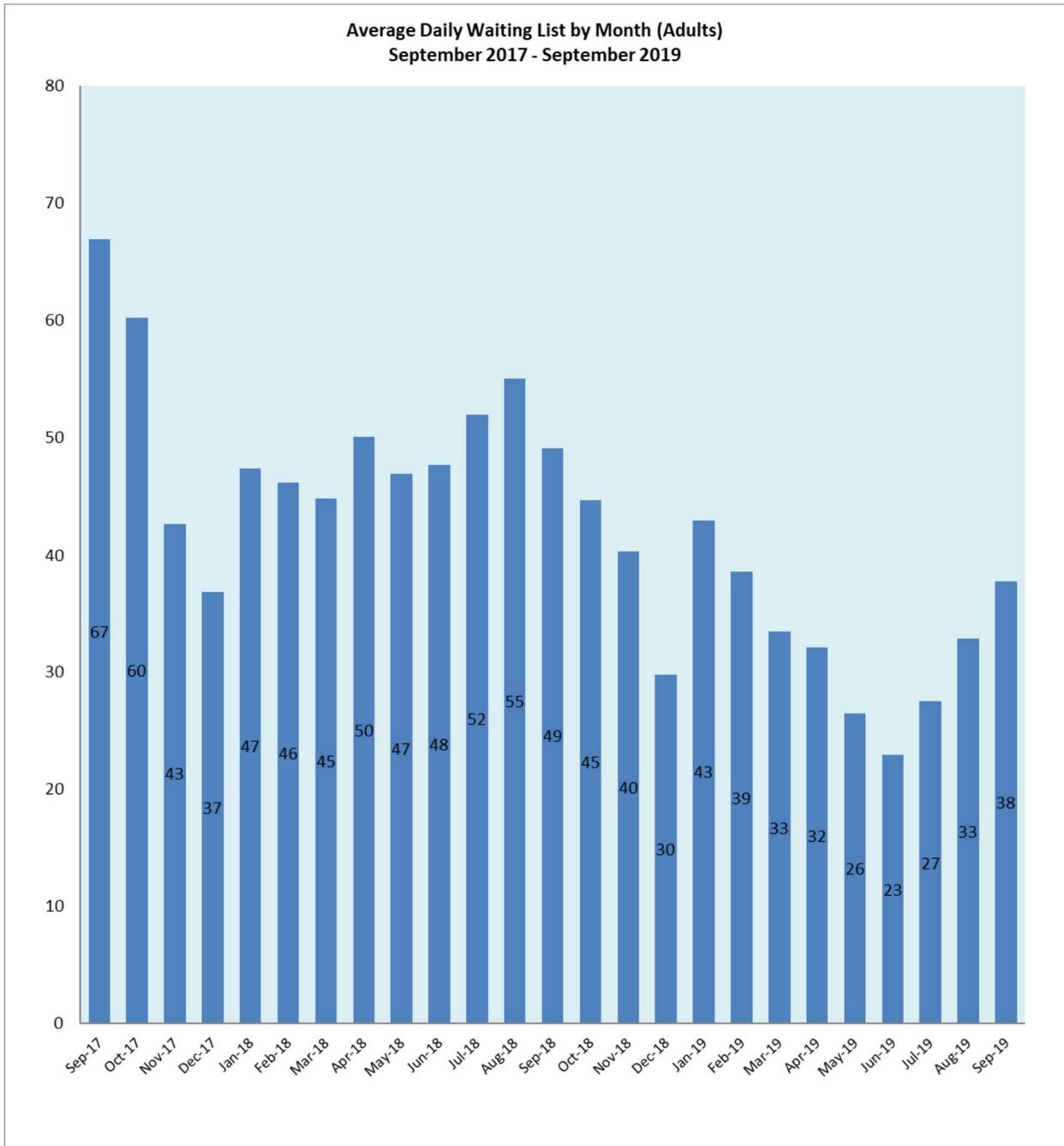


Chart B



Although the number of people waiting in EDs for hospital admission has increased in recent months, the overall trend has been downward since September 2017. This appears to indicate that State interventions designed to reduce the number of individuals waiting for NHH

admissions, and the number of days spent waiting for admission to NHH, have begun to be effective. The ER notes that many of the interventions implemented by the State are outside the direct scope of the CMHA. However, ED boarding can affect the CMHA target population in a variety of ways. And, people awaiting NHH 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. The ER will arrange for additional NAMI meetings during the next six months.

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, 2019, the State reports that those sites have a cumulative total of 1,403 members, with an active daily participation rate of 170 people statewide. This represents a three-year high in active daily participation: 23% higher than in March 2017. The State reports that all of the PSAs have been working to increase their membership and daily participation rates.

The CMHA requires the PSAs to be “effective” in helping individuals in managing and coping with the symptoms of their illness, self-advocacy, and identifying and using natural supports. As noted in previous reports, enhanced efforts to increase active daily participation appear to be warranted for the peer support agency programs. There continue to be anecdotal reports that some of the CMHCs are making more concerted efforts to refer service participants to the PSAs in their regions. Increased efforts to communicate and coordinate with PSAs have also been reported.

In addition, the ER has received anecdotal information that in some regions of the state, relationships and communications among the CMHCs and the PSAs have improved. PSAs are generally reported by CMHCs to be useful sources of employees for ACT and Mobile Crisis and Crisis Apartment services.

Finally, CMHC officials have verbally stated that the peer-operated crisis beds available in several regions are a useful intervention for some CMHC clients at risk of hospitalization.

IV. Quality Assurance Systems

The State has made substantial positive progress implementing a comprehensive, reliable and actionable QSR process. Within the past six months the ER has participated in two QSR site visits, and is increasingly confident that: (a) the revised instruments and site interview protocols are working well; and (b) the results and findings of the revised QSR instruments and process reflect, to a large degree, the quality standards of the CMHA.

DHHS has now completed the QSR process using the revised instruments and protocols at least two times for each of the ten CMHCs. Table XIX below summarizes the quality indicator scores for each domain of the QSR.

Table XIX

QSR Total Indicator Scores: All CMHCs

Indicator Number	Indicator Content	SFY 2018 Average (10 CMHCs)	SFY 2019 Average (10 CMHCs)
1	Adequacy of Assessment	80.5%	87.4%
2	Approp. Tx Planning	89.8%	89.3%
3	Adequacy of Ind. Serv. Del.	82.4%	83.5%
4	Adequacy of Hsg. Assess.	99.5%	100.0%
5	Approp. Of Hsg. Tx Planning	90.3%	86.5%
6	Adequacy of HSG. Serv. Del.	85.2%	89.0%
7	Effect. Of Hsg. Supports Del.	76.3%	84.6%
8	Adequacy of Emp. Assessment	58.0%	63.8%
9	Approp. Of Emp. Tx Planning	70.2%	70.8%
10	Adequacy of Emp. Serv. Del.	58.0%	80.0%
11	Adequacy of Ass. Of Int. Needs	94.3%	100.0%
12	Integration in Community	79.4%	81.1%
13	Adequacy of Crisis Assess.	68.9%	78.0%
14	Appropriateness of Crisis Plns.	80.6%	93.0%
15	Comp. and Effec. Crisis Del. Syst.	72.9%	72.5%
16	Adequacy of ACT screening	90.5%	98.5%
17	Imp. of ACT Servs.	54.2%	65.1%
18	Succ. Trans./Dich. From inpat.	78.0%	79.7%

As demonstrated in the table, the CMHC system as a whole scores below the 75% performance threshold on four indicators. In two domains, adequacy of crisis assessments and adequacy of employment services delivery, the system has moved from below to above the 75% threshold. Implementation of ACT services and employment assessments and treatment plans continue to be below the 75% threshold. As noted earlier in this report, DHHS requires CMHCs with a score below the performance threshold to develop a QIP, which is then monitored on at least a quarterly basis by DHHS staff. Improvements accomplished as a result of the QIPs should be evidenced in subsequent QSR reports.

DHHS is committed to using the QSR process to continuously improve the quality and effectiveness of CMHA services as the community mental health system matures. For this reason, the performance threshold for QSR scoring has been raised to 80% for the up-coming SFY 2020 cycle of QSR reviews. The ER applauds this change, since it moves closer to

requiring a level of system and provider performance that the ER considers to be substantial compliance with the CMHA (assuming that other CMHA metrics are attained).

As a companion to the QSR process, DHHS has been conducting on-site ACT and SE fidelity reviews. DHHS has engaged the Dartmouth/Hitchcock Center on Evidence-Based Practices to do the reviews and to help assist the CMHCs in attaining and assuring fidelity to the evidence-based models of ACT and SE. The Dartmouth/Hitchcock team is also assisting on workforce development and training for these and other evidence-based practices under the aegis of DHHS and the CMHCs. This partnership with the nationally respected Dartmouth/Hitchcock Center adds valuable expertise and experienced personnel to facilitate further development of, and increased adherence to, fidelity model ACT and SE in conformance with the CMHA. Year-to-year comparisons and the CMHCs QIPs have been included in the publication of recent ACT and SE fidelity reviews. The ER commends DHHS for implementing the comprehensive fidelity review process and its attendant quality improvement and technical assistance activities.

Effective and valid fidelity reviews and consequent training and workforce development activities are essential to DHHS' overall quality management efforts for the community mental health system. As noted in the previous three ER reports, the QSR and the fidelity reviews mutually support but do not supplant or replace each other. The QSR, in particular, examines outcomes from a consumer-centric perspective as opposed to an operational or organizational perspective. It is uniquely positioned to assess the quality, appropriateness, and effectiveness of specific ACT and SE services at the individual participant level. The ER continues to believe that implementation of fidelity-based models of service delivery does not necessarily mean that specific service interventions are working well or being delivered with the frequency or intensity required by a participant's individual treatment plan. The revised QSR instruments and protocols address many of these concerns. In combination, the fidelity reviews and the QSR can mutually support conclusions about the overall quality and effectiveness of the mental health system consistent with the CMHA.

The ER will continue to monitor the degree to which the QSR process produces reliable information on individual outcomes and the quality of CMHA service delivery – both at the statewide and CMHC level. In addition, over the next six months, the ER will evaluate the extent to which CMHC QIPs developed as part of the 2018-2019 QSR site visits are resulting in recommended practice changes and improved outcomes for those in the Target Population.

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 CMHA requirements for ACT. There is continued failure to meet the QSR quality threshold for implementation of high fidelity ACT services. **For the last three 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. Continued failure to meet the QSR quality threshold for indicators related to employment assessments and employment treatment planning. In addition, four regions of the state continue to have SE penetration rates below the statewide target of 18.6%;**
- 2. Failure to supply the CMHA-required level of 600 supported housing units, and having approved applicants remain on the wait list for excessive periods of time; and**
- 3. Failure to transition residents of Glencliff into integrated settings in accordance with the CMHA.**

The ER has also identified the MCT/Crisis Apartment programs as an area of concern, albeit not currently in non-compliance with the CMHA. The State will be re-procuring the three MCT/Crisis Apartment programs this fiscal year, and the ER is concerned about both program stability and model fidelity.

More than five years ago, all parties to the CMHA envisioned implementation of a number of remedial services and system interventions designed to assure positive outcomes for the defined Target Population. Most important among these outcomes was assurance of maximum community integration supported by housing and evidence based and high quality services meeting individual needs and choices. At the same time, the CMHA envisioned reduction of hospital and institutional contact and increased access to integrated community services for individuals residing in such facilities. The signatories to the CMHA envisioned high quality of life and improved personal outcomes for adult citizens of New Hampshire with serious mental illness.

As noted above, the State remains out of compliance with the CMHA in several critical areas. The State will not be able to disengage from the CMHA until these requirements are met. The ER expects that the State will demonstrate substantial progress toward meeting all CMHA requirements by June 30, 2020.

In furtherance of this goal, the ER recommends the following actions take place between now and April 30, 2020:

- 1) The parties will convene to discuss the results of the ER's Glencliff review and report findings/recommendations.

- 2) The State will share information related to the design and implementation of the new in-reach position at Glencliff.
- 3) The State will provide written updates on the 24 individuals who have been waiting more than six months for supported housing.
- 4) The State will provide a written update on implementation of specific ACT strategies identified in the working group memo.
- 5) The parties will collectively review responses to the RFP and RFI and discuss how this information impacts current and future crisis program oversight and operations.
- 6) An All Parties meeting will be held to discuss progress and strategies related to disengagement from the CMHA.

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

July to September 2019



New Hampshire Community Mental Health Agreement Quarterly Data Report

July - September 2019

New Hampshire Department of Health and Human Services

Office of Quality Assurance and Improvement

December 5, 2019

*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: December 5, 2019

Reporting Period: 7/1/2019 – 9/30/2019

Notes for Quarter

Table 1b, “Community Mental Health Center Services: Assertive Community Treatment Screening and Resultant New ACT Clients,” has been modified to report results exclusively for those individuals not already on ACT at the time of screening.

Table 1e, “Community Mental Health Center Services: Assertive Community Treatment – New Hampshire Hospital Admission and Discharge Data Relative to ACT,” and Table 1f, “Community Mental Health Center Services: Assertive Community Treatment – Reasons Not Accepted to ACT at New Hampshire Hospital Discharge Referral,” are new tables added to the report.

Table 8d, “Housing Bridge Subsidy Program: Applications,” has had the final field descriptor changed to improve understanding.

July – September 2019

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

Community Mental Health Center	July 2019	August 2019	September 2019	Unique Clients in Quarter	Unique Clients in Prior Quarter
01 Northern Human Services	122	118	122	133	127
02 West Central Behavioral Health	49	47	47	54	52
03 Lakes Region Mental Health Center	56	57	56	58	61
04 Riverbend Community Mental Health Center	89	89	86	100	110
05 Monadnock Family Services	54	50	49	54	58
06 Greater Nashua Mental Health	86	90	97	104	88
07 Mental Health Center of Greater Manchester	291	292	300	322	312
08 Seacoast Mental Health Center	66	66	68	71	73
09 Community Partners	71	72	71	81	75
10 Center for Life Management	48	49	49	49	54
Total Unique Clients	932	928	942	1,022	1,007
Unique Clients Receiving ACT Services 10/1/2018 to 9/30/2019:			1,339		

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 11/6/2019; 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 2019	January - March 2019
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July – September 2019

	Retrospective Analysis			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	1,158	37	3	1,133	44	8
02 West Central Behavioral Health	287	5	4	269	4	2
03 Lakes Region Mental Health Center	823	9	0	809	9	1
04 Riverbend Community Mental Health Center	1,272	1	0	1,296	0	0
05 Monadnock Family Services	535	4	0	651	9	0
06 Greater Nashua Mental Health	633	9	4	635	3	0
07 Mental Health Center of Greater Manchester	1,571	3	0	1,472	21	0
08 Seacoast Mental Health Center	1,286	16	0	1,451	6	0
09 Community Partners	401	1	1	403	1	1
10 Center for Life Management	756	3	1	751	0	0
Total ACT Screening	8,722	88	13	8,870	97	12

July – September 2019

Revisions to Prior Period: The field and data for “Unique Clients Screened: Individuals Not Already on ACT” was not included in the prior period. Instead, the “Unique Clients Screened” field and data was reported and included individuals on ACT who were re-screened during the period.

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 10/30/2019. “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” is 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 2019				April - June 2019			
	New ACT Clients	New ACT Clients	2019 New ACT Clients	Total New ACT Clients	New ACT Clients	New ACT Clients	New ACT Clients	Total New ACT Clients
01 Northern Human Services	6	2	6	14	5	2	4	11
02 West Central Behavioral Health	6	1	3	10	5	5	4	14
03 Lakes Region Mental Health Center	2	1	0	3	4	3	2	9
04 Riverbend Community Mental Health Center	1	1	3	5	5	4	6	15
05 Monadnock Family Services	1	0	0	1	0	0	1	1
06 Greater Nashua Mental Health	3	8	10	21	2	7	5	14
07 Mental Health Center of Greater Manchester	14	11	12	37	6	6	2	14
08 Seacoast Mental Health Center	1	1	3	5	0	1	2	3

July – September 2019

09 Community Partners	3	7	3	13	3	3	3	9
10 Center for Life Management	3	1	0	4	1	0	0	1
Total New ACT Clients	40	33	40	113	31	31	29	91

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 10/22/2019; New ACT Clients are defined as individuals who were not already on ACT within 90days 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.

July – September 2019

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

As of 9/30/2019						
	Time on List					
Total	0-30 days	31-60 days	61-90 days	91-120 days	121-150 days	151-180 days
2	2	0	0	0	0	0
As of 6/30/2019						
Total	0-30 days	31-60 days	61-90 days	91-120 days	121-150 days	151-180 days
1	1	0	0	0	0	0

Revisions to Prior Period: None.

Data Source: BMHS Report.

Notes: Data compiled 10/28/2019.

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

Community Mental Health Center	July – September 2019						April – June 2019					
	ACT at Admission		ACT on Discharge		ACT at Discharge		ACT at Admission		ACT on Discharge		ACT at Discharge	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
01 Northern Human Services	6	7	3	4	3	0	3	13	4	9	2	2
02 West Central Behavioral Health	3	3	2	1	2	0	3	6	2	4	1	1
03 Lakes Region Mental Health Center	2	4	0	4	0	0	5	7	4	3	1	3
04 Riverbend Community Mental Health Center	10	17	6	11	2	4	13	20	9	11	7	2
05 Monadnock Family Services	5	5	2	3	1	1	5	9	1	8	0	1

July – September 2019

06 Greater Nashua Mental Health	3	18	6	12	4	2	3	11	5	6	4	1
07 Mental Health Center of Greater Manchester	8	11	8	3	7	1	12	14	6	8	5	1
08 Seacoast Mental Health Center	3	3	1	2	1	0	2	8	1	7	1	0
09 Community Partners	5	12	2	10	2	0	5	8	3	5	3	0
10 Center for Life Management	2	3	2	1	1	1	2	2	1	1	1	0
Total	47	83	32	51	23	9	53	98	36	62	25	11

Revisions to Prior Period: None; this table is new and was not in the prior report.

Data Source: New Hampshire Hospital.

Notes: Data compiled 11/22/2019.

July – September 2019

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 2019	April - March 2019
Not Available in Individual's Town of Residence	0	0
Individual Refused	0	1
Individual's Insurance Does Not Cover ACT Services	0	0
Individual's Clinical Need Does Not Meet ACT Criteria	3	2
Individual Placed on ACT Waitlist	0	1
Individual Awaiting CMHC Determination for ACT	6	7
Total Unique Clients	9	11

Revisions to Prior Period: None; this table is new and was not in the prior report.

Data Source: New Hampshire Hospital.

Notes: Data compiled 11/22/2019.

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

Community Mental Health Center	September 2019						June 2019	
	Nurse	Clinician/or Equivalent	Support Worker	Peer Specialist	(Excluding Psychiatry)	nurse Practitioner	(Excluding Psychiatry)	Psychiatrist/Nu rse Practitioner
01 Northern Human Services	2.29	2.10	11.30	0.68	16.37	1.20	16.51	1.15
02 West Central Behavioral Health	0.60	1.75	5.40	0.50	8.25	0.49	7.65	0.43

July – September 2019

03 Lakes Region Mental Health Center	1.00	2.00	4.00	1.00	8.00	0.75	8.00	0.75
04 Riverbend Community Mental Health Center	0.50	2.00	8.00	1.00	11.50	0.50	10.50	0.50
05 Monadnock Family Services	1.25	2.25	3.50	1.00	8.00	0.65	9.00	0.65
06 Greater Nashua Mental Health 1	0.50	1.00	5.50	1.00	8.00	0.25	7.00	0.25
06 Greater Nashua Mental Health 2	0.50	1.00	4.50	1.00	7.00	0.25	4.00	0.25
07 Mental Health Center of Greater Manchester-CTT	1.00	10.00	3.75	1.00	15.75	0.73	15.75	0.72
07 Mental Health Center of Greater Manchester-MCST	1.00	8.00	7.25	1.00	17.25	0.73	17.25	0.72
08 Seacoast Mental Health Center	1.00	2.10	6.00	1.00	10.10	0.60	9.10	0.60
09 Community Partners	0.50	3.15	7.13	0.50	11.28	0.63	10.78	0.63
10 Center for Life Management	1.00	2.00	4.30	1.00	8.30	0.40	7.01	0.40
Total	11.14	37.35	70.63	10.68	129.80	7.18	122.55	7.04

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

Community Mental Health Center	Substance Use Disorder Treatment		Housing Assistance		Supported Employment	
	September 2019	June 2019	September 2019	June 2019	September 2019	June 2019
01 Northern Human Services	4.75	3.75	10.95	11.95	2.35	2.35
02 West Central Behavioral Health	0.40	0.40	6.00	5.00	1.40	0.20
03 Lakes Region Mental Health Center	2.00	2.75	7.00	4.00	3.00	3.00
04 Riverbend Community Mental Health Center	1.50	1.50	9.50	9.50	0.50	0.50
05 Monadnock Family Services	1.40	2.40	2.00	3.00	1.00	1.00
06 Greater Nashua Mental Health 1	5.25	3.25	6.25	6.00	1.50	1.00
06 Greater Nashua Mental Health 2	5.25	3.00	5.00	3.00	0.50	0.00
07 Mental Health Center of Greater Manchester-CCT	11.73	11.72	11.75	11.75	1.50	1.00
07 Mental Health Center of Greater Manchester-MCST	4.73	4.72	12.75	12.75	2.00	1.50
08 Seacoast Mental Health Center	2.00	2.00	6.00	5.00	2.00	1.00
09 Community Partners	2.63	2.00	6.10	3.00	1.25	1.25
10 Center for Life Management	3.00	2.00	7.00	5.71	0.30	0.30
Total	44.64	39.49	90.30	80.66	17.30	13.10

Revisions to Prior Period: None.

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

Notes: Data compiled 10/17/2019; 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

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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.

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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 2019			Penetration Rate for Period Ending June 2019
	Supported Employment Clients	Total Eligible Clients	Penetration Rate	
01 Northern Human Services	208	1,318	15.8%	14.9%
02 West Central Behavioral Health	123	625	19.7%	22.5%
03 Lakes Region Mental Health Center	253	1,339	18.9%	18.9%
04 Riverbend Community Mental Health Center	333	1,806	18.4%	19.0%
05 Monadnock Family Services	65	1,042	6.2%	6.8%
06 Greater Nashua Mental Health	250	1,967	12.7%	13.1%
07 Mental Health Center of Greater Manchester	1,361	3,462	39.3%	39.0%
08 Seacoast Mental Health Center	611	1,859	32.9%	33.7%
09 Community Partners	57	731	7.8%	8.6%
10 Center for Life Management	211	1,052	20.1%	20.8%
Total Unique Clients	3,465	14,967	23.2%	23.5%

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 10/22/2019.

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

Reported Employment Status	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 2019
Begin Date: 07/01/2019 End Date: 09/30/2019 Employment Status Update Overdue Threshold: 105 days												
Updated Employment Status:												
Full time employed now or in past 90 days	67	34	32	97	45	118	250	186	35	66	930	892
Part time employed now or in past 90 days	161	54	154	301	138	230	386	222	69	149	1,864	1,829
Unemployed	185	104	50	94	135	773	930	82	141	486	2,980	2,942
Not in the Workforce	512	162	535	924	449	262	556	765	274	107	4,546	4,413
Status is not known	9	62	125	52	10	93	11	3	15	41	421	404
Total of Eligible Adult CMHC Clients	934	416	896	1,468	777	1,476	2,133	1,258	534	849	10,741	10,480
Previous Quarter: Total of Eligible Adult CMHC Clients	939	399	897	1,475	593	1,422	2,111	1,249	542	853		
Percentage by Updated Employment Status:												
Full time employed now or in past 90 days	7.2%	8.2%	3.6%	6.6%	5.8%	8.0%	11.7%	14.8%	6.6%	7.8%	8.7%	8.5%
Part time employed now or in past 90 days	17.2%	13.0%	17.2%	20.5%	17.8%	15.6%	18.1%	17.6%	12.9%	17.6%	17.4%	17.5%
Unemployed	19.8%	25.0%	5.6%	6.4%	17.4%	52.4%	43.6%	6.5%	26.4%	57.2%	27.7%	28.1%
Not in the Workforce	54.8%	38.9%	59.7%	62.9%	57.8%	17.8%	26.1%	60.8%	51.3%	12.6%	42.3%	42.1%
Status is not known	1.0%	14.9%	14.0%	3.5%	1.3%	6.3%	0.5%	0.2%	2.8%	4.8%	3.9%	3.9%
Percentage by Timeliness of Employment Status Screening:												
Update is Current	55.2%	39.4%	74.1%	78.9%	46.1%	96.5%	91.4%	94.0%	70.0%	99.9%	80.4%	82.5%
Update is Overdue	44.8%	60.6%	25.9%	21.1%	53.9%	3.5%	8.6%	6.0%	30.0%	0.1%	19.6%	17.5%
Previous Quarter: Percentage by Timeliness of Employment Status Screening:												
Update is Current	51.4%	43.9%	78.5%	87.7%	32.7%	95.7%	93.8%	94.6%	77.1%	100%		
Update is Overdue	48.6%	56.1%	21.5%	12.3%	67.3%	4.3%	6.2%	5.4%	22.9%	0.0%		

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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	Northern Human Services	West Central Behavioral Health	Lakes Region Mental Health Center	Riverbend Community Mental Health	Monadnock Family Services	Greater Nashua Mental Health	Mental Health Center of Greater Manchester	Seacoast Mental Health Center	Community Partners	Center for Life Management	Statewide Total or Mean Percentage	Previous Quarter Statewide Total or Mean Percentage January-March 2019
Reported Employment Status												
Begin Date: 07/01/2019												
End Date: 09/30/2019												
Updated Employment Status:												
Full time employed now or in past 90 days	1	2	1	2	0	6	6	1	1	1	21	21
Part time employed now or in past 90 days	13	0	14	28	6	15	43	7	6	20	152	163
Unemployed	9	3	4	16	5	18	31	4	3	6	99	106
Not in the Workforce	13	2	15	4	4	10	4	10	3	1	66	81
Status is not known	0	0	9	0	0	5	0	0	0	0	14	18
Total of Supported Employment Cohort	36	7	43	50	15	54	84	22	13	28	352	389
Previous Quarter: Total of Supported Employment Cohort	40	12	47	47	18	55	87	28	18	37		
Percentage by Updated Employment Status:												
Full time employed now or in past 90	2.8%	28.6%	2.3%	4.0%	0.0%	11.1%	7.1%	4.5%	7.7%	3.6%	6.0%	5.4%

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days												
Part time employed now or in past 90 days	36.1%	0.0%	32.6%	56.0%	40.0%	27.8%	51.2%	31.8%	46.2%	71.4%	43.2%	41.9%
Unemployed	25.0%	42.9%	9.3%	32.0%	33.3%	33.3%	36.9%	18.2%	23.1%	21.4%	28.1%	27.2%
Not in the Workforce	36.1%	28.6%	34.9%	8.0%	26.7%	18.5%	4.8%	45.5%	23.1%	3.6%	18.8%	20.8%
Status is not known	0.0%	0.0%	20.9%	0.0%	0.0%	9.3%	0.0%	0.0%	0.0%	0.0%	4.0%	4.6%

Revisions to Prior Period: None.

Data Source: Phoenix 2.

Note 3b-c: Data extracted 10/22/2019. 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.

4a. New Hampshire Hospital: Adult Census Summary

Measure	July -September 2019	April - June 2019
Admissions	258	227
Mean Daily Census	158	155
Discharges	251	230
Median Length of Stay in Days for Discharges	14.0	18.5
Deaths	0	0

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4a: 11/5/2019; 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 2019	April - June 2019
CMHC Group Home	7	5
Discharge/Transfer to IP Rehab Facility	10	7
Glencliff Home for the Elderly	1	4
Home - Lives Alone	64	69
Home - Lives with Others	113	114
Homeless Shelter/ No Permanent Home	6	8
Hotel-Motel	5	1
Jail or Correctional Facility	3	1
Nursing Home	5	2
Other	8	7
Peer Support Housing	1	0
Private Group Home	3	1
Secure Psychiatric Unit - SPU	0	0
Unknown	25	8

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

Measure	July – September 2019	April - June 2019
30 Days	10.5% (27)	8.4% (19)
90 Days	18.6% (48)	15.0% (34)
180 Days	23.3% (60)	20.3% (46)

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4b-c: Data compiled 11/5/2019; 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 2019		
	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	45	59	104
Cypress Center	32	162	194
Portsmouth	98	293	391
Elliot Geriatric Psychiatric Unit	6	46	52
Elliot Pathways	53	42	95
Total	234	602	836
Designated Receiving Facility	April - June 2019		
	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	66	42	108
Cypress Center	39	148	187
Portsmouth	72	299	371
Elliot Geriatric Psychiatric Unit	7	82	89
Elliot Pathways	51	57	108
Total	236	629	865

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

Designated Receiving Facility	July - September 2019	April - June 2019
Franklin	9.4	8.4
Cypress Center	12.2	11.5
Portsmouth	31.7	29.7

Elliot Geriatric Psychiatric Unit	24.1	27.0
Elliot Pathways	12	12.1
Total	89.4	88.7

5c. Designated Receiving Facilities: Discharges for Adults

Designated Receiving Facility	July - September 2019	April - June 2019
Franklin	101	108
Manchester (Cypress Center)	192	193
Portsmouth	386	368
Elliot Geriatric Psychiatric Unit	54	55
Elliot Pathways	97	111
Total	830	835

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

Designated Receiving Facility	July - September 2019	April - June 2019
Franklin	6	5
Manchester (Cypress Center)	4	3
Portsmouth	6	5
Elliot Geriatric Psychiatric Unit	26	18
Elliot Pathways	8	7
Total	6	5

5e. Designated Receiving Facilities: Discharge Location for Adults

Designated Receiving Facility	July – September 2019						
	Assisted Living / Group Home	Deceased	DRF*	Home	Other Hospital	NH Hospital	Other
Franklin	0	0	0	96	0	0	5
Manchester (Cypress Center)	2	0	2	175	0	0	13
Portsmouth Regional Hospital	0	0	3	251	0	7	125
Elliot Geriatric Psychiatric Unit	29	0	1	12	0	0	12
Elliot Pathways	3	0	4	82	0	0	8
Total	34	0	10	616	0	7	163
Designated Receiving Facility	April - June 2019						
	Assisted Living / Group Home	Deceased	DRF*	Home	Other Hospital	NH Hospital	Other
Franklin	3	0	0	97	0	1	7
Manchester (Cypress Center)	5	0	6	173	0	0	9
Portsmouth Regional Hospital	0	0	1	236	0	6	125
Elliot Geriatric Psychiatric Unit	42	0	1	10	0	0	2
Elliot Pathways	2	0	0	93	0	5	11
Total	52	0	8	609	0	12	154

**Dispositions to 'DRF' represent a change in legal status from Voluntary to Involuntary within the DRF.*

5f. Designated Receiving Facilities: Readmission Rates for Adults

Designated Receiving Facility	July - September 2019		
	30 Days	90 Days	180 Days
Franklin	1.9% (2)	6.7% (7)	9.6% (10)
Manchester (Cypress Center)	6.6% (13)	9.2% (18)	12.8% (25)
Portsmouth	8.2% (32)	12.0% (47)	12.0% (47)
Elliot Geriatric Psychiatric Unit	7.7% (4)	9.6% (5)	13.5% (7)
Elliot Pathways	2.1% (2)	5.2% (5)	6.3% (6)
Total	6.3% (53)	9.9% (83)	11.3% (95)
Designated Receiving Facility	April - June 2019		
	30 Days	90 Days	180 Days
Franklin	6.5% (7)	9.3% (10)	12.0% (13)
Manchester (Cypress Center)	9.9% (19)	15.1% (29)	20.8% (40)
Portsmouth	10.5% (39)	17.8% (66)	22.4% (83)
Elliot Geriatric Psychiatric Unit	10.1% (9)	12.4% (11)	14.6% (13)
Elliot Pathways	5.5% (6)	5.5% (6)	5.5% (6)
Total	9.2% (80)	14.0% (122)	17.8% (155)

Revisions to Prior Period: None.

Data Source: NH DRF Database.

Notes: Data compiled 10/31/2019.

6. Glencliff Home: Census Summary

Measure	July - September 2019	April - June 2019
Admissions	1	4
Average Daily Census	115	118
Discharges	1	1 (nursing home)
Individual Lengths of Stay in Days for Discharges	218	553
Deaths	5	2
Readmissions	0	0
Mean Overall Admission Waitlist	25	23

Revisions to Prior Period: None.

Data Source: Glencliff Home.

Notes: Data Compiled 10/22/2019; 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 2019		April – June 2019	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
Alternative Life Center Total	224	44	NA*	NA*
<i>Conway</i>	42	13	40	12
<i>Berlin</i>	105	7	100	10
<i>Littleton</i>	44	11	62	11
<i>Colebrook</i>	33	13	NA	NA
Stepping Stone Total	346	17	377	14
<i>Claremont</i>	241	13	335	12
<i>Lebanon</i>	105	4	69	5
Cornerbridge Total	91	14	445	15
<i>Laconia</i>	25	6	272	7
<i>Concord</i>	58	6	142	8
<i>Plymouth Outreach</i>	8	2	31	NA
MAPSA Keene Total	42	19	159	19
HEARTS Nashua Total	245	36	506	35
On the Road to Recovery Total	157	10	122	10
<i>Manchester</i>	75	5	73	6
<i>Derry</i>	82	5	63	4
Connections Portsmouth Total	82	14	147	14

Peer Support Agency	July - September 2019		April – June 2019	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
TriCity Coop Rochester Total	216	26	201	24
Total	1,403	170	NA*	NA*

Revisions to Prior Period: None.

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

Notes: Data Compiled 12/3/2019; Average Daily Visits are not applicable for Outreach Programs.

NA Alternative Life Center did not report data from Colebrook for the April-June 2019 time period.*

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

Subsidy	July - September 2019		
	Total individuals served at start of quarter	New individuals added during quarter	Total individuals served through end of quarter
Housing Bridge Subsidy	813	16	829
Section 8 Voucher (NHHFA/BMHS) - Transitioned from Housing Bridge	140	11	151
Subsidy	April - June 2019		
	Total individuals served at start of quarter	New individuals added during quarter	Total individuals served through end of quarter
Housing Bridge Subsidy	812	1	813
Section 8 Voucher (NHHFA/BMHS) - Transitioned from Housing Bridge	133	7	140

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

Notes: Data Compiled 11/12/2019. Figures at start and end of each quarter are cumulative total of individuals served since CMHA quarterly reporting began in 2015.

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

Measure	As of 9/30/2019	As of 6/30/2019
Rents Currently Being Paid	338	365
Individuals Enrolled and Seeking Unit for Bridge Lease	35	13
Total	373	378

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

Notes: Data Compiled 11/12/2019; all individuals currently on Bridge Program are intended to transition from the program to other permanent housing.

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

Measure	As of 9/30/2019	As of 6/30/2019
Housing Bridge Clients Linked	339/373 (91%)	360/378 (95%)

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

Notes: Data compiled 11/13/2019; "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 (MMIS).

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 9/30/2019	Frequency as of 6/30/2019
1	282	300
2	18	16
3	1	4
4	1	2
5	1	1
6	0	0
7	0	0
8 or more	1	1

*All units are individual units; property address may include multiple buildings, such as apartment complexes.

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health data compiled by Office of Quality Assurance and Improvement.

Notes: Data Compiled 11/22/2019.

8d. Housing Bridge Subsidy Program: Applications

Measure	July - September 2019	April - June 2019
Applications Received During Period	22	28
<i>Point of Contact for Applications Received</i>	<i>CMHCs: 13; NHH: 9</i>	<i>CMHCs: 11; NHH: 14; Other: 1</i>
Applications Approved	11	14
Applications Denied	0	0
<i>Denial Reasons</i>	<i>NA</i>	<i>NA</i>
Applications in Process at End of Period	75	74

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services.

Notes: Data Compiled 11/12/2019.

8e. Housing Bridge Subsidy Program: Terminations

Type and Reason	July - September 2019	April - June 2019
Terminations – DHHS Initiated	0	0
<i>Over Income</i>	<i>NA</i>	<i>NA</i>
Exited Program – Client Related Activity	25	26
<i>Voucher Received</i>	<i>13</i>	<i>11</i>
<i>Deceased</i>	<i>1</i>	<i>0</i>
<i>Over Income</i>	<i>0</i>	<i>0</i>
<i>Moved Out of State</i>	<i>1</i>	<i>5</i>
<i>Declined Subsidy at Recertification</i>	<i>4</i>	<i>7</i>
<i>Higher Level of Care Accessed</i>	<i>3</i>	<i>1</i>
<i>Other Subsidy Provided</i>	<i>0</i>	<i>0</i>
<i>Moved in with family</i>	<i>3</i>	<i>2</i>
Total	25	26

Revisions to Prior Period: None.

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

Notes: Data Compiled 11/12/2019.

8f. Housing Bridge Subsidy Program: Application Processing Times

Average Elapsed Time of Application Processing (calendar days)*	July - September 2019	April - June 2019
Completed Application to Determination	1	1
Approved Determination to Funding Availability**	95	1
Referred to Vendor with Funded HB Slot	2	1
Leased Unit Secured	NA	NA

Revisions to Prior Period: None.

Data Source: Bureau of Mental Health Services.

Notes: Data Compiled 11/12/2019.

*Elapsed time measure reporting implemented 10/1/18 and applies to any application received on or after that date.

**Average calculated on 16 applications approved for which funding was made available in the quarter.

9. Housing Bridge Subsidy Program Waitlist: Approved Applications

As of 9/30/2019							
Time on List							
Total	0-30 days	31-60 days	61-90 days	91-120 days	121-150 days	151-180 days	181+ days
42	5	3	5	3	0	1	24
As of 6/30/2019							
Total	0-30 days	31-60 days	61-90 days	91-120 days	121-150 days	151-180 days	181+ days
44	5	3	5	13	2	0	16

Revisions to Prior Period: None.

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

Notes: Data Compiled 11/12/2019.

10. Supported Housing Subsidy Summary

Subsidy	July - September 2019	April - June 2019
	Total subsidies by end of quarter	Total subsidies by end of quarter

Housing Bridge Subsidy:	Units Currently Active	338	365
	Individuals Enrolled and Seeking Unit for Bridge Lease	35	13
Section 8 Voucher (NHHFA):	Transitioned from Housing Bridge*	151	140
	Not Previously Receiving Housing Bridge	0	0
811 Units:	PRA	56	54
	Mainstream	16	14
Other Permanent Housing Vouchers (HUD, Public Housing, VA)		1	5
Total Supported Housing Subsidies		597	591

Revisions to Prior Period: None.

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

Notes: Data Compiled 11/12/2019; 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 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.*

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

Measure	July 2019	August 2019	September 2019	July - September 2019	April - June 2019
Unique People Served in Month	291	337	308	499	517
Services Provided by Type					
Case Management	0	0	0	0	0
Crisis Apartment Service	0	0	0	0	0
Crisis Intervention Services	11	11	10	32	43
ED Based Assessment	0	0	0	0	0
Medication Appointments or Emergency Medication Appointments	0	0	0	0	0
Mobile Community Assessments	52	83	76	211	136
Office-Based Urgent Assessments	32	32	26	90	106
Other	0	0	0	0	0
Peer Support	0	0	0	0	0
Phone Support/Triage	355	383	366	1,104	1,143
Psychotherapy	0	0	0	0	0
Referral Source					
CMHC Internal	29	48	18	95	66
Emergency Department	0	13	19	32	1
Family	20	38	6	64	63

Measure	July 2019	August 2019	Septemb er 2019	July - Septembe r 2019	April - June 2019
Friend	2	4	4	10	23
Guardian	13	1	3	17	64
MCT Hospitalization	0	0	0	0	0
Mental Health Provider	8	16	28	52	55
Other	1	19	5	25	10
Police	4	16	19	39	20
Primary Care Provider	4	16	19	39	17
Self	205	226	226	657	751
School	1	0	36	37	21
Crisis Apartment					
Apartment Admissions	24	31	23	78	80
Apartment Bed Days	87	186	124	397	319
Apartment Average Length of Stay	3.6	6.0	5.4	5.1	4.0
Law Enforcement Involvement	17	18	28	63	73
Hospital Diversions Total	172	194	154	520	449

Revisions to Prior Period: None.

Data Source: Riverbend CMHC submitted report.

Notes: Data Compiled 10/29/2019; reported values other than the Unique People Served in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.

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

Measure	July 2019	August 2019	September 2019	July - September 2019	April - June 2019
Unique People Served in Month	261	286	274	679	714
Services Provided by Type					
Case Management	38	26	28	92	90
Crisis Apartment Service	10	4	6	20	28
Crisis Intervention Service	21	80	78	179	144
ED Based Assessment	0	0	0	0	0
Medication Appointments or Emergency Medication Appointments	0	0	0	0	0
Mobile Community Assessments	84	91	105	280	319
Office-Based Urgent Assessments	20	14	15	49	65
Other	246	293	264	803	833
Peer Support	20	8	14	42	112
Phone Support/Triage	566	621	646	1,833	1,795
Psychotherapy	3	2	3	8	8
Referral Source					
CMHC Internal	9	11	5	25	23
Emergency Department	0	0	0	0	2
Family	28	32	51	111	168

Friend	4	6	4	14	15
Guardian	4	3	8	15	29
MCT Hospitalization	0	0	0	0	0
Mental Health Provider	13	18	43	74	36
Other	28	45	54	127	123
Police	99	85	89	273	320
Primary Care Provider	12	15	14	41	58
Self	132	159	104	395	361
School	0	0	0	0	0
Crisis Apartment					
Apartment Admissions	4	2	3	9	15
Apartment Bed Days	10	7	10	27	46
Apartment Average Length of Stay	2.5	3.5	3.3	3	3.1
Law Enforcement Involvement	99	85	89	273	320
Hospital Diversion Total	341	379	391	1,111	1,185

Revisions to Prior Period: None.

Data Source: Phoenix 2.

Notes: Data Compiled 10/30/2019; reported values other than the Unduplicated People Served in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.

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

Measure	July 2019	August 2019	September 2019	July - September 2019	April - June 2019
Unique People Served in Month	146	146	156	377	419
Services Provided by Type					
Case Management	51	38	36	125	279
Crisis Apartment Service	94	90	111	295	295
Crisis Intervention Services	0	1	0	1	0
ED Based Assessment	14	5	10	29	33
Medication Appointments or Emergency Medication Appointments	0	0	0	0	0
Mobile Community Assessments	63	84	84	231	245
Office-Based Urgent Assessments	7	5	9	21	29
Other	0	0	0	0	0
Peer Support	68	61	77	206	302
Phone Support/Triage	177	183	170	530	522
Psychotherapy	14	5	5	24	45
Referral Source					
CMHC Internal	19	20	11	50	58
Emergency Department	12	7	15	34	31
Family	7	9	13	29	52
Friend	5	2	5	12	16

Guardian	0	0	0	0	0
MCT Hospitalization	0	0	0	0	0
Mental Health Provider	12	12	2	26	20
Other	111	111	99	321	286
Police	6	4	5	15	20
Primary Care Provider	2	0	1	3	8
Self	69	67	79	215	200
Schools	3	4	10	17	38
Crisis Apartment					
Apartment Admissions	14	21	18	53	51
Apartment Bed Days	73	124	109	306	249
Apartment Average Length of Stay	5.2	5.9	6.1	5.8	4.9
Law Enforcement Involvement	0	0	0	0	0
Hospital Diversion Total	243	232	235	710	704

Revisions to Prior Period: None.

Data Source: Harbor Homes submitted data.

Notes: Data Compiled 10/29/2019; reported values other than the Unique People Served in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.