New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Sixteen

December 15, 2022

I. Introduction

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

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

The submission of this report by the Expert Reviewer (ER) has been delayed for four months by agreement of the Parties to the CMHA. As a result, the ER anticipates that the next semiannual report will be filed with the Court on or about July 1, 2023. That report will include an analysis of quarterly data available from July 2022 to the spring of 2023.

In May of this year, the Parties agreed to participate in a series of facilitated meetings in an attempt to reach agreement on new approaches to increasing community living opportunities for residents of the Glencliff Home (Glencliff) and people on the wait list for admission to Glencliff. The ER understands that this process has resulted in consensus among the Parties to increase the supply of integrated community settings and other residential resources for Glencliff residents and people on the wait list for admission to Glencliff. The ER understands that these new strategies also will enhance in-reach activities, transition planning and informed consent, and diversions from Glencliff. The ER applauds the good faith efforts of the Parties to develop new positive approaches to benefit Glencliff residents and those on the waitlist.

For the past two-and-one-half years, the State of New Hampshire has been affected by COVID-19. The State reports that Community Mental Health Centers (CMHCs) have remained functional and open as essential businesses during this period, although some employees have been working remotely. Following Centers for Disease Control and Prevention (CDC)

recommendations and NH Division of Public Health Services (DPHS) guidance, in addition to program-specific emergency guidance provided by the Bureau of Mental Health Services (BMHS), CMHCs have focused on adjusting service delivery to maintain health and to implement safety protocols while serving participants in a way that meets participant needs and preferences. Telehealth services are being provided for participants preferring that method due to COVID-19 concerns, and in-person services remain available for individuals who prefer this method. Mental Health (MH) facilities, including New Hampshire Hospital (NHH), Glencliff, and residential treatment centers, have modified safety protocols to protect residents/patients from COVID-19. The State has implemented numerous strategies, including Medicaid plan changes, eligibility certification improvements, and staffing requirements, to insure that, to the extent possible, service response rates and service continuity are maintained.

During this reporting period, the ER:

- Conducted an all-day record review at Glencliff;
- Observed and participated in a total of eight Assertive Community Treatment (ACT) team, Supported Employment (SE) team, or Senior Administration Team meetings, at three separate CMHCs;
- Participated in a number of telephone or video conference calls with the State, the Plaintiffs, or both;
- Participated in five meetings of the Parties discussing initiatives related to Glencliff.

Summary of Progress to Date

This report reflects almost eight years of implementation efforts related to the CMHA. Within that time frame, a number of positive steps have been taken to improve the quality and effectiveness of services as required by the CMHA. However, as will be discussed in detail below, there are areas of continued non-compliance with the CMHA. These include continuing non-compliance related to ACT and facility-based in-reach work and transition planning.

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

Another accomplishment has been contracting with the Dartmouth-Hitchcock Medical Center (DHMC) to conduct external ACT and SE fidelity reviews using nationally validated fidelity review instruments and criteria. In concert with the QSR reviews referenced above, the fidelity reviews have assisted the State and the CMHCs to develop comprehensive Quality Improvement Plans (QIPs) that address important ACT and SE quality and effectiveness issues at both the consumer and CMHC operational levels. The State also continued to provide technical assistance and oversight to CMHCs that had active QIPs related to ACT and SE at the time the

fidelity reviews were suspended due to COVID-19 issues. In recent months, the State and the DHMC fidelity review team have resumed the on-site fidelity reviews.

The Parties originally envisioned that the CMHA could be fully implemented in five years, with a sixth year for monitoring of maintenance of effort. The CMHA was approved and filed with the Court on February 12, 2014, and the five-year anniversary of that event occurred more than three-and-one-half years ago. The ER was approved by the Parties and the Court, effective July 1, 2014, and the five-year anniversary of that occurred 39 months ago.

Most of calendar years 2020 and 2021 were dominated by the response to the health risks associated with COVID-19 and by the restrictions necessitated by COVID-19. As will be seen in the subsequent sections of this report, most elements of the service system defined by the CMHA have remained relatively stable. Understandably, there has been little measurable progress, but there has also been a relatively consistent level of service delivery and performance. The State is to be congratulated for maintaining services to the CMHA Target Population during these very difficult circumstances.

Nonetheless, it is important to emphasize that the pandemic has not altered the terms of the CMHA, nor diminished the State's obligations to members of the Target Population.

Data

Appendix A contains the most recent DHHS Quarterly Data Report (April through June 2022), incorporating standardized report formats with clear labeling and date ranges for several important areas of CMHA performance. The capacity to conduct and report longitudinal analyses of trends in certain key indicators of CMHA performance continues to improve. The ER emphasizes that the State must produce the necessary data reports in a timely fashion. The ER is not able to produce the six-month reports on the required schedule whenever the State is late delivering the necessary data and reports.

II. CMHA Services

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

Mobile/Crisis and Crisis Apartment Programs

The CMHA calls for the establishment of a MCT[1] and Crisis Apartments (MCT/Crisis Apartments) in the Concord Region by June 30, 2015 (Section V.C.3 (a)). DHHS conducted a procurement process for this program, and the contract was awarded on June 24, 2015.

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

Riverbend CMHC was selected to implement the MCT/Crisis Apartments in the Concord Region.

The CMHA specified that a second MCT/Crisis Apartment program be established in the Manchester region by June 30, 2016 (V.C.3(b)). The Mental Health Center of Greater Manchester was selected to implement that program. Per CMHA V.C.3(c), a third MCT/Crisis Apartment program became operational in the Nashua region on July 1, 2017. The contract for that program was awarded initially to Harbor Homes in Nashua. That contract was transferred in late 2020 to another provider, Greater Nashua Mental Health (GNMH), which is now responsible for implementing the program.

Table I, which contains data from Table 11 in Appendix A, contains a summary of key data trends from the three programs.[2]

Table I

Self-Reported Data on Mobile Crisis Services and Crisis Apartment Programs
January through June 2022

	04 Riverbend Community Mental Health Center		06 Greater Nashua Mental Health		07 Mental Health Center of Greater Manchester	
	Apr – Jun 2022	Jan – Mar 2022	Apr – Jun 2022	Jan – Mar 2022	Apr – Jun 2022	Jan – Mar 2022
Unique Clients Served by the Access Point[1,2]	417	401	268	265	542	531
Access Point Support Contacts (Telephone, Text, Chat)[1]	648	712	527	399	1,030	901
Access Point Support Contacts: Telephone	956	704	509	388	1,021	875

[2] Due to data reporting migration to a new platform, the data may be revised in the future. DHHS reports that it is working with the Access Point provider to identify and resolve any data discrepancies.

Access Point Support Contacts: Text	1	2	0	2	2	1
Access Point Support Contacts: Chat	11	6	18	9	7	25
Referral Source to Access Point[1]:						
Emergency Department	0	1	0	0	1	1
Family	37	27	37	16	30	39
Friend	1	1	1	0	0	0
Guardian	0	0	0	1	0	0
Law Enforcement[4]	0	0	0	0	0	0
Mental Health Provider	18	15	9	6	61	44
Other	149	123	85	44	148	114
Primary Care Provider	6	1	1	0	9	2
School	6	1	1	0	4	7
Self	86	102	68	29	103	72
Access Point Deployments[1]	214	169	132	65	259	211
Unique Rapid Response Clients Served by CMHC[2]	261	189	218	155	475	437
CMHC Crisis Intervention Services:						
Mobile Community Assessments	82	79	28	24	160	198
Office-Based Assessments	44	55	38	25	97	95
ED Based Assessments	23	12	1	1	0	0

Phone Support/Triage	114	90	0	0	50	154
CMHC Crisis Stabilization Services[3]	252	287	564	406	1,107	940
Unique Rapid Response Clients Served by CMHC with Crisis Events involving Law Enforcement[2]	8	10	12	7	43	77
CMHC Hospital Diversions	163	134	50	49	218	119
CMHC Crisis Apartments						
Apartment Admissions	23	28	15	5	1	6
Apartment Bed Days	72	99	48	28	2	87
Apartment Average Length of Stay	3.1	3.5	3.2	5.6	2.0	14.5

Table I includes some evidence that the MCT/Crisis Apartment programs are beginning to recover from the effects of COVID restrictions on the operations of these programs.

Table II below shows that the number of people awaiting inpatient psychiatric admission from hospital emergency departments has decreased in the most recent reporting period. Overall admissions to NHH have also decreased slightly. However, readmission rates to NHH have increased sharply. Increased readmission rates could be indicators of people who have been discharged from NHH not being effectively connected with available community resources. As will be discussed in the next section of this report, there continues to be unused ACT capacity in the New Hampshire system. The ER expects to seek additional information about whether increased enrollments in ACT upon discharge from NHH would be feasible and appropriate.

Table II
DHHS Report on the Number Waiting for Inpatient Psychiatric Admission, NHH Admissions, and NHH Readmission Rates

Comparison 12-month Period	Average # Adults Waiting per Day for NHH Admission	NHH Admissions	NHH 180-day Readmissions Average
10/1/2020-9/30/2021	35	964	17.4%
7/1/2021-6/30/2022	22	959	20.4%
Change	Down 37.1%	Down .5%	Up 17.2%

Assertive Community Treatment (ACT)

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

1. By October 1, 2014, the State will ensure that all of its 11 existing adult ACT teams operate in accordance with the standards set forth in Section V.D.2;
2. By June 30, 2014, the State will ensure that each mental health region has at least one adult ACT team;
3. By June 30, 2016, the State will provide ACT team services consistent with the standards set forth above in Section V.D.2 with the capacity to serve at least 1,500 individuals in the Target Population at any given time; and
4. By June 30, 2017, the State, through its community mental health providers, will identify and maintain a list of all individuals admitted to, or at serious risk of being admitted to, NHH and/or Glencliff for whom ACT services are needed but not available, and develop effective regional and statewide plans for providing sufficient ACT services to ensure reasonable access by eligible individuals in the future.

Table III below displays ACT staffing levels for each of the 10 CMHC regions from Tables 2a and 2b in Appendix A. Three of the regions have multiple ACT teams, and for these the staffing is reported by team.

Table III
Self-Reported ACT Staffing (excluding psychiatry):
December 2020 - June 2022

Region	FTE Dec-20	FTE Mar-21	FTE **Jun-21**	FTE Dec-21	FTE Mar-22	FTE **Jun-22**
Northern	15.75	14.03	15.87	12.43	12.22	12.11
Northern - Wolfboro	8.27	6.81	7.00	4.97	3.00	3.60
Northern - Berlin	4.17	3.94	5.43	4.83	4.88	4.94
Northern-Littleton	3.31	3.28	3.44	2.63	4.34	3.57
West Central	5.90	5.40	5.60	4.60	4.70	6.20
Lakes Region	7.00	5.00	6.00	6.00	4.00	5.00
Riverbend	10.50	10.40	10.50	9.50	8.50	7.50
Monadnock	10.32	11.17	7.70	7.71	6.33	7.87
Greater Nashua 1	8.50	7.65	8.00	8.75	6.75	9.00
Greater Nashua 2	8.50	8.65	8.00	6.00	6.00	6.00
Manchester - CTT	21.61	19.95	20.28	22.27	22.61	22.61
Manchester MCST	25.27	19.95	19.86	21.85	22.45	20.32
Seacoast	10.10	10.10	10.10	8.63	9.16	11.10
Community Part.	7.41	7.28	9.78	10.71	7.84	7.64
CLM	6.57	6.71	8.28	8.67	7.88	8.85
Total	137.43	126.29	129.97	127.12	118.44	124.20

Six of the 14 teams[3] report having fewer than the required minimum of seven FTEs to qualify as an ACT team.[4] Two of the Northern Human Services teams plus the Riverbend team report having no peer support specialist. The three Northern Human Services teams plus three other teams report having no SE staff capacity. The three Northern teams plus four other teams report having SUD treatment staff capacity of less than one FTE. Four teams report having 0.5 or less FTE of the required combined psychiatry/nurse practitioner time available to their ACT teams. Three of the Northern Human Services teams, plus three other teams, report having less than one FTE nurse per team. **As documented above, at least six of the ACT teams do not meet one or more of the CMHA requirements for staffing or team criteria set out in the CMHA.**

[3] If the three mini-teams at Northern Human Services are counted as one team, then the denominator (the total number of ACT teams) would be 12, not 14; so there is either deficient staffing for six of 14 ACT teams or four of 12 ACT teams.

[4] Two of these, Northern Wolfeboro and Northern Littleton, are considered by the State to be "mini-teams" with a staffing expectation of 5 FTE rather than 7 FTE; but this mini-team characterization does not comport with accepted ACT fidelity standards. Even accepting the State's modification to fidelity, none of the mini-teams would currently satisfy the State's standard for minimum staffing.

Table IV below, which reports data found in Table 1a in Appendix A, displays the active ACT caseloads by CMHC Region since March 2021. The current reported active monthly caseload has decreased by 111 participants since March 2021. It also has decreased by 153 participants from the ACT monthly caseload of 1,006 that was reported in June 2017, and is below the active case load of 941 that was reported for December 2020.

Table IV

Self-Reported ACT Active Caseload (Unique Adult Consumers) by Region in Specified Months: March 2021 to June 2022

Region	Active Cases Mar-21	Active Cases Jun-21	Active Cases Jan-22	Active Cases Mar-22	Active Cases Jun-22
Northern	124	110	81	86	78
West Central	60	42	49	55	48
Lakes Region	59	58	58	58	58
Riverbend	94	99	83	83	85
Monadnock	45	43	42	44	46
Greater Nashua	130	116	108	103	107
Manchester	254	240	245	256	256
Seacoast	80	80	74	74	70
Community Part.	73	77	79	74	61
CLM	45	44	50	47	45
Total*	964	909	867	878	853

* unduplicated across regions

The CMHA requires the State have the capacity to serve 1,500 individuals with ACT services "at any given time." As of June 2022, the combined ACT teams had a reported staff complement of 124.20 FTEs excluding psychiatry, which is sufficient capacity to serve 1,242 individuals based on the ACT non-psychiatry staffing ratios contained in the CMHA, a capacity 258 less than required by the CMHA. With a statewide caseload of 853, as of June 2022, there is a 389-participant gap between actual reported staff capacity and actual active participants, and a 647-participant gap between the current active caseload and the number of participants that could be served at the required ACT capacity level as set out in the CMHA.

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, including crisis response;[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 clients[6] who may qualify for and benefit from ACT.

Table V (derived from data in Table 1b in Appendix A) below presents data on ACT screens conducted by CMHCs between January and March.[7]

[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.

[7] Note that this is a retrospective table, and thus, is always one quarter behind the other State-reported data in this report. This supports the "look forward" component, which documents the extent to which individuals receive services within 90 days of a positive screen.

Table V

Self-Reported Number of Unique Clients Screened for ACT Services by CMHCs
January to March 2022
(Retrospective Analysis)

Community Mental Health Center	Total Screened (not already on ACT)	Appropriate for further ACT Assessment	Receiving ACT/ within90 days of Screening	Percent Receiving ACT of those Appropriate for Assessment within 90 days
01 Northern Human Services	1,010	26	3	12%
02 West Central Behavioral Health	161	6	0	00.0%
03 Lakes Region Mental Health Center	974	6	0	00.0%
04 Riverbend Community Mental Health Center	1,746	23	0	0.00%
05 Monadnock Family Services	538	9	0	0.00%
06 Greater Nashua Mental Health	1,406	4	0	00.0%
07 Mental Health Center of Greater Manchester	1,499	41	0	00.3%
08 Seacoast Mental Health Center	1,626	3	0	0.00%
09 Community Partners	198	1	1	100.%
10 Center for Life Management	1,313	0	0	N/A
Total	**10,473**	**119 (0.114% of all screened)**	**4 (3.36% of all assessed after screening- 0.04% of all screened)**	

Of the 10,473 unique individuals screened for ACT during this three-month period, the State reports that 119 were referred for an ACT assessment. This is a referral rate of less than one percent. Only 3.36% (4 individuals) of those referred for ACT assessments were enrolled in ACT services within 90 days of being screened. Most of the referrals for ACT screening are internal to the CMHCs. That is, people who have already had a CMHC intake, and who may already be receiving CMHC services, are those most likely to be screened for ACT services. Thus, it is perhaps not surprising that so few of the individuals screened are referred to the next step, which is the assessment for ACT.

The State has reported that about 80 percent of individuals are linked to ACT without having gone through the CMHC ACT screening process. This seems to be confirmed by the fact that 57 new clients were reported to be added, while the ACT screening process only produced 4 new ACT participants. The State asserts that these new ACT clients were identified through CMHC clinical teams due to each individual's emerging needs for the more intensive services and supports that ACT provides. Nonetheless, available screening data does not shed light on whether individuals outside of the CMHC system who would benefit from ACT services are being properly identified and referred for assessment. The ER continues to expect that the State implement initiatives to identify and screen/assess individuals outside of the CMHC system, especially those in crisis, such as those having contact with the EDs, homeless outreach workers and organizations, and/or the criminal justice system.

New ACT Clients

Since April of 2020, the State has been reporting the number of new ACT clients. Table VI (derived from Table 1c in Appendix A) summarizes these data from the four most recent reporting periods.

Table VI

Self-Reported New ACT Clients

CMHC	New Clients July to Sept. 2020	New Clients Oct – Dec 2020	New Clients Jan – Mar 2021	New Clients April –June 2021	New Clients April – June 2022
Northern Human Services	13	10	12	8	5
West Central Behavioral Health	5	10	22	8	1
Lakes Region MHC	4	4	6	4	1
Riverbend CMHC	8	15	13	4	13
Monadnock Family Services	0	0	2	2	2
Greater Nashua Mental Health	10	26	8[8]	10	7
MHC of Greater Manchester	22	18	17	7	19
Seacoast MHC	7	6	8	3	5
Community Partners	7	4	12	9	2
Center for Life Management	4	2	2	1	2
Total	**80**	**95**	**102[9]**	**56**	**57**

It should be noted that from September 2020 through June 2022, the combined ACT teams have added an average of 78 new clients per quarter, while the total number of ACT participants decreased by 56 participants in the same time period. This indicates that there is substantial turnover in the active ACT caseload. As a result, aggressive efforts to engage new ACT participants are necessary just to maintain steady state[10] operations in the ACT program, much less to grow the program. In light of this data, and to provide further context for this fluctuation in active caseloads, in the previous report, the ER recommended that the State begin capturing and reporting the following information: 1) participants' average length of stay in the service; 2) the number of participants discharged each month; and 3) the reason for their discharge (i.e., withdrawal of consent; achievement of treatment goals; moved out of state, etc.). The ER expects the State to cooperate in providing these types of data to analyze on-going issues related to ACT enrollment.

The State has been reporting data on the number of individuals waiting for ACT services on a statewide basis for the past 30 months. This information is displayed in Table VII below and, in part, in Table 1d in Appendix A. The State and the CMHCs assert that an individual eligible for ACT may have to wait for ACT services because the specific ACT team of the individual's CMHC does not currently have staff capacity to accept new clients. Beginning in January 2022

[8] This number was reported to be 38 in the previous report and has been corrected for this report based on improvements to the GNMH's electronic medical record (EMR).
[9] See Note 8.
[10] The CMHA does not specifically require "steady state" operations. Nor does the CMHA have specific caseload or enrollment requirements for ACT. However, ACT is a core remedial service directly related to meeting the qualitative and quantitative expectations of the CMHA. Thus, the ER intends to continue to monitor and report on ACT enrollment as a key indication of overall compliance with the CMHA.

the number of individuals on the wait list has been significantly reduced. The State is to be congratulated for eliminating the ACT wait list as of the most recent reporting period.

Table VII

Self-Reported ACT Wait List

		Time on List		
	Total	**0-30 days**	**31-60 days**	**61-180+ days**
December 31, 2018	6	3	0	3
March 31, 2019	2	1	1	0
June 30, 2019	1	1	0	0
September 30, 2019	2	2	0	0
December 31, 2019	5	2	2	1
March 31, 2020	10	0	3	7
June 30, 2020	13	2	2	9
September 30, 2020	11	3	5	3
December 31, 2020	2	0	1	1
March 31, 2021	4	3	1	0
June 30, 2021	6	1	4	1
January – March 2022	1	0	0	1
April – June 2022	0	0	0	0

New Hampshire Hospital (NHH) Admissions and Discharge Data Relative to ACT

In concert with other strategies to improve access to ACT services, the State has begun tracking the extent to which individuals on ACT are admitted to NHH; are referred to ACT from NHH; and are accepted into ACT upon discharge from NHH. Table VIII (reflecting data in Table 1e in Appendix A) summarizes data from the past nine quarters on these issues.

Table VIII

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

October 2019 through June 2022

	On ACT at admission	Percent of all Admissions who were on ACT	Not on ACT Referred to ACT on Discharge[11]	Percent of Not on ACT Referred for ACT	Accepted into ACT on Discharge	Percent of Those Accepted into ACT on Discharge
Oct.-Dec 2019	64	38.1%	25	24.0%	14	56.0%
Jan.-Mar. 2020	53	35.1%	28	28.6%	11	39.3%
April – June 2020	67	34.1%	33	25.4%	17	51.5%
July to Sept. 2020	37	26.1%	28	26.7%	21	75%
Oct. – Dec. 2020	40	36.0%	20	28.2%	14	70.0%
Jan. – Mar. 2021	37	34.3%	21	29.6%	11	52.4%
April – June 2021	54	18.9%	31	24.6%	17	54.8%
January – March, 2022	42	33.9%	23	28.0%	14	60.9%
April – June 2022	45	28.1%	26	22.6%	19	70.4%

The data in this table reveals that, in the latest quarter, only 22.6% of those not on ACT got referred to ACT, and of all those referred, only 16.5% got ACT upon discharge. Given these big

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

drops from phase to phase, there may be an issue with regard to eligibility criteria and linkage practices at the referral and acceptance stages.

The State has also begun reporting the reasons that individuals are not accepted into ACT upon discharge from NHH. Table IX (from data shown in Table 1f in Appendix A) summarizes this reported information.

Table IX

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

January 2020 through June 2022

Reason Not Accepted into ACT on Discharge	January – March 2020	April – June 2020	July – Sept. 2020	Oct. – Dec 2020	Jan. – March 2021	April – June 2021	Jan-Mar 2022	Oct.-Dec 2021	Apr-Jun 2022
Not Available in Individual's Town of Residence	0	0	0	0	1	0	0	1[12]	0
Individual Declined	0	0	0	0	0	0	0	1	0
Individual's Insurance does not Cover ACT	0	1	0	0	0	1	2	1	0
Does not Meet ACT Clinical Criteria	1	0	0	0	5	2	2	0	1
Individual Placed on ACT Wait List	1	1	0	0	0	0	0	0	1
Individual Awaiting CMHC Determination for ACT[13]	15	14	7	6	4	11	5	10	4
Total Unique Clients	17	16	7	6	10	14	9	13	6

[12] Individual chose to relocate to live with Guardian and transfer the CD to a new CMHC.
[13] Some of these individuals may be enrolled in ACT during a subsequent reporting period.

As with previous reports, about 50 to 80 percent of the individuals referred, but not accepted into ACT in the April 2022 through June 2022 time period, were reported to be awaiting CMHC determination of eligibility for ACT. This means that the elapsed time for CMHCs to determine ACT appropriateness has been the most prevalent reason why people referred for ACT have not yet received it post-NHH discharge. Based on State descriptions, it appears that the wait times may extend out several weeks. The State has acknowledged that delayed engagement with CMHCs at or near the time of discharge is an area in need of improvement, but this issue has not changed since the last report. The ER remains concerned about these reported delays in accessing ACT services at the CMHC level.

The ER understands that the State has been attempting to improve referrals, assessments and enrollments in ACT services and has implemented directed payments and other incentives to improve performance in this area. However, taken all together the reported data does not support a conclusion that access to ACT has been improved. Thus, the ER expects the State to continue to take additional steps to align the reported excess capacity in the ACT system with the needs of individuals for ACT services, both on discharge from NHH and the DRFs and from the ACT waiting list.

ACT Fidelity and Quality

Despite the limitations imposed because of COVID-19, the State has been able to complete QSR reviews for all of the CMHCs during State Fiscal Year 2022. The results of the reviews are summarized in the section on Quality later in this report and are tabulated in Appendix B. In previous reports, the ER has noted that one area of concern identified in the QSR reports has been the implementation of ACT services. With regard to QSR indicator number 17, ***implementation of ACT services***, seven of the ten CMHCs scored below the State's performance threshold of 80%; two others only achieved scores of 80% and 81%. The overall State average is also below the threshold at 73%. In the previous year, there were four CMHCs that scored below the 80% threshold. This fact heightens the ER's concerns about the quality issues identified with regard to ACT services, and the implications for compliance with the CMHA.

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

Because of COVID, the State has followed national EBP guidance to temporarily suspend reporting of detailed fidelity scores for reviews conducted under the COVID restrictions. Reporting of detailed fidelity scores will resume after the pandemic. The ER will work with State officials to determine how ACT fidelity review information will be incorporated into future reports.

ACT Summary Findings

Based on the above information, the ER finds that the State remains out of compliance with the ACT service standards described in Section V.D. of the CMHA. The data makes it clear that the State fails to provide a robust and effective system of ACT services throughout the state as required by the CMHA.

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

As will be seen in the recommendations section of this report, the ER expects that the State will engage in a solution-focused process, detailed in the Summary of Observations and Priorities section of this report, to share relevant data, secure recommendations from an expert consultant, and meet with the ER and all parties to develop specific activities and actions for achieving compliance with the CMHA's ACT provisions.

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)).

For the past several reporting periods the State has maintained a SE penetration rate over 25% statewide. However, as noted in Table X below (with information from Table 3a in Appendix A), five of the ten CMHCs currently report penetration rates lower than the CMHA requirement. This is consistent with data from the previous reporting period, during which five CMHC regions reported being below the state standard of 18.6% penetration

While the State continues to meet the statewide standard for SE penetration in the CMHA, this is primarily due to strong SE penetration rates in three CMHC Regions (Manchester (31.8%), Seacoast (46.3%), and Community Partners (70.6%). The ER is increasingly concerned that Target Population members in large portions of New Hampshire do not have adequate or equitable access to this essential best practice service.

Table X

Self-Reported CMHC SE Penetration Rates

March 2020 through June 2022

	Penet. Mar-20	Penet. Jun-21	Penet. Dec-21	Penet. Mar-22	Penet. Jun-22
Northern	12.00%	11.90%	12.30%	11.10%	10.50%
West Central	18.60%	17.20%	15.50%	15.30%	18.30%
Lakes Reg.	39.00%	38.20%	30.10%	20.50%	17.20%
Riverbend	13.60%	13.50%	12.70%	12.30%	12.00%
Monadnock	4.20%	4.70%	5.80%	6.40%	5.30%
Greater Nashua	11.30%	14.40%	16.10%	17.60%	20.00%
Manchester	40.60%	37.60%	36.00%	33.30%	31.80%
Seacoast	39.50%	45.30%	49.20%	49.40%	46.30%
Community Part.	13.00%	13.40%	70.10%	70.50%	70.60%
CLM	15.70%	17.80%	20.20%	19.50%	19.20%
CMHA Target	18.60%	18.60%	18.60%	18.60%	18.60%
Statewide Ave.	24.20%	25.30%	27.40%	25.9%	25.30%

The State reports data on the degree to which CMHC clients are working, either full or part time, in competitive employment.[14] Access to competitive employment is an important indicator of the quality and effectiveness of fidelity model SE services. Table XI summarizes some key findings from these data reporting efforts.

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

Table XI

Self-Reported Competitive Employment for CMHC Clients Who are Recent Users of SE Services

CMHC	Percent of SE Active Clients Employed Full or Part Time July – Sept 2020	Percent of SE Active Clients Employed Full or Part Time Oct. – Dec. 2020	Percent of SE Active Clients Employed Full or Part Time Jan. – Mar. 2021	Percent of SE Active Clients Employed Full or Part Time April - June 2021	Percent of SE Active Clients Employed Full or Part Time Jan-Mar 2022	Percent of SE Active Clients Employed Full or Part Time Apr-June 2022
Northern	36.4%	37.5%	19.0%	31.6%	40%	41.6%
WCBH	33.3%	33.3%	16.9%	33.3%	37.5%	63.6%
LRMHC	51.3%	57.2%	44.7%	100%	90.9%	84.6%
Riverbend	50.0%	50.0%	25.6%	61.2%	51.5%	63.6%
Monadnock	61.9%	83.3%	23.9%	100%	43.4%	57.9%
Nashua	42.3%	36.6%	25.3%	35.6%	29.4%	24.2%
MHCGM	60.5%	58.4%	28.0%	53.8%	54.2%	55.0%
Seacoast	31.5%	27.8%	29.2%	25.5%	32.6%	21.8%
Comm. Partners.	47.3%	40.7%	24.2%	30.8%	50.0%	44.4%
CLM	46.0%	51.1%	29.3%	51.8%	54.1%	57.8%
Statewide	47.9%	47.6%	27.7%	44.9%	48.0%	47.9%

This table includes data for 371 individuals who have received at least one billable SE service in each month of the quarter; there are 28/371 (7.5%) who are working full time and there are 150/371 (40.4%) who are working part time for a total employed of 178/371 (47.9%).

For all adult CMHC clients, 32.2% are also currently engaged in full-time or part-time employment statewide.[15]

One third (33.4%) of the smaller cohort (recent users of SE services) are unemployed and about one-fourth (24.9%) of the total eligible adult population are unemployed.

[15] The total eligible adult CMHC population is 12,337 individuals; there are 548 working full time and 2,311 working part time for a total employment percentage of 32.2%. Some individuals in this non-SE cohort could have participated in SE in the past, but are no longer actively enrolled or participating in SE.

The State reports that as of June 30, 2022, 36 individuals were waiting for SE services. Five individuals (or 13.9%) have been waiting for over a month. In the previous quarter (ending March 2022), 62 individuals were waiting for SE and 58.1% had been waiting for more than a month. The State is to be congratulated for substantially reducing the SE wait list and wait times.

SE Fidelity and Quality

As with ACT services, the limitations created by COVID-19 have prevented SE fidelity reviews from being conducted during much of the time frame covered by this report. The State has re-started on-site SE fidelity reviews as of July 2021. The ER recently observed an on-site SE fidelity review and found the process to be complete and thorough.

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

1. Indicator 9: Adequacy of employment treatment planning (Statewide average score of 77%; five of ten CMHCs below the performance threshold); and
2. Indicator 10: Adequacy of individual employment service delivery (Statewide average score of 74%; seven of ten CMHCs below the performance threshold).

As with the QSR findings related to ACT services, the ER remains concerned that in several regions of the State, target population members do not have access to an adequate supply of high quality employment services.

Supported Housing (SH)

Overview

The CMHA commits the State to achieve a capacity of 600 units of SH through a combination of: (1) the State-operated and -funded Bridge Subsidy Program; and (2) an array of Federal resources that includes both project-based and tenant-based housing subsidies. This overview section is intended to provide a general context for understanding how each set of resources contributes to meeting the SH requirements of the CMHA.

The Bridge Subsidy Program

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

- The State has committed sufficient funds to support a total of 500 Bridge Subsidy Program units, which exceeds the CMHA target by 50 units; In State Fiscal Year 2021, the State allocated new funds to the Bridge Subsidy Program and asserts that these funds will be sufficient to fund an additional 100 units. Access to these new Bridge Subsidies will be based on priorities established by Bridge Program regulations.

- Nonetheless, a total of only 280 individuals are currently occupying rental units subsidized by the Bridge Subsidy Program;
- An additional 98 individuals have been approved for a Bridge Subsidy: of these 80 (81.6%) are currently seeking appropriate housing; and 18 (18.4%) are not currently seeking housing; so, 360 individuals are already in or are on an active path to Bridge Subsidy supported housing;
- Seven individuals are reported to be on the Bridge Subsidy wait list – six of these have been waiting for 60 days or fewer;
- The State has asserted that it gives priority to individuals on the Bridge Subsidy wait list for access to available Bridge Subsidies; and
- A cumulative total of 298 individuals are reported to have converted from Bridge Subsidies to the Federal Housing Choice Voucher Program. This is an intended outcome of the Bridge Subsidy Program, in that it provides permanent Federal housing subsidies for these individuals, and allows additional people to be served by the Bridge Program. However, because the State only tracks Federal housing subsidy recipients for one year, it cannot be determined how many of these 298 individuals are still receiving a Federal housing subsidy and/or SH services. For example, in July 2020, the State reported that only about 75 individuals were then currently known to be receiving a Federal Subsidy. It is important to only count current supported housing recipients (i.e. both State and Federal subsidies currently tracked) as the CMHA requires that the State "will have [X] supported housing units" in its system at any given time.

Bridge Subsidy Program Information

As of June 2022, the State reports having 280 individuals leased in Bridge Subsidy Program units and 80 people approved for the Bridge Subsidy Program and looking for a lease, but not yet leased. It remains true that there has been a substantial drop in the aggregate number of individuals either leased or approved and looking, but not yet leased, in the Bridge Subsidy Program – from a high of 591 in June of 2017, to the current number of 360 individuals – a drop of almost 40%.

As referenced, there are seven individuals reported to be on the Bridge Subsidy Program wait list as of the end of June 2022. Of these, one individual has been on the wait list for more than two months. Given that there are at least 500 funded Bridge vouchers and only 378 Bridge vouchers already committed, leaving 122 available Bridge slots, it is unclear how anyone can be on a waitlist for a Bridge subsidy.

Table XII below provides data regarding the number of current Bridge Subsidy Program participants in leased units; the number who have received Bridge Subsidies and are seeking appropriate units to lease; and the number on the Bridge Subsidy Program waiting list. Table XIII provides quarterly data regarding the number of Bridge Subsidy program applications and

terminations. Table XIV presents information on the reasons that program participants have exited the program. Table XV provides information on unit density.

It is important to note that over the past 12-18 months, it has become more difficult to lease units with Federal and State subsidy programs due to substantial increases in rental housing costs and subsidy amount limitations. These rental market factors recently prompted HUD to issue substantially revised Fair Market Rents (FMRs) (see HUD Notice No.22-161), which nationally will increase FMRs by an average of approximately 10 percent. Hopefully, new FMRs for New Hampshire will make it easier for individuals to locate units that meet the program's rental subsidy guidelines.

Table XII

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

March 2020 through June 2022

Bridge Subsidy Program Information	Mar. 2020	June 2020	Sept. 2020	Dec. 2020	March 2021	June 2021	Dec. 2021	March 2022	June 2022
Total individuals leased in the Bridge Subsidy Program	327	328	312	300	306	271	246	266	280
Individuals approved for Bridge in process of leasing	94	79	96	96	104	50	79	66	80
Individuals on the wait list for a Bridge Subsidy[16]	49	39	85	28	41	21	0	2	7
Cumulative historical number transitioned from Bridge to a Federal HUD Housing Choice Voucher (HCV)	179	192	198	212	233[17]	266	286	295	298

[16] The State did not maintain a waitlist prior to 2018.
[17] State data at the time indicated that only 75 individuals currently had HCV subsidies.

Table XIII

Self-Reported Housing Bridge Subsidy Program Applications and Terminations

Measure	**April – June 2020**	**July-Sept. 2020**	**Oct. – Dec. 2020**	**Jan. – Mar. 2021**	**April –June 2021**	**Oct. – Dec. 2021**	**Jan. – Mar. 2022**	**Apr. – June 2022**
Applications Received	30	57	25	41	36	23	48	53
Point of Contact CMHCS NHH Other	 29 29 1	50 6 1	22 3	38 2 1	29 4 3	16 7 0	41 7 0	46 6 1[18]
Applications Approved	27	57	25	41	36	23	48	53
Applications Denied	0	0	0	0	0	0	0	0
Denial Reasons	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
Applications in Process at end of period	41	0	0	0	0	0	0	0

[18] Application source was Glencliff.

Table XIV

Self-Reported Exits from the Housing Bridge Subsidy Program

December 2020 through June 2022

Type and Reason	Oct. – Dec. 2020	Jan. – Mar. 2021	Apr. – June 2021	Oct.-Dec. 2021	Jan– Mar. 2022	April – June 2022
DHHS Initiated Terminations						
Failure to pay rent or ineligible	0	0	0	1	2	35
Client Related Activity						
HUD Voucher Received	26	24	33	11	10	3
Deceased	5	1	2	6	1	1
Over Income	0	0	4	0	1	0
Moved out of State	1	0	0	3	3	0
Declined Subsidy at Recertification	7	5	11	15	8	8
Higher level of care accessed	3	0	11	4	12	6
Other Subsidy provided	0	0	4	9	3	5
Moved in with Family	2	3	1	7	4	0
Other	2	0	4	3	0	0
Total	46	33	70	31	44	26

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 XV (with data from Table 9 in Appendix A) below displays the reported number of units leased at the same address.

Table XV

Self-Reported Bridge Subsidy Program Concentration (Density)

	Dec. 2020	**March 2021**	**June 2021**	**Dec. 2021**	**Mar. 2022**	**Jun. 2022**
Number of properties with one leased SH unit at the same address	242	234	206	213	200	217
Number of properties with two SH units at the same address	18	22	15	15	19	20
Number of properties with three SH units at the same address	3	4	6	5	8	5
Number of properties with four SH units at the same address	0	1	0	2	1	2
Number of properties with five SH units at the same address	0	1	1	0	0	0
Number of properties with six SH units at the same address	1	0	2	0	0	0
Number of properties with seven SH units at same address	1	1	0	0	0	0

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

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

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

Table XVI

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

	As of 12/31/20	As of 3/31/2021	As of 6/30/2021	As of 3/31/2022	As of 6/30/2022
Housing Bridge Tenants Linked to Mental Health Services	356 of 396 (90%)	375 of 410 (91.5%)	326 of 365[19] (89.3%)	330 of 360 (91.7%)	357 of 381 (93.7%)

These data document the degree to which Bridge Subsidy Program participants are actually receiving certain mental health services and supports.[20]

Federal SH Resources Dedicated to the Target Population

As noted in the overview section above, the CMHA states that: "By June 30, 2017 the State will make all reasonable efforts to apply for and obtain federal Department of Housing and Urban Development (HUD) funding for an additional 150 supported housing units for a total of 600 supported housing units." (CMHA V.E.3(e)). As of the end of June 2022, the State reports that it has been awarded dedicated HUD SH funding for a total of 265 SH units from two distinct HUD SH programs. Currently a total of 214 SH units/tenant based subsidies are being utilized by individuals in the Target Population, as described below:

- The State has successfully applied for and been awarded a total of 191 units of Department of Housing and Urban Development (HUD) Section 811 project-based Permanent Rental Assistance (PRA) dedicated to the Target Population. As of the date of this report, 139 individuals have occupied units funded through this Federal program;
- The State was also successful in being awarded 340[21] units of Section 811 Mainstream tenant-based vouchers for Persons with Disabilities. Of this number,

[19] This number includes some individuals who were in the Bridge Program at the beginning of the quarter but who now have by the end of the quarter transitioned to a Federal subsidy or otherwise left the Bridge Program.
[20] Some of these tenants might be receiving services from MH providers other than a CMHC.
[21] As of January 1, 2022.

74 are specifically set-aside for the Target Population. As of the date of this report, 75 individuals in the Target Population have received these tenant-based subsidies.

The SH Wait List

The CMHA states that "By January 1, 2017, the State will identify and maintain a waitlist of all individuals within the Target Population requiring SH services, and whenever there are 25 individuals on the waitlist, each of whom has been on the waitlist for more than two months, the State will add program capacity on an ongoing basis sufficient to ensure that no individual waits longer than six months for supported housing." (V.E.3(f)). As referenced above, as of June 30, 2022, there were currently reported to be seven individuals on the wait list for the Bridge Subsidy Program; one of these individuals has been on the wait list for more than two months. The State will continue to manage access of wait list individuals to new Bridge Subsidies in accordance with priorities established by Bridge Program regulations.

Transitions from Institutional to Community Settings

During the past seven and one-half years, the ER has visited both Glencliff and NHH on at least 14 separate occasions to meet with staff engaged in transition planning. The ER has also participated in six meetings of the Central Team. The CMHA required the State to create a Central Team to overcome barriers to discharge from institutional settings to community settings.

In March 2022, the State decided to concentrate the efforts of the Central Team on residents of Glencliff and individuals at NHH awaiting placement at Glencliff. In the six months between March and September 2022, the Central Team has worked with a total of 20 individuals: ten from Glencliff and ten from NHH. Eight of the ten NHH referrals to the Central Team were already on the wait list for Glencliff.

Of the 20 total referrals, a residential placement is undetermined and still pending for 11 individuals. For the nine individuals for whom a disposition is known, three are slated for independent apartments, four are slated for transitional housing, and one is slated for an adult living facility. For five of these nine individuals, the transition has already been effectuated.

Table XVII below summarizes the discharge barriers that have been identified by the Central Team with regard to these 20 individuals. Note that most individuals encounter multiple discharge barriers, resulting in a total higher than the number of individuals reviewed by the Central Team.

Table XVII

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

September 2022

Discharge Barriers	Number for Glencliff	Number for NHH
Legal	1(5.0%)	1(5.0%)
Residential	3(15.0%)	0(0.0%)
Financial	0(0.0%)	0(0.0%)
Clinical	4(20.0%)	9(45.0%)
Family/Guardian	1(5.0%)	0(0.0%)

It is notable that clinical issues continue to be the leading discharge barriers for both Glencliff and NHH, highlighting the need to increase the supply of integrated community settings linked with a variety of clinical services and supports prioritized for these individuals.

Glencliff

In April to June 2022 , Glencliff admitted four individuals and had two discharges (both to nursing facilities) and four deaths. The average daily census as of the date of the State's latest quarterly report was 69 people. There were reported to be 35 individuals on the wait list for admission to Glencliff.

Previous Expert Reviewer reports have identified that the State has had difficulty assuring full compliance with certain provisions CMHA, including those provisions related to the transition of individuals from Glencliff and the development of community residential service capacity described in CMHA §§ V.E.2 and VI.A.

On November 22, 2021, per CMHA § X.C., the Plaintiffs and the United States served the State with a Notice of Noncompliance ("Notice") referencing these provisions of the Settlement Agreement. Consistent with Section X.C.3 of the Settlement Agreement, the State sent the Plaintiffs a written response to the Notice on December 20, 2021. After further discussion, and on advice from the ER, the Parties agreed to enter into mediated discussions to resolve the issues raised in the Notice. Don Shumway, the highly respected former Commissioner of Human Services in New Hampshire, was invited to participate in and facilitate these discussions.

Between May and November, 2022, the Parties, Mr. Shumway, and the ER met – mostly face-to-face – to reach agreement on potential solutions to the disputed issues. Between meetings the Parties exchanged information and proposals for solutions.

The ER understands that in late December, 2022, the Parties reached preliminary agreement on a proposed modification to the relevant portions of the Settlement Agreement. The ER expects that these modifications soon will be submitted to the Court for final approval and incorporation into the Settlement Agreement. The Parties are confident that these modifications, if finalized and then implemented, will substantially improve opportunities for informed transition planning and access to integrated community settings for people residing at Glencliff or on the wait list for Glencliff. The ER concurs with the modifications, and applauds the good faith efforts of the Parties to reach this preliminary agreement.

Once the Court has approved the above-descried modification to the CMHA, the ER will work with the Parties to develop a detailed monitoring plan to focus on both the implementation of, and the results derived, from this modification.

The ER notes that the State has approved a new contract with the National Alliance on Mental Illness (NAMI) New Hampshire to provide in-reach services for Glencliff residents consistent with the CMHA. This contract was awarded on June 15, 2022, and in-reach services at Glencliff began in October, 2022.

State Information on In-Reach Activities

The last State report related to in-reach services at Glencliff covers the period from January 2021 through June 2022. After that time, the existing In-Reach Coordinator resigned to take a new position, and the vendor for the service (Northern Human Services) was unable to recruit a replacement. As noted above, effective June 15, 2022, the State has awarded a new In-Reach contract to NAMI of New Hampshire and in-reach activities began at Glencliff in October, 2022. Thus, for this ER report period, Table XVIII has been left blank.

Table XVIII

State Self-Reported Performance Information for Glencliff In-Reach Services

Performance Measure				
Attend service array and supports group presentations				
Meet with In-Reach Coordinator regarding individual needs and service arrays				

Participate in shared learning regarding integrated community living				
Meet with In-Reach Coordinator regarding community-based living				
Participate in specific transition discussions with In-Reach Coordinator				
Participate in meetings with In-Reach Coordinator and others regarding opportunities for community living				

Preadmission Screening and Resident Review (PASRR)

The State periodically provides data on PASRR Level II screens conducted in New Hampshire. Recent PASRR data are summarized in Table XIX below. A Level II screen is conducted if a PASRR Level I (initial) screen identifies the presence of mental illness, intellectual disability, or related conditions for which a nursing facility placement might not be appropriate. One objective of the Level II screening process is to seek alternatives to nursing facility care by diverting people to appropriate integrated community settings. Another objective is to identify the need for specialized facility-based services if individuals are deemed to need nursing facility level of care.

Table XIX

Self-Reported PASRR Level II Screens [22]

	April - June 2019	July - Sept 2019	April – June 2020	July – October 2020	April 2020– June 2021	July 2021 – June 2022
Full Approval - No Specialized Services	28.8%	31.0%	64.4%	61.3%	69.2%	75.5%
Full Approval with Specialized Services	28.8%	38.0%	0.0%	6.5%	3.1%	1.4%
Provisional – No Specialized Services	18.8%	19.7%	23.1%	0.0%	3.1%	19.6%
Provisional with Specialized Services	23.8%	11.3%	11.5%	32.3%	24.6%	1.4%
Total	100%	100%	100%	100%	100%	100%

The furthest right column of Table XIX contains data reflecting a full year of PASRR operations. For that year-long reporting period, the percentage of both full approvals and provisional approvals with specialized services has gone down. In the previous 12-month period (July 1, 2020 through June 30, 2021), the State reported that of 178 Level II PASRRs conducted, 27.7% resulted in specification of specialized services. For this period, only four of 143 PASRR screens (less than 3%) resulted in specifications for specialized services. Only one of the 142 PASRR screens indicated that Long Term Care (LTC) was not recommended.

The CMHA (IV.A.10) emphasizes efforts to address the needs of those "referred to Glencliff," so as to provide them with alternative services in an integrated community setting before they are admitted to a congregate setting like Glencliff. The State asserts that the PASRR contractor will consult with multi-disciplinary teams where appropriate to consider options for lower levels of care, such as engaging occupational therapists, daily living skill support staff, and service options through the CFI waiver. In addition, individuals admitted to Glencliff must have been turned down by at least two other facilities before being considered for admission. Clearly, interventions to divert individuals from Glencliff or other nursing facilities must be initiated before the PASRR screening process is conducted. PASRR is important to assure that people with mental illness, ID/DD, or related conditions are not inappropriately institutionalized or

[22] Until recently, the ER has not received PASRR data on a continuous basis. This explains the gaps in reporting periods in Table XIX. The furthest right-hand column contains data that incorporated data from two previous reporting periods.

placed in nursing facilities without access to necessary specialized services. However, PASRR is not by itself sufficient to divert people from nursing facility care.

New Hampshire Hospital and the Designated Receiving Facilities (DRFs)

For the time period April through June 2022, the State reports that NHH effectuated 210 admissions and 221 discharges. The mean daily census was 159, and the median length of stay for discharges was 41 days. Note that the mean daily census was 184 in the October – December 2021 time period; and was 168 in the January – March 2022 time period.

Table XX below (with data from Table 4b in Appendix A) compares NHH discharge destination information for the six most recent reporting periods.

Table XX

New Hampshire Hospital Self-Reported Data on

Discharge Destination

Discharge Destination	Percent October through Dec. 2020	Percent January through March 2021	Percent April through June 2021	Percent October – through Dec. 2021	Percent January through March 2022	Percent April through June 2022
Home – live alone or with others	69.1%	61.8%	60.9%	44.6%	44.8%	49.8%
Glencliff	0.52%	1.2%	0.38%	0	0	1.8%
Homeless Shelter/motel	6.3%	5.2%	3.76%	4.09%	7.8%	5.0%
Group home 5+/DDS supported living, peer support housing etc.	5.2%	5.2%	1.88%	3.72%	2.24%	2.3%
Jail/correc-tion	2.1%	2.3%	1.88%	1.9%	2.2%	1.4%
Nursing home/rehab facility	11.0%	10.4%	15.4%	5.95%	5.5%	10.4%
Other/un-known[23]	9.2%	13.9%	15.8%	38.14%	37.6%	29.4%

The ER is concerned that the proportion of discharge destinations listed as "other/unknown" has increased substantially in the three most recent reporting periods. At the same time, the

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

proportion discharged to home or family has decreased. The ER will work with the State to identify and correct issues with this reporting.

The State also reports information on the hospital-based Designated Receiving Facilities (DRFs) and the Cypress Center in New Hampshire. It is important to capture the DRF/Cypress Center data and analyze them in concert with NHH and Glencliff data to get a total institutional census across the state for people with serious mental illness. Table XXI (with data from Table 5a-5d in Appendix A) summarizes these data.

Table XXI

Self-Reported DRF/APRTP Utilization Data

January 2019 through June 2022

	Franklin	**Cypress**	**Portsmouth**	**Eliot Geriatric *Total Admissions***	**Eliot Pathways**	**Parkland**	**Total**
January - March 2019	126	182	349	56	123		836
April to June 2019	108	187	371	89	108		865
July to September 2019	104	194	391	52	95		836
October - December 2010	96	175	350	63	100		784
January - March 2020	114	186	333	52	105		790
April - June 2020	105	129	298	36	119		687
July - September 2020	116	159	348	51	121	54	849
October - December 2020	86	139	332	44	128	51	780
January - March 2021	76	156	324	34	156	202	948
April - June 2021	77	166	316	44	151	156	910
October - December 2021	69	133	318	42	140	7	709
January - March 2022	55	132	298	40	152	190	867
April - June 2022	76	138	321	24	155	184	898

	Franklin	**Cypress**	**Portsmouth**	**Eliot Geriatric *Percent Involuntary***	**Eliot Pathways**	**Parkland**	**Total**
January - March 2019	61.10%	20.90%	19.40%	7.90%	47.20%		27.30%
April to June 2019	43.30%	16.50%	25.10%	11.50%	55.80%		28.00%
July to September 2019	63.50%	23.40%	24.00%	7.90%	40.00%		29.50%

October - December 2010	53.50%	24.20%	21.00%	9.60%	40.00%		28.16%
January - March 2020	53.51%	24.19%	21.02%	9.62%	40.00%		28.16%
April - June 2020	44.76%	24.03%	25.84%	13.89%	42.90%		31.59%
July - September 2020	48.28%	39.00%	20.69%	21.56%	42.97%	100.00%	36.16%
October - December 2020	66.30%	28.10%	23.20%	27.30%	46.90%	100.00%	37.90%
January - March 2021	57.90%	23.70%	28.70%	14.70%	55.10%	27.20%	33.80%
April - June 2021	44.16%	25.30%	20.25%	18.18%	43.04%	25.64%	27.80%
October - December 2021	60.90%	21.80%	28.30%	9.50%	39.30%	42.90%	31.50%
January - March 2022	50.90%	28.80%	22.50%	2.50%	41.45%	21.58%	27.50%
April - June 2022	51.30%	18.80%	28.70%	0.00%	33.54%	25.00%	28.40%

	Franklin	**Cypress**	**Portsmouth**	**Eliot Geriatric *Average Census***	**Eliot Pathways**	**Parkland**	**Total**
January - March 2019	8.4	11.5	29.7	27	12.1		88.7
April to June 2019	9.4	12.2	24.1	24.1	12		81.8
July to September 2019	10.6	13.4	31.8	23.7	9.5		89
October - December 2010	10.6	13.7	29.2	20.5	12		86
January - March 2020	10.6	13.7	29.2	20.5	12		86
April - June 2020	8.5	11.1	24.8	11.9	11.9		70.9
July - September 2020	9.7	13.4	27.7	14.1	13	3.4	81.3
October - December 2020	9	13.5	28.7	17.4	12.7	4.2	85.5
January - March 2021	7.7	13.7	30.3	18.6	14.1	15.5	99.9
April - June 2021	7.5	13.0	27.9	18.4	13.0	12.2	91.9
October - December 2021	6.5	10.5	29.7	16.7	11.8	1.3	76.5
January - March 2022	6.3	11.1	26.6	20.7	14.2	11.8	90.6
April - June 2022	7.3	11.0	27.9	11.4	14.0	13.0	84.6

	Franklin	**Cypress**	**Portsmouth**	**Eliot Geriatric *Discharges***	**Eliot Pathways**	**Parkland**	**Total**
January - March 2019	108	193	368	55	111		835
April to June 2019	101	192	386	54	97		830
July to September 2019	102	198	353	60	123		836
October - December 2010	110	207	327	71	119		834
January - March 2020	110	207	327	71	119		834

April - June 2020	101	131	294	51	117		694
July - September 2020	117	164	324	41	121	48	815
October - December 2020	92	141	335	48	130	50	796
January - March 2021	76	152	323	28	155	192	926
April - June 2021	77	163	311	44	150	149	894
October - December 2021	69	134	318	36	139	13	709
January - March 2022	55	130	291	38	157	178	849
April - June 2022	72	140	320	28	158	186	904

	Franklin	**Cypress**	**Portsmouth**	**Eliot Geriatric**	**Eliot Pathways**	**Parkland**	**Total**
				Mean LOS for Discharges			
January - March 2019	5	3	5	18	7		5
April to June 2019	6	4	6	26	8		6
July to September 2019	7	5	6	25	7		7
October - December 2020	6	5	6	20	8		6
January - March 2020	6	5	6	20	8		6
April - June 2020	6	6	6	27	8		7
July - September 2020	6	7	6	18	8	5	7
October - December 2020	7	7	6	23	7	6	7
January - March 2021	8	6	6	27	7	5	6
April - June 2021	7	6	7	29	7	5	7
October - December 2021	7	5	6	30	6	7	6
January - March 2022	8	6	7	32	7	5	7
April - June 2022	7	6	6	25	6	5	6

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

DHHS tracks and reports discharge dispositions for people admitted to the DRFs and Cypress Center. Table XXII (with data from Table 5e in Appendix A) below provides a summary of these recently reported data.

Table XXII

Self-Reported Discharge Dispositions for DRFs in New Hampshire

April through June 2022

Disposition	Frank-lin	Cy-press	Ports-mouth	Elliot Geria-tric	Elliot Path-ways	Park-land	Total	Per-cent
Home	68	140	287	6	144	177	822	90.9%
NHH	0	0	3	0	1	0	4	0.44%
Residential Facility/ Assisted Living	1	0	9	19	0	0	29	3.2%
DRF[24]	0	0	0	0	0	0	0	0.0%
Hospital	0	0	10	1	2	4	17	1.9%
Death	0	0	0	2	0	0	2	0.22%
Other or Unknown	3	0	11	0	11	5	30	3.32%

Based on these self-reported data, over 90% of recent discharges from DRFs and the Cypress Center are to home, as opposed to the 49.8% discharges to home reported by NHH. It should be noted that discharges to hotels/motels or shelters are not specifically identified in the reported DRF data. Rather, these are included in the "Other" category. Thus, it is not possible to analyze whether the percentage of discharges to hotels/motels and shelters has increased during COVID. For NHH, discharges to hotels/motels and shelters have been variable over the past two years, averaging less than five percent. Note that as a group, the DRFs and Cypress Center have reduced the proportion of discharge destinations listed as "other/unknown." This is in contrast to the reverse trend at NHH.

Hospital Readmissions

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

Table XXIII

Self-Reported Readmission Rates for NHH and the DRFs

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

July 2017 through June 2022

	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%
1/2020 to 3/2020	6.6%	12.4%	21.1%
4/2020 to 6/2020	9.7%	14.7%	20.0%
7/2020 to 9/2020	6.1%	12.7%	16.4%
10/2020 to 12/2020	4.8%	12.3%	18.2%
1/2021 to 3/2021	3.0%	8.5%	13.3%
4/2021 to 6/2021	6.6%	11.9%	16.8%
10/2021 to 12/2021	6.8%	15.5%	20.3%
1/2022 to 3/2022	7.6%	11.6%	19.8%
4/2022 to 6/2022	10.5%	15.7%	21.4%

	Percent 30 Days	Percent 90 Days	Percent 180 Days
Franklin			
7 to 9/2017	NA	NA	NA
10 to 12/2107	10.2%	10.2%	10.2%
1 to 3/2018	0.0%	0.0%	1.9%
4/2018 to 6/2018	4.3%	5.8%	5.8%
7/2018 to 9/2018	6.0%	9.0%	16.4%
10/2018 to 12/2018	2.3%	4.6%	5.7%
1/2019 to 3/2019	7.9%	10.3%	10.3%
4/2109 to 6/2019	6.5%	9.3%	12.0%
7/2019 to 9/2019	1.9%	6.7%	9.6%
1/2020 to 3/2020	3.5%	6.1%	7.8%
4/2020 to 5/2020	3.8%	4.7%	4.7%
7/2020 to 9/2020	2.5%	5.0%	5.9%

10/2020 to 12/2020	6.7%	11.2%	14.6%
1/2021 to 3/2021	6.6%	6.6%	7.9%
4/2021 to 6/2021	2.6%	7.8%	9.1%
10/2021 to 12/2021	4.3%	4.3%	7.2%
1/2022 to 3/2022	1.8%	7.3%	10.9%
4/2022 to 5/2022	1.8%	3.6%	7.3%

	Percent 30 Days	**Percent 90 Days**	**Percent 180 Days**
Manchester (Cypress)			
1 to 3/2018	4.20%	9.60%	15.80%
4/2018 to 6/2018	4.50%	8.20%	11.90%
7/2018 to 9/2018	8.50%	13.90%	18.90%
10/2018 to 12/2018	7.10%	11.10%	15.20%
1/2019 to 3/2019	5.50%	14.80%	17.60%
4/2109 to 6/2019	9.90%	15.10%	20.80%
7/2019 to 9/2019	6.60%	9.20%	12.80%
1/2020 to 3/2020	3.50%	5.00%	8.50%
4/2020 to 6/2020	5.20%	11.90%	18.70%
7/2020 to 9/2020	3.10%	6.30%	7.50%
10/2020 to 12/2020	4.3%	7.9%	12.9%
1/2021 to 3/2021	5.8%	7.7%	10.9%
4/2021 to 6/2021	9.6%	11.4%	12.7%
10/2021 to 12/2021	4.5%	9.0%	9.8%
1/2022 to 3/2022	3.0%	6.1%	9.8%
4/2022 to 5/2022	3.8%	6.1%	10.6%

	Percent 30 Days	**Percent 90 Days**	**Percent 180 Days**
Portsmouth			
1 to 3/2018	8.80%	15.50%	20.60%
4/2018 to 6/2018	10.20%	15.90%	21.90%
7/2018 to 9/2018	8.40%	12.90%	19.00%
10/2018 to 12/2018	7.70%	14.90%	20.30%
1/2019 to 3/2019	12.90%	19.50%	23.50%
4/2109 to 6/2019	10.50%	17.80%	22.40%
7/2019 to 9/2019	8.20%	12.00%	12.00%
1/2020 to 3/2020	9.70%	29.20%	23.00%

4/2020 to 6/2020	7.30%	15.00%	23.60%
7/2020 to 9/2020	14.10%	21.80%	24.70%
10/2020 to 12/2020	9.3%	15.6%	20.7%
1/2021 to 3/2021	8.0%	13.2%	18.5%
4/2021 to 6/2021	7.6%	14.9%	18.4%
10/2021 to 12/2021	10.1%	18.6%	22.0%
1/2022 to 3/2022	9.1%	16.4%	20.1%
4/2022 to 5/2022	7.4%	13.1%	18.5%

	Percent 30 Days	**Percent 90 Days**	**Percent 180 Days**
Elliot Geriatric			
1 to 3/2018	NA	NA	NA
4/2018 to 6/2018	3.80%	6.70%	8.60%
7/2018 to 9/2018	7.00%	11.50%	16.10%
10/2018 to 12/2018	2.80%	5.60%	9.70%
1/2019 to 3/2019	4.90%	5.70%	7.30%
4/2109 to 6/2019	5.50%	5.50%	5.50%
7/2019 to 9/2019	2.10%	5.20%	6.30%
1/2020 to 3/2020	9.70%	14.20%	15.90%
4/2020 to 6/2020	3.30%	3.30%	4.20%
7/2020 to 9/2020	6.60%	8.30%	9.10%
10/2020 to 12/2020	9.1%	13.6%	15.9%
1/2021 to 3/2021	2.9%	5.9%	5.9%
4/2021 to 6/2021	6.8%	9.1%	13.6%
10/2021 to 12/2021	11.9%	11.9%	14.3%
1/2022 to 3/2022	5.0%	7.5%	7.5%
4/2022 to 5/2022	0.0%	0.0%	5.0%

	Percent 30 Days	**Percent 90 Days**	**Percent 180 Days**
Elliot Pathways			
10/2018 to 12/2018	6.30%	7.80%	9.40%
1/2019 to 3/2019	5.40%	5.40%	5.40%
4/2109 to 6/2019	10.10%	12.40%	14.60%
7/2019 to 9/2019	7.70%	9.60%	13.50%
1/2020 to 3/2020	9.40%	11.30%	18.90%
4/2020 to 6/2020	9.80%	9.80%	9.80%

7/2020 to 9/2020	2.00%	7.80%	7.80%
10/2020 to 12/2020	6.3%	12.5%	14.1%
1/2021 to 3/2021	5.1%	10.9%	13.5%
4/2021 to 6/2021	6.6%	9.9%	11.9%
10/2021 to 12/2021	2.9%	10.0%	12.9%
1/2022 to 3/2022	7.2%	9.9%	11.8%
4/2022 to 5/2022	6.6%	11.2%	15.8%

	Percent 30 Days	**Percent 90 Days**	**Percent 180 Days**
Parkland Regional			
10/2020 to 12/2020	7.8%	9.8%	9.8%
1/2021 to 3/2021	5.9%	7.4%	8.4%
4./2021 to 6/2021	3.2%	6.4%	8.3%
10/2021 to 12/2021	0.0%	0.0%	0.0%
1/2022 to 3/2022	3.2%	3.7%	5.8%
4/2022 to 5/2022	8.9%	13.7%	14.7%

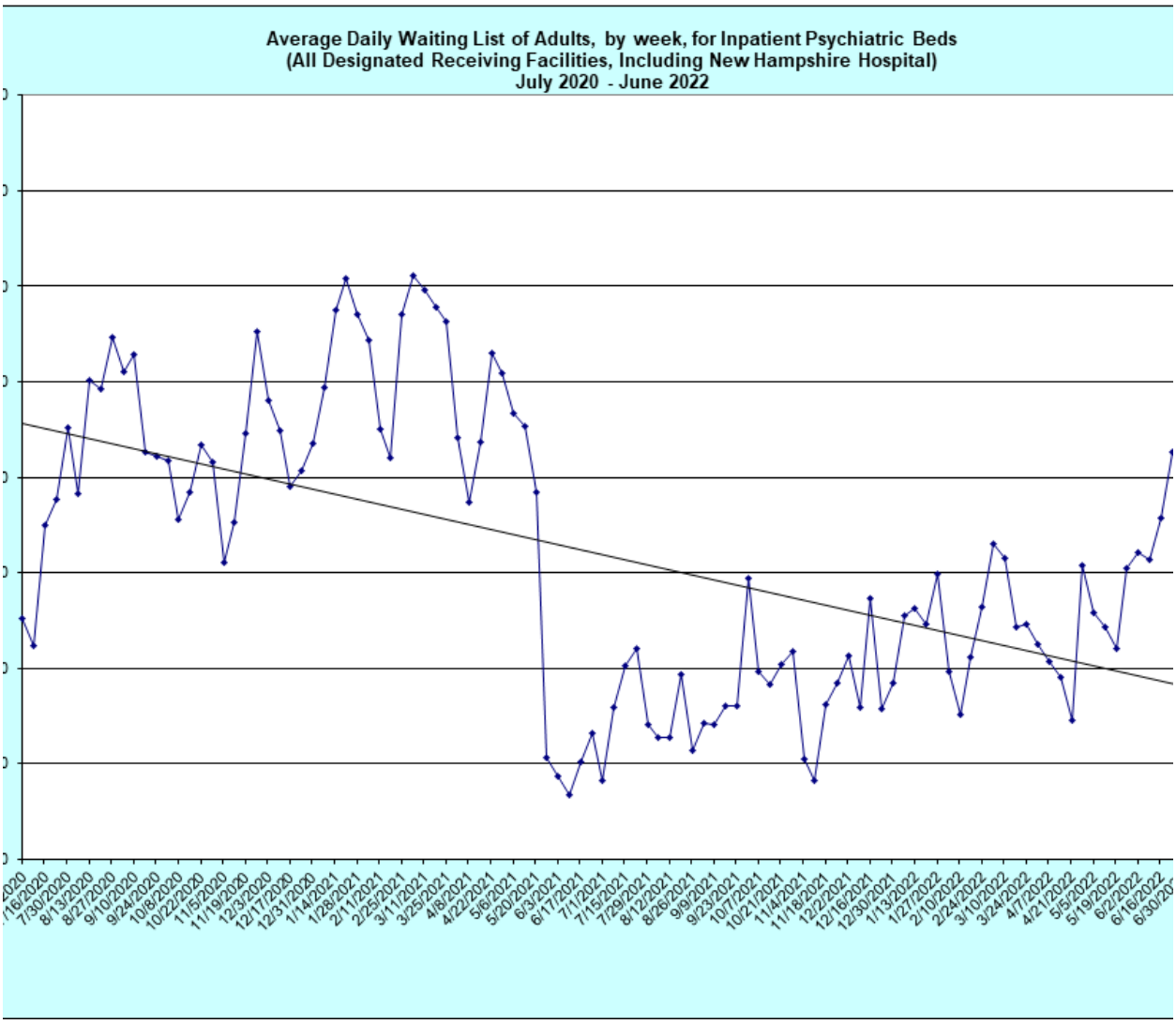
The ER notes that re-admission rates to NHH, particularly those within 90 and 180 days, had generally been declining since March of 2018, but have increased in the latest reported quarter. In the most recent Quarterly Report, it can been seen that 21.4% of discharged individuals[25] had been readmitted to NHH within 180 days. This readmission rate is substantially higher than the recent readmission rates of the DRFs and the Cypress Center, which is currently at 14.6% readmitted within 180 days. In the same time period, only 19 individuals were newly enrolled in ACT services upon discharge from NHH. The ER continues to believe that staffed, but unutilized ACT capacity is a valuable resource that, if utilized, could help reduce readmission rates from NHH.

Hospital ED Waiting List

The following chart displays information on the average daily waiting list of adults for inpatient psychiatric beds in New Hampshire.

[25] This could be a duplicated count, and some individuals might have been admitted and discharged multiple times within the reporting period.

Chart A



In 2021 DHHS implemented a number of institutional initiatives designed to substantially reduce the number of individuals and the elapsed time waiting in hospital emergency departments (EDs) for acute inpatient psychiatric beds. One such initiative was designed to free up admission beds at NHH and Glencliff by making incentive payments to nursing and assisted living facilities to admit patients from NHH and Glencliff to their facilities. The State has reported verbally that a total of 35 – 37 individuals were transitioned to nursing or assisted living facilities from NHH and Glencliff under this program. The State had previously added adult acute beds at NHH, opened new psychiatric beds at Parkland Hospital, and added at least 13 beds to transitional

housing facilities with plans to add dozens more. The initial effect of these initiatives has been to reduce the number of individuals waiting in EDs for psychiatric hospital admissions.

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

Family and Peer Supports

Family Supports

Per the CMHA, the State has maintained its contract with NAMI New Hampshire for family support services.

Peer Support Agencies

DHHS reports having 14 peer support agency program (PSA) sites, with at least one program site in each of the ten regions. The State continues to report that all peer support centers meet the CMHA requirement to be open 44 hours per week. As of June 2022, the State reports that those sites have a cumulative total of 1,840 members, with an average daily participation rate of 152 people statewide.

III. Quality Assurance Systems

As noted earlier in this report, the State and the Dartmouth fidelity team has re-started the on-site comprehensive fidelity review process. The ER was able to observe an ACT fidelity review in Nashua, and an SE fidelity review in Concord during this reporting period. Both reviews appeared to be thorough and effective, even though some interviews with staff and service participants continue to be conducted by phone or ZOOM because of COVID restrictions. However, detailed findings from these fidelity reviews have not yet been shared with the Plaintiffs. Nor has the State resumed reporting of the review's scoring process and outcomes. Both pieces of information will be important in determining whether and to what extent supported employment and ACT services are being delivered consistent with design components and fidelity standards set out in the CMHA.

As with the previous reporting period, the State has been successful in conducting QSRs for all ten CMHCs for State Fiscal Year 2022. A summary tabulation of the results of these QSR activities is included as Appendix B of this report. Due to COVID, the ER has not been able to directly observe QSR CMHC reviews during this current reporting period.

For the most recent set of QSR reviews (State Fiscal Years 2020, 2021 and 2022), the State has increased the performance threshold from 70% to 80% for each indicator and for overall average performance. CMHCs scoring less than 80% on any indicator must submit a quality improvement plan (QIP), the implementation of which is monitored by the State. QIPs are also used to prioritize technical assistance and coaching efforts designed to assist CMHCs to improve performance. The ER also monitors implementation of the QIPs through interviews with both State and CMHC staff.

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

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

1. Indicator 9: adequacy of employment treatment planning (five of 10 CMHCs below 80%; system wide average 77%);
2. Indicator 10: adequacy of employment service delivery (seven of 10 CMHCs below 80%; system-wide average 74%);
3. Indicator 15: comprehensive crisis services: (six of 10 CMHCs below 80%; system-wide average 79%); and
4. Indicator 17: implementation of ACT services (seven of 10 CMHCs below the 80%; system-wide average 73%).

In the case of Indicator 17, implementation of ACT services, individual CMHC and statewide performance has been reduced substantially from 2021 to 2022.

The four indicators listed above relate directly to remedial services specified in the CMHA (SE, Crisis Services, and ACT). The ER is concerned that quality scores remain low for three of these key indicators and is particularly concerned that quality scores for the implementation of ACT services have fallen below the minimum performance threshold.

The ER notes that performance below the 80% QSR performance threshold is not, by itself, evidence of non-compliance with the CMHA. However, QSR performance scores do provide a clear indication of: (1) whether specific remedial services are being delivered consistent with CMHA requirements; and (2) whether the purpose and objectives of the CMHA are being realized. Currently, the CMHC system continues to demonstrate need for improvement in domains directly related to, and required by the CMHA, including key design components and service standards for supported employment, ACT, and crisis services set out in Section V.

IV. Additional Recent Initiatives

The ER recognizes that implementation of CMHA-specified initiatives and requirements does not take place in a vacuum. In the past two years, and in the context of its Ten-Year Mental Health Plan, the State has undertaken initiatives intended to improve services for people with mental illness. Some individuals served through these initiatives may be, or become, members of the CMHA target population. Because these initiatives are not directly part of the CMHA, and may or may not affect the State's compliance with the CMHA, the ER has thus far not received performance or quality information about the newly developed services. As a result, it is not possible to comment here on the merits of these Ten-Year Plan initiatives. For informational purposes the ER has asked the State to provide brief summaries of the status of each of these initiatives. The State's response is reproduced below.

1. "Transforming crisis services to engage people early and divert individuals from entering inpatient settings through development of a statewide call/text/chat center and expansion of statewide mobile crisis response services.

New Hampshire Rapid Response launched statewide on January 1, 2022. New Hampshire Rapid Response is the statewide, integrated crisis response model that aligns with the national best practices of Crisis Now and is comprised of a 24/7 centralized access point, mobile response teams in each of the 10 Mental Health Regions that are available to deploy within one-hour, and office-based follow-up appointments.

A core goal of the State's 10-Year Mental Health Plan was to expand crisis intervention services and supports from 3 Mental Health Regions to all 10 and to improve access to care by implementing a centralized access point. Through a two-year stakeholder engaged process, the State transformed its mobile crisis services to be both statewide and integrated, by adding 7 additional crisis response team, serving adults as well as children, and covering both mental health and substance use disorders. This transformation also included the development of a single, statewide crisis access point, known as the Rapid Response Access Point, that serves as the state's centralized crisis call center and that provides 24/7 phone/text/chat based assessment, brief interventions, deployment of regional mobile response teams, and follow-up appointments and/or contacts. The vision of this expansion was to align with the national 9-8-8 and Crisis Now models and is being implemented in a step-approach to include the full continuum of call/text/chat, mobile crisis response, and eventually more robust location-based crisis services."

2. "Roll-out of the evidence-based practice of Critical Time Intervention (CTI) in four regions of the state.

Critical Time Intervention (CTI) is a well-researched and cost-effective, evidence-based practice that offers highly specialized interventions to individuals at critical times of transition and typically bridges the gap from institutional to community-based care. CTI is a time-limited process that has a duration of up to approximately nine (9) months. Interventions are provided to support an individual's focus on a limited, manageable number of goals while they are in the process of connecting to formal and informal community supports.

Designated Receiving Facilities (DRFs) refer individuals to the CTI program prior to discharge. The CTI program aims to reintegrate individuals into their community by facilitating connections with services and supports, with the goal of reducing hospital readmission rates. In September 2021, the Department contracted with Plymouth State University to support the statewide implementation of the CTI model in all 10 Community Mental Health Centers (CMHCs). As of September 2022, nine of the ten CMHCs have launched the CTI program and enrolled 146 individuals. The remaining CMHC is currently hiring its CTI team."

3. "Provision of state funds to each of the 10 CMHCs to support development of six new residential beds per CMHC, in an effort to expand the continuum of housing options for the target population. The State has acknowledged that these may or may not be in integrated community settings.

Numerous efforts are underway in the State to strengthen affordable and supportive housing opportunities for adults and families affected by mental illness, with an increase of over 300 beds between SFY 2019 (695 beds) and SFY 2022 (1007 beds) across a variety of models: transitional housing; peer operated housing; housing voucher programs; permanent voucher programs; and CMHC-contracted housing.

One key initiative has been the development of 60 new supported housing beds through the community mental health centers (CMHCs). CMHC contracts for SFY 2022 included provisions to expand housing by six (6) beds in each of the 10 Mental Health Regions. Twenty of these 60 beds are already operational, utilizing a variety of support models including on-site clinical and/or peer staff.

The Department's Integrative Housing Voucher Program provides a housing voucher and support for individuals with SMI or SPMI and a criminal background that may make it impossible for them to qualify for traditional housing voucher programs. The Integrative Housing Voucher Program initially began as a pilot program for 25 individuals in SFY2022, and quickly reached capacity. The Department doubled the size of the Program to 50 vouchers in SFY 2023."

Additional initiatives

"The Department expanded evidence-based Coordinated Specialty Care programing for individuals exhibiting signs of first episode psychosis (FEP). The program has been operated by

Greater Nashua Mental Health since 2018. Three additional CMHCs, Center for Life Management, Seacoast Mental Health Center, and Monadnock Family Services, launched FEP programs in SFY 2022. Over the past year, these CMHCs have utilized the evidence-based NAVIGATE model to provide shared client and provider decision-making for more than 50 individuals statewide; of which, at least half are over the age of 18. The model focuses on strengths, resiliency, psychoeducational approaches to treatment, cognitive behavioral therapy methods, coping skills, and integration of natural and peer supports. Dartmouth Health's Psychosis Early Action, Resource and Learning Services (PEARLS) Team will provide ongoing supervision, technical assistance, and quality service development and improvement to these contracted FEP programs."

V. Summary of Expert Reviewer Observations and Priorities

The ER has emphasized in this report that the State continues to be out of compliance with several key components of the CMHA. These findings are summarized below, along with expectations and recommendations for addressing these issues in the coming months.

ACT

For the last seven years, the ER has reported that the State is out of compliance with the ACT requirements of Sections V.D.3, which require that the State provide ACT services that conform to CMHA requirements and have the capacity to serve at least 1,500 people in the Target Population at any given time. Many of the State's ACT teams fail to meet CMHA requirements for staffing and team composition. In addition, seven of the ten CMHC regions have ACT services scoring below the performance threshold for implementation of ACT services.

As has been noted in prior ER reports, available ACT screening data is limited to individuals already engaged with the CMHCs. It provides no information on whether individuals outside of the CMHC system who would benefit from ACT services are being properly identified and referred for assessment.

In addition, there is substantial turnover in the ACT active client caseload, and as a result, current ACT screening and referral activities merely result in steady state operations in the ACT program. To increase active ACT caseload across New Hampshire, it is necessary to both reduce ACT turnover and identify new eligible ACT participants.

The ER believes that on-going and documented non-compliance with the ACT service provisions of the CMHA directly impacts the quality of services and the safety of Target Population individuals in New Hampshire. It also directly impacts the State's ability to fully implement

other important elements of the CMHA, including transition planning and provision of services in integrated community settings. Although the State has undertaken several initiatives to improve compliance of ACT services with the CMHA, little discernable progress can be documented.

The ER recommends that:

1) The State promptly share all relevant data from ACT fidelity reviews with the ER, the Plaintiffs, and the United States, and then promptly take effective corrective actions to ensure that each CMHC's ACT program meets the CMHA fidelity standards for ACT services and the 80% compliance standard for QSR reviews.

2) On or before January 15, 2023, the Parties identify and the State engage an expert consultant in ACT program administration and service delivery to review the New Hampshire ACT system;

3) The expert consultant undertake a 60-90 day system level review of ACT services provided by all CMHCs that analyzes past ACT workgroup strategies, team staffing, service utilization, screening, and quality performance data; describes the system's strengths and deficiencies; identifies any patterns or practices that contribute to its utilization and staffing challenges; and drafts recommendations for bringing ACT services into compliance with the CMHA;

4) The ER convene one or more solution-focused meetings to discuss the expert consultant's recommendations and to seek agreement on specific actions and outcomes for achieving compliance with the CMHA's provisions on ACT services.

The ER expects that such a process could be completed by June 1, 2023.

Supported Employment

Although the State technically meets the statewide CMHA standard for SE penetration, the ER notes that five of the ten CMHC regions of the state have penetration rates lower than the CMHA standard. At the very least, the ER considers that this demonstrates that Target Population members do not have equal access to SE services throughout New Hampshire.

<u>In response to these implementation issues, the ER recommends that, prior to June 2023 the State:</u>

1. Provide a written update on efforts to ensure reasonable access to SE services for the 36 individuals currently on the statewide waiting list;
2. Report detailed findings from the State's ongoing Supported Employment fidelity reviews as part of evaluating overall service delivery and client outcomes;
3. Continue to report on the development and implementation of CMHC quality improvement plans for the two SE-related QSR indicators; and

4. Provide technical assistance to, and report on continuing quality improvement efforts with, the five CMHCs reporting SE penetration rates lower than the CMHA requirement.

PASRR

Despite federal Medicaid and CMHA requirements, the State's PASRR process is not determining if individuals could be diverted from admission to Glencliff, or whether a transfer from either NHH or Glencliff to another nursing facility is necessary and appropriate. Similarly, given the low and declining rate of specialized services recommendations, it is questionable whether the PASRR process is accurately determining whether class members admitted to Glencliff or another nursing facility need specialized services, such as behavior or other therapies, beyond those that are part of standard nursing services.

Conclusion

As has been noted at several points in this report, the COVID-19 pandemic has affected the New Hampshire Mental Health System over the past 30 months, although the lingering areas of non-compliance noted in this report all predate the onset of the pandemic. In general, the State is to be commended for its efforts to provide basic levels of services for the CMHA Target Population, and for striving to maintain the quality of services for the Target Population, during COVID. The absence of progress towards compliance should be understood in the context of these COVID-related challenges, but it does have the practical effect of extending the period of time that is likely to be required before any maintenance of effort year can begin.

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

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

April through June 2022

New Hampshire Community Mental Health Agreement Quarterly Data Report

April – June 2022

New Hampshire Department of Health and Human Services

Bureau of Quality Assurance and Improvement

August 31, 2022

Community Mental Health Agreement Quarterly Data Report

New Hampshire Department of Health and Human Services

Publication Date: ***August 31, 2022***

Reporting Period: 4/1/2022-6/30/2022

Notes for Quarter

- Table 7. NH Mental Health Client Peer Support Agencies: Census Summary – Peer Support Agencies continue to operate a hybrid in-person and virtual model of services with limited on-site capacity due to COVID-19. The Average Daily Visits reported includes the number of individuals participating in groups online and on-site.
- Tables 11a-c. Mobile Crisis Services and Supports for Adults – Several data elements reported as zero (0), or otherwise lower than normal volume, reflect the direct or indirect impact of the COVID-19 pandemic, such as lack of crisis apartment use due to distancing and quarantine protocols.
- Table 11c. Table 11c. Data reporting for statewide Rapid Response began January 1, 2022 – These data represent reporting items from Phoenix and the Rapid Response Access Point. NH DHHS continues to work with the CMHCs and the Access Point to ensure timely and accurate data reports. Certain system changes are anticipated and data anomalies are expected to normalize in the coming months. NH DHHS will re-issue tables as needed.

Acronyms Used in this Report

ACT: Assertive Community Treatment

BMHS: Bureau of Mental Health Services

BQAI: Bureau of Quality Assurance and Improvement

CMHA: Community Mental Health Agreement

CMHC: Community Mental Health Center

DHHS: Department of Health and Human Services

DRF: Designated Receiving Facility

ED: Emergency Department

FTE: Full Time Equivalent

HBSP: Housing Bridge Subsidy Program

HUD: US Dept. of Housing and Urban Development

MCT: Mobile Crisis Team

NHH: New Hampshire Hospital

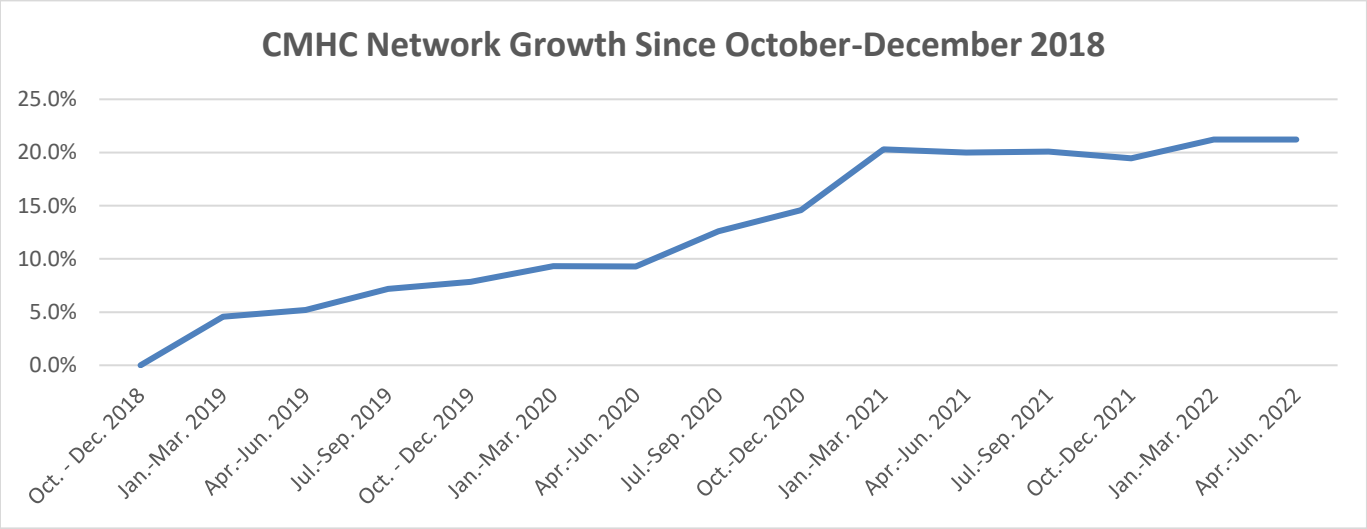
NHHFA: New Hampshire Housing Finance Authority

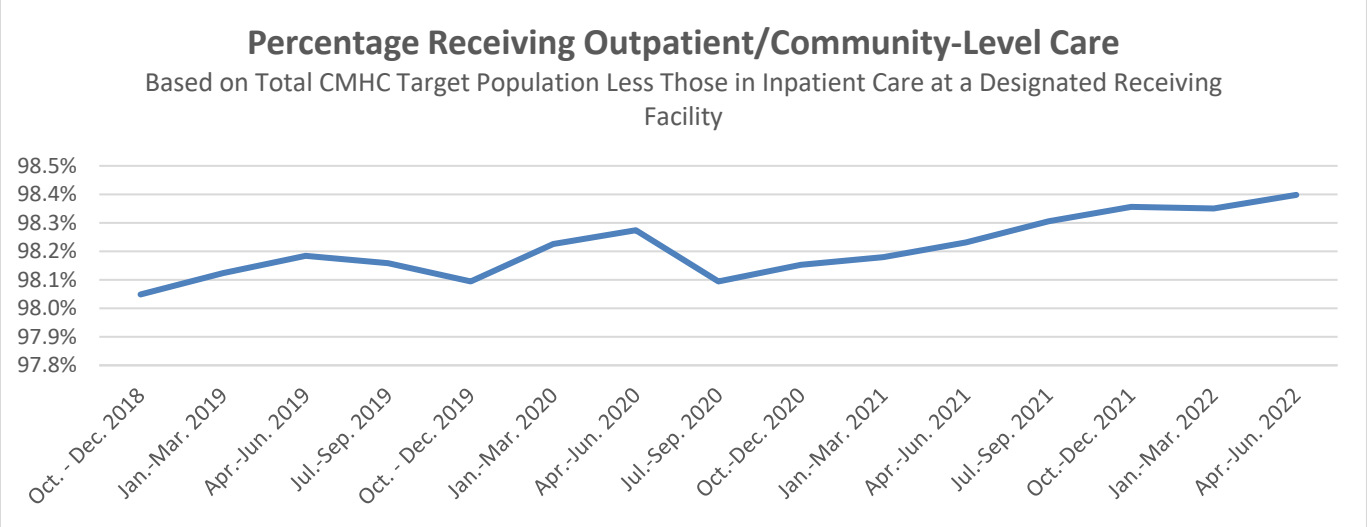
PRA: Project Rental Assistance

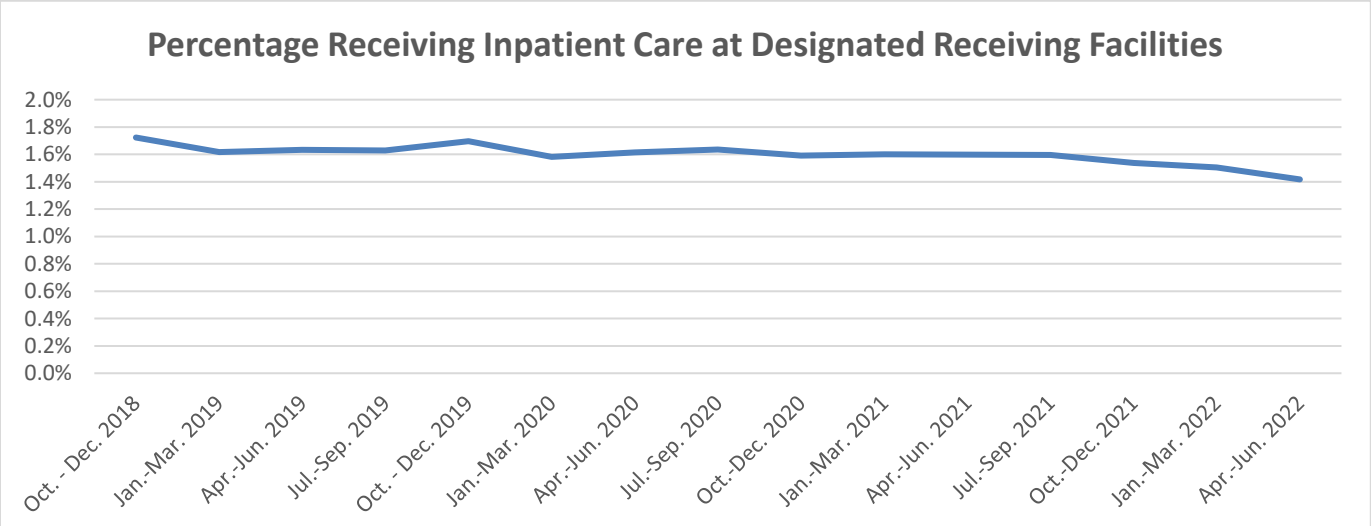
SE: Supported Employment

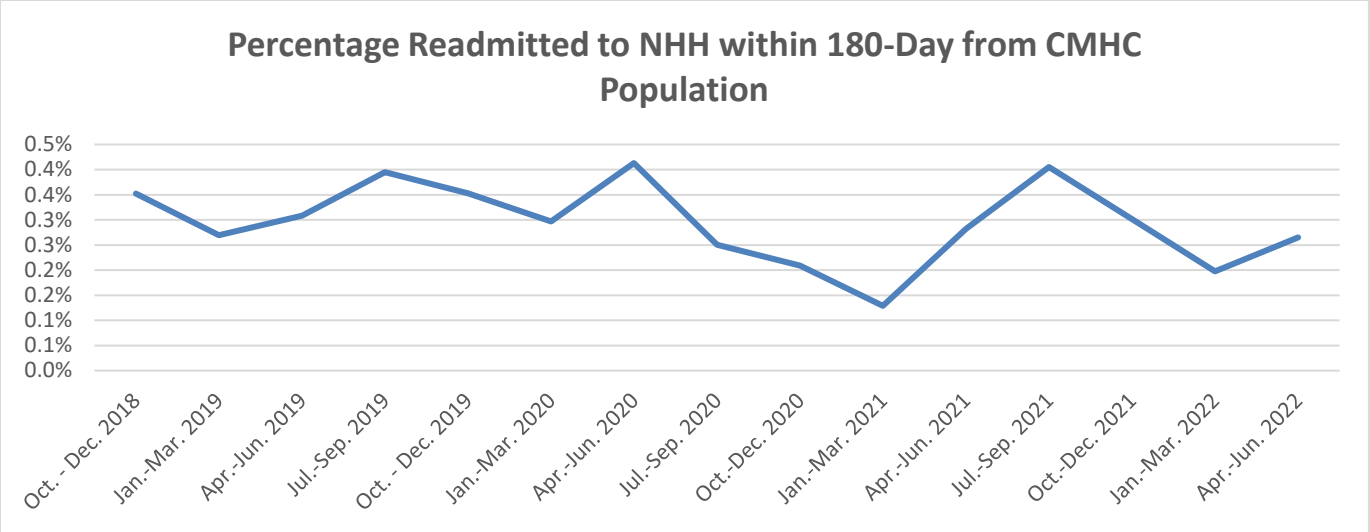
VA: Veterans Benefits Administration

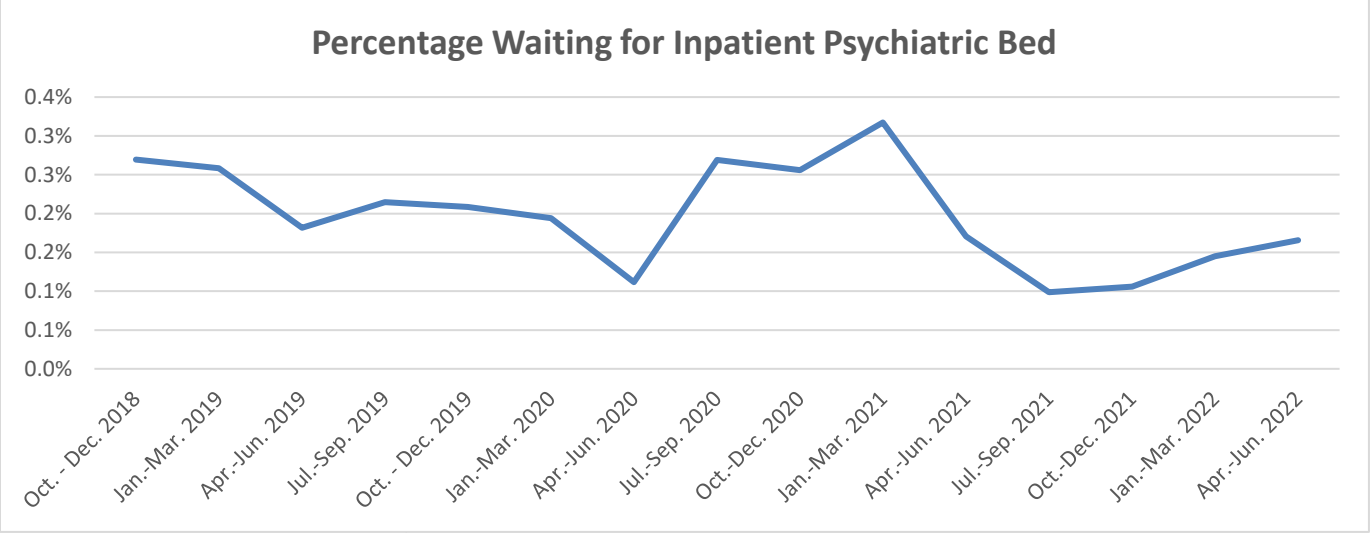
Trends: CMHA Target Population System Wide Key Trends

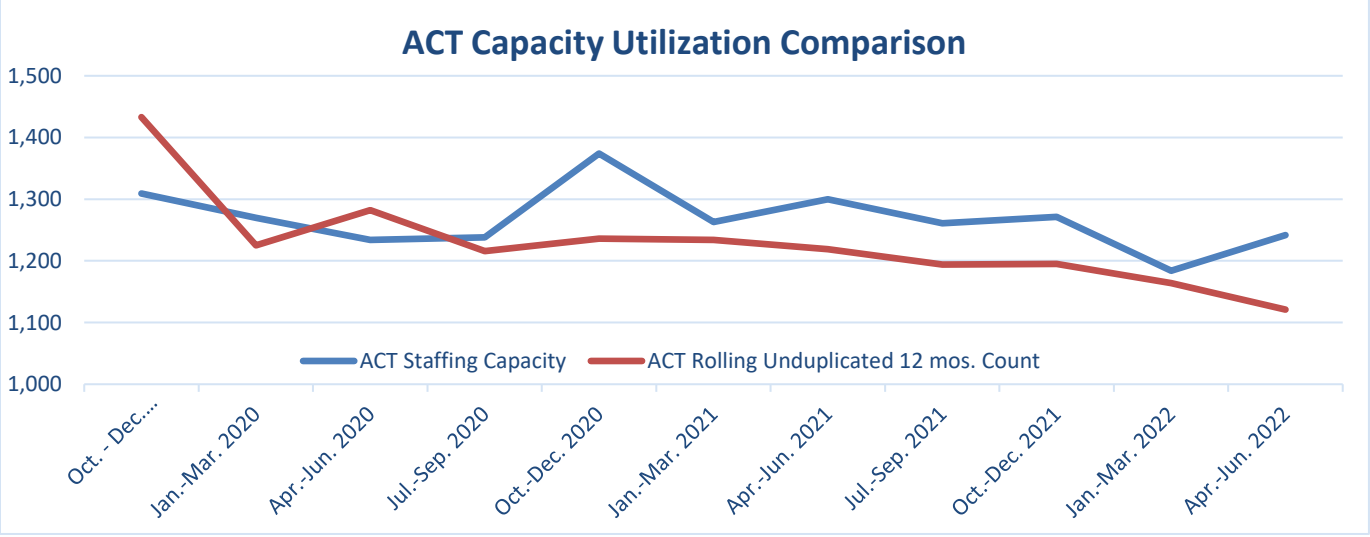


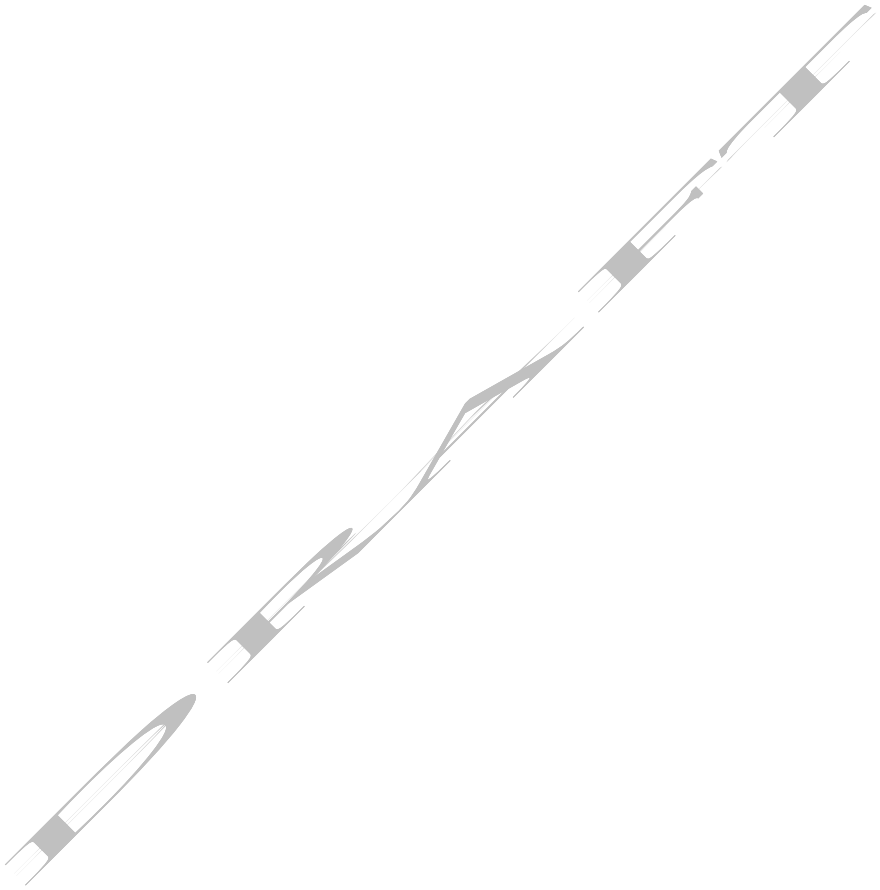





Percentage Readmitted to NHH within 180-Day from CMHC Population
0.5%
0.4%
0.4%
0.3%
0.3%
0.2%
0.2%
0.1%
0.1%
0.0%
Oct. - Dec. 2018
Jan.-Mar. 2019
Apr.-Jun. 2019
Jul.-Sep. 2019
Oct. - Dec. 2019
Jan.-Mar. 2020
Apr.-Jun. 2020
Jul.-Sep. 2020
Oct.-Dec. 2020
Jan.-Mar. 2021
Apr.-Jun. 2021
Jul.-Sep. 2021
Oct.-Dec. 2021
Jan.-Mar. 2022
Apr.-Jun. 2022


Percentage Waiting for Inpatient Psychiatric Bed
0.4%
0.3%
0.3%
0.2%
0.2%
0.1%
0.1%
0.0%
Oct. - Dec. 2018
Jan.-Mar. 2019
Apr.-Jun. 2019
Jul.-Sep. 2019
Oct. - Dec. 2019
Jan.-Mar. 2020
Apr.-Jun. 2020
Jul.-Sep. 2020
Oct.-Dec. 2020
Jan.-Mar. 2021
Apr.-Jun. 2021
Jul.-Sep. 2021
Oct.-Dec. 2021
Jan.-Mar. 2022
Apr.-Jun. 2022


ACT Capacity Utilization Comparison
1,500
1,400
1,300
1,200
1,100
1,000
ACT Staffing Capacity
ACT Rolling Unduplicated 12 mos. Count
Oct. - Dec....
Jan.-Mar. 2020
Apr.-Jun. 2020
Jul.-Sep. 2020
Oct.-Dec. 2020
Jan.-Mar. 2021
Apr.-Jun. 2021
Jul.-Sep. 2021
Oct.-Dec. 2021
Jan.-Mar. 2022
Apr.-Jun. 2022



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

Community Mental Health Center	April 2022	May 2022	June 2022	Unique Clients in Quarter	Unique Clients in Prior Quarter
01 Northern Human Services	83	77	78	87	93
02 West Central Behavioral Health	53	50	48	56	56
03 Lakes Region Mental Health Center*	57	57	58	58	61
04 Riverbend Community Mental Health Center	85	88	85	96	89
05 Monadnock Family Services	45	39	46	47	45
06 Greater Nashua Mental Health	104	105	107	110	109
07 Mental Health Center of Greater Manchester	254	261	256	270	266
08 Seacoast Mental Health Center	74	74	70	76	78
09 Community Partners	73	68	61	76	83
10 Center for Life Management	44	44	45	45	51
Total Unique Clients	**872**	**863**	**853**	**919**	**927**
Unique Clients Receiving ACT Services 7/1/21 to 6/30/2022: 1,121					

Revisions to Prior Period: None.

*Data Source: NH Phoenix 2. Notes: Data extracted 7/25/2022; clients are counted only one time regardless of how many services they receive. *Lakes Region Mental Health Center's ACT*

data is currently under review. Minor discrepancies were identified and NH DHHS data analytics is working closely with this center to correct and validate the data for resubmission.

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

Community Mental Health Center	January – March 2022 Retrospective Analysis			October – December 2021 Retrospective Analysis		
	Unique Clients Screened: Individuals Not Already	Screening Deemed Appropriate for Further	New Clients receiving ACT Services within 90 days of	Unique Clients Screened: Individuals Not Already	Screening Deemed Appropriate for Further	New Clients receiving ACT Services within 90 days of
01 Northern Human Services	1,010	26	3	974	25	1
02 West Central Behavioral Health	161	6	0	123	2	2
03 Lakes Region Mental Health Center	974	6	0	1,029	2	0
04 Riverbend Community Mental Health Center	1,746	23	0	1,444	0	0
05 Monadnock Family Services	538	9	0	573	5	0
06 Greater Nashua Mental Health	1,406	4	0	1,248	7	0
07 Mental Health Center of Greater Manchester	1,499	41	0	1,405	12	0
08 Seacoast Mental Health Center	1,626	3	0	1,511	5	2
09 Community Partners	198	1	1	228	1	0

10 Center for Life Management	1,315	0	0	1,333	2	0
Total ACT Screening	**10,473**	**119**	**4**	**9,868**	**61**	**5**

Data Source: NH Phoenix 2. 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.

Notes: Data extracted 08/01/2022. "Unique Clients Screened: Individuals Not Already on ACT" is defined as individuals who were not already on ACT at the time of screening that had a documented ACT screening during the identified reporting period. "Screening Deemed Appropriate for Further ACT Assessment: Individuals Not Already on ACT" is defined as screened individuals not already on ACT that resulted in referral for an ACT assessment. "New Clients Receiving ACT Services within 90 days of ACT Screening" are defined as individuals who were not already on ACT that received an ACT screening in the preceding quarter and then began receiving ACT services.

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

Community Mental Health Center	April - June 2022				January – March 2022			
	April 2022	May 2022	June 2022	Total New ACT Clients	October	November 2021 – New	December	Total New ACT Clients
01 Northern Human Services	3	0	2	5	3	4	6	13
02 West Central Behavioral Health	1	0	0	1	3	2	1	6
03 Lakes Region Mental Health Center*	0	1	0	1	0	3	0	3
04 Riverbend Community Mental Health Center	4	4	5	13	1	2	1	4
05 Monadnock Family Services	0	1	1	2	0	1	2	3
06 Greater Nashua Mental Health	1	2	4	7	2	0	1	3

07 Mental Health Center of Greater Manchester	8	7	4	19	9	11	8	28
08 Seacoast Mental Health Center	4	1	0	5	1	1	3	5
09 Community Partners	0	1	1	2	3	0	2	5
10 Center for Life Management	1	0	1	2	1	0	1	2
Total New ACT Clients	**22**	**17**	**18**	**57**	**23**	**24**	**25**	**72**

Revisions to Prior Period: None

Data Source: NH Phoenix 2.

*Notes: Data extracted 07/25/2022; New ACT Clients are defined as individuals who were not already on ACT within 90 days prior who then began receiving ACT services. This information is not limited to the individuals that received an ACT screening within the previous 90-day period, and may include individuals transitioning from a higher or lower level of care into ACT. *Lakes Region Mental Health Center's ACT data is currently under review. Minor discrepancies were identified and NH DHHS data analytics is working closely with this center to correct and validate the data for resubmission once the proper adjustments are made.*

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

As of 6/30/2022						
	Time on List					
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**
0	0	0	0	0	0	0
As of 3/31/2022						
Time on List						
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**
1	0	0	0	1	0	0

Revisions to Prior Period: None.

Data Source: BMHS Report.

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

Community Mental Health Center	April – June 2022						January – March 2022					
	On ACT at Admissi		Referred for ACT on		Accepted to ACT at		On ACT at Admissi		Referred for ACT on		Accepted to ACT at	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	N
01 Northern Human Services	8	10	2	8	2	1	8	10	6	4	3	
02 West Central Behavioral Health	5	4	1	3	0	1	2	6	2	4	2	
03 Lakes Region Mental Health Center	0	9	0	9	0	0	1	2	1	1	1	
04 Riverbend Community Mental Health Center	5	20	4	16	4	0	4	13	1	12	0	
05 Monadnock Family Services	3	11	3	8	3	0	2	13	5	8	3	

06 Greater Nashua Mental Health	4	14	3	11	1	2	12	9	2	7	1	
07 Mental Health Center of Greater Manchester	13	17	9	8	6	3	8	5	3	2	2	
08 Seacoast Mental Health Center	3	10	2	8	2	0	1	14	1	13	0	
09 Community Partners	3	16	1	15	0	1	4	6	1	5	1	
10 Center for Life Management	1	4	1	3	1	0	0	4	1	3	1	
Total	**45**	**115**	**26**	**89**	**19**	**8**	**42**	**82**	**23**	**59**	**14**	

Revisions to Prior Period: None

Data Source: New Hampshire Hospital.

Notes: Data compiled 8/16/22. Numbers do not include those listed as "N/A on admission", those representing moves outside of the catchment area, or those who were admitted from out-of-state and remained in-state

1f. Community Mental Health Center Services: Assertive Community Treatment – Reasons Not Accepted to ACT at New Hampshire Hospital Discharge Referral

Reason Not Accepted at Discharge	April – June 2022	January – March 2022
Not Available in Individual's Town of Residence	0	0
Individual Declined	0	0
Individual's Insurance Does Not Cover ACT Services	0	2
Individual's Clinical Need Does Not Meet ACT Criteria	1	2
Individual Placed on ACT Waitlist	1	0
Individual Awaiting CMHC Determination for ACT	4	5
Total Unique Clients	**6**	**9**

Revisions to Prior Period: None.

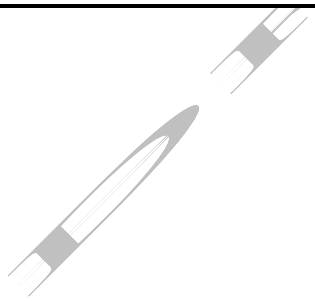
Data Source: New Hampshire Hospital.

Notes: Data compiled 8/16/2022.

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

Community Mental Health Center	June 2022						March 2022	
	Nurse	Masters Level Clinician/or	Functional Support	Peer Specialist	Total (Excluding	Psychiatrist/Nurse Practitioner	Total (Excluding	Psychiatrist/Nurse Practitioner
01 Northern Human Services - Wolfeboro	0.60	0.00	0.00	0.00	3.60	0.27	3.00	0.27
01 Northern Human Services - Berlin	0.34	0.20	1.00	0.00	4.94	0.14	4.88	0.14
01 Northern Human Services - Littleton	0.23	0.11	1.00	1.00	3.57	0.29	4.34	0.29

02 West Central Behavioral Health	0.40	1.00	0.00	1.50	6.20	0.60	4.70	0.60
03 Lakes Region Mental Health Center	1.00	3.00	0.00	1.00	5.00	0.60	4.00	0.60
04 Riverbend Community Mental Health Center	0.50	1.00	5.10	0.00	7.50	0.50	8.50	0.50
05 Monadnock Family Services	2.63	0.71	0.00	0.89	7.87	0.63	6.33	0.61
06 Greater Nashua Mental Health 1	1.00	1.00	4.00	1.00	9.00	0.15	6.75	0.15
06 Greater Nashua Mental Health 2	1.00	1.00	2.00	1.00	6.00	0.15	6.00	0.15
07 Mental Health Center of Greater Manchester-CTT	1.33	11.97	3.33	1.33	22.61	1.17	22.61	1.17
07 Mental Health Center of Greater Manchester-MCST	1.33	9.84	2.00	1.33	20.32	1.17	22.45	1.17
08 Seacoast Mental Health Center	1.00	2.10	6.00	1.00	11.10	0.80	9.16	0.80
09 Community Partners	0.50	1.00	4.76	1.38	7.64	0.70	7.84	0.70
10 Center for Life Management	1.14	0.00	5.28	1.00	8.85	0.46	7.88	0.46
Total	**13.00**	**32.93**	**34.47**	**12.43**	**124.20**	**7.63**	**118.44**	**7.61**



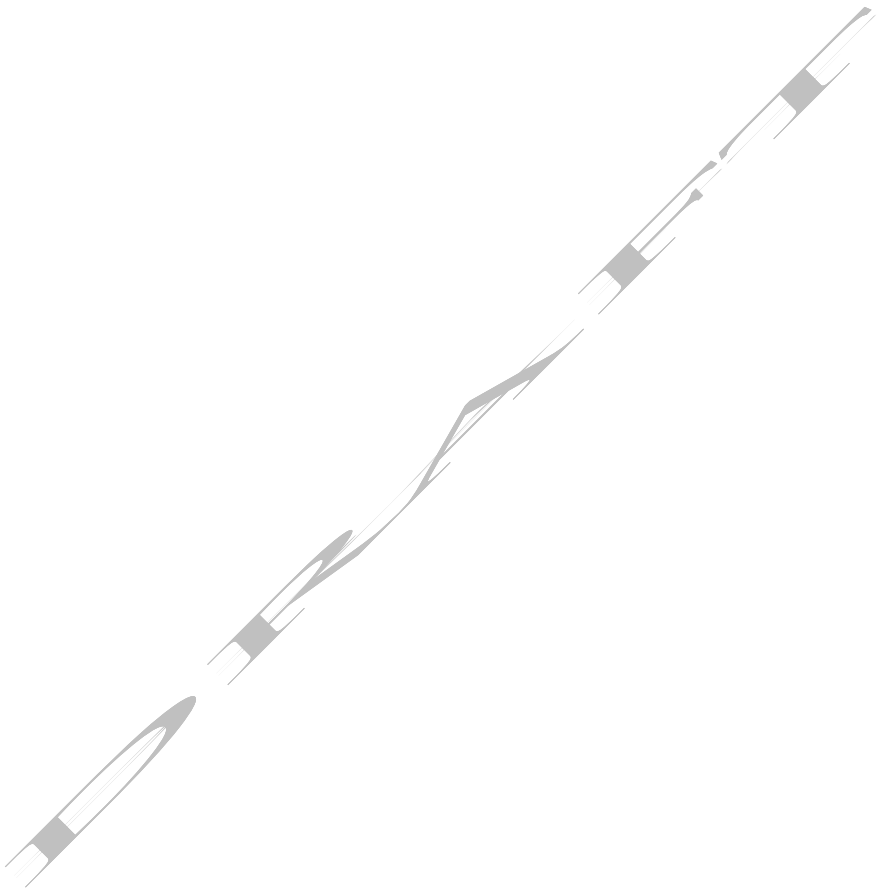
2b. Community Mental Health Center Services: Assertive Community Treatment Staffing Competencies

Community Mental Health Center	Substance Use Disorder Treatment		Housing Assistance		Supported Employment	
	June 2022	March 2022	June 2022	March 2022	June 2022	March 2022
01 Northern Human Services - Wolfeboro	0.27	0.27	3.00	3.00	0.00	0.00
01 Northern Human Services - Berlin	0.74	0.68	3.40	3.34	0.00	0.00
01 Northern Human Services - Littleton	0.40	0.40	2.00	3.00	0.00	0.00
02 West Central Behavioral Health	0.10	0.10	4.00	3.50	0.20	0.20
03 Lakes Region Mental Health Center	0.00	0.00	5.00	4.00	0.00	0.00
04 Riverbend Community Mental Health Center	0.50	1.50	6.50	7.50	0.50	0.50
05 Monadnock Family Services	0.35	0.29	2.23	2.30	0.00	0.00
06 Greater Nashua Mental Health 1	7.15	4.90	8.00	5.75	2.00	2.00
06 Greater Nashua Mental Health 2	3.15	4.15	4.00	4.00	1.00	1.00
07 Mental Health Center of Greater Manchester-CCT	13.14	13.14	17.95	17.95	1.33	1.33
07 Mental Health Center of Greater Manchester-MCST	5.16	6.49	14.33	16.46	2.66	2.66
08 Seacoast Mental Health Center	2.00	2.00	9.00	7.53	0.00	1.00
09 Community Partners	3.58	3.20	1.80	3.00	0.00	0.00
10 Center for Life Management	1.14	0.17	7.42	6.45	0.29	0.29
Total	**37.68**	**39.83**	**88.63**	**91.53**	**7.98**	**13.00**

Revisions to Prior Period: None.

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

Notes: Data compiled 7/25/2022. For 2b: the Staff Competency values reflect the sum of FTEs trained to provide each service type. These numbers are not a reflection of the services delivered, but rather the quantity of staff available to provide each service. If staff are trained to provide multiple service types, their entire FTE value is credited to each service type.



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

Community Mental Health Center	12 Month Period Ending June 2022			Penetration Rate for Period Ending March 2022
	Supported Employment Clients	Total Eligible Clients	Penetration Rate	
01 Northern Human Services	137	1,304	10.5%	11.1%
02 West Central Behavioral Health	90	492	18.3%	15.3%
03 Lakes Region Mental Health Center	291	1,689	17.2%	20.5%
04 Riverbend Community Mental Health Center	229	1,903	12.0%	12.3%
05 Monadnock Family Services	58	1,088	5.3%	6.4%
06 Greater Nashua Mental Health	497	2,487	20.0%	17.6%
07 Mental Health Center of Greater Manchester	1,053	3,308	31.8%	33.3%
08 Seacoast Mental Health Center	1,095	2,366	46.3%	49.4%
09 Community Partners	516	731	70.6%	70.5%
10 Center for Life Management	350	1,827	19.2%	19.5%
Total Unique Clients	**4,303**	**16,986**	**25.3%**	**27.4%**

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 7/25/2022

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

Reported Employment Status Begin Date: 4/1/2022 End Date: 6/30/2022 Employment Status Update Overdue Threshold: 105 days	Northern Human Services	West Central Behavioral Health	Lakes Region Mental Health Center	Riverbend Community Mental Health	Monadnock Family Services	Greater Nashua Mental Health	Mental Health Center of Greater Manchester	Seacoast Mental Health Center	Community Partners	Center for Life Management	Statewide Total or Mean Percentage	Previous Quarter Statewide Total or Mean Percentage January – March 2022
Updated Employment Status:												
Full time employed now or in past 90 days	81	32	182	141	81	174	325	246	63	223	**1,548**	**1,470**
Part time employed now or in past 90 days	117	36	458	304	142	299	326	273	81	275	**2,311**	**2,267**
Unemployed	175	91	20	65	130	850	787	122	196	641	**3,077**	**3,123**
Not in the Workforce	574	152	487	998	474	401	604	1051	159	192	**5,092**	**5,043**
Status is not known	0	50	6	27	4	110	1	1	5	105	**309**	**296**
Total of Eligible Adult CMHC Clients	**947**	**361**	**1,153**	**1,535**	**831**	**1,834**	**2,043**	**1,693**	**504**	**1,436**	**12,337**	**12,199**
Previous Quarter: Total of Eligible Adult CMHC Clients	**944**	**361**	**1,133**	**1,542**	**846**	**1,775**	**2,058**	**1,654**	**499**	**1,387**		
Percentage by Updated Employment Status:												
Full time employed now or in past 90 days	8.6%	8.9%	15.8%	9.2%	9.7%	9.5%	15.9%	14.5 %	12.5 %	15.5%	**12.5%**	**12.1%**
Part time employed now or in past 90 days	12.4 %	10.0%	39.7%	19.8%	17.1%	16.3%	16.0%	16.1 %	16.1 %	19.2%	**18.7%**	**18.6%**
Unemployed	18.5 %	25.2%	1.7%	4.2%	15.6%	46.3%	38.5%	7.2%	38.9 %	44.6%	**24.9%**	**25.6%**
Not in the Workforce	60.6 %	42.1%	42.2%	65.0%	57.0%	21.9%	29.6%	62.1 %	31.5 %	13.4%	**41.3%**	**41.3%**
Status is not known	0.0%	13.9%	0.5%	1.8%	0.5%	6.0%	0.0%	0.1%	1.0%	7.3%	**2.5%**	**2.4%**
Update is Current	66.9 %	49.3%	69.0%	84.0%	70.3%	86.5%	89.2%	93.6 %	71.8 %	99.9%	**83.2%**	**83.1%**
Update is Overdue	33.1 %	50.7%	31.0%	16.0%	29.7%	13.5%	10.8%	6.4%	28.2 %	0.1%	**16.8%**	**16.9%**
Previous Quarter: Percentage by Timeliness of Employment Status Screening:												
Update is Current	**64.1 %**	**49.0%**	**76.6%**	**86.0%**	**69.7%**	**82.9%**	**88.7%**	**91.8 %**	**74.9 %**	**99.8%**		
Update is Overdue	**35.9 %**	**51.0%**	**23.4%**	**14.0%**	**30.3%**	**17.1%**	**11.3%**	**8.2%**	**25.1 %**	**0.2%**		

Revisions to Prior Period: None.

Data Source: NH Phoenix 2.

Notes: Data extracted 7/25/2022

3c. Community Mental Health Center Clients: Adult Employment Status – Recent Users of Supportive Employment Services (At Least One Billable Service in Each of Month of the Quarter)

Supported Employment Cohort Reported Employment Status Begin Date: 4/1/2022 End Date: 6/30/2022	**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 2022**
Updated Employment Status:												
Full time employed now or in past 90 days	1	1	0	1	1	2	9	1	2	10	**28**	**35**
Part time employed now or in past 90 days	4	6	11	34	10	13	30	9	6	27	**150**	**156**
Unemployed	4	2	0	15	3	36	22	11	9	22	**124**	**154**
Not in the Workforce	3	0	2	5	5	7	10	25	1	5	**63**	**64**
Status is not known	0	2	0	0	0	4	0	0	0	0	**6**	**9**
Total of Supported Employment Cohort	**12**	**11**	**13**	**55**	**19**	**62**	**71**	**46**	**18**	**64**	**371**	**418**
Previous Quarter: Total	**15**	**13**	**11**	**64**	**23**	**85**	**96**	**43**	**20**	**48**	**418**	

of Supported Employment Cohort												
Percentage by Updated Employment Status:												
Full time employed now or in past 90 days	8.3%	9.1%	0.0%	1.8%	5.3%	3.2%	12.7%	2.2%	11.1%	15.6%	**7.5%**	**8.4%**
Part time employed now or in past 90 days	33.3%	54.5%	84.6%	61.8%	52.6%	21.0%	42.3%	19.6%	33.3%	42.2%	**40.4%**	**37.3%**
Unemployed	33.3%	18.2%	0.0%	27.3%	15.8%	58.1%	31.0%	23.9%	50.0%	34.4%	**33.4%**	**36.8%**
Not in the Workforce	25.0%	0.0%	15.4%	9.1%	26.3%	11.3%	14.1%	54.3%	5.6%	7.8%	**17.0%**	**15.3%**
Status is not known	0.0%	18.2%	0.0%	0.0%	0.0%	6.5%	0.0%	0.0%	0.0%	0.0%	**1.6%**	**2.2%**

Revisions to Prior Period: None.

Data Source: Phoenix 2.

Note 3b-c: Data extracted 7/25/2022. 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.

**LRMHC case management and FSS staff were trained in Supported Employment and have provided employment services in the absence of formal SE staff. While not able to be billed (and therefore not reflected in Table 3c data), the employment numbers reflected in Table 3b indicate that these informal employment services are resulting in desired employment outcomes.*

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

As of 6/30/2022						
	Time on List					
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180+ days**
36	31	3	2	0	0	0
As of 3/31/2022						
Time on List						
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**
62	26	16	12	6	0	2

Data Source: BMHS Report.

Notes: Data compiled 7/18/22. As of 6/30/22, 20 individuals total awaiting formal Supported Employment Services (MHCHM-8, CP-4, LRMHC-5 and MFS -3. Staffing shortages continue to be a challenges for our Mental Health Centers and BMHS is working with our partners to identify solutions and ensure that employment support services are provided in lieu of formal Supported Employed service provision.

4a. New Hampshire Hospital: Adult Census Summary

Measure	April – June 2022	January – March 2022
Admissions	210	172
Mean Daily Census	159	168
Discharges	221	181
Median Length of Stay in Days for Discharges	41	27
Deaths	0	0

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4a: Data Compiled 08/03/2022; Mean Daily Census includes patients on leave and is rounded to nearest whole number.

4b. New Hampshire Hospital: Summary Discharge Location for Adults

Discharge Location	April – June 2022	January – March 2022
CMHC Group Home	3	2
Discharge/Transfer to IP Rehab Facility	20	10
Glencliff Home for the Elderly	4	0
Home - Lives Alone	38	28
Home - Lives with Others	72	53
Homeless Shelter/ No Permanent Home	7	6
Hotel-Motel	4	8
Jail or Correctional Facility	3	4
Nursing Home	3	0
Other	22	16
Peer Support Housing	2	2
Private Group Home	0	0
Secure Psychiatric Unit - SPU	0	0
Unknown	43	52

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

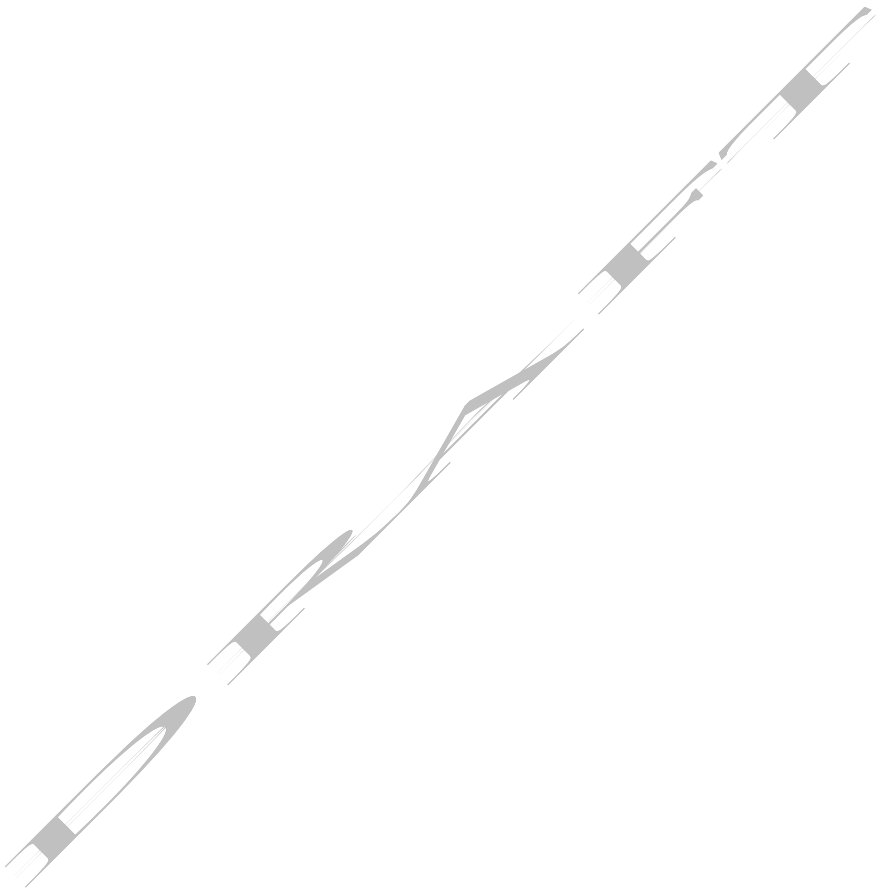
Measure	April – June 2022	January – March 2022
30 Days	10.5% (22)	7.6% (13)
90 Days	15.7% (33)	11.6% (20)
180 Days	21.4% (45)	19.8% (34)

Revisions to Prior Period: None.

Data Source: Avatar.

Notes 4b-c: Data compiled 08/03/2022; 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	April – June 2022		
	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	39	37	76
Cypress Center	26	112	138
Portsmouth	92	229	321
Elliot Geriatric Psychiatric Unit	0	24	24
Elliot Pathways	52	103	155
Parkland Regional Hospital	46	138	184
Total	**255**	**643**	**898**
Designated Receiving Facility	**January – March 2022**		
	Involuntary Admissions	**Voluntary Admissions**	**Total Admissions**
Franklin	28	27	55
Cypress Center	38	94	132
Portsmouth	67	231	298
Elliot Geriatric Psychiatric Unit	1	39	40
Elliot Pathways	63	89	152
Parkland Regional Hospital	41	149	190
Total	**238**	**629**	**867**

Revisions to Prior Period: None.

Data Source: DRF Access Database

Data Compiled 08/02/2022

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

Designated Receiving Facility	April – June 2022	January – March 2022
Franklin	7.3	6.3
Cypress Center	11.0	11.1
Portsmouth	27.9	26.6
Elliot Geriatric Psychiatric Unit	11.4	20.7
Elliot Pathways	14.0	14.2
Parkland Regional Hospital	13.0	11.8
Total	**84.6**	**90.6**

Revisions to Prior Period: None.

Data Source: DRF Access Database

Data Compiled 08/02/2022

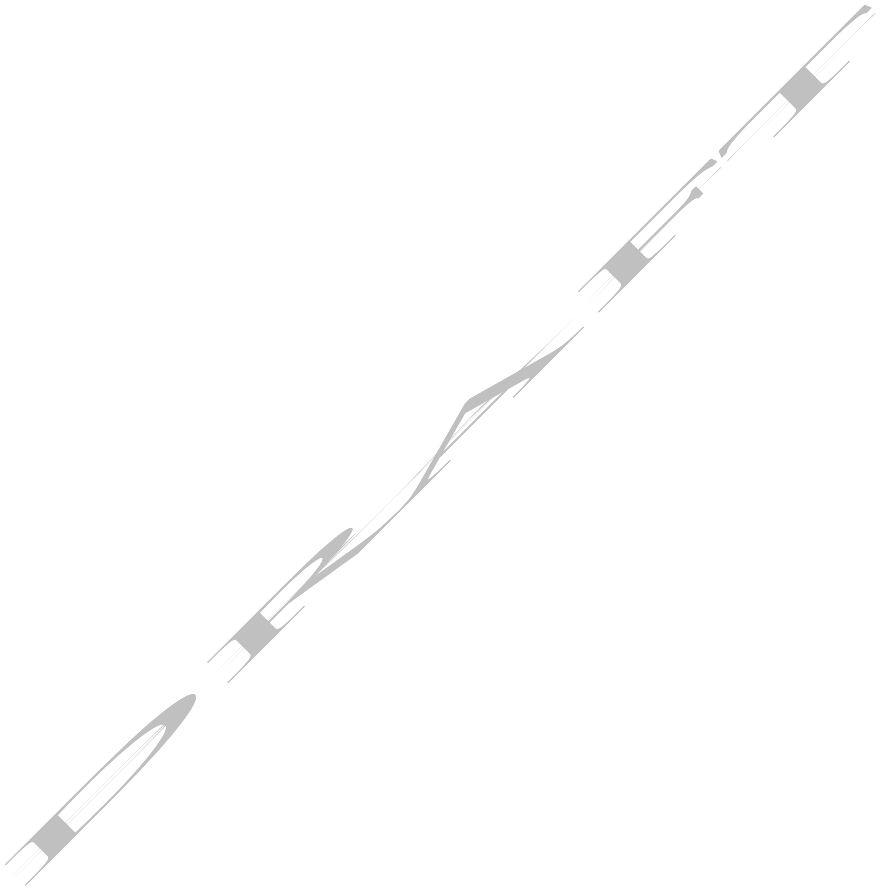
5c. Designated Receiving Facilities: Discharges for Adults

Designated Receiving Facility	April – June 2022	January – March 2022
Franklin	72	55
Manchester (Cypress Center)	140	130
Portsmouth	320	291
Elliot Geriatric Psychiatric Unit	28	38
Elliot Pathways	158	157
Parkland Regional Hospital	186	178
Total	**904**	**849**

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

Designated Receiving Facility	April – June 2022	January – March 2022
Franklin	7	8
Manchester (Cypress Center)	6	6
Portsmouth	6	7
Elliot Geriatric Psychiatric Unit	25	32
Elliot Pathways	6	7
Parkland Regional Hospital	5	5
Total	**6**	**7**

5e. Designated Receiving Facilities: Discharge Location for Adults



Designated Receiving Facility	April – June 2022						
	Assisted Living / Group Home	Deceased	DRF*	Home**	Other Hospital	NH Hospital	Other
Franklin	1	0	0	68	0	0	3
Manchester (Cypress Center)	0	0	0	140	0	0	0
Portsmouth Regional Hospital	9	0	0	287	10	3	11
Elliot Geriatric Psychiatric Unit	19	2	0	6	1	0	0
Elliot Pathways	0	0	0	144	2	1	11
Parkland Regional Hospital	0	0	0	177	4	0	5
Total	**29**	**2**	**0**	**822**	**17**	**4**	**30**
Designated Receiving Facility	**January – March 2022**						
	Assisted Living / Group Home	**Deceased**	**DRF***	**Home****	**Other Hospital**	**NH Hospital**	**Other**
Franklin	1	0	0	47	0	0	7
Manchester (Cypress Center)	0	0	1	127	0	0	2
Portsmouth Regional Hospital	2	0	0	255	5	7	22
Elliot Geriatric Psychiatric Unit	19	4	1	10	2	0	2
Elliot Pathways	2	0	0	123	2	0	30
Parkland Regional Hospital	0	0	0	165	1	0	12
Total	**24**	**4**	**2**	**727**	**10**	**7**	**75**

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

Revisions to Prior Period: None

Data Source: NH DRF Database.

Notes: Data compiled 08/02/2022

5f. Designated Receiving Facilities: Readmission Rates for Adults

Designated Receiving Facility	April – May 2022		
	30 Days	90 Days	180 Days
Franklin	1.8% (1)	3.6% (2)	7.3% (4)
Manchester (Cypress Center)	3.8% (5)	6.1% (8)	10.6% (14)
Portsmouth	7.4% (22)	13.1% (39)	18.5% (55)
Elliot Geriatric Psychiatric Unit	0% (0)	0% (0)	5% (2)
Elliot Pathways	6.6% (10)	11.2% (17)	15.8% (24)
Parkland Regional Hospital	8.9% (17)	13.7% (26)	14.7% (28)
Total	**6.3% (55)**	**10.6% (92)**	**14.6% (127)**
Designated Receiving Facility	**January – March 2022**		
	30 Days	**90 Days**	**180 Days**
Franklin	1.8% (1)	7.3% (4)	10.9% (6)
Manchester (Cypress Center)	3% (4)	6.1% (8)	9.8% (13)
Portsmouth	9.1% (27)	16.4% (49)	20.1% (60)
Elliot Geriatric Psychiatric Unit	5% (2)	7.5% (3)	7.5% (3)
Elliot Pathways	7.2% (11)	9.9% (15)	11.8% (18)
Parkland Regional Hospital	3.2% (6)	3.7% (7)	5.8% (11)
Total	**5.9% (51)**	**9.9% (86)**	**12.8% (111)**

Revisions to Prior Period: None.

Data compiled 08/02/2022

6. Glencliff Home: Census Summary

Measure	April – May 2022	January – March 2022
Admissions	4 (1 re-admission)	0
Average Daily Census	69	73
Discharges	2 (2 to Nursing Facility)	2 (2 to Assisted Living Facility)
Individual Lengths of Stay in Days for Discharges	1479, 363	256, 761
Deaths	4	3
Readmissions	1	0
Mean Overall Admission Waitlist	45	43

Revisions to Prior Period: None.

Data Source: Glencliff Home.

Notes: Data Compiled 8/11/2022; 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. Majority of individuals on waitlist have been placed on "hold" status to allow for pursuit of less restrictive placements prior to consideration for admission.

6b. Glencliff Home: In-reach Services Performance Outcomes and Measures

Outcomes and Measures:	April – June 2022		January – March 2022	
	Residents	Activities	Residents	Activities
Residents have better awareness of community-based living benefits as evidenced by:				
Residents that attended service array and supports group presentations*	0	0	0	0
Residents that met with In-Reach Liaison regarding resident-specific needs, service array and supports**	0	0	0	0
Residents are better prepared to return to community-based living as evidenced by:				
Residents that participated in shared-learning regarding integrated community-based living values	9	2	13	2
Residents that met with In-Reach Liaison and others regarding community-based living and strategies**	0	0	0	0
Community stakeholders and providers are better prepared to participate and collaborate in transition planning activities and to provide needed community-based services to residents seeking to return to community-based living as evidenced by:				
Participated in resident-specific transition discussions with In-Reach Liaison**	0	0	0	0
Participated in meetings with resident, In-Reach Liaison, and others regarding opportunities for community-based living ***	35	93	41	88

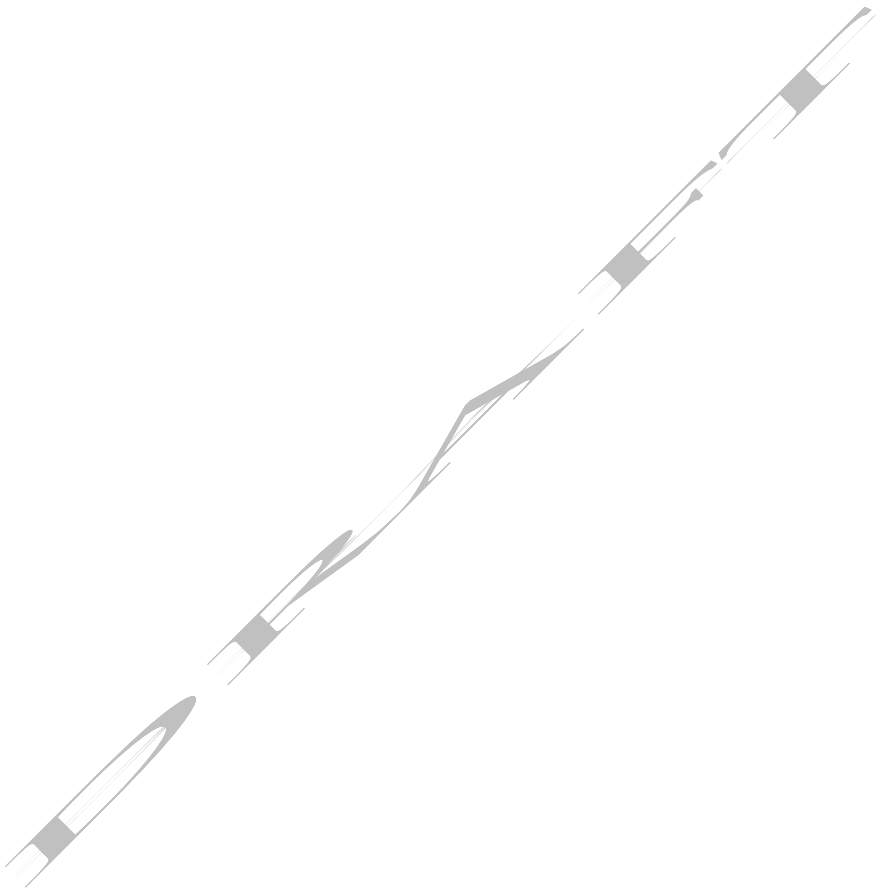
Revisions to Prior Period: None.

Data Source: BMHS.

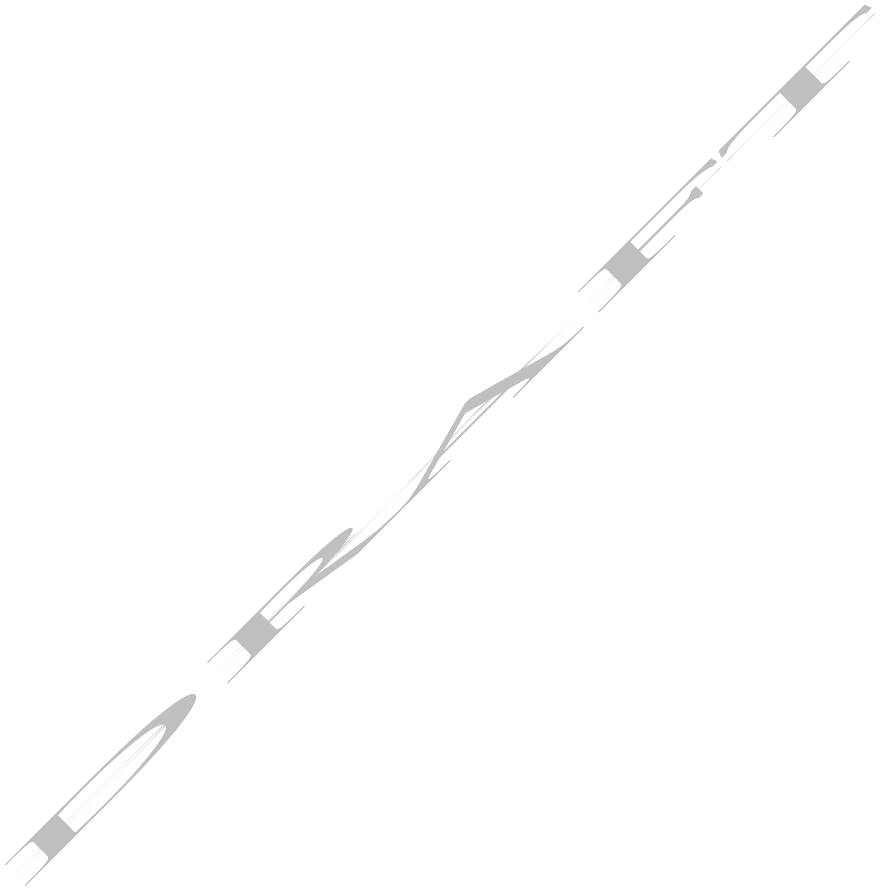
*Notes: Data 5/6/2022. Counts of residents are unduplicated per each measure; a resident may be involved in more than one activity during the reporting period. Counts of activities are unduplicated. *Indicates measures that involve activities that were temporarily suspended due to COVID-19 protocols at Glencliff Home.*

***The In-Reach Liaison position has been vacant since September 2021. NAMI-NH was awarded the In-Reach Liaison contract in July 2022 and is actively recruiting for the position.*

****The local PSA resumed in-person in-reach activities in late March 2022*



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



Peer Support Agency	April – June 2022		January – March 2022	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
Alternative Life Center Total	**213**	**35**	**139**	**33**
Conway	24	9	25	8
Berlin	104	7	9	8
Littleton	40	10	43	7
Colebrook	45	9	62	10
Stepping Stone Total	**378**	**7**	**376**	**7**
Claremont	246	6	244	6
Lebanon	132	1	132	1
Lakes Region Consumer Advisory Board Total	**89**	**3**	**155**	**7**
Laconia	32	1	63	2
Concord	57	2	92	5
Monadnock Keene Total	**216**	**34**	**427**	**37**
H.E.A.R.T.S Nashua Total	**301**	**34**	**382**	**26**
On the Road to Wellness Total	**245**	**15**	**240**	**16**
Manchester	127	9	125	8
Derry	118	6	115	8
Connections Portsmouth Total	**133**	**4**	**128**	**7**
Infinity Rochester Total	**265**	**9**	**224**	**24**

Peer Support Agency	April – June 2022		January – March 2022	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
Total	**1840**	**152**	**2,071**	**157**

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

Notes: Data Compiled 8/8/2022. Average Daily Visits are not applicable for Outreach Programs.

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

Measure	April – June 2022			January – March 202
All Housing Subsidies Targeted for CMHA Population	**Quarterly Count**	**Quarter's Total**	**Quarterly Change**	**Pri Quarte To**
1. Total Supported Housing Subsidy Funding (1.a. + 1.b.)		931	24	9
a. Percentage from Housing Bridge (2.a to 2.c.)	378	40.6%	1.2%	39
b. Percentage from Other Subsidies (3.a. to 3.f.)	553	59.4%	-1.2%	60.6
Housing Bridge Program	**Quarterly Count**	**Quarter's Total**	**Quarterly Change**	**Pri Quarte To**
2. Total Housing Bridge Program Participants at Quarter's End (2.a. to 2.c.)		378	21	3
a. Percentage Housed in Bridge Unit at Quarter's End (Active Status)	280	74.1%	-0.4%	74.5
b. Percentage Seeking Bridge Unit Lease at Quarter's End (Active Status)	80	21.2%	2.7%	18.5
c. Percentage Not Actively Seeking Bridge Unit Lease at Quarter's End (Active Status)	18	4.8%	-2.2%	7.0
d. Percentage of Participants Linked to Mental Health Care Provider Services (based on 2.a. to 2.c.)	357	381	93.7%	91.8
Subsidized Housing Through Other Voucher Programs	**Quarterly Count**	**Quarter's Total**	**Quarterly Change**	**Pri Quarte To**
3. Total Housed Through Other Voucher Program at Quarter's End (3.a. to 3.f.)		553	3	5
a. Percentage Housed Through Section 8 Subsidy – Transitioned From Housing Bridge	298	53.9%	0.3%	53.6
b. Percentage Housed Through Section 8 Subsidy – Not Previously Receiving Housing Bridge	0	0.0%	0.0%	0.0

c. Percentage Housed Through 811 – PRA Subsidy	139	25.1%	-0.5%	25.6
d. Percentage Housed Through 811 – Mainstream Subsidy	75	13.6%	0.0%	13.6
e. Percentage Housed Through Integrative Housing Program	21	3.8%	0.3%	3.5
f. Percentage Housed Through Other Permanent Housing Voucher (e.g., HUD, Local Public Housing, Veterans Administration)	20	3.6%	0.0%	3.6

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

Notes: Data Compiled 8/8/2022. Line 2.d. "Participants Linked" are Housing Bridge clients who received one or more mental health services within the previous 3 months, documented as a service or claim data found in Phoenix or the Medicaid Management Information System. Line 3.a. count is cumulative, increasing over time since inception within the CMHA Quarterly Data Report; it reflects participants who transitioned to permanent housing that is no longer funded by a Housing Bridge Subsidy. Line 3.b. is a count of CMHC clients who received a Section 8 Voucher during the reporting period but were not previously receiving a Housing Bridge Subsidy. Lines 3.c. and 3.d. counts are CMHC clients who received a PRA or Mainstream 811 funded unit with or without previously receiving a Housing Bridge Subsidy. Line 3.e. counts are criminal justice involved CMHC clients who received an Integrative Housing Subsidy from DHHS (a Bridge-like subsidy for individuals with an inability to currently qualify for a Section 8 Voucher but are anticipated to be able to qualify after 5 or less years). Line 3.f. counts are CMHC clients who received a unit funded through other HUD or Public Housing sources with or without previously receiving a Housing Bridge Subsidy.

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

Measure	April – June 2022			January – March 2022
1. Access to Program Services Statewide: Percentage of Total Active Cases by Referral Source	**Quarterly Count**	**Quarter's Total**	**Quarterly Change**	**Prior Quarter Tot**
a. Unduplicated Cases		378	5.9%	3
i. Community Mental Health Centers		96.6%	1.6%	97.5
ii. New Hampshire Hospital		2.9%	-0.5%	3.4
iii. NFI North		0.5%	-1.2%	1.7

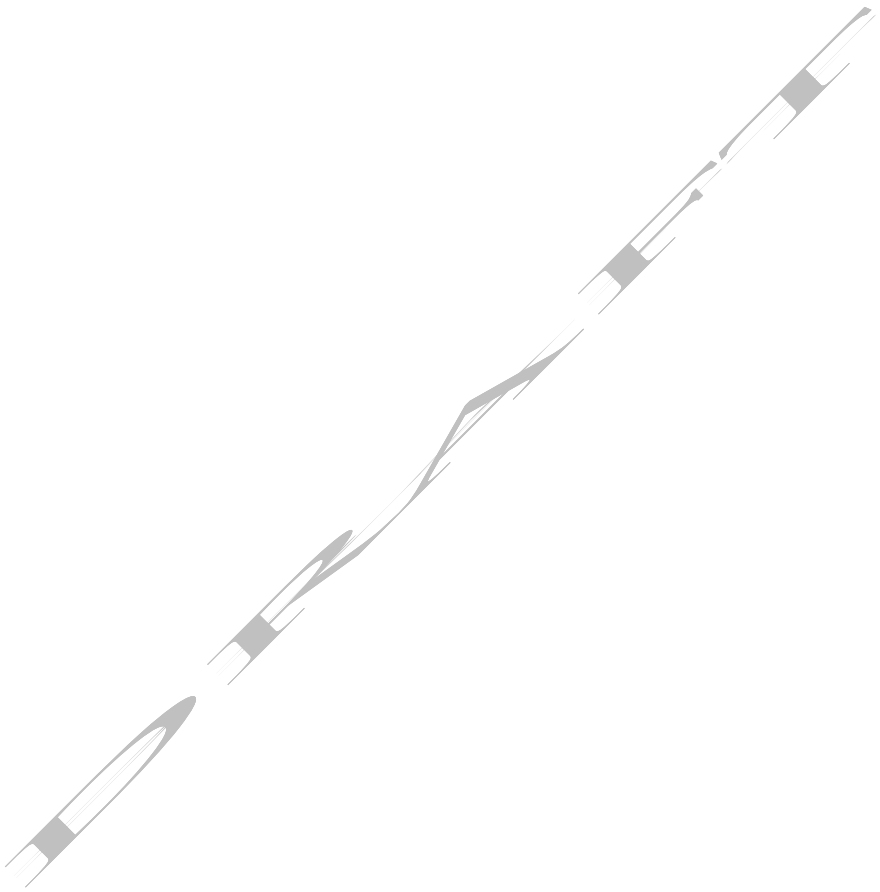
2. Access to Supported Housing: Housing Bridge Program Waitlist	**Quarterly Count**	**Quarter's Total**	**Quarterly Change**	**Pri Quarte Tot**
a. Unduplicated Individuals on Waitlist at Quarter's End (Point-in-Time Count, 2.b.i. to 2.b.iii.)		7	5	
i. Percentage Waiting 0-60 Days	6	85.7%	-14.3%	100
ii. Percentage Waiting 61-180 Days	1	14.3%	14.3%	0.00
iii. Percentage Waiting 181+ Days	0	0.0%	0.0%	0.00
3. Access to Scattered Site Housing: Percentage of Units Co-located at Same Address by Frequency	**Quarterly Count**	**Quarter's Total**	**Quarterly Change**	**Pri Quarte Tot**
a. 1 unit at same address	217	81.6%	6.4%	75.2
b. 2 units at same address	20	7.5%	0.4%	7.1
c. 3 units at same address	5	1.9%	-1.1%	3.0
d. 4 units at same address	2	0.8%	0.4%	0.4
e. 5 units at same address	0	0.0%	0.0%	0.0
f. 6 units at same address	0	0.0%	0.0%	0.0
g. 7 units at same address	0	0.0%	0.0%	0.0
h. 8 or more	0	0.0%	0.0%	0.0

Revisions to Prior Period: None.

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

Notes: Data Compiled 8/8/2022. Lines 3.a.-3.h counts represent the number of times, during the quarter, at the applicable co-location of units (e.g., 3.b. count of 15 indicates 30 actual units); property address may include multiple buildings, such as apartment complexes.

Reduction in waitlist per Line 2.a i-iii attributed to easing of pandemic and increased uptake in vaccinations resulting in landlord/property owner willingness to permit new tenants.



10. Housing Bridge Program Activity

Activity Type	April – June 2022	January – March 2022
1. Application Process and Average Elapsed Time in Days	**Quarterly Count / Days**	**Prior Quarterly Count / Days**
a. Applications Received During Period	53	48
i. Point of Contact for Applications Received	*46 CMHC, 6 NHH, 1 Glencliff*	*41 CMHC; 7 NHH*
b. Applications Approved	53	48
i. Completed Application to Determination (in Days)	1	1
c. Applications Denied	0	0
i. Denial Reasons	n/a	n/a
d. From Approval to Funding Availability (in Days)	20	9
2. Lease Up Process and Average Elapsed Time in Days	**Quarterly Count / Days**	**Prior Quarterly Count / Days**
a. Initial Lease Secured	26	12
i. From Funding Availability to Initial Lease (in Days)	89	21
b. Other Leases Secured in Quarter (Excludes Initial)	5	14
3. Removals from Waitlist [Prior to Active Status]	**Quarterly Count**	**Prior Quarterly Count**
a. Individuals Placed in Funded Status [Moved to Active]	0	0
b. Individuals Administratively Removed (3.b.i. to 3.b.x.)	0	0
Reasons for Removal i. Moved to different state	0	0
ii. Moved in with family	0	0

Activity Type	April – June 2022	January – March 2022
iii. Received PRA811 voucher	0	0
iv. Received Mainstream 811 voucher	0	0
v. Received other permanent housing voucher	0	0
vi. Required higher level of care	0	0
vii. Required DOC interventions, not ready for HBSP	0	0
viii. Moved into a sober living facility	0	0
ix. Owns own home (no longer eligible)	0	0
x. Unable to locate or contact	0	0
c. Total Individuals Removed from Waitlist (3.a. + 3.b.)	0	0
4. Exits and Terminations [After Active Status]	**Quarterly Count**	**Prior Quarterly Count**
a. Client Related Exits (4.a.i. to 4.a.ix.)	23	42
Reasons for Exit: i. Permanent Voucher Received	3	10
ii. Deceased	1	1
iii. Over Income	0	1
iv. Moved Out of State	0	3
v. Declined Subsidy at Recertification	8	8
vi. Higher Level of Care Accessed	6	12
vii. Other Subsidy Provided	5	3
viii. Moved in with family	0	4
ix. Became incarcerated	0	0
x. Transferred to Integrative Housing Voucher Program	0	0

Activity Type	April – June 2022	January – March 202
b. DHHS Initiated Terminations	3	
Reason for Termination	N/A	N/A
c. Total Program Exits and Termination (4.a + 4.b)	23	
i. Failed to pay rent for three consecutive months	0	
ii. Income over allowable limit	1	
iii. No longer eligible when removed from waitlist	2	
d. Total Program Exits and Terminations (4.b. + 4.c.)	26	4

Revisions to Prior Period: None. Data Source: Bureau of Mental Health Services and Housing Bridge Provider.

Notes: Data Compiled 8/8/2022. Average elapsed time reflects only those applications with the applicable activity occurring during the quarter. Lines 4.a. and 4.a.i. through 4.a.ix include individuals who were receiving an HBSP subsidy or who had HBSP funding approved and were seeking a unit prior to exiting the program. Includes all declinations, including declining to initiate voucher and unable to contact.

11. Rapid Response Services and Supports for Adults

	04 Riverbend Community Mental Health Center		06 Greater Nashua Mental Health		07 Mental Health Center of Greate Manchester	
	Apr – Jun 2022	Jan – Mar 2022	Apr – Jun 2022	Jan – Mar 2022	Apr – Jun 2022	Jan Ma 202
Unique Clients Served by the Access Point[1,2]	417	401	268	265	542	53
Access Point Support Contacts (Telephone, Text, Chat)[1]	648	712	527	399	1,030	90
Access Point Support Contacts: Telephone	956	704	509	388	1,021	87
Access Point Support Contacts: Text	1	2	0	2	2	
Access Point Support Contacts: Chat	11	6	18	9	7	2
Referral Source to Access Point[1]:						
Emergency Department	0	1	0	0	1	
Family	37	27	37	16	30	3
Friend	1	1	1	0	0	
Guardian	0	0	0	1	0	
Law Enforcement[4]	0	0	0	0	0	
Mental Health Provider	18	15	9	6	61	4
Other	149	123	85	44	148	11
Primary Care Provider	6	1	1	0	9	

School	6	1	1	0	4	
Self	86	102	68	29	103	7
Access Point Deployments[1]	214	169	132	65	259	21
Unique Rapid Response Clients Served by CMHC[2]	261	189	218	155	475	437
CMHC Crisis Intervention Services:						
Mobile Community Assessments	82	79	28	24	160	19
Office-Based Assessments	44	55	38	25	97	9
ED Based Assessments	23	12	1	1	0	
Phone Support/Triage	114	90	0	0	50	15
CMHC Crisis Stabilization Services[3]	252	287	564	406	1,107	94
Unique Rapid Response Clients Served by CMHC with Crisis Events involving Law Enforcement[2]	8	10	12	7	43	7
CMHC Hospital Diversions	163	134	50	49	218	11
CMHC Crisis Apartments						
Apartment Admissions	23	28	15	5	1	
Apartment Bed Days	72	99	48	28	2	8
Apartment Average Length of Stay	3.1	3.5	3.2	5.6	2.0	14

Revisions to Prior Period: None.

Data Source: Phoenix 2 & Rapid Response Access Point (RRAP)

Date Data Compiled 08/02/2022

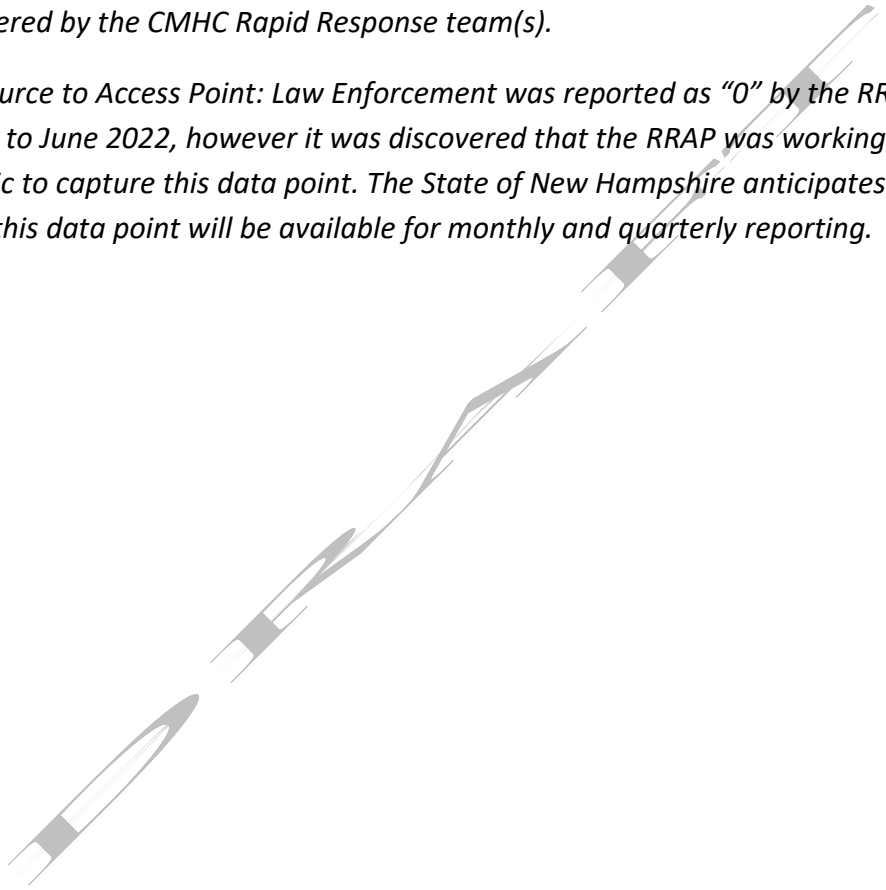
Notes:

1. The data source of this data element is the Rapid Response Access Point (RRAP).

2. Reported values, unless otherwise indicated, are not de-duplicated at the individual level. This means individuals can be counted multiple times for service use, hospital diversions, etc. This count does not include unique individuals served by the Access Point.

3. CMHC Crisis Stabilization Services include "Peer Support", "Psychotherapy", and "Other" services delivered by the CMHC Rapid Response team(s).

4. Referral Source to Access Point: Law Enforcement was reported as "0" by the RRAP from January 2022 to June 2022, however it was discovered that the RRAP was working to implement reporting logic to capture this data point. The State of New Hampshire anticipates that starting in July 2022, this data point will be available for monthly and quarterly reporting.



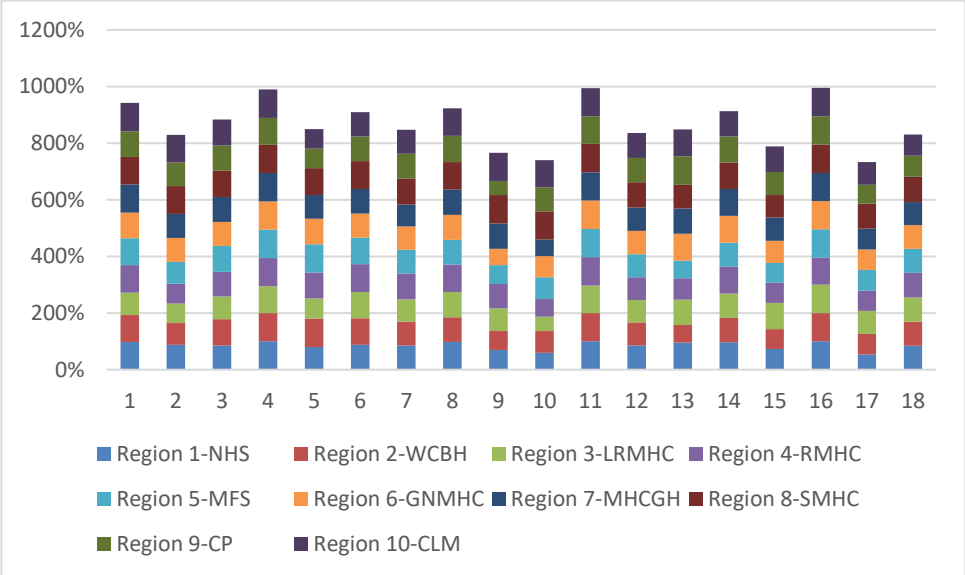
Appendix B

State Fiscal Year 2021 Quality Services Report Summary

	Region 1-NHS	Regio 2- WCBH

1	Adequacy of Assessment	98%	9
2	Appropriateness of treatment planning	88%	7
3	Adequacy of individual service delivery	86%	9
4	Adequacy of Housing Assessment	100%	10
5	Appropriate of Housing Treatment Plan	80%	10
6	Adequacy of individual housing service delivery	88%	9
7	Effectiveness of Housing supports provided	85%	8
8	Adequacy of employment assessment/screening	98%	8
9	*Appropriateness of employment treatment planning	70%	6
10	*Adequacy of individual employment service delivery	60%	7
11	Adequacy of Assessment of social and community integration needs	100%	10
12	Individual is integrated into his/her community, has choice, increased independence, and adequate social supports	86%	8
13	*Adequacy of Crisis Assessment	96%	6
14	Appropriateness of crisis plans	97%	8
15	*Comprehensive and effective crisis service delivery	73%	7
16	Adequacy of ACT Screening	100%	10
17	*Implementation of ACT Services	54%	7
18	*Successful transition/discharge from the inpatient psychiatric facility	85%	8
	AVERAGE of Indicators	**86%**	**8**

Highest Scoring CMHC(s) for each Indicator



Appendix C

Findings of the ER Glencliff On-Site Reviews

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

This review focused on the following CMHA provisions specifically relevant to transition planning and effectuating transitions to integrated community settings on the part of Glencliff residents:

> Section VI.A.1 and 3: "The State, through its community mental health providers and/or other relevant community providers, will provide *each* individual in NHH and Glencliff with effective transition planning and a written transition plan" setting forth in reasonable detail the particular services and supports needed to "successfully transition to and live in an integrated community setting" and setting forth "any barriers to transition to an integrated community setting and how to overcome them" (Emphasis added);
>
> Section VI.A.2 (a) through (e). Note that Section (e) states: that transition planning will "not exclude any individual from consideration for community living based solely on his or her level of disability";

Section VI.A.4 , which states, in part: "... the State will make all reasonable efforts to avoid placing individuals into nursing homes or other institutional settings";

Section VI.A.7 and 8, which require the State to implement a system of in-reach activities to enable Glencliff residents to meet with CMHPs to "develop relationships of trust" with CMHCs and other providers and to "actively support" residents to transition to the community with proactive efforts to educate residents and family members/guardians about community options; and

Sections V.E.2 (a) and (b) and Sections V.E.3(g) through (j), which require the State to develop integrated community living options for individuals with complex health care needs according to an implementation schedule and wait list provisions.

Based on that January 2020 review, the ER prepared recommendations for State/DHHS-led actions and interventions:

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

Based in part on the findings of the ER Glencliff report, the State developed a new transition planning policy and transition engagement protocols intended to expand and improve transition planning for all Glencliff residents. Representatives of the Plaintiffs provided substantial recommendations and examples to assist the State to design a more effective transition planning process. This revised process was finalized in October 2020.

May 8 and 9, 2021 Follow-up Review

The ER conducted a follow-up site visit to Glencliff on May 8 and 9, 2021. There were two primary purposes for the site visit:

1. To observe and monitor the implementation of the in-reach program initiated over a year ago via a contract with Northern Human Services; and
2. To observe and monitor implementation of the Glencliff Home Transition Planning Policy and Informed Choice procedure promulgated on October 1, 2020.

The site visit included the following activities, listed sequentially:

1. Introductory discussion and up-date with Glencliff senior management;
2. Extensive interview and discussion with the in-reach coordinator on contract through Northern Human Services;
3. Observation of a resident transition meeting conducted via ZOOM;
4. Observation of a face-to-face discussion of informed choice/visioning between the in-reach coordinator and a resident;[26]
5. Review of several individual resident records to identify documentation of transition planning and informed consent consistent with the revised policies implemented on 10/1/2020.

Overview

This is the ER's summary, issued shortly after the visit.

It is important to recognize that COVID has substantially affected operations at the Glencliff Home for the past 19 months. Glencliff has done a good job keeping residents and staff safe from COVID infections, in part by restricting internal face-to-face interactions and eliminating most face-to-face interactions among Glencliff and community providers. This, in turn, has impacted implementation of in-reach and community transition activities. Nonetheless, the in-reach coordinator has recorded interactions with over 40 Glencliff residents.

Glencliff has actively participated in the State's recent initiative to transfer residents of NHH and Glencliff to private nursing facilities as part of an over-all strategy to reduce the number of people who wait for psychiatric admissions in hospital emergency rooms. Glencliff management reported that the receiving nursing facilities receive a payment of $45,000 for each transfer, plus an enhanced per diem rate for as long as the resident remains at the receiving facility. Since May 5, 2021, a total of at least nine Glencliff residents[27] have been transferred to nursing facilities.

[26] Note: this resident has since been transitioned to a 3-bed medical model group home. Extensive transition planning and community service linkages had been in place, but the informed consent/visioning discussion was not conducted until the transition plan was already in place.
[27] One additional Glencliff resident transferred to a nursing facility, but the transfer occurred before the financial incentives were initiated.

This is a larger number of nursing facility transfers than Glencliff believes would have occurred absent the State's financial incentives to nursing facilities.

Glencliff management reported that the daily census on the first day of the site visit was 99, with a goal of achieving an average daily census of 95 going forward. Management reports that insufficient nursing staff is available to serve a Glencliff census greater than 95 at the current time. Thus, the incentive to transfer residents to nursing facilities from Glencliff has not resulted in new admissions capacity, but rather has assisted Glencliff to meet its staffing level shortage-driven census reduction goals.

Due to census reduction and staff shortages, Glencliff management has re-distributed residents among floors/units to make best use of available staffing. As a result, 10 -12 residents needing the least amount of nursing attention and support have moved to the Green Unit. This may create opportunities for internal programming and in-reach designed to facilitate transitions to integrated community settings. As yet though, no such special programming or targeted in-reach is reported to be in place for individuals residing in the Green Unit.

The In-Reach Coordinator

The in-reach coordinator had been in place for over a year as of the date of this report. As noted above, the in-reach coordinator has recorded interactions with over 40 individuals. The coordinator reports that he has conducted the informed consent/visioning process for 17 of these individuals. His office is in the residential building so he reports having many informal interactions/communications with residents as well as those more formal or structured interactions that result in an entry into the monthly log or progress notes for individual resident records.

The in-reach coordinator maintains a monthly activity log[28] in addition to entering transition plan information and progress notes into individual resident records. The ER utilized the most recent monthly report as a basis for detailed discussions with the in-reach coordinator. This allowed for specific discussions about informed consent, visioning, and transition planning activities with individual residents, as well as more general discussions on in-reach activities, issues, and barriers.

The in-reach coordinator reports that most of the residents he has worked with are not seeking integrated community living. He stated that guardians and family members tend to emphasize safety and medical care issues as opposed to independence and community living. He stated that he intends to address certain guardian and family member concerns in the future, but to date reports no proactive strategy or plans to address these issues.

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

Of the transitions accomplished since March 2020, three have gone to integrated community settings.[29] Two additional individuals were reported to be transitioning very soon to community settings. The in-reach coordinator reports being actively involved with these transitions to community settings, but also reports being actively involved with many residents transitioned (or transitioning) to nursing facilities or other congregate settings.

Observations

These observations are based on the extensive interview/discussions with the in-reach coordinator, observations of the two face-to-face resident meetings noted above, and record reviews.

Positive Observations

1. A total of five transitions to community settings[30] will have occurred in the past 19 months.
2. Several applications for Bridge subsidies have been submitted on behalf of Glencliff residents, and applications for Housing Choice Vouchers have also been submitted on behalf of Glencliff residents. The in-reach coordinator reports positive experiences with the Bridge Subsidy Program application process. The ER understands that at least two of the recent transitions have been facilitated by access to Housing Choice Vouchers. (The ER believes Bridge Subsidy Program subsidies could have been used for these if the vouchers had not become available.)
3. The in-reach coordinator reports positive interactions with housing staff at several CMHCs related to housing applications and housing search.
4. The in-reach coordinator reported improved relationships and communications with several CMHCs.
5. The in-reach coordinator reported several attempts to assist residents to participate in externally-provided services such as Alcoholics Anonymous and anger management.
6. Improved communications and responsiveness vis-à-vis Area Agencies and CFI applications and case management were also reported by the in-reach coordinator.

Concerns

1. The in-reach coordinator reports completing the informed consent/visioning process with only 17 residents. Plus, in a sample of records, the results of using the informed consent/ visioning script were not well documented. Nor were there any follow-up or next steps specifically described in the records. For one individual, a visioning/transition planning

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

[30] I did not use the term "integrated community settings" because one of the five is moving to an independent apartment that is part of a 24-unit facility specifically for people with disabilities.

session was recorded in January, but no further contact or communication was recorded for that individual.

2. The in-reach coordinator reports having been given written materials regarding the HOPES program by Glencliff management, but stated that no action has been taken to date to re-start the HOPES program. Thus, there are currently no formal or generally available internal services focusing on life skills training and independent living skills for residents of Glencliff.
3. The in-reach coordinator reports spending considerable time and effort assisting to effectuate nursing facility transfers for Glencliff residents. He reports contacting and communicating with numerous nursing facilities, completing facility applications, sending requested medical records, and otherwise seeking to facilitate nursing facility transfers. These efforts are well documented in the sample of individual resident records and also in the monthly activity log. The ER is concerned that the amount of time and effort being spent on nursing facility transfers reduces the amount of time available for priority, integrated community placement functions of the in-reach coordinator.
4. In fact, it appears that the in-reach coordinator has de facto become a "social work staff extender" for Glencliff. That is, he is spending considerable time and effort carrying out functions and activities typically carried out by Glencliff's two social workers. Progress notes entered into the sample of records reviewed mirrored the types and contents of progress notes typically entered by the social workers.[31]
5. At the same time, the ER could find no documentation in the sample of records reviewed that residents transferred to nursing facilities had been offered information on integrated community alternatives or other optional settings. Nor was there detailed documentation of barriers to transition to integrated community settings. And, it was not possible to identify documentation that such information was discussed or shared with individual guardians or family members. Thus, the ER cannot conclude or document that the required informed consent process was completed prior to transfers from Glencliff to other nursing facilities.
6. The in-reach coordinator identified several circumstances in which a resident's guardian or family member was opposed to transition to integrated community settings, and that such opposition caused transition planning to be discontinued. No plans or strategies for engaging these guardians/family members were developed or implemented, and the ER could find no documentation in the record that such strategies were to be attempted. The in-reach coordinator stated that he plans to address some of these issues, particularly with guardians who have multiple clients residing at Glencliff. However, he reported that such activities have not yet been initiated.

Conclusions

[31] One of the two Glencliff social workers has been out on extended medical leave, and the in-reach coordinator reports "filling in" as "part of being on the team" within Glencliff.

The Transition Planning and Informed Consent policies and procedures promulgated in October of 2020 were intended to specifically and pro-actively address non-compliance with the CMHA documented in previous site visits. And, the in-reach contract with Northern Human Services was specifically designed to provide capacity and an independent voice to effectuate the changes envisioned in the new policies to advance compliance with the CMHA.

The ER concludes that neither of these objectives has been accomplished. The ER was unable to find either documentation or anecdotal evidence that comprehensive transition planning and informed consent have been implemented at Glencliff. In fact, in the sample of records reviewed, the ER could find no documentation of informed consent that complies with Glencliff's own policies for individuals transferred to nursing facilities or other placements. Nor could the ER find documentation that other alternatives had been identified or considered by Glencliff staff, including the in-reach coordinator. Barriers to discharge to integrated community settings, and efforts to overcome these barriers, was not clearly documents in the records. Evidence that there had been efforts to intervene with or inform guardians or family members about less restrictive alternatives for the individuals transferred to nursing facilities was also not present in the records. The ER is not able to conclude or document that the purposes and specific requirements of the Glencliff transition planning policies have been carefully or systematically implemented by Glencliff or by the independently-contracted in-reach coordinator.