



# New Hampshire Community Mental Health Agreement Monthly Progress Report

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*July, August, September 2017*

New Hampshire Department of Health and Human Services

December 1, 2017

## Acronyms Used in this Report

ACT:	Assertive Community Treatment
BMHS:	Bureau of Mental Health Services
CMHA:	Community Mental Health Agreement
CMHC:	Community Mental Health Center
DHHS:	Department of Health and Human Services
SE:	Supported Employment
SFY:	State Fiscal Year

## Background

This Monthly Progress Report is issued in response to the June 29, 2016 Expert Reviewer Report, Number Four, action step 4. It reflects the actions taken in July, August and September 2017, and month-over-month progress made in support of the Community Mental Health Agreement (CMHA) as of September 30, 2017. Three months of data is released in this singular report due to delays experienced in receiving data from the Community Mental Health Centers. Data contained may be subject to change upon further reconciliation with CMHCs. This report is specific to achievement of milestones contained in the agreed upon CMHA Project Plan for Assertive Community Treatment (ACT), Supported Employment (SE) and Glenclyff Home Transitions. Where appropriate, the Report includes CMHA lifetime-to-date achievements.

## Progress Highlights

### Assertive Community Treatment (ACT)

Goal	Status	Recent Actions Taken
CMHC fidelity to ACT evidence-based practice model annually assessed.	2017: 10 of 10 completed  2018: 4 of 10 completed	<ul style="list-style-type: none"> <li>• 3 fidelity reports issued, improvement plans in place; 4<sup>th</sup> report in process</li> <li>• 2018 fidelity reports compare progress from 2017</li> <li>• New improvement plan template developed and implemented</li> </ul>
Provide ACT team services, consistent with standards set forth, with the capacity to serve at least 1,500 individuals.	Capacity: July – 1,265 August – 1,256 Sept. – 1,242  Enrollment: July – 912 August – 904 Sept. – 915	<ul style="list-style-type: none"> <li>• Ongoing technical assistance at CMHC specific level delivered by external DHHS consultant</li> <li>• Launched 6-part training series 6/27/17 for ACT team leaders, substance use specialists, and team members on Co-Occurring Disorders (COD) treatment within ACT. Series capacity permits 4 ACT staff per session; participation is high; one MCO also participates. Series runs through December 2017. Topics include: initial training on addiction and recovery; substance use and affects; screening, assessment and functional analysis; stage-wise psychosocial and medication interventions; motivational strategies for people with COD; and group treatments for people with COD.</li> </ul>

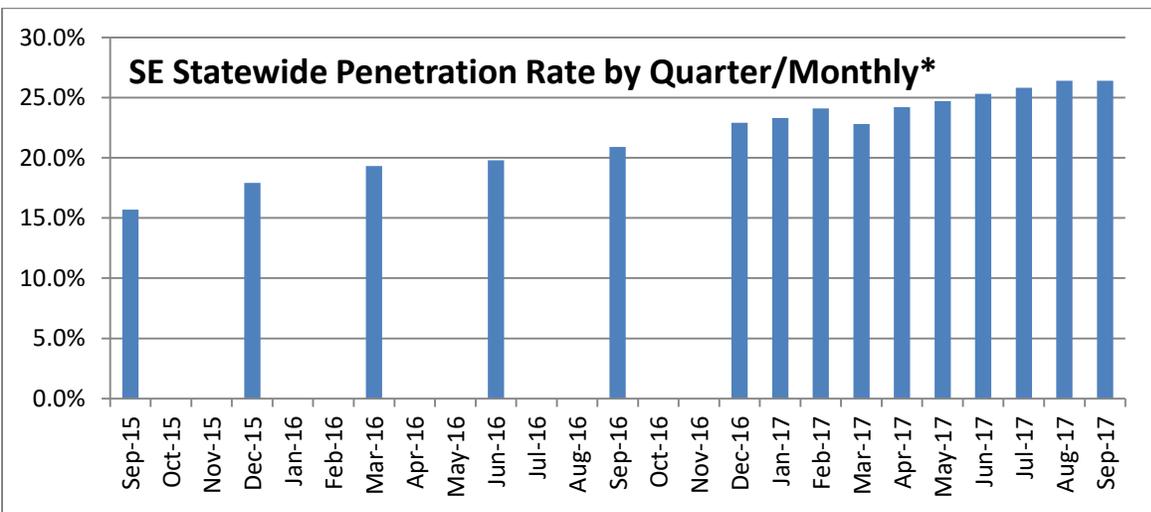
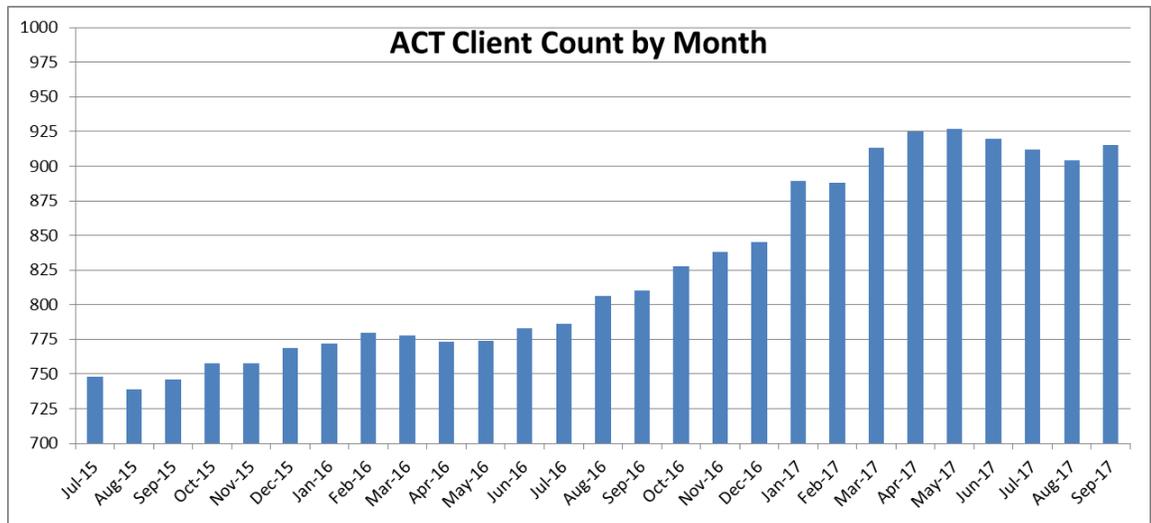
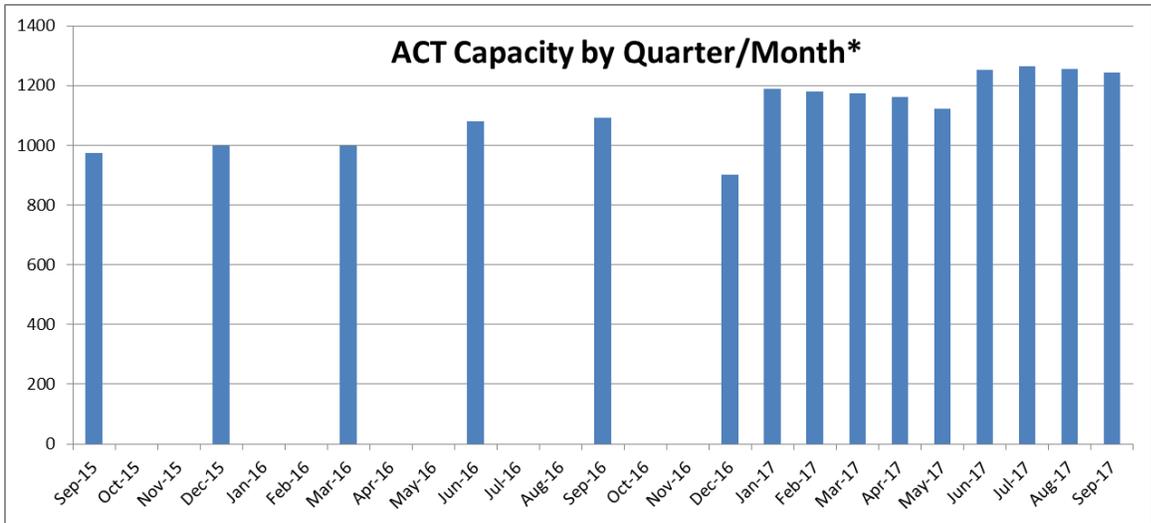
### Supported Employment (SE)

Goal	Status	Recent Actions Taken
CMHC fidelity to SE evidence-based practice model annually assessed.	2017: 10 of 10 completed  2018: 3 of 10 completed	<ul style="list-style-type: none"> <li>• 3 fidelity reports issued, improvement plans in place</li> <li>• 2018 fidelity reports compare progress from 2017</li> <li>• New improvement plan template developed and implemented</li> </ul>
Increase penetration rate of individuals with a Serious Mental Illness (SMI) receiving SE services to 18.6%.	Statewide penetration rate: July – 25.8% August – 26.4% Sept. – 26.4%	<ul style="list-style-type: none"> <li>• Ongoing technical assistance at CMHC specific level delivered by external DHHS consultant</li> <li>• Held Supported Employment Basic Training in July 2017; each CMHC was allowed 2 participants. Training designed for new SE specialists.</li> </ul>

## Glenclyff Home Transitions into Integrated Community Setting

Goal	Status	Recent Actions Taken
<p>Have capacity to serve in the community 16 (cumulatively) individuals with mental illness and complex health care needs residing at Glenclyff who cannot be cost-effectively served in supported housing.</p>	<p>14 of 16 completed<sup>1</sup></p>	<ul style="list-style-type: none"> <li>• In July 2017, a former Glenclyff resident, discharged originally in 2015, sought readmission to Glenclyff as behavioral health issues intensified. Through methods used to effectuate integrated community setting transitions, the individual was transitioned to a 4-person community residence</li> <li>• In November 2017, a resident transitioned to the community residence developed in late 2016.</li> <li>• Coordinating a 15<sup>th</sup> transition anticipated to be occur in December 2017</li> </ul>
<p>By June 30, 2017, identify and maintain a list of all individuals with mental illness and complex health care needs residing at the Glenclyff Home who cannot be cost-effectively served in supported housing and develop an effective plan for providing sufficient community-based residential supports for such individuals in the future.</p>	<p>Completed; ongoing</p>	<ul style="list-style-type: none"> <li>• 12 residents on the list</li> <li>• 11 of the 12 residents have selected their CFI transition case management service provider to actively support transition needs; the 12<sup>th</sup> is in process</li> </ul>

<sup>1</sup> Indicates residents have been transitioned into an integrated community setting; compliance with additional CMHA requirements for such transitions is under review.



\* Data is a combination of preliminary monthly and finalized quarterly data from CMHA Quarterly Data Reports.