New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Ten

September 10, 2019

I. Introduction

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

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

In this six-month period (January 1, 2019 through June 30, 2019), the ER has continued to observe the State's work to implement key service elements of the CMHA, and has continued to have discussions with relevant parties related to implementation efforts and the documentation of progress and performance consistent with the standards and requirements of the CMHA. During this period, the ER:

- Met with a clinical team and clinical leadership at New Hampshire Hospital (NHH) to review transition planning processes and issues;
- Reviewed the Preadmission Screening and Resident Review (PASRR) and Minimum Data Set (MDS) records for the six most recent admissions to Glencliff;
- Met with DHHS and PASRR contract agency staff to discuss the PASRR process and data reporting, and reviewed a set of PASRR level II assessment records;
- Observed the Quality Service Reviews (QSRs) conducted at Northern Human Services and the Mental Health Center of Greater Manchester;
- Conducted on-site visits to each of the three Mobile Crisis Teams (MCTs) and Crisis Apartment Programs (Concord, Nashua and Manchester);
- Met with DHHS Quality Management/Quality Service Review (QM/QSR) staff to discuss the Northern and Manchester QSR reviews;

- Convened an All Parties meeting to discuss progress in meeting the requirements of the CMHA;
- Convened three Assertive Community Treatment (ACT) working group meetings, with representatives of all parties, to discuss strategies for attaining CMHA compliance with regard to ACT services.

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

Summary of Progress to Date

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

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

Another major accomplishment has been contracting with the Dartmouth-Hitchcock Medical Center to conduct external ACT and Supported Employment (SE) fidelity reviews using nationally validated fidelity review instruments and criteria. In concert with the QSR reviews mentioned above, the fidelity reviews are assisting the State and the Community Mental Health Centers (CMHCs) to develop comprehensive Quality Improvement Plans (QIPs) that address important ACT and SE quality and effectiveness issues at both the consumer and CMHC operational levels. Statewide data from both the QSR and fidelity reviews are provided later in this report. These findings will play a central role in any final assessment of compliance with the CMHA, and in demonstrating the sustainability of systemic changes during the one year maintenance of effort period.

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

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

II. Data

As noted in previous reports, the New Hampshire DHHS continues to make progress in developing and delivering data reports addressing performance in some domains of the CMHA. Appendix A contains the most recent DHHS Quarterly Data Report (January to March, 2019), incorporating standardized report formats with clear labeling and date ranges for several important areas of CMHA performance. The capacity to conduct and report longitudinal analyses of trends in certain key indicators of CMHA performance continues to improve. The ER notes that completion of the six-month ER report was delayed by three months because the above-referenced Quarterly Data Report was produced too late to permit completion of this ER report by the expected June 30, 2019 date. The ER continues to emphasize that the State must take the steps necessary to produce the necessary data reports in a timely fashion.

III. CMHA Services

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

Mobile/Crisis and Crisis Apartment Programs

The CMHA calls for the establishment of a Mobile Crisis Team (MCT) and Crisis Apartments in the Concord Region by June 30, 2015 (Section V.C.3(a)). DHHS conducted a procurement process for this program, and the contract was awarded on June 24, 2015. Riverbend CMHC was selected to implement the MCT and Crisis Apartments in the Concord Region.

The CMHA specified that a second MCT and Crisis Apartments be established in the Manchester region by June 30, 2016 (V.C.3(b)). The Mental Health Center of Greater Manchester was selected to implement that program. Per CMHA V.C.3(c), a third MCT and Crisis Apartment program became operational in the Nashua region on July 1, 2017. The contract for that program was awarded to Harbor Homes in Nashua.

Table I below includes the most recent available information on activities of these three MCT/Crisis Apartment Programs.

Table I

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

	Concord Jan – March 2019	Manchester Jan – March 2019	Nashua Jan –March 2019
Total unduplicated people served	500	700	561
Services provided in response to immediate crisis:			
• Phone support/triage	959	1,520	764
• Mobile assessments	157	283	434
• Crisis stabilization appointments	54	113	0
• Emergency services medication appointments	0	0	1
• Office based urgent assessments	123	65	19
• Case Management	0		
• Peer support	0	132	405
		0	340
Referral source:			
• Self	589	433	218
• Family	38	151	50
• Guardian	25	25	1
• Mental health provider	40	33	98
• Primary care provider	15	251	4
• Hospital emergency department	4	2	41
• Police	17	210	7
• CMHC Internal	63	30	100
• Friend	15	18	14
• School	10	0	47
• Other	4	128	393
Crisis apartment admissions:	85	13	38
• Bed days	332	42	222
• Average length of stay	3.91	3.2	5.8
Law enforcement involvement	79	210	4
Total hospital diversions[1]	522	1,120	1,139

The Quarterly Data Report in Appendix A contains recent historical data for the three regional MCT/Crisis Apartment programs.

The ER conducted site visits at each of the MCT and Crisis Apartment programs in New Hampshire during the past six months. Each of the programs is fully staffed and, in the opinion of the ER, is generally operating in accordance with best practice approaches to mobile crisis and crisis apartment services. Each program is making good use of peer staff for both mobile crisis

[1] Hospital diversions are instances in which services are provided to individuals in crisis resulting in diversion from being assessed at the ED and/or being admitted to a psychiatric hospital.

response and for staffing of the crisis apartments. To varying degrees, each program is developing more effective relationships with local law enforcement agencies and local hospital emergency departments. To date, crisis apartment average lengths of stay have remained within reasonable ranges. There is some anecdotal evidence suggesting that the mobile team and crisis apartment interventions are beginning to influence pathways into hospital emergency department, inpatient psychiatric services, and local jails.

The ER remains concerned that the very high number of reported hospital diversions overstates the effect these programs have had on both psychiatric hospitalization and on emergency department boarding. However, at the same time as the MCT and crisis apartment programs have matured, there have also been other forces influencing mental health crises and psychiatric hospitalization. These include population changes in some geographic areas and the current opioid epidemic. Thus, it is not possible to assume there will be a one-for-one relationship between the diversionary successes of the MCTs and crisis apartment programs and the actual rate of psychiatric hospitalization or emergency department boarding.

Assertive Community Treatment (ACT)

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

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

The CMHA requires a robust and effective system of ACT services to be in place throughout the state as of June 30, 2015 (45 months ago). Further, as of June 30, 2016, the State was required to have the capacity to provide ACT to 1,500 priority Target Population individuals.

As displayed in Table II below, the staff capacity of the 12 adult ACT teams in New Hampshire has only increased by 1.9 FTEs since December of 2016, and has decreased by 0.5 FTE since March of 2018.

Table II

Self-Reported ACT Staffing (excluding psychiatry): December 2016 – March 2019

Region	FTE Dec-16	FTE Mar-17	FTE Jun-17	FTE Sep-17	FTE Dec-17	FTE Mar-18	FTE Jun-18	FTE Sep-18	FTE Dec-18	FTE Mar-19
Northern	11.5	11.9	12.5	12.4	13.0	11.6	12.7	13.1	17.3	16.8
West Central	5.5	7.8	7.2	7.0	6.2	5.0	5.2	5.3	5.8	6.8
Lakes Region	11.0	11.0	10.6	10.8	9.4	5.7	5.6	8.4	7.4	8.3
Riverbend	9.0	10.0	10.0	10.0	10.0	10.3	10.5	10.5	10.5	11.5
Monadnock	7.3	6.7	8.5	7.9	7.9	8.7	8.5	8.7	9.0	9.5
Greater Nashua 1	6.3	6.3	5.3	6.0	5.0	5.8	5.8	5.5	5.0	6.5
Greater Nashua 2	5.3	5.3	5.3	5.0	5.0	5.8	5.8	4.5	4.0	4.5
Manchester – CTT	15.5	14.8	16.6	16.3	12.8	17.3	15.5	14.8	14.3	14.3
Manchester MCST	21.4	21.9	22.0	22.3	19.0	19.5	16.3	17.8	15.8	15.8
Seacoast	9.5	9.5	9.5	10.5	10.5	11.5	9.5	10.5	11.1	9.1
Community Part.	6.9	4.1	8.5	6.7	7.9	9.8	9.6	9.1	7.8	8.8
CLM	7.2	8.3	9.3	9.3	9.3	9.3	8.3	7.6	6.6	7.9
Total	116.2	117.4	125.2	124.2	116.1	120.1	113.1	115.6	114.3	119.6

It is clear from the above table that overall ACT staffing has remained low. Three of the 12 adult ACT teams continue to have fewer than the 7 - 10 professionals specified for ACT teams in the CMHA. Seven teams have at least 1.0 FTE SE staff, while five have less than a full time SE specialist. Five teams report having .5 or less FTE combined psychiatry/nurse practitioner time available to their ACT teams[2]; and six of the 12 teams report having less than one FTE nurse per team. On a more positive note, all ACT teams are now reported to have at least .5 FTE Peer Staff as members of the teams.

Table III below displays the active ACT caseloads by CMHC Region for the past 21 months. The active monthly caseload decreased by four participants in the last quarter. Since June of 2017 the active monthly caseload has dropped by 83.

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

Table III

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

Region	Jun-17	Sep-17	Dec-17	Mar-18	Jul-18	Sep-18	Oct-18	Nov-18	Dec-18	Mar-19
Northern	111	113	115	114	108	102	115	111	115	120
West Central	76	68	57	46	45	44	40	39	42	41
Lakes Region	74	74	65	64	59	53	53	51	51	51
Riverbend	97	87	81	80	78	82	83	83	87	96
Monadnock	70	69	53	55	55	55	57	56	56	59
Greater Nashua	94	98	76	74	85	84	84	79	77	67
Manchester	292	287	269	277	302	306	310	312	312	303
Seacoast	69	67	54	66	69	69	67	67	71	70
Community Part.	69	75	64	66	59	61	63	62	64	66
CLM	55	54	55	59	57	55	55	54	53	51
Total*	1,006	992	881	901	917	911	927	913	927	923

The combined ACT teams have a reported March 2019 staff complement of 119.61 FTEs excluding psychiatry, which is sufficient capacity to serve 1,196 individuals based on the ACT non-psychiatry staffing ratios contained in the CMHA. With a statewide caseload of only 923 as of March 2019, the existing teams should theoretically be able to enroll an additional 273 new ACT clients without additional staff. Tapping into this unused capacity with appropriate outreach and targeting should have an impact on alleviating ED boarding and hospital readmission rates across the state. Further, the CMHA requires the State to have capacity to serve 1,500 individuals, but the current ACT capacity of 1,196 is 304 below CMHA criteria.

As noted in previous reports, the current level of ACT staffing is not sufficient to meet CMHA requirements for ACT team capacity. Furthermore, current ACT enrollment of 923 individuals is 577 below the number that could be provided ACT services with the capacity required by 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; [3]
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 (including current active ACT participants) who may qualify for and benefit from ACT.

Table IV below presents data on ACT screens conducted by CMHCs between October and December, 2018. This is the third reporting period in which these data are available, and only the first reporting period for which data on the actual number of ACT assessments that result in enrollment in ACT are available.

[3] 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.

Table IV

Self-Reported Number of Unique Clients Screened for ACT Services

Conducted by CMHCs

October through December 2018

Community Mental Health Center	**Total Screened**	**Qualified for further ACT Assessment**	**Receiving ACT/ wi 90 days of Assessment**
01 Northern Human Services	1,192	24	6
02 West Central Behavioral Health	263	1	0
03 Lakes Region Mental Health Center	974	19	2
04 Riverbend Community Mental Health Center	1,481	8	1
05 Monadnock Family Services	203	4	1
06 Greater Nashua Mental Health	925	8	0
07 Mental Health Center of Greater Manchester	2,576	7	0
08 Seacoast Mental Health Center	1,142	13	1
09 Community Partners	508	2	2
10 Center for Life Management	494	10	0
Total	**10,028**	**96 (0.96%)**	**13 (13.5%)**

Of the 10,028 unique individuals screened for ACT during this period, the State reports that 96 were referred for an ACT assessment. This is a referral rate of less than one percent. And, less than 14 percent of those referred for ACT assessments were enrolled in ACT services within 90 days of being screened. Most of the referrals for ACT screening are internal to the CMHCs. That is, people who have already had a CMHC intake, and who may already be receiving CMHC services, are those most likely to be screened for ACT services. Thus, it is perhaps not surprising

that so few of the individuals screened are referred to the next step, which is the assessment for ACT. The State has stated its intention to conduct CMHC reviews to confirm that ACT eligibility criteria were applied in line with State rules and appropriate clinical standards for a sample of clients. The ER intends to monitor and report on the results of these reviews.

The State has begun collecting and reporting data on the number of individuals waiting for ACT services on a statewide basis. This information is displayed in Table V below. An individual eligible for ACT may have to wait for ACT services because the specific ACT team of the individual's CMHC does not currently have staff capacity to accept new clients. The ER has documented above that there is a statewide gap between ACT staff capacity and ACT participation. However, in some CMHC regions new ACT staff must be hired before new ACT clients can be accepted into the program.

Table V

Self-Reported ACT Wait List:

		Time on List		
	Total	**0-30 days**	**31-60 days**	**61-180 days**
March 31, 2019	2	1	1	0
December 31, 2018	6	3	0	3

ACT Fidelity and Quality

In addition to staff capacity and active caseloads for ACT services, the ER has been tracking and reporting ACT fidelity and Quality Service Review processes and results for the past two years.

ACT Fidelity

Table VI shows ACT fidelity total scores for each CMHC for the three most recent fidelity reviews for each ACT team. Note that these have not always been completed in the same 12 month period, and thus are not always comparable among the CMHCs. In some cases, three years of fidelity scores are not available for individual CMHCs or ACT teams within the CMHCs. However, system-wide trends in ACT fidelity scores are reliably reported in Table VI below. Note that scores in the 113 to 140 range indicate full implementation of ACT; scores in the 85 to 112 range indicate fair implementation of ACT; and scores at 84 or below indicate that it is not ACT service.

Table VI

ACT fidelity Year-to Year Comparisons

	Oldest SFY2017	Middle SFY2018	Latest SFY2019	Change
CLM	111	108	113	5
Nashua 1	115	97	88	-9
Nashua 2	NA	104	90	-14
Lakes	107	91	104	13
MFS	118	110	107	-3
MHGM CTT	122	106	100	-6
MHGM MCST	116	99	92	-7
NHS	105	NA	NA	NA
Berlin	NA	115	98	-17
Conway	NA	100	103	3
Littleton	NA	106	104	-2
Riverbend	104	106	107	1
WCBH	109	NA		NA
Claremont	NA	95	93	-2
Lebanon	NA	105	83	-22
Comm partners	115	97	102	5
Seacoast	98	114	116	2
		1,439	1417	-55
Average		95.9	92.3	-3.6

Unfortunately, the overall trend in ACT fidelity scores has been downward. In addition, one ACT team (Lebanon) fell below the Fidelity threshold of 84 in the most recent fidelity review.

ACT Quality Service Review Indicators

A CMHC is required to submit a Quality Improvement Plan (QIP) for any quality indicator identified as an area in need of improvement. That threshold is any quality indicator scoring less than 70% for state fiscal year 2018, less than 75% for state fiscal year 2019, and less than 80% for state fiscal year 2020 and subsequent years."

Indicator #17 of the Quality Service Review (QSR) is specifically focused on the "implementation of high fidelity ACT services." This indicator relies on input from clinical records, ACT participants, and ACT staff to generate a composite score of the degree to which actual consumers are experiencing the delivery of high fidelity ACT services. In the past two years, the CMHC system has averaged scores on indicator 17 that are below the 70% threshold

initially used to indicate the need for quality improvement plans. The current average score for indicator 17 of the QSR is 65.1%. This is based on all ten of the QSR reviews for the most recent annual cycle having been completed. The ER notes that the performance threshold for each QRS quality indicator has been increased to 80% for the SFY 2020 QSR cycle.

The ER notes that year to year comparisons show some improvement in the fidelity of ACT services as measured by the QSR. In the past year, eight of the CMHCs have improved their performance with regard to indicator 17, albeit none of these have increased scores to the 80% performance threshold. For two of the CMHCs, the score on indicator 17 went down in the year to year comparisons.

The DHHS has been using a standardized quality improvement process (QIP) to guide ACT remedial efforts and technical assistance when a given CMHC is identified by the fidelity review or QSR as needing improvement. There is some evidence that this QIP process is producing positive improvements in the field. For example, four CMHCs have been released from selected QIP requirements recently because their Fidelity or QSR scores improved sufficiently.

ACT Summary

Based on the above information, the ER finds that the State remains out of compliance with the ACT service standards described in Section V.D. of the CMHA. The State does not currently provide a robust and effective system of ACT services throughout the state as required by the CMHA.

ACT Working Group

As noted in recent ER Reports, the DHHS has taken deliberate steps to work with CMHCs in certain Regions to increase their ACT staffing and caseloads. These actions include: (a) quarterly ACT monitoring and technical assistance with DHHS leadership and staff; (b) implementation of a firm schedule for ACT fidelity reviews; (c) incorporating a small increase in ACT funding into the Medicaid rates for CMHCs; (d) active on-site and telephonic technical assistance based on CMHC needs related to improving the quality and fidelity of ACT services; and (e) coordinated efforts to address workforce recruitment and retention. The State has identified workforce recruitment and retention issues as factors limiting the growth and expansion of the ACT teams. The State has been working collaboratively with the New Hampshire Community Behavioral Health Association to identify and track workforce gaps and shortages, and to implement a variety of strategies to improve workforce recruitment and retention. However, as noted above, ACT staffing has remained essentially static since December of 2016.

Recently, the State has received approval from the federal Centers for Medicare and Medicaid Services (CMS) to use Medicaid waiver funds for directed payments (fee schedule adjustment) to CMHCs for recipients already enrolled in ACT and for each new ACT enrollee. CMS has also

approved a fee schedule increase for people discharged from psychiatric inpatient services who receive a same- or next-day appointment at a CMHC. Taken together, these initiatives should provide incentives for CMHCs to sustain and increase their ACT caseloads. Three million dollars has been set aside under this plan to provide fee schedule increases for ACT enrollees. An additional 1.2 million dollars has been budgeted for same or next day CMHC appointments. The impact of this new funding is not likely to be measurable until at least the next ER report in December, 2019.

These initiatives are welcome, but to date have not produced the desired results in terms of increased ACT capacity, active caseload, fidelity or quality.

Thus, the ER has requested that representatives of the Plaintiffs and the State participate in an ACT working group over the past few months. The purpose of this working group has been to develop a set of feasible, measurable action plans to quickly expand and improve ACT services consistent with the CMHA. The ACT working group has met three times, and is in process of developing a final set of concrete recommendations.

Recommendations will address at least the following topic areas:

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

In support of the ACT working group efforts, DHHS has been conducting internal analyses from existing data bases, and also requesting certain new information from the CMHCs. DHHS has begun circulating the results of these analyses to the members of the ACT working group. The following is a brief list of some of the new information being made available:

1. ACT referrals from NHH by Region;
2. ACT penetration rates by Region;

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

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

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

Supported Employment (SE)

Pursuant to the CMHA's SE requirements, the State must accomplish three things: 1) provide SE services in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings consistent with their individual treatment plans (V.F.1); 2) meet Dartmouth fidelity standards for SE (V.F.1); and 3) meet penetration rate mandates set out in the CMHA. For example, the CMHA states: "By June 30, 2017, the State will increase its penetration rate of individuals with SMI receiving supported employment … to 18.6% of eligible individuals with SMI." (Section V.F.2(e)). In addition, by June 30, 2017, "the State will identify and maintain a list of individuals with SMI who would benefit from supported employment services, but for whom supported employment services are unavailable" and "develop an effective plan for providing sufficient supported employment services to ensure reasonable access to eligible individuals in the future." (V.F.2(f)).

As shown in Table VII below, for the past two quarterly reporting periods, the State has been unable to report on the statewide SE penetration rate. One of the CMHCs has been working to validate its SE reporting data, and as a result, it cannot be included in the statewide computation of penetration rates until those data are verified. Nonetheless, the ER assumes that the statewide SE penetration rate continues to exceed the CMHA requirement of 18.6% penetration.

Table VII

Self-Reported CMHC SE Penetration Rates

	Penet. Dec-17	Penet. Mar-18	Penet. Jun-18	Penet. Sep-18	Penet. Dec-18	Penet. Mar-19
Northern	39.00%	38.80%	36.90%	32.10%	NA	NA
West Central	25.30%	26.20%	31.20%	33.80%	32.20%	27.20%
Lakes Reg.	19.10%	15.40%	12.10%	11.80%	11.80%	17.90%
Riverbend	13.20%	12.60%	11.80%	16.60%	17.20%	18.60%
Monadnock	10.90%	10.40%	11.00%	9.30%	7.80%	8.00%
Greater Nashua	16.80%	14.90%	14.20%	12.60%	13.00%	13.50%
Manchester	45.30%	43.50%	44.10%	44.10%	43.90%	42.40%
Seacoast	28.00%	30.10%	29.80%	29.90%	31.00%	32.10%
Community Part.	17.70%	21.50%	20.90%	19.20%	18.00%	14.00%
CLM	20.00%	20.90%	17.50%	20.80%	22.90%	21.00%
CMHA Target	18.60%	18.60%	18.60%	18.60%	18.60%	18.60%
Statewide Ave.	26.70%	26.40%	25.90%	25.90%	NA	NA

As noted in Table VII above, four of the nine reporting CMHCs continue to report penetration rates lower than the CMHA requirement.

The State has recently begun collecting and reporting data on the degree to which CMHC clients are working, either full or part time, in competitive employment. Table VIII summarizes the initial findings from these data collection efforts.

Table VIII

Competitive Employment for CMHC Clients

CMHC	Percent of Total Clients Emp. Full or Part Time January – March 2019	Percent of SE Active Clients Employed Full or Part Time January – March 2019
Northern	27.3%	44.2%
WCBH	19.1%	43.8%
LRMHC	17.5%	27.9%
Riverbend	25.8%	61.8%
Monadnock	23.0%	52.0%
Nashua	23.9%	31.9%
MHCGM	27.8%	54.3%
Comm. Prtnrs.	34.7%	31.3%
Seacoast	20.9%	57.1%
CLM	22.8%	56.5%
Statewide	25.5%	46.7%
October to December 2018 Statewide %	22.3%	42.6%

Access to competitive employment is an indicator of the quality and effectiveness of fidelity model SE services. The data reported above is too recent to support confident trend analyses, but they do provide a reasonable baseline for future analyses. The ER will continue to review these competitive employment data in concert with the available SE fidelity and QSR reports.

SE Fidelity and Quality

The DHHS is to be commended for continuing its efforts to: (a) assure the fidelity of SE services on a statewide basis; and (b) work with the Regions with penetration rates below CMHA criteria to increase access to and delivery of SE services to target population members in their Regions. The ER will continue to monitor these issues going forward as the State works with the CMHCs to increase penetration rates to at least 18.6 percent in all regions.

Table IX displays year-over-year comparisons of SE fidelity total scores for the ten CMHCs.

Table IX

Year over Year Comparisons of SE Fidelity Scores

	Previous	Recent	Change
CLM	116	115	-1
Nashua	80	88	8
Lakes	91	95	4
MFS	103	98	-5
MHCGM	110	105	-5
NHS			
Berlin	85	85	0
Conway	91	101	10
Littleton	89	93	4
Riverbend	106	98	-8
WCBH	80	77	-3
Seacoast	107	100	-7
Comm partners	103	76	-27
total	1161	1131	-30
Average	96.75	94.25	-2.5

As can be seen in Table IX, overall CMHC system SE Fidelity scores have gone down when compared to the previous year's SE fidelity scores. The CMHC system SE scores have gone down by an average of 2.5, and only four SE programs improved SE scores in the year-to-year comparison. Two CMHCs scored below 80, close to the threshold score of 73, below which the services no longer qualify as fidelity SE.

The QSR process has identified a number of SE performance issues among the CMHCs. For example, for the indicator related to comprehensive employment assessments, nine of the ten CMHCs for which most recent QSR reports are published scored below the 75% performance threshold.[4] In the same manner, two of the ten CMHCs scored below 75% on the indicator related to the adequacy of employment service delivery. In each case, these findings have resulted in the development of QIPs, and in state technical assistance and monitoring activities designed to improve the quality and effectiveness of SE services. As with ACT services, the QSR findings are not a substitute for SE fidelity reviews, but they do add to the overall documentation of the degree to which SE services are delivered with quality and effectiveness.

[4] Although remaining under the QSR quality threshold, four of the nine did improve their scores for this indicator between last year and this year.

For example, a SE team can operate at relatively high fidelity, but if individuals are not assessed properly for inclusion in SE services, there could be issues related to matching individual needs with the services available.

System performance in supported employment assessment and service delivery, as documented by the QSR and corresponding provider fidelity reviews, indicates that the State is not yet providing SE services in the amount, duration, and intensity to allow all target population members in New Hampshire opportunities to work the maximum number of hours in integrated community settings consistent with their individual treatment plans, and that eligible individuals may not be properly identified and provided reasonable access to supported employment services.

Supported Housing (SH)

The CMHA requires the State to achieve a target capacity of 450 SH units funded through the Bridge Program by June 30, 2016. As of March 2019, DHHS reports having 389 individuals leased in Bridge Program subsidized units, and having 11 people approved for a Bridge Program subsidy but not yet leased. There are 38 individuals who are reported to be on the Bridge Program wait list as of the end of March, 2019. Of these, 24 individuals have been on the wait list for more than two months. There has been a precipitous drop in the aggregate number of individuals either leased or approved but not yet leased in the Bridge Program – from 591 in June of 2017 to 400 in March 2019. In terms of funded capacity of Bridge Program units, the State was in compliance with the CMHA standards for SH effective June 30, 2016. However, as noted above, the number has now dropped substantially below 450, and currently there are only 11 individuals reported to be approved and in the search process for a SH unit.

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

Table X

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

December 2016 through March 2019

Bridge Subsidy Program Information	Dec. 2016	March 2017	June 2017	Sept. 2017	March 2018	Sept. 2018	March 2019
Total individuals leased in the Bridge Subsidy Program	481	505	545	509	497	423	389
Individuals in process of leasing	32	48	46	58	7	0	11
Individuals on the wait list for a bridge subsidy[5]	0	0	0	0	10	35	38
Total number served since the inception of the Bridge Subsidy Program	643	675	701	742	811	812	812
Total number transitioned to a HUD Housing Choice Voucher (HCV)	83	85	85	96	119	125	137

[5] The State did not maintain a waitlist prior to 2018.

Table XI

Self-Reported Housing Bridge Subsidy Applications and Terminations

Measure	**April – June 2018**	**July – September 2018**	**October – December 2018**	**January – March 2019**
Applications Received	28	32	12	29
Point of Contact				
CMHCS	24	32	12	22
NHH	4	0	0	5
Other	0	0	0	1
Applications Approved	5	7	5	14
Applications Denied	0	0	0	0
Denial Reasons	*NA*	*NA*	*NA*	*NA*
Applications in Process at end of period	165	197	209	53
Terminations	0	0	0	1
Termination Reasons	*NA*	*NA*	*NA*	
Over Income				1

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

Table XII

Self-Reported Housing Bridge Subsidy Concentration (Density)

	Nov. 2017	Feb 2018	June 2018	Sept. 2018	Decem-ber 2018	March 2019
Number of properties with one leased SH unit at the same address	383	372	354	339	329	315
Number of properties with two SH units at the same address	31	35	26	52	27	18
Number of properties with three SH units at the same address	6	13	10	24	4	3
Number of properties with four SH units at the same address	5	4	5	12	3	2
Number of properties with five SH units at the same address	0	1	0	0	1	2
Number of properties with six SH units at the same address	0	0	0	6	0	0
Number of properties with seven + SH units at same address	3	2	2	17	2	1

It should be noted that these data do not indicate whether any of the leased units are roommate situations, and if so, whether such arrangements meet the requirements of the CMHA (V.E.1(c)).

DHHS reports and anecdotal information seems to support, that there are very few, if any, roommate situations among the currently leased Bridge Subsidy Program units.[6]

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

Table XIII

Housing Bridge Subsidy Program Tenants Linked to Mental Health Services

	As of 12/31/18	As of 3/31/19
Housing Bridge Tenants Linked	373 of 443 (84%)	337 of 400 (84.5%)

These data document the degree to which Bridge Subsidy Program participants are actually receiving certain mental health or other services and supports.[7]

The CMHA also states that: "By June 30, 2017 the State will make all reasonable efforts to apply for and obtain federal Department of Housing and Urban Development (HUD) funding for an additional 150 supported housing units for a total of 600 supported housing units." (CMHA V.E.3(e)) In 2015 New Hampshire applied for and was awarded funds to develop a total of 191 units of supported housing under the HUD Section 811 Program. All of these units will be set aside for people with serious mental illness. As of the date of this report, 43 of these new units have been developed and are currently occupied by members of the target population. It should be noted that over the life of the Bridge Program the State has accessed 137 HUD Housing Choice Vouchers (HCVs) and one HUD public housing unit. Accessing these HCVs should allow the State to free up Bridge Program slots for new applicants, rather than reduce or eliminate existing Bridge program capacity. The ER plans to work with the state and representatives of the plaintiffs to assure documentation of progress towards the 600 specified units is attained and sustained.

In addition, the CMHA states that "By January 1, 2017, the State will identify and maintain a waitlist of all individuals within the Target Population requiring supported housing services, and whenever there are 25 individuals on the waitlist, each of whom has been on the waitlist for more than two months, the State will add program capacity on an ongoing basis sufficient to ensure that no individual waits longer than six months for supported housing." There are currently reported to be 38 individuals on the wait list for the Bridge program; 24 of these individuals have been on the wait list for more than two months and 22 of them have been waiting longer than six

[6] DHHS reports that currently there is one voluntary roommate situation reflected in the above data.
[7] Note: some of these tenants might be receiving services from MH providers other than a CMHC.

months for supported housing. Based on the above data: (1) the number of units under lease for the Bridge Program has fallen below the 450 capacity standard in the CMHA: (2) there are currently only 11 individuals who have been approved for a Bridge subsidy and are actively seeking a unit; and (3) there are at least 24 people on the Bridge Program wait list who have been on the list for more than two months.

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

The State reports that it is considering changes to the management and operations of the Bridge Housing Program. As of the date of this report the State has not reported final decisions about these potential changes. The ER is not able to comment at this time about whether the anticipated changes in the Bridge Housing Program will be effective in bringing the State into compliance with the CMHA SH requirements.

Transitions from Institutional to Community Settings

During the past 60 months, the ER has visited both Glencliff and NHH on at least nine separate occasions to meet with staff engaged in transition planning under the new policies and procedures adopted by both facilities in 2014[8]. Transition planning activities related to specific current residents in both facilities have been observed, and a small non-random sample of resident transition records has been reviewed. Additional discussions have also been held with both line staff and senior clinicians/administrators regarding potential barriers to effective discharge to the most appropriate community settings for residents at both facilities.

The ER has participated in six meetings of the Central Team. The CMHA required the State to create a Central Team to overcome barriers to discharge from institutional settings to community settings. The Central Team has now had about 48 months of operational experience. As of July 2019, 57 individuals have been submitted to the Central Team, 36 from Glencliff and 21 from NHH. Of these, the State reports that 29 individual cases have been resolved,[9] two individuals are deceased, and 28 individual cases remain under consideration. Table XIV below summarizes the discharge barriers that have been identified by the Central Team with regard to these 28 individuals. Note that most individuals encounter multiple discharge barriers, resulting in a total higher than the number of individuals reviewed by the Central Team.

[8] NHH updated its transition planning policies in 2018.
[9] Two of these individuals were readmitted to NHH after 90 days, and the discharge dispositions for these two individuals are being reviewed.

Table XIV

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

July 2019

Discharge Barriers	Number for Glencliff	Number for NHH
Legal	**6 (7.14%)**	**1 (7.14%)**
Residential	**17 (30.4%)**	**5 (35.7%**
Financial	**7 (7.14%)**	**1 (7.14%)**
Clinical	**15 (26.8%)**	**4 (28.6%)**
Family/Guardian	**10 (17.86%)**	**3(21.4%)**
Other	**1 (1.79%)**	**0(7.14%)**

Glencliff

In the time period from October 2018 through March 2019, Glencliff reports that it has admitted 18 individuals, and has had one discharge and 11 deaths.

The average daily census through this period was 112 people. There have been no readmissions during this time frame. The wait list for admission has remained relatively constant at 25 to 27 people for the past six months. The one discharge effectuated during this period was reported to be to an integrated community setting: a three-person medical model group home.

CMHA Section VI requires the State to develop effective transition planning and a written transition plan for all residents of NHH and Glencliff (VI.A.1), and to implement them to enable these individuals to live in integrated community settings. In addition, Section V.E.3(i) of the CMHA also requires the State by June 30, 2017 to: "…have the capacity to serve in the community [a total of 16][10] individuals with mental illness and complex health care needs residing at Glencliff…." The CMHA defines these as: "individuals with mental illness and complex health care needs who could not be cost-effectively served in supported housing."[11]

[10] Cumulative from CMHA V.E.(g), (h), and (i).
[11] CMHA V.E.2(a)

DHHS reports that a total of 17 people have transitioned from Glencliff to integrated settings since the inception of the CMHA five years ago. There are currently 24 individuals undergoing transition planning who could be transitioned to integrated community settings once appropriate living settings and community services become available. Nine of these individuals have been assigned to Choices for Independence (CFI) waiver case management agencies in order to access case management in the community to facilitate transition planning, and five are currently in the application process. Four individuals have been found eligible for the Acquired Brain Disorder (ABD) or Developmental Disability (DD) waivers, and two have been denied eligibility for these waivers.

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

DHHS has implemented action steps to enhance the process of: (a) identifying Glencliff residents wishing to transition to integrated settings; and (b) increasing the capacity, variety and geographic accessibility of integrated community settings and services available to meet the needs of these individuals. Both sets of initiatives are intended to facilitate such community transitions for additional Glencliff residents. Despite these efforts, the frequency of transitions to integrated community settings from Glencliff has essentially stalled in the past 18 months. DHHS is currently working to revise funding procedures and provider-related requirements to facilitate new transitions to integrated setting on a timelier basis. The ER will be closely monitoring whether these initiatives result in increased transitions over the next few months. DHHS reports it is also considering a new approach and possibly staffing for Glencliff inreach activities, but no definitive plans related to inreach have been announced to date.

As noted in previous reports, the ER is at this point reluctant to focus narrowly on clinical conditions and sets of health, mental health and community services and supports for transitioned and transitioning individuals to monitor the State's progress in assisting Glencliff Home residents to transition to integrated community settings. ***Despite this reluctance, the ER is concerned that the State is not yet in compliance with the CMHA requirements with regard to transitions to integrated community settings for residents with complex medical needs***. This concern is exacerbated by the extremely slow pace of transitions to integrated community placements over the past two years. In addition, there has been no additional small-scale community residential capacity developed to serve Glencliff residents with complex medical conditions. The ER will more closely monitor the extent to which DHHS, Glencliff, the CMHCs and an array of other community partners collaborate to effectuate as many such transitions as possible over the next year.

Progress towards effectuating transitions to integrated community settings for current Glencliff residents has been very slow over the past 18 months. Unless additional efforts are brought to bear, the 24 individuals in active transition planning could remain at Glencliff indefinitely, and other residents will go without meaningful opportunities to explore potential community alternatives.

As noted in previous reports, the ER will continue to monitor the following topics/items to inform his assessment of compliance:

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

Preadmission Screening and Resident Review (PASRR)

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

PASRR Level II Screens: April through June 2019

	April through June 2019	Percent
Full Approval - No Special Services	23	28.8%
Full Approval with Special Services	23	28.8
Provisional – No Special Services	15	18.8
Provisional with Special Services	19	23.8
Total	80	100%

In the previous ER report, 10.2% of the Level II screens were approved with a specification for special services. At that time, the ER questioned whether this was an unusually low rate for specification for special services. In a comparison with one other state, the ER found substantially higher approvals for special services than was evidenced in New Hampshire at that time. In the intervening period, the State and the PASRR contractor have been reviewing protocols for specification of special services in the Level II process. For this current report, the percentage of approvals with special services has increased to over 50%.

In addition, the State has been reviewing the New Hampshire Medicaid Plan to see if revisions may be appropriate for the section(s) of that Plan identifying what special services may be covered by Medicaid for recipients for whom the Level II screen results in a specification for special services. The State reports that it has not yet completed this review. The ER expects that the review and any changes to the Medicaid Plan with respect to special services will be completed no later than October 1, 2019.

The ER has also reviewed PASRR Level II screens and admission assessments for recent admissions to Glencliff. Three of these were not completed: two because of the presence of dementia; and one because there was no diagnosed mental illness or related condition. For the three Level II screens that were completed, no special services were recommended. The ER does not attempt to supplant the clinical judgment of others, particularly not when based solely on clinical records. Nonetheless, the ER did suggest to participating state personnel that at least

two of the PASRR Level II screens reviewed at Glencliff might have considered and specified special services related to the approval.

For a variety of reasons, virtually all PASRR screens are conducted for people who are already in a nursing facility. For example, for May and June of 2019, 100% of Level II screens were conducted in nursing facilities. A possible consequence of this is that prime opportunities for diversion to integrated community settings may have already been missed by the time the PASRR screen is conducted. In addition, individuals admitted to Glencliff must typically have been turned down by at least three other facilities before being considered for admission. In combination, these facts indicate that interventions to divert individuals from Glencliff or other nursing facilities must typically be used before the PASRR screening process is initiated. PASRR is important to assure that people with mental illness, ID/DD, or related conditions are not inappropriately institutionalized or placed in nursing facilities without access to necessary special services. However, PASRR is not by itself sufficient to divert people from nursing facility care. Up-stream interventions at NHH, the DRFs, and among the CMHCs are also essential to prevent unnecessary facility placement.

New Hampshire Hospital and the Designated Receiving Facilities (DRFs)

For the time period January through March 2019, DHHS reports that NHH effectuated 189 admissions and 182 discharges. The mean daily census was 149, and the median length of stay for discharges was 27 days.

Table XVI below compares NHH discharge destination information for the five most recent reporting periods (4/2017 through 3/2019). The numbers are expressed as percentages because the length of the reporting periods had not previously been consistent, although the type of discharge destination data reported has been consistent throughout.

Table XVI

New Hampshire Hospital Self-Reported Data on

Discharge Destination

Discharge Destination	Percent April through June 2017	Percent July through September 2017	Percent October 2017 through March 2018	Percent April 2018 through September 2018	Percent October 2018 through March 2019
Home – live alone or with others	85.66%	88.3%	81.0%	81.7%	73.26%
Glencliff	0.35%	0.49%	1.0%	1.45%	1.6%
Homeless Shelter/motel	3.5%	2.94%	2.5%	3.13%	6.68%
Group home 5+/DDS supported living, etc.	5.59%	3.92%	7.1%	4.1%	4.01%
Jail/corrections	1.05%	0.49%	2%	1.45%	2.94%
Nursing home/rehab facility	3.50%	2.45%	2.7%	5.3%	4.55%

The ER is concerned that the percentage of discharges to home has been trending downward, and that the percent discharged to homeless shelters or motels has increased. Restrictions or delays in access to the Bridge Subsidy program could be one factor contributing to this trend.

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

Table XVII

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

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

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

	Franklin	Cypress	Portsmouth	Eliot Geriatric	Eliot Pathways	Total
Average Census						
Jan - March 2016	7.9	14.7	NA	19.7	18.1	

April - June 2016	7.8	13.2	21.4	22.5	16.9	81.8
July - Sept 2016	4.5	13.6	23.2	25.6	14.5	81.4
April - June 2017	4.5	12	30.3	29.3	10	86.1
July - September 2017	NA**	12.9	29.7	29.7	12.2	NA
Oct. - Dec 2017	10.1	12.3	27.7	32.6	16.1	19.7
Jan. - March 2018	6.7	11.6	32.5	34.6	NA	NA
April - June, 2018	9.1	11.9	31.7	31.7	20.4	104.8
July - September 2018	11.8	8.4	39.6	33.8	18.2	111.8
October - December 2018	10.7	9.2	27.4	33.4	10.7	91.4
January - March 2019	8.5	14.5	30.4	22.6	14.9	90.9

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

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

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. However, at this time there has been no substantial reduction in NHH admissions or NHH re-admissions. The wait list for NHH admissions of people staying in hospital EDs has been somewhat reduced, as shown in Charts A and B below. DHHS has recently begun tracking discharge dispositions for people admitted to the DRFs and Cypress Center. Table XVIII below provides a summary of these recently reported data.

Table XVIII

Self-Reported Discharge Dispositions for DRFs in New Hampshire

October, 2018 through March 2019

Disposition	Frank-lin	Cypress	Ports-mouth	Eliot Geriatric	Eliot Pathways	Total
Home	195	331	515	33	162	1,236
NHH	0	0	6	0	3	9
Residential Facility/ Assisted Living	2	16	1	62	2	83
Other DRF	3	14	9	6	4	36
Hospital	0	0	0	0	0	0
Death	0	0	0	6	0	6
Other or Unknown	13	20	175	11	14	233
Total	213	381	706	118	185	1,603

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

Based on these self-reported data, 77.1% of discharges from DRFs and the Cypress Center are to home. This is essentially the same as the 80.8% % discharges to home reported by NHH. In addition:

- 5.2% of the total DRF discharges are to residential care or assisted living, which is similar to NHH discharges for this category.
- 0.56% of the DRF discharges are to NHH, less than one half of the percent discharged to NHH from previous reporting periods.

- 2.2% of discharges are to other DRFs.
- 4.5% of the total discharges are to the other/unknown category, but 75% of these are accounted for by the Portsmouth DRF.

Hospital Readmissions

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

Table XIX

Self-Reported Readmission Rates for NHH and the DRFs

July 2017 through March 2019

	Percent 30 Days	Percent 90 Days	Percent 180 Days
NHH			
7 to 9/2017	**9.80%**	**21.60%**	**27.90%**
10 to 12/2107	**12.8%**	**26.1%**	**32.8%**
1 to 3/2018	**13.7%**	**22.7%**	**29.9%**
4/2018 to 6/2018	**7.6%**	**14.7%**	**23.4%**
7/2018 to 9/2018	**8.6%**	**19.6%**	**25.4%**
10/2018 to 12/2018	**7.3%**	**18.1%**	**25.9%**
1/2019 to 3/2019	**5.3%**	**14.8%**	**21.2%**
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%**
Cypress			
7 to 9/2017	**7.10%**	**12.40%**	**15.90%**
10 to 12/2107	**12.00%**	**18.70%**	**24.40%**
1 to 3/2018	**4.20%**	**9.60%**	**15.80%**
4/2018 to 6/2018	**4.50%**	**8.20%**	**11.90%**
7/2018 to 9/2018	**8.50%**	**13.90%**	**18.90%**
10/2018 to 12/2018	**7.10%**	**11.10%**	**15.20%**
1/2019 to 3/2019	**5.50%**	**14.80%**	**17.60%**
Portsmouth			
7 to 9/2017	**11.50%**	**17.50%**	**21.00%**
10 to 12/2107	**8.70%**	**13.70%**	**17.60%**
1 to 3/2018	**8.80%**	**15.50%**	**20.60%**
4/2018 to 6/2018	**10.20%**	**15.90%**	**21.90%**
7/2018 to 9/2018	**8.40%**	**12.90%**	**19.00%**
10/2018 to 12/2018	**7.70%**	**14.90%**	**20.30%**
1/2019 to 3/2019	**12.90%**	**19.50%**	**23.50%**

Elliot Pathways			
7 to 9/2017	**3.30%**	**6.60%**	**12.40%**
10 to 12/2107	**5.80%**	**7.70%**	**12.50%**
1 to 3/2018	**NA**	**NA**	**NA**
4/2018 to 6/2018	**3.80%**	**6.70%**	**8.60%**
7/2018 to 9/2018	**7.00%**	**11.50%**	**16.10%**
10/2018 to 12/2018	**2.80%**	**5.60%**	**9.70%**
1/2019 to 3/2019	**4.90%**	**5.70%**	**7.30%**
Elliott Geriatric			
4/2018 to 6/2018	**6.10%**	**6.10%**	**6.10%**
7/2018 to 9/2018	**5.60%**	**11.10%**	**11.10%**
10/2018 to 12/2018	**6.30%**	**7.80%**	**9.40%**
1/2019 to 3/2019	**5.40%**	**5.40%**	**5.40%**

Two facts are documented for the 21month period in which re-admission rate data has been reported. First, the rates of readmission have trended down slightly, but have not changed substantially. Second, the readmission rates, especially the 180 day readmission rate for NHH, remains very high. At least 20% of all people discharged form NHH are back in the hospital within 180 days. These data, in concert with the hospital emergency room data presented below, indicate that gaps remain in community services for people with serious mental illness, and that the essential connection between inpatient care and community services is not being effectuated for sizeable numbers of people at risk of re-hospitalization. **These facts need to be understood in light of the States ongoing difficulties increasing ACT capacity and enrollment as documented in an earlier section of this report.**

Hospital ED Waiting List

In the previous three reports, the ER has identified the waiting list (hospital ED boarding) for admission to NHH to be an important indicator of overall system performance. Chart A below displays daily adult admissions delays to NHH bi-weekly for the period July 2017 through June, 2019. Chart B shows the average daily ED waiting list by month for the same time period.

Chart A

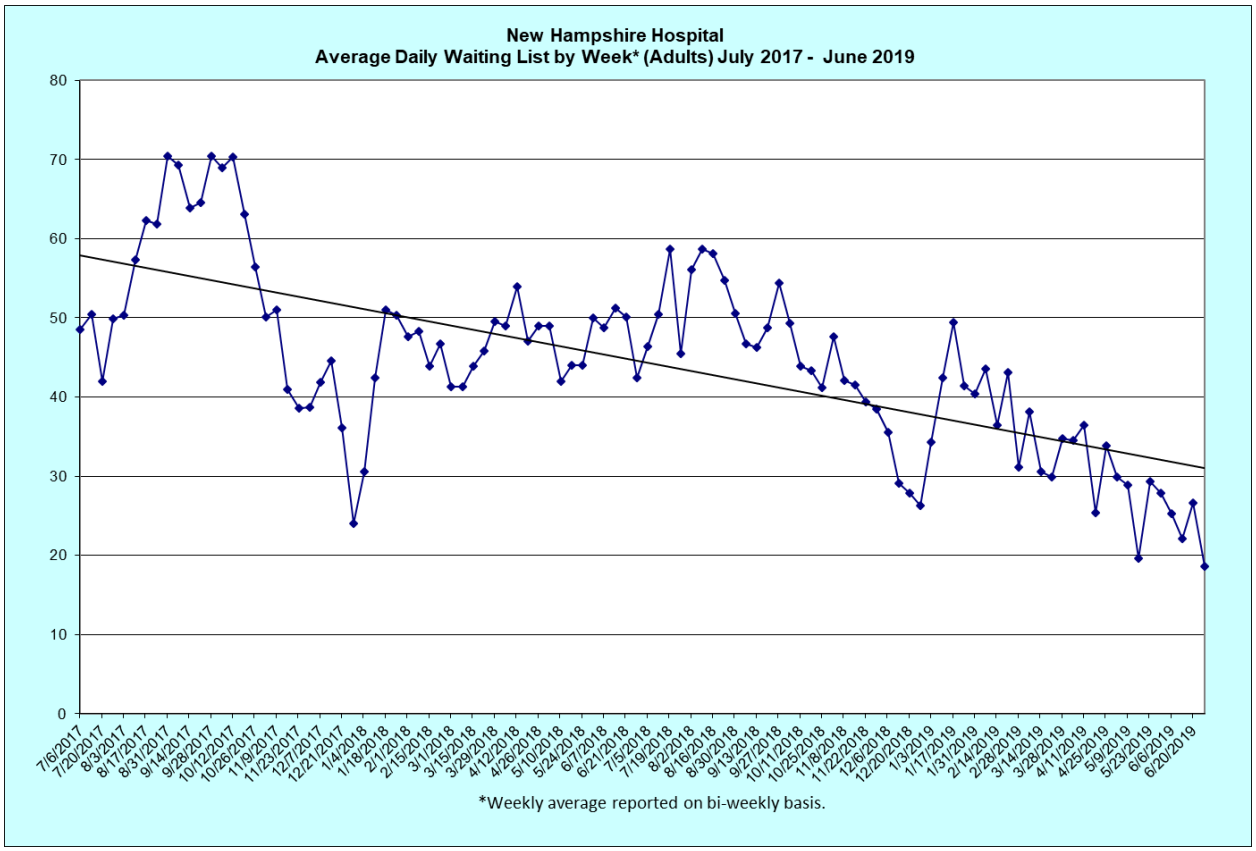
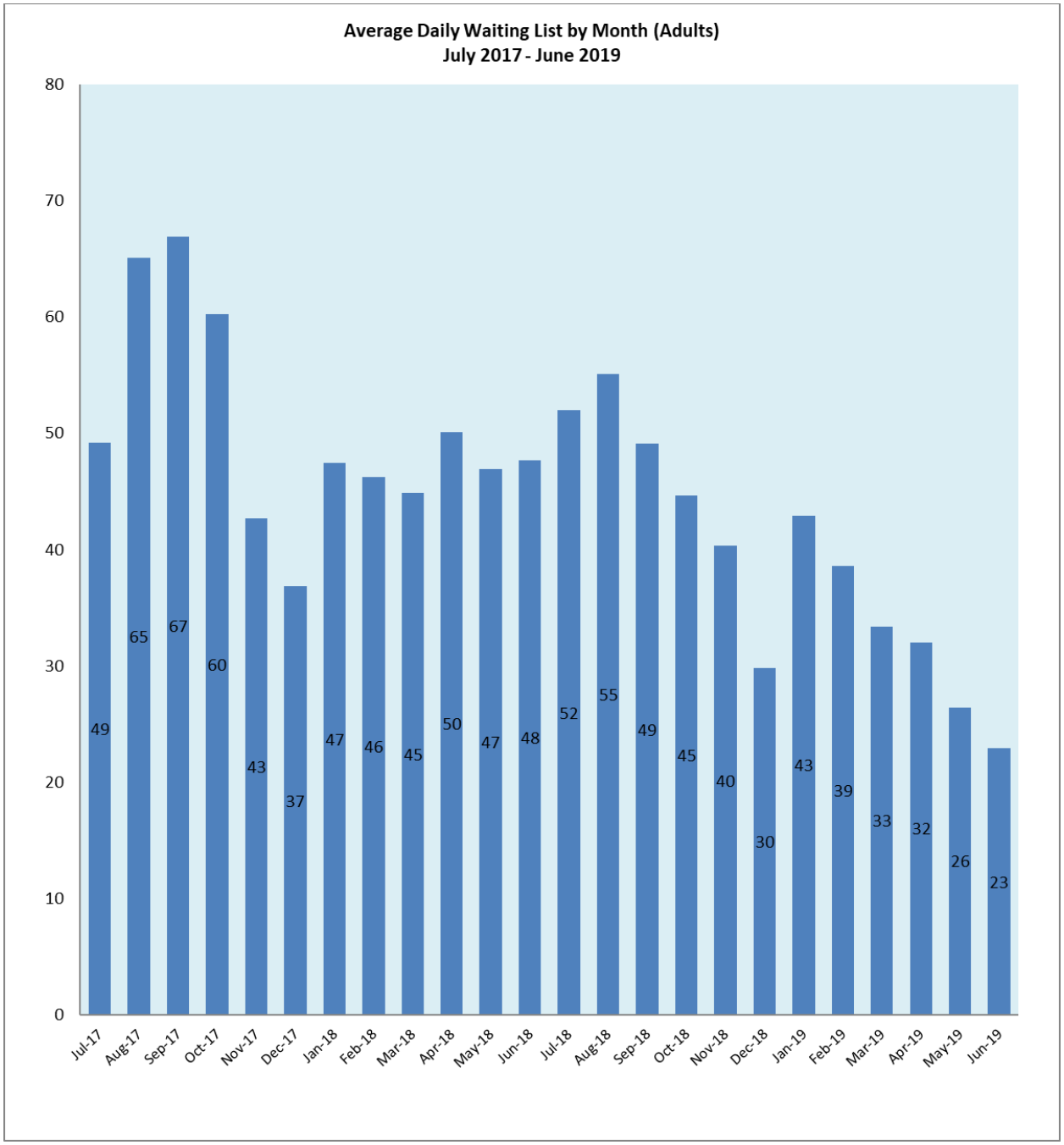

New Hampshire Hospital
Average Daily Waiting List by Week* (Adults) July 2017 - June 2019
80
70
60
50
40
30
20
10
0
7/6/2017
7/20/2017
8/3/2017
8/17/2017
8/31/2017
9/14/2017
9/28/2017
10/12/2017
10/26/2017
11/9/2017
11/23/2017
12/7/2017
12/21/2017
1/4/2018
1/18/2018
2/1/2018
2/15/2018
3/1/2018
3/15/2018
3/29/2018
4/12/2018
4/26/2018
5/10/2018
5/24/2018
6/7/2018
6/21/2018
7/5/2018
7/19/2018
8/2/2018
8/16/2018
8/30/2018
9/13/2018
9/27/2018
10/11/2018
10/25/2018
11/8/2018
11/22/2018
12/6/2018
12/20/2018
1/3/2019
1/17/2019
1/31/2019
2/14/2019
2/28/2019
3/14/2019
3/28/2019
4/11/2019
4/25/2019
5/9/2019
5/23/2019
6/6/2019
6/20/2019
*Weekly average reported on bi-weekly basis.

Chart B



Based on information reported by DHHS and illustrated above, a monthly average of 34 adults was waiting for a NHH inpatient psychiatric bed from October 2018 through March 2019. This is lower than the previous 12 month average of 46 individuals waiting in emergency departments. As can be seen in Charts A and B, the average number of adults waiting for admission has trended downward since January of 2019. If these positive trends continue, they could be

evidence that system-wide management and service linkage interventions are beginning to take effect.

Family and Peer Supports

Family Supports

Per the CMHA, the State has maintained its contract with NAMI New Hampshire for family support services. The ER will arrange for additional NAMI meetings during the next six months.

Peer Support Agencies

DHHS continues to report having a total of 15 peer support agency program (PSA) sites, with at least one program site in each of the ten regions. The State continues to report that all peer support centers meet the CMHA requirement to be open 44 hours per week. The State reports that those sites have a cumulative total of 1,763 members, with an active daily participation rate of 158 people statewide. The active daily participation has dropped from a reported 166 in the period ending December 2018, but is still above the 132 active participants reported at the end of October 2018. The State reports that all of the PSAs have been auditing and correcting their membership lists, and that the reduction in membership is primarily due to these activities.

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

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

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

IV. Quality Assurance Systems

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

DHHS has now completed the QSR process using the revised instruments and protocols at least two times for each of the ten CMHCs. Table XX below summarizes the quality indicator scores for each domain of the QSR. Average scores for the OCR questions are all above the 80% threshold, so they are not included in this summary table.

Highlighted scores are below the 75% performance threshold established for the QSR for the "year two" time period covered by this report.

Table XX

QSR Total Indicator Scores: All CMHCs

Indicator Number	Indicator Content	Prev. Avg (10 CMHCs)	Current Avg. (10 CMHCs)
1	Adequacy of Assessment	80.5%	87.4%
2	Approp. Tx Planning	89.8%	89.3%
3	Adequacy of Ind. Serv. Del.	82.4%	83.5%
4	Adequacy of Hsg. Assess.	99.5%	100.0%
5	Approp. Of Hsg. Tx Planning	90.2%	86.5%
6	Adequacy of HSG. Serv. Del.	84.2%	89.0%
7	Effect. Org Hsg. Supports Del.	76.2%	84.6%
8	Adequacy of Emp. Assessment	57.9%	63.8%
9	Approp. Of Emp. Tx Planning	70.3%	70.8%
10	Adequacy of Emp. Serv. Del.	59.7%	80.0%
11	Adequacy of Ass. Of Int. Needs	94.4%	100.0%
12	Integration in Community	79.5%	81.1%
13	Adequacy of Crisis Assess.	69.0%	78.0%
14	Appropriateness of Crisis Plns.	80.8%	93.0%
15	Comp. and Effec. Crisis Del. Syst.	72.8%	72.5%
16	Adequacy of ACT screening	90.6%	98.5%
17	Imp. Of high Fidel. ACT Servs.	54.3%	65.1%
18	Succ. Trans./Dich. From inpat.	78.1%	80.0%
	Total	1410.2%	1503.2%
	Average	78.3%	83.5%

As demonstrated in the table, the CMHC system as a whole scores below the 75% performance threshold on four indicators. Each of these indicators is related to specific standards and requirements of the CMHA. As noted earlier in this report, DHHS requires CMHCs with a score below the performance threshold to develop a QIP, which is then monitored on at least a quarterly basis by DHHS staff. Improvements accomplished as a result of the QIPs should be evidenced in subsequent QSR reports.

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

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

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

Table XXI below shows average changes in year-to-year fidelity scores for both ACT and SE. All CMHCs in the state meet the minimum performance threshold for "fair fidelity" both ACT[12] and SE. However, as displayed in the table, the fidelity scores have recently been trending downward, not up-ward. Fair fidelity scores also tended to correlate with deficits in individual service delivery and performance issues documented in the QSR. As with the QSR scores, QIPs related to fidelity findings should result in fidelity score improvements over the next round of fidelity reviews.

[12] The CMHC for which one ACT team fell below the ACT Fidelity threshold score of 84 has a second team that scored higher than the threshold. The average of the scores for these two teams is use for this table.

Table XXI

Trends in ACT and SE Fidelity Scores

Fidelity Topic	Average Year-to-Year Fidelity Score Change
ACT	-3.6
SE	-2.5

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

The ER will continue to monitor the degree to which the QSR process produces reliable information on individual outcomes and the quality of CMHA service delivery. In addition, over the next six months, the ER will evaluate the extent to which CMHC Quality Improvement Plans developed as part of the 2018-2019 QSR site visits are resulting in recommended practice changes and improved outcomes for those in the target population.

The ER and the Parties to the CMHA have discussed how the QSR and external fidelity reviews can be used to measure compliance with the CMHA, including both the appropriate standards for compliance and the specific provisions of the QSR and fidelity reviews that would be used to assess compliance. These discussions are on-going, and the ER supports the collaborative efforts of both the State and the representatives of the Plaintiffs. The ER intends to employ both the QSR and the fidelity reviews as tools to assess individual outcomes, analyze system performance, and ultimately measure compliance with the CMHA.

I. Summary of Expert Reviewer Observations and Priorities

The ER has emphasized in this report that the State continues to be far from compliant with CMHA requirements for ACT. In fact, the State has made minimal progress in meeting CMHA ACT requirements over the past four reporting periods. **For the last three years the ER has reported that the State is out of compliance with the ACT requirements of Sections V.D.3(a, b, d, and e), which together require that all ACT teams meet the standards of the CMHA; that each mental health region have at least one adult ACT Team[13]; and that by June 30, 2016, the State provide ACT services that conform to CMHA requirements and have the capacity to serve at least 1,500 people in the Target Population at any given time.**

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

1. Continued failure to meet the QSR quality threshold for SE for indicators related to employment assessments and employment treatment planning. In addition, at least four regions of the state continue to have penetration rates below the statewide target of 18.6%;
2. Failure to maintain the Housing Bridge Program at the CMHC required level of 450 units;
3. Failure to continue placing residents of Glencliff into integrated settings in accordance with the CMHA; and
4. Failure to provide agreed-upon data reports in a timely fashion.

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

Thus, frustration with slow or partial implementation of the CMHA is not solely based on bureaucratic inertia or structural barriers to implementation. Rather, the frustration is based on the realization that real people with real needs may face real life problems and real negative effects absent the services promised by the CMHA.

[13] The ER notes that each region of the state has had at least one ACT team, or ACT team-in-development, since the inception of the CMHA. However, as documented in the ACT section of this report, three regions continue to have ACT teams that do not meet the minimum staffing requirements for ACT as specified in the CMHA.

The ER supports on-going State efforts to improve CMHA implementation, and has continued to applaud positive elements of implementation, such as the QSR and the external ACT and SE fidelity reviews. However, neither the Parties to the CMHA nor the ER should continue to tolerate non-compliance with the CMHA when peoples' rights to community integration and quality of life are at risk. Real progress toward compliance with all CMHA standards and requirements must be clear and demonstrable by the end of the up-coming six month time frame.

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

January to March 2019

New Hampshire Community Mental Health Agreement Quarterly Data Report

January - March 2019

New Hampshire Department of Health and Human Services

Office of Quality Assurance and Improvement

July 3, 2019

Community Mental Health Agreement Quarterly Report

New Hampshire Department of Health and Human Services

Publication Date:

Reporting Period: 1/1/2019 – 3/31/2019

Notes for Quarter

- Revised and renamed Table 1b to improve outcome reporting of ACT screenings that result in new ACT clients. This table now reflects a retrospective analysis for the two most recent quarters that data is available. A retrospective analysis is used for this reporting because the receipt of ACT services commences after the client is found appropriate and then enrolled in ACT. The documentation of the delivery of ACT services to the client may take several weeks to capture within this report based on ACT cost center data cycles.
- Created a new Table 1c to report the total number of all individuals added to ACT during the current reporting period. These are individuals that began receiving ACT services within the current period based on data processed through the ACT cost center for the current period.
- Combined ACT Staffing Competencies into one table (formerly Tables 2b-2d); all competency data are displayed in Table 2b.
- Moved the Employment Status Point in Time data (formerly Tables 12a and 12b) to be directly following the Supported Employment Penetration Rate table. Tables 3a, 3b, and 3c now contain all employment and Supported Employment information.
- Renumbered the table reporting ACT Waiting List information to Table 1d; it was formerly Table 1c.
- Tables 8 through 10 have been realigned to improve the clarity of information reported.
- During the reporting period, and in preparation for the transition of the HBSP to a regionally delivered program model, the Bureau of Mental Health Services, in collaboration with the Housing Bridge Subsidy Program provider and the CMHC referring agents, completed a review of pending HBSP applications and approved HBSP applicants waiting to obtain an HBSP funded unit. The review resulted in numerous status changes that are documented in Appendix A.

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

Community Mental Health Center	January 2019	February 2019	March 2019	Unique Clients in Quarter	Unique Clients in Prior Quarter
01 Northern Human Services	117	116	120	126	123
02 West Central Behavioral Health	40	39	41	48	49
03 Lakes Region Mental Health Center	49	51	51	54	54
04 Riverbend Community Mental Health Center	94	96	96	106	93
05 Monadnock Family Services	59	58	59	61	62
06 Community Council of Nashua	72	75	67	79	87
07 Mental Health Center of Greater Manchester	319	309	303	335	333
08 Seacoast Mental Health Center	73	71	70	73	72
09 Community Partners	67	64	66	72	68
10 Center for Life Management	52	48	51	56	55
Total Unique Clients	**942**	**926**	**923**	**1,007**	**997**
Unique Clients Receiving ACT Services 4/1/2018 to 3/31/2019: 1,186					

Revisions to Prior Period: None.

Data Source: NH Phoenix 2

Notes: Data extracted 4/17/2019; clients are counted only one time regardless of how many services they receive.

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

Community Mental Health Center	October - December 2018 Retrospective Analysis	July – September 2018 Retrospective Analysis

	Unique Clients Screened	Appropriate for Further ACT Assessment: Individuals Not Already	New Clients receiving ACT Services within 90 days of Screening	Unique Clients Screened	Appropriate for Further ACT Assessment: Individuals Not Already	New Clients receiving ACT Services within 90 days of Screening
01 Northern Human Services	1,192	24	6	1,128	27	4
02 West Central Behavioral Health	263	1	0	306	9	2
03 Lakes Region Mental Health Center	974	19	2	652	17	0
04 Riverbend Community Mental Health Center	1,481	8	1	1,401	9	1
05 Monadnock Family Services	203	4	1	562	7	2
06 Community Council of Nashua	925	8	0	959	8	1
07 Mental Health Center of Greater Manchester	2,576	7	0	3,040	5	0
08 Seacoast Mental Health Center	1,412	13	1	1,294	14	0
09 Community Partners	508	2	2	390	2	1
10 Center for Life Management	494	10	0	719	23	0
Total ACT Screening	**10,028**	**96**	**13**	**10,451**	**121**	**11**

Revisions to Prior Period: None

Data Source: NH Phoenix 2 and CMHC self-reported ACT screening records. ACT screenings submitted through Phoenix capture ACT screenings provided to clients found eligible for state mental health services. Phoenix does not capture data for non-eligible clients; 3 CMHCs submit this data through Phoenix. 7 CMHCs self-report; all such screenings are contained in this table.

Notes: Data extracted 5/17/2019. "Unique Clients Screened" is defined as individuals that had a documented ACT screening during the identified reporting period, including individuals already on ACT who were re-screened for ACT. "Screening Deemed Appropriate for Further ACT Assessment: Individuals Not Already on ACT" is defined as screened individuals not already on ACT that resulted in referral for an ACT assessment. "New Clients Receiving ACT Services within 90 days of ACT Screening" is defined as individuals

who were not already on ACT that received an ACT screening in the preceding quarter and then began receiving ACT services.

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

Community Mental Health Center	January – March 2019				October - December 2018			
	New ACT Clients	2019 New ACT Clients	New ACT Clients	Total New ACT Clients	New ACT Clients	November 2018 New ACT Clients	December 2018 New ACT Clients	Total New ACT Clients
01 Northern Human Services	2	5	2	**9**	9	0	5	**14**
02 West Central Behavioral Health	2	2	4	**8**	4	3	5	**12**
03 Lakes Region Mental Health Center	1	2	2	**5**	0	0	1	**1**
04 Riverbend Community Mental Health Center	9	6	5	**20**	1	3	6	**10**
05 Monadnock Family Services	1	0	2	**3**	2	0	3	**5**
06 Community Council of Nashua	2	4	1	**7**	2	1	1	**4**
07 Mental Health Center of Greater Manchester	12	10	4	**26**	8	11	8	**27**
08 Seacoast Mental Health Center	2	0	0	**2**	0	2	2	**4**
09 Community Partners	2	0	5	**7**	2	1	4	**7**
10 Center for Life Management	0	1	4	**5**	1	0	0	**1**
Total New ACT Clients	**33**	**30**	**29**	**92**	**29**	**21**	**35**	**85**

Revisions to Prior Period: None

Data Source: NH Phoenix 2

Notes: Data extracted 4/18/2019; New ACT Clients are defined as individuals who were not already on ACT within 90-days prior and then began receiving ACT services. This information is not limited to the individuals that received an ACT screening within the previous 90-day period and may include individuals transitioning from a higher or lower level of care into ACT.

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

As of 3/31/2019						
	Time on List					
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**
2	1	1	0	0	0	0
As of 12/31/2018						
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**
6	3	0	0	1	1	1

Revisions to Prior Period: None

Data Source: BMHS Report

Notes: Data compiled 5/6/2019

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

Community Mental Health Center	March 2019						December 2018	
	Nurse	Clinician/or Equivalent	Support Worker	Peer Specialist	(Excluding Psychiatry)	rse Practitioner	(Excluding Psychiatry)	Psychiatrist/Nurse Practitioner

01 Northern Human Services	1.49	1.90	12.90	0.51	16.80	1.15	17.31	1.15
02 West Central Behavioral Health	0.60	1.70	3.20	1.30	6.80	0.38	5.75	0.25
03 Lakes Region Mental Health Center	0.80	2.00	4.50	1.00	8.30	0.75	7.35	0.75
04 Riverbend Community Mental Health Center	0.50	3.00	7.00	1.00	11.50	0.50	10.50	0.50
05 Monadnock Family Services	1.25	4.25	3.00	1.00	9.50	0.65	9.00	0.65
06 Community Council of Nashua 1	0.50	2.00	3.50	0.50	6.50	0.25	5.00	0.25
06 Community Council of Nashua 2	0.50	1.00	2.50	0.50	4.50	0.25	4.00	0.25
07 Mental Health Center of Greater Manchester-CTT	1.50	10.00	1.75	1.00	14.25	0.72	14.25	1.02
07 Mental Health Center of Greater Manchester-MCST	1.50	8.00	5.25	1.00	15.75	0.72	15.75	1.02
08 Seacoast Mental Health Center	1.00	2.10	5.00	1.00	9.10	0.60	11.10	0.60
09 Community Partners	0.50	2.00	5.75	0.50	8.75	0.63	7.75	0.50
10 Center for Life Management	1.25	2.00	4.04	0.57	7.86	0.40	6.55	0.40
Total	**11.39**	**39.95**	**58.39**	**9.88**	**119.61**	**7.00**	**114.31**	**7.34**

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

Community Mental Health Center	Substance Use Disorder Treatment		Housing Assistance		Supported Employment	
	March 2019	December 2019	March 2019	December 2019	March 2019	December 2019
01 Northern Human Services	4.75	4.95	12.55	12.75	2.35	2.35
02 West Central Behavioral Health	0.35	0.35	4.00	2.75	0.20	0.40
03 Lakes Region Mental Health Center	2.75	2.50	3.75	4.55	3.00	3.00
04 Riverbend Community Mental Health Center	1.50	1.50	9.50	8.50	0.50	0.50
05 Monadnock Family Services	2.40	2.40	4.00	4.00	0.50	0.50
06 Community Council of Nashua 1	1.25	2.25	5.50	4.50	1.50	1.50
06 Community Council of Nashua 2	2.00	1.00	3.50	3.50	0.50	0.50
07 Mental Health Center of Greater Manchester-CCT	11.72	12.02	11.75	11.75	1.00	1.00
07 Mental Health Center of Greater Manchester-MCST	4.72	6.02	12.75	12.75	1.50	1.50
08 Seacoast Mental Health Center	2.00	3.00	5.00	6.00	1.00	1.00
09 Community Partners	1.00	1.00	2.00	2.00	1.25	1.25
10 Center for Life Management	3.00	3.00	6.31	5.00	0.30	0.30
Total	**37.44**	**39.99**	**80.61**	**78.05**	**13.60**	**13.80**

Revisions to Prior Period: None

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

Notes: Data compiled 4/18/2019; for 2b: the Staff Competency values reflect the sum of FTEs trained to provide each service type. These numbers are not a reflection of the services delivered, rather the quantity of

staff available to provide each service. If staff is trained to provide multiple service types, their entire FTE value will be 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 March 2019			Penetration Rate for Period Ending December 2018
	Supported Employment Clients	Total Eligible Clients	Penetration Rate	
01 Northern Human Services	NA*	1,286	NA*	NA*
02 West Central Behavioral Health	173	635	27.2%	32.2%
03 Lakes Region Mental Health Center	232	1,298	17.9%	11.8%
04 Riverbend Community Mental Health Center	340	1,829	18.6%	17.2%
05 Monadnock Family Services	80	998	8.0%	7.80%
06 Community Council of Nashua	256	1,895	13.5%	13.0%
07 Mental Health Center of Greater Manchester	1405	3,317	42.4%	43.9%
08 Seacoast Mental Health Center	580	1,807	32.1%	31.0%
09 Community Partners	105	752	14.0%	18.0%
10 Center for Life Management	212	1,011	21.0%	22.9%
Total Unique Clients	**NA***	**14,602**	**NA***	**NA***

Revisions to Prior Period: None

Data Source: NH Phoenix 2

Notes: Data extracted 4/17/2019; clients are counted only one time regardless of how many services they receive.

**Northern Human Services made an adjustment to its data reporting system that inadvertently resulted in an understatement of its Supported Employment penetration rate later extracted from Phoenix. It has since made an additional adjustment to correct this issue. The supported employment penetration rate is anticipated to reflect the correction in the reporting period ending June 30, 2019.*

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

Reported Employment Status Begin Date: 01/01/2019 End Date: 03/31/2019 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 Center	Mental Health Center of Greater Manchester	Community Partners	Seacoast Mental Health Center	Center for Life Management	Statewide Total or Mean Percentage	Previous Quarter Statewide Total or Mean Percentage October - December 2018
Updated Employment Status:												
Full time employed now or in past 90 days	72	29	37	102	41	107	215	195	40	52	890	762
Part time employed now or in past 90 days	180	46	125	272	131	229	359	256	74	136	1,808	1,622
Unemployed	177	91	32	89	130	751	889	87	155	488	2,889	2,847
Not in the Workforce	470	155	589	893	436	216	586	756	266	103	4,470	3,809
Status is not known	25	71	144	90	11	106	10	3	11	46	520	1,156
Total of Eligible Adult CMHC Clients	924	392	927	1,446	749	1,409	2,059	1,297	546	825	10,577	10,196
Previous Quarter: Total of Eligible Adult CMHC Clients	869	396	876	1,365	725	1,375	2,015	1,175	563	837		
Percentage by Updated Employment Status:												
Full time employed now or in past 90 days	7.8%	7.4%	4.0%	7.0%	5.5%	7.6%	10.4%	15.0%	7.3%	6.3%	8.4%	7.0%
Part time employed now or in past 90 days	19.5%	11.7%	13.5%	18.8%	17.5%	16.3%	17.4%	19.7%	13.6%	16.5%	17.1%	15.3%
Unemployed	19.2%	23.2%	3.5%	6.1%	17.4%	53.3%	43.2%	6.7%	28.4%	59.2%	27.3%	26.6%
Not in the Workforce	50.9%	39.5%	63.5%	61.6%	58.2%	15.3%	28.5%	58.3%	48.7%	12.5%	42.3%	39.3%
Status is not known	2.7%	18.1%	15.5%	6.4%	1.5%	7.5%	0.5%	0.2%	2.0%	5.6%	4.9%	11.8%
Percentage by Timeliness of Employment Status Screening:												
Update is Current	30.4%	37.8%	78.1%	89.2%	70.0%	96.0%	76.1%	92.8%	78.8%	99.9%	78.9%	68.4%
Update is Overdue	69.6%	62.2%	21.9%	10.8%	30.0%	4.0%	23.9%	7.2%	21.2%	0.1%	21.1%	31.6%
Previous Quarter: Percentage by Timeliness of Employment Status Screening:												
Update is Current	19.6%	24.2%	74.4%	89.4%	50.9%	97.6%	78.4%	70.8%	79%	100%		
Update is Overdue	80.4%	75.8%	25.6%	10.6%	49.1%	2.4%	21.6%	29.2%	21%	0%		

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: 01/01/2019 End Date: 03/31/2019	Northern Human Services	West Central Behavioral Health	Lakes Region Mental Health Center	Riverbend Community Mental Health	Monadnock Family Services	Greater Nashua Mental Health Center	Mental Health Center of Greater Manchester	Community Partners	Seacoast Mental Health Center	Center for Life Management	Statewide Total or Mean Percentage	Previous Quarter Statewide Total or Mean Percentage October - December 2018
Updated Employment Status:												
Full time employed now or in past 90 days	1	0	0	1	0	3	7	0	0	3	15	22
Part time employed now or in past 90 days	18	7	12	33	13	12	37	10	8	23	173	145
Unemployed	9	6	3	13	7	22	30	8	4	20	122	113
Not in the Workforce	15	1	18	6	5	7	7	14	2	0	75	56
Status is not known	0	2	10	2	0	3	0	0	0	0	17	56
Total of Supported Employment Cohort	**43**	**16**	**43**	**55**	**25**	**47**	**81**	**32**	**14**	**46**	**402**	**392**
Previous Quarter: Total of Supported Employment Cohort	40	18	31	56	21	42	99	26	14	45		
Percentage by Updated Employment Status:												
Full time employed now or in past 90 days	2.3%	0.0%	0.0%	1.8%	0.0%	6.4%	8.6%	0.0%	0.0%	6.5%	3.7%	4.8%

Part time employed now or in past 90 days	41.9%	43.8%	27.9%	60.0%	52.0%	25.5%	45.7%	31.3%	57.1%	50.0%	43.0%	34.5%
Unemployed	20.9%	37.5%	7.0%	23.6%	28.0%	46.8%	37.0%	25.0%	28.6%	43.5%	30.3%	28.2%
Not in the Workforce	34.9%	6.3%	41.9%	10.9%	20.0%	14.9%	8.6%	43.8%	14.3%	0.0%	18.7%	19.0%
Status is not known	0.0%	12.5%	23.3%	3.6%	0.0%	6.4%	0.0%	0.0%	0.0%	0.0%	4.2%	13.6%

Revisions to Prior Period: None

Data Source: Phoenix 2

Note 3b-c: Data extracted 4/18/2019. Updated Employment Status refers to CMHC-reported status and reflects the most recent update. Update is Current refers to an employment status most recently updated within the past 105 days. Update is Overdue refers to an 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, or are in a sheltered/non-competitive employment workshop, or are otherwise not in the labor force or not employed and not seeking or interested in employment. Unknown refers to clients with an employment status of "unknown", or without a status reported, or with an erroneous status code in Phoenix.

4a. New Hampshire Hospital: Adult Census Summary

Measure	January - March 2019	October - December 2018
Admissions	189	193
Mean Daily Census	149	153
Discharges	182	192
Median Length of Stay in Days for Discharges	27	20
Deaths	0	0

Revisions to Prior Period: None

Data Source: Avatar

Notes 4a: Data extracted 5/13/2019; Mean Daily Census includes patients on leave and is rounded to nearest whole number

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

Discharge Location	January - March 2019	October - December 2018
Home - Lives with Others	80	79
Home - Lives Alone	50	65
CMHC Group Home	4	8
Private Group Home	1	2
Nursing Home	1	2
Hotel-Motel	4	1
Homeless Shelter/ No Permanent Home	14	6
Discharge/Transfer to IP Rehab Facility	6	8
Secure Psychiatric Unit - SPU	1	0
Peer Support Housing	0	0
Jail or Correctional Facility	6	4
Glencliff Home for the Elderly	2	4
Other	4	7
Unknown	9	6

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

Measure	January - March 2019	October - December 2018
30 Days	5.3% (10)	7.3% (14)
90 Days	14.8% (28)	18.1% (35)
180 Days	21.2% (40)	25.9% (50)

Revisions to Prior Period: None.

Data Source: Avatar

Notes 4b-c: Data compiled 5/13/2019; readmission rates calculated by looking back in time from admissions in study quarter. 90 and 180 day readmissions lookback period includes readmissions from the shorter period (e.g., 180 day includes the 90 and 30 day readmissions); patients are counted multiple times – once for each readmission; the number in parentheses is the number of readmissions.

5a. Designated Receiving Facilities: Admissions for Adults

Designated Receiving Facility	January - March 2019		
	Involuntary Admissions	Voluntary Admissions	Total Admissions
Franklin	57	69	126
Cypress Center	33	149	182
Portsmouth	81	268	349
Elliot Geriatric Psychiatric Unit	7	49	56
Elliot Pathways	58	65	123
Total	**236**	**600**	**836**
Designated Receiving Facility	**October – December 2018**		
	Involuntary Admissions	**Voluntary Admissions**	**Total Admissions**
Franklin	40	47	87
Cypress Center	46	152	198
Portsmouth	84	291	375
Elliot Geriatric Psychiatric Unit	4	60	64
Elliot Pathways	37	35	72
Total	**211**	**585**	**796**

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

Designated Receiving Facility	January - March 2019	October - December 2018
Franklin	8.5	10.7
Cypress Center	14.5	9.2

Portsmouth	30.4	27.4
Elliot Geriatric Psychiatric Unit	22.6	33.4
Elliot Pathways	14.9	10.7
Total	**90.9**	**91.4**

5c. Designated Receiving Facilities: Discharges for Adults

Designated Receiving Facility	January - March 2019	October - December 2018
Franklin	124	89
Manchester (Cypress Center)	177	204
Portsmouth	348	358
Elliot Geriatric Psychiatric Unit	56	62
Elliot Pathways	106	79
Total	**811**	**792**

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

Designated Receiving Facility	January - March 2019	October - December 2018
Franklin	5	4
Manchester (Cypress Center)	5	3
Portsmouth	6	4
Elliot Geriatric Psychiatric Unit	18	31
Elliot Pathways	8.5	7
Total	**6**	**5**

5e. Designated Receiving Facilities: Discharge Location for Adults

Designated Receiving Facility	January - March 2019						
	Assisted Living/Group Home	Deceased	DRF*	Home	Other Hospital	NH Hospital	Other
Franklin	1	0	1	116	0	0	6
Manchester (Cypress Center)	10	0	6	153	0	0	8
Portsmouth Regional Hospital	0	0	0	249	0	6	93
Elliot Geriatric Psychiatric Unit	28	3	2	20	0	0	3
Elliot Pathways	0	0	0	92	0	3	11
Total	**39**	**3**	**9**	**630**	**0**	**9**	**121**

Designated Receiving Facility	October - December 2018						
	Assisted Living/Group Home	Deceased	DRF*	Home	Other Hospital	NH Hospital	Other
Franklin	1	0	2	79	0	0	7
Manchester (Cypress Center)	6	0	8	178	0	0	12
Portsmouth Regional Hospital	1	0	9	266	0	0	82
Elliot Geriatric Psychiatric Unit	34	3	4	13	0	0	8
Elliot Pathways	2	0	4	70	0	0	3
Total	**44**	**3**	**27**	**606**	**0**	**0**	**112**

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

5f. Designated Receiving Facilities: Readmission Rates for Adults

Designated Receiving Facility	January - March 2018		
	30 Days	90 Days	180 Days
Franklin	7.9% (10)	10.3% (13)	10.3% (13)
Manchester (Cypress Center)	5.5% (10)	14.8% (27)	17.6% (32)
Portsmouth	12.9% (45)	19.5% (68)	23.5% (82)
Elliot Geriatric Psychiatric Unit	5.4% (3)	5.4% (3)	5.4% (3)
Elliot Pathways	4.9% (6)	5.7% (7)	7.3% (9)
Total	**8.9% (74)**	**14.1% (118)**	**16.6% (139)**
Designated Receiving Facility	**October - December 2018**		
	30 Days	**90 Days**	**180 Days**
Franklin	2.3% (2)	4.6% (4)	5.7% (5)
Manchester (Cypress Center)	7.1% (14)	11.1% (22)	15.2% (30)
Portsmouth	7.7% (29)	14.9% (56)	20.3% (76)
Elliot Geriatric Psychiatric Unit	6.3% (4)	7.8% (5)	9.4% (6)
Elliot Pathways	2.8% (2)	5.6% (4)	9.7% (7)
Total	**6.4% (51)**	**11.4% (91)**	**15.6% (124)**

Revisions to Prior Period: None.

Data Source: NH DRF Database

Notes: Data compiled 5/17/2019.

6. Glencliff Home: Census Summary

Measure	January - March 2019	October - December 2018
Admissions	13	5
Average Daily Census	112	111
Discharges	0	1 (3-person medical model group home)
Individual Lengths of Stay in Days for Discharges	0	550
Deaths	5	6
Readmissions	0	0
Mean Overall Admission Waitlist	27	25

Revisions to Prior Period: None.

Data Source: Glencliff Home

Notes: Data Compiled 5/7/2019; Mean rounded to nearest whole number; Active waitlist patients have been reviewed for admission and are awaiting admission pending finalization of paperwork and other steps immediate to admission.

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

Peer Support Agency	January - March 2019		October - December 2018	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
Alternative Life Center Total	**224**	**36**	**257**	**42**
Conway	33	9	28	11
Berlin	86	7	135	9
Littleton	56	10	46	10
Colebrook	49	10	48	12
Stepping Stone Total	**377**	**14**	**262**	**15**
Claremont	308	10	200	11
Lebanon	69	4	62	4
Cornerbridge Total	**180**	**14**	**139**	**12**
Laconia	69	6	54	5
Concord	84	8	59	7
Plymouth Outreach	27	NA	26	NA
MAPSA Keene Total	**144**	**14**	**43**	**14**
HEARTS Nashua Total	**411**	**34**	**423**	**35**
On the Road to Recovery Total	**122**	**10**	**82**	**10**
Manchester	64	5	48	5
Derry	58	5	34	5
Connections Portsmouth Total	**130**	**15**	**45**	**17**

Peer Support Agency	January - March 2019		October - December 2018	
	Total Members	Average Daily Visits	Total Members	Average Daily Visits
TriCity Coop Rochester Total	**175**	**21**	**139**	**21**
Total	**1,763**	**158**	**1,390**	**166**

Revisions to Prior Period: None

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

Notes: Data Compiled 5/23/2019; Average Daily Visits are not applicable for Outreach Programs.

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

Subsidy	January – March 2019		
	Total individuals served at start of quarter	New individuals added during quarter	Total individuals served through end of quarter
Housing Bridge Subsidy	812	0	812
Section 8 Voucher-Transitioned from Housing Bridge	129	8	137
Subsidy	**October - December 2018**		
	Total individuals served at start of quarter	**New individuals added during quarter**	**Total individuals served through end of quarter**
Housing Bridge Subsidy	812	0	812
Section 8 Voucher-Transitioned from Housing Bridge	125	4	129

Revisions to Prior Period: None

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

Notes: Data Compiled 5/17/2019. Figures at start and end of each quarter are cumulative total of individuals served since CMHA quarterly reporting began in 2015.

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

Measure	As of 3/31/2019	As of 12/31/2018
Rents Currently Being Paid	389	418
Individuals Accepted and Working Towards Bridge Lease	11	8
Total	400	**426**

Revisions to Prior Period: None

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

Notes: Data Compiled 5/22/2019; all individuals currently on Bridge Program are intended to transition from the program to other permanent housing).

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

Measure	As of 3/31/2019	As of 12/31/18
Housing Bridge Clients Linked	337/400 (84%)	373/443 (84%)

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

Notes: Data compiled 5/23/2019; "Housing Bridge Clients Linked" refers to Housing Bridge clients who received a mental health service(s) within the previous 3 months, documented as a service or claim data found in Phoenix or the Medicaid Management Information System (MMIS).

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

Number of HBSP Funded Unit(s)* at Same Address	Frequency as of 3/31/2019	Frequency as of 12/31/2018
1	315	329
2	18	27
3	3	4
4	2	3
5	2	1
6	0	0
7	0	1
8 or more	1	1

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

Revisions to Prior Period: None

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

Notes: Data Compiled 5/17/2019

8d. Housing Bridge Subsidy Program: Applications

Measure	January – March 2019	October - December 2018
Applications Received During Period	29	12
Point of Contact for Applications Received	*CMHCs: 22; NHH: 5; Other (1)*	*CMHCs: 12*
Applications Approved	14	5
Applications Denied	0	0
Denial Reasons	*NA*	*NA*
Total Applications in Process at End of Period	53	209

Revisions to Prior Period: Applications in Process at End of Period was incorrect.

Data Source: Bureau of Mental Health Services

Notes: Data Compiled 5/17/2019

8e. Housing Bridge Subsidy Program: Terminations

Type and Reason	January - March 2019	October – December 2018
Terminations – DHHS Initiated	*1*	*0*
Over Income	*1*	*NA*
Exited Program – Client Related Activity	*27*	*15*
Voucher Received	*8*	*4*
Deceased	*1*	*1*
Over Income	*0*	*1*
Moved Out of State	*0*	*3*
Declined Subsidy at Recertification	*13*	*3*
Higher Level of Care Accessed	*1*	*3*
Other Subsidy Provided	*2*	*0*
Moved in with family		*0*
	2	*0*
Total	***28***	***15***

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

Notes: Data Compiled 5/17/2019

8f. Housing Bridge Subsidy Program: Application Processing Times

Average Elapsed Time of Application Processing (calendar days)*	January - March 2019	October – December 2018
Completed Application to Determination	1	1
Approved Determination to Funding Availability (see waitlist, Table 9b for detail)	NA	NA
Referred to Vendor with Funded HB Slot	NA	NA
Leased Unit Secured	NA	NA

Data Source: Bureau of Mental Health Services

Notes: Data Compiled 5/17/19

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

9. Housing Bridge Subsidy Program Waitlist: Approved Applications

As of 3/31/2019							
Time on List							
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**	**181+ days**
38	13	1	0	0	0	2	22
As of 12/31/2018							
Total	**0-30 days**	**31-60 days**	**61-90 days**	**91-120 days**	**121-150 days**	**151-180 days**	**181+ days**
39	0	0	3	5	2	0	29

Revisions to Prior Period: The number of individuals waiting and the number of days waiting were miscalculated.

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

Notes: Data Compiled: 5/17/2019.

10. Supported Housing Subsidy Summary

Subsidy	January - March 2019 Total subsidies by end of quarter	October - December 2018 Total subsidies by end of quarter
Housing Bridge Subsidy: Units Currently Active	389	418
Individual actively acquiring unit	11	8
Section 8 Voucher: Transitioned from Housing Bridge*	137	129
Not Previously Receiving Housing Bridge	1	7
811 (PRA and Mainstream)*	43	40
Other (HUD, Public Housing, VA)	1	6
Total Supported Housing Subsidies	**582**	**608**

Revisions to Prior Period: Not Applicable – Table 10 is newly incorporated into this report.

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

Notes: Data Compiled 5/22/2019; Section 8 Voucher Not Previously Receiving Housing Bridge are CMHC clients that received a Section 8 Voucher without previously receiving a Housing Bridge subsidy; 811 (PRA and Mainstream) are CMHC clients that received a PRA or Mainstream 811 funded unit with or without previously receiving a Housing Bridge subsidy; Other (HUD, Public Housing, VA) are CMHC clients that received a unit funded through other HUD or Public Housing sources with or without previously receiving a Housing Bridge subsidy.

**These counts are cumulative; increasing over time since originally reporting this data within the CMHA Quarterly Data Report.*

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

Measure	January 2019	February 2019	March 2019	January - March 2019	October - December 2018
Unique People Served in Month	287	267	243	500	689
Services Provided by Type					
Case Management	0	0	0	0	0
Crisis Apartment Service	0	0	0	0	0
Crisis Intervention Services	23	20	11	54	66
ED Based Assessment	0	0	0	0	
Medication Appointments or Emergency Medication Appointments	0	0	0	0	0
Mobile Community Assessments	51	49	57	157	167
Office-Based Urgent Assessments	38	43	42	123	138
Other	0	0	0	0	
Peer Support	0	0	0	0	0
Phone Support/Triage	339	311	309	959	773
Psychotherapy	0	0	0	0	0
Referral Source					
CMHC Internal	22	20	21	63	50
Emergency Department	2	1	1	4	7
Family	14	15	9	38	40

Measure	January 2019	February 2019	March 2019	January - March 2019	October - December 2018
Friend	4	6	5	15	8
Guardian	10	5	10	25	46
MCT Hospitalization	0	0	0	0	0
Mental Health Provider	10	18	12	40	37
Other	1	1	2	4	8
Police	8	6	3	17	13
Primary Care Provider	10	3	2	15	7
Self	200	191	198	589	422
School	6	1	3	10	24
Crisis Apartment					
Apartment Admissions	28	30	27	85	71
Apartment Bed Days	124	121	87	332	273
Apartment Average Length of Stay	4.42	4.03	3.22	3.91	3.41
Law Enforcement Involvement	19	26	34	79	44
Hospital Diversions Total	183	168	171	522	566

Revisions to Prior Period: None

Data Source: Riverbend CMHC submitted report.

Notes: Data Compiled 4/23/2019; reported values other than the Unique People Served in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.

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

Measure	January 2019	February 2019	March 2019	January - March 2019	October - December 2018
Unique People Served in Month	310	273	267	700	587
Services Provided by Type					
Case Management	46	46	40	132	135
Crisis Apartment Service	14	6	6	26	112
Crisis Intervention Service	38	38	37	113	231
ED Based Assessment	0	0	0	0	0
Medication Appointments or Emergency Medication Appointments	0	0	0	0	7
Mobile Community Assessments	102	89	92	283	283
Office-Based Urgent Assessments	21	22	22	65	68
Other	302	277	214	793	823
Peer Support	0	0	0	0	0
Phone Support/Triage	519	499	502	1,520	1,596
Psychotherapy	0	1	0	1	1
Referral Source					
CMHC Internal	8	11	11	30	35
Emergency Department	1	1	0	2	3
Family	45	57	49	151	124

Friend	5	3	10	18	9
Guardian	6	12	7	25	12
MCT Hospitalization	0	0	0	0	0
Mental Health Provider	13	8	12	33	26
Other	43	46	39	128	132
Police	68	51	91	210	235
Primary Care Provider	25	9	17	51	40
Self	154	159	120	433	506
School	0	0	0	0	0
Crisis Apartment					
Apartment Admissions	7	3	3	13	16
Apartment Bed Days	18	9	15	42	73
Apartment Average Length of Stay	2.6	3.0	5.0	3.2	4.6
Law Enforcement Involvement	68	51	91	210	235
Hospital Diversion Total	384	372	364	1,120	1,157

Revisions to Prior Period: None

Data Source: Phoenix 2

Notes: Data Compiled 4/23/2019; reported values other than the Unduplicated People Served in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.

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

Measure	January 2019	February 2019	March 2019	January – March 2019	October - December 2018
Unique People Served in Month	229	237	219	561	462
Services Provided by Type					
Case Management	134	143	128	405	402
Crisis Apartment Service	109	84	75	268	308
Crisis Intervention Services	0	0	0	0	2
ED Based Assessment	17	21	6	44	18
Medication Appointments or Emergency Medication Appointments	1	0	0	1	23
Mobile Community Assessments	152	151	131	434	424
Office-Based Urgent Assessments	7	6	6	19	30
Other	0	0	0	0	1
Peer Support	144	107	89	340	351
Phone Support/Triage	279	249	236	764	677
Psychotherapy	21	12	17	50	4
Referral Source					
CMHC Internal	35	37	28	100	112
Emergency Department	16	8	17	41	0

Family	18	16	16	50	41
Friend	2	2	10	14	17
Guardian	0	1	0	1	0
MCT Hospitalization	1	0	0	1	0
Mental Health Provider	52	22	24	98	68
Other	150	129	114	393	497
Police	4	0	3	7	21
Primary Care Provider	0	2	2	4	0
Self	40	83	95	218	162
Schools	18	13	16	47	40
Crisis Apartment					
Apartment Admissions	16	12	10	38	62
Apartment Bed Days	82	70	70	222	315
Apartment Average Length of Stay	5.13	5.83	7.00	5.84	5.08
Law Enforcement Involvement	4	0	0	4	0
Hospital Diversion Total	405	394	340	1,139	1,025

Revisions to Prior Period: None

Data Source: Harbor Homes submitted data

Notes: Data Compiled 4/23/2019; reported values other than the Unique People Served in Month value are not de-duplicated at the individual person level; individual people can account for multiple instances of service use, hospital diversions, etc.

Appendix A

A1 Housing Bridge Subsidy Program: Applications Previously in Pending Status Removed

156 previously pending applications were removed from the HBSP pending application log as the applications are no longer active due to the individual being deceased, obtaining other housing options through other sources, including on their own, or have moved away or are no longer in any contact with the referring agent

A2 Housing Bridge Subsidy Program Waitlist: Approved Applications Removed from Waitlist

Waitlist Removal Reason	January – March 2019	October - December 2018
Deceased	1	NA
Individual disconnected from services	3	NA
Other permanent housing acquired	3	NA
Referring entity requested removal	8	NA
Total	**15**	**NA**

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

Notes: Data Compiled: 5/17/2019.